

Board of Directors Public meeting
Thursday 30th April 2026 at 2.00pm
Trust meeting room

Agenda

Patient story / clinical presentation: Engaging with the Christie patient portal and ePROMs – Dr James Price, Clinical Oncologist and two patients

30 mins

Public items	Decision		Lead	Page	Timing
11/26 Standard business					
a Apologies	Note		Chair		
b Declarations of interest	Note		Chair		
c Minutes of previous meeting – 26 th March 2026	Approve	*	Chair	2	5 mins
d Action plan rolling programme, action log & matters arising	Review	*	CEO	11	
12/26 Performance & finance					
a Trust report	Review	*	CEO	14	5 mins
b Integrated performance quality & finance report	Review	*	COO	22	5 mins
c Value Improvement Programme update	Review	*	COO	65	5 mins
d Risk Management strategy 2025-26 annual review	Approve	*	ECN	70	5 mins
13/26 Culture					
a Freedom to Speak Up Guardian report	Review	*	FTSUG	76	15 mins
b Addressing Health Inequalities	Review	*	DoS	102	10 mins
c Patient Voice, Involvement and Engagement across Trust Governance	Review	*	ECN	108	10 mins
14/26 Governance (regulatory / statutory compliance)					
a Reports from committees (February meetings)					
• Workforce Assurance Committee	Review	*	Committee chair	116 120	15 mins
• Quality Assurance Committee					
b Board assurance framework	Review	*	CEO	124	5 mins
c Register of matters approved by the board	Note	*	CEO	134	2 mins
d NHSE Self-certification declarations	Approve	*	CEO	136	5 mins

15/26 Any other business

For information

Reflections on the meeting

Date and time of the next meeting

Thursday 25th June 2026 at 2:00pm

D/CEO Deputy / Chief Executive Officer
EMD Executive Medical Director
DFC Director of Future Christie
COO Chief Operating Officer
ECN Executive Chief Nurse
DoS Director of Strategy
FTSUG Freedom to Speak Up Guardian

* paper attached
v verbal
p presentation



**Public meeting of the Board of Directors
Thursday 26th March 2026 at 2.00 pm
Trust Meeting Room**

Present: Chair: Prof Joe Rafferty (JR), Chair
Roger Spencer (RS), Chief Executive Officer
Alveena Malik (AM), Non-Executive Director
Grenville Page (GP), Non-Executive Director
Amanda Oates (AO), Non-Executive Director
Dr Marisa Logan-Ward (MLW), Non-Executive Director
Sarah Corcoran (SC), Non-Executive Director
Roy Dudley-Southern (RDS), Non-Executive Director,
Dr Diana Tait (DT), Non-Executive Director,
John Wareing (JW), Director of Strategy
Claire McPeake (CM), Chief Operating Officer
Vicky Sharples (VS), Chief Nurse and Executive Director of Quality
Sally Parkinson (SP), Executive Director of Finance
Dr Neil Bayman (NB), Executive Medical Director
Prof Adrian Bloor (AB), Interim Director of Future Christie
Prof Rikki Goddard-Fuller (RGF), Director of Education
David Smithson (DS), Deputy Director of Workforce

Minutes: Louise Westcott (LW), Company Secretary

In attendance: Jim Hughes (JH), non-executive director (starts 1st April)
Jeanette Livings (JL), Director of Communications
Lee Francis, Business Development Manager DNV Imatis
Lee Showman, Public Governor Bury

Clinical presentation: A patient story - Senior Adult Oncology, Dr Fabio Gomes Medical Oncology Consultant, Aida Ward Occupational Therapist, Martin Vernon (MV), Consultant Geriatrician in Supportive Oncology and a patient – Patricia Brookes and her daughter Ginette Fallows

FG introduced the service. The proportion of patients 70+ has increased from 33% to 41% between 2016 & 2025. There are more complex needs and frailty is an issue. Services need to be designed to cope with these other issues.

There's a conflict between patients on clinical trials and the real-world. There are challenges of under treatment and over treatment with more aggressive treatments for older patients. There are a range of approaches globally. Older age should be viewed as a health inequality – Christie strategies in the last 10 years have addressed this.

FG outlined the timeline of the development of the frailty service that is now described as the Senior Adult Oncology service. There was a need to have good data on impact on outcomes of treating other aspects of these patients needs. A research trial was undertaken from 2020 to provide evidence. Funding has now been secured.

Specialised clinical frailty network - 40% of patients in lung had a degree of frailty impacting quality of life and ability to undertake treatment beyond the first round. Identified that these patients needed more support to get through treatment. There was room to improve.

Trials were showing us that the bridge between oncology and geriatrics meant that we could reduce toxicity, improve quality of life and reduce admissions.

Pilot launched in 2022-24 and an MDT recruited to aid decision making and in support & rehabilitation. The team reduced unplanned use of acute services and deferrals of treatment.



The service looks at oncology and geriatric assessments to form an integrated plan. Currently working with lung and expanding to other teams. The aim is to enhance and train staff to allow them to provide this additional support across many teams.

AW introduced herself as an OT, there is also a dietician, Specialist nurse, physiotherapist and pharmacist in the team. The whole team look to support the patient through an assessment, and examples were given of patients with other issues that were unrelated to the cancer that were impacting on the cancer treatment. Look at optimisation for going into treatment, patients on treatment and those with late effects of treatment. Patients are supported and referred back to local community services.

FG introduced Patricia who is a lung cancer patient. Patricia described being a Christie patient going through treatment that was impacted by her having a fall and breaking her femur. This was operated on. Her daughter described being worried about her mum and that she now has a walking stick that has given her more independence. The support of the OT has been fantastic. The treatment has been amazing, and she described doing really well on the treatment and feeling really lucky. The team have made the treatment bearable and she's enjoying living a good life after treatment.

NB described that this service is now an established part of what we do and looking after older patients is potentially an area of inequality for our patients. We are looking to take this into future plans of taking the service into neighbourhoods.

DT asked about scaling up of the service across the Trust. FG noted the referrals come in and patients are allocated to the clinic – need better flow of frailty data to identify the patients that need the support, currently done based on age. Other teams can refer into the team from other areas across the Trust.

GP asked about the wrap around service in community and the move to neighbourhood care, how will the disparities in the different areas be addressed and different services be brought in. MV responded that local leadership & organisation is key, the 10-year plan should support more focus on this. There are huge numbers of assets that are not linked in communities. Need to make visible the patients who are most vulnerable to treatments so you can start to reduce the risk to these patients. The assessment exists and we need to work with community providers and pass on the information. There's a lot of opportunity driven by The Christie. The leadership is key and we can use our influence to line others up, it'll be difficult.

Ginette explained that her mum's diagnosis was a shock, but her treatment here has been incredible, and she has had the best care.

Item		Action
06/26	Standard business	
a	Apologies	
	Eve Lightfoot (EL), Director of Workforce, Tom Thornber (TT), Director of Future Christie, Prof Fiona Blackhall (FB), Director of Research, Prof Chris Harrison (CJH), Senior Adviser Governance & Strategy	
b	Declarations of Interest	
	No declarations made relating to the items on the agenda	
c	Minutes of the previous meeting – 29th January 2026	
	The minutes were accepted as a correct record. Question re BAF – update based on 5-year plan – amendment will be made.	LW
d	Action plan rolling programme, action log & matters arising	



	All items from the rolling programme are complete or noted on the agenda.	
07/26	Performance & Finance	
a	Trust Report	
	<ul style="list-style-type: none"> • There are no adverse variances against objectives at month 11 and we are on plan for performance and finance requirements. • The full year forecast is to achieve the finance and performance targets and objectives are all on green. • Q3 NHS oversight framework rating has been released and we are ranked 3rd nationally and in segment 1. We are working on predicting the future quarterly rating to predict the position for Q4. • We are a positive outlier regionally and nationally both financially and in respect to the national standards. • The system is looking at delivering a c£200m deficit. The GM system is performing better than Lancs & Cumbria and Cheshire & Merseyside. • GP asked about pressure in the system on community services and if there's pressure to reduce funding for these. SP responded that the long-term aim is to focus care in the community and primary services where appropriate. • Process indicators of 62-day cancer pathways – not much movement in further extension and delay or improvement this year. Delays in cancer pathways are in the diagnostic pathways. National levers are aimed at addressing these delays. There is a whole ICB and regional level harm review process of delays in cancer pathways. From Christie perspective there are pockets of concern in the wider system. • Poor performance is what signals the problem, there's a significantly increased number of longer waits and we look at harm from delays which is relatively low. The system can see this impact. • There are things in place in the system to improve the diagnostic pathway – examples such as the lung health checks have made a real difference and this needs to be scaled. <p>Report noted</p>	
b	Integrated performance quality & finance report	
	<ul style="list-style-type: none"> • CM outlined the report that aligns to the NHS Oversight Framework. • The executive summary notes the exceptions and what we are doing. • The report shows a high reporting, low harm culture. Incident reporting levels are consistent. • We are delivering a surplus financial position and our capital spend is slightly over plan with a year-end forecast on plan. • Cancer pathway performance exceeds the standards alongside growth in demand. We are delivering the faster diagnostic standard. We anticipate delivering to targets for the full year against the targets. • The health inequalities data is assessed for target patients, and this is being reviewed to see what impact this is having. • We hold high rated risks, review compliance remains high and management of risk remains timely and appropriate. • Agency & bank usage is managed within limits. • Non-recurrent VIP over delivery makes up for a shortfall in recurrent, overall VIP 	



	<p>has been achieved.</p> <p>Questions invited.</p> <ul style="list-style-type: none"> • SC congratulated the team on the VTE assessment improvement. • Question on falls and when this may improve. VS noted that a thematic review has been conducted that's generated workstreams to drive improvement. It's clear that our patient group has changed, and we are seeing more frailty that's resulted in more falls. • Challenge on the MR wait increase. CM responded that this was due to a booking issue that has been rectified. It impacted 19 patients and they have now been booked. • Challenge on management of infection control. VS noted that there is a comprehensive action plan that's reporting through QAC. IPC summits have been held to look at specific examples to share learning across the trust. This is being repeated as was very well received on top of other actions. • AM asked whether we have a home for reporting of the Health inequalities work, noting that it's clear that it runs through the work of the Board and other committees. • Response that we are looking at ensuring this is robust and considered in the governance structure, currently it cuts through all aspects of our work. We need to look at where we can have a significant impact. The biggest impact currently is in targeted lung screening. Our ambition is to get this into the governance structure so that we are clear about this impact. • RDS asked about those who don't access the health system and why and how we get to these people. • RS noted that targeted lung screening is the biggest step forward with this in many years and the impact on survival is significant. Those in deprived areas are targeted and their early diagnosis and treatment is now better than those in the least deprived areas. We need to advocate for this in the most effective way. • The Oldham, Salford and Macclesfield centres are other Christie initiatives that have significant impact on inequalities and access to treatment. • The Senior Adult Oncology service is also providing an impact on this. • Summary of health inequalities requirements and where this is assured to come to the next meeting. • DT asked how the learning from the lung health check programme is taken into other areas of cancer and the higher incidences of cancer. • NB responded that this is targeted which is different from other screening programmes, there is now a path for other screening programmes to follow. The system wide learning is difficult. The next area of focus is may be prostate. • It was noted that the governance of health inequalities is difficult as it overlays everything we do. • The data insight that we have drives some of this and that is one of the reasons why we want to do more with our data strategy to evidence system work as well as internal impacts. • NB noted that the national system is the equality delivery system (EDS), and we continue to report through this system, this comes through the WAC. 	<p>JW</p>
<p>c</p>	<p>Value Improvement Programme update</p>	
	<ul style="list-style-type: none"> • Paper shows the monthly update. 	



- This shows how operational oversight is provided and how we ensure safe and effective services alongside the programme.
- 2025/26 target has been delivered - £25.3m. We delivered more non-recurrent VIP than we planned to.
- VIP aligns to the strategy and the systems in place are maturing and described.
- Looking at reducing variation and aligning quality and safety.
- Plans for 2026/27 are being developed with support from National benchmarking and local data.
- Schemes have been clinically led.
- £25.3m target, have identified all but £2.9m of this.
- Governance for the VIP schemes was illustrated and described including quality and equality impact assessments. The process for signing off these assessments was outlined with clinical oversight and reporting through Risk & Quality Governance.
- Confidence for delivery is good and aligns to planning requirements.

Questions

- SC asked what is ready to go. CM noted that £14m of schemes is ready to be delivered from 1st April.
- Challenge on what happens if a plan fails and how that is managed. CM noted that programmes have set check points to assess all aspects including quality. This is a weekly, monthly or quarterly check dependent on scale and risk. CM outlined an example and how this has now been moved into the next financial year.
- GP noted the clear progress with the management of VIP.
- GP asked about the level of non-recurrent VIP and where we are in the long-term planning of VIP delivery. CM responded that we are going to find it hard to increase the recurrent as we are in a activity growth situation so won't reduce headcount or beds.
- The example was given of our length of stay scheme that aims to increase efficiency to manage more demand rather than to close beds.
- Monitoring of schemes is done weekly.
- We will never submit a plan with 100% recurrent VIP considering the challenge in growth in demand.
- SP noted that the underlying run rate improves over 3 years in our financial plan – productivity will go some way to address our increasing demand.
- It was noted that some VIP plans have been refused due to the QIA's.

Board noted progress to date, including delivery of £25.298m VIP in 2025/26 and the developing 2026/27 pipeline.

Board endorsed the governance and assurance arrangements (including use of the national Grip & Control checklist) and ongoing weekly tracking of delivery.

Board agreed the planned approach to clinically led service reviews informing the VIP pipeline and to continue Quality Impact Assessments (QIA) and Equality Impact Assessments (EQIA) for all schemes.

Board confirmed alignment with the Five-Year Integrated Delivery Plan and 2026/27 operational and financial plans.



d	Staff survey 2025	
	<p>DS presented the overview of the latest staff survey results.</p> <ul style="list-style-type: none"> • Detailed analysis will go to the WAC in June. Overall, these are very pleasing results in the national and regional context. • We had a 47% completion rate but actual numbers of staff who have completed the survey are higher than in previous years. Work is underway to improve this next year. • The scores across the 9 themes was outlined. • The Morale score we rank 5/206, Engagement we rank 3/206 trusts. These are excellent results. • We also compare very well against other specialist trusts, and this was illustrated. • There is work to do with the learning domain, nationally we are still in the top 1/3. This will be an area of focus. • Results have been circulated to divisions; action plans will be developed in teams to address areas of improvement. • Board asked to note the results. <p>Questions</p> <ul style="list-style-type: none"> • AO extended congratulations to everyone on the very strong results. The best place to be cared for and best place to work are especially strong and this is very impressive. • DS noted that there are some service line hot spots that need plans to come back to WAC. WAC report will rank all questions against the national benchmark. • GP asked where the 'learning' theme drop is and if this is in particular areas. DS noted a statistical anomaly in the way that it is reported. • MLW challenged on how we make a difference to underrepresented groups. DS noted that we are looking to address this in action plans • AO noted that we should be proud of these results. There is an NHS issue in terms of EDI. The new social cohesion strategy calls out the NHS on religious and racial abuse that's a national issue that we must be aware of. • Comment that the timescale to take actions before the next survey takes place is very small and makes it difficult to show impact. <p>Board noted the report and results of the latest staff survey.</p>	
e	Neighbourhood Oncology	
	<ul style="list-style-type: none"> • NB noted that the Board have heard about these plans over the last few meetings. • NB noted the responsibility to deliver this for GM, but we want to create a blueprint for how this can be used in other parts of the country. • There's a huge pressure on services as demand increases and we must work out how to deal with this increase. • Shift from hospital to neighbourhood is a focus of the 10-year plan. Other shifts from analogue to digital and treatment to prevention also need to be addressed. • Pillars of Neighbourhood Oncology were outlined. SACT, Ambulatory Acute Oncology and Integrated Supportive Oncology. 	



	<ul style="list-style-type: none"> • The mandate and mechanism were outlined. DHSC have published a Neighbourhood Health and Urgent & Community Care Framework. This talks about shaping care around people’s lives, reducing numbers coming for face-to-face appointments, and reducing emergency care. • Our plans are aligned to these frameworks. Integrated neighbourhood teams were described, we need to make these work for oncology. • We are looking at designing services of the future around equity, rolling out targeted programmes in areas of greatest need. • This is digitally dependent, but we also need to address those communities who are digitally excluded. • Need to work with communities and their existing resources / infrastructure. • Must measure the experience of patients in this service. • 5-year system value laid out, operational shifts driving system value. • 12-month plan outlined including scaling up of the SACT at home delivery. • Benefits & outcome measures outlined – aligned to neighbourhood health framework. <p>Questions</p> <ul style="list-style-type: none"> • GP asked if we foresee a problem with getting this properly funded. • NB responded that the national framework sets out what this should look like, and we are engaging commissioners with this now, but we know this will be a challenge. • SP noted that we need to make a robust case illustrating that this method of service organisation and delivery is more effective in the long run and outlining the benefits. • RDS asked if we are clear about who will commission what and will we be straying into areas that are not our area of expertise. • Response that we need to pull on different people / expertise. We are connecting with commissioners about opportunities. Need to think about the progress we can make as an IHO. • We must find a way to demonstrate to colleagues how this will be done and start by using the services that are already commissioned. We must show leadership in this area. • Demand requirements will mean that it is necessary to do this. • Context of this with the 10-year plan is very important. <p>The Board noted the expansion and strategic importance of the Neighbourhood Oncology programme and endorsed continued progression across Greater Manchester.</p>	
08/26	Planning	
a	Future Christie update	
	<ul style="list-style-type: none"> • AB presented the Future Christie update which is a transformation platform built around the patient, clinician and whole hospital. • EPR OBC has been approved, we are now looking at the strategic case and the route to procurement. We are taking advice on this. More detail will come back. • AVT has been paused due to software issues, and this now goes live again on Monday. Governance and workforce impacts are being looked at. Productivity impact is expected in the region of enabling clinics to see an additional patient in 	



	<p>each clinic. This relates to one of the high operational risks that will be coming down once this is rolled out.</p> <ul style="list-style-type: none"> • Increase in staff burn out in implementation phase of these big changes is being considered. • Data Strategy will come back next month with more detail and how this fits in. New Data Officer starts in June. 	
b	Strategy update	
	<ul style="list-style-type: none"> • JW noted the summary paper that reflects the national policy changes and how this is being considered alongside our Strategy. • We continue to progress with unforeseen developments and are now 2/3 way through the existing strategy. • We are now looking at all of the developments and how they impact on future strategy development in the next iteration. <p>Noted</p>	
09/26	Governance (regulatory / statutory compliance)	
a	Reports from Committees (February 2026)	
i	Workforce Assurance Committee	
	<p>AO fed back that there's nothing significant to note and Board should note the report.</p> <p>F&PP compliance was given significant assurance in the latest meeting and this is presented here for Board sign off.</p>	
ii	Quality Assurance Committee	
	<p>SC drew attention to the report and noted the escalations and items covered in the meeting.</p> <p>The Aseptic unit report came to yesterday's meeting and there are no alerts to escalate.</p>	
iii	Audit Committee	
	<p>Alert on medical devices training limited assurance report – going through next WAC.</p> <p>Deep dive on digital / cyber – new toolkit standards have come in, now assessed as approaching standard, clear action plan in place. Will be reported back in July.</p> <p>Recommending that as the IPQFR develops we consider adding in a digital section.</p> <p>Pharmacy report – high assurance around business side, estates constraints have been escalated.</p> <p>Internal audit plan has been agreed with 2 additions.</p>	
iv	Senior Management Committee	
	<p>SMC report shows the preparatory work done prior to consideration of items by the Board. No significant variation of items.</p>	
b	Board Assurance Framework	
	<ul style="list-style-type: none"> • BAF has been updated to show the current position against the strategic risks. • Changes to the risk scores are outlined in the cover paper with explanations. • Q3 risk scores have been added. 	



	<ul style="list-style-type: none"> • MIAA report reflected with good feedback • Supply chain risk has been considered considering global changes including pharmacy, procurement and medical physics. 	
c	Annual reporting cycle 2026/27	
	<ul style="list-style-type: none"> • Board asked to approve the reporting cycle – minimum reporting arrangements outlined. Approved 	
d	Code of Conduct for Directors and Employees	
	<ul style="list-style-type: none"> • Policy has been updated to reflect changes in prevention of fraud act and other minor updates. • Approved 	
e	Fit & Proper Persons Test Policy	
	<ul style="list-style-type: none"> • Policy has been updated to reflect changes in prevention of fraud act and other minor updates. • Approved 	
f	Fit & Proper Persons Test Compliance report	
	<ul style="list-style-type: none"> • JR noted that the evidence of compliance with the FPP framework has been through the WAC and shows compliance with the requirements for 2025/26. Noted compliance and approved to be submitted to NHSE. 	
10/26	Any other business	
	<ul style="list-style-type: none"> • NB noted that the BMA have announced a 6-day resident doctor strike from 7th - 13th April. • This tends to impact review appointments that are rescheduled and impact is minimised. • Integrated 5-year plan – finalised version attached for information. This has been accepted by NHSE. • Planning meeting on 21st July will look at AFT application. 	
	Reflections of the meeting	
	<p>Very good conversations reflective of a maturing position Time spent on the right things. Great to see progress and conversations of EDI running through all discussions.</p>	
	Date and time of the next meeting	
	Thursday 30 th April 2026 at 2pm	



Meeting of the Board of Directors - 30th April 2026
Action plan rolling programme after March 2026 meeting

C Culture P Performance S Strategy G Governance

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
April 2026		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance & quality and finance report	COO	Monthly report	12/16b
		G	Register of matters approved by the board	CEO	Approve	14/26c
	Provider licence	G	Self certification declarations	CEO	To approve the declarations	14/26d
		G	Modern Slavery Act statement (in Trust Report)	CEO	Approve	12/26a
		C	Freedom to speak up Guardian report	FTSUG	6 monthly update	13/26a
	Annual reporting cycle	P	Risk Management strategy 2025-26 annual review	ECN	Approve	12/26d
May 2026 - no meeting Planning & Development Day	Annual reporting cycle	P	Integrated performance & quality and finance report	COO	Monthly report	By email
	Planning session	S	Planning			
June 2026		C	Patient story	CEO	To hear a patient story	
	Annual reporting cycle	P	Integrated performance & quality and finance report	COO	Monthly report	
	Annual reporting cycle	G	Annual reports from audit, quality and workforce assurance committees	Committee chairs	Assurance	
	Annual reporting cycle	G	Annual compliance with the CQC requirements	ECN	Declaration / approval	
		P	Value Improvement Programme	COO	Review	
		S	Annual objectives / BAF 2026/27		Approve	
	Annual reporting cycle	G	Annual report, financial statements and quality accounts (incl Annual governance statement / Statement on code of governance)	EDoF	Approve	
July 2026 - no meeting Planning & Development Day	Planning session	P	Integrated performance & quality and finance report	COO	Monthly report	By email
	Planning session	S	Service Review day with senior leadership teams			
August 2026 - no meeting		P	Integrated performance & quality and finance report	COO	Monthly report	By email
September 2026		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance & quality and finance report	COO	Monthly report	
		P	Value Improvement Programme	COO	Review	
		S	Future Christie update	DFC	Review	
October 2026		C	Patient story	CEO	To hear a patient story	Board presentation
		P	Integrated performance & quality and finance report	COO	Monthly report	
		P	Value Improvement Programme	COO	Review	
		S	Future Christie update	DFC	Review	
		P	EPRR Compliance statement	COO	Approve	
		G	Regulatory preparedness update	ECN	Review	
		C	Freedom to speak up guardian	FTSUG	Annual report	
	Planning & Development Day	S	Board Planning & Development	Chair	Board development programme - externally facilitated	N/A

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
November 2026		C	Patient story	CEO	To hear a patient story	
	Annual reporting cycle	P	Integrated performance & quality and finance report	COO	Monthly report	
		S	Strategy update	DoS	Six month review	
		P	Value Improvement Programme	COO	Review	
		S	Future Christie update	DFC	Review	
		S	Higher Education Institute update	DoE	Note	
		S	Annual Sustainability Report - Boards responsibility for Carbon Net Zero	DCEO	Note approval by Audit Committee	
December 2026 - no Board meeting		P	Integrated performance & quality and finance report	COO	Monthly report	By email
	Planning & Development / Council	S	Board planning			
		S	Council / Board - strategy update			
January 2027		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Interim review of annual objectives	CEO	Review progress	
	Annual reporting cycle	P	Integrated performance report	COO	Monthly report	
		S	Future Christie update	DFC	Review	
		P	Value Improvement Programme	COO	Review	
February 2027 - no Board meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
	Annual reporting cycle	G	Letter of representation & independence	Chair		
	Annual reporting cycle	G	Register of directors interests / FPPT annual declaration	Chair	Circulate	By email
	Annual reporting cycle	G	Declaration of independence (non-executive directors only)	Chair		
	Planning & Development Day	S	Board development & planning	Chair	Board Development programme	N/A
March 2027		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance & quality and finance report	COO	Monthly report	For information
		S	Future Christie update	DFC	Review	08/26a
		P	Value Improvement Programme	COO	Review	07/26c
	Annual reporting cycle	S	Annual reporting cycle	Executive directors	Approve	09/26c
		C	Staff survey initial results	DoW	Review	07/26d
	Annual reporting cycle	G	FPPT Compliance report	Chair	Approve annual compliance	09/26e



**Action log following the Board of Directors meetings held on
 Thursday 26th March 2025**

No.	Agenda	Action	By who	Progress	Board review
1	06/26c	Update to Board minutes relating to Board Assurance Framework	LW	Minutes updated	Complete
2	07/26b	Summary of health inequalities requirements and where this is assured to come to the next meeting.	JW	Summary paper to April Board	30 th April Public Board



Meeting of the Board of Directors

Thursday 30th April 2026

Subject / Title	Trust report
Author(s)	Executive Directors
Presented by	Roger Spencer, Chief Executive
Summary / purpose of paper	This report brings together the key issues for the Board of Directors in relation to our performance, strategy, workforce, the Greater Manchester system landscape, the regulatory landscape and other pertinent matters within the scope of the board's responsibilities.
Recommendation(s)	The board is asked to review the contents of the paper and approve the Modern Slavery statement for publication on the Trust website.
Background Papers	Integrated Performance, Quality and Finance Report Finance Report
Risk Score	See Board Assurance Framework
EDI impact / considerations	Positive impact relating to compliance with standards
Link to: ➤ Trust's Strategic Direction ➤ Strategic Objectives	<ol style="list-style-type: none"> 1. To deliver safe, effective & equitable care 2. To deliver excellent financial and operational performance 3. To provide integrated clinical, research and education services 4. To be an excellent place to work and attract the best staff 5. To transform our services to improve access and reduce health inequalities 6. To provider leadership within the wider NHS cancer system
Acronyms or abbreviations contained in the report	<p>NHSE NHS England</p> <p>FDS Faster Diagnosis Standard</p> <p>PDR personal development review</p> <p>GM Greater Manchester</p> <p>VIP Value Improvement Programme</p> <p>EPR electronic patient record</p> <p>AI Artificial Intelligence</p> <p>NIHR National Institute for Health & Care Research</p>



Trust Report
April 2026 (March data)

Introduction

We continue to perform well with no current issues requiring escalation and a projected achievement of annual objectives across all domains.

This consolidated view of the Trust’s operational and strategic performance summarises the current position with regard to board capability assessment, compliance with operational requirements, progress against our annual strategic milestones within the context of national policy developments. Further details on the items in the report can be obtained from the links provided. Risks to our strategic milestones are reported in the Board assurance Framework and details of operational performance are in the Integrated Performance, Quality & Finance report.

NHSE have reviewed our Medium Term Plan for 2026/27 – 2028/29 and our five-year Integrated Delivery Plan. They have confirmed their assessment of its compliance subject to the conditions that the standards and performance requirements set out in the plan are delivered.

Board Capability

The Christie’s Board Capability self-assessment set out assurance of the board’s leadership capacity, governance maturity, and preparedness to meet performance expectations.

Our self-assessment of full compliance against the [NHS England provider capability](#) domains was made at our September 2025 Public Board and submitted to NHSE in October 2025.

We received confirmation from NHSE on 6th February 2026 that this assessment has been signed off by the regional team and moderated through a national process resulting in our overall capability rating being assessed as ‘Green’ for 2025/26.

The table below summarises the position with all domains rated Green, with no escalation required.

NHSE Board capability domain	Relevant Indicators	Evidence	RAG rating
1. Strategy & Leadership	Oversight Framework segment; national ranking	NOF Segment 1, Q3 ranked 3 rd nationally NHS Acute & Specialist Trusts.	Green
2. Quality of Care	62-day cancer standard; Faster Diagnosis Standard; nurse staffing	62-day and FDS remain above target. Nurse staffing consistently exceeding the minimum target of 80% planned levels	Green
3. Workforce	Sickness absence; PDR compliance; training compliance	Sickness 4.8% (lowest in GM). PDR compliance (87.2%) and mandatory training compliance (95.1%)	Green
4. Partnerships & System Role	GM Collaborative contributions; national audits	Leadership in Cancer Alliance. Lead GM aseptic programme. OECl reaccreditation confirms global top-tier status.	Green
5. Financial Sustainability	Monthly surplus; VIP delivery	Surplus (£13.29m) on plan; value improvement plan target achieved.	Green



NHSE Board capability domain	Relevant Indicators	Evidence	RAG rating
6. Improvement & Innovation	Clinical trial set-up; AI pilots; EPR milestones	Research set-up below 60-days. Digital/AI projects and Future Christie milestones progressing to plan.	

Operational Performance – Month 12 Position

We continue to perform strongly across all domains. We are in Segment 1 of the NHS Oversight Framework, the highest possible rating, and at Q3 are ranked 3rd nationally among acute and specialist providers. Our international standing as one of the top 25 global cancer centres as reported at the September 2025 board meeting. Our overall NHSE provider capability rating is assessed as 'Green' for 2025/26.

Performance across quality, operational, financial and workforce domains remain compliant with requirements. Full details are provided in the Integrated Performance Quality & Finance Report.

Strategic Objectives – Month 12 Position

Progress against the 2025/26 annual milestones of each of our six strategic objectives is currently rated Green, with risks actively managed and oversight of risks clearly assigned to committees or the board and tracked through the Board Assurance Framework.

Strategic Objective 1: Safe, Effective and Equitable Care

Quality remains consistently high, with proactive risk management and a maturing learning culture providing strong assurance on patient safety.

- Overall Status: Green
- BAF Risks: 0 ≥15
- Committee Oversight: Quality Assurance Committee
- Executive Lead: Executive Chief Nurse

There were no significant adverse quality variances in March. Three operational risks currently score above 12 and risks are actively monitored via the Risk & Quality Governance Committee, with mitigation plans in place.

Safe staffing was maintained, with nurse staffing consistently exceeding the minimum target of 80% planned levels.

Strategic Objective 2: Excellent Financial and Operational Performance

The Trust is financially stable and operationally compliant, with no deviation from plan and full delivery against agreed improvement targets.

- Status: Green
- BAF Risks: 1 ≥15
- Committee Oversight: Board of Directors
- Executive Lead: Executive Director of Finance

At Month 11, the Trust is delivering a financial surplus of £13.29 million, in line with plan. The Value Improvement Plan for 2025/26 has been achieved, and operational performance remains compliant against all major cancer standards, including the 62-day, 31-day and Faster Diagnostic Standard (FDS) metrics.



We have agreed a compliant plan for 2026/27 with our commissioners. Our plan is based on our fixed contract being paid and the variable elements being based on activity as per the contract.

NHSE have reviewed our Medium Term Plan for 2026/27 – 2028/29 and our five-year Integrated Delivery Plan. They have confirmed their assessment of its compliance subject to the conditions that the standards and performance requirements set out in the plan are delivered.

Strategic Objective 3: Integrated Clinical, Research and Education Services

The Trust is strengthening its research and academic profile, with national investment secured and a strategic education proposal in development.

- Status: Green
- BAF Risks: 0 ≥15
- Committee Oversight: Board of Directors
- Executive Lead: Director of Research and Director of Education

We are working towards the national 60-day benchmark for research trial set-up times. In April, the median time to study set-up was 73 days, an improvement from 100 days in the previous year, reflecting progress across both commercial and non-commercial studies. Further process improvements are underway to sustain and build on this position. We are also actively preparing for the implementation of the updated UK clinical trials regulatory framework, including adoption of the International Council for Harmonisation (ICH) Good Clinical Practice guideline E6 (R3), which comes into force on 28 April 2026.

Ambitious plans to establish a credentialled Masters level education suite and achieve recognised Higher Education Provider status have been shared previously with the Board, highlighting a key process of transformation that reinforces our position as a centre of excellence in cancer education. Supporting workstreams focused on programme design, procurement of an academic credentialing partner and prospective learner engagement are well advanced with an underpinning business case for the next phase of this work coming forward for approval.

Strategic Objective 4: Excellent Place to Work and Attract the Best Staff

The Christie maintains a high performing, engaged workforce with strong, nationally leading, indicators of morale, inclusion and leadership visibility.

- Status: Green
- BAF Risks: 0 ≥15
- Committee Oversight: Workforce Assurance Committee
- Executive Lead: Director of Workforce

Workforce indicators remain strong. Mandatory training compliance stands at 95.5%, and PDR completion is at 85.9%. Sickness absence is currently at 4.98%, the lowest in Greater Manchester. The Christie continues to be rated in the top category nationally for compassionate and inclusive culture, staff engagement, safe & healthy, morale and flexibility, as confirmed by the NHS Staff Survey 2025.

We have been informed by NHSE that we have the strongest improvement scores in the Resident Doctors 10-point plan regionally.

Resident doctors in England undertook strike action for 6 days, from 7th to 13th April. Detailed daily planning meetings took place, and contingency plans were put in place. Patients were advised to attend appointments as normal.



Following the trust's initial accreditation in 2023, and subsequent review in 2024, we have received confirmation in March that we have been reaccredited as a Veteran Aware organisation. We were commended on our commitment to the Armed Forces Covenant.

Strategic Objective 5: Transform Services and Reduce Inequalities

Transformation is progressing as planned, with digital infrastructure and service equity both advancing in line with strategic commitments.

- Status: Green
- BAF Risks: 0 ≥15
- Committee Oversight: Board of Directors
- Executive Lead: Future Christie Director, and Director of Strategy

Our Future Christie transformation programme remains on track. The Patient Portal has been successfully rolled out, and an outline business case for a new electronic patient record (EPR) was approved by the Board in February. The capital programme is progressing to plan and remains within budget.

We continue to address inequalities in access to services. Notably, we have consistently achieved the Faster Diagnostic Standard target for haematology patients in Mid-Cheshire, demonstrating our commitment to equitable care across the region.

