Monitor and CQC review into whistleblowing concerns at the Christie NHS Foundation Trust

Joint report

1.1 Introduction

Following whistleblowing concerns raised with Monitor and CQC regarding the Christie NHS Foundation Trust ("the Christie" or "the trust"), we worked together to carry out a limited scope review into the serious allegations raised, which centred around the culture at the Christie. The concerns related to: a culture where staff members felt inhibited to raise issues; and the way in which the trust responded to those issues. This was not considered consistent with an open and learning approach.

Our purpose was to determine whether these concerns reflected underlying issues with the organisational culture and governance at the trust. It was agreed with the trust that we would undertake the joint review. We would like to thank the trust and its staff for their help and co-operation throughout the review.

We wish to emphasise that none of the concerns and/or allegations gave rise to an immediate risk of patient harm, and that our review found no evidence to the contrary.

Our work did not highlight that there are currently serious failings of governance or culture at the trust. We found areas of the trust where there was strong staff engagement and support for the leadership team; this was particularly noted within the clinical areas reviewed. Staff survey information and local friends and family tests supported this view. However, we have identified areas of improvement for the trust particularly around staff engagement among some staff groups, the promotion of an open culture in terms of raising concerns, and some enhancements to governance processes (risk management, quality assurance committee, and processes to ensure timely resolution of issues).

Senior management at the trust acknowledged that there is work to be done in these areas, and have included actions in the trust's Organisation Development (OD) strategy to improve staff engagement. The trust has also planned to commission an external governance review to drive forward governance improvements at the trust.

1.2 Review team

The review team included: Miranda Carter, Executive Director of Provider Appraisal, Monitor; Ann Ford, Head of Hospital Inspections, CQC; a Provider Appraisal Senior Manager and a Quality Governance Associate from Monitor; two CQC inspection managers, as well as CQC specialist advisers on governance and human resources and an experienced medical director.

1.3 Scope of the review

Our work focused on the current performance of the trust and included a document review and a joint three day site visit from 28-30 July 2014. The document review covered recent board and quality assurance committee minutes, divisional governance committee minutes, risk management and incident reporting policies, HR policies, quality accounts, a list of incidents reported, patient and staff survey results, and certain HR data.

Monitor's work did not constitute a full scope governance review but focused on certain questions of the governance framework for NHS foundation trusts (the well-led framework) which were pertinent to the concerns raised by the whistleblowers:

- *Qu 4 - does the board shape an open transparent and quality-focused culture?*
- *Qu 6 - are there clear roles and accountabilities in relation to board governance (including quality governance)?*
- *Qu 7 - are there clearly defined, well-understood processes for escalating and resolving issues and managing performance?*
- *Qu 8 - does the board actively engage patients, staff, governors and other stakeholders on quality, operational and financial performance?*

CQC's work, carried out under its powers of inspection, focused on the well-led domain of its ratings framework. This incorporates five key lines of enquiry:

- *Is there a clear vision and a credible strategy to deliver high quality care and promote good outcomes for people?*
- *Do the governance arrangements ensure that responsibilities are clear, quality and performance are regularly considered and risks are identified, understood and managed?*
- *How do the leadership and culture within the organisation reflect its vision and values, encourage openness and transparency and promote delivery of high quality care across teams and pathways?*
- *How does the provider engage, seek and act on feedback from people who use the service, the public and staff?*
- *How does the organisation strive to continuously learn and improve, support safe innovation, and ensure the future sustainability and quality of care?*

1.4 Summary findings

The findings below are based on the joint work performed by Monitor and CQC.

1.4.1 Patient care

We found that all staff we engaged with are proud to work at the trust and are passionate about providing quality care and a good experience to patients. We observed strong clinical engagement and the clinical outcomes for patients are considered good.

1.4.2 Culture

We found areas of the trust where there was strong staff engagement and support for the leadership team; this was particularly noted within the clinical areas reviewed. Staff survey information and local friends and family tests supported this view. Overall the staff survey data and other HR information reviewed did not provide evidence to conclude that there were serious widespread cultural issues within the trust.

However, we did identify some staff groups and grades of staff who felt disengaged and unheard by senior managers. Linked to this, we heard some issues around the ability to raise concerns; these appeared to relate primarily to raising issues about behaviours rather than patient safety concerns. However, some staff reported staffing pressures as an area of concern.

We also heard some reports from staff of inconsistent application of policies and it was not clear that the values of the organisation were reflected in all managers' behaviours and performance appraisal.

We acknowledge that improvements are being made to Human Resources (HR) processes to help identify and understand cultural issues within the trust. The trust had developed an OD Strategy in support of its 20:20 vision strategy; this included objectives around improving staff engagement and supporting staff to maintain their physical and mental health and wellbeing. In 2013/14 the trust implemented a local friends and family test and future key initiatives being introduced include strengthening workforce information (e.g. analysis of sickness absence by reason) to facilitate better trend information and identification of concerns. This was alongside a leadership development programme which includes 360 feedback (to date this has been rolled out to 47 staff in 5 cohorts), and the establishment of 40 Christie Commitment champions.

1.4.3 Governance

It is acknowledged that at the time of our review the trust was in breach of its licence in light of board governance concerns principally around the effectiveness of the Board and as a result an Interim Chair had been appointed to address the concerns identified. As part of the process to address the board governance concerns, the Interim Chair had recently made new Non Executive appointments

to the Board. Our findings in this section around the board and the effectiveness of its committees should be seen against this context and in particular given the recognition of the need to improve effectiveness of the Board and the recent non-executive appointments it is perhaps understandable that the degree of challenge we expect to be provided by a board was not fully evident.

The trust had a devolved performance management system to divisional level. Performance was monitored monthly by divisional boards and reported through identified committees up to the Board. There was regular review of high level risks and risk registers by divisions and by the executive-led risk and quality governance committee. The board regularly saw the trust's top risks and incidents of grade three (i.e. moderate) and above. In particular, the level of patient complaints did not appear unusual when compared with similar trusts and staff provided examples of where patient feedback had resulted in a change in practices.

