OECI peer review report

OECI A&D Programme, Manual 3.2

CONFIDENTIAL

The Christie NHS Foundation Trust

Year of peer review	2025
Dates of peer review	26 and 27 February
Date approval final report	23 July 2025
Approved by	OECI A&D Board

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The OECI

The mission of the Organisation of European Cancer Institutes (OECI) is to serve as a linking organisation, coordinating interdisciplinary cancer treatment and improving the quality of cancer care. This can be achieved by integrating cancer prevention, cancer care, research and development and cancer education.

The A&D programme for OECI members focuses on the key issues for quality comprehensive cancer care, such as: organisation and planning of integrated care, multidisciplinary working, integration and translation of results from research into daily practice, integration of education, patient satisfaction and involvement, and structures for continuous quality improvement.

Audit team

The team auditors who performed the peer review of the cancer centre were:

Chair	Simon Oberst	Director of Quality and Accreditation OECI	Denmark
Auditor	Carmen Jeronimo	Biologist, Professor and Director of the Research Center, IPO Porto, Porto	Portugal
Auditor	Outi Nikunen	Senior Planning Officer / Coordinator, Finnish Cancer Center FICAN (HUS), Helsinki	Finland
Auditor	Hana Blahynkova	Start-up coordinator clinical trials, Masaryk Memorial Cancer Institute, Brno	Czech Republic
Auditor	Joseph Gligorov	Medical Oncology Full Professor at Sorbonne/Head of Breast Cancer Expert Center at APHP Tenon Hospital/Education & International Relation Director at IUC-APHP	APHP Tenon Hospital, Paris
Auditor	Rebecca Amet	OECI Accreditation Coordinator, Mater Private Network, Dublin	Ireland
OECI Co-ordinator	Willien Westerhuis	OECI A&D Coordinator	

The auditors in the team made it possible to provide this peer review report.

Objectives of The Christie

The Trusts objective is to achieve OECI re-accreditation as a comprehensive cancer centre. Progress of our goal and potential recommendations will be reported through and monitored through the projects steering committee. The Trust aims to achieve this by undertaking the designation reaccreditation, self-assessment, peer review and potential recommendations within the recommended time frame outlined by the OECI (user manual V3.2). Re-accreditation aligns with the Trusts values (see 10.1.1 The Christie Vision core graphic) and long-term objectives of how we will continue to deliver our mission – to care, discover and teach.

Our vision of how we will transform cancer treatments, care and support, and improve outcomes for our patients is focused on 4 themes:
1. Leading cancer care
2. The Christie experience
3. Local and specialist care
4. Best outcomes

Completion of the peer review, reporting and improvements is anticipated by end of Q2 2025/26. With monitoring for continuous and quality improvement by way of follow up of an improvement plan one year after certification.

The peer review report: scores and remarks

The report contains the list of the standards and sub-standards. Each sub-standard is scored by the Centre during the self assessment and by the audit team after the peer review visit. To support the scores of the auditors' score auditors formulate a remark for each standard, where applicable. The score is an indicator for the implementation degree of each item of the standard. The scoring system is based on the Plan-Do-Check-Act-circle (Deming-circle). These four stages of implementation are translated into the following possible scores:

Yes: the indicator of the standard has been implemented on a wide scale in the Centre and the Deming-cycle has been completed at least twice (> third cycle),

Mostly: the indicator has been implemented in most of the critical places in the Centre and the Deming-cycle has been completed at least once (> second cycle),

Partially: the indicator has been implemented on project bases or on a modest scale in the Centre or the Deming-cycle has not been completed (Do-Check),

No: the indicator has not yet been considered or there are plans to start working on the indicator (Plan),

Not applicable: the indicator is not applicable in the Centre.

The overview of documents that have been uploaded as evidence can be found in the centre's self-assessment environment the e-tool.

Final accreditation, decision and follow-up

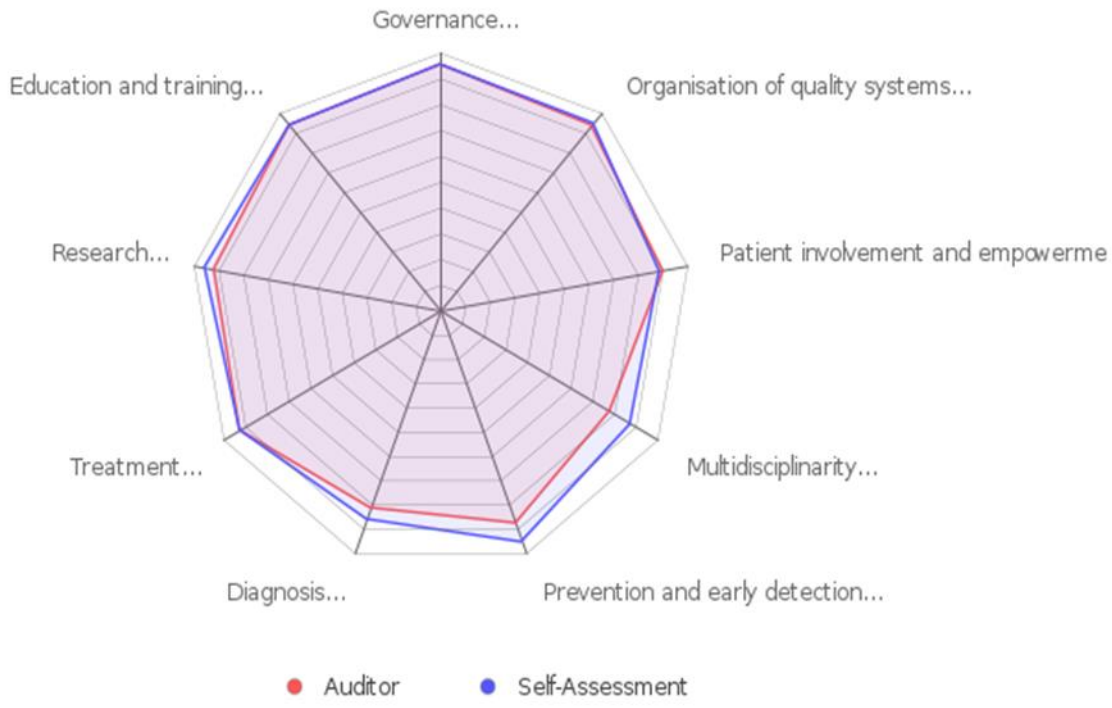
The auditors' review - related to the OECI Quality Standards - described in this report, is a snapshot of the institute. Throughout the complete Accreditation and Designation programme, the institute will develop and improve the quality of care. Therefore, to be eligible for an OECI A&D Certificate, the institute should draw up an Improvement Action Plan based on the peer review results described in this report.

The improvement plan must be sent to the OECI Accreditation Coordinator (Willien Westerhuis, w.westerhuis@iknl.nl) within 8 weeks, after the draft report has been sent. The improvement plan should include a description of how the intends to meet the standards listed in the opportunities for improvement of this report. The centre will be given a manual and template for the improvement plan.

After the Accreditation and Designation Board has approved the final report and improvement plan of your institute, the certificate will be handed over.

Part 1: Findings of the audit team with regard to the OECI quality standards

This part of the peer review report contains the nine chapters of the OECI quality standards. With the input of the peer review visit the audit team has scored the standards as the centre did during the self-assessment period. For each standard the audit team has reviewed, the team provided a general remark considering to what level the centre has met the standard.



1. Governance

§	Yes	%	Mostly	%	Partially	%	No	%	n/a	%	n/v	%	Sum Tot	Check
Chapter 1														
Score audit team	11	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	**11**	100.0
Score centre	11	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	**11**	100.0

Standard 1: Structure of the cancer centre – identifiable entity

Auditors findings
The Christie NHS Foundation Trust is a clearly identifiable entity with clear governance, and accountability for all strategy, in research, care and education in cancer, quality and safety, and with a clear budgetary responsibility. The centre serves a population of 3.2 million people across Greater Manchester and Cheshire. In addition to the main facilities in Manchester, it has 3 network radiotherapy sites: Salford, Oldham and Macclesfield and 14 systemic therapy sites.

The cancer centre has an identifiable governing entity (board of directors / executive committee).

#	Standard	Score	Auditor score
1	CORE The cancer centre has an identifiable governing entity (board of directors / executive committee with accountability for: - Strategic plan for cancer care - Plan for research - Quality and safety - Budget.	Yes	Yes

Standard 2: Structure of the cancer centre - Quality Management

Auditors findings
The Chief Nurse and Executive Director for Quality is the identifiable director with quality and risk management, and is a member of the Executive Board.

The administrative/ board level of the cancer centre includes quality management.

#	Standard	Score	Auditor score
1	CORE There is an identifiable Director who has quality and risk management as his / her responsibility.	Yes	Yes
2	The director who has quality and risk management as his/her responsibility is a member of the board of directors or senior management team of the cancer centre.	Yes	Yes

Standard 3: Strategy and quality cycle of the cancer centre

Auditors findings
A clear and well-written strategic plan for 2023-2028 is accessible to the public. Each division has a multi-year plan aligned with the Trust's overall strategy. The Trust also produces a clear and comprehensive Quality Report with KPIs and survival statistics annually.

A periodical planning and control cycle concerning oncology policy and strategy is present.

#	Standard	Score	Auditor score
1	CORE There is a written strategic plan for the cancer centre which covers at least 3 years, and which is formally endorsed by the board.	Yes	Yes
2	Each main service or department of the centre has an annual or multi-year plan which is consistent with the centre’s overall strategy plan for cancer.	Yes	Yes
3	CORE According to the planning and control cycle the centre produces a (multi-)annual report which results in a quality improvement plan.	Yes	Yes

Standard 4: Financial stewardship

Auditors findings
The multi-annual budget for the Christie NHS Foundation Trust is clear and controlled regarding its care, education and research responsibilities. Regarding the Comprehensive Cancer Centre as a whole, embracing the MCRC and University of Manchester research activities, further remarks and scoring are noted at Standard 71.

The centre has processes for ensuring financial sustainability.

#	Standard	Score	Auditor score
1	The cancer centre defines a multi-annual budget for its activities, which ensures sustainability as far as practicable.	Yes	Yes

Standard 5: Cooperation with universities

Auditors findings
For educational activities, The Christie had partnerships with 10 Universities, which are covered by a national agreement coordinated by NHS England, which replaces local agreements. At a postgraduate level, they partner with NHS England Workforce, Training and Education for the provision of postgraduate medical education. Regarding research, The Christie through the Academic Health Science Centre is part of the Manchester Cancer Research Centre, partnered with Cancer Research UK and The University of Manchester. The Christie is also part of the National Institute for Health and Care Research (NIHR) Biomedical Research Centre and hosts an Experimental Cancer Medicine Centre funded by CRUK and NIHR.

Written cooperation agreements concerning educational and research activities with at least one university are present and periodically evaluated.

#	Standard	Score	Auditor score
1	CORE For training and postgraduate education activities.	Yes	Yes
2	CORE For research activities.	Yes	Yes

Standard 6: Cooperation with external partners

Auditors findings
Service level agreements are in place for all key services not directly provided by the Trust, or provided in partnership. Examples of these include The Christie Pathology Partnership LLP which is an LLP membership agreement between the Trust and Synlab UK limited, provision of PET-CT reporting between The Christie NHS Foundation Trust and Northern Care Alliance (NCA), and provision of Systemic anti-cancer therapy (SACT) services between The Christie NHS Foundation Trust and East Cheshire NHS Trust, Macclesfield District General Hospital. For referral of patients within Greater Manchester, the Trust is part of the Greater Manchester Cancer Network which has an agreed process for inter-provider transfers for 62-day cancer patients.

There are written agreements concerning the allocation of responsibilities and tasks for referrals of patients.

#	Standard	Score	Auditor score
1	CORE There are written agreements or regulations, which are currently implemented, with other hospitals and cancer centres setting out the goals for cooperation, the division of responsibilities and tasks.	Yes	Yes
2	There are written agreements or regulations, which are currently implemented, with special cancer care service providers for all services needed that are not directly provided by the cancer centre (e.g. hospices, rehabilitation services or specialist radiology).	Yes	Yes

2. Organisation of quality systems

§	Yes	%	Mostly	%	Partially	%	No	%	n/a	%	n/v	%	Sum Tot	Check
Chapter 2														
Score audit team	49	94.2	3	5.8	0	0.0	0	0.0	0	0.0	0	0.0	**52**	100.0
Score centre	52	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	**52**	100.0

Standard 7: Integrated quality, risk and safety management

Auditors findings
The centre has a clear and well-structured quality management system that includes risk assessment and safety management for patients, employees and visitors. The trust has separate quality, and risk management policies as well as a Patient Safety Incident Response Plan, Patient Safety Incident Response (PSIRF) policy and Quality Improvement (including clinical audit) policy. More than 30 professionals work in quality management roles, supporting quality development across different units. The centre's system for incident/adverse event registration, analysis, and reporting follows the PSIRF policy, and observations indicate that it has been well implemented across units. Additionally, the local incident management system (DatixCloudIQ) includes a comprehensive dashboard for monitoring and evaluating safety and adverse events. The centre also has document management systems (HIVE for most units, Qpulse for pathology), which are accessible to all professionals.

The cancer centre has a structured policy for quality, risk and safety management.

#	Standard	Score	Auditor score
1	CORE There is a quality management system based upon continuous quality improvement and risk-based thinking and promoted by the line management.	Yes	Yes
2	The quality management system contains risk management (prospective risk assessment and prevention).	Yes	Yes
3	The quality management system contains safety management for patients, employees and visitors.	Yes	Yes
4	There is a Standard Operating Procedure (SOP) for undesirable events. This procedure is well known and accessible to all.	Yes	Yes
5	There are defined processes for reporting, investigating and taking action in response to safety incidents, adverse events and near misses, covering all departments.	Yes	Yes
6	Patients are informed of adverse events which affect them.	Yes	Yes
7	All activities of the cancer centre follow, when applicable, the guidelines of Good Clinical Practice, Good Laboratory Practice and Good Manufacturing Practice.	Yes	Yes
8	The centre has an IT and Data storage and processing system(s) which operates to Health Level 7 (HL7) standards.	Yes	Yes
9	There is a document management system that facilitates the retrieving and the updating of all SOPs.	Yes	Yes
10	CORE There is a dedicated unit or department responsible for the quality system.	Yes	Yes

Standard 8: Quality analysis and improvement

Auditors findings
The Trust has mature dashboards for all areas of the centre that are accessible to all staff and cover key KPIs/KQIs, such as waiting times, survival, and MDT activities. The dashboard is regularly monitored via the IPQFR report at multiple levels. The senior management analyses dashboard data on a monthly basis. The Risk and Quality Governance Committee is chaired by two executives (Medical Director and Chief Nurse) which ensures that risks are reviewed and action plans reviewed and completed. Observations made during interviews, as well as documented evidence provided by the centre (meeting minutes), confirm that deviations are addressed, necessary corrective actions are implemented, and their execution is regularly monitored.

The cancer centre has an integrated quality, risk and safety requirement system.

#	Standard	Score	Auditor score
1	CORE There is a quality, risk and safety dashboard with standardised indicators (including overall survival, patient satisfaction, patient quality of life, MDTs' activities).	Yes	Yes
2	This dashboard is analysed on a regular basis by senior management and acted upon.	Yes	Yes
3	CORE The line management of the centre are responsible for implementing improvements after analysing results of quality and risk and safety factors.	Yes	Yes

Standard 9: Quality reporting

Auditors findings
Information (grades) and reports (Care Quality Commission (CQC)) on accreditations are available on the website.

The centre publishes summary reports or grades from inspections and accreditations.

#	Standard	Score	Auditor score
1	The centre systematically publishes on its website summary information on feedback from external quality inspections and accreditations.	Yes	Yes

Standard 10: Introduction of new practices

Auditors findings
A clear policy for risk management and reporting is in place. There is a clear process for the introduction of new clinical techniques and technologies as evidenced by the policies. Systematic risk assessments are conducted prior to the introduction of any new technology or intervention, in accordance with established procedures. The Clinical Research Effectiveness Committee (CREC) is responsible for monitoring risk and approving applications. The centre has provided examples that support the compliance, demonstrating a structured approach to identifying and mitigating potential risks associated with new technologies and interventions.

There is a standard process for the introduction of new practices.

#	Standard	Score	Auditor score
1	Systematic risk assessment is performed before the introduction of a new technology or a new intervention.	Yes	Yes

Standard 11: Quality assurance

Auditors findings
The quality governance of the Trust is well established. The quality assurance committees report to the Board of Directors and Quality Improvement Plan is monitored through the quality and risk management governance and assurance committee. The centre has a dedicated audit committee with a clearly defined role (terms of reference). This committee shares responsibility with the Quality Assurance Committee and the Workforce Assurance Committee to ensure that the Board of Directors receives assurance that The Christie is properly governed and well-managed across all its activities. The committee maintains the internal audit function that complies with mandatory NHS internal audit standards. Internal audits are planned and conducted regularly, with an audit plan provided in the documentation. Further evidence of the centre's commitment to quality assurance includes ISO certifications (9001; 15189). Infection prevention and control (IPC) is managed by the IPC team operating under the Chief Nurse, who is the Director of Infection prevention and Control. The IPC team (IPCT) is responsible for monitoring and reporting infection rates, as well as identifying and prioritising key areas for implementation.

Quality assurance programmes (QAPs) are in place.

