The Christie
NHS Foundation Trust

Board of Directors meeting
Thursday 27th June 2024 at 12.45 pm
Seminar Room 4/5, Education Centre

Agenda
Note – meeting is taking place under pre-election conditions

Patient story / clinical presentation: Lung Cancer Services at The Christie - Kathryn Banfill, Clinical Oncology Consultant, Rachael Wooder, Lead Dosimetrist Radiotherapy and Doug Fovargue, patient
30 - 40 mins

	Public items	**Decision**		**Lead**	**Page**	**Timing**
18/24	**Standard business**					
a	Apologies			Chair		
b	Declarations of interest			Chair		
c	Minutes of previous meeting – 25th April 2024		*	Chair	2	5 mins
d	Action plan rolling programme, action log & matters arising		*	CEO	9	
19/24	**Performance & finance**					
a	Trust report	Review	*	Execs	12	10 mins
b	Value Improvement Programme	Review	*	COO	21	10 mins
c	GM ICB presentation on undertakings	Review	*	CEO	28	10 mins
20/24	**Culture**					
a	Cultural development plan	Review	*	DCEO	39	5 mins
21/24	**Strategy**					
a	Green Plan	Approve	*	DCEO	42	2 mins
22/24	**Governance (regulatory / statutory compliance)**					
a	Board assurance framework	Review	*	CEO	68	5 mins
b	Annual report and accounts 2023/24	Approve	#	CEO		2 mins
c	Reports from Committees - Audit Committee April 2024	Review	*	Committee chair	75	10 mins
d	Annual update regarding CQC requirements	Approve	*	ECN	86	10 mins
e	Board effectiveness review outcome report 2023/24	Review	*	Chair	93	5 mins
f	Board skills mix matrix	Review	v	Chair		2 mins
23/24	**Any other business**					
	Papers for information only					
	Integrated performance, quality & finance report Month 2		*			
	Board allocation framework		*			
	Date and time of the next meeting					
	Thursday 26th September 2024 at 12:45pm					

D/CEO	Deputy / Chief Executive Officer	*	paper attached
ECN	Executive Chief Nurse	v	verbal
DoF	Director of Finance	p	presentation
DoE	Director of Education	#	separate pack
COO	Chief Operating Officer		

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NHS Foundation Trust

Public meeting of the Board of Directors
Thursday 25th April 2024 at 12.45 pm
Seminar Room 4/5, Education Centre

Present: Chair: Edward Astle (EA), Chairman
Roger Spencer (RS), Chief Executive Officer
Tarun Kapur (TK), Non-Executive Director
Robert Ainsworth (RA), Non-Executive Director
Alveena Malik (AM), Non-Executive Director
Grenville Page (GP), Non-Executive Director
Prof Kieran Walshe (KW), Non-Executive Director
Dr Diana Tait (DT), Non-Executive Director
Prof Chris Harrison (CJH), Deputy CEO
Theresa Plaiter (TP), Interim Chief Nurse
Sally Parkinson (SP), Executive Director of Finance
Dr Neil Bayman (NB), Executive Medical Director
Eve Lightfoot (EL), Director of Workforce
John Wareing (JW), Director of Strategy
Prof Rikki Goddard-Fuller (RGF), Director of Education
Prof Fiona Blackhall, Director of Research
Claire McPeake (CM), Interim Chief Operating Officer
Tom Thornber (TT), Director of Strategy

Minutes: Louise Westcott (LW), Company Secretary

In attendance: Jo D'Arcy, Assistant Company Secretary
Sarah Corcoran, newly appointed NED (start date 1st June)
Joanne Roberts, Lead Operational Nurse, Networked Services
Sue Mahjoob, Freedom to Speak Up Guardian
Linda Seddon, Public Governor

Clinical presentation: Haematology Ambulatory Care, Hanna Simpson, Clinical Nurse Specialist, Claudia a teenage & young adult (TYA) patient.

HS introduced herself and Claudia. Ambulatory Care was described as the effective and safe way to deliver treatment in line with the desires of the patient. It is both more cost effective as well as a far better patient experience. Toxicity, sleep and overall wellbeing is much better. Patients need to live within 1 hour of the Trust so they can come in if something goes wrong with the CADD pump that is delivering treatment. They come in for 20 minutes a day over about 5 days. For patients who live further away they stay at StayCity in Manchester.

Support is a requirement; they must have a mobile phone and there is access to a hot bed if there are any problems that require them to come in. In general, challenges can easily be resolved over the phone so use of the bed is low.

The impact of ambulatory treatment is around improved patient experience, cost, use of inpatient beds, education & training, patient risk, and pharmacy support. It is a streamlined experience and patient engagement is very good. There is significantly less requirement to come and sit in the hospital.

Board heard from an adult patient on the presentation who came through the model, he was in hospital for 3 weeks, he had kids and grandkids and didn't want to be admitted for the expected 6 weeks. He drove himself to treatment and that worked very well. He was very happy to be going home but was concerned his wife would need to care for him and he was worried about this. This was not an issue in the end as she was happy to be with him all the time.

Claudia introduced herself. She had a sarcoma, had proton beam therapy then chemotherapy. She said she didn't know about cancer treatment and the team were very reassuring about being at home. Her mum was worried about caring for her at home. She'd come for bloods then go round and get hooked up, would have overnight bag of fluids etc then go home. She would then come in the next day for the next bag then go again. Felt a bit surreal travelling with the bag etc, but she could sleep in the car. The best thing was being able to sleep in her own bed, have family around and her pet. It was much more pleasant.

HS outlined the hot bed usage which is low. The ratio is 1:5 beds to patients is appropriate based on usage. For the regimes delivered, some would have had 58 nights in a hospital bed. We have saved nearly 1000 bed nights. StayCity spend was also outlined showing a reduction in the cost over the 4 years. As confidence increases in the way we deliver treatment, we are spending less on hotels. More patients are going home. Patients are given choice and all patients are given equity of access to the ambulatory model.

The difference in the previous model over the course of the days of treatment was illustrated. The first International Ambulatory Study Day was discussed and this will be repeated. Patient feedback was illustrated and examples with patient quotes.

TK asked about mobility /access issues and how we deal with that. HS noted that we would work with our hospital transport team to bring patients in.

KW asked what shapes which chemotherapy can be ambulatory. HS responded that they have to use a central line which does have some downsides. The regimes are chosen very carefully and we must be aware of toxicity and impact on patients from a fluid perspective. Risk versus benefit must be explored.

DT asked what proportion of chemotherapy is delivered this way. In TYA about 70% is now ambulatory and about 60% of adult delivery. The aim is to increase this, the team must be ready for this change. It must be sustainable.

TT asked about tolerance of side effects. Claudia felt she could tolerate side effects and the patients are not coming in as much with side effects. HS noted that we will gather more data as things go on. Claudia said the sleep was better. HS noted that there have been less emergency admissions and there is data to support this.

GP thanked HS for the tour and was very impressed with the experience. Barriers to patients from Christie @ sites. The pharmacy support means this can't be done in these areas. Do have it at Macc / Tameside. This will have a main site focus as this is where the sickest patients are. This is a real culture shift for the consultants who have been used to having their patients in the hospital.

SP asked Claudia about the practicalities of the backpack. Claudia said she could get on with going out and about and have it next to the bed while sleeping.

EA thanked everyone for their presentation and for taking time to speak to the Board.

Item		Action
12/24	**Standard business**	
a	**Apologies**	
	No apologies noted	
b	**Declarations of Interest**	

	None noted.	
c	**Minutes of the previous meeting – 28th March 2024**	
	The minutes were accepted as a correct record.	
d	**Action plan rolling programme, action log & matters arising**	
	All items from the rolling programme are complete or noted on the agenda. Additions to the programme have been added in red.	
13/24	**Strategy and forward planning**	
a	**Annual Corporate Objectives review & Board assurance framework 2023/24**	

	• RS noted the look back at the conclusion of 2023/24 objectives and the BAF that relates to these.
	• RS noted the areas that are not complete;
	  ○ Publication of health inequalities data – this is live from April 2024
	  ○ Actions from People & Culture Plan which runs over 3 years – some are rolled over into year 2
	  ○ Achievement of national targets – 62 day standard did hit the amended 70% standard by March 2024 but not the original 85% threshold. The Faster Diagnostic Standard (FDS) was also introduced and the system hit this but we didn't hit the target for the very small number of patients we have that qualify for that standard.
	• DT asked what the penalty is for not achieving the targets. RS noted these are in the System Oversight Framework, currently not impacting and is no penalty. Have previously been financial penalties but not this year.
	• Board noted that 62 days and FDS only apply to a very small number of patients – 62 days apply to around 25% of our patients, FDS to approx. 12 per month.
	• GP asked about health inequalities and if this is looked at from a whole pathway or just The Christie bit. RS noted that we have a responsibility to publish data and that is what this relates to – for our own patients.
	• CH added that we are looking at a self-assessment in line with national requirements and this will inform what we do. RS noted that data is included in the IPQFR. CH noted we need to describe our role as an Anchor Institute.
	• We'll look at forward objectives in the May Board planning session.
	• EA asked that we have measurable outcomes as the measure as well as the requirement to publish.
	• EA noted the achievements in a difficult year and thanked the Execs for these achievements.
		RS/LW

14/24	**Performance & finance**	
a	**Trust report**	
	• RS noted that key quality indicators for March show no significant adverse variances other than in the cancer waits. 62-day performance is under target, impacted by late referrals. • Context of current performance is significant pressure in the system, from a financial and quality perspective. This is most challenging time we have ever seen.	

	• SP noted the year end position – £6.8m surplus that includes £6.3m Joint Venture (JV) profit against a £8m deficit plan. • Spent £33.2m on capital in year, a great achievement in the context of the system position and overall NHS situation. • Achieved £12.5m CIP in year, £10.5m was non-recurrent. This presents a challenge in the new financial year. • The GM system has been supported by the PwC turnaround team in the delivery of 2023/24 outturn which was in line with the final agreed figure of £180m deficit. They are supporting into 2024/25. The system position is extremely difficult. • RA asked if PwC have helped. SP noted that they've helped in the system by adding a layer of rigour. • The Board noted the IT outage that happened in March. Lasted 14 hours, debrief has taken place. Looking at the impact, 4 patients were cancelled in theatres that day. Full debrief with lessons learned and disaster recovery will go to Audit in June. • GP noted that Audit Committee took comfort from the work going on to learn from the incident. Noted	
b	**Risk Management Strategy 2024/24 annual review**	
	• TP noted the paper. This strategy relates to internal control & management of operational / clinical risk. • The new strategy will relate to management & monitoring and will align to PSIRF and support the clinical teams. • There are on going actions that relate to the roll out of the new Datix system, we are maximising the system to help support how we work. • Milestones will be identified for the coming strategy to allow us to manage how we are progressing. This will align to the management of strategic risks as well. • The new strategy will come to QAC for approval. • All risks, including those on the BAF, will be integrated into the new Datix system. • DT asked about the new Datix system. TP noted that the incidents module has gone live and the risk module will follow. The old system has worked in the interim and the transition has gone smoothly so far. We're assured that staff are using it well. The Risk module should be live by end of May. • EA asked about the cultural change and how success will be measured. TP noted that clinical engagement will be key and we are simplifying the strategy to make it user friendly for everyone. This will enable us to more closely manage the risks. • RS noted the relevance of cultural indicators of success, we have evidence that we are a high reporting, low harm organisation. This is the measure of the culture of the use of the risk system. • GP noted that there are some risks that will not be removed but we have to recognise our risk appetite / target risk expectation. Board noted the progress and update.	

15/24	**Culture**	
a	**Freedom to Speak Up Guardian report**	
	• SM presented her 6 monthly report. Her role is around supporting staff and supporting a positive speaking up culture. • Numbers of contacts were outlined and a summary of the types of concerns was described – 1/3 around attitudes & behaviours / 1/3 around policies, procedures and processes. There was 1 concern relating to patient safety and this was resolved through line management. • There is an annual plan with a supporting action plan. The report shows last years actions including leadership training, profile raising, PSIRF launch, involvement in induction and Board self-assessment as well as introduction of the Leadership Competency Framework. • There are areas in progress including support for all staff involved in raising a concern, we have FTSU champions and EDI champions to support & signpost. There is more work to do on detriment and building confidence. Everyone has a responsibility in this. Concern is around perceived detriment and longer standing issues that are remembered. • It was noted that it would be good to capture issues that are current and those that relate to historic problems. • CM noted that there is a strong organisational memory as staff stay longer and this presents its own issues that we need to be cognisant of. • This is about openness of conversations. FTSU spans many of things we are working through such as the Cultural audit, PSIRF, Values & Behaviours. • Staff survey results are helping to focus us on this and FTSU plan 2024/25 acknowledges this. There is more engagement across the divisions with the plan and asking what teams can do to support the elements of the plan. • Messages that are being shared with staff were outlined – this is about everyone, leaders must set the example and must be open & honest, positive examples must be shared to build confidence and we must be curious and engage & listen. • NB noted how important it is to hear this across different groups – CAG, SMC etc. This is about more than the contacts with the FTSUG, we all have issues raised with us by colleagues and we must replicate this approach. The FTSUG contacts only represent a small proportion of speaking up across the Trust. • It is absolutely crucial that people are given compassionate & supportive feedback. The way this is done and setting expectations is key. • CH noted that understanding and applying policies in an equitable way is a focus from the culture audit and we will do tangible things as a result. • DT noted that activity has remained fairly static in a context of people knowing how to raise concerns and this may be positive. • AM noted that we need to be bigger & bolder so staff feel safe & secure. This means we have to look at a wider way of ensuring this works across the Trust. The success would be that contacts are about people who want to access support because they want a neutral person not someone connected to their role. We need to allow people choice. • TP noted that the organisational memory can be very positive as well. We need to acknowledge that we do this very well in many ways and places. We need to celebrate when things do go well. CH agreed that the high reporting,	SM

	low harm culture is very positive. The trend in the staff survey getting worse is no surprise in the context of the last few years and we need to support an existing open culture in very many places. The variation is being looked at. • SM noted that there are very many issues that never reach her and this is an indication of the success of the other routes for speaking up.	
16/24	**Governance (regulatory / statutory compliance)**	
a	**Board assurance framework 2024/25 incl Risk Appetite Statement**	
	• RS noted the new BAF 2024/25 that details an amended approach to the strategic risks in a different presentational format. • The annual objectives will drive some of the risks in year and these will be discussed in the May Planning day. • The Risk Appetite statement is described, and this will inform the approach to the BAF. The Board are asked to approve the statement for this year. • Board are asked to comment on the new risks that will be further described for the next iteration as well as the new format. • The allocation of committee responsibility for each risk will be amended in line with feedback. • The risks are updated on a regular basis and allocated to a committee for review and a deeper dive. • GP noted that this must be used to assist decision making and discussion. • The formulation of the risks attempts to describe the causes / consequences. • Dashboard will pick up some of the indicators. • Suggested that there may be a risk relating to the reputational risk of adverse events on public / patient confidence. This can be added. • Mitigations will be explored. • CQC's amended approach to inspection (single assessment framework) and particularly the review of the new requirements under the Well-led Domain will be a focus of a further Board discussion. • RS noted that we progressing further discussions with the CQC following the last inspection. We are also getting external expert advice. • The teams are working on preparation for future inspections. Board noted the Board Assurance Framework (BAF) 2024/25 and approved the Risk Appetite Statement for 2024/25.	LW
b	**Modern Slavery Act statement**	
	Board were asked to approve the statement that describes the Trusts approach to compliance with the terms of the Modern Slavery Act. We have training and processes in place, particularly in our procurement activities. The statement will be published on our website following Board approval. Approved.	LW
c	**Reports from Committees**	
	Quality Assurance January 2024	
	• The committee discussed the safeguarding report and received assurance around their compliance with the requirements. Two NEDs also had a visit to the team ahead of their presentation to further understand the issues.	

	• Annual Clinical Audit and QICA plan were discussed. • The Duty of Candour was discussed with a lower compliance. This is now at a much higher rate of 86% compliance. It was noted that completion of the full requirements can take a long time. The committee asked for this to come back. There was acknowledgment of the complexity. • TP noted that collaborative conversations around Duty of Candour take place at ERG. • The requirement is to complete DoC for all moderate & above cases, there is no time target and the cases are described and detail kept. • We won't impose a standard that is not in line with the reality of the cases. This is closely managed on a weekly basis in the divisions.	
d	**Framework for Board & Committee allocation**	
	• RS noted that this follows from the GGI Governance review and relates to the way we look at assurance, that is relatively complex. The way this is organised is critically important so that we are getting appropriate levels of assurance. • The Board noted the paper and further discussions and tweaks are being made following further discussion on how this works. This will come back to Board in June. The scorecard will come back in a reviewed format. • CM noted that scorecards are now considered too simple a tool to represent a complex set of indicators.	LW
e	**Self-certification declarations**	
	Board approved the declarations to be kept on file and shared if requested by NHSE.	
f	**Register of matters approved by the board**	
	• Noted by the Board	
g	**Board effectiveness review**	
	• The effectiveness review questionnaire will be circulated to Board members / attendees following this meeting with a deadline for completion and return.	
17/24	**Any other business**	
	• GP noted that this weeks Audit Committee noted that there was some concern with compliance with the requirement to make declarations. There will be further escalation to improve compliance, and this is coming back to Audit Committee at a future meeting. • GP noted the end of year paperwork was discussed and noted. • Head of Internal Audit opinion was substantial. • Anti-Fraud yearend assessment was green in all areas.	
	Date and time of the next meeting	
	Thursday 27th June 2024 at 12:45pm	
	Papers for information only	
	Integrated performance, quality & finance report	

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Agenda item 18/24d

Meeting of the Board of Directors - June 2024

Action plan rolling programme after April 2024 meeting

C Culture P Performance S Strategy G Governance

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
June 2024		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	For info section
	Annual reporting cycle	G	Annual reports from audit, quality and workforce assurance committees	Committee chairs	Assurance	Joint Audit/Quality meeting
	Annual reporting cycle	G	Annual compliance with the CQC requirements	ECN	Declaration / approval	22/24d
		P/S	Education Strategy Update	DoE	Review	19/24b
		P/S	Quality Strategy annual update	ECN	Review	19/24c
		G	Board effectiveness review	Chair	Report	22/24g
		P	Value Improvement Programme	COO	Review	19/24d
	Annual reporting cycle	G	Annual report, financial statements and quality accounts (incl Annual governance statement / Statement on code of governance)	EDoF	Approve	22/24b
July 2024 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
Planning & Development Day		S	Service Review day with senior leadership teams			
August 2024 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
September 2024		C	Patient story	CEO	To hear a patient story	
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	
		G	Standing Financial Instructions (SFI's)	DoF	Approve	
		C/P	Health inequalities self -assessment	DCEO	Review	
		P	Green Plan	DCEO	Approve	
		P	Value Improvement Programme	COO	Review	
		P	Digital Strategy Update	DCEO / CIO	Annual Review	
		G	GM ICB undertakings	GMICB	Presentation	
October 2024		C	Patient story	CEO	To hear a patient story	
		P	Integrated performance & quality report and finance report	COO	Monthly report	
		S	EDI Strategy	DoW	For approval	
		C	Culture audit review	DCEO	Review	
		C	Freedom to speak up guardian	FTSUG	Annual report	
Planning & Development Day		S	Planning with Divisional leadership teams			
		S	Strategy deep dive - system role / Cancer Alliance			
November 2024		C	Patient story	CEO	To hear a patient story	
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	
		S	Strategy update	DoS	Six month review	
		S	Clinical Outcomes Strategy review	EMD	Review	
	Annual reporting cycle	P	Interim review of annual objectives	CEO	Review progress	
		S	Boards responsibility for Carbon Net Zero	DCEO	Report	

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
December 2024 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
Planning & Development / Council of Governors Day		C	Board planning / culture training			
		S	Council / Board - strategy update			
January 2025		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance report	COO	Monthly report	For information
		P	Benchmarking	DCEO	Review	
		P	International strategy	DCEO	Review	
		S	Review of Trust strategy & annual objectives 2023-2029	DoS	Report	
		P	Value Improvement Programme	COO	Review	
		P	Sustainability Annual Report	DCEO	Report	
February 2025 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
	Annual reporting cycle	G	Letter of representation & independence	Chair	Circulate	By email
	Annual reporting cycle	G	Register of directors interests / FPPT annual declaration	Chair		
	Annual reporting cycle	G	Declaration of independence (non-executive directors only)	Chair		
Planning & Development Day		S	Planning			
		S	Strategy deep dive			
March 2025		C	Patient story	CEO	To hear a patient story	
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	
	Annual reporting cycle	G	Annual reporting cycle	Executive directors	Approve	
		P	Research & Innovation Strategy Update	DoR	Annual review	
		C	Culture Audit review	DCEO/DoW	Approve	
		G	Annual BAF review / risk deep dive	CEO	Review	
		C	Staff survey initial results	DoW	Note	
		P	Health inequalities performance review	DCEO	Review	
	Annual reporting cycle	G	FPPT Compliance report	Chair	Approve annual compliance	
April 2025		C	Patient story	CEO	To hear a patient story	
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	
		G	Register of matters approved by the board	CEO	Note April 2023 to March 2024	
	Provider licence	G	Self certification declarations	CEO	To approve the declarations	
	Annual reporting cycle	S	Annual Corporate Objectives review / BAF 2023/24	CEO	Review 2023/24 progress	
		G	Modern Slavery Act statement	CEO	Approve	
		G	Board effectiveness review	Chairman	Undertake survey	
		C	Freedom to speak up Guardian report	FTSUG	6 monthly update	
	Annual reporting cycle	P	Risk Management strategy 2023-24 annual review	ECN	Annual Review	
May 2025 - no meeting	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	By email
Planning & Development Day						
		S	Planning			

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Agenda item: 18/24d

Action log following the Board of Directors meetings held on

Thursday 25th April 2024

No.	Agenda	Action	By who	Progress	Board review
1	13/24a	Measurable outcomes for annual objectives.	RS/LW	Complete	Reflected in annual objectives 24/25 in June 2024 Private Board papers
2	15/24a	FTSU reports to capture issues that are current and those that relate to historic problems.	SM	To be added to the next report	October 2024 Board meeting
3	16/24a	Reputational risk of adverse events on public / patient confidence to be added to the BAF.	LW	Complete	Included in June 2024 Board papers
4	16/24b	Modern Slavery Act statement to be published on Trust website.	LW	Complete	N/A
5	16/24d	Framework for Board and Committee allocation to be updated following further discussion on how this works. The scorecard to also come back in a reviewed format.	LW	Complete	For information in June 2024 Board papers

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Meeting of the Board of Directors
June 2024

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

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Trust Report for May 2024 (month 2)

Draft Board Scorecard

Corporate objective	Indicators	Tolerances			Current month	Year to date	Year End cumulative position
All	CQC rating	N/A			Good	Good	Good
All	SOF Rating	N/A			2	2	2
Quality of Care & Performance							
1,6	Proportion of incidents that are low/no harm (%)	90%+			97.7%*	N/A	N/A
1,6	31 day compliance (%)	96%			98.30%	N/A	N/A
1,6	Patients meeting the faster cancer diagnosis standard (%)	75%			80%	N/A	N/A
1,6	MRSA bacteraemia infection (attributable) (N)	TBC			2	2	2
1,6	Clostridium difficile infection (attributable) (N)	TBC			3	5	5
Finance and Use of Resources							
6	Financial sustainability / liquidity (days)	>21	21 to 14	<14	95	95	95
6	Overall financial position (% variance to control total)	0% below plan	0 -10% below plan	>10% below plan	(38.2%)	(26.4%)	0.0%
6	Recurrent VIP performance (% achieved)				62%	62%	62%
6	Current cash balance (£'000)				£121,623	£121,623	£127,86
6	Exchequer capital spend to date (variance to plan %)	within 10%	10 to 20%	>30%	0%	0%	0%
6	Average length of time debt is outstanding	<15	>16 - 20	>20	10	10	10
6	Public Sector Payment Policy - trade creditors paid within 30 days (number and volume)	>95%	95 - 85%	<85%	98%	98%	98%
People and Culture							
7	PDRs completed (%)		_		85.70%	85.10%	84.94%
7	Mandatory training (%)	>80%		<79%	92.70%	92.67%	92.60%
Research							
4	New trails open per month (N)	>10	9-10	<8	TBC	TBC	TBC
4	No. patients consented into studies (N)	>300	225-299	<225	TBC	TBC	TBC
4	Christie Sponsored research: new studies opening (N)	>2	1	0	TBC	TBC	TBC
4	Research patient experience - % strongly agree they would participate in research again	90%	75-89%	<75%	100%	100%	100%
Education							
3	To be confirmed				TBC	TBC	TBC
System							
1,6	62 days (%)	>70%		<69.9%	73%	N/A	N/A
1,6	Priority patients not admitted (deferred)	0		>1	0	0	0
Digital							
4	Compliance with six monthly milestones in Digital strategy (%)	>80%		<81	91%	91%	91%
* Q4 data	NB - Research figures unavailable until month 3						

Executive Summary

- Key patient quality indicators for May show no significant adverse variances or issues for escalation.
- Performance in May for the 62-day consolidated cancer standard was 73% which is better than the operating plan standard of 70%.
- Six corporate risks are scored at 15 or above on the risk register.
- 2024/25 financial revenue plan has been agreed and submitted at a £7.0m surplus
- Cumulative financial performance at the end of May (Month 2) is a £807k surplus against a planned £584k surplus. This is a positive variance of £223k to plan.
- Key financial performance indicators in month 2 show one adverse variance which is the level of recurrent VIP identified being £8.7m identified so far against a £14m annual target
- Workforce indicators for May show a slight increase in sickness absence rates
- We have updated the project arrangements following approval of actions from the cultural audit engagement process and communications have been shared with staff.
- Individuals and groups from across the Trust have been successful in recent GM Cancer awards
- The Research & Innovation team continue to progress the focus on Inclusive Patient Public Involvement and Engagement
- Christie Education projects and events continue to support our aims and objectives.
- We remain rated overall as Good by the CQC.
- We continue to be in segment 2 of the System Oversight Framework.
- Capital schemes are progressing to plan across the Trust.
- New CQC single assessment framework is now in place, we are assessing ourselves against the quality statements as preparation for a future inspection.

Quality of Care

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

There were no newly acquired pressure ulcers in May, this is the first month this has been achieved since August 2020, falls were in line with internally set trajectory.

There were 14 complaints and 18 compliments in May which is slightly higher than the monthly average. The number of contacts with the Patient Advice and Liaison Service (PALS) service in May was 67 which is higher than the previous month.

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

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

1. Risk of not achieving the financial plan including the value improvement programme in 2024/25 (20)
2. Limitation on equipment & facilities to deliver planned activity or progress developments due to insufficient capital funding (CDEL) (16)
3. Risk that patients may experience harm due to significant delays in the management of patients with penile cancer (16)
4. There is a risk of Radiology being unable to provide an appropriate turnaround time for reporting of images due to insufficient resource (16)
5. Risk of delayed cancer referral and treatments due to not meeting 24 / 62-day targets (15).
6. Risk of not meeting regulatory requirement for central reporting of role specific training across the Trust (15)

Operational Performance

The 2024/25 NHSE Planning Guidance 2 Christie applicable cancer metrics;

- 62 day cancer standard
- 28 day Faster Diagnostic Standard (FDS)

The 62-day standard is a barometer of how well the system is performing with cancer pathways.

Compliance at the end of May against the 2 key cancer standards was;

- The 62-day consolidated standard was 73% against a threshold of 70%.
- We achieved 80% against the 75% threshold for the Faster Diagnosis Standard which measures initial referral to diagnosis.

The majority of Christie referred patients are monitored via the 31-day standard (decision to treat to treatment start).

- We have continued to achieve the 31-day standard for treatment to start within 31 days of the decision to treat at 98.9% against a target of 96%.

During May there were 2 operations cancelled on the day, 1 for no surgeon available and 1 due to no critical care bed (all 8 beds open, double review on step downs), all were rebooked within 28 days.

Financial Performance

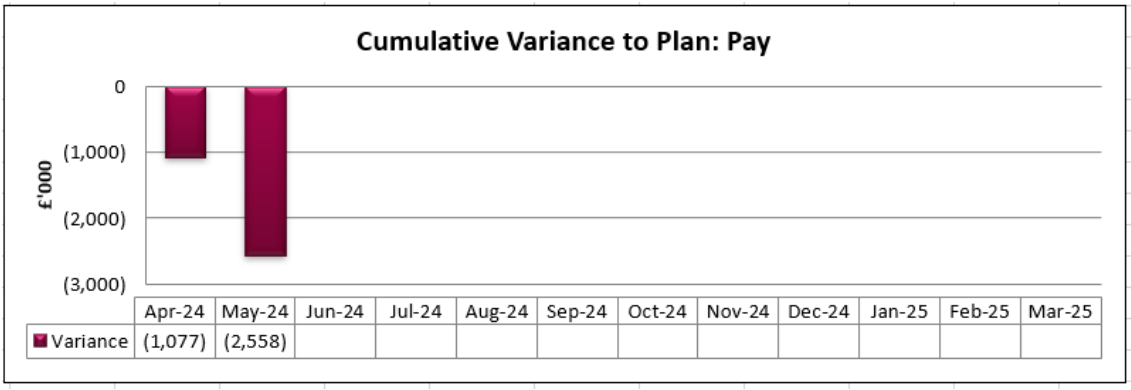
Revenue: Financial performance is ahead of plan by £308k as illustrated in the table below. The Trust is reporting a £1.476m surplus against a £1.168m planned surplus position. The better than plan position is primarily due to:-

- pay underspends arising from vacancies
- over-achievement of clinical income to-date.

Month 2 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(423,078)	(70,513)	(71,668)	(1,155)
Other Income	(70,190)	(11,687)	(11,643)	43
Pay	229,491	38,237	35,678	(2,558)
Non Pay (incl drugs)	238,194	39,699	42,079	2,380
Operating (Surplus) / Deficit	**(25,584)**	**(4,264)**	**(5,554)**	**(1,290)**
Finance expenses/ income	30,932	5,155	5,965	810
(Surplus) / Deficit	**5,349**	**891**	**411**	**(480)**
Exclude impairments/ charitably funded capital donations	(12,625)	(2,059)	(1,887)	172
Adjusted financial performance (Surplus) / Deficit	**(7,276)**	**(1,168)**	**(1,476)**	**(308)**

The pay underspend of £2.558m is illustrated in the graph below :-

- £619k relates to income backed services, including GM Cancer, R&I and The Christie Charity, which has an equivalent reduction in income
- The balance on the Trust pay underspend in M02 is due to vacancies predominantly in clinical posts, most noticeably scientific, technical and therapeutic (£683k) and consultants (£388k)



Capital: The capital plan for 2024-25 has been agreed at £17.4m. The Trust has spent £3.074m to M02, primarily on:

- TIF ward refurbishment
- Small replacement assets

Value Improvement Programme. The annual VIP target of £21.4m is split into a £14m recurrent target and a £7.4m non-recurrent target.
Year to date, a total of £3.6m has been delivered against a target of £3.6m.

The level of recurrent VIP identified to date is £8.7m giving a recurrent shortfall of £5.3m. The level of non-recurrent VIP identified to date is £7.3m in line with plan. The focus is on identifying more recurrent VIP and Divisions are working on these schemes which will deliver in year.

Workforce

Our workforce performance indicators show mandatory training compliance and personal development plan rates are both above (better than) thresholds at 92.7% and 85.7% respectively. Sickness absence rates increased slightly in May to 4.36% (threshold of 3.4%). The overall turnover for the Trust has reduced from last month to 12.94%. These issues and the associated plans for improvement have been considered by the Workforce Assurance Committee.

Staff can access a range of key information including Trust workforce policies, information on Health & Wellbeing, recruitment resources and information on leadership and PDRs through this link MeetWorkforceTeam - 1 (pagetiger.com).

SAS doctors have accepted their pay offer. The British Medical Association (BMA) Junior Doctors Committee has announced further dates for industrial action in the NHS. The five-day walkout will take place in England from 7am on Thursday 27 June until 7am on Tuesday 2 July. Divisions are now in the process of planning and preparing for this latest round of industrial action.

Ministry of Defence Employer Recognition Scheme – Silver Award - The Christie has been awarded Silver under the Ministry of Defence Employer Recognition Scheme for support to Defence and the wider Armed Forces community. The Employer Recognition Scheme was launched to reward employers who support Defence People objectives and encourage others to do the same. This includes employing serving and former members of the Armed Forces community and demonstrating flexibility towards training and mobilisation commitments for Reservists and Cadet Force Adult Volunteers.
We are delighted to have received this award in recognition of our commitment and dedication in fostering an inclusive and supportive environment for the armed forces community.

Carers Week

Carers Week is an annual awareness campaign to recognise the vital contribution made by the UK's 5.7 million carers. Carers Week this year runs from is 10 -16 June with the theme for 2024 being ‘Placing Carers on the Map’. The Christie will be promoting the campaign and there will be a number of events being held to support carers throughout the week. Full details will be posted on HIVE.

Culture

The cultural audit outcomes and engagement process have now been discussed by our Management Board and Board of Directors, who have given approval for the actions to be implemented. We have updated the project arrangements and had the first meeting of the extended oversight group that now includes senior divisional representation as well as staff side representation, our OD and communications leads and the staff governors. The communications plan for the next steps of the cultural audit implementation will focus on using the divisional cascade via the senior management committee and service divisions. We are also developing the “continuing the conversation” approach set out in the plan. The aim is to incorporate implementation of the cultural audit plan into normal business. The specific role of the board was discussed at the April public meeting. A progress report will be provided at the June meeting.

Research

We are pleased to report that one of our Radiotherapy Research Radiographers, Lucy Davies, has been awarded an NIHR Doctoral Clinical Academic Fellowship.

The R&I team made good representation at the 2024 Greater Manchester Cancer conference held on the 14th and 15th May. Professor David Thomson chaired our breakout session which highlighted the importance of research equity and showcased a selection of our inclusive research initiatives across Greater Manchester and beyond. We were pleased to present our Christie Patient Centred Research (CPCR) team led by Dr Sally Taylor, followed by a selection of developments in Radiotherapy Related Research presented by Dr Cynthia Eccles. Our session also included an overview of our Christie Research outreach initiative led by Vicky Lau and joined by Angela Power, Lead Research Nurse at Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (WWL). We were pleased to welcome our patient guests – the Ahmed family who movingly shared their experience with us, supported by Shahfaz Saeed our patient experience manager. We concluded with a panel Q&A chaired by Dr Sally Anne Pearson. Our session prompted a number of follow up discussions which we will be developing over the coming months in line with our R&I strategy.

The conference also includes a number of awards that are designed to honour outstanding work to improve lives and treatment for people with cancer in Greater Manchester.

GM Cancer Awards Winners;

- Early Career Researcher- Alicia Marie Conway
- Team Science- Manchester's PMP Accelerator Team University of Manchester, The Christie NHS FT, Welcome Trust Centre for Cell Matrix, Manchester Cancer Research Centre, Centre for Applied Pharmacokinetic Research

GM Cancer Awards Highly Commended;

- Team Science- Manchester CUP Research Group, Medical Oncologist
- Team Science - BRAINatomy – optimizing cognition in childhood brain cancer survivors
- Commitment to Equality Award- RAPID-RT – Co-designing an inclusive study to collect and utilise real-world data to evaluate patient outcomes after changes in standard-of-care radiotherapy practice -The University of Manchester; The Christie NHS Foundation Trust; Vocal (Manchester University Foundation Trust); NICE

We have celebrated the Paterson 1 year anniversary with activity on social media. The MR-linac 5-year celebration event took place focusing on their achievements over the last 5 years.

The CRUK National Biomarker Centre had a launch event at The Paterson on Friday 14th June. The event included tours of the centre and was attended by Trust, CRUK and University representatives as well as trustees of The Christie Charity.

Inclusive Patient Public Involvement and Engagement (PPIE)
The concept of "What Matters To Us" was shared by a panel of patient representatives to the audience. Recognising "What Matters" to a specific underserved community is fundamental for good Patient/Public engagement.

It was established that reaching out to individual ethnic diverse communities one by one was more challenging than to reach out to one community that is rich in ethnic diversity, e.g. Muslim community.

Hence, a Muslim Cancer Support Group is being co-created with a mix of cancer patients, Muslim Chaplains and clinicians who will run the Support Sessions for Muslim Cancer patients and carers in collaboration with Maggies.

The Muslim Cancer Support Group will hold a multi-purpose:

- To support individuals who have been impacted by cancer directly or indirectly, within a safe environment through conversations that will provide support and comfort.

- To create an awareness through education, of the various elements of Research which will allow the support group members to familiarise themselves with Research, to enable them to make an informed choice on what types of research they want to be involved in, moving the dial to help shape Research for All.

- To introduce Maggie's and the services they have on offer.

This "Model" can be upscaled and adapted to support other underserved communities by identifying and understanding "What Matters To Them".

Race Equality Framework (REF)
The National Institute of Health and Care Research has co-produced the REF as a tool to improve inclusive public involvement in Health and Care Research placing a focused approach around Race; underserved people who are from Black African-, Asian- and Caribbean-heritage communities.

The REF has been adopted as a benchmark exercise to feed into our R&I strategy around Inclusive Research/Inclusive PPIE. It is embraced and supported by the Research Senior Leadership Team (SLT) with a commitment to implementing the Framework to each area of Research by assessing needs, driving and advocating for change.

The SLT will form as a working group to complete a self-assessment of 50 questions, broken down into 5 domains.
1. Individual Responsibility
2. Leadership
3. Public Partnerships
4. Recruitment
5. Systems & Processes

This will allow us to identify the domains in order of priority and to place a focus on completing one domain at a time. The REF can be built into our Research work over 5 to 10 years. The framework is supported by training, REF public contributors, a REF Community of Practice Network to provide peer learning and to support adoption of the REF. It will help develop a successful PPIE delivery through collaboration.

Education

One of the key pillars of Christie's Education strategy centres on our commitment to accessible, inclusive education opportunities for our staff, patients and communities, linking in with The Christie's integrated strategy and work to understand and improve inequalities.

Supporting our Widening Participation agenda (and kickstarting new incentives), our workforce and professional development team are integrating flexible, tailored work experience programmes for young people, e.g., partnering with Stockport Council, The Virtual School and Stockport Family Hubs to develop long-term work experience programmes for care leavers. The tailored programme (typically 2 days a week for 10 weeks) encourages routine, provides stability and expands personal and professional confidence.