However, Monitor and the CQC cannot be sure that the trust meets good practice on all aspects of the well-led framework. The following issues were apparent from our joint review:

- We identified some concern with the role and effectiveness of the quality assurance committee. This committee met on a quarterly basis (good practice in this area would suggest the need for a more regular forum for NED oversight of quality issues). From the work undertaken, including review of the minutes of this committee, we did not find evidence to demonstrate that the committee had an inquisitive culture in which information is challenged. At the board meeting we attended we did not observe significant scrutiny of quality performance to mitigate this risk. However, we do note that recent interim NED appointments have been made to enhance the challenge to the executive team. These issues would raise questions under question 6 of the well-led framework.
- We noted some long standing issues with team leadership and performance management in a particular division (estates and facilities) which did not appear to have been adequately addressed. In addition some concerns were raised by staff from across the organisation regarding patient administration (i.e. appointment scheduling, patient letters and filing of patient notes). However, we understand from management that a new electronic patient record (EPR) system was implemented in June 2014 which aims to address these concerns. These issues would raise some concerns under question 7 of the well-led framework about picking up and resolving issues in a timely way.
- Whilst risks were regularly reviewed, there did not appear to be a single document that had all the risks recorded in one place (we were informed that corporate risks were drawn from the divisional risk registers). Some risk registers that we reviewed were clear, with controls and mitigating actions recorded and well articulated, but others were less clear. Some items included in the risk registers could be considered to be business as usual; a concern was raised by a member of staff that risk registers were being used

to flag concerns to managers as a means of getting them to listen. These issues would raise questions under question 7 of the well-led framework around appropriate escalation of risks.

We are aware that the trust is in the process of commissioning a governance review against the well-led framework which is in line with the expectations set out in the Risk Assurance Framework for NHS foundation trusts. We would expect this review to look into the areas noted above to support required improvements to governance processes.

1.4.4 Conclusion and summary recommendations

Through the joint work undertaken by Monitor and the CQC we did not find sufficient evidence to conclude that there are serious failings of governance or serious widespread cultural issues at the trust. However both CQC and Monitor have identified areas where the trust should seek to improve. These are set out below. We expect the trust to take account of our findings when undertaking its planned governance review.

In particular, given these conclusions we consider it is important that the trust:

- continues to implement its OD strategy and is assured it is fit for purpose in light of the findings of this report;
- considers whether any further enhancement is required to HR processes to help address engagement with non-clinical staff groups, and if so to implement improvements;
- considers whether any further improvements are required in the way it communicates and engages with staff to promote an open learning culture;
- reviews the processes for measuring waiting times in the outpatient department to ensure accuracy of information and timely scheduling of appointments;
- reviews its systems to ensure that patient letters are provided to all stakeholders in a timely way;
- reviews the scrutiny and challenge aspects of the quality assurance committee; and
- takes into account the findings of our work when focusing the scope of its planned governance review against Monitor's well led framework; and the well led domain of CQCs inspection framework.

Annex 1: CQC Quality report

Background to The Christie NHS Foundation Trust

The Christie is a specialist cancer centre based in Manchester that treats over 44,000 patients a year. It is a foundation trust and has around 2,416 staff and had an annual turnover of £220 million in 2013/14.

The trust serves a population of 3.2 million across Greater Manchester and Cheshire. However, 27% of its patients are referred to the hospital from other parts of the country. The trust provides radiotherapy; chemotherapy on site and through 14 other locations; specialist surgery for cancer; and a wide range of support and diagnostic services. The trust also has a dedicated clinical research environment where patients can participate in complex and early phase clinical trials, with around 400 trials taking place at any one time.

Our team

Our team was led by:

Chair: Peter Wilde, Consultant Radiologist
Head of Hospital Inspections: Ann Ford, Care Quality Commission

Monitor and CQC conducted a joint three-day site visit at the Christie between 28 and 30 July 2014. The team included: Miranda Carter, Executive Director of Provider Appraisal, Monitor; Ann Ford, Head of Hospital Inspections, CQC; a Provider Appraisal Senior Manager and a Quality Governance Associate from Monitor; two CQC inspection managers, as well as CQC specialist advisers on governance, human resources and an experienced medical director.

How we carried out this work

In advance of our visit we requested a range of background information including recent board and quality committee minutes, divisional governance committee minutes, risk management and incident reporting policies, HR policies, quality accounts, a list of incidents reported, patient and staff survey results, and certain HR data.

While on site, there was a series of joint meetings, focus groups and observations, including:

- Board observation
- HR meeting
- Interviews with:
  - Chair
  - Non-executive Chair of the Quality Assurance Committee

  - CEO
  - Medical Director
  - Director of Nursing
  - Director of Workforce
  - NHSE specialist commissioner
- Focus groups with:
  - Staff representatives
  - Consultants
  - Junior nurses (up to band 7)
  - Senior nurses (band 7 and above)
  - Junior medical staff
  - Allied health professionals
  - Administrative and other staff.

We also invited staff to write to us and to Monitor with any views they wished to contribute or to attend a drop-in session while we were on site.

A number of staff also attended drop-in sessions while we were on site. These sessions provided an opportunity for staff to speak one-to-one with a member of the team to express their opinions and experiences of the trust.

In addition, members of the team visited areas of the hospital and spoke informally with patients and a cross-section of staff in their own familiar working environment.

Whenever we carry out an inspection of a service we always ask five key questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

This work was predominately focused on the key question: is the trust well-led? However, our lines of enquiry also included elements of the other key questions. A summary of our evidence in these areas is presented below.

Summary of findings

Are services safe?

Incident reporting

The trust had a robust incident reporting system. Staff were familiar with the system and were confident in reporting incidents. Incidents were investigated and remedial actions identified and implemented.

We reviewed five incident investigation reports. These reports showed that open discussions with relevant staff took place following incidents.

The trust is in the highest 25% of reporters according to the March 2013 National Reporting and Learning System (NRLS) patient safety data, and has a lower proportion of low, moderate and severe level harms than other acute specialist trusts We also noted that the level of harm was sometimes downgraded as part of the investigation process. The trust should consider exploring this further as it may form part of the reason why there are low numbers of grade 3 and grade 4 incidents recorded.

