The Christie
NHS Foundation Trust

Board of Directors meeting
Thursday 28th November 2024 at 12.45 pm

Trust Meeting Room

Agenda

Patient story / clinical presentation: Proton Beam Therapy Service – Tom Edwards, Clinical Services Manager for Protons and Penelope Hart Spencer, Play Therapist **30 mins**

	Public items	**Decision**		**Lead**	**Page**	**Timing**
35/24	**Standard business**					
a	Apologies			Chair		
b	Declarations of interest			Chair		
c	Minutes of previous meeting – 31st October 2024	Approve	*	Chair	2	5 mins
d	Action plan rolling programme, action log & matters arising	Review	*	CEO	8	
36/24	**Performance & finance**					
a	Trust report	Review	*	Execs	11	15 mins
b	Planning	Review	p	EDoF		10 mins
37/24	**Strategy**					
a	Trust Strategy update	Review	*	DoS	19	
i	Interim review of annual objectives					20 mins
ii	Digital Strategy update					
b	Inclusive Culture Strategy	Approve	*	DoW	29	15 mins
38/24	**Governance (regulatory / statutory compliance)**					
a	Board assurance framework	Review	*	CEO	45	10 mins
b	Reports from Committees Audit Committee - October 2024	Review	*	Committee chair	54	5 mins
39/24	**Any other business**					

Papers for information

Integrated performance, quality & finance report month 7	*
Annual Sustainability Report - Boards responsibility for Carbon Net Zero	*

Date and time of the next meeting

Thursday 30th January 2025 at 12:45pm

D/CEO	Deputy / Chief Executive Officer
EDoF	Executive Director of Finance
DoS	Director of Strategy
DoW	Director of Workforce

*	paper attached
v	verbal
p	presentation

The Christie
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Public meeting of the Board of Directors
Thursday 31st October 2024 at 12.45 pm
Trust Meeting Room

Present:	Chair:	Edward Astle (EA), Chairman Roger Spencer (RS), Chief Executive Officer Tarun Kapur (TK), Non-Executive Director Alveena Malik (AM), Non-Executive Director Grenville Page (GP), Non-Executive Director Sarah Corcoron (SC), Non-Executive Director Dr Diana Tait (DT), Non-Executive Director Roy Dudley-Southern (RDS), Non-Executive Director Prof Chris Harrison (CJH), Deputy CEO Vicky Sharples (VS), Executive Chief Nurse Sally Parkinson (SP), Executive Director of Finance Dr Neil Bayman (NB), Executive Medical Director Eve Lightfoot (EL), Director of Workforce Prof Rikki Goddard-Fuller (RGF), Director of Education Prof Fiona Blackhall (FB), Director of Research Claire McPeake (CM), Interim Chief Operating Officer Tom Thornber (TT), Future Christie Director
Minutes:		Louise Westcott (LW), Company Secretary
In attendance:		Jo D'Arcy, Assistant Company Secretary Jeanette Livings, Director of Comms Sue Mahjoob (SM), Freedom to Speak Up Guardian
Observers:		Natalie Harrold, Principal Clinical Scientist Tim Lowe, Public Governor Linda Seddon, Public Governor

Clinical presentation: Nutrition & Dietetics – Lorraine Gillespie, Dietetic Manager & Specialist Oncology Dietitian

Unfortunately, the patient that was arranged to attend the Board meeting was unable to do so.

LG showed the Board a picture of the team, and explained that the service has expanded greatly over the lasts 25 years.

Nutrition is extremely important for cancer patients, they can lose muscle weight, it can impact their immune system, increase length of stay, & poor nutrition can contribute to a greater risk of mortality. Common reasons for poor nutrition are side effects of treatment, location of the tumour and effects of the tumour that can produce substances that impact taste etc.

Side effects of treatment include lack of appetite, fatigue, taste changes, pain, nausea, mouth ulcers etc. When a patient is admitted they are screened for malnutrition risk and this comes up with a score that then develops a plan that can be tailored to the patient. Some patients are then referred to the dietetics team.

LG shared the patient menu that's devised with patient input. Allergies are recorded on admission. There is 24 hour access to food & drink for inpatients, they can have food at any point that they are hungry. There is also a supplementary offering of cooked breakfasts that can heated on the ward.

We are extremely lucky to have an excellent catering system that allows flexibility and choice at meal times rather than pre-ordering. The service also provide different portion sizes, and textures

of meal for patients dependent on need and how well they can swallow. All food is tasted by the team to make sure it is suitable.

There are special diets that can be provided e.g. restricted fibre / plant based & vegan / gluten free / kosher & halal etc.

There are protected mealtimes on the wards, there's a red napkin system for patients that need support at mealtimes. Oral nutrition support drinks are also used to top up patients and ensure they are getting some nutrition.

Enteral and parenteral nutrition was described that supplements feeding either through the nose and into the stomach or straight into the stomach or through the veins. Head & neck patients can go home with a feeding tube. Patients who have problems absorbing nutrition or have bowel obstruction can go home with parenteral feeding into the vein. This is coordinated with Salford's intestinal failure team.

Criteria are set for referral to the team such as High output stomas, fistulas, bowel obstruction, dysphagia, severe mucositis etc.

A pilot was undertaken around an ambulatory nasogastric feeding service for head & neck patients to avoid them deteriorating and needing long stays in hospital. The pilot devised a pathway where the patient would come in and have training then come in each day for a few hours for 5 days and go home at night. Evaluation showed that patients were 100% satisfied, admission was prevented, and lots of counselling was required. There were some issues around travel costs for some patients. Others would have struggled to have appropriate feed without this approach.

Future developments – develop ambulatory enteral feeding service, develop outpatient services & models of care (prehabilitation, HPB, lung, gynae, TYA's), establish a nutritional support team, expand research, nutrition training & education programme for all HCP's, and to continue to expand the available menus.

TK asked if covid accelerated thinking & progress in some areas. LG agreed that the ambulatory model came from this time.

DT noted that weight loss can be very stressful for patients & carers alike so having professional help is very important. In terms of the resource is there enough to support the demand. LG noted that there is an unmet need but there has been recent investment in outpatient teams. There is also patient information that gives patients help with symptom management. This is enough for some patients. Blogs that are targeted at certain patient groups have been developed too.

The service can develop with what patients need.

TT asked about remote monitoring of patients on an ambulatory model. LG agreed that PROMs may be very helpful as an alert for larger groups.

RDS noted that there are problems of communication for patients that go on to other hospitals around their dietary needs. LG agreed that communication is crucial, and this works well here but can't always be consistent in other hospitals. There is a lot less flexibility in other hospitals.

RS noted that we are challenged on the costs of services like catering and cleaning and it is clear from this presentation that we deliver a much higher standard of care and service to our patient group with our approach.

TT noted that when he was a patient having had bowel surgery and with a stoma he found the staff on the ward to have extensive knowledge of his needs and their education is also a key part of the service.

EA thanked LG for her presentation and for taking the time to come and speak to Board.