In August we will pilot a centralised work experience programme to improve access to scientific careers for young people from under-represented and unsupported communities. Working with Manchester Cancer Research Centre and our ECMT team, this will provide a 1-week rotational programme for young people referred via In2Stem. In2stem are an

organisation which manages work experience placements for students who e.g., have an Education Health and Care Plan, experience of care/kindship care or are a recipient of free school meals. These students will also receive employability sessions and higher education application support.

This year celebrates our second Sector-based work academy programme with Trafford college. This two-week vocational training programme combines a mix of classroom sessions at the Skills Shop and bespoke workshops at the Christie. On completion of the programme, the participants will have a guaranteed interview invitation and 1-2-1 interview coaching session with SmartWorks. For successful candidates, we offer digital support sessions to mitigate any difficulties with the onboarding process. Since October 2023, 6 full time positions for Healthcare Support Workers and Domestics have been filled.

Between March and June, Christie Education hosted a series of four free study days that explored cancer and exclusion—designed and developed by our EDI Education lead, Leone Alexander. Sessions included equitable care for people in socially excluded groups (homeless, Gypsy, Roma and Traveller people, migrants, people who misuse substances, veterans, and people in contact with the criminal justice system). Cancer and loss or erasure of Identity, explored truly inclusive cancer care for Autistic people, Deaf people and people with learning disabilities highlighting the importance of making all care psychological and adopting a trauma-informed approach.

This series brought together Qualified and Trainee Health and Social Care Professionals, Charities, Researchers, HEIs, Commissioners, the public, and Experts by Experience to see cancer from an inclusive perspective, assessing who/what is currently missing in cancer screening, diagnosis, and care and what we can do to improve and develop services to ensure equity to access and quality of care. Over 1000 people have attended the series, with initial evaluation showing the experience as overwhelming positive and building a significant network to support our next series.

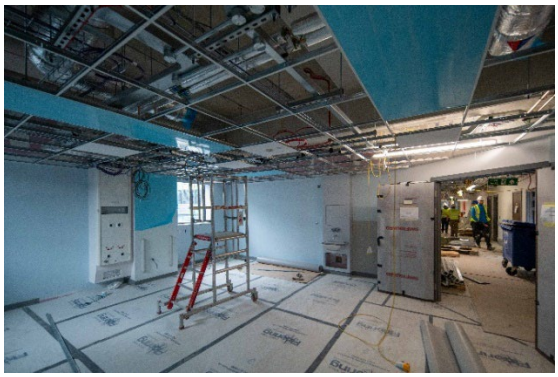
The cancer exclusion series has facilitated some important relationships with communities and organisations that are interested in working with The Christie to improve outcomes for people who may be excluded. We are now in talks with several local groups/communities, including the Sikh Foundation and Wai Yin Society, to provide cancer education in the community. Delivering community-facing education not only helps destigmatise cancer and ensure more people receive education, care, and treatment but also creates a foundation for connection and opportunities for people to consider careers in the cancer workforce.

Strategic and Service Developments

Pathology JV Re-procurement - bid submissions have been evaluated and a first round of clarification dialogue sessions undertaken in early May. Invitations to Participate in Competitive Dialogue (ITCD) - the next phase of the process, have been sent and further dialogue sessions planned for June/July.

In parallel with this, a long-term estate option for new pathology facilities at the Withington site has been identified. The trust is currently in discussion with the Christie Charity as to its role in funding and delivering the project. Meanwhile, initial planning work has commenced to scope the requirement.

Work continues on the formation of a 20-bedroom ward in the former Trust Administration and Digital floors. Internally, the completion of the electrical and mechanical services are underway as well as the decorations and suspended ceilings. Externally, the ceramic cladding is almost complete with attention turning to the brass cladding to reflect the Oak Road area. The hoarding has been removed to allow progress of the landscaping. The key project risks continue to be managed and the current date for works completion is late July.



The Art Room completed last month is now operational.

Planning Permission for the next major strategic development, the Advanced Scanning and Imaging Centre (ASIC) development was received in December 2023. The current actions remain the completion of the current design stage variations and the development of the Treasury compliant Outline Business Case. One of the key decants is pathology in the form of the replacement of the Derek Crowther building along Wilmslow Road with a new Advanced Pathology Centre. The delivery vehicle with the Christie Charity continues to be developed.

Our Carbon Energy Fund Scheme is a key project in our sustainability aspirations and puts us a step closer towards achieving the NHS Net Zero targets. All major works are complete and the scheme is anticipated to be fully operational in the summer 2024.

The replacement of the CT SIM2 is complete and the replacement of the Superficial Treatment unit remains ongoing.

A number of other capital projects are being developed at an early stage for internal prioritisation to ensure we are able to utilise any late capital funds.

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

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Agenda item 19/24b

Board of Directors meeting
Thursday 27th June 2024

Subject / Title	Value Improvement Programme 2024/25
Author(s)	Jo Bolger Leece Assistant Director: Value Improvement Programme Claire McPeake; Chief Operating Officer (Interim)
Presented by	Claire McPeake Chief Operating Officer (Interim)
Summary / purpose of paper	This paper provides: • An overview of the Value Improvement Programme (VIP) with a month 2 position. • Actions to be taken to improve the VIP position and the assurance checks on all schemes, to ensure project plans and quality impact assessments (QIA's) are in place. • Provide the outline of a framework which will support a 're-set' for the programme. • The proposed framework will focus on engagement and ownership as a devolved accountability model to adopt, adapt and improve best practice, identify opportunities and to improve financial sustainability for the future. • Assurance that the Quality Impact Assessment (QIA) process is fully embedded within governance structures.
Recommendation(s)	The Board is asked to review: • The content of the report and • The associated actions identified to improve delivery.
Background papers	NA
Risk score	Risk 3629
Link to: ➢ Trust strategy ➢ Corporate objectives	Executive objective: 1 -To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer. 6 - To maintain excellent operational, quality and financial performance Board Assurance Framework: Risk 1, Risk 6, Risk 7, Risk 9, Risk 10
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.	Value Improvement Programme: VIP Quality Impact Assessment: QIA Equality Impact Assessment: EIA Investment and Capital Planning Committee: ICPC

Agenda item 19/24b

Board of Directors meeting
Thursday 27th June 2024

Value Improvement Programme (VIP)

1 Background and Introduction

The Christie strategy 2023 to 2028 sets out how we will continue to deliver our mission - to care, discover and teach - through the 4 themes of our vision: leading cancer care, the Christie experience, local and specialist care and best outcomes.

A key enabler to delivery of the strategy is ensuring that we have financial sustainability to support and drive innovation and improvement, whilst ensuring we continue to invest in our capital and services.

As part of the financial plan submitted for 2024/25 there is a total VIP target set of £21.369m, to achieve a breakeven position. A summary of the recurrent/ non recurrent split is presented in Table 1.
Non recurrent schemes equating to £7.4m have been identified and will be held centrally, alongside recurrent growth productivity of £6.275m; the balance of £7.721m is distributed out to divisions.

Table 1:

Efficiency Savings Plan 2024/25	£000
Recurrent efficiencies	13,996
Non-recurrent efficiencies	7,400
Total Efficiencies	**21,396**
Non recurrent achieved - bank interest	(4,000)
Non recurrent achieved - vacancies	(2,000)
Non recurrent achieved - commissioner income	(1,400)
	13,996
Recurrent achieved - growth productivity	(6,275)
Recurrent divisional balance	**7,721**

The allocation method to divisions is based upon influenceable expenditure budgets, adjustments have been made to reflect CNST, insurance and income funded spend within School of Oncology. Table 2.

Table 2:

Division	Influenceable Budget	VIP Target 24/25	% of budget	VIP Target 23/24 - information only
01 Clin Support & Spec Surgery	77,631,435	2,481,297	3.20%	2,002,806
011 Drugs/ Pharmacy	7,556,979	241,540	3.20%	160,407
02 Network Services	73,613,456	2,352,873	3.20%	1,832,087
04 Trust Administration	3,185,321	101,811	3.20%	82,126
04a Corporate Development	831,211	26,568	3.20%	25,542
04b Performance Management	1,064,852	34,035	3.20%	29,327
04C Strategy	731,517	23,381	3.20%	20,387
05 Quality & Standards	2,657,827	84,951	3.20%	63,294
06 Finance & Business Development	4,902,028	156,681	3.20%	147,006
07 School of Oncology	4,211,693	134,616	3.20%	64,559
08 Estates & Facilities	25,536,123	816,199	3.20%	1,000,000
09 Human Resources	3,274,702	104,668	3.20%	86,851
14 Christie Medical Physics	25,099,536	802,245	3.20%	614,303
23 Digital Services	11,277,948	360,472	3.20%	310,485
17 Research & Innovation	0	0	0.00%	5,384
	241,574,628	**7,721,337**		**6,444,564**

This paper describes the current position of VIP at month 2, alongside some immediate improvement actions and recommendations for an updated framework for future delivery which is currently in development.

2 Month 2 position

Recurrent VIP

- Schemes totalling £8.7m have been identified recurrently against a recurrent target of £14.0m.
- This leaves £5.3m of the recurrent target unidentified.
- Table 3 summarises the position which is reported monthly through investment and capital planning committee (ICPC)

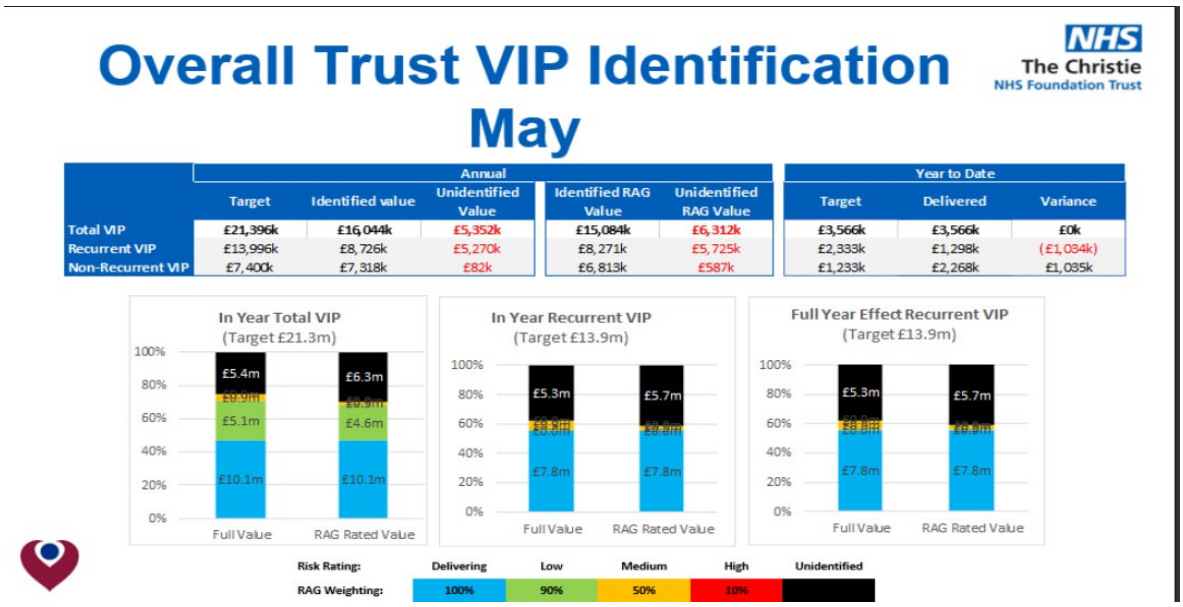


Table 3: overall position of identified value against target

3 In year (2024/25) Improvement

The VIP has a clearly documented process which has been presented at ICPC for producing and approving a Project Initiation Document (PID), including associated Quality Impact Assessment (QIA) & Equality Impact Assessment (EIA), this includes the roles and responsibilities of those involved in the scheme. All schemes are monitored on a central tracker.

Currently only a small number of schemes identified on the tracker have a project plan, and QIA in place with low assurance on delivery. To provide assurance on the likelihood that identified schemes will be delivered, a deep dive will be taking place with the following actions:

- A series of assurance checks will be carried out on existing schemes, starting with high value schemes. This is to ensure leads have support to deliver improvements at pace.
- Support will be provided to leads to develop robust plans and QIAs, this is to increase the risk rating in terms of the likelihood of delivery.
- An opportunity assessment will be carried out to identify further areas for improvement, and services where no improvements have been identified will be asked to review and present progress against their target by the end of the month.
- There will be a drive to improve engagement by celebrating success and sharing lessons learned across departments of what has been achieved so far.
- Productivity is challenging to measure across the NHS. Measures often do not capture the full range of patient related quality and outcomes that are delivered, especially when models of care are changing. However, NHS England's best estimates of productivity suggest productivity is still lower than it was pre-pandemic. Conducting a deep dive into activity by service for the Christie will identify areas for improvement and if supported by capacity and demand, will ensure services are either funded appropriately, or plans in place to improve productivity.
- A new role has been assigned to support the Value Improvement Programme; this role commenced in the beginning of June.

4 Developing the next phase for VIP

For 2024/25 and beyond, The Christie must deliver a challenging cost improvement target. In response to this challenge, a high-level framework is being developed in line with the Trust ambitions, with a focus on delivering value for money through transformation. This plan, based on benchmarking and financial analysis, focuses on three specific themes:

- Improving income
- Improving quality thereby reducing costs
- Improving efficiency and productivity

The Trust needs to deliver sustained improvement, across multiple services with varying performance objectives. Given the size, nature and complexity of the work required to deliver the VIP, the updated framework will combine:

- Top-down direction setting in line with the Trust strategy to create focus throughout the organisation.
- Broad based bottom-up values-based improvement focus to get people at all levels to take a fresh approach to solving problems, generating ideas, and improving performance.

- Cross-functional core process re-design to link activities, function, and information to achieve breakthrough improvements in efficiency and productivity.

Real transformations in performance will be delivered if efforts across all three parameters are co-ordinated and engaged. There are key differences to this approach compared to previous years, in the approach to stakeholder engagement.

- **Engagement**

It is traditionally challenging across the NHS to engage staff in programmes such as VIP, in particular maintaining momentum and keeping financial sustainability as part of everything we do.

The Christie has strong engagement foundations throughout the organisation. Building on the existing VIP with clinical leadership and engagement at its core, we will re-set and design a comprehensive timeline of activities throughout the year, to identify and effectively deliver our target.

This approach will ensure there is a clear framework and provide greater assurance of delivery enabling clinical and finance teams to work together to improve quality and to deliver safe, sustainable services for our patients and staff.

Recommendations for the VIP reset include:

- **Ideas generation** – there are multiple ways for staff to submit ideas for improvement across the Trust. By consolidating the approach any ideas for improvement can be submitted directed to the most appropriate team to support and benefits tracked. Staff involvement in decision making is key, with feedback and support for the individual to take forward.
- **Launch of a finance and clinical value maker programme** including education on how to write a business case, understanding income, defining what does good look like, how to write QIAs etc.
- **Adopting innovative technologies;** prospects for productivity gains from digital optimisation with process on how benefits will be realised.
- **Opportunity packs for each service** on where to look – this would include increased engagement in national best practice such as Getting It Right First Time (GIRFT)
- **Model hospital** review and work with the national team to see what transferable learning there is for finance, and the latest best practice efficiency checklists.
- **Maximising value for money** – taking action such as cutting duplication, e.g., for the patient it means less time waiting for treatment. Review and tackle interventions of limited or no clinical value.
- **Experienced based design:** Build on the learning from patients their families, friends, and carers to enhance experiences. Approaches such as Experienced based design increase involvement from our people in co-designing services for the future – the least waste way.
- **Building leadership and organisational capacity and capability** to deliver improvement through NHS IMPACT as an improvement approach for supporting systems and providers with continuous improvement.
- **An updated communications plan** about the financial position, efficiency and productivity opportunities and gains. This will include the proposals on how HIVE can be utilised to share success, capture ideas, and improved visibility of reporting to clinical teams.

- **Benefits realisation –** A review of all business cases invested in the last 18 months to affirm that the benefits listed in the business case have been realised. This includes links to the Sustainable Development Management Plan (SDMP).
- **An annual financial and clinical engagement launch conference**; this promotes the premise that where there is strong collaboration between finance and clinical teams implementing change across the Trust, we can improve quality and consequently reduce costs.

  The aim of the launch event will be to:
  - Seek ideas to improve the quality of our services through Clinical and Financial collaboration.
  - Renew enthusiasm amongst clinical leaders for the VIP challenge.
  - Belief that the challenge can be achieved.
  - Demystify finance, and understanding of the Value Improvement Programme, NHS financial position and capital spend.
  - Develop an understanding in delegates of how to develop ideas for their own clinical areas.
  - Facilitate discussion about the identification of interdependencies and barriers to overcome to the success delivery of clinical value improvement ideas.
  - Ideas on better ways for information sharing to ensure clinical and front-line teams are engaged and supportive of the value improvement programme.

5 Clinical Example

In September and October 2023, wait for a treatment slot in Radiotherapy was almost 5 weeks.

As well as taking immediate short-term measures, Radiotherapy have improved their use of data to identify opportunities to improve treatment capacity and waits for a treatment slot. Examples include:

- A reduction in scheduled time for lung treatments.
- A reduction in scheduled time for anal treatments.
- Designing new treatment planning solutions to remove the remaining 10% of radical lung activity delivered through older, slower techniques.
- Increasing the percentage of prostate patients that can take advantage of short course attendances (n=5) as opposed to longer course attendances (n=15).

None of these opportunities have impacted negatively on safety, efficacy, or patient experience. In fact, shortening the length of time spent in the department or reducing the number of times a patient needs to visit the department, has improved patient experience.

Ultimately these have delivered over 8 hours (24 patients) per day of additional treatment capacity. The next treatment slot is now within 1 week. A position that has been sustained since December 2023.

More opportunities are now actively being pursued in high volume disease groups (breast and lung). In addition to this, work is underway on embedding this data into our organisational systems as part of a transition into a 'continuous improvement' based approach.

Financial impact – c£650k

6 Next Steps

- Assurance checks commence for completing PID's and QIA's to be reported weekly and overseen by the Chief Operating Officer.
- The new framework will be developed as a collaborative approach, agreed, and presented to the next committee. This will include the proposed engagement event and key milestones as part of the planning approach.
- New schemes to be identified and added to the tracker, with teams encouraged to generate further ideas.
- Seek support for a financial and clinical engagement event with presentations from clinical leads about achievements this year and opportunities to work on next year's savings.

The Christie
NHS Foundation Trust

Agenda item 19/24c

Meeting of the Board of Directors

Thursday 27th June 2024

Subject / Title	ICB Undertakings
Author(s)	ICB
Presented by	Roger Spencer, CEO
Summary / purpose of paper	To update Provider Boards on the ICB undertakings
Recommendation(s)	To receive the information and discuss the current position for the system and impacts on the organisation
Background Papers	N/A
Risk Score	N/A
EDI impact / considerations	N/A
Link to: ➢ Trust's Strategic Direction ➢ Corporate Objectives	Achievement of corporate plan and objectives
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	GM Greater Manchester ICB Integrated Care Board ICS Integrated Care System

The Christie
NHS Foundation Trust

Agenda item 19/24c

Meeting of the Board of Directors

Thursday 27th June 2024

The following is provided by the GM Integrated Care System;

Background:

- Although NHS GM continues to mature there are a number of areas we have not made enough progress in and which we are working with NHSE to develop agreed actions under a single improvement plan
- These are in four key areas:
    - Leadership and governance (in a previous iteration of this was called leadership and capability but has now been updated. I am not sure if this happened before or after the slides were shared with TPC so wanted to mention it in case anybody picks up on the difference)
    - Performance and assurance
    - Financial sustainability and
    - Quality
- The specific requirements will be formalised in a letter from NHSE but in the meantime we are already working on developing the improvement plan and addressing some of the specifics areas for improvement

Governance:

- To support the work we have established governance including a board (chaired by Mark Fisher) and a wider Improvement Team (chaired by Mandy Philbin)
- The board will have overall accountability for the delivery of the agreed improvement plan and providing assurance on this to NHSE
- The wider team will develop the detail of the plan and deliver the agreed actions within it
- NHS GM will attend a monthly meeting with NHSE to provide ongoing assurance on progress
- It is critical the improvement process is owned by the whole GM system so we have representation from all parts of the system including from providers (for example chief nurse, COO, DoS, HRD etc on the improvement team as well as Chief Executive representation on the GM Board)
- The governance established to oversee this work will be for the period of time we are in this process and does not replace the governance for the ICB

Improvement Plan:

- The improvement plan is being developed around the four elements set out above and is being undertaken in a two stage process:
    1. Detailed assessment against the specific areas NHS GM is not currently seen to be delivering on
    2. Development of improvement actions that will take us further than these specific requirements and start to define where NHS GM wants to be and how we operate going forward to sustain improvement in the longer term
- The initial plan is currently in development and is due to go to the GM improvement board on 24 June with a view to it being shared with NHSE on 26 June

- The plan will have a series of success metrics so we will be able to measure the difference made
- Each action will require evidence to provide assurance of delivery and clear sign off through governance
- The improvement plan work will link into a wider piece of work on Fit for the Future which includes public, staff and stakeholder engagement work from June through to October – this is aimed at raising awareness around the challenges we face in GM and involving people in how we meet those challenges

Communications and engagement:

- The single improvement plan and process is a wide ranging piece of work
- It will be supported by a series of communications and engagement actions including further briefings and discussions through provider and locality boards
- Regular updates will be provided and these can be shared with all stakeholders – it would be good to understand if this would be helpful to board members

NHS
Greater Manchester

NHS GM Single System Improvement Plan

Stakeholder Briefing

May / June 2024

Part of Greater Manchester
Integrated Care Partnership

Background

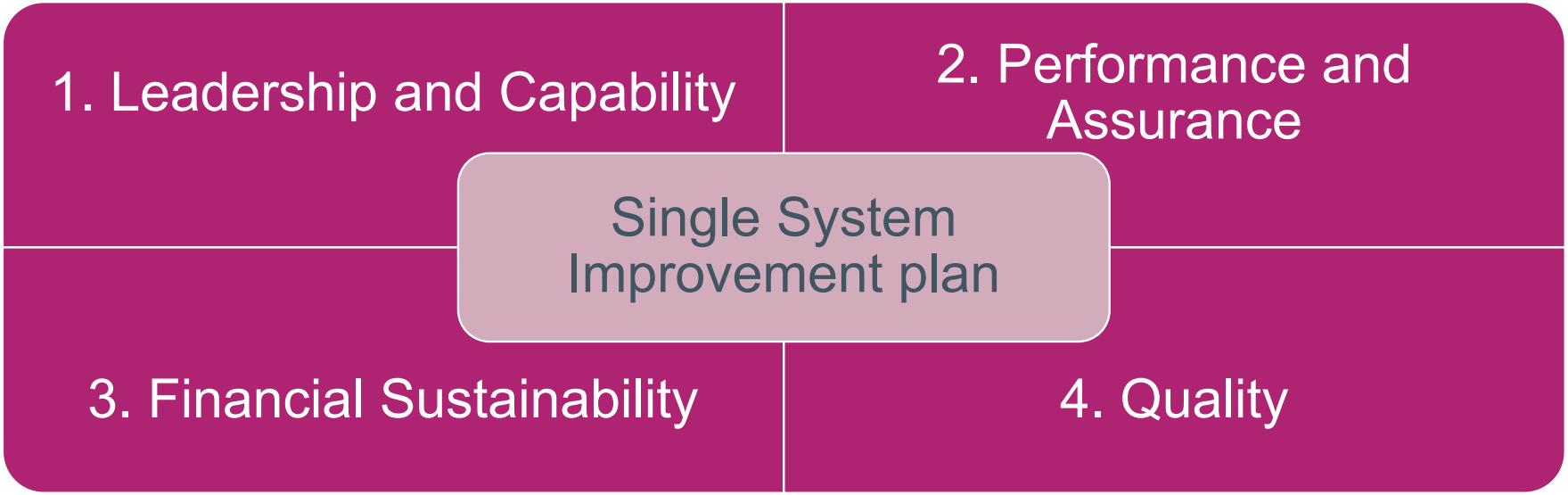
NHS Greater Manchester

- NHS Greater Manchester (NHS GM) is still a relatively new organisation which continues to grow in maturity. **Despite making good progress** in many areas, the organisation has **not made enough progress in resolving performance, finance and quality issues.**
- NHS GM will now be working more closely with NHSE on a set of formalised agreed actions under one 'single system improvement plan' - enabling a greater level of assurance in relation to our delivery. This is a process referred to legally as '**Enforcement Undertakings**'.
- The formal letter of undertakings is expected to be signed off at July's NHS Greater Manchester's Board meeting.
- Ahead of this, considerable **work is already underway to start shaping the components of a single system improvement plan** to address the grounds for the undertakings and shape the ICB making it 'Fit for the Future'.
- Existing tiering arrangements for UEC, Elective and Cancer will continue alongside this process and will provide **additional support to drive targeted improvement**.

NHS
Greater Manchester

Areas of focus in the plan

The following four areas will be the focus of the single system improvement plan



Developing the Single System Improvement Plan

NHS Greater Manchester

- The single system improvement plan is being developed in two stages:

  1. **A detailed assessment of the current position**
  2. **A detailed improvement plan for each of the four elements,** covering any aspects of the grounds that are not currently being delivered (identified through stage 1) and any further actions that will deliver additional improvement

- The plan will be outcome focused and will incorporate a series of success metrics setting out our ambition for the future
- The plan will build on existing work underway to avoid duplication, but this will be reviewed to ensure they are delivering the specific requirements
- New areas of work will be identified where actions are not currently being addressed
- The single improvement plan will be developed through May and June ahead of a meeting with NHSE where plans will be shared

Improvement Planning – 4 Chapters

NHS Greater Manchester

Leadership and capability

- Deliver the recommendations from the leadership and governance review
- Implement the Good Governance Institute well led review
- Undertake gap analysis on our capability to work as a system
- Develop and implement system owned culture, values and beliefs

Performance and Assurance

- Stress testing the system and provider operational plans
- Identifying drivers of performance and implementing plans to address them
- Developing sustainable services for the future
- Identify and spread best practice and minimum standards of delivery

Financial Sustainability

- Robust assurance and oversight on delivery of annual financial plan
- Transition into ICB FPRM process
- Develop three year plan to address underlying financial deficit position
- Clarify system commissioning intentions and implement

Quality

- Implement robust approach to provider oversight
- Align GM system and locality assurance processes
- Develop and implement approach to clinical quality and improvement
- Implement a comprehensive GM approach to patient safety

Each element of each pillar will have a detailed improvement plan behind, which will be monitored through the system improvement process

An NHS Fit for the Future

- A public, staff and stakeholder **engagement exercise** will run between **June - October** under the umbrella ‘An NHS Fit for the Future’
- This programme will enable us to **take our people along on our improvement journey** towards achieving our health, performance and financial goals.
- It aims to:
  - ✓ **Increase awareness** of the challenges we face without creating unnecessary fear
  - ✓ **Provide reassurance** that our investments and decisions will bring fairer opportunities for our citizens and have a positive impact on future generations
  - ✓ Develop **one version of the truth** about our system position
  - ✓ Begin an ongoing **programme of involving people** and communities in meeting our challenges

NHS GM System Improvement Governance

NHS Greater Manchester

- The GM governance to support the response to the undertakings and the implementation of the improvement plan includes:
  - **Overall ICB Board level accountability**
  - **SRO** - ICB Chief Executive – Mark Fisher
  - **NHS GM System Improvement Board** – meeting monthly the board will have overall responsibility for providing assurance to NHSE, it has representation from ICB Chief Officers, ICB Non-Exec Directors, Place Based Leads and Trust Provider Chief Executives
  - **NHS GM System Improvement Team** – meeting fortnightly the team will drive the development and delivery of the improvement plan with representation from across the GM system including localities and providers
- Updates will continue to be taken to through the existing NHS GM governance including GM ICB Board
- Detailed Comms and engagement plan has been developed to support the process and regular updates will be shared with locality and trust provider boards as well as staff and public

NHS
Greater Manchester

For further information on any aspect of the Undertakings or Single System Improvement Plan please contact v.sharrock@nhs.net

For further information on any aspect of An NHS Fit for the Future, please contact claire.connor@nhs.net

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Agenda item 20/24a

Board of Directors meeting
Thursday 27th June 2024

Subject / Title	Cultural Development Plan
Author(s)	Professor Christopher Harrison, Deputy CEO
Presented by	Professor Christopher Harrison, Deputy CEO
Summary / purpose of paper	Provide members of the Board with an update on the progress of the cultural audit actions
Recommendation(s)	To review the progress made with the updated oversight arrangements and the key issues outlined in the paper.
Background papers	The Christie NHSFT Cultural audit by Globis Ltd The Christie People & Culture Plan
Risk score	Risk in relation to Objective 7 Likelihood of affecting objective 3 Impact on objective 3 Overall risk 9
Link to: ➢ Trust strategy ➢ Corporate objectives	Relevant to Objective 7: People – To be an excellent place to work and attract the best staff
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.	HIVE the Trust intranet HR human resources PSIRF National Patient Safety Incident Investigation Framework

Agenda item 20/24a

Board of Directors meeting
Thursday 27th June 2024

Cultural Audit Plan

Introduction

This paper reports on the progress of the actions following the cultural audit.

Progress

Progress against specific recommendations include:

- We have changed the senior accountability arrangements in our divisions so that the divisional medical directors are now the people directly responsible for the function of the divisions. This makes the accountability for decision-making and escalation much clearer. This information will be included in a who's who of senior leadership roles in the Trust and a simple guide to our decision-making committees and what they do. This will be available to everyone. Timescale September 2024.

- We are developing guidance for senior leaders about obtaining training in specific management and leadership competencies known to impact team culture positively. This includes managing difficult conversations, undertaking appraisals and other specific skills. In the short term, this will be a written guide pointing leaders to where this training is provided and how to access it. Timescale July 2024

- In the long term, we are developing a more structured programme to provide this training and support leaders in its implementation. Our ambition is that all our senior leaders have the training and experience to manage these difficult matters sensitively and with compassion. Timescale September 2024

- Each of our four main clinical divisions is working on its own actions to improve communication. Our divisional leaders have been asked to review communication arrangements within teams to ensure that all staff can meet their line manager regularly, ideally as part of regular team meetings. Staff have been encouraged to speak directly to their line managers about how this can be arranged in each team. Timescale July 2024.

- We have implemented changes in the ways that we communicate within The Christie, with a new system that allows targeted information distribution to those who need it rather than blanket messages by email and on HIVE. Many of the notices and pictures around the Trust will have a new look. We are continuing the process of discussion and engagement so that ideas and suggestions from staff can be captured and implemented. Timescale July 2024.

- We are developing a staff workforce policy handbook that brings together the Trust's key workforce policies in one place, making them more easily accessible to leaders. This, together with making leaders more aware of the HR support available to them, will help us ensure that these policies are implemented fairly and consistently. A similar piece of work is being undertaken to produce a guide to the staff welfare and support services that are available to all colleagues. July 2024.

- We have made some temporary changes to increase the availability of space for prayers and rest. We will look to see what ongoing arrangements we can make for these important aspects of staff wellbeing and communicate this to staff as we progress. July 2024.

- We have reviewed our “Freedom to Speak Up” policy to ensure it meets best practices. As the new NHS approach to patient safety, PSIRF (the National Patient Safety Incident Investigation Framework), is implemented across the Trust, we will include ways for clinical concerns to be raised. Timescale Initial review complete—PSIRF implementation is ongoing.

- There are some parts of the organisation where we know from the staff survey and other indicators that leaders require more support. The executive and divisional teams are working with these areas to support them in addressing the issues they face. We have plans to increase the learning about effective ways of doing things between departments. Timescale In Progress

- We will further develop our understanding of The Christie's culture and what can be done to enhance it beyond the cultural audit results. This means undertaking surveys and other research to understand how things work in different parts of our organisation and how staff can be best supported. Timescale: December 2024.

Next Steps

The conversation will continue through as many routes as we can, including the enhanced communication approach and the establishment of a senior-level steering group to replace that that oversaw the original audit work. This has expanded senior medical membership and includes the elected staff governors and senior staff side representatives.

Over the next six months, the specific actions arising from the audit will be completed, and then further actions will be integrated into The Christie People & Culture Plan and our wider approach to organisational development.

Recommendation

1. The Board of Directors is asked to note the progress made with the key issues.

The Christie
NHS Foundation Trust

Agenda item 21/24a

Meeting of the Board of Directors

Thursday 27th June 2024

Subject / Title	The Christie Green Plan 2024-2027
Author(s)	Will Blair - Sustainability Manager
Presented by	Professor Chris Harrison - Deputy Chief Executive Officer Alex Beedle - Head of Facilities Will Blair - Sustainability Manager
Summary / purpose of paper	In accordance with the NHS Standard Contract Service Conditions 2024/25, The Trust must maintain and deliver a Green Plan, approved by its Governing Body, in accordance with Green Plan Guidance. This paper outlines the Draft Christie Green Plan.
Recommendation(s)	The Board are asked to approve The Christie Green Plan 2024-2027
Background papers	Sustainable Development Management Plan (2021-2024)
Risk score	9 (BAF Risk 8.4)
EDI impact / considerations	Workforce and patient impacts of the Green Plan
Link to: ➢ Trust strategy ➢ Corporate objectives	1. To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer 6. To maintain excellent operational, quality and financial performance 7. To be an excellent place to work and attract the best staff 8. To play our part in the local health care economy and community
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.	DCEO Deputy Chief Executive Officer GM Greater Manchester

Agenda item 21/24a

Board of Directors
Thursday 27th June 2024

The Christie Green Plan 2024 – 2027

1. Introduction

This report brings the Trust's Green Plan 2024-2027 to the attention of the board of directors for approval.

2. Background

In accordance with the NHS Standard Contract Service Conditions 2024/25, we are required to maintain and deliver a Green Plan, approved by the Trust Board of Directors, in accordance with Green Plan Guidance.

The board approved the previous Green Plan in June 2021. This included work on the statutory (Health and Care Act 2022) ambitions set by "Delivering a Net Zero NHS". The new Green Plan (Appendix 1) is attached.

The Green Plan covers eleven modules –

- Assurance and governance
- Workforce and system leadership
- Clinical transformation
- Digital transformation
- Travel and transport
- Estates and facilities
- Medicines
- Supply chain and procurement
- Food and nutrition
- Adaptation
- Green Space
- Biodiversity

The Green Plan has been developed through the Sustainable Development Committee and working groups. Oversight has been provided through the Net Zero and Climate Adaptation Committee (chaired by the DCEO).

3. Recommendation

The Board are asked to approve The Christie Green Plan 2024-2027.

NHS
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The Christie Green Plan 2024-2027

Contents

Professor Chris Harrison
Executive Director/ Deputy Chief Executive

Foreword

As the net zero board lead, I am delighted to introduce our Green Plan, which details how The Christie NHS Foundation Trust will support the NHS to become a net zero health service. The Trust recognises that the NHS needs to respond to the health emergency that climate change brings, which will need to be embedded into everything we do now and in the future. To ensure we continue providing health and high-quality care for all, now and for future generations.

About us

The Christie specialises in cancer treatment, research and education and is one of the largest cancer centres in Europe.

Treating more than 60,000 patients a year from across the UK, we became the first UK centre to be officially accredited as a comprehensive cancer centre and are supported by an independent charity.

The Christie employs over 3,000 staff, all of whom are determined to provide the best possible cancer care and patient experience. Some of the developments we have made in the last few years are outlined here. During our last strategy, we have built a state-of-the-art proton therapy centre as well as creating facilities in Macclesfield.

Our experts have been pioneering cancer research breakthroughs for more than 100 years and The Christie is well known for many world-firsts which have advanced cancer treatment on a global scale.

Housing the largest single site early phase clinical trials unit in the UK, we have an excellent reputation as an international leader in research and innovation, which is further strengthened by being a partner in the Manchester Cancer Research Centre (MCRC) and Health Innovation Manchester. In 2023 we opened the new Paterson building to further our scientific discoveries in partnership with the University of Manchester and Cancer Research UK.

A core element of The Christie is education. With its own School of Oncology, the first of its kind in the UK, The Christie educates healthcare professionals from across the country, enhancing the patient experience and promoting developments in cancer care.

Our partnerships

The Christie places high importance on the establishment of long-term, mutually beneficial partnerships. This is in recognition of the immense value they bring in terms of clinical excellence, academic leadership and commercial benefits.

The Christie works with world-leading organisations including Cancer Research UK and the University of Manchester. We also work closely with organisations such as HCA Healthcare to fulfil The Christie Private Care, The Christie Pharmacy Company and The Christie Pathology Partnership.

Our vision

The Christie strategy 2023 to 2028 sets out how we will continue to deliver our mission - to care, discover and teach. It has been developed following extensive consultation with staff, patients and public, and our Board of Directors.

It sets out a clear vision of how we will transform cancer treatments, care and support, and improve outcomes for our patients. Our Strategy is focused on 4 main themes:

1. **Leading cancer care**
2. **The Christie experience**
3. **Local and specialist care**
4. **Best outcomes**

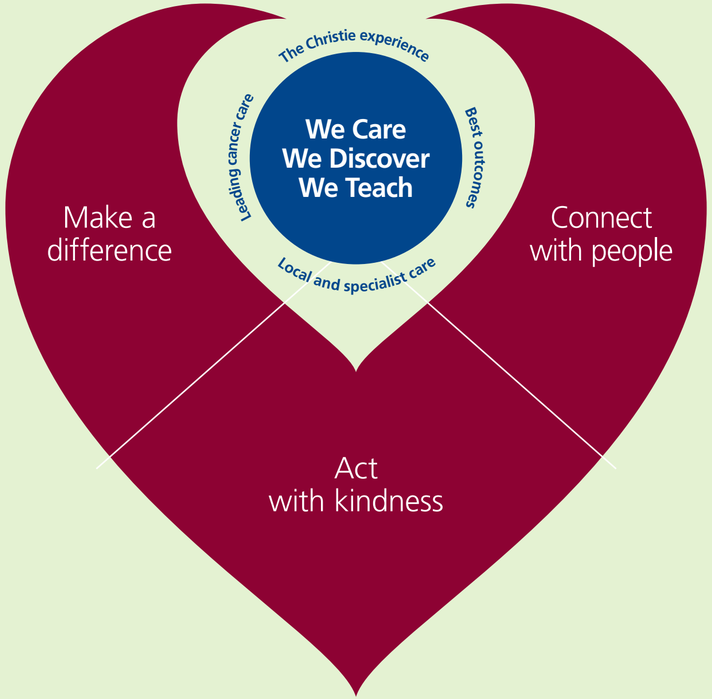
The refreshed Trust strategy has been built from integrating our clinical strategies (made up from the ambitions of our internationally recognised clinical teams and the future plans of our state-of-the-art clinical services) with our Research and Innovation, Education and Clinical Outcomes strategies which have each been renewed in parallel.

