NHS
The Christie
NHS Foundation Trust

Quality report

2025/26

Contents

Quality Report

Statement on quality from the Chief Executive

Everything we do at The Christie is focused on achieving the highest possible quality of care and outcomes for our patients. During 2025/26, the NHS continued to face significant challenge, including increasing demand and persistent variation in health outcomes across different communities. Throughout the year, we have remained focused on the quality of care and treatment we provide, supported by the strength of our patient-centred culture, the commitment and compassion of our staff, and our specialist oncology expertise. This has enabled us to respond to new and emerging demands while continuing to ensure that patients receive timely treatment, clear information and appropriate support.

Our track record of publishing information about the quality of our services continues. We publish an integrated quality, finance and performance report each month, which provides the Board with regular oversight of patient experience, patient safety and the effectiveness of care. This Quality Report draws together that intelligence to describe the progress we have made over the past year, the areas where further improvement is required, and the actions we are taking to address them, including a focus on reducing unwarranted variation and health inequalities.

The hard work and dedication of our staff remains evident in the experience reported by our patients and their families. The Christie continues to perform strongly in national patient surveys, including the National Inpatient Survey, the Friends and Family Test and the National Cancer Patient Experience Survey. Alongside celebrating these strengths, we continue to use patient feedback and experience data to better understand differences in access, experience and outcomes for different patient groups, and to inform improvement where disparities are identified.

The Board of Directors receives assurance on quality through a robust governance framework. The Quality Assurance Committee scrutinises and monitors quality performance and improvement programmes, including safety, effectiveness and patient experience, and further assurance is provided through our governors' Patient Safety and Experience Committee, supporting the Council of Governors in advising on current performance and future priorities. The voices of our patients and their families are central to this assurance, helping us to understand both where care is working well and where it needs to improve, particularly for patients who may be at greater risk of disadvantage or poorer outcomes.

The Board remains strongly committed to building on our high standards of quality and to maintaining our reputation for excellence in the years ahead, particularly in the context of continued pressure on NHS resources. Our quality strategy, which supports our five-year Trust strategy, provides a clear framework for sustaining and improving quality across our services, with reducing health inequalities and improving equity of access, experience and outcomes forming an increasingly important part of this work.

I am pleased to present this Quality Report and, on behalf of the Board of Directors, to confirm that the information it contains is accurate and provides a fair and representative account of the quality of services provided by The Christie during the year.

Roger Spencer
Chief Executive Officer
22nd May 2026

Priorities for improvement and statements of assurance from the board

Quality ambitions for 2026/2027

Two quality ambitions have been identified for 2026/27. The first focuses on reducing inpatient falls, informed by incident data from 2025/26 and supported by the establishment of a Falls Quality Improvement Task and Finish Operational Group. The second priority is to embed improvement methodology across the organisation, enabling the consistent delivery of safe, high-quality and personalised care across complex pathways and supporting a culture of continuous learning and improved patient outcomes.

We will work collaboratively to decrease the number of patient falls within the Trust. This will be achieved and evidenced by:

- Strengthen falls prevention through data-driven insight, thematic review and learning.
- Enhance education and training to support clinical competence, accountability and safe practice.
- Embed innovative falls prevention approaches within neighbourhood oncology models to support seamless care across home, community and inpatient settings.
- Strengthen multidisciplinary working to support early identification, assessment and intervention for patients at risk of falls.
- Maintain regular review of compliance with NICE standards, with oversight through the Falls Quality Improvement Task and Finish Operational Group and escalation via established governance routes.
- Co-develop patient and carer education resources with people with lived experience to support empowerment and self-management of falls risk.
- Maximise national and international collaboration to share learning and best practice in falls prevention.
- Explore and implement digital opportunities to support falls prevention across the Trust.

The Trust will work towards embedding a quality improvement methodology across the organisation. This will be achieved and evidenced by:

- Equip staff across the organisation with practical skills to apply quality improvement methodology in day-to-day practice.
- Provide access to a comprehensive quality improvement training offer, with specialist support where required.
- Demonstrate, through governance reporting, the improvement methodologies used and the resulting actions informed by patient and service user feedback.
- Improve the visibility of feedback to patients and carers so they can clearly see how their input has driven quality improvement.
- Reduce unwarranted variation and strengthen shared learning across teams, ensuring that clinical audit and quality improvement activity routinely considers protected characteristic data to support equitable care.
- Ensure quality improvement methodology underpins action plans arising from Trust quality accreditation processes, with delivery and impact reported through Quality Assurance governance.
- Strengthen alignment between clinical audit, quality improvement activity and established governance cycles across the Trust.

Achievement against quality priorities for 2025/26

We will work collaboratively to improve mouthcare for outpatients. The following has been achieved:

- The Mouth Care Matters programme was extended into outpatient and ambulatory care areas during 2025/26, building on the progress made in 2024/25 and recognising the scale of the work required. This has supported increased awareness of the importance of mouth care across all clinical staff groups, including teams working within satellite services.
- A baseline survey of staff and patient knowledge and understanding was undertaken prior to the commencement of face-to-face training to inform the training approach. Findings were shared through the Quality and Safety Group and with relevant forums, including the Patient Safety and Experience Committee Governors.
- An agreed face-to-face training programme continues to meet staff training needs and has been extended across outpatient, ambulatory care and satellite sites. All staff attending training receive an oral care handbook to support consistent and sustained practice.
- The Oral Assessment and Care Plan within the Electronic Patient Record was updated and went live on 11th December 2025. The updated documentation supports twice-daily oral assessments and delivery of appropriate care in line with patient need.
- Work has continued to ensure consistent availability of mouth care products, with dedicated oral care trolleys on inpatient wards and oral care drawers in outpatient clinic and treatment areas.

We will increase engagement and involvement with patients and their carers in continuous quality improvement. This has been achieved by:

- The Patient and Carer Engagement Forum (PCEF) has been embedded within the Trust's governance structure as a sub-group of the Patient Experience Committee, with a direct reporting line to the Quality Assurance Committee. The Forum is scheduled to meet for the first time in April 2026 and will be jointly chaired by the Associate Chief Nurse for Quality and Patient Experience and the Patient EDI Lead.
- The Quality Plan 2022–25 was extended to 2026 to support development of the 2026–28 Quality Strategy, aligning with the Patient and Carer Engagement Plan 2023–26, which was co-produced with service users. Patient experience will be one of the three strategic pillars of the new Quality Strategy, with implementation shaped collaboratively through the PCEF.
- The Trust has updated its Friends and Family Test reporting platform, enabling enhanced analysis and improved access to data at departmental level. Patient experience data is reviewed regularly through the Patient Experience Committee and increasingly utilised within divisional governance arrangements.
- A focused piece of work led by the physiotherapy team evaluated patient experience within a specialist service, demonstrating the value of the physiotherapist role within supportive oncology and its positive contribution to patient experience.
- During 2025/26, the Trust developed and launched a patient portal, providing improved access to health records and supporting improvements in outpatient pathways and waiting times identified through patient feedback.
- Patient Safety Partners have been embedded across the Trust and now contribute regularly to key governance meetings, providing valuable insight and strengthening the Trust's patient safety and quality improvement agenda.
- A new Patient Equality, Diversity and Inclusion (EDI) Lead post has been established to strengthen the Trust's focus on reducing health inequalities.

Statements of assurance from the Board

Review of services

During 2025/26 The Christie NHS Foundation Trust provided 14 relevant national health services:

- Critical care
- Haematology and transplantation
- Specialist surgery
- Endocrinology
- Clinical oncology
- Medical oncology
- Acute oncology
- Systemic anti-cancer therapy (SACT)
- Radiotherapy
- Brachytherapy and molecular imaging
- Teenage and young oncology
- Radiology
- Christie Medical Physics & Engineering
- Proton Beam Therapy

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

Participation in clinical audits and national confidential enquiries

During 2025/26, 18 national clinical audits and 2 national confidential enquiry covered relevant health services that The Christie NHS Foundation Trust provides.

During 2025/26, The Christie participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that The Christie was eligible to participate in and participated in during 2025/26 are as follows:

1. Bowel cancer (NBOCAP)
2. Lung cancer (NLCA)
3. National Prostate Cancer Audit (NPCA)
4. Oesophago-gastric cancer (NAOGC)
5. Metastatic Breast Cancer (NAoMe)
6. Primary Breast Cancer (NAoPri)
7. Ovarian Cancer (NOCA)
8. Pancreatic Cancer (NPaCA)
9. Non-Hodgkin Lymphoma (NNHLA)
10. Kidney Cancer (NKCA)
11. National Care at the End of Life (NACEL)
12. National Emergency Laparotomy Audit (NELA)

13. Learning Disabilities Mortality Review (LeDeR)
14. National Acute Kidney Injury Programme (NAKIP)
15. National audit of inpatient falls (NAIF)
16. Intensive Care National Audit and Research Centre Case Mix Programme (ICNARC)
17. Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme
18. National Comparative audit of blood transfusion – 2025 Major haemorrhage audit (NCA MHA)
19. NCEPOD Acute illness in people with a Learning Disability (NCEPOD – AILD)
20. NCEPOD Pleural Procedures (NCEPOD – PP)

The national clinical audits and national confidential enquiries that The Christie participated in, and for which data collection was completed during 2025/26, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Name of audits and enquiries	**Numbers submitted (eligible)**	**Percentage of eligible submitted**
NBOCAP	42/42	100%
NLCA	Treatment data only submitted via COSD data – recorded against Trust first seen	100%
NPCA	Treatment data only submitted via COSD data – recorded against Trust first seen	100%
NAOGC	Treatment data only submitted via COSD data – recorded against Trust first seen	100%
NAoMe	Treatment data only submitted via COSD data – recorded against Trust first seen	100%
NAoPri	Treatment data only submitted via COSD data – recorded against Trust first seen	100%
NOCA	Treatment data only submitted via COSD data – recorded against Trust first seen	100%
NPaCA	Treatment data only submitted via COSD data – recorded against Trust first seen	100%
NNHLA	Treatment data only submitted via COSD data – recorded against Trust first seen	100%
NKCA	Treatment data only submitted via COSD data – recorded against Trust first seen	100%
NACEL	80/80	100%
NELA	Awaiting final numbers (Oct'26)	NA
LeDeR	Awaiting final numbers (Nov'26)	NA
NAKIP	8300/8300 (to Feb 2026)	100%
NAIF	4/4	100%

ICNARC	Awaiting final numbers (July'26)	NA
SHOT	Awaiting final numbers (June'26)	NA
NCA MHA	40/40	100%
NCEPOD – AILD	1/3	33%
NCEPOD - PP	2/8 to date, still ongoing	NA
NBOCAP	42/42	100%

Participation in clinical research

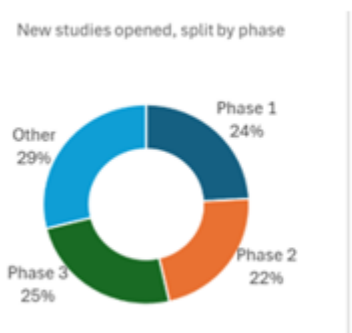
Delivering world-class cancer research remains central to the work of the Division of Research and Innovation and the wider Trust. During 2025/26, continued progress was made against strategic objectives, including global firsts in patient recruitment, significant external investment from Cancer Research UK and the National Institute for Health and Care Research (NIHR), and the launch of a number of transformational projects through The Christie Research 2030 Programme.