Item		Action
30/24	**Standard business**	
a	**Apologies**	
	John Wareing (JW), Director of Strategy, Alveena Malik (AM), Non-executive Director	
b	**Declarations of Interest**	
	None noted.	
c	**Minutes of the previous meeting – 26th September 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. Outcome measures around health inequalities – add to next report.	JW
31/24	**Performance & Finance**	
a	**Trust Report**	
	• Trust continues to deliver its activity, operational performance, quality standards and finances to target in challenging circumstances. This is shown consistently over 6 months. • Cancer waiting time targets are compliant. • GM ICS position has shown a further significant deterioration in the order of £70m. Organisations are being asked what more they can do to support the system. • Operational arrangements to bring 2 new wards into use are now complete. • Planning arrangements for 2025/26 are underway, there is significant progress in a strategic longer-term approach. Proposals will come to the November meeting. • On 18th October, we had a ministerial visit from Andrew Glynne. Cancer is in his portfolio. He visited Protons, supportive care etc. • Recruitment & retention and staffing vacancies were discussed. We are progressing with our plan to fill vacancies where we can against demand with an efficiency factor. Efficiency plans will look at this again. Turnover is low. Two year staff turnover figure needs explanation. • Discussion on the recent budget and current deficit position in the NHS. • Pathology services were discussed and the arrangements with a commercial partner that have been successful. The next phase is to complete the procurement process that looks at addressing the risks we have identified. • Slight increase in incidents and a never event in month. No concerns with any increase in moderate or severe incidents. The never event related to the delivery of insulin. Patient was unharmed. Learning has been taken and disseminated because of the event. • Thresholds have changed for PSII's compared to SI's so numbers look to have increased.	EL
b	**Value Improvement Programme Progress Report**	
	• Monthly update – identified £19.6m against a target of £21.4m.	

	• Governance structures described - focus on patient care and value • Next years programme has been launched, ideas are coming through from teams. • Our performance is excellent when compared to the rest of GM. • Recurrent of £10.5m against £14m target. • The target next year will be about £25m VIP. Our processes and systems are well set up ahead of this. • Confidence that we will get to the overall target of £21.4m but may not reach the target for recurrent.	
32/24	**Culture**	
a	**Freedom to speak up guardian annual report**	
	• SM attended to present the 6 monthly report to Board. • Types of concern raised with the FTSUG were described. 60% are about attitudes and behaviours, 14% policies, procedures and processes and 14% related to service change and its communication. • Key theme across these areas is communication and managers having the appropriate training to do the right things. Conversations are key. • Gaps in speaking up – who and how staff speak up, comparison with staff survey feedback to identify themes / issues. • National evidence shows that staff with protected characteristics find it more difficult to speak up – must continue to work with these staff to address their issues. • Plan outlines what we want to achieve – last year included the launch of the Trust values & behaviours, embedding PSIRF & its principles, incident reporting – openness & facility to challenge, embedding Respectful Resolutions, and the national FTSU month with a focus on listening. • In progress – guide for managers when receiving a concern, animated version of the policy to improve accessibility and anonymous reporting for attitudes and behaviours. • Culture is a focus for the organisation, to make this work well, there are many good engagement opportunities that give staff a voice and a governance structure to work within. • Explicit description of achievements to be included in the written report. • Board extended thanks to SM for her hard work, particularly with some challenging cases and good luck with her retirement. SM has progressed this role extremely well and has supported staff brilliantly. • Board is very committed to the cultural agenda. • The role has been reviewed in light of other organisational development work. There will be a cultural advocacy element to the role as well as satisfying the FTSUG requirements. AM has supported the team in the review.	EL
33/24	**Governance (regulatory / statutory compliance)**	
a	**Board assurance framework 2024/25**	
	• Changes to the BAF have been identified on the cover paper. • Inputs to the BAF from the Assurance Committees have been reflected in this version.	

	• Changes in risk scores over time are illustrated in the summary page. • Review of the extreme weather event risk to be undertaken. • Increase in risk score for Risk 2 relates to the embedding of the PSIRF framework.	CH
b	**Reports from Committees**	
	Workforce Assurance Committee September 2024	
	• High assurance on PDR process but committee will look at a focused review in the next meeting • Christie People & Culture Plan was reviewed, focus on 'exit interview' to improve this process and get better feedback. • Outputs needed enhancing from the Improving Junior Doctors lives paper. • Christie response to the riots was commended.	
	Quality Assurance Committee September 2024	
	• Changes in assurance ratings with landscape changes around PSIRF – risk score has increased but should come down once new processes are in place and reviewed. • Duty of Candour responses were focused on and has seen a great improvement to 100% compliance as of today. • Review of risk and learning coming up from PSIRF will be focused on.	
	Audit Committee October 2024 – verbal update	
	• GP noted that an Audit Committee took place last week. • EPRR compliance report reviewed and external assessment reported. • TPC 6 monthly update presented, controls and metrics gave assurance. • Discussion on supply chain issues and consideration of inclusion on the BAF. • Regulation 15 – premises and estates report – good evidence of controls. • Update on sustainability showed very good work in context of financial and capacity challenges.	
c	**EPRR statement of compliance**	
	• This is our annual self-assessment against NHSE core standards. • Audit Committee received assurance against standards, and we received external assessment from NHSE in line with our self-assessment. • The framework is designed against category 1 responders who are Trusts that have A&E's. Some standards are not applicable to us, and they change year on year. • Any risks associated with our EPRR self-assessment are comprehensively reviewed and assessed and do not score highly or need to be escalated. • There are no areas where we are non-compliant.	
34/24	**Any other business**	
	• No further items raised.	
	Date and time of the next meeting	
	Thursday 28th November 2024 at 12:45pm	

	Papers for information only	
	Integrated performance, quality & finance report	

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Agenda item 35/24d

Meeting of the Board of Directors - November 2024
Action plan rolling programme after October 2024 meeting

C Culture P Performance S Strategy G Governance

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
November 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 information
		S	Strategy update	DoS	Six month review	37/24a
		S	Inclusive Culture strategy	DoW	Approve	37/24b
		P	Digital Strategy update	DCEO / CIO	Annual Review	37/24a
	Annual reporting cycle	P	Interim review of annual objectives	CEO	Review progress	37/24a
		S	Annual Sustainabiltiy Report - Boards responsibility for Carbon Net Zero	DCEO	Note approval by Audit Committee	For information
December 2024 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
Planning & Development / Council of Governors Day		S	Board planning / Risk 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	Clinical Outcomes Strategy review	EMD	Review	
		P	Value Improvement Programme	COO	Review	
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	Board presentation
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	For information
	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	

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
April 2025		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 information
		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	
		S	Strategy update	DoS	Full year review	
		G	Modern Slavery Act statement	CEO	Approve	
		G	Standing Financial Instructions (SFI's)	DoF	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 2024-25 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			
June 2025		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
	Annual reporting cycle	G	Annual compliance with the CQC requirements	ECN	Declaration / approval	
		P/S	Education Strategy Update	DoE	Review	
		G	Board effectiveness review	Chair	Report	
		P	Value Improvement Programme	COO	Review	
	Annual reporting cycle	G	Annual report, financial statements and quality accounts (incl Annual governance statement / Statement on code of governance)	EDoF	Approve	
July 2025 - 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 2025 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
September 2025		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 information
		C/P	Health inequalities self -assessment	DCEO	Review	
		P	Value Improvement Programme	COO	Review	
		P	Quality Strategy update	ECN	Review	
Development session		S	Strategy / planning			
October 2025		C	Patient story	CEO	To hear a patient story	Board presentation
		P	Integrated performance & quality report and finance report	COO	Monthly report	For information
		P	EPRR Compliance statement	COO	Approve	
		C	Freedom to speak up guardian	FTSUG	Annual report	
Planning & Development Day		S	Planning with Divisional leadership teams			
		S	Strategy deep dive			