Not only do our plans ensure that the patient is at the heart of everything we do, but they also demonstrate that the key service developments will be undertaken ensuring that the Trust remains operationally, clinically and financially sustainable.

To enable our team to focus upon improving the experience and outcomes of all our oncology patients, our plans not only define the investment we intend to make into facilities and expertise, but also how we wish to work with the health professionals in Manchester and Cheshire to provide a more integrated, caring and personalised experience for our patients.

Our vision: To be a leader in both local and specialist cancer care and ensure that every patient receives the best experience and outcomes.

Our core purpose is:
to care – with compassion for our patients and staff
to discover – through world leading cancer research
to teach – using pioneering cancer education



Our Values and Behaviours

Our **values and behaviours** define how we approach our work and our mission. They sit at the heart of how we treat each other to enable us to achieve our Christie vision.

Make a difference

We are courageous and try new ideas.

We are honest and take responsibility.

Act with kindness

We care for each other and our environment.

We show appreciation and celebrate success.

Connect with people

We are inclusive.

We work together as one team.

Climate crisis

Human-induced climate change is causing dangerous and widespread disruption in nature and affecting the lives of billions of people around the world, despite efforts to reduce the risks. People and ecosystems least able to cope are being hardest hit.

There is a rapidly closing window of opportunity to secure a liveable and sustainable future for all. Without urgent, effective, and equitable mitigation and adaptation actions, climate change increasingly threatens ecosystems, biodiversity, and the livelihoods, health and wellbeing of current and future generations.

The Intergovernmental Panel on Climate Change's (IPCC) final instalment of their sixth Assessment Report on climate change impacts, adaptation and vulnerability was published on 20 March 2023. The report, which is being described as survival guide for humanity, brings into sharp focus the losses and damages experienced now, and expected to continue into the future, which are hitting the most vulnerable people and ecosystems especially hard. Climate change is a threat to human well-being and planetary health.

The world faces unavoidable multiple climate hazards over the next two decades with the 1.5°C warming threshold expected to be crossed this decade. In 2022 heat records were broken in all continents and 2023 saw the highest global temperatures in over 100 000 years. The Met Office forecasts for 2024 had suggested for the first time that values of 1.5 °C or above cannot be ruled out (see figure 1).

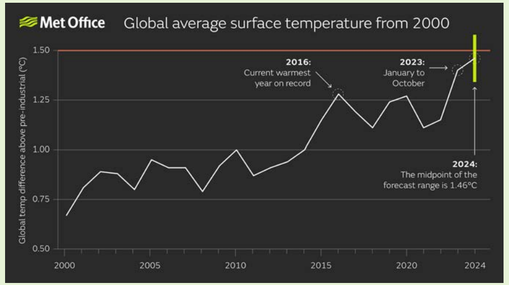


Figure 1: Met Office - Global average surface temperatures[1].

The EU's climate service confirmed in February 2024 that for the first time, global warming had indeed exceeded 1.5C across an entire year. Even temporarily exceeding 1.5 °C will result in additional severe impacts, some of which will be irreversible.

The temperatures in Manchester have also increased with many of the hottest years occurring in the last few decades (see Figure 2). A significant moment occurred in July 2022 when the UK Health Security Agency (UKHSA) declared a national state of emergency with a level 4 heat-health alert. The level 4 alert is the highest warning and the first time it had been issued on a national level. At level 4 illness and death can occur among the fit and healthy. Also, that the impacts could go beyond health and social care with potential effects on transport systems, food, water, energy supplies and businesses. On 19 July, a record temperature of 40.3 °C was recorded and verified by the Met Office in Coningsby, England, breaking the previous record set in 2019 of 38.7 °C. The same day Greater Manchester temperature reached record high of 37.7°C, with the previous record of 33.9°C from July 25th, 2019. As climate change has driven such unprecedent severe weather events it can be difficult to make the best decisions because the heat was far more intense and widespread than previous comparable heatwaves.

Risks for society will increase, including to infrastructure and low-lying coastal settlements. The cumulative scientific evidence is unequivocal: Climate change is a threat to human well-being and planetary health. Any further delay in concerted anticipatory action on adaptation and mitigation will miss a brief and rapidly closing window of opportunity to secure a liveable and sustainable future for all.

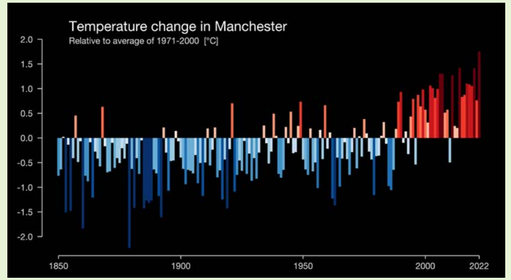


Figure 2: Temperature changes in Manchester 1884-2022

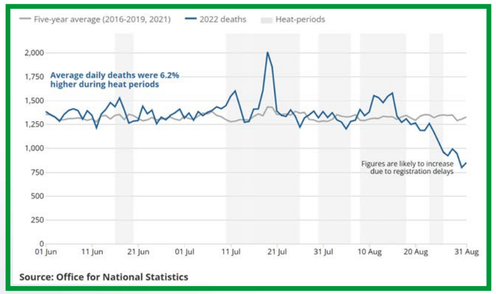
Climate crisis and health

Climate change, caused by human greenhouse gas emissions, is already harming people's health and driving widespread losses and damages.

The health impacts of climate change are happening now and are worsening. They overwhelmingly affect disadvantaged and marginalised communities and exacerbate existing health inequities. As climate change threatens the foundations of good health, with direct and immediate consequences for our patients, the public and the NHS.

The UKHSA and the Office for National Statistics (ONS) estimate that between 17 to 20 July 2022, when temperatures were at their highest, there were 1,012 excess deaths in those aged over 65. These figures demonstrate the possible impact that hot weather can have on the elderly and how quickly such temperatures can lead to adverse health effects vulnerable groups.

Many climate solutions also have benefits for health and wellbeing, and early climate action will bring long-term economic and health gains. The benefits to health far exceed the costs of implementing climate actions.



Source: Office for National Statistics

Figure 3: Daily death occurrences increase during heat-periods

Delivering a Net Zero National Health Service Report

The Delivering a 'Net Zero' National Health Service report provides targets to reduce system wide emissions within direct control (NHS Carbon Footprint) to net zero by 2040, and wider indirect emissions including the supply chain (NHS Carbon Footprint Plus) by 2045 (see figure 4). The commitments were enshrined in law with the passing of the Health and Care Act 2022.

Looking at the wider scope of the NHS Carbon Footprint Plus, Figure 5 shows that the greatest areas of opportunity – or challenge – for change are in the supply chain, estates and facilities, pharmaceuticals and medical devices, and travel.

The report also includes interim targets that are defined as defined equivalent to:

- **Reducing NHS Carbon Footprint by at least 47% from 2019/20 levels by 2028-2032;**
- **Reducing NHS Carbon Footprint Plus by at least 73% from 2019/20 levels by 2036-2038**

These are the most ambitious targets of any healthcare system in the world to address the impact of the sector and address the climate and health emergency. The Trust is committed to address the climate and health emergency, and we recognise it is our duty to contribute towards the level of ambition set out in report.

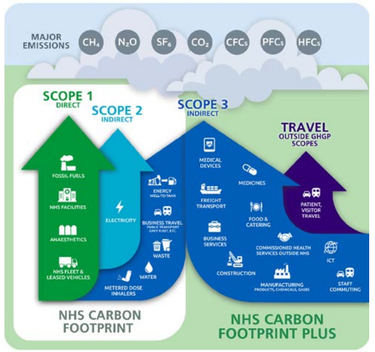


Figure 4: Green house gas scopes in the context of the NHS

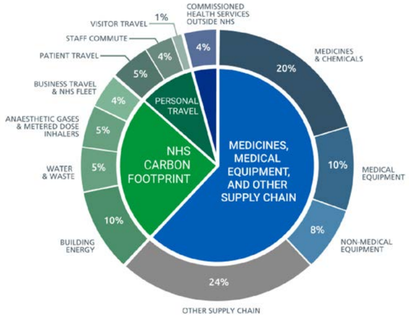


Figure 5: Sources of carbon emissions by proportion of NHS Carbon Footprint Plus

Greater Manchester Green Ambition

The Green Plan also complements our commitment to the Greater Manchester Five Year Plan for the Environment, which has set out the bold ambition for the city region to be one of the healthiest, cleanest and greenest city-regions and to be carbon neutral by 2038.

The Greater Manchester Five Year Plan for the Environment focusses on the six key parts of our daily lives where action is required:

- **Our energy supply**
- **Our transport and travel**
- **Our homes, workplaces and public buildings**
- **Our production and consumption of resources**
- **Our natural environment**
- **Our resilience and adaptation to climate change**

The NHS Greater Manchester, of which The Christie is a member, become the first Integrated Care System (ICS) to declare a climate emergency. This has been supported with the development of an ICS Green Plan that sets out how we will use the power of the system to deliver far-reaching innovation and change, and outlines priorities and targets for delivering net zero carbon emissions. The challenge set out in this Green Plan will not be easy to deliver, but by working together and building momentum across the system we can deliver change at scale and inspire other systems across the country to do the same. Furthermore, the collaborative work that takes place on the ICS Green Plan will support and enhance the implementation of the Trust Green Plan.

One of the ten ambitions in Greater Manchester's 'Our People, Our Place' strategy is to ensure the region is at the forefront of action on climate change. The Greater Manchester Combined Authority (GMCA) has formed the Green City Region, tasked with bringing together stakeholders from across the city to ensure Greater Manchester is leading the way on this agenda.

"Young people across Greater Manchester and the rest of the globe have stood up and called for politicians to take urgent action on climate change. I want to say today we are listening. I'm determined that we invest in young people and give you all hope for the future. Greater Manchester wants to be carbon neutral by 2038. Our plan is the UK's first science based commitment for a city-region like ours, and one of the first of its kind globally.

We have a science-based deadline and a deliverable plan putting us on a path towards it. Achieving our ambition will be very challenging, but it is the right thing to do. We believe this sets us apart from other UK city-regions and puts us at the top table globally. The big challenge is how we use the need to take fossil fuel out of our lives and economy to transform Greater Manchester so it works for everyone. That's the challenge I have set myself as Mayor, and it's the challenge that I am setting today.

Cities and city-regions will make the difference on climate change and, in decarbonising by 2038, Greater Manchester can create a blueprint for every other city in the world. It wouldn't be the first time. We can change ourselves, and we can inspire change in others. I say this to the people of Greater Manchester: come with us. Tackling a problem on this scale will need us all to work together."

Andy Burnham,
Mayor of Greater Manchester

Sustainable clinical practice

The provision of healthcare incurs not just financial costs, but also contributes to significant environmental ones, in the form of greenhouse gas emissions, soil degradation, desertification, the decline of life in the oceans, species extinctions, deforestation, and water and air pollution.

This could be viewed as spending ecological capital, which is equally essential to population health. The medical profession can therefore be seen as having a particular responsibility to lead the fight against climate change and wider environmental impacts.

Once the contribution of clinical activity to environmental impact is recognised, the need to create a service which is health promoting as well as skilled in responding to immediate clinical need becomes clear. This can be addressed by considering the four principles of sustainable clinical practice. Furthermore, by adopting sustainable quality improvement into service improvement and considers the 'tiple bottom line' of social, environmental and financial benefits.

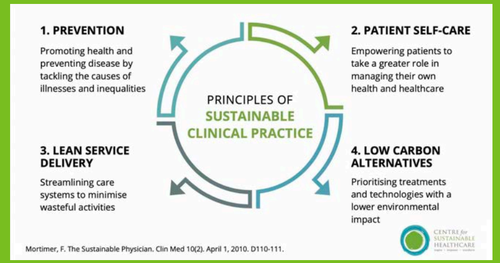


Figure 6: Sustainable principles of clinical practice

Key legislation and drivers for change

Outline of statutory, regulatory and policy requirements which were consider as part of the Green Plan.

International	
UN sustainable development goals	The Sustainable Development Goals (SDGs), also known as the Global Goals, were adopted by the United Nations in 2015 as a universal call to action to end poverty, protect the planet, and ensure that by 2030 all people enjoy peace and prosperity. The 17 SDGs recognise that that development must balance social, economic and environmental sustainability.
Climate change 2023 synthesis report summary for policymakers	Summarises the state of knowledge of climate change, its widespread impacts and risks, and climate change mitigation and adaptation.
The 2023 report of the Lancet Countdown on health and climate change	Report tracks the relationship between health and climate change across five key domains and 47 indicators, providing the most up-to-date assessment of the links between health and climate change.
National	
Climate Change Act (2008)	Established powers for the government to ensure that organisations in key sectors are aware of and prepared for the impact of a changing climate. Commits the UK government by law to reducing greenhouse gas emissions by at least 100% of 1990 levels (net zero) by 2050.
Environment Act (2021)	Includes provisions to establish a post-Brexit set of statutory environmental principles, a new environmental watchdog and provisions relating to waste, air, water and biodiversity.
Health and Care Act (2022)	The legislation states that NHS organisations must be compliant with the UK's Climate Change Act 2008 and the Environment Act 2021. The NHS must also "adapt to any current or predicted impacts of climate change" as identified in the climate change reports that the government is required to put before parliament at least every five years.
UK Health Security Agency report on Health Effects of Climate Change in the UK	This report provides an authoritative summary of the scientific evidence on the health effects of climate change, potential implications for public health, and gaps in evidence.
UK Climate Risk Independent Assessment (CCRA3) -Health and Social Care Sector Briefing (2021)	The UK Climate Risk Independent Assessment (CCRA3) was developed at a UK-wide scale involving scientists, economists, and stakeholders from across the United Kingdom. This briefing summarises how health and social care have been assessed and what types of action to adapt to climate change risks and opportunities would be beneficial in the next five years.
NHS Standard Contract Service Conditions	NHS Standard Contract Service Conditions are updated on an annual basis and include obligations that the Provider must take all reasonable steps to minimise its adverse impact on the environment.

Key legislation and drivers for change (continued)

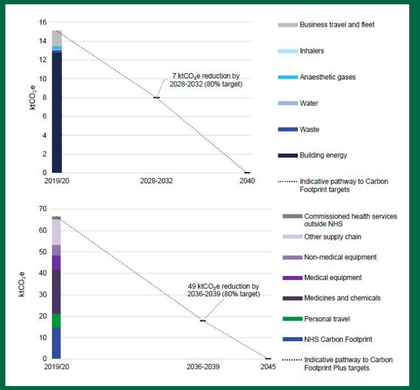
National	
NHS clinical waste strategy	The NHS clinical waste strategy aims to improve waste management practices amongst NHS trusts, NHS foundation trusts and primary care to make them more efficient and sustainable in order to save on cost, improve hospital function, and reduce the impact on the environment in line with NHS net zero carbon commitments.
Net Zero travel and transport strategy	This strategy outlines how the NHS will have fully decarbonised its fleet by 2035, with its ambulances following in 2040.
NHS Estates 'Net Zero' Carbon Delivery Plan	This delivery plan aims to address the aspects of the net zero strategy pertinent to estates and facilities activities. It sets out a clear, sequential four step investment approach to decarbonising NHS sites.
Estates Net Zero Carbon Delivery Plan - Technical Annex	This Technical Annex has been produced to support the Estates Net Zero Carbon Delivery Plan and details the interventions, activities and target dates required to achieve the eleven strategic actions within the Estates Delivery Plan.
NHS Net Zero Building Standard	The NHS Net Zero Building Standard provides technical guidance to support the development of sustainable, resilient, and energy efficient buildings that meet the needs of patients now and in the future.
Local	
The Greater Manchester Strategy	The strategy for Greater Manchester sets out a route, over the next decade, to deliver this vision for the benefit of our people, our places and our planet.
GMCA 5-Year Environment Plan for Greater Manchester 2019-2024	Sets out the aim and priorities for Greater Manchester to be a carbon neutral city region by 2038.
Greater Manchester Transport Strategy 2040	Sets out Greater Manchester's long-term ambition for transport.
Manchester Climate Change Framework 2020-2025	Manchester's high-level strategy for tackling climate change.
The NHS Greater Manchester Integrated Care Green Plan 2022–2025	The Green Plan from NHS Greater Manchester Integrated Care has at its heart a commitment to achieve a net zero carbon footprint by 2038, in collaboration with partners as part of the Greater Manchester Combined Authority Environment Plan. By 2045, this net zero commitment will also include the carbon impact of goods and services in line with a national NHS target.

Trust carbon footprint

Trust baseline

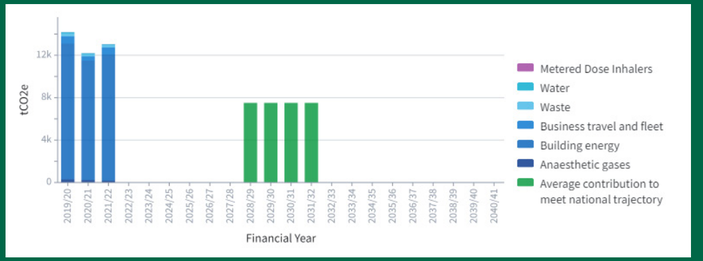
2019/20 is the base year from which trajectories to Net Zero were defined in the Delivering a Net Zero NHS report, and therefore NHS England defined the required average contributions from NHS trusts. The carbon footprint plus data provided is to be used for baselining, identifying emissions hotspots, and understanding contributions to the national emissions set out in the Delivering a Net Zero NHS report.

NHS Carbon Footprint	**15,061**	**tCO_2e**
Building energy	*12,810*	tCO_2e
Waste	*261*	tCO_2e
Water	*110*	tCO_2e
Anaesthetic gases	*284*	tCO_2e
Inhalers	*7*	tCO_2e
Business travel and fleet	*1,589*	tCO_2e
Personal travel	**6,174**	**tCO_2e**
Staff commuting	*2,198*	tCO_2e
Patient travel	*2,897*	tCO_2e
Visitor travel	*1,079*	tCO_2e
Medicines, medical equipment and other supply chain	**44,177**	**tCO_2e**
Medicines and chemicals	*20,472*	tCO_2e
Medical equipment	*6,838*	tCO_2e
Non-medical equipment	*4,679*	tCO_2e
Other supply chain	*12,188*	tCO_2e
Commissioned health services outside NHS	**1,065**	**tCO_2e**
NHS Carbon Footprint Plus	**66,477**	**tCO_2e**



NHS Carbon Footprint (2022/23)

Data provided by NHS England shows Trust contributions to the NHS Carbon Footprint up to financial year 2021/22. Furthermore this does not represent the most complete and accurate data set, as currently data for the Carbon Footprint Plus is incomplete. This Green Plan aims to address this gap going forward and also develop internal reporting process to ensure most up to date data is available.



Green success

This Trust has had early success in our journey towards net zero and aims to build upon these success stories going forward.

Sustainability nurses

Angela Hayes, Palliative Care Clinical Nurse Specialist, and Alexandra Langstaff, Ward Sister, (pictured below) were jointly named as Sustainability Nurse of the Year at the British Journal of Nursing Awards 2024. Angela and Alexandra are keen to promote greener nursing practices as part of The Christie's ongoing drive to increase our sustainability.

Innovation

Dr Robert Chuter (Principal Clinical Scientist) successfully applied for NIHR (National Institute for Health and Care Research) funding to implement an innovative research project that looked at modelling the carbon footprint of radiotherapy pathway. To improve environmental sustainability within radiotherapy, foundational works for others to develop upon are necessary. The radiotherapy pathway incudes everything that happens to the patient from diagnosis to follow up. Whilst fully understanding the carbon footprint of the radiotherapy pathway will take time and the efforts of many, it is important to begin assessing this UK wide service. This innovative research aims to support improving efficiency whilst also reducing costs in the radiotherapy pathway. This study builds on a project funded by a Greener NHS North West innovation fund.

NHS Forest Awards 2023

The Christie gardener, Phill Walker's work on Trust green space has been recognised in the NHS Forest Awards 2023. Recognition was given for projects to support biodiversity and for innovative development of green space on a healthcare site, including:

- Outdoor education spaces for children
- Living walls
- Permeable concrete
- Native planting
- Birdhouses, bat boxes, and bug hotels
- Reuse of materials on site
- Pop-up gardens
- Use of organic mulch and compost

These combined efforts have not only transformed the site into a lush and vibrant landscape but have also created a haven for native flora and fauna. The Trust greenspace now stands as a testament to the commitment to biodiversity conservation and sustainable environmental practices, serving as a model for similar projects aiming to harmonise human development with nature.

Public Sector Decarbonisation Scheme

The Trust working with our energy partner Vital Energi successfully applied for £7.9m of grant funding through the Public Sector Decarbonisation Scheme. This was to support the installation of a self-funding fully integrated energy solution comprising a unique blend of renewable technologies.

- 280kW Solar PV System
- 2MWh Battery Energy Storage System
- 700kW Heat Pump System
- Replace Boiler / New high efficiency CHP
- 3000 LED Lighting upgrade
- De-steam improvements (LTHW)
- Site wide energy saving measures
- BEMS Optimisation
- Energy infrastructure upgrades

We forecast savings of £500k on energy bills in the first year with ongoing energy savings of £1.8m per year guaranteed. The savings in terms of carbon emissions is 1250 tonnes of carbon dioxide equivalent per year.

Green Travel Plan

The Trust has achieved a 12% model swing towards sustainable travel from 2013 baseline (46% of staff using sustainable travel in 2022). This has been achieved through an award-winning Green Travel Plan, staff benefits and investment in cycling infrastructure. This has helped the Trust achieve Transport for Greater Manchester's Platinum Accreditation. The highest rating possible for travel management.

Areas of focus

This Green Plan is aligned to the main drivers of change and sources of carbon emissions across Trust activities. The aim is to further develop actions completed in the previous Green Plan and to also incorporate new ideas.

A full detailed list of the actions can be found in appendix 1.

Assurance and governance

Workforce and system leadership

Clinical transformation

Digital transformation

Travel and transport

Estates and facilities

Medicines

Supply chain and procurement

Food and nutrition

Adaptation

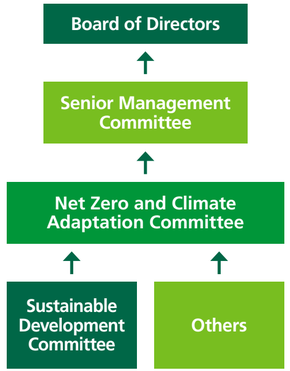
Green space and biodiversity

Assurance and governance

The Green Plan is approved by the Trust Management Board and Board of Directors. This is to ensure that it is embedded and aligned with the strategic direction of the organisation.

The Green Plan is led by a designated board-level net zero lead who chairs the Trust Net Zero and Climate Adaptation Committee. This is a senior strategic and advisory committee the meet quarterly with responsibility for delivering of Green Plan and ensuring relevant legislative and NHS England guidance compliance. The Senior Management Committee meetings are reported to Trust Net Zero and Adaptation Committee meeting by exception. Any items of specific concern or those which require Board approval will be the subject of a separate report.

The Sustainable Development Committee meets monthly and consists of stakeholders from across the organisation. This group provides operational leadership, coordination and guidance to the Trust for integration of sustainability principles and practices throughout the Trust's core activities. The committee meetings are reported to the Trust Net Zero and Climate Adaptation Committee. Additional working groups are set up when required and will also report to Trust Net Zero and Climate Adaptation Committee.



Where we are	Where we are going
• Net Zero Board Lead • Sustainability Manager • Governance structure in place • Sustainability annual report with qualitative progress data	• Publish sustainability annual report with quantitative progress data. • Monthly greenhouse gas emission for waste, business travel and medical gases reported in tonnes.

Workforce and System Leadership

This area looks at how the Trust approaches engaging, educating and developing our workforce and system partners in defining and delivering carbon reduction initiatives and broader sustainability goals. Furthermore, how sustainability will be incorporated into decision making processes.

Where we are	Where we are going
• Net Zero Board Lead • Sustainability Manager • Governance structure in place • Sustainability annual report with qualitative progress data	• Net Zero and Adaptation policy • Sustainable Impact Assessment for business cases and policy. • Provision of leadership development and education series. • Repackage relevant benefits as green benefits and update recruitment materials. • Job documentation and appraisal guidance to reference net zero target and/or healthcare emergency. • Introduce signposting to wellbeing advice and support linked to eco-anxiety.

Clinical transformation

The NHS Long Term Plan set out a commitment to deliver a new service model for the 21st century. If the NHS is to reach net zero emissions, that new service model must include a focus on sustainability and reduced emissions. This will require a focus on the 'triple bottom line' of environmental, finance and social pillars in clinical pathway design and improvement.

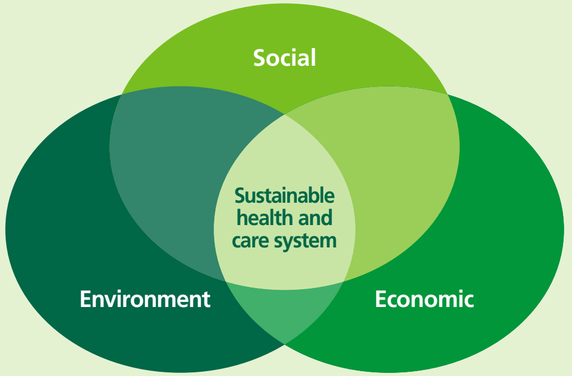


Figure 7: Three 'pillars' of sustainability

Where we are	Where we are going
• Estimating the carbon footprint of external beam radiotherapy. • Participated in Centre of Sustainable Healthcare's Green Team Competition. • Bloods Closer to Home (BCTH) to reduce travel for patients and transport organised by the Trust). • All clinic outcome forms are now to be done via the e-outcome form reducing paper. • Treatment closer to home through our three satellite centres.	• Facilitate Sustainable Quality Improvement (SusQI) training for leads across the Trust. • Incorporate SusQI into implementation plan for NHS IMPACT • Measuring the carbon footprint of a move to hypofractionation in radiotherapy • Estimating the carbon footprint of Proton Beam Therapy. • Measure carbon footprint of MR-Linac in collaboration with the manufacturer. • Measure carbon footprint of nuclear medicine with a specific aim on PET and SPECT.

Digital transformation

The direct alignments between the digital transformation agenda and a net zero NHS are clear. This Trust seeks to focus on ways to harness existing digital technology and systems to streamline service delivery and supporting functions while improving the associated use of resources and reducing carbon emissions.

Where we are	Where we are going
• Recycling/reselling/ donating ICT resources - ensure no IT waste is sent to landfill. • All new IT procured meets or exceeds current government buying standards.	• Reduce energy consumption including moving to Cloud and low CO2 data centres. • Digital First Travel Policy - eLearning and online learning • Power saving initiatives • Improved digital communications removing the need for paper.

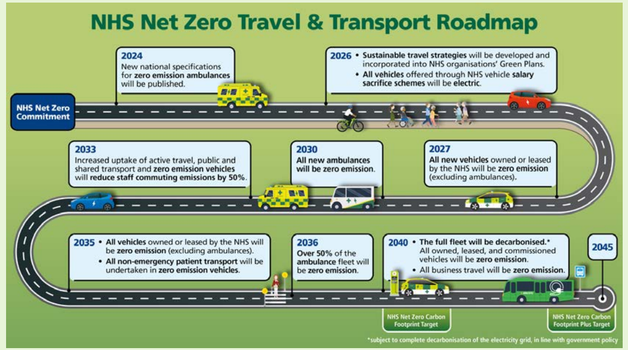


Figure 8: The NHS net zero travel and transport roadmap

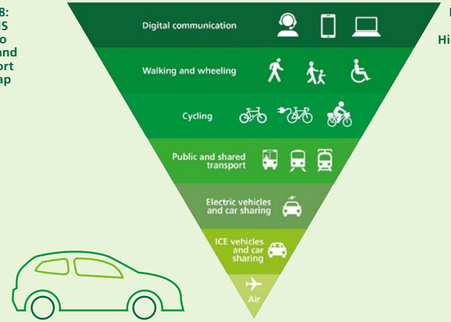


Figure 9: Travel Hierarchy

Travel and transport

NHS England has developed an NHS Net Zero Travel & Transport Strategy that describes the interventions and modelling underpinning the commitments that the NHS will have fully decarbonised its fleet by 2035, with its ambulances following in 2040 (see figure 8).

The Trust recognises its role in its delivery and as an anchor institution is committed to taking ambitious action to tackle the twin challenges of climate change and air pollution. Through adopting the transport hierarchy in the delivery of services (see figure 9). Actions to cut carbon emissions can also reduce air pollution which leads to direct improvements to health while also addressing health inequality.

Where we are	Where we are going
• Award winning Green travel plan • Annual staff travel survey (average response rate 41% since 2013) • A 12% model swing towards sustainable travel from 2013 baseline (46% of staff using sustainable travel in 2022). • Twelve electrical vehicle charge points in staff car park. • Annual Modal Shift Report • Car park eligibility process	• Revised Green Travel Plan in line with NHS Net Zero Travel and Transport Strategy • Fleet management centralised. • Air Quality Risk Assessment • Electric vehicle infrastructure strategy

Estates and facilities

The Trust estates and facilities team has a critical role to play in achieving net zero as it is an area where the NHS can take direct action needed to help reduce Carbon Footprint and also a proportion of the Carbon Footprint Plus.

Interventions have been identified in the NHS Estates Net Zero Carbon Delivery Plan four step approach to decarbonise the NHS estate by 2040 (see figure 8).

Furthermore, the NHS's clinical waste strategy published in March 2023 (see figure 9), sets out NHS England's ambition to transform the management of clinical waste by eliminating, reusing and processing it in the most cost effective and sustainable way.

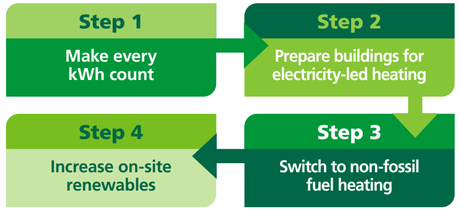


Figure 10: Four step approach to decarbonise the NHS estate by 2040. These are indicative numbers not actuals.

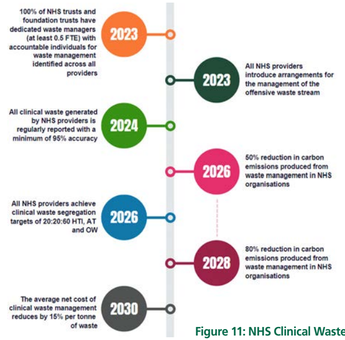


Figure 11: NHS Clinical Waste Strategy

Where we are

Estates decarbonisation schemes

The Christie put £6.9 million towards decarbonisation and also received a grant of £8 million from the government. This led to the development of the following schemes:

- Solar power system
- Battery energy storage system
- Heat pump system
- LED lighting upgrade
- Other energy infrastructure upgrades including;
  - New higher efficiency combined heat and power
  - Steam System Improvements

The schemes will deliver circa one tonne of carbon emission savings and circa £500k annually in energy cost savings.

Where we are going

- Aim to deliver of NHS waste strategy targets.
- Implementation of reusable sharp containers across the Trust.
- Trust wide waste training.
- Improve energy metering (gas and electric) across site where feasible and develop a sub-metering strategy.
- Where financially feasible return to the policy of purchasing electricity which is from 100% renewable sources
- Development of a decarbonisation plan and strategy.
- Where possible new roofing projects to have additional insulation installed to decrease heat loss.
- Incorporate sustainability into handover process to communicate and induct staff into the new building or area.
- Deliver our first redevelopment heated soley by electricity.

Medicines

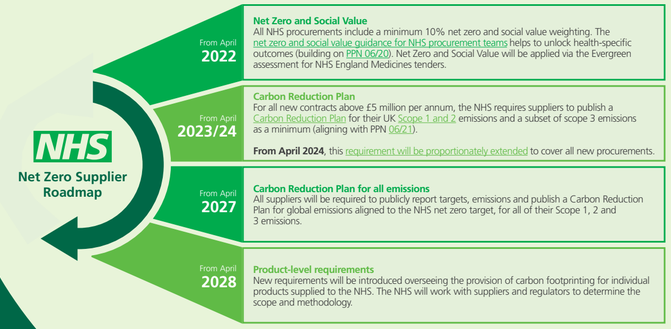
Medicines account for 25% of emissions within the NHS carbon footprint plus primarily within the manufacturing and freight inherent in the supply chain. Interventions that should be considered include optimising prescribing, substituting high carbon products for low-carbon alternatives, and improvements in production and waste processes.

Where we are	Where we are going
• Decommissioning of the nitrous oxide manifolds across site • The proportion of desflurane to all volatile gases used in surgery to 2% or less by volume.	• System wide campaign to encourage patient to bring own medicines into hospital on admission. • Campaign to encourage patients to be discharged with their controlled drugs. • Reduction in paper pharmacy documents. • Reduction in plastics wastage supplied by sponsors in study kits.

Supply chain and procurement

The Trust uses a network of suppliers to produce and deliver the goods and services needed to deliver healthcare. The emissions associated with the supply chain account for the largest proportion of the overall NHS Carbon Footprint Plus. Whilst we don't have direct control over these emissions, we have significant influence and purchasing power.

NHS Net Zero Supplier Roadmap



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Where we are	Where we are going
• All tenders include minimum 10% net zero and social value. • All tenders require a copy of company's Environmental / Sustainability Certificate (ISO 14001 or equivalent). • All tenders require company's CSR (Corporate social responsibility) policy. • Optional questions added to tenders: - Policy towards reducing the amount of single use plastics. - Plans to reduce your carbon output, in line with the NHS targets for decarbonisation. - Plans to reduce the amount of plastic packaging and future plans to utilise recycled packaging. - Carbon footprint of the product throughout the whole life cycle, including the manufacturing, use and disposal of the product.	• Develop standard Sustainability Specific Key Performance Indicators • Understand carbon footprint of "Gold" suppliers (contacts over £500,000) • Obtain and monitor Carbon Reduction plans • Ensure suppliers are complaint with the Evergreen Assessment

Food and nutrition

The nutritional quality of food served to patients has a direct impact on their health and recovery. A well-balanced plate is also a low carbon plate, consisting of minimally processed foods and seasonal, ideally locally sourced, fruit and vegetables. Improving the quality of the food served within hospitals has the potential to significantly benefit the patient experience and recovery rates, as well as improve staff health and wellbeing.

Where we are

- **Identified opportunities to make menu options healthier and lower carbon by increasing the proportion of fruit, vegetables, beans, pulses or other low carbon ingredients/proteins.**
- **Tackling obesity by empowering adults and children to live healthier lives by preventing advertising on site of unhealthy food advertising and encouraging healthier alternatives.**
- **Plastic bottled water phased out of restaurant.**

Where we are going

- **Electronic Menu book being explored for patients.**
- **Adapt menus for patient meals to use more seasonal produce.**
- **Review suppliers to meet GBSF Standards**
- **Review how waste is processed on site**

	2030s	2050s	2080s	
Summer Average Air Temperature (°C)	+0.9 to +1.9	+1.4 to +3.3	+2.6 to +6.4	↑
Summer Maximum Air Temperature (°C)	+0.9 to +2.2	+1.6 to +3.8	+2.9 to +7.4	↑
Winter Average Air Temperature (°C)	+0.7 to +1.7	+1.1 to +2.6	+1.7 to +4.5	↑
Winter Minimum Air Temperature (°C)	+0.7 to +1.7	+1.2 to +2.8	+1.7 to +4.9	↑
Annual Average Air Temperature (°C)	+0.8 to +1.5	+1.2 to +2.5	+2.0 to +4.7	↑
Summer Precipitation Rate (%)	-2 to -21	-11 to -35	-19 to -52	↓
Winter Precipitation Rate (%)	+2 to +11	+4 to +18	+9 to +32	↑

Table 1: Predicted Climate Impacts for Manchester

Where we are

- **Climate Change Risk Assessment**
- **Flood Risk Assessment**
- **Major Incident Plan**
- **Heatwave Plan**

Where we are going

- **Review Heatwave Plan in line with latest UK Climate Projections**
- **Review flood risk assessment in line with latest UK Climate Projections**
- **Review Major Incident Plan in line with latest UK Climate Projections**
- **Climate Adaptation Plan**

Adaptation

Climate change adaptation seeks to manage this risk to services, adapting or designing buildings and processes to ensure continuity of care, in a rapidly changing global climate.

Adaptation measures will complement the existing Emergency Preparedness, Resilience and Response (EPRR) measures which are developed to react to individual incidents when they occur. The Met Office has published a "Manchester Climate Pack" predicting likely climate impacts for Manchester (see Table 1).

The Climate Change Act 2008 established under section 56 that a five-yearly cycle of Climate Change Risk Assessments (CCRA) and the UK National Adaptation Programme.

- The third Climate Change Risk Assessment (CCRA3) was published June 2021. Chapter 5 covers Health, Communities and the Built Environment.
- The Third Health and Social Care Adaptation Report was published by the NHS and the UK Health Security Agency in December 2021 as part of that process.

The Health and Care act 2022 legislated that Trust must adapt to any current or predicted impacts of climate change identified in the most recent report under section 56 of the Climate Change Act 2008.

Green space and biodiversity

The benefits of access to nature and green space for mental and physical health, include positive outcomes for heart rates and blood pressure, stress levels, mood and self-esteem, obesity, type 2 diabetes, post-operative recovery, birth weight, children's cognitive development and cardiovascular disease.

