The Christie
NHS Foundation Trust

Board of Directors meeting

Thursday 25th January 2024 at 12.45 pm

Education Centre Room 4/5

Agenda

Clinical presentation: Radiotherapy at the Withington site - Rachael Edwards, Clinical Service Manager, Radiotherapy & a patient

30 - 40 mins

				Page	Timing
Public items					
01/24	**Standard business**				
a	Apologies		Chair		
b	Declarations of interest		Chair		
c	Minutes of previous meeting – 30th November 2023	*	Chair	2	5 mins
d	Action plan rolling programme, action log & matters arising	*	CEO	9	
02/24	**Key Reports**				
a	Trust report	*	CEO	12	15 mins
b	Progress report of Trust strategy	*	DoS	21	15 mins
03/24	**Approvals**				
a	National Cost Collection 2023 Submission	*	EDoF	28	5 mins
b	Trust nomination of Charity Trustee	*	CEO	43	5 mins
04/24	**Board assurance**				
a	Quality Assurance Committee report – November 2023	*	Committee chair	45	10 mins
b	Board assurance framework 2023/24	*	CEO	50	5 mins
05/24	**Any other business**		Chair		
	Papers for information only				
	Integrated performance, quality & finance report	*		56	
	PSIRF Policy & Plan	*		95	
	Date and time of the next meeting				
	Thursday 28th March 2024 at 12:45pm				

CEO	Chief Executive Officer	*	paper attached
DoS	Director of Strategy	v	verbal
COO	Chief Operating Officer	p	presentation

The Christie
NHS Foundation Trust

Public meeting of the Board of Directors
Thursday 30th November 2023 at 12.45 pm
Meeting Room 103, Ground Floor, Paterson Research Building

Present: Chair: Edward Astle (EA), Chairman
Roger Spencer (RS), Chief Executive Officer
Tarun Kapur (TK), Non-Executive Director
Robert Ainsworth (RA), Non-Executive Director
Alveena Malik (AM), Non-Executive Director
Grenville Page (GP), Non-Executive Director
Prof Kieran Walshe (KW), Non-Executive Director
Prof Chris Harrison (CJH), Deputy CEO
Bernie Delahoyde (BD), Chief Operating Officer
Theresa Plaiter (TP), Interim Chief Nurse
Sally Parkinson (SP), Interim Executive Director of Finance
Prof Fiona Blackhall (FB), Director of Research
Eve Lightfoot (EL), Director of Workforce
John Wareing (JW), Director of Strategy
Prof Richard Fuller (RF), Director of Education
Dr Vidya Kasipandian (VK), Consultant in Acute & Critical Care

Minutes: Louise Westcott (LW), Company Secretary

In attendance: Jo D'Arcy, Assistant Company Secretary
Jeanette Livings, Director of Comms & Marketing
David Holden, Good Governance Institute

Clinical presentation: A step into SACT services, Gemma Jones (GJ), Modern Matron Chemotherapy Services, Maggie Flynn (MF), Senior Healthcare Assistant and Anne-Marie Bradburn (AMB), Ward Manager Chemotherapy Services and Elizabeth Holden (EH), patient.

GJ introduced the Systemic Anti-Cancer Treatment (SACT) services that cover the Oak Road Treatment Centre, Outreach, Christie at Home, and SACT services across other sites.

The service delivers 200 patient treatments per day. There are challenges and competing pressures.

AMB summarised the service that delivers chemotherapy & immunotherapy and treats all solid tumours. They run a Saturday service and have the capacity to treat 880 patients per week on the main site plus other sites and at home. The team are passionate about improving things for patients.

Service improvements were outlined, the team are developing both treatment and bloods closer to home as well as the use of Senior Healthcare Assistants on the treatment floor. This has been very successful and there are now 11 Senior HCA's. MF introduced herself and noted the positive changes that have taken place, HCAs support the nurses to provide effective and efficient treatment. They do new patient talks to support patients and introduce them to the service and how things work. The service is amazing.

Current improvements include a named nurse for each patient, individual patient list for staff and revised opening hours / staff shift pattern. This means patients and staff are now not going home too late each day. Having a named nurse gets really good feedback. The team are also implementing ePROMs across SACT services that's helping to make things better for patients who deteriorate and increases understanding of patients condition. A SACT oral team is in development, and they go to clinics to promote the service.

Cycle 1 talks and pre-treatment consultations are now in place, this allows 1:1 for patients to discuss side effects and treatment.

Support & education for staff is in place and the practice educator role has been developed.

Future plans were outlined including expanding the prep team with clerical support, and the pre-assessment telephone clinic, this assesses toxicity, pharmacy requirements etc ahead of them coming in.

The service is also developing a new patient clinic in collaboration with the Maggie's Centre. Morning sessions are arranged for all new patients and this also ensures they see the centre.

Challenges were outlined that include prescriptions, screening and scheduling. Meetings take place regularly between pharmacy and the SACT team to understand competing pressures and issues to try and get the best results for patients.

Staffing retention and vacancies have been an issue, this has improved with the improvements that have been put in. Currently the team only have 1 vacancy, this is an incredible achievement. New staff have a supernumerary period of 8 weeks.

In terms of the patient and staff experience, the service has been streamlined, the prep team have expanded, pre-treatment consultations are in place and there is the new nurse led oral clinic. There has been great feedback from patients.

Elizabeth Holden joined to speak about her experience as a patient. She noted she's been a patient since 2018 and has low grade stage 3 ovarian cancer. She is a Prof Gordon Jayson patient – he's an amazing doctor. EH hadn't had chemo since early 2019, was on an inhibitor but is now back having treatment. The introduction is brilliant, the changes are fantastic and make things easier. Script screening is very slow and any work between the service and pharmacy is important. She fed back that it would be better to do the new patient talk ahead of the first treatment and not on the first day. This would significantly reduce the patient's stress. This would be great. The slow delivery of prescriptions is still a problem. The ePROM feedback gets looked at and is great, may be difficult for some people who are not into computers. It is holistic which is fantastic. It feels like the team are treating the person not the disease. Very caring & compassionate, staff are brilliant. Sophie Maycock was singled out as being brilliant, would have been lost without her. It is great to not have to finish later, this is better for patients and staff. Less staff around later in the day for patients on long treatments. The wait for the line to be flushed and then removed does take time at the end of the treatment, can be frustrating but understand the pressures.

Expanding the pre-assessment over the phone would be really positive so this sounds great. Maggie's collaboration also sound great, anything that makes things more comfortable is great. Good to be part of a group & less alone. EH noted that in terms of services closer to home – cannot have bloods and treatment on the same day and need to speak to patients before appointments are made 'closer to home' as may sound brilliant but it isn't always, so must speak to the patient first. Bloods and treatment on the same day – not always great. FB explained that there has to be a time delay, so this is a pharmacy requirement. This needs to be better communicated to patients so that they understand why they come in for bloods the day before. It's a communication issue. EH noted that she has bloods done an hour before the outpatient appointment but they are never ready for the consultation so the doctor can't make an informed decision in that consultation. This needs to be looked at so that the consultant has the information they need to undertake the appointment.

FB asked if the new patient talk should be sent out to patients or done in person. EH strongly recommended that it is done on site with a family member and not a video. They should come to the site. GJ thanked EH for agreeing to speak to the Board.

EH thanked the Board and said how much she enjoyed this opportunity, anything that makes things more efficient for staff and less scary for patients is fabulous.

EA thanked EH for speaking to Board and to the team for their presentation.

RS thanked the team for the great work they do. This is the biggest SACT service in the country and its fantastic that the service is fully staffed as this is not typical. This is testament to the fantastic team and leadership here. The numbers we deliver is unlike anywhere else.

Item		Action
35/23	**Standard business**	
a	**Apologies**	
	Dr Neil Bayman (NB), Executive Medical Director	
b	**Declarations of Interest**	
	None noted.	
c	**Minutes of the previous meeting – 26th October 2023**	
	The minutes were accepted as a correct record.	
d	**Action plan rolling programme, action log & matters arising**	
	All items from the rolling programme are complete or noted on the agenda for 8th December Board / Governor Time Out. Freedom to speak up training was noted in the last meeting – EA encouraged anyone who has not completed this to do so please.	
36/23	**Key Reports**	
a	**Trust report**	
	RS drew attention to the following; Key quality indicators show no significant variances. Cancer waiting time (CWT) performance is generally good apart from the 62 day pathway that is under the target. Improvement work is on going to improve the waits for patients, particularly in radiotherapy and some surgical pathways. The CQC action plan is reported on the agenda, we have had a visit from commissioners and feedback around the action plan that has now been completed. Received notification from NHSE that we have been moved from segment 1 to 2 discussions have taken place with the NHSE Regional Director about the exit criteria for returning to segment 1. This relates to completion of the CQC action plan. The Board will hear more about this and how we respond. The financial situation in the ICS is the biggest challenge. Our financial position has improved and we have been involved in turnaround meetings with the ICB. SP noted that we are £1.9m better than the £8m deficit plan. The GM ICS set a break even plan in May, the significant risk in this plan has materialised. The system is in financial turnaround with a £210m deficit. £1.2m industrial action funding has been received and we have been asked to submit a reforecast. We have done this and set a £4.5m deficit as the reforecast position. PwC challenged this, we have now gone in at a £4m deficit at year end. There is huge risk in the system plan, there will be further challenge and we expect to be asked to further improve this plan. Scrutiny is huge. The capital plan still hasn't been approved in GM so it is very difficult to make decisions. This is significant and very difficult. Impacts are far wider than the financial position, its not a sustainable position.	

	EA noted that the Board supported the executive's efforts to reduce the forecast deficit and formally noted the improved forecast submitted to the ICB. GP asked about whether it is possible to get to break even at year end. Do we understand the risk to do this. GP asked about CIP and noted the pressures on this from industrial action etc. Do we know what we can deliver on a recurrent basis. SP responded that if we receive the £2.3m for unfunded activity in additional income, we would be closer to break even. In terms of CIP, the team have identified areas where we can make efficiencies, teams are looking at this now. It's more about productivity than efficiency. Teams have been hampered by industrial action etc. GP noted that there's a strong focus on grip & control. A short Audit Committee meeting is taking place next week to look at this further. MIAA have been asked to look at this and assess the serious and dedicated focus on the issue. The Board will be briefed following Audit Committee. RS noted the potential changes to commissioning arrangements during the planning round at the end of the year. We have spoken with specialist commissioning colleagues who expect specialist commissioning to be devolved to the ICB next year. This will take the form of a delegation with specific conditions to ring fence the funding for specialist services. NHSE will take the decision in December. RS noted that the formula is changing to a population-based budget formula. We'll be contracting with specialist commissioning in the same way for the rest of this year. GP asked if we need to ensure we are secure in this new approach. SP noted that the population-based approach is a risk as GM is over funded on that basis with no consideration for deprivation. RS noted that we must understand our activity plan and the associated funding to support it. SP noted the further detail in the report on finance and welcomed feedback on the level of detail and presentation. CH noted the link between the financial issues and the question of health inequalities that is about the need to meet differential needs. The advocacy for GM and the North of England to the centre around national resource allocation is crucial. RS noted that we made a detailed submission to the consultation on this new formula. They have not put weight on the deprivation question. We made representations to the NHSE national team and health inequalities team around the significance of this. CH noted that we must work within the system to push for this. Representations are being made in appropriate forums to make these points around deprivation. EA asked for consideration of inclusion of progress against KPI's in research and education. FB noted that there are new nationally set KPI's for research delivery that can be fed in, in line with the national reporting. RF noted that there's a challenge to understand what is useful to report back and this is being looked at.	FB/RF
b	**CQC Action Plan**	
	TP noted the paper. The purpose is to inform the Board that we have completed	

	the action plan following the inspections in 2022. The Trust were rated as Good. We received a number of must and should do actions. The action plan was developed and submitted to the CQC. The actions have been assigned to leads and monitored through a weekly meeting. The assurance committees have reviewed the progress and evidence of completion. The completed action plan & evidence was reported through the Commissioner Quality meeting and up to the GM System Quality Group. They confirmed they had received the required assurances. The action plan is complete and all stipulated actions carried out. The Board noted and accepted that the action plan is complete and the appropriate actions taken. The 'should do' recommendations are ongoing aspects of work that the Trust have developed, and we have commissioned work around our culture and assurance processes to support progress on these elements of work. These activities will continue to be reported to the Board. The Globis report and the Good Governance Institute review will be discussed in the new year. TK noted that the 'must do's' are task based and the should do's are more cultural. It was agreed that the should do's are not tick box exercises.TP noted that these link to our existing plans around EDI etc. GP asked about the target around staff experiencing discrimination, this should be zero tolerance and any accusation should be dealt with seriously. EL responded that this has been reviewed and changed in the people & culture plan, the Trust is looking at implementing a 'just and restorative learning' culture. AM asked to pick this up with EL. EDI is always challenging in the wider context with resourcing and staff retention. AM noted that this is a constant learning issue and we must look at best practice from elsewhere. VK noted that there is a True for Us review from the Berwick Report that links to the culture work and this will be factored in. EA noted that no amount of policies changes culture on their own. This is a first step. KW noted that this was reviewed at the QAC and given high assurance. CH noted that we must have the policies as well as the demonstration of progress. RS agreed that demonstrating progress is difficult and this is what is required. EA noted that there are key KPI's that can support this. We need to learn from the issues that came out of the report. GP noted that the underpinning arrangements to Board are critical to providing assurance. Approved.	
c	**The Board's responsibilities for Carbon Net Zero**	
	EA noted the importance of this issue for the organisation. CH introduced this item that is to bring to the attention of the Board the production of the Sustainable Management Plan. This was reviewed by the Audit Committee at its last meeting in October. GP noted that the committee concluded that there needs to be a bigger discussion. The production of the report completes the requirement. The Board will have a further discussion at a future meeting. Noted.	CH

37/23	**Board Assurance**	
a	**Audit Committee report – 19 October 2023 and Terms of Reference**	
	GP noted the finance update and The Christie Pharmacy update as well as the DSP Toolkit, sustainability and EPRR. The committee are sighted on the new declarations system (Declare) and there is scrutiny of the items declared. GP noted that preparations are in place to reprocure internal audit and counter fraud services. We are going out for a joint contract with WWL. There have been 2 companies express an interest. This will take place in January. EA asked if there were any concerns from the committee's perspective. GP noted that there isn't anything to flag. KW noted the medium assurance ratings. GP noted that the system and national challenges impact the progress on many of these elements. SP noted that in terms of gifts & hospitality we are working with staff to support them to know what to do when they are offered gifts.	
b	**Workforce Assurance Committee report – 14 November 2023**	
	TK noted that there are many items given moderate assurance that reflects plans that are not fully implemented at this time. TK noted the great talks from staff around the work they do, some in support areas that do not often receive attention. The Workforce dashboard is developing very well.	
c	**Board assurance framework 2023/24**	
	RS presented the BAF, there are no significant changes and levels of assurance have been added to the BAF. EA asked what the biggest risks are. RS responded that the financial system risk is the biggest risk. This impacts other risks also. The impact at The Christie is not so great in financial terms and we are doing very well in the face of the system risk. This also impacts on cancer waits, and there is impact on the continuation of some services, e.g., dermatology at Tameside has closed. The improvements we are making with certain patient pathways should impact on the 62-day target. This remains a high risk.	
d	**Chairs objectives**	
	EA noted that he is sharing his objectives with the Board for comment and suggestions. GP noted that the NEDs have a clear role to play and would appreciate more specific objectives. There is a specific set of guidance around NEDs needing an objective on EDI that came in June. The action to add explicit EDI objectives for all NEDs has been completed.	
38/23	**Any other business**	
	EA reported that as part of his induction he has met with Richard Leese and Cathy Cowell who were very positive around the Christie and the role we play in the system. CH noted that the way the GM ICB is structured means that there are fewer	

	arrangements for NEDs to work directly in the system. RS noted that this may be due to the genesis of the GM ICB from GM devolution. GP asked about negative feedback in the Friends & Family test and how we learn from this. TP noted that we are using the Oak Road Treatment Centre as a pilot for the Friends & Family questionnaire through the patient experience group as well as the national surveys. This reports to the Quality Assurance Committee.	
	Date and time of the next meeting	
	Thursday 25th January 2024 at 12:45pm	
	Papers for information only	
	Integrated performance, quality & finance report	
	Trust Sustainability Annual Report	

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Meeting of the Board of Directors - January 2024

Agenda item 01/24d

Action plan rolling programme after November 2023 meeting

Month	From Agenda No	Issue	Responsible Director	Action	To Agenda no
January 2024		Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	Integrated performance report	COO	Monthly report	For information
		Trust nomination of Charity trustee	CEO	Approve	02/24c
		National Cost Collection 2023 Submission	EDoF	Approve	02/24e
	CQC 'should do'	Culture Audit report	CEO	Report	02/24b
		Review of Trust strategy 2023-2029	DoS	Report	02/24d
February 2024 - no meeting		Integrated performance & quality report and finance report	COO	Monthly report	By email
	Annual reporting cycle	Letter of representation & independence	Chair	Circulate	By email
	Annual reporting cycle	Register of directors interests / FPPT annual declaration	Chair		
	Annual reporting cycle	Declaration of independence (non-executive directors only)	Chair		
March 2024		Patient story	CEO	To hear a patient story	
	Annual reporting cycle	Corporate planning (corporate objectives / BAF 2023/24)	Executive directors	Approve next year's BAF	
	Annual reporting cycle	Integrated performance & quality report and finance report	COO	Monthly report	
		Digital Update	EMD/Dep CEO	Update	
		Draft New Green Plan	DCEO	Review	
		Annual reporting cycle	Chair	Approve	
	Annual reporting cycle	FPPT Compliance report	Chair	Approve annual compliance	
April 2024		Patient story	CEO	To hear a patient story	
	Annual reporting cycle	Integrated performance & quality report and finance report	COO	Monthly report	
		Register of matters approved by the board	CEO	April 2022 to March 2023	
	Annual reporting cycle	Annual Corporate Objectives	CEO	Review 2022/23 progress	
		Modern Slavery Act update	CEO	Approve	
		Board effectiveness review	Chairman	Undertake survey	
		Freedom to speak up Guardian report	FTSUG	Quarterly update	
May 2024		Patient story	CEO	To hear a patient story	
	Annual reporting cycle	Integrated performance & quality report and finance report	COO	Monthly report	
	Provider licence	Self certification declarations	EDoF&BD	To approve the declarations	
		Responsible Officer report	EMD	Medical Appraisal & Revalidation Annual report	
	Annual reporting cycle	Annual compliance with the CQC requirements	ECN	Declaration / approval	
	Annual reporting cycle	Risk Management strategy 2021-24 annual review	CN&EDoQ	Annual Review	

Month	From Agenda No	Issue	Responsible Director	Action	To Agenda no
June 2024		Patient story	CEO	To hear a patient story	
	Annual reporting cycle	Integrated performance & quality report and finance report	COO	Monthly report	
	Annual reporting cycle	Annual reports from audit, quality and workforce assurance committees	Committee chairs	Assurance	
	Annual reporting cycle	Annual compliance with the CQC requirements	ECN	Declaration / approval	
	Annual reporting cycle	Annual report, financial statements and quality accounts (incl Annual governance statement / Statement on code of governance)	EDoF&BD	Approve	
July 2024 - no meeting		Integrated performance & quality report and finance report	COO	Monthly report	By email
August 2024 - no meeting		Integrated performance & quality report and finance report	COO	Monthly report	By email
Sep-24		Patient story	CEO	To hear a patient story	
	Annual reporting cycle	Integrated performance & quality report and finance report	COO	Monthly report	
		Standing Financial Instructions (SFI's)	DoF	Approve	
October 2024		Patient story	CEO	To hear a patient story	
	Annual reporting cycle	6 monthly review of annual objectives	DCEO	Interim review & update	
	BAF Risk	Christie role in addressing healthcare inequalities	DCEO	Report	
		Integrated performance & quality report and finance report	COO	Monthly report	
		Freedom to speak up guardian	FTSUG	Annual report	
November 2024		Patient story	CEO	To hear a patient story	
	Annual reporting cycle	Integrated performance & quality report and finance report	COO	Monthly report	
		CQC Action Plan	ECN	Approve for submission	
		Boards responsibility for Carbon Net Zero	DCEO	Report	
December 2024 - no meeting		Integrated performance & quality report and finance report	COO	Monthly report	By email

NHS
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Agenda item: 01/24d

Action log following the Board of Directors meetings held on

Thursday 30th November 2023

No.	Agenda	Action	By who	Progress	Board review
1	36/23a	Consideration to be given for inclusion within the Trust Report of progress against KPI's in relation to research and education.	FB/RF	Directors of each division have considered how this can be reported	January Trust Report
2	36/23c	The Board to have a further discussion at a future meeting on the Board's responsibilities for Carbon Net Zero.	CH	Added to rolling programme for March 2024	March Board meeting

The Christie
NHS Foundation Trust

Agenda item 02/24a

Meeting of the Board of Directors
Thursday 25th January 2024

Subject / Title	Trust report
Author(s)	Executive Directors
Presented by	Roger Spencer, Chief Executive
Summary / purpose of paper	This report brings together the key issues for the Board of Directors in relation to our performance, strategy, workforce, the Greater Manchester system landscape, the regulatory landscape and other pertinent matters within the scope of the board's responsibilities.
Recommendation(s)	The board is asked to note the contents of the paper.
Background Papers	Integrated Performance, Quality and Finance Report Finance Report
Risk Score	See Board Assurance Framework
EDI impact / considerations	
Link to: ➢ Trust's Strategic Direction ➢ Corporate Objectives	Achievement of corporate plan and objectives
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	CEO Chief Executive Officer MCRC Manchester Cancer Research Centre NHSI NHS Improvement JFP Joint Forward Plan CQC Care Quality Commission GM Greater Manchester ICB Integrated Care Board ICS Integrated Care System CIP Cost Improvement Programme

The Christie
NHS Foundation Trust

Trust Report

January 2024

Executive Summary

- Key quality indicators for December show no significant adverse variances or issues for escalation.
- Our operational performance indicators in December shows no significant adverse variances other than our compliance against some of the national Cancer Waiting Times standards.
- Performance in December for the 62-day consolidated cancer standard was 70.8% which is consistent with the trajectory to meet the operational standard by March 2024.
- Cumulative financial performance at the end of December (Month 9) is a £1.1m deficit against a planned £6.0m deficit. This is a positive variance of £4.9m to plan and is a function of improved performance against plan, income to negate the costs of industrial action combined with releases from the Trust balance sheet.
- Key financial performance indicators in month 9 show no adverse variances other than the level of recurrent efficiency achieved, this is £2.0m against a year-end target of £6.4m.
- Our planning process for 2024/25 has continued with Divisions providing the anticipated level of activity and resource to deliver this in 2024/25. This will be collated for the first cut of the Trust's annual plan which will be the focus of the Board's planning day in February and subsequent submission to GM ICB in March.
- Workforce indicators for December show a slight decrease in sickness absence rates with plans to address this being scrutinised by the Workforce Assurance Committee
- The annual staff vaccination programme continues. Our compliance rates are the highest in Greater Manchester
- Our Cultural Audit report has been published on the trust intranet alongside a plan for further engagement events.
- We remain rated overall as Good by the CQC and we have completed our CQC Action Plan.
- We continue to be in segment 2 of the System Oversight Framework.
- Our governance review, with a particular focus on assurance about the CQC fundamental care standards, is nearing completion and will be reported in February.

Quality of Care

Indicators of the Safety and Effectiveness of our services showed no significant adverse variances in November. Details of Novembers quality indicators are given in the Integrated Performance, Quality and Finance Report.

There were 10 formal complaints in December which is lower that the monthly average. The number of contacts with the Patient Advice and Liaison Service (PALS) service in December was 27, lower than the previous month.

Nurse staffing numbers met the levels to ensure appropriate levels of safety and care with indicative staffing to maintain a 1:8 nurse to patient ratio which is nationally recommended.

Four corporate risks are scored at 15 or above on the risk register. These are monitored by the Risk Committee to ensure that appropriate controls are in place and reviewed by the board's assurance committees to provide assurance to the board:

1. Risk of not achieving the financial plan including the cost improvement programme (16).
2. Risk of delayed cancer referral and treatments due to not meeting 24 / 62-day targets (15).
3. Risk of patients being lost to follow up (15).
4. Risk that patients may experience harm due to significant delays in the management of patients with penile cancer (16).

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. PSIRF is a learning and improvement framework with an emphasis on the system and culture. One of the underpinning principles of PSIRF is to undertake fewer "investigations" and deploy resource to improving systems and processes; this means taking the time to conduct systems-based investigations by people that have been trained to do them. The Patient Safety Strategy challenges everyone to think differently about learning and what it means for our organisation. This Patient Safety Incident Response Plan (PSIRP) sets out how The Christie will respond to patient safety incidents reported by staff and patients, their families, and carers as part of work to continually improve Patient Safety Learning Responses (PSLRs) by:

- Refocusing Patient Safety Learning Responses towards a system analysis approach and the rigorous identification of factors and system issues
- Focusing on addressing these causal factors and the use of improvement sciences to prevent or continuously and measurably reduce repeated patient safety risks and incidents.
- Transferring the emphasis from the quantity to the quality of patient safety incident inquiries such that it increases our stakeholders' (notably patients, families, carers, and staff) confidence in the improvement of patient safety through learning from incidents.
- Acting proportionately to incidents and risks, ensuring a compassionate and engaged response is taken with affected parties whilst aiming to release resource from investigation processes to improvement programmes and work streams.

As a trust, we are required to transition to this new framework by April 2024. This will begin with the introduction of Divisional Patient Safety Improvement groups that will triage incidents on a weekly basis and assign appropriate and proportionate learning responses.

The consultation period of PSIRF is currently underway and has progressed through Patient Safety Committee and Risk and Quality Governance Committee for review. There has also been engagement with our Specialist Commissioners at NHSE and the ICB about the detail of our PSIRF Policy and Plan to ensure external oversight, and in advance of submitting

these documents for approval. The Quality Assurance Committee have reviewed the documents and will provide updates as appropriate to Board.

The Patient Safety Team are progressing with trust wide recruitment for Patient Safety Champions across various multidisciplinary roles. These champions will aim to further enhance our patient safety culture and support staff throughout the transition to PSIRF.

Operational Performance

Our operational performance indicators show no significant adverse variances. Compliance at the end of December against the 62-day consolidated standard was 70.8%. We have continued to achieve the 31-day standard for treatment to start within 31 days of the decision to treat. During December there were 4 operations cancelled on the day for non-clinical reasons, all were rebooked within 28 days.

From October 2023, there are three key standards that we are measured against;

1. Faster Diagnosis Standard – referral to diagnosis threshold 75%
2. 62-day referral to treatment standard, (merging all 62-day standards) threshold 70%
3. One headline 31-day decision to treat to treatment standard threshold 96%.

It is likely that from 1st April, the 62 day standard will be 85%.

The divisional management teams have refreshed their improvements plans to ensure that we begin to see sustainable improvement in terms of delivery against the cancer waiting times targets. Key areas of focus are outpatient waits for first appointments and radiotherapy capacity. In radiotherapy 4 hours of additional capacity have opened this month.

Transfer of Bolton Oncology care

In line with our corporate objective 5.4 Continue transfer of management and accountability of local outpatient oncology care, the trust has now completed the transfer of oncology outpatient activity from Bolton Foundation Trust to the Christie.

The financial implication of the transfer is cost neutral in terms of associated income versus the cost of the Christie managing and resourcing the local service in Bolton. The total value of this service transfer is £2.5m. This transition has been approved in line with the scheme of delegation.

Network service division have been liaising with Bolton in relation to the transfer for many years, so reaching agreement is a significant milestone. The programme of work to transfer the service commenced this month and the project will be closed by year end.

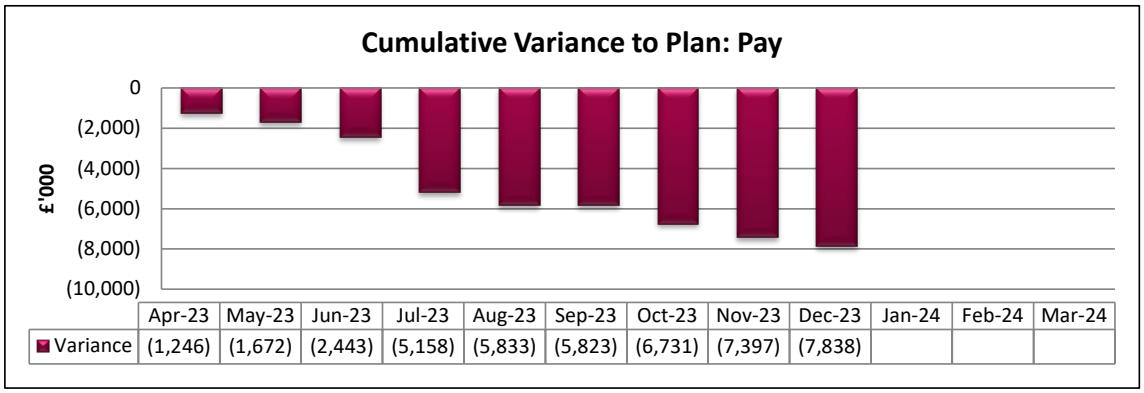
Financial Performance

Revenue: Financial performance is ahead of plan as illustrated in the table below. The Trust is reporting a £1.1m deficit against a £6m planned deficit position. This is mainly due to pay underspends due to vacancies, interest received on the Trust's cash balances being above planned levels, income to negate the costs of industrial action combined with releases from the Trust balance sheet.

The significant variances in clinical income and non-pay are both related to the overspend (and associated over achievement of income) in relation to pass through drugs.

Month 9 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(373,973)	(280,525)	(299,614)	(19,089)
Other Income	(68,922)	(51,664)	(49,959)	1,705
Pay	212,477	159,299	151,461	(7,838)
Non Pay (incl drugs)	218,370	163,854	181,943	18,090
Operating (Surplus) / Deficit	**(12,048)**	**(9,036)**	**(16,168)**	**(7,132)**
Finance expenses/ income	28,723	21,542	23,621	2,079
(Surplus) / Deficit	**16,675**	**12,506**	**7,453**	**(5,054)**
Exclude impairments/ charitably funded capital donations	(8,637)	(6,478)	(6,332)	146
Adjusted financial performance (Surplus) / Deficit	**8,038**	**6,028**	**1,121**	**(4,908)**

The cumulative pay underspend of £7.8m is illustrated in the graph below (note £4.2m of this relates to income backed services, including GM Cancer, R&I and The Christie Charity, hence there is an equivalent reduction in expenditure).



Capital: Of the latest revised capital plan of £30.9m, the Trust has spent £13.9m to M9. The remainder of the capital programme will be spent in Q4 on the following scheduled projects:

- Digital projects: £2.3m
- Delivery of the CT simulator and superficial skin unit: £1.0m
- Installation of the second linear accelerator at Salford: £2.7m
- TIF ward: £9.9m
- Backlog maintenance and other small assets: c£1.0m

Cost improvement: The level of recurrent CIP identified to date is under plan at £2m compared to a target of £6.4m. Whilst divisions are working on the delivery of cost improvement schemes, this has been significantly impacted by the management of industrial action. The annual CIP target of £12.5m is forecast to be delivered but predominantly through non-recurrent measures; this will create associated pressures for 2024/25.

KPIs: As shown in the table there are no significant variances from the planned financial performance against key measures other than the level of recurrent CIP delivered to date:

Measure of Financial Performance	Red / Amber / Green rating
Revenue: Trust Control Total compared to plan	£4.9m improvement on plan
Capital: Capital expenditure against plan	£7.6m under plan
CIP identified (recurrent) against target of £6.4m	£2.0m identified
Debtor days compared to 15-day target	12 days
Cash balance	£134m
Better Payment Practice Code (95% target)	97%

Assessment of 'best case' scenario: As previously report to Board, the Trust has reviewed the risks and opportunities in delivery of the Trust's operational plan combined with the financial and operational performance to date to inform a revised year end scenario of break even.

From discussion with GM ICB and PwC, the Trust has been advised to include the profit generated from the joint venture, The Christie Private Care (TCPC), in the year end position. This would add a further estimated £5.8m income to the breakeven position resulting in a 'best case' outturn of £5.8m surplus.

GM Recovery: The GM system continues to be supported by the PwC turnaround team and the Trust is fully engaged in this process. This work included optimising the 2023/24 year-end position, identifying any flexibilities in balance sheet position and assessing the underlying run rate. As part of this work, the Trust has reviewed and revised a 'best case' scenario which has been combined to provide a GM ICB best case scenario of £180m deficit which has been accepted by NHSE.

Workforce

Our workforce performance indicators show mandatory training compliance and personal development plan rates are both above (better than) thresholds at 90.7% and 84.1% respectively. Sickness absence rates have decreased slightly in November to 4.48% (threshold of 3.4%). The overall all year turnover is 10.19%. These issues and the associated plans for improvement have been considered by the Workforce Assurance Committee.

The annual staff vaccination programme commenced on Monday 25th September 2023. Both covid and influenza vaccines are available for all staff with the opportunity to receive both vaccines at one appointment. There is also the opportunity to receive each vaccine independently for those who wish to do so. We aim to complete covid vaccination by the end of January, with influenza vaccines available until March. Current compliance for all staff as of 03/01/23, Covid :41%, Flu: 59%. The Christie is the highest performing Trust across Greater Manchester for compliance.

Globis Mediation have completed their work on a wide-ranging audit of our organisational culture to better understand some of the CQC feedback and comments from staff, triangulating these with other sources of information such as the NHS Staff Survey. The report has been circulated to staff and is also available to read on HIVE here as well as our external website here under 'organisational culture'. A full timetable of drop in-sessions and existing formal meetings and forums to discuss the independent cultural audit report findings has been communicated on the Trust intranet.

The early themes emerging from the staff engagement process include: the role of the board in leading changes in culture, training and support for leaders in important people management issues, ensuring our speaking up procedures encompass clinical issues, clarification of leadership expectations and accountabilities, promotion and awareness of our workforce wellbeing services and, making sure our workforce policies are up to date and available to staff. These themes are being tested through the engagement process and will be developed into an overall programme for reporting to the board. The Board will receive further updates on the progress of this work at their March meeting.

Industrial Action

Junior doctors have rejected a new government offer of an additional 3% pay increase and staged further industrial action from 20th December – 23rd December 2023 and 3rd January – 9th January 2024.

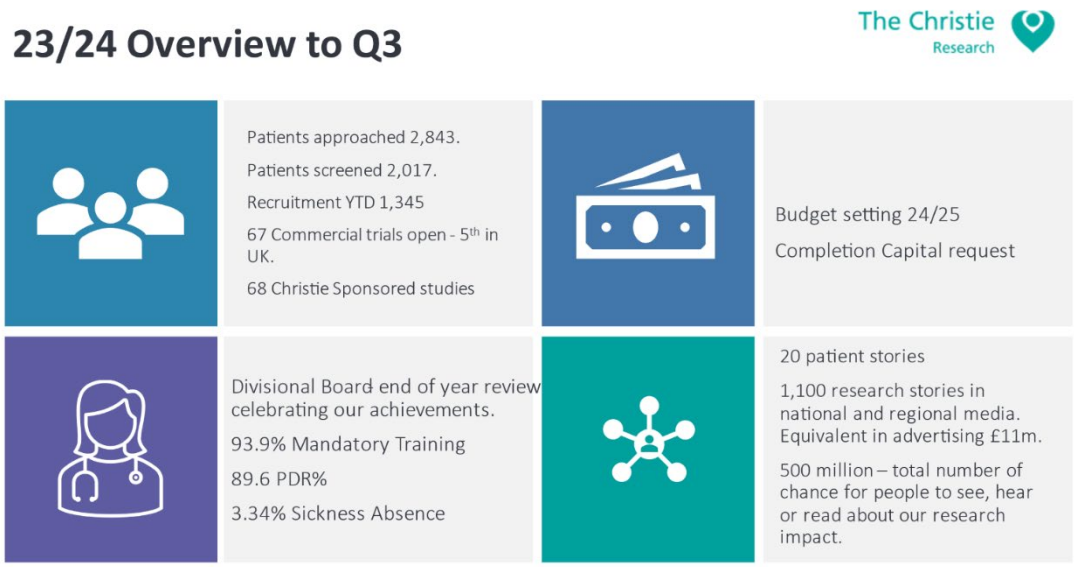
The BMA consultants committee has put a new pay offer from the Government to its members who are currently voting on these proposals in a referendum. The results of the referendum will be known later this month. Should members not accept the proposals, consultants have voted in favour of continuing industrial action.

The BMA have also put an offer from the Government to SAS Doctors. Like their consultant colleagues, SAS doctors have voted to take industrial action if the offer is not accepted.

Pulse Survey
People Pulse is a quarterly staff survey that gives staff the opportunity to regularly share views about their working experience. Feedback will be used to shape a range of support both at the Christie and nationally. The survey should take no longer than 5 minutes to complete. Staff can find the survey link at www.nhspeoplepulse.com. Thank you for taking time to share your views.

Health Inequalities
A Quality Improvement project led by Susy Pramod (Tissue Viability Lead Nurse) addressing skin tone bias in wound care has been selected by the NHS England National Healthcare Inequalities Improvement Programme and NHS IMPACT (the new shared NHS approach to continuous improvement) for spread and adoption across healthcare settings. This work, which received a prize at the Trust's Quality Improvement and Clinical Audit awards last month, introduces a skin tone assessment to already established wound care tools to address the disparity for patients with dark skin tones who are more likely to be diagnosed with higher-stage pressure ulcers due to a lack of accurate assessment and early identification.

Research



Progress against Strategy
The Senior Leadership Team is now in place with the Divisional Manager, Kay Faulkner joining The Christie Research and Innovation team in December 2023.

Priorities for the next quarter are:-

- Development of our operational plan to support delivery of our strategy for 2024/25.
- Development of Key Performance Indicators to enable us to track our progress and impact.
- Reviewing our risks

Recruitment targets for research continue to be on track. Pressures in aseptics production capacity currently pose a risk to meeting all targets and staff are working together to optimise capacity and bring some product production out of aseptics.

The Division held its first face to face and hybrid meeting since covid to reflect on progress through the year and celebrate achievements on December 20th. Presentations highlighted national and international awards, practice changing publications and plans to accelerate and improve research delivery aligned with our strategy.

Education

In support of individual and team professional development, education to support service development and external impact, the Christie Charity/Christie Education relaunched the Tomkins family bursary scheme. The scheme supports all staff groups to undertake shorter term visits/immersive learning opportunities with other cancer centres of excellence, with a requirement to translate learning into service improvement. In partnership with the Tomkins family, seven bursaries were awarded to a mix of individuals and teams across clinical practice, research/clinical scientists/education and apprentices education.

As part of the developing wider Christie international impact, an education focused group has been set up with colleagues from Peter Mac (Melbourne, Australia). Output from this group has identified prestigious exchange fellowships, virtual practice exchanges (supporting early career colleagues with QI ideas) and shared education development. Both Christie and Peter Mac are committed to multiprofessional exchange and education development, including opportunities for non clinical staff in engineering, physics, patient administration, finance and strategy.

In support of wider Christie activity, and educational excellence, Leonie Alexander joins us as our EDI Education lead. This key appointment has a critical role in the design/quality of education and ensuring outward facing EDI events that are relevant to all colleagues in their work context. This has included a launch of a network of events, including a planned series around cancer care, inclusion and social justice (aimed at all staff) – focusing on equitable care, identity, inclusion and trauma informed, holistic care.

Strategic and Service Developments

The Paterson building is now operational with most of the Trust's groups either having moved in or in the process of moving in. With maximising space utilisation being of key importance, the level of occupancy will be reviewed over the coming months with further groups moving in if possible and areas reallocated if appropriate. Arrangements to close the old, vacated Estate space when the groups move is ongoing and some of the areas may be re-allocated.

Pathology JV Re-procurement – the project team have completed review of the Supplier Questionnaires and three suppliers have been invited to the next stage of the procurement. Site visits will take place in January, followed by initial bid submission in mid-March. Following review by the project team the Competitive Dialogue will commence.

Work continues on the formation of a 20-bedroom ward in the former Trust Administration and Digital floors. Internally, work continues with the partitions and mechanical and electrical services. Externally, the steel frame to support the cladding has commenced and the replacement of the existing combustible cladding is about to commence. This is to be replaced due to the change in use of the building to an inpatient facility. Several risks were identified in respect of the delivery of the project and these continue to be managed.

Work on the refurbishment of the existing Art Room has commenced and is scheduled to complete in May 2024. This project is funded by The Christie Charity and the art service has been moved to a temporary location to allow the service to continue during the works.

Planning Permission for the next major strategic development, the Advanced Scanning and Imaging Centre development along Wilmslow Road was received in December 2023; ahead of programme and without any objections being received. Before the demolition of the existing buildings in the area can commence, a programme of decanting several uses must complete with the most significant decant being the Pathology services. In the meantime, the development of the designs and staff engagement continues.

Our Carbon Energy Fund Scheme is a key project in our sustainability aspirations and puts us a step closer towards achieving the NHS Net Zero targets. Most of the works are complete with the systems continuing testing and commissioning. The scheme will deliver circa one tonne of carbon emission savings and circa £500k annual in energy cost savings.

The validation survey phase of the review of the presence of Reinforced Aerated Autoclaved Concrete (RAAC) has been completed and issued and has confirmed the previous view that there is no known RAAC on the site.

More information about our new developments can be found at: http://christie.nhs.uk/about-us/our-future/our-developments/.

Greater Manchester System

Specialised Commissioning Delegation

As highlighted in previous reports, there is a national policy to delegate responsibility for a commissioning several specialised services to ICBs from 2024/5.

The NHSE Board met on 7th December to consider whether to approve several recommendations related to the delegation of specialised services. The Board approved the recommendation to delegate responsibility to all ICBs in the Northwest, subject to the condition that the budget be ringfenced and spent on specialist services only; this includes growth and reserves.

Further detail will be discussed by the Board of Directors at their Planning Day on 2nd February.

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Agenda item 02/24b

Meeting of the Board of Directors
Thursday 25th January 2024

Subject / Title	Progress report of the Trust Strategy 2023-28
Author(s)	Director of Strategy
Presented by	Director of Strategy
Summary / purpose of paper	This paper provides the Board with an update on progress with the Trust's 2023-2028 Strategy
Recommendation(s)	Members of the Board are asked to: - Note the contents of the report
Background papers	Trust Strategy 2023-28
Risk score	N/A
Link to: ➢ Trust strategy ➢ Corporate objectives	N/A
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	LCC Leading Cancer Care BO Best Outcomes L&S Local & Specialist CE Christie Experience R&I Research & Innovation USP unique selling point GM Greater Manchester TIF targeted investment fund MFT Manchester Foundation Trust NMGH North Manchester General Hospital JV joint venture CODU Clinical Outcomes Data Unit SDE secure data environment

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Agenda item 02/24b

Meeting of the Board of Directors
Thursday 25th January 2024

1. Background

A refreshed Trust Strategy was approved by the Board of Directors in March 2023. This followed an extensive period of work within the Trust to engage staff, Governors and the Board in the process to review the previous 5 year Strategy and refresh it for the 2023 – 2028 period.