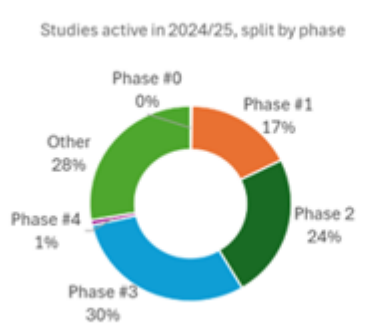
A key strategic priority is the delivery of accessible and inclusive research, aligned with the ambitions of the NHS Long Term Plan and the National Cancer Plan. During 2025/26, this was progressed through the delivery of an Inclusive Research Forum and the establishment of a new, NIHR-funded collaboration with Stockport County FC Community Trust, aimed at increasing awareness of, and access to, cancer clinical research.

Ensuring the safety of patients who choose to participate in research is of fundamental importance. During 2025/26, the Patient Safety Incident Response Framework (PSIRF) was increasingly integrated into Research and Innovation governance arrangements, complementing existing regulatory and assurance processes. This has strengthened oversight of patient safety within research activity, supported a more consistent and learning-focused approach to incident review, and helped ensure that clinical research is delivered safely and in a way that promotes a positive experience for patients.

Research performance

Figure 1





A total of 3393 patients were consented throughout the year and at the close of 2025/26 we have 479 studies open, with 395 in follow up and a further 88 studies in set up. The distribution across study phase is shown in figure 1. (Christie Data Insights, 2026).

Quality goals and the CQUIN framework

There were no CQUIN's in 2025/26.

Care Quality Commission

The Christie NHS Foundation Trust is registered with the Care Quality Commission (CQC). The Trust is registered to provide the following regulated activities:

- diagnostic and screening procedures
- treatment of disease, disorder or injury
- assessment or medical treatment for persons detained under the Mental Health Act 1983
- surgical procedures

The Trust has no conditions on its CQC registration.

A CQC inspection rating of Good was published on 12 May 2023 following the inspection of medical core services and the well-led domain during 2022/23.

During 2025/26, the Trust underwent CQC inspections under the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) for its PET-CT service and pathways, and for its radiotherapy service, with a particular focus on satellite service provision. Both inspections have been formally closed by the CQC. IR(ME)R inspections do not result in formal ratings.

No regulatory enforcement action was taken against The Christie NHS Foundation Trust during 2025/26.

Data Quality

During 2025/26, The Christie NHS Foundation Trust submitted patient records to the Secondary Uses Service (SUS) for inclusion in Hospital Episode Statistics (HES). The percentage completeness of records in the latest published data as at March 2026 is set out below:

	% of records in published data which included the patient's valid NHS number	**% of records in published data which included the patient's valid general practitioner registration code**
Admitted Patient Care	94.5%	99.0%
Outpatient Care	99.4%	93.2%
Accident and Emergency Care	Not applicable	Not applicable

As part of the Trust's quality improvement programme, the following actions are being taken to strengthen data quality:

- The Trust continues to undertake a comprehensive programme of clinical coding audits, including annual individual coder audits, Healthcare Resource Group (HRG) deep-dive audits and targeted classification code audits as required.
- A suite of routine data quality reports is used to support assurance and continuous improvement.
- The Band 6 Senior Performance Analyst role has been revised to include day-to-day supervision of the Data Quality Officers, strengthening oversight and providing a clearer link with operational teams responsible for data inputting.

- In addition, work is underway to establish a Radiology Information System (RIS) User Group to improve consistency in the recording of imaging activity across services.
- The Trust also continues to work collaboratively with commissioners to respond to data quality challenges.

Information Governance

The Christie NHS Foundation Trust's overall compliance score for the Data Security and Protection Toolkit (DSPT) 2024/25 was rated as *approaching standards*. At the time of reporting, the supporting evidence is under review by MIAA**.**

The 2025/26 DSPT assessment is currently in progress and will be completed in line with the national submission deadline of 30 June 2026**.**

Coding Audit

A Data Security and Protection Toolkit Clinical Coding Internal Audit took place during the financial year by the Trust's NHS Digital approved auditor. The results of the audit are as follows:

	Mandatory requirement	Advisory requirement	2025-26	2024-25	2023-24
Primary Diagnosis	>=90%	>=95%	92.5	90	91.5
Secondary Diagnosis	>=80%	>=90%	93.9	93.7	91.4
Primary Procedure	>=90%	>=95%	93.3	94.7	92.8
Secondary Procedure	>=80%	>=90%	92.6	94.5	92.2

Reporting against core indicators

NHS Outcomes Framework	Indicator	The Christie Performance 2024/25	The Christie Performance 2025/26	National average	National Highest/ lowest
The value and banding of the summary hospital-level mortality indicator ("SHMI") The percentage of patient deaths with palliative care coded at either diagnosis or specialty level	Preventing people from dying prematurely. Enhancing quality of life for people with long-term conditions.	This is not applicable to The Christie as we are a specialist cancer hospital.			
The Christie NHS Foundation Trust considers that this indicator is not applicable to the Trust as all our patients have a cancer diagnosis and are not part of the inclusion criteria.					

NHS Outcomes Framework	Indicator	The Christie Performance 2024/25	The Christie Performance 2025/26	National average	National Highest/ lowest
The Trusts patient reported outcome measures scores for: • groin hernia surgery • varicose vein surgery • hip replacement surgery • knee replacement surgery	Helping people to recover from episodes of ill health or following injury	This is not applicable to The Christie as we are a specialist cancer hospital.			
The Christie NHS Foundation Trust considers that this indicator is not applicable to the Trust as all our patients have a cancer diagnosis and are not part of the inclusion criteria.					

NHS Outcomes Framework	Indicator	The Christie Performance 2024/25	The Christie Performance 2025/26	National average	National Highest/ lowest
The percentage of patients aged: 0 to 14 15 or over Readmitted to a hospital which forms part of the Trust within 28 days of being discharged from hospital which forms part of the Trust.	Helping people to recover from episodes of ill health or following injury	This is not applicable to The Christie as we are a specialist cancer hospital.			
The Christie NHS Foundation Trust considers that this indicator is not applicable to the Trust as all our patients have a cancer diagnosis and are not part of the inclusion criteria.					

NHS Outcomes Framework	Indicator	The Christie (National) Performance Q1 25/26	The Christie (National) Performance Q2 25/26	The Christie (National) Performance Q4 25/26
National Pulse Survey 4 Measures taken in Q1, Q2 & Q4	Engagement	6.95 (6.41)	7.01 (6.29)	6.75 (6.22)
	Advocacy	7.29 (6.27)	7.60 (6.05)	7.38 (6.00)
	Involvement	7.00 (6.38)	6.97 (6.34)	6.52 (6.26)
	Motivation	6.56 (6.59)	6.45 (6.49)	6.36 (6.39)
*PULSE survey replaced the National Staff Friends & Family Test in April 2021				

The Christie NHS Foundation Trust considers that this data is as described for the following reasons: to show the percentage of staff who would recommend The Christie as an organisation that provides good quality care for their family or friends.

The Christie NHS Foundation Trust intends to take the following actions to improve this percentage and so the quality of its services, by continuing to monitor compliance to the above target and to take any remedial action if required: This will be reviewed through quarterly Board level scrutiny of the outcomes of the Quarterly People Pulse Survey.

NHS Outcomes Framework	Indicator	The Christie Performance 2024	The Christie Performance 2025	National average 2025
The percentage of patients admitted as an inpatient to the Trust who would recommend the Trust as a provider of care to their family or friends.	Ensuring that people have a positive experience of care.	96%	96%	94%

The Christie NHS Foundation Trust considers that this data is as described for the following reasons: to show the percentage of patients admitted to the Trust who would recommend The Christie as an organisation that provides good quality care for their family or friends.

The Christie NHS Foundation Trust intends to take the following actions to improve this percentage and so the quality of its services, by continuing to monitor compliance to the above target and to take any remedial action if required: This will be reviewed through monthly Board level scrutiny of the National Friends and Family test.

NHS Outcomes Framework	Indicator	The Christie Performance 2024/25	The Christie Performance 2025/26	National average 2025/26 (Q1-Q3)	National Highest/ Lowest 2025/26 (Q1-Q3)
Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism	Treating and caring for people in a safe environment and protecting them from avoidable harm.	91.3%	93.1%	91.1% At the time of reporting only Q1-Q3 national figures were available.	H – 99.8% L – 14.9%

The Christie NHS Foundation Trust considers that this data is as described for the following reasons: to show the percentage of patients admitted to The Christie that have had a full risk assessment of venous thromboembolism.

The Christie NHS Foundation Trust intends to take the following actions to improve this percentage and so the quality of its services, by continuing to monitor compliance to the above target and to take any remedial action if required: This will be reviewed through monthly Board level scrutiny of the results of the venous thromboembolism assessments on admission.

NHS Outcomes Framework	Indicator	The Christie Performance 2024/25	The Christie Performance 2025/26	National average 2025/26	National Highest/ Lowest 2025/26
Rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over.	Treating and caring for people in a safe environment and protecting them from avoidable harm.	84.9	80.0	31.5	H – 86.2 L – 2.6
The Christie NHS Foundation Trust intends to take the following actions to improve this percentage and so the quality of its services, by continuing to monitor compliance to the above target and to take any remedial action if required: This will be reviewed through monthly Board level scrutiny of the results of the C.difficile numbers and through the monthly review with our commissioners. **The Christie rate is high due to a relatively small number of bed days in comparison to the number of C-Diff cases.					

NHS Outcomes Framework	Indicator	The Christie Performance 2025/26	
The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period	Treating and caring for people in a safe environment and protecting them from avoidable harm.	Total number of Patient Safety incidents	10527
		Percentage of all total incidents reported	87%

Freedom to speak up

The Christie is committed to fostering an open and transparent culture in which staff feel safe, supported and confident to speak up, and where raising concerns is part of normal, everyday practice.

Most speaking up occurs through routine conversations with supervisors and line managers, enabling issues to be identified and resolved promptly. There is an increased focus on strengthening support, guidance and training for managers and supervisors to ensure they are confident and equipped to respond appropriately to concerns raised.

Staff have access to a range of speaking up routes, as outlined in the Freedom to Speak Up policy, allowing individuals to choose the option that feels most appropriate. The Trust's Freedom to Speak Up Guardian, supported by a network of trained Freedom to Speak Up Champions, provides confidential advice and support to staff wishing to raise concerns. The Champion Network has continued to expand during the past year to strengthen local support.