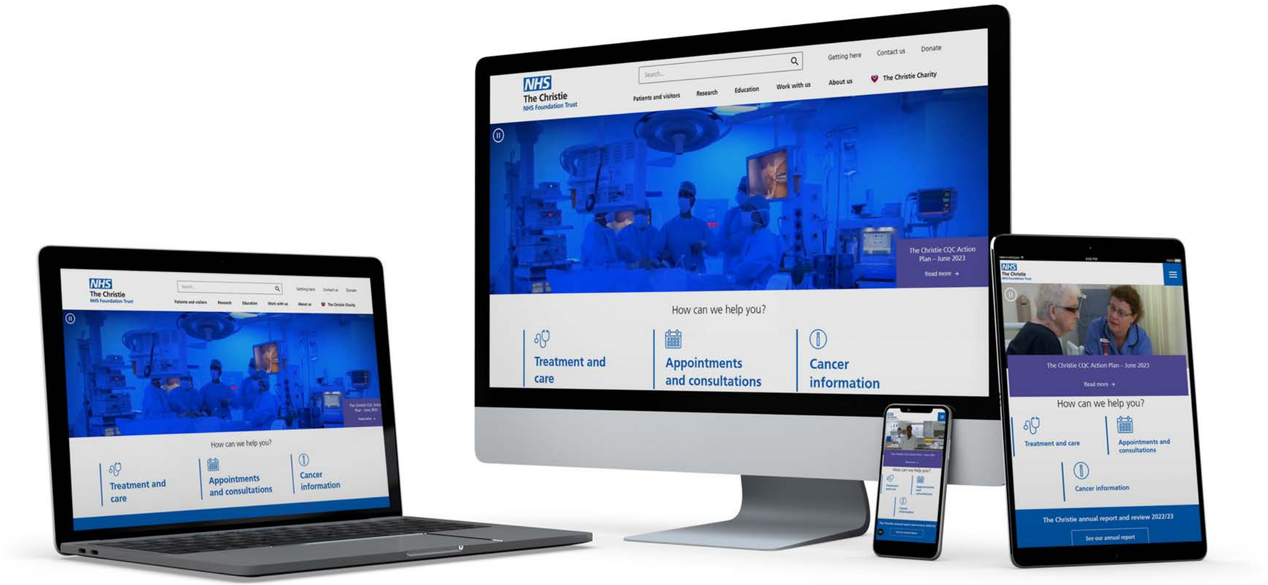
When people have more access to green space where they live, income-related health inequalities are less marked. In England alone, it has been calculated that the NHS could save an estimated £2.1 billion every year in treatment costs if everyone had access to good quality green space.

Where we are

- Wildflower gardens
- Fruit trees and vegetable
- Bug hotels
- Outdoor education spaces for children
- Living walls
- Permeable concrete
- Indigenous plant species prioritised in landscaping.
- Reuse of materials on site.
- Birdhouses and bat boxes.
- Tree registers.

Where we are going

- Biodiversity strategy to maintain and further develop green spaces onsite.



Communication plan

The success of the plan requires engaging and accessible communications with all stakeholders. Achieving net zero and adapting to the impacts of climate change will require collaboration with all stakeholders as all skills on knowledge will be required to build a truly sustainable healthcare service.

Our main focus will be to use existing communications channels to promote our work, encouraging staff and others to consider green issues in all they do. Key channels of communications include our intranet Hive, internal newsletter Chinwag and the monthly Team Briefing. All communications activity will link in with work carried out by our Organisational Development team.

Externally, we will also use existing channels to promote our best practice work in the area. This includes media relations for any projects of particular significance, social media and The Christie's website.

The Trust's communications team will lead on all communications activity.

Tracking progress

To support the delivery of the Green Plan a range a reports and data collections will be used to monitor progress. These are both internal and external reporting methods to ensure good governance and transparency. The reports will utilise a combination of qualitive and quantitative data. The reporting methods may be subject to change throughout the delivery Green Plan to ensure compliance with local, regional and national requirements.

Monthly	Quarterly	Six monthly	Annual
• Waste tonnage/emissions • Medical gas emissions • Fleet milage/emissions • Business travel emissions	• Greener NHS Data Collection • Quarterly dashboard report to Net Zero and Climate Adaptation Committee • Presentation to Development and sustainability committee.	• Written report to the Trust Audit Committee	• Trust Annual report • Trust Sustainability Report • NHS Fleet Data Collection • Greener NHS Green Plan Support Tool • Estates Returns Information Collection • NHS Premises Assurance Model • Annual staff travel survey modal shift report

Challenges and risks

Training will help to embed sustainability into operations and governance, create sustainable improvements and change culture.

Introduction

There are a number of challenges and risks that the organisation faces in ensuring implementation of the Green Plan and the underpinning work programme. The risk assessment of the plan is currently scored at nine. We have identified seven key risks that we must work together with key stakeholders both within and outside of the Trust to overcome in the next year.

Organisational vision

Although significant progress has been made in the last Green Plan, sustainability is still not fully embedded into the organisational culture as evidenced by no formal consideration for sustainability in business cases. This could be addressed by ensuring that there is a sustainable impact assessment for business cases, procedures and policies.

Workforce and system leadership

Due to the scope of the work involved with responding to the climate crisis it is anticipated that additional staff resources will be needed. Training is also required to ensure that all staff understand the commitments around delivering a net zero service and how climate change will impact the service we provide at this Trust. Particular attention needs to be focused on raising awareness around the urgency of the climate crisis. Training will help to embed sustainability into operations and governance, create sustainable improvements and change culture. Through education we will be able to support adaptation and also incorporating the 'triple bottom line' into care pathways.

Finance

Budget constraints and access to financial capital is limited, if the Trust is to reach the NHS net zero targets, we will require significant access to capital. The cost to achieve net zero is not included here as there is no reliable way of doing this at present. In addition, there current is no sustainability budget that reflects the requirements of delivering the Green Plan annual work programme.

Adaptation

Climate change is already happening. There is a clear and immediate need for the reducing our carbon emissions to net zero, and to adapt to the impacts of climate change that can't be avoided. Building resilience into the system as it protects and promotes the health of populations now and in the future. To meet our obligations to adapt the premises and the manner in which services are delivered to reduce risks associated with climate change and severe weather an adaptation plan needs developed. In addition, emergency planning policy and procedures need updating in line with the latests climate science.

Carbon Footprint Plus

The Trust currently does not have a process in place to report the carbon footprint plus, carbon budget and trajectories. Current challenges are the volume of data that needs collecting and categorised to produce a footprint.

Conclusion

We have seen a significant increase in levels of interest and engagement, as public consciousness grows. The frequency of staff enquiries has grown as they see opportunities in their own work areas.

This will only intensify, as people will come to expect large public sector organisations like ours to be leading from the front on sustainability and climate change. This will undoubtedly present challenges, but we will continue to find innovative ways of engaging staff with this agenda.

Embedding sustainability into the core values of our organisation is vital to ensure sustainable healthcare and support the Trust to continue to deliver exceptional care in a time when the climate crisis is escalating. There may be many challenges but there are also opportunities to create a better healthcare model for patients through a service that delivers socially, financially and environmentally.

Appendix 1

Area	Action	Division	Lead	Timeframe	Reporting measures
Assurance and governance	Publish sustainability annual report with quantitative progress data, covering as a minimum greenhouse gas emission in tonnes, emissions reduction projections and an overview of the Green Plan progress to deliver those reductions.	Net Zero and Climate Adaptation Committee	Executive Director/ Deputy Chief Executive Officer	March 25	Sustainability Annual Report published Greenhouse Gas Equivalencies Annual update of Green Plan
Assurance and governance	Quarterly dashboard report covering as a minimum greenhouse gas emission in tonnes for waste, business travel and medical gases, progress against Greener NHS deliverables and Green Plan progress.	Net Zero and Climate Adaptation Committee	Sustainability Manager	March 25	Greenhouse Gas Equivalencies Quarterly reports produced
Workforce and system leadership	Develop Net Zero and Adaptation Policy.	Net Zero and Climate Adaptation Committee	Sustainability Manager	March 25	Policy in place
Workforce and system leadership	Sustainable Impact Assessment for business cases, policies and procedures.	Finance and Business Development/Quality and Standards	Director of Finance and Business Development	March 25	Launch of Sustainable Impact Assessment
Workforce and system leadership	Aim for 20% of staff to have completed 'Building a net zero NHS' via the Electronic Staff Record (ESR).	Estates and Facilities	Sustainability Manager	March 27	Electronic Staff Record (ESR)
Workforce and system leadership	Investigate specialist support linked to eco-anxiety and included in tender for new Employee Assistance Programme.	Workforce	Head of Engagement and Organisational Development	March 25	Support available to staff
Workforce and system leadership	Update recruitment materials, job documentation and appraisal guidance documentation to reference net zero target and/or healthcare emergency (link to Trust behaviour of 'We care for each other and our environment')	Workforce	Head of Engagement and Organisational Development/ Head of Workforce Transformation and Systems	March 25	Greenhouse Gas Equivalencies Quarterly reports produced
Workforce and system leadership	Provision of leadership development and education series linked to green agenda.	Workforce	Head of Engagement and Organisational Development/ Head of Workforce Transformation and Systems	March 25	Training delivered Certification
Workforce and system leadership	Seek to make best use of sustainability apprenticeship within a centralised role to best promote sustainability within the organisation	Estates and Facilities	Sustainability Manager	March 26	Electronic Staff Record (ESR)

Area	Action	Division	Lead	Timeframe	Reporting measures
Sustainable models of care	Remote consultations embedding the use of video consultations and/or more telephone consultations where appropriate to futureproof the level of service we can offer.	Clinical Networked Services	Divisional Transformation Lead	March 25	Patient travel Patient transport
Sustainable models of care	Expand Oral Chemo Clinic live remote consultations releasing patients on oral chemo from face-to-face Consultant follow up appointments (not complex patients).	Clinical Networked Services	Senior Sister SACT+ SACT Deputy Service Manager	April 25	Patient travel Patient transport
Sustainable models of care	Measure the carbon footprint of a move to hypofractionation (less treatments for same outcome, meaning less travel), the patient benefit and the resource implications of further implementation too.	Radiotherapy	Radiotherapy Physics - Principal Clinical Scientist	March 26	Carbon Footprint
Sustainable models of care	Carbon footprinting of proton beam therapy, MR-Linac, and PET/SPECT	Radiotherapy	Radiotherapy Physics - Principal Clinical Scientist	March 26	Carbon Footprint
Sustainable models of care	Promote and facilitate Sustainable Quality Improvement training for leads across the Trust. Identify leads and provide additional support to eLearning packages to identify and carry out projects.	Quality and Standards	Clinical Audit Manager	March 26	Number of SusQI projects registered and completed Monitor uptake of ESR modules QI scores reported and commentary on SusQI Promote examples of projects delivering SusQI via quarterly and annual QICA reporting, Quality Improvement and Clinical Audit (QICA) Awards and publications
Sustainable models of care	Incorporate SusQI into implementation plan for NHS IMPACT	Quality and Standards	Clinical Audit Manager	March 25	Quality Plan and monitoring
Digital transformation	Move to Cloud to reduce energy consumption	Digital	Head of Digital Service Delivery	March 27	Reduction in on-premises server infrastructure.
Digital transformation	Digital First Travel Policy - eLearning and on line learning	Digital	Digital Lead Clinical Implementer	March 25	Travel Expenses Grey fleet mileage and spend Grey fleet emission (tonnes) Trust fleet mileage and spend
Digital transformation	Power Saving Initiatives - Reduction in Network equipment energy consumption	Digital	Head of Digital Service Delivery	March 26	Reduction in POE network switches across the Trust.

Appendix 1 (continued)

Area	Action	Division	Lead	Timeframe	Reporting measures
Digital transformation	Improved digital communication removing the need for paper	Digital	Digital Lead Clinical Implementer	March 25	tbc
Digital transformation	Remove physical phones where they are no longer needed	Digital	Head of Digital Service Delivery	March 26	Procurement Spend
Digital transformation	Implementation of eConsent and eReferral	Digital	Head of Digital Portfolio	March 25	Printing and postal costs.
Digital transformation	Replace infrastructure to a new, power efficient data centre	Digital	Head of Digital Service Delivery	March 25	90% of our server infrastructure moved to the new Patterson Datacentre/Cloud.
Digital transformation	Replaced mechanical hard drives for our main storage with Solid state drives	Digital	Head of Digital Service Delivery	March 26	Procurement Spend
Supply chain and procurement	Develop standard Sustainability Specific Key Performance Indicators	Procurement	Deputy Head of Procurement	March 25	Inserted into KPI's of all new contracts
Supply chain and procurement	Understand carbon footprint of "Gold" suppliers, whose total contract value is over £500,000	Procurement	Deputy Head of Procurement	March 25	Included in annual reports
Supply chain and procurement	Obtain and monitor Carbon Reduction plans	Procurement	Deputy Head of Procurement	March 25	Updated procurement process documentation
Travel and transport	Incorporate and implement NHS Net Zero Travel and Transport Strategy actions into Trust Green Travel Plan	Estates and Facilities	Sustainability Manager	March 25	Green Travel Plan Updated Annual staff travel survey Grey fleet mileage and spend Grey fleet emission (tonnes) Trust fleet mileage and spend
Travel and transport	Air Quality Risk Assessment	Estates and Facilities	Sustainability Manager	March 26	Risk Assessment
Estates and facilities	Develop EV infrastructure plan by identifying local/ regional grid capacity and working with local network operators and authority to plan for increased capacity where necessary	Estates and Facilities	Estates Officer - Specialist/ Sustainability Manager/ Operational Estates Manager/Capital team	March 26	Strategy produced
Estates and facilities	Achieve NHS clinical waste strategy clinical waste segregation targets of 20:20:60 HTI (High temperature incineration) AT (alternative treatment) and OW (offensive waste) .	Estates and Facilities	Waste Minimisation Officer/ Site Services Manager	March 26	Waste Tonnage Scorecard
Estates and facilities	Implementation of reusable sharp containers across the trust replacing 95% of single use plastic sharp containers. Procurement and business case required.	Estates and Facilities	Waste Minimisation Officer/ Site Services Manager	March 25	Procurement Process and waste CO2 figures
Estates and facilities	Trust wide waste training via ESR mandatory training so all clinical and nonclinical staff are fully aware of waste segregation to maintain waste compliance and waste reduction.	Estates and Facilities	Waste Minimisation Officer/ Site Services Manager	March 25	ESR training records
Estates and facilities	Trust improves Energy Metering (Gas & Electric) across site where feasible and develop a sub-metering strategy including new building developments.	Estates and Facilities	Operational Estates Manager/Capital team	March 25	Project Scoping documents, design briefs
Estates and facilities	Where financially feasible return to the policy of purchasing electricity which is from 100% renewable sources.	Estates and Facilities	Procurement Team/ Energy manager	March 25	Future bills
Estates and facilities	Where possible new roofing projects to have additional insulation installed to decrease heat loss.	Estates and Facilities	Operational Estates Manager	March 25	Scoping documents and design briefs
Estates and facilities	Heat Decarbonisation Plan and working with funding partners to produce viable bids for future consideration.	Estates and Facilities	Director of Capital/Head of Estates and Facilities/ Operational Estates Manager/Energy manager	March 25	Scoping Documents, Completed applications for additional Funding
Medicines	Decommissioning of nitrous manifolds	Estates and Facilities	Technical Manager for Hard Facility Services	March 25	Nitrous manifolds decommissioned
Medicines	Implementation of NHS Guidance on Desflurane decommissioning and clinical use	Clinical Support and Specialist Surgery	Anaesthetic Consultants	March 25	Greener NHS Dashboard
Adaptation	Climate Adaptation Plan	Risk and quality governance committee	Sustainability Manager/ Head of Emergency Preparedness	March 26	Climate Adaptation Plan in place

Appendix 1 (continued)

Area	Action	Division	Lead	Timeframe	Reporting measures
Adaptation	Creation of Adverse Severe Weather Plan in line with latest UK Climate Projections and UKHSA Guidelines	Emergency Preparedness Team and EPRR Committee	Head of Emergency Preparedness, Sustainability Manager, Head of Estates and Facilities	April 25	EPRR Committee
Adaptation	Review flood risk assessment in line with latest UK Climate Projections	Emergency Preparedness Team and EPRR Committee	Head of Emergency Preparedness, Sustainability Manager	April 25	EPRR Committee
Adaptation	Review Major Incident Plan in line with latest UK Climate Projections	Emergency Preparedness Team and EPRR Committee	Head of Emergency Preparedness	April 25	EPRR Committee
Green Space and Biodiversity	Biodiversity Strategy	Estates and Facilities	Technical Manager for Hard Facility Services/ Sustainability Manager	March 26	Strategy in place
Medicines	System wide campaign to encourage patient to bring own medicines into hospital on admission	Clinical Pharmacy / GM Pharmacy	Chief Technician / Head of Strategic Pharmacy Transformation	March 25	Quantity and value of supply from Pharmacy on admission and discharge across GM
Medicines	Encouraging the minimisation of medicine and related waste by promoting optimal prescribing of medicines	Pharmacy	Director of Pharmacy	March 27	Reduction in medicine wastage
Medicines	Reduction in paper related to clinical trial pharmacy documentation	Pharmacy Clinical Trials / Research and Innovation / Digital	Senior Clinical Trials Pharmacist	March 25	Reduction in paper purchased by clinical trials.
Medicines	Reduction in paper kardexes for inpatients and rewritten kardexes with the introduction of Better Care EPMA system in Trust. Reduction in other associated charts too i.e. Insulin	Pharmacy / Digital	Electronic Prescribing and Medicines Administration Pharmacy Technician	March 26	Reduction in paper charts across trust
Medicines	Reduction in paper related to aseptic pharmacy documentation	Pharmacy Aseptics / Digital	Lead Aseptic Pharmacist	March 27	Reduction in paper purchased by aseptics
Medicines	Reduction in plastics wastage supplied by sponsors in study kits	Pharmacy Clinical Trials/ Research and Innovation	Senior Clinical Trials Pharmacist	March 27	Reduction of plastic kits through work done on Research and Innovation workstream
Food and nutrition	Electronic Menu book being explored for patients	Estates and facilities	Catering Manager	March 25	Digital menu book in place
Food and nutrition	Adapt menus for patient meals to use more seasonal produce.	Estates and facilities	Catering Manager	March 25	Review menus and cycles
Food and nutrition	Review suppliers to meet Government Buying Standards for Food (GBSF) Standards	Estates and facilities	Catering Manager	March 25	Liaise with NHS Supply Chain
Food and nutrition	Review how waste is processed on site	Estates and facilities	Catering Manager	March 25	Explore possibilities of Dehydration compactor to reduce waste weight.
Supply chain and procurement	Ensure suppliers are complaint with the Evergreen Assessment	Procurement	Deputy Head of Procurement	March 25	Review the possibilty of including Evergreen Assessment as a criteria in all tenders

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The Christie
NHS Foundation Trust

Agenda Item 22/24a

Meeting of the Board of Directors

Wednesday 27th June 2024

Subject / Title	Board Assurance Framework 2024/25
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 2024/25. The risks outlined impact on achievement of the corporate objectives and the relevant objectives are indicated for each risk. The paper includes a snapshot of the risks ordered by current risk score and a report with the detail relating to each risk. The risks are reviewed alongside the risks on the Trust risk register.
Recommendation(s) (assure / **alert** / advise)	The Board are asked to; • note the Board Assurance Framework (BAF) 2024/25, • assign a level of assurance to items on the agenda of the committee that relate to the risks, • consider if there are any further risks that need to be added to the BAF, • reflect the review of the risk in the BAF for the next meeting.
Background papers	Board assurance framework 2023/24. Corporate objectives 2024/25, operational plan and revenue and capital plan 2024/25.
Risk score	N/A
Link to: ➢ Trust strategy ➢ Corporate objectives	• Trust's strategic direction • Divisional implementation plans • Our Strategy • Key stakeholder relationships
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	BAF Board assurance framework MDT multi-disciplinary team NICE National Institute for Health & Care Excellence PSIRF Patient Safety Incident Response Framework IP(QF)R Integrated Performance Quality & Finance Report GM Greater Manchester

BOARD ASSURANCE FRAMEWORK 2024/25 OVERVIEW OF RISKS

RISK No.	Risk Title	Risk Description	Responsible Committee	Inherant Risk Score	Q1	Q2	Q3	Q4	Target Risk Score	Current Risk Score
RISK 10	**Financial balance**	If we do not achieve the planned activity levels and our target efficiency savings there is a risk that we won't achieve financial balance leading to us having to repay the difference to our agreed plan in the following year	Audit Committee	**25**					**2**	**20**
RISK 5	**Impact of the system capital allocation framework**	If the capital planning and allocation system does not enable full use of our charitable and commercial reserves there is a risk that we may not be able to fund our capital and asset replacement programmes leading to delays, cancellations or reprioritising of planned projects and equipment not being replaced when needed	Board of Directors	**25**					**10**	**16**
RISK 14	**Legal and statutory compliance**	If we do not maintain an awareness of and respond to changing statutory and legal requirements there is a risk that we will fail to comply leading to being sanctioned for being in regulatory or statutory breach.	Audit Committee	**20**					**8**	**16**
RISK 9	**Industrial action**	If there is ongoing industrial action, there is a risk of business disruption leading to delayed or cancelled care	Workforce Assurance Committee	**25**					**5**	**16**
RISK 7	**Ineffective GM 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	**25**					**5**	**15**
RISK 11	**Cyber attack**	If we are subjected to a cyber-attack there is a risk of loss of data and operational disruption leading to patient care being delayed or cancelled	Audit Committee	**25**					**4**	**12**
RISK 4	**Changes in quality regulation**	If the CQC or other regulatory body changes their approach to regulation there is a risk that we will not be able to demonstrate compliance leading to us being assessed as not meeting the fundamental care standards.	Board of Directors	**15**					**4**	**12**
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	**20**					**4**	**9**
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	**20**					**4**	**9**
RISK 6	**Insufficient contractual support for networked cancer care provision**	If the GM system does not continue to support local provision of cancer care with contractual and funding flow changes there is a risk that we are unable to devolve more systemic therapy, clinical trials and radiotherapy treatments to local communities leading to persistence or increases in inequalities in provision to economically deprived and ethnically diverse communities.	Quality Assurance Committee	**12**					**6**	**9**
RISK 15	**Patient confidence in services**	There is a risk that adverse events will attract media coverage resulting in a decrease in public confidence in our services	Board of Directors	**12**					**2**	**9**
RISK 8	**Extreme weather events**	If there is an extreme weather event (heat wave, freeze, floods etc) due to climate change 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	**16**					**4**	**8**
RISK 12	**Ineffective response to cultural audit**	If our response to the cultural audit is insufficient there is a risk that a negative culture will persist in some specific parts of our organisation leading to an increase in the number of staff reporting a poor experience.	Workforce Assurance Committee	**16**					**2**	**8**
RISK 13	**Insufficient data on patient protected characteristics**	If we are unable to capture data on the protected characteristics of our patients there is a risk we will be unable to assess any inequalities in access, experience or outcomes leading to lack of focus in addressing health inequalities	Workforce Assurance Committee	**10**					**4**	**8**
RISK 2	**Not learning from patient safety incidents**	If we are unable to fully implement the new Patient Safety Reporting 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	**12**					**1**	**6**

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 Date of Last Review Jun-24	**9**
Associated Corporate Objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer	Executive Lead Responsible Committee Assurance Level Risk Appetite	Exec Medical Director **Quality Assurance Committee** High Cautious

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	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	Uncertainty around what / when. External factors	Level 1 – Data and management reports • Review of NICE guidelines through risk-based process with divisional support • risk register in place. Level 2 – Management team and committee scrutiny • Review NICE guidelines compliance through QAC and monthly IPQFR Level 3 – External assurances • NICE	None identified	Forward views of upcoming NICE guidelines assessed	Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	4	**20**			**0**			**0**			**0**			**0**	2	2	**4**

RISK 2	Not learning from patient safety incidents	Date Risk Opened	Current Risk Score
Description	**If we are unable to fully implement the new Patient Safety Reporting Framework (PSIRF) there is a risk that we will miss opportunities to learn lessons and improve patient safety leading to preventable patient harm.**	Apr-24 Date of Last Review Jun-24	**6**
Associated Corporate Objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer	Executive Lead Responsible Committee Assurance Level Risk Appetite	Exec Chief Nurse **Quality Assurance Committee** High Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	Training programme led by Exec Chief Nurse & Medical Director. Review through Patient Safety & Experience Committee and Risk & Quality Governance. Introduction of new DATIX system	None identified	Level 1 – Data and management reports • PSIRF reports to Patient Safety Committee / Risk & Quality Governance / Senior Management Committee • ERG Level 2 – Management team and committee scrutiny • Review compliance through QAC Level 3 – External assurances • MIAA review • Updates presented to ICB	None identified	Full roll out of new Datix - Risk module Training programme across the Trust	Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	3	4	**12**			**0**			**0**			**0**			**0**	1	1	**1**

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 Date of Last Review Jun-24	**9**
Associated Corporate Objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey. To be an international leader in professional and public cancer education. To maintain excellent operational, quality and financial performance.	Executive Lead Responsible Committee Assurance Level Risk Appetite	Workforce Director **Workforce Assurance Committee** High Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	Recruitment & retention Trust-wide group reporting to Workforce Committee. Partnership with external provider to deliver our domestic recruitment offer, advertising and brand – social media Staffing levels maintained through coordinated utilisation of bank and agency International Recruitment Programme Christie People and Culture Plan 2023-26 Quarterly oversight of Trust wide vacancies and recruitment activity presented to the workforce committee Divisional oversight of recruitment activity and vacancies discussed at the monthly service review meetings Turnover analysis and exit interview data presented and discussed six monthly at the workforce committee Robust sickness absence management and health and wellbeing offer	National staff shortages impacting recruitment	Level 1 – Data and management reports • Divisional oversight of recruitment through Service & Operatonal Review meetings Level 2 – Management team and committee scrutiny • Review compliance through WAC • F&PP Compliance report to WAC / Board Level 3 – External assurances • National staff survey • MIAA audit	None identified	Recruitment of onboarding coordinator	Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	5	**20**			**0**			**0**			**0**			**0**	2	2	**4**

RISK 4	Changes in quality regulation	Date Risk Opened	Current Risk Score
Description	**If the CQC or other regulatory body changes their approach to regulation there is a risk that we will not be able to demonstrate compliance leading to us being assessed as not meeting the fundamental care standards.**	Apr-24 Date of Last Review Jun-24	**12**
Associated Corporate Objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey. To be an international leader in professional and public cancer education. To maintain excellent operational, quality and financial performance.	Executive Lead Responsible Committee Assurance Level Risk Appetite	Exec Chief Nurse **Board of Directors** Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	Self assessments underway against 2022 must do actions and well-led quality indicators. Attendance at CQC briefings / NHS Providers briefings	Lack of national understanding of the detail of the new inspection regime	Level 1 – Data and management reports • Self assessment against 2022 Must Do's • Self assessment against Well Led quality indicators Level 2 – Management team and committee scrutiny • QAC /WAC review of CQC regulations Level 3 – External assurances • GGI review • Globis Culture Audit	Full review of well-led quality indicators to indentify gaps	Plan in development for full review of well led	Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	3	**15**			**0**			**0**			**0**			**0**	4	1	**4**

RISK 5	Impact of the system capital allocation framework	Date Risk Opened	Current Risk Score
Description	**If the capital planning and allocation system does not enable full use of our charitable and commercial reserves there is a risk that we may not be able to fund our capital and asset replacement programmes leading to delays, cancellations or reprioritising of planned projects and equipment not being replaced when needed.**	Apr-24 Date of Last Review Jun-24	**16**
Associated Corporate Objectives	To promote equality, diversity & sustainability through our system leadership for cancer care	Executive Lead Responsible Committee Assurance Level Risk Appetite	Exec Director of Finance **Board of Directors** Eager

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	Alternative proposals put forward by GM ICB indicate allocation options linked to existing or nationally calculated depreciation. Participation at local and national level (NHSE / GM ICB) to influence allocation. Development of mitigating financial strategies. Identification & implementation of new models of working.	National / local funding rules / arrangements. Cap on CDEL	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 •	None identified	Capital bids collated including level of priority, impact on patient care and activity should the bid not be approved. Manage capital priorities within existing ICB allocation and support the ICB to deliver a compliant capital plan. New models being	Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	5	**25**			**0**			**0**			**0**			**0**	5	2	**10**

RISK 6	Insufficient contractual support for networked cancer care provision	Date Risk Opened	Current Risk Score
Description	**If the GM system does not continue to support local provision of cancer care with contractual and funding flow changes there is a risk that we are unable to devolve more systemic therapy, clinical trials and radiotherapy treatments to local communities leading to persistence or increases in inequalities in provision to economically deprived and ethnically diverse communities.**	Apr-24 Date of Last Review Jun-24	**9**
Associated Corporate Objectives	To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey. To promote equality, diversity & sustainability through our system leadership for cancer care	Executive Lead Responsible Committee Assurance Level Risk Appetite	Chief Operating Officer **Quality Assurance Committee** Cautious

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	Participating in GM ICS meetings. Work with GM Cancer Alliance and pathway leads across the system. Exec attendance at system meetings. Working with GM / Cheshire Trusts to develop pathways	GM ICB / Specialised Commissioning decisions on funding	Level 1 – Data and management reports • GM Cancer Board Level 2 – Management team and committee scrutiny • Reports to Senior Management Committee & Board of Directors Level 3 – External assurances • MIAA	None identified	Highlighting financial / operational / risks at provider oversight meetings	Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	3	**12**			**0**			**0**			**0**			**0**	3	2	**6**

RISK 7	**Ineffective GM 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 Date of Last Review Jun-24	**15**
Associated Corporate Objectives	To promote equality, diversity & sustainability through our system leadership for cancer care To maintain excellent operational, quality and financial performance.	Executive Lead	Chief Operating Officer
		Responsible Committee	**Quality Assurance Committee**
		Assurance Level	
		Risk Appetite	Cautious

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	Executive led monthly divisional performance review meetings. Integrated performance & quality report to Management Board and Board of Directors monthly. Weekl;y performance reporting via trust operational group. Escalation internally & across GM of delays impacting waiting time targets. Monitoring cancer waiting time standards through GM Cancer & IPR.	Impact of ongoing Industrial Action leading to delays in referrals	Level 1 – Data and management reports • repors to Senior Management Committee and Board Level 2 – Management team and committee scrutiny • 6 monthly review by QAC Level 3 – External assurances • MIAA review of 62 days / Cancer Alliance	None identified	Supporting cancer improvement plans in GM Cancer Pathway improvement workstream in GM Cancer	Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	5	**25**			**0**			**0**			**0**			**0**	5	1	**5**

RISK 8	**Extreme weather events**	Date Risk Opened	Current Risk Score
Description	**If there is an extreme weather event (heat wave, freeze, floods etc) due to climate change 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 Date of Last Review Jun-24	**8**
Associated Corporate Objectives	To maintain excellent operational, quality and financial performance.	Executive Lead	Deputy Chief Executive
		Responsible Committee	**Audit Committee**
		Assurance Level	
		Risk Appetite	Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	What we have in place to prevent the risk materialising (reduce likelihood): Sustainable Development Management Plan (SDMP) - with aims to reduce system wide emissions within direct NHS control (NHS Carbon Footprint) by 80% by 2028-2032 What we have in place to reduce the impact of the risk if it materialises (reduce impact): Business Continuity Plan (BCP) - sections on extreme weather conditions	In development - Climate Change Adaptation Plan (CCAP) - adapt normal business processes to changed environment	Level 1 – Data and management reports • SDMP compliance • BCP compliance and effectiveness Level 2 – Management team and committee scrutiny • 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 • Regular briefing of governors through DSC Level 3 – External assurances • Internal audit of compliance with NHS requirements • NHSE review of plans and progress	None identified	•Developing methodology to assess carbon footprint in collaboration with other Trusts •Developing a CC •Annual Report - Check what audit scrutiny this receives	Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	4	**16**			**0**			**0**			**0**			**0**	4	1	**4**

RISK 9	**Industrial action**	Date Risk Opened	Current Risk Score
Description	**If there is ongoing industrial action, there is a risk of business disruption leading to delayed or cancelled care**	Apr-24 Date of Last Review Jun-24	**16**
Associated Corporate Objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey. To be an international leader in professional and public cancer education. To maintain excellent operational, quality and financial performance.	Executive Lead	Chief Operating Officer
		Responsible Committee	**Workforce Assurance Committee**
		Assurance Level	
		Risk Appetite	Cautious

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	Close working with unions /staff side. Established Business continuity plans in place. Planning meetings in place around strike acton and incident management approach used. Management of patient demand. Risk assessments undertaken. Enhanced rates of pay agreed. National escalation process (For BMA in absence of derogations)	Impact of ongoing Industrial action	Level 1 – Data and management reports • Review of incidents from periods of action • BCP compliance & effectiveness Level 2 – Management team and committee scrutiny • Reports to Senior Management Committee • Reports to Board of Directors Level 3 – External assurances • External reporting on impact to ICB	None identified	Detailed planning of patient demand and catch up. Staff cover planned. Further engagement with Regional Union Reps. Restrictions on annual leave/ TOIL during strike action. Reduction in appointments. Closure of elective admissions. Booking of staff via TEMPRE – Direct Engagement. Use of junior medical staff / acting down. Retraining and redeployment. Exploration of mutual aid with MFT	Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	5	**25**			**0**			**0**			**0**			**0**	5	1	**5**

RISK 10	Financial balance	Date Risk Opened	Current Risk Score
Description	**If we do not achieve the planned activity levels and our target efficiency savings there is a risk that we won't achieve financial balance leading to us having to repay the difference to our agreed plan in the following year**	Apr-24 Date of Last Review Jun-24	**20**
Associated Corporate Objectives	To maintain excellent operational, quality and financial performance.	Executive Lead	Exec Director of Finance
		Responsible Committee	**Audit Committee**
		Assurance Level	
		Risk Appetite	Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
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 the 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. Trusts VIP programme reviewed by MIAA and all recommendations implemented including developing a VIP SOP, improved governance of VIP schemes and escalating VIP reporting and responsibility to ICPC. VIP delivery at a divisional level monitored via the Trusts Service Operational Review framework	Commissioning intentions. Funding growth	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	None identified	VIP Programme recommnedations implemented	Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	5	**25**			**0**			**0**			**0**			**0**	2	1	**2**

RISK 11	Cyber attack	Date Risk Opened	Current Risk Score
Description	**If we are subjected to a cyber-attack there is a risk of loss of data and operational disruption leading to patient care being delayed or cancelled**	Apr-24 Date of Last Review Jun-24	**12**
Associated Corporate Objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey. To be an international leader in professional and public cancer education.	Executive Lead	Deputy Chief Executive
		Responsible Committee	**Audit Committee**
		Assurance Level	
		Risk Appetite	Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	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) Q4 23/24	The Trust does not currently have cyber security insurance.	Level 1 – Data and management reports • Regular updates from NHS Digital - Vulnerability Monitoring Service Level 2 – Management team and committee scrutiny • Reports to Senior Management Comittee and Audit Committee Level 3 – External assurances • Cyber Essentials + accreditation July 2023 • MIAA undertaking Data Protection Toolkit assessment (DPST)	None identified	Review of alerts MFA fully rolled out Explore security insurance options	Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	5	**25**			**0**			**0**			**0**			**0**	2	2	**4**

RISK 12	Ineffective response to cultural audit	Date Risk Opened	Current Risk Score
Description	**If our response to the cultural audit is insufficient there is a risk that a negative culture will persist in some specific parts of our organisation leading to an increase in the number of staff reporting a poor experience.**	Apr-24 Date of Last Review Jun-24	**8**
Associated Corporate Objectives	To be an excellent place to work and attract the best staff	Executive Lead	Deputy Chief Executive
		Responsible Committee	**Workforce Assurance Committee**
		Assurance Level	Medium
		Risk Appetite	Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	Plan developed through extensive engagement with staff following production of Globis Culture Audit and approved by Board. Board responsibilities outlined. Work commenced to implement agreed actions and continue to communicate with staff. Advisory Group in place and meetings arranged.	None identified	Level 1 – Data and management reports • Culture oversight group • Divisional action plans from staff survey Level 2 – Management team and committee scrutiny • Reporting to Workforce Committee, Workforce Assurance Committee and Board of Directors Level 3 – External assurances • Globis culture audit • Annual CQC Staff Survey 2023	None identified	Implemenetation of agreed action plan Cost additional resource requirments Advisory Group meetings to take place and review progress / report	Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	4	**16**			**0**			**0**			**0**			**0**	1	2	**2**

RISK 13	**Insufficient data on patient protected characteristics**	Date Risk Opened	Current Risk Score
Description	**If we are unable to capture data on the protected characteristics of our patients there is a risk we will be unable to assess any inequalities in access, experience or outcomes leading to lack of focus in addressing health inequalities**	Apr-24 Date of Last Review Jun-24	**8**
Associated Corporate Objectives	To be an excellent place to work and attract the best staff	Executive Lead	Exec Medical Director
		Responsible Committee	**Workforce Assurance Committee**
		Assurance Level	
		Risk Appetite	Cautious

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	Collation of existing data into a report for publication on the website. Areas of poor data quality identified and group established to identify actions to improve	Lack of data from national spine	Level 1 – Data and management reports • published data • review by Exec Team monthly Level 2 – Management team and committee scrutiny • Integrated Performance report to Senior Management Committee and Board of Directors Level 3 – External assurances • Submissions to NHSE	None identified	Reports to be tailored to ensure they accurately reflect our services / patient group	Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	2	**10**			**0**			**0**			**0**			**0**	2	2	**4**

RISK 14	**Legal and statutory compliance**	Date Risk Opened	Current Risk Score
Description	**If we do not maintain an awareness of and respond to changing statutory and legal requirements there is a risk that we will fail to comply leading to being sanctioned for being in regulatory or statutory breach.**	Apr-24 Date of Last Review Jun-24	**16**
Associated Corporate Objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey. To be an international leader in professional and public cancer education. To integrate our clinical, research and educational activities as an internationally recognised and leading comprehensive cancer centre To maintain excellent operational, quality and financial performance.	Executive Lead	Chief Executive Officer
		Responsible Committee	**Audit Committee**
		Assurance Level	
		Risk Appetite	Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	Engagement in national updates and regulatory briefings. Membership of NHS Providers. Exec Team engagement in national briefings. Close working with regulators, GM ICS and NHSE	None identified	Level 1 – Data and management reports • Regular reports to Executive Team • Monthly IPQFR Level 2 – Management team and committee scrutiny • Board self-assessments April 2024 • Board reporting on regulatory changes Level 3 – External assurances • CQC Inspection Reports (IR(M)ER) • SOF Rating 2	None identified	Take MIAA checklists / advisory notes to appropriate assurance committees	Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	4	**20**			**0**			**0**			**0**			**0**	4	2	**8**

