The Christie
NHS Foundation Trust

Board of Directors meeting
Thursday 25th May 2023 at 12.45 pm

Seminar Room 4/5, Education Centre

Agenda

Clinical presentation: Aseptic Suite & research including the patient pathway, Anna McNicholas, Lead Aseptic Pharmacist / Damian Child, Director of Pharmacy

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Public items					
16/23	**Standard business**				
a	Apologies			Chair	
b	Declarations of interest			Chair	
c	Minutes of previous meeting – 27th April 2023		*	Chair	2
d	Action plan rolling programme, action log & matters arising		*	CEO	9
17/23	**Board assurance**				
a	Board assurance framework 2023/24		*	CEO	12
b	Audit Committee summary report to Board – April 2023		*	Committee Chair	18
c	PSIRF feedback / discussion following training		**v**	ECN	
18/23	**Key Reports**				
a	Trust report		*	CEO	21
b	Integrated performance, quality & finance report		*	COO	28
c	Risk Management Strategy and Policy 2021-2024 annual review		*	ECN	62
d	CQC update		**p**	ECN	
19/23	**Approvals**				
a	NHS Provider License conditions: self-certification declarations		*	CEO	68
20/23	**Any other business**			Chair	

Date and time of the next meeting
Thursday 29th June 2023 at 12:45pm

CEO	Chief Executive Officer	*	paper attached
COO	Chief Operating Officer	v	verbal
EDoF	Executive Director of Finance	p	presentation
ECN	Executive Chief Nurse		

The Christie
NHS Foundation Trust

Public meeting of the Board of Directors
Thursday 27th April 2023 at 12.45 pm
Seminar Room, The Christie at Oldham, Rochdale Road, Oldham, OL1 2JH

Present: Chair: Chris Outram (CO), Chairman
Roger Spencer (RS), Chief Executive Officer
Kathryn Riddle (KR), Non-Executive Director
Dr Jane Maher (JM), Non-Executive Director
Robert Ainsworth (RA), Non-Executive Director
Alveena Malik (AM), Non-Executive Director
Tarun Kapur (TK), 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
Eve Lightfoot (EL), Director of Workforce
Prof Janelle Yorke (JY), Executive Chief Nurse
Dr Neil Bayman (NB), Executive Medical Director
Sally Parkinson (SP), Interim Executive Director of Finance
Prof Fiona Blackhall (FB), Director of Research
John Wareing, Director of Strategy

Minutes: Louise Westcott, Company Secretary

In attendance: Jo D'Arcy, Assistant Company Secretary
Linda Seddon, Public Governor
Jeanette Livings, Director of Marketing & Comms
Sue Mahjoob, Freedom to Speak Up Guardian

Clinical presentation Tour of the Oldham site and talk from staff & patients and Christie at Oldham and the community, led by Julie Davies, Lead Radiographer, Christie at Oldham

JD led a tour of the Christie at Oldham. The unit opened in 2010 and has all services closer to home including a wig service, there has just been a refurbishment and all flooring and major equipment has been replaced. McMillan have a centre in the unit with information mapped to local services. Benefit's advice is given to patients and frailty assessments are also done. Everything is available close to where treatment is given including physiotherapy and complimentary therapy. There's free car parking for patients too. All disciplines work together. There are SLA's in place for the crash team etc.

JD stressed how involved the staff are with the centre and the community.

The Board spoke to a patient in the waiting area who said the service he gets is fabulous, wonderful and he is so grateful, but the car parking can be a problem when it's already full.

The Board spoke to Sally Goodwin (SG), Senior Radiographer who showed them the new CT scanner. She explained that they do deep inspiration breath hold (DIBH) for breast patients and how it works and that it reduces the dose around the heart. The masks were shown for and how they are made. SG explained that the new scanners give a better patient experience and better-quality scans. The speakers can be set in multiple languages. SG described stress management techniques for patient going through the scanner – few patients need referral to Withington and the CALM team.

The Board had a tour of one of the linear accelerators with Jack Hannant (JH), and Tom Potter (TP), senior radiographers. The new Elekta machines give higher definition are mush slicker and

allow delivery of the best standard of treatment. JM asked f it was nice to work here. JH responded that its good for staff and better for patients who are in & out more quickly.

JH noted that the staff work long days in teams of 4 from 8 till 8. They sometimes work past 8pm if needed. KW asked about servicing of the machines. JH responded that they can add in time at the end of the day when necessary.

Board spoke to another patient who noted she found it very hard on the CT scanner and is going to the Withington site for specialist support to complete her treatment but that the staff were absolutely brilliant.

JD presented some slides to the board about the community engagement undertaken by the service and team. The unit serve a very diverse population ethnically and in terms of deprivation.

JD outlined the ways that the service listens, trains, and fosters links with the community and local groups, JD is part of the Mayors Committee. This results in more referrals into the information centre and increases understanding and brings patients forward to receive treatment.

Many staff live in the locality, the communications team have set up links and they have maintained those links. Rotaries, church groups, mosques, temples etc – people come for open evenings. Local schools are engaged – pupils come and sing at Christmas etc, great for patients.

The community is invited in, visits take place to the community, staff attend meetings and events, and provide information in multiple languages and formats. The local community were brilliant during covid. Local companies supported the centre. Very much a 2-way process.

This expands to other healthcare professionals, and they do training, GP practices & practice nurses are invited in and knowledge is shared. They can then share information on our services with their patients.

GP project – run in 2019 and funded for 1 year to get it established, it is now part of routine service. Approached 29 GP practices – McMillan support free display units for them stocked with the latest information. There is a named link person in each GP practice, and we constantly share information with them. Database of resources established. 26 of the 29 practices are still working with us. This has increased referrals.

All local services and support groups have been mapped so we give patients this information. Can refer them to support closer to home. This is passed on to the Withington site too for them to send patients this information.

Staff badges have flags on to indicate what other languages staff can speak so that patients can see it easily.

Going forward – the team have identified new languages that need to be added e.g., Ukrainian. Also link in with local foodbanks. JD spoke about how staff bought Christmas presents for a patient who was struggling financially.

Sustainability of community engagement, targeting mosques and temples to get more links that can be sustained so we can provide the right information and resources for them and keep that going.

An example was shared of working with people with disabilities and constantly communicating and breaking down barriers by increasing knowledge.

CO thanked JD and the team for outlining their successes and challenges.

RS noted that JD is the exemplar of moving specialised care closer to home. The service has been pioneering and new ideas / development start here because of the leadership and learning that comes from here. Things that Oldham have helped us learn have been applied to our other centres.

JD expressed how proud she is of the team.

AM noted how inspiring the work of the team is. AM noted that not all women go to mosques and temples. JD noted that the team talk to the women's groups and understand that the difference in some cultures means that we must adapt how we approach groups.

Mosques and temples are great fundraisers and do give to us. The link with the mayor has helped with these links as multiple communities are represented in the mayoral group.

Item		Action
11/23	**Standard business**	
a	**Apologies**	
	Prof Richard Fuller (RF), Director of Education	
b	**Declarations of Interest**	
	None received	
c	**Minutes of the previous meeting – 30th March 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 noted on the agenda.	
12/23	**Board Assurance**	
a	**Board assurance framework 2022/23**	
	RS noted the closing position of the BAF. The cover paper outlines how the risks have been scored at year end and which risks didn't achieve the target score. Some risks will be carried over and others have completed at year end. It was noted that the Audit Committee discussed this and noted the carry forward arrangements as well as some risks being redescribed or new based on the new objectives.	
b	**Quality Assurance Committee report – March 2023**	
	KW noted the report and the assurance levels assigned to the items that were presented for assurance. It was noted that many items received high assurance and 2 items received medium assurance. The lost to follow up risk - the committee were assured that the right things were being done but that the actions haven't been fully implemented. This has also been added to the internal audit plan for this year.	
c	**Board effectiveness review**	
	Will be circulated following the meeting. Board members were asked to complete and return.	
d	**Register of matters approved by the board**	
	The Board noted the summary of matter approved by Board in year.	
13/23	**Key Reports**	
a	**Trust report incl Modern Slavery Statement**	
	RS outlined some issues in the report. Financial position at the end of the year – surplus of £1.4m, great achievement	

	and in line with plan. We're still not quite finished with the plan for 2023/24 financial activities. Operationally we have industrial action taking place that's affecting the delivery of services. The milestones for the Paterson redevelopment scheme were achieved at the end of March and the occupation by UoM colleagues is underway. We are now in the phase where basic science colleagues are working from the centre. It was noted that it was 6 years yesterday since the fire. RS mentioned the provider licence has been updated from the end of March. This introduces new requirements in the licencing conditions. On Friday of last week, we were noted of an inspection of radiotherapy services against the IRMER regulations. This is a pilot of a new CQC approach. We must complete a questionnaire, have staff interviews then the CQC will come on site. Board will be kept updated on this. Since the papers were circulated, we have received a response to our factual accuracy response and anticipate publication of our report in the next couple of weeks. RS noted the modern slavery statement in the report and asked for approval of the statement for publication on the website. GP asked what assurances we get from suppliers to ensure they comply with the requirements. RS noted we undertake the required activities in procurement. GP asked if we are doing enough. SP to feedback through the audit committee. SP noted that we work through frameworks and will get further detail to feedback outside the meeting. CH noted the section relating to health inequalities and noted that there are additional duties relating to health inequalities that have come in. A further report will come to Board on what this means for the organisation. CO extended congratulations to the team on the amazing work to complete the Paterson build.	
b	**Integrated performance, quality & finance report**	
	BD outlined the month 12 performance. There was 1 SI incident, no Never Events, no Major and 1 Moderate incident and 4 risks at 15+ Effective There have been 6 cases of C.diff with no lapses in care, 1 case of MRSA with no lapses in care, 8 cases of E-Coli and 8 cases of Covid nosocomial infections. Mandated training is at 87.1%, PDR compliance was at 84.9% and sickness was 4.41% overall. TK asked about IPC measures for covid – BD described this. Performance against some targets is still low and we continue to monitor them closely. 18 Weeks was at **96.7%,** 62 day performance was at **71.3%,** 24 day performance achieved **77.6% and** 31 day performance was at **97.7%** There were 34 x 104-day waiters and 1 patient was a 52 week wait. Referrals were within the predicted range in month and overall activity is on plan with some ups and down as seen in the report. In terms of the financial position, we achieved a £1.4m surplus compared to a	

	breakeven plan Capital performance to month 12 is £3.3m below the proposed plan submitted to NHSE and we achieved 59% of the recurrent CIP 2022/23 target identified. In terms of the Junior Doctors 96-hour Industrial Action, on 11-16th April (just after Easter break). 75% of Junior doctors across the 4 days participated in strike action. In terms of recorded cancellations there were 2 elective surgical cases, 3 day cases, 2 New outpatient appointments and 173 follow-up appointments – all of which have been rebooked. There were more displaced patients and work is being done to assess the full impact. A significant amount of planning was required, and no escalations happened during this period. Everyone was very flexible and the planning worked very well. In terms of the RCN/Unite Strike, planning meetings are established. The RCN were planning 48 hours of action, Sunday 30/4 – Tuesday 2/05, it has just been agreed that RCN legally cannot strike on the Tuesday so it will finish at 11:59 on Monday 01/05. There are no derogations and no strike committees, this is very difficult and will cause problems for us. Unite are taking action for 24 hours on 02/05. There is an impact on activity, and we need to reschedule some planned activities, the strikes will cause problems for patients. Some transplant patients have been deferred. Incident management will be open and there is more senior level presence on site. It was noted that future Ballots are expected. CO noted how difficult the industrial action is for the Trust. Questions were invited. RA asked about the 62 day target and what the sanctions are for non-achievement. BD noted that from June the symptomatic patients will be moved in with standard patients. We are looking at this target as a system which will benefit the patient the most. The target will remain. Action planning focuses on the 24 day internal target. We are also looking at bringing clinics under our control. Bolton is next. BD noted that as a system we will never hit this target if NCA and MFT don't hit it. RS noted that the proposal is to modernise cancer targets to reduce to 3 simple targets. FDS/31/62 – the faster diagnosis standard (FDS) drives the others. Many organisations are struggling with the FDS. Achievement of this will enable sustained delivery of the other targets. The resources required to hit the FDS are the same as those for achievement of other targets such as the 18 weeks. GP noted the positive Friends & Family Test results and wondered if we could look at the key themes to address poor responses. JY noted that the new Lead Nurse for patient experience is delving in to this and will bring the detail to QAC. **Report noted**	
c	**Freedom to Speak Up 6 monthly report**	
	CO welcomed SM. SM introduced herself and noted the activity that's come through in the last 6 months. SM noted that there are no trends in the contacts. Attitudes and behaviours are still the top category. The Trust has purchased a respectful resolutions package that's all about supporting staff with difficult situations, this includes a tool to help people speak up. 1/3 of contacts relate to policies. 1 contact related to patient safety and this was dealt with through the proper	

	channels. 3 related to management support and staffing and this is unusual. The wider context is of the launch of the People & Culture Plan and launch of the Values & Behaviours framework. SM noted the NHSE/NGO Board self-assessment was included with the papers. The reflection & planning tool will be further discussed at the Workforce Assurance Committee in May, and this will be reported back to the Board through their report. Achievements were outlined including promotional videos of senior staff and what it's like to speak up and listen. Ethnic diversity group films were also shared around experience of our staff. A Schwarz Round on speaking up was undertaken. NHS staff survey results were outlined around the 4 questions linked to speaking up, our results reflect national trends. We show a decrease in 'staff confident to raise clinical safety issues' and have improved on 'staff raising anything concerned about would be addressed'. Reporting violence & bullying has fallen. The team are looking on what they can do to address the issues from the survey. It was noted that the violence figures are less reliable as there are very low numbers & this relates to us not having an A&E. A 'Respectful resolutions' package has been put in to support staff with issues relating to areas of worsening feedback. EL noted that we provide divisional breakdowns of reports to look at where issues are raised. Further detail is coming back to the Workforce Assurance Committee. AM asked about the questions. EL noted that we could add in a local question to ask why a response has been given. EL to take forward. We are focusing on the experience of those with protected characteristics. AM asked about national trends and whether we follow these and if so, is there national advice. SM responded that we do follow national trends and that we also look at the national guidance. SM noted the training and compliance and noted the focus on training managers. Going forward the team are looking at the use of the staff survey results to identify where additional effort should be focussed, embedding the Patient safety specialist around a safety culture, development of posters – Who to speak up to/Fear and Futility and indicators of effectiveness are being explored. Honest feedback from the Schwarz Round – people generally share negatives rather than positives. SM noted that this is all about emotions and how things felt for staff. KR noted that a clinical or staffing concern being raised is very unusual and reflects national issues. KR noted that SM is a fantastic FTSUG and great to work with.	**EL**
14/23	**Approvals**	
a	**Corporate and Annual Objectives 2023/24 & risk appetite statement**	
	RS outlined the refreshed corporate objectives and annual objectives that sit under each of these. The Board Assurance Framework will be fully developed from the approved objectives. The Board were asked to note the risk appetite statement that will be published	

	on the website. Board were asked to approve the annual objectives and the risk appetite statement. GP noted that categories of risk appetite are often seen in other organisations, and we may look at developing a similar look to the risk appetite going forward. Approved.	
15/23	**Any other business**	
	No items raised.	
	Date and time of the next meeting	
	Thursday 25th May 2023 at 12:45pm	

The Christie
NHS Foundation Trust

Agenda item 16/23d

Meeting of the Board of Directors - May 2023

Action plan rolling programme after April 2023 meeting

Month	From Agenda No	Issue	Responsible Director	Action	To Agenda no
May 2023	Annual reporting cycle	Integrated performance & quality report and finance report	COO	Monthly report	18/23a
	Provider licence	Self certification declarations	EDoF&BD	To approve the declarations	19/23b
	Annual reporting cycle	Risk Management strategy 2021-24 one year review	CN&EDoQ	Annual Review	18/23d
		Annual sustainability report	ECN	Update	18/23c
June 2023	Annual reporting cycle	Integrated performance & quality report and finance report	COO	Monthly report	
		Greater Manchester Cancer update	GM Cancer lead	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 2023 - no meeting		Integrated performance & quality report and finance report	COO	Monthly report	By email
August 2023 - no meeting		Integrated performance & quality report and finance report	COO	Monthly report	By email
Sep-23	Annual reporting cycle	Integrated performance & quality report and finance report	COO	Monthly report	
October 2023	Annual reporting cycle	6 monthly review of annual objectives / review of strategy	DCEO	Interim review & update	
		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 2023	Annual reporting cycle	Integrated performance & quality report and finance report	COO	Monthly report	
December 2023 - no meeting		Integrated performance & quality report and finance report	COO	Monthly report	By email
January 2024	Annual reporting cycle	Integrated performance report	COO	Monthly report	

Month	From Agenda No	Issue	Responsible Director	Action	To Agenda no
February 2024 - no meeting		Integrated performance & quality report and finance report	COO	Monthly report	By email
March 2024	Annual reporting cycle	Corporate planning (corporate objectives / BAF 2023/24)	Executive directors	Approve next year's BAF	
	Annual reporting cycle	Letter of representation & independence	Chair	Directors to sign	
	Annual reporting cycle	Register of directors interests	Chair	Report for approval	
	Annual reporting cycle	Integrated performance & quality report and finance report	COO	Monthly report	
	Annual reporting cycle	Declaration of independence (non-executive directors only)	Chair	For completion by NEDs	
		5 year strategy 2023-29 - year 1 review	DCEO		
		Digital Update	EMD/Dep CEO	Update	
		Workforce update	DoW	Quarterly review	
		Annual reporting cycle	Chair	Approve	
April 2024	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	
	Annual reporting cycle	Risk Management strategy 2021-24	CN&EDoQ	Annual Review	
		Modern Slavery Act update	CEO	Approve	
		Board effectiveness review	Chairman	Undertake survey	
		Freedom to speak up Guardian report	FTSUG	Quarterly update	

The Christie NHS Foundation Trust

Agenda item: 16/23d

Action log following the Board of Directors meetings held on

Thursday 27th April 2023

No.	Agenda	Action	By who	Progress	Board review
1	13/23c	To look at adding in a local question to the staff survey to ask why a response has been given.	EL	Complete	Reported through May Workforce Assurance Committee

The Christie
NHS Foundation Trust

Agenda Item 17/23a

Thursday 25th May 2023

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
NHS Foundation Trust

Agenda Item 17/23a

Board of Directors meeting

Thursday 25th May 2023

Board Assurance Framework 2023/24

1 Introduction

The board assurance framework (BAF) 2022/23 was presented to the Board of Directors and Quality Assurance Committee in March and Audit Committee in April.