The Freedom to Speak Up Plan sets out the Trust's aims and actions to promote and sustain a positive speaking up culture, underpinned by shared values and behaviours. The profile of speaking up is actively promoted across the organisation, including regular engagement by the Guardian at team meetings across Trust sites and participation in staff induction programmes.

The Freedom to Speak Up Guardian provides twice-yearly reports to key governance committees, including the Board of Directors. These reports include thematic analysis of concerns raised, actions taken to strengthen speaking up culture, and review of relevant Staff Survey results, which inform priorities and actions for the year ahead.

Review of quality performance in 2025/26

The Christie has an established framework for quality reporting that underpins both monthly quality performance reporting within routine performance reports and this annual Quality Account. The Board of Directors is clear that quality must be reported and scrutinised regularly to enable the early identification of emerging risks or adverse trends.

Monthly Trust-wide quality performance is reviewed through the Senior Management Committee, which is attended by senior leaders across the organisation, including both clinical and non-clinical leadership, as well as the Directors of Research and Education. Divisional quality performance is reviewed through regular performance meetings with the executive team. Any areas of concern are escalated and monitored through divisional governance routes or the Risk and Quality Governance Committee, as appropriate.

The Board's Quality Assurance Committee provides oversight and assurance on quality across the organisation. Quality reports are also shared with the Council of Governors, supported by a Quality Governor Sub-Committee which receives detailed assurance on quality matters. Executive Directors undertake regular visits to clinical areas and meetings with clinical leaders, alongside Non-Executive Directors and Governors, to gain direct assurance on the quality of care, environment and patient experience.

This section of the Quality Account draws on monthly performance reporting and includes additional indicators where annual reporting is more appropriate. Data is sourced from established surveys, audits and routine information systems designed to provide focused assurance on the quality and safety of care delivered.

Patient experience

Patient satisfaction with care at The Christie remains very high, and the Trust continues to focus on delivering the best possible experience for patients and their families during what is often a time of significant stress and uncertainty.

Friends and Family Test

The NHS Friends and Family Test (FFT) provides the Trust with direct, regular and near real-time feedback from patients about their experience of care. This feedback plays a key role in shaping service improvement and enhancing the patient experience.

Following an inpatient stay or outpatient appointment, patients are invited to respond to the question: *"Overall, how was your experience of the service?"* Responses can be submitted via a free text message or an online form. Text messages are issued within 48 hours of an episode of care. To reduce respondent burden for patients who attend frequently, invitations are sent no more than once per month and ask patients to reflect on their most recent experience.

Responses are recorded using a five-point scale ranging from very good to very poor. Patients are also invited to provide additional comments to highlight what could have been improved. All feedback is anonymised, and patients are encouraged to contact the Patient Advice and Liaison Service (PALS) where they wish to raise issues directly.

FFT response rates and ward and department level results are reviewed monthly and reported through the Trust's performance reporting arrangements. Aggregate results are published in the performance report, with full access to FFT data available to all staff via the Trust's intranet.

During 2025, the Trust implemented a new FFT reporting platform, improving the accessibility and depth of analysis available at departmental and organisational level. For 2025, the Trust achieved a 96% positive FFT score, with an overall response rate of 45%. Feedback remained overwhelmingly positive, with strong themes relating to staff, care and treatment, and the quality of information provided. The most common area for improvement related to appointments and waiting times.

In response to this feedback, two key improvement initiatives were delivered during 2025: the launch of the patient portal, improving access to information and communication, and changes to phlebotomy appointment scheduling. These changes are expected to positively impact waiting times and the experience of attending for blood tests. The Quality and Standards Team continues to work closely with services to review FFT feedback, with oversight provided through the Patient Experience Committee.

Work is ongoing to explore the routine collection of demographic data through FFT, which will support the Trust's equality, diversity and inclusion objectives and enable a more nuanced understanding of patient experience across different population groups.

National inpatient survey 2024 results published in 2025

The Christie again achieved excellent results in the Care Quality Commission (CQC) annual inpatient survey, with performance rated as "much better than expected". This rating reflects the proportion of patients reporting positive experiences of care, which was significantly higher than the national average across the survey.

Patients were eligible to participate if they were aged 16 years or over and had spent at least one night in hospital. The survey differed from previous years in its methodology, sampling period and questionnaire content, and was delivered using a push-to-web approach, offering both online and paper completion.

A total of 1,250 patients were invited to take part, with 477 responses received, giving a response rate of 41%. The Trust's overall care score was 9.2, compared with a national average of 8.2, representing performance that was much better than expected.

The survey is structured across 12 sections (excluding Virtual Wards, which are not applicable to the Trust). Results showed that in 10 sections, The Christie scored much better than most trusts; feedback on the quality of care section is not formally graded. At individual question level, performance was much better than other trusts for 37 questions, better for 5 questions, and somewhat better for 2 questions. These results represent a significant improvement compared with the previous year and demonstrate consistently high levels of patient-reported experience of inpatient care.

The survey findings identified improving the conditions that support patient sleep as a key area for focus in the coming year. This has been incorporated into the action plan developed in response to the survey results and will also be supported through the introduction of a senior nurse night-time quality assurance and engagement programme.

Following publication of the 2024 survey results, findings were shared with key managers and presented through relevant Trust committees and governance forums.

National Cancer Patient Experience Survey 2024 – published in 2025.

The Cancer Patient Experience Survey (CPES) is a national annual survey comprising 61 questions that capture patient experience across the cancer pathway, from diagnosis through treatment and post-treatment support. The survey covers 14 domains, including primary care support prior to diagnosis, hospital care, and living with and beyond cancer; therefore, not all questions relate directly to services provided by The Christie.

Despite this, CPES provides an important source of intelligence, enabling the Trust to monitor trends over time and benchmark performance against other providers nationally. In 2024, 1,440 Christie patients were invited to participate, with 682 responses received, representing a 47% response rate.
Results are presented as percentage scores and benchmarked against an expected range, adjusted for Trust size and patient demographics. Scores above the upper limit of the expected range indicate statistically significant performance exceeding the national average. In 2024, the Trust's overall care score was 9.2, an improvement from 9.0 in 2023 and above the national average, indicating excellent patient-reported experience.

The Christie was a positive outlier for 19 survey questions (compared to 11 in 2023). Performance was particularly strong in the Hospital Care domain, where all nine questions scored above the expected range. Strong performance was also demonstrated in the support from hospital staff, decision-making about treatment, and discussions regarding research opportunities sections.
One question scored below the expected range, relating to whether patients felt they had received enough understandable information about their response to immunotherapy. This area is being reviewed as part of the Trust's ongoing patient experience improvement work.

Comparison with 2023 results shows statistically significant improvement in nine questions, covering areas such as information provision about diagnostic tests and treatment, involvement in decision-making, understanding of chemotherapy and side effects, support for carers, access to community support, and overall rating of care. No questions showed a statistically significant decline compared with the previous year.

Following publication of the 2024 survey results, findings were shared with key managers and presented through relevant Trust committees and governance forums. A comprehensive action plan has been developed in response to the survey findings and is monitored through the Patient Experience Committee.

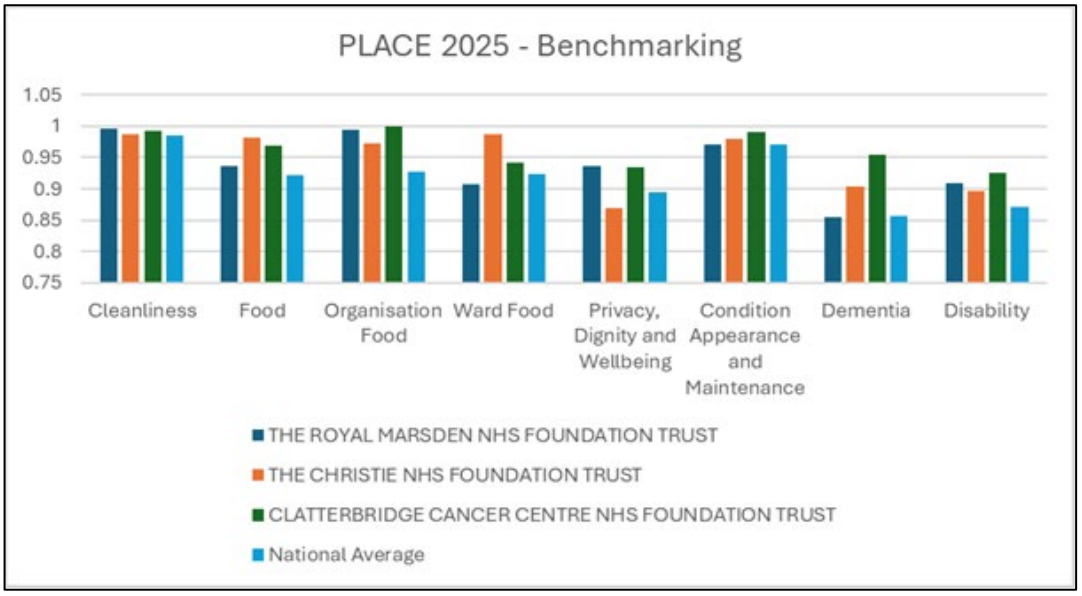
PLACE Assessment

The Patient-Led Assessments of the Care Environment (PLACE) is an annual assessment that reviews the care environment from a patient perspective. Patient assessors are recruited and undertake mandatory training prior to the assessment, which is carried out alongside an equal number of staff assessors and an independent assessor from another NHS Trust. Some assessors were new to the process while others had participated previously; the Trust-led training supported consistency and provided an opportunity for assessors to meet, ask questions and gain confidence before the assessment.

The assessments review a range of domains including privacy and dignity, food and hydration, cleanliness, accessibility, and the general condition and maintenance of the environment, as well as how well the environment supports the care of people living with dementia and disability. In addition, two organisational assessments relating to facilities and food provision are completed in advance of the assessment day.

Due to infection prevention and control advice, Ward 4 was not assessed. The Oncology Critical Care Unit (OCCU) was not assessed as it is not appropriate for PLACE, and Ward 11 was closed for refurbishment. Assessments were undertaken across outpatient areas including Department 22, Oak Road Patient Treatment Centre, Radiotherapy and Proton Beam Therapy. All main circulation areas were included, such as the Oak Road foyer, lifts, corridors, public toilets, external areas, car parks C and D, and Trust entrances. The lunchtime meal service on wards 2 and 10 was also assessed.

The Withington site scored above the national average in three PLACE domains, while also identifying areas for improvement. Results were benchmarked against comparator specialist Trusts, including The Royal Marsden and The Clatterbridge Cancer Centre, to support learning and continuous improvement.