RISK 15	**Patient confidence in services**	Date Risk Opened	Current Risk Score
Description	**There is a risk that adverse events will attract media coverage resulting in a decrease in public confidence in our services**	May-24 Date of Last Review Jun-24	**9**
Associated Corporate Objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey. To be an international leader in professional and public cancer education. To integrate our clinical, research and educational activities as an internationally recognised and leading comprehensive cancer centre To be an excellent place to work and attract the best staff	Executive Lead	Chief Executive Officer
		Responsible Committee	**Board of Directors**
		Assurance Level	
		Risk Appetite	Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	Adherence to Workforce policies monitored through divisional structures Process in place to identify issues and escalate concerns. Comms plan in place to share patient stories and news on services / developments Website updates	None identified	Level 1 – Data and management reports • Regular reports to Executive Team • Monitoring & reporting of clinical / HR events Level 2 – Management team and committee scrutiny • Quality Asurance Committee review of clinical cases • Workforce Assurance Committee review of HR cases Level 3 – External assurances • MIAA audits commissioned to review specific issues where appropriate	None identified	Proactive review and response by the senior responsible person of activities that could result in negative publicity	Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	3	**12**													1	2	**2**

The Christie
NHS Foundation Trust

Agenda Item 22/24c

Board of Directors

Thursday 27th June 2024

Subject / Title	Reports from Board Committees
Author(s)	Committee secretaries
Presented by	Committee Chairs
Summary / purpose of paper	For the board to note the discussions held at the following meetings: • Audit Committee draft minutes April 2024
Recommendation(s)	To note
Background papers	Full papers from the Quality Assurance, Audit and Workforce Assurance Committees
Risk score	See Board Assurance Framework Corporate Objective 1 - 7
Link to: ➢ Trust strategy ➢ Corporate objectives	
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	

DRAFT

Audit Committee
Tuesday 23rd April 2024
Seminar Room 4/5, Education Centre and MS Teams
Minutes

Present:	Grenville Page (GP) Robert Ainsworth (RA) Kieran Walshe (KW)	Committee Chair, Non-Executive Director Non-Executive Director Non-Executive Director
In Attendance:	Sally Parkinson (SP) Theresa Plaiter (TP) Louise Westcott (LW) Claire McPeake (CMcP) Richard Postill (RP) David Smithson (DS) Sharon Hassall (SH) Damian Child (DC) Anne-Marie Harrop (AMH) Simon Davies (SD) Kevin Howells (KH) Matt Derrick (MD)	Executive Director of Finance Interim Chief Nurse and Executive Director of Quality Company Secretary Interim Chief Operating Officer Deputy Director of Finance Deputy Director of Workforce Assistant Director of Finance - Financial Services Director of Pharmacy MIAA MIAA MIAA Grant Thornton
Minutes:	Jo D'Arcy (JD)	Assistant Company Secretary

10/24	Standard Items	Action
a	**Apologies**	
	None received.	
b	**Declarations of interest**	
	• RA declared interest as Chair of The Christie Pharmacy and RP declared interest as the Finance Director for The Christie Pharmacy.	
c	**Minutes of the previous meetings held on 15th February 2024**	
	• The minutes from the meeting on 15th February 2024 were approved as a correct record. Noted that following review since the last meeting, Digital will report to the Board on strategy and Audit Committee on compliance and assurance. This also forms part of the Audit Committee handbook recommended requirements.	
d	**Rolling programme, action log & matters arising**	
	• All rolling programme items noted as on the agenda for the meeting. • Rolling programme being reviewed alongside GGI recommendations. • Action log items covered as part of agenda items. SP noted the action relating to salary overpayments and the number of write offs, the team have communicated with HR on assurances. **Noted**	
11/24	**Performance & finance assurance**	
a	**The Christie Pharmacy Company update & NED feedback from visit to Pharmacy**	
	GP noted that the NED tour of The Christie Pharmacy was very informative and useful. DC presented the report to the Committee noting the following key points: • Compliance and regulation are detailed within the report and all in accordance with requirements. Noted on HMRC compliance that The	

	Clatterbridge are currently being investigated, The Christie Pharmacy are different to them and no problems anticipated but something to be aware of. • General Pharmaceutical Council inspection visit for new Pharmacy, inspector was satisfied and new licence was issued. • A scheduled Home Office inspection took place at the beginning of April, inspector happy for controlled drug licence to continue. • TCPC Board meetings take place monthly following on from operational monthly KPI meetings with Trust representatives. The positive impact of the opening of the outpatient pharmacy is represented by the graph in the paper and pleased to report that now back to above 80% target for all prescriptions and staff sickness absence level has reduced. • Dispensing activity continues to increase, now taking on Christie at Bolton patients and also taking on more work this year to increase activity. • Internal audit plan in place, appendix within the report details the plan agreed. • Completed external audit stocktake of TCPC with a low error rate. • Risks scored above 10 are flagged in the report, the full risk register gets reviewed at TCPC Board. All risk register actions and mitigations are logged in Datix, report contains the highlights. The Committee discussed the following: • GP asked if the level of risk is appropriately recognised in terms of patient safety and experience in relation to the significant increase in volumes and the ongoing issue with the robot efficiency and effectiveness. DC confirmed confidence that the risk is operational and not a risk to patient safety, patients may be kept waiting longer but only in terms of minutes and hours and not days so may have an impact on experience but not safety. The longer-term plans in place will help and looking at doing things better to lower the risk. There are appropriate escalation procedures in place to manage the risk. RA noted the need to differentiate between the inpatient and outpatient pharmacy; the outpatient pharmacy is looking good following investment. The inpatient pharmacy now needs work to make it a better experience which will need investment. Mitigations are in place to make it a safe environment. • The Committee discussion led to high assurance being agreed based on the understanding of the risk and mitigations in place. **Assurance level given (BAF ref 6.4):** High.	
b	**Digital outage major incident update**	
	• CMcP attended to update the Committee on the 14-hour major digital outage which happened on 27th March noting the following key points: • The outage related to a reconfiguration on a server undertaken by the data centre provider. • A hot debrief took place after the incident occurred. Full action plan now in place to ensure more robust business continuity plans in place. The Committee discussed the following: • A full report and the updated EPRR policy will go to Risk & Quality Governance Committee. • CMcP clarified that the change didn't go through the standard approval board as it was considered a minor change by the data centre provided but this wasn't the case. The change took out 14 servers rather than just	

	1. Within the contract, the response time should have been a 4-hour window and it wasn't. No patient harm was caused, the debrief collated all required incidents and escalations as part of the outage. Further work to determine whether it would have been the Trust or data centre provider who would have been accountable should there have any harm. VMWare (data centre provider) are part of the approval board but the engineer thought the change was so minor it wouldn't have had an effect, Trust members of the approval board thought differently. • Noted that the difference of opinion between the data centre provider and Trust is an issue. CMcP confirmed this is being investigated and will form part of the report. • Action agreed to put on the audit recommendation tracker and for a short paper on the findings and actions taken to come to the next Committee meeting. **Action: CMcP to report back on the findings and actions taken to Audit Committee in June. Assurance level will be assigned once findings and actions reported.**	**CMcP**
12/24	**Governance (regulatory / statutory compliance)**	
a	**Audit committee annual report – draft for approval**	
	GP gave an overview of the report with the following points noted from the Committee discussion: • The report needs to include all audits undertaken during the year that were presented to the Workforce Assurance Committee and Quality Assurance Committee. • Priorities for the Committee for 2024/25 to be expanded on and to include: o how the Audit Committee receives assurance from the other assurance Committees. o GGI recommendation improvements to be noted. o Coverage of Digital to be strengthened. o Coverage of antifraud work plan to be included. **Action: above points to be included within the report for presentation at the joint assurance committee meeting in June.**	**JD**
b	**Annual governance statement (AGS) – draft for approval**	
	SP presented the AGS to the Committee noting the following key points: • Comments received from GP have been incorporated into revised version. • No further comments received. The Committee **approved** the AGS.	
c	**Unaudited accounts – review**	
	SP presented the unaudited accounts to the Committee noting the following key points: • All senior members of Finance team have reviewed the accounts which includes disaggregation of the Charity. • Process around the timetable, preparation of the accounts and external audit overview given. Annual accounts audit commences on 25th April. • Accounts overview 2023/24: Plan NHSE control total £8.0m deficit. Trust surplus £6.8m, operational income £472.2m, cash available £136.6m, total assets employed £544.5m.	

	• Adjusted financial performance shown as to how £6.8m surplus reached. • Presentation of accounts; group accounting convention for single reporting segment; The Christie NHS Foundation Trust is the parent with the group including The Christie Pharmacy Limited. • Accounting policies; Going concern accounted for with going concern assessment done for audit purposes. • Assets; valuation and impairment; Full valuation for 2023/24 in line with accounting policy, buildings have increased: total net increased carrying value of £16.8m, net revaluation reserve increase of £13.5m and net impairments reversal to I&E of £3.3m. District valuer undertakes valuation. • Non-current assets; expenditure in year and assets under construction in year were confirmed. • Accounting for joint ventures; £6.3m recognised profit share for The Christie Clinic and £0.6m for Christie Pathology Partnership. No cash drawn down this year for CPP. RA asked on The Christie Clinic profit and if Healthcare America have the same strategy, SP confirmed this is the case. KW asked if the joint ventures do not get consolidated into the group if the asset value of the shares in these companies get included in the Trust assets value. SP confirmed they are included on the balance sheet and accounted for our profit share as an investment in the joint venture. GP asked how confident are we that the investment we hold in joint ventures are not subject to unacceptable risk and are appropriately safeguarded. SP confirmed that they are equity accounted for as the Trust does not control the JV, hence only account for their share. • RA asked about retained profits in joint ventures and if they have enough cash to pay. SP confirmed yes this is the case. Analytical review: • Operating income note 3; gone up and down throughout the year but level of income hasn't changed and all accounted for. • Operating expenditure note 4; operating expenditure of £468.5m. Increased by £46.1m. • Finance costs note 8; Finance income increase of £2.2m, average interest rate 4.9% in year (2022/23 average interest 2.89 %). Finance costs decrease of £60k in line with loan repayments. • Statement of financial position; confirmation of statement provided. • Non-current assets; increased by £22.6m, majority in property, plant and equipment. £5m disposal relates to charity taking its assets. • Current assets; healthy level and debt collection in a good place. • Current and Non-Current Liabilities; decrease of £4.8m (4%). • Statement of changes in taxpayers' equity; summary of changes in reserves and Public Dividend Capital (PDC) over the year, represents the taxpayers investment in the Trust. Total movement decrease of £35.2m. GP asked in relation to the money left in joint ventures, does it reduce PDC. SP confirmed no as the cash is part of the assets of the JV, hence are equity accounted for. GP referred to The Christie at Macclesfield and with it being funded by the Charity, do we pay PDC on it. SH confirmed the value of donated assets is removed from the asset base before calculating. • Cash flow statement; important to understand where cash is used. • Critical Accounting Judgements described.	

	• Group accounts – TCPC has done well due to growth. Generated profit of £465k less corporation tax of £116k, in year surplus of £349k. The Committee discussed the following: • AMH asked on the surplus position and how well it be viewed across GM. SP confirmed The Christie are the only one in our position, seen as different as a specialist Trust. • GP thanked SP, SH, RP and the finance team for their hard work. The Committee **acknowledged** the unaudited accounts.	
d	**Board assurance framework (BAF) 2023/24**	
	LW presented the BAF to the Committee noting the following key points: • Year-end position for 2023/24, year-end risk score has been added in, all target scores achieved. • New BAF to be presented to Board in April. • No issues to highlight. • GP noted that the revised BAF links to risk and a strengthened approach to bring increased scrutiny. The Committee **acknowledged** the BAF.	
e	**Declarations of interest update Q4 2023/24**	
	LW presented the report to the Committee noting the following key points: • Appendix provides an extract from the system with all declarations. All have been approved by designated approver. No issues to raise. • MIAA conflict of interests review completed and management responses provided. One outstanding recommendation relating to training to be completed by end of Q2. Assurance rating given was substantial. • 75% compliance at the end of Q4, those outstanding have been chased. New financial year starts new declaration requirement. • GP asked about the 145 staff members outstanding and what action can be taken to address. LW confirmed Civica informed we are the highest compliance rate they have seen. SP added it is line management responsibility to address. LW added it is also picked up as part of medical appraisals and appraisals are not signed off until the declaration made. Different issues for different groups, not one answer to address. GP noted the need for management thought as to how to assure appropriate compliance. • KW noted it may relate to those who have nothing to declare but still need to do it, would be useful to see staffing groups for those not completing. • Discussion with internal auditors around decision maker level confirmed it varies from Trust to Trust so not able to compare. • GP asked for consideration to be given to a briefing using Trust mechanisms to confirm that Audit Committee have requested a summary of those not completing with an update to come to next Committee. • Discussion around quarterly reviews leading to challenge and whether there is a need to move away from a quarterly update to a half yearly or annual update with exception update if required. There is assurance on the process so not necessarily appropriate to review in so much detail. SP confirmed the detail could be taken to Execs. RA noted happy to move to 6 monthly updates with exception reports as a starting point. • GP summarised with the detail to be reviewed by Execs and a move to 6 monthly update (from July meeting) with exception reports where required.	

	Actions: • Staffing groups for those not completing declarations to be provided as part of next report to Committee. Consideration to be given to a briefing using Trust mechanisms to confirm that Audit Committee have requested a summary of those not completing. • Rolling programme to be updated to reflect move to 6 monthly updates with exception reports as necessary at other meetings. The Committee **acknowledged** the report.	**LW** **JD**
f	**Audit committee effectiveness outcome report 2023/24**	
	GP confirmed the following to the Committee: • The outcome of the effectiveness review is consistent with previous years. • It was noted about the timings and length of meetings which is being reviewed. • AMH noted that it would be good to include in future reports where feedback had been obtained from external audit and internal audit. • A private planning meeting for NEDs and internal auditors to be added to diary before February Audit Committee – for auditors to arrange. **Action:** private planning meeting for NED and internal auditors to be arranged prior to the February 2025 Audit Committee. The Committee **acknowledged** the report.	**AMH/SD**
13/24	**Internal Audit**	
a	**Internal Audit Progress Report**	
	SD presented the report to the Committee noting the following key points: • The following reviews have been finalised: o Patient Consent – to be reported to the Quality Assurance Committee (Substantial Assurance) o Managing Conflicts of Interest – reported to the Audit Committee (Substantial Assurance) o Assurance Framework (N/A Assurance) o Risk Management Core Controls (N/A Assurance) The following reviews are in progress: o Equality Diversity System 2022 - to be reported to the Workforce Assurance Committee (Draft Report) o Data Protection & Security Toolkit Phase 1 - to be reported to the Audit Committee (Fieldwork) • One proposed audit plan change that needs Audit Committee approval; request to change GM Cancer Alliance review with Clinical Skills Training Review. SP added context to confirm as part of the CQC inspection, clinical skills training was identified and is different to mandatory training which is compliance monitored separately so wanted some assurance that staff are completing the right training and being reported properly. TP added want assurance that staff are trained appropriately and accordingly to deliver safe care, important to gain assurance. The Committee **approved** the change to the audit plan. • Appendix A covers contract performance, plan is almost complete. • Appendix C provides a summary of the completed reviews: o Patient consent review, will be going to QAC for reporting. o Managing conflicts of interest, substantial assurance received with 4	

	medium risk recommendations and 1 low risk. Recommendations relate to staff being reminded of their responsibilities to make timely declarations of interest, looking to implement a formal training programme for staff, updating waiver documentation to require individuals completing the form to declare any interest, following up the non-declarations with staff identified, to remind them of their role and responsibilities in making a full declaration of any fees/gifts received, ensuring a reconciliation of declarations made (Procurement/Research) is undertaken to the CIVICA system, to ensure any discrepancies identified are reported and escalated to the system (CIVICA) for update. • AMH provided the update on the Assurance Framework review; made some recommendations around including heat maps and more visual information and more info on risk tolerances and appetite. Updates through the year to include internal and external sources to be made clearer. SP asked for clarification on risk appetite; AMH confirmed by example where risk 5.1 has the risk appetite noted as cautious with a target score of 9 but another risk had a lower score and also cautious so need to ensure defined appropriately. LW confirmed this has been changed for the new BAF. GP added the need to be clear on what risk appetite means and clear on the scoring and actions to take to reduce to target score and timeframe to achieve. If target score not achievable for whatever reasons we made need to accept level of risk, this needs to be documented along with mitigations. • Risk Management review - one minor change to R&QGC ToR required. TP confirmed this update has been done. The Committee **acknowledged** the report.	
b	**Internal audit follow up report 2023/24 and update on audit actions**	
	SD presented the report to the Committee noting the following key points: • Follow up to end of Q4, progress has been made for a number of reviews. Reporting good progress in the audit opinion. • All recommendations have been subject to review and deadlines extended where required. • SP noted that the CEO had asked all Executives to report to Audit Committee with updates on those recommendations not implemented and confirmed they are available to the Committee to update. • CMcP updated on the Trust's largest risk; Mosaiq business continuity plan. There are now 2 plans in place – a disaster recovery plan and a plan that confirms what to do within the first 3 hours. Both plans are being reviewed. Theatre Man plan also being reviewed and updated. iQemo plan being reviewed with Digital. • GP noted that delays to timescales for recommendations should be more of an exception with the onus on managers to ensure they are clear on what the recommendations are and expectations and the timescale agreed is realistic whilst stretching taking account of risk level. • SP confirmed the Admin & Clerical Bank paper is for presenting to the Committee based on a previous Audit Committee requirement. DS presented the paper setting out its aim is to provide assurance on managing the risks associated with the bank which is run by the CSSS division. The paper provides detail on 3 key areas and highlights the potential risks, employment status being the highest risk. DS assured	

	around controls in place, which are detailed in the paper. Regular reviews take place and bank workers are rotated. If requirements become more longer term, recruitment requirements are considered and correct recruitment process followed. Training requirements and process is robust to ensure completed before starting work on the bank. Robust controls in place to manage the 3 risks identified. KW asked how many people are on the bank and does it include opportunity for part time staff to be on the bank. DS confirmed yes and part time staff are used more often, also see an increase in the summer with students. People like the flexibility of the work. • SD asked on the management of the bank; how the Trust are identifying the use of the admin bank into planning, if they follow rosters and if reconciliations are done on timesheets. DS confirmed requirements are identified through work plans, filled by assignments not rosters required to cover vacancies or maternity cover etc. The Committee **acknowledged** the report.	
c	**Head of internal audit opinion 2023/24**	
	AMH presented the Head of internal audit opinion to the Committee noting the following key points: • Pleased to report substantial assurance, demonstrating 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. • The paper confirms how the conclusion has been reached through work undertaken in-year, management responses and the assurance framework. • Includes prompts to review for the AGS. • GP asked on the opinion given there are 31 outstanding audit actions. AMH confirmed the report is written at a point in time, there has been good progress and a wide range of substantial assurances within the year. • GP thanked MIAA. The Committee **acknowledged** the audit opinion.	
d	**Internal audit plan 2024/25**	
	SD presented the plan to the Committee noting the following key points: • Plan submitted for approval; has had amendments following discussions - Biobank changed to Board reporting and clinical skills training added to replace GM Cancer Alliance. • GP asked the Committee if the plan is sufficient in terms of the complexities of the Trust. Some areas didn't make the plan in terms of resource limitations and asked for thoughts. • SP referred to having a review of R&I done this year and also included in the follow up so comfortable that it doesn't need to be in this year's plan but needs to be included in this year's follow up. MCRC doesn't feel like a big risk. CQC preparedness / action plan already gets lots of attention. People plan has a lot of internal scrutiny and goes through WAC. • RA noted there are always areas where want to do more and have to draw a line somewhere, satisfied based on SP's comments. KW agreed noting that internal audit tells us whether we're doing the things we'd said we'd do so would seem too early to look at people plan and cultural review but would look to add further down the line. Changing nature of CQC and how the Trust use this would be useful for future.	

	• GP summarised, task for Audit Committee is to keep plan in view as year progresses. SD added the plan is flexible and can be changed in year. The Committee **approved** the 2024-25 audit plan.	
e	**Internal audit charter**	
	• SD noted the charter was provided to the Committee for information. The Committee **acknowledged and accepted** the audit charter.	
f	TIAN NHS Monthly Insight Report April 2024 - for information only	
	Noted.	
14/24	**Anti-fraud**	
a	**Anti-fraud annual report 2023/24**	
	KH presented the report to the Committee noting the following key points: • Proactive exercise on asset management ongoing. • 9 fraud presentations within year, also completed bespoke presentations to department areas. • Updated anti-fraud policy and made recommendations for other policies. • 19 fraud referrals in year; £5.5k fraud identified and prevented around £1k of fraud by not falling for phishing emails, commended the Finance team. • Fraud risk assessment process ongoing that leads to the plan. • Component Ratings for the Government Functional Standard 013 for Counter Fraud all green and testament to the controls in place at the Trust. • GP asked if there is anything that the Trust should be doing a more of. SP noted that part of speaking up is to ensure staff report any fraud. Can work on concluding quicker on issues raised and need to find a way to do this and better reporting of outcomes. • RP asked on response rate to counter fraud survey; KH confirmed the Trust had a better response rate than other Trusts, around 400 responses so far. Report will come to next Committee. The Committee **acknowledged** the report.	
b	**Anti-fraud work plan 2024/25**	
	• KH presented the plan to the Committee noting that the Counter Fraud Authority had added a proactive exercise on procurement. The Committee **approved** the 2024/25 plan.	
15/24	**External Audit**	
a	**Informing the audit risk assessment 2023/24**	
	MD presented the risk assessment to the Committee for awareness and noting, the following discussion points were noted: • GP asked on the impact of laws and regulations and if we are confident that we have a complete understanding across the whole spectrum. SP confirmed it is understood across the Trust within divisions and held by the areas who have to comply with them and manage how they are regulated; it is more around how each division is assured on compliance. • AMH asked external audit on expectations and what is seen elsewhere. MD confirmed the audit is primarily interested in finance and accounts related regulations. • Committee discussion around the question posed in the risk assessment	

	looks to seek wider assurance than finance. The Committee **acknowledged** the update.	
b	**External audit plan 2023/24**	
	MD presented the audit plan to the Committee noting the following key points: • GT have reviewed the draft accounts. • The paper provides a summary of the plan, the risks are largely the same as last year, summary given. • Materiality set at 2% of prior year gross expenditure, will be reviewed as part of review and reported in audit findings if changed. • VFM work progressing well. No significant weaknesses identified so far other than follow up to previous year significant weakness. Required to report on VFM work at same time as accounts work in June and will conclude on audit shortly after in line with NHS reporting requirements. • The group audit scope and risk assessment are also set out in the plan. Take assurance from auditor for The Christie Pharmacy which is a separate GT team. • Required risks for consideration are included in the plan; fraud and revenue recognition, do not consider as an improper risk at this stage. Required to consider if there is a fraud risk in expenditure recognition; satisfied as part of planning but will keep under review. • The progress as part of prior year audit recommendations will be followed up as part of this years review - significant and unusual transactions; based on transaction to the Charity last year, do not expect this to be an issue going forward. Useful economics lives of property, plant and equipment; depreciation calculation to be reviewed. Assets at nil value to be reviewed; considerable number on the asset register which is common across public sector clients. • The plan also includes the timetable for reporting in line with statutory deadlines and confirms GT do not carry out any non-audit services for the Trust. • GP asked SP if content with no value assets. SP confirmed it is a big job given the number of assets, need a more robust process and continual work but good progress. The Committee **approved** the audit plan.	
17/24	**Escalations to the Board of Directors**	
	• Declarations of interest – non-compliance of decisions makers to be highlighted to Board.	**GP**
18/24	**Reflections of the meeting**	
	• Timing of meeting worked well.	
19/24	**Any other business**	
	None.	
	Date of next meeting:	
	Wednesday 26th June 2024, 2.30pm followed by joint meeting with Quality and Workforce Assurance Committee, 3.45pm	

The Christie
NHS Foundation Trust

Agenda item 22/24d

Meeting of the Board of Directors

Thursday 27th June 2024

Subject / Title	Annual update regarding Care Quality Commission (CQC) requirements
Author(s)	Chief Nurse & Executive Director of Quality Deputy Chief Nurse Associate Chief Nurse for Quality & Patient Safety Associate Chief Nurse for Quality & Patient Experience Trust CQC Project Lead
Presented by	Chief Nurse & Executive Director of Quality
Summary / purpose of paper	To provide the Board of Directors with an update on CQC regulator approach, the Trusts annual position and preparedness
Recommendation(s)	The Board are asked notes the change and position and support actions taken by the Trust to date.
Background papers	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Care Quality Commission (Registration) Regulations 2009
Risk score	BAF Risk: 4, 15
Link to: ➢ Trust strategy ➢ Corporate objectives	1. To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	CQC - Care Quality Commission ICS - Integrated Care System IPQFR - Integrated performance, quality and finance report KLOE - Key lines of enquiry SACT - Systemic anti-cancer therapy SDM - Shared Decision Making

The Christie
NHS Foundation Trust

Agenda item 22/24d

Meeting of the Board of Directors

Thursday 27th June 2024

Annual update regarding Care Quality Commission (CQC) requirements

1. Purpose

The purpose of this report is to provide both an overview of the Care Quality Commission's (CQC) change in approach to Provider regulation through its new assessment framework and an annual update on the Trust position and preparation.

2. Background

As part of its registration with the Care Quality Commission (CQC) the Trust is required to demonstrate standards set out by the CQC under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009.

Through its governance processes, the Board of Directors has established an approach to demonstrate on-going compliance and this is through the board committees of Audit, Workforce and Quality Assurance, through operational governance committees, through the integrated performance, quality, and finance report (IPQFR) and through internal and external audit reports.

The ratings of CQC inspections have historically been based on evidence requested by the CQC, and care witnessed during a programme of routine and/or responsive inspection activity of core services and well-led inspections. Inspections have assessed whether the quality of services we provide to our patients meet the fundamental standards and are rated as inadequate, requires improvement, good or outstanding. The judgement is based on the key lines of enquiry (KLOEs); safe, effective, caring, responsive and well-led.

3. New approach to regulation

In August 2021 the CQC published its strategy which signalled a change in approach to regulation. The new approach uses a Single Assessment Framework for all Providers with the aim of providing more flexibility, moving away from scheduled inspections, and responding to risk in a proportionate and responsive way.

The CQC will be making more use of data; their new approach will involve an increased use of CQC Insight, which is a tool that brings together and analyses information about organisations to monitor changes to the quality of care.

The Single Assessment Framework has been developed from the 5 key questions traditionally asked by the CQC (previously known as the KLOES) are services: Safe, Effective, Caring, Responsive and Well Led. Under each key question are a set of quality statements, these are commitments that Providers (as well as commissioners and system leaders) should live up to. In total there are 34 quality statements.

The quality statements will be expressed as 'I' statements, describing what patients and the public expect, and as 'We' statements, describing the expectations of the CQC, and the mechanisms by which providers are held to account.

In addition to the quality statements, evidence is grouped into six categories (please see appendix 1 for NHS Acute Hospital evidence categories):

- People's experience
- Feedback from staff and leaders
- Feedback from partners
- Observation
- Processes
- Outcomes

Evidence considered by the CQC will be scored between 1 (significant shortfalls) to 4 (Exceptional standards). Under each evidence category, scores will be combined to give a Quality Statement score which will be converted into a percentage. At key question level the percentage is translated into a rating using the thresholds, as per below:

- 4 = Over 87% (outstanding)
- 3 = 63 to 87% (good)
- 2 = 39 to 62% (requires improvement)
- 1 = 25-38% (inadequate)

CQC will continue to provide an overall Trust rating using the existing scale: Outstanding, Good, Required Improvement and Inadequate. The first Trust level assessments under the new framework will cover all the 8 quality statements under the well-led question.

Current ratings will remain in place until Trusts receive their first assessments under the new framework.

The existing arrangement for quarterly relationship meetings will continue with an agenda set two weeks before the meetings and ad hoc contact will be made as required between the Trust and the CQC.

A new CQC portal is in development to support the revised framework, this was expected to be in place by March 2024 for submission of statutory notifications (serious injury, events that stop a service and Deprivation of Liberty Safeguards) and is expected to support data submissions in the future however, this is delayed with further information being awaited from the CQC at the time of this report.

4. Annual Trust update

Throughout 2023/24, the Trust has continued its regular engagement meetings with the CQC. These are attended by the Executive Chief Nurse & Director of Quality, the Deputy Chief Nurse and a designated CQC inspection manager for the trust. These meetings provide a Trust-wide quality update, with specific responses to trust level service questions raised under the broader CQC principles of Safe, Effective, Caring, Responsive and Well-Led.

The Christie NHS Foundation Trust's medical core service was last inspected 11-12th October 2022 followed by a well led inspection 15-17th November 2022. On 12th May 2023, the Trust was rated overall as 'Good' by the Care Quality Commission.

Overall trust quality rating	Good
Are services safe?	Requires Improvement
Are services effective?	Outstanding
Are services caring?	Outstanding
Are services responsive?	Outstanding
Are services well-led?	Requires Improvement

The CQC report identified 7 ‘must do’ actions to meet regulatory requirements. These include:

- The trust must ensure staff complete mandatory training, including safeguarding training in accordance with the relevant schedule and receive relevant training, supervision and appraisal to perform their duties competently. (Regulation 18 (1)(2)(a)
- The trust must ensure that policies are reviewed and ratified in a more timely manner. (Regulation 17 (1))
- The trust must ensure that serious incidents and mortality reviews are investigated in a timely manner and learning is shared across the organisation as required. (Regulation 12 (2)(b))
- The trust must ensure there is an effective process to manage complaints, in particular, ensuring the timeliness of responses. (Regulation 16 (2))
- The trust must ensure there is an effective process to manage the administration of the fit and proper persons checks. (Regulation 5)
- The trust must ensure that patient risk assessments are consistently completed and reviewed in a timely manner for all patients. (Regulation 12 (1)(2)(a)(b))
- The service must ensure the proper and safe management of medicines, to include the completion of antimicrobial documentation for safe prescribing in line with trust policies. (Regulation 12(1)(2)(g))

On the 30th November 2023, a completed report of the actions and supporting evidence was approved by Trust Board of Directors and submitted to the CQC, Specialist Commissioners and GM ICB for oversight.

The report also identifies 4 ‘should do’ actions which the trust is not required to submit an action plan or report to the CQC. Work continues to ensure improvements against these actions, which will be reported seperately to board.

- The trust should continue to make improvements in culture across the organisation, support staff when raising concerns and act on them in a timely way
- The trust should continue to develop and promote fundamental strategies such as the equality, diversity and inclusion strategy and take appropriate actions to improve staff engagement, especially those with particular equality characteristics
- The trust should consider monitoring delayed discharges or transfers of care in regard to patient experience
- The trust should ensure there is an effective process to provide information in an accessible format for service users with information or communication needs

5. Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection

On the 21 April 2023 the CQC gave notification to inspect the radiotherapy department at the Trust for compliance with the Ionising Radiation (Medical Exposure) Regulations. The inspection was done using the CQC's new process. This involved completion and submission of a self-assessment questionnaire followed by discussion with key personnel and meetings with staff where necessary which took place 31 May 2023.

The final report published 12 July 2023 identified 3 areas for improvement:

- The employer must ensure that written procedures in respect of those matters described in Schedule 2 are reflective of local practice and that they contain sufficient detail for all duty holders. Regulation 6.
- The employer must ensure that clinically significant incidents are clearly defined within the employer's procedures. Regulation 6(1)(a).
- The employer must ensure that procedures for making pregnancy enquiries are inclusive of all individuals of childbearing potential. Regulation 6(1)(a).

An action plan to address the areas for improvement has been submitted to the CQC on 26 July 2023. An outcome letter from the CQC dated 09 August 2023 confirmed the CQC as satisfied that the actions taken, or are intending to take, will address the recommendations made with a view to maintaining compliance with IR(ME)R in the future and the inspection file closed.

6. Preparedness

As we prepare for the new CQC framework of assessment we continue to ensure our 'must do' actions are maintained and evidenced and the 'should do' workstreams continue to deliver the required improvement.

Focus is being directed towards our preparedness for the new single assessment framework; a self-assessment is currently in progress against the 34 quality statements and a repository of examples for each of the evidence categories is being developed.

Preparation is being directed and overseen by the Chief Nurse and Executive Director of Quality in weekly meetings with key stakeholders.

The Christie CODE and The Christie Quality Mark accreditations will be reviewed against the 34 quality statements and corresponding evidence categories to ensure alignment.

Quarterly engagement meetings between the CQC Greater Manchester Hospital Inspector, CQC GM locality Operations Manager, Chief Nurse and Executive Director for Quality and Deputy are planned for 2024/25 (July, October and January dates booked).

Staff engagement with the new assessment framework is being planned.

External scrutiny of our preparedness against the new framework of assessment is planned for later this year, this will include training & briefing for the Board on the new framework.

7. Conclusion

The Trust continues to meet the outcomes required by the CQC under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009.

Actions are ongoing to ensure the Trust is prepared for the new CQC assessment framework.

8. Recommendation

The Board is asked to approve the content of this paper.

Appendix 1.

Sector groupings	Link to website	Evidence categories	Safe							Effective						Caring					Responsive							Well led								Evidence categories
			Learning culture	Safe systems, pathways and transitions	Safeguarding	Involving people to manage risks	Safe environments	Infection prevention and control	Safe and effective staffing	Medicines optimisation	Assessing needs	Delivering evidence-based care and treatment	How staff, teams and services work together	Supporting people to live healthier lives	Monitoring and improving outcomes	Consent to care and treatment	Kindness, compassion and dignity	Treating people as individuals	Independence, choice and control	Responding to people's	Workforce wellbeing and enablement	Person-centred care	Care provision, integration and	Providing information	Listening to and involving people	Equity in access	Equity in experiences and	Planning for the future	Shared direction and culture	Capable, compassionate and inclusive leaders	Freedom to speak up	Governance and assurance	Partnerships and communities	Learning, improvement and	Environmental sustainability – sustainable development	Workforce equality, diversity and inclusion	
NHS acute hospital services	https://www.cqc.org.uk/assessment/evidence-categories/nhs-acute-hospital-services-	People's Experience	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■		■	■	■	■	■	■	■					■				People's Experience
		Feedback from staff and leaders	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	Feedback from staff and leaders
		Feedback from partners		■		■							■				■						■										■				Feedback from partners
		Observation					■	■	■	■	■		■				■	■		■		■		■												Observation
		Processes	■	■	■	■	■	■	■	■	■	■	■	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	Processes
		Outcomes									■	■			■										■											Outcomes

■	Key category for all assessment service groups in sector group
■	Service specific (added after 13.09)
■	Service specific (added before 13.09)

The Christie
NHS Foundation Trust

Agenda item 22/24e

Board of Directors meeting

Thursday 27th June 2024

Subject / Title	Board effectiveness review outcome report 2023/24
Author(s)	Jo D'Arcy, Assistant Company Secretary
Presented by	Edward Astle, Chair
Summary / purpose of paper	This paper provides the board of directors with the findings of the effectiveness review of the board of directors for 2023/24.
Recommendation(s)	The board of directors to note the findings of the self-assessment and consider any improvements as a result of the comments made.
Background Papers	N/A
Risk Score	N/A
EDI impact / considerations	N/A
Link to: ➢ Trust's Strategic Direction ➢ Corporate Objectives	Achievement of corporate plan and objectives
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	N/A

The Christie
NHS Foundation Trust

Agenda Item 22/24e

Board of Directors meeting
Thursday 27th June 2024

Board effectiveness review outcome report 2023/24

1. Background

The board complete an annual review of their effectiveness. During 2023/24 the following changes occurred to the membership of the board of directors:

- Kathryn Riddle, Non-Executive Director, left the Board of Directors in May 2023.
- Christine Outram, Chair, left the Board of Directors in September 2023.
- Jane Maher, Non-Executive Director, left the Board of Directors in September 2023.
- Edward Astle was appointed as Chairman in October 2023.
- Janelle Yorke, Executive Chief Nurse and Director of Quality, left the Board of Directors in December 2023.
- Theresa Plaiter was appointed as interim Executive Chief Nurse and Director of Quality in January 2024.
- Diana Tait was appointed as Non-Executive Director in January 2024.
- Bernie Delahoyde, Chief Operating Officer, left the Board of Directors at the end of March 2024.
- Claire McPeake was appointed as interim Chief Operating Officer in March 2024.

2. Introduction

Members of the board were asked to complete a self-assessment questionnaire that asked 22 questions with the provision for comments to be provided. The questionnaire is appended to this report at appendix 2. The questions were designed to assess the effectiveness of behaviours, process and support to the board of directors meetings.

This report presents the combined responses from the 12 forms received.

3. Findings

The responses to the 22 questions are summarised below with the full results provided in appendix 1:

	1 Strongly disagree	2 Disagree	3 Do not agree or disagree	4 Agree	5 Strongly agree	Unanswered
Work of the board	7%	1%	20%	61%	10%	1%
Skills and dynamics of the board	4%	4%	24%	52%	15%	1%
Mechanics of the board	0%	0%	33%	64%	3%	0%
Chairmanship of the Board	8%	0%	37%	33%	10%	12%
Overall total (average)	**4.75%**	**1.25%**	**28.5%**	**52.5%**	**9.5%**	**3.5%**

Given the restructure to the questionnaire this year, there is no previous years' comparable data. However, the data from the previous 4 years based on the prior format is shown below:

	2022/23			2021/22			2019/20			2018/19		
Status	**No**	**%**		**No**	**%**		**No**	**%**		**No.**	**%**	
1. Hardly ever / Poor	0	0		0	0		1	0.4		0	0	
2. Occasionally / Below average	0	0		0	0		0	0		0	0	
3. Some of the time / Average	46	10.1		38	9.3		4	1.5		0	0	
4. Most of the time / Above average	221	48	88.6	168	41.3	89.7	102	39.4	98.1	88	26.4	100
5. All of the time / Fully achieved	183	40		197	48.4		152	58.7		245	73.6	
TOTAL:	**456**	**100**		**407**	**100**		**259**	**100**		**333**	**100**	
Don't know	1	0.2		3	0.7		0	0		0	0	
N/A	2	0.4		0	0		0	0		0	0	
Unanswered	3	0.7		1	0.3		0	0		0	0	

4. Suggested actions

The following are suggestions and will be subject to discussion by the Board;

1. More on performance: *to be incorporated in forward agenda*
2. Frequency of Board meetings: *review length of public board for each meeting, and frequency of board meetings in a year's time*
3. More on culture: *continued focus through Board meetings*
4. More on governance: *review once refreshed BAF/scorecard have been in place for a few months*
3. More board development: *rolling programme of Board activities set for the year with additional training offered on Board development, 'softer' development sessions planned once new directors in post*
4. Embed paper guidelines: *in progress*
5. Chair feedback: re*flect feedback in personal objectives, particularly inclusion in meetings, more individual support; maintain/enhance diversity and harness NED and Exec skills around the table.*

5. Recommendation

The board of directors are asked to note the findings of the self-assessment and consider any improvements as a result of the comments made.