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Agenda item: 35/24d

Action log following the Board of Directors meetings held on

Thursday 31st October 2024

No.	Agenda	Action	By who	Progress	Board review
1	30/24d	Outcome measures around health inequalities – add to next report	JW	To be incorporated into next report	March 2025
2	31/24a	Two-year voluntary staff turnover figure in dashboard needs explanation	EL	To be noted in next Board meeting	November 2024
3	32/24a	Explicit description of achievements to be included in future Freedom to speak up guardian annual reports.	EL	As part of next FTSU annual report to Board	October 2025

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Agenda item 36/24a

Meeting of the Board of Directors
November 2024

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

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Trust Report
November 2024 (October data)

Board Scorecard

Corporate objective	Indicators	Tolerances			Current month	Year to date
All	CQC rating	N/A			Good	Good
All	SOF Rating	N/A			2	2
Quality of Care & Performance						
1,6	Proportion of incidents that are low/no harm (%)	90%+			96.3%	N/A
1,6	31 day compliance (%)	96%			98.5%	N/A
1,6	Patients meeting the faster cancer diagnosis standard (%)	75%			81.3%	N/A
1,6	MRSA bacteraemia infection (attributable) (N)	TBC			0	2
1,6	Clostridium difficile infection (attributable) (N)	TBC			7	31
Finance and Use of Resources						
6	Financial sustainability / liquidity (days)	>21	21 to 14	<14	87	87
6	Overall financial position (% variance to control total)	0% below plan	0 - 10% below plan	>10% below plan	0.0%	0.0%
6	Recurrent VIP performance (% achieved)				75%	75%
6	Current cash balance (£'000)				£126,632	£126,632
6	Exchequer capital spend to date (variance to plan %)	within 10%	10 to 20%	>30%	17%	14%
6	Average length of time debt is outstanding	<15	>16 - 20	>20	8	8
6	Public Sector Payment Policy - trade creditors paid within 30 days (number and volume)	>95%	95 - 85%	<85%	99%	99%
People and Culture						
7	PDRs completed (%)				87.1%	N/A
7	Mandatory training (%)	>80%		<79%	93.7%	N/A
7	Voluntary turnover in first 2 years (%)	<31%		>32%	13.25%	N/A
Research						
4	New trails open per month (N)	>10	9-10	<8	14	100
4	No. patients consented into studies (N)	>250	200-249	<199	232	1483
4	Christie Sponsored research: new studies opening (N)	>2	1	0	2	11
4	Research patient experience - % strongly agree they would participate in research again	90%	75-89%	<75%	8 (89%)	41 (85%)
Education						
3	Undergraduate placement activity	>165	135-165	<135	144	253
3	CPD activity (internal & external)	>440	340-440	<340	780	927
System						
1,6	62 days (%)	>70%		<69.9%	80.8%	N/A
1,6	Priority patients not admitted (deferred)	0		>1	0	0
Digital						
4	Customer Satisfaction score of "Good"	>95%	85-94%	<85%	97.3%	97.4%

Executive Summary

- We remain rated overall as Good by the CQC.
- We continue to be in segment 2 of the System Oversight Framework.
- Key patient quality indicators for October show no significant adverse variances there was one issue for escalation relating to a never event. We remain a high reporting, low harm organisation.
- Performance in October for the 62-day consolidated cancer standard was 80.8% which is better than the operating plan standard of 70%.
- Eight operational risks are scored at 15 or above on the risk register.
- Cumulative financial performance at the end of October (Month 7) is a (£4.5m) surplus against a planned (£4.1m) surplus. This is a favourable variance of (£0.4m) to plan.
- Key financial performance indicators in month 7 show one adverse variance which is the level of recurrent VIP identified being £10.5m identified so far against a £14m annual target.
- Workforce indicators for October show a slight increase in sickness absence rates.
- PDR performance and mandatory training performance is over the established thresholds.
- The NHS Staff Survey 2024 is now live. All staff are encouraged to be part of this and take a few minutes to fill in the survey.
- Christie Education projects and events continue to support our aims and objectives.
- Capital schemes are progressing to plan across the Trust.
- NHSE have informed us that they will update the NHS Oversight and Assessment Framework and underpin this with a new NHS Performance, Improvement and Regulation Framework.

Quality of Care

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

Pressure ulcers and falls were in line with internally set trajectory in October.

There were 15 complaints in October, higher than the monthly average. The number of contacts with the Patient Advice and Liaison Service (PALS) service in October was 42 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.

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

1. Not identifying and delivering 2025/26 recurrent VIP programme impacting on financial sustainability and ability to treat patients (16)
2. Limitation on equipment & facilities to deliver planned activity or progress developments due to insufficient capital funding (CDEL) (16)
3. There is a risk that patients awaiting stem cell treatments may experience delays (16)
4. Risk of delayed patient treatment due to extended turnaround times in histopathology results (16)
5. Financial and Operational Risk to The Christie in relation to Transfer of Mid-Cheshire Foundation Trust Clinical Haematology service in 2025 (16)
6. Risk to treatment delivery due to workforce recruitment & retention in Aseptics (15)
7. There is a risk to the Trust's ability to demonstrate compliance and adherence to its regulatory and statutory requirements (15)
8. Risk of disruption to operations & patient safety due to out-of-date evacuation plans (15)

Operational Performance

The 2024/25 NHSE Planning Guidance has two 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 October against the 2 key cancer standards was;

- The 62-day consolidated standard was 80.8% against a threshold of 70%.
- We achieved 81.3% 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 98.5% against a target of 96%.

During October there were 13 operations cancelled on the day for non-clinical reasons. The table below outlines the reasons.

Hospital Cancelled - listed procedure incorrect	1	Interventional Radiology
List Overran	3	Surgery
Unavailability of Critical Care Beds	7	Surgery
Urgent procedure took precedence	2	Interventional Radiology

Financial Performance

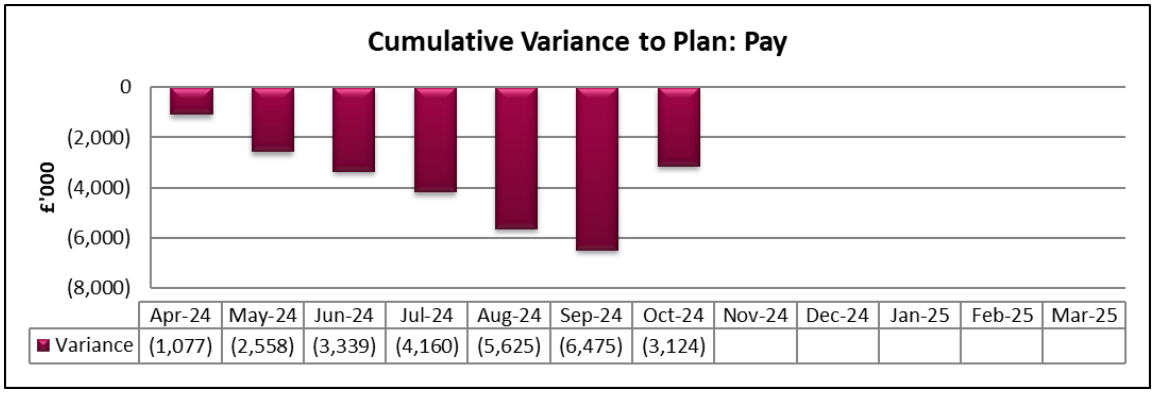
Revenue: Financial performance is ahead of plan by (£0.4m) as illustrated in the table below. The Trust is reporting a (£4.5m) surplus against a (£4.1m) planned surplus position. The better than plan position is primarily due to :-

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

Month 7 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(423,907)	(247,263)	(258,578)	(11,315)
Other Income	(77,294)	(44,990)	(43,604)	1,386
Pay	234,288	136,526	133,390	(3,136)
Non Pay (incl drugs)	241,329	140,774	149,701	8,927
Operating (Surplus) / Deficit	**(25,584)**	**(14,953)**	**(19,091)**	**(4,138)**
Finance expenses/ income	30,932	18,040	21,673	3,633
(Surplus) / Deficit	**5,349**	**3,087**	**2,582**	**(505)**
Exclude impairments/ charitably funded capital donations	(12,355)	(7,203)	(7,116)	87
Adjusted financial performance (Surplus) / Deficit	**(7,006)**	**(4,116)**	**(4,534)**	**(418)**

The pay underspend of (£3.1m) is illustrated in the graph below :-

- (£2.7m) relates to income backed services, including GM Cancer, R&I and Charity-funded posts, which has an equivalent reduction in income.
- The balance on the Trust pay underspend in M07 is mainly due to vacancies predominantly in clinical posts, most noticeably scientific, technical and therapeutic (£2.1m) and consultants (£1.7m).
- These are offset by the back-dated pay-award to Apr-24 actioned within M07.