An action plan has been produced and will be updated via PEC (Patient Experience Committee). Many of the original actions were resolved quickly after the assessment so the main actions are now generic issues or those requiring financial investment e.g. ward upgrades. There will be some attention to access issues and Privacy & Dignity requirements which will be discussed at PEC.

Patient feedback included the following comments;

'Christie is a wonderful hospital that continues to provide a brilliant environment and cancer treatment.'

The Christie at Macclesfield site also performed well and whilst the site does not serve food, it scored highly in all other areas and achieved higher scores than the national averages in all of the domains assessed.

"A very calming and welcoming reception area with plenty of seating. All staff were polite.'

The building has been open for approx. 3.5 years. The fabric of the building is still immaculate with the exception of the flooring in the lifts. Actions required included replacement of the lift floors and enhancement of the highlighted marking on the main glass doors.

Patient experience stories to the Board

Board meetings are held on the last Thursday of the month at 2.00pm. There are no meetings in February, May, July, August, or December.

Date	Presenters	Topic / area
April 2025	Faye Sharpley, Clinical Director for Haematology and David, a patient	Haematology, with a focus on Christie@ Macclesfield and the overarching Haematology strategy
May 2025	**No meeting**	
June 2025	Rosie Gill, Soft Facilities Manager and Brian Turner, patient assessor	PLACE assessment
July 2025	**No meeting**	
August 2025	**No meeting**	
September 2025	Omer Aziz, Colorectal Surgeon, Rebecca Halstead, Clinical Nurse Specialist and Toby, a patient	A 360-degree view of The Christie's National Peritoneal Tumour Centre
October 2025	Dr David Wolfe, Consultant Clinical Oncologist and Kevin, a patient	Improving outcomes by learning from every patient (RAPID-RT)
November 2025	Dr Caroline Wilson & Dr Alexandra Lewis, Acute oncology and breast medical oncology consultants, and Joanne, a patient	Driving efficiencies in breast cancer treatment
December 2025	**No meeting**	
January 2026	Fiona Thistlethwaite, Consultant and Deanna, a patient	Clinical Research Facility (CRF) trials
February 2026	**No meeting**	
March 2026	Dr Fabio Gomes, Medical Oncology Consultant and a patient	Senior Adult Oncology

Quality Plan 2022 – 2025

The Quality Plan is designed for staff, patients, carers and stakeholders and was developed in partnership under the leadership of the Chief Nurse and Executive Director of Quality. It sets out the Trust's quality ambitions and the arrangements in place to govern, measure and deliver high-quality care. The Plan is structured around three core themes: Safe care, Quality Improvement and Clinical Effectiveness, and Positive experience.

An extension to the Quality Plan was approved to include 2025/26, enabling continuity while the next Quality Strategy was developed. This extension supported alignment with changes to the regulatory assessment framework and the wider NHS context, ensuring the Trust remains responsive and well-positioned for the future.

At The Christie, our purpose is to deliver the highest possible quality of care and outcomes for our patients through services that are safe, effective, caring, responsive and well-led. Quality is central to everything we do and informs how services are planned, delivered and continuously improved.

The Quality Plan reflects national learning from a range of published reviews and aligns with the shared definition of quality set out by the NHS England National Quality Board (2021). It recognises the importance of strong leadership, effective collaboration and a positive organisational culture in enabling excellent patient and staff experiences and improving outcomes. The Trust remains firmly committed to delivering safe, effective and personalised care, supported by a culture of learning and continuous improvement.

Delivering the ambitions of the Quality Plan requires a structured and multifaceted approach, bringing together culture, leadership, education and development, and consistently high standards of care. Good progress has been made against the Quality Plan priorities over the past year, with evidence of tangible patient benefit through listening, collaboration, compassion and learning across the organisation.

Safer Staffing

The National Quality Board (NQB) published guidance on *Getting staffing right* to ensure the right people with the right skills are in the right place at the right time. This was strengthened by NHS Improvement's Developing Workforce Safeguards (2018), which set out fourteen recommendations against which Trust compliance is assessed. The Christie NHS Foundation Trust remains committed to embedding this national guidance to support the robust review, ratification and assurance of nurse staffing levels.

Nursing staffing establishments are formally reviewed at least twice each year, drawing on data from the Safer Nursing Care Tool (a nationally validated workforce planning tool), alongside patient outcomes, quality indicators and the professional judgement of senior nursing leaders. The Nursing Safe Staffing Bi-annual Establishment Review and monthly safe staffing data are published on the Trust's website to support transparency and Board assurance.

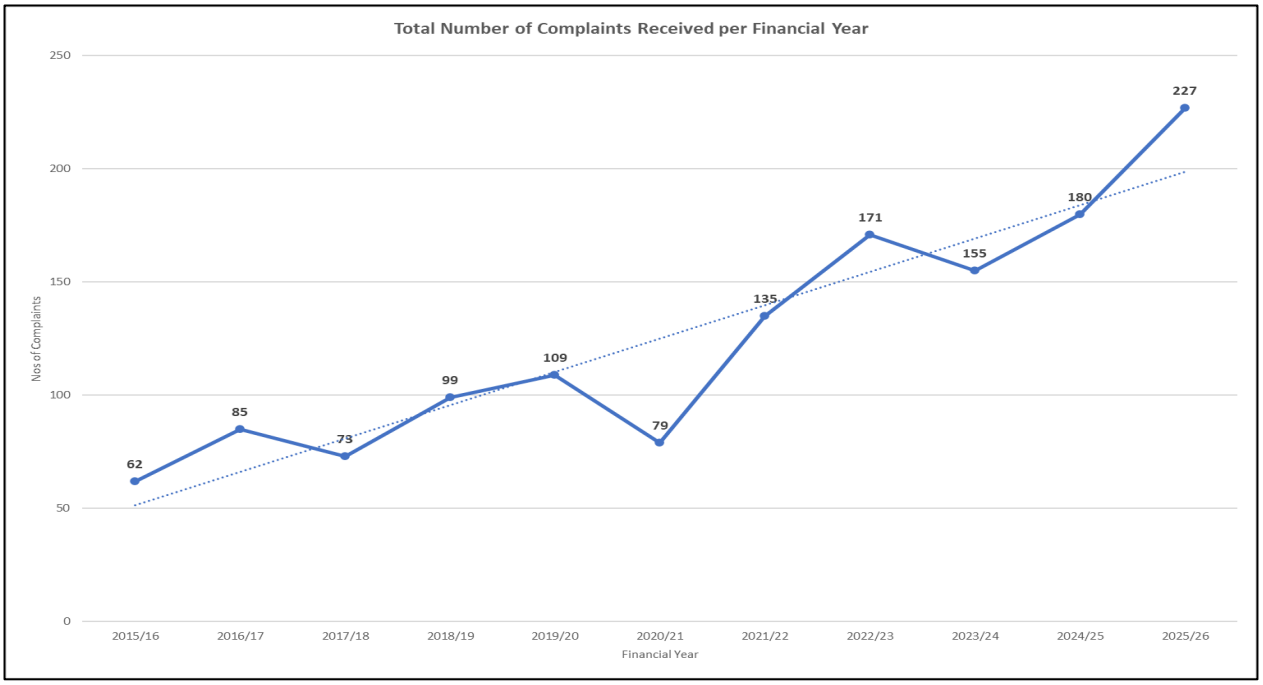
Complaints

The Trust continues to prioritise the resolution of concerns at the earliest opportunity. Clinicians, matrons and clinical area leaders maintain a strong and visible presence across wards and clinical departments, with a focus on patient experience and the continual improvement of care and service delivery on a day-to-day basis.

The number of complaints received has increased year on year; however, this should be considered in the context of a corresponding increase in overall clinical activity and patient contacts. As activity levels grow, a proportional increase in complaints and feedback is expected. The Trust continues to view complaints as a valuable source of learning and assurance and closely monitors complaint volumes alongside activity data to ensure appropriate context and Board oversight.

All complaints are reviewed in detail and cross-referenced with incidents and claims to support a transparent and joined-up approach to learning. Issues raised within complaints are logged separately, enabling multiple themes within a single complaint to be clearly identified, analysed and used to drive improvement in care and services.

The chart below sets out a comparison of complaints received over recent financial years:



Learning from Complaints 2025/26

The following table gives examples of complaints issues that have been raised and associated actions taken as a result:

Issues	Actions taken
Issues with delays and miscommunication in regard to receiving chemotherapy treatment.	Pharmacy has invited new staff to visit the aseptic unit so they can better understand how treatments are made and the timeframes involved. This will help improve communication and set clearer expectations for future patients. The teams have also reflected on this incident together and are looking at how communication tools can be used more effectively to prevent similar issues in the future.
Patient received details regarding another patient in letter correspondence.	Reinforced the need for staff to verify patient identifiers at multiple points during document preparation, especially before issuing letters. Staff also received refresher training on accurate patient record selection and the importance of cross-checking details to minimise the risk of selecting incorrect patient records in future.
Radiotherapy treatment delays.	A time-in-motion study was conducted throughout August 2025, across all radiotherapy machines. The study provided an invaluable insight which has enabled improvements to be made to the scheduling processes, which in turn has helped to reduce delays.

Clinical indicators - Clinical effectiveness

Christie survival estimates 2021-2024 (followed up to 2025)

We present here up to date one year survival estimates, by stage, for Christie patients diagnosed in the years 2021 to 2024 inclusive, followed up at the end of 2025, (Table 1). Estimates by stage are not available for all cancer types either due to small numbers or the nature of data capture. Stage groups are based on TNM staging.

Cancer type	All stages combined	Stage I	Stage II	Stage III	Stage IV
Brain	66.02 (62.44, 69.11)				
Breast	97.88 (97.53, 98.16)	99.62 (99.3, 99.8)	99.19 (98.79, 99.45)	96.94 (95.53, 97.76)	83.99 (80.59, 86.85)
Colon	84.71 (82.77, 86.24)	Unable to estimate	96.59 (92.35, 98.03)	95.2 (93.07, 96.47)	66.99 (62.95, 70.41)
Lung	66.44 (65.27, 67.49)	89.68 (88.21, 90.97)	77.89 (73.71, 81.14)	63.5 (60.3, 66.01)	43.79 (41.72, 45.76)
Melanoma	94.76 (93.22, 95.82)	Unable to estimate	97.08 (92.41, 98.89)	94.1 (90.9, 96.2)	79.82 (70.26, 85.36)
Ovary	85.75 (84.05, 87.19)	97.44 (92.26, 99.17)	Unable to estimate	79.73 (75.01, 83.22)	77.19 (71.87, 81.64)
Prostate	97.81 (97.42, 98.15)	99.36 (98.77, 99.66)	99.0 (98.44, 99.36)	98.34 (97.53, 98.88)	93.39 (91.83, 94.66)
Rectal	90.81 (89.27, 92.13)	97.5 (92.66, 98.69)	92.63 (87.7, 95.06)	95.87 (94.12, 97.12)	74.15 (69.03, 78.56)

Table 1: One year overall survival estimates (percentages with 95% confidence intervals) by cancer type for Christie patients. Data for The Christie data are for patients diagnosed between 2021 and 2024 inclusive using data from eforms in CWP followed up at the end of 2025. These include patients with a DS or MDT form in the time period for those where a date of diagnosis was recorded or date seen could be used as a proxy. Survival was unable to be estimated for groups with low numbers of patients, denoted as 'Unable to estimate' in the table.