Alongside this the Trust also revised its Values and Behaviours which underpin our approach to delivering the Strategy.

2. Introduction

The Trust Strategy brings together a number of key elements of the Trusts activity, specifically, Clinical, Education, Research & Innovation and Outcomes strategies. The diagram below details how these various elements come together to support the Trust delivering its overall vision, '*to care, to discover, to teach*'

As in the previous strategy, the Vision is supported by four pillars, Leading Cancer Care, The Christie Experience, Local & Specialist and Best Outcomes. These pillars provided the framework for the development of a number strategic objectives which will be delivered during the next 5 years.

3. Progress

Delivery against each of the key objectives in the Strategy is detailed in the tables below; each of the objectives in the strategy are cross referenced to our key themes of reducing inequalities, involving outcomes and reducing waits as well as the Annual Corporate Objectives.

Strategic Objective	Project / Activity	Current Actions	Inequalities	Outcomes	Waits	Corporate Objective
Leading Cancer Care						
To realise the potential of the Paterson.	Relocate Christie and University staff into the Paterson.	Moved University and Christie staff into the building (April – December 2023).		✔		2
To grow a pipeline of leaders.	Develop the Global Cancer Leaders Programme.	Charity Business Case completed and funding agreed (September 2023). Recruitment to the first two posts underway.	✔			3
To accelerate Research delivery.	Scope expansion of Clinical Research Facility capacity. Embed RedCap database for sponsored research. Establish pipeline for paperless consent / data collection.	Scoping work completed Database installed, and commissioning underway. Scoping work underway.	✔	✔		2
To develop sustainable opportunities for international partnerships.	Develop new international partnerships. Sustain existing partnerships.	Developing partnership with Peter Mac, Australia (new). Exploring opportunities in Middle East (Kings Partnership) (new). Maintaining existing work programme with Nigeria (April 2023 – March 2024).				2,3

Strategic Objective	Project / Activity	Current Actions	Inequalities	Outcomes	Waits	Corporate Objective
To amplify accessible and inclusive cancer care education.	Attain recognition as a leader in cancer education. Grow as a forward thinking inclusive educational establishment.	Review of education governance against external standards (March 2024) Development of educational partnerships practice framework (March 2024) Reviewing USP, branding and market positioning (April 2023 – March 2024) Launch of People Development Group focussing on opportunities and access to education. Revising Christie Education Structures (April 2023 – March 2024).	✔			3
Christie Experience						
To improve the inpatient experience and efficiencies	Develop 'TIF' wards Implement 'Order Comms'.	Construction of Targeted Investment Fund (TIF) wards underway (completion 2024). Implement Order Comms across the Trust.			✔	6
To establish system wide Research Outreach.	Expand access to research trials.	Increased number of open research trials in Wigan / East Cheshire / Salford / Oldham (3 to 7).	✔	✔		2
To embed Cancer partnerships beyond GM.	Transfer haematology services form Leighton.	Providing short term mutual aid and planning for service transfer during 2024.		✔	✔	8

Strategic Objective	Project / Activity	Current Actions	Inequalities	Outcomes	Waits	Corporate Objective
To grow active patient and public engagement across cancer education.		Work to commence in 2024/5				8
Local & Specialist Care						
To lead a single non surgical oncology service across GM.	Transfer local non surgical oncology services to The Christie in line with GM agreement.	Transfer of Bolton service underway Planning for transfer of services at MFT (NMGH, Wythenshawe).	✔	✔	✔	6, 8
To collaborate with system partners to maximise access to cancer diagnosis and treatment.	Support backlog reduction / system cancer waiting time performance.	Provision of mutual aid (e.g. surgery, radiotherapy) and support to providers in Greater Manchester and the North West (April 2023 – March 2024). Supporting the work of the GM Targeted Lung Health Check programme (April 2023 – March 2024)	✔	✔	✔	6
To establish the Advanced Scanning & Imaging Centre.		Design development in process, delivery partner selected. Outline Planning permission obtained (January 2024).		✔	✔	6
To develop next generation cancer pathology.	Reprocure JV partner for the Christie Pathology Partnership	Procurement commenced October 2023 and on track; for completion by May 2025.		✔		6

Strategic Objective	Project / Activity	Current Actions	Inequalities	Outcomes	Waits	Corporate Objective
Best Outcomes						
To accelerate improving outcomes through Clinical Outcomes Data Unit (CODU).	Launch the CODU.	Team established (September 2024).		✔		1
To upskill a cohort of 'data enhanced' clinicians to support clinic teams.	Establish outcomes minimum data set.	Gap analysis completed, project plan developed and disease group engagement to commence.	✔	✔		1
Develop a secure data environment (SDE)with regional and national capability		Working with partners as part of the GM SDE programme	✔	✔		1
Work in partnership with the GM Cancer Alliance to establish and report on inequality metrics.		Working with GM Cancer as part of the GM system cancer outcomes group; specific projects to be developed in partnership during 2024. Projects to understand impact of inequality on service provision underway.	✔			5, 8
Improve Outcomes for Older People through the Senior Adult Oncology Service	Develop full business case.	Pilot scheme completed (2023) Full business case developed and approved (January 2024). Service embedded within the Trust from April 2024.	✔	✔		1

4. Risks

There are a number of potential threats or risks to the delivery of our Strategy. The key risks relate to finance and capacity. The NHS remains under significant financial pressure and a number of our programmes require capital or revenue to proceed. This will remain a challenge in the near term. Post COVID, the NHS remains under heightened service pressure with increased demand and waiting lists. Ensuring the appropriate balance between delivering the day to day requirements and our longer term ambition will be critical to successful of the Strategy.

5. Next Actions

Work will continue during the next reporting period to develop a 'forward look' on activities that will support the delivery of the Strategy alongside a focus on delivery timescales.

6. Recommendation

Members of the Board are requested to note the contents of the report and the progress in the months since the Strategy was approved.

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Agenda item 03/24a

Meeting of the Board of Directors
Thursday 25th January 2024

Subject / Title	National Cost Collection 2023 Submission Brief
Author(s)	Gavin Rush, Head of Costing
Presented by	Sally Parkinson, Director of Finance
Summary / purpose of paper	This paper provides a summary of the National Cost Collection (NCC) for Financial Year 2022/23 submitted in December 2023, including issues and recommendations for future collections.
Recommendation(s)	The Board is asked to: • Approve the outputs of this year's National Cost Collection (NCC) as outlined above following Director of Finance Sign-off.
Background papers	n/a
EDI impact/considerations	n/a
Risk score	
Link to: ➢ Trust strategy ➢ Corporate objectives	The National Cost Collection is required as part of the trusts provider licence.
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	NCC - National Cost Collection PLICs – Patient Level Information Costing NHSE – NHS England

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Agenda item 03/24a

Meeting of the Board of Directors
Thursday 25th January 2024

National Cost Collection 2023 Submission Brief

1. Background

The National Cost Collection (NCC) is a Patient Level Information Cost (PLICs) collection that covers all areas of the trust's activity. This was previously known as Reference Costs. The NCC provides costing information to NHS England (NHSE) for use in national tariff, benchmarking, spending reviews and economics.

2. Purpose

The purpose of this brief is to provide a high-level summary of the submitted information, outline key changes to the collection, priorities for future collections and set out an action plan in line with national guidance.

3. Current Position

The overall costs of the trust have increased by 2% from £283m last year to £287m. The cost mix has remained static except for High-Cost Drugs and Chemotherapy, this is driven by a counting change from NHSE. More detail can be found in Appendix A to C. The Quantum reconciles to 0.41%, details of the reconciliation and agreed adjustments can be found in Appendix D and E.

	2021/22		2022/23			
Cost Summary	**£000's**	**% of Cost**	**£000's**	**% of Cost**	**Variance**	**Variance %**
Total Quantum	**£282,969k**		**£287,297k**		**£4,327k**	**2%**
Admitted patient care	£77,006k	27%	£68,379k	24%	(£8,627k)	(11%)
Outpatient care	£37,234k	13%	£43,692k	15%	£6,459k	17%*
Chemotherapy and radiotherapy	£130,676k	46%	£63,845k	22%	(£66,831k)	(51%)*
Critical care	£7,300k	3%	£5,955k	2%	(£1,346k)	(18%)
High cost drugs and devices	£7,614k	3%	£80,092k	28%	£72,477k	952%*
Supplementary Information /Other	£23,139k	8%	£25,334k	9%	£2,195k	9%

**Counting Change from NHS England Re procurement of High Cost Chemo Drugs and delivery of Chemotherapy*

As part of this years NCC there has been a significant counting change in relation to Chemotherapy and Radiotherapy, both in terms of activity and drug costs.

- Chemotherapy and Radiotherapy drugs are now excluded on a named drug basis. This has two implications on this year's submission:
    - Named drugs are now costed and reported under "High Cost Drugs and Devices" as opposed to "Chemotherapy and Radiotherapy".
    - Drugs associated with Chemotherapy and Radiotherapy have traditional reported under "Procurement" HRG's, with the introduction of named drug reporting any associated drugs not on the named list have now been mapped back to the core attendance. This has had a ponticular impact on Outpatient attendance related to Chemotherapy and Radiotherapy.
- In addition to the change in drug cost allocation there has also been a counting change in terms of Chemotherapy and Radiotherapy activity. Previously this activity has been classed as unbundled, however this year NHSE have instructed costing teams to "re-bundle" this activity and create core attendances.

The traditional Reference Cost Workbook was retired this year and replaced with a new aggregated feed, however this new feed is not fit for purpose and placed inappropriate restrictions on the submittable data. As a result, an additional £15.9m was excluded from this year's submission that should have been include, this account for around 5.6% of the total quantum submitted and therefore is a material issue outside the trusts control. More details are included in appendix E.

The costing team has experienced significant turnover over the last year, as a result we now have a completely different team to the one who prepared last year's submission. Due to the turnover and vacancies we have contracted with a third party organisation, Care Costing, for support in the production of this year's collection. As of the 1st October the costing team are now fully established.
The 2022/23 NCC has be subject to significant delays and disruption by NHSE. The submission window was due to open on 16th October with submission on 6th November, on the 11th of October the submission window was cancelled. The current window is opened 20th November with a named submission day for the Northwest of 11th December, and is due close on 12th January, with no view on when the outputs will be published.

4. Audit & Costing Standards

The NHSE Audit program was stud down as part of the Covid-19 response and has yet to be re-established. Given the turnover in the team and changes in the system there are currently no audit standards outstanding.

5. Issues and Improvements for 2023/24

Due to staffing issues and several delays from NHSE there has been significant disruption to the costing process for financial year 2022/23. Going forward the following areas have been identified to improve the quality of PLICs data and add value to the trust:

- Review the use of current systems and benchmarking tools to ensure more transparency and resilience within the costing team and ensure that outputs are relevant for users.
- Revitalisation of the PLICs engagement programme to both improve data quality and add value.
- Review Data Quality issues outlined in Appendix F and G.
- More work is required with the Contract Information team to understand and reconcile costing activity with SUS. Appendix H.

7. Finance Director Sign Off

In line with national guidance the 2022/23 NCC required Director of Finance Sign-off, this can be found in Appendix I. To support with improving internal governance it is also recommended this brief is submitted to Board for minuting.

8. Recommendation

The Board of Directors is asked to:

- Approve the outputs of this year's National Cost Collection (NCC) as outlined above following Director of Finance Sign-off.

9. Appendixes

9.1 Appendix A: Change in Cost Base

Worksheet Name	2021/22 Val	2022/23 Val	Variance Val	Var % Val	2021/22 Act	2022/23 Act	Variance Act	Var % Act	2021/22 Unit	2022/23 Unit	Variance Unit	Var % Unit
Admitted patient care[1]	£77,006k	£68,379k	(£8,627k)	(11%)	£22k	£24k	1,516	7%	£3.45k	£2.87k	(£582)	(17%)
Outpatient attendances	£34,834k	£37,450k	£2,615k	8%	£245k	£247k	1,772	1%	£0.14k	£0.15k	£10	7%
Procedures in outpatients[2]	£2,399k	£6,243k	£3,843k	160%	£17k	£16k	(1,156)	(7%)	£0.14k	£0.39k	£247	179%
Cancer multi-disciplinary teams	£2,665k	£2,649k	(£16k)	(1%)	£11k	£11k	175	2%	£0.24k	£0.23k	(£5)	(2%)
Chemotherapy and radiotherapy [2]	£130,676k	£63,845k	(£66,831k)	(51%)	£405k	£219k	(185,954)	(46%)	£0.32k	£0.29k	(£31)	(10%)
Critical care	£7,300k	£5,955k	(£1,346k)	(18%)	£2k	£2k	(429)	(19%)	£3.24k	£3.26k	£24	1%
Diagnostic imaging & nuclear medicine	£18,769k	£20,760k	£1,991k	11%	£42k	£43k	1,458	3%	£0.45k	£0.48k	£31	7%
High cost drugs and devices [2]	£7,614k	£80,092k	£72,477k	952%	£7k	£138k	130,865	1839%	£1.07k	£0.58k	(£490)	(46%)
Specialist palliative care	£1,566k	£1,719k	£154k	10%	£6k	£7k	813	14%	£0.27k	£0.26k	(£10)	(4%)
Direct access pathology	£139k	£205k	£66k	47%	£9k	£13k	3,221	34%	£0.01k	£0.02k	£1	10%
	£282,969k	**£287,297k**	**£4,327k**	**2%**	**£767k**	**£719k**	**(47,719)**	**(6%)**	**£9.34k**	**£8.53k**	**(£805)**	**(9%)**

Comments:

1. This movement is driven mainly by excluded legally sensitive and restricted data (LSRD) that has been excluded in year as a result of a submission issues outlined in appendix E. This is outside of the trusts control and is currently sitting with NHSE for correction going forward.
2. This movement effect several areas and is a result of a counting and coding changes relating to Chemotherapy and Radiotherapy.

9.2 Appendix B: Top-Down Allocations

Allocation	2021/22 Spend	2022/23 Spend	Spend Movement	% Movement
Z_CLIN_EXCELLENCE	(£1,161k)	(£1,230k)	(£69k)	6%
Z_DEPN_BUILD_DON	£2,185k	£2,875k	£690k	32%
Z_DEPN_BUILD_PUR	£5,656k	£6,618k	£962k	17%
Z_DEPN_EQUIP_DON	£887k	£1,705k	£818k	92%
Z_DEPN_EQUIP_PUR[1]	£8,208k	£9,778k	£1,569k	19%
Z_FLOOR_AREA	£12,030k	£12,590k	£560k	5%
Z_HEATED_VOLUME	£6,175k	£11,164k	£4,990k	81%
Z_MADEL	(£2,196k)	(£720k)	£1,476k	(67%)
Z_MEDICAL_ENGINEERING	£531k	£599k	£68k	13%
Z_PROCUREMENT	£580k	£648k	£69k	12%
Z_TOTAL_SPEND[2]	£6,031k	(£120k)	(£6,151k)	(102%)
Z_TOTAL_SPEND_PAY[3]	£8,308k	£14,220k	£5,912k	71%
Z_WTE	£22,349k	£11,761k	(£10,588k)	(47%)
Z_WTE_DIV_CCCS	£1,347k	£1,584k	£237k	18%
Z_WTE_DIV_CMPE	£1,936k	£2,231k	£295k	15%
Z_WTE_DIV_CNS	£805k	£1,073k	£268k	33%
Z_WTE_MED	£715k	£971k	£257k	36%
Z_WTE_NUR	£417k	£402k	(£16k)	(4%)
Z_WTE_SVC_AHP	£477k	£508k	£30k	6%
	£75,280k	**£76,658k**	**£1,377k**	**2%**

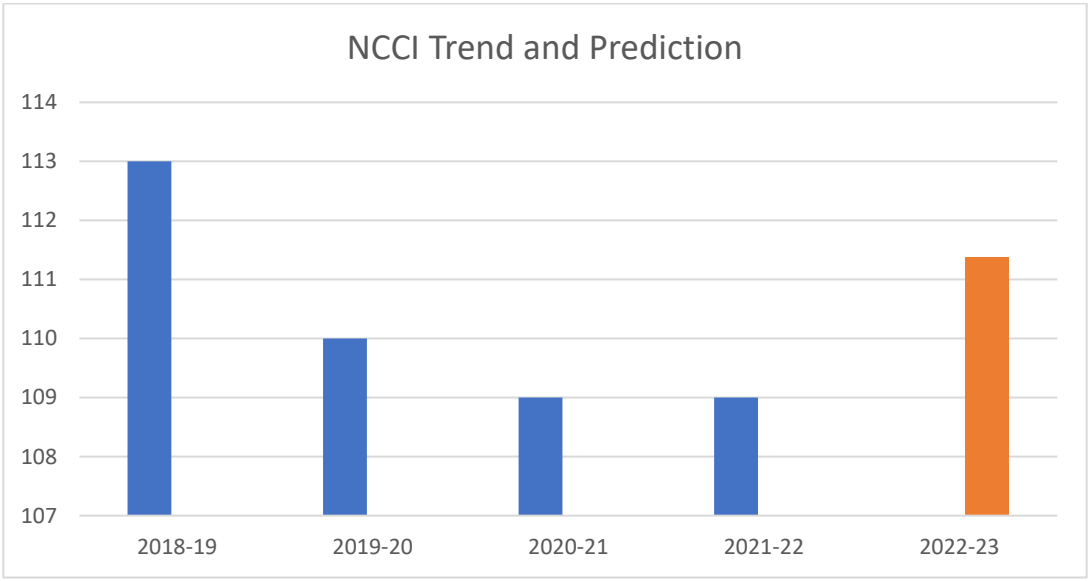
Notes:

1. Purchased IT Equipment & Software
2. Finance Charges and GM Cancer Income
3. Pay Awards

9.3 Appendix C: Benchmarking

The Benchmarking data looks at our internal PLICs Data compared to an Estimated National Average cost to predict the NCCI for this year's NCC Submission. The NCC PLICS data include submitted data plus excluded LRSD, as this was previously collected and include in National Average.

NCC POD	NCC PLICS	Est National Avg	Sum of Expected NCCI
ACC	£7,592,805.09	£4,477,960.71	1.70
CHEMD	£30,732,645.43	£21,915,088.53	1.40
CHEMP	£0.00	£0.00	1.00
CHEMSDA	£0.00	£0.00	1.00
CL	£35,323,659.31	£46,495,119.82	0.76
CMDT	£2,648,745.36	£1,914,297.46	1.38
DA	£205,224.13	£76,768.50	2.67
DC	£10,894,230.10	£12,237,166.90	0.89
EL	£34,079,906.48	£30,661,944.22	1.11
HCD	£85,073,711.84	£79,837,289.12	1.07
IMAGDA	£3,532.04	£4,194.58	0.84
IMAGOP	£17,873,253.16	£9,625,266.89	1.86
IMAGOTH	£2,107,104.29	£302,586.97	6.96
IMAGUM	£783,905.08	£436,845.40	1.79
NCL	£2,110,159.31	£2,225,272.51	0.95
NEL	£29,275,887.04	£22,135,598.35	1.32
NES	£2,598,332.74	£3,606,937.35	0.72
OPROC	£6,260,625.21	£3,677,181.48	1.70
RADO	£593,841.86	£547,234.11	1.09
RADP	£10,447,244.82	£8,625,532.12	1.21
RADT	£22,823,599.31	£22,078,317.30	1.03
RP	£6,305.21	£4,362.07	1.45
SPAL	£1,814,083.26	£1,372,009.25	1.32
Grand Total	**£303,248,801.09**	**£272,256,973.66**	**1.11**



9.4 Appendix D: Quantum Reconciliation

STATEMENT OF COMPREHENSIVE INCOME	Maincode / Subcode	Last year 31 Mar 2022 2021/22 £000	Before consolidation of charity 31 Mar 2023 2022/23 £000	After consolidation of charity 31 Mar 2023 2022/23 £000	Charity Movement	After Impairment Adjustment 30 Jun 2023 2022/23 £000	Impairment Movement
Operating income from patient care activities	SCI0100A	325,701	364,629	364,629	0	364,629	0
Other operating income	SCI0110A	77,415	64,505	73,134	8,629	71,772	(1,362)
Operating expenses	SCI0125A	(377,420)	(435,059)	(429,270)	5,789	(422,453)	6,817
OPERATING SURPLUS / (DEFICIT)	SCI0140A	**25,696**	**(5,925)**	**8,493**	**14,418**	**13,948**	**5,455**
FINANCE COSTS							
Finance income	SCI0150	185	3,408	4,539	1,131	4,539	0
Finance expense	SCI0160	(1,426)	(1,356)	(1,356)	0	(1,356)	0
PDC dividend expense	SCI0170	(7,935)	(8,425)	(8,425)	0	(8,425)	0
NET FINANCE COSTS	SCI0180	**(9,176)**	**(6,373)**	**(5,242)**	**1,131**	**(5,242)**	**0**
Other gains/(losses)	SCI0190A	(56)	(4,008)	(4,034)	(26)	(4,034)	0
Share of profit/(loss) of associates/ joint ventures	SCI0200	4,896	6,717	6,717	0	6,717	0
Gains/(losses) from transfers by absorption	SCI0210	1,332	792	792	0	798	6
Corporation tax expense	SCI0230	(107)	(90)	(90)	0	(90)	0
SURPLUS/(DEFICIT) FROM CONTINUING OPERATIONS	SCI0240A	**22,585**	**(8,887)**	**6,636**	**15,523**	**12,097**	**5,461**
Surplus/(deficit) from discontinued operations and the gain/(loss) on disposal of discontinued operations	SCI0240B	0		0	0	0	0
SURPLUS/(DEFICIT) FOR THE YEAR	SCI0240	**22,585**	**(8,887)**	**6,636**	**15,523**	**12,097**	**5,461**

Reconciliation of National Costs Quantum to Trust Audited Annual Accounts	£'000
Operating expenses from consolidated accounts	£422,453
Other operating income (all)	(£71,772)
Other operating income - Not Permitted (See Annex 1)	
Non-patient care income recorded in patient care	(£25,563)
Finance income	(£4,539)
Finance expenses (including unwinding of discounts)	£1,356
PDC dividend expense	£8,425
Other gains/(losses) including sale of assets	£4,034
Share of profit/(loss) of associates/ joint ventures	(£6,717)
Impairments net of (reversals)	(£1,552)
PFI support income	£0
Local improvement finance trust (LIFT)	
Private finance initiative (PFI) set-up costs	
Depreciation related to donated or government granted non-current assets (cash or non cash)	(£4,580)
Donations/grants of physical assets and or cash for the purchase of capital assets - all	£0
Provider sustainability fund / Financial recovery fund / Marginal rate emergency tariff funding (PSF/FRF/MRET)	
Final Accounts - FAQ Adjustment 1 (Allowable COVID-19 exceptional unit expenditure) (Complete Analysis B)	£0
Final Accounts - FAQ Adjustment 2 (Top-up reimbursement income)	£0
Final Accounts - FAQ Adjustment 3	(£15,946)
Final Accounts - FAQ Adjustment 4	
Final Accounts - FAQ Adjustment 5	
Pre Costing Software Subtotal	**£305,599**
Clinical and support services supplied to or received from other organisations (P2P). This includes regionally managed pathology or radiology services.	
Hosted Services (Genetics Laboratory, Intensive Care Support Services, Child Health Information Services (CHIS) Sexual Assault Referral Centres (SARC))	
Income received from other providers for maternity pathways if included in Line 2	
Payments made to other providers for maternity pathways if the cost in your ledger and included in Line 1	
National Screening Programmes	£0
Limb Fitting Services (Formally discrete external aids and appliances)	£0
Health promotion programmes (All)	£0
Home delivery of drugs and supplies: cost of drugs and administration costs	£0
Hospital travel costs scheme (HTCS) & Patient transport services (PTS)	£0
Learning disability services (non mental health or where Mental health is unable to disaggregate)	£0
Specified Services (ambulance, mental health providers and named providers) Only those services allowed or who provide the designated services	£0
NHS continuing healthcare, NHS-funded nursing care and excluded intermediate care - adults and children	£0
Non NHS Funded services - pooled or unified budgets, social care services, primary medical services and prison services, or services funded by local authorities etc	£0
Cost of non NHS Patients - Private patients, overseas visitors and other non-NHS patients (Complete Analysis A)	(£8,534)
Cost of care contracted out to private providers (Outsourced Activity)	(£3,129)
Adjustment for charities	£15,501
Critical Care Transport Network	£0
Emergency Care Streaming - Provided by GPs Only	£0
Emergency Care Streaming - Excluding GP Costs	£0
Agreed adjustments - please ensure you have authorisation from NHS Improvement Please include reference(s) here	(£20,955)
Total National Cost Collection Quantum	**£288,482**

NCC Submission Filed	£287,297
Variance	**(£1,185)**
Variance % (1% Tolerance)	(0.41%)

Line 30 - Analysis A

Cost of non NHS Patents - Private patients, over seas visitors and other non-NHS patients	
Cost of Private Patients	£0
Cost of Overseas Visitors (non-reciprocal)	(£288)
Cost of Other non-NHS patients	(£7,902)
Total cost of non-NHS patients	(£8,190)

Line 34 - Analysis B

Centrally funded COVID costs excluded from submission (per TAC return)	
NHS 111 additional capacity	£0
After care and support costs (community, mental health, primary care)	£0
COVID Medicine Delivery Unit (CMDU) service	£0
COVID-19 - Vaccination programme - Vaccine centres	£0
COVID-19 - Vaccination Programme - Provider/ Hospital hubs	£0
COVID-19 - Vaccination Programme - Local vaccination service	£0
COVID-19 - Vaccination Programme - Lead employer	£0
COVID-19 - Vaccination Programme - vaccination site decommissioning costs	£0
COVID-19 - Vaccination Programme - System Vaccination Operations Centre SVOC	£0
COVID-19 - Vaccination Programme - Vaccination of Healthy 12-15s (via SAIS)	£0
COVID-19 virus testing - rt-PCR virus testing	£0
NIHR SIREN testing - antibody testing only	£0
COVID-19 virus testing - rt-PCR virus testing - locally procured reagents	£0
COVID-19 virus testing - Rapid/point of care testing - locally procured reagents costs	£0
COVID-19 virus testing - Rapid/point of care testing - all other locally procured devices	£0
NIHR SIREN testing - research staff costs	£0
Total cost of centrally funded COVID costs excluded from submission (per PFR return)	£0

9.5 Appendix E: Agreed Adjustments

NCC Summary Code	NCC Summary Name	Current Value	Notes
Activity	Proton Beam Therapy	£21,009,578	Proton Beam Therapy Exclusion Request. Highly specialised. One of 2 providers in England. On Open-Book arrangement with NHSE. No established national currencies. Extremely high cost and low volume.
Activity	TCC Trading	£1,247,298	Commercial Trading Activity with Private Company. Unrelated to the delivery of NHS Care. Request for exclusion of net profit/loss which should not impact NHS costs.
Activity	Group Subs Assos JVs	(£916,192)	Dividends received from Commercial Activities unrelated to NHS Care. These should not deflate NHS costs.
Activity	Group Subs Assos JVs	(£385,255)	Net profit/loss of commercial group company unrelated to the delivery of NHS Care. Request for exclusion of net profit/loss which should not impact NHS costs.
		£20,955,428	

Legally Sensitive Records that could not be submitted

Excluded from Aggregated Submission Legally Restricted Sensitive Data (LRSD)	Excluded LRSD	Included LRSD	Total LRSD	% of Cost	Last Year	Movement
Total Quantum	**£15,946k**	**£627k**	**£16,573k**		**£19,089k**	**(£2,516k)**
Admitted patient care	£8,633k	£5k	£8,638k	52%	£12,370k	(£3,733k)
Outpatient care	£78k	£240k	£318k	2%	£363k	(£45k)
Chemotherapy and radiotherapy	£866k	£0k	£866k	5%	£1,949k	(£1,083k)
Critical care	£1,641k	£0k	£1,641k	10%	£2,353k	(£712k)
High cost drugs and devices	£4,628k	£374k	£5,003k	30%	£1,902k	£3,101k
Supplementary Information /Other	£99k	£9k	£108k	1%	£152k	(£44k)

9.6 Appendix F: Data Quality

Data Feeds	Final output	Latest Comment
CREATE_M_IP	OK (On The Whole)	
CREATE_M_OP	OK (On The Whole)	Level_02 03 no M12 Data. Investigate.
CREATE_M_ACC	OK (On The Whole)	Around 50% of processed rows have problems identified. Part year issue that relates to AACU unit.
CREATE_M_DUM	OK	
CREATE_A_BLOOD	Some Issues	Blood Red Cells known issue M2-M12.Low matching in places.
CREATE_A_CONTACTS	OK (On The Whole)	Low CWP 371 and CWP 483 matching - Level 02 Processed Rows Matching. Overall below 95% matching.
CREATE_A_DRUG	Some Issues	Low matching OP - HOMECARE DRUGS and M12 a bit higher - Level 02 Processed Rows.
CREATE_A_EVENTS	OK (On The Whole)	Low matching M1 & M4.
CREATE_A_IMAGING	OK (On The Whole)	Low matching M1. 30% Rows with problems + Low endocrinology matching - Level 02 Processed Rows Matching.
CREATE_A_INCOME	OK	
CREATE_A_MOSAIQ_RADIO	OK	
CREATE_A_PATHOLOGY	Some Issues	Level 02 - FM PHE Data low matching. Known issue with test codes mapping and M12 data missing. Sits with Pieter/Dane.
CREATE_A_SCHED	Some Issues	Below 95% overall matching. 40% Rows with problems + Low iQemo matching - Level 02 Processed Rows Matching
CREATE_A_THEATRE_SUPPLIES	OK (On The Whole)	10% processed rows have problems identified. Theatre 8 & 9 have a drop from M5 & M6 onwards.
CREATE_A_THEATRE	OK (On The Whole)	28% processed rows have problems identified.
CREATE_A_WARDSTAY	OK	
CREATE_A_WIP_PRIOR_YEAR	OK	
CREATE_O_ADD_OPCS	Not OK	No Data At All for 2022-23. Known issue with CIT.
CREATE_O_GL_OVH_BUILD	OK	
CREATE_O_GL_OVH_ROOM	OK (On The Whole)	15% processed rows have problems identified
CREATE_O_GL_OVH	OK (On The Whole)	Level 02 - Z_CLIN_EXCELLENCE half comparing to last year. Need to check Clinical Excellence vs Ledger.
CREATE_O_GL	OK	
CREATE_O_SACT	OK (On The Whole)	Below 95% overall matching.
CREATE_R_ACTIVITY_HRG	OK	
CREATE_R_ACTIVITY	OK	
CREATE_R_COST_DRIVERS_ACTIVITY	OK	
CREATE_R_COST_DRIVERS	OK	
CREATE_R_GL_COST_AREA	OK	

9.7 Appendix G: Data Validation Engine

There are currently no submission failures in the final submission, the table below summarises submission warnings:

Final Submission Warnings	APC	OP	SI	SWC	AGG	Grand Total	Comments
Is EL, Alos cannot be less than 1	424	0	0	0	0	424	Daycase incorrectly coded as inpatients
Cannot be £50k or more	33	0	0	0	0	33	Relates to CAR-T and specialist care
Sum of all costs for an outpatient appointment is £500 or more, where POD is CL or NCL	0	4,521	0	0	0	4,521	Relates to Chemotherapy and Chemo Drugs
Sum of all costs for an outpatient appointment is £5000 or more, where POD is OPROC	0	204	0	0	0	204	Relates to Chemotherapy and Chemo Drugs
Average unit cost UnCur should not be less than £20	1	11	171	0	18	201	
The average unit cost of WF01# should be less than WF02#	0	8	0	0	0	8	
Cannot be more than 480 minutes when ActCstID is *	980	330	0	0	0	1,310	Relates to Chemotherapy
TotCst is more than £0, ActCnt cannot be 0 or lower	383	147,309	754	151	0	148,597	Historic counting issue
Total	**1,821**	**152,383**	**925**	**151**	**18**	**155,298**	

Some of the key submission failures that have been corrected are outlined below. This is not an exhaustive list and does not include any low volume, low materiality, or presentational submission failures.

Comments/Resolutions	APC	OP	SI	SWC	AGG	Grand Total
HRG Codes that are not in this years list of Allowable HRGs. They fall into different Categories.					1,018	1,018
Change applied to resolve a warning created this issue. Isuue with a link in one of our scripts. Link changes to fix the failure and the warning.	2,601	21,285	40,228	25		64,139
	2,601	**21,285**	**40,228**	**25**	**1,018**	**65,157**

9.7 Appendix H: SUS reconciliation

Matching Rule (IP)	PLICS	SUS	Discrepancy	Variance %	Investigate	Notes
In PLICS Only - Closing Work in Progress	186	0	186	1%	No	WIP not in SUS
In PLICS Only - Other	114	0	114	0%	Yes	
In PLICS Only - Private Patient Trading	2,695	0	2,695	9%	No	Private Patients not in SUS
In SUS and PLICS (Perfect Match)	26,487	26,487	0	0%	No	Matched
In SUS Only - Other	0	117	(117)	(0%)	Yes	
	29,482	**26,604**	**2,878**	**10%**		

Variance (IP)	**231**	**Net Var**	**(3)**
Variance %	**0.78%**		**(0.01%)**

Matching Rule (OP)	PLICS	SUS	Discrepancy	Variance %	Investigate	Notes
In PLICS Only - Other	1,728	0	1,728	0%	Yes	1,565 of them relates to the 1st of April missing from SUS
In PLICS Only - Private Patient Trading	13,352	0	13,352	3%	No	Private Patients not in SUS
In SUS and PLICS (Fuzzy Match)	1	1	0	0%	No	Matched
In SUS and PLICS (Perfect Match)	452,443	452,443	0	0%	No	Matched
In SUS Only - DNAs, Cancellations, Too Lates, and Blanks	0	142,682	(142,682)	(31%)	No	Not included in PLICs
In SUS Only - Hotline Clinics	0	26,552	(26,552)	(6%)	No	Not included in PLICs
In SUS Only - Other	0	495	(495)	(0%)	Yes	Not included in PLICs
In SUS Only - Unbundled Imaging	0	3,880	(3,880)	(1%)	No	Not included in PLICs
	467,524	**626,053**	**(158,529)**	**(34%)**		

Variance (IP)	**2,223**	**Net Var**	**1,233**
Variance %	**0.48%**		**0.26%**

9.8 Appendix I: Finance Director Sign Off

As Director of Finance (or equivalent position) I certify the following:

- The activity included in the National Cost Collection in 2023 for The Christie NHS Foundation Trust (RBV) is consistent with the activity submitted to the sector's mandated dataset submitted to NHS Digital for financial year 2022/23.
- The quantum has been reconciled to the unaudited accounts submitted to NHS England and NHS Improvement on 30th June 2023
- With the exceptions of those issues included in the body of this report, the trust has complied with the Approved Cost Guidance for England, including the relevant costing standards for England for 2022/23 and the National Cost Collection guidance.
- I have reviewed and ensured any mandatory validations are correct and all uncorrected non-mandatory validations have been reviewed and do not impact on the data quality of the overall submission.

Director of Finance Comments:

The disruption created by such a delayed NCC is unacceptable and has resulted in the costing team being unable to support internal development and progress our costing engagement programme. This has had a detrimental effect on both the quality and value of work that our costing team produced.

This year's submission has also been particularly difficult due to issues around the DVE process. This process has been particularly time consuming and manual. A significant amount of time is spent correctly presentational issues that do not impact the quality of the date. This process needs to be significantly improved before we can consider any more regular collections.

The counting change regarding Chemotherapy and Radiotherapy has created significant additional workload to the costing team to comply with national guidance. This change should be made as part of the NCC Grouper, it is unacceptable to expect costing teams to change activity in this way.

With the retirement to the traditional workbook and the introduction of the new Aggregated Feed, it is apparent that the new feed is not fit for purpose and as a result we have excluded £15m of activity that should have been included. This is a material issue with this year's collection.

The main benefit to the trust from completing the NCC is the published results, however in recent years these have been published so late they are no longer relevant and of very limited use.

I can confirm that, at an appropriate time, the costs included in this return will be reviewed with clinicians and services, and any errors or issues corrected as part of the 2022/23 submission.

Signed:	
Position:	Director of Finance
Trust:	The Christie NHS Foundation Trust (RBV)
Date:	13/12/2023

A signed copy should be submitted to NHS England and NHS Improvement via costing@england.nhs.uk citing 'Executive authorisation of NCC 2023 RBV in the subject line'. The trust should maintain a copy of this signed document

The Christie
NHS Foundation Trust

Agenda item 03/24b

Board of Directors

Thursday 25th January 2024

Subject / Title	Trust nomination of Charity Trustee
Author(s)	Company Secretary
Presented by	Roger Spencer, CEO
Summary / purpose of paper	To ask the Board of Directors to approve the recommendation of the Executive Directors to appoint Dr Neil Bayman, Executive Medical Director as a Foundation Trust trustee from 1st October 2023
Recommendation(s)	The Board is asked to approve the appointment of Dr Neil Bayman as a Foundation Trust trustee from 1st April 2024
Background papers	Charity Articles of Association
Risk score	N/A
Link to: ➢ Trust strategy ➢ Corporate objectives	Our Strategy NHS Long Term Plan GM Cancer Plan
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	FT Foundation Trust AoA Articles of Association

The Christie
NHS Foundation Trust
Agenda item 03/24b

Board of Directors meeting

Thursday 25th January 2024

Trust nomination of Charity Trustee

1. Introduction

This paper asks the Board of Directors to consider a recommendation on the replacement Foundation Trust trustee following the end of the term of office of the Chair of the charity board and Foundation Trust trustee, Kathryn Riddle.

4. Process

In line with the approved Articles of Association (AoA), the Christie Charity is required to have 9 Trustees: 4 Foundation Trust Trustees and 5 non- Foundation Trust Trustees.

The Trust provides two ex officio officers, the postholders of 1) the Trust Chief Executive role and 2) the postholder of the Director of Finance role as well as 2 nominated FT Trustees.

In line with the agreed articles, the Executive of the Trust are responsible for making a recommendation to the Board of Directors as to who they will nominate to be the other two FT Trustees. It is noted that the FT does not have to nominate members of its own Board but will select the individuals based on their ability to bring value to the Charity Board. The FT Board is required to approve these 2 Trustee nominations. The term for the nominated FT Trustees in the AoA is 3 years followed by two further terms of three years.

The Board of Directors agreed that Kathryn Riddle serve a term of 1 year to provide continuity to the charity and was to be a FT Trustee from 1st April 2023 to 31st March 2024. Edward Astle was then nominated as an FT Trustee from 1st October 2023.

The Board is now asked to consider a recommendation from the Executive for a replacement FT Trustee for Kathryn Riddle.

The Executive consider that it would benefit the Trust and the aims of the charity to have more medical expertise on the Charity Board.

3 Recommendation

The Board of Directors are asked to approve the recommendation of the Executive Directors to appoint Dr Neil Bayman, Executive Medical Director, as a Foundation Trust trustee from 1st April 2024.

The Christie
NHS Foundation Trust

Agenda Item 04/24a

Meeting of the Board of Directors
Thursday 25th January 2024

Subject / Title	Quality Assurance Committee report – November 2023
Author(s)	Company Secretary's Office
Presented by	Committee Chair
Summary / purpose of paper	This paper provides the board with a summary of the assurance items considered by the Quality Assurance Committee at their November meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions
Background papers	Quality Assurance Committee papers 23rd November 2023
Risk score	Board Assurance Framework (BAF) references noted within the report
Link to: ➢ Trust strategy ➢ Corporate objectives	• Trust's strategic direction • Divisional implementation plans • Our Strategy • Key stakeholder relationships
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	QAC Quality Assurance Committee PALS patient advice & liaison PHSO parliamentary & health service ombudsman CQC Care Quality Commission IR(M)ER Ionising Radiation Medical Exposure Regulations SUI serious untoward incident GMC General Medical Council

The Christie
NHS Foundation Trust

Agenda item 04/24a

Meeting of the Board of Directors
Thursday 25th January 2024

Quality Assurance Committee report – November 2023

1 Introduction

The Quality Assurance Committee took place on 23rd November 2023. The following summary gives the Board information on the items that were considered, and any actions required by the Board.

2 Quality Assurance Committee agenda items

The items listed in the report below were all presented to the Quality Assurance Committee for assurance in November. An assurance level was discussed and agreed for each listed item using the following criteria:

HIGH	MEDIUM	LOW
Substantial assurance provided over the effectiveness of controls in mitigating the risk in delivering our targets.	Some assurances in place or controls are still maturing so effectiveness cannot be fully assessed but should improve.	Assurance indicates limited effectiveness of controls.

Assurance level descriptions

The Committee Chair will note any actions required by Board and make escalations to Board, as necessary.

3 Recommendation

The Board are asked to note the reports received for assurance by the Quality Assurance Committee in November 2023.