Appendix 1 – Detailed results

1 Strongly disagree	2 Disagree	3 Do not agree or disagree	4 Agree	5 Strongly agree

Work of the board						
	1	**2**	**3**	**4**	**5**	**Unanswered**
The Board agenda balance/focus is appropriate	1	0	1	9	1	0
The Board are effective in overseeing the Trust's strategy	1	0	1	9	1	0
The Board are effective in overseeing performance	1	1	1	8	0	1
The Board are effective in overseeing culture	1	0	6	4	1	0
The Board are effective in overseeing governance (risks, compliance etc)	1	0	5	4	2	0
The Board have sufficient understanding of wider context: NHS nationally and regionally, peer benchmarks	1	0	2	8	1	0
The Board are effective in making decisions	1	0	2	6	3	0
The Board and committees are implementing the recommendations from the governance review effectively	0	0	1	10	1	0
TOTAL	**7**	**1**	**19**	**58**	**10**	1
Skills and dynamics of the board						
The Board has appropriate diversity of skills, experience, background etc	0	1	4	6	1	0
The Board has effective induction, training and support programmes	0	0	5	5	1	1
There are balanced contributions from all members of the Board	1	0	4	5	2	0
There is an open culture where members can say what they think and where constructive challenge is welcome	0	2	0	8	2	0
There are constructive relations between Executives and Non-Executive members	1	0	1	7	3	0
There is a constructive relationship between the Chair and CEO	1	0	3	6	2	0
TOTAL	**3**	**3**	**17**	**37**	**11**	**1**
Mechanics of the board						
The frequency and length of Board meetings is appropriate	0	0	5	7	0	0
Board papers are of appropriate quality and length	0	0	5	7	0	0
The frequency and length of Board Time Outs is appropriate	0	0	2	9	1	0
TOTAL	**0**	**0**	**12**	**23**	**1**	**0**
Chairmanship of the Board						
The Chair promotes a culture of openness around the Board table	1	0	5	3	2	1
The Chair ensures that the Board exercises collective responsibility and is effective in building consensus	1	0	4	4	2	1
The Chair is effective in supporting individual members of the Board e.g., through induction and the annual self-evaluation exercise	1	0	7	1	1	2
The Chair oversees an effective Committee structure, with clear remits and appropriate skills	1	0	3	7	0	1
The Chair sets high ethical standards	1	0	3	5	1	2
TOTAL	**5**	**0**	**22**	**20**	**6**	**7**

The Christie NHS Foundation Trust

EXECUTIVE SUMMARY

The Christie NHS Foundation Trust

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

Safety

- Two serious incidents were reported in May. There were 5 incidents in total reported in May which require a learning response. 2 incidents were reported with the classification of moderate, two as low harm and one as no harm. Details of each incident can be found on slide 7. All the incidents are still progressing through to full root cause analysis. No never events were reported in month.
- There are 6 Trust level risks scored at 15+. Details of these can be found on slide 12.
- Safer staffing numbers have met the required acuity levels to ensure appropriate levels of safety and care for our patients. Indicative staffing, in line with nursing establishments, is set to maintain a 1:7 nurse to patient ratio. On occasion this has been extended to 1:8 which is in line with recommended national staffing ratios. While we have seen an increase in patient safety incidents, following thematic review, these were not related to nurse staffing ratios.
- There were 3 cases of C-Difficile, 4 cases of E-Coli, 2 cases of Klebsiella, 2 cases of MSSA and 2 cases of MRSA reported in May that were deemed attributable to the Trust. No lapses in care were identified. One of the cases of HOHA C-Diff has been uploaded as occurring at the Trust due to admission and sample date, however this case has been attributed to another Trust as identified elsewhere in March & April.

Performance

- In May the new combined 62-day performance subject to validation was at 73% which is above the new standard of 70%. The new combined 31-day performance was 98.9% which is above the new standard of 96%. The internal 24-day performance is below standard and is at 72.9%. All 62 and 24-day breaches are reviewed to ensure any delays are understood and plans can be implemented to mitigate any future delays. Improvement plans are in place and performance is expected to improve before the end of the financial year. The Trust's RTT 18-week performance is well above standard at 98.7%. The Trust achieved the 75% faster diagnosis standard in May with a compliance score of 80%.
- There were no patients waiting over 52 weeks at the end of May.
- Referral numbers in May reduced slightly from April but remained high and well above the 23/24 average.

HR

- Staff absence increased very slightly from April to a position of 4.36% against a target of 3.4%.
- PDR performance has improved from April's position and mandatory training has also improved slightly. Mandatory training performance remains well above the set standard.

Finance

- The Trust is reporting a surplus at the end of M2 of (£1,476k) against a M2 YTD plan of (£1,168k), which gives a month 2 variance of (£308k) better than plan.
- Capital performance to month 2 was £1,366k below the plan submitted to NHSE&I in April 24.
- Performance to month 2 was £1,366k below the plan submitted to NHSE&I in April 24. This is lower than the plan position due to the TIF Ward position.
- The Trust has incurred £3,074k on capital schemes to month 2, primarily on the TIF ward refurbishment.

SUMMARY DASHBOARD

NHS
The Christie
NHS Foundation Trust

Indicator	Threshold / Standard 24/25	New Standards	Jan-24	Feb-24	Mar-24	Apr-24	May-24	YTD
Serious Incident Reported	-		2	2	0	1	2	3
Never Events	0		0	0	0	0	0	0
Radiation Incidents Reported (IRMER Reportable)	0		1	2	1	1	3	4
Radiation Incidents Reported (IRMER Reportable - Grade 2 or above)	0		0	1	0	0	0	0
Number of Pressure Ulcers (Post admission - Grade 2 or above) - Rate per 1000 occupied bed days	0.5		0.4	0.2	0.4	1	0.0	0.8
Inpatient Falls Resulting in Harm (Grade 2 or above) - Rate per 1000 occupied bed days	3.8		2.5	3.8	3.8	4.7	3.6	4.7
VTE Assessments Completed	95%		99.2%	98.9%	98.5%	98.5%	98.3%	-
Sepsis - timely treatment with IV antibiotics (established inpatients)	90%		88.8%	90.0%	90.2%	90.0%	87.0%	-
Sepsis - screening (presenting as an emergency)	90%		96.9%	98.0%	99.1%	94.9%	100.0%	-
Number of Corporate Risks Grade 15 or Above	-		5	4	4	6	6	-
Safe Staffing (% of planned hours vs actual hours across all inpatient areas)	-		89.0%	88.3%	88.2%	88.7%	89.5%	-
28 Day Faster Diagnosis Standard	75%	75%	52.9%	60.0%	55.0%	81.3%	80.0%	-
62 Day Compliance	70%	70%	60.0%	68.3%	74.9%	71.9%	73.0%	-
62 Day Compliance - Upgrades								-
62 Day Compliance - Screening								-
24 Day Compliance	85%	85%	63.7%	71.7%	76.4%	71.8%	72.9%	-
31 Day Compliance	96%	96%	97.3%	99.0%	98.9%	98.3%	98.3%	-
31 Day Compliance - Subsequent Drug Therapy								-
31 Day Compliance - Subsequent Radiotherapy								-
31 Day Compliance - Subsequent Surgery								-
18 Weeks Compliance - Incomplete Pathways	92%	92%	97.3%	98.0%	98.0%	98.4%	98.7%	-
Patients waiting >52 Weeks	0		1	1	3	0	0	0
Patients waiting >62 days at end of month (62 Day Classic)	80		136	119	94	129	119	-
Patients waiting >104 days at end of month (All 62 Day Targets)	-		72	45	51	47	51	-
Length Of Stay (Elective & Non-Elective Inpatients)	-		6.16	6.74	6.67	7.81	6.39	-
Patients Discharged Beyond Ready for Discharge Date	-		8	8	5	14	2	16
Patients Discharged Beyond Ready for Discharge Date - Total Bed Days Lost (days counted in the month of discharge)	-		211	151	119	213	15	228
Patients Discharged Beyond Ready for Discharge Date - Average Bed Days Lost (days counted in the month of discharge)	-		26.4	18.9	23.8	15.2	7.5	22.7
Hospital Cancelled Operations on the day for non clinical reasons	0		1	5	6	3	2	5
Hospital Cancelled Operations on the day for non clinical reasons - NOT rebooked within 28 days	0		0	0	0	0	0	0
Complaints Received	12 (23/24 Avg)		12	15	8	12	14	26
PALS Contacts	35 (23/24 Avg)		28	21	19	32	67	99
Inquests	-		3	1	3	4	2	6
Coroner Request	-		6	7	5	5	13	18

SUMMARY DASHBOARD

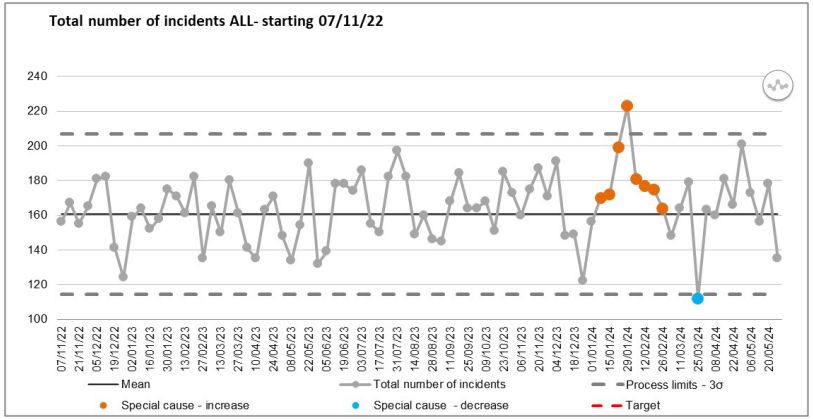
NHS
The Christie
NHS Foundation Trust

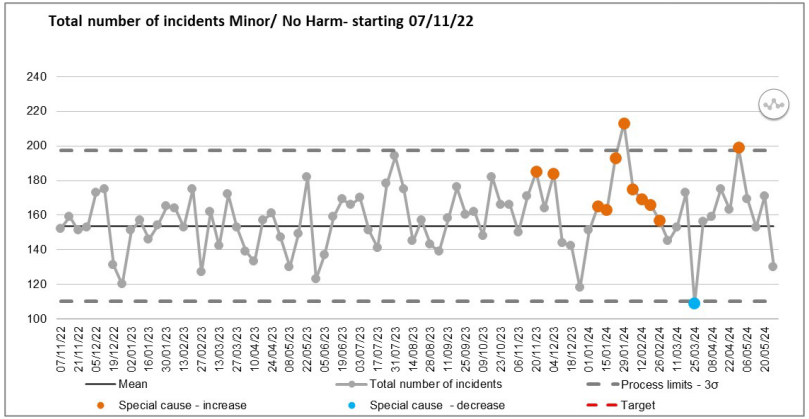
Indicator	Threshold / Standard 24/25		Jan-24	Feb-24	Mar-24	Apr-24	May-24	YTD
MRSA	TBC for 24/25		0	0	0	0	2	2
C-Difficile - All Attributable Cases (Pre & Post 48 Hours)			7	5	12	2	3	5
C-Difficile - Attributable Cases Due To Lapse In Care			0	0	2	0	0	0
MSSA Bacteraemia - Attributable			3	2	0	1	2	3
E-Coli - Attributable			6	4	3	6	4	10
Klebsiella Species - Attributable			2	4	2	1	2	3
Pseudomonas Aeuriginosa - Attributable			0	0	0	0	0	0
Palliative Radiotherapy 30 Day Suvival Rate	-		91.9%	88.6%	90.6%	89.1%	-	-
Final Chemotherapy 30 Day Survival Rate	-		99.5%	99.3%	99.4%	99.3%	-	-
Surgery 30 Day Survival Rate	-		100.0%	100.0%	100.0%	100.0%	-	-
Staff Sickness	3.4%		5.05%	4.62%	4.21%	4.35%	4.36%	-
Staff Mandatory Training	>80%**	<80%	91.8%	92.0%	92.6%	92.7%	92.7%	-
Staff PDRs	-		87.0%	86.5%	84.9%	84.6%	85.7%	-

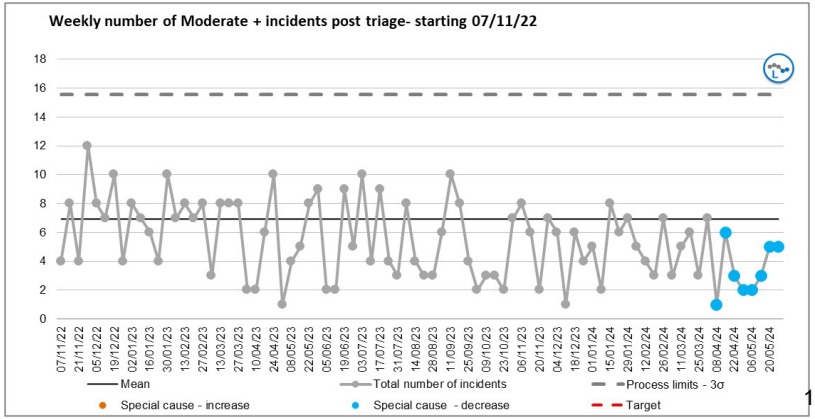
***Compliance if <80% & risk assessment in place**

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

Incident Reporting

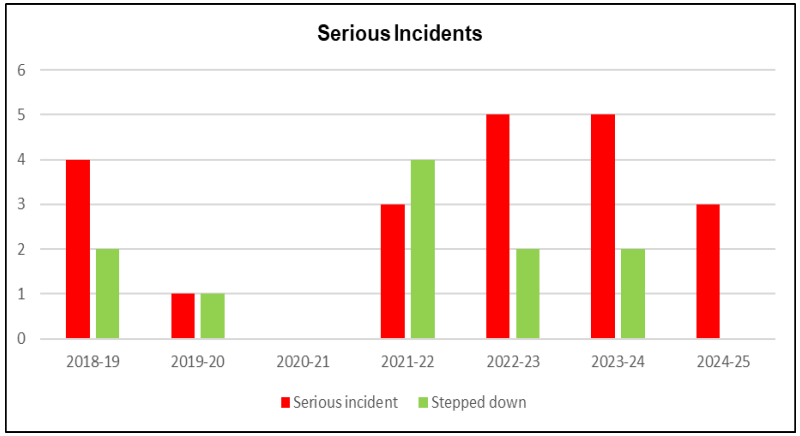






Special cause decrease can be noted for reported weekly moderate incidents (post triage) , this reflects the change in incident grading in the new Datix system from March 2024 .'Near miss' incidents can now be submitted (graded as no harm) which previously were submitted as moderate in severity.

Serious Incidents and Never Events



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

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

Serious incidents
There were 2 serious incident identified in May 2024:
1065- GCSF not prescribed
1713- MSCC patient – care of a deteriorating patient

Incidents identified that require a Learning Response

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May 2024 – RCA/learning response to be presented to ERG		
Reference	**Description**	**Reported Harm Level**
1003	Trastuzumab cycle not commenced as prescribed	No Harm
846	Details of patient's life expectancy shared against their wishes	Moderate
1059	Sertraline not prescribed on admission, patient missed multiple doses. Confusion noted.	Moderate
1874	MRSA Blood stream infection	Low harm
2129	MRSA Blood stream infection	Low harm

Learning - Patient Safety Incidents

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Agreed learning and revised severity outcome following executive reviews May 2024

Ref	Description	Root cause	Learning	Outcome
430	Fall resulting in fracture to neck of femur.	Patient fell due to pyjamas getting caught on foot leading to a fall. Additional risk identified of water on floor.	• Review changing time of autorun of showers to midday (currently midnight) • Patient education via signage and falls leaflet caution when showers running. • Thematic review- to present through Divisional Quality Meeting and Friday focus.	Severe Harm
W83526/ W83527	This investigation concerns two incidents that were reported due to delays in acknowledging and acting on results for two different patients.	The process in place for the plastic surgery team to acknowledge and act upon results requires strengthening.	• To review and update process for reviewing and actioning scans. • To include in local induction for new members of the team • Plastic surgery team to review process/safety netting appointments post investigations.	W83526 Moderate W83527 No Harm
W83622-MDT	Cross contamination of IV lines.	N/A- PSIRF learning response	• A standard line label should be used Trust wide to ensure consistency in practice. • IPC in conjunction with the ward managers to undertake auditing of lines through each inpatient area pre and post new labels to ensure practice is embedded into practice. • IV lines to be discussed during bedside handover. • Task and finish group to be set up to review current practice and implement improvements • Intravenous policy review.	Minor

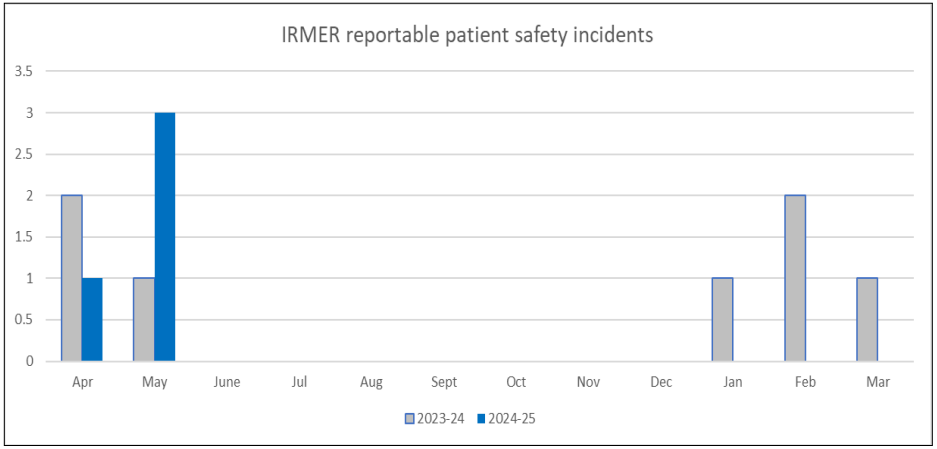
Learning - Patient Safety Incidents

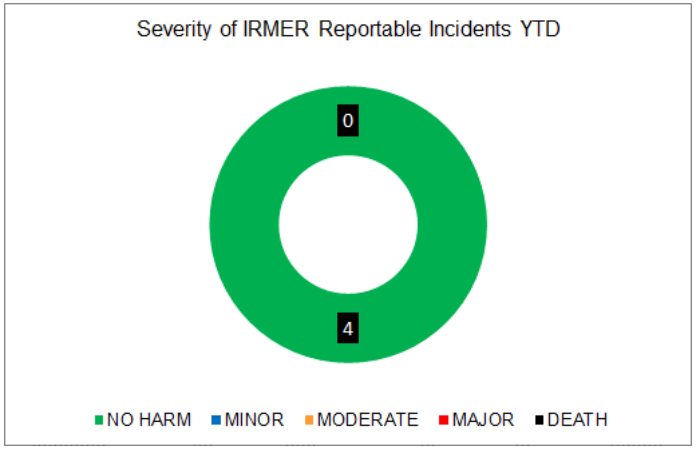
The Christie NHS Foundation Trust

Agreed learning and revised severity outcome following executive reviews May 2024

Ref	Description	Root cause	Learning	Outcome
W84528	A patient on a clinical trial received an expired intravenous treatment in error.	There were multiple contributing factors that led to the situation arising, and safe systems were not in place to support staff	• Team reflection and shared learning about checking of expiry dates prior to administration • Review and update of SOP for unused/expired trial SACT • Purchase of new fridge to allow clear segregation • Introduction of 'quarantine' stickers • Themed review of stock management across the Trust	No Harm
W84647	Patient continued to take Posaconazole whilst on Navitoclax, Venetoclax, vincristine and Ambisome. There is a known drug reaction that increases the potency of venetoclax and Vincristine.	• The patient had been informed to stop the antifungal medication. • There were some missed opportunities to question patients' medication when he called the hotline, and again at the bloods and review appointment with the day unit doctor.	• Patients to have a medication review on starting venetoclax, ensuring that Posaconazole is not continued according to regime. – all medical teams to be informed of this • Nursing staff to double check when administering vincristine, to be discontinuing Posaconazole/ azoles as appropriate. • IQEMO message added when prescribing ven/nav on first cycle - "Ensure patient is not taking azole antifungals (especially NO Posaconazole) prior to starting. • Develop an alert card / patient information regarding specific regime.	Moderate

Radiation Incidents





There were 3 IRMER reportable incidents in May 2024:
1844 – no harm
2127 – no harm
2026 – no harm

Harm Free Care

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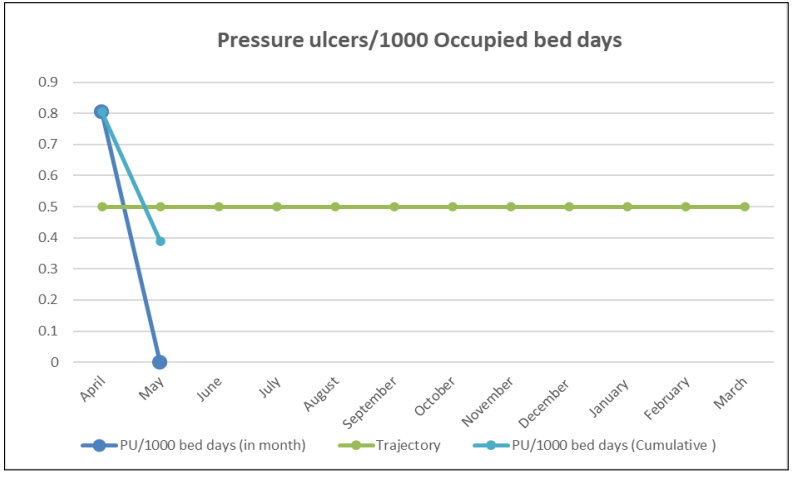
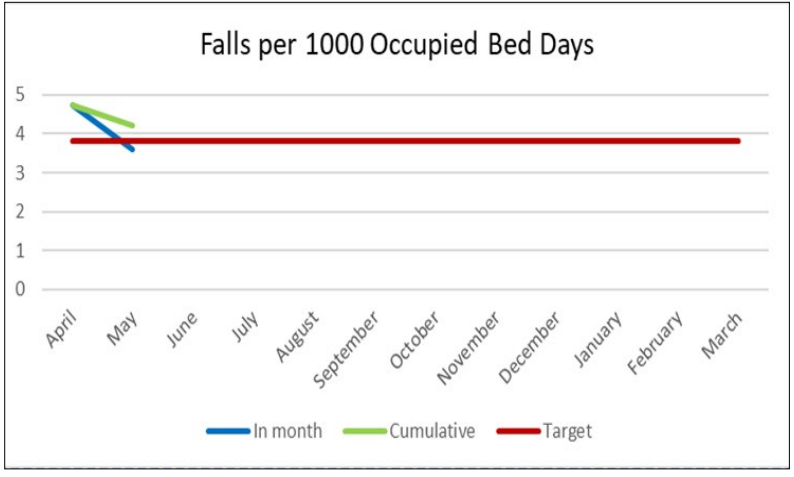
Pressure ulcers per 1000 occupied bed days



The ambition for 2024/25 is to maintain previous good performance of no more than 0.5/1000bed occupied days a month.

No pressure ulcers were reported in May 2024

Falls per 1000 occupied bed days



The ambition for 2024/25 is to maintain previous good performance of no less than 3.8 falls per 1000 bed occupied days..

3.6 falls per 1000 OBD occurred during May 2024 (n=20)

80% of falls resulted in no harm

65% of falls related to use of the bathroom or commode

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

Corporate Risks

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There are 6 Trust-wide 15+ risks in May

Description	Score	Controls
24/25 Financial Revenue Risk (Risk ID 3683)	20	Divisions working to increase level of recurrent VIP schemes identified in order to achieve Trust VIP target
24/25 Capital Envelope Restrictions (Risk ID 3628)	16	Capital priorities to be managed within existing ICB allocation and support the ICB to deliver a compliant capital plan. Current proposal from NHSE to support system revenue plan involves further reduction to capital envelope. At the time of updating the GM ICB had not accepted this proposal.
There is a risk that patients may experience harm due to significant delays in the management of patients with penile cancers. (Risk ID 3319)	16	Additional Theatre capacity established. Additional list planned, expected by August – this will reduce risk to 12.
Risk of delayed cancer treatments due to failure to meet 24 / 62 day target (Risk ID 2407)	15	Compliant with target for last 2 months. Work ongoing to ensure this is sustainable, at which point risk can be reduced.
There is a risk of Radiology being unable to provide an appropriate turnaround time for reporting of images due to insufficient resource (Risk ID 3380)	16	Risk reviewed at CSSS Governance and alongside risk 2767 and agreed to incorporate the 2 risks together as risk and cause are the same and impact of risk outlined covering 2767.
Risk of not meeting regulatory requirement for central reporting of role specific training across the Trust (Risk ID 3689)	15	Key issue is the ability to report compliance – not that training is not taking place. Task and finish group established to deliver Christie Learning Zone as the single database for all training. This relates to role specific training – not to mandatory training which remains compliant.

Safe Staffing

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		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	16525	13000	5219	5.2
	Total monthly ACTUAL	14932	12295		
	Average Fill Rate %	90.4%	94.6%		
Care Staff	Total monthly PLANNED	10626	7078	5219	2.9
	Total monthly ACTUAL	8686	6373		
	Average Fill Rate %	81.7%	90.0%		
ALL Staff	Total monthly PLANNED	27151	20078	5219	8.1
	Total monthly ACTUAL	23618	18668		
	Average Fill Rate %	87.0%	93.0%		

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	2252	1754	77.9%	2035	1570	77.1%	143	23.2
Palatine Ward	3227	2850	88.3%	2522	2264	89.8%	860	5.9
Ward 10	2175	1929	88.7%	1531	1483	96.9%	830	4.1
Ward 11	1818	1841	101.3%	1552	1546	99.6%	814	4.2
Ward 12	1863	1798	96.5%	1464	1564	106.8%	851	4.0
Ward 4	1840	1820	98.9%	1437	1434	99.8%	823	4.0
Ward 2	1019	955	93.7%	656	682	104.0%	331	4.9
Acute Assessment Unit	2331	1985	85.2%	1803	1752	97.2%	567	6.6
TOTAL	16525	14932	90.4%	13000	12295	94.6%	5219	5.2

Registered Nursing Associates	DAY			NIGHT		
	Hours Planned	Hours Actual		Hours Planned	Hours Actual	
Critical Care Unit						
Palatine Ward						
Ward 10						
Ward 11						
Ward 12		46				
Ward 4						
Ward 2		12				
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	614	328	53.4%	0	0	100.0%	143	2.3
Palatine Ward	1245	1045	83.9%	920	781	84.9%	860	2.1
Ward 10	1825	1295	71.0%	947	825	87.1%	830	2.6
Ward 11	1965	1446	73.6%	1452	1216	83.7%	814	3.3
Ward 12	1557	1551	99.6%	1274	1248	98.0%	851	3.3
Ward 4	1741	1568	90.1%	1412	1321	93.6%	823	3.5
Ward 2	380	350	92.1%	257	281	109.3%	331	1.9
Acute Assessment Unit	1299	1103	84.9%	816	701	85.9%	567	3.2
TOTAL	10626	8686	81.7%	7078	6373	90.0%	5219	2.9

110

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

Patient Experience

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Positive feedback received…..

Thanks for the kindness of staff during a partner's treatment. The polite , friendly manner of staff has cheered them up every day.

There was a very comprehensive letter received into the Trust that highlighted the amazing work of a wide range of people including the catering team, ward-based staff, medical team, supportive care team and other specialities. The family wished to extend their gratitude for the kindness, empathy, flexibility and thoughtfulness of those involved in the care. There was also an appreciation for the fact that when issues arose that were promptly acted upon by senior members of the care. The communication between the care teams and the family were also highlighted.

You allowed my mum to resume normality and enjoy her life with her friends and family. We will always be eternally grateful

A lady wished to say that everyone has been kindness itself during the whole journey and incredibly supported throughout. She thanked both the clinical teams who'd conducted her treatment and administrative teams who'd helped her with transport. She felt very reassured and now a few months following treatment is 'feeling on top of the world' thanks to all their efforts.

Friends & Family Test

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Monthly Summary

	OUTPATIENT RESPONSES						Total responses	% Recommended
	1 - Very Good	2 - Good	3 - Neither Good nor Poor	4 - Poor	5 - Very Poor	6 - Don't Know		
Apr-24	1951	204	47	29	23	19	2273	94.81%
May-24	1534	167	34	18	9	10	1772	95.99%
YTD Total	3485	371	81	47	32	29	4045	95.33%

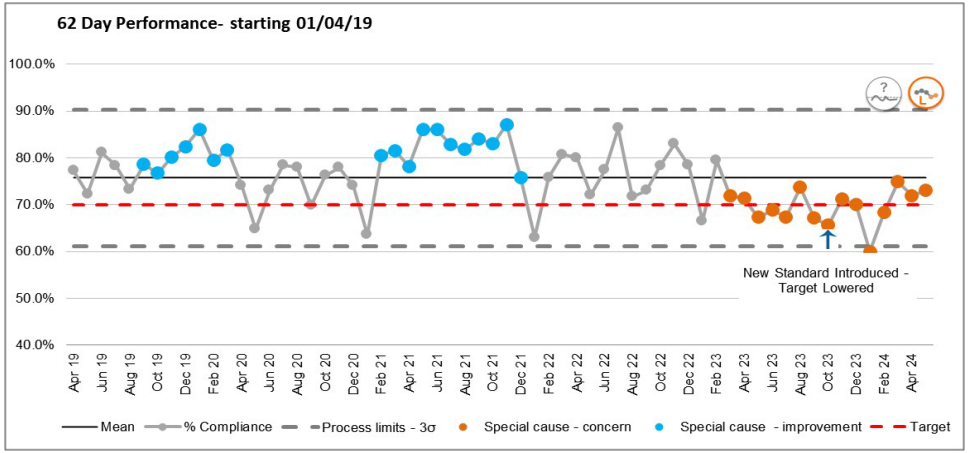
	INPATIENT & DAYCASE RESPONSES						Total Number of people eligible to respond	Total Responses	Response Rate	% Recommended
	1 - Very Good	2 - Good	3 - Neither Good nor Poor	4 - Poor	5 - Very Poor	6 - Don't Know				
Apr-24	265	27	5	2	2	1	986	302	30.6%	96.69%
May-24	208	25	4	4	1	1	884	243	27.5%	95.88%
YTD Total	473	52	9	6	3	2	1870	545	29.14%	96.33%

Ward name	INPATIENT & DAYCASE RESPONSES - BY WARD						Total Number of people eligible to respond	Total responses for each ward	Response rate for each ward
	1 - Very Good	2 - Good	3 - Neither Good nor Poor	4 - Poor	5 - Very Poor	6 - Don't Know			
04 Ward (Dept 52)	5	2	1	0	0	0	96	8	8.3%
10 Ward-Surg Onc Unit (Dept 4)	20	5	0	0	0	0	126	25	19.8%
11 Ward (Dept 4)	5	0	0	1	0	0	108	6	5.6%
12 Ward (Dept 4)	4	0	0	0	0	0	81	4	4.9%
The BMR Unit (Dept 16)	6	1	0	0	0	0	21	7	33.3%
Endocrine Ward (Dept 63)	10	0	1	0	0	0	30	11	36.7%
Haematology Day Unit (Dept 26)	50	7	1	1	1	0	126	60	47.6%
Integrated Procedure Unit (Dept 2)	100	9	0	2	0	1	195	112	57.4%
Palatine Ward (Dept 27)	8	1	1	0	0	0	101	10	9.9%
Total	208	25	4	4	1	1	884	243	27.5%

Cancer Standards

The Christie NHS Foundation Trust

62 Day / 31 Day / 18 Weeks



		May
50% Shared Breach		53
50% Shared Compliance		128
Full Christie Breach		16
FULL Christie Compliance		51
FULL Referring Provider Breach		132
Grand Total		380
62 Combined		73.0%
24 Day Compliance		72.92%
31 Day	Breach	4
	Compliance	387
Grand Total		391
31 day - Subsequents	Breach	5
	Compliance	410
Grand Total		415
31 day - Combined	Breach	9
	Compliance	797
Grand Total		806
31 day - Combined		98.9%

National Standard	Standard	May-23	Jun-23	Jul-23	Aug-23	Sep-23	New Standard	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
62 Day	85%	67.3%	68.8%	67.4%	73.7%	67.1%	70%	65.6%	71.2%	70.1%	60.0%	68.3%	74.9%	71.9%	73.0%
62 Day Upgrades	85%	74.0%	87.7%	74.4%	75.5%	78.7%									
62 Day Screening	90%	63.6%	100.0%	58.3%	33.3%	66.7%									
24 Day Internal	85%	74.6%	75.4%	69.0%	75.5%	70.6%	85%	68.3%	69.6%	73.2%	63.7%	71.7%	76.4%	71.8%	72.9%
31 Days	96%	98.3%	96.7%	97.4%	98.9%	96.0%	96%	98.8%	98.9%	99.2%	97.3%	99.0%	99.1%	98.9%	98.9%
31 Day Subsequent Drug	98%	100.0%	100.0%	100.0%	98.9%	99.3%									
31 Day Subsequent XRT	94%	99.5%	100.0%	100.0%	98.9%	98.6%									
31 Day Subsequent Surgery	94%	100.0%	100.0%	100.0%	98.9%	96.8%									
18 Weeks - Incomplete Pathways	92%	96.9%	97.4%	96.7%	96.7%	97.8%	92%	97.7%	97.2%	97.2%	97.3%	98.0%	98.0%	98.4%	98.7%

	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Compliances	11	7	5	7	17	10	9	9	6	11	13	12
Breaches	10	10	5	6	3	5	2	8	4	9	3	3
%	52.4%	41.2%	50.0%	53.8%	85.0%	66.7%	81.8%	52.9%	60.0%	55.0%	81.3%	80.0%

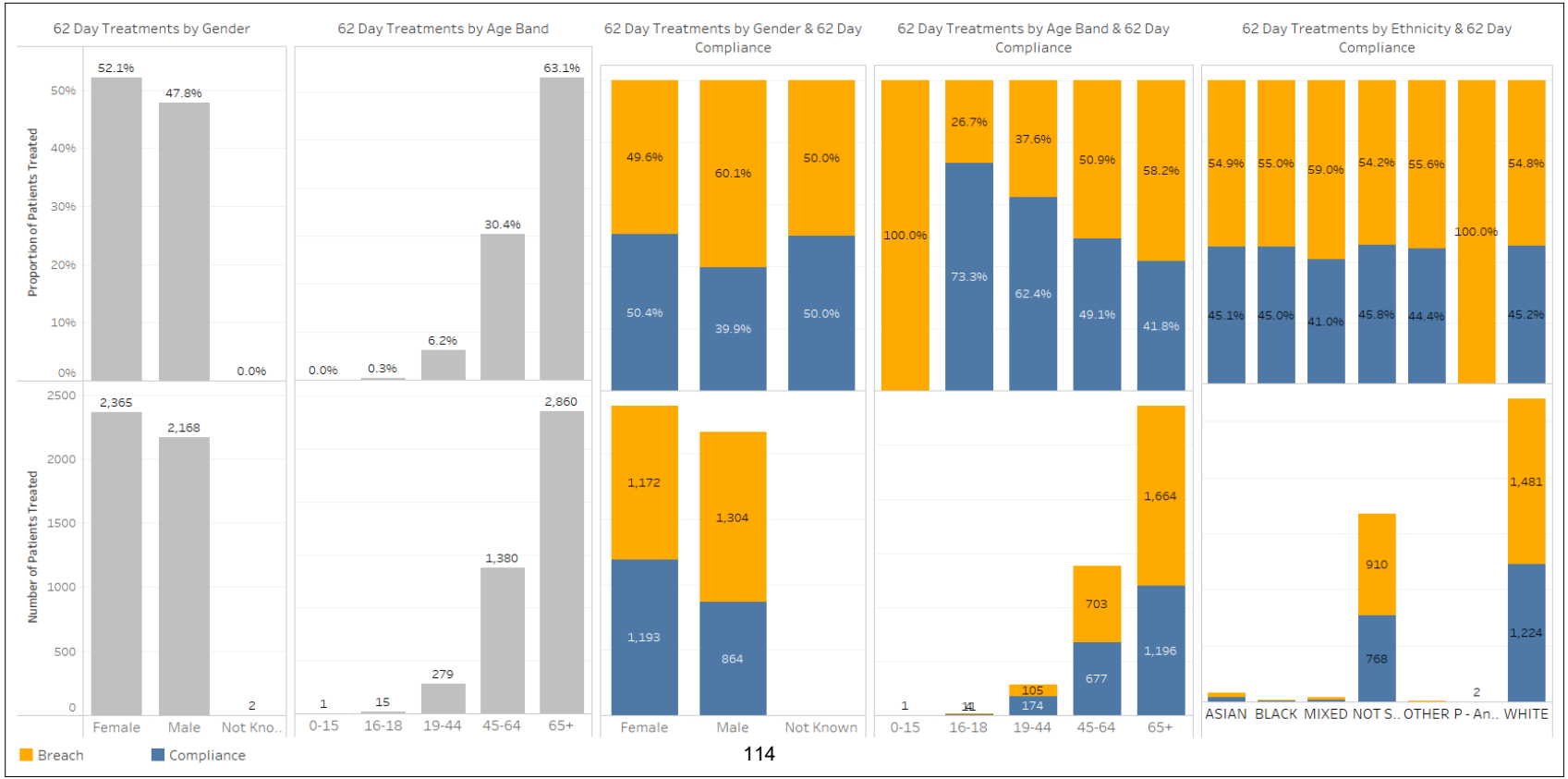
**Patients are reported in the month the compliance/breach occurs.*