Capital: The capital plan for 2024-25 has been agreed at £18.4m. The Trust has spent £7.7m to M07, which is 85% year to date against the capital plan, primarily on:

- TIF ward refurbishment
- Ongoing digital projects
- 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. The level of recurrent VIP identified to date is £10.5m giving a recurrent shortfall of £3.5m. The level of non-recurrent VIP identified to date is £9.4m, over plan by (£2.0m). Year to date, £12.5m has been delivered against a target of £12.5m.

KPIs: Variances from the planned financial performance against key measures include capital expenditure and the level of recurrent VIP delivered to date. As shown in the table, there are no other significant variances:

Measure of Financial Performance	Red / Amber / Green rating
Revenue: Trust Control Total compared to plan	£0.4m ahead of plan
Capital: Capital expenditure against plan	£1.3m **under** plan
VIP identified (recurrent) against target of £14m	£10.5m identified
Debtor days compared to 15-day target	8 days
Cash balance	£126.6m
Better Payment Practice Code (95% target)	99%

Workforce

Our workforce performance indicators show mandatory training compliance and personal development plan rates are both above (better than) thresholds at 93.7% and 87.2% respectively. Sickness absence rates increased slightly in October to 5.07% (threshold of 3.4%). The overall turnover for the Trust has reduced from last month to 11.63%. These issues and the associated plans for improvement have been considered by the Workforce Assurance Committee.

The Christie is supporting UK Disability History Month, from 14th November to 20th December 2024. This year's theme Disability, Livelihood and Employment signals the importance and value of supporting disabled people at work, ensuring they have a voice. Over the period, we will be promoting events, webinars and podcasts, a selection of reading and resources, and showcase good practice. Staff can engage in these activities to develop knowledge and awareness via HIVE - UK Disability History Month 2024. For anyone wishing to join the Ability and Wellbeing Staff Network please contact the-christie.abilityandwellbeing@nhs.net. Or the-christie.equality@nhs.net for any of the other Staff Networks.

Last year The Christie signed up to NHS England's first ever charter on sexual safety at work, with ten pledges for organisations to follow to safeguard staff. In doing so we commit to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our staff. To support our commitment the Trust has now published its Sexual Safety at Work Policy.

The NHS Annual Staff survey closes on Friday 29 November, so staff have just 2 weeks left to fill it in. Prizes are on offer for departments/teams with the highest response rates and the most improved response rates (when compared to 2023 survey). You can check divisional/departmental current response rates in the spreadsheet available here.

Research

We have consented 1,483 patients' so far this year across a range of trials and the number of studies opening is 56% higher than last year. This includes 11 Christie Sponsored Research Studies; one of those studies is **TOURIST.**

November is Lung Cancer Awareness Month. We would like to highlight TOURIST; the world's largest clinical trial using radiotherapy in the treatment of metastatic lung cancer for patients who typically have about a year to live. This trial has opened for recruitment, funded by a £3.4 million grant by NIHR and with Dr David Woolf as Joint Chief Investigator and The Christie as sponsor in collaboration with Southampton Clinical Trials Unit.

Cancer Research UK will invest a total of £5.9 million to develop new radiotherapy technologies and techniques over the next five years. The funding will support The Christie and University of Manchester as part of the RADNET funding programme to discover ways to improve radiotherapy treatments including the use of virtual clinical trials.

Congratulations to Dr John Lim and Dr Ana Ortego Franco on graduation from the European Society for Medical Oncology Leaders Generation Programme. At The Christie Annual Staff Awards, Gemma Butterworth, an Advanced Clinical Practitioner, won Learner of the Year and Experimental Cancer Medicine Team (ECMT) won the Sustainability Award. Professor

Gordon Jayson was also honoured for Research, Education and Clinical service through the Lifetime Achievement Award in Memory of Professor Derek Crowther.

The NIHR Clinical Research Network (CRN) 2014-2024, has become NIHR Regional Research Delivery Networks from October 2024. Over the last 10 years of the CRN, The Christie has recruited 16,971 patients to Clinical Studies.

Cancer Research UK have published a new policy report, *Sequencing Success: Genomics for cancer research and care.* The full report and executive summary are available to read here. The ambitions they set out for the future of the UK's genomic research and healthcare sectors are also introduced in this article. This work builds on the opportunities to use genomics for earlier detection and diagnosis of cancer, innovative research into the biological nature of cancer, and the development of precision medicines highlighted in our programme for government, *Longer, Better Lives*.

Education

Christie Education continues to support a broad, multiprofessional cohort of undergraduate students and apprentices with new colleagues from Health Psychology undertaking placements at The Christie. We continue to be a national leader, and beacon of best practice, in digital clinical placements (DCP) which combine high quality coaching and mentoring with meaningful, immersive clinical experience. Our DCP programme, pioneered by the radiotherapy education group, provides opportunities for undergraduates to gain direct cancer care experience that would not normally be available on their professional courses.

Colleagues from Research & Innovation and Education have been on site in Cairo delivering a workshop as part of a collaboration with NHS Global and the Egyptian Healthcare Authority (EHA). The EHA are seeking to better integrate their cancer services within their developing public hospital network across the country. Professor Mark Saunders, Professor Sarah O'Dwyer, and Rachel Chown have been in Cairo visiting the hospital site and facilitating a wide range of talks delivered by themselves, in addition to 14 other Christie speakers who joined virtually to cover a range of discipline and disease groups topics.

Continuing our learning with and from other major comprehensive cancer organisations, Ellie McManus (Associate Director of Education) has joined the Education Advisory Board of Institut Gustave Roussy.

Strategic and Service Developments

Pathology JV Re-procurement - the procurement process continues, and we intend to issue the final statement of requirements in December with a view to BAFO completion in January 2025. We are dovetailing this process with plans to develop new pathology facilities and anticipate making final contract award during Q4. The long-term estate option for new pathology facilities at the Withington site has been identified. The trust is continuing dialogue with The Christie Charity as to its role in funding and delivering the project.

The new 20-bedroom ward in the former Trust Administration and Digital floors is complete and known as Wards 14 and 15. The wards opened in October and feedback from staff and patients on the new spaces has been very good. Work has been commissioned to undertake a minor refurbishment to the remaining wards in this financial year and additional works on Ward 12.

The replacement of the Superficial Treatment unit is nearing completion. Work has commenced on the formation of a temporary pharmacy to support the replacement of the existing inpatient pharmacy robot by the end of March 2025. Finally, engagement remains ongoing for the first phase of the multi-year linear accelerator replacement programme.