We noted that the trust had a high level of reported medication errors compared with other trusts. When we discussed this, the trust, confirmed that it had a low threshold for reporting such incidents, including prescribing, dispensing and administration issues.

One report highlighted the lack of a dedicated tissue viability service for the trust and a business case was being prepared to resolve this. However, we found that in some cases the actions arising from the investigations were sometimes weak. For example, one report contained the phrase “retrain the staff member who made the error, raise awareness with staff”. These actions did not fully address the wider issues relating to the incident or involve any measures that would demonstrate that the actions taken had been effective in reducing the risk of reoccurrence.

Are services effective?

Appraisal and performance management

There was a new Performance and Development Review policy out for consultation with staff representatives.

The documentation linked the trust’s 20:20 vision, principles, behaviours and objectives to the process. Additionally, the policy included the ‘Trust Pledges’ that required those in a managerial role to self-assess their performance against the pledges.

There was an expectation that line managers met with staff regularly for an informal review and a more formal mid-year review. However, they were not required to document these events.

There was a lack of consistency across the trust in how this policy was implemented. A number of the staff we spoke with said that they did not have regular meetings with their line manager. Staff held mixed views of the process. One member of staff had never had an appraisal and never saw their line manager; another confirmed that they received regular appraisals and felt their professional development was linked in to the process. Other comments ranged in between these two points.

An audit was being carried out on the views of staff about the effectiveness of the process, but the results were not available at the time of our site visit

We also heard mixed views regarding the management's response to staff not behaving consistently with the values of the trust. For example, the trust confirmed that senior clinicians had been disciplined when behaviours were not appropriate, indicating that the trust was prepared to take action when required. However, many of the issues raised by staff in the drop-in sessions related to inter-staff issues/grievances that they felt had not been adequately addressed.

Doctors in training told us that they felt well supported in their roles and supervision was effective.

The most recent staff survey results show that 87% of staff had an appraisal in the last 12 months, which is above the national average (80%).

The result for support from immediate managers was slightly worse than the national average. There was no change from previous years.

Monitoring of completion of appraisals for the last seven months showed amber and red performance across all divisions. The limits for the RAG rating were reduced in September 2013 for red to be below 79%. The range for June 2014 was 56% to 88%, with an overall 82% for the trust. The worst performing division was Performance (56%). This equated to 18 members of staff. Completion rates were monitored through Divisional Boards. The HR Director told us that staff on long-term sickness and maternity leave were not included in the figures and they were confident that the data was accurate.

A process of Team Performance Review was devised for departments where it may be inappropriate for staff to have individual objectives, for example, the Estates and Facilities department. However, appraisals for these teams were still captured in the overall data.

Are services responsive?

Complaints management

The level of complaints is relatively low, with 66 complaints made in 2013. This is similar to other specialist trusts based on Monitor's benchmarking information Complaints were resolved informally where possible. All complaints were seen centrally in Quality and Governance and an investigating officer appointed.

The complainant was contacted and a plan agreed with them. Complaints were monitored through the Divisional Boards, the 'Risk and Quality Governance Committee', and the Patient Experience and Patient Safety Committee, as well as at Board level. Serious complaints were reviewed by the Executive Team at their regular weekly meetings.

Ninety-five per cent of complaints were closed within the trust's target during 2012/13.

As part of the trusts planned audit programme an external consultant had completed a review of complaints earlier this year. As a result, an action plan had been developed to further improve the trust's response to complainants.

The Patient Safety and Experience Quarterly report included an analysis of complaints data and PALS data. The report included both positive and negative comments from the PALS data.

Is the service caring?

Patient involvement and experience

Recent data reported back to the trust informally by the Picker Institute shows that 96% of patients would be willing to recommend the trust.

Members of the Patient Experience Committee were very enthusiastic about patient involvement. The trust draws on all national surveys such as the cancer patient survey, chemotherapy survey and the radiotherapy survey, and uses the survey results (that are largely very positive) to review and improve patient experience.

Members of the committee include patients, and the committee holds focus groups for these patients about four times a year on specific patient-related issues.

In addition, 200 patients a month were surveyed using iPads and 'every patient in a day surveys' were also carried out. Patient feedback was used to improve services.

Patients we spoke with were very positive about the care they received at the trust and felt listened to and involved in decisions about their care.

Patient information was well presented there was information for patients who had agreed to participate in research projects and clinical trials.

Patients were involved in service development and there had been comprehensive consultation with patients and a range of key stakeholders as part of developing the 20:20 strategy.

Are services well-led?

We found that staff were proud to work at the trust and were passionate about providing high quality care and good patient experiences. There is strong medical and senior clinical engagement and clinical outcomes were good.

The executive team were broadly considered to be visible to staff, but non-executive directors were considered unknown. We found areas of the trust where there was strong staff engagement and support for the leadership team.

However, some staff groups and grades of staff felt disengaged and not listened to by senior managers. They felt that the trust did not consider their contribution to be important.

There was widespread support for the trust's 20:20 vision. However, we were not assured that the trust's values/behaviours were well embedded throughout the organisation.

In addition, there were a number of governance systems and processes that would benefit from review and additional scrutiny so the trust can fully assure itself of its performance.

However, we found no evidence of serious widespread cultural or governance issues within the trust.

Detailed findings: Well-led

Vision and strategy for this service

The trust's 20:20 vision presented its plans and ambitions for services, research and education until 2020. The vision set out the trust's commitment to continuously improving the provision of cancer services to its patients. The vision had been the subject of wide consultation and was well publicised and visible throughout the trust. The 20:20 vision included four Key Themes: Leading cancer care; the Christie experience; local and specialist care; and best outcomes.

The trust had a strategic plan for 2014-2019 and its strategic objectives were clearly articulated in the Quality Strategy 2014-2017.

Risk Management; Organisational Development, Education and Clinical Audit strategies are an integral part of the quality strategy. The strategy has four core objectives:

- To ensure a culture where high quality care and outstanding leadership are fundamental in all that the trust does.