Comparing Christie outcomes with national one year cancer survival

Based on the most recent nationally available survival estimates by stage at diagnosis, the Trust demonstrates comparable, and in some cases better, one-year survival outcomes for patients when compared with the national average (see Table 2).

The latest national survival data available relates to cancers diagnosed between 2016 and 2020, with follow-up to 2021. While NHS England intends to publish survival estimates on an annual basis, the release of more up-to-date data has been delayed. To ensure meaningful comparison, this report presents Trust-level survival estimates calculated for the same diagnosis and follow-up period as the most recent published national data.

Cancer type	Source	All stages combined	Stage I	Stage II	Stage III	Stage IV
Brain	**Christie**	59.03 (56.09, 61.54)				
	England	40.5 (39.9, 41.2)				
Breast	**Christie**	97.17 (96.81, 97.49)	99.59 (99.3, 99.76)	98.69 (98.21, 99.04)	96.29 (94.76, 97.22)	84.2 (81.61, 86.46)
	England	94.8 (94.7, 94.9)	97.7 (97.5, 97.9)	96.7 (96.5, 96.9)	93.5 (93, 94)	66.6 (65.5, 67.6)
Colon	**Christie**	81.72 (80.33, 83.02)	Unable to estimate	94.31 (90.56, 96.15)	94.38 (92.33, 95.9)	65.74 (62.73, 68.57)
	England	70.8 (70.5, 71)	95.2 (94.4, 96)	92 (91.5, 92.5)	85.7 (85.1, 86.2)	42.2 (41.5, 42.8)
Lung	**Christie**	55.3 (54.2, 56.23)	84.63 (82.63, 86.19)	70.25 (66.16, 73.62)	54.04 (51.27, 56.45)	35.02 (33.43, 36.5)
	England	41.5 (41.2, 41.7)	88.1 (87.1, 89.1)	75.8 (74.2, 77.4)	52.6 (51.9, 53.4)	22.5 (22.2, 22.9)
Melanoma	**Christie**	95.94 (94.83, 96.72)	Unable to estimate	97.93 (90.58, 98.98)	97.66 (94.32, 98.68)	80.6 (73.51, 85.12)
	England	95 (94.8, 95.1)	99.1 (98.8, 99.2)	96.3 (95.5, 96.9)	94.3 (93, 95.3)	56.9 (53.6, 60)
Ovary	**Christie**	87.22 (85.9, 88.42)	95.19 (90.6, 97.57)	90.39 (77.82, 94.47)	78.39 (73.89, 82.21)	72.99 (67.23, 77.31)
	England	74.7 (74.2, 75.2)	96.1 (95.5, 96.6)	89.6 (87.5, 91.3)	74.3 (73.3, 75.4)	57.7 (56.2, 59.1)
Prostate	**Christie**	97.56 (97.17, 97.91)	99.45 (98.94, 99.71)	99.12 (98.31, 99.54)	98.81 (98.03, 99.28)	90.96 (89.25, 92.41)
	England	93.8 (93.7, 93.9)	98.2 (98, 98.4)	98.4 (98.2, 98.7)	97.7 (97.4, 98)	87.7 (87, 88.3)
Rectal	**Christie**	86.81 (85.25, 88.14)	97.7 (93.2, 98.79)	91.51 (86.93, 94.01)	92.63 (90.26, 94.2)	69.75 (65.55, 73.54)
	England	80.3 (80, 80.6)	95.7 (95, 96.3)	91.7 (90.6, 92.7)	90.2 (89.7, 90.7)	51.9 (50.9, 52.9)

Table 2: One year overall survival estimates (percentages with 95% confidence intervals) by cancer type. Data for The Christie data are for patients diagnosed between 2016 and 2020 inclusive, using data from eforms in CWP followed up at the end of 2021. England data are taken from survival data published by NHS England for patients diagnosed in 2016 – 2020 followed up in 2021. Survival was unable to be estimated for groups with low numbers of patients, denoted as 'Unable to estimate' in the table. Both estimates are overall survival with estimates for all stages combined non-standardised for both The Christie and England figures, but England figures for stage are standardised by age whereas The Christie are not.

As a specialist cancer centre, The Christie provides care at specific points in the cancer pathway rather than at the point of diagnosis. For some cancer types, the Trust treats a higher proportion of patients with more complex or advanced disease, while for others the most severe cases are managed elsewhere. These differences in case mix and referral patterns are important contextual factors and are taken into account when comparing survival outcomes for Christie patients with national figures.

One and five year cancer survival in Greater Manchester compared to England

As the specialist cancer centre for Greater Manchester, The Christie serves a population of approximately 3.2 million people across Greater Manchester and Cheshire. As such, outcomes for patients treated at The Christie make an important contribution to overall cancer outcomes for the Greater Manchester system.

Presented here are the most recent nationally published survival estimates, showing one-year survival for all cancers combined across Greater Manchester compared with similar Integrated Care Board (ICB) regions and England as a whole (Figure 2).

For the period 2016–2020, one-year survival in Greater Manchester is comparable with neighbouring regions and the England average, while London demonstrates higher survival rates. Variations in outcomes may reflect differences in cancer type prevalence between regions, as well as variation in stage at diagnosis, particularly in areas with higher levels of deprivation where later presentation is more common.

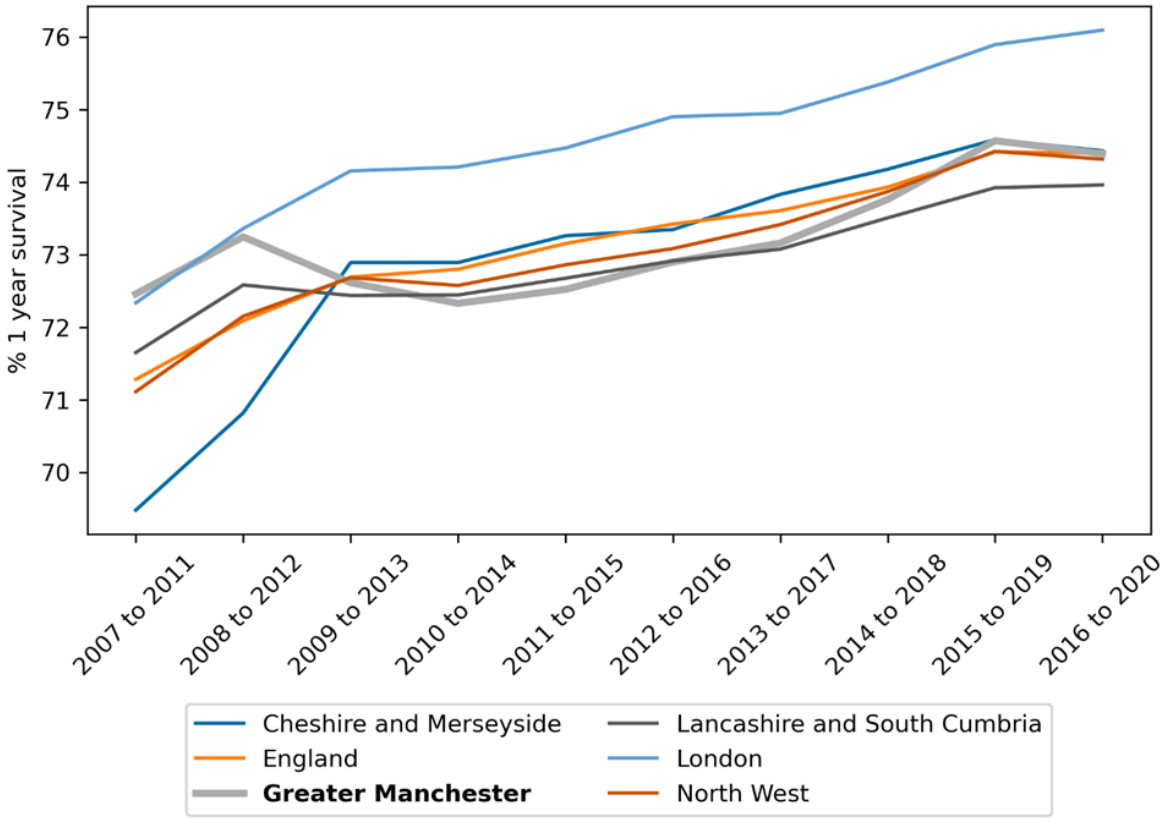


Figure 2: Trend estimates of one-year net survival for adults, (aged 15 to 99 years) averaged over 13 selected cancers by region.

Methodology

The analysis presented in this report was produced by the Clinical Outcomes and Data Unit. Survival analysis for patients treated at The Christie is based on diagnosis and staging information recorded at the patient's first appointment using diagnosis and staging forms, or via multidisciplinary team (MDT) records where diagnosis and stage are confirmed.

One-year survival is calculated from the recorded date of diagnosis. Where a date of diagnosis is not available, the date first seen at The Christie is used as a proxy, provided the patient had not received previous treatment for that cancer. Patients without a diagnosis and staging form, MDT record, recorded diagnosis date, or suitable proxy date have been excluded from the analysis.

The cancer types included in this report are restricted to those published within national survival datasets by NHS England and which are directly comparable with the specialist services provided by The Christie.

Survival definitions

There are several recognised methods for calculating cancer survival rates. The definitions of the methods used in this report are set out below. The method applied is specified within the relevant figure and table captions. Differences in methodology mean that direct comparison between Trust-level and national survival estimates should be interpreted with appropriate caution.

- **Overall (non-standardised) survival**
  This method estimates survival from the time of diagnosis to death from any cause, or to the end of follow-up. This approach has been used for all survival estimates relating to Christie patients presented in this report, and for national estimates for all stages combined in Table 2.