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

Future Christie Project
The organisation has initiated "The Future Christie programme" to support the delivery of the Christie strategy 2023 to 2028 and take a longer-term view on the modernisation of care, discovery and education models. The aim of the programme is to ensure the Christie can continue to deliver the latest innovative care and enhance patient and workforce experience for the next 10 years in line with the national focus for the NHS. Our aim is to define an ambitious and achievable programme that catapults The Christie into adopting proven technology and practice to advance the Christie strategy.

The outline timeframe for this project is;
- **Setup phase (6 months)** – To define the principles, structure and programmes of work.
- **Phase 1** (Up to 5 years) – Accelerate modernisation to catch up with current digitally enabled care providers. Embedding advances in Smart hospital, AI/automation, Big Data, remote monitoring, into the model of care.
- **Phase 2** (5 years and beyond) – Position The Christie in terms of digital infrastructure and innovative and capable partners to move into global exemplar in the delivery of cancer care through the next generation of health innovations.

Regulation and Governance
On 13th November, NHSE wrote to Trusts to describe the evolution of their operating model. The message following the publication of Lord Darzi's recent report was that the system we have needs to be optimised and every part of the NHS needs greater clarity on what they are accountable for. The work of NHSE hopes to ensure that the way the NHS works supports delivery of today's priorities and sets the NHS up to deliver the neighbourhood health model that will underpin a health and care system that is fit for the future.

The focus of the refresh of the operating framework is focused on 4 things:
- Simplify & reduce variation.
- Shift resources, time & energy to neighbourhood health.
- Devolve decision making to those best placed to make changes.
- Enable leaders to manage complexity at a local level.

As NHSE's ways of working continue to develop and evolve, and as they look to devolve decision-making to the local level, the functions where NHS England add most value will also change and may reduce. NHSE want to see self-managing, self-improving systems with ICB's critical to the delivery of strategic shifts from treatment to prevention, from analogue to digital and from hospital to community. ICB's will continue to be the system leader for the NHS, convening and working across all key partners within their integrated care system. The identified goal is to give more freedoms for the top performers – those who are improving population health, reducing inequality of outcomes and who deliver high patient satisfaction and use resources effectively.

NHSE intend to capture this approach through an updated NHS Oversight and Assessment Framework and underpin this with a new NHS Performance, Improvement and Regulation Framework.

ICBs will continue to have oversight of how providers deliver the outcomes that they have been commissioned for. Where performance is below an acceptable level, and the use of commissioning levers has not secured improvement, NHS England will step in with both the ICB and provider to support rapid improvement and by using regulatory powers in a defined set of circumstances.

Strong boards are essential for all organisations if the NHS is to deliver its objectives. To be effective, boards need the right information at the right time and used in the right way. As part of NHSE's commitment to support leaders to deliver and improve, they have published

the Insightful Board guides for both ICBs and providers. These guides provide clarity around the critical information boards need to understand their organisations, and the culture and governance necessary to support information flow, so it can be used most effectively when overseeing their organisations.

ICBs will continue to have first line oversight of how providers deliver outcomes. NHSE will work with regional colleagues to embed any revisions to ways of working between them and the regional team, the foundation of all this in GM will therefore continue to be the GM provider oversight arrangements which are already in place, which already involve regional colleagues as appropriate. It will continue to be one conversation, bringing finance, performance, and quality together.

The Christie
NHS Foundation Trust

Agenda item 37/24a

Meeting of the Board of Directors
Thursday 28th November 2024

Subject / Title	Trust Strategy and annual objectives update
Author(s)	Louise Westcott, Company Secretary John Wareing, Director of Strategy
Presented by	John Wareing, Director of Strategy
Summary / purpose of paper	This paper provides the Board of Directors with an update on progress against the annual objectives for 2024/25 and in year delivery against the Trust Strategy. This report has a spotlight on progress in relation to our digital strategy which is a key enabler of our overall Trust Strategy.
Recommendation(s) (assure/alert/advise)	The board of directors are asked to; • Note the update on progress against the annual objectives
Background papers	N/A
Risk score / BAF reference	See BAF risks (agenda item 38/24a)
Link to: ➢ Trust strategy ➢ Corporate objectives	All Corporate objectives (as set out in appendix 1)
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	LCC Leading Cancer Care BO Best Outcomes L&S Local & Specialist CE Christie Experience R&I Research & Innovation GM Greater Manchester MFT Manchester Foundation Trust CODU Clinical Outcomes Data Unit SDE Secure Data Environment EPR electronic patient record PAS patient administration system EPMA electronic prescribing & medication administration KPI key performance indicator OCIO operational chief information officer

The Christie
NHS Foundation Trust

Agenda item 37/24a

Meeting of the Board of Directors
Thursday 28th November 2024

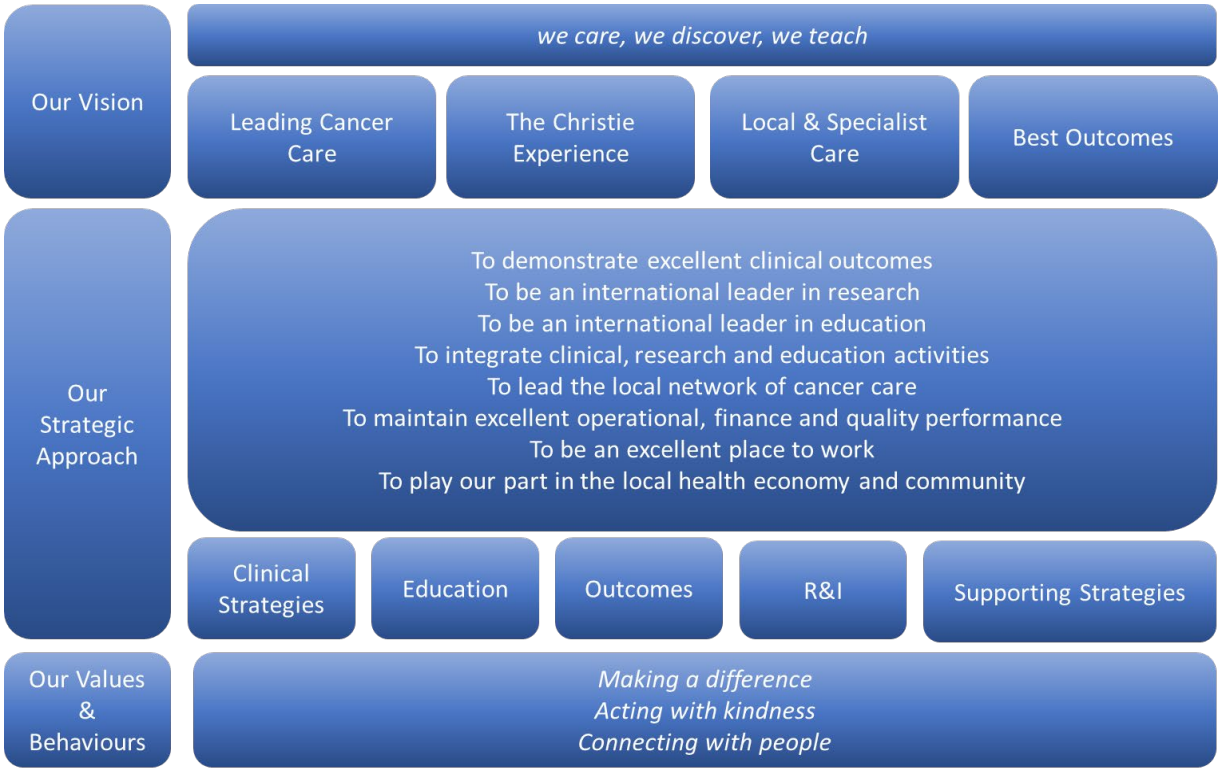
1 Background

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

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

2 Introduction

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



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

3 Main Strategy Themes

The table below outlines the main themes of the 2023-28 Strategy. The colours indicate how these key themes and projects address issues of cancer waits, improving patient outcomes

and addressing health inequalities. These themes inform the production of the annual objectives each year.