- To promote and support quality initiatives and develop quality improvement incentives.
- To use data to demonstrate best outcomes and achievement of established standards.
- To ensure the delivery of quality standards is inherent in the attitudes, behaviours and performance of the trust's workforce.

The trust had developed an Organisational Development Plan/Strategy that was being implemented at the time of our visit.

Governance, risk management and quality measurement

There was a devolved performance management system to divisional level, and divisional boards met monthly and monitored key performance indicators such as sickness, absence, incidents and complaints. Performance was then reported through the identified committees and upwards to the board.

We saw robust evidence to show that Board Assurance Framework (BAF) was presented every six months to the board and quarterly to the Quality Assurance and Risk Committee The BAF for 2014/15 had not yet been completed at the time of our visit. However the BAF for 2013/14 had been completed.

The Risk Management Strategy and Framework clearly laid out responsibilities and roles within the process (RM01 v 01.4 issued October 2011 was under review). There were detailed scoring criteria and detailed terms of reference for each of the groups with a remit for monitoring risk.

The divisional director for each division was required to develop a divisional risk register based on extreme and high level corporate risks and local risk assessment scores. Ward and departmental managers were responsible for managing risks locally, for establishing risk registers for each clinical and non-clinical area and for reviewing and updating these registers.

All high level risks were reviewed monthly by the divisional general manager and reported to the divisional boards and risk and quality governance committee. In addition, all risks on the risk register were reviewed quarterly by each division and documented clearly in the divisional board meeting minutes. The top 10 key risks on the risk register were formally reviewed at each meeting of the risk and quality governance committee, when a representative from the division was required to attend to submit their intended risk treatment action plan. A report of a review of the full register (i.e. all risks recorded on Datix) was submitted to the risk and quality governance committee every six months.

However, there did not seem to be a single document that had all the risks recorded in one place. We were informed that corporate risks were drawn from the divisional risk register.

Some risk registers we reviewed were clear with controls and mitigating actions recorded and well-articulated. Others were less clear regarding controls and mitigating actions.

We considered some items included in the registers to be routine business matters, such as manual handling training and control of infection risks. One ward manager informed us that the risk register was used to get managers to listen to their concerns as this had been the only way in the past that they could secure action. However, we were informed that this approach was no longer working and the ward manager had been told to downgrade some of the risk grading's.

We reviewed the Quality Assurance Committee (QAC) annual reports (2012-2013 and 2013 to 2014). We found that both annual reports did not contain sufficient analyses and data to enable the Board of Directors to obtain robust assurance that all quality and safety issues had been monitored effectively.

The reports show that the QAC met four times a year, and had an additional joint meeting with the Audit Committee. There was insufficient detail about areas of concern, governance lapses or how the committee had reviewed and evaluated the evidence it was presented with to come to a position of assurance.

We also reviewed minutes from the Quality Assurance Committee meeting and found that sometimes the minutes did not provide evidence that the Quality Assurance Committee had an inquisitive culture in which data is challenged. For example, the February 2014 minutes relating to the audit of the whistleblowing policy did not show evidence that the QAC sought assurance that staff had been asked how confident they felt about raising concerns. It simply stated that four whistleblowing concerns had been raised (two through CQC and two internally).

Similarly, the evidence referred to is the trust's Consent to Treatment policy. No audit or patient experience feedback data is presented to support the conclusion that the trust is compliant with the standard.

This is also the case relating to patients at risk of suicide, homicide or harm; the evidence collated does not use incidents, claims or complaints or PALS data to provide assurance that no harms or poor patient experience had occurred for this group of patients.

In the end of life care action plan there was an action that every patient should have a named registered nurse and stated under the progress column that this was discussed at the band 7 nurses meeting in August 2013. It then stated that the action was complete. But no audit data is presented to provide assurance to the QAC that on any given day, patients surveyed had a named registered nurse.

This is important because if the committee does not constructively challenge the data it is presented with, then conclusions drawn from the data may be sub-optimal.

We observed a Board of Directors meeting held on 28 July 2014 and noted that the QAC report to the board stated those papers the QAC had received last month. There was a lack of information about what problems the QAC had identified, where the risks to quality were and what assurance had been secured in relation to robust action plans to resolve the issues identified.

At the time of our visit the trust was planning to commission a governance review against the Well Led framework that was in line with the expectations set out in the Risk Assurance Framework for NHS foundation trusts. We would expect that this review, coupled with our findings lead to improvements in governance and risk management processes.

Audit

Audits are monitored at Divisional Boards and the trust's Quality Assurance Committee.

There is a comprehensive audit programme and the trust contributes to 100% of national audits it is eligible for. There is evidence that the trust uses outcomes from national audits to improve and support changes in systems and practice. A new policy had been introduced to capture more internal audit projects.

However, only 45% of clinical audit projects were completed last year. There was no clear evidence of assurance that a robust plan had been developed to recover from the position where many audits were overdue for completion.

Leadership and culture

Staff were very proud of the work they did and proud to work at the trust. There was a very strong commitment to delivering the best for patients. Care and treatment was patient-centred and clinical outcomes were very positive.

Clinical staff felt that they were supported to develop professionally. Research and innovation was supported and encouraged.

Clinical staff were highly engaged and we found very positive examples of clinicians influencing and being involved in high level decision-making about the provision of services.

Nursing staff were generally positive about their line managers and the support they received and found the senior team to be approachable and accessible.

The outpatients department was one area where there had been a lack of consistency in leadership, and staff shortages were affecting the staff. Although there were no concerns regarding the delivery of care to patients, some of the staff we spoke with expressed concern about high levels of stress related to short staffing.

In addition, staff expressed concerns regarding patient administration, in particular the scheduling of outpatient appointments, timely provision of patient letters and the filing of patient notes. There was also some concern about the way the trust was recording data in relation to patient waiting times within the outpatient department, and that the methods of calculation were not accurately reflecting patient waiting times. This may mean that the trust is being falsely assured as to its performance in this area.