#	Standard	Score	Auditor score
1	Quality assurance programmes are part of the policy for quality and risk management covering all departments.	Yes	Yes
2	There is a QAP for clinical research.	Yes	Yes
3	CORE There is an internal audit system following an annual plan covering all departments.	Yes	Yes
4	There is a programme for infection control.	Yes	Yes
5	Infection rates are monitored.	Yes	Yes
6	Results of the infection control programme are reported and analysed.	Yes	Yes

Standard 12: Cancer data registration

Auditors findings
The centre maintains a registry/dashboard that provides data on diagnosed and treated patients. The dashboard is accessible to all staff. Additionally, it is actively working to improve the reporting and utilisation of clinical outcome data / treatment trends with the support of the Clinical Outcomes & Data Unit (CODU). Data is submitted to the Cancer outcomes and services data set (COSD) monthly in accordance with UKHSA specifications. Further efforts are suggested to enhance the analysis of outcomes across the entire patient pathway. This work is already partially integrated into regional Pathway Boards, which aim to improve the patient pathway, experience, and outcomes.

Cancer patient data are used for developing strategic planning and quality improvement of care processes.

#	Standard	Score	Auditor score
1	CORE The number of new patients, newly diagnosed patients and treated patients by tumour type in the cancer centre are available annually at the cancer centre level.	Yes	Yes
2	The diagnostic trends of cancer patients by tumour type / stage are known at an institutional level and reported annually to the board of the cancer centre for future planning.	Yes	Mostly
3	The centre reports all new cancer patients to the regional of national cancer registry.	Yes	Yes
4	The treatment trends of cancer patients by tumour type are known at the cancer centre level and MDT level and reported annually to the board for future planning.	Yes	Mostly
5	CORE The outcome data of cancer patients by tumour type are known at the cancer centre level and MDT level and are used by management for strategic planning / or policy decisions.	Yes	Mostly

Standard 13: Waiting and throughput times

Auditors findings
There are standard national guidelines for waiting times, which are actively monitored, and any delays are addressed, as evidenced by the 62-day improvement plan. Performance is reported regularly (weekly and monthly) to senior and executive management, as well as externally to NHS England via the Cancer Waiting Times database. These waiting times are monitored by patient 'trackers' and delays are actioned as evidenced by the '62 day improvement plan'.

For critical stages in the care process the maximum waiting times are defined.

#	Standard	Score	Auditor score
1	There are standards for the maximum waiting times between referral and first visit to outpatients’ clinic or admission to the cancer centre.	Yes	Yes
2	There are standards for the maximum waiting time between first visit and the time of definitive diagnosis.	Yes	Yes

3	There are standards for the maximum waiting times between definitive diagnosis and first treatment.	Yes	Yes
4	There is a record and continuous monitoring of the actual waiting times against the standards.	Yes	Yes
5	CORE If maximum waiting times are exceeded improvement actions are defined promptly.	Yes	Yes

Standard 14: Complications registry

Auditors findings
The PSIRF policy defines procedures for registering, analysing, and reporting complications and Serious Adverse Events. Incident management is overseen by the Divisional Patient Safety Improvement Groups (DPSIG), which ensure a multidisciplinary approach to incident response and improvement. Regular patient safety priority workstream meetings facilitate data review, learning response evaluation, and monitoring of safety improvement plans.

The board of the cancer centre gets standardised reports on complications and Serious Adverse Events at regular intervals for future evaluations.

#	Standard	Score	Auditor score
1	CORE The cancer centre has a comprehensive system for reporting, registration and assessing complications and Serious Adverse Events.	Yes	Yes
2	The global report of complications registry data is reported to the medical management at least annually.	Yes	Yes
3	Improvement actions are developed and implemented in agreement with all departments and disciplines concerned.	Yes	Yes
4	The effect of improvement actions is measured and reported at least annually.	Yes	Yes

Standard 15: Technical quality of medical equipment

Auditors findings
The medical devices policy and management of medical devices document outline the Trust's systematic approach to purchasing, implementation, maintenance calibration, repair and disposal of devices. A structured maintenance programme is in place, ensuring regular calibrations and safety checks, are all recorded within the centrally managed eQuip system. The Clinical Technical Support Group (CTSG) oversees compliance with medical device regulations. Only trained and competent personnel are authorised to handle specialised technical equipment, with mandatory training recorded and maintained.

Medical equipment is safe, efficient and accurate.

#	Standard	Score	Auditor score
1	There is a maintenance programme for medical equipment, including calibrations and safety checks.	Yes	Yes

2	Safety checks and calibrations are carried out as scheduled.	Yes	Yes
3	Medical devices used for diagnosis are periodically certified by an authorised authority.	Yes	Yes
4	The centre has processes to ensure that only trained and competent personnel handle specialised technical equipment (including new equipment).	Yes	Yes

Standard 16: HRM – staffing

Auditors findings
The Trust has a Good Rostering Policy. The Trust uses Healthroster to ensure safe working conditions for clinical professions. A bi-annual audit using the Safer Nursing Care Tool is also utilised to ensure the correct and safe levels of nursing. Additionally, the Trust follows the National Quality Board expectations for nursing and care staff. The Trust has a Workforce assurance committee that monitors staffing. The Trust appeared to be well staffed with 'pinch-points' in areas such as radiography, haemato-oncologists and pharmacists, reflective of national shortages. Overall, staffing was observed to be adequate, and staff well-being was well supported.

Staffing levels are planned.

#	Standard	Score	Auditor score
1	Staffing levels of key disciplines are planned in all clinical departments so as to ensure safety and high quality care and by reference to the guidelines or standards of professional societies or regulators, where applicable.	Yes	Yes

Standard 17: HRM – appraisal policy and support system

Auditors findings
The centre has well-established appraisal policies and a support system for all staff groups, including physicians, nurses, and allied health professionals. Annual appraisals are mandatory and governed by the Trust’s Appraisal and Revalidation of Medical Staff Policy for medical staff and the Personal Development Review (PDR) Policy for all other employees. Additionally, dedicated monthly educational time effectively supports individual training and development needs. Mandatory training is recorded and monitored.

The centre has a comprehensive appraisal policy and support system for its staff.

#	Standard	Score	Auditor score
1	CORE Regular appraisal of all staff (medical, nursing, supportive disciplines, technicians, administrative) is part of the human resources management of the cancer centre.	Yes	Yes
2	Appraisal is done at defined intervals (preferably annually).	Yes	Yes
3	The results of appraisal are documented and used for individual training needs.	Yes	Yes
4	Every member of staff has a training record	Yes	Yes
5	The centre ensures that all employees hold current appropriate practicing certificates.	Yes	Yes
6	Mental health support programmes are available to all employees.	Yes	Yes

Standard 18: Privacy, protection of, and access to personal data

Auditors findings
The Trust's data protection policy is in place, with annual assessments conducted through the NHSE Data Security Protection Toolkit (DSPT). There are Data Protection policies and a Data Protection Officer. There is a medical records policy with information on how patients can access their own medical record, relevant information is available on the Trust's website. The Trust Privacy Notice also acts as the patient charter and it is reviewed by the Caldicott Panel. There is a policy on informed consent for clinical treatment and research.

Written procedures regarding privacy and protection of, and access to personal data are present.

#	Standard	Score	Auditor score
1	CORE Personal data protection is guaranteed for patients according to the General Data Protection EU Regulation (GDPR) 2016/679.	Yes	Yes
2	There is an institutional data protection officer.	Yes	Yes
3	There is a policy on access for patients to their own patient record.	Yes	Yes
4	The centre has a policy for sharing a patient health record with other health care providers for the benefits of that patient and in accordance with the privacy regulations.	Yes	Yes
5	There is a patient charter that is periodically evaluated and renewed.	Yes	Yes
6	CORE There are policies on informed consent for diagnostics, treatment and research, that meet national laws and regulations.	Yes	Yes

3. Patient involvement and empowerment

§	Yes	%	Mostly	%	Partially	%	No	%	n/a	%	n/v	%	Sum Tot	Check
Chapter 3														
Score audit team	31	81.6	6	15.8	1	2.6	0	0.0	0	0.0	0	0.0	**38**	100.0
Score centre	30	78.9	6	15.8	2	5.3	0	0.0	0	0.0	0	0.0	**38**	100.0

Standard 19: Patient involvement

Auditors findings
The Patient Experience and Engagement Plan is led by the Executive Chief Nurse, the Director of Quality and involves staff, patients and caregivers. The plan is intended to cover Experience and Engagement at all Christie sites and for all patient groups. Evidence of participation in the Patient Led Assessments of the care environment inspections was uploaded. The patient experience committee holds monthly member group meetings. Patients are not represented on the clinical and research effectiveness committee. It was noted during the peer review that patient representatives are not involved in the standard process of introducing new practices or new research activities.

It is the mission of the centre to encourage patient involvement in services.

#	Standard	Score	Auditor score
1	CORE The cancer centre involves patients and patient's voluntary organisations and support groups in the planning and organisation of services.	Yes	Yes
2	The standard process of introducing new practices in clinical care ensures that patients are involved.	Partially	Partially
3	There is a committee representing patients and serving as a link between the cancer centre and the patients for advice and consultation.	Yes	Yes

Standard 20: Patient education programmes

Auditors findings
Patient education is well-organised, although an overarching policy is lacking. All patients, regardless of their treatment have access to a wide range of educational resources, including one to one consultations, printed materials, group sessions and support through the Maggie's centre. Education programmes are available through the patient information centre and through the organisation's website, and the audit team has been provided evidence of patient education examples such as for surgical procedures in gynae oncology or robotic-assisted laparoscopic prostatectomy. Patient education sessions are provided for certain chemotherapy regimens, based on clinical need and relevance. Staff have an accessible communication policy and SOP with information to help and support patients that have a disability, impairment of sensory loss. Information is available for patients, family members and caregivers. There is a long history with engagement with the public through open days, conferences and public events.

Patient education programmes are in place.

#	Standard	Score	Auditor score
1	There are policies in place for patient education programmes where responsibilities and accountabilities of the staff are stated.	Partially	Mostly
2	CORE There are patient education programmes that aim at improving patient understanding of their illness, diagnosis, including information on self-care and how to manage multiple aspects of their illness or survivorship.	Mostly	Yes
3	The centre makes specific provisions for access for individuals with disabilities and special needs (e.g. reduced mobility, visual and hearing difficulties).	Mostly	Mostly
4	CORE An information and support centre is available in the cancer centre and easily accessible for staff, patients, family members and care givers.	Yes	Yes
5	The centre organises public events to showcase advances in cancer research.	Mostly	Mostly

Standard 21: Patients' rights and preferences

Auditors findings
The policy and SOP for respecting patients' preferences are in place and help support staff and patients with communication needs. The Equality Diversity team publishes an annual EDI calendar with important dates and events for the various populations. During the Peer Review, chapels and spiritual care services for all faith groups were found in the hospital. The collaboration with Maggie's centre is well organised. A support group for Muslim cancer patients is in development.

The centre has a policy on patients' preferences.

#	Standard	Score	Auditor score
1	The centre has a policy on respecting patients' preferences (religious, cultural, social).	Mostly	Mostly

Standard 22: Patient information

Auditors findings
The organisation offers a wide range of information on different aspects of cancer treatment. Information on cancer treatment is well organised through patient booklets and collaboration with Maggie's Centre. Maggie's provides group or personal training sessions for different groups of patients. Feedback is collected through a patient experience survey. Information on clinical trials is available through the Cancer Research UK website, where it is possible to select the location of Manchester. Patient feedback is collected through the National Institute of Health and Care Research. The cancer information centres and the Trust's website both have information available relating to supportive care.

Information is provided to patients.

#	Standard	Score	Auditor score
1	CORE The cancer centre provides information material that is readable, up-to-date, appropriate and available in languages commonly spoken by the population served.	Yes	Yes
2	Information about possible diagnostic and treatment options is provided.	Yes	Yes
3	The information includes information about follow-up after treatment.	Yes	Yes
4	The information includes information about clinical trials available.	Yes	Yes
5	The information includes information about supportive care	Yes	Yes
6	The information includes information about palliative care	Yes	Yes
7	Information on relevant patients' rights is provided to patients, and their caregivers.	Yes	Yes

Standard 23: Informing patients about their care

Auditors findings
Patients are informed about diagnostic results, treatment options and follow-up through a system of shared decision-making. A wide range of training is available to staff on communication with patients. The main role is played by the Clinical Nurse Specialist and the Maggie's Centre. Patients receive contact information cards; this information is also available in disease/treatment-specific information booklets. Patients treated by the Trust receive information on the 24-hour hotline for advice, for example if someone feels unwell. This 24-hour hotline service is available to all patients and they can also use it for admission to the acute assessment unit for the management of side effects after drug treatment without hospitalisation. Information about the patient's next visit is disseminated through a 'paper letter'. Staff have indicated, patients would appreciate a 'text message' via mobile phones.

There are procedures for informing patients about the diagnostic results, treatment and follow-up, and survivorship support.

#	Standard	Score	Auditor score
1	CORE There are procedures in place which specify how and by whom patients are informed about their diagnostic results, treatment options, follow-up, and survivorship support, which involve shared decision-making.	Yes	Yes
2	Expertise and specific training on communicating with patients and their families is available for staff.	Yes	Yes
3	The information communicated to the patient is recorded in the patient's record.	Yes	Yes
4	If patients are referred to another healthcare provider, they are informed about the continuity of their care	Yes	Yes
5	Patients receive information about their contact person for all matters related to their care.	Yes	Yes
6	CORE All patients are given contact information of clinical staff in case of emergency.	Yes	Yes

Standard 24: Informing patients on admission

Auditors findings
Patients receive an initial letter regarding their first appointment at The Christie. General information is available on the Trust's website. Information about the admission procedure is communicated to the patient by the specialist team and letters are sent to the patient prior to admission. Information about patient associations and self-help and support groups is provided by their CNS or through cancer information centres, all of which refer to external charities and support groups.

Cancer patients are informed about the cancer centre admission and welcoming procedures.

#	Standard	Score	Auditor score
1	All patients visiting the cancer centre receive general information about the hospital.	Yes	Yes
2	Detailed information about the admission procedure is available and communicated to patients.	Yes	Yes
3	Information about patients' associations and about self-help and support groups is given to patients and their caregivers.	Yes	Yes

Standard 25: Discharge procedure, follow-up and survivorship care planning

Auditors findings
The discharge process is via the intranet HIVE (titled Discharge documents for ward staff) so that staff have access to all documents needed to support and guide the discharge process. Clinical letters are sent electronically to the patient's GP on discharge from a clinical episode. The entire discharge process is done through the discharge team, which also provides treatment summaries for some disease groups. The end-of-life care plan is maintained in the electronic medical record and can be shared with patients and their relatives. Collaboration with the discharge team was double-checked during the peer review and all departments highly valued the work of this team.

A discharge procedure and related care plans are defined.

#	Standard	Score	Auditor score
1	CORE There is a defined discharge procedure including giving information on further treatment, follow-up, re-admission and home care.	Yes	Yes
2	The centre has processes to inform the patient's general practitioner of a transfer of care.	Yes	Yes
3	The patient is provided with an individual survivorship plan which is discussed with the patient and includes details of all support services and support groups available.	Mostly	Mostly
4	The patient is provided with an individual plan for end of life care, which is discussed with the patient and care givers.	Yes	Yes

Standard 26: Patient satisfaction / experience

Auditors findings
The Trust uses various tools to collect feedback from patients, including Friends and Family surveys, PLACE inspections, etc. The satisfaction surveys are analysed, reported and provided with action plans. The centre uses electronic Patient Reported Outcome Measures (ePROMs) for most clinical teams. Patient experience is monitored through the National Cancer Patient Experience Survey.

Patients' experience of cancer care is an integrated part of the quality improvement system of the centre.

#	Standard	Score	Auditor score
1	CORE The cancer centre has methods to regularly gather patients' experiences during outpatient and inpatient care.	Yes	Yes
2	CORE Satisfaction surveys are analysed, reported and acted upon through the line management of the centre.	Yes	Yes
3	The centre uses questionnaires to ascertain the perceptions of the patient's health status, level of impairment, disability and health-related quality of life (e.g. Patient-Reported Outcome Measures (PROM)).	Mostly	Mostly
4	The centre uses questionnaires to assess the impact of the process of care on the patient's experience, e.g. communication and timelines of assistance (e.g. Patient-Reported Experience Measures (PREM)).	Yes	Yes

Standard 27: System for receiving and managing complaints

Auditors findings
The complaints procedure is described in the Complaints and Concerns Policy. The complaints department is headed by the Patient Experience and Improvement Lead. Detailed information is available through the information centre and on the website. Complaints and claims are recorded electronically in the DatixCloudIQ system. The complaints department publishes a monthly information bulletin that is distributed across the Trust.

The cancer centre has a complaints procedure.

#	Standard	Score	Auditor score
1	The cancer centre has a defined complaints procedure.	Yes	Yes
2	CORE The cancer centre has a clearly identified complaints officer or a complaints office.	Yes	Yes
3	The actions undertaken by the complaints officer are recorded in a file that is used to produce an annual report.	Yes	Yes
4	The complaints office gives feedback on his / her findings to any member of staff who is the subject of a complaint.	Yes	Yes

Standard 28: Collaboration with patient organisations

Auditors findings
The Trust works with a wide range of patient organisations and charities. The Trust also participates in local and regional initiatives to support cancer education within populations across Greater Manchester. The Trust has a monthly membership group which includes patients and members of the public and meets to discuss developments within the Trust.

The centre collaborates with patient organisations.