Strategic Objective 6: Leadership Within the Wider NHS Cancer System

The Christie's leadership role within the regional and international cancer system is recognised and expanding.

- Status: Green
- Key Updates: OECl reaccreditation; GM Collaborative leadership; network expansion
- BAF Risks: 0 ≥15
- Committee Oversight: Board of Directors
- Executive Lead: Director of Strategy

The Trust continues to play a leading role within the Greater Manchester Provider Collaborative, contributing to all eight shared priorities and leading the GM Aseptic programme. Our haematology network has expanded to include Macclesfield and Crewe with active plans to extend to additional sites, further consolidating our system leadership.

The Modern Slavery Act 2015 (the Act) establishes a duty for commercial organisations to prepare an annual slavery and human trafficking statement. This is a statement of the steps the organisation has/is taking to ensure that slavery and human trafficking is not taking place in any of its supply chains or in any part of its own business. Part of the requirement of the Act is to produce a statement that is approved by the board and published on the website.

Christie contracts include specific clauses relating to the Modern Slavery Act and when undertaking formal procurement exercises, we include an assessment where bidder responses are assessed on a PASS/FAIL basis. Assurance around our procurement arrangements are reviewed by our internal auditors and reported to Audit Committee. This was last undertaken in 2023 with a particular focus on commercial partnerships. The updated statement for 2026/27 is appended to this report for approval. Following Board approval, the statement will be published on the trust website.

The table below summarises our current delivery status against the six strategic objectives, including risk ratings and committee oversight.



Strategic Objective	Risk rating	Committee oversight
1 Safe, Effective and Equitable Care		Quality Assurance Committee
2 Excellent Financial and Operational Performance		Board of Directors
3 Integrated Clinical, Research and Education Services		Board of Directors
4 Excellent Place to Work and Attract the Best Staff		Workforce Assurance Committee
5 Transform Services and Reduce Inequalities		Board of Directors
6 Leadership Within the Wider NHS Cancer System		Board of Directors

National Policy Developments

The Trust is appraised of and involved in shaping current NHS policy and well positioned to take advantage of emerging opportunities.

Recent updates to NHS England policy frameworks are directly relevant to our strategic planning. These include;

1. Neighbourhood Health Framework (DHSC / NHS England), published: 17 March 2026

- Introduces a nationally defined Neighbourhood Health Service model as a core delivery mechanism for the 10 Year Health Plan.
- Sets out expectations for:
 - Place-based, multidisciplinary neighbourhood teams
 - Joint NHS–local authority governance and commissioning
 - A “left shift” from hospital to community and from sickness to prevention
- Establishes archetypes, outcomes and metrics to support consistent implementation while allowing local variation.
- Signals future changes to financial flows and incentives to enable neighbourhood delivery.

This is a major structural policy underpinning medium-term service redesign, with implications for provider collaboration, commissioning models, governance arrangements and workforce planning.

2. Quality and Outcomes Framework (QOF) Guidance 2026/27, published: 26 March 2026

- Provides detailed guidance on interpretation and verification of QOF indicators for 2026/27.
- Effective from 1 April 2026 and replaces previous versions.
- Supports revised GP contract arrangements and performance monitoring.

Why it matters:

Relevant for system performance oversight, primary care integration and understanding incentives affecting system demand and access.

3. Finance and Reporting: DHSC Group Accounting Manual 2025–26, published: March 2026

- Updated accounting and reporting guidance for DHSC group bodies, including NHS trusts and ICBS.



- Includes changes to reporting expectations, audit requirements and performance disclosures.

Relevant for year-end accounts, audit committees and Board assurance on financial governance.



SLAVERY AND HUMAN TRAFFICKING STATEMENT

Introduction from the Board

We are committed to improving our practices to combat slavery and human trafficking.

Organisations Structure

The Christie is a specialist cancer centre serving a primary population of 3.2 million across Greater Manchester and Cheshire. We are an NHS Foundation Trust with over 4,300 employees and an annual turnover of approximately £587m.

Our business

We are a specialist cancer centre and we treat approximately 60,000 patients a year. We are a world pioneer in the care, treatment and research of cancer. We operate out of our main site in Withington, South Manchester and have radiotherapy centres at Salford, Oldham and Macclesfield as well as chemotherapy and outpatient services at sites across 14 other sites in Greater Manchester and Cheshire. We also provide chemotherapy service and treatment in patients' homes.

Our policies on slavery and human trafficking

We are committed to ensuring that there is no modern slavery or human trafficking in any part of our business and in so far as is possible we require our suppliers to hold a similar ethos.

The Christie NHS Foundation Trusts' guidance on Modern Slavery is to:

- Comply with legislation and regulatory requirements
- Make suppliers and service providers aware that we promote the requirements of the legislation
- Consider modern slavery factors when making procurement decisions
- Develop awareness of modern slavery issues

We will:

- Aim to include modern slavery conditions or criteria in specification and tender documents wherever possible,
- Evaluate specifications and tenders with appropriate weight given to modern slavery points,
- Encourage suppliers and contractors to take their own action and understand their obligations to the requirements.

Trust staff must:

- Contact and work with the Procurement department when looking to work with new suppliers so appropriate checks can be undertaken.

Procurement staff will:

- Undertake awareness training where possible.
- Aim to check and draft specifications to include a commitment from suppliers to support the requirements of the Act.
- Will not award contracts where suppliers do not demonstrate their commitment to ensuring that slavery and human trafficking are not taking place in their own business or supply chains.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ending 31 March 2025.

SIGNATURE:



POSITION: Chief Executive Officer, The Christie NHS Foundation Trust

DATE: 30th April 2026





Safety (slides 3-15): Incident reporting culture is robust, with 97% of incidents resulting in low/no harm and 22% being near misses, which reflects proactive risk identification. IPC MRSA remains above trajectory, while E.coli and Klebsiella trends are improving. Sustained focus on IPC fundamentals and compliance monitoring continues to prevent future spikes and maintain patient safety.

Finance (slides 16-20): The Trust has delivered a materially favourable year-end financial outturn (£13.29m), supported by effective control of pay, agency, and non-pay expenditure, alongside full delivery of the in-year Value Improvement Programme along with additional DSF (£3.3m). This strong financial position has been achieved while maintaining operational performance and workforce stability, with capital underspend understood and intentionally managed to support future service delivery and sustainability.

Access & Performance (slides 21-30) : Access standards performance is characterised by stable processes showing common-cause variation, indicating systems that are broadly under control but sensitive to capacity, workforce availability, and pathway sequencing rather than isolated failures. Where volatility persists (notably 62-day and 24-day pathways), the data triangulates operational pressure, diagnostic and treatment capacity, and workforce constraints, reinforcing the need for sustained end-to-end pathway grip rather than short-term recovery actions

Workforce (slides 31-36) : Workforce metrics support overall service delivery, with low and stable agency usage, managed bank reliance, and no evidence of workforce instability driving quality or access deterioration. Observed workforce cost pressures align with activity demand and national pay factors rather than local staffing failures, providing assurance that performance challenges elsewhere are system-based rather than workforce-led.

Outcomes (slides 37-38): Clinical outcomes remain within expected national and historical ranges, with 30-day post-SACT mortality showing no signal of deterioration and consistent performance after case-mix adjustment. These outcomes triangulate positively with quality, pathway performance, and workforce data, indicating that operational pressures have not translated into adverse patient outcome trends.

Research (Slides 39-42): Research delivery continues to perform strongly in recruitment volume, while challenges in study setup and first-participant recruitment reflect wider national pressures rather than isolated Trust performance issues. Triangulated analysis of operational capacity, workforce availability, and process efficiency highlights where variability persists, with strengthened oversight and digital enablement providing assurance on control rather than reliance on informal workarounds.

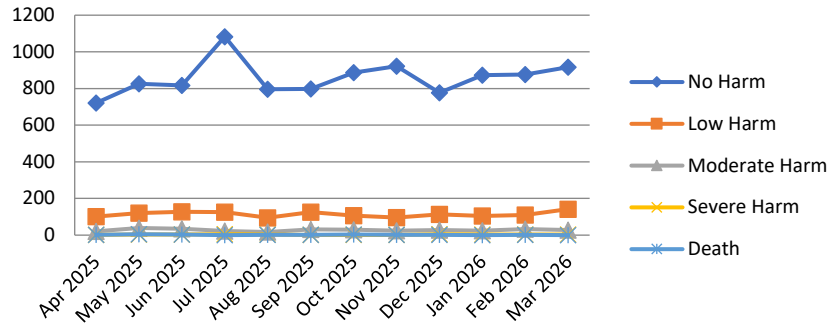
Overall Assessment: Overall, the Trust continues to operate within a position of control, with quality, clinical outcomes, workforce stability and financial performance collectively supporting safe and sustainable care delivery, despite persistent system and pathway pressures. Variability in access standards and research delivery reflects structural capacity and sequencing constraints rather than deterioration, with the data providing assurance that risks are understood, governance is effective, and performance issues are being managed within existing operational and financial resilience.



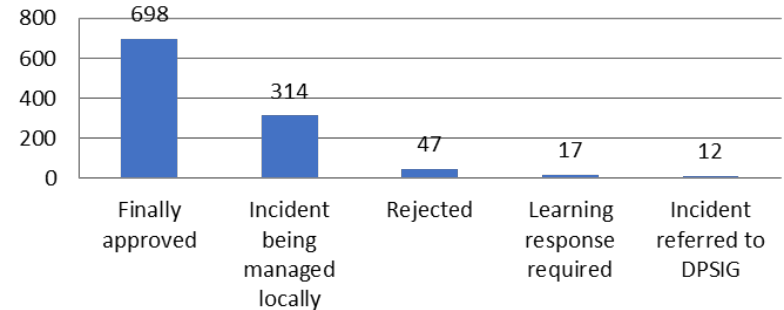
A total of 1088 incidents were reported to DCIQ in March 2026.

- At the time of reporting, 64% of incidents have been finally approved. 4% of incidents have been rejected for reasons such as duplication and incidents which involve care provided by an external trust.
- 97% of all incidents reported resulted in low/no harm.
- 22% of incidents were reported to be a 'near miss', evidencing a positive reporting culture.
- Reporting trends in March were within the expected limits.

Incidents by Reported (Month) and Severity (Intital)



Incidents by Approval status

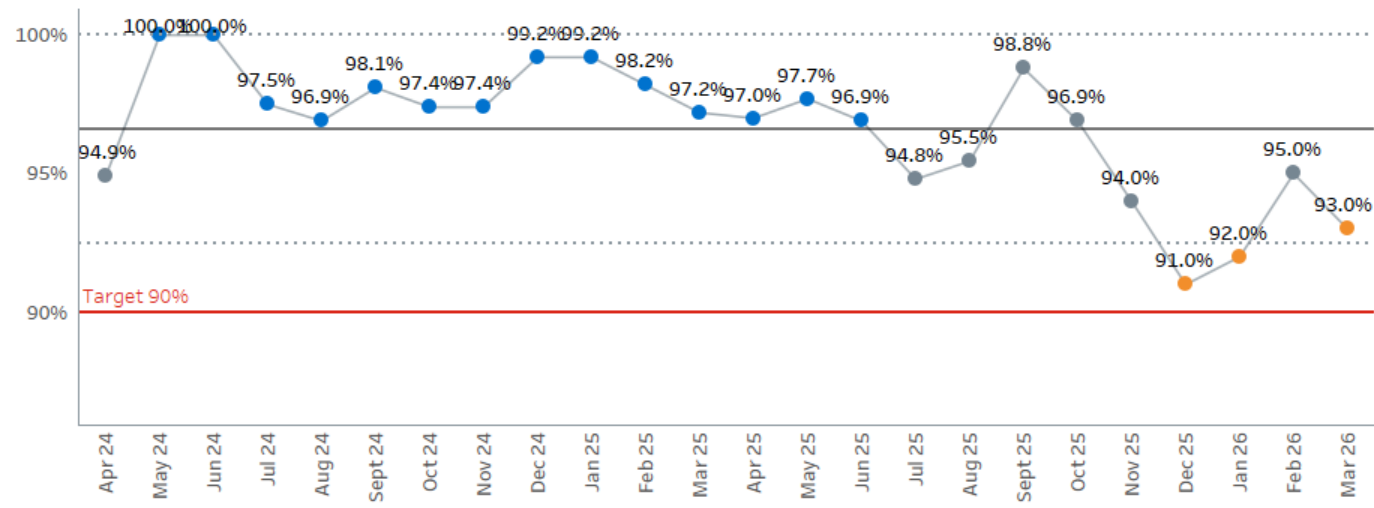


Integrated Performance Report - Patient Care Metrics Summary

Metric	Month	Measure	Target	Variation	Assurance
Sepsis - screening (presenting as an emergency)	March	93.00%	90.00%		
Sepsis - timely treatment with IV antibiotics (established inpatients)	March	92.00%	90.00%		
VTE Assessment Within 14 Hours of Admission	March	96.20%	95.00%		
Falls per 1000 bed days	March	2.9	3.8		
Pressure sores per 1000 bed days	March	0.4	0.5		
Category 3 pressure ulcers	March	0.0	0.0		
Hospital Cancelled Operations on the day for non clinical reasons	March	9.0	0.0		




Sepsis - screening (presenting as an emergency)




Icons

Concerning



Passing



Summary

Concerning Something's going on! Something, a one-off or a continued trend or shift of numbers in the wrong direction.

Passing If a target lies outside of those limits in the right direction then you know that the target can consistently be achieved.

Understanding the performance

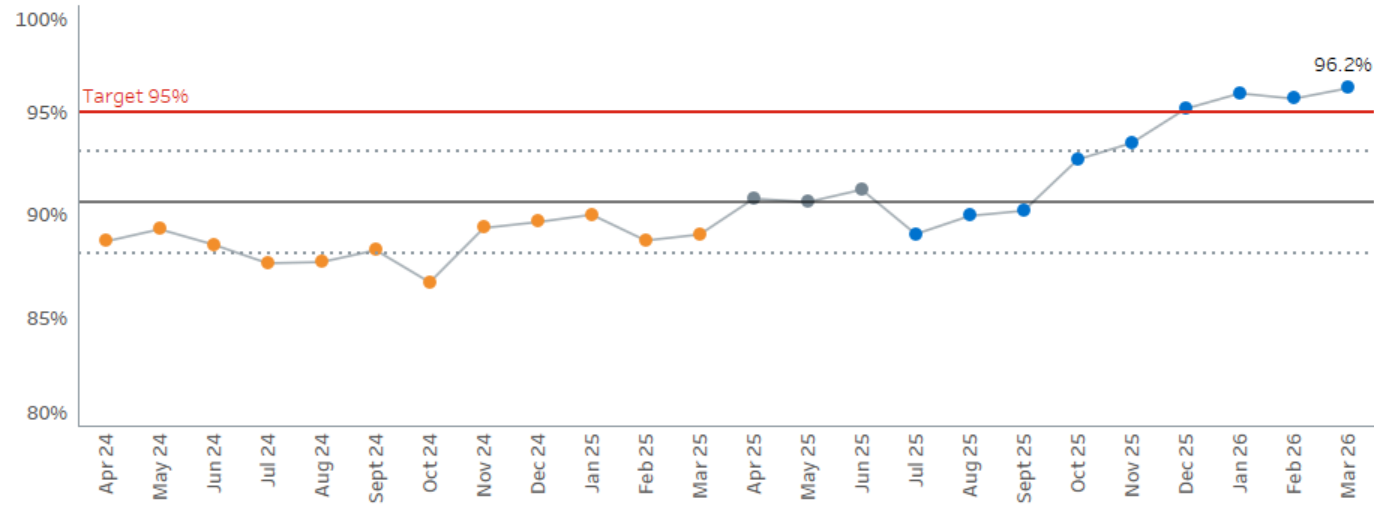
The sepsis screening performance for emergency admissions has maintained above the 90% performance baseline. Performance has been improving since December 2025 but there is a concern that changes have happened leading to poorer performance. The Trust has held a vacant position of Sepsis specialist nurse since September 2025 despite attempted recruitment and this support for clinical areas has potentially impacted performance. The breaches have been incident reported for investigation and all were either low or no harm for patients.

Actions (SMART)

The sepsis specialist nurse has returned to post since the beginning of April 2026 which will increase the visibility of the service and support for staff across the clinical areas with regard to suspected sepsis management. The sepsis specialist nurse will be in a position to support those staff that are leading on the investigation of sepsis pathway breaches and support any actions and learning. The online e-learning module that supports staff updates has been updated to reflect updated sepsis pathway management.



VTE Assessment Within 14 Hours of Admission



Icons

Improving

Failing

Summary

Improving Something good is happening! Something, a one-off or a continued trend or shift of numbers in the right direction.

Failing If a target lies outside of those limits in the wrong direction then you know that the target cannot be achieved.

Understanding the performance

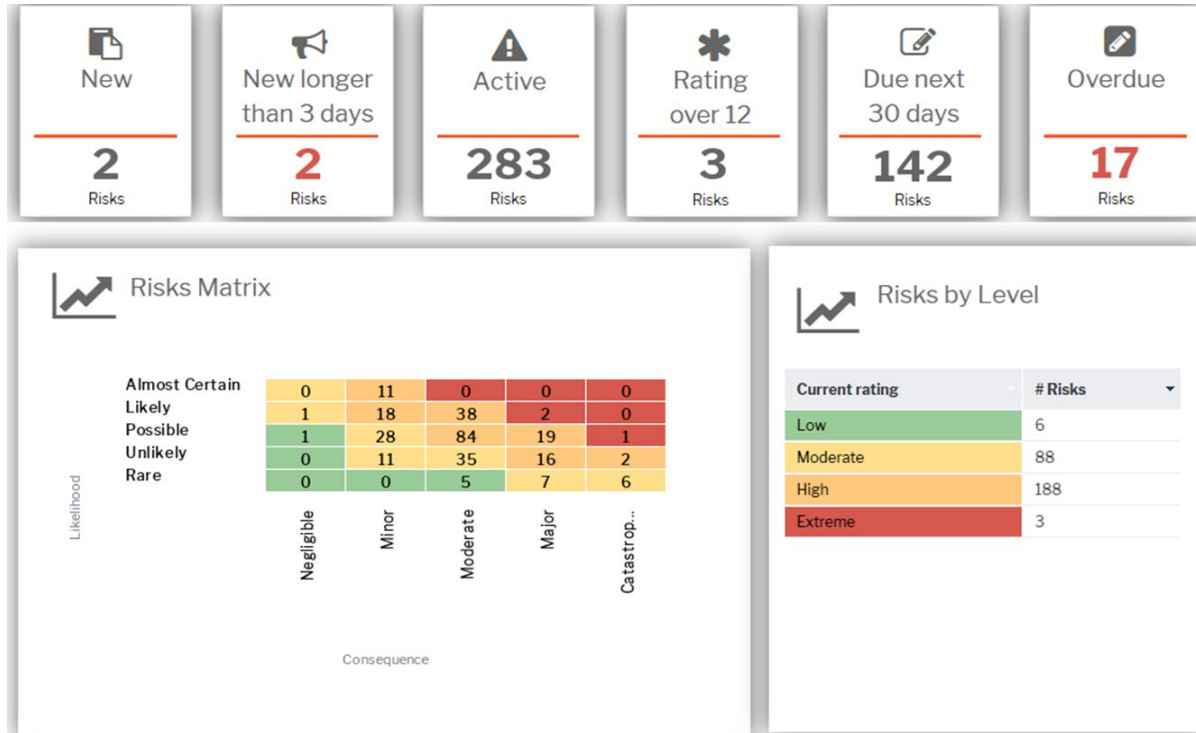
- Performance against VTE assessment within 14 hours shows a sustained upward trajectory, with a clear shift from sub-threshold variation to consistent delivery above the 95% standard in recent months.
- Earlier volatility reflects process variation at the front door, including timing of clerking, handover between admitting teams, and reliance on individual rather than system prompts.
- The improvement pattern demonstrates a genuine change in system performance, rather than a one-off fluctuation, supported by multiple data points showing delivery at or above target.
- Ongoing monitoring confirms that recent improvement is embedded across services, reducing reliance on escalation or retrospective correction.

Actions (SMART)

- Standardise admission workflows so VTE assessment is completed as part of first clerking, with clear accountability assigned to the admitting clinician on every admission.
- Embed automated prompts and checks within admission documentation/EPR to support real-time completion rather than retrospective fixes.
- Sustain weekly performance review at divisional level using SPC to confirm continued process control and identify early warning signs of slippage.
- Targeted feedback and refresher support for any areas falling below trajectory, with actions agreed and reviewed within the next reporting cycle



Risk Profile



- In March 2026 there were 283 open risks recorded in DCIQ
- Of the 283 risks open, 66% (n= 188) were rated as high
- 3 risks were reviewed as being 'extreme' (≥15)
- 94% of all active risks were reviewed within planned timeframes (17 risks were overdue ²⁸ scheduled review)



Trust wide risk register

Risk ID	Risk	Risk register	Type	Subtype	Status	Risk owner	Date opened	Initial rating	Current likelihood	Current consequenc	Previous Rating	Current rating	Target rating	Movement	Next Review Date
101	There is a risk to the Trust's ability to demonstrate compliance and adherence to it's regulatory and statutory requirements under PSIRF	Trust wide	External Risk	Strategic Planning Risk	Active	Katerina Pearson	10/03/2025	16	3	3	15	9	6	↓	16/04/2026
267	Risk of; Ineffective management and application of procedural and clinical documents due to fragmented document control systems.	Trust wide	Operational Risk	Change Risk	Active	Benjamin Vickers	28/02/2019	15	4	3	12	12	3	↔	09/04/2026
496	There is a risks that patients may experience delays to their care and treatment due to limited medical resources within the anaesthetic service	Trust wide	Clinical Risk	Patient Safety / Outcomes Risk	Active	Lauren Oswald,	23/07/2025	9	4	3	16	12	6	↓	20/04/2026
514	There is a risk that patients may experience harm due to significant delays in the management of patients with colorectal cancers.	Trust wide	Clinical Risk	Patient Safety / Outcomes Risk	Active	Tracey Jones,	05/09/2025	16	3	4	12	12	8	↔	16/04/2026
530	There is a risk that may impact patient safety due to non- compliance with mandatory training	Trust wide	Workforce Risk	Workforce Performance Risk	Active	Mr David Smithson	22/09/2025	12	4	3	12	12	6	↔	30/06/2026
548	If the Trust does not deliver the 2026/27 recurrent Value Improvement Programme (VIP) target due to the challenging scale of savings, then there is risk of limited capacity to invest in and improve patient care, leading to reduced ability to achieve	Trust wide	Financial Risk	Financial Management / Waste Reduction Risk	Active	Jo Leece	30/09/2025	12	4	4	16	16	8	↔	23/04/2026
617	There is a risk of a patient coming to harm due to unclear and non-standardised operational processes for clinical correspondence	Trust wide	Clinical Risk	Patient Safety / Outcomes Risk	Active	Suzanne MacGregor	19/12/2025	9	4	3	12	12	6	↔	16/04/2026
630	Risk that the Aseptic unit will be unable to deliver required capacity during a period of recovery following shutdown due to a recognised inability to maintain required operational & safety standards	Trust wide	Operational Risk	Business Continuity Risk	Active	Joanne McCaughey	26/01/2026	20	4	4	16	16	4	↔	16/04/2026
640	(Business continuity risk) Failure of back up isolator resulting in inability to produce trial / critical medications.	Trust wide	Operational Risk	Business Continuity Risk	Active	Jackie Wrench	11/02/2026	15	3	5	16	15	5	↔	08/04/2026



Risks with a current risk score of 15 and above:

Risk ID	Risk	Risk register	Type	Subtype	Status	Risk owner	Date opened	Initial rating	Current likelihood	Current consequence	Previous Rating	Current rating	Target rating	Movement	Next Review Date
548	If the Trust does not deliver the 2026/27 recurrent Value Improvement Programme (VIP) target due to the challenging scale of savings, then there is risk of limited capacity to invest in and improve patient care, leading to reduced ability to achieve	Trust wide	Financial Risk	Financial Management / Waste Reduction Risk	Active	Jo Leece	30/09/2025	12	4	4		16	8	↔	23/04/2026
630	Risk that the Aseptic unit will be unable to deliver required capacity during a period of recovery following shutdown due to a recognised inability to maintain required operational & safety standards	Trust wide	Operational Risk	Business Continuity Risk	Active	Joanne McCaughey	26/01/2026	20	4	4	16	16	4	↔	16/04/2026
640	(Business continuity risk) Failure of back up isolator resulting in inability to produce trial / critical medications.	Trust wide	Operational Risk	Business Continuity Risk	Active	Jackie Wrench	11/02/2026	15	3	5	16	15	5	↔	08/04/2026

- As of the current reporting period, 3 risks have a score of 15 and above.
- In March, all extreme risks were reviewed within the required trust timescales and so were compliant with the trust's risk review process.

Downgraded risks:

- 1 risk was downgraded in March 2026 (Risk ID 634)

Risk ID	Risk	Risk register	Type	Subtype	Status	Risk owner	Date opened	Initial rating	Current likelihood	Current consequence	Previous Rating	Current rating	Target rating	Movement	Next Review Date
634	Risk that ePro upgrade results in degraded performance/application crashing resulting in typing backlogs, disruption to workflow of secretarial and clinical staff, and delays to AVT rollout.	Digital Portfolio	Operational Risk	Change Risk	Active	Leon Lau	30/01/2026	9	2	3	9	6	3	↓	17/04/2026



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	16798	13573	5336	5.6
	Total monthly ACTUAL	16079	13564		
	Average Fill Rate %	95.7%	99.9%		
Care Staff	Total monthly PLANNED	9217	6059	5336	2.9
	Total monthly ACTUAL	8436	6836		
	Average Fill Rate %	91.5%	112.8%		
ALL Staff	Total monthly PLANNED	26015	19632	5336	8.4
	Total monthly ACTUAL	24515	20400		
	Average Fill Rate %	94.2%	103.9%		

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	2246	2137	95.1%	2035	2053	100.9%	193	21.7
Palatine Ward	3538	2982	84.3%	2627	2494	94.9%	925	5.9
Ward 10	2035	1886	92.7%	1782	1684	94.5%	788	4.5
Ward 11	1782	1815	101.9%	1426	1447	101.5%	652	5.0
Ward 12	1782	1881	105.6%	1426	1537	107.8%	846	4.0
Ward 4	1850	1906	103.0%	1426	1483	104.0%	794	4.3
Ward 2	1426	1445	101.3%	1069	1069	100.0%	567	4.4
Acute Assessment Unit	2139	2027	94.8%	1782	1797	100.8%	571	6.7
TOTAL	16798	16079	95.7%	13573	13564	99.9%	5336	5.6

Registered Nursing Associates	DAY			NIGHT		
	Hours Planned	Hours Actual		Hours Planned	Hours Actual	
Critical Care Unit						
Palatine Ward						
Ward 10						
Ward 11						
Ward 12						
Ward 4		15				
Ward 2						
Acute Assessment Unit						

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	0	0	100.0%	0	0	100.0%	193	0.0
Palatine Ward	1426	1054	73.9%	713	1052	147.5%	925	2.3
Ward 10	1731	1328	76.7%	713	928	130.2%	788	2.9
Ward 11	1426	1281	89.8%	1069	923	86.3%	652	3.4
Ward 12	1426	1596	111.9%	1069	1212	113.4%	846	3.3
Ward 4	1426	1569	110.0%	1069	1373	128.4%	794	3.7
Ward 2	713	737	103.4%	713	609	85.4%	567	2.4
Acute Assessment Unit	1069	871	81.5%	713	739	103.6%	571	2.8
TOTAL	9217	8436	91.5%	6059	6836	112.8%	5336	2.9

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

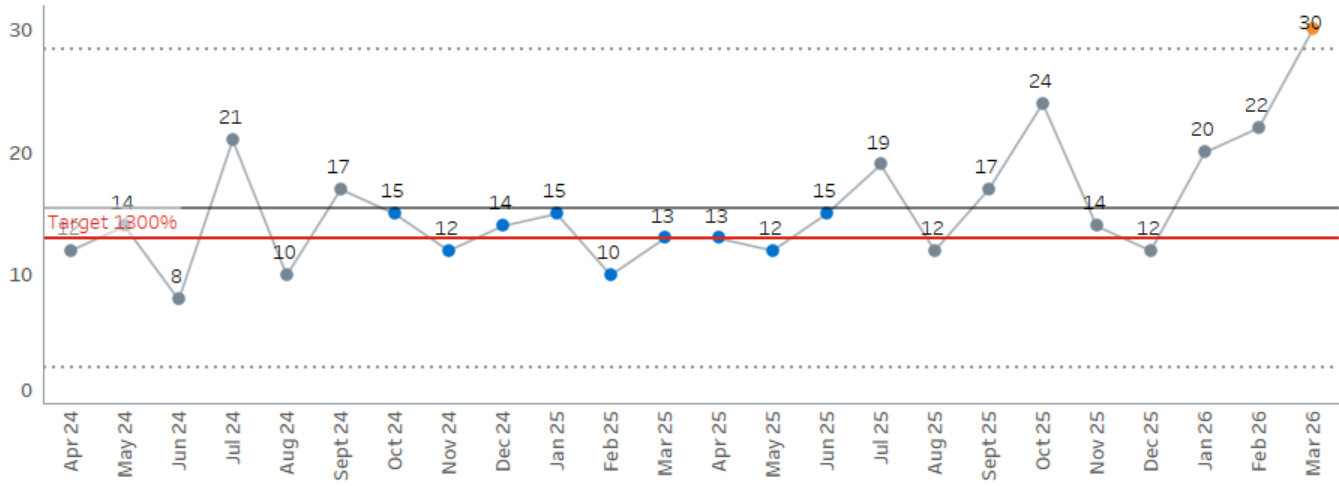


Integrated Performance Report - Friends & Family Test & Patient Experience

Metric	Month	Measure	24/25 Avg	Variation	Assurance
Inpatient Response Rate	March	36.70%	34.00%		
Inpatient Recommended Score	March	95.90%	97.00%		
Outpatient Recommended Score	March	96.20%	96.00%		
Number of new complaints	March	22	13		
Number of PALS	March	61	37		



Integrated Performance Report - Complaints



Icons

Concerning

Hit & Miss

Summary

Concerning Something's going on! Something, a one-off or a continued trend or shift of numbers in the wrong direction.

Hit or Miss The process limits on SPC charts indicate the normal range of numbers expected. If a target lies within those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean the more likely the target will be achieved or missed at random.

Understanding the performance

Over the last 12 months complaints have increased previously averaging 12 per month, no around 19 per month, representing roughly a 30% increase in formal complaints.

On review of the open caseload, a high proportion of formal complaints are being logged for routine enquiries from patients. This is further supported by a near 50% reduction in recorded PALS contacts over the last quarter. Conversion of PALS to formal complaints is also increasing indicating a reduction in local resolution, informal resolution and service level patient engagement.

Actions (SMART)

- All complaints received triaged by HofQG with PALS team to ascertain best resolution route with enquirer.
- All complaints offered resolution meeting in place of written correspondence.
- PALS officer (supporting service management teams) to attempt resolution of complaints informally within 72 hours of receipt before logging as a formal complaint.
- Service teams and management to attempt resolution of dissatisfaction at service level.



HCAIs against thresholds 2025-26 – HOHA & COHA only

Indicator	Threshold	Position	YTD	Threshold adjusted to month 12	Difference
<i>C.Difficile</i>	≤ 52	Below trajectory	39	52	-13
E.coli BSI	≤ 43	Above trajectory	67	43	+24
Klebsiella spp. BSI	≤ 24	Above trajectory	34	24	+10
P.Aeruginosa BSI	≤ 8	Above trajectory	10	8	+2

HCAIs being monitored

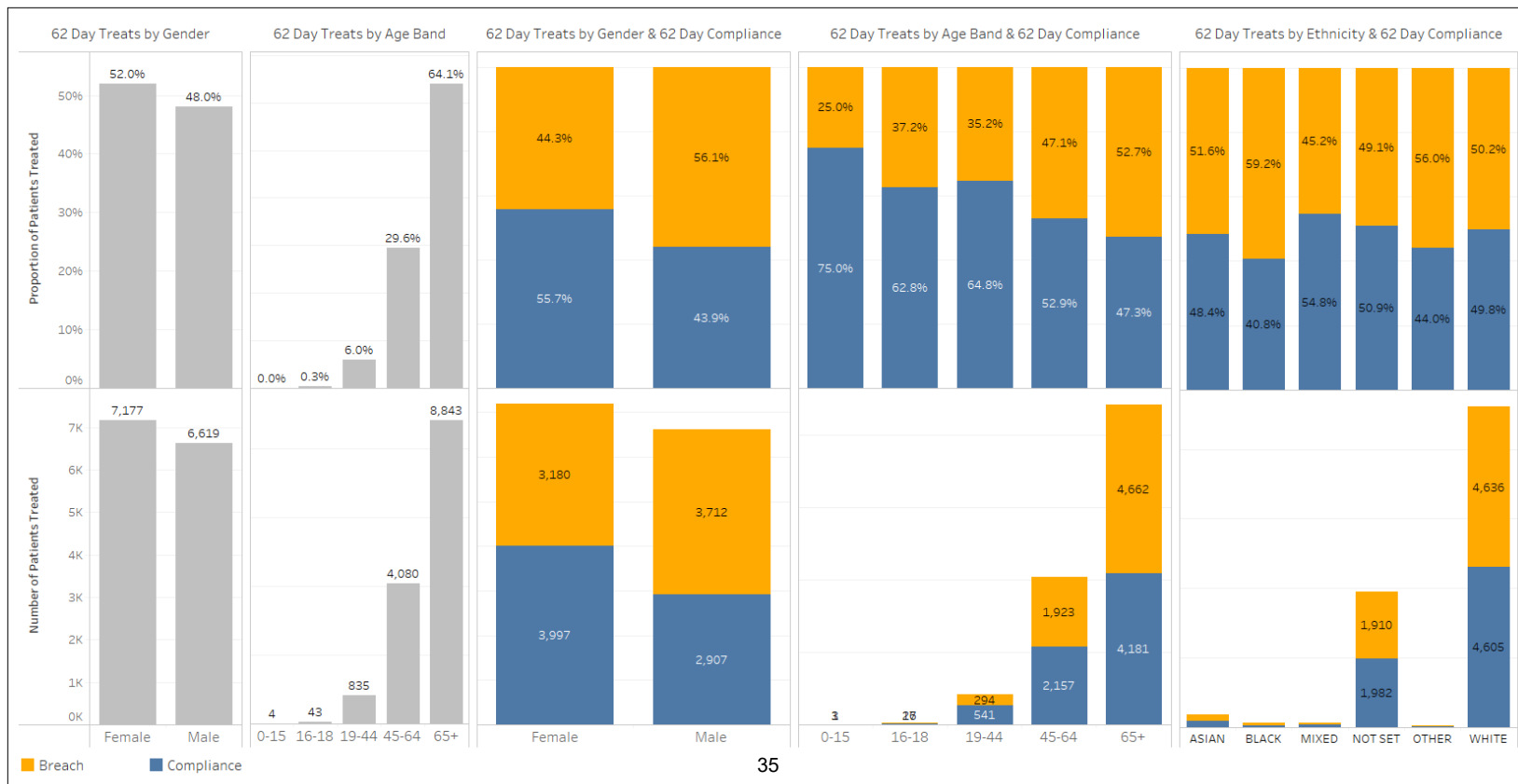
Indicator	Target	Position	YTD	Threshold adjusted to month 12
MRSA BSI	Zero tolerance	Above trajectory	2	-
MSSA BSI	No target	No target	23	-

There have been no further spikes in E.coli and Klebsiella however, due to high numbers over Q2 and Q3 we remain over agreed 2025/26 Threshold. IPC Improvement plan in place, using themes from learning response reviews into each case of HCAI, with oversight of impact into Infection Prevention Control Committee, which reports into Risk, Quality Governance Committee. Assurance reported into Quality Assurance Committee.