We found that in the outpatient department a local policy had been implemented for taking time off in lieu that did not allow staff to record periods of less than 30 minutes. This meant that if staff worked 25 minutes extra on a shift, they were not able to record and take this time back in lieu of hours worked. Some of the staff we spoke with felt

this was unfair. There was no evidence in the documents available that this protocol had been ratified through the trust's governance procedures. The director of nursing and quality was not aware that this protocol was in place and agreed to look into this local arrangement.

Non-clinical staff were less engaged and some felt remote from the senior team. This was a particular issue in the estates department, who felt the trust had not responded to some long-standing management issues in an appropriate and timely way. Non-clinical staff also expressed concern that they were not as valued as their clinical colleagues and that the matters they raised were not always heard or escalated appropriately.

We also heard some reports from staff that policies were not applied consistently and it was not clear that the values of the organisation were reflected in the behaviours of all managers and their approaches to performance appraisal. This was a particular issue with staff graded at band 4 and below.

It was not clear that the trust fully analyses available data to gain an insight into cultural differences and performance across the trust. For example, the HR team did not know how staff survey data or sickness/absence rates compared across departments or directorates and the trust relied on line managers to record reasons for resigning (exit interviews having recently been discontinued due to lack of take-up). The monthly integrated performance report breaks down some data by division, but there is no sub-division or ward data available. We found that the trust monitored referrals to occupational health (OH) by area and that this is reported to the Health and Safety Committee: it was not apparent that this was reported to the board.

Monitor's benchmarking data demonstrated staff turnover to be average, and appraisals to be in the top quartile for specialist foundation trusts. However vacancies were in the upper quartile.

Improvements were being made to Human Resources (HR) processes to help identify and understand cultural issues within the trust. The trust has developed an Organisational Development Strategy in support of its 20:20 vision strategy that included objectives regarding the improvement of staff engagement and supporting staff to maintain their health and wellbeing.

Key initiatives that were being introduced included implementing a monthly local friends and family test, and strengthening workforce information (e.g. analysis of sickness absence by reason) to facilitate better trend information and early identification of concerns as well as the establishment of the 40 Christie Commitment Champions.

The senior team and the board were visible within the trust. The executive team carried out regular executive walk-rounds, including the Chief Executive, Executive Director of Nursing and Quality and Medical Director (among other executive directors). The executive walk-round programme 'tracker' clearly shows that patients were included in the walk-rounds and that their views were sought.

There was a strong focus on cleanliness and facilities-related issues. However, the executive walk-round action tracker did not show evidence that the executive team identified patient safety issues, take these away and own them. Beyond cleanliness and facilities issues there was little evidence to indicate that the executive directors were actively seeking out what problems and challenges were faced by front line staff.

We found this was a missed opportunity for the senior team and the board to actively seek out the challenges and safety issues and compare this information to the performance data and use it proactively to prevent problems developing.

Leadership development

The trust had a bespoke leadership development programme in place. The 4th cohort of 10 staff were currently undertaking the programme. This included a 360 degree feedback programme that was also bespoke. The purpose of the programme was to support the professional development of managers and leaders within the trust and develop potential. The nursing staff we spoke with were very positive about this programme and felt that it supported their professional development as managers and leaders.

However, We heard concerns from non-clinical staff about the quality of management skills demonstrated by their line managers. We were not assured that leaders at every level within the trust built effective team relationships, encouraged and supported inter-team and cross-boundary co-operation, or demonstrated trust and openness.

Support for staff

There were three stated routes for staff to raise issues of concern – Respect at Work (the bullying policy), through raising a grievance or the whistleblowing policy. Mechanisms for handling these issues were explained in the Equality, Diversity and Human Rights training and in an ‘e-lite bite’ module. Ninety-seven per cent of staff had completed this training.

Staff advisors were available and easily contacted through the Discover web page and were advertised in the staff newsletter ‘Chinwag’, published quarterly.

Staff reported that they knew how to raise personal concerns and most felt comfortable in doing so. They were familiar with the Human Resource policies and procedures and knew how to access them.

The respect at work policy audit report 2013, presented at a staff forum on 25 June 2014, showed that the advisors were contacted 14 times from April 2013 to March 2014, raising 10 issues of bullying and four of harassment. This was a reduction from 16 in the previous year. The Employee Assistance Programme received four requests for support for bullying in the year 2013-14 and six in the previous year.

For the year 2012-13, the Human Resource department received eight complaints (one upheld) under the Respect at Work Policy and seven grievances (one upheld and one in part) relating to bullying.

There is a staff wellbeing programme led by the Director of HR. All new polices were subject to an equality impact assessment.

We met with staff representatives who reported mixed experiences for staff. Some felt that the HR processes became protracted and that resolution of concerns and performance issues were not completed in a timely way, which could be distressing for colleagues.

Patient feedback

The management team highlighted a number of ways in which the trust actively gathers feedback from patients. There is also a patient forum that meets twice a year and reports into the patient experience committee. We heard about changes in process that were made in response to patient feedback, such as patients now being assessed on one day and treated the next so that they came to the trust for two shorter sessions as they had requested.

Although our work identified concerns regarding the engagement of some staff groups and some areas for improvement within the governance arrangements in the trust, we did not identify sufficient evidence to conclude that there are serious failings of governance or widespread systemic concerns about the culture of the organisation.

Innovation, improvement and sustainability

The trust has an international reputation for research and development in its specialist field and is widely involved in international research and development, The trust supports early phase clinical trials and was actively leading a wide range of cancer research projects.

The trust is a partner in the Manchester Cancer Research Centre and Manchester Academic Health Science Centre.

The trust was working with other specialist hospitals to benchmark its services.

Areas for improvement

Action the trust should take to improve

- continues to implement its OD strategy and is assured it is fit for purpose in light of the findings of this report;
- considers whether any further enhancement is required to HR processes to help address engagement with non-clinical staff groups, and if so to implement improvements;
- considers whether any further improvements are required in the way it communicates and engages with staff to promote an open learning culture;
- reviews the processes for measuring waiting times in the outpatient department to ensure accuracy of information and timely scheduling of appointments;
- reviews its systems to ensure that patient letters are provided to all stakeholders in a timely way;
- reviews the scrutiny and challenge aspects of the quality assurance committee; and
- takes into account the findings of our work when focusing the scope of its planned governance review against Monitor's well led framework; and the well led domain of CQCs inspection framework.