#	Standard	Score	Auditor score
1	The cancer centre identifies and co-operates with existing patient organisations.	Yes	Yes

4. Multidisciplinarity

§	Yes	%	Mostly	%	Partially	%	No	%	n/a	%	n/v	%	Sum Tot	Check
Chapter 4														
Score audit team	16	57.1	4	14.3	8	28.6	0	0.0	0	0.0	0	0.0	**28**	100.0
Score centre	22	78.6	3	10.7	3	10.7	0	0.0	0	0.0	0	0.0	**28**	100.0

Standard 29: Patient pathways

Auditors findings
The Trust feeds into the Greater Manchester (GM) Pathway Boards. Not all pathways are present and/or clear. There is inconsistency between the documents available for each cancer type and pathway. The Haematology pathways are a good example of a defined pathway. The functions of the different disciplines are mostly clear depending on the treatment modalities for cancer specific guidelines available via GM pathway boards e.g. breast and colorectal. Supportive and palliative care are not always clearly described in written pathways.

Patient pathways are defined for all tumours and sub-types treated in the centre, which chart the process from patient admission up to the end of follow-up of care.

#	Standard	Score	Auditor score
1	CORE There is a written patient pathway for each tumour (sub)type treated in the centre, except for very rare cancers.	Yes	Partially
2	The functions of the different disciplines involved in the diagnosis, treatment and follow-up of the patient are defined and described in the patient pathways.	Yes	Mostly
3	Supportive and palliative care is specifically included in the patient pathways.	Yes	Partially

Standard 30: Patient pathways: co-ordination of patients on the pathway

Auditors findings
Patients experience continuity of care as they have a consultant that is responsible for their care from referral to discharge as evidenced in breast oncology guidelines. The Clinical Nurse Specialists for each cancer type also support patients. Contact between disciplines is managed via the electronic patient record and that disease group meeting. Communication with GPs is done electronically and by post.

Patients have co-ordination to ensure their continuity of care on the pathway.

#	Standard	Score	Auditor score
1	CORE For every patient there is an identified co-ordinator or manager (or written process for case management) of their pathway from admission until end of follow-up, including the implementation of MDT recommendations.	Yes	Yes
2	There are routines in place for referral and feedback amongst nursing, palliative care and supportive disciplines.	Yes	Yes
3	There are procedures in place for informing the patients' General Practitioner about key recommendations, decisions and diagnostic and treatment results in a timely manner.	Yes	Yes

Standard 31: Implementation of guidelines

Auditors findings
While the auditors observed significant variability in the guidelines referenced by different MDTs, it is agreed on which clinical guidelines are used across MDTs (including local, national, and international guidelines - such as ESMO and NICE). However, the management of the local guidelines within regional Pathway boards appears inconsistent. Auditors identified outdated guidelines that had not been revised for several years (GI/Gynaecology), indicating a lack of systematic updating mechanisms for local guidelines. This also impacts the familiarity of new clinical staff with relevant guidelines. Changes in practice are reviewed and accepted by the GM pathway boards. Certain cancers such as NETs have their own Christie guidelines. Christie led MDTs have annual reviews and look at possible deviations. Deviations are recorded in the patient record, although not structurally evaluated.

For each type of cancer, consensus has been reached among the disciplines involved about the clinical guidelines used for diagnosis, treatment and follow-up.

#	Standard	Score	Auditor score
1	CORE It is formally agreed which clinical guidelines (institutional/local/regional/national/international) are used for diagnostics, treatment and follow-up.	Yes	Yes
2	The guidelines are easily accessible in written and/or digital form.	Yes	Yes
3	The guidelines are updated on a regular basis (at least every year) according to new evidence and evaluation of processes and outcomes.	Yes	Partially
4	It is defined who is responsible for updating and authorising the guidelines.	Yes	Yes
5	All new clinical staff are made familiar with the guidelines relevant to their work.	Partially	Partially
6	There is a policy that each decision that differs from the guidelines is recorded in the patient's record.	Mostly	Mostly
7	An evaluation of deviations from the guidelines is made by the MDT at regular intervals (at least once a year).	Partially	Partially

Standard 32: Electronic patient record

Auditors findings
There is an electronic health record, Christie Web Portal that is accessible by all clinical staff. There are some areas that need to be digitised but this is in the process of being implemented (March 2025).

There are electronic patient records to ensure the safety, timelines and continuity of care.

#	Standard	Score	Auditor score
1	CORE Each patient has an Electronic Patient Record which enables all relevant disciplines along the patient pathway to access the full information concerning the patient.	Yes	Mostly

Standard 33: Process of multidisciplinary team meetings

Auditors findings
Christie led MDTs follow a standard SOP which outlines mandated attendance. As the Christie is not a diagnostic centre, most patients are already discussed before referral to the Christie. Clinical trial opportunities are discussed and highlighted as evidenced by the Haematology SOP. Supportive care disciplines was present via an advanced cancer nurse who - in case of need- refer to the supportive care department.

The centre has MDT groups covering every tumour type which follow a Standard Operating Procedure (SOP).

#	Standard	Score	Auditor score
1	CORE An SOP exists for every MDT which specifies core and extended attendance from all relevant diagnostic and therapeutic disciplines, including oncology nursing and supportive care.	Yes	Yes
2	CORE SOPs state for each MDT whether all patients are fully discussed or listed on the agenda according to standard patient pathways following definitive diagnosis.	Yes	Yes
3	All patients are listed for an MDT discussion when newly managed in the centre and before any complex decision in the management of the patient (for instance regarding metastasis).	Mostly	Mostly
4	There is a defined procedure to inform the members of the MDT with sufficient notice which patients will be discussed.	Yes	Yes
5	The inclusion of patients in clinical trials is a structured aspect of the MDT meeting.	Yes	Yes
6	The MDT meetings take place in a room with facilities to show the relevant results of the examinations (imaging, pathology).	Yes	Yes

Standard 34: Multidisciplinary team meetings

Auditors findings
MDT outcomes are recorded live into the patient record. The discussion of outcome with the patient is also recorded in the patient record. The MDT coordinator was unable to write all information during the discussion and the result of MDT not visible for the rest of the team. The audit team saw that the live reporting on the screen was different than what was discussed. There was no clear validation process for the conclusion.

Information, dissemination and access to expertise in the MDT

#	Standard	Score	Auditor score
1	The medical record of the patient is available during the MDT meeting.	Yes	Yes
2	The conclusions and recommendation resulting from the MDT meeting are documented in the medical record of the patient.	Yes	Partially
3	The conclusions and advice resulting from the MDT meeting are accessible for all physicians and other disciplines involved in the care, in the medical record of the patient at most 24 hours later.	Yes	Yes
4	According to a defined procedure the conclusions and recommendations resulting from the MDT are communicated to the patient for shared decision-making, in which the patient has the right to consent to or refuse a particular treatment.	Yes	Yes
5	Access to and information from the molecular tumour board should be made available in the MDT when relevant.	Yes	Yes

Standard 35: MDT review

Auditors findings
As evidenced during the MDT leaders' meeting, Christie MDTs have an annual group business meeting. Some MDTs such as NETs meet twice a year. Regional patient pathways are not regularly updated.

Multi-disciplinary team (MDT) review

#	Standard	Score	Auditor score
1	CORE Every MDT meets at least twice a year in a learning event to review outcomes, quality of procedures, patient pathways and indicators, for quality improvement.	Partially	Partially
2	Patient pathways are updated regularly, based upon the review.	Yes	Partially

Standard 36: Rare cancers

Auditors findings
The Christie is a reference centre. The Christie offers a sarcoma service which is part of the Greater Manchester and Oswestry Sarcoma service. It is one of the centres for soft tissue and bone sarcoma. The Christie are accredited by European Neuroendocrine Tumour Society (ENETS).

Management of rare cancers.

#	Standard	Score	Auditor score
1	Procedures are in place to consult or to refer patients with rare cancers to a designated reference centre or a European Reference Network.	Mostly	Yes

5. Prevention and early detection

§	Yes	%	Mostly	%	Partially	%	No	%	n/a	%	n/v	%	Sum Tot	Check
Chapter 5														
Score audit team	12	92.3	0	0.0	0	0.0	0	0.0	1	7.7	0	0.0	**13**	100.0
Score centre	13	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	**13**	100.0

Standard 37: Screening and early detection

Auditors findings
The Christie does not take part in screening programmes such as for breast or bowel. The Christie hosts the Greater Manchester Cancer Alliance with a specific remit to participate in national early diagnosis and primary care programmes. The centre is active on early detection screening programmes which are more research focussed, e.g. screening trials, risk predication and earlier detection with ctDNA. An example of an early detection screening test is NHS Galleri. The results of this study are being used for a sub-study with GMCA, which is advising new EDx technology and innovation in cancer alliances. Early detection programmes and early detection research are carried out by the Manchester Biomedical Research Centre, in which Cancer Prevention and Early Detection is one of seven funded research themes.

Involvement in screening and early detection.

#	Standard	Score	Auditor score
1	The cancer centre participates in regional or national screening programmes.	Yes	N.a.
2	The cancer centre participates in specific early detection programmes.	Yes	Yes
3	The cancer centre participates in research into early detection, risk stratification and/or screening.	Yes	Yes

Standard 38: Oncogenetic service

Auditors findings
An oncogenetic service is available through the NHS Greater Manchester Cancer Alliance Pathway Boards. Referral guidelines are managed by the cancer pathway boards. Psychological support is offered by the regional clinical genetics teams.

Access to an oncogenetic clinic is available.

#	Standard	Score	Auditor score
1	CORE An oncogenetic clinic is available and accessible to all appropriate patients.	Yes	Yes
2	Guidelines for referral to oncogenetic services are available.	Yes	Yes
3	Recommendations for individuals at increased risk are based on guidelines.	Yes	Yes
4	Psychological support is offered in the oncogenetic service.	Yes	Yes

Standard 39: Cancer risk reducing strategies in the cancer centre

Auditors findings
Strategies to reduce cancer risk are available on patient leaflets through the cancer information centre, through the CNS or through the website. The centre is also widely active on TV, in the news, in local media, through social media and in collaboration with families. The smoking cessation policy describes the processes to ensure a smoke- and nicotine-vapour-free environment for patients and staff. The service is accessible to both staff and patients, with participants being followed up for one year and success rates monitored. The Christie is a smoke-free site with no-smoking and vaping signs in public areas in the Trust, such as gardens and entrances. Alcohol counselling is provided. Several training programmes are organised for patients and their families.

Cancer risk reducing strategies in the cancer centre.

#	Standard	Score	Auditor score
1	CORE Information is available throughout the cancer centre on overall healthy living in the fields of diet, smoking, alcohol, exercise, spotting signs and symptoms.	Yes	Yes
2	CORE There is a non-smoking policy in the cancer centre.	Yes	Yes
3	All public parts of the cancer centre are clearly designated smoke-free areas.	Yes	Yes
4	CORE Support is provided to patients to quit smoking.	Yes	Yes
5	Access to services is offered to patients to reduce alcohol intake where appropriate.	Yes	Yes
6	Support is provided to employees to quit smoking.	Yes	Yes

6. Diagnosis

§	Yes	%	Mostly	%	Partially	%	No	%	n/a	%	n/v	%	Sum Tot	Check
Chapter 6														
Score audit team	24	66.7	7	19.4	3	8.3	0	0.0	2	5.6	0	0.0	**36**	100.0
Score centre	28	77.8	6	16.7	0	0.0	0	0.0	2	5.6	0	0.0	**36**	100.0

Standard 40: Radiology

Auditors findings
Weekly and monthly rotas ensure there are sufficient staff to cover each area, shift and modality. Turnover and recruitment of experienced MR radiographers has prevented the centre's 4th MR scanner operating consistently to full capacity. Interviews with researchers suggest that there are sufficient slots for patients enrolled in clinical trials. Turnaround times are typically achieved despite staff shortages as evidenced by reporting performance document. The unit has SOPs available for most modalities via HIVE. SOPs are reviewed every 3 years. Monitoring of activity and equipment is well documented via the monthly Radiology Quality and Governance meeting. Radiologists' written reports are typically available to attending physicians within 48 hours of the examination or sooner in emergency cases. With the exception of a single static x-ray machine (commissioned in 2014), all equipment in clinical use is no older than 10 years, and all part of an ongoing planned capital replacement programme.

The radiology department is sufficiently staffed, resourced and effectively managed.

#	Standard	Score	Auditor score
1	CORE Staffing levels of key disciplines are planned so as to ensure safety, accuracy and high quality care.	Mostly	Partially
2	The unit has up-to-date Standard Operating Procedures which describe the imaging methods and are reviewed at least once a year.	Mostly	Mostly
3	CORE The radiologist's written report is available to the attending doctors at the latest 72 hours after the examination.	Mostly	Mostly
4	There is a record of waiting times for radiology, measured from the time of notification by the physician to the performing of the radiological examination.	Yes	Yes
5	The department holds learning events for quality improvement at least twice per year.	Yes	Yes
6	Clinical audits are carried out in accordance with national procedures.	Mostly	Mostly
7	All images (mammograms, ultrasound documentation, MRI) are stored in a digital format.	Yes	Yes
8	Equipment is no older than ten years.	Yes	Mostly
9	CORE Quality control of all equipment used for imaging is routinely performed, according to the relevant national protocols and/or European guidelines.	Yes	Yes

Standard 41: Nuclear medicine

Auditors findings
Nuclear medicine has policies and well-established procedures for the maintenance, safety monitoring and calibration of medical equipment. Staff are well aware of the SOPs and training records are well maintained and monitored. Nuclear medicine has robust quality assurance processes overseen by medical physicists. Equipment quality assurance is monitored through a dashboard. There appears to be limited capacity for PET CT based on the population served. The agreed leadership model for nuclear medicine is a triumvirate of senior medical, physics and operational leaders rather than a single director.

The nuclear medicine department is sufficiently staffed, resourced and effectively managed.

#	Standard	Score	Auditor score
1	CORE Staffing levels of key disciplines are planned so as to ensure safety, accuracy and high quality care.	Yes	Mostly
2	The unit has up-to-date Standard Operating Procedures which describe the imaging methods and are checked at least once a year.	Mostly	Mostly
3	CORE The nuclear medicine specialist's written report is available to the attending doctors at the latest 72 hours after the examination.	Yes	Yes
4	There is a record of waiting times for nuclear medicine, measured from the time of notification by the physician to the performing of the examination.	Yes	Yes
5	The department holds learning events for quality improvement at least twice per year.	Yes	Yes
6	Clinical audits are carried out in accordance with national procedures as required by EU COUNCIL DIRECTIVE 2013/59/EURATOM.	Yes	Yes
7	All images are stored in a digital format.	Yes	Yes
8	Equipment is no older than ten years.	Yes	Yes
9	CORE Quality control of all equipment used for imaging is routinely performed, according to the relevant national protocols and/or European guidelines.	Yes	Yes

Standard 42: Logistics of scheduling diagnostic examinations

Auditors findings
There is a well-defined policy / SOP for scheduling diagnostic tests, including reserving time for urgent cases and diagnostic procedures essential for cancer diagnosis and staging before the start of oncological treatment. Staff are aware of this policy and act accordingly.

Agreements have been reached about scheduling appointments and giving priority to urgent examinations (CT, MRI, mammography).

#	Standard	Score	Auditor score
1	There is a policy for scheduling diagnostic examinations.	Yes	Yes
2	Arrangements are in place about giving priority to urgent examinations (CT, MRI, mammography).	Yes	Yes
3	There is a Standard Operating Procedure for keeping appointment slots available for emergencies.	Yes	Yes

Standard 43: Molecular diagnostics

Auditors findings
Genetic testing takes place through the national genomic testing service with hubs across the country. Molecular testing for Christie patients takes place at the North West Genomics Laboratory hub led by Manchester Foundation Trust (MFT). The Christie hosts a regular Molecular Tumour Board to advise on the most complex molecular cases.

Arrangements are in place for molecular diagnostics.

#	Standard	Score	Auditor score
1	CORE The cancer centre has a molecular diagnostics programme for the use of all tumour sub-types where clinically validated.	Yes	Yes
2	The pathology laboratory/institute has specialists and equipment for molecular pathology for those tumour sub-types for which clinically validated tests are approved.	Yes	N.a.
3	The molecular diagnostics laboratory works to Good Clinical Practice and Good Laboratory Practice standards.	Yes	N.a.
4	The centre has a formal link with a molecular tumour board to support therapeutic decisions.	Yes	Yes

Standard 44: Pathology

Auditors findings
There are policies and SOPs for sample processing, analysis and storage, which are regularly updated and managed through Qpulse, a quality management system. Although the department's space is limited, it is well-equipped with well-maintained equipment and the medical and technical staff seems adequate based on current institutional needs and best practice guidelines. Digitisation is still in progress. The Pathology Department operates as a joint venture with SYLAB and processes about 11,000 slides annually, including specimen samples. The department is accredited under ISO 15189 and actively participates in interlaboratory quality assurance programmes. Besides clinical functions, the department is closely involved in research, leading the biobank and contributing to several research projects.

The pathology laboratory / institute is sufficiently staffed, resourced and effectively managed.

#	Standard	Score	Auditor score
1	The pathology laboratory/institute processes at least 10,000 histologies/year.	Yes	Yes
2	CORE The pathology laboratory/institute has sufficient Board-certified pathologists available to fulfil the requirements of each specialty served by an MDT in the centre.	Yes	Yes
3	A sufficient number of qualified medical technical assistants/technical assistants are on regular duty according the Good Clinical/Laboratory Practice and European/National guidelines.	Yes	Yes
4	CORE The laboratory has Standard Operating Procedures covering the collection, pre-analytical and analytical phases, reporting and storage of specimens of all kinds which follow international standards.	Yes	Yes
5	The laboratory has a recognised quality management (QM) system.	Yes	Yes
6	The laboratory participates regularly in quality assurance inter laboratory tests.	Yes	Yes

Standard 45: Pathology reporting

Auditors findings
There is no recorded data on the turnaround time of intraoperative frozen section reports, which may be due to logistical issues (the samples must be transported from the operating theatres to the pathology facilities). Pathology reports follow the guidelines of the Royal College of Pathologists (RCPath) and guarantee the use of internationally recognised and up-to-date tumour classification systems and thorough documentation of lymph node status and resection margins. Pathology reports are structured and the updated WHO classification of tumours is applied. Routine reporting is within 5 days, but reporting time for more complex cases is more than 5 days. IHC is routinely performed by the laboratory within 24 hours of receiving the request.