2 Updates to risks

The risks in the 2023/24 framework have been reviewed to reflect the annual objectives against each of the 8 agreed corporate objectives. Some risks are redescribed to reflect changes to the objectives and others have been carried over from last year. There are also new risks that will continue to be developed and described through continual review by the executive directors and the company secretary.

3 Suggested updates

The committee are asked to consider the papers received in their meeting and assign a level of assurance to issues relating to the risks identified on the BAF. This level of assurance will then be added to the BAF and reported to Board. Rolling programmes have been updated to ensure that the committee receives appropriate assurances on the new risks identified for this year.

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

4 Recommendation

To note the Board Assurance Framework (BAF) 2023/24 that reflects the risks to achievement of the corporate objectives.

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	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 asurance committee rolling programmes	None identified		Averse	Quality		**8**						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.	Incomplete data set	**12**	Local audit of compliance reported to Executive Team	None identified	Regular review and reporting to executive team	Cautious	Quality		**12**						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	None identified		Averse	Quality		**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.	None identified		Averse	Quality		**4**						Year end
1.5	Risk of exceeding the thresholds for harm free care indicators (falls, pressure ulcers, venous thromboembolism)	ECN	1	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.	Risk assessments for falls and skin assessment not always completed in a timely manner	**4**	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.	None identified		Averse	Quality		**4**						Year end
1.6	Lack of preparedness for a CQC inspection leading to a poor performance	ECN	2	4	Assessment against standards on going. Timetable of mock inspections being arranged. Looking at Trust wide requirements.	Full understanding of CQCs new approach to inspection	**8**	Good rating 2023	None identified	Engagement in CQC's regulation updates	Averse	Quality		**8**						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	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.	Oversight of potential legislative impact	**12**	Reports to Quality Assurance Committee	None identified	Regular discussion and review of legislative changes through CRSC	Cautious	Quality		12						Year end
2.2	Risk of not meeting year 1 deliverables of the Research & Innovation Strategy	DoR	3	4	Approved Research & Innovation Strategy.	External factors / pipeline of high quality researchers	**12**	Reports to Quality Assurance Committee	None identified	Recruitment & retention plans linked to Trust plan	Cautious	Quality		12						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	None identified		Cautious	Quality		9						
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	None identified		Cautious	Quality		9						

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	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 School of Oncology strategy due to reduction in demand	DoE	3	3	Review the deliverables and prioritise in line with financial investment available. Maximise the potential of external income. Refresh the School of Oncology 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. School of oncology board reports to Management Board.	Continuing inability to deliver all strategic objectives due to difficulty in accessing curent investment funds to deliver new initiatives.	**9**	Reporting to Workforce Assurance Committee and Board	None identified		Cautious	Workforce		9						Year end
3.2	Protected time for staff for the delivery of education	DoE	3	3	Monitoring of workforce numbers / turnover. Active recruitment and investment in Christie pipeline.	External factors / pipeline of high quality oncologists	**9**	Reporting to Workforce Assurance Committee and Board	None identified		Cautious	Workforce		9						Year end
3.3	Lack of progress with organisational governance arrangements for Christie Education	DoE	3	3	Project group in place. Plans established and resourse identified.	External factors	**9**	Reporting to Workforce Assurance Committee and Board	None identified		Cautious	Workforce		9						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	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	DCEO	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		Cautious	Board		6						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		Cautious	Board		9						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		Cautious	Board		12						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	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					12						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.	None identified	**12**	Regular reports to Management Board and Board of Directors	None identified					12						Year end
5.3	Inequity of access for patients to Christie trials due to delays in implementing governance arrangements for Christie led & hosted trails 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 chemeotherapy 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		Averse	Quality		12						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	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	4	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.	None identified	**12**	Executive Team monitor activity weekly. Integrated performance report to Management Board, Quality Assurance Committee and Board of Directors.	None identified		Cautious	Audit / Quality		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.	None identified	External advice sought on new models of working	Cautious	Audit		16						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. Progress and objectives set/reviewed by Quarterly Digital board.	Internal capability & expertise to support system going forward.	**12**	Reports to Management Board & Board of Directors.	None identified		Cautious	Audit		12						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		Averse	Audit / Board		9						Year end
6.5	Reputational damage, service disruption and financial loss due to cyber-attack.	COO	3	5	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.	**15**	Data Security and Protection Toolkit submissions with audits undertaken. Digital board reporting. Board level Senior Information Risk Owner in place.	None identified		Averse	Audit		15						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	None identified	**12**	Published Trust Strategy	None identified		Averse	Board		12						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	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 Asuurance Committee reports	None identified		Averse	Workforce		12						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	None identified		Averse	Workforce		12						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.	None identified	**9**	Nominations Committee decisions reported to Council of Governors. Adgherence to Fit & Proper Persons regulation - report to Audit Committee	None identified		Averse	Audit		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.	None identified		Averse	Workforce		9						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	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		Cautious	Board		6						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 Board of Directors.	None identified		Cautious	Board		6						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	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 Quality Assurance Committee	None identified		Cautious	Audit		8						Year end
8.4	Reduced ability to provide services and support to patients due to national / global influences (supplies / fuel costs / strikes etc)	DCEO	3	3	Group in place to review supply chain. Close working with unions. Business continuity plans in place. Planning meetings in place around strike acton and incident management approach used.	Global position. Lack of control for supply chain e.g. radioisotopes	**9**	Reports to Audit Committee	None identified		Cautious	Audit		9						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		Cautious	Audit		9						Year end

The Christie
NHS Foundation Trust

Agenda Item 17/23b

Meeting of the Board of Directors
Thursday 25th May 2023

Subject / Title	Audit Committee report – April 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 Audit Committee at their April meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions
Background papers	Audit Committee papers 25th April 2023
Risk score	BAF references noted within 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.	DoF Director of Finance CIO Chief Information Officer

The Christie
NHS Foundation Trust

Agenda item 17/23b

Meeting of the Board of Directors
Thursday 25th May 2023

Audit Committee report – April 2023

1 Introduction

The Audit Committee took place on 25th April 2023. The following summary gives the Board information on the items that were considered, and any actions required by the Board.

2 Audit Committee agenda items

The items listed below were all presented to the Audit Committee for assurance.

During the discussions relating to the assurance ratings to be assigned to the relevant agenda items, a requirement for a further discussion to take place was identified to ensure that all Committee members are confident with the process for assigning assurance levels based on the associated BAF risks and the information being presented to the Committee to mitigate those risks. For the purposes of this meeting, the Committee Chair suggested an assigned level of satisfaction until this discussion has taken place.

Agenda item	BAF reference	Assurance rating suggested	Comments and associated action (where applicable)
The Christie Pharmacy Company update	6.4	High	• Company status confirmed as a going concern, a financial surplus of £254K is currently projected for 2023/24. • The Company has established internal governance arrangements with a programme of audit work. • It has been a challenging year with the failing robot and staffing issues. Actions are in place to address the challenges and all identified risks are logged on the risk register. • The final pieces of equipment for the new robot are being installed and staff are being trained on the new system. • The new Pharmacy is aiming for a scheduled opening w/c 15th May. Additional posts agreed to grow the establishment and a review of pay undertaken as salaries had become uncompetitive, have seen significant improvements in recruitment due to this. All changes are affordable and within agreed budgets.

Agenda item	BAF reference	Assurance rating suggested	Comments and associated action (where applicable)
Year-end activity and governance	N/A	High	In respect of the agenda items regarding all the year-end activity and governance in relation to: • accounts finalisation, • annual governance statement, • Committee effectiveness evaluation, • external audit planning work, • receipt of the annual report and progress updates from the internal auditors, and • Head of internal audit opinion A high assurance level was agreed by Committee members following the meeting in terms of the progress being made. Also noted that some comments and questions had been received in advance of the meeting relating to the Committee annual report, annual governance statement and accounts and these are being addressed.

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 Audit Committee in April.

Assurance level descriptions:

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.

The Christie
NHS Foundation Trust

Agenda item 18/23a

Meeting of the Board of Directors
Thursday 25th May 2023

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. It incorporates existing reports and responds to the feedback from the Board Time Out in July 2022.
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
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

The Christie
NHS Foundation Trust
Agenda item 18/23a

Meeting of the Board of Directors
Thursday 25th May 2023

Trust Report

Introduction

Executive Summary

- We have four high risks on the risk register all of which have controls and mitigation in place – these are overseen the by risk committee with assurance provided by the three board assurance committees
- Financial performance is strong with a cumulative £415k deficit against a £607k deficit plan and no significant variances in financial metrics
- GM Integrated Care Board submitted a balanced plan for revenue at the beginning of May
- Operational performance is strong other than for the 62-day referral to treatment standard which we have not met mainly because of referrals being received late in this pathway
- The quality of care remains high with no significant adverse variances in indicators of the effectiveness, safety, or patient experience of our services
- Our workforce indicators show good performance other than the staff absence rate which is slightly above the target threshold
- We are assessing the ongoing impact of industrial action on our patients.
- Research & Innovation have launched their strategy with staff and seen very good performance against internal performance indicators as well as an increase in the capacity of the aseptic service for delivery of trials
- Christie education continues to develop and provide support to staff across the Trust
- We are currently undergoing a CQC inspection of our radiotherapy service for compliance with the Ionising radiation medical exposure regulations (IR(ME)R)
- We have been rated 'Good' by the CQC following their inspection in October & November 2022.

This report brings together the key issues for the Board of Directors in relation to our performance, strategy, workforce, and the Greater Manchester system landscape, the regulatory landscape and other pertinent matters within the scope of the board's responsibilities.

This format consolidates information provided in a range of routine reports for the board and responds to requests from board members for regular and structured reporting of key system and regulatory developments.

Risks

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.
2. Risk of prolonged disruption to services, due to a severe cyber security incident.
3. Risk of delayed cancer referral and treatments due to not meeting 24 / 62-day targets.
4. Risk of patients being lost to follow up.

See details in Integrated Performance, Quality and Finance Report
Responsible Executive Director - Chief Nurse
Responsible Assurance Committee – Quality/Audit/Workforce depending on risk

Financial Performance

Financial performance is ahead of plan. The Trust is reporting a £415k deficit against £607k expected deficit planned position. This is mainly due to interest received being above planned levels and a pay underspend due to vacancies and industrial action. Capital expenditure is £191k over the NHSI plan mainly due to the spend on backlog maintenance and the new ward development.

As shown in the table there are no significant variances from the planned financial performance against key measures.

Measure of Financial Performance	Red / Amber / Green rating
Revenue: Trust Control Total compared to plan	£415k deficit
Capital: Capital expenditure against plan	£191k over plan (48%)
CIP achieved (recurrent) against target	Will report in month 2
Debtor days compared to 15-day target	11 days
Cash balance	£142,842k

2023/24 Planning
The Trust is part of the Greater Manchester Integrated Care System (GM ICS) and as such, must plan for its revenue and capital expenditure to fit within the cumulative capital and revenue limit for the GM ICS.

At the beginning of May, after a prolonged planning process, GM Integrated Care Board (GM ICB) submitted a balanced plan for revenue. Delivery of the revenue plan remains a significant challenge and includes "system savings" of £123m (which remains in the ICB plan and haven't been allocated to individual providers) with no current identified mitigation. This is in addition to significant levels of cost improvement plans (CIP) in individual provider plans. Whilst there are organisations in balance and some with deficits, this is a planning assumption and should the system deliver the revenue plan, the expectation would be for deficit plans to improve.

The Christie NHS FT 2023/24 revenue plan is a £8m deficit. At a high level, this deficit is created by activity in excess of contracted activity plus inflation costs in excess of that funded in tariff. The challenge for the Trust will be to identify and deliver cost improvements (in addition to the CIP already included in the plan) or receive funding for activity delivered to close this £8m gap.

Management Board and Divisions have been briefed on the Trust and GM's overall financial plan; CIP targets have been allocated to individual Divisions.

Financial details are provided in the Integrated Performance, Quality and Finance Report
Responsible Executive Director – Finance Director
Responsible Assurance Committee – Audit

Operational Performance
Overall performance remains strong apart from the 62-day referral to treatment standard. The April 62-day position has deteriorated slightly from March to 71.7% compliance (subject to validation). We have continued to achieve the 31-day standard for treatment to start within 31 days of the decision to treat.

Activity levels are monitored against agreed 2023/24 plan. These will be reported from month 2. Two operations were cancelled on the day for non-clinical reasons in April. Both were rebooked.

Performance details are in the Integrated Performance, Quality and Finance Report
Responsible Executive Director – Chief Operating Officer
Responsible Assurance Committee – Quality Assurance

Quality of Care
The reported metrics confirm that the quality of care at The Christie continues to be maintained despite the pressures of recent years.

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

1:6 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 12 in-patient falls in April (reduced from 22 in March), and only one of these was of moderate harm, with 3 being minor harm and 8 no harm. This equates to 2.58 falls per 1000 occupied bed days (last year's performance was 3.6).

We continue to report cases of a range of infections although other than for C Difficile there are no national standards or thresholds. Although we continue to have patients with C Difficile, reflecting community prevalence of infection and the vulnerability of our patients, audits show that in no case has infection been the result of a lapse in the standards of care. There were 9 cases of hospital acquired nosocomial COVID-19 infections in April. There was 1 MRSA Bacteraemia in April with no lapses in care.

The number of formal complaints decreased in April compared to the monthly average, the number of contacts with the Patient Advice and Liaison Service (PALS) service decreased from 55 in March to 46 in April. No serious incidents were reported in April. There were 14 incidents reported in month with the classification of moderate and none with the classification of major all of which are going through to full root cause analysis. Our post treatment mortality rates remain within the expected very low limits.

See details in Integrated Performance, Quality and Finance Report
Responsible Executive Directors - Chief Nurse and Medical Director
Responsible Assurance Committee – Quality Assurance

Workforce
Our summary workforce performance indicators continue to show overall good performance. The mandatory training compliance is at 89.3% and personal development plan rates are at 84.7%.

Sickness absence rates have reduced in April but are still slightly above the threshold of 3.4%. The annual adjusted turnover rate is at 14.09%. These issues and the associated plans for improvement have been considered by the new Workforce Assurance Committee.

RCN members at the Christie staged industrial action between 30th April and 1st May and Unite members took action on 2nd May. The RCN's mandate for industrial action has now expired and from 23 May to 23 June, members will be balloted on whether to take further action. The BMA will also ballot NHS consultants in England for strike action from the 15th May.

The NHS Staff Council has accepted the pay offer made by the government for Agenda for Change staff in England. The additional payments for the previous pay year (2022/23) will be paid as a non-consolidated lump sum, and the new salary rates for this year (2023/24) will take effect from 1st April 2023. Staff will receive payments in June's salaries.