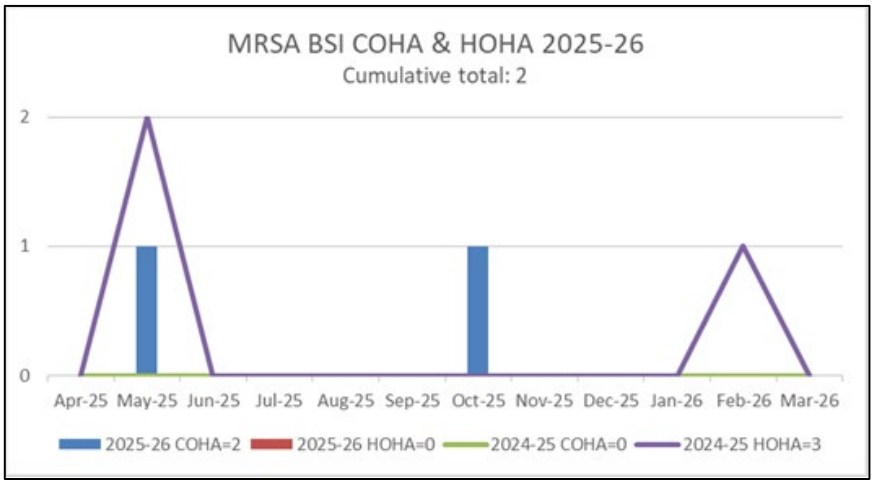
- **Net survival**
  Net survival estimates survival from the time of diagnosis to death or follow-up, adjusted for the expected survival of the general population with the same age, sex and socio-economic profile. This method aims to estimate cancer-specific survival and is used for the data presented in Figure 1.

- **Age-standardised survival**
  Survival estimates are adjusted using International Cancer Survival Standard (ICSS) weightings to account for differences in age distribution. This approach supports comparison over time and between regions and is used for the stage-specific national estimates shown in Table 2.

Healthcare acquired infections (HCAI)

Methicillin-resistant Staphylococcus aureus Blood Stream Infection (MRSA BSI)

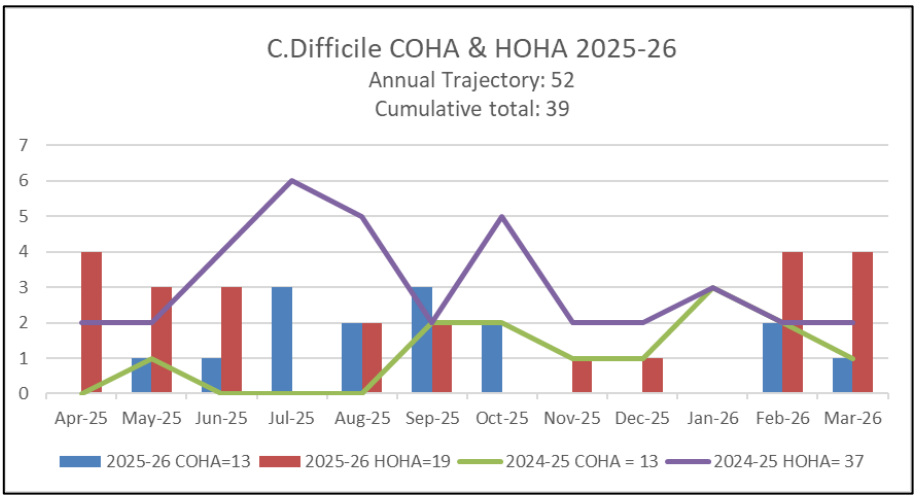
The graph below shows the total of MRSA BSI that were community onset hospital acquired and hospital onset hospital acquired. In 2025/26 we had two cases of MRSA BSI, against a threshold of 0.



Each MRSA bloodstream infection has triggered a collaborative healthcare-associated infection (HCAI) learning response in line with the Patient Safety Incident Response Framework (PSIRF). These reviews have brought together clinical teams, infection prevention and control specialists, and governance colleagues to identify contributory factors and learning. Resulting action plans have been developed and reviewed through the executive oversight group to ensure learning is embedded and improvement actions are delivered.

Healthcare acquired infections - Clostridioides Difficile (CDI)

During 2025/26, the Trust reported 39 healthcare-associated cases of Clostridioides difficile infection (CDI) against an agreed threshold of no more than 52 cases. The threshold for the year was increased to reflect the national rise in CDI. Performance remained well below this revised threshold, providing assurance that infection prevention and control measures continue to be effective.



Each case of Clostridioides difficile infection (CDI) is subject to a full Patient Safety Incident Response Framework (PSIRF) learning response, enabling the identification of learning and appropriate improvement actions. These cases were investigated through the HCAI PSIRF process, with findings and resulting actions overseen by the Executive Review Group.

In addition to CDI and MRSA, the Trust monitors and reports monthly at Board level on bloodstream infections caused by E. coli, Klebsiella, Pseudomonas and methicillin-susceptible Staphylococcus aureus (MSSA), including cases classified as hospital onset and community onset, hospital-acquired. During 2025/26, performance for Pseudomonas and MSSA remained stable compared with 2024/25. An increase in E. coli and Klebsiella bloodstream infections was observed year on year. A thematic review has been undertaken to identify contributory factors, and the resulting improvement actions are reflected within the Infection Prevention and Control (IPC) annual improvement plan. A second IPC summit is planned for summer 2026 to strengthen key areas of IPC practice and support delivery of the improvement priorities.

The coming year will maintain a sustained focus on infection prevention best practice and safe and effective antimicrobial stewardship.

Incident Management

The Trust has a well-established system for incident reporting and review, enabling learning from patient safety events and supporting the prevention of recurrence. Until March 2024, patient safety incidents were reported from the Trust's internal reporting system to the National Reporting and Learning System (NRLS). From April 2024, the Trust transitioned to reporting incidents via the Learning from Patient Safety Events (LFPSE) service.

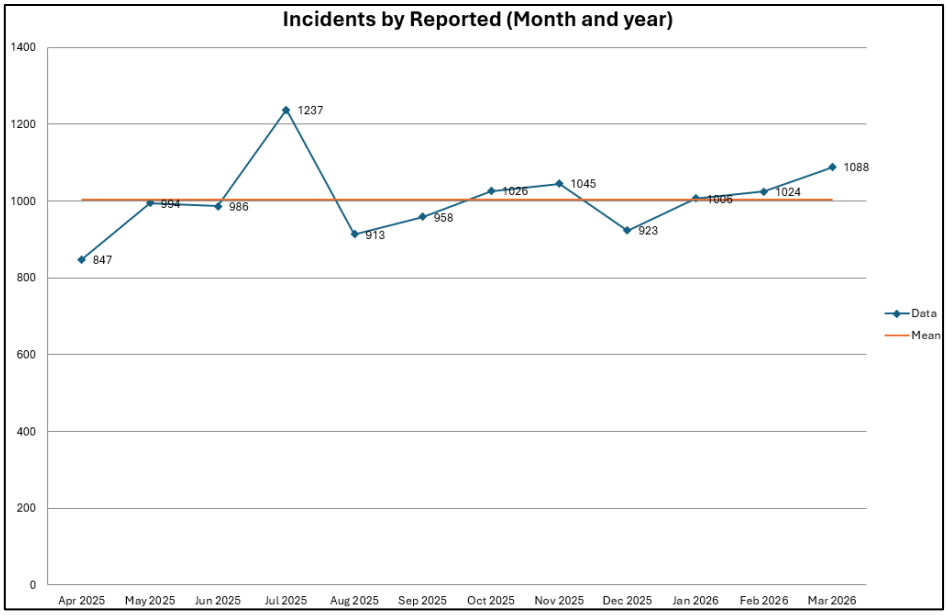
Benchmarking against comparable specialist Trusts demonstrates high levels of incident reporting alongside low levels of patient harm, providing assurance of a positive reporting, learning and safety culture within the organisation.

The Trust transitioned to the Patient Safety Incident Response Framework (PSIRF) in April 2024 and continues to operate in line with its published PSIRF Plan and Policy. As part of PSIRF governance arrangements, incidents are triaged and reviewed through weekly Divisional Patient Safety Improvement Group (DPSIG) meetings. These forums review themes and trends, identify where formal learning responses are required, and ensure appropriate engagement with patients and staff. Learning responses focus on system-based improvement and are designed to support continuous learning and safer care.

Patient Safety Incidences

The Christie is regarded as a high-reporting, low-harm organisation, reflecting a positive culture of openness, learning and patient safety. The chart below illustrates the number of patient safety incidents reported each month during 2025/26.

When interpreting incident reporting data, it is important to note that The Christie has a relatively small inpatient bed base, and that over 95% of patient activity is delivered through ambulatory care, including outpatient and day-case services. This context is taken into account when reviewing reporting volumes and harm levels.



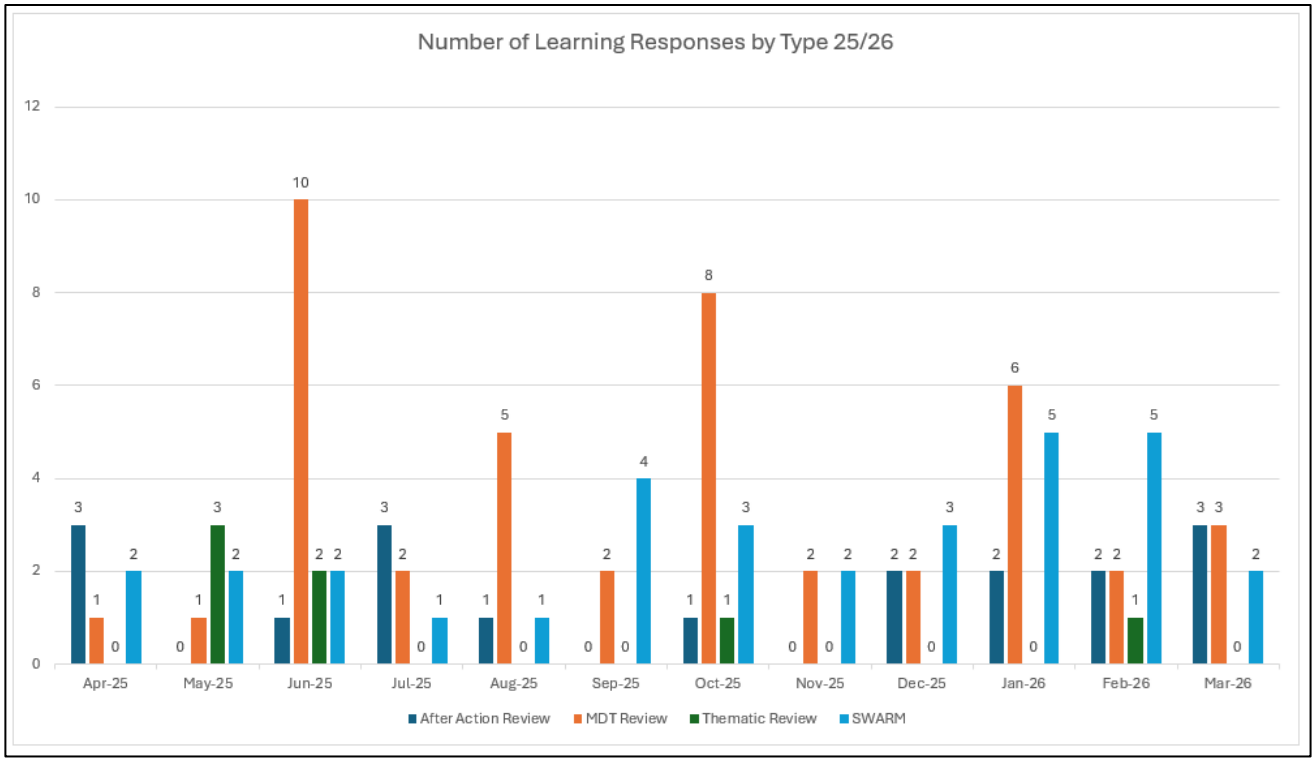
As part of the Trust's ongoing embedding of the Patient Safety Incident Response Framework (PSIRF), a range of insight is routinely reviewed, including patient safety incidents, complaints, and engagement with patients, staff and other stakeholders. This triangulated approach supports the identification of key Patient Safety Priorities and the development of focused workstreams to drive continuous improvement.