Annex 2: Monitor's work and findings

1. Introduction/ background

The Christie is a specialist cancer centre based in Manchester. It has around 2,416 staff and an annual turnover of £220 million in 2013/14.

In April 2014, concerns in relation to the Christie were raised to Monitor and the CQC. Monitor and the CQC subsequently met with a group of four whistleblowers in June 2014 to understand the issues in more detail and to seek further evidence. As a result of the allegations raised, the CQC and Monitor agreed to conduct a joint review to determine whether the concerns raised reflected underlying issues with the culture and governance at the trust. It was agreed with the trust that this review would take place under Monitor's existing regulatory oversight role and would focus on the cultural aspects of the well-led framework and the CQC's well led inspection domain. We would like to thank that trust and its staff for their help and co-operation throughout the review.

Monitor and the CQC conducted the joint review in July 2014. This report sets out Monitor's programme of work, findings and recommendations.

2. Summary of work undertaken

Monitor and the CQC conducted a joint three day site visit at the Christie between 28 and 30 July 2014. The review team included: Miranda Carter – Executive Director of Provider Appraisal, Monitor; Ann Ford – Head of Hospital Inspections, CQC; a Provider Appraisal Senior Manager and a Quality Governance Associate from Monitor; 2 CQC inspection managers, as well as CQC specialist advisers on governance, HR and an experienced medical director.

Whilst on site there were a series of joint meetings, focus groups and observations.

These comprised:

- Board observation
- HR meeting
- Quality Governance meeting
- Interviews with:
    - Chair
    - Non-executive Chair of the Quality Assurance Committee
    - CEO
    - Medical Director
    - Director of Nursing
    - Director of Workforce
    - NHSE specialist commissioner
- Focus Groups with:
    - Staff side

- Consultants
- Junior nurses (up to band 7)
- Senior nurses (band 7 and above)
- Junior medical staff
- Allied health professionals
- Administrative and other staff.

We also invited staff to write to Monitor and/or the CQC in confidence with any views they wished to contribute or attend a drop in session whilst we were on site. Monitor received a number of emails, the majority of which were positive emails of support for the trust, its culture and management. However, some raised concerns.

While we were on site a number of staff took up the opportunity to attend drop-in sessions. The drop-in sessions provided staff with the opportunity to speak one to one with a member of the review team in confidence to express their opinions and experiences of the trust.

In addition, CQC members of the review team visited areas of the hospital and spoke informally with patients and a cross section of staff in their working environment.

In advance of our visit we requested a range of background information including recent board and quality committee minutes, divisional governance committee minutes, risk management and incident reporting policies, HR policies, quality accounts, a list of incidents reported, patient and staff survey results, and certain HR data.

Monitor completed a limited scope governance review focusing on the aspects of the well-led framework most pertinent to assessing culture (in particular, the ability of staff to raise concerns and bullying/harassment). The CQC performed a review of the trust focusing on its well-led domain.

3. Summary of findings

We found that staff are proud to work at the trust and are passionate about providing quality care and good patient experience. There is strong medical and senior clinical engagement and the clinical outcomes for patients are good.

We found areas of the trust where there was strong staff engagement and support for the leadership team. Overall the scope of our work did not provide evidence to conclude that there were serious failings of governance or widespread systemic concerns about the culture of the trust.

However, there were some staff groups (notably clerical and administrative, junior clinical and estates) and grades of staff who felt disengaged, unheard by senior managers and felt that some in the trust did not consider their contribution to be important.

Whilst acknowledging the limited scope of our review, from what we and the CQC have seen we were unable to conclude that the trust meets good practice on all aspects of the well-led framework.

Our detailed findings below are set out against the key questions from the Well Led Framework, which were included within the scope of the review.

3.1 Findings linked to Q4 of the well-led framework - does the board shape an open transparent and quality-focused culture?

3.1.1 Staff survey

Our review of national staff survey information showed the trust to perform well when benchmarked against other specialist trusts, for example, on staff engagement, communication between senior managers and staff and ability to contribute towards improvements at work.

The trust scored slightly below average on questions relating to staff feeling satisfied with the quality of work and patient care they are able to deliver, and staff agreeing their role makes a difference to patients.

The percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months as reported in the 2013 staff survey was lower than the average for acute specialist trusts (18% versus 22% average).

The trust scored above average for acute specialist trusts in the 2013 national staff survey on the questions relating to recommending the trust as a place to work or receive treatment. The local friends and family survey results for 2013/14 showed an average of 98% of staff recommending the trust as a place for treatment (the lowest scoring area was clinical networked services with a score of 94%). The survey showed an average of 88% of staff recommending the trust as a place to work; the lowest score when split by department was 56% for those who chose not to declare where they worked.

Overall, the 2013 staff survey results do not show the trust to be a significant outlier when compared with the average for acute specialist trusts.

3.1.2 Analysis of HR data to understand cultural issues

It is not clear that the trust fully analyses data available to it to gain an insight into cultural differences and performance across the trust. For example: the HR team did not know how staff survey data or sickness/absence rates compared across departments or directorates within the trust and the trust relies on line managers to record reasons for resigning (exit interviews having recently been discontinued due to lack of take up). The monthly integrated performance report breaks down some data by division but there is no sub-division or ward data available. We are aware that the trust monitors referrals to occupational health (OH) by area and that this is reported to the Health and Safety Committee: it is not apparent that this is reported to the board.

Monitor's benchmarking data shows staff turnover and sickness levels to be around the median, and appraisals to be in the top quartile level, for specialist foundation trusts. However, vacancies are at the upper quartile.

The HR team explained that it had started to analyse reasons for sickness absence, and the OD strategy includes plans to review and further improve all division and departmental reports to ensure high quality data is available and acted upon.