The Trust celebrated Equality, Diversity and Human Rights Week which took place from 9-12 May 2023. Throughout the week, the Trust shared valuable resources such as blogs, guidance, videos, and case studies aligned to the 4 themes for 2023 which were inclusive recruitment, psychological and physical safety of staff, pay gaps and health inequalities. The Trust's EDI manager also delivered several EDI Roadshows across all Christie sites and the EDI Staff Network Groups promoted National Staff Network Day at the Christie Engagement Stand. Our colleagues in the Catering Department supported the week by serving a selection of "Foods from around the World".

The Trust marked Mental Health Awareness Week from 15th – 21st May 2023. The theme for this year's Mental Health Awareness Week was anxiety. Staff were invited to attend several events intended to increase awareness and understanding around anxiety by providing information on the

things that can help prevent it from becoming a problem and offering preventative approaches and support.
See details in Integrated Performance, Quality and Finance Report
Responsible Director - Director of Workforce
Responsible Assurance Committee – Workforce Assurance Committee

Research
The Research and Innovation Division Strategy 2023-2028 was launched at the April Divisional Board meeting in which around 120 staff attended virtually. The Strategy outlines 6 guiding principles;

1) Research for all patients
2) Valuing & promoting our staff
3) Time to lead research & train the next generation
4) Expanding our research environment
5) Delivering research to patients faster
6) Driving research from idea to impact

The division have seen good performance against key performance targets. The Christie has completed study setup 8.5% faster on average than other UK sites over the last year. The Christie has recruited on average 81.2% more patients than the global average in currently active studies.

Our capacity to produce investigational medicinal products within our aseptic services unit has significantly increased following completion of the isolator replacement programme and recruitment and training of additional staff. Capacity has risen from a limit of around 300 patient treatments a month to a current capacity of circa 400 patients a month (dependent on treatment complexity). Additional recruitment is now underway to ensure that further incremental expansion in both new trials set-up and aseptic production capacity can be delivered to support the Trust's growing clinical trials portfolio.

Responsible Director - Director of Research
Responsible Assurance Committee - Quality

Education
Christie Education colleagues continue to make significant impact through a range of external, scholarly activities.

The Christie Library (Dan Livesey and colleagues) has been commissioned by the International Society of Geriatric Oncology (SIOG) to support guidelines focusing on autologous stem cell transplantation in the treatment of multiple myeloma. This follows a successful evidence review with SIOG in 2022. The Christie Library will be supporting the European Organisation for Research and Treatment of Cancer (EORTC) to conduct a systematic review on non-melanoma skin cancer and quality of life in patients.

Dr Ganesh Radhakrishna (Director, PG Medical Education) completes his tenure as Chair of the Clinical Oncology education group at the Royal College of Radiologists and will take up education editorial leadership for the Clinical Oncology journal.

A joint initiative (MCRC and The Christie) led to a very successful MCRC Christie Alumni reception at ESTRO, with post hoc evaluation indicating the reception was the best attended in comparison to others, was well rated by attendees and provided a real touchstone for some collaborations.

Recent National Awards have included the 2023 Student Nursing Times award (Digital Oncology pathways placement) and 2023 Education, Innovation, and Excellence Award in Clinical Oncology, Royal College of Radiologists (online and collaborative approach to the teaching of communication skills in undergraduate medicine).

Responsible Director - Director of Education
Responsible Assurance Committee - Quality

Strategic and Service Developments
The Paterson project completed on schedule and within budget on 31st March 2023. University of Manchester, CRUK and Christie staff are moving into the building and transferring work from Alderley Park. The established governance meetings will continue until the final account is settled and all staff are transferred but this is a significant and pivotal achievement.

The outpatient pharmacy and new dispensing robot on the Withington site is complete and being commissioned to open in May/June 2023.

Works will commence on the formation of a 20-bedroom ward in the former Trust Administration and Digital floors in May. Several other schemes are at pre-construction and construction stages including the replacement of radiotherapy equipment in Oldham and Salford, the replacement of two CT scanners in radiology and the charity funded Art Room renovation.

The design and engagement for the proposed Advanced Imaging and Scanning Centre development along Wilmslow Road continues with the scheme being well received during consultation sessions and the design developing well.

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

Responsible Director – Director of Finance
Responsible Assurance Committee – Board

Greater Manchester System
A near final draft of the Carnell Farrer report on the Leadership and Governance Review of the ICS has been circulated. The review has identified the further development requirements for the ICS in the context of a system which is one of the largest, most complex, and challenged in the country, and a system which is gradually dealing with a whole set of performance, financial, and population health challenges. The report is clear that to be effective the system needs to work together to address the findings.

The Integrated Care Partnership has published a strategy to outline their priorities for health and care as well as the broader factors impacting health. This is the health & care element of the GM Strategy. The strategy outlines 6 missions;

1) Recovery of NHS & care services
2) Strengthening our communities
3) Increasing prosperity
4) Prevention & early detection
5) Supporting our workforce and carers
6) Achieving financial sustainability

Responsible Director – Director of Strategy, with Chief Operating Officer for system performance issues and Deputy CEO for strategic issues. The CEO is the chair of the Greater Manchester Cancer Alliance Board.
Responsible Assurance Committee – Board

Regulation
We were notified on 21st April of a CQC inspection of our radiotherapy service for compliance with the Ionising radiation medical exposure regulations (IR(ME)R). We are in the inspection process currently and have submitted a detailed response to a detailed self-assessment questionnaire that

we are required to submit. The data submission will be considered by the CQC, and they will follow this up with meetings with key stakeholders in radiotherapy and a site inspection.

Following our CQC inspection in October and November 2022 the final inspection report was published on 12th May and we were rated as 'Good' overall. The Management Board have considered the report and the 'must' and 'should' do's that have been identified and an action plan required by our regulator is being developed together with our operational teams. This is being communicated across the organisation and discussed in key forums and progress will be monitored through the Quality Assurance Committee. The deadline for submission is 5th June. An Independent Culture Review has been commissioned following the report. This will give us a more detailed assessment of the issues and advise us on how we can ensure a healthy culture which promotes engagement and diversity. The terms of reference are published here.

We have received confirmation from NHS England on 18th May 2023 that the NHS response to COVID-19 has been formally stepped down from an NHS level 3 incident. This means that we are moving away from incident arrangements and that the acute COVID-19 data collection process has been stood down. The letter acknowledges that stepping down the incident is done in the knowledge that COVID-19 as a health issue itself, as well as the wider long-term impact of the pandemic, will continue to be significant for years to come. New waves and novel variants will continue to impact on patient numbers, as well as staff absences, and services for those suffering the effects of 'long COVID' will continue to be needed.

Responsible Director – Executive Chief Nurse and Deputy CEO
Responsible Assurance Committee - Board

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EXECUTIVE SUMMARY

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

Safe

- No serious incidents were reported in April. There were 14 incidents reported in month with the classification of moderate, one as minor and one as no harm, details of which can be found on slides 8 & 9. 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 14.
- 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 1:6 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.

Responsive

- Performance against the 62 day standard has not been met with a performance of 71.7%, subject to validation. The 62 day unvalidated upgrade performance is also below the standard with a performance of 65.9%. The internal 24 day target is also below standard and is at 73.5%. All 62 and 24 day breaches are reviewed to ensure any delays are understood and plans can be implemented to mitigate any future delays. All 31 day targets and 18 week RTT standards have been achieved in April subject to validation. Performance against the CWT thresholds is constantly monitored.
- The one patient waiting over 52 weeks at the end of April is an 18 week patient that has complex needs and their pathway includes several missed appointments and treatment dates cancelled by the patient.
- Referral numbers in April expectedly dropped from March due to the Easter period but are in line with the April 2022 total.

Effective

- There were 2 cases of C-Difficile, 6 cases of E-Coli, 4 cases of Klebsiella, 1 case of MSSA, 1 case of Pseudomonas and 1 case of MRSA in April that were deemed attributable to the Trust. No lapses in care have been identified.
- There were 9 cases of hospital acquired nosocomial Covid-19 infections in April due to an outbreak on Ward 12.
- Staff absence levels reduced from March to a position of 3.91% against a target of 3.4%.
- Performance against the against the PDR standard has been maintained and is above the 84.5% standard, whilst there has been a small improvement in the mandatory training performance which is also above the set standard.

Well – Led

- The Trust is reporting a £415k deficit against £607k expected deficit planned position. This is mainly due to interest received being above planned levels and a pay underspend due to vacancies and industrial action
- Capital expenditure is £191k over the NHSI plan mainly due to the spend on backlog maintenance and the TIF ward. The cash balance is £142,842k.
- Performance for month 1 was an overspend of £191k above the plan submitted to NHSE&I.
- The Trust has incurred £588k on capital schemes in month 1, primarily on the backlog maintenance programme and the TIF ward.

SUMMARY DASHBOARD

NHS
The Christie
NHS Foundation Trust

Safe

Indicator	Threshold / Standard 23/24	Jan-23	Feb-23	Mar-23	Apr-23
Serious Incident Reported	-	2	1	1	0
Never Events	0	0	0	0	0
Radiation Incidents Reported (IRMER Reportable)	0	2	0	0	0
Radiation Incidents Reported (IRMER Reportable - Grade 2 or above)	0	1	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
Inpatient Falls Resulting in Harm (Grade 2 or above) - Rate per 1000 occupied bed days	3.6 (22/23 Avg)				2.6
VTE Assessments Completed	95.0%	97.8%	98.0%	98.6%	98.2%
Sepsis - timely treatment with IV antibiotics (established inpatients)	90.0%	97.1%	97.4%	89.2%	96.9%
Sepsis - screening (presenting as an emergency)	90.0%	93.7%	94.2%	94.8%	95.0%
Number of Corporate Risks Grade 15 or Above	-	4	4	4	4
Safe Staffing (% of planned hours vs actual hours across all inpatient areas)	-	92.2%	86.0%	88.1%	82.7%

Responsive

Indicator	Threshold / Standard 23/24	Jan-23	Feb-23	Mar-23	Apr-23
62 Day Compliance	85.0%	66.10%	79.40%	71.90%	71.70%
62 Day Compliance - Upgrades	85.0%	77.50%	78.80%	77.80%	65.90%
62 Day Compliance - Screening	90.0%	77.80%	100.00%	100.00%	75.00%
24 Day Compliance	85.0%	72.30%	85.80%	76.90%	73.50%
31 Day Compliance	96.0%	96.90%	98.30%	97.70%	97.90%
31 Day Compliance - Subsequent Drug Therapy	98.0%	99.20%	100.00%	99.60%	100.00%
31 Day Compliance - Subsequent Radiotherapy	94.0%	99.00%	99.50%	99.30%	99.00%
31 Day Compliance - Subsequent Surgery	94.0%	99.10%	100.00%	98.30%	98.80%
18 Weeks Compliance - Incomplete Pathways	92.0%	97.10%	96.40%	96.50%	96.50%
Patients waiting >52 Weeks	0	2	1	1	1
Patients waiting >104 days at end of month (All 62 Day Targets)	-	38	45	34	34
Length Of Stay (Elective & Non-Elective Inpatients)	6.8	6.58	7.30	7.06	7.77
Hospital Cancelled Operations on the day for non clinical reasons	0	1	1	12	2
Cancelled Operations due to COVID Reasons	0	0	0	0	0
Hospital Cancelled Operations on the day for non clinical reasons - NOT rebooked within 28 days	0	0	0	0	0
Complaints Received	14 (22/23 Avg)	11	15	19	11
PALS Contacts	44 (22/23 Avg)	41	45	55	46
Inquests	-	3	2	0	2
Coroner Request	-	5	1	7	11

SUMMARY DASHBOARD

NHS
The Christie
NHS Foundation Trust

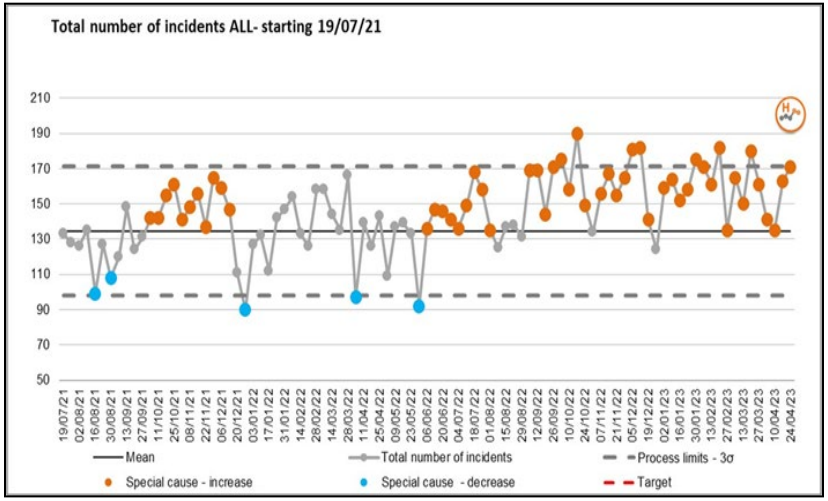
Effective

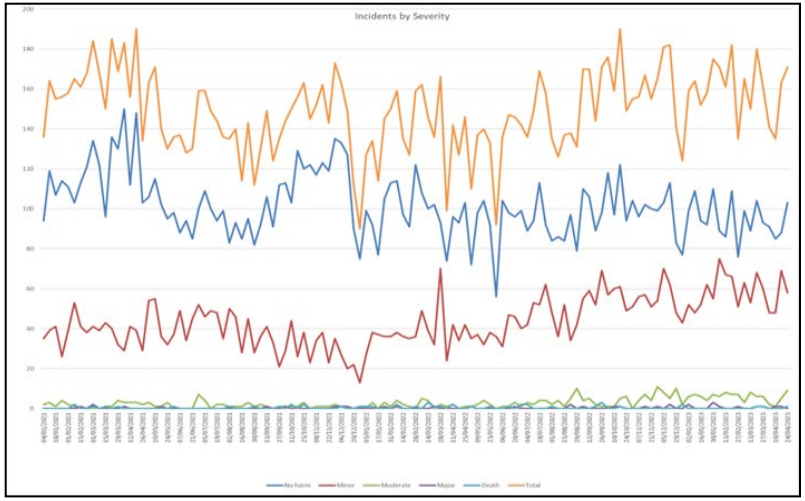
Indicator	Threshold / Standard 23/24		Jan-23	Feb-23	Mar-23	Apr-23
MRSA	0		0	1	1	1
C-Difficile - All Attributable Cases (Pre & Post 48 Hours)	51		5	4	6	2
C-Difficile - Attributable Cases Due To Lapse In Care	0		0	0	0	0
MSSA Bacteraemia - Attributable	25		2	2	5	1
E-Coli - Attributable	58		4	4	8	8
Klebsiella Species - Attributable	17		4	2	1	4
Pseudomonas Aeuriginosa - Attributable	10		1	2	0	1
COVID infections - Hospital Aquired	0		0	0	8	9
Palliative Radiotherapy 30 Day Suvival Rate	-		90.4%	86.5%	88.5%	-
Final Chemotherapy 30 Day Survival Rate	-		99.4%	99.4%	99.2%	-
Surgery 30 Day Survival Rate	-		100.0%	100.0%	100.0%	-
Staff Sickness	3.4%		4.13%	4.05%	4.41%	3.91%
Staff Mandatory Training	>80%**	<80%	88.7%	88.4%	87.1%	89.3%
Staff PDRs	>94.5%	<84.5%	84.5%	82.7%	84.9%	84.7%

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

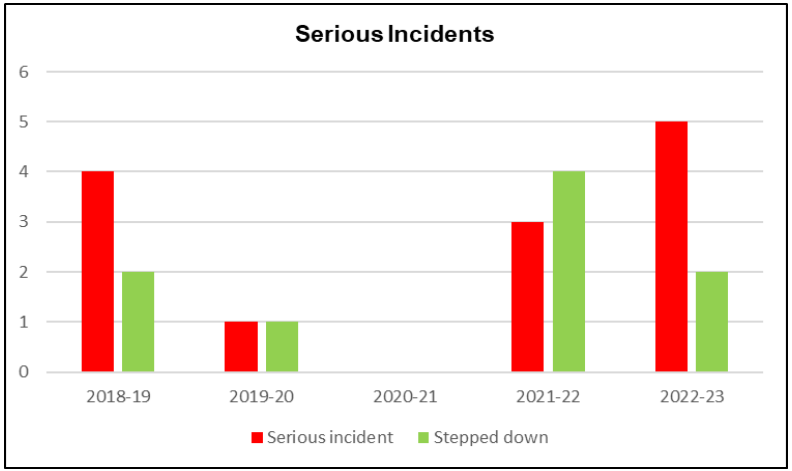
****Infection targets currently set at 22/23 totals whilst waiting on confirmation of 23/24 targets**

1.1 - Incident Reporting





1.2 - 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 were 0 serious incidents identified in April