Agenda item	BAF reference	CQC regulation reference	Assurance rating	Comments and associated action (where applicable)
Patient Safety Quarterly Report July - September 2023	1.1, 1.3 & 1.5	20	High	• An increase in incidents into Datix in the last quarter, which is a positive, remain a high volume but low harm reporting Trust. No SIs declared in the quarter. • The policy requirement for incident management performance for all investigations to be completed with 60 working days (84 calendar days) has been maintained since April and this is monitored through the Patient Safety Improvement Group & Executive Review Group. • Duty of candour compliance performance is at 50% (of eligible cases), struggling to track when an apology has been provided and closing down the case. The process for final investigation letters has become more robust, with letters being approved by the Patient Safety Specialist. • Mortality review compliance is now also included in the report to support the CQC report recommendation. No actions identified.
Patient Experience & Clinical Effectiveness Quarterly Report July - September 2023	1.4	16	High	• Total complaints received in Q2 was 39, which represents a 20% increase in since the previous quarter but a 9% decreased compared to corresponding period last year. Compliance is at 100% on responding to complaints. • 119 PALS contacts in quarter, 30 of these raised concerns with the majority relating to issues with communication and care and treatment. • 2 new PHSO contacts in Q2, there are 4 other cases currently under investigation by the PHSO. **Actions identified:** • Committee to receive further detail once the feedback is received from the PHSO on the case referrals. • Case referral figures to the PHSO to be obtained from other specialist Trusts including Clatterbridge and Marsden for comparison.
Learning from Complaints Annual Report	1.4	16	High	• Overall complaint figure has seen a steady rise. Data this year is in line with increasing activity and recovery from the pandemic, similar position at other Trusts. • Trying to get more feedback from complainants, QR code has been added to

Agenda item	BAF reference	CQC regulation reference	Assurance rating	Comments and associated action (where applicable)
				communications to complainants to assist with promoting survey for completion. No actions identified.
Completed CQC improvement plan	1.6	12, 16, 17	High	• Progress and completion of the actions has been monitored through designated weekly action plan meetings and reported through the Trust's governance and assurance structure for each action with evidence to show how completion was assessed. • The action plan and supporting evidence has now been completed and reviewed by the Specialised Commissioning team in line with the stipulated process. • The Specialised Commissioning team have reported to the Greater Manchester System Quality Group that they have received the required assurance that the actions have been completed. • Ongoing monitoring will continue. • In relation to the four 'should do' recommendations, although there is no requirement to demonstrate the actions taken, there is also an action plan for these which will continue to be monitored to provide assurance. No actions identified.
Completed CQC IR(ME)R action plan	1.6		High	• Self-assessment questionnaire completed by the Trust along with the request for documentation as part of CQC's new process. • Final report published by CQC on 12th July 2023. identified three areas for improvement. An action plan to address the areas for improvement was submitted to the CQC on 26th July 2023. An outcome letter from the CQC dated 9th August 2023 confirmed the CQC as satisfied that the actions taken, or are intending to take, will address the recommendations made with a view to maintaining compliance with IR(ME)R in the future and the inspection file closed. • The progress of actions was monitored through designated action plan meetings and completed ahead of the target completion date. The completed action plan will be noted at Radiation Protection & Medical Exposures Committee and Health & Safety Committee for completeness. However, the completed actions and supporting evidence was approved by the Risk & Quality Governance Committee

Agenda item	BAF reference	CQC regulation reference	Assurance rating	Comments and associated action (where applicable)
				on 23rd October 2023. No actions identified.
Cancer waiting times	6.1		Medium	• The Trust is not currently seeing an improvement since the last time presented in November 2022, performance against standards has not improved. There has been changes to the ways on reporting with there now being three key standards to report on. The paper provides the details on the pathways and shows a rise in 62-day referrals, treating more patients and also seeing more patients that are referred later in the pathway. **Actions identified:** • Progress update to come back to the Committee in June 2024.
Consent practice audit	1.6	11	High	• For the 2022 audit, significant improvements noted. • There was one SUI recorded relating to where the consent had been signed by family members (twice) as the patient was not English speaking. A Datix incident was entered and the Doctor informed with education in place. • There was an increase in the number of consent forms completed by consultants in this audit compared to previous years demonstrating high level engagement with the process. There has also been an increase in obtaining consent in advance which is in keeping with GMC guidance. • In terms of legibility, there are still some deficiencies but individually, specialties are doing much better. When looking at the forms, a strict process is followed and have seen improvements. • There has also been an improvement seen since the last audit in the writing to patients, still a need to address this for some specialties. No actions identified.

NHS
The Christie
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Agenda Item 03/24b

Thursday 25th January 2024

Board Assurance Framework 2023/24

Subject / Title	Board Assurance Framework 2023/24
Author(s)	Louise Westcott, Company Secretary
Presented by	Louise Westcott, Company Secretary
Summary / purpose of paper	This paper provides the Board with the closing position of the Board Assurance Framework 2023/24 that summarises the risks to achievement of the corporate objectives. The cover paper gives detail of the updates.
Recommendation(s)	To note the Board Assurance Framework (BAF) 2023/24
Background papers	Board assurance framework 2022/23. Corporate objectives 2023/24, operational plan and revenue and capital plan 2022/23.
Risk score	N/A
Link to: ➢ Trust strategy ➢ Corporate objectives	• Trust's strategic direction • Divisional implementation plans • Our Strategy • Key stakeholder relationships
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	BAF Board assurance framework ECN Executive chief nurse EDoF Executive director of finance EMD Executive medical director COO Chief operating officer DoW Director of workforce DCEO Deputy chief executive officer

The Christie
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Agenda Item 03/24b

Board of Directors meeting

Thursday 25th January 2024

Board Assurance Framework 2023/24

1 Introduction

The board assurance framework (BAF) 2022/23 was presented to the Board of Directors, Workforce Assurance Committee and Quality Assurance Committee in November.

2 Updates to risks

The risks in the 2023/24 framework reflect the annual objectives against each of the 8 agreed corporate objectives. The executive directors and the company secretary have reviewed the risks and updated the BAF with the latest position. In addition, the following has been updated this month;

- Target risk scores updated.
- Where a risk has been assessed by an assurance committee the level of assurance has been added.
- The risk score at the end of Quarter 3 has been added for each risk.
- Education Risks (3.1 – 3.3) have all be rescored and their risk scores reduced in line with progress against the annual objectives.
- Risk 6.1: Key performance targets not achieved – the risk score has been increased from 12 (3/4) to 15 (5/3) in line with the top operational risk. This reflects the risk of not achieving the 62 day national cancer wait target and the 24 day internal wait target. This will be reassessed following the introduction of the new standards and the performance in January 2024.

3 Suggested updates

There are no other suggested updates to the risks identified in the Board Assurance Framework this month.

4 Recommendation

The Board are asked to note the Board Assurance Framework (BAF) 2023/24 that reflects the risks to achievement of the corporate objectives and note assurance levels assigned by the Assurance Committees following review of the risks, as detailed in the committee reports to Board.

Corporate objective 1 - To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer

Number	Principal Risks	Exec Lead	Likelihood	Impact	Key Control established	Key Gaps in Controls	Current Risk Score	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Risk appetite (Averse / Cautious / Eager)	Responsible committee	Assurance level achieved (High / Medium / Low)	Opening Position	Position at end of Q1	Position at end of Q2	Position at end of Q3	Position at end of Q4	Target risk score	Target date for completion
1.1	Not meeting national requirements of Patient Safety Incident Response Framework (PSIRF)	ECN	2	4	Associate Chief Nurse for Quality and Patient Safety and Associate Medical Director for Patient Safety leading training and implementation programme. Progress monitored through Risk & Governance Committee and Quality Assurance Committee. Updates presented to ICB	None identified	**8**	Monitoring of reporting requirements through reports / asurance committee rolling programmes. Plan approval at Management Board January 2024	None identified	Team progressing implementation of PSIRF. Detail & dates in September 23 Board paper	September Board paper	Averse	Quality	High	**8**	8	8	8		**2**	Year end
1.2	Lack of data to fully understand equity of access to services & its impact on outcomes	COO	4	3	Project established to address data quality gap with clinical leadership. Go live date of July 2023 for identified projects. Impact to be assessed in January 2024.	Incomplete data set	**12**	Local audit of compliance reported to Executive Team. MIAA audit re GM cancer Q3	None identified	Regular review and reporting to executive team. System changes identified	July implementaion of actions. Review in January 24	Cautious	Quality	Mediu m	**12**	12	12	12		**4**	Year end
1.3	Risk to patients and reputational risk to trust of exceeding healthcare associated infection (HCAI) standards	ECN	2	3	Patients with known or suspected HCAI are isolated. Medicines management policy contains prescribing guidelines to minimise risk of predisposition to C-Diff & other HCAI's. RCA undertaken for each known case. Review of harm undertaken. Induction training & bespoke training if issues identified. Close working with NHS England at NIPR meetings. Clinical advisory group in place. Following national guidance. IPC BAF in place	None identified.	**6**	Levels reported through performance report to Management Board and Board of Directors and quarterly to NHS Improvement. MIAA audit planned Q2	None identified	Actions relating to IPC BAF identified with target dates - full report to Sept 23 QAC	Monthly assessment of progress	Averse	Quality	High	**6**	6	6	6		**6**	Year end
1.4	Failure to learn from patient feedback (patient satisfaction survey / external patient surveys / complaints / PALS)	ECN	2	2	Monthly patient satisfaction survey undertaken and reported through performance report. Negative comments fed back to specific area and plans developed by ward leaders to address issues. Action plans developed and monitored from national surveys. Complaints and PALs procedures in place. Action plans monitored through the Patient Experience Committee	None identified	**4**	Management Board and Board of Directors monthly Integrated performance and quality report. National survey results presented to Board of Directors. MIAA audits - complaints Q1 / risk management Q4. CQC Inpatient survey results. National Cancer Patient Experience Survey results	None identified	Team progressing implementation of PSIRF	September 23 / January 24 Board papers	Averse	Quality	High	**4**	4	4	4		**2**	Year end
1.5	Risk of exceeding the thresholds for harm free care indicators (falls, pressure ulcers, venous thromboembolism)	ECN	2	4	All falls with low harm come through Friday-Focus and moderate/above through ERG. Falls prevention group operational. Training required for all nursing/HCA staff. All hospital acquired pressure ulcers reviewed through Friday-Focus. Monitoring of VTE assessment compliance through Thrombosis Committee. Continuous assessment of progress against thresholds. At 6 monthly position will further assess likely year end position and risk score.	Risk assessments for falls and skin assessment not always completed in a timely manner	**8**	QI project evaluating introduction of bedside handover to improve compliance with risk assessments. Risk assessment compliance added to CWP and monitored daily. Regular reports to Quality Assurance committee. MIAA audit risk management Q4	None identified	Continuous monitoring through monthly reports. Escalations in place where appropriate. No current concerns.	Monthly assessment of progress	Averse	Quality	High	**8**	8	8	8		**2**	Year end
1.6	Lack of preparedness for a CQC inspection leading to a poor performance	ECN	2	4	Assessment against standards ongoing. Timetable of mock inspections being arranged. Looking at Trust wide requirements. Assessment of assurance process to ensure all regualtions assessed. GGI review & actions. Assessment of impact of new regulatory approach undertaken.	Full understanding of CQCs new approach to inspection	**8**	Good rating 2023. MIAA audit - risk management Q4	None identified	Engagement in CQC's regulation updates / webinars	Regular engagement meetings in diary	Averse	Quality	High - for comple tion of action plans	**8**	8	8	8		**4**	Year end

Corporate objective 2 - To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey

	Principal Risks	Exec Lead	Likelihood	Impact	Key Control established	Key Gaps in Controls	Current Risk Score	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Risk appetite (Averse / Cautious / Eager)	Responsible committee	Assurance level achieved (High / Medium / Low)	Opening Position	Position at end of Q1	Position at end of Q2	Position at end of Q3	Position at end of Q4	Target risk score	Target date for completion
2.1	Risk to research profile and patient access to trials through reduced funding & changes to funding streams	DoR	3	4	Regular dialogue with national funding organisations on potential impact; open dialogue with strategic pharma partners; strong academic investment strategy to retain and attract world leading academics. Reporting to NHSE/I as and when required. Engaging in national webinars and updates. Sign up to regulators alerts - legislative changes assimilated into local processes as they arise. Any associated risks discussed and communicated. Levels of risk and mitigation reported through Research Division Board and Christie Research Strategy Committee. Approved Research & Innovation Strategy. Quarterly review of impact and risk score.	Oversight of potential legislative impact	**12**	Reports to Quality Assurance Committee. MIAA audit of The Christie sponsored research Q2	None identified	Regular discussion and review of legislative changes through CRSC & Divisional Board	Monthly meetings review progress	Cautious	Quality	High	**12**	12	12	12		**4**	Year end
2.2	Risk of not meeting year 1 deliverables of the Research & Innovation Strategy	DoR	3	4	Approved Research & Innovation Strategy. 6 monthly assessment of progress.	External factors / pipeline of high quality researchers	**12**	Reports to Quality Assurance Committee. MIAA audit of The Christie sponsored research Q2	None identified	Recruitment & retention plans linked to Trust plan	Monthly meetings review progress	Cautious	Quality	High	**12**	12	12	12		**6**	Year end
2.3	Risk of not meeting externally set research targets in the changing national landscape	DoR	3	3	Monitoring & reporting of targets. Delivery of the approved R&I strategy	None identified	**9**	Reports to Quality Assurance Committee. MIAA audit of The Christie sponsored research Q2	None identified	Monitoring through R&I divisional meetings	Monthly meetings review progress	Cautious	Quality	High	**9**	9	9	9		**3**	year-end
2.4	Protected time for staff for the delivery of research	DoR	3	3	Recruitment & Retention Trust wide group in operation reporting to the workforce committee. Divisional oversight of recruitment activity and vacancies discussed at the monthly service review meetings.	External factors / pipeline of high quality researchers	**9**	Reports to Quality Assurance Committee showing delivery of research ambitions	None identified	Working with Workforce Team on job planning - on going process	Monthly meetings review progress	Cautious	Quality	High	**9**	9	9	9		**6**	Year-end

Corporate objective 3 - To be an international leader in professional and public cancer education

	Principal Risks	Exec Lead	Likelihood	Impact	Key Control established	Key Gaps in Controls	Current Risk Score	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Risk appetite (Averse / Cautious / Eager)	Responsible committee	Assurance level achieved (High / Medium / Low)	Opening Position	Position at end of Q1	Position at end of Q2	Position at end of Q3	Position at end of Q4	Target risk score	Target date for completion
3.1	Risk to delivery of the Christie Education strategy due to reduction in demand	DoE	2	2	Review the deliverables and prioritise in line with financial investment available. Maximise the potential of external income. Refresh the Christie Education focus on integration of objectives with clinical and research divisions. Work with finance to review funding options, develop business cases for high priority initiatives and look at alternative funding sources. Christie Education board reports to Management Board. 6 monthly assessment of progress.	Continuing inability to deliver all strategic objectives due to difficulty in accessing curent investment funds to deliver new initiatives.	**4**	Reporting to Workforce Assurance Committee and Board	None identified	Divisional Board being restructured. Reporting to Management Board and DCEO	Divisional Board to manage timelines of actions	Cautious	Workforce		**9**	9	9	4		**4**	Year end
3.2	External factors / pipeline of high quality clinical and teaching staff	DoE	3	2	Monitoring of workforce numbers / turnover. Active recruitment and investment in Christie pipeline.	External factors / pipeline of high quality oncologists	**6**	Reporting to Workforce Assurance Committee and Board	None identified	Active recruitment practices / investment	Divisional Board to manage timelines of actions	Cautious	Workforce		**9**	9	9	6		**3**	Year end
3.3	Lack of progress with organisational governance arrangements for Christie Education	DoE	2	2	Project group in place. Plans established and resourse identified. Project progress reported to Board of Directors.	External factors	**4**	Reporting to Workforce Assurance Committee and Board	None identified	Project group identified actions and timelines, reported through Education Board.	Divisional Board to manage timelines of actions	Cautious	Workforce		**9**	9	9	4		**4**	Year end

Corporate objective 4 - To integrate our clinical, research and educational activities as an internationally recognised and leading comprehensive cancer centre

	Principal Risks	Exec Lead	Likelihood	Impact	Key Control established	Key Gaps in Controls	Current Risk Score	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Risk appetite (Averse / Cautious / Eager)	Responsible committee	Assurance level achieved (High / Medium / Low)	Opening Position	Position at end of Q1	Position at end of Q2	Position at end of Q3	Position at end of Q4	Target risk score	Target date for completion
4.1	Lack of evidence to show progress against the ambition to be leading comprehensive cancer centre	DoR	2	3	Reaccreditation by OECI - reinspection due. Baseline measures identified and presented to Board of Directors. Looking at how we can be part of International Benchmarking. MCRC Strategy. Designated as the most technologically advanced cancer centre in the world outside North America. In segment 1 (System oversight framework).	Availability of comprehensive data with which to compare ourselves	**6**	Updates to Board Time Outs / Board of Directors meetings	None identified	OECI project lead appointed and coordinating OECI reaccreditation application.	Deadline for submission of data	Cautious	Board		**6**	6	6	6		**2**	Year end
4.2	Lack of progress with The Christie's international ambitions and partnerships	DCEO	3	3	International Board in place. Monitoring of progress reported through regular engagement and meetings	External factors	**9**	Updates to Board of Directors	None identified	International Board actions identified and plans in place	Managed through International Board	Cautious	Board	High	**9**	9	9	9		**3**	Year end
4.3	Failure to establish new governance arrangements for MCRC partnership	DCEO	3	4	Partnership Board in place. Good relationships established with partners. Paterson replacement complete and in use.	None identified	**12**	Updates to Board of Directors	None identified	MCRC meetings identified way forward	Regular metings	Cautious	Board		**12**	12	12	12		**9**	Year end

Corporate objective 5 - To promote equality, diversity & sustainability through our system leadership for cancer care

	Principal Risks	Exec Lead	Likelihood	Impact	Key Control established	Key Gaps in Controls	Current Risk Score	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Risk appetite (Averse / Cautious / Eager)	Responsible committee	Assurance level achieved (High / Medium / Low)	Opening Position	Position at end of Q1	Position at end of Q2	Position at end of Q3	Position at end of Q4	Target risk score	Target date for completion
5.1	Inability to fully implement the 2023/24 Greater Manchester Cancer operating model	CEO	3	4	CEO chairs Manchester Cancer Board. Director of Strategy attendance at key meetings. Christie Strategy 2023-28 approved	None identified	**12**	Reports to Management Board and Board of Directors	None identified	GM Cancer Board monitoring progress and sharing & reviewing progress through regular meetings	Annual objectives assessed at 6 and 12 months	Averse	Board		**12**	12	12	12		9	Year end
5.2	Failure to implement 2023/24 objectives of the SACT strategy	COO	3	4	Strategy on track but constrained by other trusts. Expansion on Withington site. 6 monthly assessment of progress.	None identified	**12**	Regular reports to Management Board and Board of Directors. Six monthly assurance reports to Quality Assurance Committee.	None identified	SACT team report to Board on progress June 2023. On going assessments of demand and response in place	SACT Board manages action progress and reports through QAC	Averse	Quality		**12**	12	12	12		**3**	Year end
5.3	Inequity of access for patients to Christie trials due to delays in implementing governance arrangements for Christie led & hosted trials at the networked centres	DoR /COO	3	4	Research & Innovation Strategy approved. Approval for the trust to further expand the management of local oncology and chemotherapy services across GM. Focus on improved digital access e.g. appointments / ePROMs and Shared Decision Making. Chemotherapy services in locations across GM & Cheshire - strategy on track but constrained by other trusts.	Workforce and engagement from other trusts.	**12**	Regular reports to Quality Assurance Committee and Board of Directors	None identified	Working with other Trusts to understand issues and actions. Monitored through R&I / SACT boards	SACT Board manages action progress and reports through QAC	Averse	Quality	High	**12**	12	12	12		**9**	Year end

Corporate objective 6 - To maintain excellent operational, quality and financial performance

	Principal Risks	Exec Lead	Likelihood	Impact	Key Control established	Key Gaps in Controls	Current Risk Score	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Risk appetite (Averse / Cautious / Eager)	Responsible committee	Assurance level achieved (High / Medium / Low)	Opening Position	Position at end of Q1	Position at end of Q2	Position at end of Q3	Position at end of Q4	Target risk score	Target date for completion
6.1	Key performance targets not achieved	COO	3	5	Executive led monthly divisional performance review meetings. Integrated performance & quality report to Management Board and Board of Directors monthly. Weekl;y performance reporting via trust operational group. Escalation internally & across GM of delays impacting waiting time targets. Monitoring cancer waiting time standards through GM Cancer & IPR.	Impact of ongoing Industrial Action	**15**	Executive Team monitor activity weekly. Integrated performance report to Management Board, Quality Assurance Committee and Board of Directors.	None identified	Weekly monitoring through Executive Team, actions discussed and escalated as appropriate	Monthly review of annual targets	Cautious	Quality	Mediu m	**12**	12	12	15		**12**	Year end
6.2	Change in financial regime resulting in inability to deliver the Trust's strategic plan.	EDoF	4	4	Participating at national level and ICS (Greater Manchester) level to influence the new financial framework and its implementation. Development of mitigating strategies including efficiency and transformational programmes. Identification and consideration of new models of working to deliver and finance the Trust's strategic plan.	Changes in national funding arrangements and delegation of commissioning functions.	**16**	To continue to report through Managment Board and Board of Directors via financial reports and updates. Executive Team monitor activity weekly. MIAA audit - CIP Q2 / financial systems Q3 / Critical Apps Q3	None identified	External advice sought on new models of working. Close working with national & regional team	Monthly assessment of progress towards annual plan	Cautious	Audit	High	**16**	16	16	16		**4**	Year end
6.3	Digital programme unable to support delivery of operational objectives	COO	3	4	CWP (clinical web portal) on stable platform. Review of digital programme and to align ditial strategy with Service strategies. Key projects moving forward e.g.Order comms. EPMA, ePROMs, clinical outcomes.	Internal capability & expertise to support system going forward.	**12**	Reports to Management Board & Board of Directors. MIAA audit - Data Protection Toolkit (DPST) Q4	None identified	Progress and objectives set/reviewed by Quarterly Digital board. Esaclations through Management Board.	Monthly assessment of progress towards annual plan	Cautious	Audit	Mediu m	**12**	12	12	12		**4**	Year end
6.4	Not delivering the objectives of our commercial partnerships resulting in negative financial / patient experience or reputational impact	EDoF	3	3	Partnership Boards in place. Review of contract arrangemnts for CPP. TCP - Internal and external auditors in place. MIAA governance audit gave significant assurance. KPI's reported via partnerhip board structure.	None identified	**9**	Close contact with partners & management of joint incidents. Regular reports to Board and Audit Committee	None identified	Issues outlined and escalated through Boards	Regular assessment of progress towards annual plan	Averse	Audit / Board	High	**9**	9	9	9		**3**	Year end
6.5	Reputational damage, service disruption and financial loss due to cyber-attack.	COO	3	4	Risk committee regular reporting on cyber security alerts established. Digital Programme progression of key cyber security improvement projects continues. Digital Board reporting. NHS Digital linked monitoring tools being deployed. Internal scanning tools deployed. External summary reports provided. Regular testing and reporting of security vulnerabilities. Staff training mandatory. Cyber incident response support established via NHS Digital. Cyber essential assessment underway.	The Trust does not currently have cyber security insurance.	**12**	Data Security and Protection Toolkit submissions with audits undertaken. Digital board reporting. Board level Senior Information Risk Owner in place.MIAA audit - Data Protection Toolkit (DPST) Q4	None identified	Actions identified through MIAA DSPT review. Progress monitored on target dates through divisional meetings.	Monthly review of identified actions	Averse	Audit	Mediu m	**15**	15	12	12		**12**	Year end
6.6	Not implementing the in year objectives of the Trust strategy and its underpinning plans (Quality / Patient Experience / Risk Management / Operational)	DCEO	3	4	Strategy / plans approved and reported through assurance committees. 6 monthly assessment reported to Board.	None identified	**12**	Published Trust Strategy	None identified	Objectives monitored through appropriate divisional board	Annual objectives assessed at 6 and 12 months	Averse	Board		**12**	12	12	12		**4**	Year end

Corporate objective 7 - To be an excellent place to work and attract the best staff

	Principal Risks	Exec Lead	Likelihood	Impact	Key Control established	Key Gaps in Controls	Current Risk Score	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Risk appetite (Averse / Cautious / Eager)	Responsible committee	Assurance level achieved (High / Medium / Low)	Opening Position	Position at end of Q1	Position at end of Q2	Position at end of Q3	Position at end of Q4	Target risk score	Target date for completion
7.1	Failure to achieve the year 1 milestones of the People and Culture Plan 2023/26	DoW	3	4	Plan approved and actions underway against each element of the plan	None identified	**12**	Workforce Assurance Committee reports. MIAA audit EDS 22 Q4.	None identified	Target dates for all elements of the plan identified	Monthly review of identified actions	Averse	Workforce	Medium	**12**	12	12	12		**4**	Year end
7.2	Risk of negative impact on delivery of services and staff engagement levels due to Trustwide staffing gaps in some occupations and ability to recruit and retain	DoW	4	3	Recruitment & Retention Trust wide group in operation reporting to the workforce committee. Commenced programme of work with an external organisation to develop our recruitment offer, advertising and brand. Commenced a programme of recruiting international nurses over a 6 month period. Quarterly oversight of Trust wide vacancies and recruitment activity presented to the workforce committee. Divisional oversight of recruitment activity and vacancies discussed at the monthly service review meetings. Turnover analysis and exit interview data presented and discussed six monthly at the workforce committee.	National staff shortages impacting recruitment	**12**	National staff survey 2021 results. Reports to Management Board . Agency spend. Workforce Committee Oversight. MIAA audit - sickness absence Q1	None identified	Recrutiment and retention workplan in place - monitored through Workforce Assurance Committee	Regular assessment of progress towards annual plan	Averse	Workforce	High	**12**	12	12	12		**6**	Year end
7.3	Management of Board succession and appointment of new Chair / NEDs	DoW/CS	3	3	External search agency appointed to undertake Chair recruitment process. Plan outlined for future requirements to replace NEDs as they come to end of term. New Chair successfully appointed to start October 2023. Process for recruitment of 2 NEDs commenced July 2023.	None identified	**9**	Nominations Committee decisions reported to Council of Governors. Adherence to Fit & Proper Persons regulation - report to Audit Committee. Use of external search partner.	None identified	NED recruitment underway and plans outlined for further recruitment with timelines. Skill mix assessment updated and plan in place for Board discussion once new Chair in post.	Year end review of succession plan to determine future NED requirements	Averse	Audit	Medium	**9**	9	9	9		**9**	Year end
7.4	Race/Disability discrimination impacting staff experience and therefore patient care	DoW	3	3	Staff networks established, Board development sessions planned across the year focussing on discrimination. EDI programme board monitors delivery of the EDI plan, monitoring of risks and WRES/WDES action plans. EDS2022 progress against plans monitored at the Management Board. Workforce Assurance Committee oversight of progress.	None identified	**9**	Reports to Workforce Committee, Management Board and Workforce Assurance committee. Staff story at each Workforce Assurance Committee. MIAA audit EDS 22 Q4.	None identified	WRES / EDS2022 action plans identify actions & timelines	Regular assessment of progress towards annual plan	Averse	Workforce	Medium	**9**	9	9	9		**6**	Year end

Corporate objective 8 - To work with others in promoting a sustainable environment and eliminating health inequalities																						
	Principal Risks	Exec Lead	Likelihood	Impact	Key Control established	Key Gaps in Controls	Current Risk Score	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Risk appetite (Averse / Cautious / Eager)	Responsible committee	Assurance level achieved (High / Medium / Low)	Opening Position	Position at end of Q1	Position at end of Q2	Position at end of Q3	Position at end of Q4	Target risk score	Target date for completion
8.1	Impact on our ability to obtain planning approval for future capital developments.	EDoF	2	3	Close working with Manchester City Council (MCC) planning and development issues as well as implementation of the Trust's green travel plan. Strategic planning framework approved which includes current and future requirements for travel to site. Regular communication with residents through the Neighbourhood Forum and newsletters and with local councillors. Agreement by MCC of strategic development plan and delivery of the Trust's 5 year Capital Plan delivery	None identified	**6**	Monitored through Management Board & Board of Directors. Capital programme shared with MCC and Board of Directors.	None identified	MCC aware of current and future plans and timelines. Planning team engaged in discussions alongside Neighbourhood Forum	Dates in line with capital plan	Cautious	Board		**6**	6	6	6		**3**	Year end
8.2	Not able to progress our role as an Anchor Institution	DoS	2	3	Engagement in relevant GM meetings	None identified	**6**	Monitored through Trust report to Board of Directors.	None identified	Continued attendance at relevant GM meetings	6 monthly review of progress	Cautious	Board		**6**	6	6	6		**3**	Year end
8.3	Failure to progress towards achievement of the NHS net zero Carbon targets through failure to achieve the annual milestones for The Christie set out in the Sustainable Development Management Plan (SDMT)	DCEO	4	2	Progress against SDMT plan regularly reported to Sustainability Committee and to Management Board as part of Integrated Performance Report. Progress against objectives overseen and reviewed by DCEO as Trust Net Zero lead. Board training on net zero Carbon arranged for November 2022	None identified	**8**	Progress against SDMT plan regularly reported to Board of Directors as part of Integrated Performance Report. Annual Report to Board of Directors. Oversight by Audit Committee	None identified	Actions outlined in SDMT with annual objectives	Annual milestones monitored monthly	Cautious	Audit	Mediu m	**8**	8	8	8		**4**	Year end
8.4	Reduced ability to provide services and support to patients due to national / global influences (supplies / fuel costs / industrial action)	COO	5	4	Industrial Action - close working with unions. Business continuity plans in place. Planning meetings in place around strike acton and incident management approach used. Management of demand. Risk assessments undertaken.	Impact of ongoing Industrial Action	**20**	Reports to Management Board and Board of Directors	Impact of ongoing Industrial Action	Detailed planning of patient demand and catch up. Staff cover planned. Liaision with unions and national team.	On going dependent on mandate to take action	Averse	Board		**9**	9	20	20		**10**	Year end
		DCEO	3	3	Group in place to review supply chain.	Global position. Lack of control for supply chain e.g. radioisotopes	**9**	Reports to Audit Committee	None identified	Escalations in place for supply issues through procurement team.	As appropriate dependent on issue	Cautious	Audit		**9**	9	9	9		**3**	Year end
8.5	Failure to adapt to climate change & other environmental factors e.g., floods / extreme temps / new pathogen	DCEO	3	3	Business continuity planning process in place. Plans tested and reviewed.	Uncertainty around what / when	**9**	Sustainable Development Plan in place and reported to Audit Committee	None identified	EPRR lead out to advert	Appointment to be made by end November 2023	Cautious	Audit	Medium	**9**	9	9	9		**3**	Year end

The Christie NHS Foundation Trust

EXECUTIVE SUMMARY

The Integrated Performance, Quality & Finance report presents a summary dashboard that provides an overview of performance.

Safety

- One serious incident was reported in December, details of which can be found on slide 6. There were 5 incidents reported in month with the classification of moderate and one with the classification of death, details of which can be found on slide 7. All the incidents are still progressing through to full root cause analysis. No never events were reported in month.
- There are 4 Trust level risks scored at 15+. Details of these can be found on slide 13.
- Safer staffing numbers have met the required acuity levels to ensure appropriate levels of safety and care for our patients. Indicative staffing, in line with nursing establishments, is set to maintain a 1:7 nurse to patient ratio. On occasion this has been extended to 1:8 which is in line with recommended national staffing ratios. While we have seen an increase in patient safety incidents, following thematic review, these were not related to nurse staffing ratios.
- There were no cases of C-Difficile, 4 cases of E-Coli, 2 cases of Klebsiella. 1 case of Pseudomonas and 2 cases of MSSA in December that were deemed attributable to the Trust. No lapses in care have been identified.
- There were no nosocomial Covid-19 infection outbreaks affecting patients or staff members in December.

Performance

- In December the new combined 62-day performance subject to validation was at 70.8% which is above the new standard of 70%. The new combined 31-day performance was 98.6% which is above the new standard of 96%. The internal 24-day performance is below standard and is at 71.6%. All 62 and 24-day breaches are reviewed to ensure any delays are understood and plans can be implemented to mitigate any future delays. Improvement plans are in place and performance is expected to improve between December and the end of the financial year. The Trust's RTT 18-week performance is well above standard at 97.2%. The Trust has achieved the 75% faster diagnosis standard in December with a compliance score of 76.9%.
- There was one patient waiting over 52 weeks at the end of December. The long wait can be attributed to long periods of patient choice to delay the proposed treatment.
- Referral numbers in December expectedly reduced from a high point in November but were in line with the same period in 2022. Overall YTD referral levels continue to remain higher than 22/23 levels.

HR

- Staff absence improved from November to a position of 4.48% against a target of 3.4%.
- PDR performance has improved from November's position whilst mandatory training performance has deteriorated slightly. Mandatory training performance remains well above the set standard.

Finance

- At month 9 the Trust is reporting a year-to-date deficit of £1,121k against an in-month plan of £6,028k, which gives a positive year to date variance of £4,908k.
- Performance to month 9 was £7,596k below the original plan submitted to NHSE&I in April 23. Whilst there is slippage on some schemes including the TIF Ward, other projects are ahead of plan.
- The Trust has incurred £13,895k on capital schemes to month 9, primarily on the backlog maintenance programme, the linear accelerators and CT scanner replacements, Digital Services Electronic Health Records projects, final works on the Paterson scheme, the Proton treatment planning system and the TIF ward refurbishment. This includes £39k capital expenditure on the charity funded Art Room refurbishment.
- All Providers within GM have agreed to reduce annual capital spend against original plans by a proportionate amount as the original GM ICS plan was oversubscribed. The impact of this is a £3.6m reduction to original forecast planned capital spend for the Christie. This is now offset by a potential additional £4m increase to our plan for additional spend on the TIF ward scheme currently being finalised with GM

SUMMARY DASHBOARD

NHS
The Christie
NHS Foundation Trust

Indicator	Threshold / Standard 23/24	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	New Standards	Oct-23	Nov-23	Dec-23	YTD
Serious Incident Reported	-	0	0	0	2	0	0		0	0	1	3
Never Events	0	0	0	0	0	0	0		0	0	0	0
Radiation Incidents Reported (IRMER Reportable)	0	2	1	0	0	0	0		0	0	0	3
Radiation Incidents Reported (IRMER Reportable - Grade 2 or above)	0	0	0	0	0	0	0		0	0	0	0
Number of Pressure Ulcers (Post admission - Grade 2 or above) - Rate per 1000 occupied bed days	0.4 (22/23 Avg)	0.2	0.4	0.2	0.2	0.8	0.6		0.2	0.2	0.4	-
Inpatient Falls Resulting in Harm (Grade 2 or above) - Rate per 1000 occupied bed days	3.6 (22/23 Avg)	2.6	4	4	2.7	2.9	4.4		9	2.9	3.8	-
VTE Assessments Completed	95.0%	98.0%	98.2%	98.8%	97.8%	98.6%	98.7%		98.3%	98.6%	98.4%	-
Sepsis - timely treatment with IV antibiotics (established inpatients)	90.0%	96.9%	95.1%	90.2%	92.2%	90.1%	97.7%		93.0%	96.9%	90.0%	-
Sepsis - screening (presenting as an emergency)	90.0%	95.0%	95.3%	98.7%	96.1%	96.0%	97.1%		95.1%	95.6%	98.3%	-
Number of Corporate Risks Grade 15 or Above	-	4	4	4	4	5	5		5	5	4	-
Safe Staffing (% of planned hours vs actual hours across all inpatient areas)	-	82.7%	87.4%	85.7%	86.5%	84.1%	87.8%		87.1%	87.4%	88.8%	-
28 Day Faster Diagnosis Standard	75.0%	50.0%	45.5%	52.4%	41.2%	50.0%	53.8%	75%	84.2%	71.4%	76.9%	-
62 Day Compliance	85.0%	71.3%	67.3%	68.8%	67.4%	73.7%	67.1%					-
62 Day Compliance - Upgrades	85.0%	67.1%	74.0%	87.7%	74.4%	75.5%	78.7%	70%	65.3%	70.6%	70.8%	-
62 Day Compliance - Screening	90.0%	75.0%	63.6%	100.0%	58.3%	33.3%	66.7%					-
24 Day Compliance	85.0%	73.8%	74.6%	75.4%	69.0%	75.5%	70.6%	85%	68.3%	69.1%	71.6%	-
31 Day Compliance	96.0%	97.8%	98.3%	96.7%	97.4%	98.9%	96.0%					-
31 Day Compliance - Subsequent Drug Therapy	98.0%	100.0%	100.0%	100.0%	100.0%	98.9%	99.3%	96%	97.5%	98.1%	98.6%	-
31 Day Compliance - Subsequent Radiotherapy	94.0%	99.2%	99.5%	100.0%	100.0%	98.9%	98.6%					-
31 Day Compliance - Subsequent Surgery	94.0%	98.8%	100.0%	100.0%	100.0%	98.9%	96.8%					-
18 Weeks Compliance - Incomplete Pathways	92.0%	96.5%	96.9%	97.4%	96.7%	96.7%	97.8%	92%	97.7%	97.2%	97.2%	-
Patients waiting >52 Weeks	0	1	1	1	1	2	2		1	0	1	10
Patients waiting >62 days at end of month (62 Day Classic)	80	89	84	102	109	105	114		114	136	132	-
Patients waiting >104 days at end of month (All 62 Day Targets)	-	34	42	44	46	40	52		64	58	72	-
Length Of Stay (Elective & Non-Elective Inpatients)	-	7.77	7.1	6.59	7.02	6.99	8.04		7.31	7.19	6.70	-
Patients Discharged Beyond Ready for Discharge Date	-					1	17		13	12	16	59
Patients Discharged Beyond Ready for Discharge Date - Total Bed Days Lost (days counted in the month of discharge)	-	*Reporting commenced last week of Aug*				9	159		247	114	126	655
Patients Discharged Beyond Ready for Discharge Date - Average Bed Days Lost (days counted in the month of discharge)	-					9	9.4		19	9.5	7.9	11.1
Hospital Cancelled Operations on the day for non clinical reasons	0	2	4	2	5	9	0		12	5	4	43
Hospital Cancelled Operations on the day for non clinical reasons - NOT rebooked within 28 days	0	0	1	1	1	0	0		0	0	0	3
Complaints Received	14 (22/23 Avg)	11	11	11	12	19	5		12	20	10	111
PALS Contacts	44 (22/23 Avg)	46	51	42	35	42	42		37	34	27	356
Inquests	-	2	5	2	2	1	2		0	4	1	19
Coroner Request	-	11	12	4	3	4	3		3	3	1	44

SUMMARY DASHBOARD

NHS
The Christie
NHS Foundation Trust

Indicator	Threshold / Standard 23/24	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23		Oct-23	Nov-23	Dec-23	YTD
MRSA	0	1	0	0	1	0	0		1	0	0	3
C-Difficile - All Attributable Cases (Pre & Post 48 Hours)	36	2	3	4	4	3	4		5	7	0	32
C-Difficile - Attributable Cases Due To Lapse In Care	0	0	0	0	0	0	0		0	0	0	0
MSSA Bacteraemia - Attributable	25	1	1	1	2	4	2		2	2	2	17
E-Coli - Attributable	29	5	4	7	6	8	2		5	6	4	47
Klebsiella Species - Attributable	14	4	2	0	1	2	2		1	5	2	19
Pseudomonas Aeuriginosa - Attributable	10	1	0	2	1	1	2		1	0	1	9
COVID infections - Hospital Aquired	0	2	1	0	0	7	8		0	0	0	18
Palliative Radiotherapy 30 Day Suvival Rate	-	91.7%	91.3%	91.3%	86.6%	91.2%	90.3%		92.5%	92.6%	-	-
Final Chemotherapy 30 Day Survival Rate	-	98.9%	99.3%	99.5%	99.4%	99.4%	99.3%		99.5%	99.3%	-	-
Surgery 30 Day Survival Rate	-	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	-	-
Staff Sickness	3.4%	4.09%	4.03%	3.87%	4.29%	4.35%	4.58%		4.89%	4.49%	4.48%	-
Staff Mandatory Training	>80%** <80%	89.4%	92.1%	92.9%	91.9%	92.2%	91.2%		90.4%	91.3%	90.7%	-
Staff PDRs	-	84.7%	84.5%	85.6%	85.9%	86.5%	85.2%		84.5%	83.6%	84.1%	-

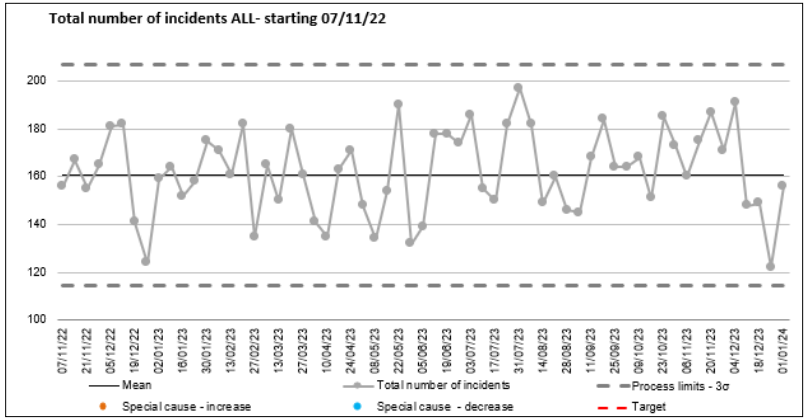
***Compliance if <80% & risk assessment in place*

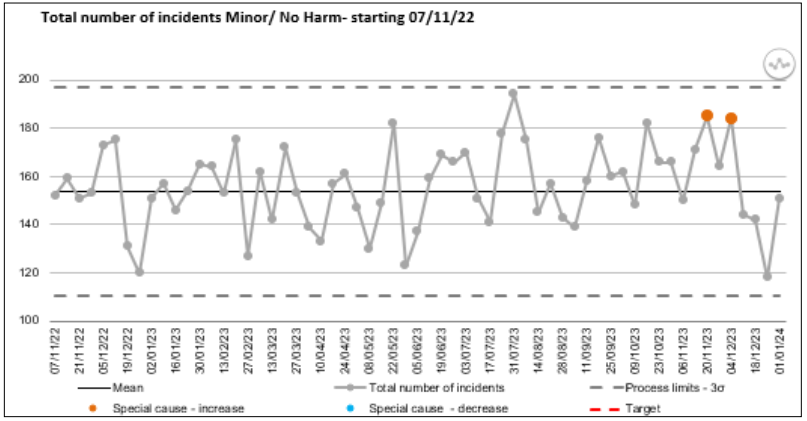
****Data unavailable for the whole month due to being out of sync with SUS reporting. Data will be backdated and refreshed each month.*

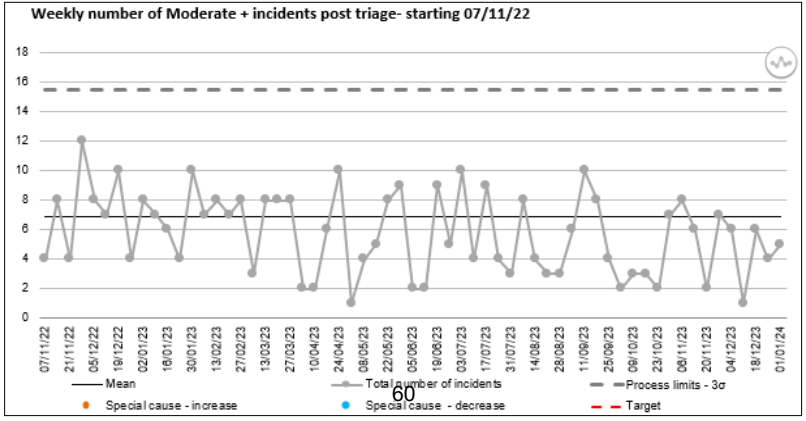
*****Measures currently monitored externally in the Oversight Framework reporting process.*

Due to the differences in reporting periods and the specification and measurement of the metrics involved, from next month the indicators highlighted in the above dashboard will also be presented alongside other indicators in a separate scorecard.

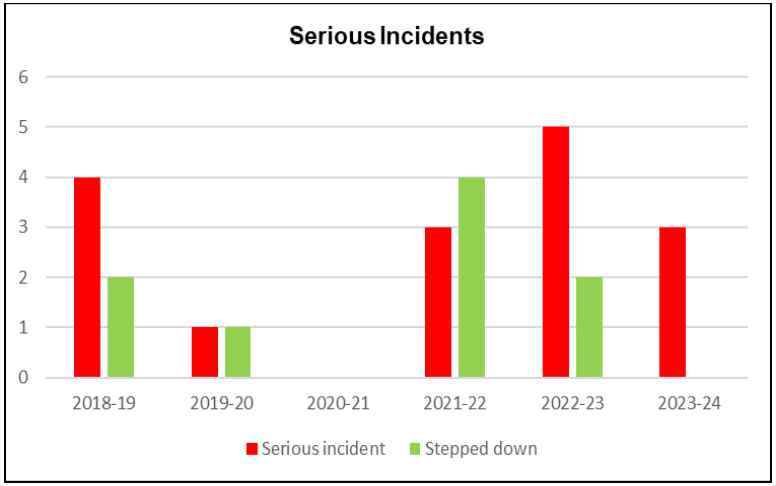
Incident Reporting







Serious Incidents and Never Events



Never Events – are defined are serious incidents that are wholly preventable

The last Never Event occurred in January 2020 which was the only incident in the last 5 years.