Arrangements are in place for pathology reporting.

#	Standard	Score	Auditor score
1	For frozen sections for intra-operative reports the actual time from arrival in pathology to communication of the result is recorded (guidance value maximum 30 minutes).	N.a.	Partially
2	Standardised pathologists' reports include lymph nodes and resection margins specification, according to guidelines.	Mostly	Mostly
3	Pathologists' reports contain histological type according validated international classifications.	Yes	Yes
4	CORE Pathologists' reports for routine histology and immuno-histochemistry are provided within five working days of reception of the specimen.	N.a.	Partially
5	The laboratory/institute holds oncology-focussed learning events for quality improvement at least once per year.	Yes	Yes

7. Treatment

§	Yes	%	Mostly	%	Partially	%	No	%	n/a	%	n/v	%	Sum Tot	Check
Chapter 7														
Score audit team	85	89.5	8	8.4	2	2.1	0	0.0	0	0.0	0	0.0	**95**	100.0
Score centre	85	89.5	10	10.5	0	0.0	0	0.0	0	0.0	0	0.0	**95**	100.0

Standard 46: 24/7 access to specialist care

Auditors findings
Emergency care is provided 24 hours a day, 7 days a week. The Christie has an acute assessment unit with 23 beds for in-patients and a nearby Acute Ambulatory Care Unit with 10 trolley chairs for patients with toxicities. Outpatient appointments are made based on the patient's needs - 30 minutes for a new patient, 10 minutes for a routine follow-up visit.

Arrangements are in place for 24/7 care by specialised staff.

#	Standard	Score	Auditor score
1	CORE There are arrangements in place to provide all relevant specialist care for patients 24 hours a day, every day.	Yes	Yes
2	CORE There is an acute oncology assessment unit particularly for patients with toxicities which operates according to Standard Operating Procedures.	Yes	Yes
3	The cancer centre can admit patients during day and night in the event of an emergency.	Yes	Yes
4	Time slots for outpatient appointments are allocated according to patients' needs (e.g. longer times for new patients).	Yes	Yes

Standard 47: Surgical oncology

Auditors findings
A minimum surgical volume per surgeon has been established. An on-call rota is available for each surgeon speciality. Breast and pancreatic cancer surgery is not undertaken by the centre. Treatment plans and recommendations are available in standard electronic MDT documentation. There is an established biobank, with immediately available frozen sections within working hours for elective surgery. There are quarterly morbidity and mortality (M&M) meetings where data is also available on unexpected readmissions for surgery within 90 days, this is done for those tumours where surgery is performed at The Christie.

The surgical oncology department is sufficiently staffed, resourced and effectively managed.

#	Standard	Score	Auditor score
1	CORE Minimum surgical volumes per cancer surgeon are defined for each tumour type.	Yes	Yes

2	CORE There is 24-hour availability of surgical oncologists in all major specialties including at weekends and on public holidays.	Yes	Yes
3	All treatment plans and recommendations of the MDT form the basis for surgery.	Yes	Yes
4	If there are any deviations from the surgical treatment plan, they are recorded in the patient record and communicated appropriately to the patient and multidisciplinary team.	Yes	Yes
5	Technical and organisational processes for fresh tissue, frozen sections and biobanking are in place for all surgical procedures.	Yes	Yes
6	30-day mortality after surgery is recorded and evaluated.	Yes	Yes
7	Unexpected re-admissions to surgery within 90 days is recorded and evaluated.	Yes	Yes
8	The technical quality of surgery is regularly monitored for all procedures.	Yes	Mostly

Standard 48: Reconstructive surgery

Auditors findings
Reconstructive surgery is offered for all tumour types, and patient information about reconstructive surgery is provided via the website or locally by the system partner.

Reconstructive surgery is offered to all appropriate patients.

#	Standard	Score	Auditor score
1	CORE There is a full range of reconstructive surgery, immediate or delayed, including aesthetic and functional restoration surgery for all body regions.	Yes	Yes
2	Patient information about reconstructive surgery is proactively provided in written form and includes benefits and risks.	Yes	Yes

Standard 49: Radiotherapy

Auditors findings
Radiotherapy is delivered in the four sites of the Centre. The radiotherapy department is well staffed and resourced. Activities are covered by the clinical oncologists, radiographers and nurses. The department delivers radiotherapy, chemo-radiotherapy, and palliative radiotherapy in a well-structured and organized manner. Treatment is guided locally by Standard Operating Procedures (SOPs), protocols, and workbooks, adhering to best-practice guidelines. There is a 24-hour on call service and slots are reserved for research and emergencies. Healthroster is used to ensure staffing levels of key disciplines. Clinicians from the radiotherapy department are available 24/7 for referrals. The radiotherapy department is open from Monday to Friday, on call for weekends. There are local business continuity plans for Radiotherapy and Proton beam therapy. All patients have a medical consultation as part of their referral and treatment pathway prior to commencing treatment. Adequate information is provided to each patient about diagnosis and therapy planning. RT treatment technique, single dose, total dose, total treatment time is recorded into electronic medical record. Learning from incidents, complaints and sharing best practice is disseminated monthly trust wide via learning for improvement bulletins.

The radiotherapy department is sufficiently staffed, resourced and effectively managed.

#	Standard	Score	Auditor score
1	CORE Staffing levels of key disciplines are planned so as to ensure safety, accuracy and high quality care.	Yes	Yes
2	CORE The centre has a 24-hour on-call service outside working hours (including weekends and public holidays), if necessary through co-operation agreements.	Mostly	Yes
3	CORE The radiotherapy department has a written contingency plan.	Yes	Yes
4	Each patient has a medical consultation prior to the commencement of radiotherapy.	Yes	Yes
5	Adequate information is provided to each patient about diagnosis and therapy planning, which includes explanation of treatment options, side effects and self-management during therapy.	Yes	Yes
6	The relevant radiation data (e.g. RT treatment technique, single dose, total dose, total treatment time) are recorded in line with the guidelines.	Yes	Yes
7	Any deviation from the dose prescribed by the physician is justified and documented.	Yes	Yes
8	The unit has processes for recording the complications of treatment in the patient record and at department level for quality purposes.	Yes	Yes
9	The department holds learning events for quality improvement at least twice per year.	Mostly	Mostly

Standard 50: Radiotherapy equipment

Auditors findings
The radiotherapy department is adequately equipped. The radiotherapy department has 15 linear accelerators and 4 proton gantries spread over four locations. All equipment is modern and well maintained. There is a maintenance programme for medical equipment, including calibrations and safety checks. Medical equipment used for treatment is periodically certified by a competent authority. The department effectively meets the demand for radiotherapy and guarantees the availability of treatments for all referred patients.

The radiotherapy department is sufficiently equipped and medical equipment is safe, efficient and accurate.

#	Standard	Score	Auditor score
1	CORE The radiotherapy department has at least two megavoltage linear accelerators.	Yes	Yes
2	There is one megavoltage linear accelerator for every 350 new cancer patients per year.	Yes	Yes
3	CORE The main radiotherapy department of the centre has sufficient linear accelerators to meet the demands of providing radiotherapy to all its patients.	Yes	Yes
4	There is a maintenance programme for medical equipment, including calibrations and safety checks.	Yes	Yes
5	Safety checks and calibrations are carried out as scheduled.	Yes	Yes
6	CORE Medical devices used for treatment are periodically certified by an authorised authority.	Yes	Yes

Standard 51: Radio-chemotherapy

Auditors findings
Radio chemotherapy is administered according to the treatment plan established during the multidisciplinary team (MDT) meeting for each specific cancer type (e.g., head and neck cancer) and follows standardised protocols. Patients receive coordinated care from clinical oncologists responsible for both radiotherapy and chemotherapy, ensuring comprehensive management throughout treatment. SOP for sequential/simultaneous radio-chemotherapy is established for all clinical treatment protocols. Blood count monitoring and laboratory test are documented. The side effects of radio-chemotherapy are recorded and evaluated.

Chemo-radiation therapy follows appropriate standard procedures.

#	Standard	Score	Auditor score
1	The unit has an SOP for sequential / simultaneous radio-chemotherapy.	Yes	Yes
2	Blood count monitoring and laboratory tests are documented during radio-chemotherapy.	Yes	Yes
3	The side effects of radio-chemotherapy are recorded and evaluated.	Yes	Yes

Standard 52: Palliative radiotherapy

Auditors findings
Palliative radiotherapy is provided to patients with spinal cord compression or neurological symptoms on the same day (until 20:00) or the following morning after the primary physician requests urgent treatment. The therapeutic goal for palliative radiotherapy is documented.

Palliative radiotherapy is offered.

#	Standard	Score	Auditor score
1	In the case of patients with spinal cord compression and neurological symptoms, a plan for treatment is drawn up within 24 hours of the suspected diagnosis.	Yes	Yes
2	In palliative radiotherapy, the therapeutic goal (local control or solely symptom alleviation) is documented.	Yes	Yes

Standard 53: Medical oncology (oncology and haemato-oncology)

Auditors findings
Medical oncology care is adequately staffed, funded and managed. All necessary information is provided to patients. The Christie is one of the pioneering cancer centres with a department specifically for teenagers and young adults. The nursing staff is scheduled via an electronic system. The capacity of the chairs and beds is constantly reviewed at all locations. Learning experiences are described in the Learning for Improvement Bulletin, which is distributed to all employees. Verbal and written information is provided to patients to inform them about treatments, side effects and self-management.

The medical oncology and haemato-oncology departments are sufficiently staffed, resourced and effectively managed

#	Standard	Score	Auditor score
1	CORE Staffing levels of key disciplines are planned so as to ensure safety and high quality care.	Yes	Yes
2	CORE There are sufficient chairs and beds to manage patient numbers for systemic therapies.	Yes	Yes
3	The department holds learning events for quality improvement at least twice per year.	Yes	Yes
4	Adequate information is provided to each patient about diagnosis and therapy planning, which includes explanation of treatment options, side effects and self-management during therapy.	Yes	Yes
5	The time between the patient consultation agreeing to the treatment plan (post MDT) and the commencement of treatment does not exceed 21 days (if there are no medical contra-indications).	Mostly	Mostly

Standard 54: Medical oncology, anti-cancer drugs: prescription and pharmacy preparation

Auditors findings
There is a digital quality system for the prescription, preparation and administration of cancer medication. The IQEMO system is used for the prescription, preparation and distribution of cancer medication. All aspects of the management of medicines are described in the Medicines Practice Operational Policy. A draft version of the SOP for the manipulation of a small selection of risk-assessed monoclonal antibodies using a closed system transfer device is going through the process of ratification and publication on HIVE - these monoclonal antibodies are not prepared under the direct supervision of the pharmacist but reconstituted at ward level by suitably trained nursing staff.

There is a system for the prescription, preparation, distribution and administration of anti-cancer drugs.

#	Standard	Score	Auditor score
1	CORE There is a quality assured digital system for the prescription, preparation and administration of anti-cancer drugs.	Yes	Yes
2	CORE There is an SOP for the prescription of anti-cancer drugs.	Yes	Yes
3	Anti-cancer drugs are prepared in a centralised pharmacy unit.	Mostly	Mostly
4	There are SOPs for the preparation of anti-cancer drugs in pharmacy.	Yes	Yes
5	Anti-cancer drugs are prepared under the direct supervision of a qualified pharmacist.	Mostly	Mostly
6	CORE A validation procedure for the whole process, including prescription, preparation, distribution and administration, is implemented.	Yes	Yes

Standard 55: Medical oncology, anti-cancer drugs: administration

Auditors findings
The administration of cancer medication is controlled by operational policy, and cancer medication is only administered in oncology or haematology-oncology departments. All nurses who administer systemic anticancer therapies (SACT) follow the SACT training programme of the United Kingdom Oncology Nursing Society (UKONS). Every patient has a medical consultation prior to the start of systemic therapy. The relevant data (dosage and total treatment time) are recorded in the electronic medical file IQEMO. Unexpected side effects of cancer medication are reported via the MHRA yellow card system.

Administering of anti-cancer drugs is controlled and effectively managed.

#	Standard	Score	Auditor score
1	CORE There are SOPs for the administration of anti-cancer drugs.	Yes	Yes
2	Anti-cancer drugs are administered only in oncology or haemato-oncology wards (for inpatients).	Yes	Yes
3	There are dedicated day-care units for the administration of anti-cancer drugs.	Yes	Yes

4	CORE Anti-cancer drugs are administered by nurses who have completed a specific training programme for chemotherapy administration.	Yes	Yes
5	CORE Each patient has a medical consultation prior to the commencement of systemic therapy.	Yes	Yes
6	The relevant data (dosage and total treatment time) are recorded in line with the guidelines.	Yes	Yes
7	A specific procedure for reporting unexpected side effects of anti-cancer drugs is implemented.	Yes	Yes
8	Quality and risk management practices for anti-cancer drugs are regularly evaluated.	Yes	Yes

Standard 56: Nursing, tasks and responsibilities of oncology nurses

Auditors findings
All nurses must undergo basic oncology training during their induction period. The centre employs cancer nurses who are experts in most tumour sites. Roles and responsibilities of nurses with additional expertise/focus areas are described. There are head nurses and associate head nurses in all clinical divisions.

The cancer centre employs nurses formally educated in oncology whose tasks and responsibilities are defined according to the level of their education.

#	Standard	Score	Auditor score
1	For each technical, clinical or outpatient department where patients with cancer are treated, there are nurses trained in oncology.	Yes	Yes
2	The cancer centre employs nurses with expertise in most of the tumours that are treated in the cancer centre.	Yes	Yes
3	The cancer centre employs Advanced Practice Nurses according to the EONS definition who have acquired an expert cancer nursing knowledge base, complex decision-making skills and clinical competencies for expanded practice.	Yes	Yes
4	There are job descriptions including the tasks and responsibilities of cancer nurses.	Yes	Yes
5	Roles and responsibilities of nurses with additional expertise/focus are described (e.g. palliative care, stoma care, wound dressing, pain, social care nurses, bone marrow transplant nurses, care pathway coordinator etc.).	Yes	Yes
6	The nursing staff has among its members a Lead Cancer Nurse.	Yes	Yes

Standard 57: Pain service

Auditors findings
Guidelines for the use of pain assessments can be found in the clinical guidelines for epidural analgesia, clinical guidelines for patient-controlled analgesia (PCA) and acute perioperative pain management. Systematic pain screening is provided. The staff are regularly educated about pain management. Patients are provided with verbal and local and nationally produced information sources about pain management. A defined pain team is available for both inpatients and outpatient patients.

A protocol for pain control is implemented in the cancer centre.

#	Standard	Score	Auditor score
1	CORE There is systematic screening of pain with validated assessment tools throughout the pathway of the patient.	Yes	Yes
2	Guidelines regarding pain treatment for patients with cancer are implemented in all relevant departments.	Yes	Yes
3	There is regular education for staff on pain management according to a yearly plan.	Yes	Yes
4	Patients and their caregivers receive verbal and written information about pain management.	Yes	Yes
5	CORE A defined pain team or pain specialists as part of the palliative care team are available to both in- and outpatients.	Yes	Yes

Standard 58: Referral to supportive disciplines

Auditors findings
There are guidelines that define the indications for referral to supportive care, which focuses on improving the quality of rehabilitation, secondary cancer prevention, survival and end-of-life care. The supportive care team has special clinics every day from Monday to Friday and offers a service for inpatients at the weekend. In addition, the Supportive Oncology department was established to further improve supportive care for older oncology patients and cancer treatments at all stages of cancer treatment.

There is a standard policy concerning access of patients to supportive disciplines.

#	Standard	Score	Auditor score
1	CORE There are guidelines which define the indications for referral and the types of intervention from supportive disciplines.	Yes	Yes
2	In appropriate cases, supportive disciplines are regularly part of clinical sessions.	Yes	Yes

Standard 59: Psycho-oncology

Auditors findings
The psycho-oncology service has been established. Structured screening tools are only used for outpatients, not for inpatients. Patients are referred to the psycho-oncology service via a digital form in the electronic patient record system.

Cancer patients have access to psycho-oncology services.

#	Standard	Score	Auditor score
1	CORE There is a psycho-oncology service with competence in oncology psychiatry and/or clinical psychology.	Yes	Yes
2	CORE Structured screening with validated assessment tools is systematically used.	Mostly	Mostly
3	Procedures are defined about the way to refer patients to the psycho-oncology service, including patients in psychological distress.	Yes	Yes

Standard 60: Rehabilitation

Auditors findings
Patients are referred to rehabilitation services such as physiotherapy and occupational therapy via a digital form in the electronic patient record system. The rehabilitation service closely works with discharge team for community referrals. To achieve timely access for rehabilitation services, the centre has recently created a number of new posts.

There is access to rehabilitation services for cancer patients.

#	Standard	Score	Auditor score
1	CORE There is timely access to rehabilitation services with multidisciplinary interventions for cancer patients and survivors.	Mostly	Mostly
2	There is a defined procedure for referral to cancer rehabilitation services within and outside the centre.	Yes	Yes

Standard 61: Social counselling

Auditors findings
Social counselling is organised, with referrals via the electronic patient record system, which is accessible to all relevant disciplines. The description of the role of social work is clearly described in the adult social work job description.