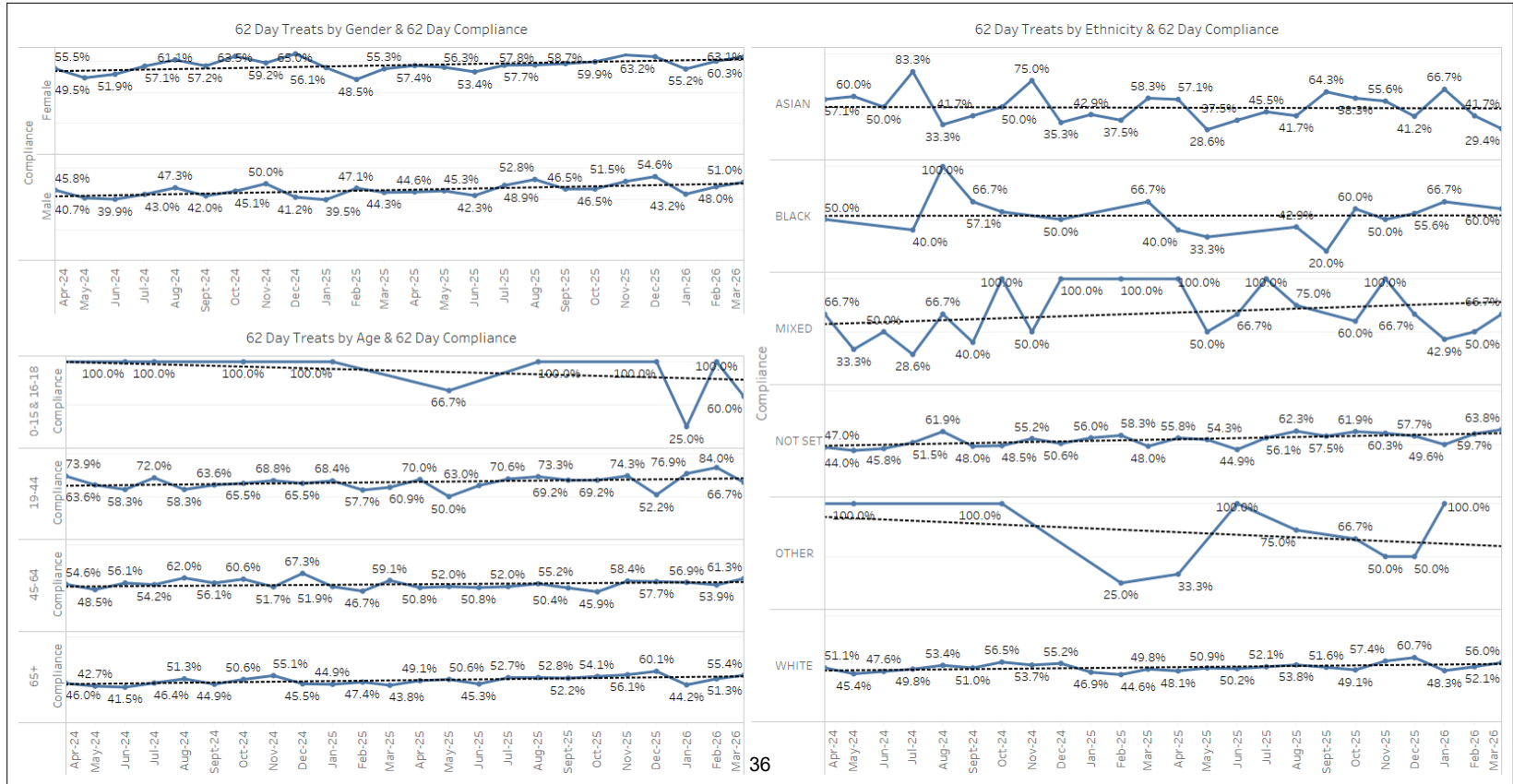
Cancer Standards – Health Inequalities Analysis

62 Day Treatments between 01/04/2023 – 31/03/2026 analysed by gender, age and ethnicity.



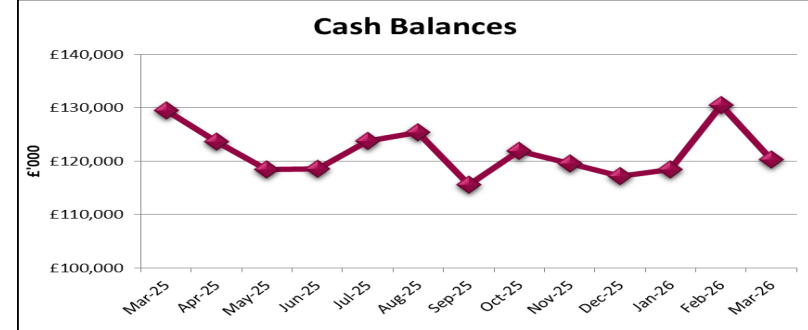
Cancer Standards – Health Inequalities Analysis

62 Day Treatments between 01/04/2023 – 31/03/2026 analysed by gender, age and ethnicity.



This report outlines the M12 consolidated financial performance of The Christie NHS Foundation Trust and its wholly owned subsidiary The Christie Pharmacy Ltd.

Month 12 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(470,563)	(470,563)	(483,804)	(13,241)
Other Income	(80,266)	(80,266)	(103,325)	(23,059)
Pay	267,276	267,276	278,949	11,673
Non Pay (incl drugs)	257,597	257,597	276,778	19,181
Operating (Surplus) / Deficit	(25,957)	(25,957)	(31,402)	(5,446)
Finance expenses/ income	22,739	22,739	26,577	3,838
(Surplus) / Deficit	(3,218)	(3,218)	(4,826)	(1,608)
Exclude impairments/ charitably funded capital donations	(4,282)	(4,282)	(8,468)	(4,186)
Adjusted financial performance (Surplus) / Deficit	(7,500)	(7,500)	(13,294)	(5,794)



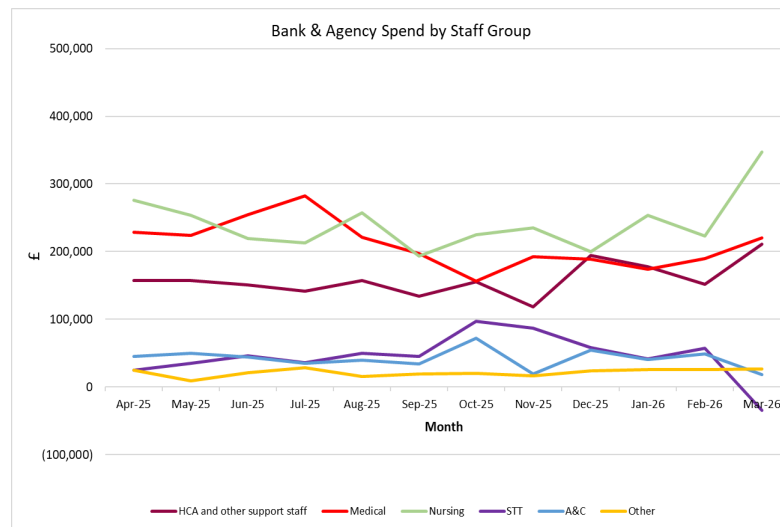
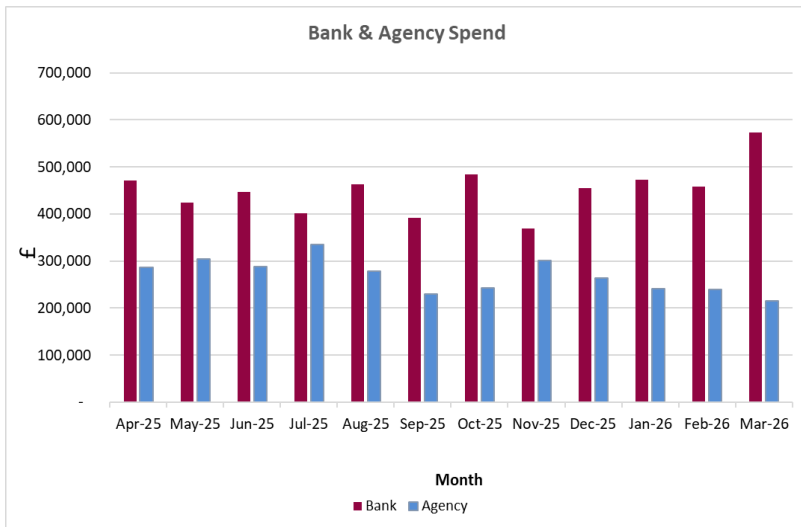
I&E

- The Trust is reporting a surplus at the end of month 12 of (£13.29m) against a YTD plan of (£7.50m), which gives a YTD positive variance of (£5.79m). Identified in-year VIP is £25.3m against a target of £25.3m. The VIP shortfall against the recurrent VIP target is £1.3m (RAG rated shortfall £1.3m), where £11.4m has been identified against a target of £12.6m (90% of recurrent target identified). Non-recurrent identified VIP is £13.9m against a target of £12.6m, overachieving by (£1.3m).

Balance sheet / liquidity

- The cash balance as of 31st March 2026 is £120.3m, over-achieving the previous year end forecast of £109.3m.
- Capital spend for 2025-26 was £41.05m, this was £10m below the plan submitted to NHSE. The underspend was anticipated and will be carried forward into the 2026-27 Capital plan.
- Targets have been achieved against payment of creditors paid within the 30-day Better Payment Practice Code target.

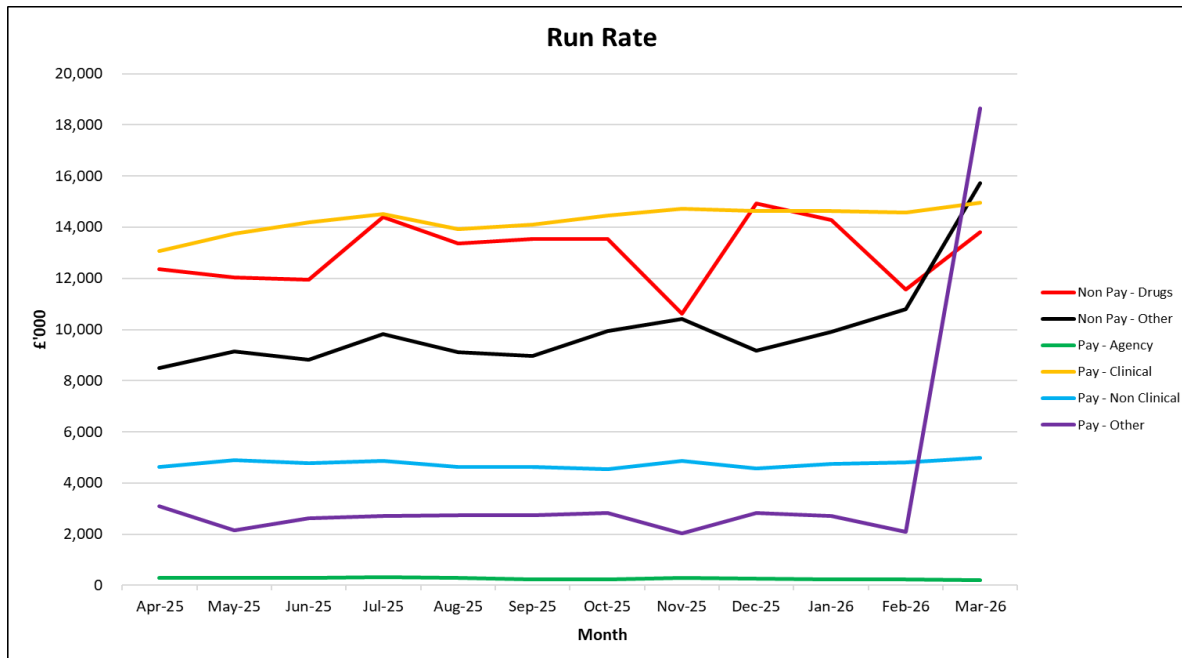




Agency spend in month 12 is £0.21m, £3.22m YTD, a decrease of (£0.02m) from month 11. The spend is predominantly on medical agency.

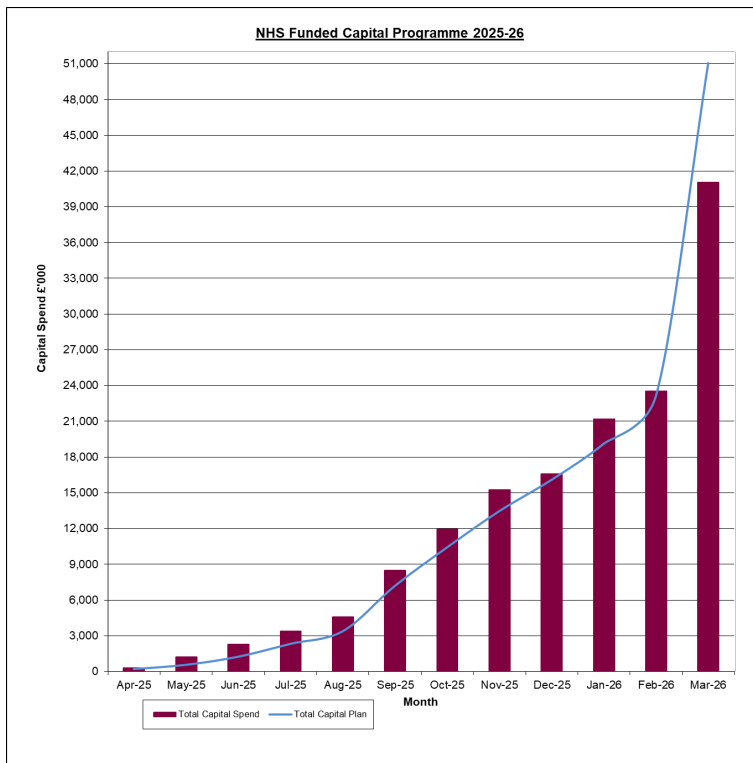
Alongside this, bank spend in month 12 is £0.57m and £5.41m YTD, an increase of £0.12 m from month 11.





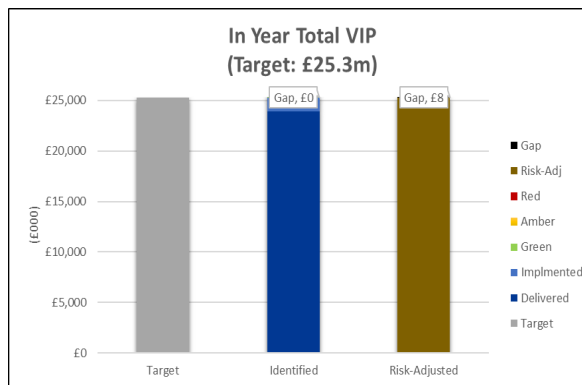
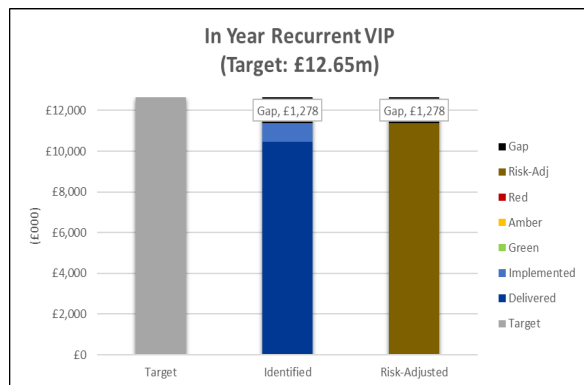
- Drugs spend in month 12 is £13.8m, an increase of £2.2m from month 11 driven by an increase in cost and volume drug expenditure.
- Non-Pay – Other spend in month 12 is £15.7m, an increase of £4.9m from month 11 includes £2.6m non-oncology PET offset by equivalent income. The balance is driven by increased spend on clinical supplies and services as well as education and training.
- Key elements of 'Non-Pay Other' spend consist of clinical supplies and services, premises and infrastructure costs and R&I costs.
- Pay – Agency spend in month 12 is £0.2m, in line with month 11.
- Pay – Clinical spend in month 12 is £15.0m, an increase of £0.3m from month 11.
- Pay – Other spend in month 12 is £18.7m, an increase of £16.6m from month 11 driven by employer pension contributions.





The Trust has incurred £41.1m up to month 12 on capital schemes underspending by £10.0m against the 2025-26 plan. The Trust had forecast an underspend, which will be carried forward into the 2026-27 Capital Plan. Capital expenditure is primarily on the ASIC scheme, the estates backlog programme, digital projects and a significant operational asset replacement programme across all divisions.





Total In year CIP

- Total identified VIP schemes reported are £25.3m (£13.9m non recurrent / £11.4m recurrent).
- Risk adjusted identified schemes value £25.3m, leaving £0.0m unidentified.

Recurrent

- Schemes totalling £11.4m have been identified recurrently against a recurrent target of £12.6m
- This leaves £1.3m of the recurrent target unidentified, RAG rated unidentified £1.3m.



	Annual					Year To Date		
	Target (£000)	Identified (£000)	Unidentified (£000)	Risk-Adjusted Identified (£000)	Risk-Adjusted Unidentified (£000)	Target (£000)	Delivered (£000)	Variance (£000)
Total VIP	25,298	25,298	0	25,275	23	23,147	23,147	0
Recurrent VIP	12,649	11,371	1,278	11,371	1,278	11,595	10,409	1,186
Non-Recurrent VIP	12,649	13,927	(1,278)	13,903	(1,254)	11,552	12,738	(1,186)

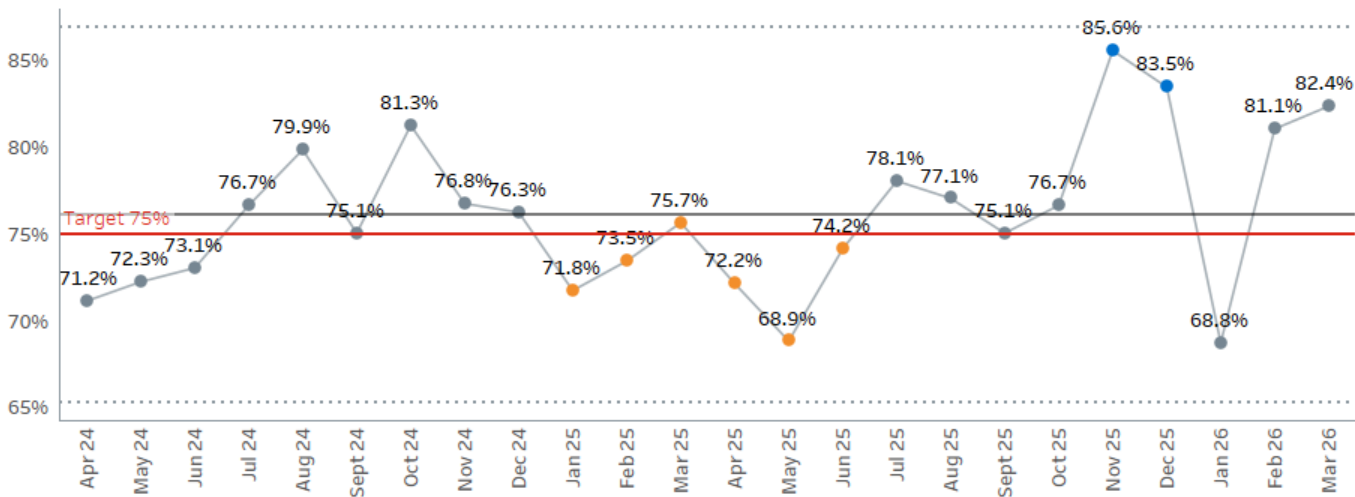


Integrated Performance Report - Cancer Standards Summary

Metric	Month	Measure	Target	Variation	Assurance
18 weeks	March	96.00%	92.00%		
24 day (Internal Target)	March	79.10%	85.00%		
28 Day FDS	March	92.50%	80.00%		
31 day	March	99.20%	96.00%		
62 Day	March	82.40%	75.00%		
Waiting >52 Weeks	March	0.00%	0.00%		



Percentage of patients treated for cancer within 62 days of referral



Icons

Common Cause

Hit & Miss

Summary

Common Cause This system or process is currently not changing significantly. It shows the level of natural variation you can expect from the process or system itself.

Hit or Miss The process limits on SPC charts indicate the normal range of numbers expected. If a target lies within those limits we know that the target may/may not be achieved. The closer the target line lies to the mean the more likely the target will be achieved or missed at random.

Understanding the performance

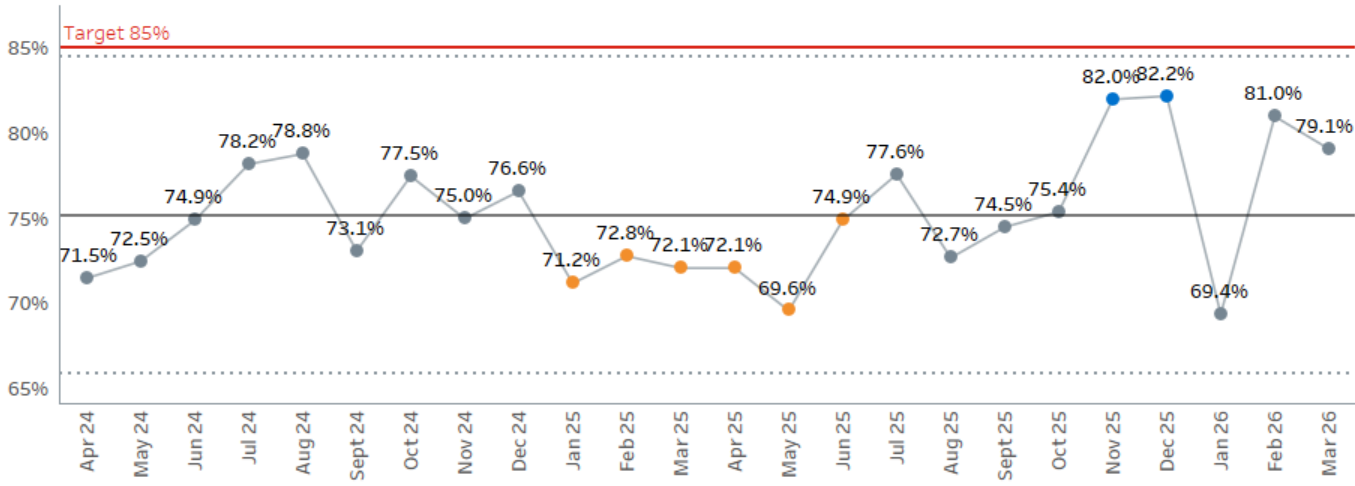
- Performance against the 62-day standard shows common-cause variation over time, with results fluctuating around the target rather than demonstrating sustained improvement or deterioration. This indicates a process that is currently stable but not reliably capable of consistently delivering the target.
- Periods of improved performance have not yet translated into sustained delivery, suggesting that gains remain fragile and dependent on local conditions rather than embedded system change. The significant dip in January reflects the sensitivity of the pathway to capacity and sequencing, reinforcing the need to focus on end-to-end pathway grip rather than isolated interventions.
- Overall, this profile confirms the need to move beyond short-term recovery actions and ensure that improvement initiatives are systematic, staffed and sustained, with ongoing monitoring to distinguish genuine improvement from normal variation.

Actions (SMART)

- Pathway focus: Maintain a clearly defined improvement focus on the highest-impact tumour sites and pathway pinch points, with monthly SPC review to assess whether actions are shifting the mean rather than creating short-term variation.
- Consistency and grip: Embed standardised pathway management expectations (PTL discipline, clock ownership and escalation triggers) to reduce unwarranted variation and improve reliability.
- Capacity alignment: Continue to align diagnostic, theatre and workforce capacity to forecast demand, ensuring any additional capacity deployed is recurrent where possible and targeted to known constraints.
- Sustainability and oversight: Keep actions under routine executive oversight through established performance forums, with agreed measures tracked over time to confirm whether improvements are being sustained rather than intermittently achieved.



Percentage of patients treated for cancer within 24 days of IPT (Internal Target)



Icons

Common Cause

Failing

Summary

Common Cause This system or process is currently not changing significantly. It shows the level of natural variation you can expect from the process or system itself.

Failing If a target lies outside of those limits in the wrong direction then you know that the target cannot be achieved.

Understanding the performance

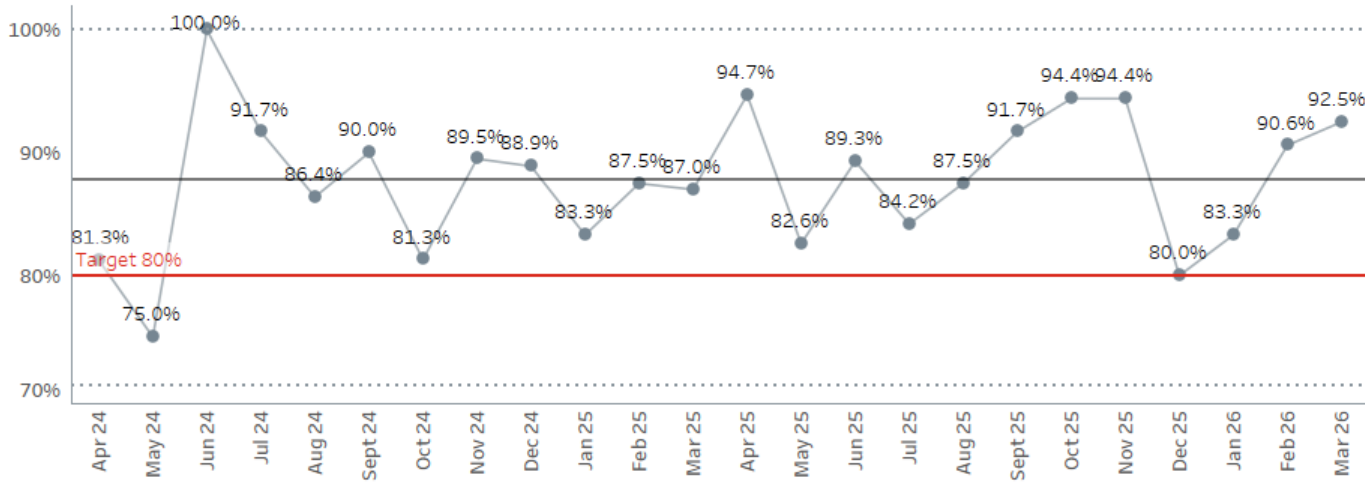
- Performance against the internal 24-day IPT target shows ongoing variation around the mean, with several months below the 85% target and occasional short periods of improvement that have not been sustained.
- The SPC signal indicates continued instability, suggesting the process is not yet consistently capable of delivering the target level of performance.
- Periods of deterioration align with known operational pressures, including capacity constraints across diagnostics, workforce availability, and delivery sequencing, rather than a single point failure.
- This pattern indicates that improvement to date has relied on reactive recovery actions, rather than embedded system changes capable of sustaining performance within control limits.
- As a result, while performance can temporarily improve, the current process does not yet demonstrate reliable delivery at or above the target level.

Actions (SMART)

- Daily pathway oversight: Implement a standardised daily review of patients approaching the 24-day threshold, with explicit ownership for resolution and escalation where risk of breach is identified.
- Constraint-focused improvement: By [specified date], complete a targeted review of the highest-impact pathway constraints (diagnostics, treatment slots, and clinical decision points) and implement agreed mitigations with named leads.
- Capacity alignment: Align diagnostic and treatment capacity plans to forecast demand by [month], including agreed contingencies for predictable pressure periods.
- Sustainability monitoring: Embed SPC review of 24-day performance into routine operational governance, with monthly assessment of whether actions are reducing variation and moving the mean toward the target.



Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks



Icons

Common Cause

Hit & Miss

Summary

Common Cause This system or process is currently not changing significantly. It shows the level of natural variation you can expect from the process or system itself.

Hit or Miss The process limits on SPC charts indicate the normal range of numbers expected. If a target lies within those limits we know that the target may/may not be achieved. The closer the target line lies to the mean the more likely the target will be achieved or missed at random.

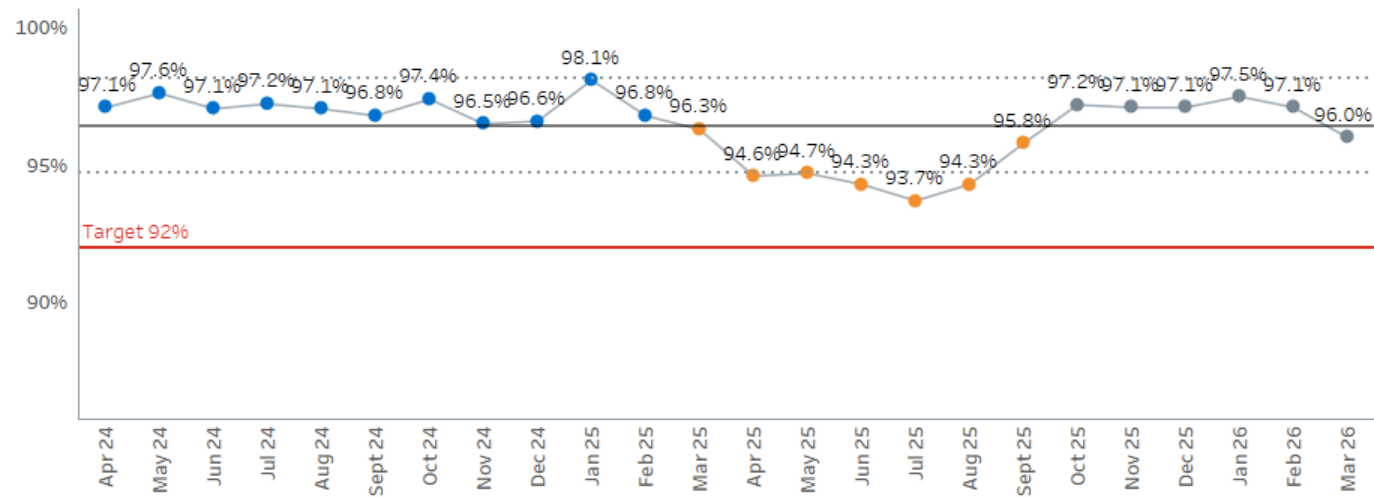
Understanding the performance

- Until April 2025, the performance threshold for this measure was 75%, and performance has consistently met or exceeded the target throughout the period shown. The trajectory demonstrates stable delivery with common-cause variation, consistent with a process that is performing as designed against the prevailing standard.
- Month-to-month fluctuation is expected and reflects normal operational variability rather than signal deterioration. There is no evidence of special-cause variation or loss of control, and performance has remained above the target even during periods of system pressure.
- From April 2025, the target increased, which changes the framing of assurance from achievement of the historic standard to capability against the higher expectation. Actions are therefore focused on strengthening reliability and reducing variation to support sustained delivery at the higher threshold.

- ### Actions (SMART)
- Diagnostic pathway grip: Weekly pathway-level review of urgent referrals breaching or at risk of breaching the 4-week standard, with named clinical and operational owners and clear recovery actions agreed and tracked.
 - Capacity and demand alignment: Targeted actions to protect diagnostic capacity for urgent suspected cancer pathways, supported by forward demand modelling and escalation where mismatches are identified.
 - Reliability focus at pinch points: Standardisation of booking, reporting, and escalation processes at known high-variance points in the pathway to reduce unwarranted delay and variation.
 - Sustaining improvement: Performance monitored through routine governance, with actions embedded into business-as-usual operational meetings rather than time-limited improvement initiatives. Sustained delivery measured over multiple months to confirm improvement is held.




Percentage of patients treated within 18 weeks




Icons

Common Cause



Passing



Summary

Common Cause This system or process is currently not changing significantly. It shows the level of natural variation you can expect from the process or system itself.











Passing If a target lies outside of those limits in the right direction then you know that the target can consistently be achieved.

- ## Understanding the performance
- Performance shows common cause variation, indicating a stable process operating within an expected range rather than random fluctuation or deterioration.
 - The target is being consistently achieved, but current run levels sit close to the lower control range at points, highlighting limited headroom rather than over-delivery.
 - Periods of softer performance align with known system pressures (capacity, pathway complexity, downstream constraints), suggesting structural drivers rather than isolated events.
 - Sustained performance therefore depends on maintaining grip on known pressure points, rather than reactive recovery actions.

- ## Actions (SMART)
- Agree and maintain a minimum operational threshold for RTT performance that triggers early review before performance drifts towards tolerance limits (Specific, Measurable).
 - Embed weekly pathway-level review of long waiters and conversion risks within existing performance governance, with clear clinical and operational ownership (Achievable, Relevant).
 - Protect baseline capacity assumptions by monitoring theatre, diagnostic and workforce availability against plan, with explicit actions agreed where erosion is identified (Relevant, Time-bound).
 - Formally review sustainability quarterly, confirming whether current performance remains process-controlled or requires system redesign rather than incremental improvement (Time-bound).