3.1.3 Addressing behaviour inconsistent with the trust's values

We heard mixed views as to management's response to staff not behaving consistently with the values of the trust. For example, the trust gave examples where senior consultants/clinicians had been disciplined/dismissed where behaviours were not appropriate demonstrating the trust is prepared to take action when required; in contrast, we heard issues raised by staff in the drop-in sessions around inter-staff issues/grievances which they felt had not been adequately addressed.

3.1.4 Visibility of the board

The executive team was broadly considered to be visible to staff, but non-executives were less known The review team noted the trust has a long standing programme of executive walkarounds with staff reporting varying degrees of whether or not they thought these were effective. Some staff highlighted changes which had occurred as a result. The review team is aware there is no standard list within the trust of senior managers who should participate in such events; in some trusts the walkaround programme would also include non executive directors.

3.1.5 Reporting culture

The trust is in the highest 25% of reporters according to the March 2013 National Reporting and Learning System (NRLS) patient safety data, and has a lower proportion of low, moderate and severe level harms than other acute specialist trusts. We noted the trust had a high level of reported medication errors compared with other trusts. This was discussed with the trust, which confirmed it had a low threshold for the reporting of such incidents and which would include prescribing, dispensing and administration issues.

Most staff we spoke to felt comfortable reporting harm and errors and highlighted appropriate improvement actions which had resulted. For example: the junior medical staff focus group noted a non-chemotherapy drug overdose incident that had led to changes in practice and had been communicated to all doctors. However, we did hear from a member of nursing staff who felt under intense scrutiny when incidents were being reviewed although this was not a universal view (junior medical staff in their focus group reported they felt supported). Additionally, we heard from a member of the clinical staff who felt concerns over the lack of staff to deliver high quality services were not receiving timely action by the relevant senior managers.

However, we did identify that some staff felt there was little point in raising certain issues (staffing pressures, health and safety) with management because they did not feel these concerns would be addressed adequately. This was raised in the administrative and other staff focus group, and via drop-in sessions with lower grade nursing staff, estates and clerical and administrative staff.

In the 2013 national staff survey, the trust scored slightly below the acute specialist average for staff reporting errors, near misses or incidents witnessed in the last month (90% versus 92% average).

3.1.6 Communication with staff

The trust has a range of communication forums with staff including a monthly Team Brief meeting where the interim CEO updates divisional leads and general managers on activities at the trust, and a quarterly magazine 'Chinwag' which is circulated to all staff. There are 40 staff champions of the Christie Commitment, who participate in bi-monthly workshops with HR to help develop the OD programme. In the 2013 staff survey, the trust scored better than the average for acute specialist trusts in relation to staff reporting good communication between senior management and staff (39% versus average of 35%).

However our work identified that not all staff groups felt listened to (notably clerical & administrative, junior clinical and estates). Senior management felt there were adequate communication channels but whilst staff agreed with this in some areas, this was not a consistent view throughout the trust. Some staff reported a lack of communication, understanding, explanation and engagement.

We also heard some concerns from staff that the results of surveys were not communicated clearly; this related primarily a survey undertaken in September 2013 in which the trust had started to participate. Some staff (in the senior nurses' focus group and at some drop in sessions) reported there had been no clear statement from management on the outcomes of this survey, which they believed reflected adverse results which were not being shared. We raised this with management who informed us that the outcomes were not communicated as the survey was not fully concluded.

3.1.7 Values and leadership

From our interactions with staff and the HR meeting, whilst there was widespread support for the trust's 20:20 vision we were not assured from the scope of our work that the Christie values/behaviours were well embedded throughout the trust.

We heard some concerns from (non-clinical) staff about the quality of line management skills particularly in the estates department. We were not assured that leaders at every level build effective team, inter-team and cross-boundary co-operation, trust and openness. The quality of appraisals and frequency of 1:1 meetings with managers was raised as a concern by some staff. The OD strategy includes plans to deliver a modular leadership development programme and the trust has started to implement 360 feedback (this has been rolled out to 47 staff in 5 cohorts).

3.2 Findings linked to Q6 – are there clear roles and accountabilities in relation to board governance (including quality governance)?

It is acknowledged that at the time of our review the trust was in breach of its licence in light of board governance concerns principally around the effectiveness of the Board and as a result an Interim Chair had been appointed to address the concerns identified. As part of the process to address the board governance concerns, the Interim Chair had recently made new Non Executive appointments to the Board. Our findings in this section around the board and the effectiveness of its committees should be seen against this context and in particular given the recognition of the need to improve effectiveness of the Board and the recent non-executive appointments it is perhaps understandable that the degree of challenge we expect to be provided by a board was not fully evident.

3.2.1 Quality Committee

Whilst there are governance structures in place which provide for discussion, scrutiny and challenge of those issues affecting the trust, the majority of this function is undertaken by the executive directors of the trust. As an example, the main forum for discussion of the quality of care being delivered by the trust is the monthly risk and quality governance committee which is chaired by an executive director. The NED chaired quality assurance committee meets on a quarterly basis only. Through our meeting with the chair of the committee, coupled with our observations of the July 2014 board meeting and the CQC's findings we were not assured that there is sufficient NED challenge on quality.

3.2.2 Board Observation

We observed the July 2014 board meeting and noted there was limited discussion and debate when quality and performance information was presented. However we did note good engagement of clinicians in the business cases presented. We recognise that the trust has recently made new interim non executive appointments to provide additional challenge to the executive team on quality.

3.3 Findings linked to Q7 – are there clearly defined, well-understood processes for escalating and resolving issues and managing performance?

3.3.1 Risk Management

The board regularly sees the trust's top risks and sees incidents of grade 3 and above (i.e. incidents rated moderate or above, using the NPSA's descriptions of degree of harm/severity). The trust communicates with commissioners on all potential serious incidents (SIs) and investigates these fully; clinical staff were able to discuss changes in practice following SI investigations.

Whilst there is a clear process for SIs and significant risks to patient safety, we heard from some staff via the drop-in sessions/focus groups that not all incidents were acted upon in a timely way. There was a view that, whilst in the majority of cases those resulting in patient harm were addressed, those incidents or near misses relating to staff or system/processes issues were not always managed with the same robustness.