Social counselling for cancer patients is provided according to guidelines.

#	Standard	Score	Auditor score
1	CORE Social counselling is organised according to guidelines and is accessible for all cancer patients throughout the cancer pathway.	Yes	Yes
2	CORE Domains of social counselling provided include benefits advice, employment rights and housing needs.	Yes	Yes

Standard 62: Nutrition

Auditors findings
Nutrition screening is carried out within 24 hours of admission for all inpatients. All inpatients are screened weekly during their hospital stay. Outpatients are referred to the dietitian within the MDT or to the local dietitian. However, for outpatients the screening and timely access to nutrition specialists is limited to head and neck, upper gastrointestinal (UGI) and CAR-T patients. The nutritional screening and nutritional care plan are described in the nutrition policy. The Patient-Generated Subjective Global Assessment (PG-SGA) tool is used for preoperative outpatients.

There is access to nutrition specialists for cancer patients.

#	Standard	Score	Auditor score
1	There are screening tools which are used to identify patients who will benefit from support of nutrition specialists.	Mostly	Partially
2	There is timely access to nutrition specialists for cancer patients throughout the patient pathway.	Mostly	Mostly

Standard 63: Involvement of caregivers

Auditors findings
Care providers can help during meals and with personal activities, and play an important role in the process of information gathering and assessment for enhanced care observations (ECO). Each ward has a quiet family room. The SOP for visitors is described.

Arrangements for the involvement of caregivers are defined

#	Standard	Score	Auditor score
1	In agreement with the healthcare team, caregivers can participate in certain personal activities (e.g. meals, washing).	Yes	Yes
2	Each inpatient ward has a room for meetings with caregivers.	Yes	Yes
3	Visiting time restrictions are lifted according to the needs of the patient and caregivers, including the possibility of overnight stay of caregivers if necessary.	Yes	Yes

Standard 64: Survivorship support

Auditors findings
Advice and support is given in the form of verbal and written information leaflets available via the website, including survival rates and living with and after cancer, including diet, exercise and symptoms. Patients are supported by their cancer specialists and clinical teams and are referred to other support services such as the information centre, Macmillan Cancer Support and Maggie's. Information about the possible late effects of cancer treatments is discussed as part of obtaining consent for treatment; written information about possible late effects of their cancer is also provided at that time.

Advice and support is offered to all patients and caregivers during treatment and survivorship.

#	Standard	Score	Auditor score
1	CORE Advice and support is given to patients and caregivers on prevention of recurrence and overall healthy living in the fields of diet; exercise; spotting signs and symptoms.	Yes	Yes
2	Information is given to patients on relevant peer groups for patients with similar cancers.	Yes	Yes
3	Information and support is given to patients about the potential late effects of their cancer.	Yes	Yes
4	Information and support is given to patients about self management.	Yes	Yes

Standard 65: Support to children and caregivers of cancer patients

Auditors findings
Information booklets on supportive care are offered including to family and caregivers.

Support to children and caregivers of cancer patients is provided.

#	Standard	Score	Auditor score
1	Caregivers are given specific support and advice for helping patients.	Yes	Yes
2	Specific support for children of cancer patients is provided by trained staff (e.g. a family therapist).	Yes	Yes

Standard 66: Palliative care team

Auditors findings
The palliative care team is a multidisciplinary team led by a palliative care consultant. The palliative care team meets daily to assess the team's caseload and the team is discussed weekly during an MDT. The supportive care team provides information and guidance according to the examples in the patient information leaflets.

The composition and tasks of the palliative care team are defined.

#	Standard	Score	Auditor score
1	The composition of the palliative care team is defined.	Yes	Yes
2	The palliative care team is led by a specialised physician in palliative medicine.	Yes	Yes
3	All patients referred for palliative care are discussed during scheduled meetings of the palliative care team, according to an SOP.	Yes	Yes
4	The palliative care team provides education and guidance of palliative care (e.g. symptom control) for patients, caregivers and health professionals.	Yes	Yes

Standard 67: Palliative care

Auditors findings
The centre has established clear policies for specialised palliative care services as part of the patients' pathway, outlining referral to supportive & palliative care services / MDT. There is some inconsistency in the documentation of patient pathways in general, and as a result, supportive and palliative care are not always clearly described in all written regional pathways. A dedicated 24/7 telephone hotline service for palliative care patients is established to provide support and advice is in place. Supportive and Palliative Care MDT Operational Policy is a written policy for specialised palliative care services as part of the patients pathway.

Palliative care is organised according to written procedures.

#	Standard	Score	Auditor score
1	CORE The centre has a written policy which defines when and how patients are referred to specialised palliative care services as part of their care pathway.	Yes	Yes
2	Palliative care is specifically described in the patient pathways within the cancer centre and beyond (such as primary care and hospices).	Mostly	Partially
3	There is a help line service covering the immediate needs of palliative care patients.	Yes	Yes

Standard 68: End of life care

Auditors findings
Plans for end-of-life care are discussed with patients and recorded in the electronic medical file. Staff receive communication training. The supportive care team works closely with the discharge team if the patient wants to die at home. The centre offers access to spiritual care through a multifaith chaplaincy service.

End of life care is appropriately and sensitively arranged according to patients' needs and wishes.

#	Standard	Score	Auditor score
1	CORE There is a policy for ascertaining the wishes and preferences of patients and relatives for end of life care.	Yes	Yes
2	The centre provides information on end of life services available both within the centre and the local community (e.g. hospices, at home services).	Yes	Yes
3	End of life care is a part of the care pathway of cancer patients with incurable disease offered in collaboration with palliative care providers in the community or hospice.	Yes	Yes
4	The centre provides access to spiritual care and bereavement support services.	Yes	Yes

8. Research

§	Yes	%	Mostly	%	Partially	%	No	%	n/a	%	n/v	%	Sum Tot	Check
Chapter 8														
Score audit team	48	90.6	4	7.5	0	0.0	1	1.9	0	0.0	0	0.0	**53**	100.0
Score centre	53	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	**53**	100.0

Standard 69: Strategic planning for oncology research

Auditors findings
The Research Strategy for the Christie is current from 2023-2028 and is complementary to the overall strategy of the Centre. This is complemented in terms of translational research and fundamental science by the strategy of the Manchester Cancer Research Centre, and the Manchester Research Nexus which also brings independent research institutes into focus. The strategy is clear and ambitious, containing many different themes and funding streams nationally. Specific aims for overall research performance (grants, publications) could perhaps be clearer, but reporting on activities, results, successes and evaluations is comprehensive. The scientific reports are thorough and explanatory, and the scope of the research at the Christie and MCRC from fundamental science to clinical studies, including such aspects as epidemiology, health services research etc, is robust and cohesive. Research activities are regularly monitored, with periodic reporting and external evaluation by a Scientific Advisory Board.

The research strategy plan is regularly updated.

#	Standard	Score	Auditor score
1	CORE There is a regularly updated research strategic plan covering at least three years, which is integrated in the overall strategy of the cancer centre.	Yes	Yes
2	Specific aims for research performance are defined (publications, grants, innovations etc.).	Yes	Mostly
3	CORE The cancer centre research performance/activity is regularly evaluated and communicated in a scientific report.	Yes	Yes
4	CORE[1] The centre has research groups and output covering basic, translational and clinical research.	Yes	Yes

[1] This is only a core standard for an OECI Comprehensive Cancer Centre

Standard 70: Organisational structure

Auditors findings
There is a well-defined organisation structure for research and innovation, both inside the Christie and in the Manchester Cancer Research Centre. This is complex, because there are a number of important strategic initiatives with the centre which are funded and managed in different ways, for instance the ACED alliance, the BRC, and RadNet. However, in sum, the Centre has the management structure to manage this complexity. The individual research groups in Christie and MCRC are well defined. The Centre has one of the largest early phase clinical trials units in Europe, with (for instance) 55 tumour-agnostic trials. It is also the leading recruiting centre within the national Experimental Cancer Medicine centres network in the UK.

The organisational responsibilities within the research, innovation and development structure are clearly defined.

#	Standard	Score	Auditor score
1	CORE There is a defined organisational structure specifically for research and innovation related to cancer.	Yes	Yes
2	The individual research group structures are clearly defined.	Yes	Yes
3	The qualifications and responsibilities of research group leaders are clearly defined.	Yes	Yes
4	The centre has a dedicated phase I/II clinical research unit.	Yes	Yes

Standard 71: Means for conducting research activities

Auditors findings
In practice the cancer research budgets are defined within the constituent members of the Comprehensive Cancer Centre (CCC). The original figures quoted to the audit team related to the Christie R&I division, and the audit team members are satisfied that in the individual budget lines, financial monitoring is achieved. However, the total annualised quantum of research funding is what is important to identify in the CCC to show visibility to all the research endeavours in the whole centre, clinical, translational and fundamental science, and also to be able to benchmark these metrics and others against other large Comprehensive Cancer Centre in Europe. The audit team suggests that this global budgetary exercise is performed on an annual basis. The Christie and MCRC provide ample access to a plethora of technological platforms and core facilities across the whole research continuum. The Christie provides annually internal funding for 3 programmes: Ideas, career development fellowship and patients' involvement.

A planned cycle for resourcing the infrastructure of research activities is defined

#	Standard	Score	Auditor score
1	CORE The cancer research budget covering both external and internal funding for the cancer centre is defined each year.	Yes	No
2	CORE The cancer centre provides access to shared technological platforms for research activities.	Yes	Yes

3	The cancer centre provides internal funding for research activities.	Yes	Yes
4	The use of financial resources and accounting of research activities is monitored and reported.	Yes	Yes

Standard 72: Periodical external site visit / review

Auditors findings
The centre has a high level international Scientific Advisory Board which attends regularly to provide advice on the research strategy and organisation of the centre. The performance of research groups in MCRC is done through a CRUK quinquennial review process. The NIHR also conducts a review of the Clinical Research Facility at regular intervals. The biobank is subject to external certification, and other core facilities experience both internal and external quality inspections.

Periodical external site visits of research are organised

#	Standard	Score	Auditor score
1	CORE An external Scientific Advisory Board (SAB) meets at regular intervals and advises the cancer centre on its cancer research strategy, organisation, infrastructure and overall performance.	Yes	Yes
2	CORE The performance of each research group is externally or internally reviewed at regular intervals.	Yes	Yes
3	There is a periodical external site visit/review for research support facilities.	Yes	Yes

Standard 73: Research collaboration

Auditors findings
The Cancer centre supports a raft of strategic collaborations and networks, both in the UK, in Europe and globally. The C7 initiative will bring together 7 of the most influential Comprehensive Cancer Centres globally including MD Anderson, Peter Mac in Melbourne, Princess Margaret in Toronto and The Christie. There is significant outreach from The Christie in Kenya. The Christie is part of the ACED International Alliance for Cancer Early Detection, RadNet for Radiotherapy, and Accelerator Awards of CRUK in Italy and Spain. Several of these initiatives are led by the Christie. Many researchers hold leadership positions and actively participate in international organisations focused on specific cancer types.

The cancer centre is part of research networks.

#	Standard	Score	Auditor score
1	The cancer centre supports formalised collaborations with international research organisations and networks.	Yes	Yes
2	The cancer centre co-ordinates international research projects.	Yes	Yes

Standard 74: Scientific interaction and integration

Auditors findings
There is a structured collaboration between researchers from the centre's various partners. A new programme has been set up - Christie Research 2030 Charity Programme - to support career development grants for doctors, with specific time for research activities in addition to clinical responsibilities. There is a structured mechanism to support this and discussions during interviews emphasised the supportive culture of the institution and the funding available for research activities.

There is structured co-operation between researchers and clinicians.

#	Standard	Score	Auditor score
1	CORE Regular briefings on research activities, results and new opportunities are organised through information sharing and meetings for laboratory researchers and clinicians.	Yes	Yes
2	CORE There are funding mechanisms and/or programmes to give clinicians protected time for clinical and/or translational research.	Yes	Yes

Standard 75: Scientific dissemination programme

Auditors findings
The Christie has a comprehensive programme of seminars, conferences and colloquia in a hybrid or in-person format. These include The Christie Grand Rounds series, The Christie Schwartz Rounds, Christie Education facilitated events, study days, MCRC Director's lectures, CRUK events and BRC events. On translation, The Christie has a Research Effectiveness Committee which horizon scans for new technologies into practice, and monitors developments at the National Institute for Clinical Excellence (NICE).

A scientific knowledge transfer programme is present in the cancer centre.

#	Standard	Score	Auditor score
1	CORE There is a structured, documented and up-to-date scientific programme in the cancer centre through colloquia, seminars and theme-specific conferences.	Yes	Yes
2	There are procedures in place to ensure that results from internal and external research are translated into new practice (e.g. diagnostic tools, treatment or prevention).	Yes	Yes

Standard 76: Research talent development

Auditors findings
The Centre has various instruments and policies for recruiting and developing research talent at different career stages. Emphasis is placed on the career pipeline, with many PhD programmes, Clinical Research Training Fellowships and MB-PhDs. In addition the NIHS funds programmes for Academic Clinical Fellows and Academic Clinical Lecturers.

There is a policy for research talent development.

#	Standard	Score	Auditor score
1	There is a programme in place for research talent development.	Yes	Yes

Standard 77: Grant proposals

Auditors findings
All grant proposals from The Christie and University of Manchester (UoM) researchers are peer-reviewed internally or externally before they are submitted, depending on the type of funding. Training programmes are available for researchers from The Christie, MCRC and UoM, covering essential skills such as grant writing, project management and financial management.

There is a procedure for dealing with grant proposals.

#	Standard	Score	Auditor score
1	There is an internal review of grant proposals before submission to funding bodies.	Yes	Yes
2	There is an internal evaluation of the success of the grant proposals.	Yes	Yes
3	CORE The cancer centre has training programmes and supportive services for grant applicants.	Yes	Yes

Standard 78: Prevention and detection and handling of scientific misconduct

Auditors findings
There is a code of conduct for good research practices at the University of Manchester. Research misconduct is handled within the disciplinary procedure of the employee involved.

Conduct of research is defined by core principles of research integrity.

#	Standard	Score	Auditor score
1	There is a code of conduct regarding good research practices, covering the research environment, data practices and management, publication and dissemination, such as those of the European Code of Conduct for Research Integrity.	Yes	Yes
2	There is a procedure to deal with violation of research integrity, such as research misconduct.	Yes	Yes

Standard 79: Intellectual property and innovation

Auditors findings
Innovation is an explicit part of the strategy of the Cancer Centre. CRUK funds data innovation awards. Additionally, the Centre works with the CRUK Cancer Research Horizons team and the University of Manchester Innovation Factory. There are clear rules for the ownership of IP, in which the University of Manchester assists. MCRC has a Commercialisation and Innovation Lead who signposts to support for Technology Transfer according to the individual project / technology. The Centre has commercialisation and industry opportunities driven by the dedicated Commercialisation and Innovation Lead who works across The Christie and MCRC partnership.

There are policies in place for protection of intellectual property and innovation.

#	Standard	Score	Auditor score
1	Innovation strategy is an explicit part of the strategic plan of the centre.	Yes	Yes
2	There are rules for ownership of intellectual property and patents.	Yes	Yes
3	There is a unit providing support for the protection and utilisation of intellectual property (Technology Transfer Office).	Yes	Yes
4	There is a unit (internal or external) providing support for business development arising from research.	Yes	Yes

Standard 80: Organisation of clinical research

Auditors findings
The clinical research management unit and institutional review board (IRB) are defined. All clinical research at The Christie is under a framework where proposals are submitted for review and approval by an external NHS research ethics committee. The NIHR also provides guidance on trial design. The centre has a dedicated core clinical research management team within The R and I Division, which oversees study set up, costing and income, contracting, and Quality Assurance. This unit has an annual plan and arrangements for promoting clinical trials. The clinical trials public database is part of Cancer Research UK UK-wide website which states location and eligibility, but the management unit also maintains an internal database of trials. The UK Health Research Authority sets standards that The R and I Division implements. The coordination and monitoring of clinical research activities as well as their financial management and quality is done through a variety of oversight committees, including the Christie Research Management and Oversight Committee and R&I Quality Committee. There is an annual report of clinical trials but this is subsumed within a wider research report. Patient consents and data protection are well controlled and organised.

Tasks of the Clinical Research Management unit and Institutional Review Board (IRB) are defined.

#	Standard	Score	Auditor score
1	CORE There is a Research Ethical Committee (internal or external) or Institutional Review Board (IRB) that evaluates ethical aspects of all research proposals on human subjects or material.	Yes	Yes

2	There is a scientific review board/committee that evaluates the quality, feasibility and priority of clinical trial proposals.	Yes	Yes
3	CORE There is an institutional clinical research management unit dedicated to cancer patients.	Yes	Yes
4	The unit has an annual plan for its activities.	Yes	Yes
5	The cancer centre has a policy for promoting clinical trials, including internal and public information on trial availability.	Yes	Yes
6	The unit has dedicated personnel ensuring that clinical trials are conducted according to the trial protocols and Good Clinical Practice guidelines.	Yes	Yes
7	The unit ensures the process of administrative, scientific and ethical/legal review and approval as well as the feasibility of new clinical trials.	Yes	Yes
8	The unit co-ordinates and monitors the clinical research activities as well as their financial management.	Yes	Yes
9	CORE The cancer centre keeps an up-to-date database of clinical trials, including the accrual of patients.	Yes	Mostly
10	The cancer centre provides an annual report on clinical trial activities.	Yes	Mostly
11	Personal data protection is guaranteed for patients in clinical trials according to the appropriate legislation, including GDPR.	Yes	Yes
12	The inclusion of a patient in a clinical trial is immediately available in the medical file of the patient, including the signed informed consent.	Yes	Yes
13	The institutional clinical research management unit has specific resources (expertise and financial) to manage investigator-initiated trials.	Yes	Yes

Standard 81: Promotion of clinical research

Auditors findings
The cancer centre publishes the ongoing clinical trials on its website for patients and external doctors. The researchers publish or contribute to the publication of the results of the clinical trials in both scientific and public publications.