1.3 – Incidents identified that require a Learning Response

April 2023

Reference	Grade	Description	Outcome
W76876	Moderate	Blood transfusion incident with transplant patient	Root cause analysis
W76702	Moderate	Patient started on doxycycline and co-trimoxazole whilst also receiving warfarin (bleeding risk)	Root cause analysis
W76699	No harm	Incorrect thyroid uptake in thyroid imaging	Root cause analysis
W76535	Moderate	Unwitnessed fall	Root cause analysis
W76619	Moderate	Biopsy sample labelled incorrectly	Root cause analysis
W76924	Moderate	Patient clerked in and continued to be treated with edoxaban	Root Cause analysis
W76592	Moderate	Chest drain removed prematurely, which resulted in the patient requiring a repeat procedure	Root cause analysis
W77170	Moderate	Higher morphine prescribed than was required	Root cause analysis

1.3 – Incidents identified that require a Learning Response

April 2023

Reference	Grade	Description	Outcome
W77116	Moderate	Adjuvant Trastuzumab treatment did not continue after completion of chemotherapy.	Root Cause Analysis
W77140	Moderate	Consultants dictations not typed on 24th February, which delayed referral for radiotherapy	Rapid Review
W77146	Minor	Patient on long-term lithium 1000mg and citalopram 40mg- developed signs of lithium toxicity	Root Cause Analysis
W77136	Moderate	When patient returned to ward patient stated that neck brace and collar not fitted correctly after radiotherapy planning scan.	Rapid Review
W77199	Moderate	Delayed referral for HER2 treatment	Rapid Review
W77270	Moderate	Per usual practice, actinomycin should be omitted from any chemo cycles delivered concomitant to radiotherapy given concerns of radio sensitization, however actinomycin was not crossed off prescription	Root Cause Analysis
W77184	Moderate	MRSA bloodstream infection	Root Cause Analysis
W77116	Moderate	Adjuvant Trastuzumab treatment did not continue after completion of chemotherapy.	Root Cause Analysis

1.4 – Learning - Patient Safety Incidents

Agreed learning and revised severity outcome following executive reviews April 2023

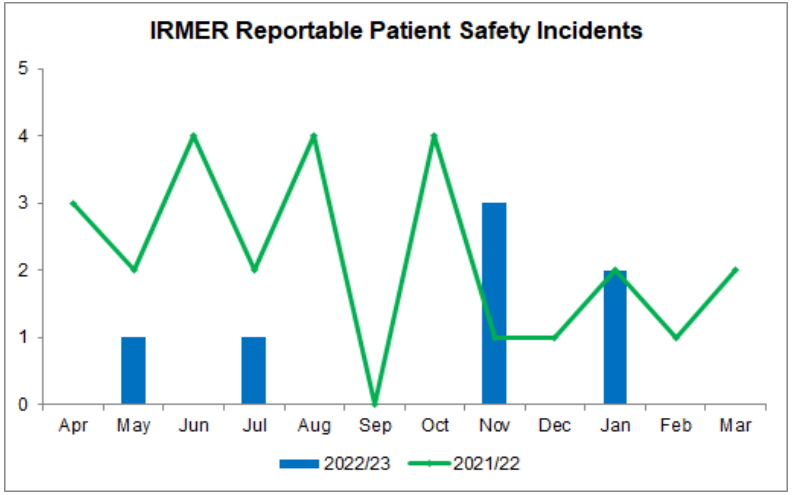
Ref	Description	Root cause	Learning	Outcome
W75018	A product labelled “not for human use” was administered to a patient participating in the phase I clinical trial	Gap in storage management processes - the product was stored on the site for > 12months after the trial opened to recruitment.	• Demonstration kits to be fully quarantined from clinical products • Arrangements for the management and storage of test/demonstration kits used in the clinical trial setting to be incorporated into the quality system documentation (SOP) • Escalation processes should be agreed and clearly documented in an easy to read, accessible format. Procedures will be communicated to all staff within aseptic and pharmacy teams • Learning from the site’s experience to be shared with the sponsor to consider the risks associated with demonstration kit labelling and extended storage of such products at sites.	No Harm
W75184	Delayed transfer to The Christie for urgent radiotherapy to metastatic spinal cord compression (MSCC) from an external Trust	Transport failure on 19/01 could not bring patient to Christie in time for treatment. Inpatient bed not available on 20/01 due to bed pressures across GM	• Clarify policy for treating patients at satellites • Prioritising of capacity at the Christie for MSCC patients • Clearly defined roles responsibilities for each stage of MSCC pathway referral process • Liaise with NWAS re emergency transfer for MSCC and prioritization between the urgent transport team and PTS	Moderate

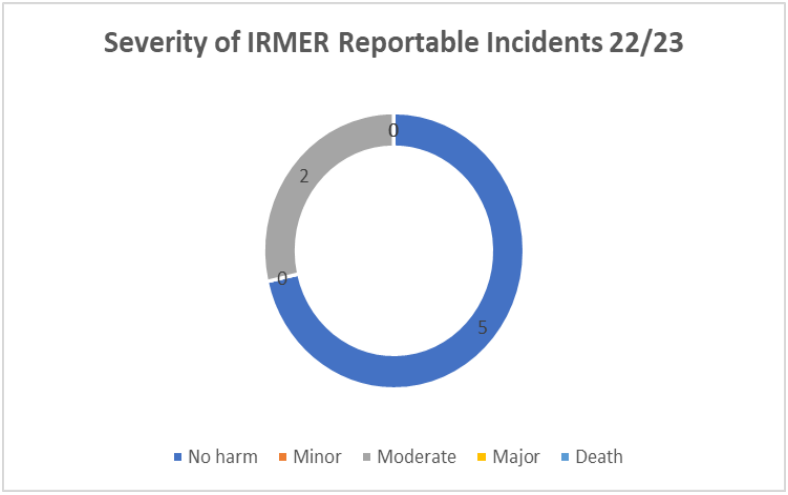
1.4 – Learning - Patient Safety Incidents

Agreed learning and revised severity outcome following executive reviews April 2023

Ref	Description	Root cause	Learning	Outcome
W75440	Tissue samples that were accessed as part of a trial were transferred from ECMT office to the MCRC biobank as agreed in the trial arrangements. Issues with sample traceability and record keeping were subsequently identified during processing within MCRC.	Failure of the TRF team to follow the agreed documented process.	• Reconcile the data from all information systems and update the BioRepository with correct sample information for all TARGET samples (where possible & document gaps in information). Biobank have advised that the remedial work will take a minimum of 6 months to complete. A status update will be given on 30th June 2023. • SOP's for storing and recording samples updated and shared developed to support research teams in the practical implementation of storage solutions for tissue blocks and slides • Review of the storage conditions for samples collected and stored for ECMT studies to ensure they are in line with regulatory requirements and best practice • The mechanism for escalation and support for all members of the TRF team will be clarified, with ongoing input from the Research Manager. The team workload will be monitored, and appropriate actions taken as needed.	Moderate

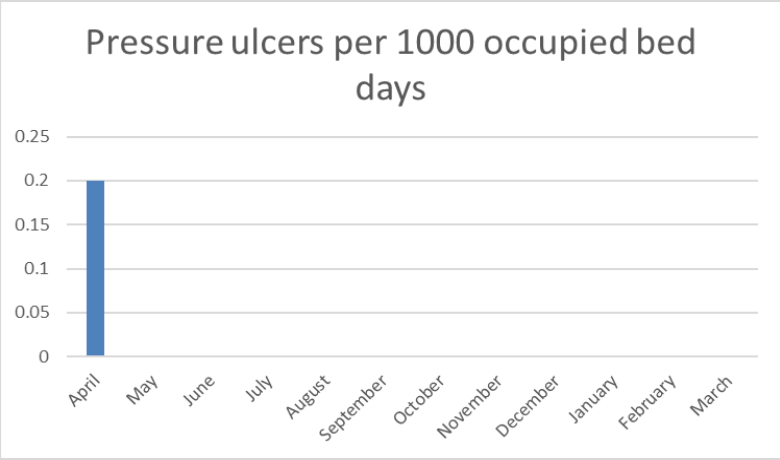
1.5 - Radiation Incidents

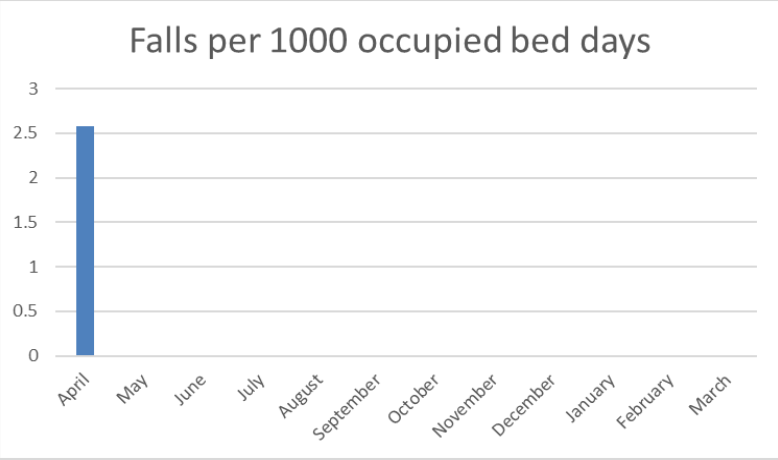




There were 0 IRMER reportable patient safety incidents in April 2023.

1.6 – Harm Free Care





The was one category 2 pressure ulcer that developed during admission in April.

There were no category 3 & 4 pressure ulcers acquired during hospital admission. This equates to 0.2 pressure ulcers per 1000 occupied bed days (last years performance was 0.4)

There were 12 in-patient falls in April (reduced from 22 in March), and only one of these was of moderate harm, with 3 being minor harm and 8 no harm.

This equates to 2.58 falls per 1000 occupied bed days (last years performance was 3.6)

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

1.7 - Corporate Risks

There are 4 Trust-wide 15+ risks in April

Description	Score	Controls
Financial Risk 2023-24 (ID 3378)	16	End of March financial plan submitted to GM at £15.6m deficit; we continue to work with the GM ICB to finalise the Trust's capital and revenue 23/24 plan.
Post clinic appointments processes are contributing to a risk to patients being lost to follow up (ID 3299)	15	T&F group merged with the managed waiting list T&F group as they are both linked and work has been completed on the process mapping of risk in each area. There is a system C demonstration related to the waiting list booked for the 26th April 2023, to review process and application to our trust. ongoing conversations being had with digital about ERS
Risk to delayed cancer referral and treatments due to not meeting 24 / 62 day target (ID 2407)	15	In addition to existing mitigations: 1. Putting in place ad hoc clinics and improving management of clinic capacity around bank holidays. 2. Introducing method of tracking patients through the pathway on a more regular basis using DSMs. 3. Looking to introduce a method of pre-consent ahead of RTP to reduce delays in booking RTP appointments.
Risk of prolonged disruption to services, due to a severe cyber security incident. (ID 3218)	15	CE plus actions (to progress towards the standard) continue to be worked on. Working with NCA and the wider cyber special interest group to help shape GM cyber maturity governance and opportunities on collaborative improvements. GM Cyber crisis simulation event to be run on 20th April (instigated by Christie Cyber Security Manager). National cyber team to focus on assessing approx 25 key suppliers to the NHS. Around one third are used by the Christie. Awaiting further details on timescales

1.8 – 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	17289	13068	5188	5.0
	Total monthly ACTUAL	14372	11501		
	Average Fill Rate %	83.1%	88.0%		
Care Staff	Total monthly PLANNED	10342	5896	5188	2.4
	Total monthly ACTUAL	7514	5149		
	Average Fill Rate %	72.7%	87.3%		
ALL Staff	Total monthly PLANNED	27631	18963	5188	7.4
	Total monthly ACTUAL	21886	16650		
	Average Fill Rate %	79.2%	87.8%		

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	2268	2001	88.2%	1990	1681	84.5%	108	34.1
Palatine Ward	3070	2559	83.4%	2622	2044	78.0%	805	5.7
Ward 10	2610	1931	74.0%	1573	1407	89.4%	677	4.9
Ward 11	1809	1717	94.9%	1520	1473	96.9%	816	3.9
Ward 12	1821	1695	93.1%	1460	1388	95.0%	752	4.1
Ward 4	2201	1935	87.9%	1477	1480	100.2%	780	4.4
Ward 2	1059	695	65.7%	683	455	66.6%	803	1.4
Acute Assessment Unit	2453	1840	75.0%	1744	1575	90.3%	447	7.6
TOTAL	17288.5	14371.91667	83.1%	13067.5	11501.41667	88.0%	5188	5.0

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	575	202	35.1%	0	0	100.0%	108	1.9
Palatine Ward	1285	1152	89.6%	962	897	93.3%	805	2.5
Ward 10	2179	1033	47.4%	684	383	55.9%	677	2.1
Ward 11	1731	1350	78.0%	1134	1070	94.4%	816	3.0
Ward 12	1471	1102	75.0%	929	773	83.2%	752	2.5
Ward 4	1478	1377	93.2%	1136	1128	99.3%	780	3.2
Ward 2	468	344	73.4%	328	277	84.6%	803	0.8
Acute Assessment Unit	1157	955	82.5%	724.5	622	85.9%	447	3.5
TOTAL	10342.25	7513.666667	72.7%	5895.5	5148.833333	87.3%	5188	2.4

Safer staffing numbers have met the required acuity levels to ensure appropriate levels of safety and care for our patients.

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Positive feedback received…..

“I have been undergoing test for penile cancer. I just want to say what fantastic service I received & I wanted to pass on my appreciation. The speed of the process was second to none & the staff, Nurses, Doctors, Surgeon, anaesthetist & support staff have all been very kind, helpful & supportive. I was seen in department 22 penile cancer section. All my appointments have been on time & again the staff from checking in to seeing the doctor have been fantastic. I have received 5 star treatment from the staff at The Christie & professor Sangar's team.”

"Hi just want to say how amazingly I was looked after by Professor Renehan and his team when I came for cytoreduction last year (a year ago as now) the care and support I got was second to none, the carers nurses even the lady that gave me a foot massage. Its been a rough year but I'm getting there .Thankyou all so much from myself and family.”

"I wanted to thank the staff at The Christie for the amazing care you gave my Mum this morning. Receiving such devastating news has been really difficult for mum and the family but everyone was so very kind, compassionate, and altogether lovely.”

"I would like to compliment members of the Imported TIVAD dept today (IPU) whom I met today .The main nurse explained everything to me in a way that reassured me and made me feel confident. She explained step by step what was happening during the procedure and couldn’t have been more helpful and distracted me in a pleasant way , making me forget what was happening. An overall excellent experience Thankyou very much."