The PSIRF Plan is reviewed on an annual basis to assess progress, learning and emerging risk, and to ensure continued alignment with the Trust's Patient Safety Priorities. For 2025/26, the agreed Patient Safety Priorities are:

- End of life care
- Deteriorating patient
- Medication safety
- Transfusion safety
- Patients lost to follow-up

Summary of Learning Responses

Patient safety events are triaged and reviewed in line with Patient Safety Incident Response Framework (PSIRF) principles, with proportionate learning responses agreed based on the nature of the event and the potential for learning. The emphasis of this approach is on identifying system-level learning and prioritising improvement actions that support safer care. The table below sets out the number and type of learning responses undertaken during 2025/26.



Duty of Candour

The Trust has a Duty of Candour Policy in place that reflects the requirements of Regulation 20 of the Health and Social Care Act**.** For each notifiable patient safety incident, the incident handler is responsible for ensuring that a Duty of Candour discussion takes place as soon as reasonably practicable. Where appropriate, this conversation may be undertaken by a more suitable individual, such as the responsible consultant or a senior nurse.

Information shared during the Duty of Candour discussion is considered as part of any subsequent learning response. The individual leading the Duty of Candour process remains in contact with the patient and/or their family as appropriate throughout this period. On completion of the learning response, feedback is provided, including an explanation of the findings and any learning identified.

Never Events

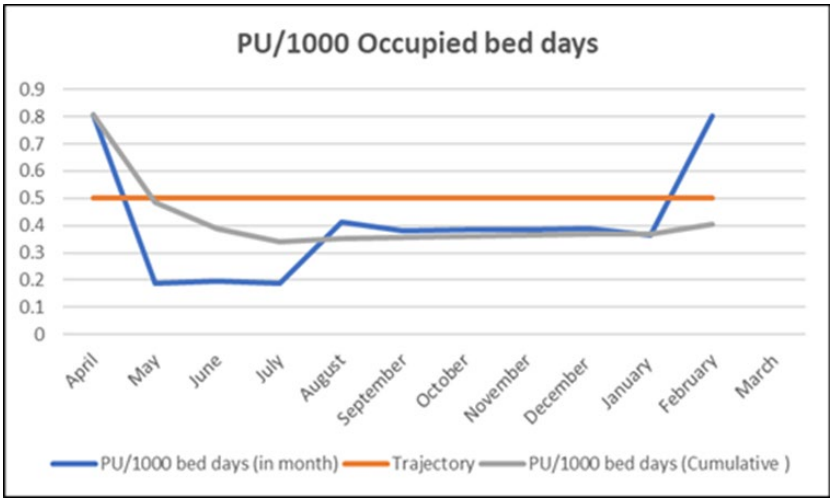
During 2025/26, the Trust reported two Never Events to the Strategic Executive Information System (StEIS).

One incident related to an overdose of insulin due to incorrect device selection, which did not result in patient harm. Learning was identified through a Patient Safety Incident Investigation (PSII) and actions included the introduction of dedicated insulin stations in ward areas to support safe device selection by staff.

The second incident related to a suspected wrong-site surgery. A proportionate learning response is currently underway in line with PSIRF, and findings will be used to identify learning and improvement actions to strengthen patient safety.

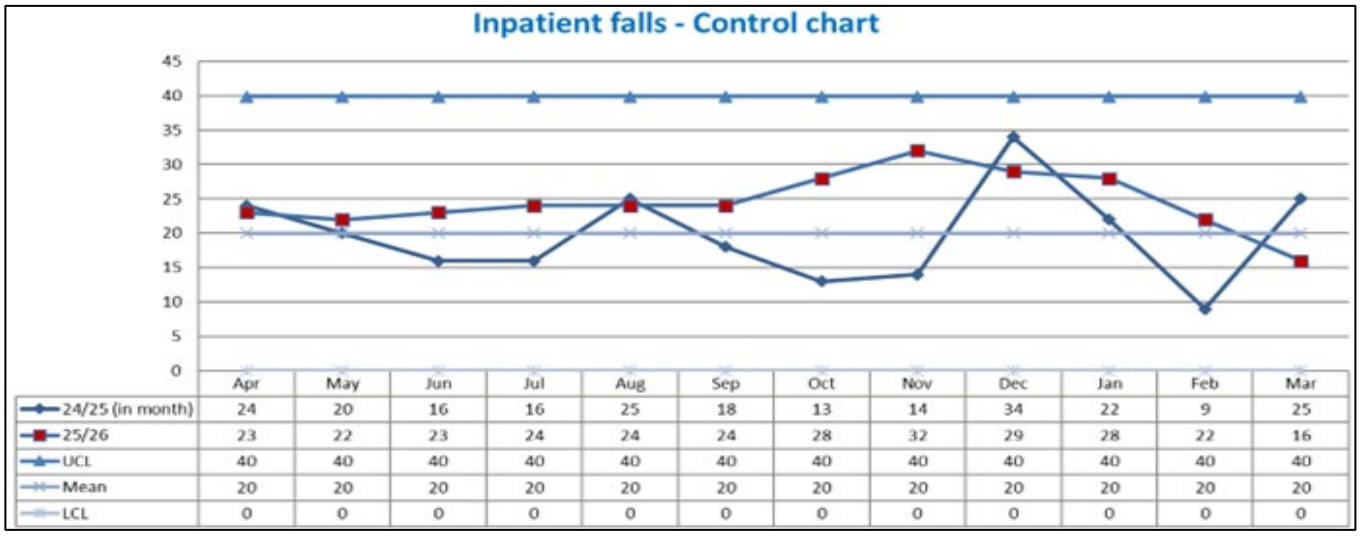
Pressure Ulcers

The Trust set an internal ambition for 2025/26 of no more than 0.5 hospital-acquired category 2 pressure ulcers per 1,000 occupied bed days, and no category 3 or 4 pressure ulcers. By the end of February 2026, there had been 23 hospital-acquired pressure ulcers, including one category 3 pressure ulcer, equating to 0.40 per 1,000 occupied bed days, which remained within the agreed threshold. No category 4 pressure ulcers were reported during the year. This performance was supported by a robust pressure ulcer prevention training programme, continued use of skin tone assessment to support early identification of skin changes across different skin tones, and learning from all category 2 and above pressure ulcers through PSIRF-aligned reviews and oversight via the Fundamentals of Care Group.



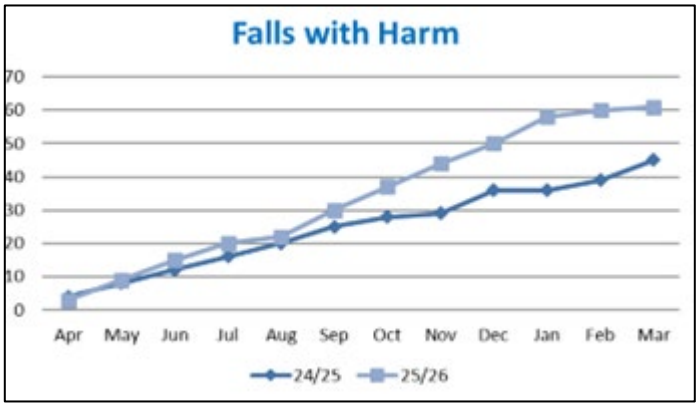
Patient Falls 2025/26

Falls are monitored per 1000 occupied bed days which enables us to identify trends against our activity. The trust trajectory remains at 3.8 falls per 1000 OBD, against a national average of 6.8 falls per 1000 OBD.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
24/25 (in month)	24	20	16	16	25	18	13	14	34	22	9	25
25/26	23	22	23	24	24	24	28	32	29	28	22	16
UCL	40	40	40	40	40	40	40	40	40	40	40	40
Mean	20	20	20	20	20	20	20	20	20	20	20	20
LCL	0	0	0	0	0	0	0	0	0	0	0	0

Inpatient falls with harm 2025/26



Falls with harm 2025/26

During 2025/26, the Trust saw an increase in reported patient falls compared with the previous year, as illustrated in the charts above. All falls are recorded on the Trust's incident management system to ensure appropriate review and investigation. Where there is identified potential for learning, or where care has not met agreed Trust standards, incidents are considered for a proportionate learning response in line with PSIRF principles. Trust-wide learning is shared through the Learning for Improvement Bulletin and via the Quality and Safety Group on a monthly basis.

In response to the increase in falls, a thematic review was undertaken to identify common contributory factors. As a result, a Falls Quality Improvement Operational Group was established, led by the Deputy Chief Nurse and Falls Lead. The Group provides strategic oversight, coordination and leadership for falls prevention and management, promoting safe physical activity and ensuring a consistent, evidence-based approach across the organisation.

The Group provides assurance that falls prevention, risk assessment, intervention and post-fall management are aligned with NICE guidance, through systematic review of compliance, outcomes and evidence of implementation. Where gaps are identified, actions are agreed, delivery is monitored and any risks are escalated through Trust governance arrangements as appropriate.

The Trust is also working collaboratively with international partners in Australia to share learning and explore innovative approaches to support falls prevention and management.

Local Clinical Audits

During 2025/26, a total of 208 clinical audits and quality improvement projects were completed. These covered a wide range of themes, including patient outcomes, patient experience and pathway-based improvement, and were led by colleagues across medical, nursing, allied health professional and operational teams.

The figures for 2025/26 are not directly comparable with previous years**,** as this year's analysis excludes Priority D individual interest projects, which had been included in earlier reports. The distribution of audits and quality improvement projects across Trust divisions is shown in the table below:

	Number of completed audits in						
Division	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**	**2025/26**
Clinical Support and Specialist Surgery	72	83	81	92	74	78	101
Networked Services	98	93	88	102	119	117	88
Other (Quality & standards, School of Oncology, Research)	22	11	15	23	21	23	20
Total	**192**	**187**	**184**	**217**	**214**	**218**	**209**

The findings from these audits are reported within the Annual Clinical Audit Report, with selected audit outcomes also presented to the Quality Assurance Committee to support Board-level oversight and assurance.