Serious incidents
There was 1 serious incident identified in December 2023:

W82455 – complications following mucin drain insertion.

Incidents identified that require a Learning Response

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December 2023 – RCA identified through PSIG/ERG

Reference	Description	Reported Harm Level
W81888	Patient with Breast Ca previously diagnosed with liver metastases at DGH, referred and treated at The Christie with SACT. Lesions identified from recent scan to likely be non – cancerous.	Moderate
W81983	Chest drain removed despite residual moderate-large pleural effusion and not reinserted	Death (confirmed through RCA that death was not attributed to the incident)
W82287	Staff member injured whilst trying to move patient bed from ward to IPU.	Moderate
W82197	Patient attended for chemotherapy, identified as being acutely unwell. Medical review completed but no treatment or investigation initiated. Patient continued to deteriorate.	Moderate
W82495	Patient given an incorrect SACT bolus and pump	Moderate
W82648	Patient prescribed RXC004 0.5mg capsules he was dispensed 1mg tablets. Double the daily dose taken by the patient.	Moderate

Learning - Patient Safety Incidents

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NHS Foundation Trust

Agreed learning and revised severity outcome following executive reviews December 2023

Ref	Description	Root cause	Learning	Outcome
W74842	A clinical review was requested to take place prior to Cycle 3 chemotherapy with the intention of planning and introducing a course of radiotherapy to run concurrently. The appointment was not booked and therefore the patient did not have the review as required and proceeded to receive Cycle 3 and Cycle 4 chemotherapy without starting concurrent radiotherapy as intended.	Failure to book outpatient appointment led to deviation in planned treatment schedule	• Shared learning within the medical team including juniors and specialist registrars regarding concurrent pathways. • Update the protocol to make it more user friendly with an explicit timeline of Mandatory medical reviews. • Shared learning with investigatory teams throughout the Trust .	No Harm
W80813	An infusion of Actrapid insulin 50 units in 50 millilitres was administered instead of the intended vancomycin infusion.	There was a deviation from usual process where upon an insulin infusion was prepared in advanced and stored in the drugs fridge. This was compounded by the non-adherence to the identity checks listed in the Patient Identity Policy and the administration guidelines in MPOP	• Add 500mg vials of vancomycin to OCCU pharmacy top up list, to prevent drug being made up and split into two syringes. • Staff to be informed no medication to be made up in advance and stored in the fridge • Audit to be undertaken to ensure staff are following identification and medicines policy • Improve access to digital devices at point of care	Minor

Learning - Patient Safety Incidents

NHS
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NHS Foundation Trust

Agreed learning and revised severity outcome following executive reviews December 2023

Ref	Description	Root cause	Learning	Outcome
W81819/ **W81820**	Patient was due post-transplant cyclophosphamide as part of their haplo-identical reduced intensity transplant. This is used to prevent graft vs host disease (GVHD) and needs to be administered between 60-72 hours post stem cell infusion. The dose had not been delivered to the ward for treatment and had been made in house by pharmacy aseptics outside normal working hours. This resulted in a long delay in treatment of approx. 7 hours.	Unclear communication/no documentation in the ordering process between Baxter and The Christie Haematology Team	• Create an SOP/statement for Baxter which will ensure all haematology treatment regimens containing time critical medication, regardless of when the original order is sent, is supplied to the ward without having to duplicate the request through iQemo. • Develop a process of ensuring all weekend treatments are either on the ward or have been ordered ready for the weekend. • Process to standardise ordering emails between Baxter and pharmacy. • Explore opportunities to extend working hours OOH aseptics	Minor
W80756	Lost to follow-up project identified a patient who had not been reviewed since conclusion of chemotherapy treatment on 13.11.2019. When it was identified that the patient was lost to follow up, a Clinical Nurse Specialist (CNS) attempted to contact the patient, but sadly identified that the patient had passed away.	Absence of safety netting procedures for missed appointments, where follow up appointments have not been requested or outcome forms not actioned in a reasonable time frame.	• Reminder to all clinicians and administrative teams to complete and action the e outcome form in a timely manner with clear instruction of next step. • To move to a managed Waiting list for follow ups that would be actioned with 48 hours (2 working days) • Recruitment of 1 WTE additional Band 2 Outpatient reception staff	Moderate

Learning - Patient Safety Incidents

NHS
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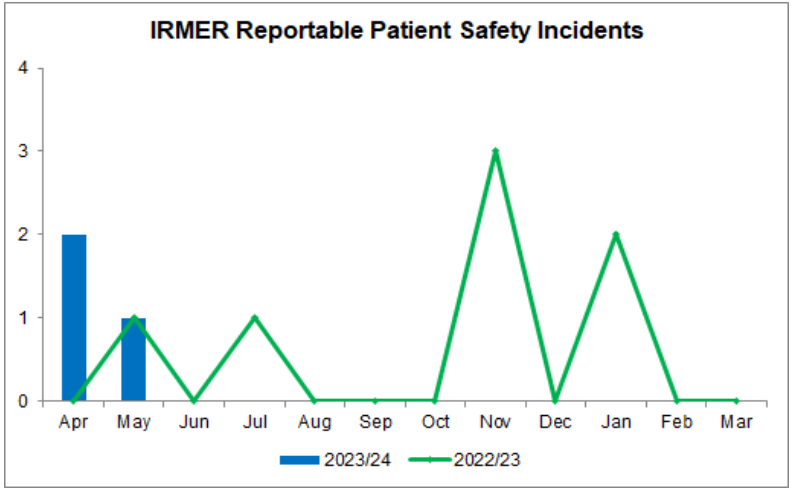
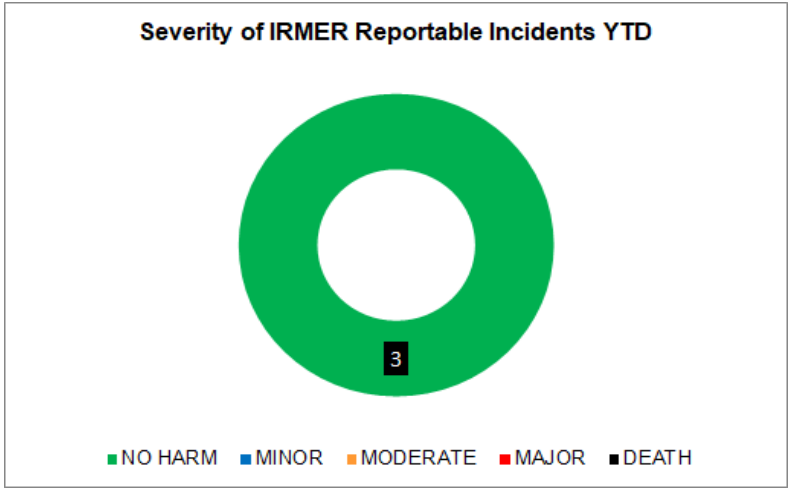
NHS Foundation Trust

Agreed learning and revised severity outcome following executive reviews December 2023

Ref	Description	Root cause	Learning	Outcome
W81016	The patient had attended the trust with symptoms of a urine infection and delivered a sample to the research team. Patient uncontactable following results of urine sample, patient required antibiotics. No next of kin details available. Due to patient living close to trust and police/GP unable to attend, safeguarding practitioner conducted welfare check – unable to locate patient. Patient later admitted to local hospital post fall and RIP.	Previous medical history of recurrent UTI and the patient's proximity to the hospital led to decision making to ask the patient to 'drop off' a urine sample was outside of usual systems and processes. The decision following escalation by the safeguarding team was to make a home visit to conduct a welfare check, was likely due to the patient living near to the Trust which made this possible.	• Opportunities to document up to date/alternative contact details in clinical records- for discussion at outpatient improvement group. • Review of Trust safeguarding policy.	No Harm

Radiation Incidents



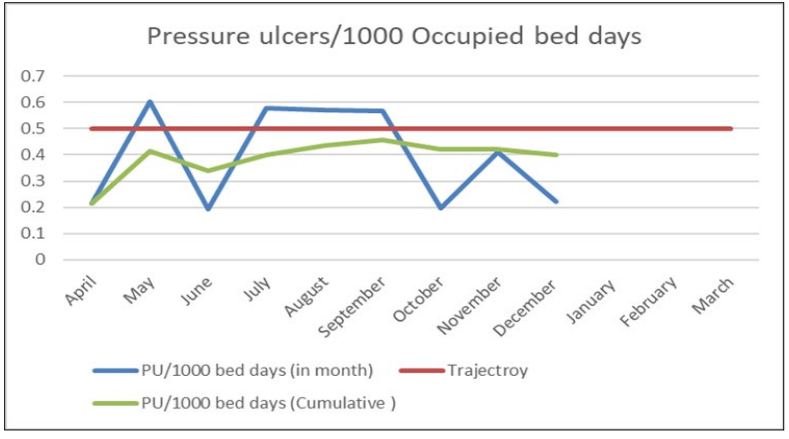


There were no IRMER reportable patient safety incident in December.

Harm Free Care

The Christie NHS Foundation Trust

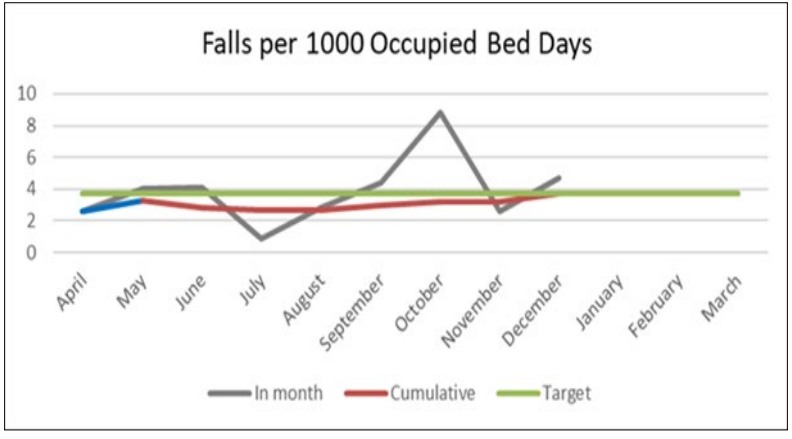
Pressure ulcers per 1000 occupied bed days



To date, 18 patients (0.40 per 1000 occupied bed days (OBD)) acquired pressure ulcers during the admission. This is against the ambition of no more that 0.5 per 1000 OBD.

No patient have developed category 3 or 4.

Falls per 1000 occupied bed days



21 falls in month on inpatient Wards. Currently at 3.8 falls per 1000 occupied bed days. This is against the ambition of no more that 3.8 per 1000 OBD.

81 % of falls were no harm

67

All harms are discussed at Friday FoCUS (a multi-professional forum for shared learning)

Corporate Risks

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There are 4 Trust-wide 15+ risks in December

Description	Score	Controls
Financial Risk 2023-24 (ID 3378)	16	This Trust's financial outturn is in the process of being reviewed and a 'best case' scenario quantified. this is likely to improve the financial position and will be confirmed following the M9 position.
Post clinic appointments processes are contributing to a risk to patients being lost to follow up (ID 3299)	15	Planned go live for the managed waiting list is the week of the 8th January 2024- will review end of January to confirm mitigations are working and reduced risk of patients being lost to follow up
Risk to delayed cancer referral and treatments due to not meeting 24 / 62 day target (ID 2407)	15	Risk remains high, currently reviewing PTL twice weekly and continue to work on improvement actions which are being monitored by execs via a weekly meeting.
There is a risk that patients may experience harm due to significant delays in the management of patients with penile cancer (ID 3319)	16	Weekly performance meeting of penile risks and discusses the patients waiting and who has been listed.

Safe Staffing

		DAY	NIGHT	Cumulative count over the month of patients at 23:59 each day	CHPPD (Care Hours Per Patient Per Day)
		Hours	Hours		
Registered Nurses	Total monthly PLANNED	17008	13109	4449	6.1
	Total monthly ACTUAL	14926	12023		
	Average Fill Rate %	87.8%	91.7%		
Care Staff	Total monthly PLANNED	10130	6103	4449	3.2
	Total monthly ACTUAL	8671	5505		
	Average Fill Rate %	85.6%	90.2%		
ALL Staff	Total monthly PLANNED	27138	19212	4449	9.2
	Total monthly ACTUAL	23613	17528		
	Average Fill Rate %	87.0%	91.2%		

Registered Nurses	DAY			NIGHT			Cumulative count over the month of patients at 23:59 each day	CHPPD (Care Hours Per Patient Per Day)
	Hours Planned	Hours Actual	% Fill Rate	Hours Planned	Hours Actual	% Fill Rate		
Critical Care Unit	1693	1510	89.2%	2054	1775	86.4%	139	23.6
Palatine Ward	3425	2858	83.4%	2577	2172	84.3%	778	6.5
Ward 10	2505	2020	80.6%	1506	1414	93.9%	686	5.0
Ward 11	1810	1896	104.8%	1534	1526	99.5%	762	4.5
Ward 12	1718	1850	107.7%	1402	1475	105.2%	747	4.5
Ward 4	1917	1848	96.4%	1599	1544	96.6%	710	4.8
Ward 2	1039	844	81.3%	495	414	83.7%	185	6.8
Acute Assessment Unit	2902	2100	72.4%	1944.5	1704	87.6%	442	8.6
TOTAL	17008	14926	87.8%	13109	12023	91.7%	4449	6.1

Registered Nursing Associates	DAY			NIGHT		
	Hours Planned	Hours Actual		Hours Planned	Hours Actual	
Critical Care Unit						
Palatine Ward						
Ward 10						
Ward 11					7	
Ward 12		8				
Ward 4		79			119	
Ward 2		96				
Acute Assessment Unit		16				

Care Staff	DAY			NIGHT			Cumulative count over the month of patients at 23:59 each day	CHPPD (Care Hours Per Patient Per Day)
	Hours Planned	Hours Actual	% Fill Rate	Hours Planned	Hours Actual	% Fill Rate		
Critical Care Unit	852	499	58.5%	0	0	100.0%	139	3.6
Palatine Ward	1285	947	73.7%	966	873	90.4%	778	2.3
Ward 10	1865	1269	68.0%	769	603	78.3%	686	2.7
Ward 11	1428	1626	113.8%	1152	1172	101.7%	762	3.7
Ward 12	1250	1508	120.6%	953	855	89.7%	747	3.2
Ward 4	1789	1525	85.3%	1228	1233	100.4%	710	3.9
Ward 2	378	265	70.1%	242	207	85.7%	185	2.6
Acute Assessment Unit	1284	1034	80.5%	794	564	71.0%	442	3.6
TOTAL	10130	8671	85.6%	6103	5505	90.2%	4449	3.2

*Nursing Associate hours are displayed seperately due to national guidance, however the actual hours are included alongside the Registered Nursing hours. The Trust does not have enough Nursing Associate posts to enable planned established hours.

Patient Experience

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NHS Foundation Trust

Positive feedback received…..

"The whole team at radiology have been incredible. Informed of all that is going on including updates when times overrun. Advice on pain relief and medication and always cheerful and have wonderful bedside manner. They have made me feel listened to and treated with empathy and dignity at all times.

"Patients daughter wanted to express gratitude for the amazing care and treatment her mother has received. The family were worried due to patients age and disability that she would not be offered treatment or seen as a priority however this could not have been further from truth. As a family we appreciated the consultant and team treatment of my mum."

"Pre-op care was excellent, impressed with organisation of all needing to be done and collaboration between Christie and local health services. All queries were dealt with before surgery by various teams. All staff lovely and approachable from pre-op to anaesthetic staff to physios, doctors and CNS's. Care shown by CCU staff was fantastic. It is obvious how much they loved their vocation. Very enthusiastic and showed strong team spirit making environment normal putting patient at ease."

Compliment for restaurant: Staff really helpful especially with food advice regarding allergies or vegetarian options were requested."

"Compliments for the whole team at Christie @ Oldham."

Friends & Family Test

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Monthly Summary

	INPATIENT & DAYCASE RESPONSES						Total Number of people eligible to respond	Total Responses	Response Rate	% Recommended
	1 - Very Good	2 - Good	3 - Neither Good nor Poor	4 - Poor	5 - Very Poor	6 - Don't Know				
Apr-23	207	27	4	0	2	1	780	241	30.9%	97.10%
May-23	280	20	1	2	0	1	926	304	32.8%	98.68%
Jun-23	247	24	6	2	3	0	927	282	30.4%	96.10%
Jul-23	223	23	2	1	2	1	810	252	31.1%	97.62%
Aug-23	222	8	3	3	1	0	841	237	28.2%	97.05%
Sep-23	208	25	8	2	4	1	894	248	27.7%	93.95%
Oct-23	237	26	4	4	2	0	827	273	33.0%	96.34%
Nov-23	265	28	5	1	0	1	980	300	30.6%	97.67%
Dec-23	168	19	2	3	4	2	846	198	23.4%	94.44%
YTD Total	2057	200	35	18	18	7	7831	2335	29.82%	96.66%

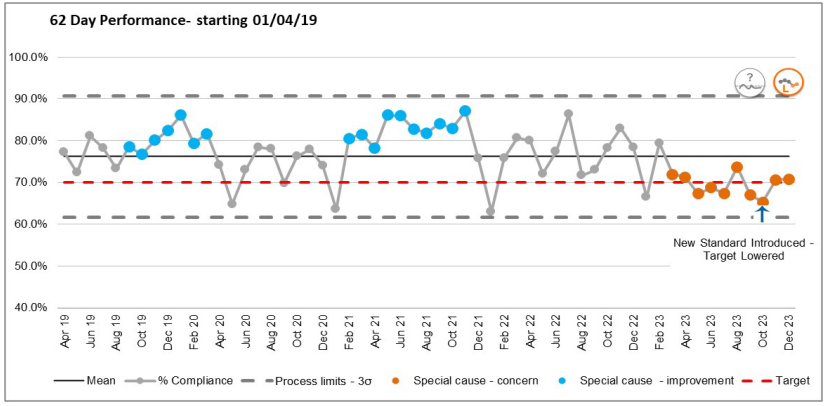
	OUTPATIENT RESPONSES						Total responses	% Recommended
	1 - Very Good	2 - Good	3 - Neither Good nor Poor	4 - Poor	5 - Very Poor	6 - Don't Know		
Apr-23	1348	165	38	19	10	18	1598	94.68%
May-23	1336	166	52	18	13	12	1597	94.05%
Jun-23	1458	181	54	23	21	20	1757	93.28%
Jul-23	1310	148	35	16	13	16	1538	94.80%
Aug-23	1215	167	29	14	10	16	1451	95.24%
Sep-23	1396	140	40	17	5	19	1617	94.99%
Oct-23	1606	170	47	17	7	9	1856	95.69%
Nov-23	1770	227	42	22	11	20	2092	95.46%
Dec-23	1079	144	30	14	9	8	1284	95.25%
YTD Total	12518	1508	367	160	99	138	14790	94.83%

Ward name	INPATIENT & DAYCASE RESPONSES - BY WARD						Total Number of people eligible to respond	Total responses for each ward	Response rate for each ward
	1 - Very Good	2 - Good	3 - Neither Good nor Poor	4 - Poor	5 - Very Poor	6 - Don't Know			
04 Ward (Dept 52)	9	0	0	0	0	0	88	9	10.2%
10 Ward-Surg Onc Unit (Dept 4)	22	4	1	0	0	1	150	28	18.7%
11 Ward (Dept 4)	2	0	0	0	0	0	98	2	2.0%
12 Ward (Dept 4)	5	0	0	2	2	0	112	9	8.0%
The BMR Unit (Dept 16)	7	0	0	0	0	0	27	7	25.9%
Endocrine Ward (Dept 63)	5	1	0	0	0	0	17	6	35.3%
Haematology Day Unit (Dept 26)	33	3	0	0	0	0	91	36	39.6%
Integrated Procedure Unit (Dept 2)	79	11	0	1	2	1	177	94	53.1%
Palatine Ward (Dept 27)	6	0	1	0	0	0	86	7	8.1%
Total	168	19	2	3	4	2	846	198	23.4%

Cancer Standards

The Christie NHS Foundation Trust

62 Day / 31 Day / 18 Weeks



National Standard	Standard	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	New Standard	Oct-23	Nov-23	Dec-23
62 Day	85%	71.3%	67.3%	68.8%	67.4%	73.7%	67.1%				
62 Day Upgrades	85%	67.1%	74.0%	87.7%	74.4%	75.5%	78.7%	70%	65.3%	70.6%	70.8%
62 Day Screening	90%	75.0%	63.6%	100.0%	58.3%	33.3%	66.7%				
24 Day Internal	85%	73.8%	74.6%	75.4%	69.0%	75.5%	70.6%	85%	68.3%	69.1%	71.6%
31 Days	96%	97.8%	98.3%	96.7%	97.4%	98.9%	96.0%				
31 Day Subsequent Drug	98%	100.0%	100.0%	100.0%	100.0%	98.9%	99.3%	96%	97.5%	98.1%	98.6%
31 Day Subsequent XRT	94%	99.2%	99.5%	100.0%	100.0%	98.9%	98.6%				
31 Day Subsequent Surgery	94%	98.8%	100.0%	100.0%	100.0%	98.9%	96.8%				
18 Weeks - Incomplete Pathways	92%	96.5%	96.9%	97.4%	96.7%	96.7%	97.8%	92%	97.7%	97.2%	97.2%

As of October 2023, all 62-day standards are merged in to one 62-day standard and all 31-day standard types are merged in to one combined 31-day standard. The Targets have been lowered from 85% to 70% for the new combined 62-day standard and a new combined target of 96% assigned to the new 31-day combined standard.

72

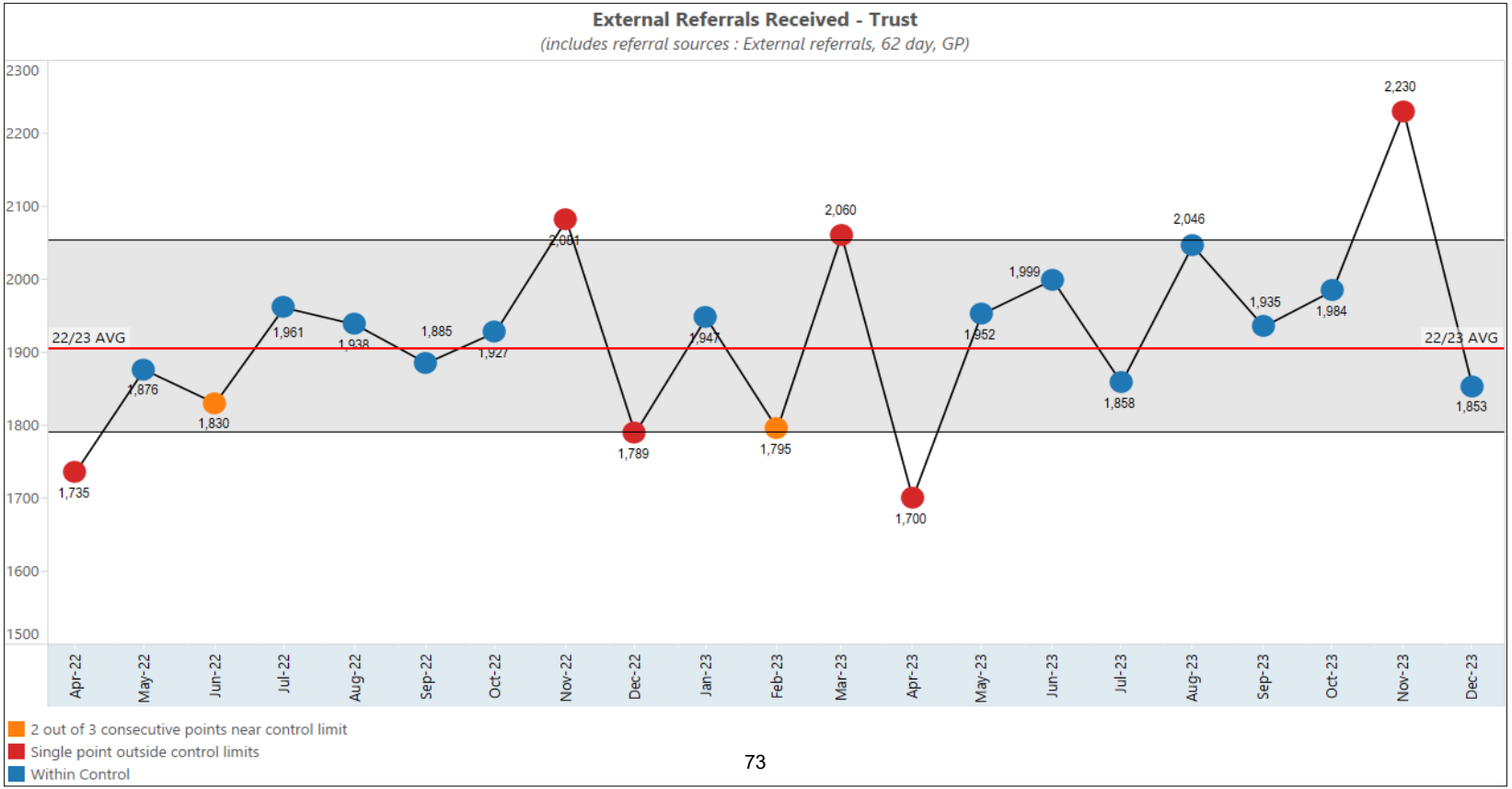
		Dec
50% Shared Breach		64
50% Shared Compliance		106
Full Christie Breach		8
FULL Christie Compliance		44
FULL Referring Provider Breach		119
Grand Total		341
62 Combined		70.8%
24 Day Compliance		71.64%
31 Day	Breach	8
	Compliance	339
31 day - Subsequents	Breach	8
	Compliance	794
31 day - Combined	Breach	16
	Compliance	1,133
31 day - Combined		98.6%

		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
28 Day Faster Diagnosis (standard 75%)	Compliances	2	5	11	7	5	7	16	10	10
	Breaches	2	6	10	10	5	6	3	4	3
	%	50.0%	45.5%	52.4%	41.2%	50.0%	53.8%	84.2%	71.4%	76.9%

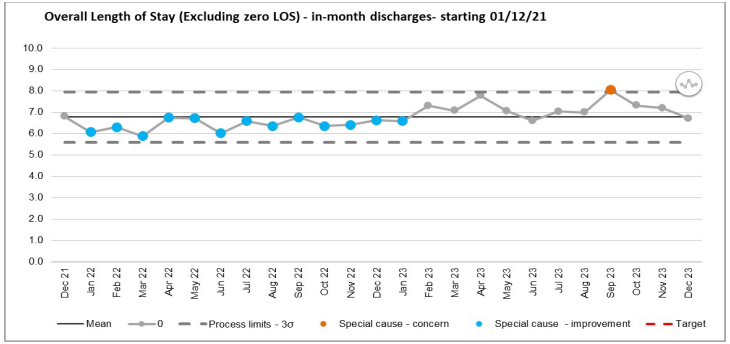
**Patients are reported in the month the compliance/breach occurs.*

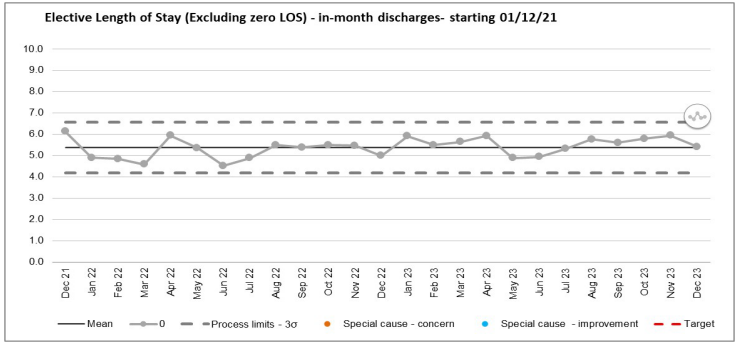
Referrals Analysis

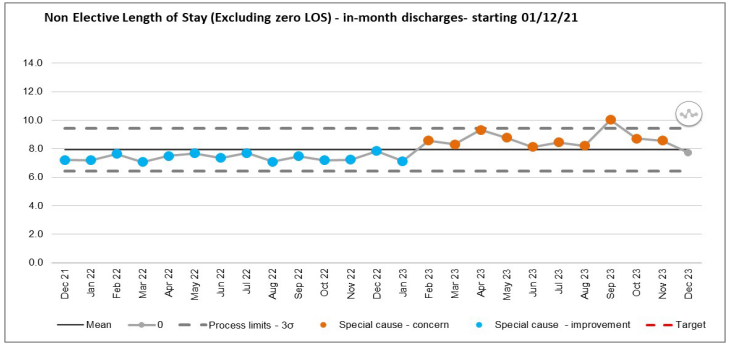
The Christie NHS Foundation Trust

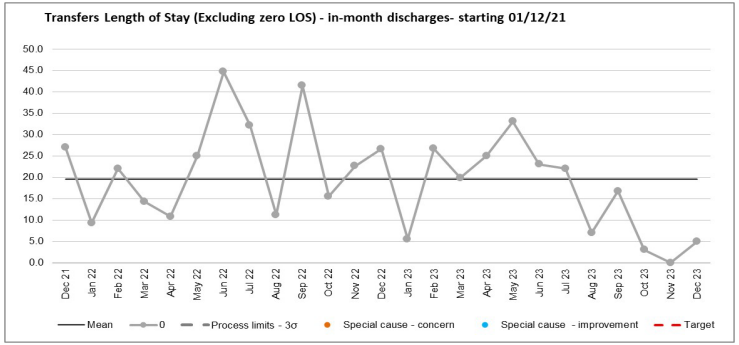


Length of Stay





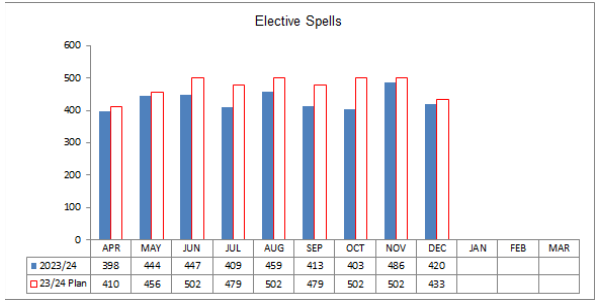




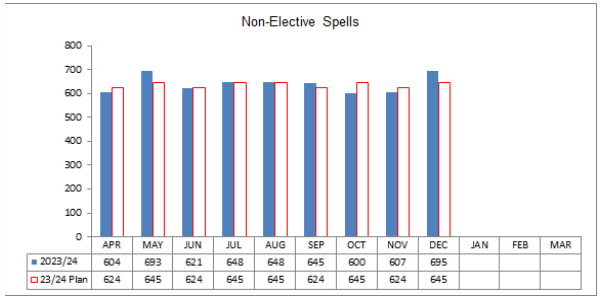
Elective, transfer patients and overall length of stay continues to be well within control limits – note special cause variation increase in non-elective LoS impacting on flow.

Activity

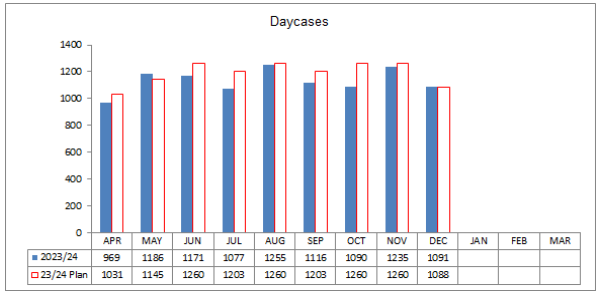
The Christie NHS Foundation Trust



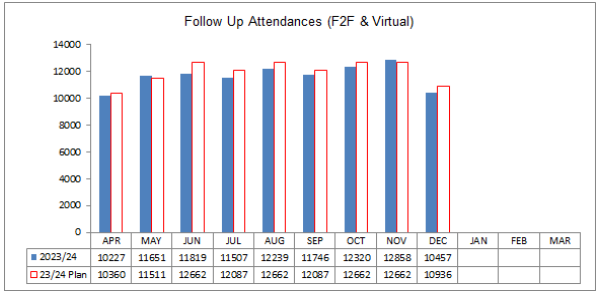
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	398	444	447	409	459	413	403	486	420			
23/24 Plan	410	456	502	479	502	479	502	502	433			



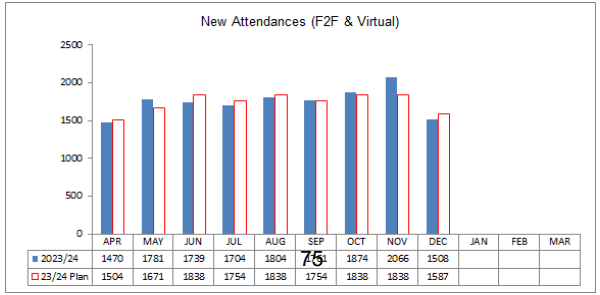
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	604	693	621	648	648	645	600	607	695			
23/24 Plan	624	645	624	645	645	624	645	624	645			



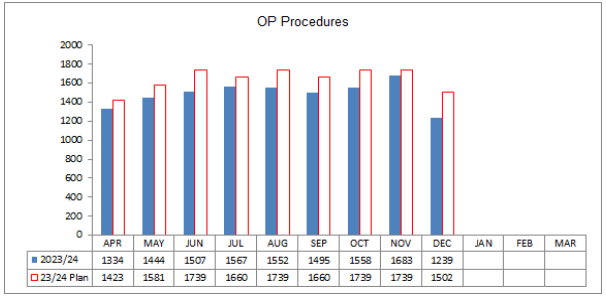
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	969	1186	1171	1077	1255	1116	1090	1235	1091			
23/24 Plan	1031	1145	1260	1203	1260	1203	1260	1260	1088			



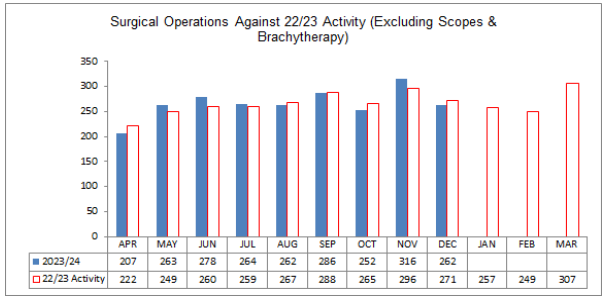
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	10227	11651	11819	11507	12239	11746	12320	12858	10457			
23/24 Plan	10360	11511	12662	12087	12662	12087	12662	12662	10936			



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	1470	1781	1739	1704	1804	1804	1874	2066	1508			
23/24 Plan	1504	1671	1838	1754	1838	1754	1838	1838	1587			

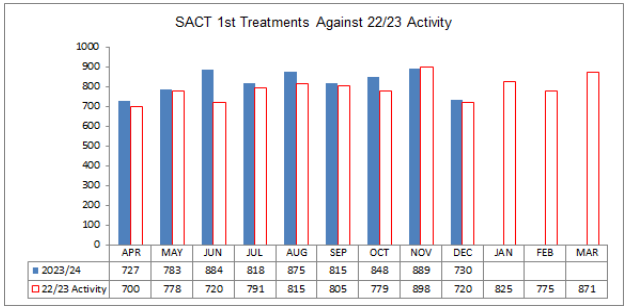


	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	1334	1444	1507	1567	1552	1495	1558	1683	1239			
23/24 Plan	1423	1581	1739	1660	1739	1660	1739	1739	1502			

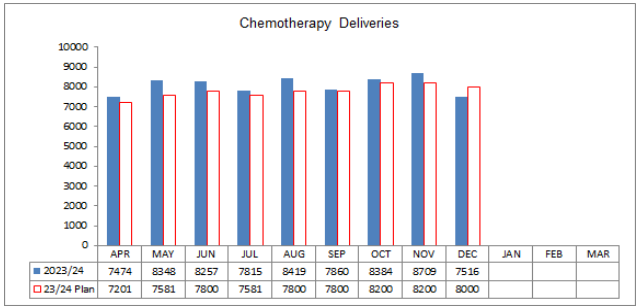


	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	207	263	278	264	262	286	252	316	262			
22/23 Activity	222	249	260	259	267	288	265	296	271	257	249	307

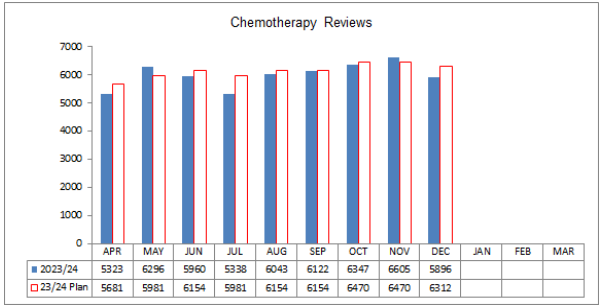
Activity



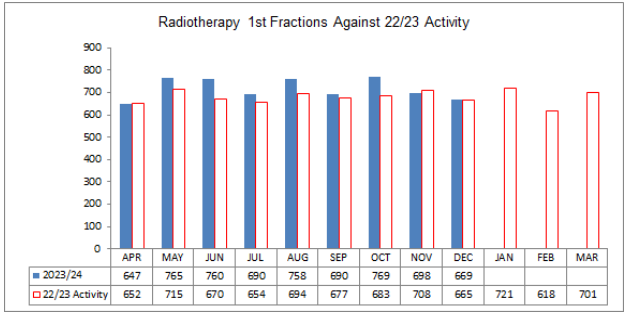
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	727	783	884	818	875	815	848	889	730			
22/23 Activity	700	778	720	791	815	805	779	898	720	825	775	871



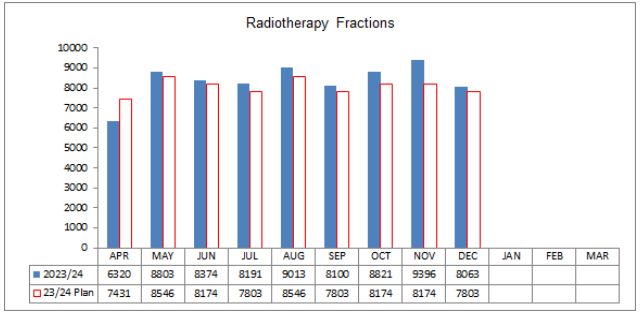
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	7474	8348	8257	7815	8419	7860	8384	8709	7516			
23/24 Plan	7201	7581	7800	7581	7800	7800	8200	8200	8000			



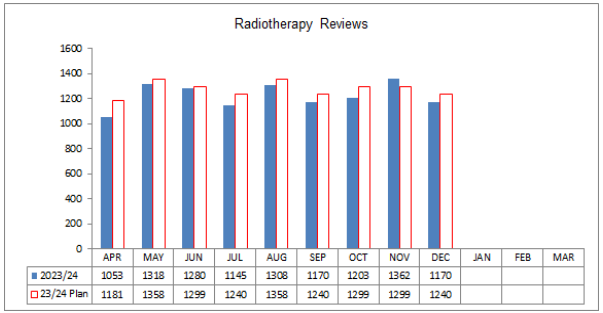
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	5323	6296	5960	5338	6043	6122	6347	6605	5896			
23/24 Plan	5681	5981	6154	5981	6154	6154	6470	6470	6312			



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	647	765	760	690	758	690	769	698	669			
22/23 Activity	652	715	670	654	694	677	683	708	665	721	618	701



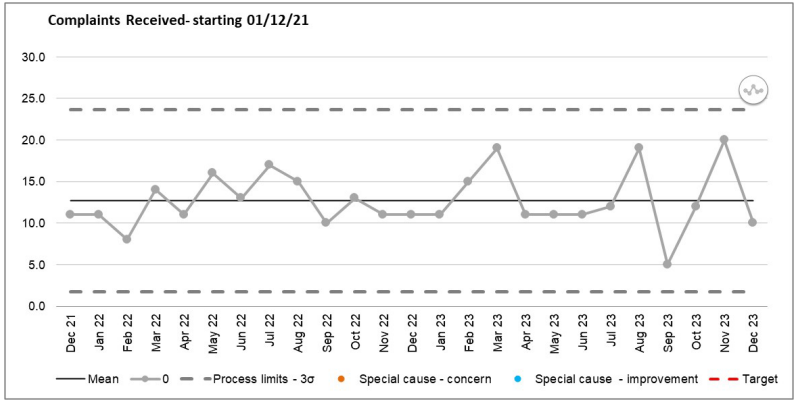
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	6320	8803	8374	8191	9013	8100	8821	9396	8063			
23/24 Plan	7431	8546	8174	7803	8546	7803	8174	8174	7803			

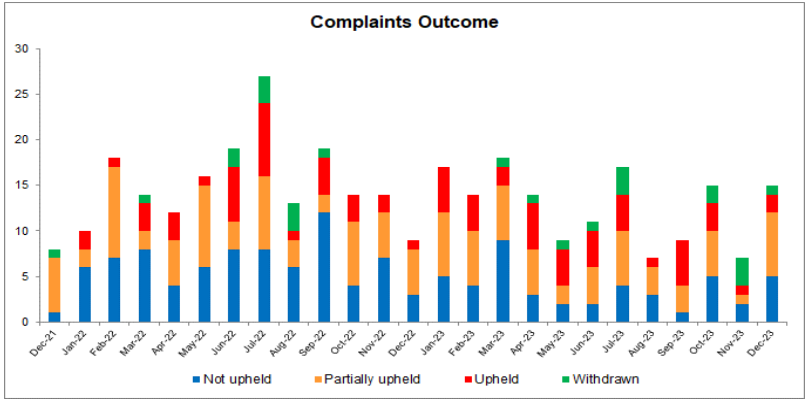


	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	1053	1318	1280	1145	1308	1170	1203	1362	1170			
23/24 Plan	1181	1358	1299	1240	1358	1240	1299	1299	1240			

SACT 1st Treatments, 1st Fractions & Surgical Operations do not form part of the 23/24 activity plan and are used as supplementary guides to productivity. The figures are monitored against the previous year's month for comparison.