2.2 – Friends & Family Test

The Christie NHS Foundation Trust

Monthly Summary

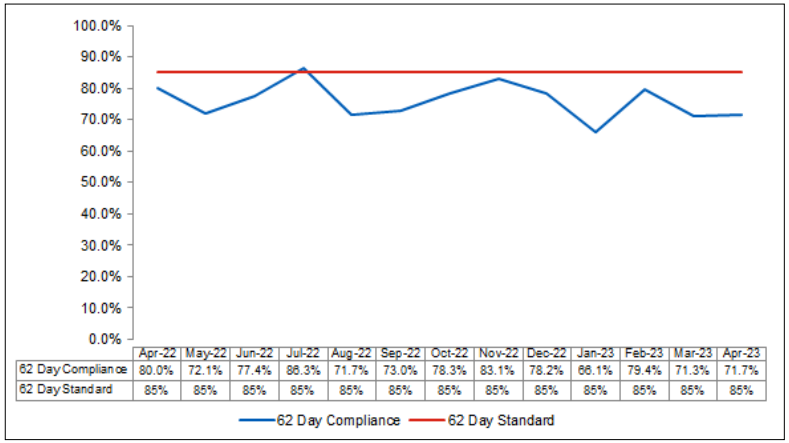
	INPATIENT & DAYCASE RESPONSES						Total Number of people eligible to respond	Total Responses	Response Rate	% Recommended
	1 - Very Good	2 - Good	3 - Neither Good nor Poor	4 - Poor	5 - Very Poor	6 - Don't Know				
Apr-23	207	27	4	0	2	1	780	241	30.9%	97.10%
YTD Total	207	27	4	0	2	1	780	241	30.90%	97.10%

	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%
YTD Total	1348	165	38	19	10	18	1598	94.68%

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)	6	3	0	0	0	0	65	9	13.8%
10 Ward-Surg Onc Unit (Dept 4)	32	2	3	0	1	0	114	38	33.3%
11 Ward (Dept 4)	5	0	0	0	0	0	68	5	7.4%
12 Ward (Dept 4)	3	1	1	0	0	1	56	6	10.7%
The BMR Unit (Dept 16)	14	0	0	0	0	0	40	14	35.0%
Endocrine Ward (Dept 63)	5	0	0	0	0	0	14	5	35.7%
Haematology Day Unit (Dept 26)	30	7	0	0	0	0	113	37	32.7%
Integrated Procedure Unit (Dept 2)	107	11	0	0	1	0	224	119	53.1%
Palatine Ward (Dept 27)	5	3	0	0	0	0	86	8	9.3%
Total	207	27	4	0	2	1	780	241	30.9%

3.1 - Cancer Standards

62 Day / 31 Day / 18 Weeks



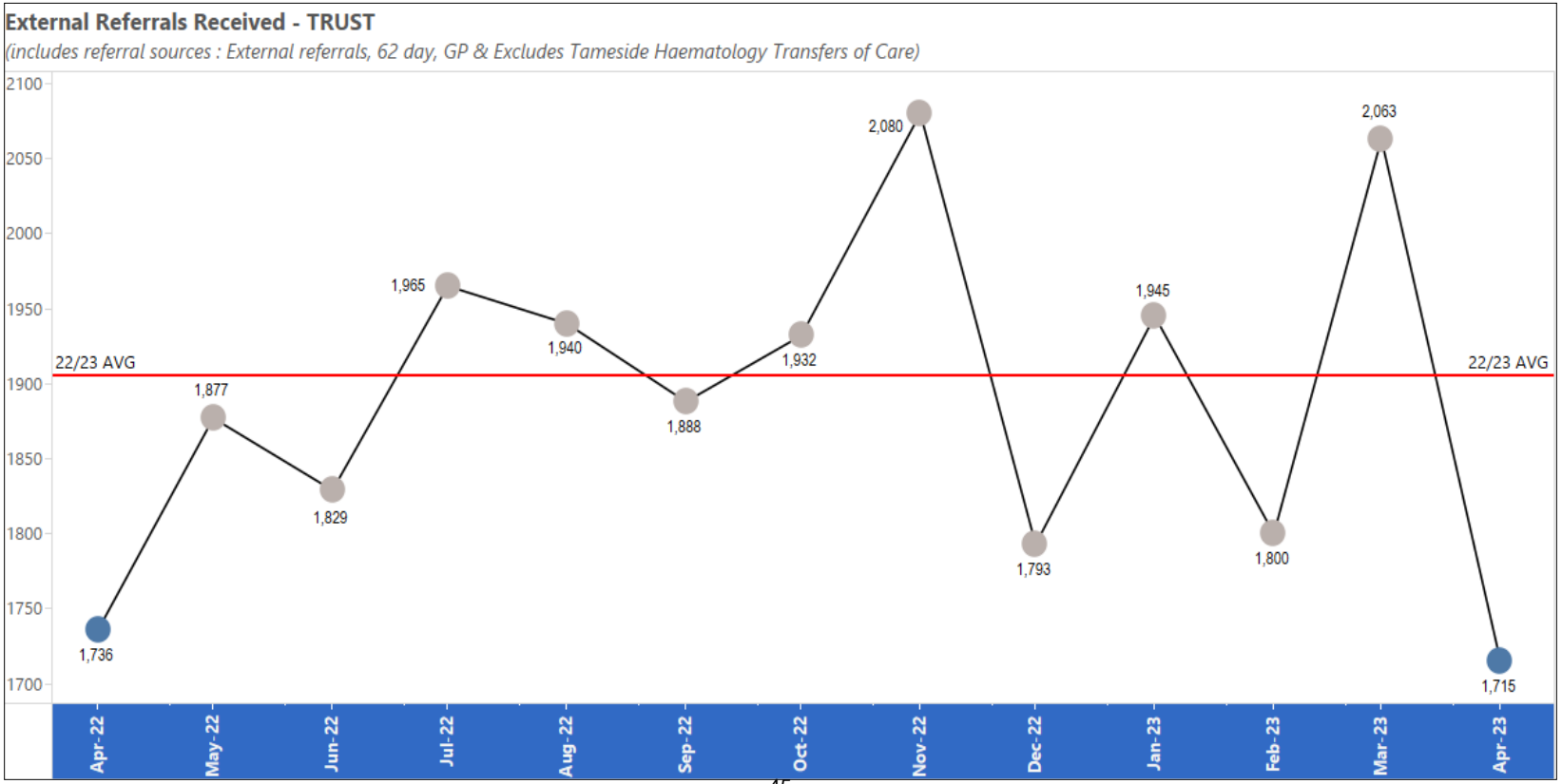
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
62 Day Compliance	80.0%	72.1%	77.4%	86.3%	71.7%	73.0%	78.3%	83.1%	78.2%	66.1%	79.4%	71.3%	71.7%
62 Day Standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

			62 Days			
			62 Classic		Upgrades	
			Pts	Acc Num	Pts	Acc Num
62 Compliance	(CaRP Rec)	Total Timeframe	166	63.5	102	42.5
FULL Christie Compliance	> 38 Days	<= 62 Days	23	23	3	3
FULL Christie Breach	<= 38 Days	> 62 Days	5	5	6	6
50% Shared Breach	> 38 Days	> 62 Days, Treat > 24 Days	26.0	13.0	17.0	8.5
50% Shared Compliance	<= 38 Days	<= 62 Days	45.0	22.5	50.0	25.0
FULL Referring Provider Breach	> 38 Days	> 62 Days, Treat <= 24 Days	67	67	26	26
TOTAL Compliances			68.0	45.5	53.0	28.0
TOTAL Breaches			31.0	18.0	23.0	14.5
% Compliance				71.7%		65.9%

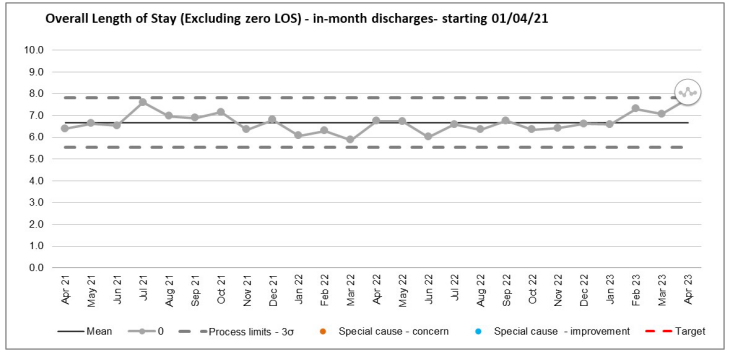
National Standard	Standard	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
62 Day	85%	80.00%	72.10%	77.40%	86.30%	71.70%	73.00%	78.30%	83.10%	78.20%	66.10%	79.40%	71.90%	71.70%
62 Day Upgrades	85%	87.40%	80.40%	75.00%	86.30%	84.30%	86.50%	84.40%	83.00%	80.80%	77.50%	78.80%	77.80%	65.90%
62 Day Screening	90%	66.70%	50.00%	100.00%	83.30%	57.10%	50.00%	88.90%	50.00%	83.30%	77.80%	100.00%	100.00%	75.00%
24 Day Internal	85%	81.20%	80.40%	80.60%	89.70%	79.90%	82.40%	87.60%	84.10%	82.30%	72.30%	85.80%	76.90%	73.50%
31 Days	96%	98.10%	98.00%	98.50%	98.60%	98.70%	98.20%	97.80%	97.20%	98.20%	96.90%	98.30%	97.70%	97.90%
31 Day Subsequent Drug	98%	100.00%	99.60%	99.50%	100.00%	100.00%	99.60%	100.00%	99.70%	99.20%	99.20%	100.00%	99.60%	100.00%
31 Day Subsequent XRT	94%	100.00%	99.40%	99.20%	99.80%	99.60%	99.60%	99.20%	99.50%	99.60%	99.00%	99.50%	99.30%	99.00%
31 Day Subsequent Surgery	94%	100.00%	100.00%	100.00%	100.00%	100.00%	99.10%	99.10%	99.10%	100.00%	99.10%	100.00%	98.30%	98.80%
18 Weeks - Incomplete Pathways	92%	97.80%	98.30%	98.60%	97.90%	97.30%	97.60%	98.10%	98.40%	96.70%	97.10%	96.40%	96.50%	96.50%

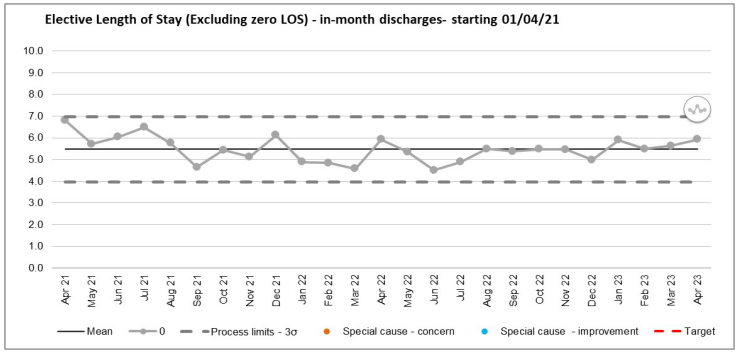
**All target positions are subject to validation and are correct as of the time of reporting.*

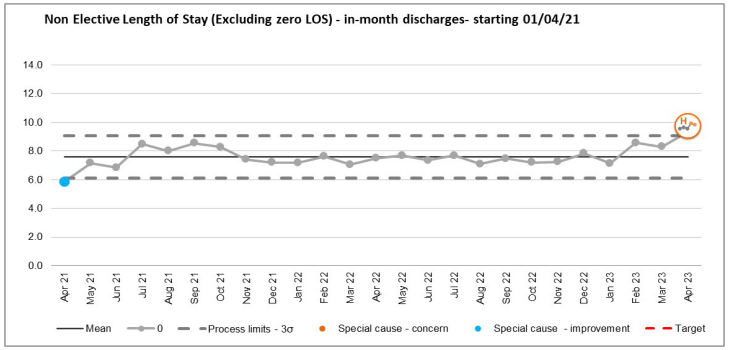
3.2 – Referrals Analysis

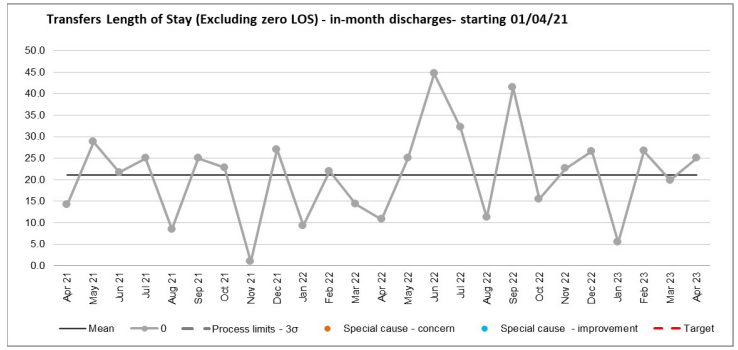


3.3 – Length of Stay



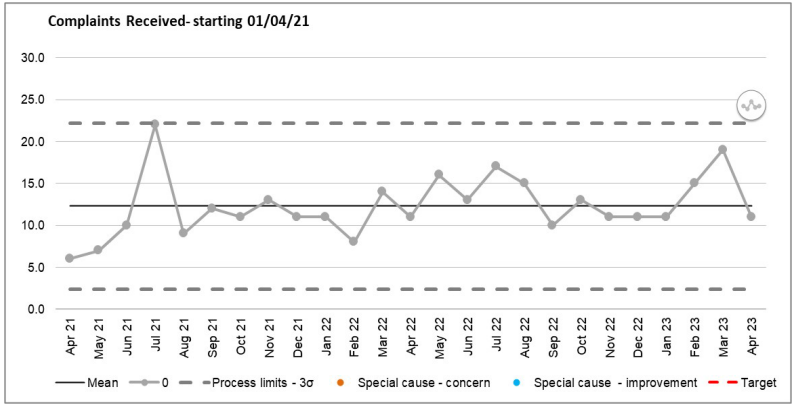






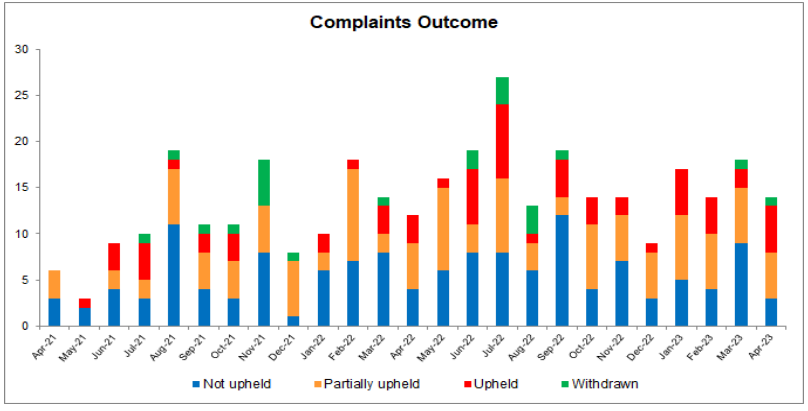
Overall length of stay as well as Elective admission types continue to be well within control limits. There has been a slight raise in non-elective LOS due to the discharge in April of some long stay patients.

3.5 - Complaints



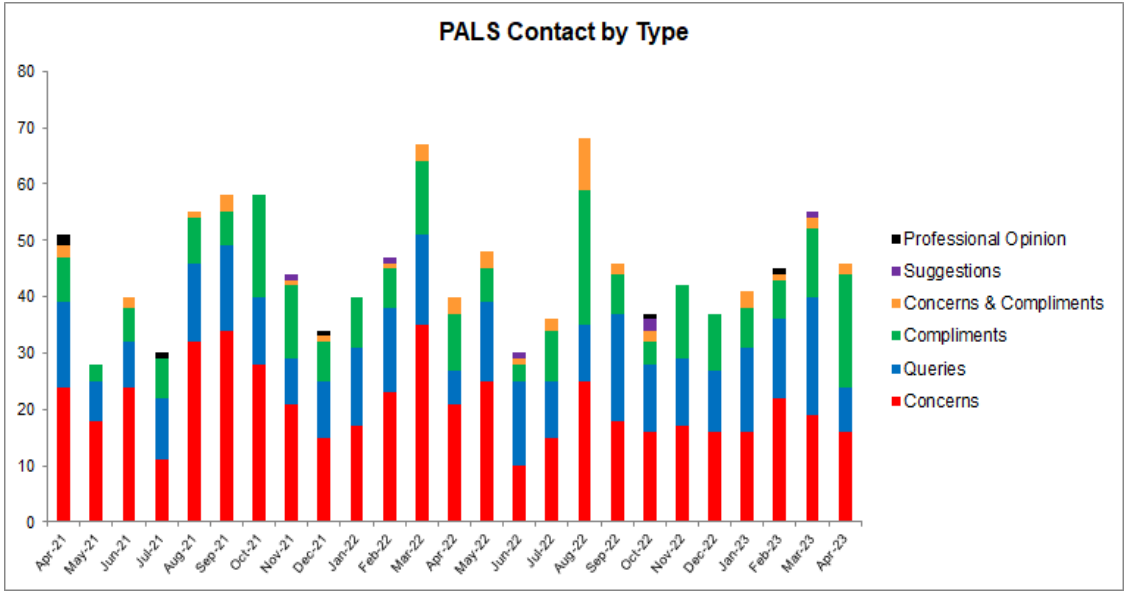
11 new complaints received in April 2023

14 complaints were closed in April 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. 1 case was referred to the PHSO in April 2023. 2 cases remain under investigation.