In addition, staff from a range of areas (including junior medical staff) raised concerns with the administration of outpatient appointments, scheduling, letters and notes. We noted that the risk of a large filing backlog is recorded on the networked services risk register with a score of 12 for review at end of July 2014. It is not clear whether scheduling and patient appointment letters are seen as a risk by the trust or not. From our review, we were not clear how this risk is being escalated up through the organisation to ensure it is addressed in a timely way.

These observations raise questions on whether good practice in this area is fully met. A more detailed review would be required to conclude on this area.

Management has informed us that a new electronic patient record (EPR) system was implemented in June 2014 which aims to address the administration concerns. A six month post implementation audit is currently being undertaken by the trust to see if these issues have been resolved. This is scheduled to be reported to the audit committee in January 2015.

3.3.2 Identifying and resolving issues relating to staff concerns

Our work has focused on HR issues as culture was the focus of our work. We have not through our work identified significant concerns around raising and resolving quality concerns.

It is not clear that the board would be aware of detailed feedback from staff (aside from national staff surveys) and the board report accompanying the national staff survey results does not comment on divisional differences to help the board understand the responses in detail. The trust has implemented a local friends and family survey for staff which is reported by division, this covers two questions (would you recommend the trust as a place: (i) to work, and (ii) for treatment). The full year average scores against these two questions showed that 88% of respondents would recommend the trust as a place to work and 98% as a place for treatment. The overall response rate was 28%.

Where detailed data does exist or shows areas of concern, it is not clear that the trust actively addresses this on a timely basis. We were aware from our work that concerns raised by some members of the estates team around local line management appeared to be long standing issues.

At the drop-in sessions, a number of staff raised concern as to the length of time it took to address behavioural issues and poor working relationships. It appears the trust tries to use mediation as a first step, but staff felt that in order to generate any action on their complaint they are pressured to go through a formal grievance procedure which is both stressful and takes a long time: this caused much dissatisfaction.

3.4 Findings linked to Q8 of the well-led framework - does the board actively engage patients, staff, governors and other stakeholders on quality, operational and financial performance?

3.4.1 Patient feedback

The level of complaints is relatively low in absolute terms (66 complaints in 2013/14) although is not dissimilar to other specialist cancer trusts in terms of complaints per patient episode based on Monitor benchmarking information. The management team highlighted a number of ways in which the trust actively solicits feedback from patients. There is a patient forum meeting biannually reporting into the patient experience committee; given the limited scope of our review we have not reviewed the minutes of these meetings to assess the appropriateness of the quality and frequency of this engagement with patients. We were made aware of changes in process made in response to patient feedback, such as patients now being assessed on one day and treated the next so that they came to the trust for two shorter sessions rather than one longer one.

3.4.2 Staff engagement

In the 2013 and 2012 national staff survey, the Christie scored higher than the average for acute specialist trusts on overall staff engagement (2013: 3.97 versus 3.91 average). It scored slightly below the average for acute specialist trusts on staff receiving support from immediate managers in 2013 and the average for staff motivation at work.

From our focus groups and via emails we received, we found that doctors felt highly engaged and listened to by management; however this was not the case for some other clinical staff and for sections of non clinical staff. In the focus groups and drop-in sessions a number of staff (primarily but not exclusively Band 4 and below) raised concerns that their ideas, concerns and issues were not listened to or acted upon by management.

Management acknowledged that structures needed to improve to ensure that views of staff were being heard. The senior management team told us they were aware of concerns expressed by the staff side representatives and were seeking clarification. The HR team had been asked to liaise with the staff side representatives to identify areas of staff concerns which had not been communicated through existing reporting channels. However this process is new and untested.

Some staff at the drop-in sessions raised concerns that staff surveys were not anonymous. Senior management confirmed that the national staff survey is conducted by an external firm on an anonymous basis. We have not tested in detail whether internal staff surveys are conducted on an anonymous basis. There may be an issue in gathering accurate feedback from staff if staff do not believe the assurance from management that responses are anonymous.

Some staff felt there were times where trust-wide policy and procedures (particularly on HR matters) were not being applied consistently across the trust (for example staff sickness policy. This was raised as an issue to us at drop-in sessions, via email and at the administrative and other staff focus group.

3.5 Other matters identified through our review

The following information was observed during our review, whilst not specifically linked to our key lines of enquiry these issues raised would be pertinent to a governance review:

- Staff understood and supported the trust's strategy to increase the provision of ambulatory care where clinically appropriate. Some staff did express concern their workload had increased as a result, with little additional staff support being provided by the trust. A member of staff commented that the workforce plan may not be consistent or lagged behind the trust's strategic direction. We have not tested whether the divisional leadership and workforce structures have been adequately adjusted to reflect the shift in the trust's activity.

- Staff in outpatients raised concerns that certain metrics were not being recorded properly (e.g. DNA rates and 20 minute patient waits) which may indicate either an issue with measurement or a lack of understanding as to how these metrics are measured. We were informed by management that waiting times were subject to internal audit review, however we did not test this under the scope of this review.

5. Recommendations

The CQC has focused its work against the well led domain of its inspection regime; findings in its report are consistent with our work. We have drawn upon the CQC's report to conclude on whether any further regulatory action is required. Whilst we have identified some concerns around engagement with certain staff groups and some areas for consideration/improvement within the governance arrangements in the trust, we have not identified sufficient evidence to conclude that there are serious failings of governance or widespread systemic concerns about the culture of the trust.

Given these conclusions we consider it is important that the trust:

- continues to implement its OD strategy and is assured it is fit for purpose in light of the findings of this report;
- considers whether any further enhancement is required to HR processes to help address engagement with non-clinical staff groups, and if so to implement improvements;

- considers whether any further improvements are required in the way it communicates and engages with staff to promote an open learning culture;
- reviews the processes for measuring waiting times in the outpatient department to ensure accuracy of information and timely scheduling of appointments;
- reviews its systems to ensure that patient letters are provided to all stakeholders in a timely way;
- reviews the scrutiny and challenge aspects of the quality assurance committee; and
- takes into account the findings of our work when focusing the scope of its planned governance review against Monitor's well led framework; and the well led domain of CQCs inspection framework.