NHS Staff Survey

Indicator	2024	2025	National Average (Specialist Trusts only)
Q14c - % of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	15.4%	15.6%	16.3%
Q15 - % of staff believing that the Trust provides equal opportunities for career progression or promotion regardless of ethnic background, gender, religion, sexual orientation, disability, age	64.1%	61.2%	55.3%

During 2024/25, the Trust undertook a wide-ranging programme of engagement which informed the development of a new Standard Operating Procedure (SOP) for the management of violence and aggression, alongside a revised policy. These documents were implemented and made readily accessible across the Trust during 2025/26.

Learning from Deaths: Inpatient mortality reviews at the Christie 2025-26

The Trust's arrangements for learning from deaths are aligned with NHS Improvement guidance published in 2017. As a tertiary specialist cancer centre, The Christie does not participate in the Hospital Standardised Mortality Ratio (HSMR) or Summary Hospital-level Mortality Indicator (SHMI), as these measures are not appropriate for specialist services.

All inpatient deaths are screened against a defined set of triggers, and bereaved families are invited to raise any concerns regarding the care provided during the preceding admission. In addition, all inpatient deaths are reviewed by the Medical Examiners, who may commission a Structured Case Note Review (SCR) where indicated.

Where one or more triggers are identified, an SCR is undertaken using the Royal College of Physicians (RCP) methodology by one or more independent clinical reviewers. The findings are considered by the Mortality Surveillance Group (MSG), which escalates any concerns regarding the quality of care to the Executive Review Group (ERG) for oversight and further action as required.

RCP ratings for quality of care and avoidability of death are set out below:

Care score:

Score	Explanation
1	Very poor
2	Poor
3	Adequate
4	Good
5	Excellent

Avoidability score:

Score	Explanation
1	Definitely avoidable
2	Strong evidence of avoidability
3	Probably avoidable (more than 50:50)
4	Possibly avoidable but not very likely (less than 50:50)
5	Slight evidence of avoidability
6	Definitely not avoidable

Cases with overall care scores of 1 or 2, and avoidability scores of 1, 2 or 3, are escalated by the Mortality Coordinators to the Executive Review Group (ERG) for enhanced scrutiny and oversight.

The review process is designed to identify both examples of good practice and opportunities for improvement. Feedback is provided to the responsible clinicians and, where appropriate, shared with bereaved families. Summaries of findings are also provided to the Coroner when requested.

The findings presented in this report reflect those validated at the Mortality Surveillance Group (MSG) meeting held on 5th March 2026. The review process remains ongoing beyond this date.

Table 1: Activity 2025-26 *@02/04/2026*	Quarter 1 Apr – Jun	Quarter 2 Jul - Sep	Quarter 3 Oct - Dec	Quarter 4 Jan – Mar	**Total**
No. deaths	81	91	115	99	**386**
No. deaths that have triggered SCR review	18	14	33	14	**79**
No. completed SCRs	18	14	29	7	**68**
No. discussed at MSG	18	14	17	1	**50**

The Executive Review Group (ERG) reviews all inpatient deaths on a weekly basis to support oversight and identify any emerging themes or trends. During 2025/26, a total of 386 deaths were recorded on site at the Withington location.

A comparison with previous years is presented in the table below. The lower number of deaths recorded in 2020/21 and 2021/22 reflects reduced inpatient activity during the COVID-19 pandemic. During this period, all deaths occurring within 28 days of a positive COVID-19 test underwent a Structured Case Note Review (SCR), contributing to higher review rates.

On-site deaths annually:

	2021-2022	2022-2023	2023-2024	2024-2025	2025-2026
Total deaths in year	251	318	320	390	386
Deaths following emergency admission	216 (86%)	260 (82%)	269 (84%)	323 (83%)	322 (83%)
Emergency admissions - year	7,752	8,657	9,292	10,497	10,721
% deaths / total emergency admissions	2.79%	3.00%	2.89%	3.08%	3.00%
Total admissions (excluding day cases)	11,833	13,088	13,526	14,621	14,526
% deaths / total admissions	2.12%	2.43%	2.37%	2.67%	2.66%

Table 3: 2025-26 Assessment of avoidable deaths* as confirmed at Mortality Surveillance Group meeting as of 5th March 2026:
*RCP rating 1=definitely avoidable, 2=strong evidence avoidability, 3=probably avoidable (more than 50-50), 4=possibly avoidable but not very likely, 5 Slight evidence of avoidability, 6=definitely not avoidable

2025 – 2026 Month	Total Deaths (non LeDeR)	Total Deaths Reviewed (non LeDeR)	Deaths Avoidable > 50% (non LeDeR)	RCP1	RCP2	RCP3	RCP4	RCP5	RCP6	LeDeR Deaths	LeDeR Deaths Reviewed	LeDeR Deaths Avoidable > 50%
Apr	30	5	0	0	0	0	0	0	5	0	-	-
May	24	6	0	0	0	0	0	0	6	0	-	-
Jun	27	6	0	0	0	1	0	0	5	0	-	-
Jul	34	5	0	0	0	0	0	0	5	0	-	-
Aug	25	6	0	0	0	0	0	2	4	0	-	-
Sep	32	3	0	0	0	0	0	0	3	0	-	-
Oct	43	12	0	0	0	0	1	0	11	0	-	-
Nov	33	2	0	0	0	0	0	0	2	1	1	-
Dec	39	4	0	0	0	0	0	1	3	0	-	-
Jan	45	1	0	0	0	0	0	1	0	0	-	-
Feb	21	0	0	0	0	0	0	0	0	0	-	-
Mar	33	0	0	0	0	0	0	0	0	0	-	-
Total	**386**	**50**	**0**	**0**	**0**	**1**	**1**	**4**	**44**	**1**	**1**	**0**

Table 4: 2025-26 Ratings of overall care* after Mortality Surveillance Group meeting as of 05th March 2026:
*RCP rating 1=very poor care, 2=poor care, 3=adequate care, 4=good care, 5=excellent care

2025 - 2026 Month	Total deaths	Total Deaths Reviewed	RCP 1	RCP 2	RCP 3	RCP 4	RCP 5
Apr	30	5	0	0	1	3	1
May	24	6	0	0	0	3	3
Jun	27	6	0	1	1	0	4
Jul	34	5	0	0	0	1	4
Aug	25	6	0	0	0	4	2
Sep	32	3	0	0	0	3	0
Oct	43	12	0	0	1	4	7
Nov	33	2	0	0	0	0	2
Dec	39	4	0	0	0	4	0
Jan	45	1	0	0	0	1	0
Feb	21	0	0	0	0	0	0
Mar	33	0	0	0	0	0	0
Total	**386**	**50**	0	1	3	23	23

Table 3 for the previous years:

	Total Deaths (not LD)	Total Deaths Reviewed (not LD)	Deaths Avoidable > 50% (not LD)	RCP1	RCP2	RCP3	RCP4	RCP5	RCP6	LD Deaths	LD Deaths Reviewed	LD Deaths Avoidable > 50%
2021-22	251	95	0	-	-	-	2	2	91	0	0	0
2022-23	318	65	0	-	-	-	1	1	63	1	1	0
2023-24	320	74	0	-	-	-	3	4	67	0	0	0
2024-25	388	67	0	-	-	-	-	5	62	**2**	**2**	0

Table 4 for the previous years:

	Total deaths	Total Deaths Reviewed	RCP 1	RCP 2	RCP 3	RCP 4	RCP 5
2021-22	251	95	-	1	6	39	49
2022-23	318	66	-	2	4	27	33
2023-24	320	74	-	3	4	31	32
2024-25	390	69	-	-	10	23	36

The data presented reflects the final ratings from completed Structured Case Note Reviews (SCRs), as ratified by the Mortality Surveillance Group (MSG) as of 5 March 2026, for both overall care and avoidability of death.

There was one death assessed as having a greater than 50% likelihood of avoidability and one death assessed as having a possible element of avoidability. There were no cases rated as very poor care, and one case rated as poor care. A small number of deaths showed slight evidence of avoidability, primarily related to system and process issues rather than individual practice.

No deaths required external notification to the Care Quality Commission (CQC), and the Trust did not receive any mortality outlier alerts during this period. One death was referred to the Learning from Lives and Deaths – People with a Learning Disability and Autistic People (LeDeR) programme, with care assessed as excellent and the death not considered avoidable.

Where learning was identified, this related to areas such as infection prevention and control, timely investigation following inpatient falls, and reinforcement of existing clinical guidance for high-risk patient groups. Learning actions have been taken forward through established governance routes, including specialty morbidity and mortality forums and Trust-wide quality improvement groups, to support continuous improvement in care.

Learning from deaths

Learning from Structured Case Note Reviews (SCRs) is shared with the responsible clinical teams and escalated through governance routes where required. Further assurance is provided through triangulation with disease-specific Morbidity and Mortality (M&M) discussions, with key learning and outcomes reviewed at the Mortality Surveillance Group (MSG).

Key themes identified during 2025/26 included:

- Infection prevention and control practices across the Trust
- Clinical guidance relating to Pneumocystis jirovecii pneumonia prophylaxis for patients receiving long-term steroids or immunosuppressive therapy
- Inpatient falls prevention and management

Improvement actions arising from these themes have been progressed through established Trust governance groups to support sustained learning and continuous improvement in care.

Performance Key Indicators – National Cancer standards

The following table provides assurance that the Trust has met the National Cancer Standards performance targets during 2025/26

National targets and minimum standards	Target	Threshold 2025/26	Q1	Q2	Q3	Q4	Year
Infection control	Number of Attributable C-Diff cases	**52**	12	12	4	11	39
	Number of MRSA Bacteraemia	**0**	1	0	1	0	2
Cancer Targets	% of cancer patients waiting a maximum of 31 days for diagnosis to first definitive treatment	**96%**	98.8%	99.2%	99%*	99%*	99%*
	% of cancer patients waiting a maximum of 28 days from GP referral to receiving a confirmed diagnosis.	**80%**	88.6%	87.2%	89.2%*	89.2%*	88.6%*
	% of cancer patients waiting a maximum of 62 days from GP referral to first definitive treatment including rare and testicular cancers (based on national allocated position).	**75%**	71.7%	76.7%	81.9%*	77.5%*	77%*
18 Weeks	18 week incomplete pathways	**92%**	94.5%	94.6%	97.1%*	96.9%*	95.9%*
6 Weeks diagnostic waits	Maximum 6 week wait for diagnostic procedures	**99%**	98.2%	97.6%	98.9%	98.2%	98.2%

*subject to validation as national upload deadlines have not passed at the time of reporting.

Feedback on the 2025/26 Quality Report:

The Quality Report was sent to:

- Healthwatch
- Direct Commissioning, North West Region, NHS England
- Lead governor for The Christie NHS Foundation Trust

Responses to request for feedback:

Healthwatch Manchester advised they were unable to provide a review due to capacity and resource constraints within the timeframe and suggested seeking feedback from another Healthwatch organisation, however, no additional response was received in advance of publication.

No other comments were received prior to publication.

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