Complaints



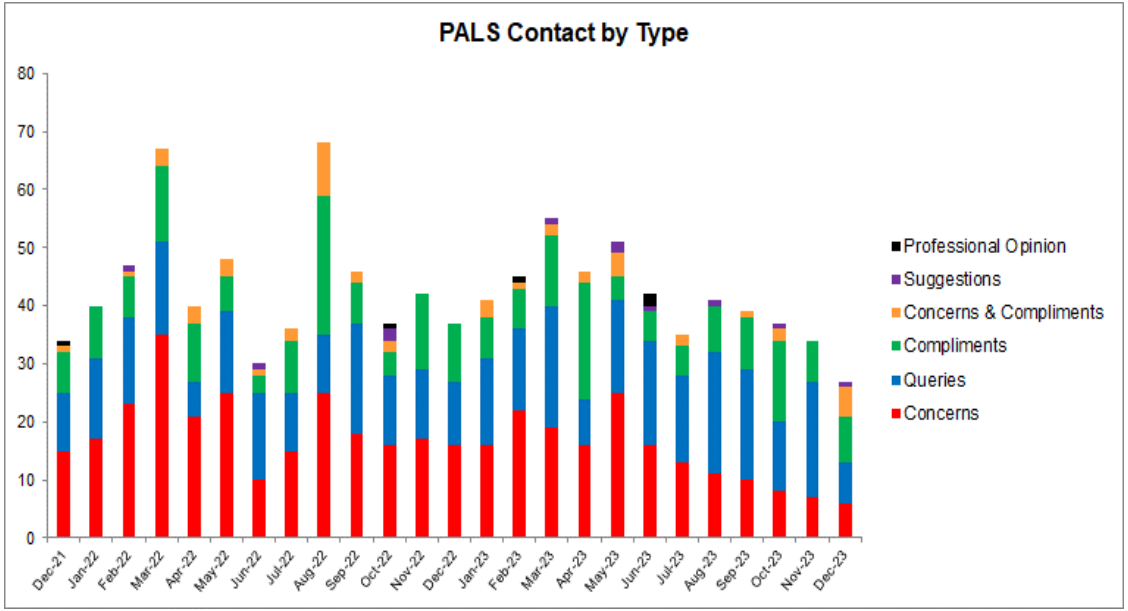


10 new complaints received in December 2023

15 complaints were closed in December 2023

Ombudsman Cases
Complainants have the right to refer their case to the Parliamentary and Health Service Ombudsman (PHSO) if they are not satisfied it has been resolved by the Trust. 0 cases were referred to the PHSO in December 2023. 5 active cases in total with the PHSO.

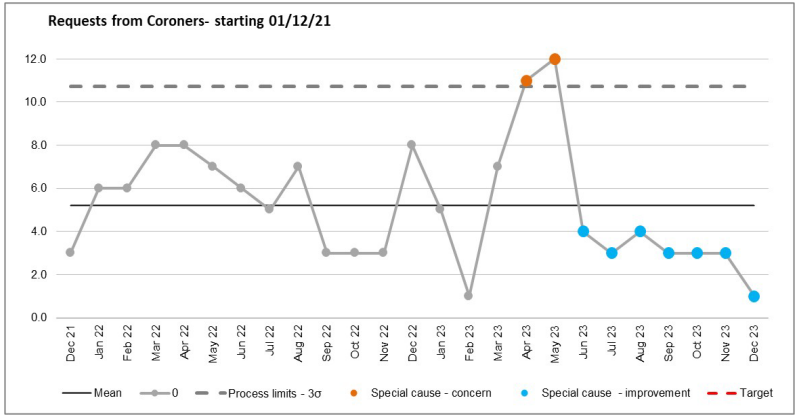
PALS

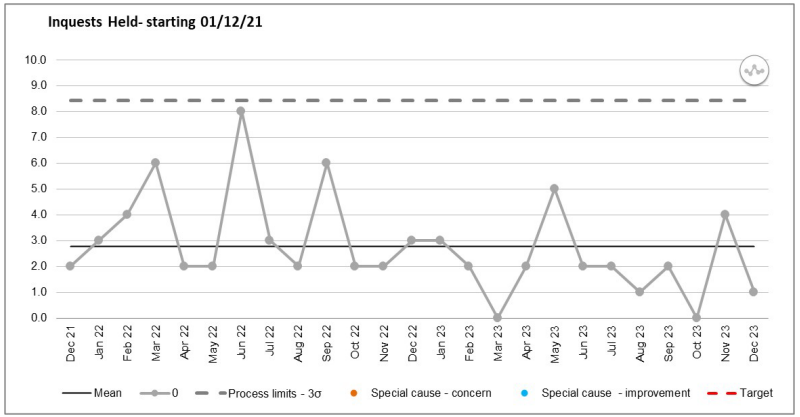


27 PALS contacts have been received in December 2023.

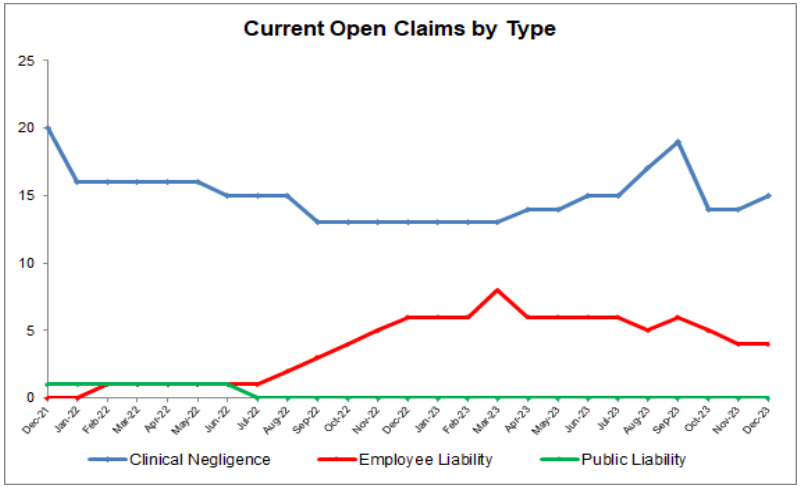
6 of those raised concerns about their experience at The Christie but did not wish to proceed with a formal complaint. The other reasons for contacting PALS are captured in the graph.

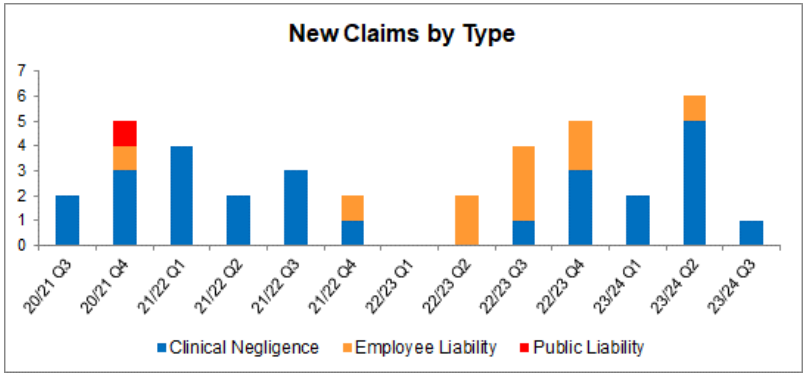
Inquests


Requests from Coroners- starting 01/12/21
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22
Oct 22
Nov 22
Dec 22
Jan 23
Feb 23
Mar 23
Apr 23
May 23
Jun 23
Jul 23
Aug 23
Sep 23
Oct 23
Nov 23
Dec 23
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


Inquests Held- starting 01/12/21
10.0
9.0
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22
Oct 22
Nov 22
Dec 22
Jan 23
Feb 23
Mar 23
Apr 23
May 23
Jun 23
Jul 23
Aug 23
Sep 23
Oct 23
Nov 23
Dec 23
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

Claims





1 new claim received in December 2023.

0 claims closed in December 2023.

Healthcare Associated Infections

NHS
The Christie
NHS Foundation Trust

Curent Month	Community Onset - Indeterminate Acquisition (COIA)	Community Onset - Community Acquired (COCA)	Community Onset - Healthcare Acquired (COHA)	Healthcare Onset - Healthcare Acquired (HOHA)	Lapses in Care	Area(s) Occurred
Clostridium Difficile	1	1			0	
E.coli Bacteraemia		4	3	1	0	(PW x1) (IPU x1) (W11 x1) (W12 x1)
Klebsiella spp.		2	2		0	(AAU x1) (W4 x1)
Pseudomonas aeruginosa bacteraemia		2	1		0	(W11 x1)
MSSA Bacteraemia			1	1	0	(W12 x1) (IPU x1)
MRSA Bacteraemia					0	

YTD	Community Onset - Indeterminate Acquisition (COIA)	Community Onset - Community Acquired (COCA)	Community Onset - Healthcare Acquired (COHA)	Healthcare Onset - Healthcare Acquired (HOHA)	Lapses in Care
Clostridium Difficile	6	10	11	21	0
E.coli Bacteraemia		28	22	25	0
Klebsiella spp.		10	11	8	0
Pseudomonas aeruginosa bacteraemia		6	4	5	0
MSSA Bacteraemia		6	8	9	0
MRSA Bacteraemia		1	2	1	0

Organism	COVID 19 first positive 3 – 7 days from admission (HO-iHA)	COVID 19 first positive 8 – 14 days from admission (HO-pHA)	COVID 19 first positive 15 or more days from admission (HO-dHA)	TOTAL (YTD)	Lapses in care
COVID-19	5	9	11	25	0

Organism	Number of Cases (YTD)	Lapses in care
CPE colonisation / infection	6	0

There were no cases of C-Difficile, 4 cases of E-Coli, 2 cases of Klebsiella. 1 case of Pseudomonas and 2 cases of MSSA in December that were deemed attributable to the Trust. **No lapses in care have been identified.**

Definitions

COCA - Cdiff: Is not categorised HOHA and the patient has not been discharged from the same reporting organisation in the 84 days prior to the specimen date (where day 1 is the specimen date)

E.coli, Klebs, Pseudo, MSSA, MRSA: Is not categorised HOHA and the patient has not been discharged from the same reporting organisation in the 28 days prior to the specimen date (where day 1 is the specimen date)

COIA - Symptoms commenced within first two days of admission and has been an inpatient in the trust in the past 4 weeks

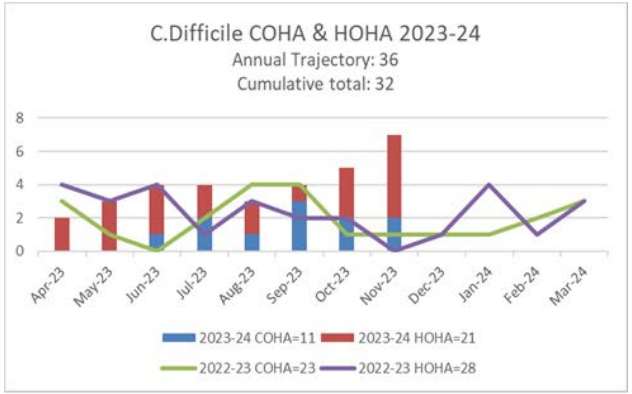
COHA - Symptoms commenced within first two days of admission and inpatient in the past 12 weeks (but not past 4 weeks)

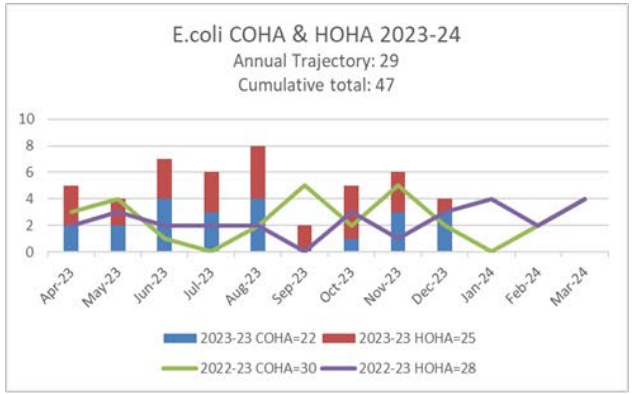
HOHA - Symptoms commenced within first two days of admission (No admission in past 12 weeks)

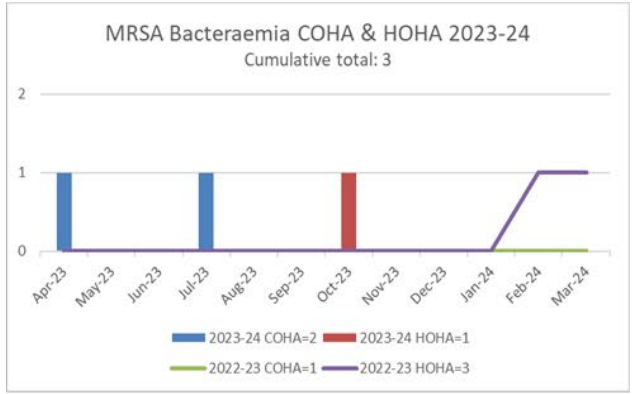
Healthcare Associated Infections

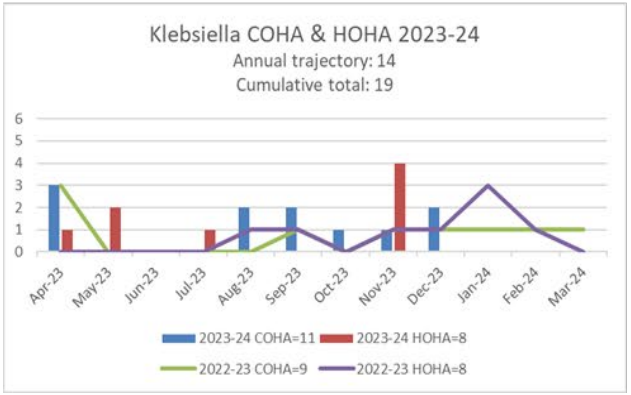
The Christie NHS Foundation Trust

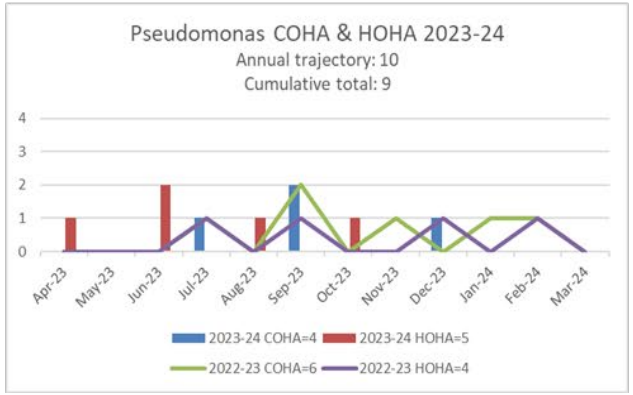
Alert Organisms

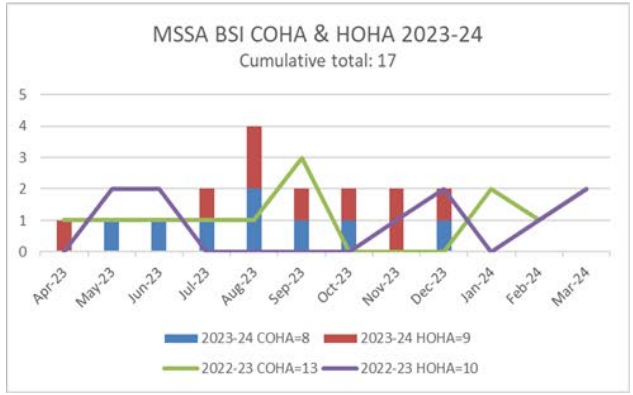








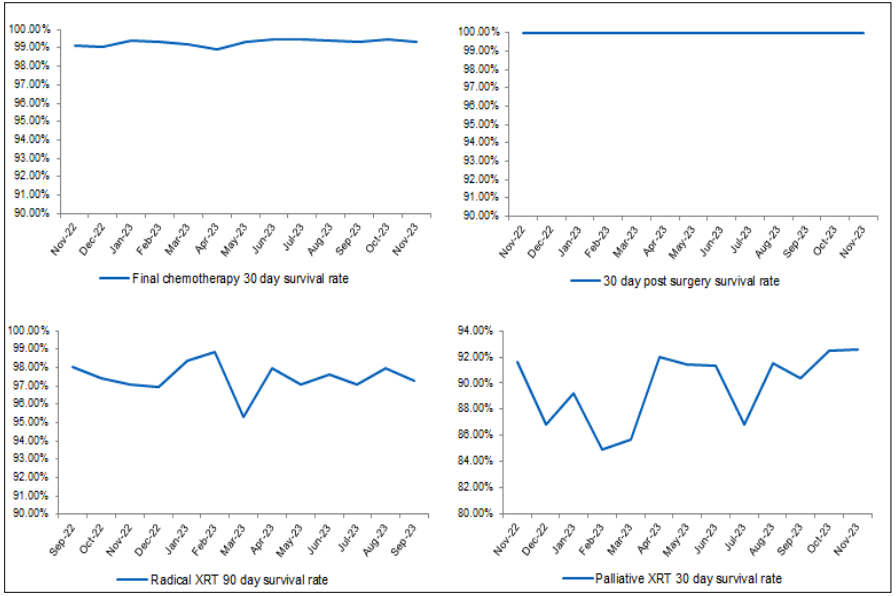




Mortality Indicators & Survival Rates

The Christie NHS Foundation Trust

Survival Rates



Inpatient Deaths – Onsite Deaths

		Dec-23
Number of NHS Christie onsite deaths	Elective/planned admission	3
	Non Elective/emergency admission	25
	TOTAL	**28**
Number of deaths that have triggered Structured Casenote Review (SCR) Note: screening is ongoing so further triggers may be identified	Mortuary screened triggers (including reported to the coroner) - 0	**2**
	Bereaved families raised concern – 0	
	Medical Triggers - 2	
	Nursing Triggers - 0 (inc in family concern)	
	(note there may be more than one trigger)	

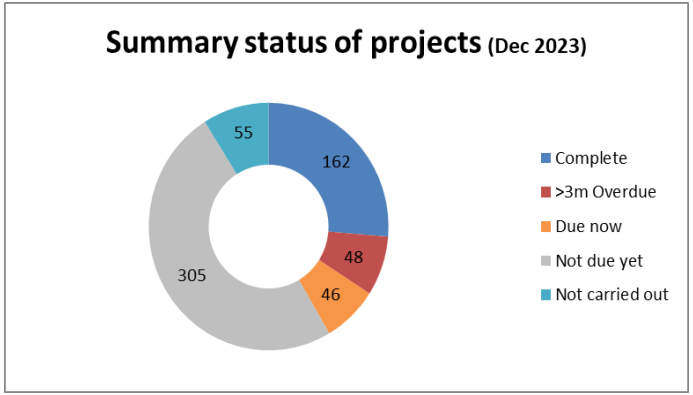
The Christie process for learning from deaths follows the 2017 NHSI guidance. All in-patient deaths are screened and where flagged by one or more triggers an independent structured case note review (SCR) is undertaken. Reviews are discussed by the Mortality Surveillance Group and the findings and actions from these are reported to the Executive Review meetings. Quarterly reports are made to Patient Safety and the Trust Quality Assurance Committees.

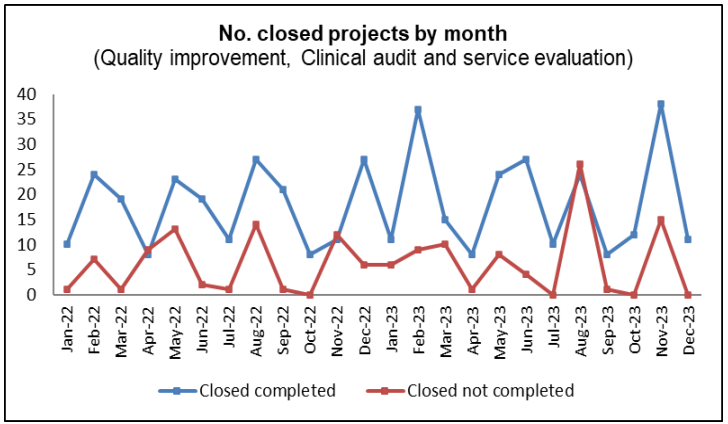
Quality Improvement & Clinical Audit

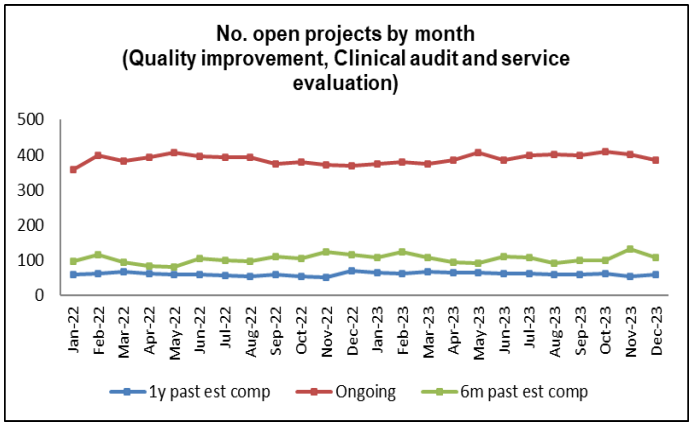
The Christie NHS Foundation Trust

QICA programme – Quality Improvement and Clinical Audit Including service evaluations and patient surveys

Reminders are sent mid-quarter which lead to increased number of closed projects







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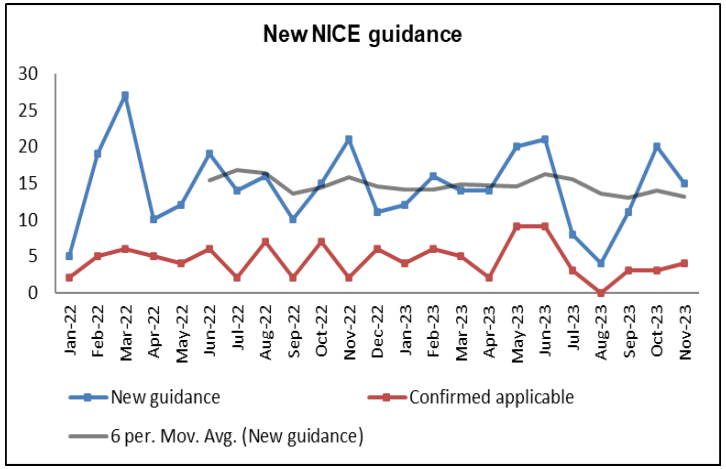
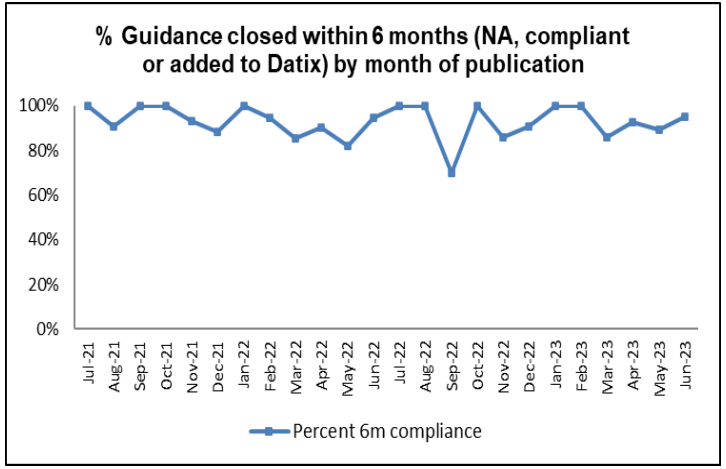
NICE Guidance





Implementation of nationally agreed best practice
The trust has a risk-based process with divisional support to assess applicability and implement relevant guidance.

Guidance that is not resolved or on the risk register is monitored and escalated if there are issues.

The trust aims to close guidance within 6 months of publication. Guidance may be:

- compliant
- not applicable to the trust
- non or partially compliant with actions managed via the risk register

Note: normal trust processes for NICE guidance were paused during the Covid19 pandemic, affecting timescales

HR Metrics Sickness

NHS
The Christie
NHS Foundation Trust

4.48%
Monthly Absence

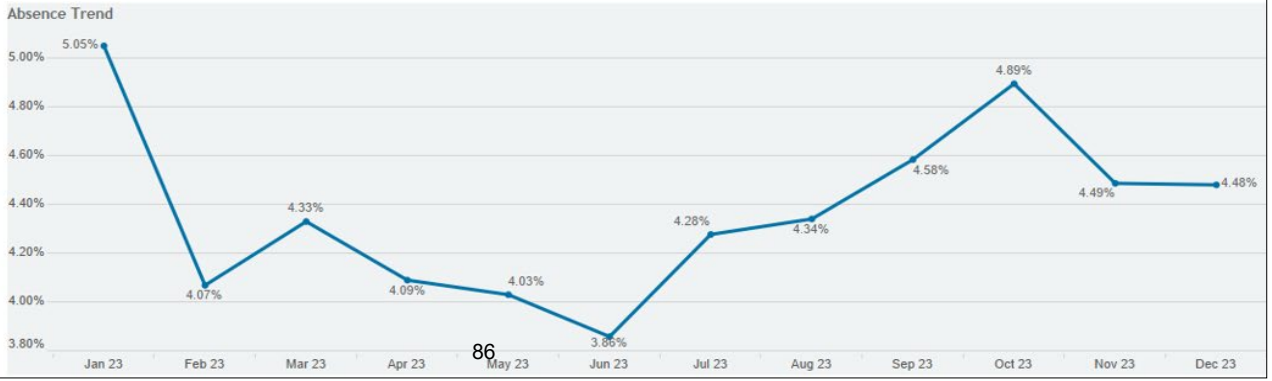
4.37%
Yearly Absence

97
Returned Last Month

54
No. of Employees on Long Term Sick

41
No. of Employees on Short Term Sick

Division	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
Christie Medical Physics & Engineering	3.24%	2.45%	2.26%	1.67%	2.32%	3.24%	3.35%	3.65%	3.51%	3.24%	3.67%	3.01%
Clinical Networked Services	4.67%	3.68%	4.27%	3.82%	3.50%	3.89%	4.71%	4.61%	4.46%	5.51%	4.41%	4.44%
Clinical Support & Specialist Surgery	5.66%	5.05%	5.00%	4.92%	5.51%	4.66%	4.70%	4.96%	5.87%	6.21%	5.38%	5.78%
Corporate Development	0.55%	0.52%	0.29%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.80%	0.00%	0.66%
Digital Services	1.80%	1.55%	1.65%	1.83%	2.53%	1.23%	1.27%	3.01%	3.15%	1.39%	1.39%	1.23%
Education (School of Oncology)	4.60%	3.35%	1.42%	1.86%	0.93%	0.43%	0.20%	0.65%	2.05%	2.73%	3.74%	2.37%
Estates & Facilities	11.11%	8.97%	9.79%	8.93%	5.89%	5.81%	7.64%	7.36%	7.34%	6.87%	7.77%	6.69%
Finance & Business Development	2.75%	1.83%	2.43%	1.88%	3.43%	2.50%	2.06%	1.26%	1.75%	2.23%	2.27%	2.14%
GM Cancer	3.78%	1.36%	0.00%	0.35%	0.86%	0.00%	0.73%	0.00%	0.54%	0.06%	0.60%	0.00%
Performance	4.01%	4.32%	7.10%	7.40%	9.78%	8.85%	9.24%	8.46%	2.67%	3.42%	6.91%	10.66%
Quality & Standards	7.96%	6.44%	5.78%	4.25%	5.93%	3.95%	2.43%	6.04%	8.98%	7.06%	9.92%	7.28%
Research & Innovation	4.42%	3.13%	3.73%	3.73%	3.62%	3.32%	3.23%	3.13%	3.16%	3.10%	2.60%	2.96%
Strategy	3.70%	0.00%	0.00%	2.19%	0.00%	0.00%	0.00%	0.45%	0.00%	0.00%	0.00%	0.00%
Trust Administration	6.42%	6.21%	5.85%	6.65%	6.88%	6.21%	6.23%	5.87%	5.83%	5.51%	5.51%	5.51%
Workforce	1.75%	0.93%	1.40%	0.52%	0.35%	1.93%	3.30%	1.62%	2.11%	1.31%	3.00%	4.97%



HR Metrics – Mandatory Training

The Christie NHS Foundation Trust

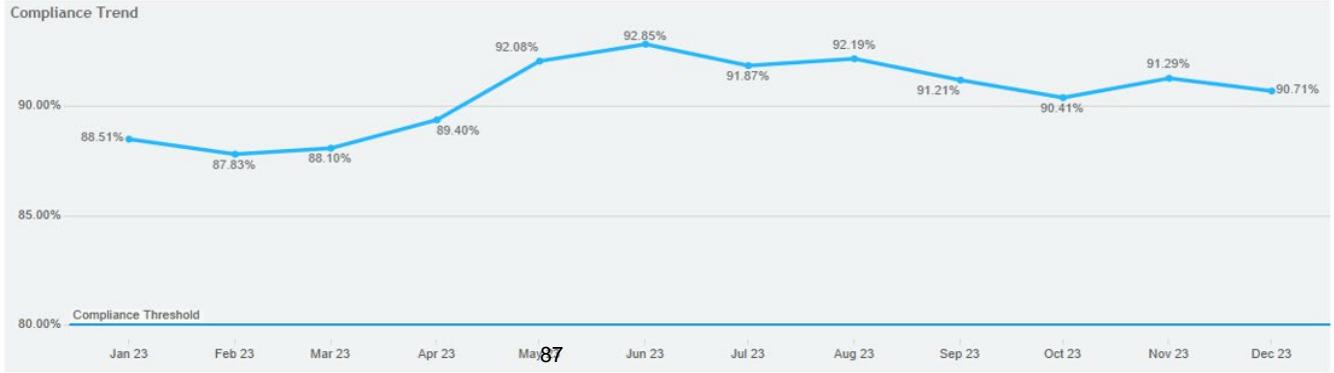
90.73%
Compliance

5,141
Outstanding Modules

81.73%
Face to Face

92.81%
Online

Division	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
Christie Medical Physics & Engineering	95.37%	94.95%	95.06%	96.03%	96.20%	95.32%	95.46%	95.99%	95.74%	94.43%	94.66%	93.95%
Clinical Networked Services	87.62%	87.45%	85.86%	87.05%	90.05%	90.84%	90.10%	90.63%	89.21%	89.11%	90.03%	89.28%
Clinical Support & Specialist Surgery	83.39%	81.15%	81.96%	84.99%	88.93%	90.30%	89.00%	88.96%	87.88%	86.59%	88.39%	88.09%
Corporate Development	96.19%	95.58%	95.71%	96.12%	100.00%	100.00%	100.00%	100.00%	100.00%	99.48%	98.43%	98.95%
Digital Services	94.86%	96.21%	98.97%	98.35%	98.55%	98.38%	96.79%	96.46%	94.88%	95.85%	95.49%	90.08%
Education (School of Oncology)	93.91%	94.14%	94.81%	94.11%	96.06%	96.70%	95.27%	94.77%	94.71%	91.82%	94.31%	97.10%
Estates & Facilities	93.65%	93.13%	95.21%	93.98%	94.46%	95.03%	93.81%	94.33%	94.54%	92.15%	90.87%	92.49%
Finance & Business Development	97.14%	97.75%	99.67%	97.93%	99.11%	99.37%	99.45%	99.54%	98.63%	98.47%	97.86%	97.38%
GM Cancer	82.66%	80.54%	86.04%	87.44%	92.97%	95.42%	91.29%	91.32%	92.28%	91.55%	90.96%	95.12%
Performance	95.03%	96.39%	95.06%	95.32%	93.38%	94.12%	98.80%	96.20%	92.28%	93.32%	98.66%	95.10%
Quality & Standards	92.26%	92.17%	92.86%	94.08%	93.04%	94.48%	94.97%	93.76%	90.37%	88.25%	91.19%	91.79%
Research & Innovation	94.20%	93.53%	93.57%	94.32%	96.53%	97.33%	96.68%	96.97%	96.00%	95.38%	95.72%	93.93%
Strategy	95.49%	93.22%	93.85%	94.17%	98.26%	96.80%	93.33%	97.50%	95.69%	93.08%	96.50%	95.92%
Trust Administration	97.99%	98.33%	93.15%	93.56%	96.04%	95.45%	95.57%	94.42%	93.39%	89.64%	91.79%	91.73%
Workforce	88.84%	92.94%	91.61%	92.72%	96.12%	96.30%	91.18%	96.50%	97.31%	97.41%	97.69%	94.36%



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HR Metrics - PDR

The Christie NHS Foundation Trust

84.07%
Compliance

466
Expired

449
Due Soon (3 Months)

68.73%
Predicted Compliance
(If the Due Soon were to expire)

Division	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
Christie Medical Physics & Engineering	88.84%	88.07%	90.00%	90.46%	92.08%	91.97%	93.12%	91.94%	89.88%	86.69%	88.98%	85.04%
Clinical Networked Services	83.43%	81.33%	80.90%	81.26%	86.13%	86.71%	89.15%	89.18%	86.99%	84.96%	81.68%	81.99%
Clinical Support & Specialist Surgery	84.59%	84.94%	87.08%	85.64%	82.19%	83.71%	81.07%	80.43%	81.81%	82.15%	79.70%	82.63%
Corporate Development	88.57%	75.68%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	90.91%	90.91%	90.91%	100.00%
Digital Services	91.11%	89.36%	93.62%	93.75%	89.69%	88.00%	81.00%	83.00%	78.43%	77.45%	85.58%	84.91%
Education (School of Oncology)	92.19%	90.48%	92.31%	94.03%	89.39%	91.18%	92.42%	92.31%	92.65%	88.24%	91.67%	84.72%
Estates & Facilities	83.40%	82.68%	84.28%	80.60%	72.10%	78.21%	81.47%	85.41%	83.82%	86.07%	85.02%	83.20%
Finance & Business Development	90.63%	88.89%	96.67%	89.06%	95.24%	90.63%	92.19%	92.19%	90.63%	93.85%	89.86%	95.77%
GM Cancer	57.14%	53.85%	71.79%	61.90%	65.96%	65.31%	73.47%	80.39%	82.35%	83.02%	75.00%	85.45%
Performance	91.30%	90.91%	91.30%	82.61%	72.73%	68.42%	70.00%	70.00%	72.73%	73.91%	73.91%	73.91%
Quality & Standards	82.76%	76.67%	87.10%	78.79%	82.35%	88.24%	90.91%	94.29%	90.91%	90.91%	96.77%	90.91%
Research & Innovation	82.08%	87.02%	90.71%	88.24%	85.37%	86.56%	86.15%	88.28%	85.32%	84.35%	89.56%	89.61%
Strategy	33.33%	30.00%	30.00%	30.00%	50.00%	60.00%	60.00%	60.00%	66.67%	66.67%	60.00%	50.00%
Trust Administration	66.67%	80.00%	85.71%	92.86%	92.86%	92.86%	92.86%	86.67%	82.35%	82.35%	88.24%	68.75%
Workforce	94.92%	98.28%	94.74%	91.38%	98.28%	95.16%	95.00%	95.08%	89.83%	91.38%	91.23%	94.83%

Workforce Metrics - Turnover

NHS
The Christie
NHS Foundation Trust

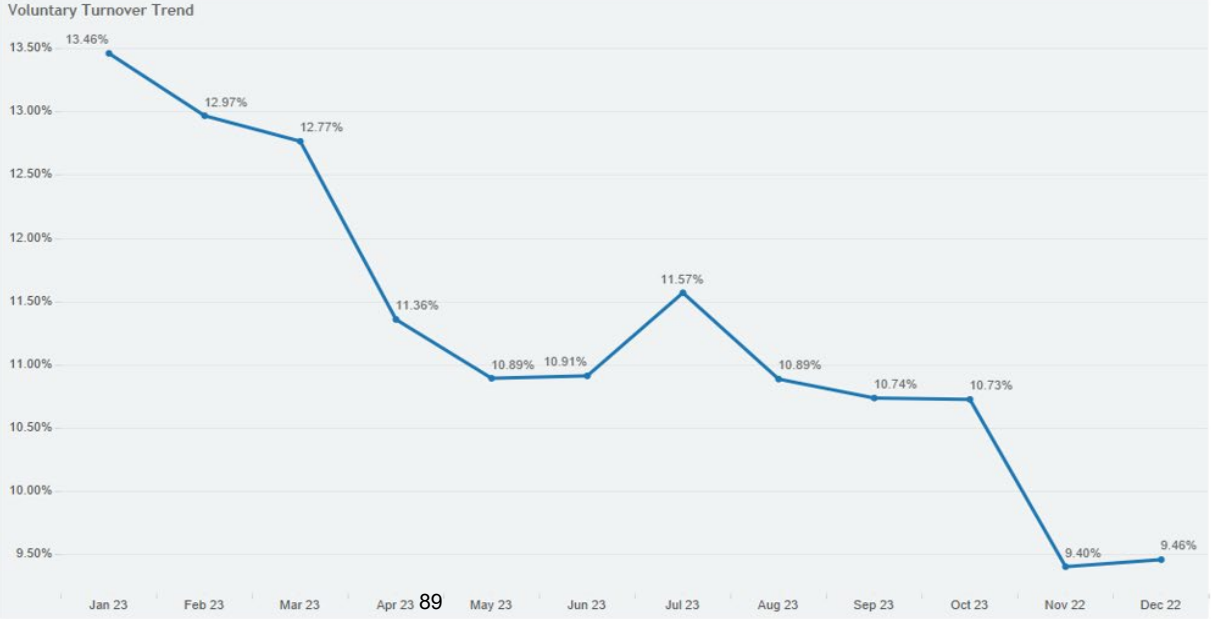
39
Leavers

9.46%
Voluntary Yearly Turnover

10.19%
All Yearly Turnover

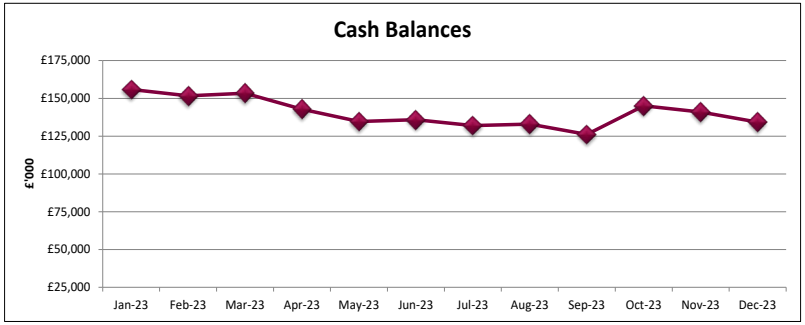
3,727
Headcount

Dismissal	1
End of Fixed Term Contract	2
Retirement	8
Voluntary Resignation	26
Others	2
Grand Total	39



Finance (Executive Summary)

Month 9 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(373,973)	(280,525)	(299,614)	(19,089)
Other Income	(68,922)	(51,664)	(49,959)	1,705
Pay	212,477	159,299	151,461	(7,838)
Non Pay (incl drugs)	218,370	163,854	181,943	18,090
Operating (Surplus) / Deficit	**(12,048)**	**(9,036)**	**(16,168)**	**(7,132)**
Finance expenses/ income	28,723	21,542	23,621	2,079
(Surplus) / Deficit	**16,675**	**12,506**	**7,453**	**(5,054)**
Exclude impairments/ charitably funded capital donations	(8,637)	(6,478)	(6,332)	146
Adjusted financial performance (Surplus) / Deficit	**8,038**	**6,028**	**1,121**	**(4,908)**



This report outlines the month 9 consolidated financial performance of The Christie NHS Foundation Trust and its wholly owned subsidiary The Christie Pharmacy Ltd.

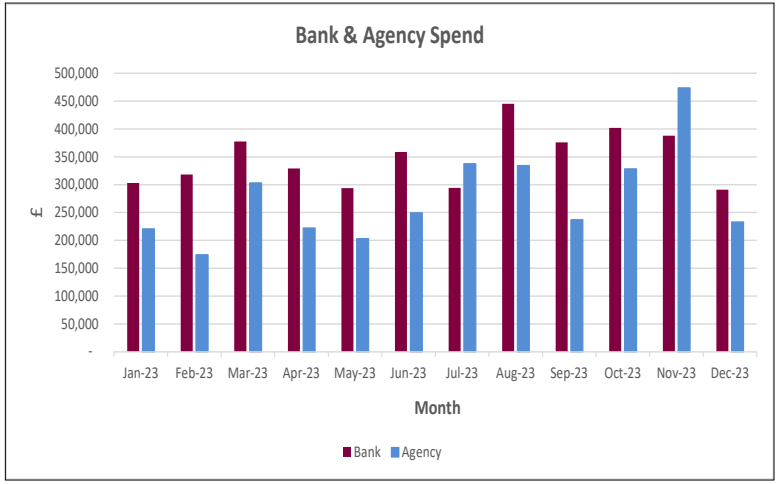
I&E

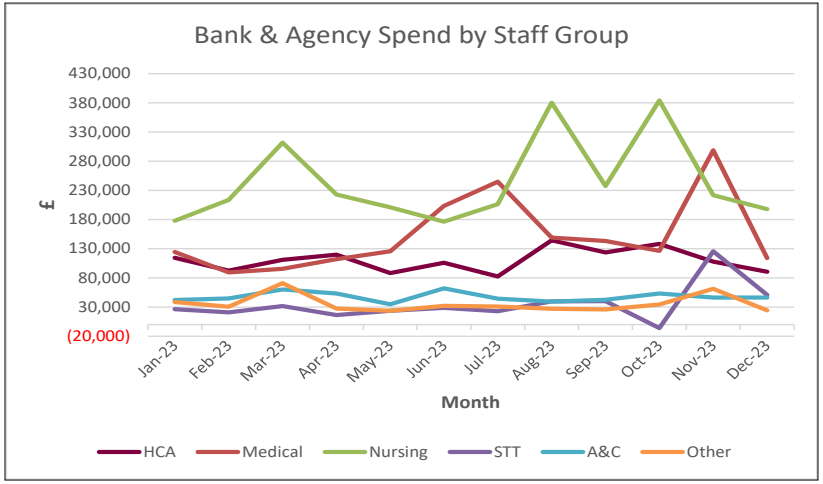
- The Trust is reporting a year-to-date deficit of £1,121k against an in-month plan of £6,028k, which gives a positive year to date variance of £4,908k.
- The month 9 position is a surplus of £877k against a deficit in month plan of £670k which gives a positive in month variance of £1,547k.
- The month 9 position is at a deficit of £1,547k against plan.
- 2023-24 CIP – Identified in year CIP is £12.5m (£10.6m non recurrent / £1.9m recurrent).

Balance sheet / liquidity

- The cash balance is £134,243k.
- Capital expenditure is under CDEL original plan by £7,635k.
- Targets have been achieved against payment of our NHS creditors paid within the 30 day Better Payment Practice Code target.