Leading cancer care	The Christie experience	Local & specialist care	Best outcomes
LCC 1 Realise the potential of the Paterson development - seamless integration of research with clinical care	CE1 Improve in-patient experience and efficiencies through emerging / next generation ward environments	L&S 1 Lead a single Christie non-surgical oncology service with equitable care for all patients across GM	BO 1 Drive improvements in quality, safety and patient experience through real-time data for 'data-enhanced clinicians'
LCC 2 Grow pipeline of Christie leaders with regional, national, and international influence through an active model of staff development	CE 2 Establish system-wide Christie Research Outreach - access to research for every patient across Greater Manchester	L&S 2 Collaborate with system partners to improve access to cancer diagnosis and treatment targeting areas of greatest need	BO 2 Accelerate the use of real-world data and improving outcomes through launching a multidisciplinary Clinical Outcomes & Data Unit (CODU)
LCC 3 Accelerate research delivery through efficiencies and innovation - tomorrow's treatments to patients faster	CE 3 Personalise the Christie out-patient experience embedding digital healthcare tools	L&S 3 Expand cancer survivorship programme with system leadership for managing late effects, supportive care and research	BO 3 Develop a secured-data environment with regional/national capability in collaboration with research partners
LCC 4 Create sustainable opportunities for our staff to work within international partnerships to tackle cancer inequalities locally and globally	CE 4 Embed cancer partnerships beyond GM by building on the success of national service networks and hosting Operational Deliver Networks	L&S 4 Establish a Christie Advanced Cancer Scanning Centre for state-of-the-art diagnostics and increasing system capacity	BO 4 Work in partnership with the GM Cancer Alliance to establish and report cancer equality metrics and KPIs
LCC5 Amplify accessible and inclusive cancer care education and training for Christie staff, external colleagues, and patients	CE5 Grow active patient and public engagement opportunities across cancer education priorities	L&S 5 Work with partner organisations to integrate a sustainable next-generation cancer pathology service in cytogenetics, histopathology, and blood sciences	BO 5 Improve outcomes for older patients with cancer through the Christie Senior Adult Oncology service

	Cancer waits
	Outcomes
	Inequalities

4 Annual objectives

The Board approved the annual objectives for 2024/25 in June 2024. The table at appendix 1 summarises the progress against the objectives at month 7. The annual objectives relate to the in-year delivery of the overall strategy and the table shows where each objective links to a theme within the strategy as well as any link to a risk on the Board Assurance Framework. There are no issues to escalate to Board following the assessment of progress at this stage in the year.

5 Risk

There are a number of potential threats or risks to the delivery of our Strategy and Annual Objectives a number of which are articulated through the Board Assurance Framework.

6 A focus on Digital

The Trust's approach to digital delivery is a key enabler of our Strategy and our emerging plans for Future Christie. The table below summarises the high level objectives of the Digital Strategy 2023-28 and outlines progress in year 1 and year 2 as well as summarising the focus for the coming years.

HIGH LEVEL OBJECTIVE	RAG	MEASURED BY	NOTES
Year 1 (2023/24)			
Build a department with a positive culture and effective leadership		Staff survey results Sickness rates Turnover rates	Year on year increase in staff survey results. All Digital results are now above the Trust average
Deliver maturity capability		Maturity assessments including NHS DMA, SDI and Gartner IT Score	Improved 4 maturity points in the Gartner IT score (3). Now above the global average (+2)
Year 2 (2024/25)			
Deliver Frontline Digitisation		EPMA, Order Comms and Patient Portal projects delivered	Programmes are due to deliver before the end of the FY but are delayed beyond their original target date
Introduce operational oversight and standards		Service oversight in place with defined KPIs EPR operational oversight in place with defined KPIs	Both service and EPR oversight in place reporting to the OCIO. Service is more mature than EPR, a maturity plan is in place
Year 3 + (2025 -2028)			
Align Digital strategy objectives to the Trust strategy		Future Christie	Digital Strategy was written before the Trust strategy. Future Christie programme will bridge them.
Democratise benefits realisation		Future Christie	Democratise control and responsibility for benefits realisation via digital transformation, to the divisions
Invest in growth and transformation		Future Christie	Trust investment to provide the platforms, systems and transformation processes
Set up for success (PAS and EPR)		Future Christie	An EPR and PAS assessment are required to ensure our main systems will meet future ambitions
Mature digital governance		Future Christie	Revised governance is needed to bring Digital transformation from a Digital division level to a trust level

7 Summary

There has been good progress with the annual objectives that continue to deliver on aspects on the overall Trust Strategy and no issues require escalation to the Board.

8 Recommendation

The Board are asked to note the contents of the report and progress against the Annual Objectives and Trust Strategy.

The Christie NHS Foundation Trust

Appendix 1: Annual Objectives 2024/25

1. To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer.							
	BAF risk	**Strategy Theme ref**	**Annual objective**	**Reporting**	**Timescale**	**Director**	**Progress**
1.1	14		Publish all information required under the NHS Code of Governance for Provider Trusts – including relevant oversight framework metrics (See below)	Trust Annual Report & Accounts and other governance documents prepared and reported to board with appropriate audit opinion	30.6.24	CS	Complete
1.2	14		Publish information on our quality of care in 2023/24 in our annual Quality Report and Accounts	Annual Quality Report prepared and reported to board with appropriate audit opinion	30.06.24	ECN	Complete
1.3	14		Publish relevant metrics as set out in the NHS oversight metrics for 2024/25	Monthly report to board	Monthly	COO	Complete to month 7
1.4	1	BO1/O2 /03/05	To deliver the 2024/25 milestones in our Clinical Outcomes Strategy	Annual report to Quality Assurance Committee	31.3.25	EMD	Progressing to plan
1.5	13		Publish progress with EDS 2022 self-assessment action plan	Effective web site page – six monthly report to Workforce Assurance Committee	6 monthly	DoW	On Trust website
1.6	6 13		Publish self-assessment and action plan for health inequalities based on socio-economic deprivation, ethnicity, and other community characteristics	Effective web site page – six monthly report to Board	6 monthly	DCEO	NHS Providers self assessment completed and reported to the Board.
1.7	5		Develop the ASIC business case to HMT principles for Board consideration and support for wider funding strategy	Board approved business case	31.3.25	EDoF	Progressing to plan
1.8	4		Prepare for the new CQC inspection regime	QAC and Board reports	31.3.25	ECN	Regular reporting in place

1. To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer.							
	BAF risk	**Strategy Theme ref**	**Annual objective**	**Reporting**	**Timescale**	**Director**	**Progress**
1.9		LSC3 BO5	Deliver the benefits of the Senior Adult Oncology service across a wider range of tumour pathways	Senior Management Committee reports	31.3.25	EMD	Progressing to plan