The cancer centre promotes and disseminates internally and externally clinical research projects and their results.

#	Standard	Score	Auditor score
1	The cancer centre publishes the ongoing clinical research trials on its website for patients and external physicians.	Yes	Yes
2	The cancer centre promotes the participation to clinical trials to the patients by means of brochures, website, etc.	Yes	Yes
3	The researchers publish or participate in the publication of the results of the clinical trials, both in scientific and public papers.	Yes	Yes

4	The cancer centre organises internal meetings to share the results of the clinical and translational research realised in the centre among its research community.	Yes	Yes
5	The results of the clinical trials are communicated on the website.	Yes	Yes

Standard 82: Biobank

Auditors findings
An institutional policy for biobanking patient samples is in place, supported by documented procedures for informed consent and patient management. The centralised biobank database, STARLIMS, facilitates the integration of samples with relevant clinical and pathological data, ensuring efficient tracking and accessibility for research. However, keeping the clinical linkage to include the follow-up data of patients is still a work in progress in the centre, the focus of an ongoing project.

Biobanking is conducted according to defined procedures

#	Standard	Score	Auditor score
1	The cancer centre has a written policy for biobanking patient samples.	Yes	Yes
2	CORE There are SOPs defining the patient information, informed consent, collection, storage, registration, recovery and use of the biological samples.	Yes	Yes
3	CORE There is a centralised biobank database which provides linking to detailed clinical data.	Yes	Mostly
4	The cancer centre biobank has facilities for long-term storage of paraffin blocks for research purposes.	Yes	Yes

9. Education and training

§	Yes	%	Mostly	%	Partially	%	No	%	n/a	%	n/v	%	Sum Tot	Check
Chapter 9														
Score audit team	18	94.7	1	5.3	0	0.0	0	0.0	0	0.0	0	0.0	**19**	100.0
Score centre	18	94.7	1	5.3	0	0.0	0	0.0	0	0.0	0	0.0	**19**	100.0

Standard 83: Analysing and providing for oncology training needs

Auditors findings
Training is well organised at all levels and includes both competency-based education and continuous professional development. The centre offers a wide range of vocational training courses for all staff working at The Christie. This is led by Christie Education, a multi-professional training centre. The emphasis of this training is on the skills needed for the future workforce. The training programmes comprehensively cover CPE for medical students, nurses, allied health professionals and other disciplines. Staff have the option of registering free of charge. All Christie volunteers also receive training and support for their role within the centre. Academic training is also available through various partner institutions, in particular the University of Manchester. The Institute/Christie through a variety of funding mechanisms ensures that continuing professional development (CPD) for staff is financially supported through a variety of CPD/study leave budgets.

The cancer centre analyses the specific training and continuous education needs in oncology and defines training and educational programmes.

#	Standard	Score	Auditor score
1	The cancer centre analyses the specific training and oncological continuous education needs of its staff regularly (preferably annually, cross reference to Chapter 2, Standard 17).	Yes	Yes
2	CORE Relevant training is provided to all staff according to individual needs, institutional requirements, and regulatory requirements, including Good Clinical Practice and prevention and control of infections, including hand hygiene.	Yes	Yes
3	Based on the analysis, the institution defines an annual or multi-annual oncology training programme for physicians.	Yes	Yes
4	Based on the analysis, the cancer centre defines an annual or multi-annual oncology training programme for researchers.	Yes	Yes
5	Based on the analysis, the cancer centre defines an annual or multi-annual oncology training programme for nurses.	Yes	Yes
6	Based on the analysis, the cancer centre defines an annual or multi-annual oncology training programme for supportive disciplines.	Yes	Yes
7	The centre ensures that all volunteers who work in the centre (whether with patients or not), are given appropriate training and support for their role (directly or by other bodies).	Yes	Yes
8	The cancer centre collects and analyses feedback about the quality of the continuous professional education and training programmes.	Yes	Yes

Standard 84: Undergraduate academic education in oncology

Auditors findings
Educational programmes are well organised for the various healthcare professionals and there are also some programmes for international visitors. The Christie works with at least nine universities and medical schools in the UK to offer educational modules for doctors, nurses, allied health professionals and other professionals. It annually hosts a large number of medical students. Exchange programmes for other centres in the world are offered, but these could perhaps be extended.

The cancer centre provides oncology education for undergraduate degrees.

#	Standard	Score	Auditor score
1	CORE The cancer centre provides undergraduate oncology education.	Yes	Yes
2	The cancer centre provides undergraduate oncology education for medical students.	Yes	Yes
3	The cancer centre provides undergraduate oncology education for nursing students.	Yes	Yes
4	The cancer centre provides undergraduate oncology education for supportive discipline students.	Yes	Yes
5	The cancer centre collects and analyses feedback about the quality of the undergraduate oncology education.	Yes	Yes
6	The cancer centre offers oncology education to medical/nursing/supportive discipline students from other countries, e.g. through exchange programmes.	Mostly	Mostly

Standard 85: Postgraduate academic education in oncology

Auditors findings
The Christie offers a comprehensive range of postgraduate education and vocational training for qualified professionals across the entire multi-professional cancer team, including physicians, nurses, allied health professionals, scientists, and engineers. E.g. there is a 6 hours/ month of obligatory training for nursing staff, depending on each department's required skills. Protected time for such education is offered. The Christie is a major regional training hub in specialist cancer care for the North of England, providing bespoke training for registrars on clinical and integrated clinical academic pathways. Training and education offered through Christie Education also includes outreach to other centres in the world through digitally offered courses. Evaluations and feedback are regularly obtained, including surveys of training experiences and interviews.

The cancer centre provides oncology education of postgraduate students.

#	Standard	Score	Auditor score
1	CORE The cancer centre provides postgraduate oncology education for physicians.	Yes	Yes
2	CORE The cancer centre provides postgraduate oncology education for nurses (including palliative care).	Yes	Yes

3	The cancer centre provides education in oncology for supportive disciplines.	Yes	Yes
4	The cancer centre collects and analyses feedback about the quality of the postgraduate education.	Yes	Yes
5	The cancer centre offers oncology education to physicians/nurses/supportive disciplines from other countries, e.g. through exchange programmes and/or organisation of specific courses.	Yes	Yes

Part 2: General remarks, strengths, opportunities and conclusion

The second part of the final peer review report describes the general remarks, strengths and opportunities which have been identified by the audit team and approved by the OECI A&D Board.

Following the OECI accreditation visit, the audit team, and A&D Board, have identified strong areas. Some issues have been identified as opportunities for improvement. These are listed in the audit score (appendix 1) and described in this part of the report. The A&D Board expects to receive an improvement plan on these issues. Based upon this plan the OECI Accreditation and Designation certificate can be awarded.

A. General remarks

During the peer review visit, the audit team encountered a highly motivated staff, striving for excellence and with a clear objective of patient-centred care. The interviews we held were honest and inspiring. We believe that The Christie is an attractive employer nationally in the UK, and the evidence bears this out. The physical environments of the hospital and the research buildings are uplifting.

We pay tribute to the team organising the peer review visit which was efficiently implemented.

B. Strengths of the cancer centre with regard to the OECI quality standards

94.8% of the standards are scored as 'yes' or 'mostly' by the audit team (Appendix 1). This means that for those indicators the standard has been implemented in the most critical places in the cancer centre and that the plan-do-check-act cycle (Deming-cycle) has been completed at least twice. The strengths described below relate to only the most significant of these high scored standards. The OECI A&D Board encourages the centre to maintain continuous quality improvement for these and other standards by running the Deming-cycle periodically.

Translational and Clinical Research

Translational and Clinical Research at The Christie/MCRC are outstanding in their scope and depth. The Centre declares to publish an average around 1,000 peer reviewed papers annually, 542 of which were specified as being international peer reviewed publications in the index year. Around half of those papers were generated from the Centre with first and last authors, indicating leading research from the Centre, and many with high impact. Very good examples of research which span the cancer research continuum were shown, including cfDNA methylation-based classifiers for cancers of unknown origin; Proton research (the Torpedo trial); RadBone predictive factors; and precision cancer medicine trials. Research at the Paterson building is supported by excellent core facilities and both wet and dry labs, with quick interface into the clinical buildings.

Nurturing of new research talent is a major priority and practice of the Centre, and the reviewers heard evidence of those PhD students and younger post-docs whose careers had been supported and furthered in the Centre.

International collaborations are extensive. The C7 initiative brings together 7 of the most influential Comprehensive Cancer Centres globally including MD Anderson, Peter Mac in Melbourne, Princess Margaret in Toronto and the Christie. There is significant outreach from the Christie in Kenya. The Christie is part of the ACED International Alliance for Cancer Early Detection, RadNet for Radiotherapy, and Accelerator Awards of CRUK in Italy and Spain.

Clinical Research is also at the forefront of international practice. There is immense scope in the portfolio of studies. With such large numbers, classification becomes difficult. Whilst the total portfolio seems to exceed 850 trials, 83 of these were declared to be early phase, and the proportions of the interventional portfolio relating to academically initiated, and industry sponsored trials was approximately equal. The Clinical Research Facility has excellent facilities and staffing, with a large capacity for patients on trials, and is well managed.

Finally, the Christie has an impressive system for protected time for clinical staff doing cancer research, and this results in a very high proportion of doctors (and some nurses and AHPs) leading research studies. The review team interviewed a number of these PIs.

Systematic Education and Training Programme

Christie Education has formalised one of the most comprehensive cancer education and training programmes globally. It brings together the normal undergraduate and postgraduate education programmes with a very extensive continuing professional education programme spanning all professions and disciplines involved in cancer diagnosis, treatment and care, and researchers across the continuum. As such, it is a truly joined-up programme responsive to the needs of the staff in Christie/MCRC and the wider community. This wider community involves at least 10 University partners, national outreaches of training (for instance, around Proton therapy) and international exchanges, observerships and trainings.

In addition to the statutory or mandatory trainings, the extensive suite of education includes more than 20,000 learning episodes per year. These include modules on precision oncology, surgery and interventional cancer care. Advanced diagnostics and imaging, supportive and holistic cancer care, leadership training, and even primary care oncology in General Practice.

The ethos of Christie Education is to be accessible and inclusive, and it aims to support career development in all disciplines, apprentice and early career, through to advanced practice professionals. To support this there is a dedicated process of faculty development – train the trainers.

Supportive Oncology

Supportive Oncology is the new nomenclature of the composite team at the Christie which in other centres is generally known as ‘supportive and palliative care,’ and the culture, practices and ways of working of the team were explained to the audit team in interviews. This was found to be a strong and cohesive multiprofessional team, responsive to the needs of patients early in their journey at The Christie. This team has published its evaluation and research results and is at the forefront of innovative practice in supportive and palliative care.

Related to this area, the discharge teams are to be commended for the efficiency of their function in organising supported return to home environments and organising primary and community care.

Radiotherapy Department

Among many good departments, the radiotherapy (RT) department was found to be well organised and managed, and with access to all innovative RT techniques, including proton beam therapy where appropriate. This department, together with the satellite units, is active in research and innovation and is leading a number of clinical studies in RT as well as translational work. Its educational outreach encompasses not only proton therapy but other advanced radiation therapy techniques.

Quality of patient involvement and patient information

The Christie could be considered an exemplar when it comes to patient involvement and the scope of patient information and support. With the combination of its own locally produced material and media, Macmillan Cancer Support, Maggie’s, and other collaborations, the spread of information about cancer and the cancer journey is extensive and holistic, including information about clinical trials. The Information and Support centre and the Maggie’s Centre are also a major benefit for patients. Patient involvement in the co-design of the services and design of the Centre and its operations is extensive, and the overall culture of the Christie is patient-centred, inclusive and respectful of diversity. Specifically, the Teenage and Young Adult (TYA) unit is very well designed and appointed, with engaging facilities and a stimulating environment for adolescents and young adults together with appropriate educational support.

Quality management system and culture

The quality management system with its suites of data collection has a high specification. This results in the ability to generate dashboards at various levels with a multiplicity of quality indicators. The audit team were given evidence of regular and appropriate use of dashboards and quality indicators to monitor activity and continuous improvements. The Centre generates data on PROMs and PREMs and has a good handle on the overall survival of its patient by cancer type and stage of diagnosis. While not perfect, the centre is willing to try new methods to capture patient outcomes such as e-PROMs. Overall, the culture of the Christie is one of continuous improvement and openness to evaluation.

Within this area, the ICT team deserves credit for its development and analytic work, supporting the data requirements of the Christie, and ensuring interoperability and data protection.

Overall levels of staffing and staff wellbeing

Whilst of course there are pressure points with particular professional/disciplines, the overall levels of staffing including nursing complement were found to be satisfactory. The Christie is a popular employer in the Greater Manchester (GM) area, on account of its specialty, its terms and conditions and its training and education programmes. Wellbeing of the staff is an obvious priority, with staff having access to mental health support services and positive line management.

Quality of the nursing profession

This requires particular highlighting, since the opportunities for nurses to specialise, and to access further training and education, is extensive. There is a considerable pride within the nursing cadre, in the way nurses work collaboratively with other professionals at the Christie. Good career development possibilities within the organisation are possible, and nurses can achieve significant leadership positions.

Patient trackers

This is an important unit and function within the Christie, and is effective in accelerating the patient journey and avoiding unnecessary delays.

Day Care and Outpatient Units

Both these units are well staffed, well organised, and in uplifting environments. This represents a big improvement over the previous OECI visit. The Outpatients unit has been completely re-modelled, and its ways of working modified to avoid long waiting times in clinic. The hubs for doctors, nurses and AHPs appear to be working effectively. The Day Care Unit is very extensive with 83 chairs/beds, and is well staffed with experience chemotherapy nurses who also have to take time to train their newer colleagues. Safety procedures in the delivery of SACT were checked and found to be satisfactory.

Early Detection

Early detection is a priority at the Christie, with particular pathways designed to address this challenge. This is not only through the oncogenetics function, but also other initiatives to identify patient at high risk through research programmes. One of the most prominent of these in which The Christie took a lead was the major Lung Cancer screening research programme over many years, which has changed practice in this area. There are also strong links with the biomarker centre in generating data for future targeted screening programmes.

Acute Assessment Unit – Acute Ambulatory Care Unit

The AAU and AACU are excellent units designed to receive patients with acute toxicities. The Acute Ambulatory Care Unit has a high throughput, and manages to stabilise patients generally within a few hours and return them home to a supported environment. The inpatient unit is well organised and appointed, staffed with highly trained nurses and with satisfactory medical support.

C. Opportunities for the cancer centre with regard to the OECI quality standards

4.4% of the sub-standards are scored as 'partially' or 'no' by the audit team (Appendix 1). This means that indicator is not yet implemented (plan) or implemented on a modest scale. According to the evidence seen by the audit team the Deming-cycle has not been completed for these sub-standards. The following opportunities were particularly identified by the audit team. These together with standards scored partially or no by the auditors should be addressed in the improvement plan.

Building capacity in Nuclear Medicine

This is an area which is being developed at the present time with a prospective new head of Nuclear Medicine, and prospective further investment in PET-CT equipment. At the precise time of the audit the area represents an area of opportunity to consolidate and push forward in innovation and research, perhaps developing the collaborations in supply of tracers to meet increasing demand and innovation.

Multidisciplinary Teams

In general, within the Christie these are mature and well-functioning organs of multiprofessional working. The audit team observed some of the MDTs in their case conferences and also had further interview with MDT chairs. There is room for improvement in the way that the MDT decisions are recorded and validated, and in fact the audit team observed on screen a part of the notes recorded by the coordinator which was not exactly as spoken within the meeting, but was not corrected by the rest of the MDT team because the writing on the screen was too small for them to observe. There also seem to be an opportunity to improve efficiency and safety, in that we were informed in one MDT that there were effectively 2 sets of notes, one within the EPR and other to generate the letter to the GP. This could be clarified.

Documentation of Patient Pathways

This is a tricky area, and we are aware that different patient pathways have differing scopes, some wholly within the Christie, and others shared between institutions within the GM network, where the responsibility for keeping the documented patient pathways lies with the Cancer Alliance, not the Christie. However, some of the Patient Pathways the audit team were directed to were past their revision/updating date, raising questions as to frequency of revision. Furthermore, there is a wide variety in the form and detail of the documents. Some are outline flowcharts of the diagnostic and treatment and care processes, others are effectively local clinical guidelines built around NICE decisions. There could be a benefit of an overall review of these documents, their form/content, and the process of regular revision. A more consistent approach to defining these pathways, including the integration of palliative and supportive care, should be implemented.

Digitalisation

This is a huge area of ongoing development and opportunity for the Christie to continue to be a national leader in cancer care. We give below brief headings where we believe that development should focus as priorities:

- Digital pathology and biobanking. Digital pathology will improve accuracy and save time. With biobanking, the key is to increase the linkage to patient data to include follow-up data of the patient whose samples are in the bank.
- Patient portal. This can be developed further to including digital messaging to patients to remind them of appointment (often letters are still used). e-PROMs can also be further developed.
- Digital communication with GPs. Again, letters are slow and sometimes fail to arrive on time.
- The EPR is not fully implemented. In some areas (Wards) there are still paper files or parts of the process not fully digitalised
- Electronic drug prescription (non SACT) – in some cases this process is not fully digitalised
- Interoperability of all major programmes/systems. This is a significant and ongoing challenge, both within the Christe/MCRC, and further out into the Cancer Alliance to improve the seamlessness of the patient pathways.