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

Cancer Standards – Health Inequalities Analysis

62 Day Treatments between 01/05/2023 – 31/05/2024 analysed by gender, age and ethnicity.

NHS
The Christie
NHS Foundation Trust



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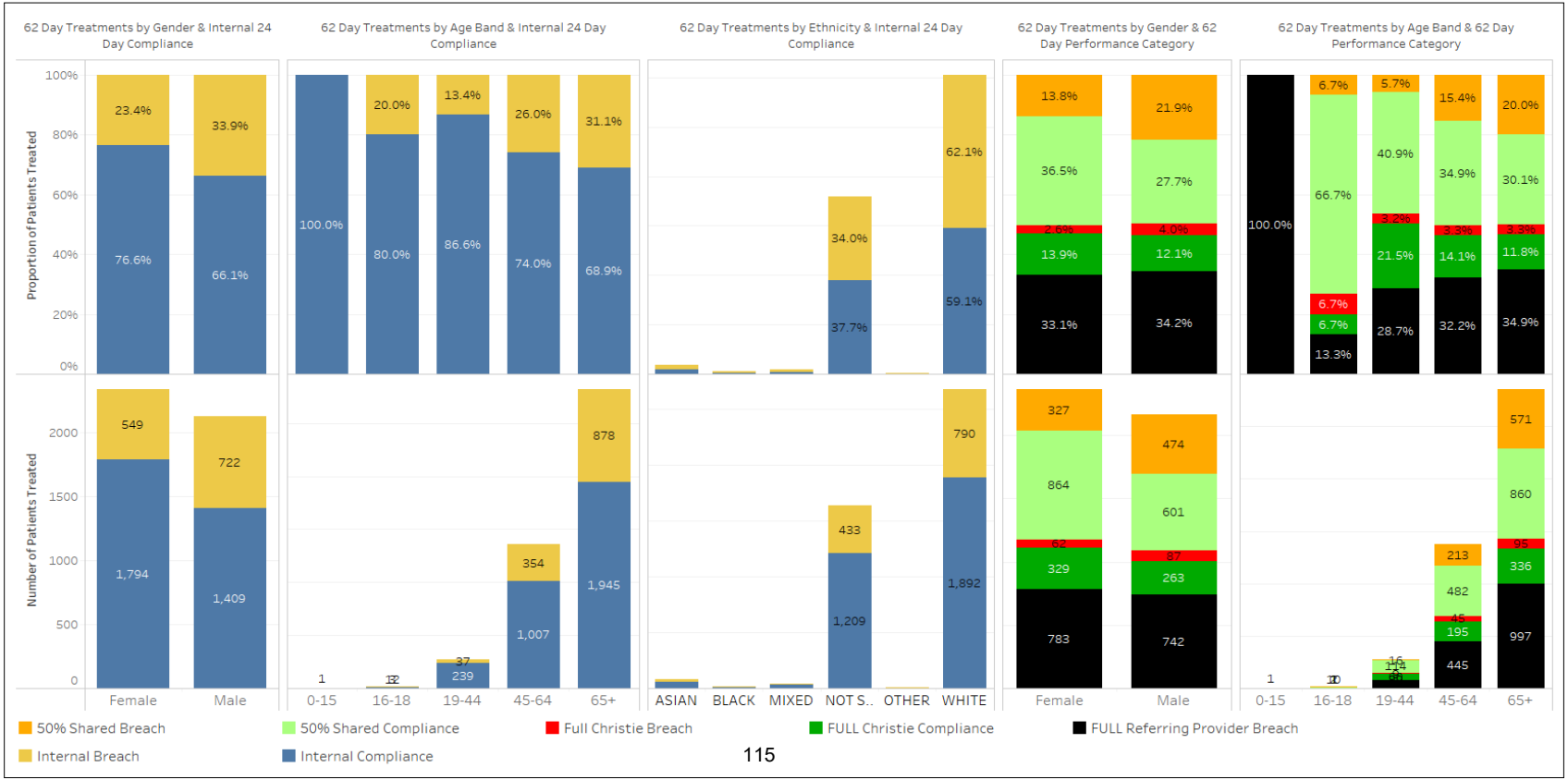
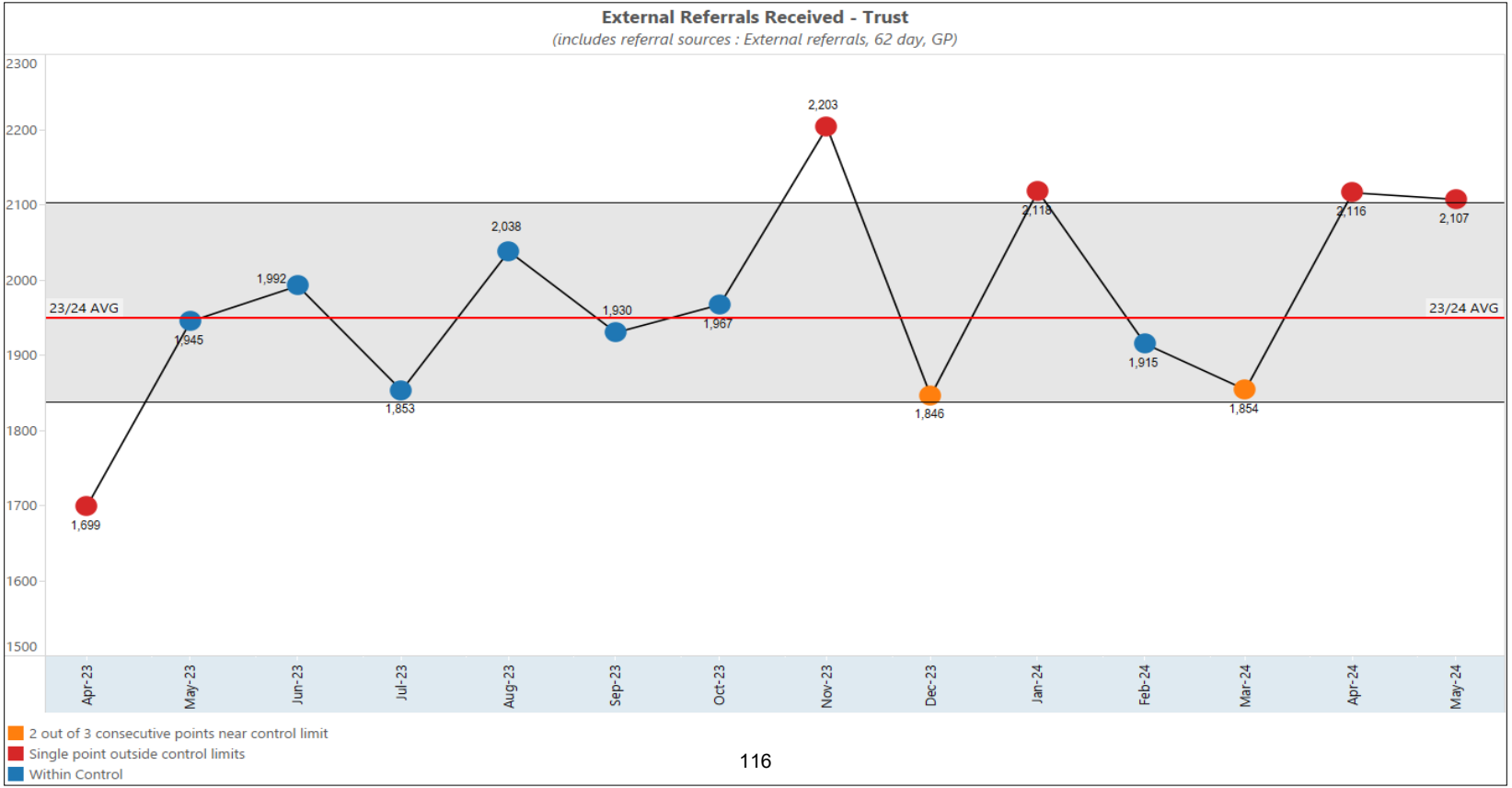
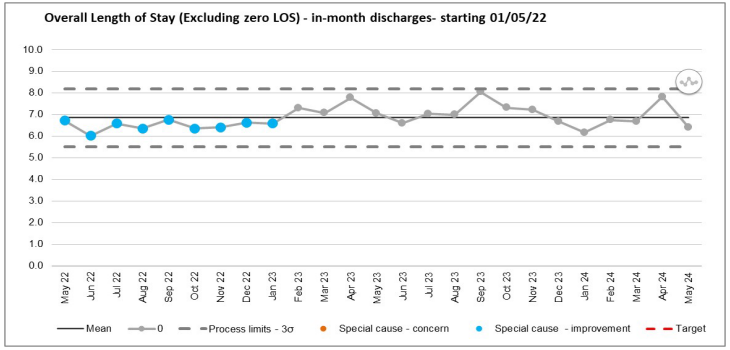
The Christie NHS Foundation Trust

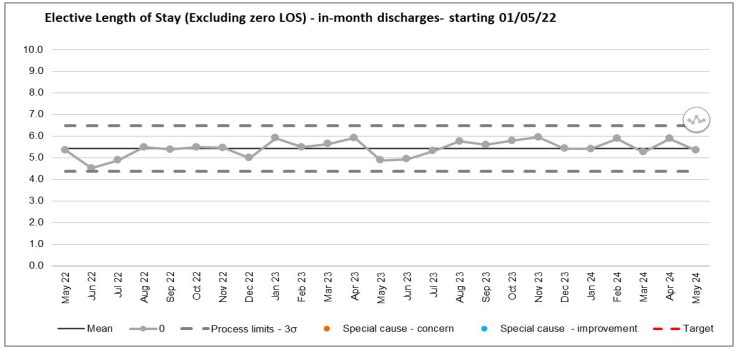


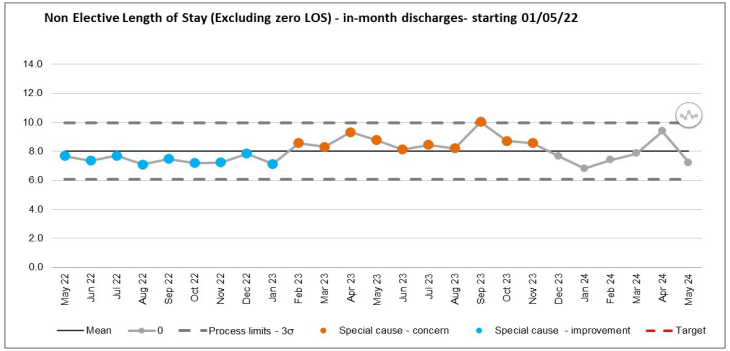
Referrals Analysis

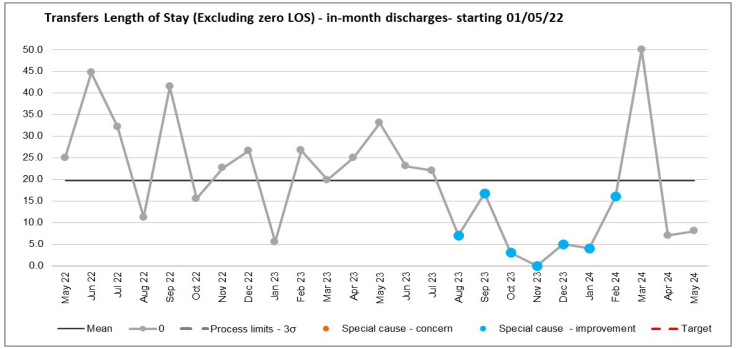


Length of Stay



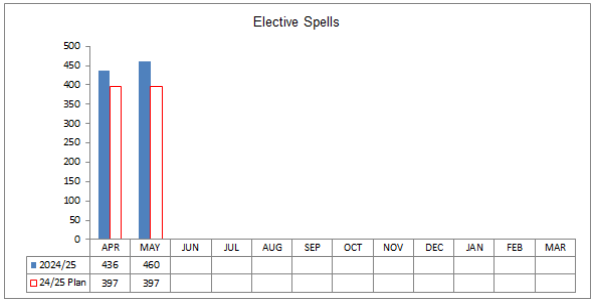


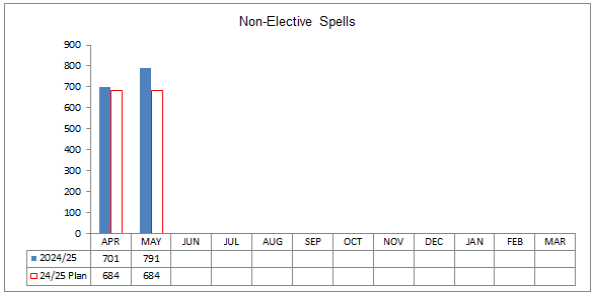


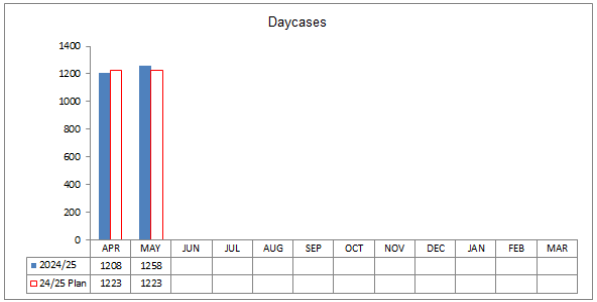


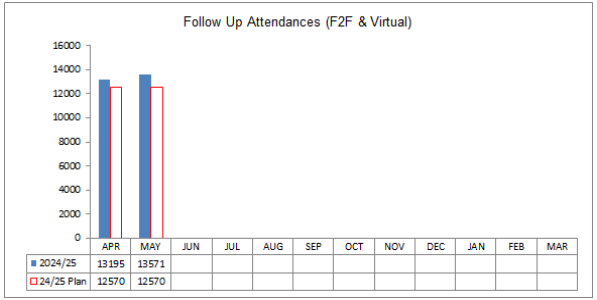
Overall length of stay continues to be well within control limits. The recent spike in transfers relates to the discharge of one patient who was an inpatient for a longer than average period.

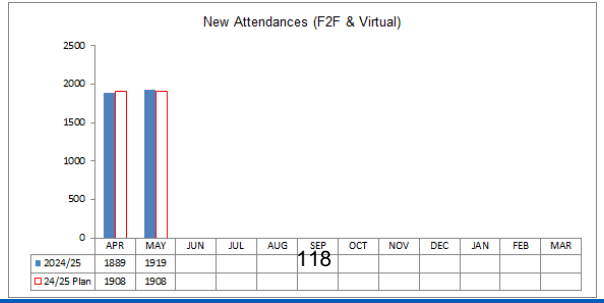
Activity

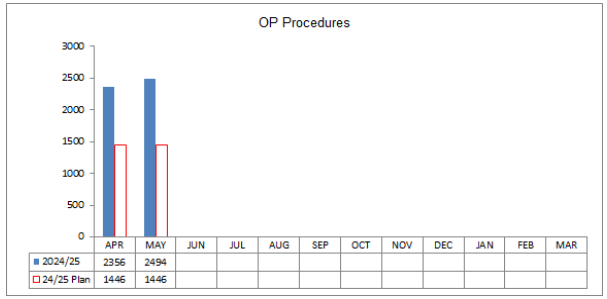

Elective Spells
500
450
400
350
300
250
200
150
100
50
0
APR MAY JUN JUL AUG SEP OCT NOV DEC JAN FEB MAR
2024/25 436 460
24/25 Plan 397 397

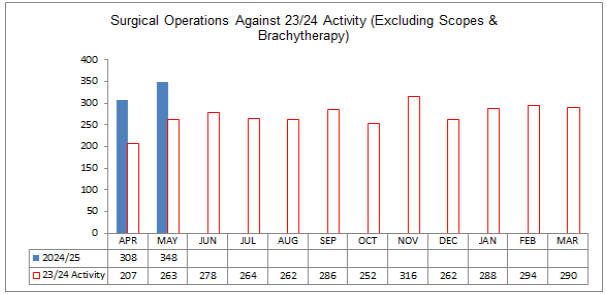

Non-Elective Spells
900
800
700
600
500
400
300
200
100
0
APR MAY JUN JUL AUG SEP OCT NOV DEC JAN FEB MAR
2024/25 701 791
24/25 Plan 684 684


Daycases
1400
1200
1000
800
600
400
200
0
APR MAY JUN JUL AUG SEP OCT NOV DEC JAN FEB MAR
2024/25 1208 1258
24/25 Plan 1223 1223


Follow Up Attendances (F2F & Virtual)
16000
14000
12000
10000
8000
6000
4000
2000
0
APR MAY JUN JUL AUG SEP OCT NOV DEC JAN FEB MAR
2024/25 13195 13571
24/25 Plan 12570 12570

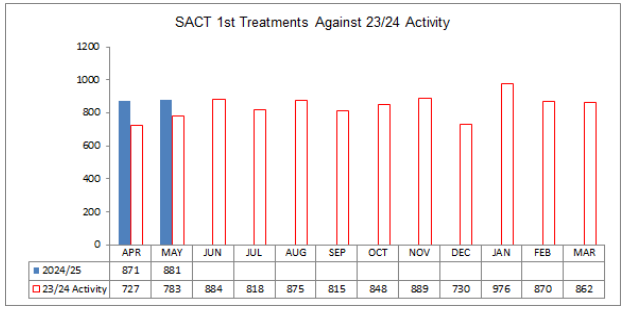

New Attendances (F2F & Virtual)
2500
2000
1500
1000
500
0
APR MAY JUN JUL AUG SEP OCT NOV DEC JAN FEB MAR
2024/25 1889 1919
24/25 Plan 1908 1908


OP Procedures
3000
2500
2000
1500
1000
500
0
APR MAY JUN JUL AUG SEP OCT NOV DEC JAN FEB MAR
2024/25 2356 2494
24/25 Plan 1446 1446

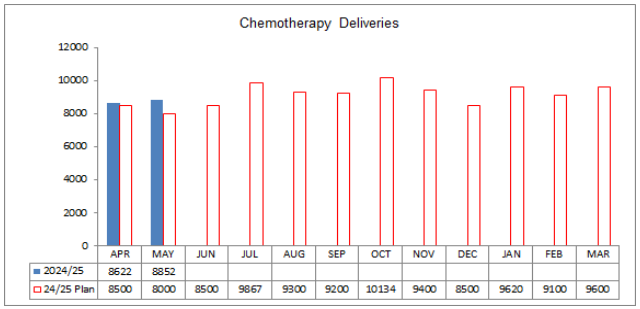

Surgical Operations Against 23/24 Activity (Excluding Scopes & Brachytherapy)
400
350
300
250
200
150
100
50
0
APR MAY JUN JUL AUG SEP OCT NOV DEC JAN FEB MAR
2024/25 308 348
23/24 Activity 207 263 278 264 262 286 252 316 262 288 294 290

Activity

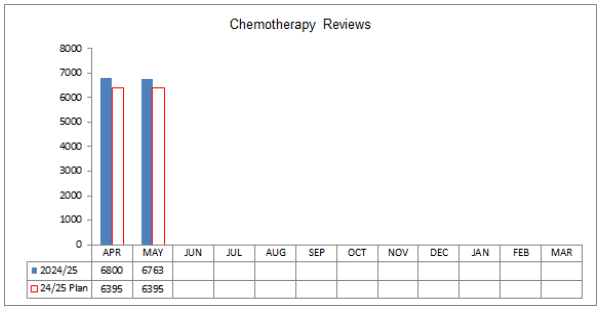
The Christie NHS Foundation Trust



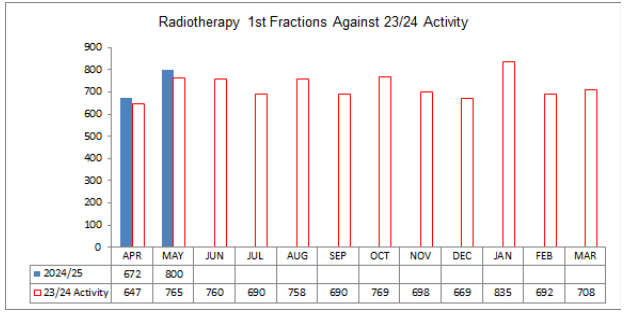
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2024/25	871	881										
23/24 Activity	727	783	884	818	875	815	848	889	730	976	870	862



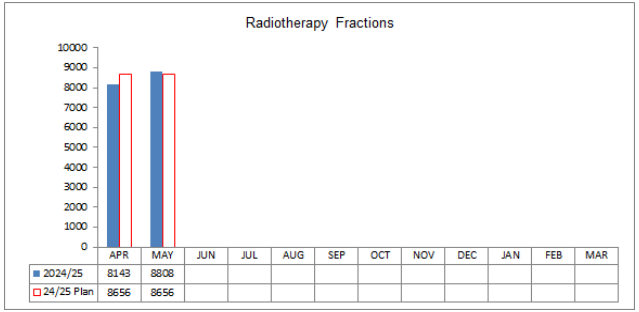
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2024/25	8622	8852										
24/25 Plan	8500	8000	8500	9867	9300	9200	10134	9400	8500	9620	9100	9600



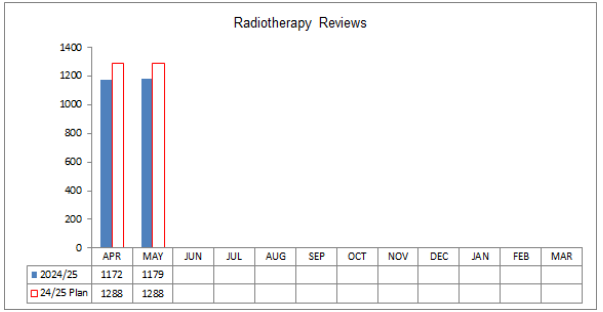
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2024/25	6800	6763										
24/25 Plan	6395	6395										



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2024/25	672	800										
23/24 Activity	647	765	760	690	758	690	769	698	669	835	692	708



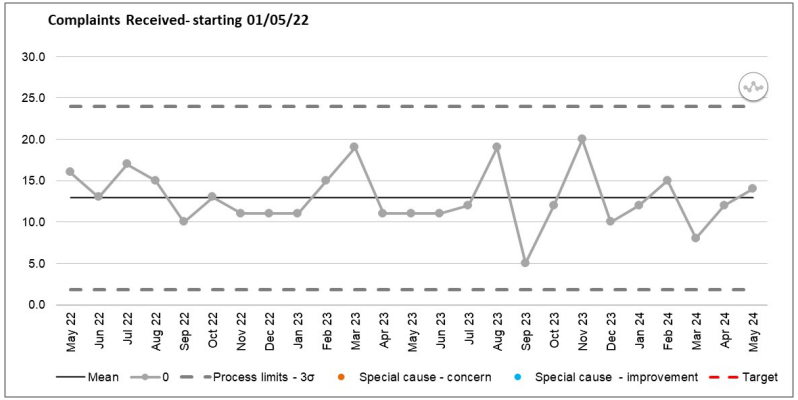
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2024/25	8143	8808										
24/25 Plan	8656	8656										

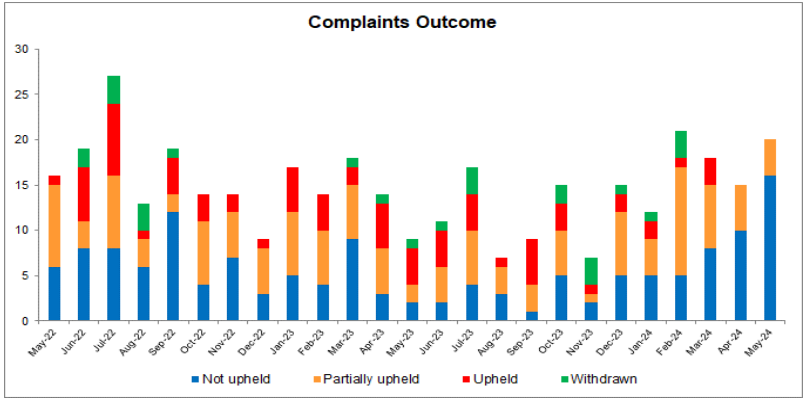


	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2024/25	1172	1179										
24/25 Plan	1288	1288										

SACT 1st Treatments, 1st Fractions & Surgical Operations do not form part of the 24/25 activity plan and are used as supplementary guides to productivity. The figures are monitored against the previous year's month for comparison.

Complaints



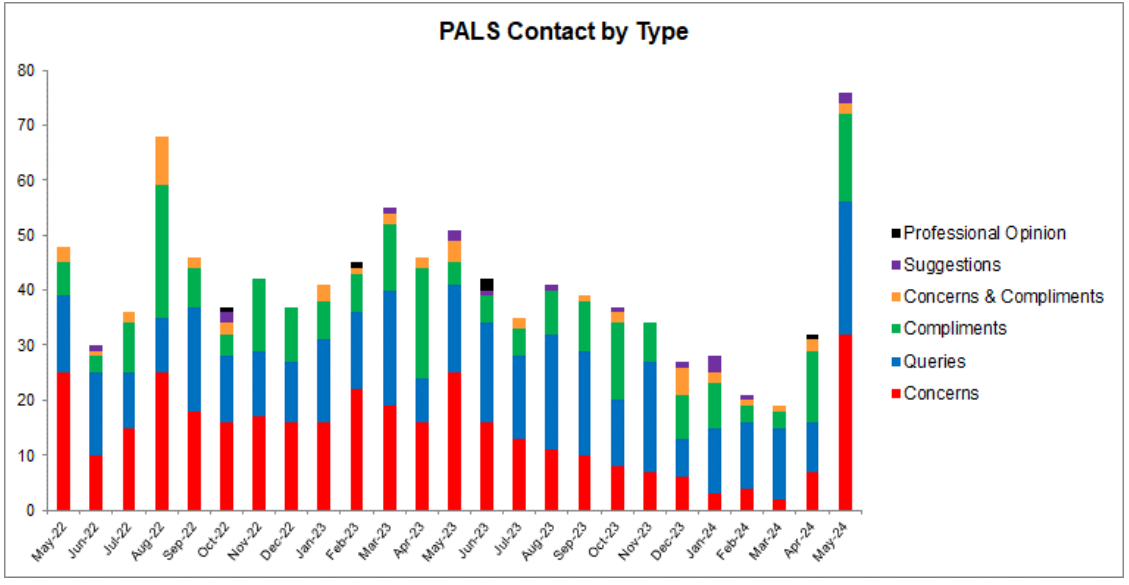


14 new complaints received in May 2024

20 complaints were closed in May 2024

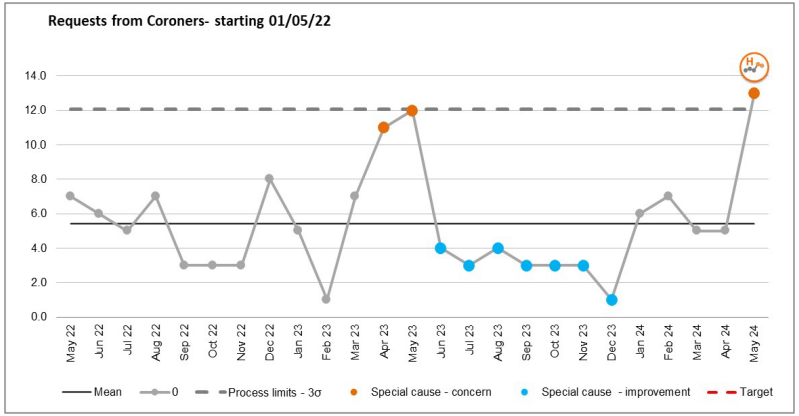
Ombudsman Cases
Complainants have the right to refer their case to the Parliamentary and Health Service Ombudsman (PHSO) if they are not satisfied it has been resolved by the Trust. 0 cases were referred to the PHSO in March 2024. 5 active cases in total with the PHSO.

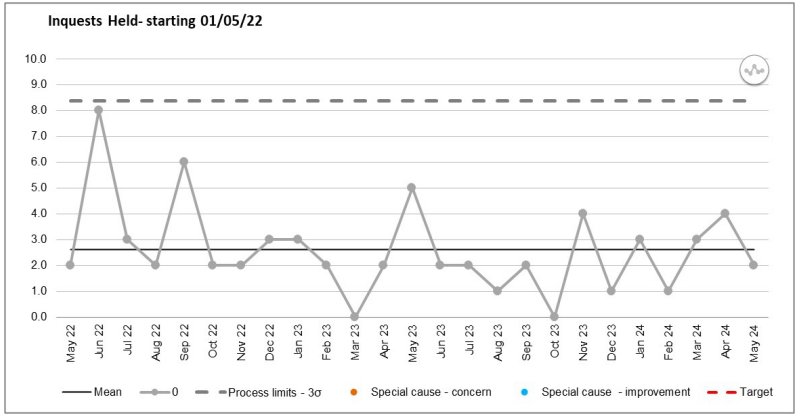
PALS



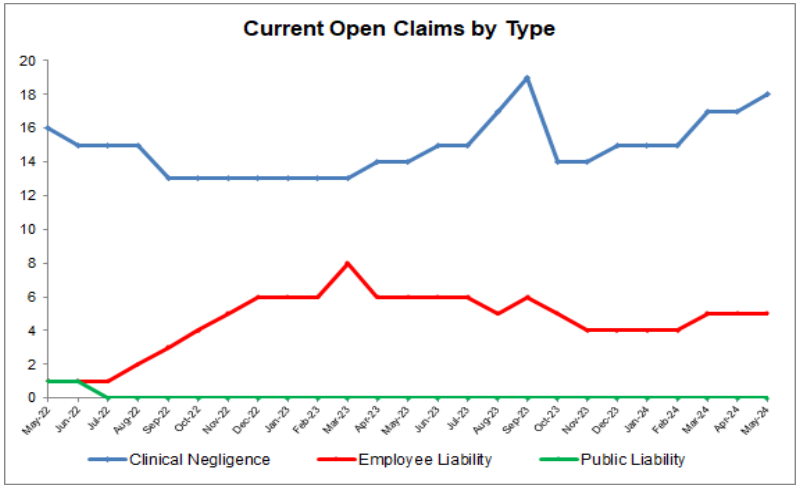
67 PALS contacts have been received in May 2024.

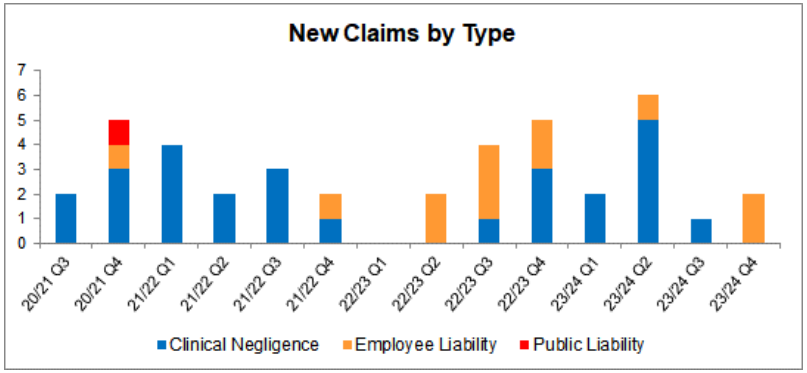
Inquests


Requests from Coroners- starting 01/05/22
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
May 22
Jun 22
Jul 22
Aug 22
Sep 22
Oct 22
Nov 22
Dec 22
Jan 23
Feb 23
Mar 23
Apr 23
May 23
Jun 23
Jul 23
Aug 23
Sep 23
Oct 23
Nov 23
Dec 23
Jan 24
Feb 24
Mar 24
Apr 24
May 24
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


Inquests Held- starting 01/05/22
10.0
9.0
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
May 22
Jun 22
Jul 22
Aug 22
Sep 22
Oct 22
Nov 22
Dec 22
Jan 23
Feb 23
Mar 23
Apr 23
May 23
Jun 23
Jul 23
Aug 23
Sep 23
Oct 23
Nov 23
Dec 23
Jan 24
Feb 24
Mar 24
Apr 24
May 24
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

Claims





1 new claim received in May 2024

0 claims closed in May 2024

Healthcare Associated Infections

NHS
The Christie
NHS Foundation Trust

Curent Month	Community Onset - Indeterminate Acquisition (COIA)	Community Onset - Community Acquired (COCA)	Community Onset - Healthcare Acquired (COHA)	Healthcare Onset - Healthcare Acquired (HOHA)	Lapses in Care	Area(s) Occurred (HOHA & COHA)
Clostridium Difficile		3	1	2		(1 x AAU) (1 x W10)
E.coli Bacteraemia		2	1	3		(1 x W4) (1 x W12) (2 x W11)
Klebsiella spp.				2		(1 x W11) (1 x PW)
Pseudomonas aeruginosa bacteraemia						
MSSA Bacteraemia				2		(1 x W4) (1 x IPU)
MRSA Bacteraemia				2		(1 x W12) (1 x PW)

YTD	Community Onset - Indeterminate Acquisition (COIA)	Community Onset - Community Acquired (COCA)	Community Onset - Healthcare Acquired (COHA)	Healthcare Onset - Healthcare Acquired (HOHA)	Lapses in Care
Clostridium Difficile		4	1	4	
E.coli Bacteraemia		8	3	7	
Klebsiella spp.			1	2	
Pseudomonas aeruginosa bacteraemia			2		
MSSA Bacteraemia		2		3	
MRSA Bacteraemia				2	

There were 3 cases of C-Difficile, 4 cases of E-Coli, 2 cases of Klebsiella, 2 cases of MSSA and 2 cases of MRSA reported in May that were deemed attributable to the Trust. No lapses in care were identified. One of the cases of HOHA C-Diff has been uploaded as occurring at the Trust due to admission and sample date, however this case has been attributed to another Trust as identified elsewhere in March & April.