Finance (Expenditure)

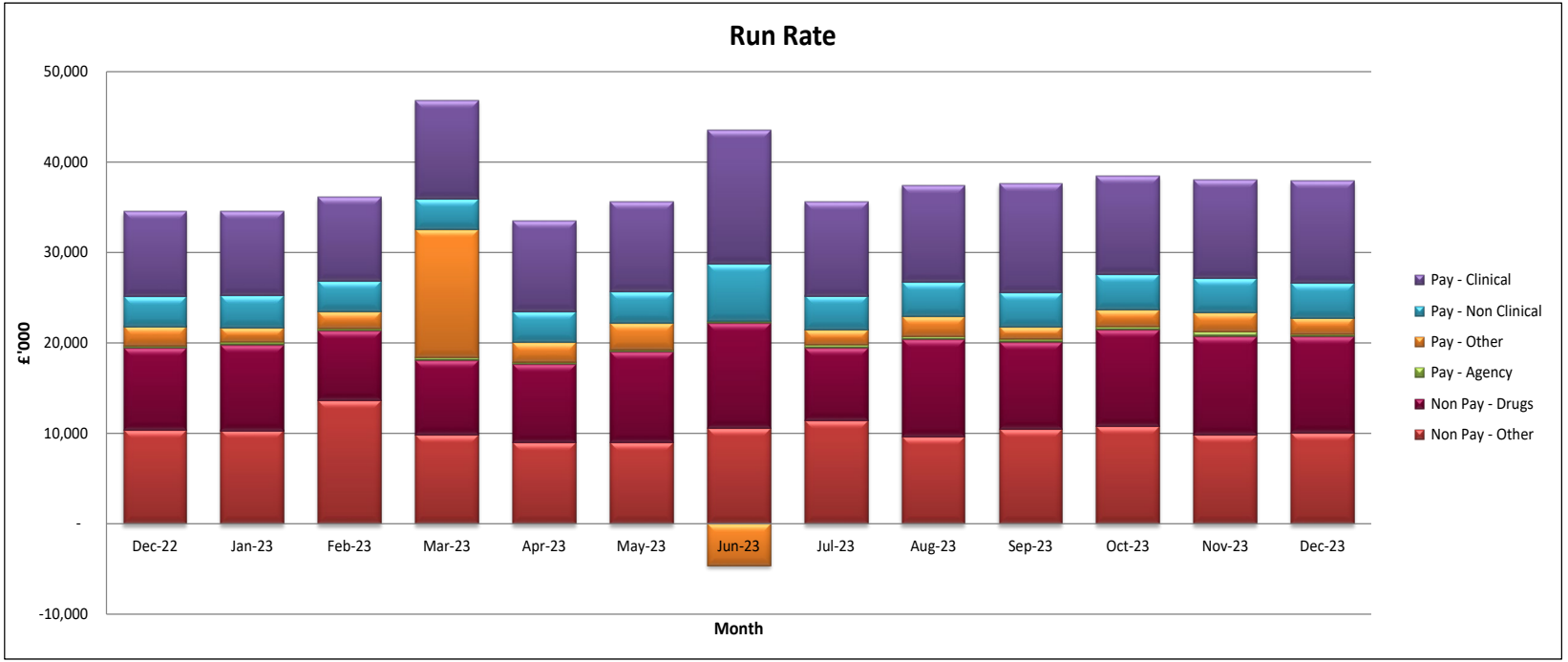




The agency spend is £233k in month 9, a decrease of £241k from month 8. This is mainly due to a decrease on medical and scientific, technical, and therapeutic agency spend.

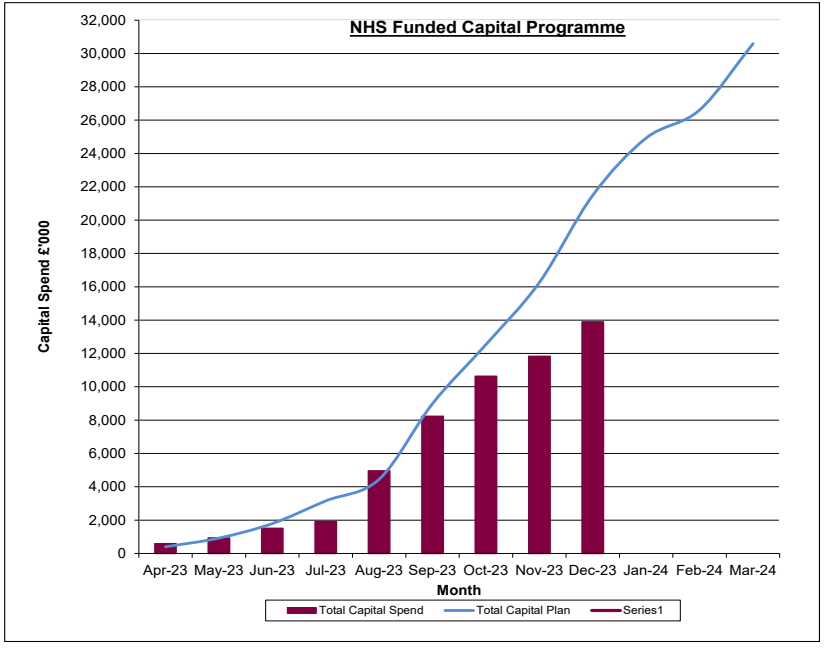
Alongside this, bank usage has decreased by £97k in month compared to M8, largely driven by lower spend on HCA and Nursing bank.

5.2 - Finance (Expenditure)



- Drugs spend in month 9 is £10,665k, a decrease from month 8 of £242k.
- Pay – Agency spend in month 9 is £233k, a decrease of £208k from month 8.
- Pay – Clinical has increased by £436k compared to month 8 relating to Industrial Action and increased ECAPs
- Key elements of 'Non Pay Other' spend consist of clinical supplies and services, premises and infrastructure costs.

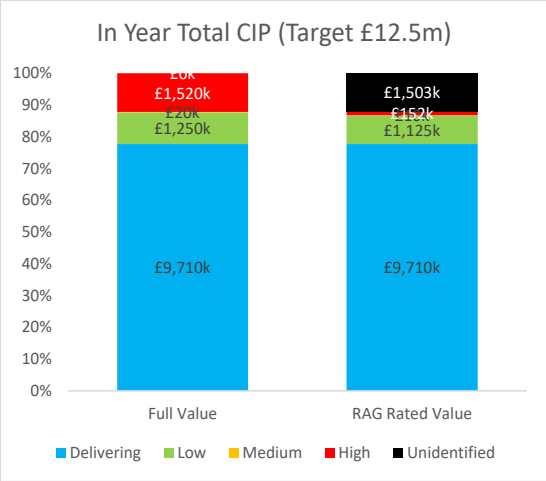
Finance (Capital)

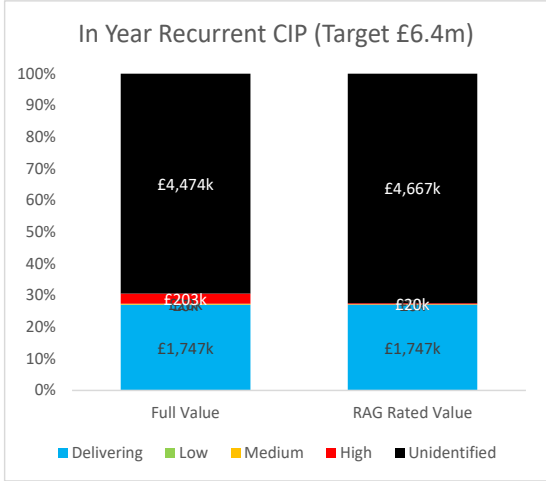


	Original Plan	Revision	Revised plan/ forecast		Year to date- original plan	Year to date - actual	Year to date - variance
	Apr-23 £k	£k	o/s £k		£k	£k	£k
Annual depreciation charge 2023-24	**21,370**	**2,000**	**23,370**		**12,466**	**13,700**	**(1,234)**
GM capital plan control total - Trust own cash	**19,820**	**392**	**20,212**		**13,291**	**10,031**	**3,260**
PDC capital funded schemes	**10,083**	**525**	**10,608**		**8,200**	**3,825**	**4,375**
Loan and lease funded schemes	**686**	**(686)**	**0**		**0**	**0**	**0**
Total annual capital programme under CDEL	**30,589**	**231**	**30,820**		**21,491**	**13,856**	**7,635**
ASIC development	**0**	**0**	**0**		**0**	**0**	**0**
Art room refurbishment	**0**	**150**	**150**		**0**	**39**	**(39)**
Charity funded programme	**0**	**150**	**150**		**0**	**39**	**(39)**
Total Trust Annual Capital Programme	**30,589**	**381**	**30,970**		**21,491**	**13,895**	**7,596**

Performance to month 9 was £7,596k below the original plan submitted to NHSE&I in April 23. Whilst there is slippage on some schemes including the TIF Ward, other projects are ahead of plan.
The Trust has incurred £13,895k on capital schemes to month 9, primarily on the backlog maintenance programme, the linear accelerators and CT scanner replacements, Digital Services Electronic Health Records projects, final works on the Paterson scheme, the Proton treatment planning system and the TIF ward refurbishment. This includes £39k capital expenditure on the charity funded Art Room refurbishment.
All Providers within GM have agreed to reduce annual capital spend against original plans by a proportionate amount as the original GM ICS plan was oversubscribed. The impact of this is a £3.6m reduction to original forecast planned capital spend for the Christie. This is now offset by a potential additional £4m increase to our plan for additional spend on the TIF ward scheme currently being finalised with GM

Finance (CIP)





Total In year CIP

- Total identified CIP schemes reported are £12.5m (£10.6m non recurrent / £1.9m recurrent).
- Risk adjusted identified schemes value £11m leaving £1.5m unidentified.

Recurrent

- Schemes totalling £2m have been identified recurrently against a recurrent target of £6.4m.
- This leaves £4.5m of the recurrent target unidentified, this increases to £4.7m when risk adjusted.

	Annual					Year to Date		
	Target	Identified value	Unidentified Value	Identified RAG Value	Unidentified RAG Value	Target	Delivered	Unidentified
Total CIP	**£12,500k**	**£12,500k**	**£0k**	£10,997k	(£1,503k)	**£9,375k**	**£9,374k**	**(£0k)**
Recurrent CIP	£6,445k	£1,970k	(£4,474k)	£1,777k	(£4,667k)	£4,833k	£1,411k	(£3,422k)
Non-Recurrent CIP	£6,055k	£10,529k	£4,474k	£9,220k	£3,165k	£4,541k	£7,963k	£3,422k

The Christie NHS Foundation Trust

Meeting of the Board of Directors

Thursday 25th January 2024

Subject / Title	Patient Safety Incident Response (PSIRF) Plan Update
Author(s)	Patient Safety Team
Summary / purpose of paper	To provide Board with sight of the PSIRF plan and policy that has been through the Trust governance structures and has been approved by the Quality Assurance Committee at its January 2024 meeting on behalf of the Board.
Recommendation(s)	For information.
Background papers	N/A
Risk score	Board Assurance Framework – Risk 1.1
Link to: ➢ Trust strategy ➢ Corporate objectives	• 1. To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer.
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	• PSIRP - Patient Safety Incident Response Plan • PSS - Patient Safety Strategy • PSIRF - Patient Safety Incident Response Framework • PSLRs - Patient Safety Learning Responses • PSIIs - Patient Safety Incident Investigations

Patient safety incident response plan

Effective date:

Estimated refresh date:

	NAME	TITLE	SIGNATURE	DATE
Author	**Patient Safety Team**			
Reviewer				
Authoriser				

Contents

Introduction to the Patient Safety Incident Response Framework

Purpose

This Patient Safety Incident Response Plan (PSIRP) sets out how The Christie NHS Foundation Trust intends to respond to patient safety incidents over a period of 12 to 18 months from April 2024. The plan is not a permanent rule that cannot be changed, and we acknowledge the challenge that this fundamental shift in approach brings with it. As an organisation we will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of the people affected.

The NHS Patient Safety Strategy (PSS) was published in July 2019 and describes the Patient Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework 2015 (SIF). This document is the Patient Safety Incident Response Plan (PSIRP). It describes what we have done at The Christie NHS Foundation Trust to prepare to “go live” with PSIRF.

The Serious Incident Framework (2015) provided structure and guidance on how to identify, report and investigate an incident resulting in severe harm or death. PSIRF, on the other hand, is best considered as a learning and improvement framework with an emphasis on the system and culture. One of the underpinning principles of PSIRF is to undertake fewer “investigations” and deploy resource to improving systems and processes; this means taking the time to conduct systems-based investigations by people that have been trained to do them. The Patient Safety Strategy challenges everyone to think differently about learning and what it means for our organisation. This Patient Safety Incident Response Plan (PSIRP) sets out how The Christie will respond to patient safety incidents reported by staff and patients, their families, and carers as part of work to continually improve Patient Safety Learning Responses (PSLRs) by:

- Refocusing Patient Safety Learning Responses towards a system analysis approach and the rigorous identification of factors and system issues

- Focusing on addressing these causal factors and the use of improvement sciences to prevent or continuously and measurably reduce repeated patient safety risks and incidents.
- Transferring the emphasis from the quantity to the quality of PSIIs such that it increases our stakeholders' (notably patients, families, carers, and staff) confidence in the improvement of patient safety through learning from incidents.
- Acting proportionately to incidents and risks, ensuring a compassionate and engaged response is taken with affected parties whilst aiming to release resource from investigation processes to improvement programmes and work streams.

Scope

This document covers responses conducted solely for the purpose of system learning and improvement. There is no remit within this plan or PSIRF to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Therefore, other processes and governance is outside of the scope of this document for example.

- Inquests
- HR issues
- Professional Conduct
- Complaints
- Claims
- PALS
- Freedom to Speak Up

The principal aims of each of the above responses differ from the aims of a patient safety response and are outside the scope of this plan.

This plan explains the scope for a systems-based approach to learning from Patient Safety Incidents (PSIs). We will identify incidents to review through nationally and locally defined patient safety priorities. An analysis of which is explained later within this document.

Responses covered in this plan include:

• Patient Safety Learning Responses (PSLRs)

• Patient Safety Incident Investigations (PSIIs)

Our safety culture

As a Trust, The Christie have endeavoured to approach incident investigations with a focus on learning for improvement, seeking to adopt a restorative just culture within the organisation.

We recognise a culture of strong psychological safety underpins openness and transparency in incident reporting and promotes respectful investigations with meaningful system-based learning. The Christie encourages the reporting of incidents where any member of staff feels something has happened, or there is a risk, which has led to, or may lead to, harm to patients or staff.

Engagement and involvement in patient safety incidents

PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, and staff).

We are committed to continuously improving the care and services we provide. We want to learn from any incident where care does not go as planned or expected by our patients, their families, or carers to prevent recurrence.

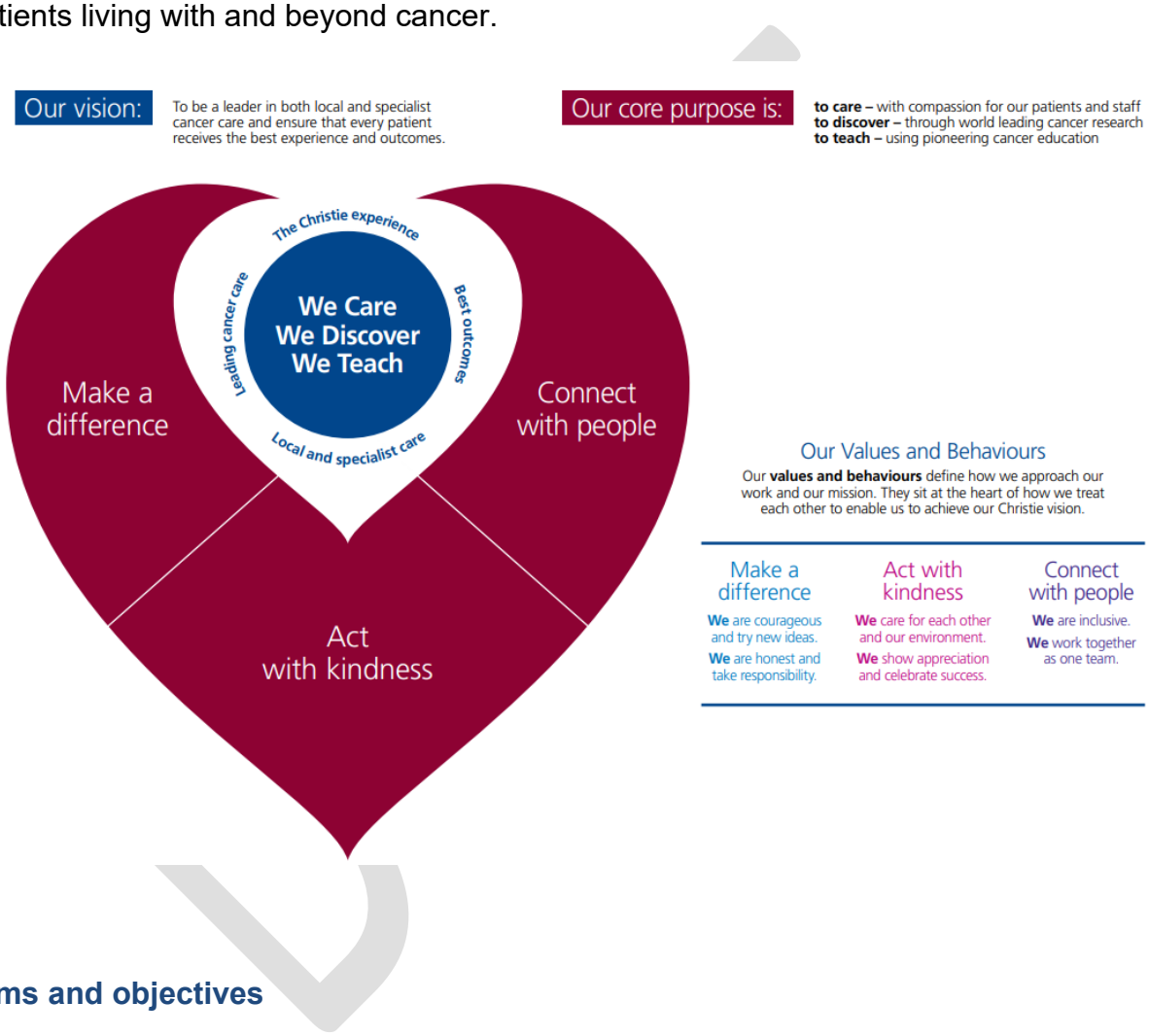
We recognise and acknowledge the significant impact patient safety incidents can have on patients, their families, and carers.

Getting involvement right with patients and families in how we respond to incidents is crucial, particularly to support improving the safety of the services we provide. Where staff are engaging in learning responses, guidance documents will be available to ensure they understand and are supported throughout the process.

Our Values

The Christie Trust Values

The Christie NHS Foundation Trust aims to demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer.



Aims and objectives

The implementation of PSIRF will incorporate the four strategic aims of the PSIRF upon which this plan is based, the overarching aims and how these will be achieved through specific objectives (see Table 1), and our Trust visions embodied in our work.

Table 1

PSIRF, Strategic Objectives and Values & Behaviours		
To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer.		
PSIRF Aims	**Aim Description**	**Christie Values**
Compassionate engagement and involvement of those affected by patient safety incidents	When a patient safety incident investigation (PSII) or other learning response is undertaken, organisations should meaningfully involve those affected, where they wish to be involved.	Connect with People, We are Inclusive, We work as one team
Application of a range of system-based approaches to learning from patient safety incidents	Organisations are encouraged to use the national system-based learning response tools and guides, or system-based equivalents, to explore the contributory factors to a patient safety incident or cluster of incidents, and to inform improvement.	Make a Difference, We are Courageous and try new ideas
Considered and proportionate responses to patient safety incidents	Some patient safety incidents, such as Never Events and deaths thought more likely than not due to problems in care (that is, those meeting the Learning from Deaths criteria for investigation) all require a PSII to learn and improve. Some incident types will also require specific reporting and/or review processes to be followed.	We are honest and take responsibility
Supportive oversight focused on strengthening response system functioning and improvement	All healthcare organisations providing and overseeing NHS-funded care must work collaboratively, with a mutual understanding of the aims of this framework, to provide an effective governance structure around the NHS response to patient safety incidents. Adopting a culture of psychological safety within governance and safety reporting.	We act with kindness, we show appreciation and celebrate successes

The Christie services

The Christie NHS Foundation Trust is the largest single cancer centre in Europe, treating over 60,000 patients per year. The trust provides Radiotherapy, systemic anti-cancer therapy (chemotherapy, immunotherapy, trial drugs), specialist surgery and a wide range of diagnostic and supportive services. Proton Beam therapy is also delivered, making the Christie the first NHS trust in the UK to offer this specialised treatment.

The Christie serves a population of 3.2 million across Greater Manchester and Cheshire, at our main Withington site and across satellite sites. As a national specialist in Cancer care, around a quarter of our patients are referred to us from other parts of the country.

The Christie at Home service provides chemotherapy and immunotherapy treatments to patients in their own homes.

Our sites:

- The Christie main site (Withington)
- The Christie at Macclesfield
- The Christie at Oldham
- The Christie at Salford
- Peripheral Outreach clinics (Bolton, Oldham, Wigan, Leighton, Stepping Hill)
- Bloods closer to Home (Winsford, Ashton-under Lyne, Worsley, Cheadle, Oldham, Bury, Bolton, Altrincham)

A trust wide review of our divisions and services was conducted to support our understanding of the scope of PSIRF. The services and their relevant divisions have been outlined in the below table.

Our divisions and associated services:

Division	Services
Network Services	• Clinical Oncology • Medical Oncology • Referrals and bookings • Haematology Services • Teenage/Young Adult Oncology • Metastatic Spinal Cord Compression • Systemic anti-cancer treatment services • Outpatient Services • Proton Beam Therapy • Radiotherapy • Pharmacy services • Satellite sites • Medical Physics • Clinical Engineering • Diagnostic Radiology (Physics) • Mechanical Workshop • Medical Illustration • Nuclear Medicine • Radioisotopes • Radiopharmacy • Radiotherapy Physics • Ultrasound Medical Physics
Clinical Support and Specialist Surgery	• Inpatient wards • Acute ambulatory care • Critical Care/acute oncology Outreach • Chaplaincy • Complex Discharge • Complementary Therapies • Endocrinology • Hospital at night team • Health Records / Central Admin • Integrated Procedures Unit/procedure team • Surgical admissions • Radiology Services • Interpreter service & Transport • Nutrition & Dietetics • Critical Care Unit • Patient Flow / Bed Management • Pre-op Assessment • Rehabilitation • Surgical Theatres • Anaesthetic • Supportive Care • Psycho-Oncology

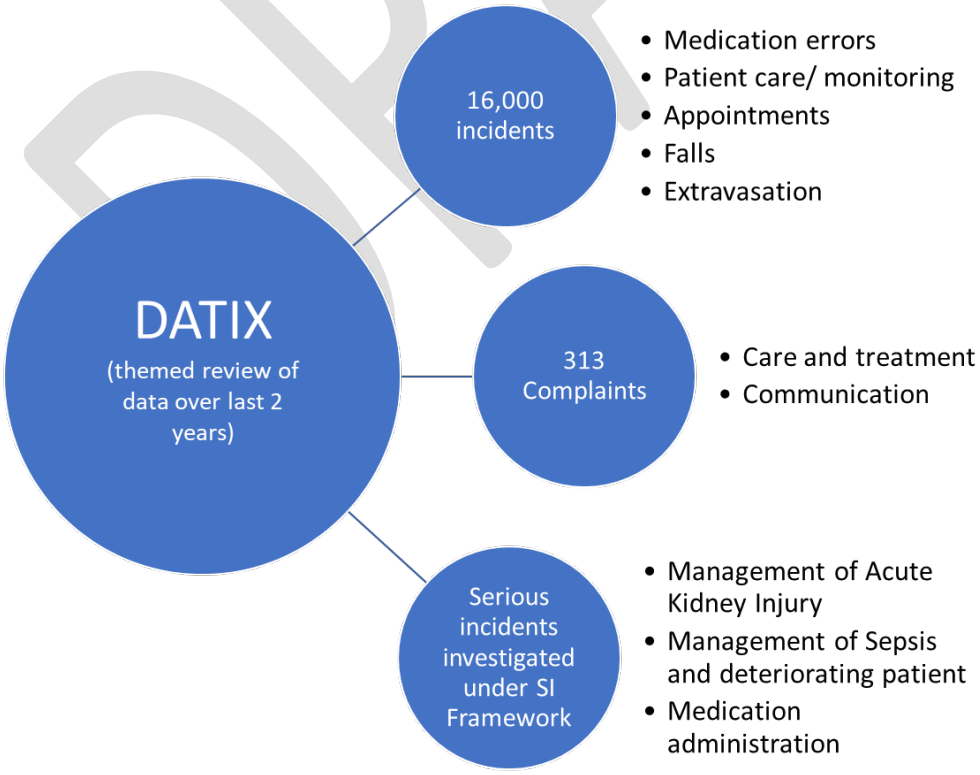
Research and Innovation	• Clinical Research Facility • Clinical Trials Unit • Disease specific research teams • Biobank • Research teams • Central Research • Patient recruitment
Corporate	• Patient experience, quality, and complaints • Patient Safety • Infection prevention and control • Tissue Viability • Sepsis • Safeguarding • Quality Improvement and Clinical Audit • Freedom to speak up • Health and Safety • Performance • Finance • Workforce • Human Resources
Corporate Development	• Occupational Health • Communications • Engagement • Marketing
Digital Services	• Applications • Analytics & Statistics • Business Intelligence • Clinical Data Capture • Cyber Security • Information Governance • Infrastructure • Software Development/Solutions/CWP • Techbar support
Capital Estates & Facilities	• Capital/ facilities projects • Soft Facilities • Hard Facilities • Site services
Christie Pathology Partnership	• Bereavement services • Blood sciences • Oncology genetics • Pathology • Histopathology • Haematology • Biochemistry • Blood Transfusion Lab
School of Oncology	• Education • Education Centre • Clinical Skills Team • Medical Library

Defining our patient safety incident profile

To successfully define our patient safety incident profile, it was imperative to first understand key risks and patient safety issues most pertinent to us from varied sources of available data. Our approach to defining our incident profile is described below:

Data Sources

A themed analysis of data within our Local Incident Reporting System (DATIX) was conducted. This highlighted the key themes within incidents and complaints that were received over the past 2 years. In addition to this we reviewed incidents that met the Serious Incident Framework and were investigated and reported to STEIS (external reporting system). The data breakdown is shown in the diagram below. We also supported this DATIX analysis with anecdotal evidence gathered from various engagement activity, including our Friday Focus group (bimonthly meeting to share learning). Advice was also sought from subject matter experts, e.g. clinical nurse specialists, pharmacy teams etc. to further support our Patient Safety Priorities.



Stakeholder Engagement

A variety of stakeholders were approached to give insight to areas of concern regarding risk to patient safety. Included in engagement were divisional governance leads, committee groups, complaints and claims team, and subject matter experts . Anecdotal insight was also sourced from 'frontline' staff via qualitative care audits and feedback in response to incidents. We will continue to engage our staff with the assistance of Patient Safety Champions within a variety of areas across the Trust. These members of staff will, with support from the Patient Safety Team, work to enhance our patient safety culture, embed core PSIRF principles and share trust wide learning.

From our data analysis and stakeholder engagement, the following patient safety priorities were identified and agreed. These priorities will be a focus for incident responses and safety improvement over the next 12-18 months from April 2024.

Identified priority	Description	Source of Evidence / Data
Reduction of inpatient falls which lead to injury.	Whilst an inpatient resulting in long bone fracture	Complaints, Incidents, falls committee
Management of the deteriorating Patient	Delay/ failure to recognise and treat deterioration resulting in escalation to level 2 care.	Incidents, anecdotal evidence, mortality reviews.
The identification and management of Acute Kidney Injury.	Failed recognition and response resulting in escalation to level 2 care.	Incidents, AKI Nurse Specialist, Anecdotal
The identification and management of signs of Sepsis	1 Hour ABX Breach/ inappropriate management of signs of sepsis resulting in escalation to level 2 care.	Incidents, Sepsis Nurse Specialist, Anecdotal
Tissue Viability – Acquisition or Deterioration as an inpatient	Local Priority	Incidents, Clinical Records Data, TVN lead, complaints.
Infection Prevention & Control - HOHAI	Hospital onset, Hospital acquired C. difficile infections. Hospital onset, Hospital acquired MRSA blood stream infections	Incidents, Clinical Records Data, IPC lead Nurse
Extravasation of systemic anti-cancer treatment.	Local oncology Specific priority	Incident data
Disability	National priority	National Priority
Medicines Safety	Reducing medication administration errors.	Incidents, Anecdotal, serious incident investigations, complaints.
Patient's 'lost to Follow Up' post treatment resulting in moderate + harm	Reduction in incidents regarding lack of follow up during patient treatment pathway	Risk Register, Incidents, Complaints, Patient Feedback
Safe transfusion administration	Failure to follow transfusion policy- proportionate learning response applied	Risk Register, Incidents, SI
Never Event	As defined in the national Never Event List 2018.	Incidents
Death	National - Where an incident has or is thought to have in the opinion of a medical professional resulted in the death of a service user	MSG Process

Defining our patient safety improvement profile

The Christie Patient Safety Priorities were defined and mapped against our current patient safety related improvement workstreams. The table below outlines the existing workstreams within the organisation and those planned to meet the requirements of PSIRF and to progress our patient safety improvements.

Workstream	Purpose
Existing workstreams	
Falls prevention group	Monitoring of falls per 1000 bed days Themed reviews of monthly falls to support improvement plans
Medicines and Transfusion Safety Group	Joint group for blood transfusion and medicines management Assess themes from incidents to support improvement plans and actions
SACT incidents group reviews extravasation incidents	Review of Extravasation incidents to provide shared learning and future improvements
Infection Prevention and Control Committee	Committee to oversee standards of practice within Infection Prevention and Control Thematic analysis of incidents, reviews, and outbreaks to enable future learning
Lost to follow up/open referrals group	Monitoring of agreed actions to reduce risk of patients being lost to follow up Reviewing incidents relating to 'lost to follow up' to support improvement plans.
Planned workstreams	
Fundamentals of care- Falls (incorporate existing Falls Prevention Group) Tissue Viability	Analysis of recurring themes from various patient safety sources- incidents, complaints, learning responses. Development of system based actions to support sustainable improvement.

	Monitoring of ongoing system based actions
Acute Oncology Group- Deteriorating patient Acute Kidney Injury Sepsis recognition and management	Analysis of recurring themes from various patient safety sources- incidents, complaints, learning responses. Development of system based actions to support sustainable improvement. Monitoring of ongoing system based actions
Medicines and Transfusion Safety Group **(continued)**	Joint group for blood transfusion and medicines management Assess themes from incidents to support improvement plans and actions
Infection Prevention and Control Committee **(continued)**	Committee to oversee standards of practice within Infection Prevention and Control Thematic analysis of incidents, reviews, and outbreaks to enable future learning
SACT incidents group reviews extravasation incidents **(continued)**	Review of Extravasation incidents to provide shared learning and future improvements

Our patient safety incident response plan: national requirements

The national requirements are outline below with the required responses as per PSIRF guidance.

	Patient Safety Incident Type	Required Response	Anticipated Improvement Route
	National Patient Safety Priorities		
Events requiring a specific type of response as set out in policies or regulations	**Incidents meeting Never Event criteria**	PSII	Create local organisational actions and feed these into the quality improvement workstreams
	Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs)		
	Death of a person with a learning disability/ neurodiversity more likely than not due to problems in care		
	Child deaths	Refer for child death overview panel review	
	Death of a person with a learning disability	Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this	National LeDeR team notification
	Safeguarding incidents in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/ violence • adults (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead Healthcare Organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	

Our patient safety incident response plan: local focus

The guidance in this table outlines the advised learning responses based on criteria within each patient safety profile. The type of response will also depend on:

- the views of those affected, including patients and their families
- capacity available to undertake a learning response
- what is known about the factors that lead to the incident(s)
- whether improvement work is underway to address the identified contributory factors
- whether there is evidence that improvement work is having the intended effect/benefit
- if an organisation and its ICB are satisfied risks are being appropriately managed

	Patient Safety Incident Type	Required Response	Anticipated Improvement Route
Consideration of PSII by Divisional PSIG	**Sepsis** Failed recognition and/or treatment of sepsis resulting in deterioration	Multidisciplinary Team Review under Divisional PSIG PSII if prompted by Divisional PSIG	Create local and organisational actions and feed these into the **Patient Safety Priority Improvement Group (PSPIG) Acute Oncology**
	Infection Prevention & Control COHA/ HOHA, Clostridium Difficile (toxin positive) MRSA BSI	PIR	NIPR
	Transfusion Failure to follow correct transfusion policy (including near miss)	After Action Review/ Rapid Review	Create local and organisational actions and feed these into the **Patient Safety Priority Improvement Group (PSPIG) Medicines and Transfusion Safety**
	Falls Fall whilst inpatient resulting in long bone fracture Falls resulting in major harm to individual	After Action Review– to determine if fall preventable Unpreventable fall- learning through Falls Prevention Group Preventable- PSII	Learning and actions to support **Patient Safety Improvement Group (PSPIG) Fundamentals of Care**
	Extravasation Extravasation resulting in severe harm to individual	SWARM for immediate reflection and shared learning After Action review if requested by Divisional PSIG PSII if requested by Divisional PSIG	Create local and organisational actions and feed these into the **Patient Safety Priority Improvement Group (PSPIG) Extravasation**
	Lost to follow up/ open referrals Lost to follow up/ open referral that has resulted in a significant delay to an individual	After Action review if requested by Divisional PSIG PSII if requested by Divisional PSIG	Create local and organisational actions and feed these into the **Patient Safety Priority Improvement Group (PSPIG) Lost to follow up/ open referrals**
Local divisional management	**Other incidents which have resulted in moderate to severe harm or a near miss where there is potential for wider learning**	Duty of Candour Divisional PSIG assessment: MDT Review/ AAR/ PSII	Relevant improvement workstream Shared learning at SCOPE
	Other incidents/ prevalent themes which have resulted in minor or no harm but there is potential for wider learning	Themed review by area Rapid review	Local action plans and improvements Shared learning at Quality and Safety Group

The Christie
NHS Foundation Trust

PATIENT SAFETY INCIDENT RESPONSE POLICY

Document reference:	tbc	Version:	V01
Accountable committee (document owner):		Risk and Quality Governance Committee	
Date approved by accountable committee:	tbc	Document author:	Patient Safety Specialist
Ratified by:	Documentation Ratification Committee	Date ratified:	tbc
Date issued:	tbc	Review date:	tbc
Target audience:	All staff	Equality and Health Inequality Analysis	tbc

Key points

To outline the approach of The Christie to implementing the Patient Safety Incident Response Framework, including:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents
- Supportive Oversight focused on strengthening response system functioning and improvement

CONTENTS

1. ASSOCIATED DOCUMENTS

Duty of Candour Policy
Patient Safety Incident Response Plan (link)
Risk management strategy and policy
Freedom to speak up

2. INTRODUCTION

2.1 Statement of intent

The Patient Safety Incident Response Framework represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS. It is a key part of the NHS patient safety strategy.

PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of system-based approached to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement

The Board of Directors is committed to ensuring that:

- the safety of patients, staff, visitors are maintained.
- effective reporting of near misses and untoward incidents takes place.
- Meaningful learning happens, and system-based changes are made to mitigate future similar incidents.
- a culture exists where staff can freely express their concerns in the interest of patient safety.

2.2 Equality and Health Inequality Analysis

As part of its development, this policy was analysed to consider its impact on different groups protected from discrimination by the Equality Act 2010. The requirement is to consider if there are any unintended impact for some groups, and to consider if the policy will minimise discrimination for all protected groups in accessing services across the Trust.

This analysis has been undertaken and recorded using the Trust's Equality and Health Inequality Analysis (EHIA) toolkit, and appropriate measures incorporated to remove barriers and advance equality in the delivery of this policy.

2.3 Greener NHS

This policy has been developed in line with the statutory requirement to progress towards net zero carbon. As a result, the document is designed to be used electronically in order to reduce paper waste (example statement that may be used).

2.4 Values and Behaviours

Our Trust's Values and Behaviours define how we approach our work and treat each other and sits alongside what we do. It applies to all colleagues and outlines the behaviours that is required when we interact with each other, our patients, and our visitors.

2.5 PURPOSE

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out how The Christie NHS Foundation Trust (the Trust) will approach the development and maintenance of effective systems and

processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety across our services.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management as an integral aspect to operational processes across the Trust.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF and which we can align to our Trust values and behaviours.

This policy should be read in conjunction with our current patient safety incident response plan, which is a separate document setting out how this policy will be implemented (see associated documents).

2.6 SCOPE

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across the Trust.

Responses under this policy follow a systems-based approach. This recognises that safety is provided by interactions between components of the system and not from a single component.

Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

Where other investigative processes exist with a remit of determining liability or to apportion responsibility for acts or omissions, or cause of death, their principal aims differ from a patient safety incident response; are therefore outside of the scope of this policy;

- claims handling,
- human resources investigations into employment concerns,
- professional standards investigations,
- information governance concerns
- estates and facilities concerns
- financial investigations and audits
- safeguarding concerns
- coronial inquests and criminal investigations
- mortality reviews
- complaints (except where a significant patient safety concern is highlighted)

For clarity, the Trust considers these processes as separate from any patient safety incident response., However, Information from a patient safety incident response process can be shared with those leading other types of investigation, but these other processes, and their findings, should not influence the remit of a patient safety incident response and its subsequent recommendations for improving patient safety in a given area.

3. DEFINITIONS

Term	Meaning

Chief Executive	The person who has delegated responsibility from the Board of Directors for the management of governance arrangements within the Trust and is ultimately responsible for ensuring that the Trust meets its obligations with regards to the safe and effective delivery of services. This is delegated to responsible individuals within the Trust.
Clinician	A qualified medically trained doctor, nurse, allied health professional or pharmacist
The Patient Safety Incident Response Framework (PSIRF)	PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.
Patient safety learning response Learning response	The Patient Safety Incident Response Framework (PSIRF) promotes a range of system-based approaches for learning from patient safety incidents. National tools have been developed which trust's should utilise to explore the contributory factors to a patient safety incident or cluster of incidents, and to inform improvement.
Patient Safety Incident Investigation (PSII)	- An in-depth review of a single patient safety incident or cluster of events to understand what happened and how. Utilised where there has been serious harm to patients
The Patient Safety Partner (PSP)	is a new and evolving role developed by NHS England to help improve patient safety across the NHS. PSPs can be patients, carers, family members or other lay people (including NHS staff from another organisation)
Patient	A person who is receiving medical care from the Christie.
Treatment	The application of medicines, surgery etc to a patient, the care and management of a patient in order to combat, ameliorate or prevent a disease, disorder or injury.
Trust	The Christie NHS Foundation Trust
Patient Safety Incident	Any unintended or unexpected incident that could have led or did lead to harm for one or more patients receiving NHS funded care
Incident	An unplanned, unintended event or circumstance which caused actual or potential damage, loss or harm to a patient, staff, visitor or member of the public. It may be clinical in origin, (i.e. relating to the direct care of a patient) or non-clinical (i.e. property or financial loss, theft, fire, verbal abuse or threatening behaviour).

4. DUTIES

4.1 Board of Directors

The Board is responsible for ensuring that a framework is in place to support the reporting and investigation of incidents and near misses in line with the Patient Safety Incident Response Framework.

4.1.1 Chief executive

The chief executive has overall accountability for patient safety and therefore this policy. Responsibility for ensuring compliance with this policy is delegated to the executive directors, who must ensure that all their staff are informed of the need to

report incidents and that all incidents, complaints, or claims are investigated and managed effectively and appropriately.

4.2 Senior manager and individuals as applicable

4.2.1 Executive Chief Nurse and Director of Quality/Medical Director

Responsible for:

- Ensuring the executive directors and chief executive receives effective communication of the progress and outcome of patient safety learning responses and safety improvement work internally and with our external stakeholders such as the NHSE Specialist Commissioner, Integrated Care Board and the CQC.
- Informing the executive directors of any suspected criminal or malicious activity and, following consultation, inform the police where necessary.
- Ensuring key learning points are disseminated through the appropriate forums and committees, including the board of directors.
- Promote the trust patient safety culture
- Ensure the organisation meets national patient safety incident response standard
- Ensure PSIRF is central to overarching safety governance arrangement
- Quality assure learning response outputs (PSII)

4.2.2 Associate Chief Nurse and Associate Medical Director for Quality and Patient Safety

To support the Chief Nurse and Medical Director with oversight of patient safety activity within the Trust
To support the Patient Safety Specialist and Patient Safety team to promote continuous improvement and and compassionate engagement in patient safety improvements
To support the PSIRF Delivery Group (Associate Chief Nurse to Chair)
Promote the trust patient safety culture
Ensure the organisation meets national patient safety incident response standard

4.2.3 Patient Safety Specialist

- Lead and support local implementation of the NHS Patient Safety Strategy
- PSSs lead and directly support, patient safety ‘insight’, ‘involvement’ and ‘improvement’ activity and ensure that systems thinking, human factors understanding and just culture principles are embedded in all patient safety processes.
- Support other leads in the organisation in ensuring that all staff are trained in Level 1 of the NHS patient safety syllabus
- Work closely and collaboratively with those within their organisation who have specific patient safety responsibilities, including at operational level
- Support and advise Executive Directors, and Trust Board on matters of patient safety and process

4.2.4 Divisional associate chief nurse

- Oversight and governance of the local management of incidents
- Oversight of patient safety incident responses and improvements
- Ensure compliance with Duty of Candour guidelines and policy
- Chair Divisional Patient Safety Improvement Group on a weekly basis to review moderate + harm incidents as well as emergent incident themes/concerns

- Ensure the involvement and engagement of staff and patients in incident investigations
- Ensure compliance with patient safety training requirements amongst nursing staff
- Ensure the dissemination of learning, both locally and trust-wide
- Provide assurance to the PSIRF delivery group regarding ongoing divisional learning responses, action plans, recommendations and emerging themes
- Promote the trust patient safety culture

4.2.5 Divisional Directors

- Oversight of divisional incidents/ emerging themes/concerns
- Oversight of patient safety incident responses and improvements
- Support compliance with Duty of Candour guidelines and policy.
- Assist the chair of divisional Patient Safety Improvement Group to review moderate + harm incidents as well as emergent incident themes/concerns
- Ensure the involvement and engagement of staff and patients in incident investigations
- Ensure compliance with patient safety training requirements
- Ensure the dissemination of learning, both locally and trust-wide
- Provide assurance to the PSIRF delivery group regarding ongoing divisional learning responses, action plans, recommendations and emerging themes
- Promote the trust patient safety culture

4.2.6 Divisional Associate medical director

- Oversight of divisional incidents/ emerging themes/concerns
- Oversight of patient safety incident responses and improvements
- Ensure compliance with Duty of Candour guidelines and policy.
- Assist the chair of divisional Patient Safety Improvement Group to review moderate + harm incidents as well as emergent incident themes/concerns
- Ensure the involvement and engagement of staff and patients in incident investigations
- Ensure compliance with patient safety training requirements amongst medical staff
- Ensure the dissemination of learning, both locally and trust-wide
- Provide assurance to the PSIRF delivery group regarding ongoing divisional learning responses, action plans, recommendations and emerging themes
- Promote the trust patient safety culture

4.2.7 Patient safety team

- Review divisional learning response decision making and agree terms of reference
- Assign patient safety incident investigation (PSII) leads
- Review recommendations from learning responses to develop safety action plans to support ongoing improvement work
- Undertake regular audits of PSIRF process to support successful implementation
- Provide assurance to the Executive Review Group regarding ongoing divisional learning responses, action plans, recommendations and emerging themes
- Promote the trust patient safety culture

- Monitor trust compliance with incident management, duty of candour, safety action plans and training
- Support all employees with the escalation of concerns
- Support the safety improvement plans for patient safety priorities

4.2.8 Divisional governance teams

- Oversight and governance of the local management of incidents
- Oversight of patient safety incident responses and improvements
- Ensure compliance with Duty of Candour guidelines and policy
- Participate in the Divisional Patient Safety Improvement Group on a weekly basis to review moderate + harm incidents as well as emergent incident themes/concerns
- Ensure the involvement and engagement of staff and patients in incident investigations
- Ensure compliance with patient safety training requirements
- Ensure the dissemination of learning, both locally and trust-wide
- Promote the trust patient safety culture

4.2.9 All staff

All Trust employees, whether permanent, temporary or working under an honorary contract, have a duty to report something that has happened that is:

- contrary to the trust's specified standards of care,
- an individual has been or could have been injured,
- an incident that places or has placed individuals at unnecessary risk or
- an incident that could put the trust in an adverse legal or media situation.