Integrated Performance Report - External Referrals Received Summary

Metric	Month	Measure	24/25 Avg	Variation	Assurance
External Referrals Received - ALL Specialties	March	2,332	2,067		
External Referrals Received -Clinical Oncology	March	965	978		
External Referrals Received -Haematology	March	260	141		
External Referrals Received -Medical Oncology	March	664	549		
External Referrals Received -Surgical Specialties	March	406	365		



Integrated Performance Report - Inpatient Length of Stay Averages

Metric	Month	Measure	Target	Variation	Assurance
Inpatient LOS - All Patients (excluding zero LOS)	March	7.0	7.0		
Inpatient LOS - Elective Patients (excluding zero LOS)	March	6.7	6.0		
Inpatient LOS - Non-Elective Patients (excluding zero LOS)	March	7.1	7.7		
Inpatient LOS - Transfer Patients (excluding zero LOS)	March	48.5	18.3		

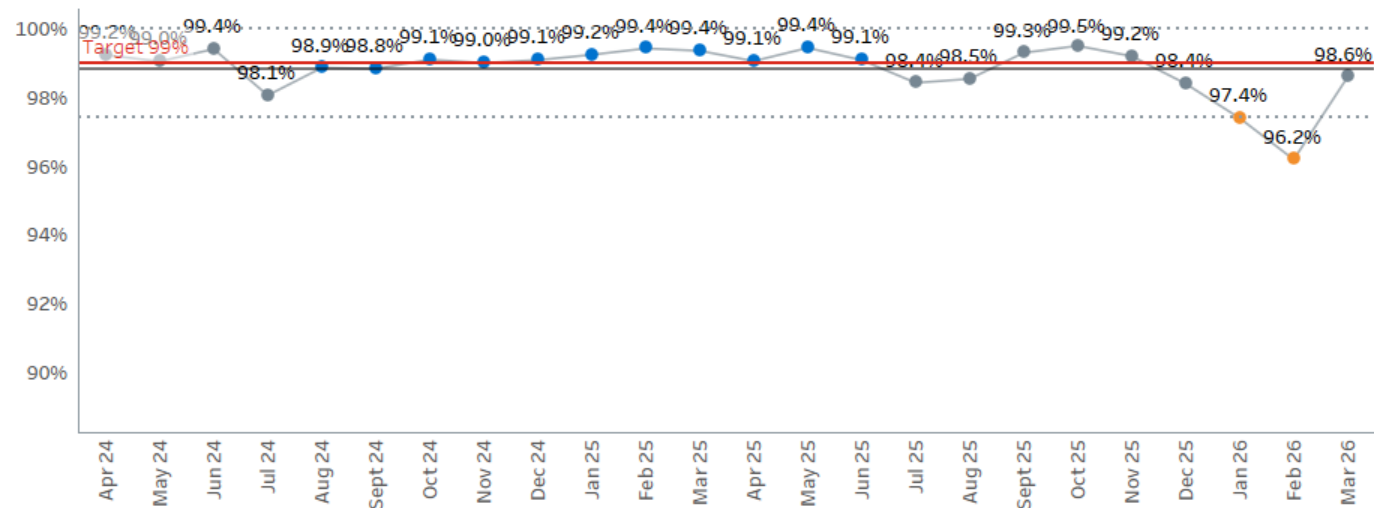


Integrated Performance Report - Diagnostic 6 Week Waiting Times Summary

Metric	Month	Measure	Target	Variation	Assurance
Magnetic Resonance Imaging	March	97.40%	99.00%		
Computed Tomography	March	99.20%	99.00%		
Non-obstetric Ultrasound	March	100.00%	99.00%		
Dexa Scan	March	98.20%	99.00%		
Cardiology - Echocardiography	March	98.50%	99.00%		
Flexi Sigmoidoscopy	March	100.00%	99.00%		
Cystoscopy	March	100.00%	99.00%		
Barium Enema	March	100.00%	99.00%		
Colonoscopy	March	100.00%	99.00%		
Gastroscopy	March	100.00%	99.00%		
DM01 Return - All Scans	March	98.60%	99.00%		



All Scans - DM01 6 Week Waiting Time Compliance



Icons

Common Cause

Hit & Miss

Summary

Common Cause This system or process is currently not changing significantly. It shows the level of natural variation you can expect from the process or system itself.

Hit or Miss The process limits on SPC charts indicate the normal range of numbers expected. If a target lies within those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean the more likely the target will be achieved or missed at random.

Understanding the performance

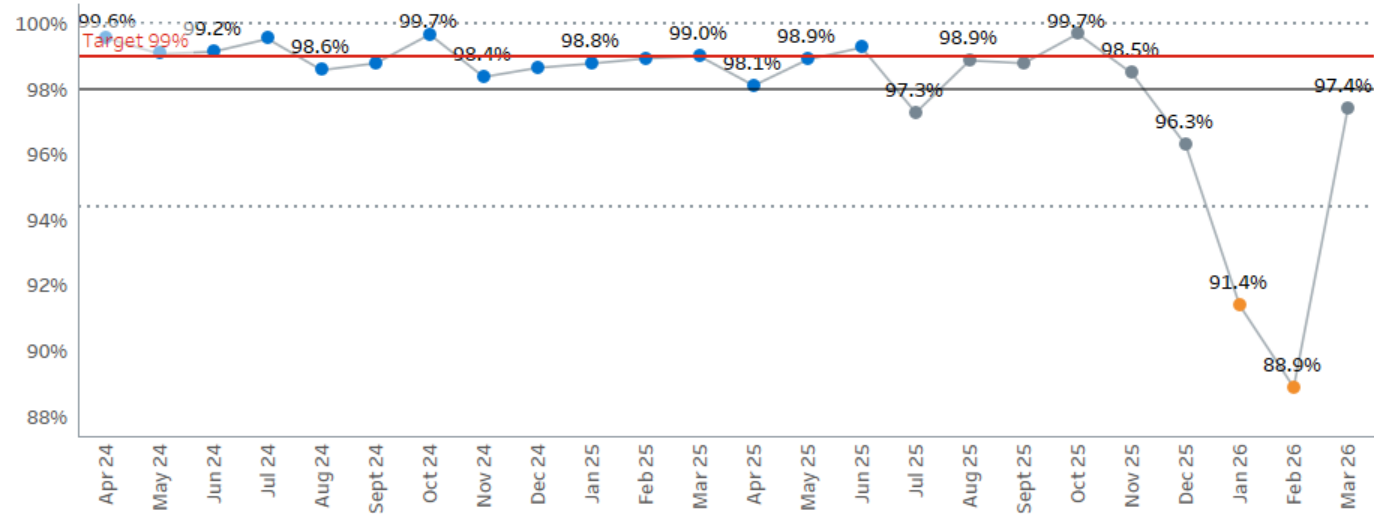
- Overall DM01 6-week waiting time compliance remains high and stable, with performance largely operating within expected control limits. The SPC demonstrates common-cause variation, indicating a capable and generally predictable process rather than a deterioration in system performance.
- Recent dips below target are consistent with natural variation rather than a sustained shift, however they signal reduced tolerance at the margins when capacity or pathway pressures emerge. Continued high performance is therefore reliant on maintaining grip on key enablers (capacity alignment, pathway flow, reporting discipline) rather than relying on recovery actions after breaches occur.

Actions (SMART)

- Sustain grip on leading indicators: Weekly review of DM01 trajectory, capacity utilisation and long-wait position through formal performance forums, with exception-based escalation where tolerance is breached.
- Protect system resilience: Maintain agreed contingency capacity and workforce cover for diagnostic pathways, with clear triggers for early deployment during periods of demand volatility.
- Targeted variance review: Undertake rapid root-cause reviews for any breaches or downward trends persisting beyond two consecutive weeks, with time-bound corrective actions agreed and tracked.
- Embed assurance and learning: Quarterly SPC review to confirm process stability, refresh controls, and ensure improvement actions remain effective and proportionate to risk.



MRI 6 Week Waiting Time Compliance



Icons

Common Cause

Hit & Miss

Summary

Common Cause This system or process is currently not changing significantly. It shows the level of natural variation you can expect from the process or system itself.

Hit or Miss The process limits on SPC charts indicate the normal range of numbers expected. If a target lies within those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean the more likely it is that the target will be achieved or missed at random.

Understanding the performance

- MRI 6-week waiting time performance has been consistently close to the target line, with the majority of variation explained by common cause rather than structural change in the process.
- The SPC position indicates a stable process operating near its natural limits, meaning small fluctuations around the target are expected unless the system is fundamentally changed.
- The recent below-target points represent hit-and-miss variation, not a sustained shift, but they signal reduced resilience when demand or capacity pressure increases.
- Proximity to the target line means the service is more sensitive to short-term disruptions (e.g. capacity loss, demand spikes, or non-attendance), increasing the likelihood of random target breaches.
- Sustained compliance therefore requires process control and forward grip, not reactive recovery once breaches occur.

Actions (SMART)

- Demand & Capacity Matching:** Weekly validation of MRI demand versus available slots (including utilisation and short-notice losses) to ensure capacity plans remain aligned with forecast activity.
- Operational Grip:** Introduce a rolling 6–8 week forward look for MRI position, reviewed at weekly operational meetings, with clear escalation triggers before compliance is lost.
- Variation Reduction:** Target non-value-added capacity loss (e.g. DNA rates, late cancellations, downtime) through focused actions owned by Radiology and Divisional Ops leads.
- Sustainability Assurance:** Maintain SPC monitoring as the primary performance lens, with actions triggered by signals of change rather than single-point breaches, ensuring focus remains on system improvement rather than short-term firefighting.



Area Selection

Please select your area using the filters below. This will affect all other sections of the dashboard.

Summary Table

The table below summarises the position as of the end of the previous month for the main HR KPI metrics.

Metric - the KPI metric

Measure - the value of the **Metric** as of the end of the **Month**

Target - the Trust defined minimum or maximum limit for each **Metric**

Mean - the average of the **Measures** over the past 12 months

Division
The Christie

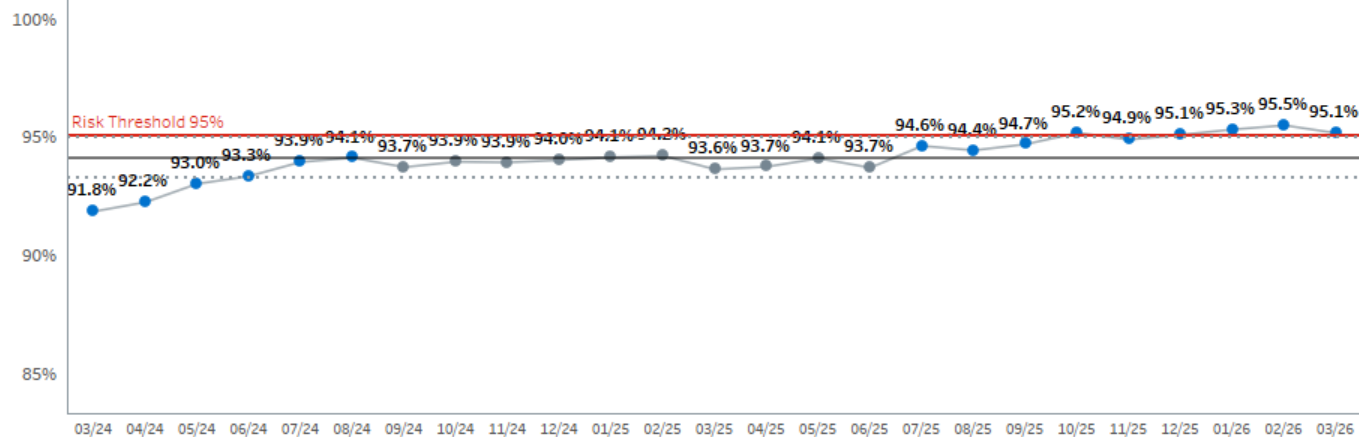
Directorate
All Directorates

Metric	Month	Measure	Risk Threshold / Target	Mean	Performance	Assurance
Appraisal	March 2026	87.19%	90.00%	87.66%		
Mandatory Training	March 2026	95.15%	95.00%	94.09%		
Absence	March 2026	4.75%	4.10%	4.79%		
All Turnover	March 2026	11.62%	11.00%	11.71%		
Voluntary Turnover	March 2026	9.30%	9.00%	9.54%		
Vacancy Rate	March 2026	5.93%	5.00%	8.05%		

Our People - Mandatory Training and Appraisal Compliance

The Christie: All Directorates

Mandatory Training



Performance

Improving



Assurance

Failing



Summary

- There are 3,073 outstanding modules.
- The Face to Face training compliance % for March is 87.5%
- The online training compliance % for March is 95.9%

Performance

Concerning



Assurance

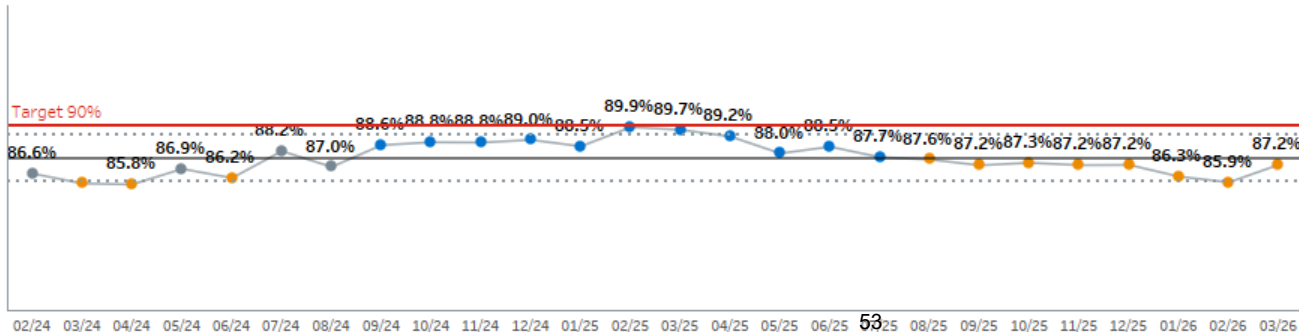
Failing



Summary

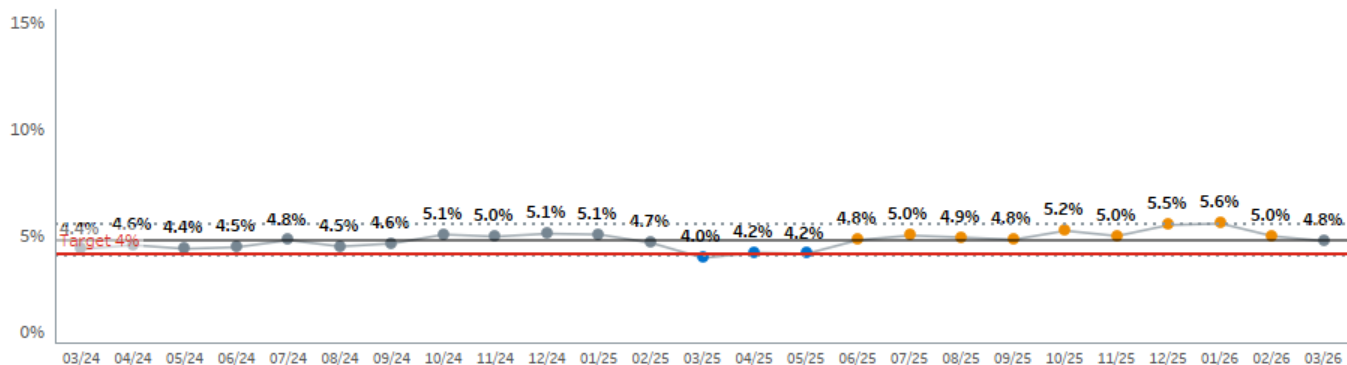
- There are 460 outstanding appraisals.

Appraisal



Our People - Sickness Absence

All Absence



Performance	Assurance
Common Cause 	Hit & Miss

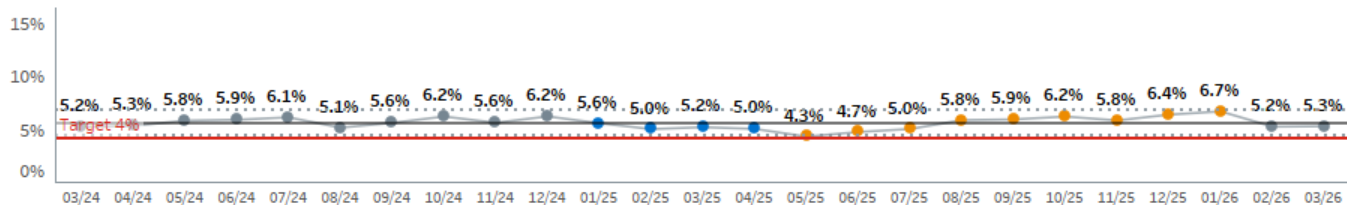
Summary

- The rolling yearly sickness absence % is 4.9% as of March.
- There were 198 absences still open at the end of March.

Performance	Assurance
Common Cause 	Failing

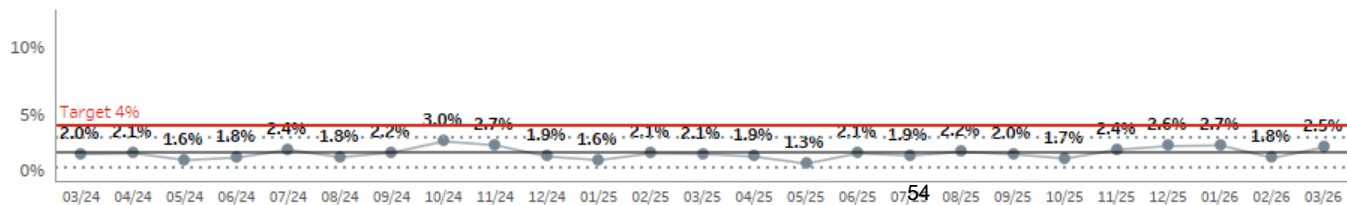
Performance	Assurance
Common Cause 	Passing

Nursing and Midwifery



Performance	Assurance
Common Cause 	Passing

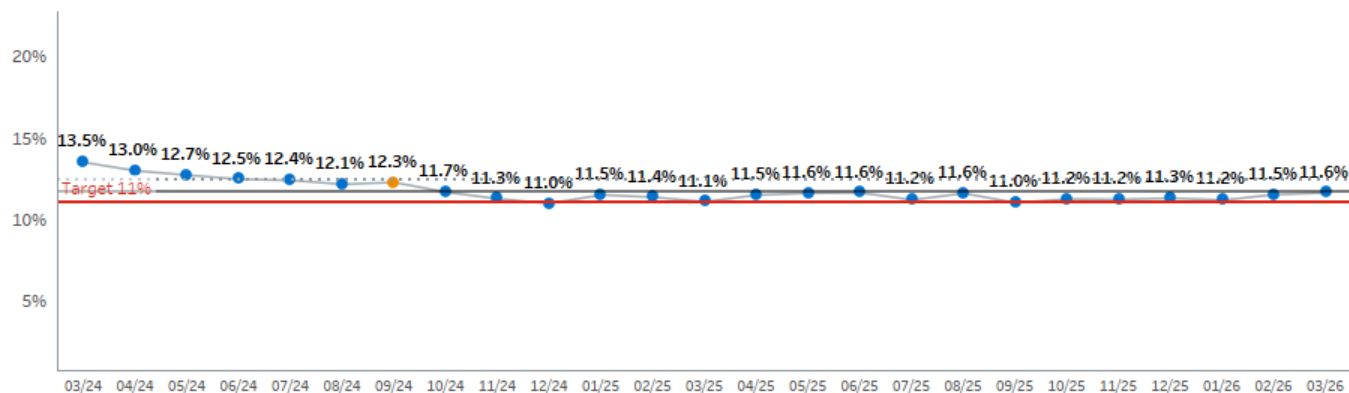
Medical and Dental



Our People - Turnover

The Christie: All Directorates

All Turnover



Performance

Improving



Assurance

Hit & Miss



Summary

- 49 colleague(s) left the Trust in March.
- The top non-voluntary leaving reason was End of Fixed Term Contract.

Performance

Improving



Assurance

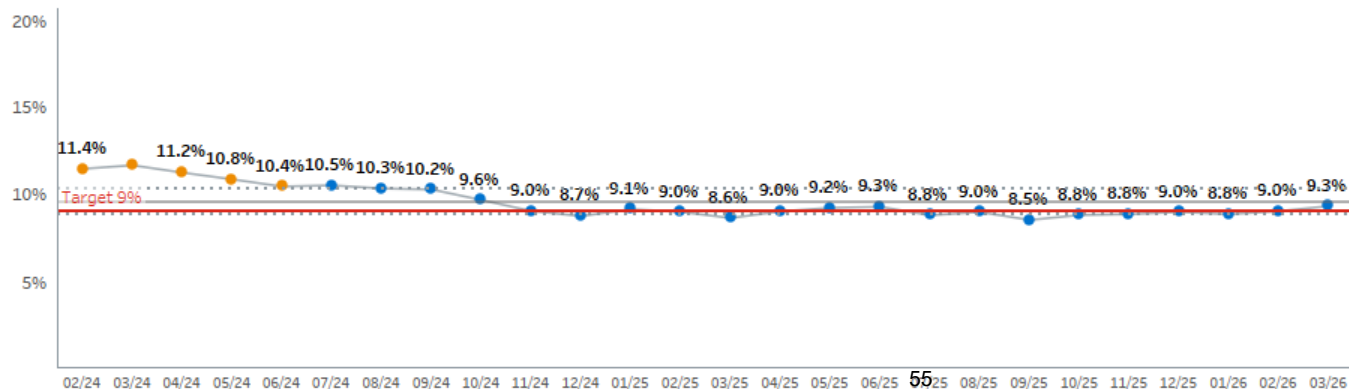
Hit & Miss



Summary

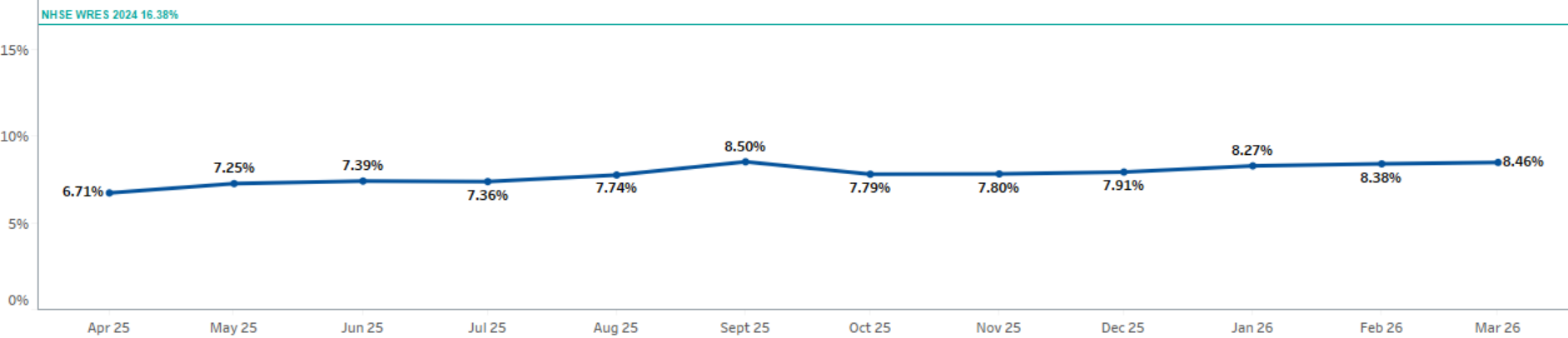
- The top voluntary leaving reason was Retirement Age.

Voluntary Turnover

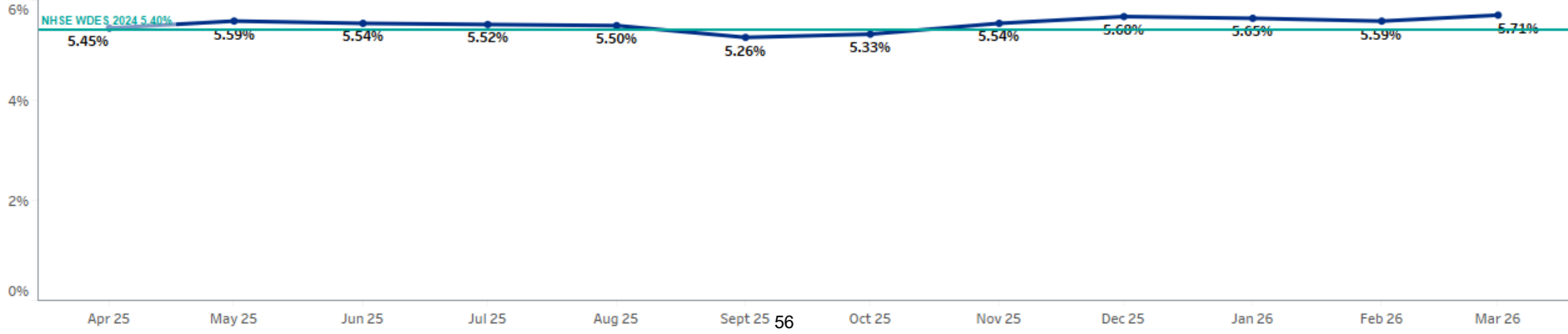


Our People - Senior Management Representation

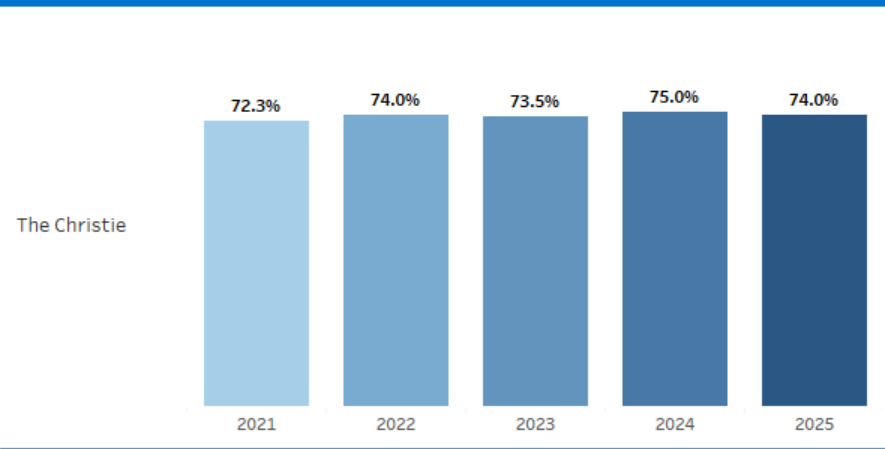
Senior Management (Band 8A - VSM) BAME %



Senior Management- (Band 8A - VSM) Disability %

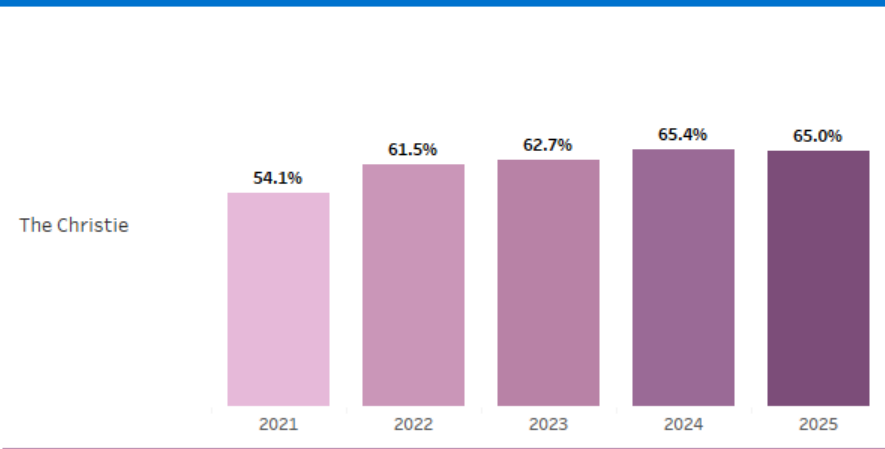


Staff Engagement Score



Sub-score	2021	2022	2023	2024	2025
Advocacy sub-score	82.7%	79.5%	77.9%	80.7%	81.0%
Involvement sub-score	69.7%	72.7%	72.2%	73.0%	72.0%
Motivation sub-score	64.7%	69.9%	70.4%	71.3%	70.0%

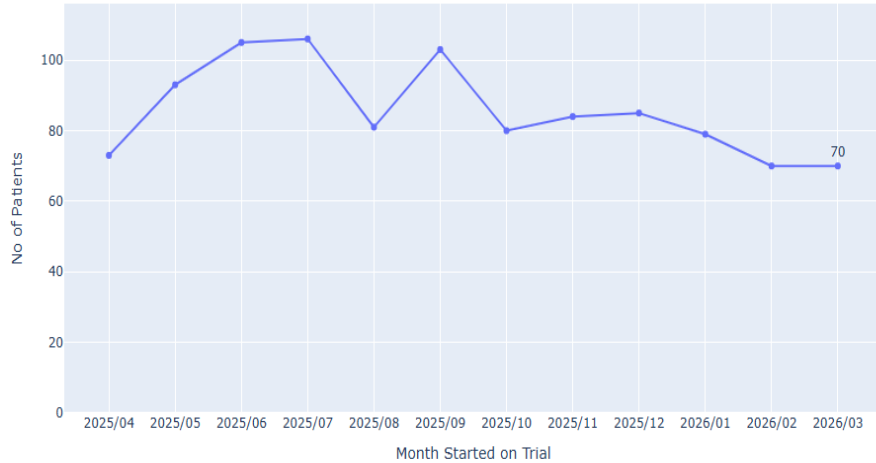
Morale Score



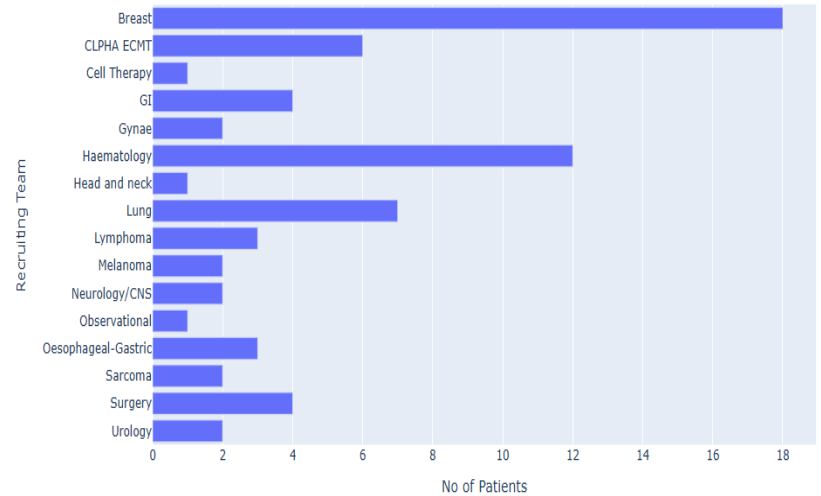
Sub-score	2021	2022	2023	2024	2025
Stressors sub-score	60.4%	66.8%	66.7%	68.1%	68.0%
Thinking about leaving sub-score	54.0%	62.0%	64.6%	67.1%	66.0%
Work pressure sub-score	48.0%	55.6%	56.8%	61.1%	61.0%

Clinical Trial Entries

Number of patients consenting to a treatment clinical trial, 01/04/25 - 31/03/26



Patients Starting on a Trial in March 2026

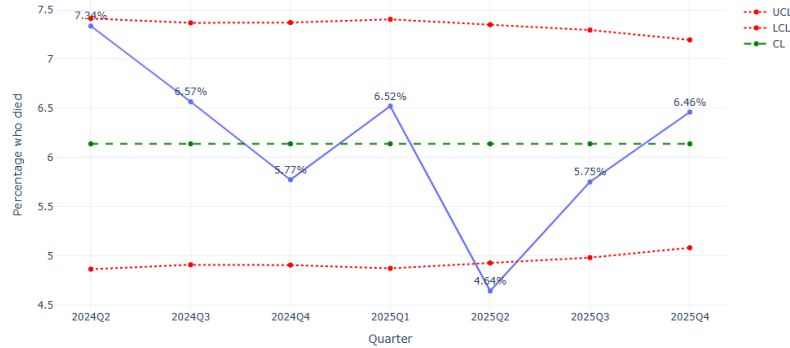


Breast continue to recruit the highest number of patients.

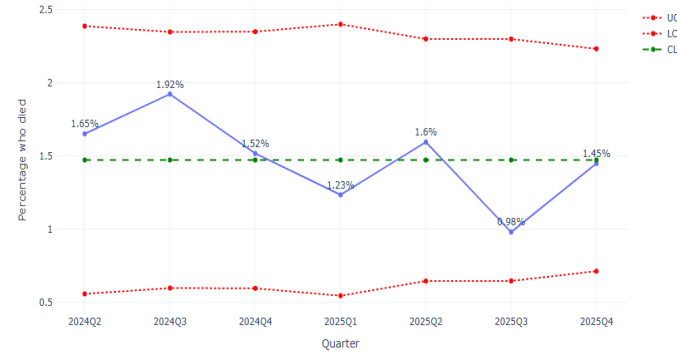


30-Day SACT Mortality

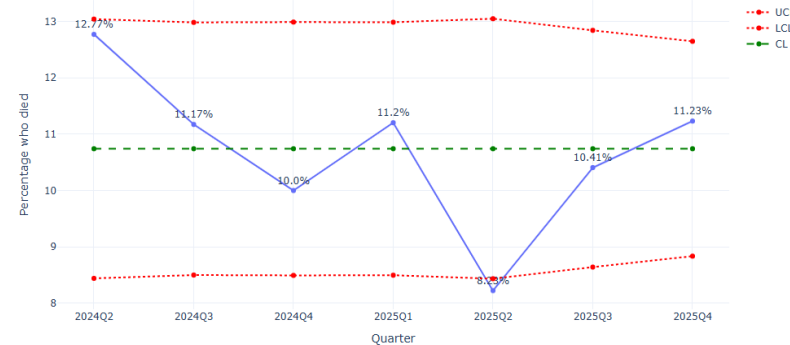
Unadjusted 30 day mortality rate - Patients who died within 30 days of receiving their final SACT treatment
Any treatment intent



Unadjusted 30 day mortality rate - Patients who died within 30 days of receiving their final SACT treatment
Curative treatment intent



Unadjusted 30 day mortality rate - Patients who died within 30 days of receiving their final SACT treatment
Palliative treatment intent



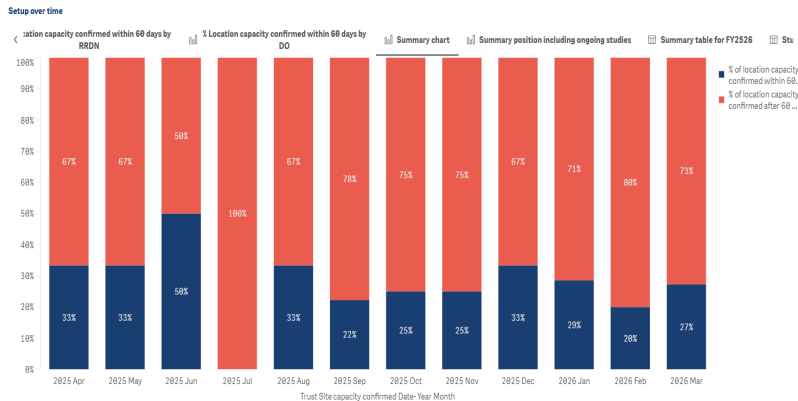
The control line shows the 30-day mortality rate over the entirety of time frame shown (Last administrations up to 30/09/2025 (end of Q3)).