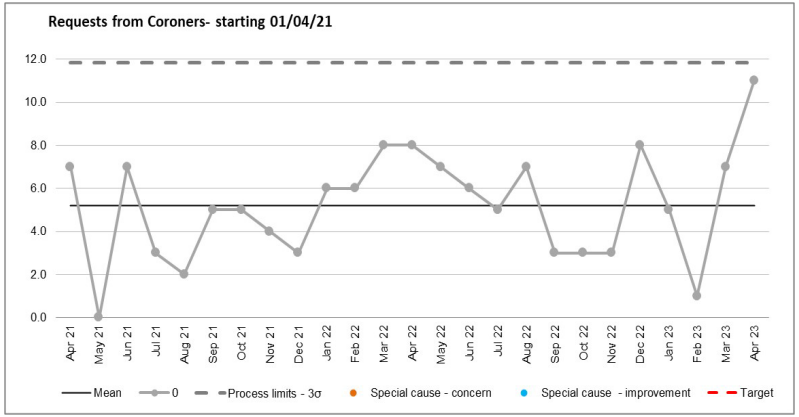
3.5 - PALS

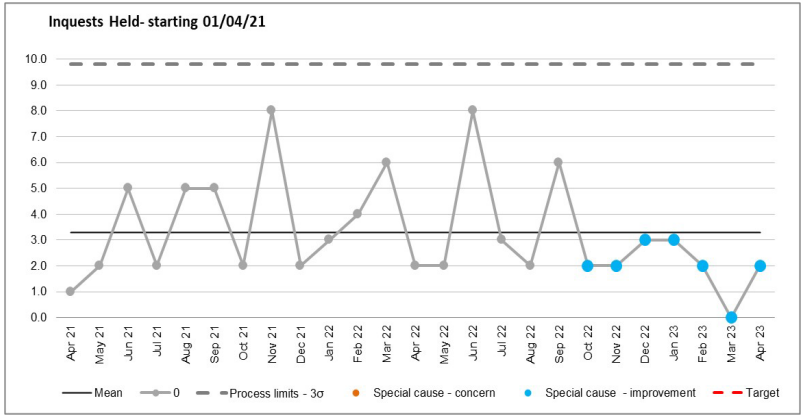


46 PALS contacts have been received in April 2023.

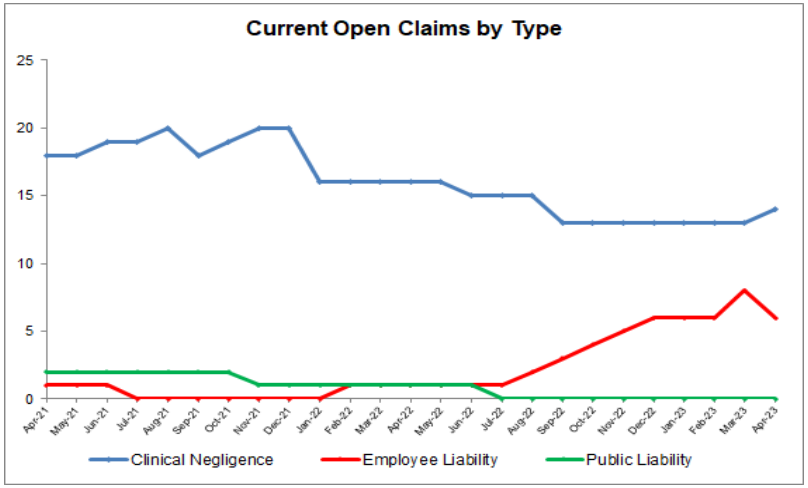
18 of those raised concerns about their experience at The Christie but did not wish to take them down the formal complaints route. The other reasons for contacting PALS are captured in the graph.

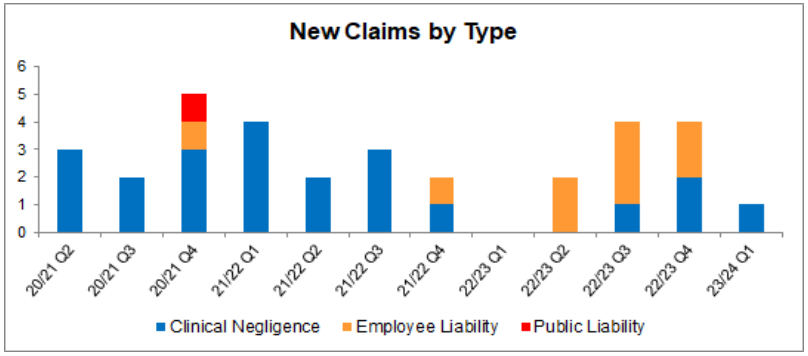
3.6 - Inquests


Requests from Coroners- starting 01/04/21
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
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
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


Inquests Held- starting 01/04/21
10.0
9.0
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
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
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

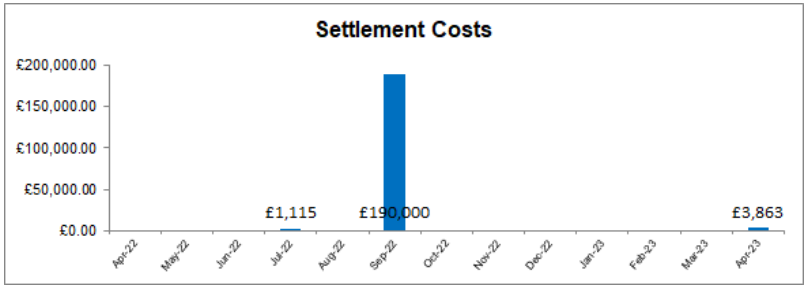
3.7 - Claims





1 new 'Clinical Negligence' claim received in April 2023.

1 claim 'Employer's Liability claim settled in April 2023 in the sum of £3,862.50.



Healthcare Associated Infections

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				2	0	(Ward 12) (Ward 2)
E.coli Bacteraemia		3	2	3	0	(Ward 10) (PTWx2) (Ward 4) (AAUx2) (AACU) (WW)
Klebsiella spp.			3	1	0	(Ward 12)
Pseudomonas aeruginosa bacteraemia				1	0	(PTW)
MSSA Bacteraemia				1	0	(Ward 11)
MRSA Bacteraemia			1		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				2	0
E.coli Bacteraemia		3	2	3	0
Klebsiella spp.			3	1	0
Pseudomonas aeruginosa bacteraemia				1	0
MSSA Bacteraemia				1	0
MRSA Bacteraemia			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	Lapses in care
COVID-19	1	2	6	9	0

Organism	Number of Cases	Area(s) Occurred	Lapses in care
CPE colonisation / infection	0		0

There were 2 cases of C-Difficile, 8 cases of E-Coli, 4 cases of Klebsiella, 1 case of MSSA, 1 case of Pseudomonas and 1 case of MRSA in April 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)

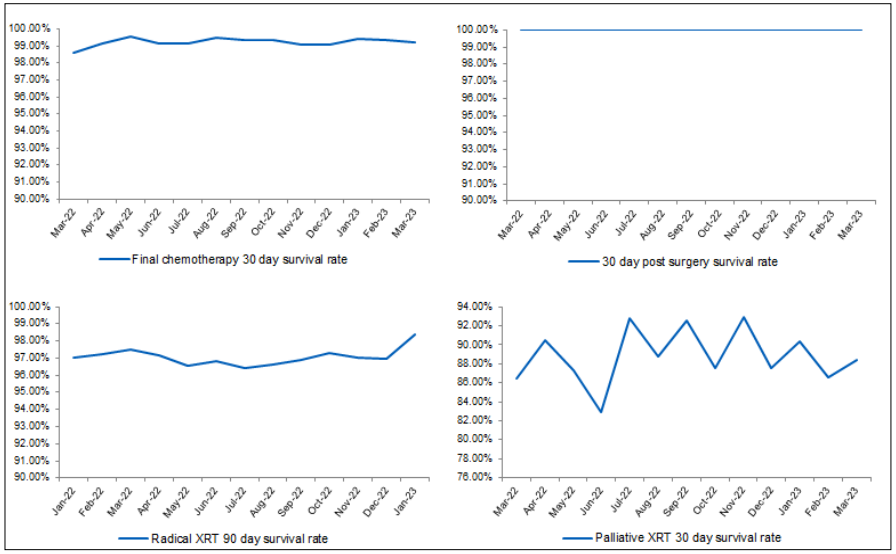
COIA - Symptoms commenced within first two days of admission and has been an inpatient in the trust in the past 4 weeks

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)

4.2 - Mortality Indicators & Survival Rates

Survival Rates



Inpatient Deaths – Onsite Deaths

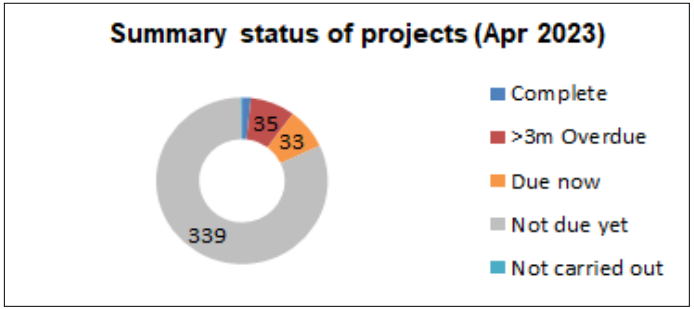
		Apr-23
Number of NHS Christie onsite deaths	Elective/planned admission	5
	Non Elective/emergency admission	22
	TOTAL	**27**
Number of deaths that have triggered Structured Casenote Review (SCR) Note: screening is ongoing so further triggers may be identified	Mortuary screened triggers (including reported to the coroner) - 1	**2**
	Bereaved families raised concern – 1	
	Medical Triggers - 1	
	Nursing Triggers - 0 (inc in family concern)	
	COVID-19 - 0	
	(note there may be more than one trigger)	

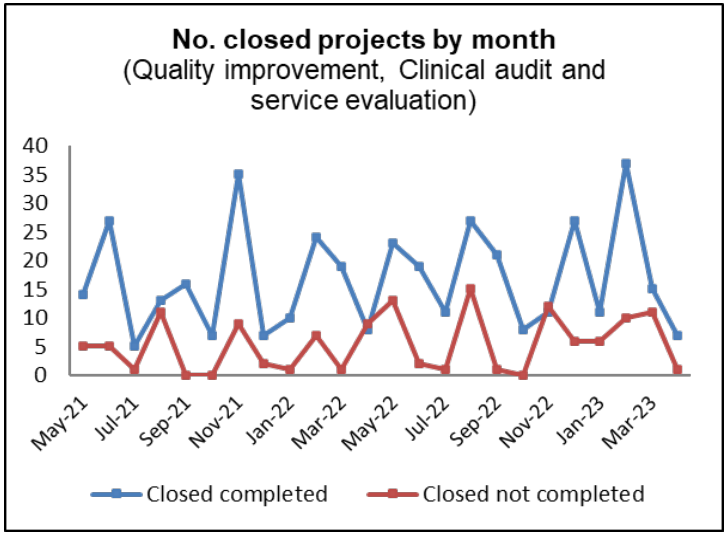
The Christie process for learning from deaths follows the 2017 NHSI guidance. All in-patient deaths are screened and where flagged by one or more triggers an independent structured case note review (SCR) is undertaken. Reviews are discussed by the Mortality Surveillance Group and the findings and actions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

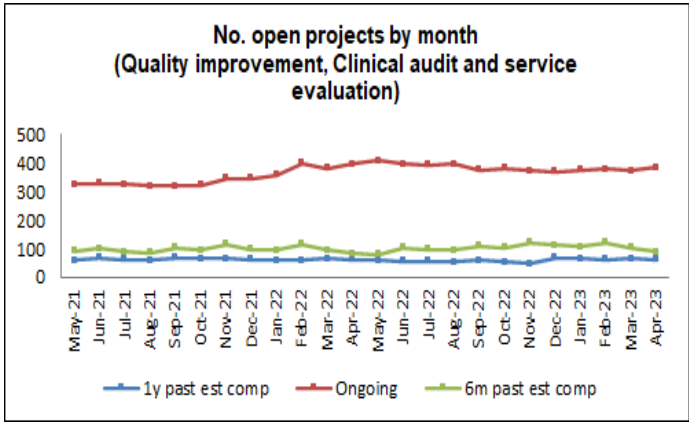
4.3 - Quality Improvement & Clinical Audit

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

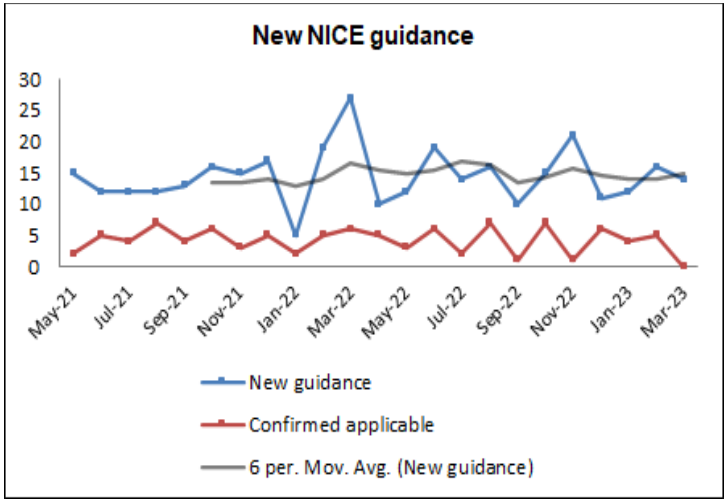


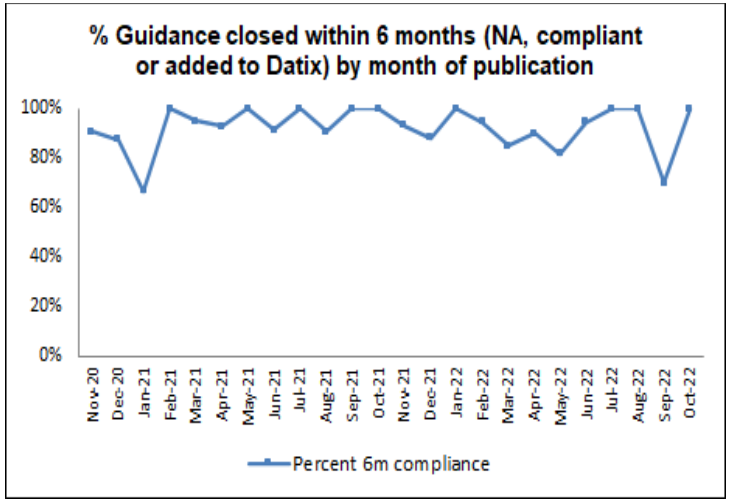




53

4.4 - 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:

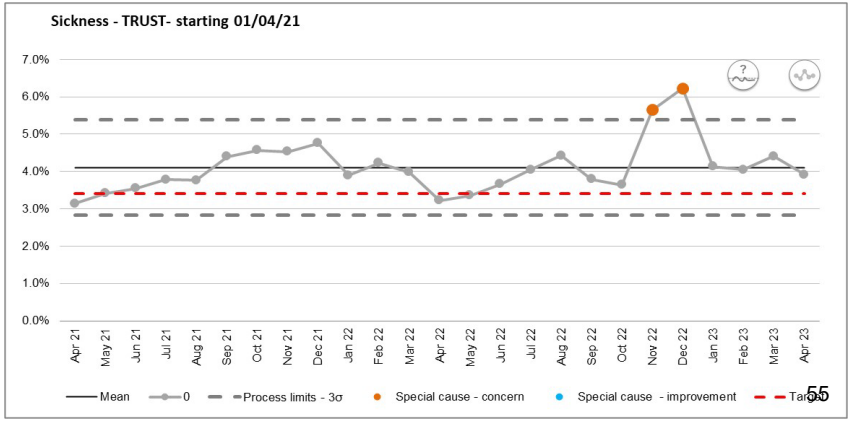
- compliant
- not applicable to the trust
- non or partially compliant with actions managed via the risk register

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

4.5 - HR Metrics (Sickness)

Division	Ex C-19	Inc COVID												
	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	YTD
Christie Medical Physics and Engineering	1.62%	2.32%	1.73%	2.87%	2.20%	3.55%	2.92%	2.26%	4.91%	2.75%	2.56%	2.30%	1.72%	1.72%
Clinical Networked Services	2.63%	3.58%	4.23%	4.15%	3.80%	3.26%	3.08%	5.03%	5.46%	3.55%	3.66%	4.40%	3.62%	3.62%
Clinical Support and Specialist Surgery	4.27%	3.59%	4.82%	3.99%	5.65%	4.12%	3.22%	7.07%	8.02%	4.22%	5.03%	5.24%	4.77%	4.77%
Corporate Development	0.08%	0.18%	0.35%	0.52%	0.00%	0.09%	0.18%	0.91%	0.50%	0.56%	0.53%	0.31%	0.00%	0.00%
Digital Services	3.73%	1.01%	1.69%	2.79%	1.21%	1.36%	4.57%	4.51%	3.85%	1.76%	1.58%	1.45%	1.74%	1.74%
Education (School of Oncology)	4.59%	5.54%	4.36%	2.52%	1.24%	1.35%	1.13%	0.39%	0.86%	3.96%	3.33%	0.80%	1.65%	1.65%
Estates & Facilities	5.86%	6.07%	8.17%	9.04%	10.03%	9.07%	10.09%	12.14%	11.94%	10.67%	8.51%	9.70%	8.39%	8.39%
Finance & Business Development	1.44%	0.37%	1.16%	0.60%	1.23%	1.33%	2.76%	4.57%	3.62%	2.76%	1.87%	2.49%	1.81%	1.81%
Medical Director's Office	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Performance	2.62%	1.96%	1.25%	4.54%	3.16%	8.16%	5.05%	10.69%	4.46%	3.89%	4.15%	7.10%	6.91%	6.91%
Quality and Standards	8.12%	7.25%	4.84%	6.62%	6.07%	3.45%	3.99%	7.24%	9.09%	7.45%	6.98%	6.03%	4.03%	4.03%
Research and Development	1.41%	2.12%	2.53%	3.22%	4.03%	3.26%	3.12%	4.22%	4.91%	4.16%	3.18%	3.71%	3.56%	3.56%
Strategy	0.00%	0.00%	0.00%	0.00%	1.65%	1.77%	6.38%	6.38%	8.24%	3.62%	0.00%	0.00%	2.33%	2.33%
Trust Administration	0.00%	0.00%	1.04%	0.00%	5.61%	6.21%	6.20%	6.21%	6.61%	6.21%	6.21%	5.85%	6.21%	6.21%
Workforce	1.95%	2.06%	1.82%	3.10%	2.76%	1.51%	2.86%	4.28%	3.60%	1.74%	0.96%	1.24%	0.51%	0.51%
TRUST	**3.22%**	**3.36%**	**3.66%**	**4.05%**	**4.43%**	**3.79%**	**3.64%**	**5.65%**	**6.22%**	**4.13%**	**4.05%**	**4.41%**	**3.91%**	**3.91%**