Collective understanding of quality in the complete pathway

Within the Cancer Alliance there are of course shared pathways and instances where surgery is performed in other hospitals and where for instance radiotherapy is conducted at The Christie, or even the MDT concerned is chaired from the Christie. Since quality of surgery is a shared aim of the Alliance, there is a collaborative opportunity to compile data on surgical quality, resection margins, re-operation/re-admission rates on key complex surgeries.

Pathology Facilities and Reporting

It is well known that the pathology laboratories at the Christie are cramped and not fit for purpose as activity increases in this important area. Plans for redevelopment are afoot, which the reviewers completely support as a significant opportunity. Regarding pathology reporting, the department should review and optimise the processes and recording of actual reporting times to ensure optimal turnaround times.

Staffing pressure points

Having noted above the general satisfactory levels of staffing at the Christie, we were made aware of particular pressure points which the Centre is trying to address, namely: radiographers; haemato-oncologists; and pharmacists. We know that The Christie is effectively part of a market here, and is playing its role to recruit and train, and to continue to promote the Centre as a highly attractive employer and healthcare provider.

Research overall budgetary envelope

This is a complex area for such a diverse centre with many different institutions, strategic initiatives and other funding streams. However, in common with many other large comprehensive centres, there is an opportunity to compile data on the totality of research budgets/annual expenditure in all areas of research: clinical; translational and fundamental science, bringing together and annualising core funding, competitive research grants; commercial trials income, internal or philanthropic funding, etc., so as to present the overall research funding envelope for benchmarking purposes.

D. Points for future consideration

Promoting the overall brand and achievements

The Christie is already a brand with global significance, but could be even more visible, not least in continental Europe. The excellence of its research and quality of care, and education, could deserve to be even more widely known. This could be around particular achievements, or strategic collaboration, or educational outreach. The Christie brand is powerful as a mark of quality and innovation, and deserves wider dissemination. The emerging C7 alliance could be instrumental in this regard.

More international presence for research / international opportunities for staff

Building on the above point, it could be that the obvious deficits of Brexit can be overcome within the emerging European cancer environment. The second half of the European €4 bn Horizon Europe Mission on Cancer could still provide The Christie/MCRC with collaboration and funding opportunities, even as a non-EU country. It may be that the OECI network can be of assistance in this endeavour. One instance could be the promotion of international opportunities for staff, including observerships for staff of other cancer centres in Europe.

More effective use of outcome data to drive improvements

As outcome data becomes more complete and sophisticated, it would seem possible that The Christie/MCRC can develop more real world data sets in key areas such as poor prognosis cancers or cancers where clinical trials are less available, to investigate optimal treatments or modalities or predispositions to pre-neoplasia. Bioinformatics is already a strength at the Christie/MCRC, and further studies could surely emerge in this important area.

Further push on supportive oncology

With ever improving survival rates, the importance and impact of supportive oncology becomes more prominent. We noted that there continue to be pressure points in building up the complement of AHPs in the group. The Christie could also help establish the best UK and European templates of survivorship care plans for different circumstances of living with and beyond cancer.

E. Progress since previous report

The following paragraphs summarise the improvement action points noted in the OECI previous accreditation report, and the progress The Christie has achieved on these. In these paragraphs we reflect the responses directly provided by the centre in interview. Altogether, all improvement points have been achieved.

1. Take appropriate action to increase accrual into clinical trials and review the low number of high impact papers, with an objective of developing further papers.
   This area has seen very substantial improvement with large recruitments into clinical trials, and a significant increase in production of high impact papers.

2. To develop research into survivorship care to implement survivorship plans into practice
   This has been achieved with survivorship clinics, a more comprehensive approach to survivorship care plans, and the development of PROMS.

3. To improve onward care for patients who have been discharged following treatment, ensuring patients have access to key workers closer to home.
   This has seen substantial improvement with the development of supportive oncology clinics and contacts with primary and community care upon discharge.

4. To improve the comprehensive medical record system by integrating the doctors' notes and the chemotherapy record system.
   Achieved with iQemo, EPMA and the new HER.

5. To improve the IT hardware and the positioning of IT cables throughout the Trust.
   Achieved.

6. To review the chemotherapy quality control process, ensuring verification checks by the pharmacist are in place.
   Achieved by integrating the iQemo electronic SACT prescribing system with the Baxter compounding system. The whole system is validated and checked by pharmacists.

7. To improve on the outpatient's pharmacy area, to ensure a patient friendly waiting area, reduction in waiting times and to implement more sufficient back-office space for pharmacy staff.
   A new OP pharmacy unit has been established which is spacious and efficient.

8. To implement a clear and structured process for the medication room on ward 12
   - *Ward Managers have received refresher training on the Medicines Practice Operational Policy (MPOP) and cascaded to their teams.*
   - *The ward was undertaking regular spot checks of the treatment room by the Matron to ensure compliance with safe medicine practice in addition to monthly audits of practice and access lists regularly being reviewed*
   - *Ward 12 is currently undergoing an extensive refurbishment which includes the fitting of new medication cupboards and a key management system (Abloy) that provides a full audit trail of all key transactions*

9. To improve patient flow and to review capacity across the outpatient department
   A complete and new department has been built, and in addition:
   - *Patient flow system initially rolled out to all outpatient, SACT and phlebotomy areas*
   - *All clinic templates reviewed and updated to streamline activity*

10. To improve the process of registration within the PET CT department, ensuring that there is one process for booking and registering patients
    - *The process was reviewed following the visit – identified there is one process for booking and registering patients via the RIS system.*

    However, issues with capacity in PET remain and are addressed in the Opportunities.

11. To devise a directory of services by tumour group for use both internally and for cross health professionals
    Achieved.

12. To review the staffing within the psycho-oncology service ensuring sufficient staff to manage the patients' needs
    Achieved by
    - *Appointment of a Lead Nurse in Mental Health*
    - *Increase in the second Psychiatrist's clinical sessions (PA's)*
    - *Increase of specialty doctor to full time*

F. Conclusion and Designation

The designation type of the institute is proposed by the audit team, analysed by the independent Accreditation and Designation Committee and approved by the A&D Board. As shown in the following figure and based on the quantitative data the preliminary designation was:

	Criteria OECI Cancer Centre	Criteria OECI Comprehensive Cancer Centre		Manchester, 2017	Manchester 2023
Presence of the three treatment facilities surgery oncology, radiotherapy and medical oncology, and research and education ?	Qualitative / quantitative assessment through accreditation	Qualitative / quantitative assessment through accreditation		Qualitative / quantitative assessment through accreditation	Qualitative / quantitative assessment through accreditation
Annual budget for cancer care in PPP (1.1.5)	> 25 million euro	> 50 million euro		€ 233.230.160,00	€ 368.259.738,00
Annual budget for cancer research in PPP (1.1.5)		> 8 million euro		€ 41.091.529,00	€ 20.881.119,00
Number of cancer care inpatient beds plus the number of beds/chairs in the ambulatory day units (2.2.1)	>100	> 150		184+124	197+155
Number of FTE physicians dedicated to cancer (2.3.1)	> 30	> 50		122	285
Number of newly treated cancer patients per year (2.1.1.2)	> 1500	> 2500		11.437	11.168
Research					
Number of peer-reviewed scientific publications (8.4.2)	>35	**> 125**		381	542
Number of scientific publications with an impact factor (IF) over 10 (8.4.2)		> 17		95	93
Number of scientific publications with an impact factor (IF) between 5 and 10 (8.4.2)		> 50		108	211
Number of studies active - currently open for patient accrual (8.5.1 - Subtotal for Designation (A))	>20	**> 75**		382	228
Does these open studies include Phase I trials?		Yes		Yes	Yes
The total number of patients recruited to prospective interventional clinical trials in the index year as a percentage of patients newly treated in the centre**		> 10%		6,3%	7,6%
Preliminary designation: Comprehensive Cancer Centre To be designated as an OECI CCC the Centre / Institute needs to fulfil all the General Criteria and 4 out of 6 Research Critieria (at least 2 for publications and 2 for trials). The numbers in bold should be fulfilled.					

Based upon the OECI quality standards the audit team has assessed the following domains for comprehensiveness as set by the OECI:

1. *The direct provision of care for a wide variety of cancers, based on a multidisciplinary organisation and a patient-centred approach, from prevention to survivorship (clinical pathways).*

2. *A clearly identifiable entity maintaining an extensive network in the fields of care, research and education.*

3. *A high level of infrastructure and expertise, dedicated to basic and clinical research, with a transitional approach and well-established integration of research into care.*

4. *A learning-focused institution whose activities cover education, training and the dissemination of knowledge in all disciplines.*

5. *An organisation focused on quality and progress, with systems and services that guarantee constant improvement and encourage innovation.*

Final conclusion:

The Christie NHS Foundation Trust is an exemplar Comprehensive Cancer Centre which has even further developed in the five years since OECI's previous peer review visit, implementing very nearly all the recommendations made, and the action points agreed. As a result, the Christie is high performing in excellence of patient care, and in the quantity and quality of the research. Around half the international peer reviewed papers were generated from the centre with first and last authors, indicating leading research from the centre, much with high impact. The Christie has an impressive array of clinical trials, many in the early phase. The Christie Education is a very comprehensive programme of continuous professional education and undergraduate and graduate provision in oncology, which reaches out even into General Practice and beyond the UK. Digitalisation requires further and continuous development to improve efficiency, accuracy and good communication. Similarly, the documentation of patient pathways would benefit from greater consistency of form. The Christie is well known internationally, and will benefit from membership of the new C7; however, European collaborations could be strengthened, despite the downsides of Brexit, and thus the Christie could become even more prominent globally for the quality of its patient provision, its clinical and translational research, and its educational programme.

Final designation type: OECI Comprehensive Cancer Centre

Appendix 1: Overview of the auditor scores

§	Yes	%	Mostly	%	Partially	%	No	%	n/a	%	n/v	%	Sum Tot	Check
Chapter 1														
Score audit team	11	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	**11**	100.0
Chapter 2	Yes		Mostly		Partially		No		n/a		n/v		**Tot**	
Total	49	94.2	3	5.8	0	0.0	0	0.0	0	0.0	0	0.0	**52**	100.0
Chapter 3	Yes		Mostly		Partially		No		n/a		n/v		**Tot**	
Total	31	81.6	6	15.8	1	2.6	0	0.0	0	0.0	0	0.0	**38**	100.0
Chapter 4	Yes		Mostly		Partially		No		n/a		n/v		**Tot**	
Total	16	57.1	4	14.3	8	28.6	0	0.0	0	0.0	0	0.0	**28**	100.0
Chapter 5	Yes		Mostly		Partially		No		n/a		n/v		**Tot**	
Total	12	92.3	0	0.0	0	0.0	0	0.0	1	7.7	0	0.0	**13**	100.0
Chapter 6	Yes		Mostly		Partially		No		n/a		n/v		**Tot**	
Total	24	66.7	7	19.4	3	8.3	0	0.0	2	5.6	0	0.0	**36**	100.0
Chapter 7	Yes		Mostly		Partially		No		n/a		n/v		**Tot**	
Total	85	89.5	8	8.4	2	2.1	0	0.0	0	0.0	0	0.0	**95**	100.0
Chapter 8	Yes		Mostly		Partially		No		n/a		n/v		**Tot**	
Total	48	90.6	4	7.5	0	0.0	1	1.9	0	0.0	0	0.0	**53**	100.0
Chapter 9	Yes		Mostly		Partially		No		n/a		n/v		**Tot**	
Total	18	94.7	1	5.3	0	0.0	0	0.0	0	0.0	0	0.0	**19**	100.0
Total	294	85.2	33	9.6	14	4.1	1	0.3	3	0.9	0	0.0	**345**	100.0

Yes	The indicator has been on a wide scale in the cancer centre and the Deming-cycle has been completed at least twice (> in third cycle)
Mostly	The indicator has been implemented in most of the critical places in the cancer centre and the Deming-cycle has been completed at least once (> in second cycle)
Partially	The indicator has been implemented on project basis or on a modest scale in the cancer centre or the Deming-cycle has not been completed (Do)
No	The indicator does not get attention or there are plans to start working on the indicator (Plan)
Not applicable	The indicator is not applicable in the cancer centre / the centre is not responsible for this indicator due to the health care system
Not verified	The auditors have not addressed this indicator and are not able to provide a verified answer

Appendix 2: Peer review agenda

DAY 1: 26 February 2025

Audit team	Timing (hours)	Min	Audit team	Method	Professional discipline	Content	Location	Name Participants	Function
Team 1 & 2	8.30 - 8.40	10	All	Welcome	Local Accreditation Coordinator Board of Directors Management Team		Auditorium	Roger Spencer	Chief Executive
								Professor Chris Harrison	Deputy Chief Executive
								Dr Neil Bayman	Executive Medical Director
								Narinder Saini	Deputy Chief Nurse
								Claire McPeake	Interim Chief Operating Officer
								Sally Parkinson	Executive Director of Finance and Business Development
								John Waring	Director of Strategy
								Professor Fiona Blackhall	Director of Research & Innovation, Professor of Thoracic Oncology and Honorary Consultant in Medical Oncology
								Professor Rikki Goddard-Fuller	Director of Christie Education and Honorary Consultant Stroke Physician
								Eve Lightfoot	Director of Workforce
								Louise Westcott	Company Secretary
								Zoe Gale	Compliance Lead
								Isabel Kelsey	Compliance Officer
	No walking time required								
	08:45 - 09:10	25	All	Opening meeting Presentation by chair of the audit team	All participants of peer review and other interested	PPT by OECI, including: Peer review objectives Explanation procedures Closing plenary meeting Follow up	Auditorium	Roger Spencer	Chief Executive
								Professor Chris Harrison	Deputy Chief Executive
								Dr Neil Bayman	Executive Medical Director
								Narinder Saini	Deputy Chief Nurse
								Claire McPeake	Interim Chief Operating Officer
								Sally Parkinson	Executive Director of Finance and Business Development
								John Waring	Director of Strategy
								Professor Fiona Blackhall	Director of Research & Innovation, Professor of Thoracic Oncology and Honorary Consultant in Medical Oncology
								Professor Rikki Goddard-Fuller	Director of Christie Education and Honorary Consultant Stroke Physician
								Eve Lightfoot	Director of Workforce
								Louise Westcott	Company Secretary
								Zoe Gale	Compliance Lead
								Isabel Kelsey	Compliance Officer
								Representation from Management Team / Head of Departments	Other participants from Management Team / Head of Departments
								Representation from other participants	Others participating in peer review
	5 minutes								
	09.15 - 09.55	40	All	Trust presentation 10 min + Interview 30 min	Board of Directors	Presentation max 10 min	Auditorium	Roger Spencer	Chief Executive
								Professor Chris Harrison	Deputy Chief Executive
								Dr Neil Bayman	Executive Medical Director
								Narinder Saini	Deputy Chief Nurse
								Claire McPeake	Interim Chief Operating Officer
								Sally Parkinson	Executive Director of Finance and Business Development
								Professor Fiona Blackhall	Director of Research & Innovation, Professor of Thoracic Oncology and Honorary Consultant in Medical Oncology
								Professor Rikki Goddard-Fuller	Director of Christie Education and Honorary Consultant Stroke Physician
								Eve Lightfoot	Director of Workforce
								Louise Westcott	Company Secretary
	5 minutes								
	10.00 - 10.30	30	All	Interview	Management Team / Head of Departments		Auditorium	Jackie Wrench	Divisional Director for Network Services (NWS)
								Claire Adams	Divisional Associate Chief Nurse for Network Services (NWS)
								Mr Chellish Selvaseker	Consultant Colorectal and Laparoscopic Surgeon and Associate Medical Director for Clinical Support and
								Jen Freer	Deputy Chief Operating Officer
								Annie Dewberry	Divisional Associate Chief Nurse for Clinical Support and Specialist Surgery (CSSS) - Nursing and AHPs
								Rachel Edwards	Clinical Service Manager - Radiotherapy
								Katie Freeman-Jones	Acting Service Manager for Radiology
								Professor Jon Bell	Clinical Director of Radiology and Consultant Interventional Radiologist
								Caroline Rogers	Head of Systemic Anti-Cancer Therapy (SACT)
								Gemma Jones	Clinical service manager - Oak Road Treatmet Centre and SACT services
								Dr Ed Smith	Consultant Clinical Oncologist and Clinical Director for Protons (Neil to confirm with CH)
								Dr Natalie Cook	Honorary Consultant in Medical Oncology and Clinical Senior Lecturer, Experimental Cancer Medicine Team - requested by the OECI
								Professor Fiona Blackhall	Director of Research & Innovation, Professor of Thoracic Oncology and Honorary Consultant in Medical Oncology
								Kay Faulkner	Divisional Manager- Research and Innovation
								Dr Lip Lee	Consultant Clinical Oncologist & Clinical Director for Clinical Oncology
								Miss Eva Myriokefalitaki - CD for surgery	Consultant in Gynaecological Oncology Surgery & Clinical Director for Surgery