The UCL and LCL are the upper and lower confidence limits (respectively) around the CL. 95% Confidence limits.

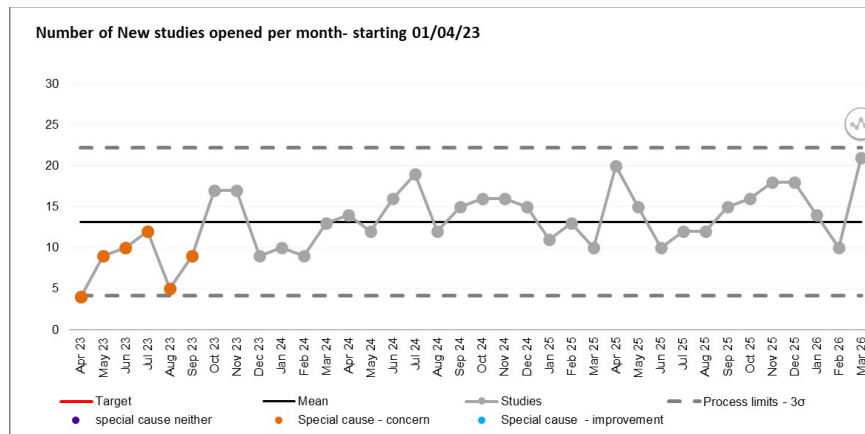
Current rates of 30-day post SACT mortality are within the normal range expected and are consistent with those published by NDRS* for The Christie and for national average rates.



% studies opening within 60 days (commercial)



New studies opened per month



Understanding performance

Continued pressure on commercial trials against national performance target for Capacity and Capability to complete within 60 days.
 Highest number of studies opened in March 2026 showing increase in output.
 Last 2 months 100% observational studies. Lower quartile for Cancer performance against other trusts.

Actions to address performance

Workshops to define Tiered/ proportional approaches to Set Up, Staged Gateways agreed, Deep dive into breaches of 61-75 days.
 Pathology- reviewing processes and proportionality.
 EDGE rollout (June) & Florence (early Autumn).



The new NHS Oversight Framework 2025/26 describes a consistent and transparent approach to assessing ICBs and NHS trusts and foundation trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement. The data below relates to Q3 (Access to services module data has been excluded for specialist cancer Trusts whilst the national team work on a different way of displaying this data). Metrics have been grouped into domains and will be scored individually and across each domain, with Trust's being segmented into an overall score for comparison against other Trusts. The information is to be publicised on the Model Hospital platform.

Select a trust

The Christie NHS Foundation Trust (RBV)
▼

i [View the glossary page](#)

Average score

1.36

Lower by 0.23 from previous quarter

Trusts are scored on up to 30 measures of performance (metrics). Scores range from 1.00 (high performing) to 4.00 (low performing).

[How has average score been calculated?](#)

Trust in financial deficit?

No

No change from previous quarter

If an organisation is reporting a financial deficit or in receipt of deficit support, that organisation's segment can be no greater than 3.

[How is financial deficit applied?](#)

Segment

1 - High performing

Previous quarter's segment: 1

Each trust is assigned to a segment ranging from 1 – 4 based on average metric score and taking into consideration the financial deficit override.

[How has segment been calculated?](#)

Trust rank

3 out of 134

Previous quarter's rank: 7 out of 134

Each trust is ranked first on segment and then average score within that segment. Ranks range from 1 (the segment one trust with lowest average score) to 134 (segment four trust with the highest average score).

[How has rank been calculated?](#)

Performance domains ?

- Access to services
- Finance and productivity
- Effectiveness and experience
- Patient safety
- People and workforce

(Blank)	i
1 - High performing	i
1 - High performing	i
1 - High performing	i
1 - High performing	i

Average score by trust rank placement

Segment ● 1 ● 2 ● 3 ● 4 Selected trust ●

i [View full league table](#)

Quarter		Segment			Finance and productivity domain segment						
Q3 2025/26		1 - High performing			1 - High performing						
Return to overview											
Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard	
Finance and productivity	Finance	Planned surplus/deficit	2025/26	1.39	%	0.00 →	1.00	5 out of 134	-1.54	0	
Finance and productivity	Finance	Variance year-to-date to financial plan	Month 9 2025	0.01	%	0.01 ↑	1.00	22 out of 134	-0.13		
Finance and productivity	Finance	Combined finance	Q3 2025/26				1.00				
Finance and productivity	Productivity	Implied productivity level	Q2 2025/26 vs Q2 2024/25	8.30	%	9.14 ↑	1.16	8 out of 134	2.60		

Quarter		Segment			Effectiveness and experience domain segment						
Q3 2025/26		1 - High performing			1 - High performing						
Return to overview											
Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard	
Effectiveness and experience	Effective flow and discharge	Average number of days from discharge ready date to actual discharge date (including zero days)	Dec-25	0.20	days	0.17 ↓	1.29	13 out of 127	0.83		
Effectiveness and experience	Patient experience	CQC inpatient survey satisfaction rate	2024		score		1.00				



Quarter		Segment		Patient safety domain segment							Return to overview
Q3 2025/26		1 - High performing		1 - High performing							
Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard	
Patient safety	Patient safety	Number of MRSA bacteraemia cases (12 months)	Jan 25 - Dec 25	3.00	count	1.00 ↓	2.66		3.00	0	
Patient safety	Patient safety	Proportion of E. coli bacteraemia	Jan 25 - Dec 25	1.35	rate	0.07 ↓	3.54		1.17	1	
Patient safety	Patient safety	NHS Staff survey - raising concerns sub-score	2024	6.93	out of 10	0.00 →	1.11	6 out of 134	6.42		
Patient safety	Patient safety	Proportion of C. difficile infections	Jan 25 - Dec 25	0.81	rate	-0.17 ↑	1.00		1.12	1	

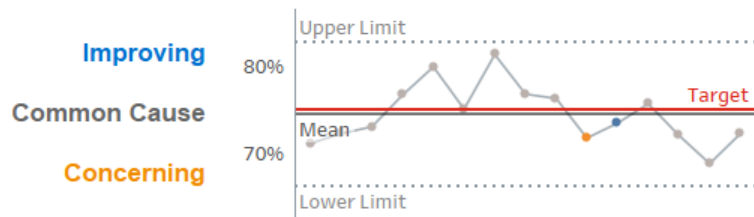
Quarter		Segment		People and workforce domain segment							Return to overview
Q3 2025/26		1 - High performing		1 - High performing							
Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard	
People and workforce	Retention and culture	Sickness absence rate	Q2 2025/26	4.77	%	0.53 ↓	1.90	53 out of 134	5.03		
People and workforce	Retention and culture	NHS staff survey engagement theme sub-score	2024	7.52	out of 10	0.00 →	1.02	2 out of 134	6.88		



Integrated Performance, Quality & Finance Report - New Reporting Guidance

SPC Charts

A Statistical Process Control (SPC) chart is a graphical tool used to monitor, control, and improve a process by tracking data points over time and identifying variations that may indicate potential problems. Depending on the metric, a positive result could be either an upward or downward trend.



SPC Rules

These judgements are calculated based on the following set of rules:



a data point is part of a series of 6 or more points in an upward or downward trend



a data point is part of a series of 6 or more points above or below the mean



a data point is part of a series of 3 points that are approaching the control limits



a single data point is outside the control limits

Please note:

SPC charts can be an effective tool for identifying important variations in a dataset. However, the results can become less reliable when based on a sample that is too small.

64

Interpreting Performance Icons



Common Cause This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.



Improving **Something good is happening!** Something, a one-off or a continued trend or shift of numbers in the right direction.



Concerning **Something's going on!** Something, a one-off or a continued trend or shift of numbers in the wrong direction.

Interpreting Assurance Icons



No Target There is **no** set target for this data



Hit or Miss The process limits on SPC charts indicate the normal range of numbers expected. If a target lies **within** those limits then we know that the target may or may not be achieved. ...



Passing If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.



Failing If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.

Board of Directors

Thursday 30th April 2026

Subject / Title	Value Improvement Programme (VIP) 2025/26 – Month 12 Final Position
Author(s)	Jo Leece – Associate Director Value Improvement Programme
Presented by	Claire McPeake – Chief Operating Officer
Summary / purpose of paper (alert / advise / assure)	<p>This report provides the Month 12 (year-end) position of the Value Improvement Programme (VIP) for 2025/26. It confirms delivery of the Trust’s in-year financial improvement target and provides assurance on:</p> <ul style="list-style-type: none"> • Final in-year delivery against the £25.3m VIP target • The recurrent and non-recurrent split at year end • Identified recurrent shortfall and non-recurrent over-delivery • Governance, quality assurance and implications for 2026/27 planning
Recommendation(s)	<p>The Board is asked to:</p> <ul style="list-style-type: none"> • Note the Month 12 position confirming delivery of the £25.3m Value Improvement Programme target for 2025/26. • Note the recurrent shortfall of £1.3m and that this has been fully offset by non-recurrent over-delivery in-year. • Acknowledge that the recurrent shortfall will be addressed through the 2026/27 Value Improvement Programme. • Receive assurance on governance, quality impact assessment and organisational grip supporting delivery and sustainability.
Background papers / source of assurance	VIP Board reports 2025/26
Risk score / BAF reference	Board Assurance Framework: Risk 1, Risk 6, Risk 7, Risk 9, Risk 10
EDI impact/considerations	All Value Improvement Programme schemes have been subject to Quality Impact Assessment (QIA), including consideration of equality impacts where required. No adverse equality impacts have been identified where assessments are complete.
Link to: ➤ Trust strategy ➤ Corporate objectives ➤ CQC Quality standard	Executive objective: To deliver safe, effective & equitable care To deliver excellent financial and operational performance Links to: Trust strategy – The Christie Strategy 2023–2028



<p>➤ Regulation</p>	<p>Corporate objectives – Five-Year Integrated Delivery Plan CQC Quality standards – safe, effective, responsive, well-led Regulation – NHS England planning and financial governance requirements (Grip & Control)</p>
<p>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.</p>	<p>VIP – Value Improvement Programme CIP – Cost Improvement Programme MHS – Model Health System GIRFT – Getting It Right First Time NHSE – NHS England BAF – Board Assurance Framework QIA – Quality Impact Assessment EIA – Equality Impact Assessment OPIG – Operational Performance Improvement Group</p>



Board of Directors

Thursday 30th April 2026

Value Improvement Programme

1.0 Background

The Value Improvement Programme (VIP) is the Trust's overarching framework for delivering cost improvement, productivity and operational efficiency in accordance with national planning guidance and the Trust's Five-Year Integrated Delivery Plan. Progress against the 2025/26 programme has been reported to the Board throughout the year.

This paper provides the final year-end position for 2025/26, confirming delivery and setting out implications for recurrent sustainability and the forward programme.

2.0 Financial Overview – Month 12

The Trust has delivered its full £25.3m VIP target in 2025/26.

- Recurrent VIP: £11.4m delivered against a £12.6m target, resulting in a £1.3m shortfall
- Non-recurrent VIP: £13.9m delivered against a £12.6m target, resulting in £1.3m over-delivery

The recurrent shortfall has been fully mitigated by non-recurrent delivery, resulting in no net in-year financial gap.

The recurrent gap has been formally risk-rated and is being carried forward into the 2026/27 planning cycle, consistent with previous Board reports and national guidance.

All schemes contributing to the 2025/26 outturn have either been implemented, risk-adjusted, or formally mitigated through non-recurrent delivery in line with established governance arrangements. There are no outstanding unidentified schemes or unmitigated delivery gaps remaining at year end.

3.0 Recurrent Sustainability and Forward Planning

Consistent with previous Board updates, the Trust has prioritised delivery of the overall in-year financial position while strengthening its focus on recurrent sustainability.

Actions in place include:

- Carry-forward of the £1.3m recurrent gap into the 2026/27 VIP programme
- Increased emphasis on clinically led service and pathway reviews
- Use of national benchmarking (GIRFT, Model Health System) to identify sustainable productivity opportunities



- Strengthened benefits realisation and executive oversight through OPIG

This approach supports a managed transition from in-year mitigation to sustainable, recurrent improvement.

4.0 External assurance and CIP development

NHS England confirmed (Appendix 1) that the Trust's Medium Term Plan met required conditions and noted that, at the end of March 2026, 63% of the Trust's 2026/27 Cost Improvement Programme schemes were fully developed or implemented, with further work required to accelerate development of remaining schemes. This risk aligns with issues already recognised by the Trust, particularly in relation to recurrent sustainability beyond the 2025/26 year-end position. The Trust delivered the full £25.3m in-year Value Improvement Programme target for 2025/26, with a £1.3m recurrent shortfall offset through non-recurrent delivery and formally carried forward into the 2026/27 programme. Actions to address scheme development and sustainability are being managed through existing Value Improvement Programme governance, with progress monitored through established executive oversight and reported through routine Board assurance processes.

5.0 Governance and Quality Impact Assessment

Delivery of the Value Improvement Programme continues to be supported by established governance arrangements:

- Executive oversight through the Operational Performance Improvement Group (OPIG)
- Clear divisional accountability for scheme delivery
- Routine performance reporting and escalation
- Quality Impact Assessments completed where required to ensure patient safety, clinical quality and experience are protected

These arrangements are consistent with those previously presented to the Board and provide assurance that value improvement activity is delivered safely and responsibly.

Delivery of the 2025/26 Value Improvement Programme has been achieved in line with national planning and financial governance expectations. The programme is underpinned by external benchmarking and assurance, including the use of Model Health System and GIRFT intelligence, and ongoing reporting through established regional and national oversight routes. This provides additional assurance on the quality and transparency of the year-end position.

6.0 Summary

At the end of 2025/26, the Trust has delivered the £25.3m Value Improvement Programme target. While a £1.3m recurrent shortfall remains, this has been fully offset in-year and is being addressed through the planned 2026/27 programme.



While the in-year Value Improvement Programme target has been fully delivered, residual risk remains focused on recurrent sustainability and ongoing demand growth. These risks are recognised and are being actively managed through the 2026/27 planning process, existing executive oversight, and established escalation and assurance routes.

Over the course of 2025/26, the Value Improvement Programme has continued to develop, with increased clinical leadership involvement, clearer divisional accountability, and enhanced benefits realisation arrangements. This has supported not only in-year delivery but also the development of a stronger platform for more sustainable, recurrent improvement in future years.

The Board is provided with assurance that the Value Improvement Programme is governed in line with agreed arrangements and aligned to national expectations and the Trust's strategic objectives.



Agenda item 12/26d

Meeting of the Board of Directors

Thursday 30th April 2026

Subject / Title	Risk Management Strategy 2025-26 Annual Review.
Author(s)	Daniel Redfern; Head of Quality Governance & Risk Ben Vickers; Associate Director Quality Governance
Presented by	Vicky Sharples, Chief Nurse & Executive Director of Quality
Summary / purpose of paper	To provide annual Board assurance on the implementation and effectiveness of the Risk Management Strategy 2025–2027, including progress against objectives and responses to internal audit recommendations.
Recommendation(s)	The Board is asked to note the progress against the objectives in the Risk Management Strategy 2025–2027 and the response to Mersey Internal Audit Agency recommendations.
Background papers / source of assurance	Risk Management Strategy and Policy 2025–2027 Mersey Internal Audit Agency Audit of Risk Management, January 2026.
EDI impact/considerations	Effective risk management supports safe and equitable care across the organisation by enabling the timely identification and mitigation of risks that may disproportionately affect different patient or staff groups. No adverse equality, diversity or inclusion impacts have been identified in relation to this paper.
Link to: ➤ NHS Oversight Framework ➤ CQC Quality standard ➤ Regulation	Supports delivery of the Trust Strategy and compliance with the NHS Oversight Framework and Care Quality Commission regulatory requirements.
Risk score	N/A
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	MIAA - Mersey Internal Audit Agency CODE - Care, Observation, Documentation, Experience CRF - Clinical Research Facility PSIRF - Patient Safety Incident Response Framework



Meeting of the Board of Directors

Thursday 30th April 2026

Risk Management Strategy 2025-26 annual review

Executive Summary

Context and background

The Trust implemented a three-year Risk Management Strategy (2025–2027) in February 2025 to strengthen the identification, assessment and management of risk across the organisation. This paper provides the Board with an annual assurance update on the effectiveness of the strategy, the maturity of the Trust’s risk profile, and progress in responding to internal audit recommendations.

Scope of paper

The paper reviews progress against the objectives of the Risk Management Strategy during 2025/26, including implementation of the Datix risk management module, improvements in risk governance and risk literacy, and actions arising from the January 2026 Mersey Internal Audit Agency review. It also highlights areas for further development.

Key findings / insights

The Trust has made significant progress in strengthening its risk management framework. The overall risk profile has been rationalised, with a substantial reduction in the number of active risks and a marked decrease in extreme-rated risks. Risk descriptions and mitigation actions have improved, supporting clearer ownership and more effective controls. Risk governance is embedded through divisional structures and assurance committees, and investment in training has improved risk literacy across clinical and corporate teams. Internal audit provided substantial assurance, with all recommendations accepted and either completed or on track.

Implications

Improved oversight and maturity of risk management enhance the Trust’s ability to deliver safe, high-quality and equitable care, supports compliance with regulatory and oversight requirements, and strengthens organisational resilience.

Next steps

The Trust will complete remaining audit actions, continue embedding risk management as business as usual, and further develop risk training. A key area for progression is the review and clarification of the Trust’s risk appetite to support more objective decision-making about which risks should be tolerated, treated or terminated in pursuit of strategic objectives.

Recommendation

The Board is asked to note and receive assurance on the progress made in implementing the Risk Management Strategy 2025–2027 and the response to internal audit recommendations, and to support the proposed next steps, including further development of the Trust’s approach to risk appetite.



Risk Management Strategy 2025-26 annual review

1) Introduction

The Trust introduced a three-year risk management strategy in February 2025 and throughout 2025/26 has been developing the approach to risk management.

This report provides an update on the progress made in implementing the new strategy, Datix risk management module and associated Trust policy, along with the outcome of a review of the Risk Management processes undertaken by MIAA in January 2026.

2) Purpose of Report

As part of the Trusts system for internal control around Risk Management, The Board of Directors are asked to review the Risk Management Strategy annually. The Board are asked to note the progress against the objectives and the response to the recommendations of the MIAA 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.

Strategic risks and risks to the achievement of the corporate objectives are presented to the Board through the Board Assurance Framework and assurance on their management is monitored through the assurance committees.

The reporting of risks, and progress against associated actions, are reported through the Trust governance structures, including the relevant assurance committee and the Board of Directors.

4) 2025/26 Progress against risk management strategy

The Trust launched a three-year risk management strategy and policy in February 2025, which set out annual objectives; **figure one** details the progress against these objectives. Throughout 2025/26 the risk profile of the organisation has developed in its maturity.

- Reduced the number of active risks from >900 to <300.
- Reduced the volume and duration of risks scoring extreme (>12).
- Risk descriptions are clearer ensuring the controls and mitigation are more aligned to reducing the likelihood or occurrence or reducing the impact where possible.



- 71 risk owners have undertaken risk management training with NHS Impact improving risk literacy across the organisation.

5) Outcome of MIAA review of Trust's Risk Management Processes

The Mersey Internal Audit Agency (MIAA) undertook a review of the Trust's Risk Management processes in January 2026, providing substantial assurance on the effectiveness of the arrangements in place. The audit identified one medium and two low-rated recommendations, all of which were accepted by the Trust, as detailed in **figure two**.

The medium recommendation relates to strengthening the consistency and quality of risk entries by ensuring risks are clearly articulated, aligned to the Trust's risk appetite through the use of target scores, and supported by appropriate mitigation actions. This work is being addressed as part of business-as-usual activity and is subject to ongoing monthly oversight through the Risk & Quality Governance Committee.

The two low-rated recommendations focused on clarifying risk escalation processes and strengthening formal assurance reporting arrangements. Updates to the Risk Management Policy to confirm escalation to the Board Assurance Framework and clarify assurance flows to the Quality Assurance Committee are on track and due for ratification in May 2026. In addition, an annual risk management assurance report has now been embedded into the Quality Assurance Committee cycle of business and was completed in March 2026.

Overall, the audit provides assurance that the Trust's risk management framework is robust, with clear actions in place to further strengthen consistency, transparency and Board-level assurance.

6) Recommendations

The board can be assured there is adequate oversight of risk management which is embedded through divisional governance arrangements and assurance committee structures, refinement of the risk profile has improved visibility of emerging risks and improved the rigour of control actions.

Through training and further development of the Trust's risk management approach, the scoring of risks is now clearer and applied more objectively across the organisation. To strengthen this further, it is recommended that the Trust undertakes a review of its approach to risk appetite, to enable clearer assessment of risks that are within or outside appetite and to support consistent decisions to tolerate, treat or terminate risks in support of the Trust's strategic objectives.



Figure 1

Objective	Progress	Status
1) Embed new risk policy and demonstrate good risk governance	<p>Introduction of risk included in staff-wide induction programme.</p> <p>Introduction of risk profile overview/dashboard for all risk registers.</p> <p>Business Intelligence (BI) tool within DCIQ provides divisional oversight with high-level overview of risk profile.</p>	Complete – ongoing risk management improving through regular oversight and governance under BAU
2) Transition from D/Web to DCIQ risk module	<p>Went LIVE with Enterprise Risk Management (ERM) module in March 2025</p> <p>All risks reviewed and transferred by risk owners.</p> <p>Staff and managers supported with “how to guides”.</p> <p>Risk management drop-in sessions commenced</p>	Complete – ongoing risk management within divisions/organisation continue under BAU.
3) Ensure consistent risk management against current principles	<p>Risk management guidance available to all staff.</p>	<p>Complete - March 2025.</p> <p>All addressed within DCIQ risk management module</p>
4) Develop comprehensive risk training alongside learning needs analysis	<p>NHS elect training commenced 2025/26 with a mix of face-to-face and virtual in order to capture staff.</p> <p>55 staff attended training with further 27 planned.</p> <p>Staff groups include senior nursing staff, medical leaders, Allied Health Professionals (AHP), governance, digital and pharmacy colleagues.</p>	March 2026 – completion expected by end of Q4 2025/26



Figure 2

Recommendation	Due	Progress	Owner	Status
<p>The Trust should continue with the review of all risks to ensure that for every risk:</p> <ul style="list-style-type: none"> • The wording of risk is appropriate and describes the actual risk and not an issue that has occurred or an inherent risk associated with a clinical pathway / practice • All risks have a target risk score (aligned to the Trust’s risk appetite) • Mitigation actions are documented for all risks that need to be <i>treated</i> 	31 January 2027	<p>Accepted; BAU under monthly review at Risk & Quality Governance committee.</p>	Associate Director of Quality Governance	On Track
<p>The Trust should update the Risk Management Policy to include the following:</p> <ul style="list-style-type: none"> • Confirm the process for risk escalation to the BAF • Clarify the risk management assurance reporting from Risk & Quality Governance Committee (RQGC) to Quality Assurance Committee (QAC) via the integrated governance quarterly update report. 	31 May 2026	<p>Accepted; Updated Risk Policy to be ratified in May 2026.</p>	Associate Director of Quality Governance	On Track
<p>The QAC cycle of business should include an annual assurance report on risk management.</p> <p>Also, the integrated governance report to QAC should include assurance on risk improvement outcomes and associated actions to deliver the three-year risk improvement strategy.</p>	31 March 2026	<p>Accepted; Annual update on Risk Management Strategy to QAC in March 2026.</p> <p>Added to business cycle – Annual March</p>	Associate Director of Quality Governance	COMPLETE

**Meeting of the Board of Directors
 Thursday 30th April 2026**

Subject / Title	Freedom to Speak Up report - 1st October 2025 to 31 st March 2026
Author(s)	Fiona Jenkinson Freedom to Speak up Guardian
Presented by	Fiona Jenkinson Freedom to Speak up Guardian
Summary / purpose of paper	This report provides a six-monthly update on Freedom to Speak Up (FTSU) activity within The Christie, covering the period from 1st October 2025 to 31st March 2026. It outlines key developments in promoting a speaking up culture, including staff engagement, training, and FTSU Champion recruitment, and presents data on the nature and volume of concerns raised. The paper also reflects on national guidance, staff feedback, and demographic trends which are informing ongoing improvements to the FTSU service.
Background papers	Previous six-month Freedom to Speak Up report
Risk score / BAF reference	N/A
EDI impact/considerations	FTSUG attends EDI network steering group meetings
Link to: ➤ Trust strategy ➤ Corporate objectives	This paper directly supports delivery of the Christie People and Culture Plan (2026–2030) and the Inclusive Culture Strategy (2025–2030) by strengthening psychological safety and advancing actions under the four strategic pillars: Purposeful and Compassionate Leadership, Connectivity and Conversation, Improving Experience and Outcomes, and Effective Governance.
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.	FTSU – Freedom to Speak Up FTSUG – Freedom to Speak Up Guardian NGO – National Guardian’s Office EDI – Equality, Diversity, and Inclusion NHSE – NHS England PC – personal computer PSIRF – Patient Safety Incident Response Framework HR – Human Resources



Board of Directors Meeting
Thursday 30th April 2026

Freedom to Speak Up report 1st October 2025 to 31st March 2026

1. Background

The Freedom to Speak Up Guardian's role is to support staff to effectively raise concerns, address barriers to speaking up and foster a positive speaking up culture so that concerns raised are viewed as an opportunity for learning and improvement.

The current Freedom to Speak Up Guardian (FTSUG) has now been in post for 12 months, having had an overlap with the Interim Guardian who then remained on the National Guardian's Office (NGO) register for a further 10 months to advise and support staff on any conflicts of interest which arose for the new FTSUG. The Interim Guardian has now stepped back from this role, and any conflicts of interest will be escalated to the Executive Lead for FTSU.

This report presents a six-monthly update on activity to the Board of Directors.

2. Activity

To highlight the importance of speaking up and listening, the FTSUG continues to attend meetings as required and is present at Trust induction days.

The local induction pack template provides details on the role of the FTSUG and reference to speaking up and listening.

Promotion of speaking up was supported by focused activity 13-17 October, Freedom to Speak Up Week. Use has also been made of HIVE blogs, weekly staff bulletins and the quarterly magazine to raise the profile of the service.

The Guardian has visited the satellite sites at Oldham, Bolton, Macclesfield and Salford, delivering bespoke awareness training at Oldham and Salford. Sessions have also been delivered for The Christie Institute for Oncology Education team, Admin and Clerical team and a session is planned for Macclesfield in April.

Within the 6 months covered by this report the Freedom to Speak Up Policy has been reviewed and will soon receive its final approval.

3. Staff Survey

During this period, the Trust received the 2025 NHS Staff Survey results. Four questions contribute to the "raising concerns" sub-score covering staff confidence in raising concerns and belief that action will be taken.

- **Q20a:** I would feel secure raising concerns about unsafe clinical practice
- **Q20b:** I am confident that my organisation would address my concern
- **Q25e:** I feel safe to speak up about anything that concerns me in this organisation
- **Q25f:** If I spoke up about something that concerned me, I am confident my organisation would address my concern



3.1 Overview

The survey indicates that staff broadly feel psychologically safe to raise concerns, and the Trust continues to perform above the national average on all four Speak Up indicators. However, a gap persists between feeling able to speak up and believing the organisation will act on concerns. Free-text comments echo this: staff feel comfortable raising issues, but trust in confidentiality, follow-up, and not experiencing detriment remains variable.

3.2 National Comparison

The Christie outperforms the national average on all four indicators, with the strongest margin in Q25f (confidence that action would be taken). This suggests that challenges with follow-up are not unique to the Trust, though improvement is still required given the survey feedback.

3.3 Division and Directorate Variation

Results vary significantly across directorates. Several areas—including Finance & Procurement, Performance, Research & Innovation, Trust Administration, Biobank and Hard Facilities—perform strongly across all indicators. Others—such as Day Nursery, Radiology, Soft Facilities, Central Services and GMCS—show much lower confidence, especially regarding follow-up, with some scores falling below 45%. This variation highlights localised cultural issues requiring targeted, directorate-specific action.

Appendix 1 shows the Staff Survey data in more detail.

3.4 Themes from Free-Text Feedback

Themes closely aligned to the quantitative findings include (for more detailed analysis see Appendix 2):

- Staff feel able to raise concerns but have less confidence in follow-up.
- The FTSU Guardian is highly valued, though wider organisational responses are seen as inconsistent or delayed.
- Fear of detriment remains a barrier, including concerns about being “named” or treated differently.
- Some processes reduce psychological safety, such as being asked to raise issues directly with the person involved.
- Confusion about FTSU remit creates unrealistic expectations.
- Operational barriers, particularly Datix complexity, discourage reporting.
- Visibility and access vary, especially across satellite sites.

3.5 Organisational Learning

Key learning points include:

- FTSU Guardian support is viewed positively, but organisational responses are uneven.
- Fear of detriment continues to inhibit speaking up.
- Feedback loops are weak, reducing confidence that concerns lead to change.
- Some processes unintentionally compromise psychological safety.
- Ongoing confusion about FTSU boundaries contributes to frustration.
- Variation across directorates highlights uneven leadership cultures.



3.6 Organisational Actions

- Strengthen psychological safety: embed non-retaliation commitments, develop a mechanism to report detriment, and avoid directing staff to confront those they raised concerns about.
- Improve the organisational response system: set clear timelines for acknowledgement, updates, and closure; ensure divisions give structured feedback; audit follow-up.
- Enhance fairness and confidentiality: mandatory manager training and independent oversight where needed.
- Increase visibility and clarity: publish “You said / We did” updates, improve communication about FTSU remit, expand Champion visibility (including satellites), and simplify Datix-related processes.

3.7 Actions Required of the FTSU Guardian

- Be explicit about remit, confidentiality and process limits at first contact.
- Maintain contact throughout the case; escalate systemic issues earlier.
- Increase targeted presence in low-scoring areas.
- Standardise triage approaches for bullying, safety, and discrimination concerns.

3.8 Benchmark Against Specialist Cancer Trusts

The Christie ranks second for Q25e and Q25f and third for Q20a and Q20b within the specialist cancer cohort. Clatterbridge performs consistently higher across all measures, while The Christie is broadly aligned with The Royal Marsden.

3.9 Benchmark Against GM Hospitals

Within Greater Manchester, The Christie ranks:

- 1st for Q20b, Q25e and Q25f
- 2nd for Q20a

The Trust performs notably above the GM provider average, particularly in confidence that concerns are taken seriously and acted upon.

See Appendix 1 for more detailed data on benchmarking.

4. National guidance and reports

NGO Annual Report 2024–25 (Nov 2025)

A high-level overview of information covering national speaking-up activity, highlighting ongoing cultural challenges across the NHS—particularly inappropriate behaviours, worker safety issues, and reduced confidence in organisational responses. It also outlines the NGO’s work in training and supporting Guardians and notes upcoming system changes ahead of the NGO’s closure and the transfer of its functions to other national bodies. No action required for individual Trusts.

NHS England – Future of Freedom to Speak Up: Engagement Pack (Jan 2026)

Sets out NHS England’s proposals for how the Speak Up function will operate after the NGO closes in June 2026, including distributing responsibilities across NHSE, DHSC, CQC and providers. The pack seeks organisational feedback and emphasises the need to maintain strong Guardian support, manage risks, and ensure consistent delivery of speaking-up processes across the system. We have fed back into this process as part of the consultation exercise.



Temporary Workers, Permanent Voices: A Speak Up Review (NGO, Mar 2026)

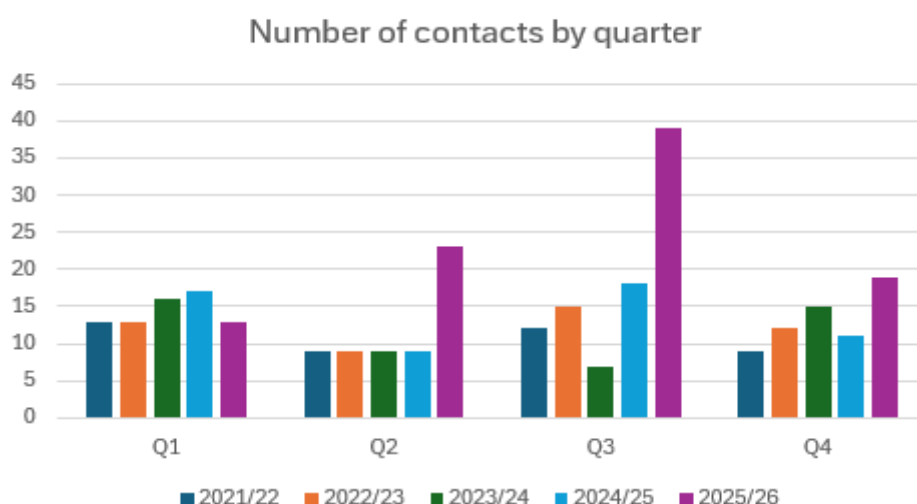
A national review responding to HSSIB findings of discrimination and fear of speaking up among temporary workers. Drawing on insights from over 900 individuals, it identifies systemic barriers faced by temporary staff and makes six recommendations for improving protection, culture, and reporting pathways across healthcare providers and workforce suppliers.

We can use the recommendations to strengthen protections for temporary workers by improving speak-up mechanisms, ensuring equal voice and safeguarding against retaliation across all employment types.

This can be achieved by ensure they receive robust induction, training and communications, providing multiple safe and confidential reporting routes, and clearly protecting against detriment or retaliation. This can be supported by regular monitoring of concerns raised by temporary workers, so learning is acted on and their voices lead to meaningful change.

5. Contacts

5.1 Number of contacts by quarter and total last 5 years



5.2 Type of contact

The table below describes the activity from 1st October 2025 to 31st March 2026. Concerns are reported as the primary concern but may have more than one issue.

Note: - Due to the confidentiality requirements of case work, the Guardian is unable to access case files to report on actions taken for cases involving conflicts of interest handled by the Interim Guardian.