Any member of staff who is involved in, witnesses, or discovers an incident or near miss must:

- ensure that the situation is made safe and the relevant manager is informed of the incident or near miss.
- complete an incident report form within 48 hours of knowledge of the incident, accurately completing the appropriate sections within the incident report form and provide a reason if not reported within 48 hours
- assist with any incident investigation and take all reasonable steps to minimise risks
- Work in line with trust values and behaviours, upholding a positive patient safety culture

4.3 Committees in level of hierarchy

4.3.1 Quality Assurance Committee

The Quality assurance committee will assess trust performance regarding patient safety from cross-examination of the following reports:

- Patient Safety Incident Panels reports
- Quarterly update of Patient Safety improvement workstreams, aligned to Patient Safety Profile

4.3.2 Risk and Quality Governance Committee

The Risk and Quality Governance Committee will provide information and assurances to the board of directors that The Christie is safely managing all issues relating to patient safety and risk.

The committee receives a monthly report on progress of agreed actions and/or recommendations from patient safety incident investigations as well as assurance of improvement group/ workstream progress and safety action plans.

4.3.3 Patient safety committee

The Patient Safety Committee will monitor the progress of improvement groups/workstreams relating to local and national patient safety priorities and ensure that any issues are escalated appropriately to the Risk and Quality Governance Committee. Improvement groups/workstreams will report directly into this committee to gain support and give assurance. This committee will review the trust patient safety profile and priorities on a quarterly basis.

5. PATIENT SAFETY INCIDENCE RESPONSE FRAMEWORK

5.1 Our patient safety culture

As a Trust, The Christie have endeavoured to approach incident investigations with openness, transparency, and with a focus on learning for improvement, seeking to adopt a restorative just culture within the organisation.

The main goals of restoration when an incident has happened have been outlined as follows:

- Moral engagement
- Emotional healing
- Reintegration of the practitioner
- Organisational learning
- Prevention

PSIRF will enhance these by creating much stronger links between a patient safety incident and learning for improvement.

We recognise a culture of strong psychological safety underpins openness and transparency in incident reporting and promotes respectful investigations with meaningful system-based learning. We encourage the reporting of incidents where any member of staff feels something has happened, or there is a risk, which has led to, or may lead to, harm to patients or staff.

We aim to work in collaboration with those affected by a patient safety incident – staff, patients, families, and carers to arrive at learning and improvement within the culture we strive for. This will continue to increase transparency and openness amongst our staff in reporting of incidents and engagement in establishing learning and improvements that follow.

We are clear that patient safety incident responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk. Specifically, they are not to apportion blame or liability of an individual or the organisation.

Our safety culture has also progressed in a positive way with reporting of patient safety incidents improving over time. The introduction of a new incident management system, Datix Cloud IQ, (DCIQ), in 2024 which will simplify internal reporting for staff whilst improving our insight into themes and trends. The introduction of Datix Cloud IQ will enable staff to report incidences of 'good care' assisting in learning from episodes which have gone well or better than expected.

We will utilise findings from our staff survey metrics based on specific patient (and staff) safety questions to assess if we are sustaining our ongoing progress in improving our safety culture. As a Trust, The Christie have endeavoured to approach incident investigations with a focus on learning for improvement, seeking to adopt a restorative just culture within the organisation.

5.2 Patient safety partners

The Patient Safety Partner (PSP) is a new and evolving role developed by NHS England to help improve patient safety across the NHS in the UK. At The Christie, we are excited to welcome PSPs who will offer support alongside our staff, patients, families/carers to influence and improve safety across our range of services.

PSPs can be patients, carers, family members or other lay people (including NHS staff from another organisation) and this offers a great opportunity to share interests, experiences, and skills to help develop the new PSP role and be a part of our team.

This exciting new role across the NHS will evolve over time and in The Christie the main purpose of the role is to be a voice for the people who use our services and ensure that patient safety is at the forefront of all we do. The PSPs will be supported in their role by the Patient Safety Specialist for the Trust who will provide supervision, guidance, and development for the role.

5.3 Addressing health inequalities

The Trust recognises that the NHS has a core role to play in reducing inequalities in health by improving access to services and tailoring those services around the needs of the local population in an inclusive way.

The Trust is committed to delivering on its statutory obligations under the Equality Act (2010) and will use data intelligently to assess for any disproportionate patient safety risk to patients from across the range of protected characteristics.

The introduction of a new incident management system will allow for the details of patients to be directly drawn from the healthcare record and incidents can then be analysed by protected characteristics to give insight into any apparent inequalities.

Within our patient safety response toolkit, we will directly address if there are any particular features of an incident which indicate:

- health inequalities may have contributed to harm or demonstrate a risk to a particular population group, including all protected characteristics.

- When constructing our safety actions in response to any incident we will consider inequalities, and these will be inbuilt into our documentation and governance processes.

Engagement of patient, families and staff following a patient safety incident is critical to the review of patient safety incidents and our response. We will ensure that we use

available tools such as easy read, translation and interpretation services and other methods as appropriate to meet the needs of those concerned and maximise their potential to be involved in our patient safety incident response.

5.4 Engaging and involving patients, families and staff following a patient safety incident

PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required. We will include this feedback in considering terms of reference for investigations.

We are firmly committed to continuously improving the care and services we provide. We want to learn from any incident where care does not go as planned or expected by our patients, their families, or carers to prevent reoccurrence.

We recognise and acknowledge the significant impact patient safety incidents can have on patients, their families, carers and staff. Getting involvement right with patients , their families and staff in how we respond to incidents is crucial, particularly to support improving the safety of the services we provide.

Part of this involves our key principle of being open, honest and transparent whenever there is a concern about care not being as planned or expected.
As well as meeting our regulatory and professional requirements for Duty of Candour, we want to be open and transparent with our patients, families, and carers because it is the right thing to do regardless of the level of harm caused by an incident.

As part of our new policy framework, we will be outlining procedures to support patients, families, and carers – based on our existing Duty of Candour Policy (link). This will be underpinned by nominated individuals within our divisions who will assist with family liaison and support families and carers through any investigation or learning review. Patients and their families will be provided information on the learning response process and timelines, as well as contact details for further available support.

Compassionate engagement of staff involved in a patient safety incident is a priority of the trust as we recognise the impact an incident can have on staff, their health and personal/work lives. Through engagement and support of staff we can ensure impactful learning is identified and safety recommendations/actions are considered both on a local and organisational level, with the goal of improving patient and staff safety. Where staff are engaging in learning responses, guidance documents will be available to ensure they understand and are supported throughout the process.

Staff are supported by the trust by a leadership team who promote a culture of psychological safety and are invested in the positive engagement of staff in patient safety incidents. Staff are encouraged to access support available including professional advocates, employee assistance programme, local leadership support, occupational health and staff complementary therapy.

We will continue to engage our staff with the assistance of Patient Safety Champions within a variety of areas across the Trust. These members of staff will, with support from the Patient Safety Team, work to enhance our patient safety culture, embed core PSIRF principles and share trust wide learning.

In addition, in The Christie we have a Patient Advice and Liaison Service (PALS). People with a concern, comment, complaint or compliment about care or any aspect of the Trust services are encouraged to speak with a member of their clinical or ward/department team. Should the clinical or ward/department team be unable to resolve the concern then PALS can provide support and advice to patients, families, carers, and friends. PALS is a free and confidential service and the PALS team act independently of clinical teams when managing patient and family concerns. The PALS service will liaise with staff, managers and, where appropriate, with other relevant organisations to negotiate immediate and prompt solutions.

PALS can help and support with the following:

• advice and information
• comments and suggestions
• compliments and thanks
• informal complaints
• advice about how to make a formal complaint

If the PALS team is unable to answer the questions raised, the team will provide advice in terms of organisations which can be approached to assist.

We recognise that there might also be other forms of support that can help those affected by a Patient Safety incident and will work with patients, families, and carers to signpost to their preferred source for this. Links to available support can be found in appendix 1.

5.5 Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses to arbitrary and subjective definitions of harm or severity.

Beyond nationally set requirements, organisations can explore patient safety incidents relevant to context and the populations they serve rather than only those that meet a certain defined threshold.

The Christie will take a proportionate approach to its response to patient safety incidents to ensure that the focus is on maximising improvement, this marks a fundamental shift in the operational response to a safety event and our collective understanding of how to respond to it.

To fulfil this, we have undertaken planning of our current resource for patient safety responses and our existing improvement workstreams. We have used insight from our patient safety incidents and other data sources both qualitative and quantitative to explore what we know about our safety position and culture; this has formed our Patient Safety Profile and Patient Safety Incident Response Plan.

Our Patient Safety Incident Response Plan 2024 details how this has been achieved as well as how The Christie will meet both national and local priorities for patient safety. This plan represents how we will respond to patient safety incidents over the

next 12-18 month. However, this will remain flexible and will be regularly reviewed. Each patient safety incident will be assessed in light of the specific circumstances in which it occurred, and the needs of those affected

5.51 Resources and training to support patient safety incident response

The Christie has committed to ensuring we fully embed PSIRF and meet its requirements. We have therefore used the NHS England patient safety response standards (2022) to frame the resources and training required to allow for this to happen.

The Trust will have in place governance arrangements to ensure that learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff. undertaken by the most appropriate staff, but not the staff directly involved in the incident. Local learning is a key principle of this policy and our services, specialities and divisions can decide on the most appropriate person to undertake a learning response.

Where the incident meets the threshold for a PSII, the investigator role will be identified through the ERG. Responsibility for the proposal to designate leadership of any other learning response sits within the senior leadership team of the relevant Division. Clinical, Operational and Nursing & AHP leadership will need to work collaboratively to deliver PSIRF principles in their area.

The Trust has governance arrangements in place to ensure that learning responses are not undertaken by staff working in isolation. Divisional Governance leads including the designated member of the senior leadership team and their Governance Manager, will manage the selection of an appropriate learning response lead to ensure the rigour of approach to the review and will maintain records to ensure an equitable allocation.

The Patient Safety team will support learning responses and can provide advice on cross-system and cross-divisional working where this is required.
Those staff affected by patient safety incidents will be provided the necessary support and be given time to participate in learning responses. All Trust managers will work within our just and restorative culture principles and utilise other staff support such as staff advocates to ensure there is a dedicated staff resource to support such engagement and involvement. Divisions will have processes in place to ensure managers work within this framework to ensure psychological safety throughout the organisation.

The Trust will utilise both internal and, if required, external subject matter experts with relevant knowledge and skills, where necessary, throughout the learning response process to provide expertise (e.g., clinical, or human factors review), advice and proofreading.

5.52 Training

The Trust has adopted the E-Learning for Health patient safety training package to ensure that all staff are aware of their responsibilities in reporting and responding to patient safety events and to comply with the NHS England Health Education England Patient Safety Training Syllabus as follows:

Training	Content	Staff Group	Training route	Provider
Patient safety syllabus level 1	Essentials for patient safety	Required for all staff	E-learning	Health Education England
Patient safety syllabus level 2	Access to practice	Recommended for staff managing incidents and undertaking local investigations and/or the following learning responses: • After Action Review • SWARM huddle • MDT review • Themed review	E-learning	Health Education England
Patient safety Investigation lead (PSII)	Systems-based approach to investigations	Recommended for Investigation Lead for PSII	Approximately 20 hours pre-recorded online study session	Health services safety investigations body

5.53 Our patient safety incident response plan

Our plan sets out how the Trust intends to respond to patient safety incidents over a period of 12-18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan. The plan was developed by using a range of data sources:

- Incident data
- Risk data
- Stakeholder engagement
- Complaints

A variety of stakeholders were approached to give insight to areas of concern regarding risk to patient safety. Included in engagement were divisional governance leads, committee groups, complaints and claims team, and subject matter experts . Anecdotal insight was also sourced from 'frontline' staff via qualitative care audits and feedback in response to incidents. Our full plan can be found here (insert link once uploaded)

5.54 Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan in full every 12 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 months. There will also be a

quarterly review of the plan and its effectiveness, which will be reported into Risk and Quality Governance Committee via Patient Safety Committee.

We will continue to assess ourselves against the Patient safety incident response standards, and update our policy accordingly. This will form part of annual reports to Risk and Quality Governance Committee, and Quality Assurance Committee.

Updated plans will be published on our website, replacing the previous version.
A rigorous planning exercise will be undertaken every three years and more frequently if appropriate (as agreed with our Integrated Care Board (ICB) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, Patient Safety Incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

5.6 Responding to patient safety incidents

5.61 Patient safety incident reporting arrangements

Incident report forms should be completed as soon as possible after the incident or near miss has occurred (whilst events can be clearly remembered), and certainly within 48 hours of knowledge of the incident. A reason should be provided if reported beyond 48 hours. This timescale enables timely escalation and assessment of the incidents internally, but also means that the relevant external reporting requirements can also be met. These reports will then be routinely uploaded to Learning from Patient Safety Events platform (LFPSE) to support national learning. Incidents that need to be shared across organisations need to be highlighted to the Patient Safety Team (as per external incident SOP), so that they can be reported and allow for cross- system learning.

5.62 Patient safety incident response decision-making

The Trust will have arrangements in place to allow it to meet the requirements for review of patient safety incidents under PSIRF. Some incidents will require mandatory PSII, others will require review by, or referral to another body or team depending on the event. These are set out in our PSIRF plan (insert link here). Nationally, PSIRF itself sets no further rules or thresholds to determine what method of response should be used to support learning and improvement. The Trust has developed its own response mechanisms to balance the effort between learning through responding to incidents and/ or exploring issues and improvement work. In the work to create our plan we have considered what our incident insight and engagement with key internal and external stakeholders has shown us about our patient safety profile. We have used this intelligence to build our local priorities for PSII and our toolkit for responding to other patient safety incidents.

We have established a process for our response to incidents which allows for a clear ‘Ward to Board’ set of mechanisms allowing for oversight of incident management and our PSIRF response (Fi. 8.2.1).

5.62.1 Divisional Patient Safety Improvement Group (DPSIG)

Oversight and governance of the local management of incidents will be the role of the Divisional Patient Safety Improvement Group (DPSIG). Chaired by a nominated senior lead within the Division e.g The Associate Chief Nurse or equivalent and

supported by the divisional medical director and divisional director as required. The DPSIG should adopt a multidisciplinary approach to local oversight of patient safety incident responses and improvements.

Where it is felt that the opportunity for learning and improvement is significant, regardless of severity or result of the event, incidents should be escalated within the Division
The DPSIG will meet on a weekly basis to discuss the previous week's incidents that have been escalated within division, are moderate and above or those that are considered to meet the thresholds for a learning response as set out in the Patient Safety Incident Response Plan. The group will ensure any mitigation that is needed to prevent recurrence and whether the Statutory Duty of Candour requirement has been met.

Divisions will have review mechanisms in place to ensure that patient safety incidents can be responded to proportionately and in a timely fashion in line with the timeframes detailed in the table (Fig 8.2.2). This should include consideration and prompting to service teams where Duty of Candour applies (see Policy).

Most incidents will only require local review within the management structure of the service(s), this local management of incidents is captured in Datix DCIQ, incident handlers will be assigned within a service or division and for the incident record to be finally approved feedback to the reporter will be mandated.

Where a PSII is not required, the DPSIG will consider any incident as having potential for a learning response. The tool to be utilised for the learning response will be specified and a suitable member of the divisional team allocated to undertake the learning response. The DPSIG will also specify any subject matter expert input required. There will be clear records maintained regarding this decision-making process within the minutes of the DPSIG.

Divisional Patient Safety Improvement Groups (DPSIG) will consider any such incidents for further escalation to the PSIRF Delivery Group, followed by Executive Review Group as per process in Fig 1 below.

5.62.2 PSIRF Delivery Group

The outcomes of the DPSIG for each division will be discussed weekly with the PSIRF Delivery Group. This group will have oversight of the requested learning responses and the outcomes of such reviews to ensure that recommendations are founded on a systems-based approach and safety actions are valid and contribute to existing safety improvement plans or the establishment of such plans where they are required. The PSIRF Delivery Group arrangements will include the recording of safety actions arising from any learning response and these details will be used to inform potential safety improvement plans.

The PSIRF Delivery Group will have overall oversight of such processes and will support & review the decision making of the DPSIGs through quarterly audits. This will ensure that the Executive Review Group and Board can be assured that the intent of PSIRF and its main principles are being implemented within our organisation and meeting the national patient safety incident response standards.

The PSIRF Delivery Group will act as liaison with external bodies and partner providers to ensure effective communication via a single point of contact for the Trust

in relation to external incidents. They will also support cross divisional learning responses and enable shared learning for the purpose of improvement.

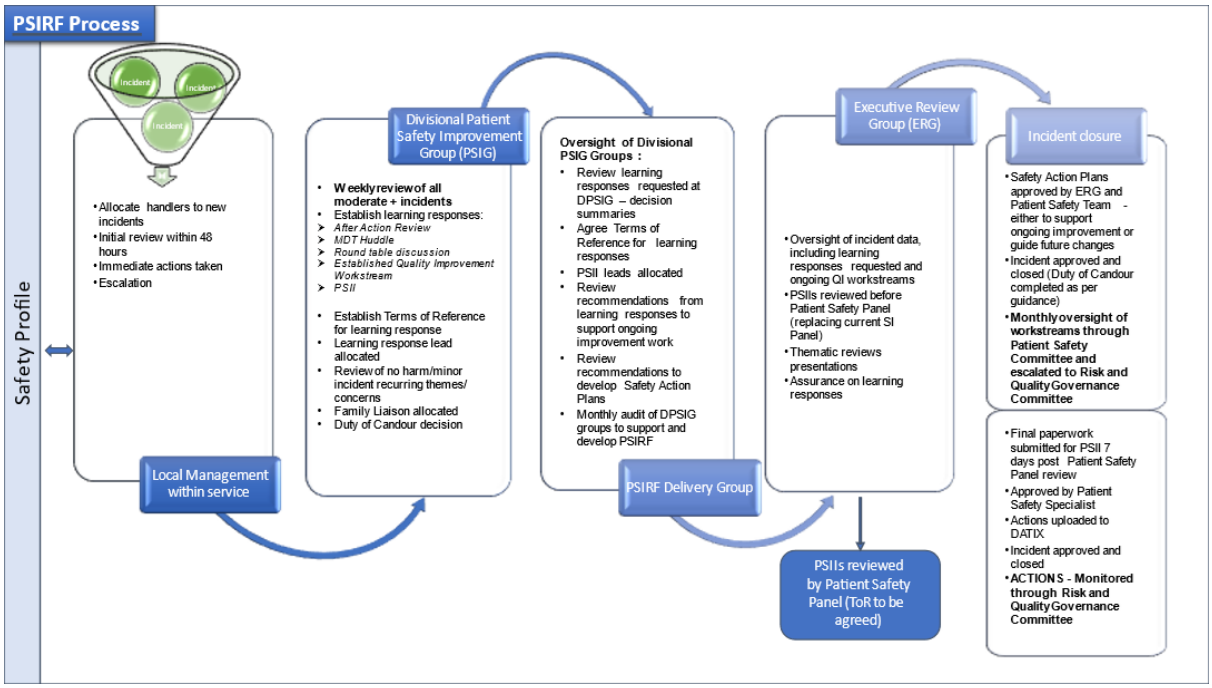
5.62.3 Trust Executive Review Group

The Trust will maintain the Executive Review Group (ERG) to oversee the operation and decision-making of the PSIRF Delivery Group and the incident responses it has delegated responsibility to commission. Patient Safety Learning Responses that highlight recommendations and/or safety actions outside of the Trust patient safety priorities will be reviewed through this group. Through this mechanism the Board will be assured that it meets expected oversight standards but also understands the ongoing and dynamic patient safety improvement profile of The Christie. All incidents that meet PSII threshold will initially be reviewed through the Execute Review Group.

5.62.4 Trust Patient Safety Panel

Incidents that meet the threshold of PSII as described in the PSIRF Plan and through the incident management escalation processes will be finally reviewed by the Trust Patient Safety Panel. This review will confirm the actions and/or recommendations from the PSII and assurance of the plans for ongoing improvement. The actions will be monitored through Risk and Quality Governance Committee once confirmed and through the relevant Patient Safety Improvement Project where applicable.

Fig 1



5.62.5 Incident Guidance and Escalation

Local level incidents:
Managers of all service areas will have arrangements in place to ensure that staff are supported to report and respond to incidents within their area. Incident responses should include immediate actions taken to ensure safety of patients, public and staff,

as well as indication of any measures needed to mitigate a problem until further review is possible. This may include for example, withdrawing equipment or monitoring a procedure. Any response to an incident should be fed back to those involved or affected and appropriate support offered. Where Duty of Candour applies this must be carried out according to Trust guidance (see Policy)
Divisional Patient Safety Improvement Group will have specific delegated powers to commission thematic reviews of such events.

Incidents with positive or unclear potential for PSII
All staff (directly or through their line manager) must ensure notification of incidents that may require a higher level of response as soon as practicable after the event through Divisional escalation processes (including out of hours) and this must include the Divisional Risk and Governance team. Duty of Candour disclosure should take place according to Trust guidance. Where it is clear that a PSII is required (for example, for a Never Event) the Division should notify the Patient Safety team as soon as practicable so that the incident can be shared to executive level staff. The incident will be escalated to Specialist Commissioners and shared externally through LFPSE reporting. A rapid review will be undertaken by the Division to inform decision making at the DPSIG and onward escalation following this.

Incidents where there is uncertainty if a PSII is required, must also be reported to the Patient Safety team. Decision making regarding escalation to the Trust Patient Safety Panel can be considered at the next possible Executive Review Group. A rapid review will be undertaken by the Division to inform this decision making. Significant incidents which may require consideration for ad-hoc PSII due to an unexpected level of risk and/or potential for learning should be included in this category.

The PSIRF Delivery Group will meet at the earliest opportunity to discuss the nature of any escalated incident, immediate learning (which should be shared via an appropriate platform), any mitigation identified by the rapid review or that is still required to prevent recurrence and whether the Duty of Candour requirement has been met. The group will define terms of reference for a PSII to be undertaken and identify the appropriate investigation lead. The panel will also designate subject matter expert input required for any investigation or highlight any cross system working that may be necessary, as well as indicating how immediate learning is to be shared.

Where an incident does not meet the requirement for PSII, the PSIRF Delivery Group may request a PSLR or closure of the incident at a local level, with due consideration of any Duty of Candour requirement being met. It will be at the group's discretion in such circumstances to specify a particular tool is used to complete a PSLR. The PSIRF Delivery Group will also indicate how immediate learning is to be shared.

5.63 Responding to cross-system incidents/issues
The Patient Safety team will forward those incidents identified as presenting potential for significant learning and improvement for another provider directly to that organisation's patient safety team or equivalent. Where required, summary reporting can be used to share insight with another provider about their patient safety profile. The Trust will work with partner providers and the relevant ICBs to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system incidents. The Patient Safety team will act as the liaison point for such working and will have supportive operating procedures to ensure that this is effectively managed.

The Trust will defer to the ICB for co-ordination where a cross-system incident is felt to be too complex to be managed as a single provider. We anticipate that the ICB will give support with identifying a suitable reviewer in such circumstances and will agree how the learning response will be led and managed, how safety actions will be developed, and how the implemented actions will be monitored for sustainable change and improvement.

5.64 Timeframes for learning responses

Incident	Timeframe for completion
Requiring SWARM tool	As soon as possible, maximum within 1 week
Requiring After Action Review/ MDT Review	1 calendar month
Patient Safety Incident Investigation (PSII)	To be agreed alongside Terms of Reference/ Engagement
All locally managed incidents	1 calendar month

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of the start date. No PSII should take longer than six months.

The time frame for completion of a PSII will be agreed with those affected by the incident, as part of the setting of terms of reference prior to the commencement of the PSII learning response, provided they are willing and able to be involved in that decision. A balance must be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant.

This should be accepted by Divisional PSIG and recorded in Datix. A date for presentation at ERG will be provided by the Patient Safety Team at the commencement of a PSII.

In exceptional circumstances (e.g., when a partner organisation requests an investigation is paused, or the processes of an external body delays access to information) the Trust can consider whether to progress the PSII and determine whether new information indicates the need for further investigative activity once this is received. This would require a decision by the PSIRF Delivery Group and approval from ERG.

In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the Trust and those affected.

A learning response must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of their start date. No learning response should take longer than six months to complete.

5.65 Safety action development and monitoring of improvements

The Christie acknowledges that any form of patient safety learning response (PSII or review) will allow the circumstances of an incident or set of incidents to be understood, but that this is only the beginning. To reliably reduce risk, better safety recommendations are needed.

The Trust has developed systems and processes in place to design, implement and monitor safety recommendations using an integrated approach to reduce risk and limit the potential for future harm. This process follows on from the initial findings of any form of learning response which might result in identification of aspects of the Trust's working systems where change could reduce risk and potential for harm – areas for improvement.

The Trust will generate safety actions in relation to each of these defined areas for improvement. Following this, the Trust will have measures to monitor any safety action and set out review steps. Under PSIRF it is not the role of the investigator or the learning response lead to define actions at the end of their learning response.

Learning responses should not define actions as this can lead to premature attempts to devise a solution, often in isolation and without the proper consideration of impact on other areas or a reliance of another team to deliver the action. Safety actions in response to a defined area for improvement depend on factors and constraints outside of the scope of a learning response. To achieve successful improvement safety action development will be completed in a collaborative way with a flexible approach from Divisions and with the support of the PSIRF Delivery Group.
This should reduce the number of discrete actions logged in Datix and move the organisation to a more holistic and inclusive set of ongoing and dynamic safety recommendations.

5.66 Safety Action development

The Trust will use the process for development of safety actions as outlined by NHS England in the Safety Action Development Guide (2022) as follows:

- Agree areas for improvement – specify where improvement is needed, without defining solutions
- Define the context – this will allow agreement on the approach to be taken to safety action development
- Define safety actions to address areas of improvement – focussed on the system and in collaboration with all teams involved
- Prioritise safety actions to decide on testing for implementation
- Define safety measures to demonstrate whether the safety action is influencing what is intended as well as setting out responsibility for any resultant metrics i.e. How do we know it has worked?

Safety actions will be clearly written and follow Specific Measurable Achievable Realistic Timely (SMART) principles and have a designated owner. They will also

Be documented in a learning response report or in a safety improvement plan as applicable.

- Start with the owner, eg "Head of patient safety to...".
- Be directed to the correct level of the system: that is, people who have the

- levers to activate change (ideally this should include the person closest to the
- work and who has been empowered to act).
- Be succinct: any preamble about the safety action should be separate.
- Standalone: that is, readers should know exactly what it means without reading
- the report.
- Make it obvious why it is required (ie given evidence in the learning response
- report or safety improvement plan).

Safety actions will be developed using a systems approach:

Area for improvement		Set out where improvement is needed
Work system	Person(s)	How **can individual or team characteristics** be modified or changed to reduce risk or improve performance?
	Tasks	How can the **task or activity** be modified or redesigned to reduce risk or improve performance?
	Tools and technology	How can **tools, equipment or technology** be modified or redesigned to reduce risk or improve performance?
	Internal environment	How can the **physical environment** be modified or redesigned to reduce risk or improve performance?
	Organisation	How can **organisational factors** be modified or redesigned to reduce risk or improve performance?
	External environment	How can **regulatory or societal factors** be modified or redesigned to reduce risk or improve performance?

Safety actions will be developed by Divisional Patient Safety Improvement Groups for local issues, with approval from PSIRF Delivery Group. These will be reported through to ERG for oversight.

5.67 Learning Response Action Monitoring:

Safety actions must continue to be monitored within the Divisional governance arrangements to ensure that any actions put in place remain impactful and sustainable. Divisional reporting on the progress with safety actions including the outcomes of any measurements will be made to the Patient Safety Committee, with escalations to the Risk & Quality Governance Committee.

For some safety actions with wider significance, these will be supported by the PSIRF Delivery Group.

5.68 Safety improvement plans

The Trust patient safety incident response plan has outlined the local priorities for focus of investigation under PSIRF. These were developed due to the opportunity they offer for learning and improvement across areas where there is no existing plan or where improvement efforts have not been accompanied by reduction in apparent risk or harm.

The Trust will use the outcomes from existing patient safety incident reviews (SI and RCA reports, rapid reviews and themed reviews) where present and any relevant learning response conducted under PSIRF to create related safety improvement plans to help to focus our improvement work. The Patient Safety Team Divisions will work collaboratively with the Divisions Patient Safety Team and others to ensure there is an aligned approach to development of plans and resultant improvement.

Where overarching system issues are identified by learning responses outside of the Trust local safety priorities, a safety improvement plan will be developed. These will be identified through Divisional governance processes and reporting to the PSIRF Delivery Group which may commission a safety improvement plan. Again, the Divisions will work collaboratively with the Patient Safety Team and others to ensure there is an aligned approach to development of the plan and resultant improvement efforts.
Monitoring of progress regarding safety improvement plans will be overseen by reporting by PSIRF Delivery Group. By the Patient Safety Committee, with escalation to Risk and Quality Governance Committee.

5.7 Oversight roles and responsibilities
The trust board (or those with delegated responsibility, including members of board quality sub-committees), is responsible and accountable for effective patient safety incident management in their organisation. This includes supporting and participating in cross system/multi-agency responses and/or independent patient safety incident investigations (PSIIs) where required.

The executive lead responsibilities are outline in section 4.1.2

5.8 Complaints and appeals
The Trust is committed to dealing with any complaints that may arise as quickly and as effectively as possible as set out in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

People with a concern, comment, complaint or compliment about care or any aspect of the Trust services are encouraged to speak with a member of their clinical or ward/department team. Should the clinical or ward/department team be unable to resolve the concern then PALS can provide support and advice to patients, families, carers, and friends. PALS is a free and confidential service and the PALS team act independently of clinical teams when managing patient and family concerns. The PALS service will liaise with staff, managers and, where appropriate, with other relevant organisations to negotiate immediate and prompt solutions. More information can be accessed via the PALS homepage on The Christie website.

Complaints will be handled respectfully ensuring that all parties concerned feel involved in the process and assured that the issues raised have been comprehensively reviewed and the outcomes shared in an open and honest manner. Complaints can be valuable aids in developing and maintaining standards of care and that lessons learnt from complaints can be used positively to improve services Outcomes and recommendations from a complaint will be shared with the services to ensure that changes can be considered and implemented where appropriate.

The Trust is committed to dealing with any complaints that may arise as quickly and as effectively as possible as set out in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

The Christie NHS Foundation Trust will treat complaints seriously and ensure that complaints, concerns, and issues raised by the Complainant are properly investigated in an unbiased, non-judgmental, transparent, timely and appropriate manner. The outcome of any investigation, along with any resulting actions will be explained to the complainant by the investigating team. The Trust has set out its complaints processes in the Complaints and Concerns Policy (Complaints and concerns policy)

Complaints will be handled respectfully ensuring that all parties concerned feel involved in the process and assured that the issues raised have been comprehensively reviewed and the outcomes shared in an open and honest manner. Complaints can be valuable aids in developing and maintaining standards of care and that lessons learnt from complaints will be used positively to improve services and patient experience.

Outcomes and recommendations from a complaint will be shared with the services to ensure that changes can be considered and implemented where appropriate.

6. CONSULTATION PROCESS

This revised Policy has undergone wide consultation across divisional colleagues and subject matter experts. Relevant feedback has been incorporated into this document.

This policy has been approved by the Patient Safety Committee and the Risk and Quality Governance Committee and this is clearly documented in the minutes of the meetings.

This policy has been ratified by the document ratification committee and this is clearly documented in the minutes of the meeting.

7. DISSEMINATION, IMPLEMENTATION & TRAINING

7.1 Dissemination

This policy will be available on HIVE for all staff to access and sent to managers within the trust for dissemination to staff within their areas of responsibility.

7.2 Implementation

All managers are responsible for ensuring that staff in their departments are aware of the Patient Safety Incident Response Framework and their associated responsibilities. Divisional teams will be supported with their implementation by the Patient Safety Team.

The patient safety team will audit the success of implementation via audits of divisional and trust incident management process as well as output from patient safety priority improvement groups.

7.3 Training/Awareness

The Trust has adopted the E-Learning for Health patient safety training package to ensure that all staff are aware of their responsibilities in reporting and responding to patient safety events and to comply with the NHS England Health Education England Patient Safety Training Syllabus.

All staff, clinical and non-clinical are expected to undertake level one patient safety syllabus training on induction and to repeat each three years.

8. PROCESS FOR MONITORING EFFECTIVE IMPLEMENTATION

Standard to be monitored	Process for monitoring	Frequency	Person responsible	Committee accountable	Frequency of monitoring ,
Adherence to this policy	Audit	Annually	Patient Safety Specialist	Risk and Quality Governance Committee	Annually
Effective divisional triage of incidents and required learning responses	Audit	Quarterly	Clinical Patient Safety and Risk Manager	Patient Safety Committee	Quarterly
Effective patient engagement in incident management and learning responses.	Audit	Quarterly	Clinical Patient Safety and Risk Manager	Patient Safety Committee	Quarterly
Review of improvement workstreams in relation to patient safety priorities	Audit	Quarterly	Clinical Patient Safety and Risk Manager	Patient Safety Committee	Quarterly

9. REFERENCES (IF APPLICABLE)

10. VERSION CONTROL SHEET

Version	Date	Author	Status	Comment
1.0	Jan 2024	Patient Safety Team	Draft	New policy

11. APPENDICES

11.1 APPENDIX 1 – Support services

National guidance for NHS trusts engaging with bereaved families;
https://www.england.nhs.uk/wp-content/uploads/2018/08/learning-from-deaths-working-with-families-v2.pdf

Learning from deaths – Information for families
https://www.england.nhs.uk/publication/learning-from-deaths-information-for-families/
explains what happens after a bereavement (including when a death is referred to a coroner) and how families and carers should comment on care received.

Help is at Hand – for those bereaved by suicide.
https://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf
specifically for those bereaved by suicide this booklet offers practical support and guidance who have suffered loss in this way.

Mental Health Homicide support
https://www.england.nhs.uk/london/our-work/mental-health-support/homicide -
support/ for staff and families. This information has been developed by the London region independent investigation team in collaboration with the Metropolitan Police. It is recommended that, following a mental health homicide or attempted homicide, the principles of the duty of candour are extended beyond the family and carers of the person who died, to the family of the perpetrator and others who died, and to other surviving victims and their families.

Child death support
https://www.childbereavementuk.org/grieving-for-a-child-of-any-age
https://www.lullabytrust.org.uk/bereavement-support/
Both sites offer support and practical guidance for those who have lost a child in infancy or at any age.

Complaint's advocacy
https://www.voiceability.org/about-advocacy/types-of-advocacy/nhs-complaints-advocacy The NHS Complaints Advocacy Service can help navigate the NHS complaints system, attend meetings and review information given during the complaints

Healthwatch
https://www.healthwatch.co.uk/ -Healthwatch are an independent statutory body who can provide information to help make a complaint, including sample letters
You can find your local Healthwatch from the listing (arranged by council area) on the Healthwatch sitehttps://www.healthwatch.co.uk/your-local-healthwatch/list

Parliamentary and Health Service Ombudsman
https://www.ombudsman.org.uk/ makes the final decisions on complaints patients, families and carers deem not to have been resolved fairly by the NHS in England, government departments and other public organisations.

Citizens Advice Bureau
https://www.citizensadvice.org.uk/ provides UK citizens with information about healthcare rights, including how to make a complaint about care received

11.2 APPENDIX 2 - Operational and Assurance Levels

PSIRF Operational and Assurance Levels	
Quality assurance committee	Risk and Quality Committee Approve recommendations/action plans resulting from PSII's Receive a summary of learning response outputs monthly Receive a quarterly update of Patient Safety improvement workstreams, aligned to Patient Safety Profile
Risk and Quality Governance Committee	Approve recommendations/action plans resulting from PSII's Receive a summary of learning response outputs monthly Receive a quarterly update of Patient Safety improvement workstreams, aligned to Patient Safety Profile
Patient Safety Committee	To receive and scrutinise evidence of implementation of the PSIRF to effectively assure the Board the Christie is delivering improvements to safety standards aligned to the Patient Safety Profile. Monitor the progress of improvement groups/workstreams relating to local and national patient safety priorities Monitor Safety Improvement plans (for incidents not on Patient Safety Profile) Ensure that any issues are escalated appropriately to the Risk and Quality Governance Committee. Quarterly review of patient safety profile and priorities
Executive Review Group	To assure the board, through oversight and sign off learning responses, that the Trust has maintained or improved insight into patient safety incident responses, that all statutory requirements are met as part of the learning response. Approve all PSIIs and associated recommendations/action plans

PSIRF Delivery Group	Provide assurance and support to the chairs of DPSIG in the implementation of PSIRF Plans, Improvement Programmes and Learning Responses. Review recommendations from learning responses to develop safety action plans to support ongoing improvement work. Provide assurance to the Executive Review Group regarding ongoing divisional learning responses, action plans, recommendations and emerging themes.
Divisional Governance Teams / Divisional Patient Safety Improvement Group	Provide assurance to the PSIRF delivery group regarding ongoing divisional learning responses, action plans, recommendations and emerging themes Provide assurance of DPSIG oversight of divisional incidents, emerging themes and safety concerns
Operational Management / Team Leader / Supervisor / Person in Charge	Prompt review of incidents reported within their area of responsibility, to manage or escalate as appropriate
All Staff	Report incidents to Datix to support the management of safety events in their respective areas

The Christie
NHS Foundation Trust

PATIENT SAFETY INCIDENT RESPONSE POLICY

Document reference:	tbc	Version:	V01
Accountable committee (document owner):		Risk and Quality Governance Committee	
Date approved by accountable committee:	tbc	Document author:	Patient Safety Specialist
Ratified by:	Documentation Ratification Committee	Date ratified:	tbc
Date issued:	tbc	Review date:	tbc
Target audience:	All staff	Equality and Health Inequality Analysis	tbc

Key points

To outline the approach of The Christie to implementing the Patient Safety Incident Response Framework, including:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents
- Supportive Oversight focused on strengthening response system functioning and improvement

CONTENTS

1. ASSOCIATED DOCUMENTS

Duty of Candour Policy
Patient Safety Incident Response Plan (link)
Risk management strategy and policy
Freedom to speak up

2. INTRODUCTION

2.1 Statement of intent

The Patient Safety Incident Response Framework represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS. It is a key part of the NHS patient safety strategy.

PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of system-based approached to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement

The Board of Directors is committed to ensuring that:

- the safety of patients, staff, visitors are maintained.
- effective reporting of near misses and untoward incidents takes place.
- Meaningful learning happens, and system-based changes are made to mitigate future similar incidents.
- a culture exists where staff can freely express their concerns in the interest of patient safety.

2.2 Equality and Health Inequality Analysis

As part of its development, this policy was analysed to consider its impact on different groups protected from discrimination by the Equality Act 2010. The requirement is to consider if there are any unintended impact for some groups, and to consider if the policy will minimise discrimination for all protected groups in accessing services across the Trust.

This analysis has been undertaken and recorded using the Trust's Equality and Health Inequality Analysis (EHIA) toolkit, and appropriate measures incorporated to remove barriers and advance equality in the delivery of this policy.

2.3 Greener NHS

This policy has been developed in line with the statutory requirement to progress towards net zero carbon. As a result, the document is designed to be used electronically in order to reduce paper waste (example statement that may be used).

2.4 Values and Behaviours

Our Trust's Values and Behaviours define how we approach our work and treat each other and sits alongside what we do. It applies to all colleagues and outlines the behaviours that is required when we interact with each other, our patients, and our visitors.

2.5 PURPOSE

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out how The Christie NHS Foundation Trust (the Trust) will approach the development and maintenance of effective systems and

processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety across our services.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management as an integral aspect to operational processes across the Trust.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF and which we can align to our Trust values and behaviours.

This policy should be read in conjunction with our current patient safety incident response plan, which is a separate document setting out how this policy will be implemented (see associated documents).

2.6 SCOPE

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across the Trust.

Responses under this policy follow a systems-based approach. This recognises that safety is provided by interactions between components of the system and not from a single component.

Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

Where other investigative processes exist with a remit of determining liability or to apportion responsibility for acts or omissions, or cause of death, their principal aims differ from a patient safety incident response; are therefore outside of the scope of this policy;

- claims handling,
- human resources investigations into employment concerns,
- professional standards investigations,
- information governance concerns
- estates and facilities concerns
- financial investigations and audits
- safeguarding concerns
- coronial inquests and criminal investigations
- mortality reviews
- complaints (except where a significant patient safety concern is highlighted)

For clarity, the Trust considers these processes as separate from any patient safety incident response., However, Information from a patient safety incident response process can be shared with those leading other types of investigation, but these other processes, and their findings, should not influence the remit of a patient safety incident response and its subsequent recommendations for improving patient safety in a given area.

3. DEFINITIONS

Term	Meaning

Chief Executive	The person who has delegated responsibility from the Board of Directors for the management of governance arrangements within the Trust and is ultimately responsible for ensuring that the Trust meets its obligations with regards to the safe and effective delivery of services. This is delegated to responsible individuals within the Trust.
Clinician	A qualified medically trained doctor, nurse, allied health professional or pharmacist
The Patient Safety Incident Response Framework (PSIRF)	PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.
Patient safety learning response Learning response	The Patient Safety Incident Response Framework (PSIRF) promotes a range of system-based approaches for learning from patient safety incidents. National tools have been developed which trust's should utilise to explore the contributory factors to a patient safety incident or cluster of incidents, and to inform improvement.
Patient Safety Incident Investigation (PSII)	- An in-depth review of a single patient safety incident or cluster of events to understand what happened and how. Utilised where there has been serious harm to patients
The Patient Safety Partner (PSP)	is a new and evolving role developed by NHS England to help improve patient safety across the NHS. PSPs can be patients, carers, family members or other lay people (including NHS staff from another organisation)
Patient	A person who is receiving medical care from the Christie.
Treatment	The application of medicines, surgery etc to a patient, the care and management of a patient in order to combat, ameliorate or prevent a disease, disorder or injury.
Trust	The Christie NHS Foundation Trust
Patient Safety Incident	Any unintended or unexpected incident that could have led or did lead to harm for one or more patients receiving NHS funded care
Incident	An unplanned, unintended event or circumstance which caused actual or potential damage, loss or harm to a patient, staff, visitor or member of the public. It may be clinical in origin, (i.e. relating to the direct care of a patient) or non-clinical (i.e. property or financial loss, theft, fire, verbal abuse or threatening behaviour).