RAG Rating (>=Apr-16): <=3.4 GREEN; >3.4 RED



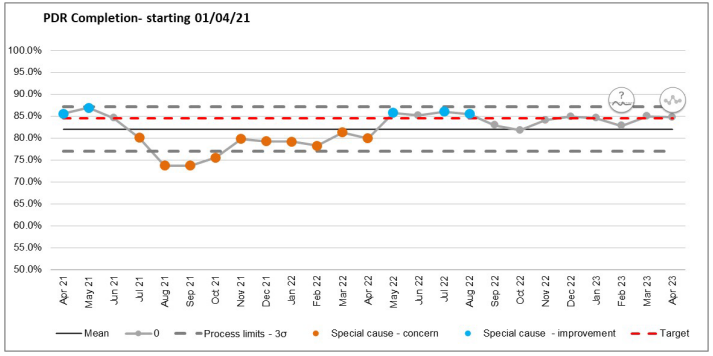
The sickness rate for April is **3.91%**

From May 2022 sickness figures now include COVID related sickness

4.6 - HR Metrics (PDRs & Essential Training)

Division	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Christie Medical Physics and Engineering	90.9%	91.4%	89.2%	87.9%	85.0%	83.3%	83.8%	88.4%	88.8%	87.4%	87.4%	90.1%
Clinical Networked Services	88.1%	86.7%	87.9%	87.5%	85.8%	82.3%	84.7%	85.9%	83.4%	80.5%	80.0%	81.2%
Clinical Support and Specialist Surgery	80.9%	81.4%	83.0%	84.0%	81.3%	79.7%	82.2%	83.6%	84.6%	84.0%	86.3%	85.7%
Corporate Development	94.4%	89.2%	84.0%	85.3%	96.9%	93.9%	91.2%	93.9%	88.6%	75.0%	90.0%	100.0%
Digital Services	87.9%	81.3%	88.0%	79.1%	71.6%	79.3%	82.6%	85.4%	91.1%	88.5%	93.6%	93.8%
Education (School of Oncology)	88.7%	85.7%	85.0%	77.6%	66.1%	68.3%	90.5%	87.3%	92.2%	87.7%	92.3%	94.1%
Estates & Facilities	82.6%	81.6%	83.0%	80.5%	74.4%	78.8%	84.3%	83.2%	83.4%	82.0%	84.1%	80.7%
Finance & Business Development	89.9%	90.1%	93.0%	89.6%	87.9%	87.3%	93.7%	89.1%	90.6%	87.5%	95.2%	89.2%
Medical Director's Office	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	100.0%	100.0%	100.0%	100.0%
Performance	82.6%	87.0%	88.0%	87.5%	87.5%	82.6%	91.3%	91.3%	91.3%	87.0%	91.3%	82.6%
Quality and Standards	78.6%	88.5%	92.0%	92.0%	85.2%	78.6%	75.0%	76.7%	82.8%	74.2%	84.4%	78.8%
Research and Development	88.4%	90.4%	92.0%	90.5%	89.2%	88.1%	86.3%	81.7%	82.1%	83.0%	90.5%	88.2%
Strategy	66.7%	66.7%	75.0%	50.0%	50.0%	37.5%	37.5%	30.0%	33.3%	30.0%	30.0%	30.0%
Trust Administration	86.7%	80.0%	80.0%	86.7%	86.7%	86.7%	73.3%	80.0%	66.7%	80.0%	85.7%	92.9%
Workforce	92.3%	84.6%	87.0%	89.1%	89.7%	93.2%	91.7%	94.9%	94.9%	98.3%	93.3%	91.5%
Grand Total	**85.7%**	**85.1%**	**86.0%**	**85.5%**	**82.9%**	**81.8%**	**84.0%**	**84.9%**	**84.5%**	**82.7%**	**84.9%**	**84.7%**

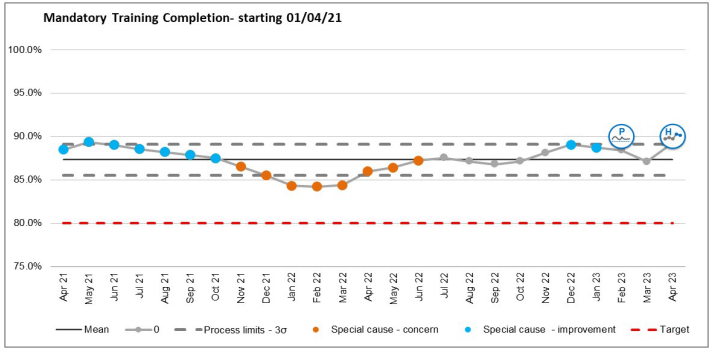
RAG Rating: >=94.5% GREEN; 85<>94.5 AMBER; <=84.5 RED



PDR Compliance for April is 84.7%

Division	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Christie Medical Physics and Engineering	93.5%	94.6%	94.6%	94.9%	92.8%	94.1%	94.1%	96.1%	95.3%	95.3%	95.3%	95.8%
Clinical Networked Services	82.9%	84.1%	85.4%	84.8%	85.1%	85.6%	87.2%	87.9%	87.8%	87.5%	84.6%	87.1%
Clinical Support and Specialist Surgery	82.9%	83.2%	82.6%	82.1%	81.4%	82.0%	83.2%	84.6%	83.4%	82.8%	80.7%	84.7%
Corporate Development	93.5%	98.5%	95.1%	96.2%	98.6%	99.2%	98.7%	97.2%	97.3%	95.3%	97.4%	95.7%
Digital Services	93.2%	94.0%	92.0%	92.4%	94.6%	94.5%	96.2%	96.6%	97.0%	96.7%	98.7%	98.1%
Education (School of Oncology)	95.4%	95.7%	95.3%	93.2%	94.7%	95.0%	96.5%	94.3%	93.6%	94.1%	94.3%	94.4%
Estates & Facilities	93.3%	92.8%	93.7%	93.4%	93.8%	92.1%	92.1%	93.0%	94.3%	93.4%	94.8%	93.9%
Finance & Business Development	97.2%	96.7%	98.1%	98.8%	99.9%	99.0%	98.4%	98.3%	98.1%	98.2%	98.8%	98.0%
Medical Director's Office	100.0%	90.0%	90.0%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Performance	98.4%	99.2%	97.6%	96.8%	97.2%	97.9%	97.4%	95.7%	96.4%	95.6%	95.6%	95.1%
Quality and Standards	88.0%	87.5%	87.7%	92.6%	88.3%	89.4%	88.3%	90.4%	93.0%	93.5%	93.2%	94.1%
Research and Development	90.8%	91.7%	92.6%	92.6%	92.8%	92.6%	93.3%	94.0%	94.0%	93.7%	92.4%	94.6%
Strategy	94.4%	94.6%	96.9%	93.6%	95.5%	95.5%	88.2%	87.3%	99.0%	98.1%	91.0%	93.1%
Trust Administration	92.6%	93.8%	94.5%	93.9%	93.9%	98.3%	99.4%	98.2%	98.2%	98.2%	93.5%	93.2%
Workforce	91.1%	92.2%	90.0%	86.4%	88.4%	89.5%	89.8%	90.3%	90.9%	94.1%	92.8%	92.4%
Grand Total	**86.4%**	**87.2%**	**87.5%**	**87.1%**	**86.8%**	**87.1%**	**88.1%**	**89.0%**	**88.7%**	**88.4%**	**87.1%**	**89.3%**

RAG Rating >80% GREEN or <80% with risk assessment undertaken; <80% RED with no risk assessment undertaken

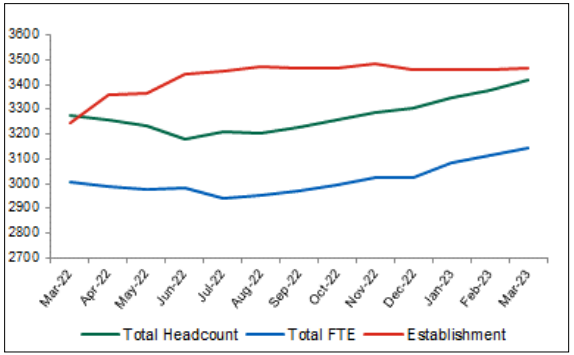


Mandatory Training Compliance for April is 89.3%

4.7 - Workforce Metrics

Total FTE & Total Headcount

Trust	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
Total Headcount	3277	3255	3234	3180	3212	3205	3227	3254	3289	3302	3349	3379	3418
Total FTE	3009	2988	2977	2985	2943	2951	2971	2994	3027	3025	3083	3115	3141
Establishment	3247	3361	3361	3445	3451	3473	3465	3466	3483	3462	3462	3461	3465



Leavers

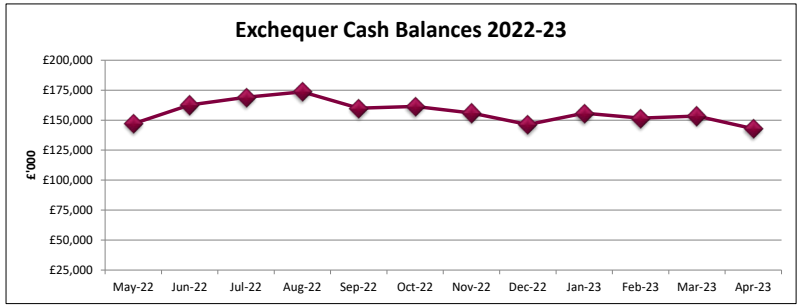
Leavers Headcount	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Dismissal	1	2	1	4	0	0	0	1	2	1	1	1	0
End of Fixed Term Contract	4	8	7	8	18	12	5	1	0	0	1	1	6
Mutually Agreed Resignation	0	0	0	0	0	0	0	0	0	0	0	0	0
Redundancy	0	0	0	1	0	0	0	0	0	0	0	0	0
Retirement	6	4	3	7	4	0	7	3	3	5	3	10	4
TUPE	0	0	0	0	0	0	0	0	0	0	1	0	0
Voluntary Resignation	42	37	24	58	46	48	28	25	27	35	24	30	28
Others	1	1	0	0	1	0	1	0	0	2	0	34	1
Grand Total	54	52	35	78	69	60	41	30	32	43	30	76	39
12 Month Turnover % Headcount	17.74%	17.54%	17.47%	18.98%	19.60%	19.93%	19.77%	19.34%	18.96%	18.70%	18.04%	18.77%	17.89%
Adjusted 12 month Turnover %*	15.01%	14.97%	15.24%	14.54%	16.78%	16.73%	16.53%	16.10%	15.80%	15.66%	15.22%	14.97%	14.09%

* Turnover based on substantive leaving reasons only (Dismissal, M.A.R.S, Redundancy, Retirement, Voluntary Resignation, Other)

5.1 - Finance (Executive Summary)

The Christie NHS Foundation Trust

	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000
Clinical Income	(31,068)	(29,679)	1,390
Other Income	(5,194)	(5,049)	145
Pay	17,560	15,784	(1,775)
Non Pay (incl drugs)	17,698	17,690	(8)
Operating (Surplus) / Deficit	**(1,004)**	**(1,253)**	**(249)**
Finance expenses/ income	2,883	2,464	(418)
Joint venture profit	(489)	(76)	413
(Surplus) / Deficit	**1,390**	**1,135**	**(255)**
Exclude impairments/ charitably funded capital donations	(720)	(720)	0
Adjusted financial performance (Surplus) / Deficit	**670**	**415**	**(255)**



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

I&E

- At month 1 the Trust is reporting a £415k deficit against £607k expected deficit planned position. This is mainly due to interest received being above planned levels and a pay underspend due to vacancies and industrial action
- 2023-24 CIP – will be reported on from month 2.

Balance sheet / liquidity

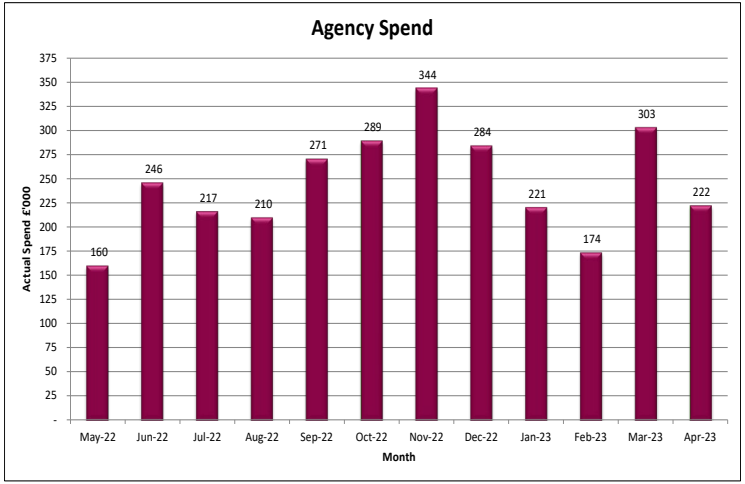
- The cash balance is £142,842k.
- Capital expenditure is £191k over the NHSI plan mainly due to the spend on backlog maintenance and the TIF ward.

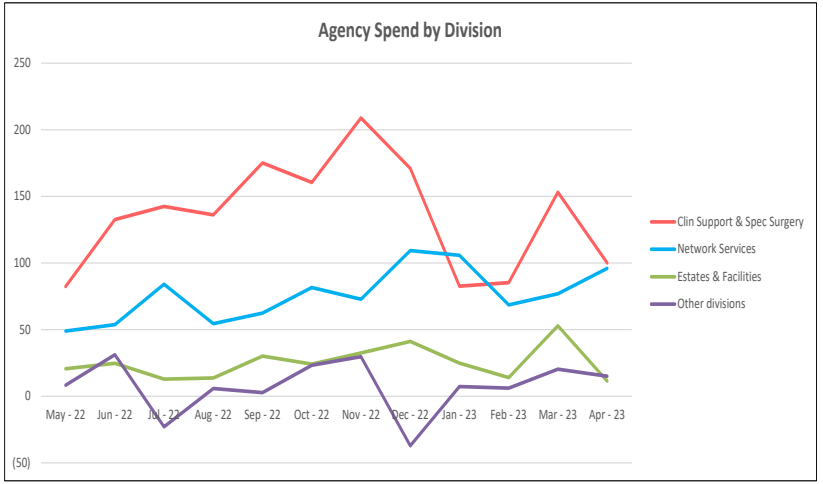
Other

- Due to the profiling of TCPC profit it is not included in M1 financial position
- 98% of our trade creditors and 97% of our NHS creditors are paid within the 30 day Better Payment Practice Code target.