Quarter	No. of contacts	Issue category	Description	Action
2025/26 Q3	39	Attitudes and behaviours (x15)	Incivility from managers	Escalated to ICT Matron and Assoc Director of Risk plus separate item escalated to Deputy head of workforce



Quarter	No. of contacts	Issue category	Description	Action
			<p>Reports bullying from manager and b6s. Feels race may be a factor.</p> <p>Anon concerns about culture in pre-op (x3)</p> <p>Staff member overheard senior colleagues saying unprofessional things about her</p> <p>Behaviours of line manager/ impact on staff and patients/ family</p> <p>Staff member accused of being unprofessional, experienced microaggressions and unequal support</p> <p>Concern escalated to FTSUCH re: medical provision in area & leadership</p> <p>Concerns relating to line manager/ Attitudes and behaviours of line manager/ poor culture</p> <p>Concerns re colleague behaviours and competency.</p> <p>Negative working relationship with manager</p>	<p>No action taken, matron supporting</p> <p>Investigation by matron. New to Healthroster - learning and improvements, staff reminded re breaks and periods when less busy</p> <p>Senior review, formal investigation ongoing</p> <p>Contact withdrew</p> <p>Senior review, formal investigation ongoing</p> <p>Advice provided</p> <p>Escalation to Deputy head of workforce</p> <p>Contact spoke with Head and Deputy Head of Workforce</p> <p>Contact withdrew</p>



Quarter	No. of contacts	Issue category	Description	Action
		Policies, procedures and processes (x11)	Concerns re: culture in Radiotherapy Physics	Manager implemented Respectful Resolutions & wellbeing strategies
			Relationship with colleague/clarity of roles/ allegations of harassment	Advice provided
			Concerns relating to line manager/ Attitudes and behaviours of line manager	Pending
			Use of action plan	Options given, decided not to escalate
			Feels blamed for patient's relapse	The contact has escalated their concerns
			Advice regarding toilet facilities	Advice given via email; own actions taken
			Management of flexible working request	Escalation to head of Division, investigation ongoing as part of a wider piece of work
			Band 4 asked to train a Band 5 who will be their line manager	Advice given, own actions taken
			Trainees' involvement in private surgery without indemnity.	Escalated to Head of Medical workforce for The Christie and Christie Private Care. Investigation held, Legal position strongly reinforced with all surgical consultants.
			Experiences whilst on placement	Escalation to 8a matron, conversation with undergrad education team. Contact happy that issues addressed
		Flexible working & carer's passport rejected following partner's death	Escalation to head of Division, investigation ongoing as part of a wider piece of work	



Quarter	No. of contacts	Issue category	Description	Action
			Staff member asked to raise a concern under the disciplinary policy to EROG but feels anxious and unsafe.	Own actions taken
			Inappropriate social media posts	Policies reinforced with person named
		Quality and safety (x7)	Team unsettled following implementation of change, previously escalated to matron (x2)	Escalation to divisional lead nurse and then back to 8a and 8b matrons for the team
		Performance capability (x2)	Team member demonstrating poor behaviours and performance, not complying with government guidelines	Formal grievance has been raised; contact has left the organisation.
			Concerns re: colleague's MH	Advice given, Service Lead and Head of Medical workforce aware
		Worker safety or wellbeing (x1)	In person chat about working conditions, followed up by 2 emails from contact.	Advice given but contact withdrew
		Bullying or harassment (x5)	Bullying by line manager	Contact withdrew
			Bullying by colleague	Escalation to Deputy head of workforce
			Feeling bullied from below	Advice from HR, open dialogue with line manager, work around team MH
			Staff member feeling bullied, reported to FTSUCH	Senior review, formal investigation ongoing



Quarter	No. of contacts	Issue category	Description	Action
			Bullying and Harassment by line manager	Escalation to Deputy head of workforce
2025/26 Q4	19	Attitudes and behaviours (x7)	Struggling to line manage a colleague	Spoke with HR, used Performance Management Policy
			Contact raised concerns, was named in a grievance	Formal Investigation Ongoing
			Feels targeted by senior colleague, thinks culture and needs to change.	Manager and matron aware, colleague spoken with. Performance management advice from HRBP
			Team dynamics	Withdrew
			Concerns on behalf of colleague	Advice given. Ongoing
			Manager behaviours and implementation of policy	Advice given. Ongoing
			Targeted behaviour from manager	Advice given. Ongoing
		Other (x1)	Contacting wanting alternate union rep information	Signposted to info
		Policies, procedures and processes (x6)	Extension of probation	Advice from HR and RCN
			Anon - annual leave carry-over. No name or details.	Unable to investigate due to lack of detail
			Anon form raising concern re: Palantir involvement in NHS	Added to wider set of complaints, signposted to organisational response
			Band 5 covering Band 8a duties	Advice from HR. Ongoing
			Advice regarding shifts and working pattern	Advice given. Ongoing



Quarter	No. of contacts	Issue category	Description	Action
		Quality and safety (x2)	Poor experiences of new job	Advice given. Ongoing
			Concerns around an incident, general ICT procedures/ preparedness	Included in wider cultural review. Ongoing
		Performance capability (x1)	Safety of theatre out of hours staffing	New case, awaiting meeting, escalation to Patient Safety team
			Concerns surrounding member of medical staff	Advice from Deputy Head of Workforce, signposted to details in Media reports and BMA hearing report.
		Worker safety or wellbeing (x1)	Concerns regarding experiences of new HCAs in same area	Advice and signposting

5.3 Summary of Concerns

Across the period 1 October 2025 to 31 March 2026, the FTSU service received 58 contacts, with Attitudes and Behaviours the most common theme (40% of cases). Policies, Procedures and Processes accounted for a further 30%, followed by Quality and Safety and Bullying or Harassment. Many cases involved more than one issue, and overall 60% contained an element of behavioural concern and 58% related to policies or processes—both slight improvements on the previous six months. The continuing rise in concerns about senior colleagues reflects ongoing cultural pressure points. Cases were often complex, resulting in a wide range of actions including advice, signposting, escalation to senior nursing or HR, formal investigations, and in some cases wider cultural reviews. A number of contacts withdrew after initial discussion. Overall, casework indicates sustained demand for support with behavioural and cultural issues, highlighting the essential role of FTSU in identifying patterns and enabling organisational learning.

Over the past six months, learning from contacts has highlighted recurring themes around culture, behaviours, and systems. There is a clear need to reinforce a no-blame culture while addressing inappropriate behaviours early and consistently, with a proportion of concerns contributing to a wider cultural review. Clear leadership is required to support staff where relationships with line managers are challenging, alongside timely use of HR advice and policies. Finally, there is increased recognition of the need to improve induction, team working, policy awareness, and support for neurodivergent staff and those working in high-intensity environments.



6.0 Who is raising concerns?

Over 18 months, Nursing and Midwifery, Allied Health Professionals, and Additional Clinical Services generated disproportionately high levels of Speak Up contacts relative to their workforce size, suggesting either greater need or higher confidence in using the route. In contrast, Administrative and Clerical, Medical and Dental staff, and Healthcare Scientists were under-represented, which may indicate barriers to speaking up or lower awareness. The presence of 'Unknown' and 'Other' categories also reflects gaps in data completeness. Overall, frontline clinical teams are strongly engaged with FTSU, while other staff groups may require targeted outreach to ensure equitable access to the service.

6.1 Number of FTSUG contacts by staff group

Staff group	Q3&4 24/25	Q1&2 25/26	Q3+4 25/26	Total for 18 months
Additional clinical services	4	6	10	20
Additional professional, scientific and technical	2	3	2	7
Administrative and clerical	8	2	2	12
Allied health professionals	4	7	11	22
Estates and ancillary	1	3	3	7
Healthcare scientists	0	0	0	0
Medical and dental	2	0	4	6
Nursing and midwifery	5	7	15	27
Students	0	0	1	1
Unknown	1	0	7	8
Other	2	6	0	8
Total	29	36	56	121

Staff group	Total number (18 months)	% of total no. of contacts	Staff numbers by group 2026	% of total number of staff
Additional clinical services	20	16.5%	433	10.3%
Additional professional, scientific and technical	7	5.8%	159	3.8%
Administrative and clerical	12	10%	1256	29.8%
Allied health professionals	22	18.2%	464	11%
Estates and ancillary	7	5.8%	298	7.1%
Healthcare scientists	0	0	219	5.2%
Medical and dental	6	5%	374	8.9%
Nursing and midwifery	27	22.3%	1007	23.9%
Students	1	0.8%	8	0.2%
Other	8	6.6%		
Unknown	8	6.6%		
Total	121		4218	



6.2 Role

Role	Q3&Q4 2024/2025	Q1&2 2025/2026	Q3&4 2025/2026
Senior leader	0	11%	0
Manager	20.7%	8%	23.2%
Worker	75.9%	53%	66%
Anonymous	3.4%	28%	10.8%
Denominator – number of cases	29	36	56

6.3 Method of speaking up

To make it easy for staff to speak up, there are a number of ways to speak with the FTSUG, and staff choose the method that works best for them.

Method	Q3&Q4 2024/2025	Q1&Q2 2025/2026	Q3+4 2025/2026
Face to face	5	7	2
MS Teams	2	2	3
Telephone	0	3	3
Form on intranet	2	4	10
Email	19	18	37
Letter	1	0	0

6.4 Demographics

When appropriate, all contacts are asked to provide their demographic information at their first meeting with the FTSUG, the purpose of this is to make a comparison with the overall workforce demographics to identify gaps.

In most areas over 50% of contacts provided this information during the 6 months covered by this report. Contacts were less willing to provide information on their religion and gender, reporting being under 50% in both these categories.

Age	16-24	2
	25-34	7
	35-44	11
	45-54	12
	55-64	1
	Unknown	23
	Total who answered	59%
Ethnicity	Asian Other	2
	Black Caribbean	2
	Indian	3
	Mixed other	1
	Pakistani	2
	White British	20
	White European	1
	White Other	1
	Unknown	24
	Total who answered	57%



Disability	Yes	4
	No	28
	Unknown	24
	Total who answered	57%
Religion	Christian	11
	Hindu	2
	Muslim	4
	No religion	9
	Unknown	30
	Total who answered	46%
Sexuality	Heterosexual	23
	Gay woman	1
	Gay man	0
	Unknown	32
	Total who answered	43%

The gaps in recording demographic data were identified as needing improvement, so if we look at Q4 data separately, following improvements in data capture, we see the following:

Demographic	Total who answered
Age	76%
Disability	71%
Ethnicity	65%
Religion	59%
Sexuality	59%

6.5 Timeliness of FTSUG response

Average response time from first contact over Q3 & Q4 was 1.04 days, Q4 was quicker (0.87 days), and most responses occurred on the same day or next day.

Average response time, where applicable, from first contact to first meeting was 5.89 days. Again, Q4 showed improved responsiveness (3.0 days), reducing the overall six-month average.

7. FTSU plan

The Freedom to Speak Up plan (**Appendix 3**) describes the aims and action to promote, develop and support the culture, values and behaviour that will meet the ambition that “we are comfortable to speak up.”

The FTSU plan for 2025/2027 was developed in conjunction with the previous plan and feedback from staff via the staff survey to ensure that it meets the ambition to progress improvements in speaking up culture.

Over the six months covered by this report the following actions contributed to achieving our deliverables:



- Raising awareness of FTSUG and the speaking up and listening message at team meetings (using material targeted to the area), via HIVE and in-person at staff induction as part of the Values & Behaviours session
- Further expansion and development of the FTSU Champion network including the implementation of a development afternoon, development of a “Champion’s Guide” and soon to be released promotional posters. There are now 20 champions.
- Development of materials and daily programme of items to support October’s Freedom to Speak Up Week.
- Refreshed NHSE board self-assessment of leadership and governance arrangements in relation to speaking up (presented at Workforce Assurance Committee February 2025), using the new framework published last year.
- Ongoing work to support those named in concerns
- Developing relationships with stakeholders and ensuring quarterly meetings with key teams and individuals.

8. National Freedom to Speak Up Week.

National Freedom to Speak Up Week took place from 13–18 October, with a focus on the importance of follow-up in strengthening speaking-up culture. The Christie used the week to launch the expanded FTSU Champions network and hosted a daily presence at the Staff Engagement Stall, providing information on how to raise concerns and what happens next—an area highlighted as a barrier in the 2024 Staff Survey. Engagement was high and led to an increase in cases. Additional activity included promoting national webinars via HIVE, sharing updates through a newsletter, and hosting an FTSU-themed Schwartz Round.

With uncertainty around future national events due to the closure of the NGO, The Christie will continue to hold its own FTSU Week from 12–17 October. The proposed theme, “Speak Up: Stronger Together,” reflects a collective approach to speaking up across the NHS. Planned activity includes cross-departmental listening events, partnership work with staff networks, unions and HR, and promotion of staff well-being support.

9. Freedom to Speak Up Training

The National Guardian’s Office, in association with Health Education England launched Freedom to Speak Up e-learning training divided into three modules, Speak Up for all staff, Listen Up for managers at all levels and Follow Up for Senior leaders. The Speak Up module is part of the Trust mandatory training programme and 97.03% of staff are compliant.

Through the process of all Trust mandatory training being reviewed the decision was made for FTSU training to remain mandatory.

10. FTSU service effectiveness

The anonymous Speak Up survey, completed at case closure, provides consistent and positive feedback on staff experience across Q3 and Q4. The NGO requires that Guardians ask those who contact the FTSUG if they would speak up again or have experienced detriment. Additional questions are asked about support and communication. The feedback tool is completed via a link so that responses are anonymous. The questionnaire is sent when a case is closed, and not all cases are closed in the quarter where they are reported, and not all questions are answered.

13 respondents participated and the results show strong and improving confidence in the Speak Up process: all respondents in Q4 and half in Q3 said they would speak up again, with the remainder selecting “Maybe” and no one reporting detriment. All staff reported feeling well



supported—most “very well supported”—and communication was consistently rated positively, though some Q4 respondents noted slower organisational updates once concerns were escalated beyond FTSU. Staff valued being listened to, receiving compassionate and practical support, and having a safe, confidential space to raise concerns. Areas for improvement relate to organisational follow-up, including timeliness of updates, clarity on next steps, and visibility of learning. Overall, the survey provides strong assurance of trust in the FTSU service, with feedback indicating a supportive and psychologically safe experience for those who speak up.

For transparency, comments are included in their entirety in **Appendix 4**

11. Conclusion

The Board of Directors is asked to note the detail in the report and receive a further update in six months’ time.

12. References

[National Guardian's Office annual report 2024 to 2025 - GOV.UK](#)

[NHS England » Future of Freedom to Speak Up: engagement pack](#)

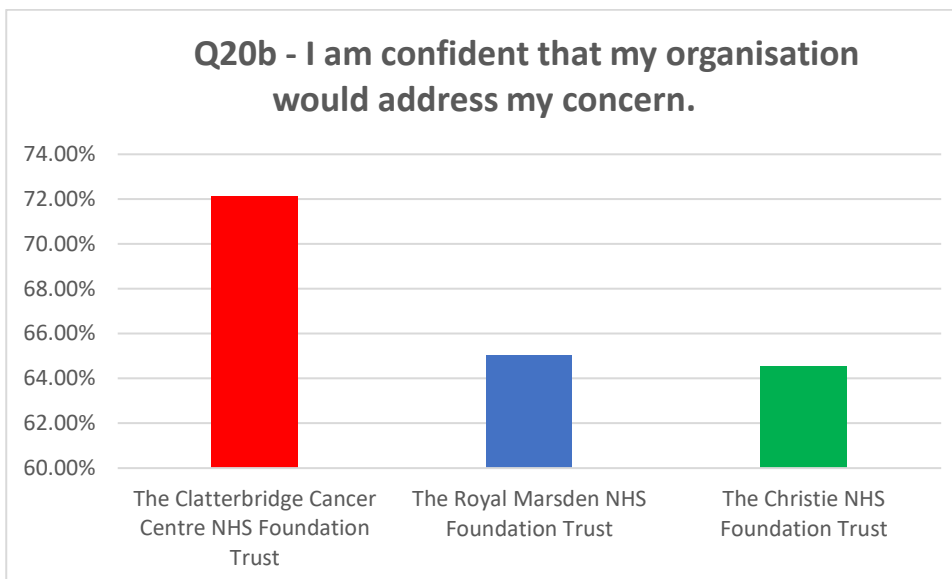
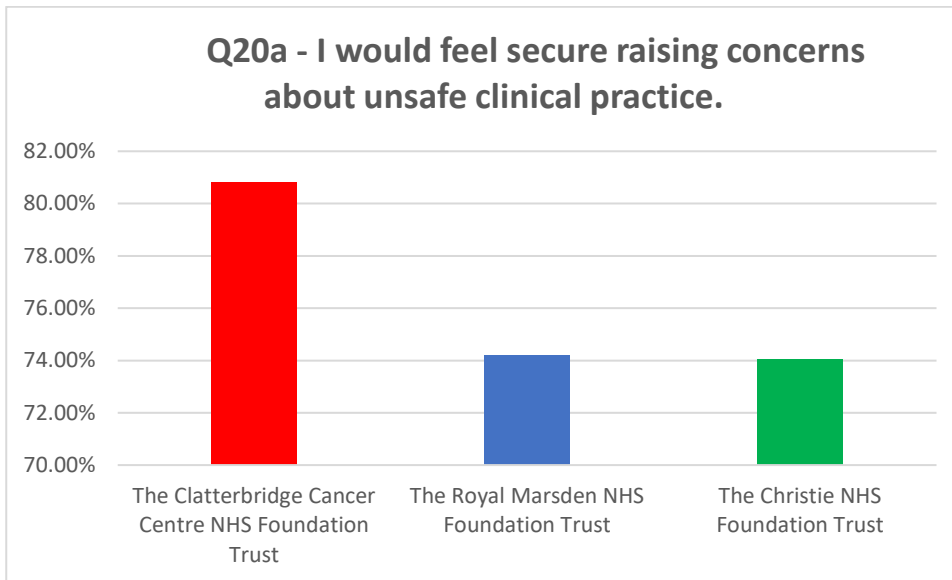
[Temporary Workers, Permanent Voices: A Speak Up Review - National Guardian's Office](#)

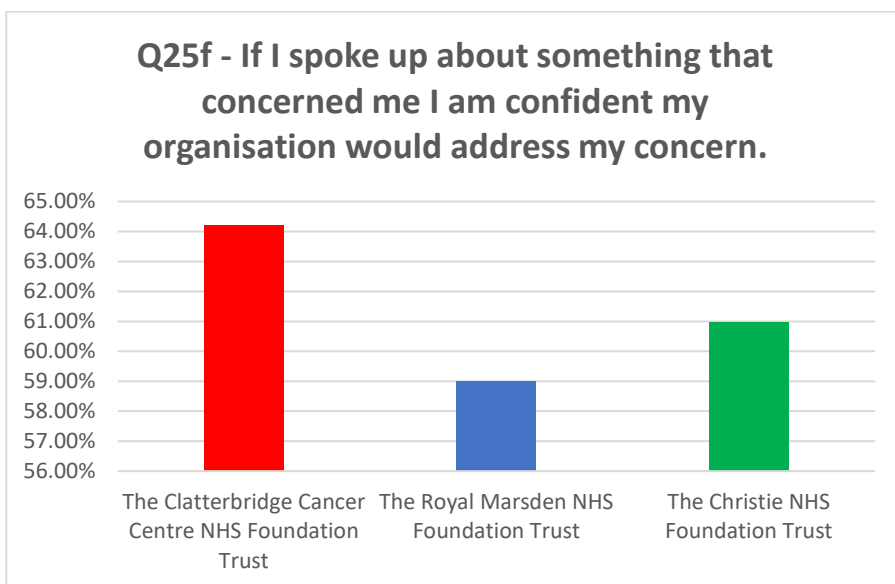
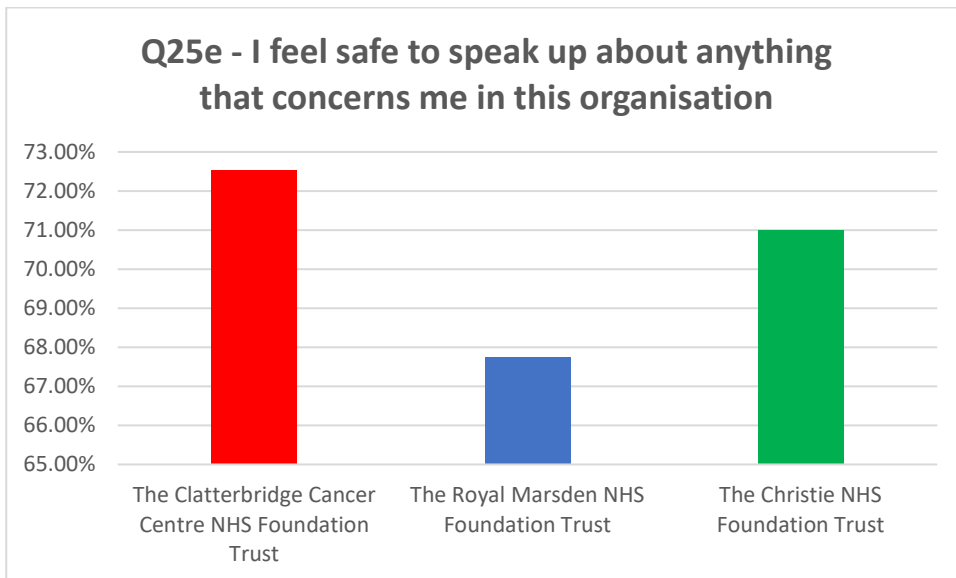
[HIVE - Freedom to Speak Up plan](#) – copy in **Appendix 3**



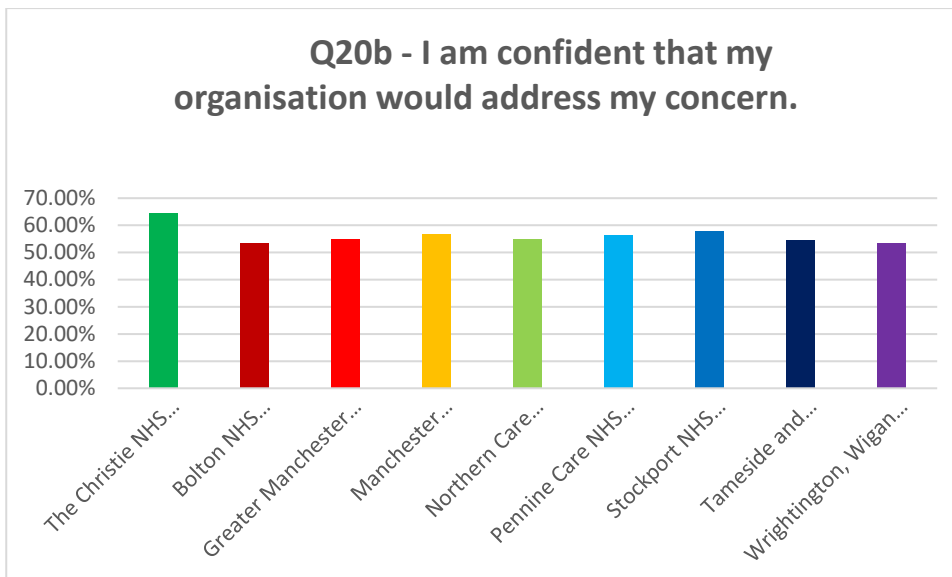
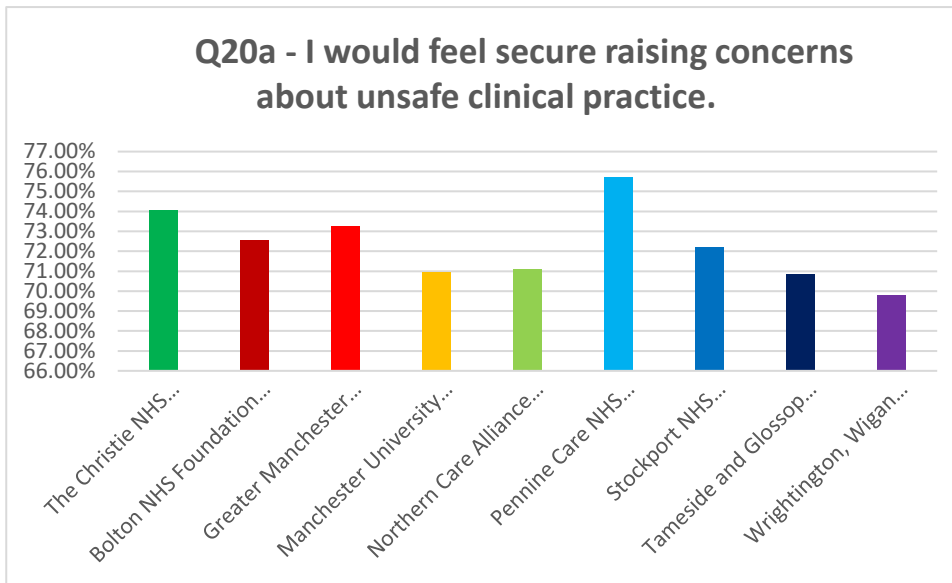
Appendix 1 Staff Survey results - Graphs to support text in the report.

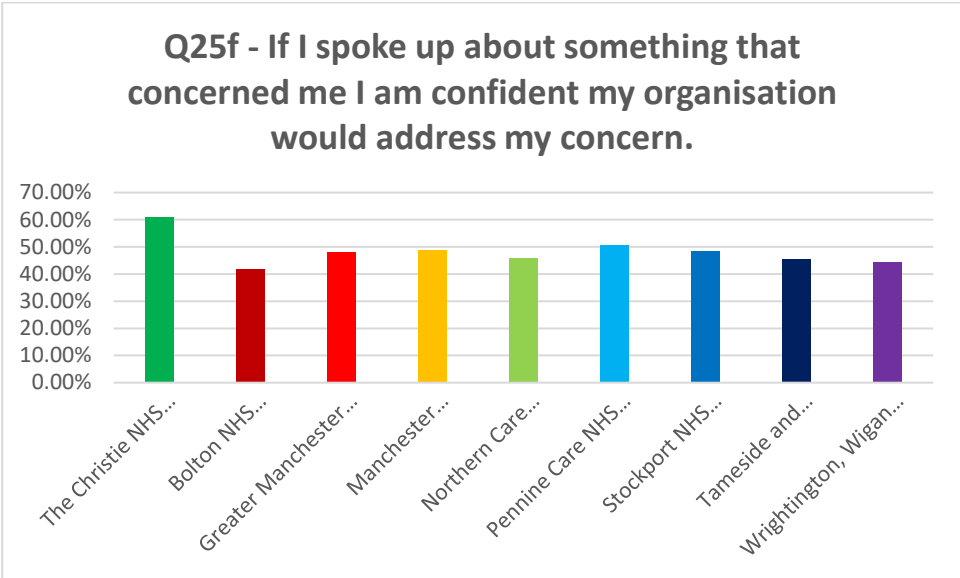
Benchmark for 3 Specialist Cancer Trusts





Benchmark of Greater Manchester Hospitals





Appendix 2 – Themed Summary of Staff Survey Free-Text Comments

1. Lack of Action / Poor Follow-Up (≈90 comments)

The largest theme by a significant margin, with staff repeatedly reporting that concerns are not acted on, that little or nothing changes, that issues are dismissed, or that there is no follow-up after speaking up or submitting Datix. Many note long delays, superficial responses, or concerns being “swept under the carpet.”

2. Fear of Retaliation / Detriment (≈45 comments)

Many staff expressed fear of being named, treated differently, or suffering career damage. Several describe actual experiences of detriment, including hostile treatment, intimidation, and worsening workplace relationships after raising concerns.

3. Issues With Line Management Behaviour (≈80 comments)

Strongly recurring concerns about managers being unapproachable, unsupportive, biased, avoiding accountability, or directly contributing to poor culture. Some staff describe behaviour as bullying or dismissive or note manager reluctance to deal with issues.

4. Desire for Confidentiality / Anonymity (≈35 comments)

Staff frequently asked for anonymous routes, assurance that their identity will not be shared, and stronger privacy protections. Many cited confidentiality breaches or fear that raising concerns will not be kept private.

Examples: “prefer anonymous route”, “concerns shared”, “no true confidentiality”.

5. Datix / System Barriers (≈30 comments)

A significant number of staff described Datix as time-consuming, confusing, overly complex, or something they can’t complete within clinical workload. Several said they avoid reporting because the system is too difficult or because they lack access.

6. Positive Experiences with Speaking Up (≈25 comments)

Alongside the concerns, many staff noted positive experiences, feeling listened to, validated, and supported—particularly praising the FTSU Guardian’s approach. However, these were often contrasted with poorer organisational follow-up.

7. Cultural and Interpersonal Behaviour Concerns (≈40 comments)

Comments referenced poor team culture, incivility, bullying, microaggressions, passive-aggressive behaviour, and poor relationships within teams. Staff often described feeling unsafe, excluded, or undermined.



8. Organisational Systems / Structure Problems (≈20 comments)

Themes included slow organisational decision-making, lack of accountability, processes that undermine psychological safety, and confusion about FTSU's remit. Some staff reported being told to confront the person they were concerned about, which they found unsafe or inappropriate.

9. Practical and Environmental Barriers (≈15 comments)

Some comments related to workload pressures, lack of time to speak up, poor working conditions, or challenges with physical environments (e.g., space constraints, equipment).

Summary

The free-text comments highlight repeated concerns around lack of action or follow-up (≈90 mentions), line-management behaviours (≈80), and cultural issues including bullying and incivility (≈40). Many staff expressed fear of retaliation (≈45) and a strong desire for confidential or anonymous routes (≈35). Practical barriers, particularly relating to Datix usability and workload pressures (≈30), also affected staff confidence in reporting. Alongside these challenges, a number of staff described positive experiences (≈25), particularly relating to empathetic support from the FTSU Guardian. Overall, the comments demonstrate that while staff generally feel able to raise concerns, confidence in organisational response, follow-up, and psychological safety remains inconsistent.



Appendix 3 Freedom to Speak Up 2025-27 Plan and Deliverables

Deliverable	Action	Timescale
Ensuring safety, quality, and organisational learning		
In-depth analysis of Staff survey results, to inform Speak-Up activity and highlight which areas may require more support to develop their Speak-Up culture	<ul style="list-style-type: none"> Asses if priority action areas from the 2023 Christie Independent Cultural Audit are featuring in Speak up disclosures Divisional presentations to Workforce Committee on focus for action following staff survey results 2024 	November 2025 Completed
Continue to embed Speaking Up as an important element in the implementation of the Patient Safety Incident Response Framework (PSIRF). Build awareness of the clear mechanisms for raising, investigating, and escalating clinical concerns to build confidence of staff and ensure Speaking Up is aligned with the culture of PSIRF.	<ul style="list-style-type: none"> Regular triangulation meetings with Patient Safety leads. Make PSIRF part of the conversation when visiting areas in person. Ensure that when Speak Up disclosures have a concern for patient safety DATIX forms have been completed. Liaise with patient safety leads when a need for more education regarding PSIRF is required. Roll out of Anonymous reporting for inappropriate behaviours via the Datix system (planned 01/08/2025) 	Ongoing
Promoting a Speaking Up culture		
Develop and expand the Champion network, including targeted recruitment of Champions from the areas most dissatisfied (recommendation from the Regional FTSU network meeting March 2025)	<ul style="list-style-type: none"> Active recruitment drive at Induction, via comms, using blogs and newsflash Link with EDI champions and Mental Health first aiders Targeted recruitment of medics as Speak-up champions 	March 2026 Completed



<p>Target barriers to speaking up, particularly for those with protected characteristics</p>	<ul style="list-style-type: none"> Engage with EDI champions to identify barriers to speaking up, encourage EDI champions and Mental Health first aiders to complete additional Speak Up training Review NGO paper “Listening & Learning: amplifying the voices of overseas-trained workers” and how the learning can be applied at The Christie. Targeted Champion recruitment to reflect our diverse workforce 	<p>March 2026 Ongoing</p>
<p>Supporting workers compassionately</p>		
<p>Campaign relating to FTSU promoting the Just and Learning Culture charter, incorporating ‘Civility Saves Lives’</p>	<ul style="list-style-type: none"> Liaise with comms, use of blogs, HIVE 	<p>October 2026</p>
<p>Initiate discussion around the issues raised in the HPMA paper “When We Do Harm” and the “Avoiding Harm” programme, acknowledging the impact that the application of policies and processes can have on our workforce.</p>	<ul style="list-style-type: none"> Promote these conversations from Board level downwards Initiate conversations with HR team Share paper with leaders throughout the trust 	<p>October 2026</p>
<p>Collaborating with leadership to drive cultural change</p>		
<p>Triangulation of FTSU information, patient safety concerns, and employee relations matters</p>	<ul style="list-style-type: none"> Meet regularly with other leads for staff wellbeing and safety Present themes and learning to Workforce Committee, Senior Management Committee and The Board 	<p>Ongoing</p>
<p>Review feedback from those who raised a concern to share learning, including free-text responses from the staff Survey 2024</p>	<ul style="list-style-type: none"> Review feedback, highlight themes and share learning with the Workforce Committee, Senior Management Committee and The Board 	<p>October 2025 Completed</p>



Engagement beyond the organisation		
<p>Engage with national issues relating to the development and promotion of Freedom to speak Up, and related NHS/Healthcare culture initiatives.</p>	<ul style="list-style-type: none"> • Disseminate papers from the NGO and other affiliated organisations • Develop external Speak-Up networks through the “buddy” system, regional meetings and national networks 	<p>Ongoing</p>



Appendix 4 FTSU Service Questionnaire - Staff comments

The comments are reproduced in their entirety so that complete transparency is maintained to provide assurance that the service is delivering the required standard of support for the staff.