	5 minutes	5							
	10.35 - 11.15	40	All	Presentation 10 min Interview 30 min	Research activities and developments	Combination of basic & clinical research	Seminar room 4 & 5	Professor Fiona Blackhall	Director of Research & Innovation, Professor of Thoracic Oncology and Honorary Consultant in Medical
								Professor Rob Bristow	Scientific Director Director - Manchester Cancer Research Centre Director - Cancer Research UK (CRUK) Manchester Centre Chief Academic Officer and Honorary Consultant
								Dr Natalie Cook	Honorary Consultant in Medical Oncology and Clinical Senior Lecturer, Experimental Cancer Medicine Team
								Dr Stephen Taylor	Head of Cancer Science, University of Manchester
								Professor Peter Hoskin	Professor of Clinical Oncology and Head of the Christie Fellowship Board
	5 minutes								
	11.20 -12.00	40	All	Presentation 10 min Interview 30 min	Improvement points previous visit	Quality manager, scientific director, medical director	Seminar room 4 & 5	Professor Chris Harrison	Deputy Chief Executive
								Dr Neil Bayman	Executive Medical Director
								Professor Fiona Blackhall	Director of Research & Innovation, Professor of Thoracic Oncology and Honorary Consultant in Medical Oncology
								Narinder Saini	Deputy Chief Nurse
	5 minutes								
	12.05 - 12.40	35	All	LUNCH			Seminar room 4 & 5		
	5 minutes								
Team 1	12.45 - 13.15	30	Team 1	Interview	Supportive care and survivorship	Physio-, swallow-, occupational therapist, nutritionist, programme managers rehabilitation and survivorship	Seminar room 5	Katharine Pantelides	Interim Head of Allied Health Professionals / Rehabilitation Manager
								Tamsin Steward	Occupational Therapy Lead
								Katy Kift	Specialist Speech and Language Therapy
								Loraine Gillespie	Dietetic Manager and Specibaist Oncology Dietician
								Jeni Carden-Jones	Survivorship
								Tiam Lau	Lead Nurse for Psych-oncology
								Diane Dolan	Social Worker
	5 minutes								
	13.20 - 13.50	30	Team 1	Interview	Nurses	Specilised and non-specialised	Seminar room 5	John Murray	Nurse Clinician in Bone Marrow Transplant and Advanced Practice Education Lead Advanced Clinical Practitioner (ACP)
								Rebecca Halstead	Lead Colorectal and Peritoneal Oncology Clinical Nurse Specialist (CNS)
								Liz Perry	Matron for Acute Oncology (AAU, AACU and Hotline)
								Sabrina Scott	Ward Manager
								TBC	B5/6 from OPD/SACT
	5 minutes								
	13.55 - 14.25	30	Team 1	Tour + interview	Outpatient department		OPD	Jo Roberts	Outpatients department Matron
								Danielle Berman	Outpatients department ward manager
								Sophie Shepherd	Outpatients department team leader
								Dr Yvonne Summers	Consultant Medical Oncologist
	5 minutes								
	14.30 - 15.00	30	Team 1	Tour + interview	Pharmacy		Pharmacy	Damien Child	Director of Pharmacy
								Joanne McCaughey	Lead Pharmacist for Pharmacy Operational Services
								Phaedra McHale-Hillary	Medicines Safety Officer
	5 minutes								
	15.05 - 15.30	25	Team 1	Observe	MDT / Tumour group	Live MDT meeting where patients are	MDT room	Haematology	Dr Samar Kulkani Consultant Heamatology (MDT Lead)
	5 minutes								
	15.35 - 16.05	30	Team 1	Tour + interview	Ambulatory SACT service	+ Patient record check	Oak Road Treatment Centre	Caroline Rogers	Head of Systemic Anti-Cancer Therapy (SACT)
								Gemma Jones	Clinical Service Manager for Oak Road Treatment Centre and SACT services
								Rhona Johnson	Senior SACT Clinical Educator
								Mary O'Mahony	Quality Manager for SACT services
	10 minutes								
	16.15 - 16.45	30	Team 1	Interview	Pain expert and Palliative team		Seminar room 5	Dr Richard Berman	Consultant in supportive care, palliative medicine and symptom management Deputy Clinical Director for Supportive Oncology Honorary Senior Lecturer in Cancer Sciences
								Mark Warren	Operational Lead and Clinical Nurse Specialist in Supportive & Palliative Care
								Dr Ahmed Aboelnaga	Clinical Fellow
								Stephanie Meachin	Pain Clinical Nurse Specialist
	5 minutes								

	16.50 - 17.10	20	Team 1	Interview	Heamatology MDT Lead		Seminar room 5	Dr Samar Kulkarni	Consultant Heamatology (MDT Lead)
Team 2	12.50 - 13.15	25	Team 2	Observe	MDT / Tumour Group	Live MDT meeting where patients are discussed	MDT room	Uro-oncology MDT (penile, testicular retroperitoneal sarcoma)	Mr Jeremy Oates (Consultant Urological Surgeon)
	5 minutes	5							
	13.20 - 13.50	30	Team 2	Tour + Interview	Nuclear Medicine		Nuclear Medicine	Heather Williams	Consultant Medical Physicist and Nuclear Medicine Group Leader
								Andrew Harris	Consultant Clinical Scientist and Christie Nuclear Medicine Physics Lead
								Wendy Jennison	Lead Clinical Technologist - Nuclear Medicine
								Louise Garlick	Nurse - Nuclear Medicine
	5 minutes	5							
	13.55 - 14.25	30	Team 2	Tour + Interview	Radiotherapy		Radiotherapy	Rachel Edwards	Clinical Service Manager - Radiotherapy
								Jane Kimberley	Principle Radiographer - Governance (Radiotherapy and Protons)
								TBC	Clinical Director for Clinical Oncology & Consultant Clinical Oncologist
								Cynthia Eccles	Consultant Research Radiographer, Head of Radiotherapy Research and Development
								TBC	Radiographer
	5 minutes	5							
	14.30 - 15.00	30	Team 2	Tour + Interview	Radiology		Radiology	Professor Jon Bell	Clinical Director of Radiology and Consultant Interventional Radiologist
								Sarah Whelehan	Principle Radiographer / Governance Lead
								Sarah O'Connell	Clinical Specialist Radiographer / Direcorate Operations Manager
								TBC	Lead Nurse - Radiology
	10 minutes	5							
	15.10 - 15.40	30	Team 2	Tour + Interview	Ward Medical Oncology	+ Patient record check	Wd 14 / 15	Nicola Doherty	Matron - Medical Wards
								Lis Perry	Matron - Acute Oncology
								Dr Tim Cooksley	Consultant in Acute Medicine
								Dr Safwaan Adam	Consultant Endocrinologist
	10 minutes	5							
	15.50 - 16.20	30	Team 2	Presentation 10 min + Interview 20 min	ICT department	Medical records, status of electronic files,	Seminar room 4	Alistair Reid-Pearson	Chief Information Officer
								Matt Barker-Hewitt	Deputy Chief Information Officer
								Jo Williams	Digital Lead Clinical Implementer
								TBC	Consultant Medical Oncologist and Associate Medical Director for Digital Services
								Fabio Gomes	Director for Clinical Outcomes and Consultant in Medical Oncology
	5 minutes								
	16.25 - 16.45	20	Team 2	Interview	MDT Coordinators		Seminar room 4	Jade Hilton	Pathway tracker / MDT Coordinators
								Alice Seed	Pathway tracker / MDT Coordinators
								Deborah Wright	Pathway tracker / MDT Coordinators
								Marie Lockwood	Cancer Performance Manager
	5 minutes								
	16.50 - 17.10	20	Team 2	Interview	Uro-oncology MDT Lead		Seminar room 4	Mr Jeremy Oates	Consultant Urological Surgeon (Uro-oncology MDT Lead)
	5 minutes								
Team 1 & 2	17.15 - 17.25	10		Review	Local Accreditation Coordinator		Seminar room 4 / 5		
	17.25 - 18.30	65		Break	Travel time & Hotel				
	18.30 - 22.00			Working dinner	Hotel	Scoring day 1 and preparation day2			

DAY 2: 27 February 2025

Audit team	Timing (hours)	Min	Audit team	Method	Professional discipline	Content	Location	Name participants	Function
Team 1 & 2	8.30 - 8.40	10	Auditors	Review	Local Accreditation Coordinator	Previous day	Seminar room 4 & 5	Zoe Gale	Compliance Lead
								Isabel Kelsey	Compliance Officer
	5 minutes								
	8.45 - 9.25	40	All	Interview + presentation (10 min)	Education & training	incl HRM, resident, PhD	Seminar room 4 & 5	Professor Rikki Goddard-Fuller	Director of Christie Education and Honorary Consultant Stroke Physician
								Professory Peter Hoskin	Professor of Clinical Oncology and Head of the Christie Fellowship Board
								Ellie McManus	Associate Director of Christie Education
								Rachel Chown	Associate Director of Integrated Research and Education Strategy
								David Smithson	Deputy Director of Workforce
								Shona Jackson	Mandatory Training Manager
								TBC	Lead Registrar / Clinical Oncology Trainee - TBC
	5 minutes								
	9.30 - 10.10	40	All	Interview + presentation (10 min)	Quality management	Quality reporting; online available tools / guidelines / Dashboard	Seminar room 4 & 5	Dr Vidya Kasipandian	Associate Medical Director for Quality & Patient Safety Consultant in Critical Care abd Anaesthesia
								David Wright	Associate Chief Nurse for Quality & Patient Experience
								Ben Vickers	Patient Safety Specialist and Head of Risk
								Sharon Ingram	Matron for Quality & Standards and NMP Lead Nurse
								Phil Higham	Patient Experience and Improvement Lead
								Narinder Saini	Deputy Chief Nurse
								Zoe Gale	Compliance Lead
	10 minutes								
Team 1	10.20 - 10.50	30	Team 1	Tour + interview	Surgery (on the surgery ward)		Ward 10	Mr Chelliah Selvasekar - TBC	Consultant Colorectal and Laparoscopic Surgeon and Associate Medical Director for Clinical Support and Specialist Surgery (CSSS)
								Miss Eva Myriokefalitaki	Clinical Director for Surgery and Theatres, Consultant in Gynaecological Oncology Surgery
								Aislinn (Ash Giles)	Matron for surgery
								TBC	Ward Manager
	10 minutes								
	11.00 - 11.30	30	Team 1	Interview	Prevention and early detection		Seminar room 4 & 5	Dr Sacha Howell	Senior Lecturer and Honorary Consultant in Medical Oncology / Oncogenetics
								Charlotte Finchett	Health Improvement Manager
								Professor Andrew Renehan	Professor of Cancer Studies and Surgery & Honorary Consultant Colorectal Surgeon
								Professor Fiona Blackhall	Director of Research & Innovation, Professor of Thoracic Oncology and Honorary Consultant in Medical Oncology, Cancer Cluster Lead for Biomedical Research Centre
	5 minutes								
	11.35 - 12.05	30	Team 1	Interview	MDT Leads		Seminar room 4 & 5	Dr Richard Berman	Consultant in supportive care, palliative medicine and symptom management, Deputy Clinical Director for Supportive Oncology, Honorary Senior Lecturer in Cancer Sciences. MDT Lead for Palliative and non palliative supportive oncology
								Dr Mairead McNamara	Senior Lecturer / Honorary Consultant in Medical Oncology MDT Lead for Neuroendocrine tumours (NETs)
								Dr David Thomson	Consultant Clinical Oncologist Head & Neck Lead
								Mr Chelliah Selvasekar	Consultant Colorectal and Laparoscopic Surgeon and Associate Medical Director for Clinical Support and Specialist Surgery (CSSS) - GI MDT
								Miss Eva Myriokefalitaki	Clinical Director for Surgery and Theatres and Consultant in Gynaecological Oncology Surgery Gynae MDT Lead
								Professor Paul Lorigan	Professor of Medical Oncology / Honorary Consultant Melanoma MDT Lead
	5 minutes								
	12.10 - 12.40	30	Team 1	Interview	Head nurses (2 or 3)		Seminar room 4 & 5	Ev Dolan	Divisional Associate Chief Nurse for Research and Innovation
								Annie Dewberry	Divisional Associate Chief Nurse for Clinical Support and Specialist Surgery - Nursing and AHPs
								Claire Adams	Divisional Chief Nurse for Network Services
								David Wright	Associate Chief Nurse for Quality and Patient Experience
	5 minutes								
	12.45 - 13.15	30	Team 1	Interview	Patient representatives		Seminar room 4 & 5	Jo Mayer	Patient representative from Patient Experience Committee
								Phil Ormesher	Public Governor
								Mike Norcross	Public Governor
15 minutes									

Team 2	10.20 - 10.50	30	Team 2	Tour + Interview	Haematology transplantation ward		Haematology	Vicky Burns	Head of Directorate Services - Haematology
								Dr Sumar Kulkarni	Lead Clinician for Apheresis and Deputy Clinical Director for Haematology
								Naomi Brennan	Matron for Palatine Ward
								Oseyaede Eboiyehi	Quality Manager for Haematology
								TBC	Cell Therapy Nurse
	5 minutes								
	10.55 - 11.25	30	Team 2	Tour + Interview	Pathology		Pathology	Dr Phil Monaghan	Head of Service, Consultant Clinical Scientist and Clinical Director of Pathology
								Neil Wrathall	Pathology Quality, Governance and GDPR Lead
								Catherine Billington	Histopathology Service Manager
								Deborah Seale	Blood Sciences Service Manager
								Jane Rogan	Biobank Manager
								Dr Pedro Oliveira	Consultant Histopathologist
	10 minutes								
	11.35 - 12.05	30	Team 2	Tour + Interview	Research clinical trial unit + scientific administration		Experimental Cancer Medicine (ECMT), Clinical Research Facility (CRF) and Paterson Research Building	Professor Fiona Blackhall	Director of Research & Innovation, Professor of Thoracic Oncology and Honorary Consultant in Medical Oncology
								Professor Fiona Thistlethwaite	Medical Oncology Consultant and Medical Director of Christie Clinical Research Facility
								Rachel Chown	Associate Director of Integrated Research and Education Strategy
								Kay Faulkner	Divisional Manager- Research and Innovation
	10 minutes								
	12.15 - 12.45	30	Team 2	Tour + interview	Basic research labs		Paterson Cancer Research Centre	Dr Claus Jorgensen	Deputy Director of CRUKMI
								Dr Dominic Rothwell	Deputy Director of the CRUK Biomarker Centre
								Dr Stephen Taylor	Head of Cancer Science, University of Manchester
								Dr Caroline Wilkinson	Chief Operating Officer of the CRUK Manchester Institute
								Dr Stuart Pepper	Chief Laboratory Officer of the CRUK Manchester Institute
	5 minutes								
	12.50 - 13.20	30	Team 2	Interview	Clinical researchers		CODU meeting room 1 & 2	Dr Rob Metcalf	Honorary Consultant in Medical Oncology
								Dr Natalie Cook	Honorary Consultant in Medical Oncology and Clinical Senior Lecturer, Experience Cancer Medicine Team. Manchester Experimental Cancer Medicine Centre Clinical Lead
								Dr Gerben Borst - TBC	Honorary Consultant Clinical Oncologist
								Professor Corinne Faivre-Finn	Professor of Thoracic Radiation Oncology and NIHR Senior Investigator, University of Manchester Honorary Consultant in Clinical Oncology
								Professor Omer Aziz - TBC	Consultant Colorectal and Laparoscopic Surgeon. Manchester Academic Health Science Centre Honorary Clinical Chair
								Dr Emma Searle	Consultant Haematologist - Early Phase Trials
									Deputy Medical Director - Christie Clinical Research Facility
									Honorary Senior Lecturer - University of Manchester
	10 minutes								

Team 1 & 2	13.30 - 14.00	30	All	LUNCH			Seminar room 4 & 5		
	14.00 - 15.25	85	All	Discussion + Formulation preliminary results	Only the audit team + OECI coordinator		Seminar room 4 & 5		
	5 minutes								
	15.30 - 16.00	30	All	Preliminary results	Local Accreditation Coordinator Board of Directors Management Team	Initial feedback in private setting	Auditorium	Roger Spencer	Chief Executive
								Professor Chris Harrison	Deputy Chief Executive
								Dr Neil Bayman	Executive Medical Director
								Narinder Saini	Deputy Chief Nurse
								Claire McPeake	Interim Chief Operating Officer
								Sally Parkinson	Executive Director of Finance and Business Development
								John Waring	Director of Strategy
								Professor Fiona Blackhall	Director of Research & Innovation, Professor of Thoracic Oncology and Honorary Consultant in Medical Oncology
								Professor Rikki Goddard-Fuller	Director of Christie Education and Honorary Consultant Stroke Physician
								Eve Lightfoot	Director of Workforce
								Louise Westcott	Company Secretary
								Professor Rob Bristow	Scientific Director Director - Manchester Cancer Research Centre Director - Cancer Research UK (CRUK) Manchester Centre Chief Academic Officer and Honorary Consultant
								Zoe Gale	Compliance Lead
								Isabel Kelsey	Compliance Officer
	5 minutes								
	16.05 - 16.30	25	All	Closing plenary session: Preliminary results	All participants of peer review and other interested	PPT by OECI: Preliminary findings	Auditorium	Roger Spencer	Chief Executive
								Professor Chris Harrison	Deputy Chief Executive
								Dr Neil Bayman	Executive Medical Director
								Narinder Saini	Deputy Chief Nurse
								Claire McPeake	Interim Chief Operating Officer
								Sally Parkinson	Executive Director of Finance and Business Development
								John Waring	Director of Strategy
								Professor Fiona Blackhall	Director of Research & Innovation, Professor of Thoracic Oncology and Honorary Consultant in Medical Oncology
								Professor Rikki Goddard-Fuller	Director of Christie Education and Honorary Consultant Stroke Physician
								Eve Lightfoot	Director of Workforce
								Louise Westcott	Company Secretary
								Zoe Gale	Compliance Lead
								Isabel Kelsey	Compliance Officer
								Representation from management team and other participants	Management team and others
	16.30 - 18.00	90		Break	Travel time & hotel				
	18.00 -			Working dinner	Scoring and reporting				