58

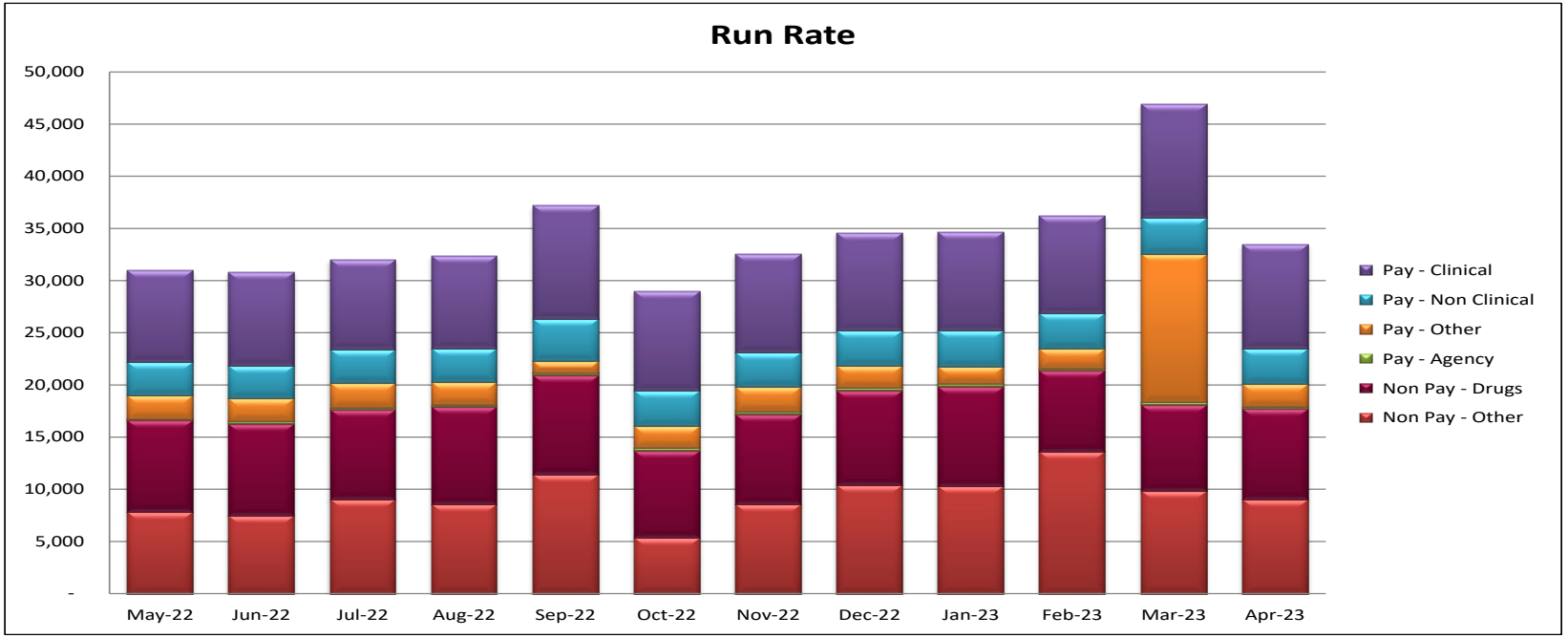
5.2 - Finance (Expenditure)





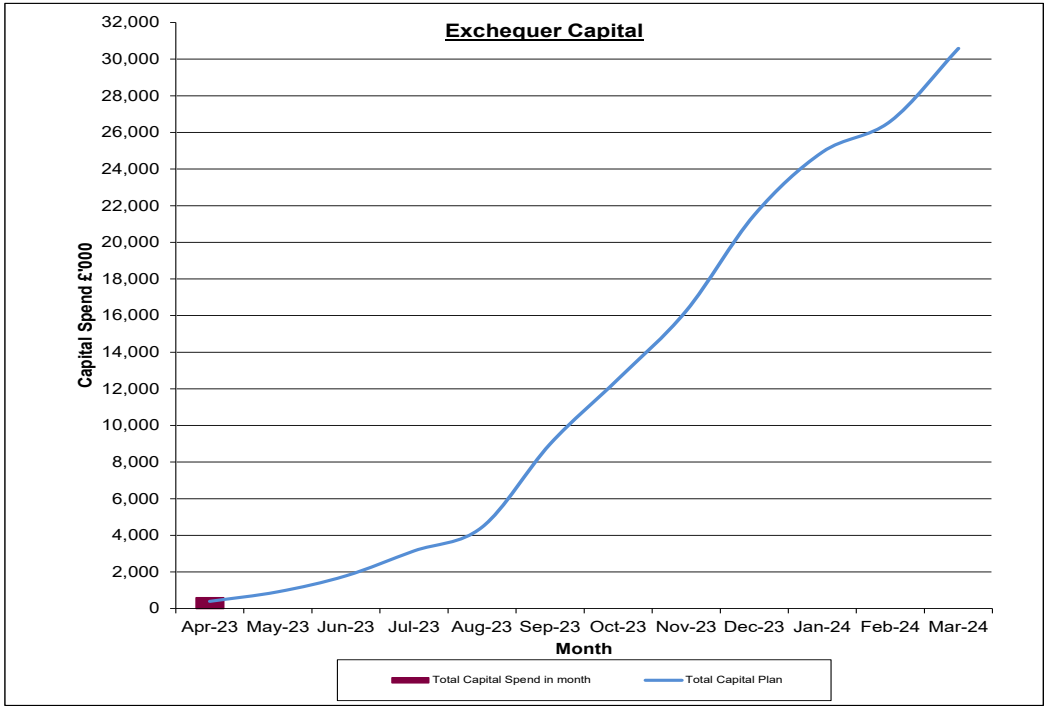
The agency spend is £222k relating to month 1 23/24, a decrease of £81k from month 12 22/23 mainly due to improvements in Estates and CSSS. Alongside this, bank usage has decreased by £49k in month.

5.2 - Finance (Expenditure)



Drug spend in month 1 is £8,712k an increase on month 12 of £505k.
Pay Agency spend in month 1 is £222k a decrease from month 12 which was £303k
There is a significant reduction in pay other in M1 as a result of M12 including a one off increase for pension adjustments and an accrual non consolidated pay award.

5.3 - Finance (Capital)



Performance for month 1 was an overspend of £191k above the plan submitted to NHSE&I.
The Trust has incurred £588k on capital schemes in month 1, primarily on the backlog maintenance programme and the TIF ward

NHS
The Christie
NHS Foundation Trust

Agenda item 18/23c

Meeting of the Board of Directors

Thursday 25th May 2023

Subject / Title	Risk Management Strategy and Policy 2021-2024 annual review
Author(s)	Ben Vickers, Head of Risk and Patient Safety Specialist
Presented by	Janelle Yorke, Chief Nurse and Executive Director of Quality
Summary / purpose of paper	This paper provides an update on progress against the Risk Management Strategy and Policy for 2021-24
Recommendation(s)	The Board of Directors are asked to note the content of the report, and approve the actions described.
Background papers	Risk Management Strategy and Policy 2021-2024 MIAA Risk management Audit 2022 Risk Management Compliance Audit 2023
Risk score	n/a
Link to: ➢ Trust strategy ➢ Corporate objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness.
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.	MIAA Mersey Internal Audit Agency CODE Care, Observation, Documentation, Experience CRF Clinical Research Facility PSIRF Patient Safety Incident Response Framework

Agenda item 18/23c

Board of Directors

Risk Management Strategy and Policy 2021-2024 annual review

1) Introduction

The Risk Management Strategy and Policy 2021-2024 replaced the previous policy 2017-2020. The updated document was developed through extensive consultation with a broad range of staff from across the organisation and was approved by the Risk & Quality Governance Committee and the Management Board.

2) Purpose of Report

The Board of Directors are asked to note the progress against the 3 objectives and approve the response to the recommendations of the MIAA Audit and the internal Risk Management audit.

3) Background

The Trust has a holistic approach to Risk Management across the organisation, which embraces financial, corporate, reputational, clinical, non-clinical and project risks. The Trust takes all reasonable steps in the management of risk with the overall objective of protecting patients, staff and its assets.

The primary concern is the provision of a safe environment together with having systems and processes in place to identify, assess, evaluate, and assign responsibilities to manage risks within the Trust. This is achieved by ensuring that risk management and corporate governance is an integrated process through which the organisation will identify, assess, analyse, and manage risks and incidents at every level of the organisation and aggregate the results at a corporate level.

The Patient Safety and Risk Team undertook an audit of compliance with the Risk Management Strategy in February 2023, the audit demonstrated significant improvement across the Trust with all audit measures. An update on progress against the three objectives of the strategy are detailed in figure 1.

In December 2022, MIAA undertook an audit of the Risk Management Strategy and oversight and rated ‘moderate’ assurance. The full MIAA report was approved at Risk and Quality Governance Committee in March 2023. The recommendations are detailed below and include the management response to each (Figure 2):

An updated action plan has been developed to address areas for improvement against the 3 strategic objectives of the Risk Management Strategy as well as the recommendations of the two audits undertaken in 2022 and 2023.

Delivery against the 3 objectives of the Risk Management Strategy 2021-2024 (as of May 2023)

Figure 1

Objective	Progress
1) Increase involvement, knowledge and accountability of all staff in the risk management process and integrated governance	Training needs analysis completed Risk management training rolled out to risk owners Quality Mark expanded to include relevant sites. This now includes Radiotherapy and Proton Beam on the Withington site, and Macclesfield, Salford and Oldham satellite sites Christie CODE expanded – Ward 2 and CRF have now achieved gold accreditation
2) Greater insight, transparency and triangulation of data	Patient Safety Incident Response Framework (PSIRF) project underway. This includes a plan to analyse the Trusts safety profile which will be used to develop the Trust Patient Safety Incident Response Plan (current national deadline is September 2023) New Datix software has been procured which will enable greater oversight of incident management Human factors training now available on Christie Learning Zone
3) Refine and improve processes and systems to build effective risk management	Audit of risk registers, including compliance with risk review dates, and confirmation of associated risk assessments Learning for improvement bulletin well established – review planned to improve inclusion of risks and complaints alongside incidents

Action plan to continue improvement against the 3 Risk Management Objectives, and address learning identified from both the internal risk audit, and the MIAA audit

Figure 2

No	Issue	Action required (reference to detail)	Action Lead responsibility	Deadline Date	Expected Evidence of Completion/RAG
1	Review Risk Management Strategy 2021-2024 12 months earlier than planned	Undertake a review of the current Risk Management Strategy to address the following Areas: 1. Divisional governance arrangements for risk assessment and acceptance prior to adding to risk registers 2. Roles & Responsibility of risk oversight at Divisional and Board Level 3. Review and ratify risk appetite statement of the Board 4. Publish risk appetite statement on Trust website 5. Align the Board Assurance Framework (BAF) to the revised Risk Management Strategy	Professor Janelle Yorke, Executive Chief Nurse & Director of Quality	July 2023	Revised Risk Management Strategy 2023-2026 in place
2	Risk Management Thresholds and Assurance Reporting	To undertake a review of the current risk thresholds and management / oversight of risks at a Service, Divisional or Trust Wide Level. 1. Review the standard risk reporting produced by the Patient Safety and Risk Team to ensure robust assurance and accountability	Ben Vickers, Head of Risk & Patient Safety Specialist	October 2023	Revised Strategy and Governance Oversight in place from October 2023 Risk and Quality Governance Committee.

No	Issue	Action required (reference to detail)	Action Lead responsibility	Deadline Date	Expected Evidence of Completion/RAG
		is obtained at Risk & Quality Governance Committee 2. Review the definitions of "Corporate Risk Register", "Top 5 Trust wide Risks" and "Key Risks Report" 3. Confirm accountable roles for risk management and oversight at a divisional level 4. Confirm process for escalation of risks 5. Confirm process for interconnected / risk dependencies and decision making on where to oversee such risks *e.g. a digital risk in a clinical setting or an operational risk with a proposed digital solution unknown to stakeholders.*			
3	The Trust should ensure its risk assessment form is reviewed and updated, to ensure compliance with best practice in the management of risk.	Update current Risk Assessment form; 1) Within divisional governance arrangements form to be assessed prior to adding to Risk Register 2) Revised format to include additional fields: Hazards, Impact, Contributing Factors. To be included in DATIX Cloud Risk Module.	Ben Vickers, Head of Risk & Patient Safety Specialist	June 2023	New risk assessment in place and Datix Structures updated.
4	Undertake Bi-Annual internal Risk Management Audit Q2	Q2 of 2022-2023 – Completed Q4 2022-2023 Completed	Ben Vickers, Head of Risk & Patient Safety	March 2023 – COMPLET	Significant improvement across the Trust against all metrics in Audit.

No	Issue	Action required (reference to detail)	Action Lead responsibility	Deadline Date	Expected Evidence of Completion/RAG
	and Q4 of each financial year to measure compliance with current policy at divisional level.	Q2 – 20232024 July 2023.	Specialist	ED Recurrent Action	
5	Risk Management Training for Risk Owners	1. Add to Christie Learning Zone. 2. 181 Risk Owners in Datix as numerator 3. Monitor compliance through ERG and Risk and Quality Governance Committee.	Ben Vickers, Head of Risk & Patient Safety Specialist	1 & 2 completed	Compliance report to ERG 6th April 2023

The Christie
NHS Foundation Trust

Agenda item 19/23b

Meeting of the Board of Directors
Thursday 25th May 2023

Subject / Title	NHS Improvement self-certification declarations
Author(s)	Company Secretary
Presented by	Chief Executive
Summary / purpose of paper	NHS foundations trusts are required to undertake the following self-certification declarations: • G6 (systems for compliance with licence conditions) & CoS7 (continuity of service – availability of resources) • FT4 (corporate governance statement) • Training of governors
Recommendation(s)	To approve the declarations
Background papers	NHS Improvement's annual plan review
Risk score	BAF risks under corporate objective 6
Link to: ➢ Trust strategy ➢ Corporate objectives	Strategic objective 6. To maintain excellent operational, quality and financial performance
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.	CoS continuity of service

The Christie
NHS Foundation Trust

Agenda item 19/23b

Meeting of the Board of Directors
Thursday 25th May 2022

NHS Improvement self-certification declarations

1. Introduction

NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services and have complied with governance requirements.

Providers therefore need to self-certify the following after the financial year end:

NHS provider licence condition

- The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6)
- If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service (Condition CoS7)
- The provider has complied with required governance arrangements (Condition FT4)
- Governor training

The aim of self-certification is for providers to carry out assurance that they comply with the conditions.

We are no longer required to return our completed provider licence self-certifications or templates to NHS England. NHS England will contact a select number of NHS foundation trusts to ask for evidence that they have self-certified. This can either be through providing the completed templates or relevant board minutes and papers recording sign-off.

2. Recommendation

The board is asked to note and approve the self-certifications for:

- G6 systems for compliance with licence conditions and CoS7 (continuity of service) – availability of resources (appendix 1)
- FT4 corporate governance statement (appendix 2)
- Governor training (appendix 3)

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates **2022/23** Please complete the explanatory information in cell E36

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed	Please fill details in cell E22

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	Confirmed	Please fill details in cell E22

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.	Confirmed	Please fill details in cell E22

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

We have maintained our Single Oversight Framework rating of 1 for finance and use of resources and we have achieved our NHSEI control total

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Roger Spencer	**Name**	Chris Outram
Capacity	Chief Executive	**Capacity**	Chair
Date	25 May 2023	**Date**	25 May 2023

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

N/A

Worksheet "FT4 declaration"

Financial Year to which self-certification relates 2022-23 Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	No material rosks identified	#REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	No material risks identified	#REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	No material risks identified. There are a wide range of controls in place including the Scheme of Delegation and Standing Financial Instructions. There are clear terms of reference for all committes and we undertake an annual committee effectiveness review. All board members are subject to an annual appraisal (the NEDs and the CEO have appraisals led by the chairman, the chairman has an appraisal led by the senior independent NED and the executive directors have appraisals led by the chief executive). There is a clear organisational structure with clear reporting lines. Governance arrangements have been assessed for their effectiveness by MIAA and assurance given. The review Head of Internal Audit Opinion for the year gave Substantial Assurance, that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.	#REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	There are a range of systems and/or processes in place which evidence the Trust's on-going compliance. The trust holds 8 board of directors meetings per year and receives a monthly Integrated Performance Report structured to reflect performance against key indicators. The trust also holds monthly meetings of its assurance committees (Quality Assurance, Workforce Assurance and Audit) in line with the trust's constitution. The board receives and approves the Annual Plan and receives monthly updates from the Executive Director of Finance. The Board Assurance Framework is discussed at each meeting of the board and the assurance committees and has received a green rating from our internal auditors. Further assurance is gained via the external audit opinion, Internal Audit annual plan (approved by the Audit Committee) and the risk & quality governance committee meetings. The clinical divisions feed into monthly management board meetings, attended by senior clinicians and managers, which in turn feeds into the board of directors. In regard to the Single Oversight Framework our finance and use of resources score has again been rated as 1.	#REF!
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	No material risks identified. There are a range of systems and/or processes in place which evidence the Trust's on-going complaince with this requirement, including the composition of the board of directors . The quality assurance committee reviews quality of care including approval of the annual clinical audit plan, learning from deaths, reports on patient safety and experience, health & safety and updates from the risk & quality governance committee. We have been rated as Good by the health regulator. Single Oversight Framework - we have again been rated as 1 for all of the five themes of:• Quality of care• Finance and use of resources• Operational performance• Strategic change• Leadership and improvement capability (well-led)	#REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	There are a range of controls in place to mitigate staffing risks. These include ward staffing reviews, e-rostering for all ward staff and a centralised bank for nursing posts. The board of directors receives a monthly safe staffing update via the integrated performance report. All Board members have been assessed and declared as Fit & Proper under the CQC Regulation 5.	#REF!

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature R Spencer **Signature** Chris Outram

Name Roger Spencer **Name** Chris Outram

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A Please Respond

Worksheet "Training of governors"

Financial Year to which self-certification relates 2022/23

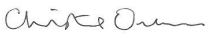
Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed	OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Roger Spencer	**Name**	Chris Outram
Capacity	Chief Executive	**Capacity**	Chairman
Date	25.05.2023	**Date**	25.05.2023