2. To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey							
	BAF risk	**Strategy Theme ref**	**Annual objective**	**Reporting**	**Timescale**	**Director**	**Progress**
2.1	3 6 12	LCC 1/3 CE 2	Implement 2024/25 (year 2) milestones of Research & Innovation division strategy	Six monthly report to Quality Assurance Committee Annual report to board Effective web site page	31.3.25	DRI	Progressing to plan
2.2		LCC 1	Ensure plan for relocation of research teams into Paterson facility implemented	Regular reporting to Quality Assurance Committee	31.3.25	DRI	Teams relocated as planned

3. To be an international leader in professional and public education for cancer care							
	BAF risk	**Strategy Theme ref**	**Annual objective**	**Reporting**	**Timescale**	**Director**	**Progress**
3.1	3 12	LCC 2/5 CE 5	Implement the 2024/25 milestones of the Christie Education strategy	Six monthly report to Workforce Assurance Committee / Annual report to Board Effective web site page	31.3.25	DE	Progressing to plan
3.2			Implement future organisational governance arrangements for Christie Education and relationship to Education Sector	Six monthly reporting to Workforce Assurance Committee Report to Board	31.3.25	DCEO/ DE	Progressing to plan. Board report October 2024

4. To integrate our clinical, research and educational activities as an internationally recognised and leading comprehensive cancer centre							
	BAF risk	Strategy Theme ref	Annual objective	Reporting	Timescale	Director	Progress
4.1			Ensure the website carries accurate, up to date information on our services as a Comprehensive Cancer Centre	Annual report to Audit Committee on publication scheme	31.3.25	DCEO	Publication scheme audit complete
4.2			Prepare for and secure reaccreditation with the OECI as a Comprehensive Cancer Centre	Achievement of reaccreditation	TBC	DCEO	Progressing to plan
4.3			Develop our network of international relationships through the OECI by participating in OECI working groups	Reporting of attendance / involvement in working groups	31.3.25	DCEO	Fully participating
4.4			Secure agreement on new governance arrangements for MCRC partnership with University of Manchester and CRUK	Agreement in place and reported to board	31.3.25	DCEO	On going discussions with UoM
4.5			Promote the reputation of The Christie internationally by supporting attendance and scholarly contributions at prestigious international professional and corporate events.	Reporting of attendance at international meetings	31.3.25	DCEO	Continues across the Trust
4.6		LCC 4	Continue to develop partnerships in Australia, Kenya and Uganda, and others as appropriate	Include in regular international programme reports to board of directors	31.3.25	DCEO	Progressing
4.7	2, 4		Implement year 1 milestones of the Patient and Public Involvement & Engagement plan	Annual report to the Quality Assurance Committee	31.3.25	DCEO	Progressing to plan
4.8		LCS 5	Reprocure joint venture partner for The Christie Pathology Partnership	Regular report to Board	31.12.24	DoS	Progressing to plan

5. To promote equality, diversity & sustainability through our system leadership for cancer care							
	BAF risk	Strategy Theme ref	Annual objective	Reporting	Timescale	Director	Progress
5.1	6 7		Provide direction and guidance as chair of GM cancer board and represent cancer at Trust Provider Collaborative	Reporting to Board of attendance /involvement	31.3.25	CEO	Regular reporting / involvement in place
5.2	6 7	LSC 2	Participate as part of senior leadership team of Greater Manchester Cancer	Reporting to Board of attendance/involvement	31.3.25	DoS	Progressing as planned
5.3	6 7	LSC 2	Fully implement the GM Cancer operating model	Regular reporting to Board	31.3.25	CEO	Model in place, Board chaired by CEO
5.4	6		Continue transfer of management and accountability of local outpatient oncology care (including systemic therapy) – contracts to be held by The Christie NHS FT	Regular reporting to Senior Management Committee and Board	31.3.25	COO	Progressing as planned
5.5	6	LSC 1	Develop and increase access to local systemic anti-cancer therapy in line with agreed plan	Regular reporting to Senior Management Committee and Board	31.3.25	COO	Progressing as planned
5.6	6		Increase local access to Christie led & hosted trials	Regular reporting to Senior Management Committee and Board	31.3.25	DoR	Progressing with limitations, report in January 2025
5.7	6 7	CE 3	Transfer haematology services from Leighton to The Christie	Regular reporting to Senior Management Committee and Board	31.3.25	COO	Case approved subject to funding
5.8	7	CE 3	Building on existing partnerships beyond Greater Manchester	Regular reporting to Senior Management Committee and Board	31.3.25	COO	Progressing to plan

6. To maintain excellent operational, quality and financial performance							
	BAF risk	Strategy Theme ref	Annual objective	Reporting	Timescale	Director	Progress
6.1	2 4		Implement 2024/25 (year three) milestones of our 2022/24 Quality Strategy including CODE & Quality Mark	Annual report to Board of Directors	6 monthly	ECN	Progressing to plan
6.2	2		Implement the 2024/25 milestones of our Patient Experience plan	6 monthly report to Quality Assurance Committee	6 monthly	ECN	Progressing to plan
6.3	2		Implement the 2024/25 milestones of the Trust Risk Management Strategy	Annual report to Board	31.3.25	ECN	Progressing to plan
6.4	1, 7, 10		Achieve the agreed operational activity plan for 2024/25	Monthly performance reports to Senior Management Committee and Board	Monthly	COO	On plan
6.5	7		Achieve relevant national targets set out in 2024/25 NHS planning guidance	Monthly performance reports to Senior Management Committee and Board	Monthly	COO	On plan
6.6	11		Implement 2024/25 (Year 2) milestones of the Digital Strategy	Six monthly reporting to Audit Committee	31.3.25	DCEO	
6.7			Achieve the Trust's 2024/25 revenue plan	Monthly financial performance reports to Senior Management Committee & Board	Monthly	EDoF	On plan
6.8		CE 1	Deliver the Trust's 2024/25 capital plan within the available allocated CDEL	Monthly financial performance reports to Senior Management Committee & Board	Monthly	EDoF	On plan
6.9			Achieve the agreed level of the value-improvement programme	Monthly financial performance reports to Senior Management Committee and Board	31.3.25	COO	On plan overall
6.10			Develop the Trust group structure to deliver the Trust strategy	Regular reports to Board	31.3.25	EDoF	Plans progressing
6.11		CE 1	Complete new ward accommodation (TIF scheme) and operationalise	Regular reporting to Senior Management Committee and Board	31.3.25	COO	Complete

7. To be an excellent place to work and attract the best staff							
	BAF risk	Strategy Theme ref	Annual objective	Reporting	Timescale	Director	Progress
7.1	3 12		Achieve year 2 milestones of The Christie People & Culture Plan 2023/26	Regular reporting to Workforce Assurance Committee	31.3.25	DoW	Progressing to plan
7.2	3 12		Development of refreshed Equality, Diversity and Inclusion (EDI) plan 2024-29	Regular reporting to Workforce Assurance Committee	31.3.25	DoW	Inclusive Culture plan for approval in November
7.3	3 12		Progress agreed actions from Culture Audit	Board and Workforce Assurance Committee reports	31.3.25	DCEO	In Inclusive Culture Plan

8. To play an active part in the local health care economy and community							
	BAF risk	Strategy Theme ref	Annual objective	Reporting	Timescale	Director	Progress
8.1	4, 5, 6,7		Demonstrate effective collaboration in the GM System through active participation in relevant fora	Regular reports to Board	31.3.25	DoS	In place
8.2	8		Achieve 2024/25 milestones for Trust Sustainability Plan (Green Plan)	Six monthly reports to Audit Committee	31.3.25	DCEO	Complete
8.3	14		Participate in Anchor institutions initiative	Six monthly reports to Board	31.3.25	DoS	Participating
8.4			Regularly engage local residents regarding the Trust's plans	Continued meetings of the Neighbourhood Forum reported through Senior Management Committee as part of capital reporting	31.3.25	EDoF	Progressing to plan