- *I was given a listening ear, staff was patient and empathetic with me. I really felt comfortable with her. One thing I am happy about is she always check up on you to see your progress so far and gives way to see her again if situations are still the same.*
- *A very positive and supportive process, I have also learnt a lot during this and have been guided on how to navigate a situation like then and been given very good tangible advice on recruitment will influence my practice going forward.*
- *Positive, however very draining on my well being.*
- *I feel better for speaking up because I have been aware over the time I have worked here that things are "not right" and that nothing will change if people don't speak up.*
- *I felt that raising my concern lead to an opportunity for a supportive and safe discussion involving objective advice on how to deal with it. I was reassured of confidentiality, and feel that the service within the Trust is invaluable.*
- *I am glad I have spoken up but unsure of what to do going forward. This has been ongoing for a long time and we have only been given one update which was a long time after the initial investigation. We have not been given any guidance on what to do going forward, eg, if the problems persist do we continue to speak up? how long are we meant to wait with seeing no improvement before we take action again, what action if so as it feels like nothing is changing.*
- *Really good support from the FTSU guardian. Very easy to arrange a time to talk, and she kept in touch throughout. Had complete trust in the FTSU's professionalism and ability to understand the nature of the issue raised. She validated my concern, gave advice on next steps- who to contact, and followed up with me following that meeting. Overall, really good level of support.*
- *Raising the concern was difficult but I felt well supported by Jane. Once Jane had escalated further up in the organisation, I felt supported and listened to by Kate & David, but the communication following this meeting was poor and led to me feeling despondent. Whilst there is now a conclusion it feels unsatisfactory in relation to my desired outcome. The feedback I have now received seems to only be concerned with policy & procedure, rather than attitudes and behaviours, which underpinned my concerns. Time will tell if there is meaningful change.*



Suggestions for improvement of the FTSU service: -

- *In my opinion staff who go through situations in the hands line managers or who ever put them through such situations, these managers should be brought to book and spoken to or adviced and told how their action affects the the staff. Thank u*
- *Maybe more helpful with linking in other services available within The Christie.*
- *I feel that it would be beneficial for discussions to take place outside of the Trust if possible.*
- *further advice given on what to do after you have raised your concern if the problems continue.*
- *Regular feedback whilst the concern is ongoing, even if to say there is nothing to report.*



**Meeting of the Board of Directors
 Thursday 30th April 2026**

Subject / Title	Addressing Health Inequalities														
Author(s)	Louise Westcott, Company Secretary John Wareing, Director of Strategy														
Presented by	John Wareing, Director of Strategy														
Summary / purpose of paper	This paper summarises the statutory and regulatory requirements relating to reducing health inequalities and demonstrates what we are doing as an organisation to address these requirements.														
Recommendation(s)	The Board are asked to: <ul style="list-style-type: none"> • note the assurance table and the work being undertaken to address requirements relating to health inequalities and • note that this will be updated and presented on a 6 monthly basis to show ongoing progress. 														
Background papers	Various national guidance as outlined in the paper.														
Risk score	N/A														
EDI Impact	The paper strengthens the Trust's approach to EDI and health inequalities, provides clear assurance to the Board against statutory and regulatory requirements, and supports progression towards more equitable access, experience and outcomes for patients, communities and the workforce. No mitigating actions are required beyond the planned monitoring and improvement activity already set out.														
Link to: ➤ Trust strategy ➤ Corporate objectives	<ul style="list-style-type: none"> • Trust's strategic direction • Divisional implementation plans • Key stakeholder relationships 														
Acronyms or abbreviations where they appear in the attached paper.	<table> <tr> <td>GM</td> <td>Greater Manchester</td> </tr> <tr> <td>EDI</td> <td>Equality, diversity, inclusion</td> </tr> <tr> <td>WRES</td> <td>workforce race equality standard</td> </tr> <tr> <td>WDES</td> <td>workforce disability equality standard</td> </tr> <tr> <td>EQIA</td> <td>equality impact assessment</td> </tr> <tr> <td>EHIA</td> <td>equality health impact assessment</td> </tr> <tr> <td>NHIR</td> <td>National Institute for Health & Care Research</td> </tr> </table>	GM	Greater Manchester	EDI	Equality, diversity, inclusion	WRES	workforce race equality standard	WDES	workforce disability equality standard	EQIA	equality impact assessment	EHIA	equality health impact assessment	NHIR	National Institute for Health & Care Research
GM	Greater Manchester														
EDI	Equality, diversity, inclusion														
WRES	workforce race equality standard														
WDES	workforce disability equality standard														
EQIA	equality impact assessment														
EHIA	equality health impact assessment														
NHIR	National Institute for Health & Care Research														

**Meeting of the Board of Directors
Thursday 30th April 2026**

Addressing Health Inequalities

1. Introduction

All NHS bodies must continue to demonstrate how they are meeting their statutory duties to have due regard to reducing health inequalities in access, experience and outcomes, and how this is continually being translated into sustained and systemic action across all pathways. This includes maintaining a clear and explicit focus on improving population health embedding prevention as core business. These priorities should be consistent with the NHS 10-year Health Plan and its three shifts (from sickness to prevention, from hospital to community and from analogue to digital).

All activity should therefore reflect not only delivery against agreed plan commitments, but also how health inequalities, prevention and sustainability are embedded through governance arrangements, performance oversight and ongoing decision making for the populations we serve.

2. Background

Boards should expect to see an equality thread in every paper, particularly when decisions, service redesign or resource allocation are at stake. They should also expect regular, structured assurance that the Trust complies with the law and national expectations.

The assurance table below is designed to help the Board ensure that health inequalities are central to their work. It brings together statutory and regulatory requirements and translates them into clear assurance questions and provides a structure for evidence. This aims to move from fragmented reporting to a coherent, auditable approach to health inequalities governance.

Assurance on health inequalities is a collective responsibility of the Board, and the attention that it pays to it is a test of whether a board truly understands its role. Every board member has a duty to understand the requirements, ask the right questions, and ensure the organisation meets its obligations. It is a matter of compliance and assurance, not the delivery of a clinical service or the provision of professional advice.

The Director of Strategy is a named executive with overarching leadership ensuring that relevant considerations are reflected in strategy, operational planning, workforce and finance.

As part of our approach to ensuring the Trust is discharging its responsibilities, we will use the NHS Alliance (previously NHS Providers) self-assessment tool to provide the Board with further assurance on our health inequalities approach. The tool contains 25 questions in four domains. The output of the assessment is a report with suggested areas for development. This will be reported to the Board in October.

3. Recommendation

The Board are asked to note the assurance table and the work being undertaken to address requirements relating to health inequalities and to note that this will be updated and presented on a 6 monthly basis to show ongoing progress and to note the plan to complete the NHS Alliance self-assessment that will be reported to the Board in October.

No.	Legal/Regulatory Source	Assurance Question	Evidence (Examples)
1	<p>NHS Act 2006 (as amended by the Health and Care Act 2022) – Section s63A</p> <p>NHS Foundation Trust Provider Licence WS2 – ‘The Triple Aim’</p>	<p>Is the Trust reducing inequalities in access, experience and outcomes?</p>	<p>The Trust is taking action to reduce inequalities through:</p> <ul style="list-style-type: none"> • The Christie Strategy (2023 – 2028) which focuses on providing care closer to home (local and specialist) – opening of Christie @ centres in Oldham, Salford & Macclesfield plans for a Neighbourhood Oncology Centre at Leighton and Neighbourhood Oncology. • Development of chemotherapy services at 14 locations in GM and Cheshire providing local access alongside chemotherapy at home. • Development of ‘Bloods Closer to Home’ services across GM and Cheshire. • Within Education, clear Institute leadership and specialist staff focused on inequalities / EDI • Research access and participation dashboards <p>The Trust’s Provider Capability Assessment rating (Green) confirms the organisation is meeting the conditions of the Provider Licence.</p>
2	<p>Equality Act 2010 – Section 149 (PSED)</p>	<p>Is the Trust fulfilling the PSED, including equality analysis and public reporting?</p>	<p>The Trust continues to fulfil its duties under the Equality Act 2010; as evidenced through</p> <ul style="list-style-type: none"> • 2025 EDI Annual Report • 2025 EDA submission • 2026 Gender Pay Gap Report • WRES & WDES Action Plan 2025-2026 • Inclusive Culture Strategy 2025-2030
3	<p>Health and Care Act 2022 – Duties on Integrated Care Boards and partner Trusts</p> <p>Provider Licence WS1 - Cooperation</p>	<p>Is the Trust working effectively with commissioners (ICB, specialised commissioning, regional teams) to reduce inequalities?</p>	<p>The Trust continues to work with system partners to address inequalities in cancer care. The Cancer Alliance, which is hosted by The Christie, has developed a GM-Tackling-Inequalities-in-Cancer-Strategy to which the Trust is signed up.</p> <p>The Trust participates in work with regional/national education partners to address inequalities (e.g. Digital Clinical Placements, community focused Education / GatewayC)</p>

No.	Legal/Regulatory Source	Assurance Question	Evidence (Examples)
			The Trust's Provider Capability Assessment rating (Green) confirms the organisation is meeting the conditions of the Provider Licence.
4	NHS England Core20PLUS5 Framework	Has the Trust identified Core20 and PLUS groups and delivered actions across the five priority areas?	<p>Early diagnosis is one of the 5 areas identified for accelerated improvement within the Core20PLUS5 model. Through its work with partners on, for example, lung screening the Trust contributes to this area. It does not directly provide screening / early diagnosis services.</p> <p>Through our Cancer and Exclusion series we work with groups/communities who are excluded, including people experiencing homelessness, those in contact with the criminal justice system, sex workers, people with disabilities, the Gypsy, Roma and Traveller community, and people who may be socially excluded.</p>
5	NHS England Operational Planning and Delivery Guidance	Is the Trust monitoring and addressing inequality in access, waiting times, and outcomes?	The Trust monitors information related to inequalities through the Integrated Performance, Quality & Finance Report submitted to the Board and Board Assurance Committees. This includes segmentation of those patients on a 62-day pathway by ethnicity / deprivation.
6	NHS England Planning Guidance – Digital inclusion	Has the Trust identified digitally excluded groups and put alternative access routes in place?	<p>Information is being supplied to patients on a 'digital first' basis however where necessary hard copy information is available to patients. Individual assessments are undertaken to ensure patients receive information as requested.</p> <p>The Trust has worked to ensure it meets the requirements contained in the Accessible Information Standard.</p> <p>Within Education: education on digital exclusion for Educators, supervisors, and support for students and the workforce who may be experiencing digital exclusion; Institute learner support service offers advice/consultation</p>
7	NHS England Corporate Governance Framework and CQC Single Assessment Framework (Well-Led)	Does the BAF contain a clearly defined inequality risk with appropriate controls and assurances?	<p>The Board Assurance Framework (Risk 12) considers how we ensure effective staff engagement. Using the established controls, we take a sensitive and appropriate approach to that engagement recognising the diversity of our workforce.</p> <p>Assurance is provided through the Board Assurance Committee structure and external assessment such as the Annual Staff Survey.</p>

No.	Legal/Regulatory Source	Assurance Question	Evidence (Examples)
8	Equality Act 2010 (PSED) and NHS England Equality & Health Inequalities Impact Assessment Guidance	Are EQIAs/EHIAs consistently completed and used to inform decisions?	EQIAs are required for all business cases, each value improvement programme and policy development. Education: EHIA process is embedded, and we have developed a robust product development process, to ensure all new education developed within the state is evidence-based/meets the needs of learners and centres' equity.
9	NHS England Planning Guidance	Does the Trust and the operating divisions have clear objectives to reduce inequalities, and is progress monitored?	The Trust's 5-year Integrated Delivery Plan makes explicit reference to reducing inequalities in access, experience and outcomes. Our Neighbourhood Oncology approach is being designed to address inequalities. Deployment of the 5-year plan objectives across the organisation has taken place as part of the planning process.
10	NHS England Core20PLUS5 Framework	Are targeted interventions in place for high-need groups, with evidence of impact?	The Trust contributes to a number of targeted interventions to address inequalities, for example, support to Lung Health Check programme roll out, the development of the Senior Adult Oncology service. Within Education the Trust has launched the 'Cancer by exclusion' series and 'Experts by Experience' model to support targeted, accessible interventions. There have been high levels of engagement with exclusion series within the ICS and nationally. The Gateway C national education programme for community/primary care has high levels of engagement and emerging evidence of impact on practice in this area.
11	NHS Standard Contract; Data Quality Maturity Model; Equality Act 2010	Is ethnicity, deprivation, disability and language data recorded with sufficient completeness and quality?	Data collection is undertaken. It is recognised that both the completeness and quality require improvement and an action plan is in place.
12	NHS England "Anchor Institutions" Framework and the NHS Long Term Plan	Is the Trust acting as an anchor institution supporting local employment, social value and community wellbeing?	The Trust demonstrates its role as an anchor institution by actively supporting local employment and community wellbeing through attendance at local recruitment fairs and partnerships with colleges and Jobcentre Plus. These activities promote inclusive access to jobs, develop local talent and maximise social value for the communities we serve.

No.	Legal/Regulatory Source	Assurance Question	Evidence (Examples)
			<p>Widening participation initiatives include supporting interns, Care leavers, People with disabilities, and young people seeking asylum.</p> <p>Community engagement: Place-based sessions in local hubs, co-produced education, and plans for paid community health ambassadors.</p>
13	NIHR Research Inclusion Strategy; NIHR Equality, Diversity and Inclusion Strategy (2022–2027)	Is the Trust ensuring equitable access to research opportunities and improving inclusion of under-served groups in clinical research?	<p>NIHR Research Inclusion Plans at study and portfolio level.</p> <p>Monitoring of recruitment by ethnicity, deprivation, age, sex, disability and underserved groups- current gap, will improve once we implement EDGE with NHS number for EDI monitoring.</p> <p>Use of NIHR INCLUDE guidance and under-served group frameworks.</p> <p>Research delivery metrics and dashboards (EDGE-enabled).</p>

Agenda item 13/26c

Meeting of Board of Directors

Thursday 30th April 2024

Subject / Title	Patient Voice, Involvement and Engagement Across Trust Governance
Author(s)	Vicky Sharples, Chief Nurse and Executive Director of Quality
Presented by	Vicky Sharples, Chief Nurse and Executive Director of Quality
Summary / purpose of paper	This paper provides assurance to the Board that The Christie has a comprehensive, embedded and effective approach to hearing the patient voice and involving patients, carers and communities throughout governance, quality improvement, safety, service design and research. It demonstrates alignment with NHS England statutory guidance, the Patient Safety Incident Response Framework (PSIRF) and Care Quality Commission (CQC) Well-Led expectations, and describes how patient voice is visible, influential and drives improvement across the Trust.
Recommendation(s)	The Board of Directors is asked to note that patient and carer voice is systematically embedded across Board, committee and operational governance. The Trust's approach meets national expectations for working in partnership with people and communities. Robust mechanisms are in place to ensure patient insight influences decisions, safety learning and service improvement.
Background papers / source of assurance	Patient Experience Committee reports and minutes Quality Assurance Committee minutes Patient stories presented to the Board National Cancer Patient Experience Survey results Friends and Family Test reports Complaints and Patient Advice and Liaison Service (PALS) thematic analysis Patient Safety Incident Response Framework policy and learning summaries Internal accreditation outcomes (CODE and Quality Mark) Membership engagement and focus group summaries
EDI impact/ considerations	EDI considerations embedded patient voice and involvement activity has been developed with Equality, Diversity and Inclusion principles embedded from the outset, including: Proactive engagement with diverse communities and age-specific forums (for example, Teenage and Young Adult patients) Use of multiple engagement routes (in-person, online and community-based) Focus on understanding and addressing inequalities in access, experience and outcomes through lived experience
Link to:	Trust Strategy and Corporate Objectives: Supports delivery of compassionate, person-centred, high-quality cancer



	<p>care and system leadership.</p> <p>Board Assurance Framework: Indirect link / emerging risk – strengthens assurance against risks related to quality, safety, experience and reputation.</p> <p>NHS Oversight Framework: Domain: Quality of care and patient experience</p> <p>CQC Quality Standards: Well-Led, Caring, Responsive</p>
Risk score	BAF Risk 4 – compliance with regulatory standards
Acronyms or abbreviations where they appear in the attached paper.	<p>PSIRF – Patient Safety Incident Response Framework</p> <p>PALS – Patient Advice and Liaison Service</p> <p>EDI – Equality, Diversity and Inclusion</p> <p>CQC – Care Quality Commission</p>



Meeting of the Board of Directors

Thursday 30th April 2026

Patient Voice, Involvement and Engagement Across Trust Governance

Executive Summary

Context and background

National NHS England guidance and statutory duties require NHS Trusts to work in partnership with people and communities, embedding patient and carer voice within leadership, decision-making and assurance processes. For a specialist cancer Trust such as The Christie, meaningful involvement of patients and carers is essential to delivering safe, effective, compassionate and equitable care.

This paper is brought to the Board to provide assurance on the breadth, depth and impact of patient voice, involvement and engagement activity across the Trust.

Scope of the paper

The paper summarises:

- Formal patient feedback and assurance mechanisms
- In-person and online engagement activity
- Co-creation and patient involvement within governance structures
- Patient involvement in safety learning under PSIRF
- How patient insight informs Board and committee assurance

Key findings or insights

- The Christie has a multi-layered approach to patient voice, combining formal feedback, engagement activity and co-creation.
- Patient stories, national surveys, complaints, PALS and Patient Safety Partners provide robust qualitative and quantitative assurance.
- Engagement activity is routine, inclusive and continuous, rather than episodic.
- Patients and carers are increasingly involved in safety learning, service design and governance, not just feedback.
- Patient insight is visible within Board and committee discussions, supporting strong Well-Led outcomes.

Implications

- Strengthens Board assurance regarding quality, safety, experience and organisational culture.



- Supports compliance with NHS England guidance, PSIRF and CQC expectations.
- Enhances trust, transparency and system credibility.
- Reduces risk of disengagement, harm and unwarranted variation in experience.

Next steps or options

- Continue to embed patient voice within governance and assurance reporting.
- Strengthen feedback loops.
- Use lived experience further to address health inequalities and inform transformation.
- Maintain oversight through Quality Assurance Committee and Board reporting.

Recommendation

The Board of Directors is asked to note that patient and carer voice is heard, seen and acted upon throughout governance at The Christie, providing confidence that decisions, learning and improvement are informed by lived experience.



Patient Voice, Involvement and Engagement at The Christie NHS Foundation Trust Purpose

1.0 Introduction

To provide the Board with assurance on the range, depth and impact of activity undertaken at The Christie to hear the patient voice and meaningfully involve patients, carers and communities in governance, quality improvement, safety, service design and research, in line with national NHS England guidance and CQC Well-Led expectations.

2.0 Background

The Christie has a comprehensive, multi-layered approach to patient voice, involvement and engagement. Activity spans formal assurance mechanisms, regular engagement activity (in-person and online), co-creation within governance structures, and compassionate involvement following patient safety incidents. Collectively, these approaches ensure patient and carer insight is visible, influential and embedded across Trust governance, rather than being treated as a standalone engagement function.

3.0 Mechanisms of patient voice and involvement

3.1. Formal Patient Feedback and Assurance Mechanisms

The Trust uses multiple formal feedback and assurance routes to ensure patient voice informs quality oversight and Board decision-making:

- Patient stories at Board, providing lived experience directly to the Trust's most senior decision-making forum.
- National surveys including National Cancer Patient Experience Survey and National Inpatient Survey.
- Friends and Family Test feedback, used to triangulate experience at service level.
- Patient Safety Partners, contributing insight and challenge within patient safety governance.
- PALS and Complaints, managed as key sources of organisational intelligence rather than solely responsive processes.
- Internal accreditation processes (CODE and Quality Mark), with direct involvement of patients and carers in assessing quality and experience.
- PSIRF implementation, which has increased compassionate engagement and involvement of patients, families and carers following safety incidents.

These mechanisms ensure that patients' insights and experience is systematically captured, analysed and acted upon.

3.2. In-Person Engagement Mechanisms

In-person engagement remains a core strength of The Christie's approach, enabling meaningful dialogue with patients, carers and communities.

Key activity includes:

- Executive and non-executive clinical area walk-rounds, providing direct visibility of patient experience and frontline feedback.



- Macmillan coffee mornings (including Macclesfield), supporting informal and accessible engagement.
- Annual cultural events, enabling inclusive engagement across diverse communities.
- Annual Members' Meetings, providing accountability to members and the public.
- Christie Neighbourhood Community Engagement Forum, supporting place-based and community-focused dialogue.
- Patient and Public Involvement and Engagement (PPIE) groups linked to research activity.
- Christie Patient-Centred Research initiatives, ensuring research priorities reflect patient need.
- Monthly Members' focus groups.
- Spotlight events, allowing members to engage directly with clinical and research teams.
- Post-treatment 'Living With and Beyond Cancer' events, focusing on longer-term outcomes and survivorship.
- PLACE assessments, incorporating patient perspectives on the care environment.

These mechanisms ensure patient engagement is routine, continuous and relationship-based, rather than limited to consultations.

3.3. Online Engagement and Digital Access

The Trust has developed accessible online routes to widen participation and reach patients who may be unable to engage in person:

- Monthly online focus groups.
- Condition-specific support such as melanoma mindfulness sessions.
- The Christie website as a route for individuals to become members and engage with Trust activity.

These approaches support inclusive engagement, particularly for patients managing long-term or complex care needs.

3.4. Maggie's Centre and Holistic Support Engagement

Working in partnership with Maggie's Centre, the Trust supports engagement and involvement across the cancer pathway:

- Pre-treatment engagement, supporting informed decision-making.
- Condition-specific support groups (including bowel and gynaecological cancer).
- Look Good Feel Better sessions, complementary therapies and wellbeing support.
- Arts rooms and therapeutic spaces supporting emotional and psychological wellbeing.

This strengthens patient voice by engaging with individuals beyond clinical treatment alone, reflecting what matters to patients and carers.

3.5. Co-Creation and Embedded Governance Involvement

Patient involvement at The Christie extends beyond feedback into co-creation and shared governance:

- Patient representation on the Patient Experience Committee, ensuring lived experience informs assurance discussions.
- Patient representation at the Supportive Oncology Board, influencing service development and priorities.



- Co-designed engagement between patients and staff in cytoreductive surgery pathways.
- Teenage and Young Adult (TYA) Patient Forum and Young Voices Network, ensuring age-appropriate and tailored involvement.
- Patient feedback shaping the design of ward refurbishments and ASIC building design.
- Engagement on Quality strategy and patient safety agenda via the governor patient safety and experience committee, attended by non-executives and chief nurse.
- Engagement on finance and planning agenda via the governor development and sustainability committee.
- Public engagement on Trust developments via the Neighbourhood forum, attended by Director of Finance and Head of estates and Facilities.

This approach demonstrates a shift from consultation to active partnership, aligned with national expectations for meaningful involvement.

3.6. Learning, Safety and Compassionate Engagement (PSIRF)

Under the Patient Safety Incident Response Framework (PSIRF), The Christie has strengthened its approach to compassionate engagement and involvement:

- Patients, families and carers are offered opportunities to share what matters to them following safety incidents.
- Their perspectives inform learning responses, improvement actions and assurance reporting.
- Governance oversight ensures learning from lived experience is translated into system improvement rather than blame.

This supports a just culture, enhances trust and strengthens the Board's assurance on safety and quality.

3.7. Board and Committee Assurance

Collectively, these activities ensure that:

- Patient voice is heard directly at Board level.
- Committees receive triangulated insight from experience data, complaints, engagement activity and safety learning.
- Governance discussions are informed by what matters to patients, not solely performance metrics.
- The Trust can demonstrate strong alignment with CQC Well-Led expectations and NHS England guidance on working in partnership with people and communities.

4.0. Conclusion

The Christie has a mature and embedded approach to hearing the patient voice and involving patients, carers and communities throughout governance, quality improvement, safety, service design and research. The breadth and depth of engagement activity, combined with formal assurance mechanisms and co-creation within governance structures, provides the Board with confidence that patient voice is visible, influential and driving improvement across the organisation.



5.0 Next steps

To further strengthen the visibility, coordination and impact of patient voice across the Trust, the following next steps are proposed:

- Establish a Trust-wide Patient Partnership and Co-creation Group to provide a coordinated and purposeful approach to patient and carer involvement, supporting co-creation across quality improvement, safety learning, service design and transformation.
- In the context of Advanced Foundation Trust status, this group will provide a clear, single mechanism for patient and public voice at Trust level, replacing the current Council of Governors while maintaining and strengthening meaningful patient and community influence over Trust decision-making.
- Ensure patient voice, experience and engagement continue to be systematically embedded within Board and committee decision-making, proportionate to the issue under consideration and explicitly reflected in assurance narratives.
- Maintain alignment with NHS England guidance on working in partnership with people and communities and Care Quality Commission Well-Led expectations, with regular review of effectiveness and impact to provide ongoing assurance to the Board.

6.0. Recommendation

The Board of Directors is asked to note that patient and carer voice is heard, seen and acted upon throughout governance at The Christie, providing confidence that decisions, learning and improvement are informed by lived experience.



**Meeting of the Board of Directors
 Thursday 30 April 2026**

Subject / Title	Workforce Assurance Committee report – March 2026
Author(s)	Jo D’Arcy, Assistant Company Secretary Amanda Oates, Committee Chair
Presented by	Amanda Oates, Committee Chair
Summary / purpose of paper (alert / advise / assure)	This paper provides the Board with a AAA summary of the items considered by the Workforce Assurance Committee at their March meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions required.
Background papers / sources of assurance	Workforce Assurance Committee papers – 19 March 2026
EDI impact / considerations	The report has a positive EDI impact. It outlines actions that support inclusive workforce culture, wellbeing, staff development and compliance with statutory equality duties. Continued monitoring through the EDI annual report, staff survey results, and workforce dashboard will ensure that any EDI risks are identified and addressed.
Link to: ➤ Board Assurance Framework ➤ Trust strategy ➤ Corporate objectives ➤ CQC Quality standard ➤ Regulation	<ul style="list-style-type: none"> • Board Assurance Framework – Risks 3, 4 and 12 • Corporate objective 4 - to be an excellent place to work and attract the best staff • CQC Regulations – 5, 9, 10, 12 and 18
Risk score	N/A
Acronyms or abbreviations that appear in the attached paper.	EDI – Equality, Diversity & Inclusion MIAA – Mersey Internal Audit Agency



**Meeting of the Board of Directors
 Thursday 30 April 2026**

Workforce Assurance Committee summary report – March 2026

1 Introduction

The committee took place on 19 March 2026. Quoracy met with 4 of 4 members present, including the Chair. All decisions are valid.

2 AAA summary from committee meeting

The summary in Appendix 1 gives the Board information on the items that were considered by the committee at their meeting and the key items agreed for reporting under the headings of Alert / Advise / Assure.

An assurance level was discussed and agreed for each item presented as an ‘assure’ item using the following criteria:

Strong	High	Medium	Low
Controls are suitably designed, being consistently applied and are effective in practice	Some issues identified that if not addressed, could increase the likelihood of the risk materialising	Some assurances in place or controls are still maturing so effectiveness cannot be fully assessed but should improve	Assurance indicates poor effectiveness of controls

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 summary report from the committee in March 2026.



Appendix 1

Staff Story - Christie @ Salford, presentation from Jemma Shardlow, Operational Manager Therapeutic Radiographer

The presentation provided an overview of the satellite radiotherapy centre and highlighted recent service developments, including the successful replacement of a linear accelerator in July 2024 and the increasing complexity of treatments offered. While this has enhanced staff skills, it has also resulted in longer treatment times and the operational challenges associated with the unpredictable nature of SRS. Workforce issues featured prominently, with low turnover among radiographers and ACPs but high turnover in the Band 2/3 group within a small staffing team. The robust training and induction approaches were outlined along with the ongoing support for staff development, succession planning needs within the ACP team, and efforts to improve retention through flexible working.

The presentation also covered staff morale and culture, noting strong team cohesion supported by wellbeing initiatives, team events, peer-led meetings and a mental health first aider. Areas for development included strengthening community engagement, improving communication on Trust-wide wellbeing offers, and increasing workforce diversity. The upcoming 15th anniversary was identified as an opportunity for greater Trust involvement. The committee commended the positive culture and proactive workforce planning and requested a future focus on succession planning for satellite centres.

Alert	Assurance rating (if applicable)	Action (to be taken)	By Whom	Target Date
No alerts to raise.				

Advise:	Assurance rating (if applicable)
Medical devices training audit – 3 out of 4 high risk recommendations have now been completed, final recommendation to be completed by July 2026. Medium and low risk recommendations all in progress and on track. Progress update to the committee scheduled for June 2026.	Medium
Role essential training – trust wide compliance now at 89.9% with daily reporting by staff group. Progress noted and further assurance update due to the committee in September 2026.	Medium

Assure:	BAF reference	CQC reference	Assurance rating
FPPT compliance - annual report on FPPT and CQC regulation shows adherence to the regulation.	4	5	Strong
Workforce dashboard – improvements noted in sickness absence, mandatory training, and vacancy rate reduction, time to hire remains strong (2nd in region)	3, 4 & 12	18	High
Reducing sickness absence – positive progress noted, though further detail on wellbeing interventions to come back to the committee in September 2026.	12	N/A	High
National training survey – all actions completed; ongoing monitoring embedded.	N/A	N/A	High

<u>Risks discussed (including any new risks identified):</u>
<ul style="list-style-type: none"> • Board assurance framework – risks 3 & 12: <ul style="list-style-type: none"> ○ Recruitment and retention - no change to score. ○ Staff engagement – staff survey 2025 results to come in June, will provide assurance on controls.



The following agenda items were also discussed during the meeting:

- Approval of previous minutes and a review of actions
- Director of Workforce report
- Resident Doctors - payroll accuracy report
- EDI annual report
- Freedom to Speak Up Guardian (FTSUG) annual review
- Resident doctors strategic oversight group quarterly report
- Committee effectiveness review – outcome report
- Committee Terms of Reference
- Committee annual report – draft
- Internal audit progress report and recommendation tracker update



Meeting of the Board of Directors

Thursday 30 April 2026

Subject / Title	Quality Assurance Committee report – March 2026
Author(s)	Jo D’Arcy, Assistant Company Secretary Sarah Corcoran, Committee Chair
Presented by	Sarah Corcoran, Committee Chair
Summary / purpose of paper (alert / advise / assure)	This paper provides the Board with a AAA summary of the items considered by the Quality Assurance Committee at their March meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions required.
Background papers / sources of assurance	Quality Assurance Committee papers – 25 March 2026
EDI impact / considerations	The report has a positive EDI impact, with a clear focus on safe, effective and equitable care, including oversight of access, patient safety, feedback, and learning, and strengthened use of EDI insight within complaints, incidents and patient experience reporting.
Link to: ➤ Board Assurance Framework ➤ Trust strategy ➤ Corporate objectives ➤ CQC Quality standard ➤ Regulation	<ul style="list-style-type: none"> • Board Assurance Framework – Risks 1, 2, 4 and 7 • Corporate objective 1 - To deliver safe, effective & equitable care • Corporate objective 3 - To provide integrated clinical, research and education services • Corporate objective 5 - To transform our services to improve access and reduce health inequalities • Corporate objective 6 - To provider leadership within the wider NHS cancer system • CQC Regulations – 9, 10, 12, 16 and 20
Risk score	N/A
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	EDI – Equality, Diversity & Inclusion MIAA – Mersey Internal Audit Agency PDR – Performance Development Review



**Meeting of the Board of Directors
 Thursday 30 April 2026**

Quality Assurance Committee summary report – March 2026

1 Introduction

The committee took place on 25 March 2026. Quoracy met with 5 of 5 members present, including the Chair. All decisions are valid.

2 AAA summary from committee meeting

The summary in Appendix 1 gives the Board information on the items that were considered by the committee at their meeting and the key items agreed for reporting under the headings of Alert / Advise / Assure.

An assurance level was discussed and agreed for each item presented as an ‘assure’ item using the following criteria:

Strong	High	Medium	Low
Controls are suitably designed, being consistently applied and are effective in practice	Some issues identified that if not addressed, could increase the likelihood of the risk materialising	Some assurances in place or controls are still maturing so effectiveness cannot be fully assessed but should improve	Assurance indicates poor effectiveness of controls

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 summary report from the committee in March 2026.



Appendix 1

Alert	Assurance rating (if applicable)	Action (to be taken)	By Whom	Target Date
Aseptic unit risk update - the committee was alerted to a low-assurance risk relating to the aseptic services unit supporting clinical trials, following a challenging 12-month period of external inspections that identified significant deficiencies, contamination issues and five major risks. Recommissioning of the main unit has been delayed due to contamination from adjacent building works and further findings during validation, compounded by senior staff sickness. While no patient harm or product contamination was identified, capacity for new clinical trials remains constrained, with reliance on a single isolator and limited external alternatives. Robust remedial actions, strengthened governance and PSIRF-based learning are in place, with plans to reopen at reduced capacity in mid-April; however, resilience and capacity risks remain until actions are completed and assurance improves.	Low	To report back to the committee in June with confirmation of the completion of actions (following regional inspectorate team giving feedback on the action plan): <ul style="list-style-type: none"> • Make safe actions to be completed. • Become fully operational in the main unit. 	Director of Pharmacy	24.06.2026
Lost to follow up progress update - the committee received a low-assurance update noting that weakened controls around appointment outcoming have increased risk and impacted patient processes, with 22 patients affected in the past six months. Immediate mitigations are in place, including additional booking capacity, weekly high-grip oversight, automated system flags and enhanced reporting; however, the risk remains until improvements are embedded and supported by planned automation and future EPR design.	Low	Further progress report due in June to support increased assurance.	Chief Operating Officer	24.06.2026

Advise:	Assurance rating (if applicable)
Risk management strategy 2024-27 update - MIAA review provided substantial assurance. Three actions identified as part of the review, one of which has been added to the rolling programme, with the remaining actions in the process of finalisation. Strategy to be presented to Board for approval.	High
Quality Strategy 2026-28 - the committee received and endorsed the final Quality Strategy, providing high assurance that it is clear, well-structured and aligned to the Trust's five-year Integrated Delivery Plan. The strategy sets out clear measures of success and will form the framework for future reporting, with plans in place to cascade and embed it across the organisation through a delivery and communications programme, supported by ongoing Committee oversight of progress and outcomes.	High



Assure:	BAF reference	CQC reference	Assurance rating
<p>Integrated governance assurance report - incident management continues to improve, complaint and incident volumes remain consistent. Learning from Friends & Family Test feedback is being enhanced, including improved data capture, clearer EDI insight and strengthened feedback loops to departments, with summary themes to be reported to a future meeting.</p>	1, 2, 4	9, 10, 12, 16, 20	Strong
<p>Performance against national Anti-Microbial Resistance (AMR) targets - report received in response to the NHSE “Act now: protect our present, secure our future” request. High assurance that the Trust’s AMR position is clinically appropriate for a specialist cancer centre. While overall antimicrobial usage is high, this is consistent with peer cancer centres and reflects the complexity of our immunocompromised patient population; compliance with prescribing standards is strong, supported by monthly audit, EPMA benefits and proactive governance oversight. Robust plans are in place for 2026/27 to respond to anticipated national targets, with clear arrangements for quarterly monitoring through clinical and IPC committees and annual reporting to the Board.</p>			High

<p><u>Risks discussed (including any new risks identified):</u></p> <ul style="list-style-type: none"> • Aseptic unit risk • Lost to follow up risk • Board Assurance Framework: <ul style="list-style-type: none"> ○ NICE risk score reduced to 6 following implementation of model of care. ○ PSIRF risk is a 9 – aligned to operational risk ○ 62 day risk remains at a 12 to reflect ongoing issues

The following agenda items were also discussed during the meeting:

- Approval of previous minutes and a review of actions
- Internal audit progress report and audit recommendation tracker
- Digital clinical safety assurance bi-annual report (medium assurance)
- Patient Safety Incident Response Framework (PSIRF) 6-monthly maturity assessment
- Board assurance framework (BAF) 2025/26
- Quality assurance committee – draft annual report
- Quality assurance committee effectiveness review – outcome report



**Board of Directors meeting
 Thursday 30th April 2026**

Subject / Title	Board Assurance Framework
Author(s)	Louise Westcott, Company Secretary
Presented by	Louise Westcott, Company Secretary
Summary / purpose of paper	This paper provides the Board with the Board Assurance Framework that summarises the risks to achievement of the strategic objectives. The cover paper gives detail of the updates.
Recommendation(s)	<ul style="list-style-type: none"> • To note the risks and controls relating to the strategic risks on the Board Assurance Framework, • To note that updates will be made to the risks that are the responsibility of the Board following discussion. • To scrutinise and review the assigned risks, controls and assurances and confirm any changes for Board approval.
Background papers	Board assurance framework. Strategic objectives 2025/26, operational plan and revenue and capital plan 2025/26.
Risk score	N/A
Link to: ➤ Trust strategy ➤ Strategic objectives	<ul style="list-style-type: none"> • 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



Board of Directors meeting
Thursday 30th April 2026

Board Assurance Framework

1 Introduction

The board assurance framework (BAF) is presented to each Board and assurance committee meeting. The risks identified in the framework relate to achievement of the strategic objectives.