4. DUTIES

4.1 Board of Directors

The Board is responsible for ensuring that a framework is in place to support the reporting and investigation of incidents and near misses in line with the Patient Safety Incident Response Framework.

4.1.1 Chief executive

The chief executive has overall accountability for patient safety and therefore this policy. Responsibility for ensuring compliance with this policy is delegated to the executive directors, who must ensure that all their staff are informed of the need to

report incidents and that all incidents, complaints, or claims are investigated and managed effectively and appropriately.

4.2 Senior manager and individuals as applicable

4.2.1 Executive Chief Nurse and Director of Quality/Medical Director

Responsible for:

- Ensuring the executive directors and chief executive receives effective communication of the progress and outcome of patient safety learning responses and safety improvement work internally and with our external stakeholders such as the NHSE Specialist Commissioner, Integrated Care Board and the CQC.
- Informing the executive directors of any suspected criminal or malicious activity and, following consultation, inform the police where necessary.
- Ensuring key learning points are disseminated through the appropriate forums and committees, including the board of directors.
- Promote the trust patient safety culture
- Ensure the organisation meets national patient safety incident response standard
- Ensure PSIRF is central to overarching safety governance arrangement
- Quality assure learning response outputs (PSII)

4.2.2 Associate Chief Nurse and Associate Medical Director for Quality and Patient Safety

To support the Chief Nurse and Medical Director with oversight of patient safety activity within the Trust
To support the Patient Safety Specialist and Patient Safety team to promote continuous improvement and and compassionate engagement in patient safety improvements
To support the PSIRF Delivery Group (Associate Chief Nurse to Chair)
Promote the trust patient safety culture
Ensure the organisation meets national patient safety incident response standard

4.2.3 Patient Safety Specialist

- Lead and support local implementation of the NHS Patient Safety Strategy
- PSSs lead and directly support, patient safety ‘insight’, ‘involvement’ and ‘improvement’ activity and ensure that systems thinking, human factors understanding and just culture principles are embedded in all patient safety processes.
- Support other leads in the organisation in ensuring that all staff are trained in Level 1 of the NHS patient safety syllabus
- Work closely and collaboratively with those within their organisation who have specific patient safety responsibilities, including at operational level
- Support and advise Executive Directors, and Trust Board on matters of patient safety and process

4.2.4 Divisional associate chief nurse

- Oversight and governance of the local management of incidents
- Oversight of patient safety incident responses and improvements
- Ensure compliance with Duty of Candour guidelines and policy
- Chair Divisional Patient Safety Improvement Group on a weekly basis to review moderate + harm incidents as well as emergent incident themes/concerns

- Ensure the involvement and engagement of staff and patients in incident investigations
- Ensure compliance with patient safety training requirements amongst nursing staff
- Ensure the dissemination of learning, both locally and trust-wide
- Provide assurance to the PSIRF delivery group regarding ongoing divisional learning responses, action plans, recommendations and emerging themes
- Promote the trust patient safety culture

4.2.5 Divisional Directors

- Oversight of divisional incidents/ emerging themes/concerns
- Oversight of patient safety incident responses and improvements
- Support compliance with Duty of Candour guidelines and policy.
- Assist the chair of divisional Patient Safety Improvement Group to review moderate + harm incidents as well as emergent incident themes/concerns
- Ensure the involvement and engagement of staff and patients in incident investigations
- Ensure compliance with patient safety training requirements
- Ensure the dissemination of learning, both locally and trust-wide
- Provide assurance to the PSIRF delivery group regarding ongoing divisional learning responses, action plans, recommendations and emerging themes
- Promote the trust patient safety culture

4.2.6 Divisional Associate medical director

- Oversight of divisional incidents/ emerging themes/concerns
- Oversight of patient safety incident responses and improvements
- Ensure compliance with Duty of Candour guidelines and policy.
- Assist the chair of divisional Patient Safety Improvement Group to review moderate + harm incidents as well as emergent incident themes/concerns
- Ensure the involvement and engagement of staff and patients in incident investigations
- Ensure compliance with patient safety training requirements amongst medical staff
- Ensure the dissemination of learning, both locally and trust-wide
- Provide assurance to the PSIRF delivery group regarding ongoing divisional learning responses, action plans, recommendations and emerging themes
- Promote the trust patient safety culture

4.2.7 Patient safety team

- Review divisional learning response decision making and agree terms of reference
- Assign patient safety incident investigation (PSII) leads
- Review recommendations from learning responses to develop safety action plans to support ongoing improvement work
- Undertake regular audits of PSIRF process to support successful implementation
- Provide assurance to the Executive Review Group regarding ongoing divisional learning responses, action plans, recommendations and emerging themes
- Promote the trust patient safety culture

- Monitor trust compliance with incident management, duty of candour, safety action plans and training
- Support all employees with the escalation of concerns
- Support the safety improvement plans for patient safety priorities

4.2.8 Divisional governance teams

- Oversight and governance of the local management of incidents
- Oversight of patient safety incident responses and improvements
- Ensure compliance with Duty of Candour guidelines and policy
- Participate in the Divisional Patient Safety Improvement Group on a weekly basis to review moderate + harm incidents as well as emergent incident themes/concerns
- Ensure the involvement and engagement of staff and patients in incident investigations
- Ensure compliance with patient safety training requirements
- Ensure the dissemination of learning, both locally and trust-wide
- Promote the trust patient safety culture

4.2.9 All staff

All Trust employees, whether permanent, temporary or working under an honorary contract, have a duty to report something that has happened that is:

- contrary to the trust's specified standards of care,
- an individual has been or could have been injured,
- an incident that places or has placed individuals at unnecessary risk or
- an incident that could put the trust in an adverse legal or media situation.

Any member of staff who is involved in, witnesses, or discovers an incident or near miss must:

- ensure that the situation is made safe and the relevant manager is informed of the incident or near miss.
- complete an incident report form within 48 hours of knowledge of the incident, accurately completing the appropriate sections within the incident report form and provide a reason if not reported within 48 hours
- assist with any incident investigation and take all reasonable steps to minimise risks
- Work in line with trust values and behaviours, upholding a positive patient safety culture

4.3 Committees in level of hierarchy

4.3.1 Quality Assurance Committee

The Quality assurance committee will assess trust performance regarding patient safety from cross-examination of the following reports:

- Patient Safety Incident Panels reports
- Quarterly update of Patient Safety improvement workstreams, aligned to Patient Safety Profile

4.3.2 Risk and Quality Governance Committee

The Risk and Quality Governance Committee will provide information and assurances to the board of directors that The Christie is safely managing all issues relating to patient safety and risk.

The committee receives a monthly report on progress of agreed actions and/or recommendations from patient safety incident investigations as well as assurance of improvement group/ workstream progress and safety action plans.

4.3.3 Patient safety committee

The Patient Safety Committee will monitor the progress of improvement groups/workstreams relating to local and national patient safety priorities and ensure that any issues are escalated appropriately to the Risk and Quality Governance Committee. Improvement groups/workstreams will report directly into this committee to gain support and give assurance. This committee will review the trust patient safety profile and priorities on a quarterly basis.

5. PATIENT SAFETY INCIDENCE RESPONSE FRAMEWORK

5.1 Our patient safety culture

As a Trust, The Christie have endeavoured to approach incident investigations with openness, transparency, and with a focus on learning for improvement, seeking to adopt a restorative just culture within the organisation.

The main goals of restoration when an incident has happened have been outlined as follows:

- Moral engagement
- Emotional healing
- Reintegration of the practitioner
- Organisational learning
- Prevention

PSIRF will enhance these by creating much stronger links between a patient safety incident and learning for improvement.

We recognise a culture of strong psychological safety underpins openness and transparency in incident reporting and promotes respectful investigations with meaningful system-based learning. We encourage the reporting of incidents where any member of staff feels something has happened, or there is a risk, which has led to, or may lead to, harm to patients or staff.

We aim to work in collaboration with those affected by a patient safety incident – staff, patients, families, and carers to arrive at learning and improvement within the culture we strive for. This will continue to increase transparency and openness amongst our staff in reporting of incidents and engagement in establishing learning and improvements that follow.

We are clear that patient safety incident responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk. Specifically, they are not to apportion blame or liability of an individual or the organisation.

Our safety culture has also progressed in a positive way with reporting of patient safety incidents improving over time. The introduction of a new incident management system, Datix Cloud IQ, (DCIQ), in 2024 which will simplify internal reporting for staff whilst improving our insight into themes and trends. The introduction of Datix Cloud IQ will enable staff to report incidences of 'good care' assisting in learning from episodes which have gone well or better than expected.

We will utilise findings from our staff survey metrics based on specific patient (and staff) safety questions to assess if we are sustaining our ongoing progress in improving our safety culture. As a Trust, The Christie have endeavoured to approach incident investigations with a focus on learning for improvement, seeking to adopt a restorative just culture within the organisation.

5.2 Patient safety partners

The Patient Safety Partner (PSP) is a new and evolving role developed by NHS England to help improve patient safety across the NHS in the UK. At The Christie, we are excited to welcome PSPs who will offer support alongside our staff, patients, families/carers to influence and improve safety across our range of services.

PSPs can be patients, carers, family members or other lay people (including NHS staff from another organisation) and this offers a great opportunity to share interests, experiences, and skills to help develop the new PSP role and be a part of our team.

This exciting new role across the NHS will evolve over time and in The Christie the main purpose of the role is to be a voice for the people who use our services and ensure that patient safety is at the forefront of all we do. The PSPs will be supported in their role by the Patient Safety Specialist for the Trust who will provide supervision, guidance, and development for the role.

5.3 Addressing health inequalities

The Trust recognises that the NHS has a core role to play in reducing inequalities in health by improving access to services and tailoring those services around the needs of the local population in an inclusive way.

The Trust is committed to delivering on its statutory obligations under the Equality Act (2010) and will use data intelligently to assess for any disproportionate patient safety risk to patients from across the range of protected characteristics.

The introduction of a new incident management system will allow for the details of patients to be directly drawn from the healthcare record and incidents can then be analysed by protected characteristics to give insight into any apparent inequalities.

Within our patient safety response toolkit, we will directly address if there are any particular features of an incident which indicate:

- health inequalities may have contributed to harm or demonstrate a risk to a particular population group, including all protected characteristics.

- When constructing our safety actions in response to any incident we will consider inequalities, and these will be inbuilt into our documentation and governance processes.

Engagement of patient, families and staff following a patient safety incident is critical to the review of patient safety incidents and our response. We will ensure that we use

available tools such as easy read, translation and interpretation services and other methods as appropriate to meet the needs of those concerned and maximise their potential to be involved in our patient safety incident response.

5.4 Engaging and involving patients, families and staff following a patient safety incident

PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required. We will include this feedback in considering terms of reference for investigations.

We are firmly committed to continuously improving the care and services we provide. We want to learn from any incident where care does not go as planned or expected by our patients, their families, or carers to prevent reoccurrence.

We recognise and acknowledge the significant impact patient safety incidents can have on patients, their families, carers and staff. Getting involvement right with patients , their families and staff in how we respond to incidents is crucial, particularly to support improving the safety of the services we provide.

Part of this involves our key principle of being open, honest and transparent whenever there is a concern about care not being as planned or expected.
As well as meeting our regulatory and professional requirements for Duty of Candour, we want to be open and transparent with our patients, families, and carers because it is the right thing to do regardless of the level of harm caused by an incident.

As part of our new policy framework, we will be outlining procedures to support patients, families, and carers – based on our existing Duty of Candour Policy (link). This will be underpinned by nominated individuals within our divisions who will assist with family liaison and support families and carers through any investigation or learning review. Patients and their families will be provided information on the learning response process and timelines, as well as contact details for further available support.

Compassionate engagement of staff involved in a patient safety incident is a priority of the trust as we recognise the impact an incident can have on staff, their health and personal/work lives. Through engagement and support of staff we can ensure impactful learning is identified and safety recommendations/actions are considered both on a local and organisational level, with the goal of improving patient and staff safety. Where staff are engaging in learning responses, guidance documents will be available to ensure they understand and are supported throughout the process.

Staff are supported by the trust by a leadership team who promote a culture of psychological safety and are invested in the positive engagement of staff in patient safety incidents. Staff are encouraged to access support available including professional advocates, employee assistance programme, local leadership support, occupational health and staff complementary therapy.

We will continue to engage our staff with the assistance of Patient Safety Champions within a variety of areas across the Trust. These members of staff will, with support from the Patient Safety Team, work to enhance our patient safety culture, embed core PSIRF principles and share trust wide learning.

In addition, in The Christie we have a Patient Advice and Liaison Service (PALS). People with a concern, comment, complaint or compliment about care or any aspect of the Trust services are encouraged to speak with a member of their clinical or ward/department team. Should the clinical or ward/department team be unable to resolve the concern then PALS can provide support and advice to patients, families, carers, and friends. PALS is a free and confidential service and the PALS team act independently of clinical teams when managing patient and family concerns. The PALS service will liaise with staff, managers and, where appropriate, with other relevant organisations to negotiate immediate and prompt solutions.

PALS can help and support with the following:

• advice and information
• comments and suggestions
• compliments and thanks
• informal complaints
• advice about how to make a formal complaint

If the PALS team is unable to answer the questions raised, the team will provide advice in terms of organisations which can be approached to assist.

We recognise that there might also be other forms of support that can help those affected by a Patient Safety incident and will work with patients, families, and carers to signpost to their preferred source for this. Links to available support can be found in appendix 1.

5.5 Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses to arbitrary and subjective definitions of harm or severity.

Beyond nationally set requirements, organisations can explore patient safety incidents relevant to context and the populations they serve rather than only those that meet a certain defined threshold.

The Christie will take a proportionate approach to its response to patient safety incidents to ensure that the focus is on maximising improvement, this marks a fundamental shift in the operational response to a safety event and our collective understanding of how to respond to it.

To fulfil this, we have undertaken planning of our current resource for patient safety responses and our existing improvement workstreams. We have used insight from our patient safety incidents and other data sources both qualitative and quantitative to explore what we know about our safety position and culture; this has formed our Patient Safety Profile and Patient Safety Incident Response Plan.

Our Patient Safety Incident Response Plan 2024 details how this has been achieved as well as how The Christie will meet both national and local priorities for patient safety. This plan represents how we will respond to patient safety incidents over the

next 12-18 month. However, this will remain flexible and will be regularly reviewed. Each patient safety incident will be assessed in light of the specific circumstances in which it occurred, and the needs of those affected

5.51 Resources and training to support patient safety incident response

The Christie has committed to ensuring we fully embed PSIRF and meet its requirements. We have therefore used the NHS England patient safety response standards (2022) to frame the resources and training required to allow for this to happen.

The Trust will have in place governance arrangements to ensure that learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff. undertaken by the most appropriate staff, but not the staff directly involved in the incident. Local learning is a key principle of this policy and our services, specialities and divisions can decide on the most appropriate person to undertake a learning response.

Where the incident meets the threshold for a PSII, the investigator role will be identified through the ERG. Responsibility for the proposal to designate leadership of any other learning response sits within the senior leadership team of the relevant Division. Clinical, Operational and Nursing & AHP leadership will need to work collaboratively to deliver PSIRF principles in their area.

The Trust has governance arrangements in place to ensure that learning responses are not undertaken by staff working in isolation. Divisional Governance leads including the designated member of the senior leadership team and their Governance Manager, will manage the selection of an appropriate learning response lead to ensure the rigour of approach to the review and will maintain records to ensure an equitable allocation.

The Patient Safety team will support learning responses and can provide advice on cross-system and cross-divisional working where this is required.
Those staff affected by patient safety incidents will be provided the necessary support and be given time to participate in learning responses. All Trust managers will work within our just and restorative culture principles and utilise other staff support such as staff advocates to ensure there is a dedicated staff resource to support such engagement and involvement. Divisions will have processes in place to ensure managers work within this framework to ensure psychological safety throughout the organisation.

The Trust will utilise both internal and, if required, external subject matter experts with relevant knowledge and skills, where necessary, throughout the learning response process to provide expertise (e.g., clinical, or human factors review), advice and proofreading.

5.52 Training

The Trust has adopted the E-Learning for Health patient safety training package to ensure that all staff are aware of their responsibilities in reporting and responding to patient safety events and to comply with the NHS England Health Education England Patient Safety Training Syllabus as follows:

Training	Content	Staff Group	Training route	Provider
Patient safety syllabus level 1	Essentials for patient safety	Required for all staff	E-learning	Health Education England
Patient safety syllabus level 2	Access to practice	Recommended for staff managing incidents and undertaking local investigations and/or the following learning responses: • After Action Review • SWARM huddle • MDT review • Themed review	E-learning	Health Education England
Patient safety Investigation lead (PSII)	Systems-based approach to investigations	Recommended for Investigation Lead for PSII	Approximately 20 hours pre-recorded online study session	Health services safety investigations body

5.53 Our patient safety incident response plan

Our plan sets out how the Trust intends to respond to patient safety incidents over a period of 12-18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan. The plan was developed by using a range of data sources:

- Incident data
- Risk data
- Stakeholder engagement
- Complaints

A variety of stakeholders were approached to give insight to areas of concern regarding risk to patient safety. Included in engagement were divisional governance leads, committee groups, complaints and claims team, and subject matter experts . Anecdotal insight was also sourced from 'frontline' staff via qualitative care audits and feedback in response to incidents. Our full plan can be found here (insert link once uploaded)

5.54 Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan in full every 12 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 months. There will also be a

quarterly review of the plan and its effectiveness, which will be reported into Risk and Quality Governance Committee via Patient Safety Committee.

We will continue to assess ourselves against the Patient safety incident response standards, and update our policy accordingly. This will form part of annual reports to Risk and Quality Governance Committee, and Quality Assurance Committee.

Updated plans will be published on our website, replacing the previous version.
A rigorous planning exercise will be undertaken every three years and more frequently if appropriate (as agreed with our Integrated Care Board (ICB) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, Patient Safety Incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

5.6 Responding to patient safety incidents

5.61 Patient safety incident reporting arrangements

Incident report forms should be completed as soon as possible after the incident or near miss has occurred (whilst events can be clearly remembered), and certainly within 48 hours of knowledge of the incident. A reason should be provided if reported beyond 48 hours. This timescale enables timely escalation and assessment of the incidents internally, but also means that the relevant external reporting requirements can also be met. These reports will then be routinely uploaded to Learning from Patient Safety Events platform (LFPSE) to support national learning. Incidents that need to be shared across organisations need to be highlighted to the Patient Safety Team (as per external incident SOP), so that they can be reported and allow for cross- system learning.

5.62 Patient safety incident response decision-making

The Trust will have arrangements in place to allow it to meet the requirements for review of patient safety incidents under PSIRF. Some incidents will require mandatory PSII, others will require review by, or referral to another body or team depending on the event. These are set out in our PSIRF plan (insert link here). Nationally, PSIRF itself sets no further rules or thresholds to determine what method of response should be used to support learning and improvement. The Trust has developed its own response mechanisms to balance the effort between learning through responding to incidents and/ or exploring issues and improvement work. In the work to create our plan we have considered what our incident insight and engagement with key internal and external stakeholders has shown us about our patient safety profile. We have used this intelligence to build our local priorities for PSII and our toolkit for responding to other patient safety incidents.

We have established a process for our response to incidents which allows for a clear ‘Ward to Board’ set of mechanisms allowing for oversight of incident management and our PSIRF response (Fi. 8.2.1).

5.62.1 Divisional Patient Safety Improvement Group (DPSIG)

Oversight and governance of the local management of incidents will be the role of the Divisional Patient Safety Improvement Group (DPSIG). Chaired by a nominated senior lead within the Division e.g The Associate Chief Nurse or equivalent and

supported by the divisional medical director and divisional director as required. The DPSIG should adopt a multidisciplinary approach to local oversight of patient safety incident responses and improvements.

Where it is felt that the opportunity for learning and improvement is significant, regardless of severity or result of the event, incidents should be escalated within the Division
The DPSIG will meet on a weekly basis to discuss the previous week's incidents that have been escalated within division, are moderate and above or those that are considered to meet the thresholds for a learning response as set out in the Patient Safety Incident Response Plan. The group will ensure any mitigation that is needed to prevent recurrence and whether the Statutory Duty of Candour requirement has been met.

Divisions will have review mechanisms in place to ensure that patient safety incidents can be responded to proportionately and in a timely fashion in line with the timeframes detailed in the table (Fig 8.2.2). This should include consideration and prompting to service teams where Duty of Candour applies (see Policy).

Most incidents will only require local review within the management structure of the service(s), this local management of incidents is captured in Datix DCIQ, incident handlers will be assigned within a service or division and for the incident record to be finally approved feedback to the reporter will be mandated.

Where a PSII is not required, the DPSIG will consider any incident as having potential for a learning response. The tool to be utilised for the learning response will be specified and a suitable member of the divisional team allocated to undertake the learning response. The DPSIG will also specify any subject matter expert input required. There will be clear records maintained regarding this decision-making process within the minutes of the DPSIG.

Divisional Patient Safety Improvement Groups (DPSIG) will consider any such incidents for further escalation to the PSIRF Delivery Group, followed by Executive Review Group as per process in Fig 1 below.

5.62.2 PSIRF Delivery Group

The outcomes of the DPSIG for each division will be discussed weekly with the PSIRF Delivery Group. This group will have oversight of the requested learning responses and the outcomes of such reviews to ensure that recommendations are founded on a systems-based approach and safety actions are valid and contribute to existing safety improvement plans or the establishment of such plans where they are required. The PSIRF Delivery Group arrangements will include the recording of safety actions arising from any learning response and these details will be used to inform potential safety improvement plans.

The PSIRF Delivery Group will have overall oversight of such processes and will support & review the decision making of the DPSIGs through quarterly audits. This will ensure that the Executive Review Group and Board can be assured that the intent of PSIRF and its main principles are being implemented within our organisation and meeting the national patient safety incident response standards.

The PSIRF Delivery Group will act as liaison with external bodies and partner providers to ensure effective communication via a single point of contact for the Trust

in relation to external incidents. They will also support cross divisional learning responses and enable shared learning for the purpose of improvement.

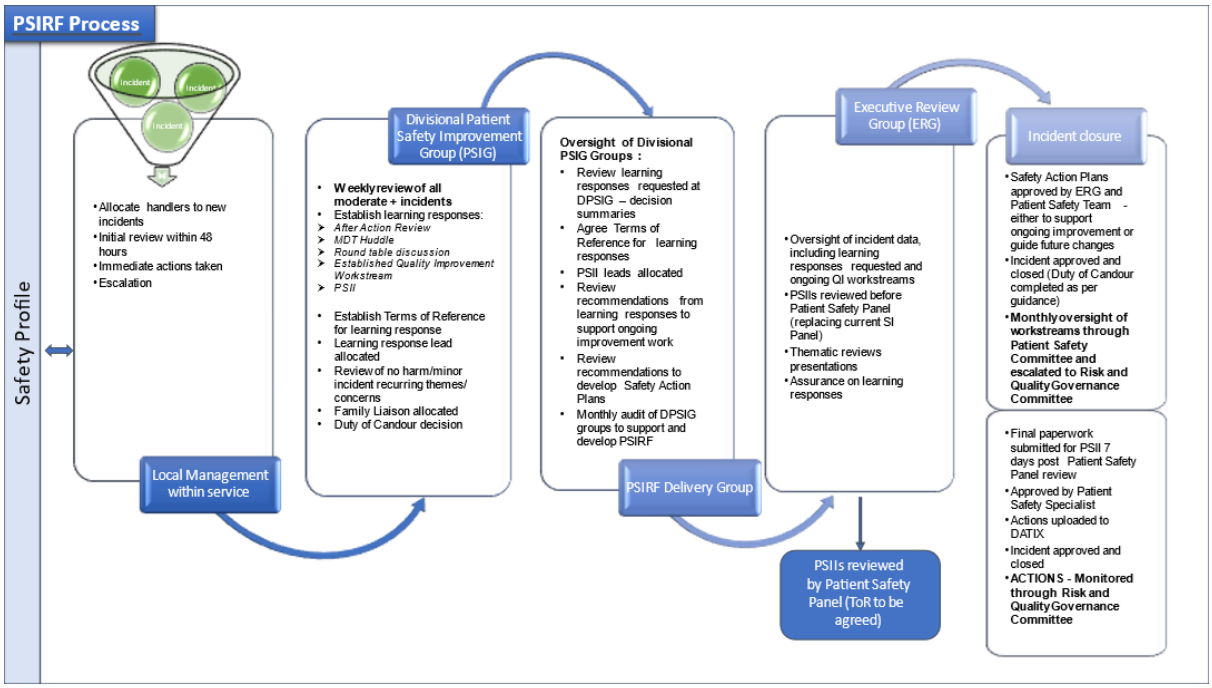
5.62.3 Trust Executive Review Group

The Trust will maintain the Executive Review Group (ERG) to oversee the operation and decision-making of the PSIRF Delivery Group and the incident responses it has delegated responsibility to commission. Patient Safety Learning Responses that highlight recommendations and/or safety actions outside of the Trust patient safety priorities will be reviewed through this group. Through this mechanism the Board will be assured that it meets expected oversight standards but also understands the ongoing and dynamic patient safety improvement profile of The Christie. All incidents that meet PSII threshold will initially be reviewed through the Execute Review Group.

5.62.4 Trust Patient Safety Panel

Incidents that meet the threshold of PSII as described in the PSIRF Plan and through the incident management escalation processes will be finally reviewed by the Trust Patient Safety Panel. This review will confirm the actions and/or recommendations from the PSII and assurance of the plans for ongoing improvement. The actions will be monitored through Risk and Quality Governance Committee once confirmed and through the relevant Patient Safety Improvement Project where applicable.

Fig 1



5.62.5 Incident Guidance and Escalation

Local level incidents:
Managers of all service areas will have arrangements in place to ensure that staff are supported to report and respond to incidents within their area. Incident responses should include immediate actions taken to ensure safety of patients, public and staff,

as well as indication of any measures needed to mitigate a problem until further review is possible. This may include for example, withdrawing equipment or monitoring a procedure. Any response to an incident should be fed back to those involved or affected and appropriate support offered. Where Duty of Candour applies this must be carried out according to Trust guidance (see Policy)
Divisional Patient Safety Improvement Group will have specific delegated powers to commission thematic reviews of such events.

Incidents with positive or unclear potential for PSII
All staff (directly or through their line manager) must ensure notification of incidents that may require a higher level of response as soon as practicable after the event through Divisional escalation processes (including out of hours) and this must include the Divisional Risk and Governance team. Duty of Candour disclosure should take place according to Trust guidance. Where it is clear that a PSII is required (for example, for a Never Event) the Division should notify the Patient Safety team as soon as practicable so that the incident can be shared to executive level staff. The incident will be escalated to Specialist Commissioners and shared externally through LFPSE reporting. A rapid review will be undertaken by the Division to inform decision making at the DPSIG and onward escalation following this.

Incidents where there is uncertainty if a PSII is required, must also be reported to the Patient Safety team. Decision making regarding escalation to the Trust Patient Safety Panel can be considered at the next possible Executive Review Group. A rapid review will be undertaken by the Division to inform this decision making. Significant incidents which may require consideration for ad-hoc PSII due to an unexpected level of risk and/or potential for learning should be included in this category.

The PSIRF Delivery Group will meet at the earliest opportunity to discuss the nature of any escalated incident, immediate learning (which should be shared via an appropriate platform), any mitigation identified by the rapid review or that is still required to prevent recurrence and whether the Duty of Candour requirement has been met. The group will define terms of reference for a PSII to be undertaken and identify the appropriate investigation lead. The panel will also designate subject matter expert input required for any investigation or highlight any cross system working that may be necessary, as well as indicating how immediate learning is to be shared.

Where an incident does not meet the requirement for PSII, the PSIRF Delivery Group may request a PSLR or closure of the incident at a local level, with due consideration of any Duty of Candour requirement being met. It will be at the group's discretion in such circumstances to specify a particular tool is used to complete a PSLR. The PSIRF Delivery Group will also indicate how immediate learning is to be shared.

5.63 Responding to cross-system incidents/issues
The Patient Safety team will forward those incidents identified as presenting potential for significant learning and improvement for another provider directly to that organisation's patient safety team or equivalent. Where required, summary reporting can be used to share insight with another provider about their patient safety profile. The Trust will work with partner providers and the relevant ICBs to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system incidents. The Patient Safety team will act as the liaison point for such working and will have supportive operating procedures to ensure that this is effectively managed.

The Trust will defer to the ICB for co-ordination where a cross-system incident is felt to be too complex to be managed as a single provider. We anticipate that the ICB will give support with identifying a suitable reviewer in such circumstances and will agree how the learning response will be led and managed, how safety actions will be developed, and how the implemented actions will be monitored for sustainable change and improvement.

5.64 Timeframes for learning responses

Incident	Timeframe for completion
Requiring SWARM tool	As soon as possible, maximum within 1 week
Requiring After Action Review/ MDT Review	1 calendar month
Patient Safety Incident Investigation (PSII)	To be agreed alongside Terms of Reference/ Engagement
All locally managed incidents	1 calendar month

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of the start date. No PSII should take longer than six months.

The time frame for completion of a PSII will be agreed with those affected by the incident, as part of the setting of terms of reference prior to the commencement of the PSII learning response, provided they are willing and able to be involved in that decision. A balance must be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant.

This should be accepted by Divisional PSIG and recorded in Datix. A date for presentation at ERG will be provided by the Patient Safety Team at the commencement of a PSII.

In exceptional circumstances (e.g., when a partner organisation requests an investigation is paused, or the processes of an external body delays access to information) the Trust can consider whether to progress the PSII and determine whether new information indicates the need for further investigative activity once this is received. This would require a decision by the PSIRF Delivery Group and approval from ERG.

In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the Trust and those affected.

A learning response must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of their start date. No learning response should take longer than six months to complete.

5.65 Safety action development and monitoring of improvements

The Christie acknowledges that any form of patient safety learning response (PSII or review) will allow the circumstances of an incident or set of incidents to be understood, but that this is only the beginning. To reliably reduce risk, better safety recommendations are needed.

The Trust has developed systems and processes in place to design, implement and monitor safety recommendations using an integrated approach to reduce risk and limit the potential for future harm. This process follows on from the initial findings of any form of learning response which might result in identification of aspects of the Trust's working systems where change could reduce risk and potential for harm – areas for improvement.

The Trust will generate safety actions in relation to each of these defined areas for improvement. Following this, the Trust will have measures to monitor any safety action and set out review steps. Under PSIRF it is not the role of the investigator or the learning response lead to define actions at the end of their learning response.

Learning responses should not define actions as this can lead to premature attempts to devise a solution, often in isolation and without the proper consideration of impact on other areas or a reliance of another team to deliver the action. Safety actions in response to a defined area for improvement depend on factors and constraints outside of the scope of a learning response. To achieve successful improvement safety action development will be completed in a collaborative way with a flexible approach from Divisions and with the support of the PSIRF Delivery Group.
This should reduce the number of discrete actions logged in Datix and move the organisation to a more holistic and inclusive set of ongoing and dynamic safety recommendations.

5.66 Safety Action development

The Trust will use the process for development of safety actions as outlined by NHS England in the Safety Action Development Guide (2022) as follows:

- Agree areas for improvement – specify where improvement is needed, without defining solutions
- Define the context – this will allow agreement on the approach to be taken to safety action development
- Define safety actions to address areas of improvement – focussed on the system and in collaboration with all teams involved
- Prioritise safety actions to decide on testing for implementation
- Define safety measures to demonstrate whether the safety action is influencing what is intended as well as setting out responsibility for any resultant metrics i.e. How do we know it has worked?

Safety actions will be clearly written and follow Specific Measurable Achievable Realistic Timely (SMART) principles and have a designated owner. They will also

Be documented in a learning response report or in a safety improvement plan as applicable.

- Start with the owner, eg "Head of patient safety to...".
- Be directed to the correct level of the system: that is, people who have the

- levers to activate change (ideally this should include the person closest to the
- work and who has been empowered to act).
- Be succinct: any preamble about the safety action should be separate.
- Standalone: that is, readers should know exactly what it means without reading
- the report.
- Make it obvious why it is required (ie given evidence in the learning response
- report or safety improvement plan).

Safety actions will be developed using a systems approach:

Area for improvement		Set out where improvement is needed
Work system	Person(s)	How **can individual or team characteristics** be modified or changed to reduce risk or improve performance?
	Tasks	How can the **task or activity** be modified or redesigned to reduce risk or improve performance?
	Tools and technology	How can **tools, equipment or technology** be modified or redesigned to reduce risk or improve performance?
	Internal environment	How can the **physical environment** be modified or redesigned to reduce risk or improve performance?
	Organisation	How can **organisational factors** be modified or redesigned to reduce risk or improve performance?
	External environment	How can **regulatory or societal factors** be modified or redesigned to reduce risk or improve performance?

Safety actions will be developed by Divisional Patient Safety Improvement Groups for local issues, with approval from PSIRF Delivery Group. These will be reported through to ERG for oversight.

5.67 Learning Response Action Monitoring:

Safety actions must continue to be monitored within the Divisional governance arrangements to ensure that any actions put in place remain impactful and sustainable. Divisional reporting on the progress with safety actions including the outcomes of any measurements will be made to the Patient Safety Committee, with escalations to the Risk & Quality Governance Committee.

For some safety actions with wider significance, these will be supported by the PSIRF Delivery Group.

5.68 Safety improvement plans

The Trust patient safety incident response plan has outlined the local priorities for focus of investigation under PSIRF. These were developed due to the opportunity they offer for learning and improvement across areas where there is no existing plan or where improvement efforts have not been accompanied by reduction in apparent risk or harm.

The Trust will use the outcomes from existing patient safety incident reviews (SI and RCA reports, rapid reviews and themed reviews) where present and any relevant learning response conducted under PSIRF to create related safety improvement plans to help to focus our improvement work. The Patient Safety Team Divisions will work collaboratively with the Divisions Patient Safety Team and others to ensure there is an aligned approach to development of plans and resultant improvement.

Where overarching system issues are identified by learning responses outside of the Trust local safety priorities, a safety improvement plan will be developed. These will be identified through Divisional governance processes and reporting to the PSIRF Delivery Group which may commission a safety improvement plan. Again, the Divisions will work collaboratively with the Patient Safety Team and others to ensure there is an aligned approach to development of the plan and resultant improvement efforts.
Monitoring of progress regarding safety improvement plans will be overseen by reporting by PSIRF Delivery Group. By the Patient Safety Committee, with escalation to Risk and Quality Governance Committee.

5.7 Oversight roles and responsibilities
The trust board (or those with delegated responsibility, including members of board quality sub-committees), is responsible and accountable for effective patient safety incident management in their organisation. This includes supporting and participating in cross system/multi-agency responses and/or independent patient safety incident investigations (PSIIs) where required.

The executive lead responsibilities are outline in section 4.1.2

5.8 Complaints and appeals
The Trust is committed to dealing with any complaints that may arise as quickly and as effectively as possible as set out in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

People with a concern, comment, complaint or compliment about care or any aspect of the Trust services are encouraged to speak with a member of their clinical or ward/department team. Should the clinical or ward/department team be unable to resolve the concern then PALS can provide support and advice to patients, families, carers, and friends. PALS is a free and confidential service and the PALS team act independently of clinical teams when managing patient and family concerns. The PALS service will liaise with staff, managers and, where appropriate, with other relevant organisations to negotiate immediate and prompt solutions. More information can be accessed via the PALS homepage on The Christie website.

Complaints will be handled respectfully ensuring that all parties concerned feel involved in the process and assured that the issues raised have been comprehensively reviewed and the outcomes shared in an open and honest manner. Complaints can be valuable aids in developing and maintaining standards of care and that lessons learnt from complaints can be used positively to improve services Outcomes and recommendations from a complaint will be shared with the services to ensure that changes can be considered and implemented where appropriate.

The Trust is committed to dealing with any complaints that may arise as quickly and as effectively as possible as set out in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

The Christie NHS Foundation Trust will treat complaints seriously and ensure that complaints, concerns, and issues raised by the Complainant are properly investigated in an unbiased, non-judgmental, transparent, timely and appropriate manner. The outcome of any investigation, along with any resulting actions will be explained to the complainant by the investigating team. The Trust has set out its complaints processes in the Complaints and Concerns Policy (Complaints and concerns policy)

Complaints will be handled respectfully ensuring that all parties concerned feel involved in the process and assured that the issues raised have been comprehensively reviewed and the outcomes shared in an open and honest manner. Complaints can be valuable aids in developing and maintaining standards of care and that lessons learnt from complaints will be used positively to improve services and patient experience.

Outcomes and recommendations from a complaint will be shared with the services to ensure that changes can be considered and implemented where appropriate.

6. CONSULTATION PROCESS

This revised Policy has undergone wide consultation across divisional colleagues and subject matter experts. Relevant feedback has been incorporated into this document.

This policy has been approved by the Patient Safety Committee and the Risk and Quality Governance Committee and this is clearly documented in the minutes of the meetings.

This policy has been ratified by the document ratification committee and this is clearly documented in the minutes of the meeting.

7. DISSEMINATION, IMPLEMENTATION & TRAINING

7.1 Dissemination

This policy will be available on HIVE for all staff to access and sent to managers within the trust for dissemination to staff within their areas of responsibility.

7.2 Implementation

All managers are responsible for ensuring that staff in their departments are aware of the Patient Safety Incident Response Framework and their associated responsibilities. Divisional teams will be supported with their implementation by the Patient Safety Team.

The patient safety team will audit the success of implementation via audits of divisional and trust incident management process as well as output from patient safety priority improvement groups.

7.3 Training/Awareness

The Trust has adopted the E-Learning for Health patient safety training package to ensure that all staff are aware of their responsibilities in reporting and responding to patient safety events and to comply with the NHS England Health Education England Patient Safety Training Syllabus.

All staff, clinical and non-clinical are expected to undertake level one patient safety syllabus training on induction and to repeat each three years.

8. PROCESS FOR MONITORING EFFECTIVE IMPLEMENTATION

Standard to be monitored	Process for monitoring	Frequency	Person responsible	Committee accountable	Frequency of monitoring ,
Adherence to this policy	Audit	Annually	Patient Safety Specialist	Risk and Quality Governance Committee	Annually
Effective divisional triage of incidents and required learning responses	Audit	Quarterly	Clinical Patient Safety and Risk Manager	Patient Safety Committee	Quarterly
Effective patient engagement in incident management and learning responses.	Audit	Quarterly	Clinical Patient Safety and Risk Manager	Patient Safety Committee	Quarterly
Review of improvement workstreams in relation to patient safety priorities	Audit	Quarterly	Clinical Patient Safety and Risk Manager	Patient Safety Committee	Quarterly

9. REFERENCES (IF APPLICABLE)

10. VERSION CONTROL SHEET

Version	Date	Author	Status	Comment
1.0	Jan 2024	Patient Safety Team	Draft	New policy

11. APPENDICES

11.1 APPENDIX 1 – Support services

National guidance for NHS trusts engaging with bereaved families;
https://www.england.nhs.uk/wp-content/uploads/2018/08/learning-from-deaths-working-with-families-v2.pdf

Learning from deaths – Information for families
https://www.england.nhs.uk/publication/learning-from-deaths-information-for-families/
explains what happens after a bereavement (including when a death is referred to a coroner) and how families and carers should comment on care received.

Help is at Hand – for those bereaved by suicide.
https://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf
specifically for those bereaved by suicide this booklet offers practical support and guidance who have suffered loss in this way.

Mental Health Homicide support
https://www.england.nhs.uk/london/our-work/mental-health-support/homicide -
support/ for staff and families. This information has been developed by the London region independent investigation team in collaboration with the Metropolitan Police. It is recommended that, following a mental health homicide or attempted homicide, the principles of the duty of candour are extended beyond the family and carers of the person who died, to the family of the perpetrator and others who died, and to other surviving victims and their families.

Child death support
https://www.childbereavementuk.org/grieving-for-a-child-of-any-age
https://www.lullabytrust.org.uk/bereavement-support/
Both sites offer support and practical guidance for those who have lost a child in infancy or at any age.

Complaint's advocacy
https://www.voiceability.org/about-advocacy/types-of-advocacy/nhs-complaints-advocacy The NHS Complaints Advocacy Service can help navigate the NHS complaints system, attend meetings and review information given during the complaints

Healthwatch
https://www.healthwatch.co.uk/ -Healthwatch are an independent statutory body who can provide information to help make a complaint, including sample letters
You can find your local Healthwatch from the listing (arranged by council area) on the Healthwatch sitehttps://www.healthwatch.co.uk/your-local-healthwatch/list

Parliamentary and Health Service Ombudsman
https://www.ombudsman.org.uk/ makes the final decisions on complaints patients, families and carers deem not to have been resolved fairly by the NHS in England, government departments and other public organisations.

Citizens Advice Bureau
https://www.citizensadvice.org.uk/ provides UK citizens with information about healthcare rights, including how to make a complaint about care received

11.2 APPENDIX 2 - Operational and Assurance Levels

PSIRF Operational and Assurance Levels	
Quality assurance committee	Risk and Quality Committee Approve recommendations/action plans resulting from PSII's Receive a summary of learning response outputs monthly Receive a quarterly update of Patient Safety improvement workstreams, aligned to Patient Safety Profile
Risk and Quality Governance Committee	Approve recommendations/action plans resulting from PSII's Receive a summary of learning response outputs monthly Receive a quarterly update of Patient Safety improvement workstreams, aligned to Patient Safety Profile
Patient Safety Committee	To receive and scrutinise evidence of implementation of the PSIRF to effectively assure the Board the Christie is delivering improvements to safety standards aligned to the Patient Safety Profile. Monitor the progress of improvement groups/workstreams relating to local and national patient safety priorities Monitor Safety Improvement plans (for incidents not on Patient Safety Profile) Ensure that any issues are escalated appropriately to the Risk and Quality Governance Committee. Quarterly review of patient safety profile and priorities
Executive Review Group	To assure the board, through oversight and sign off learning responses, that the Trust has maintained or improved insight into patient safety incident responses, that all statutory requirements are met as part of the learning response. Approve all PSIIs and associated recommendations/action plans
PSIRF Delivery Group	Provide assurance and support to the chairs of DPSIG in the implementation of PSIRF Plans, Improvement Programmes

	and Learning Responses. Review recommendations from learning responses to develop safety action plans to support ongoing improvement work. Provide assurance to the Executive Review Group regarding ongoing divisional learning responses, action plans, recommendations and emerging themes.
Divisional Governance Teams / Divisional Patient Safety Improvement Group	Provide assurance to the PSIRF delivery group regarding ongoing divisional learning responses, action plans, recommendations and emerging themes Provide assurance of DPSIG oversight of divisional incidents, emerging themes and safety concerns
Operational Management / Team Leader / Supervisor / Person in Charge	Prompt review of incidents reported within their area of responsibility, to manage or escalate as appropriate
All Staff	Report incidents to Datix to support the management of safety events in their respective areas