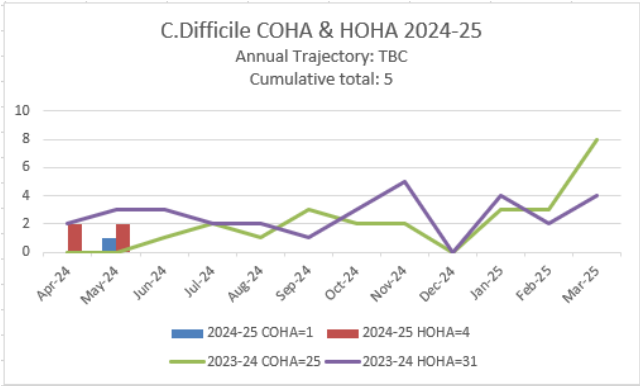
Definitions

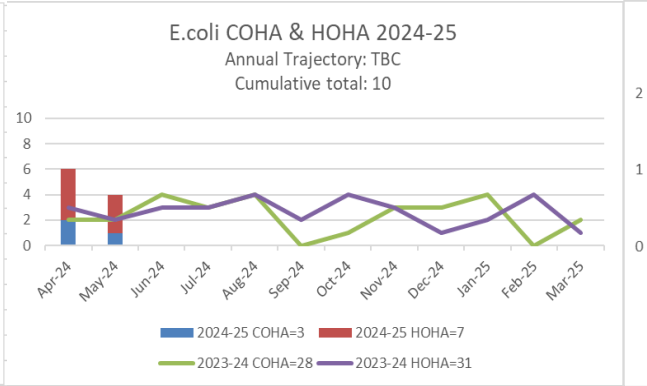
COCA - Cdiff: Is not categorised HOHA and the patient has not been discharged from the same reporting organisation in the 84 days prior to the specimen date (where day 1 is the specimen date)
E.coli, Klebs, Pseudo, MSSA, MRSA: Is not categorised HOHA and the patient has not been discharged from the same reporting organisation in the 28 days prior to the specimen date (where day 1 is the specimen date)
COIA - Symptoms commenced within first two days of admission and has been an inpatient in the trust in the past 4 weeks
COHA - Symptoms commenced within first two days of admission and inpatient in the past 12 weeks (but not past 4 weeks)
HOHA - Symptoms commenced within first two days of admission (No admission in past 12 weeks)

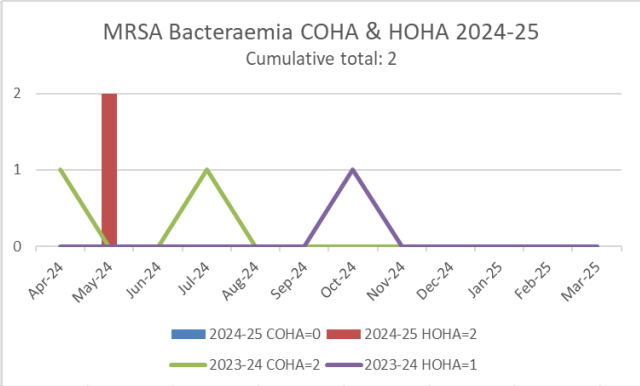
Healthcare Associated Infections

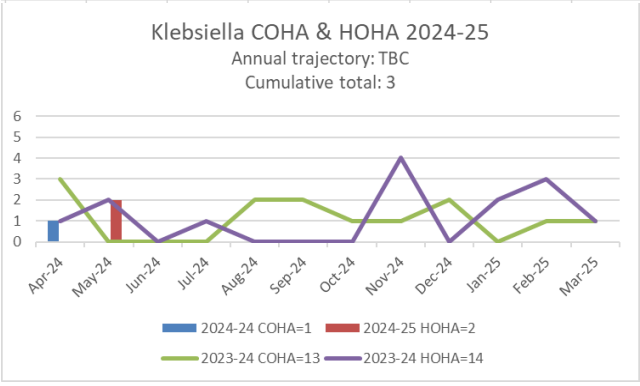
The Christie NHS Foundation Trust

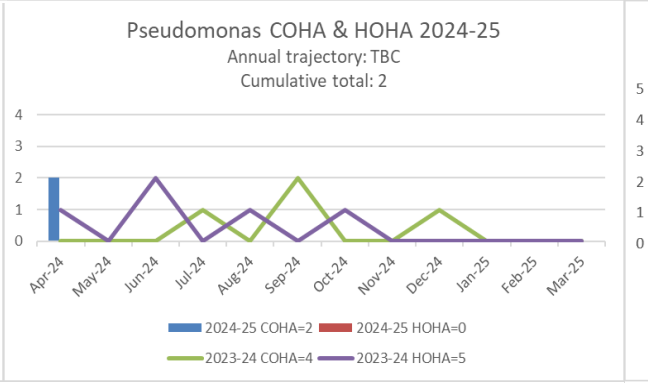
Alert Organisms

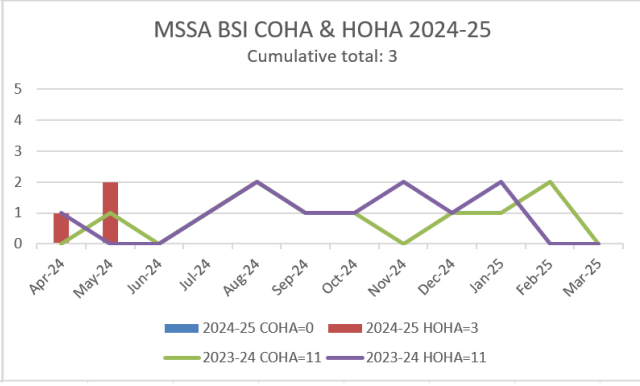








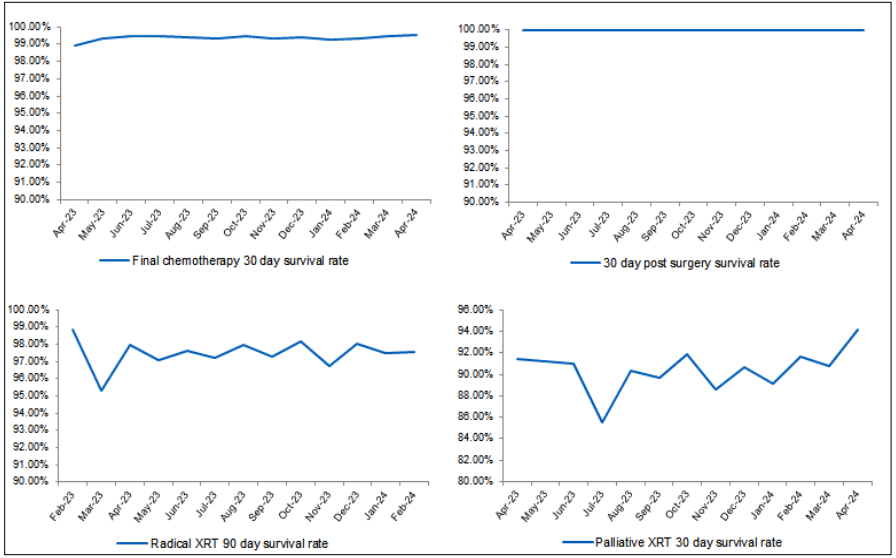




All cases reviewed through IPC team and reported through NIPR. 125

Mortality Indicators & Survival Rates

Survival Rates



Inpatient Deaths – Onsite Deaths

		May-24
Number of NHS Christie onsite deaths	Elective/planned admission	9
	Non Elective/emergency admission	34
	TOTAL	**43**
Number of deaths that have triggered Structured Casenote Review (SCR) Note: screening is ongoing so further triggers may be identified	Mortuary screened triggers (including reported to the coroner) - 0	**5**
	Bereaved families raised concern – 0	
	Medical Triggers - 2	
	Nursing Triggers - 3 (inc in family concern)	
	(note there may be more than one trigger)	

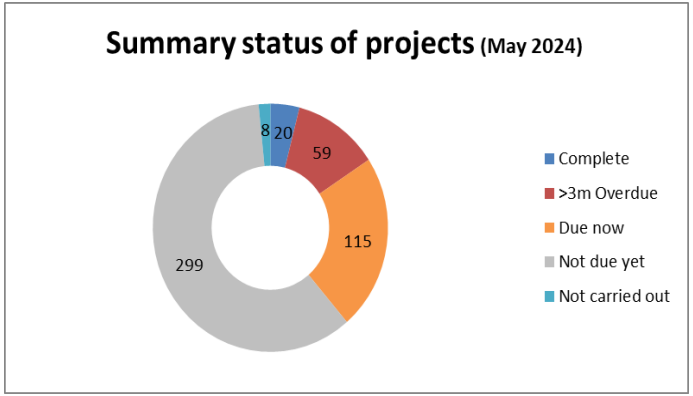
The Christie process for learning from deaths follows the 2017 NHSI guidance. All in-patient deaths are screened and where flagged by one or more triggers an independent structured case note review (SCR) is undertaken. Reviews are discussed by the Mortality Surveillance Group and the findings and actions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

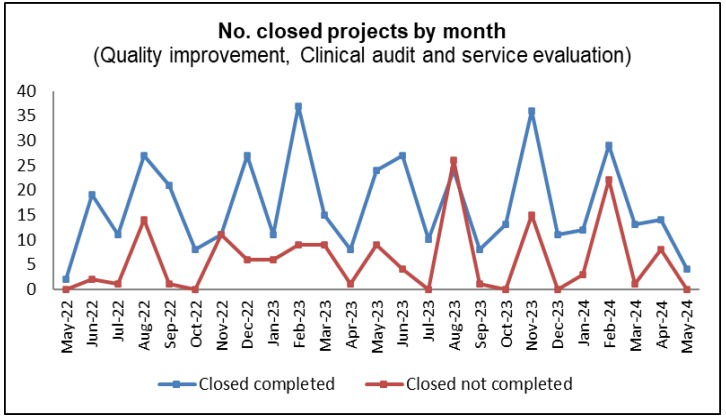
Quality Improvement & Clinical Audit

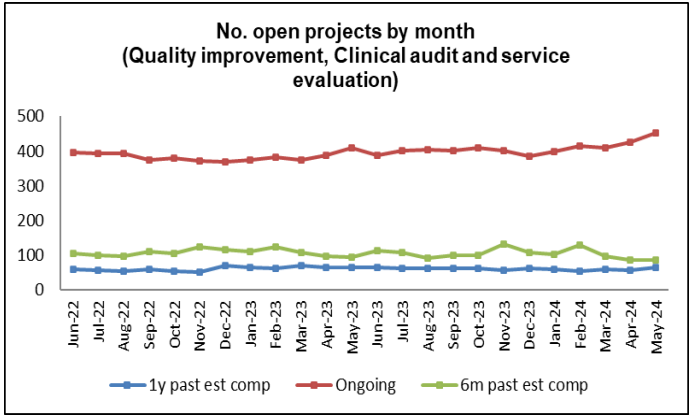
The Christie NHS Foundation Trust

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

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







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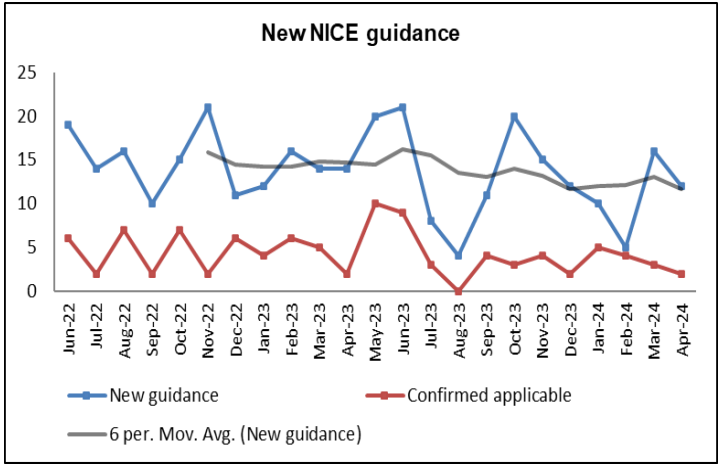
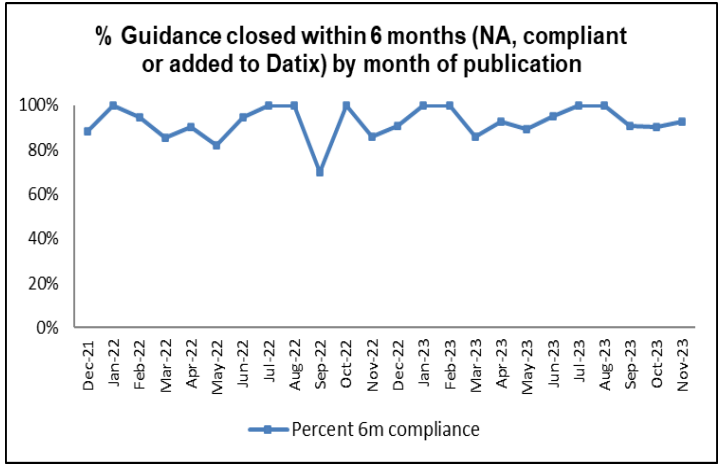
NICE Guidance





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

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

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

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

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

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HR Metrics Sickness

NHS
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NHS Foundation Trust

Last updated: 10/06/2024

Performance | Absence

Monthly Sickness %	Yearly Sickness %	Absences Ended	Long Term	Short Term
4.36%	4.36%	440	48	392

Trust Overview

Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24
3.88%	4.34%	4.47%	4.77%	4.95%	4.61%	4.47%	5.05%	4.62%	4.21%	4.35%	4.36%

	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24
CMPE	2.94%	3.41%	3.63%	3.47%	3.24%	3.89%	2.71%	3.55%	2.85%	2.32%	2.99%	2.47%
CNS	3.84%	4.71%	4.57%	4.53%	5.40%	4.40%	4.34%	5.11%	5.01%	4.80%	4.49%	4.62%
Corporate Development	0.00%	0.00%	0.00%	0.00%	0.80%	0.00%	0.66%	0.00%	0.00%	0.00%	0.00%	0.00%
CSSS	4.63%	4.61%	5.18%	6.07%	6.36%	5.46%	5.81%	6.43%	5.65%	5.26%	5.45%	5.76%
Digital Services	1.26%	1.65%	3.51%	3.84%	1.39%	1.51%	1.91%	2.75%	2.12%	1.39%	1.13%	2.81%
Education	0.72%	0.32%	0.62%	2.27%	2.98%	4.34%	2.41%	3.91%	2.32%	1.69%	2.42%	1.09%
Estates & Facilities	5.96%	7.76%	7.38%	7.27%	6.77%	7.63%	6.55%	6.48%	5.14%	5.67%	5.97%	4.63%
Finance	2.50%	2.06%	1.26%	1.75%	2.29%	2.27%	2.40%	1.05%	2.30%	1.40%	1.49%	0.84%
GM Cancer	0.19%	0.73%	0.12%	0.54%	0.29%	2.23%	0.00%	1.76%	1.95%	2.07%	1.65%	0.06%
Performance	8.85%	9.24%	8.46%	2.67%	3.42%	6.91%	10.66%	4.98%	6.06%	7.95%	9.00%	7.94%
Quality and Standards	6.87%	5.76%	9.06%	11.93%	9.97%	9.79%	7.17%	6.06%	4.13%	2.03%	3.17%	5.19%
Research and Innovation	3.37%	3.39%	3.37%	3.59%	3.26%	3.07%	3.15%	3.95%	4.45%	3.26%	3.00%	2.83%
Strategy	0.00%	0.00%	0.45%	1.21%	0.00%	0.00%	0.72%	1.15%	0.00%	5.38%	9.65%	13.17%
Trust Administration	6.21%	6.23%	5.87%	5.83%	5.51%	5.51%	5.51%	5.76%	5.76%	5.48%	0.41%	0.00%
Workforce	2.27%	3.46%	1.72%	2.42%	1.31%	3.22%	4.97%	5.49%	3.55%	1.10%	1.60%	1.58%

HR Metrics – Mandatory Training

The Christie NHS Foundation Trust

Last updated: 05/06/2024

Performance | Mandatory Training

Overall Compliance	Modules Outstanding	F2F Compliance	Online Compliance
92.68%	3,469	82.83%	94.32%

Trust Compliance

Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24
88.84%	89.62%	90.39%	90.02%	89.85%	90.68%	91.30%	91.75%	91.96%	92.60%	92.67%	92.68%

	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24
CMPE	92.41%	93.13%	94.00%	94.58%	85.97%	87.70%	88.62%	93.31%	93.94%	94.72%	94.61%	94.07%
CNS	85.91%	87.48%	88.69%	87.88%	88.12%	89.07%	89.45%	90.02%	90.41%	91.13%	92.14%	92.08%
Corporate Development	97.14%	97.59%	98.32%	98.88%	91.56%	90.73%	93.29%	98.90%	99.45%	100.00%	98.90%	96.17%
CSSS	85.67%	86.57%	86.53%	86.24%	90.60%	91.30%	91.90%	89.10%	89.20%	89.67%	89.66%	89.56%
Digital Services	95.51%	94.89%	95.64%	94.24%	89.35%	91.63%	90.49%	94.98%	94.47%	96.46%	95.54%	96.70%
Education	93.99%	94.80%	94.37%	95.42%	93.06%	92.15%	94.91%	98.43%	98.96%	98.62%	98.40%	98.28%
Estates & Facilities	92.81%	92.02%	93.25%	93.89%	93.65%	94.11%	94.42%	94.14%	94.24%	94.27%	94.80%	95.07%
Finance	97.78%	98.79%	98.48%	98.36%	92.90%	94.26%	95.89%	97.54%	98.78%	98.87%	98.84%	98.48%
GM Cancer	92.84%	88.60%	88.99%	90.18%	95.84%	95.20%	92.88%	95.31%	92.73%	94.01%	95.97%	95.73%
Performance	92.31%	96.70%	94.81%	91.43%	95.86%	95.59%	95.53%	96.98%	99.45%	98.08%	95.41%	96.19%
Quality and Standards	90.21%	91.23%	90.29%	89.76%	92.13%	95.71%	95.00%	92.95%	91.65%	94.39%	93.73%	93.99%
Research and Innovation	94.80%	95.08%	96.24%	95.28%	96.83%	97.53%	96.57%	95.71%	95.74%	96.34%	95.68%	95.67%
Strategy	87.88%	88.64%	91.55%	92.13%	98.22%	97.74%	98.64%	91.94%	92.75%	94.93%	88.41%	95.15%
Trust Administration	92.31%	92.76%	91.67%	90.84%	99.44%	98.32%	98.88%	91.60%	90.48%	93.61%	99.15%	95.15%
Workforce	92.87%	90.01%	95.62%	97.26%	92.86%	98.57%	97.71%	94.59%	96.00%	96.11%	94.54%	96.28%

HR Metrics - PDR

The Christie NHS Foundation Trust

Last updated: 05/06/2024

Performance | Appraisal

Overall Compliance
85.68%

Expired Appraisals
449

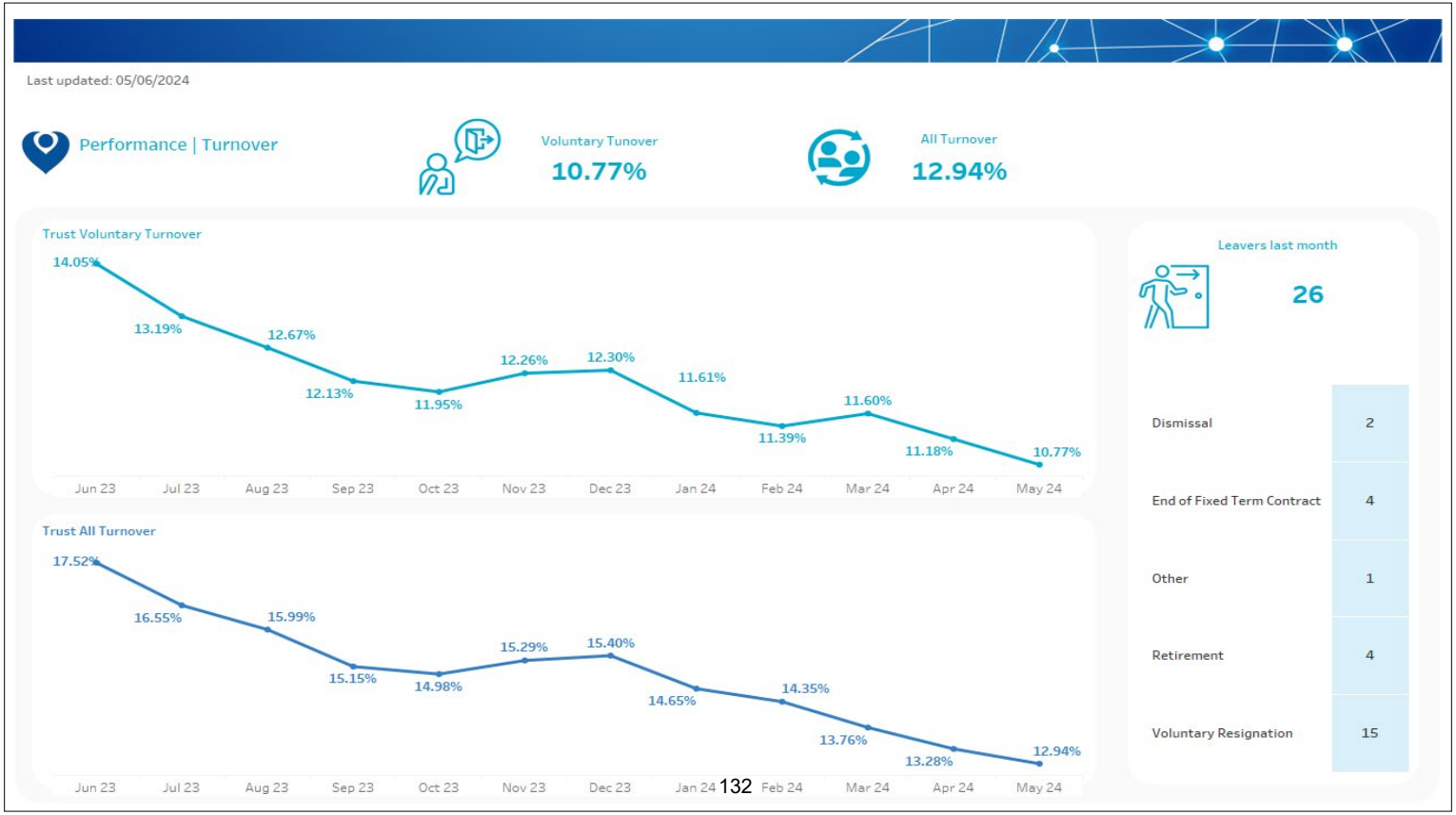
Appraisals Due Soon
511

Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24
88.00%	87.60%	87.61%	86.78%	86.27%	85.84%	86.33%	87.04%	86.45%	84.94%	84.61%	85.68%

	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24
CMPE	94.61%	95.12%	94.29%	91.60%	89.47%	92.03%	85.16%	84.06%	86.80%	84.46%	83.72%	85.15%
CNS	89.46%	89.83%	90.17%	88.15%	86.40%	83.26%	84.71%	86.39%	85.51%	85.15%	82.03%	85.53%
Corporate Development	100.00%	100.00%	100.00%	100.00%	90.91%	100.00%	100.00%	100.00%	76.92%	84.62%	84.62%	84.61%
CSSS	86.07%	84.74%	83.18%	84.12%	84.30%	83.60%	85.47%	87.10%	85.15%	82.06%	81.29%	83.31%
Digital Services	87.76%	81.82%	80.20%	79.41%	82.52%	84.62%	83.81%	83.02%	81.82%	79.09%	81.25%	83.03%
Education	89.55%	93.85%	92.31%	92.42%	90.77%	88.24%	90.14%	94.37%	93.51%	92.94%	93.02%	92.30%
Estates & Facilities	80.26%	82.83%	86.27%	84.10%	86.01%	85.60%	85.94%	85.08%	86.56%	87.55%	88.01%	84.92%
Finance	82.81%	84.13%	87.88%	90.77%	94.03%	94.12%	97.14%	94.37%	94.37%	94.29%	95.77%	95.89%
GM Cancer	80.85%	81.63%	86.00%	88.24%	86.27%	82.14%	85.71%	87.50%	91.23%	84.21%	84.50%	82.75%
Performance	72.73%	70.00%	70.00%	72.73%	72.73%	78.26%	78.26%	77.27%	90.91%	91.67%	100.00%	100.00%
Quality and Standards	97.06%	96.97%	96.97%	97.06%	96.97%	96.88%	96.77%	100.00%	90.91%	86.11%	85.29%	83.33%
Research and Innovation	90.57%	87.50%	88.22%	85.91%	85.32%	90.14%	90.76%	89.29%	89.49%	86.07%	86.63%	87.90%
Strategy	60.00%	60.00%	60.00%	66.67%	77.78%	70.00%	50.00%	55.56%	66.67%	66.67%	71.43%	71.42%
Trust Administration	92.86%	92.86%	93.33%	87.50%	82.35%	94.12%	76.47%	75.00%	75.00%	73.33%	84.62%	84.61%
Workforce	93.22%	91.67%	90.16%	93.44%	93.33%	92.98%	96.49%	91.53%	88.71%	93.55%	90.32%	93.75%

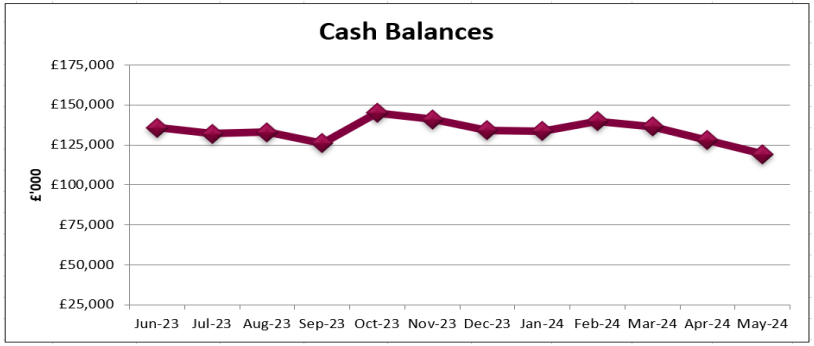
Workforce Metrics - Turnover

The Christie NHS Foundation Trust



Finance (Executive Summary)

Month 2 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(423,078)	(70,513)	(71,668)	(1,155)
Other Income	(70,190)	(11,687)	(11,643)	43
Pay	229,491	38,237	35,678	(2,558)
Non Pay (incl drugs)	238,194	39,699	42,079	2,380
Operating (Surplus) / Deficit	**(25,584)**	**(4,264)**	**(5,554)**	**(1,290)**
Finance expenses/ income	30,932	5,155	5,965	810
(Surplus) / Deficit	**5,349**	**891**	**411**	**(480)**
Exclude impairments/ charitably funded capital donations	(12,625)	(2,059)	(1,887)	172
Adjusted financial performance (Surplus) / Deficit	**(7,276)**	**(1,168)**	**(1,476)**	**(308)**



This report outlines the M2 consolidated financial performance of The Christie NHS Foundation Trust and its wholly owned subsidiary The Christie Pharmacy Ltd.

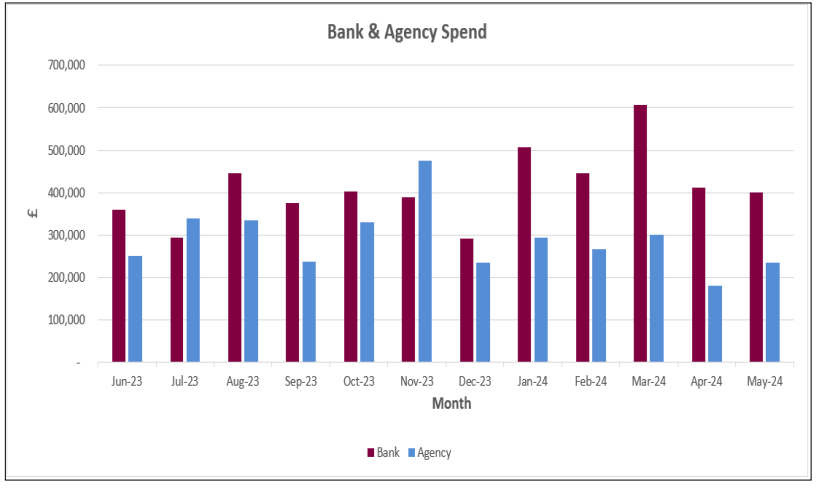
I&E

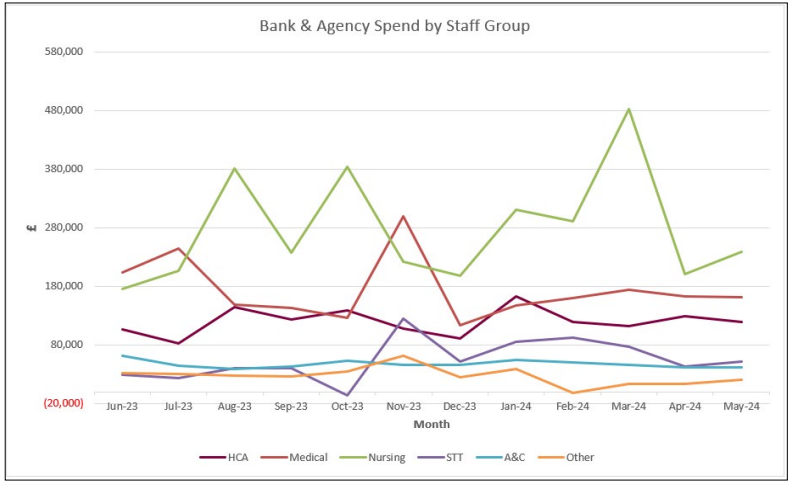
- The Trust is reporting a surplus at the end of M2 of (£1,476k) against a M2 YTD plan of (£1,168k), which gives a month 2 variance of (£308k) better than plan.
- Identified in year VIP is £16.0m against a target of £21.4m. The majority of the VIP shortfall is against the recurrent VIP target where £8.7m has been identified against a target of £14m, therefore a recurrent shortfall of £5.3m.

Balance sheet / liquidity

- The cash balance is £121,623k.
- Capital performance to month 2 was £1,366k below the plan submitted to NHSE&I in April 24.
- Targets have been achieved against payment of our NHS creditors paid within the 30 day Better Payment Practice Code target.

Finance (Expenditure)

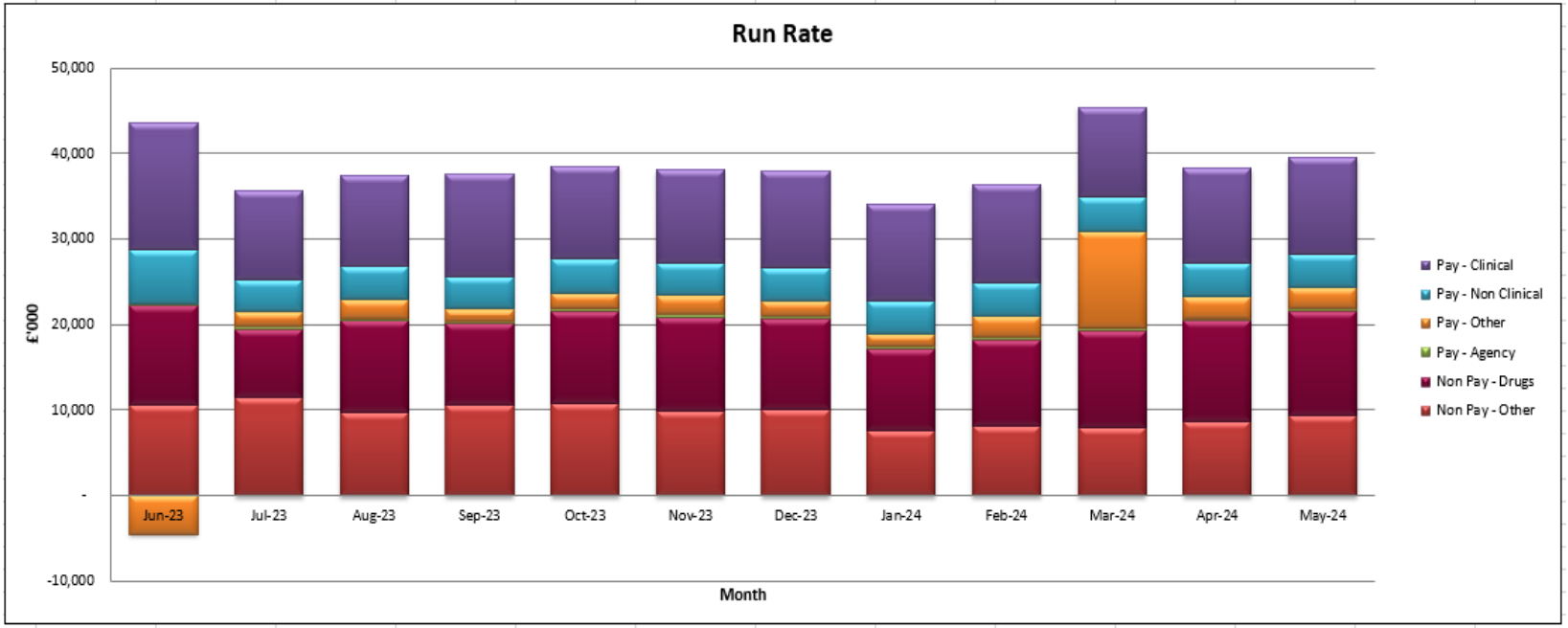




The agency spend is £234k in month 2, an increase of £55k from month 1. This is mainly due to a sizeable increase on nursing agency spend, with a further noticeable increase in Scientific, Technical and Therapeutic agency spend alongside.

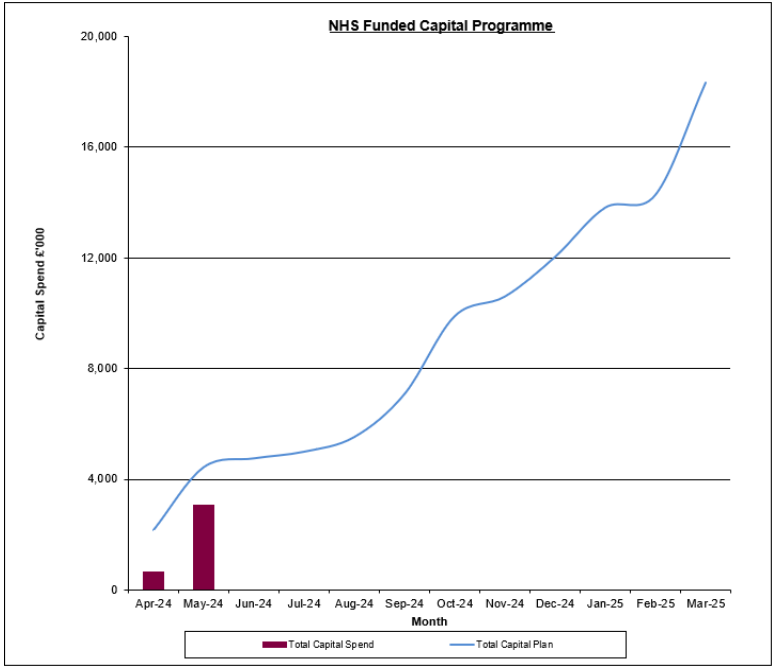
Alongside this, bank usage has decreased by (£11k) in month compared to month 1, mainly driven by lower spend on nursing compared to month 1, a small decrease in HCA spend but offset by an increase in Non-Clinical Other spend.

Finance (Expenditure)



- Drugs spend in month 2 is £12,245k, an increase from month 1 of £467k.
- Pay – Clinical spend in month 2 is £11,298k.
- Pay – Other spend in month 2 is £2,469k, a reduction from month 1 of £73k.
- Pay – Agency spend in month 2 is £234k, an increase of £55k from month 1.
- Key elements of 'Non-Pay Other' spend consist of clinical supplies and services, premises and infrastructure costs and R&I costs.

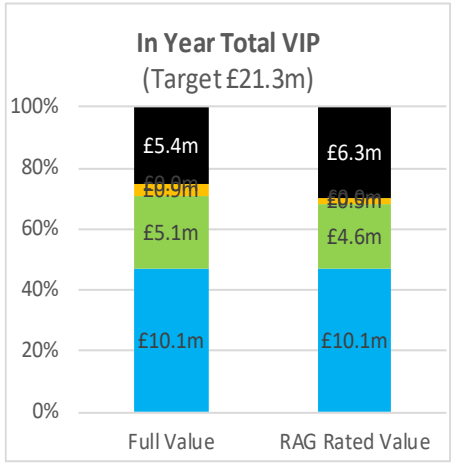
Finance (Capital)

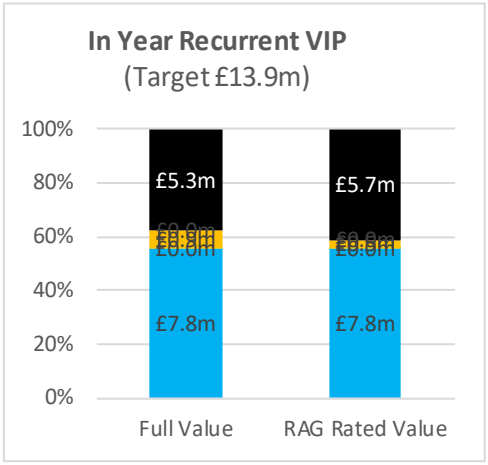


Performance to month 2 was £1,366k below the plan submitted to NHSE&I in April 24. This is lower than the plan position due to the TIF Ward position.

The Trust has incurred £3,074k on capital schemes to month 2, primarily on the TIF ward refurbishment.

Finance (CIP)





Total In year CIP

- Total identified VIP schemes reported are £16.0m (£7.3m non recurrent / £8.7m recurrent).
- Risk adjusted identified schemes value £15.1m leaving £6.3m unidentified.

Recurrent

- Schemes totalling £8.7m have been identified recurrently against a recurrent target of £14.0m.
- This leaves £5.3m of the recurrent target unidentified.

Risk Rating:	Delivering	Low	Medium	High	Unidentified
RAG Weighting:	100%	90%	50%	10%	

	Annual					Year to Date		
	Target	Identified value	Unidentified Value	Identified RAG Value	Unidentified RAG Value	Target	Delivered	Variance
Total VIP	**£21,396k**	**£16,044k**	**£5,352k**	**£15,084k**	**£6,312k**	**£3,566k**	**£3,566k**	**£0k**
Recurrent VIP	£13,996k	£8,726k	£5,270k	£8,271k	£5,725k	£2,333k	£1,298k	(£1,034k)
Non-Recurrent VIP	£7,400k	£7,318k	£82k	£6,813k	£587k	£1,233k	£2,268k	£1,035k

The Christie
NHS Foundation Trust

For information

Meeting of the Board of Directors

Thursday June 2024

Subject / Title	Framework for Board & Committee allocation
Author(s)	Louise Westcott, Company Secretary
Presented by	Roger Spencer, Chief Executive
Summary / purpose of paper	This paper describes the allocation of items that the Board are required to review in terms of strategy, performance and compliance and where that activity will take place. This responds to actions identified in the GGI review that were approved by Board in March 2024. The allocation framework has been updated following its original review at the April Board meeting and further scrutiny from executive leads and non-executive committee chairs.
Recommendation(s)	The Board allocation framework attached at appendix 1 outlines the agreed allocation of key items following Board review. Board should receive this for information.
Background Papers	10/24a GGI assurance review action plan 16/24d Framework for Board & Committee allocation Good Governance Improvement – The Christie NHS FT, Enhancing Board Assurance January 2024
Risk Score	See Board Assurance Framework
EDI impact / considerations	Ensure governance arrangements provide assurance and appropriate oversight of EDI requirements for the organisation
Link to: ➢ Trust's Strategic Direction ➢ Corporate Objectives	Achievement of corporate plan and objectives
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	GGI Good Governance Improvement LLP EDI Equality, Diversity, Inclusion QAC Quality Assurance Committee WAC Workforce Assurance Committee TCP The Christie Pharmacy

The Christie
NHS Foundation Trust

For information

Board of Directors meeting

Thursday 27th June

Framework for Board / Committee allocation

1 Introduction

At the March 2024 Board of Directors meeting, the Board approved an action plan responding to recommendations made in the GGI governance review 2023 as well as additional actions agreed by the Chair and Executive Directors. At the April 2024 Board meeting, the Board were presented with a framework outlining where oversight of key items is reviewed. This has had further scrutiny from executive leads and non-executive committee chairs and has been updated to reflect the discussions.

2 Background

The Board has allocated oversight for the full range of its responsibilities to one of its assurance committees (Audit, Quality, Workforce) or retained oversight at the full Board. In line with the actions agreed following the GGI review and as good practice, the allocation of items on the rolling programmes of the Board and its committees has been reviewed. This was done alongside the review of the Terms of Reference of the assurance committees. This has informed the production of a high level Board allocation framework (appendix 1).

3 Allocation of key items

Attached at appendix 1 is a revised summary of the key items that require Board oversight in relation to strategy, performance and assurance. The list of key items describes broad topics and is not exhaustive. For each item the framework indicates where strategy / performance and compliance will be reviewed.

The executive leads and non-executive committee chairs met to discuss the proposed allocation framework following discussion at the April 2024 Board meeting. It was agreed that further clarification was necessary around certain issues such as CQC Regulation 15 – Premises and equipment. Our existing Health & Safety report to Quality Assurance Committee covers certain aspects of the regulation but further assurance in relation to our physical assets and infrastructure is now included on the Audit Committee rolling programme for July 2024.

It was also stressed that the role of Audit Committee is not to oversee corporate performance, it is about the framework of governance and control to support achievement of objectives. Audit committee has oversight of the whole risk management framework. Audit Committee doesn't look at revenue, productivity and capital, this is the Boards role.

It was also noted that the work on the Culture audit needs to align with the Christie People and Culture Plan and this is reviewed through the Workforce Assurance Committee where any required improvements are monitored and assurance sought.

Board and committee agendas have been restructured to distinguish between

1. Compliance / Assurance items,
2. Performance items,
3. Risk items (allocated BAF risks/objectives) and this is reflected in the committee terms of reference.

There was also discussion around the need to provide clarity in committee papers as to whether they are addressing compliance / assurance reporting, performance reporting or risk. Compliance/assurance papers need to explicitly state the source of assurance on the cover page and in the body of the report.

Committee chairs will now provide clearer and fuller verbal reports to the board and council of governors, identifying key areas covered through the assurance committees.

Committee annual reports to the Board should include assurance that each has reviewed all required compliance areas as well as summarising the assurance levels it can provide.

5 Recommendation

The Board allocation framework attached at appendix 1 outlines the agreed allocation of key items following Board review.

Appendix 1

Board Allocation Framework

Item	Strategy	Scorecard	Performance	Compliance	Risk
Patient		Board			Board and specific allocation to Audit / QAC / WAC
Outcomes	Board		Board/QAC	QAC	
Experience	Board		Board	QAC	
Safety	Board		QAC	QAC	
System					
Health Inequalities	Board		Board	QAC	
System working	Board		Board	n/a	
Development					
Projects	Board		Board	Project Board / Audit	
Commercial partnerships	Board		Board	Audit (TCP)	
Finances					
System of internal control	Board		n/a	Audit	
Conflicts of interest	Board		Audit	Audit	
Procurement	n/a		Audit	Audit	
Revenue	Board		Board	n/a	
Productivity	Board		Board	n/a	
Capital	Board		Board	n/a	
Culture					
Staff survey	Board		Board/WAC	n/a	
People & Culture Plan	Board		Board	WAC	
EDI plan	Board		WAC	WAC	
Freedom to Speak Up*	Board		Audit	Audit	
Strategy	Board		Board	n/a	
Research	Board		Board	QAC	
Education	Board		Board	WAC	
Digital	Board		Board/Audit	Audit	
Sustainability	Board		Board	QAC	
Estates / facilities	Board		Board	Audit / QAC	
Legal	Board		Audit	Audit	
BAF risk deep dive's	n/a		Board	All	

* In line with the new NHS audit committee handbook 2024 this must sit with Audit Committee