2 Background

The Board Assessment Framework reflects the risks to achievement of the strategic objectives. These are regularly reviewed by the company secretary and executive directors.

3 Updates to risks

All risks in the framework have been reviewed to reflect the current position. Controls, gaps and assurances have been updated.

Q4 risk scores have been added for all risks.

5 Recommendation

The Board are asked;

- To note the risks and controls relating to the strategic risks on the Board Assurance Framework,
- To note that updates will be made to the risks that are the responsibility of the Board following discussion.
- To scrutinise and review the assigned risks, controls and assurances and confirm any changes for Board approval.



BOARD ASSURANCE FRAMEWORK - OVERVIEW OF RISKS

RISK No.	Risk Title	Risk Description	Responsible Committee	Risk Appetite	Inherent Risk Score	Q4 24/25	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	Target Risk Score	Current Risk Score	Review /Target date
RISK 10	Financial balance	If we do not achieve the operational plan and our planned efficiency savings there is a risk that we won't achieve financial balance on NHS activity.	Board of Directors	Averse	25		5	5	15	15	5	15	Achieved VIP 25/26 Current risk relates to VIP 26/27
RISK 15	Technological advancements	If we do not keep pace with technological advancements, there is a risk that we will not provide the best possible experience to our patients and carers	Board of Directors	Cautious	20		12	12	12	12	8	12	Reviewed Q4 25/26
RISK 7	Ineffective Greater Manchester system-wide cancer pathways	If diagnostic, MDT and referral processes at local hospitals across the GM system are not efficient there is a risk that we receive patients on 62-day pathways late leading to them not being treated within 62 days.	Quality Assurance Committee	Cautious	25		12	12	12	12	8	12	Reviewed Q3 25/26
RISK 4	Compliance with regulatory standards	If we do not continuously review our compliance with the regulatory standards and take corrective action where needed there is a risk that we will fall below required fundamental standards and quality of care will be reduced.	Board of Directors	Averse	15		12	12	12	12	4	12	Q1 26/27
RISK 13	Transformational capacity & capability	If we do not develop transformational capacity & capability, there is a risk that we will not transform services to improve access and reduce health inequalities	Board of Directors	Cautious	20		12	12	12	12	8	12	Reviewed Q4 25/26
RISK 14	Supply chain	If there are disruptions to the supply of essential products and services for the treatment and care of our patients, there is a risk of service disruption leading to delayed or cancelled care.	Audit Committee	Averse	12	9	9	9	9	12	3	12	Reviewed Q4 25/26
RISK 8	Emergency event	If there is a serious emergency event (pandemic/cyber-attack/extreme weather event etc) there is a risk of business disruption (increased staff absence, increased patient non-attendance and equipment malfunction) leading to delayed or cancelled care.	Audit Committee	Averse	20	12	10	10	10	10	5	10	Review Q3 25/26
RISK 2	Learning from patient safety incidents	If we do not follow the Patient Safety Incident Response Framework (PSIRF) there is a risk that we will miss opportunities to learn lessons and improve patient safety leading to preventable patient harm	Quality Assurance Committee	Averse	15		12	12	9	9	4	9	Q4 26/27
RISK 3	Recruitment and retention of skilled staff	If we are unable to maintain current levels of skilled staff there is a risk that they will not have the time or expertise required for excellent care and communication leading to a reduction in the standards of patient safety and experience.	Workforce Assurance Committee	Averse	20		9	9	9	9	6	9	Reviewed Q4 25/26
RISK 6	NHSE Financial Framework and support for growth	If the changes in the NHSE financial framework do not maintain the level of income needed to support the planned growth in activity there is a risk that we will not be able to provide optimum care	Board of Directors	Cautious	16		16	16	16	8	4	8	Reviewed Q2 25/26
RISK 12	Staff engagement	If we do not maintain levels of staff engagement there is a risk that turnover and sickness absence will increase leading to workforce shortages, poor staff experience and a deterioration in the quality of patient care.	Workforce Assurance Committee	Averse	16		8	8	8	8	4	8	Review June 26
RISK 9	Integrated research, education & service	If our research, education and clinical services do not operate as an integrated whole there is a risk that we will not secure the benefits of high-quality research and education on patient care and that this will lead to less-than-optimal quality of care.	Board of Directors	Averse	12	8	8	8	8	8	4	8	Reviewed Q4 25/26
RISK 1	New technologies and increased standards of care	If there are changes to NICE guidance or other advances in practice that we have not anticipated (diagnostic, therapeutic, care) there is a risk that there will be a delay in their introduction leading to a delay in patients obtaining the benefits of new treatments.	Quality Assurance Committee	Cautious	20	6	6	6	12	6	4	6	Review Q4 25/26
RISK 5	Capital funding	If we don't receive adequate CDEL there is a risk that we won't deliver the planned improvements resulting in delays in providing the best possible environment & equipment to provide care	Board of Directors	Eager	15		5	5	5	5	5	5	Reviewed Q3 25/26 / Within tolerance

RISK 1	New technologies and increased standards of care															Date Risk Opened	Current Risk Score	
Description	If there are changes to NICE guidance or other advances in practice that we have not anticipated (diagnostic, therapeutic, care) there is a risk that there will be a delay in their introduction leading to a delay in patients obtaining the benefits of new treatments.															Apr-24	6	
																Date of Last Review		
																Mar-26		
Associated Strategic Objectives	To deliver safe, effective & equitable care															Executive Lead	Exec Medical Director	
																Responsible Committee	Quality Assurance Committee	
																Assurance Level	Medium	
																Risk Appetite	Cautious	
Actions	Key Control established	Key Gaps in Controls	Assurance			Gaps in			Actions to address			Target date						
	Annual planning process with divisions. 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. Model for delivery of upcoming NICE guidance established and in place	Uncertainty around what / when. External factors. Issue with breast cancer treatment - scale of impact	Level 1 – Data and management reports • Review of NICE guidelines through risk-based process with divisional support • risk register in place. <input type="checkbox"/> Level 2 – Management team and committee scrutiny • Review NICE guidelines compliance through QAC and monthly IPQFR <input type="checkbox"/> Level 3 – External assurances • NICE <input type="checkbox"/>	None identified			None identified			Review Q4 25/26								
Scoring	Inherent Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	4	20	2	3	6	2	3	6	4	3	12	2	3	6	2	2	4

RISK 2	Learning from patient safety incidents															Date Risk Opened	Current Risk Score	
Description	If we do not follow the Patient Safety Incident Response Framework (PSIRF) there is a risk that we will miss opportunities to learn lessons and improve patient safety leading to preventable patient harm															Jun-25	9	
																Date of Last Review		
																Mar-26		
Associated Strategic Objectives	To deliver safe, effective & equitable care															Executive Lead	Exec Chief Nurse	
																Responsible Committee	Quality Assurance Committee	
																Assurance Level	Medium	
																Risk Appetite	Averse	
Actions	Key Control established	Key Gaps in Controls	Assurance			Gaps in			Actions to address			Target date for						
	The Trust has undertaken external training for the patient safety strategy covering all components of the patient safety strategy. The patient safety team have/ will continue to host training for incident handlers to ensure management of incidents across teams is standardised. Improvement workstreams have been established to implement recommendations following the publication of learning responses. Review through Patient Safety & Experience Committee and Risk & Quality Governance. Introduction of new DATIX system	New ways of working require new skills across the organisation and resource at a team level to manage incidents.	Level 1 – Data and management reports • PSIRF reports to Patient Safety Committee / Risk & Quality Governance / Senior Management Committee • ERG <input type="checkbox"/> Level 2 – Management team and committee scrutiny • Review compliance through patient safety reports to QAC <input type="checkbox"/> Level 3 – External assurances • MIAA review of PSIRF processes confirms substantial assurance • Updates presented to ICB • MIAA Health & Safety - substantial assurance	Embed quality improvement methodology across the Trust			Embed agreed Quality Improvement methodology across the Trust by Q4 26/27			Q4 26/27								
Scoring	Inherent Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	3	5	15	3	4	12	3	4	12	3	3	9	3	3	9	2	2	4

RISK 3	Recruitment and retention of skilled staff										Date Risk Opened	Current Risk Score						
Description	If we are unable to maintain current levels of skilled staff there is a risk that they will not have the time or expertise required for excellent care and communication leading to a reduction in the standards of patient safety and experience.										Apr-24	9						
											Date of Last Mar-26							
Associated Strategic Objectives	To deliver safe, effective & equitable care To deliver excellent financial and operational performance To be an excellent place to work and attract the best staff										Executive Lead	Workforce Director						
											Responsible Committee	Workforce Assurance Committee						
											Assurance Level	High						
											Risk Appetite	Averse						
Actions	Key Control established	Key Gaps in Controls	Assurance			Gaps in			Actions to address			Target date for						
	Staffing levels maintained through coordinated and risk based utilisation of bank and agency Christie People and Culture Plan 2023-26 Quarterly oversight of Trust wide vacancies and recruitment activity presented to the workforce committee & WAC Divisional oversight of recruitment activity and vacancies discussed at the monthly service review meetings Turnover analysis and 'next chapter' data presented and discussed six monthly at the workforce committee Robust sickness absence management and health and wellbeing offer Connect & reflect sessions in place for new starters within first 3 months of employment Weekly executive led vacancy management panel in place Recruitment of onboarding coordinator Nursing workforce lead appointed Completion and reporting to WAC of progress against the 10 point plan to improve resident doctors lives.	National staff shortages impacting recruitment.	Level 1 – Data and management reports • Divisional oversight of recruitment through Service & Operational Review meetings Level 2 – Management team and committee scrutiny • Review compliance through WAC People & Culture plan updates and update on compliance with CQC regulation • F&PP Compliance report to WAC / Board • Safe staffing 6 monthly reviews to external standard Level 3 – External assurances • National staff survey • CQC Inpatient survey • OECl accreditation • MIAA Bank & Admin audit - Moderate assurance	None identified	None identified	Reviewed Q4 25/26												
Scoring	Inherent Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	5	20	3	3	9	3	3	9	3	3	9	3	3	9	2	3	6

RISK 4	Compliance with regulatory standards										Date Risk Opened	Current Risk Score						
Description	If we do not continuously review our compliance with the regulatory standards and take corrective action where needed there is a risk that we will fall below required fundamental standards and quality of care will be reduced.										Jun-25	12						
											Date of Last Mar-26							
Associated Strategic Objectives	To deliver safe, effective & equitable care To deliver excellent financial and operational performance To be an excellent place to work and attract the best staff										Executive Lead	Exec Chief Nurse						
											Responsible Committee	Board of Directors						
											Assurance Level	Medium						
											Risk Appetite	Averse						
Actions	Key Control established	Key Gaps in Controls	Assurance			Gaps in			Actions to address			Target date for						
	Self assessments underway against 2022 must do actions and well-led quality indicators. Attendance at CQC briefings / NHS Providers briefings Engagement in national updates and regulatory briefings. Designated leads for statutory requirements across the Trust reporting into committee structure. Policies and procedures in place e.g. conflicts of interest, SFIs, Document ratification processes. Membership of NHS Providers to receive most up to date advice and guidance. Exec Team engagement in national briefings. Close working with regulators, GM ICS / ICB and NHSE. Attendance at system level and national meetings. Leads identified internally for each statutory requirement e.g. health & safety / IRMER / CQC etc Excellence in action programme underway.	External political factors	Level 1 – Data and management reports • Self assessment against 2022 Must Do's • Self assessment against Well Led / Safety quality indicators Level 2 – Management team and committee scrutiny • QAC /WAC review of CQC regulations - all on rolling programmes • Board level training on new CQC assessment framework Feb 24 • Board reporting on regulatory changes • Work of the 3 assurance committees • Board capability self-assessment Level 3 – External assurances • CQC Inspection Reports (IR(M)ER) • NOF Rating 1 (Q1 rated 3/134 acute & specialist trusts) • MIAA role specific training audit (CQC Reg 19) - Limited assurance Oct 24 • MIAA data quality audit Oct 24 - moderate assurance • OECl accreditation • MIAA Medical devices Training - limited assurance • MIAA Key Financial systems - substantial assurance • MIAA Health & Safety - substantial assurance	External well-led review (underway, will report Q1 26/27)	Plan in development for full review of all domains (1 per quarter) Actions relating to role specific training data reporting and compliance - reporting to WAC March 26	Q1 26/27												
Scoring	Inherent Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	3	15	4	3	12	4	3	12	4	3	12	4	3	12	4	1	4

RISK 5	Capital funding										Date Risk Opened	Current Risk Score						
Description	If we don't receive adequate CDEL there is a risk that we won't deliver the planned improvements resulting in delays in providing the best possible environment & equipment to provide care										Jun-25	5						
											Date of Last Mar-26							
Associated Strategic Objectives	To deliver excellent financial and operational performance										Executive Lead	Exec Director of Finance						
											Responsible	Board of Directors						
											Assurance Level	High						
											Risk Appetite	Eager						
Actions	Key Control established	Key Gaps in Controls			Assurance			Gaps in		Actions to address		Target date for						
	Financial planning includes utilisation of 'capital freedoms' (CDEL) to increase the CDEL allocation to deliver our plan. Capital planning is part of our planning process and based on risk assessment within divisions. NHSE rules for 26/27 allow greater freedom with CDEL / capital spend	National / local funding rules / arrangements.			Level 1 – Data and management reports • Monthly finance reports Level 2 – Management team and committee scrutiny • summary of progress with capital plan/strategy implementation at Board / Planning Days • Regular reporting to Senior Management Committee & Board of Directors Level 3 – External assurances • ICB allocation - maximum capital freedoms			None identified		None identified		Reviewed Q3 25/26 / Within tolerance						
Scoring	Inherent Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	3	5	15	1	5	5	1	5	5	1	5	5	1	5	5	1	5	5

RISK 6	NHSE Financial Framework and support for growth										Date Risk Opened	Current Risk Score						
Description	If the changes in the NHSE financial framework do not maintain the level of income needed to support the planned growth in activity there is a risk that we will not be able to provide optimum care										Jun-25	8						
											Date of Last Mar-26							
Associated Strategic Objectives	To deliver excellent financial and operational performance										Executive Lead	Exec Director of Finance						
											Responsible	Board of Directors						
											Assurance Level	High						
											Risk Appetite	Cautious						
Actions	Key Control established	Key Gaps in Controls			Assurance			Gaps in		Actions to address		Target date for						
	Senior team attendance at national and regional meetings to keep updated on policy changes and influence discussions on cancer. Monthly service & operational reviews to ensure efficient delivery of service. Board member attendance at national events to influence policy. 2026/27 contract signed	External political factors			Level 1 – Data and management reports • SOR's • Divisional Boards reports Level 2 – Management team and committee scrutiny • SMC reporting Level 3 – External assurances • External Audit VfM assessment • Signed contract for 26/27 in line with activity • MIAA Key Financial systems - substantial assurance			None identified		Continued attendance at regional & national events and on going discussions with ICB to understand funding		Reviewed Q2 25/26						
Scoring	Inherent Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	4	16	4	4	16	4	4	16	4	4	16	2	4	8	1	4	4

RISK 7	Ineffective Greater Manchester system-wide cancer pathways										Date Risk Opened	Current Risk Score						
Description	If diagnostic, MDT and referral processes at local hospitals across the GM system are not efficient there is a risk that we receive patients on 62-day pathways late leading to them not being treated within 62 days.										Apr-24	12						
											Date of Last Mar-26							
Associated Strategic Objectives	To deliver safe, effective & equitable care To deliver excellent financial and operational performance										Executive Lead	Chief Operating Officer						
											Responsible	Quality Assurance						
											Assurance Level	Medium						
											Risk Appetite	Cautious						
Actions	Key Control established	Key Gaps in Controls			Assurance			Gaps in		Actions to address		Target date for						
	Executive led monthly divisional performance review meetings. Integrated performance & quality report to Management Board and Board of Directors monthly. Weekly performance reporting via trust operational group. Escalation internally & across GM of delays impacting waiting time targets. Monitoring cancer waiting time standards through GM Cancer & IPQFR.	NHS pressures leading to delays in referrals from other Trusts			Level 1 – Data and management reports • 62 / 31 / 24 day reports to Senior Management Committee and Board • Service & Operational Review feedback Level 2 – Management team and committee scrutiny • 6 monthly review by QAC Level 3 – External assurances • MIAA review of 62 days / Cancer Alliance			Evidence of progress in underperforming parts of the pathway		Pathway improvement workstream in GM Cancer - reporting on progress 6 monthly to QAC		Reviewed Q3 25/26						
Scoring	Inherent Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	5	25	4	3	12	4	3	12	4	3	12	4	3	12	4	2	8

RISK 8	Emergency event					Date Risk Opened		Current Risk Score										
Description	If there is a serious emergency event (pandemic/cyber-attack/extreme weather event etc) there is a risk of business disruption (increased staff absence, increased patient non-attendance and equipment malfunction) leading to delayed or cancelled care.					Apr-24	10											
						Date of Last												
						Mar-26												
Associated Strategic Objectives	To maintain excellent operational, quality and financial performance.					Executive Lead	Chief Operating Officer											
						Responsible	Audit Committee											
						Assurance Level	Medium											
						Risk Appetite	Averse											
Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for												
	No ability to reduce likelihood as an organisation, however we do have an Annual Assurance process that is externally reviewed to develop our Statement of Compliance Adaptations to existing buildings / equipment to manage temperature rises. GM approach. Business Continuity Plans (BCP) - regularly tested and reviewed Extreme weather plan approved & published on intranet Data Security and Protection Toolkit submissions with audits undertaken. Digital board reporting. Board level Senior Information Risk Owner in place. Reviews of risk registers, alerts, reports, actions and observations MIAA audit - Data Protection Toolkit (DPST) 2024/25 approaching standards (new assessment) - improvement plan submitted to NHSE, actions completed (pending MIAA audit review) - report to July Audit Committee.	The Trust does not currently have cyber security insurance.	Level 1 – Data and management reports • SDMP compliance • BCP compliance and effectiveness • Approved Extreme weather plan • Regular updates from NHS Digital - Vulnerability Monitoring Service Level 2 – Management team and committee scrutiny • Emergency Planning & Resilience Committee - reporting of regular testing of BCP's • Quarterly Net Zero and Climate Adaptation Committee (NZACAC) advises Executive Director • Annual SDMP report to MB and BoD (Assurance Scrutiny by Quality Assurance Committee) • Statutory disclosures in Trust Annual Report • Reports to Senior Management Committee and Audit Committee • Annual Assurance Report and Statement of Compliance- substantial compliance Level 3 – External assurances • Internal audit of compliance with NHS requirements • NHSE review of plans and progress - agreement of current compliance (as in self-assessment) • MIAA Data Protection Toolkit assessment (DPST) - Substantial assurance July 2024 / approaching standards for 2024/5 (new assessment)	Not at 100% compliance for self-assessment / external assessment	Developing methodology to assess carbon footprint in collaboration with other Trusts Developing a CC Adaptation plan in development for future developments	Review Q3 25/26												
Scoring	Inherent Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	4	20	5	2	10	5	2	10	5	2	10	5	2	10	5	1	5

RISK 9	Integrated research, education & service					Date Risk Opened		Current Risk Score										
Description	If our research, education and clinical services do not operate as an integrated whole there is a risk that we will not secure the benefits of high-quality research and education on patient care and that this will lead to less-than-optimal quality of care.					Jun-25	8											
						Date of Last												
						Mar-26												
Associated Strategic Objectives	To provide integrated clinical, research and education services					Executive Lead	Chief Executive Officer											
						Responsible	Board of Directors											
						Assurance Level	High											
						Risk Appetite	Averse											
Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion											
	Research / Education / CODU plans all approved and being monitored through divisional boards and SMC OECE accreditation achieved and reported to Board Business case for expansion of CRF approved at January 2026 Board. Well-led review undertaken to assure on governance		Level 1 – Data and management reports • Divisional Board reports Level 2 – Management team and committee scrutiny • Regular reports on progress to Board and assurance committees Level 3 – External assurances • OECE accreditation	None identified	None identified		Reviewed Q4 25/26											
Scoring	Inherent Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	3	4	12	2	4	8	2	4	8	2	4	8	2	4	8	1	4	4

RISK 10	Financial balance																	Date Risk Opened Apr-24	Current Risk Score
Description	If we do not achieve the operational plan and our planned efficiency savings there is a risk that we won't achieve financial balance on NHS activity.																Date of Last Mar-26	15	
Associated Strategic Objectives	To maintain excellent operational, quality and financial performance.																Executive Lead Responsible	Exec Director of Finance Board of Directors	
																	Assurance Level Risk Appetite	High Averse	
	Key Control established	Key Gaps in Controls	Assurance			Gaps in			Actions to address			Target date for							
Actions	Activity plans agreed with Divisions and progress monitored weekly at TOG and monthly at Senior Management Committee. Variable income performance tracked as part of month end financial position and reviewed in the clinical Divisions monthly financial meetings. 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. Agreed governance of VIP schemes and escalating VIP reporting and responsibility to SMC. VIP delivery at a divisional level monitored via the Trusts Service Operational Review framework Board has received monthly financial report showing performance 2025/26 VIP achieved from month 6 - focus on 2026/27 Prices locked in for gas / electricity prior to escalations in Middle East resulting in control of price for 80% of power requirement.	Commissioning intentions. Funding growth. Impact of cost increases (power/medicines etc) as a result of global factors (war in Middle East)	Level 1 – Data and management reports • Monthly Divisional scrutiny of financial position • Trust Operation Group (TOG) review weekly Level 2 – Management team and committee scrutiny • Reports to Senior Management Committee, Audit Committee and Board of Directors Level 3 – External assurances • MIAA review of financial systems • External audit of Annual Accounts • MIAA review of VIP programme • MIAA Key Financial systems - substantial assurance			None identified			Complete Quality Impact Assessments for all identified schemes as they arise			Achieved VIP 25/26 Current risk relates to VIP 26/27							
Scoring	Inherent Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk			
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	
	5	5	25	1	5	5	1	5	5	3	5	15	3	5	15	1	5	5	

RISK 12	Staff engagement																	Date Risk Opened Jun-25	Current Risk Score
Description	If we do not maintain levels of staff engagement there is a risk that turnover and sickness absence will increase leading to workforce shortages, poor staff experience and a deterioration in the quality of patient care.																Date of Last Mar-26	8	
Associated Strategic Objectives	To be an excellent place to work and attract the best staff																Executive Lead Responsible	Director of Workforce Workforce Assurance	
																	Assurance Level Risk Appetite	Medium Averse	
	Key Control established	Key Gaps in Controls	Assurance			Gaps in			Actions to address			Target date for							
Actions	Inclusive Culture Strategy developed through extensive engagement with staff and approved by Board. Board responsibilities outlined. Service & Operational reviews include 'people & culture' focus for all divisions. Progress reports to WAC. Divisions report staff engagement activity / priorities to Workforce Committee on rolling programme Workforce Assurance committee receive regular presentations from divisions on cultural activities. Strategic Leaders Forum - scheduled across the year Divisional plans in place for events and meetings across the year	None identified	Level 1 – Data and management reports • Divisional action plans from staff survey • Service & operational reviews Level 2 – Management team and committee scrutiny • Reporting to Workforce Committee, Workforce Assurance Committee and Board of Directors • Board development session on Inclusive Culture facilitated by NHS Providers expert Sept 2024 • Board approved Inclusive Culture Plan Nov 2024 Level 3 – External assurances • Annual CQC Staff Survey 2024 / 2025			None identified			Implementation of next phase of People & Culture Plan - reporting to WAC June 2026			Review June 26							
Scoring	Inherent Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk			
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	
	4	4	16	2	4	8	2	4	8	2	4	8	2	4	8	2	2	4	

RISK 13	Transformational capacity & capability												Date Risk Opened	Current Risk Score				
Description	If we do not develop transformational capacity & capability, there is a risk that we will not transform services to improve access and reduce health inequalities												Jun-25	12				
													Date of Last Mar-26					
Associated Strategic Objectives	To transform our services to improve access and reduce health inequalities												Executive Lead	Dir of Future Christie				
													Responsible Committee	Board of Directors				
													Assurance Level	Medium				
													Risk Appetite	Cautious				
Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for												
	<p>Future Christie Director and Medical Director in place. Director of Transformation appointed. Service Planning day with senior leadership team. Communication plan with wider organisation commenced. Alignment of Digital & Transformation under Future Christie. Year 1 objectives on track for delivery - patient portal / expanded AI / EPR outline case / staff engagement Strategic projects scoped and resource described - use of commercial partner to provide short term resource where identified as necessary. Transformation Committee meeting weekly. External assessments commissioned for AFT application process - financial / Well-led / content of application</p>	None identified	<p>Level 1 – Data and management reports</p> <ul style="list-style-type: none"> • Exec review weekly <p>Level 2 – Management team and committee scrutiny</p> <ul style="list-style-type: none"> • Monthly to SMC and Board • Board approved EPR OBC • Transformation Committee reporting <p>Level 3 – External assurances</p> <ul style="list-style-type: none"> • Deloitte engaged in options appraisal for new EPR • MIAA Key Financial systems - substantial assurance • PWC undertaking assessment of financial modelling • AuditOne Well-led review / assessment of AFT application 	External assessment of capability and readiness to be developed	Year 1 objectives on track for delivery - patient portal / expanded AI / EPR outline case / staff engagement	Reviewed Q4 25/26												
Scoring	Inherent Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	4	20	3	4	12	3	4	12	3	4	12	3	4	12	2	4	8

RISK 14	Supply chain												Date Risk Opened	Current Risk Score				
Description	If there are disruptions to the supply of essential products and services for the treatment and care of our patients, there is a risk of service disruption leading to delayed or cancelled care.												Nov-24	12				
													Date of Last Mar-26					
Associated Strategic Objectives	To deliver safe, effective & equitable care To deliver excellent financial and operational performance												Executive Lead	Chief Operating Officer				
													Responsible Committee	Audit Committee				
													Assurance Level	Medium				
													Risk Appetite	Averse				
Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for												
	<p>Pharmacy - TCP procurement team work closely with regional & national drug procurement teams. Mutual aid MOU in place in NW. Management with clinicians to avoid impact on care</p> <p>Medical Physics - close relationship with national supply chains and management of demand based on availability of radioactive materials. BCP in place for Radiopharmacy to maintain supplies and regular discussions with supplier of FDG for the PETCT scanner.</p> <p>Procurement - policies & processes in place for management of supplies incl escalations & triggers / communication.</p>	National / international shortages / supply issues - may result in price increases	<p>Level 1 – Data and management reports</p> <ul style="list-style-type: none"> • Regular reports to relevant committee • Monitoring & review by management team <p>Level 2 – Management team and committee scrutiny</p> <ul style="list-style-type: none"> • Reports to The Christie Pharmacy Company Board and Audit Committee, via Trust Drug & Therapeutics Committee • Escalations from Risk & Quality Governance to Senior Management Committee <p>Level 3 – External assurances</p> <ul style="list-style-type: none"> • MIAA audits commissioned to review specific issues where appropriate 	None identified	<p>Continuous review of alerts</p> <p>March 2026 - Comprehensive review undertaken of all aspects of supply chain risk in the context of escalated conflict in the Middle East</p>	Reviewed Q4 25/26												
Scoring	Inherent Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	3	4	12	3	3	9	3	3	9	3	3	9	4	3	12	3	1	3

RISK 15	Technological advancements										Date Risk			Current Risk Score							
Description	If we do not keep pace with technological advancements, there is a risk that we will not provide the best possible experience to our patients and carers										Jun-25			12							
											Date of Last Mar-26										
Associated Strategic Objectives	To transform our services to improve access and reduce health inequalities										Executive Lead			Dir of Future Christie							
											Responsible Committee			Board of Directors							
											Assurance Level			Medium							
										Risk Appetite			Cautious								
Actions	Key Control established			Key Gaps in Controls			Assurance			Gaps in			Actions to address			Target date for					
	Future Christie team leading service change ambitions incorporating technological advances with partners. Engaging with other health providers around effective systems on the market. Development of strategic outline case for new EPR Year 1 objectives on track for delivery - patient portal / expanded AI / EPR outline case / staff engagement			Recognition of fast moving market			Level 1 – Data and management reports • reports to Board of Directors Level 2 – Management team and committee scrutiny • Execs, SMC and Board reports Level 3 – External assurances • Deloitte engaged in options appraisal for new EPR • OECl accreditation			Development of full business cases			EPR business case to Board July 2026. Seeking expertise internally & externally around best option - 'expert customer'			Reviewed Q4 25/26					
Scoring	Inherent Risk						Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L		I		Score		L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5		4		20		3	4	12	3	4	12	3	4	12	3	4	12	2	4	8

Meeting of the Board of Directors
Thursday 30th April 2026

Subject / Title	Register of matters approved by the board – 1 st April 2025 to 31 st March 2026
Author(s)	Company secretary
Presented by	Chief Executive
Summary / purpose of paper	For the board of directors to note the matters approved by the board from 1 st April 2025 to 31 st March 2026
Recommendation(s)	For the board to note
Background Papers	Complete register from April 2007 (available to directors on request from the company secretary)
Risk Score	n/a
Link to: ➤ Trust's Strategic Direction ➤ Corporate Objectives	Corporate 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.	GDPR General Date Protection Requirement GM Greater Manchester CQC care quality commission



Register of matters approved by the board of directors in public– 1st April 2025 to 31st March 2026

Item	Date of meeting	Agenda item	Subject	Remarks/ Follow up
279	24.04.2025	15/25a	Modern Slavery statement	Approved
280	24.04.2025	15/25c	Standing Financial Instructions (SFI's)	Approved
281	24.04.2025	18/25d	NHS Provider License conditions: self-certification declarations	Approved
282	24.04.2025	18/25e	Trust proposal of nomination of FT Trustee to Christie Charity Board – Joe Rafferty	Approved
283	26.06.2025	22/25a	Strategic & annual objectives 2025/26, draft BAF and risk appetite statement	Approved
284	26.06.2025	24/25c	Annual compliance with the CQC requirements	Approved
285	26.06.2025	24/25d	Annual report and accounts 2024/25 (approved at joint assurance committee)	Approval noted
286	25.09.2025	29/25c	Board capability self-assessment	Approved
287	25.09.2025	29/25d	Board assessment statement on Winter Planning	Approved
288	23.10.2025	33/25c	Board endorsed programme priorities for the next quarter, including AVT deployment, EPR business case completion, and JAC Phase 1 implementation.	Endorsed
			Board supported continued integration of data strategy & EPR planning as enablers for an intelligent hospital model.	Supported
289	23.10.2025	35/25c	EPRR Compliance statement	Approved
290	29.01.2026	03/26b	Board delegated authority to the Chief Executive and Executive Director of Finance to submit a compliant plan pending agreement of income with commissioners	Delegated authority
291	26.03.2026	09/26c	Annual reporting cycle 2026/27	Approved
292	26.03.2026	09/26d	Code of Conduct for Directors and Employees	Approved
293	26.03.2026	09/26e	Fit & Proper Persons Test Policy	Approved
294	26.03.2026	09/26f	Fit & Proper Persons Test Compliance report	Approved



**Meeting of the Board of Directors
Thursday 30th April 2025**

Subject / Title	NHS Improvement self-certification declarations
Author(s)	Company Secretary
Presented by	Chief Executive
Summary / purpose of paper	<p>NHS foundations trusts are required to undertake the following self-certification declarations:</p> <ul style="list-style-type: none"> • 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



Meeting of the Board of Directors
Thursday 30th April 2025

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)



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. Please Respond

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. Please Respond


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 achieved NHS Oversight Framework rating of 1 for finance and use of resources and achieved our NHSE control total, ranking for NHS Acute & Specialist Trusts - Q1 3rd, Q2 7th, Q3 3rd. Overall capability rating assessed as 'Green' for 2025/26

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 Joe Rafferty

Capacity Chief Executive

Capacity Chair

Date 30 April 2026

Date 30 April 2026

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

N/A


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 risks identified
2 The Board has regard to such guidance on good corporate governance as may be issued by NHS England from time to time	Confirmed	No material risks identified
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 committees 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. MIAA have conducted their internal audits according to the agreed plan and recommendations agreed and being implemented. These have all been reviewed through the committee structure. In year we asked Audit One to undertake a Well-led review and actions will be agreed on receipt of the report.
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 (5 x Quality Assurance, 5 x Workforce Assurance and 5 x Audit) in line with the trust's constitution. The board receives and approves the Annual Plan and receives regular 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 senior management committee meetings, attended by senior clinicians and managers, which in turn feeds into the board of directors. In regard to the NHS Oversight Framework our finance and use of resources score has again been rated as 1. The overall Head of Internal Audit opinion for the period 1st April 2025 to 31st March 2026 provides Substantial Assurance, that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.
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 compliance 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 CQC. NHS Oversight Framework - we have 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). Board's direct engagement with patients through visits and patient/clinician presentations at Board meetings.
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.

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 Joe Rafferty

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

Worksheet "Training of governors"

Financial Year to which self-certification relates

2025/26

Please Respond

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

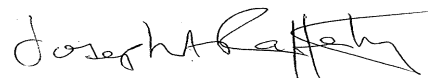


Name Roger Spencer

Capacity Chief Executive Officer

Date 30 April 2026

Signature



Name Joe Rafferty

Capacity Chairman

Date 30 April 2026