KEY:

BAF – Board assurance framework	DoS – Director of Strategy
(D)CEO – (Deputy) Chief Executive Officer	DoW – Director of Workforce
EDoF – Executive Director of Finance	ECN – Executive Chief Nurse
COO – Chief Operating Officer	

Strategy Themes;

LCC	Leading Cancer Care
CE	Christie Experience
LCS	Local & Specialist Care
BO	Best Outcomes

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Agenda item 37/24b

Meeting of the Board of Directors

Thursday 28th November 2024

Subject / Title	Inclusive Culture Strategy 2025-2030
Author(s)	David Smithson, Deputy Director of Workforce Rebecca Coles, Head of OD/ Engagement Novlette Balela, Equality, Diversity & Inclusion Manager
Presented by	Rebecca Coles, Head of OD / Engagement
Summary / purpose of paper	This paper: • Introduces the Trust's Inclusive Culture Strategy
Recommendation(s) (assure/alert/advise)	The Board of Directors are asked to: • Approve the Inclusive Culture Strategy 2025-2030
Background papers	N/A
Risk score / BAF reference	Risk 12 – Ineffective response to cultural audit
Link to: ➢ Trust strategy ➢ Corporate objectives	Executive objective: 5.To promote equality, diversity & sustainability through our system leadership for cancer care
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	EDI – Equality, Diversity & Inclusion CAG – Clinical Advisory Group

Agenda item 37/24b

Meeting of the Board of Directors
Thursday 28th November 2024

Inclusive Culture Strategy

1.0 Introduction

This paper introduces our first ever five-year Inclusive Culture Strategy. The strategy replaces our annual EDI plan. We are at a pivotal point in our inclusive culture journey. Our conversations and practices are shifting. We're actively moving from a more traditional 'compliance' approach to equality, towards an environment where we truly pay attention to all the factors that make up culture. We aim to create a culture where everyone feels valued, listened to and respected; and where we draw on the skills and lived experiences of all. We know that for people to thrive at work, they need to feel safe, feel they belong and feel included. We must therefore understand, encourage and celebrate diversity across our organisation and our patient groups.

2.0 Background

Our Inclusive Culture Strategy has been aligned to our Trust Strategy and other organisational and NHS strategies including the Christie People and Culture Plan, Our Values and Behaviour Framework the NHS People Promise and the NHS EDI Improvement Plan.

The Strategy Model is built on 4 themes: -

1. Purposeful and compassionate leadership
2. Harnessing connectivity and conversation
3. Improved experience and outcomes
4. Effective governance, policy, systems and data

We have drawn the threads of leadership, connection, conversation and relationships into how we deliver change in our equality, diversity and inclusion work. There is also a core focus on developing a sense of community, both internally across our teams and through paying attention to the broader communities that we serve.

To develop these themes, we have consulted with a wide range of stakeholders including: -

- Trust Board at a Board Development Day
- Senior Management Committee
- Clinical Advisory Group (CAG)
- Staff Side via Staff Forum

- Membership Forum (including patient representatives)
- EDI Steering Group
- Divisional Boards

3.0 Next Steps

Subject to Trust Board approval of the Strategy content, the document will undergo further branding to ensure it reflects a shift from our 'EDI brand' to a more culture focus. The fully branded version will be launched in January 2025. Work will commence shortly on the development of an EDI dashboard to monitor and measure impact of the strategy.

4.0 Recommendation

The Board of Directors are asked to approve the Inclusive Culture Strategy 2025-2030.

EQUALITY, DIVERSITY AND INCLUSION
at The Christie

NHS
The Christie
NHS Foundation Trust

Inclusive culture strategy 2025 - 2030

Draft version: 32 November 2024

Foreword

I'm incredibly proud to introduce our five year Inclusive Culture Strategy. An organisation is only as great as its people, and at The Christie we have some of the most talented, caring, and skilled people in the NHS.

We have a strong sense of who we are as an organisation and what we stand for. Our Values 'Make a Difference, Act with Kindness and Connect with People' bind us together and form the basis on which we recruit, develop and support individuals and teams.

We are at a pivotal point in our inclusive culture journey. Our conversations and practices are shifting. We're actively moving from a more traditional 'compliance' approach to equality, towards an environment where we truly pay attention to all the factors that make up culture.

The NHS People Promise articulates the value of a positive, compassionate and inclusive culture. To make this happen, it is critical that capable, compassionate and inclusive leaders are present to drive it forward. The relationship between leadership and culture is well known, and advocated by NHS England, the NHS Leadership Academy and the CQC.

We have therefore drawn the threads of leadership, connection, conversation and relationships into how we deliver change in our equality, diversity and inclusion work. There is also a core focus on developing a sense of community, both internally across our teams and through paying attention to the broader communities that we serve. We aim to create a culture where everyone feels valued, listened to and respected; and where we draw on the skills and lived experiences of all.

We know that for people to thrive at work, they need to feel safe, feel they belong and feel included. We must therefore understand, encourage and celebrate diversity across our organisation and our patient groups. More than this, we must also actively seek out and eliminate any discrimination. There is no room for discrimination of any kind at The Christie.

Although we have made progress in these areas, there remains more to do. Our strategy provides a clear commitment and ambition for the future against which we can measure our success. We hope you will feel as excited as we are about bringing this strategy to life.

Eve Lightfoot, Director of Workforce

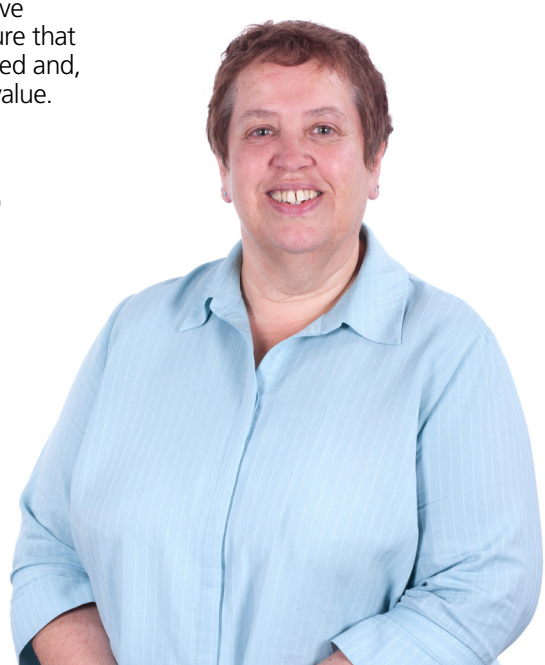
Much like The Christie embrace, inclusion aims to embrace all people regardless of gender, race, disability, religion or belief.

It is about the giving of equal access and opportunities and removing barriers, intolerance and discrimination from our workplace.

Inclusion is crucial to our society, and we must all work together to make inclusive and diverse spaces, including at The Christie. This does not mean you have to know everything, but understanding what inclusion means is a great starting place. Whether it is consideration of your colleagues' challenges during Ramadan, or exchanging duties to support a disabled colleague, inclusion means we work within a culture where a mix of people can come to work, feel comfortable and confident to be themselves and work in a way that suits them but also delivers the services we need to provide for our patients, who, of course, come from a wide variety of backgrounds.

By being an inclusive space, we can ensure that everyone feels valued and, importantly, adds value.

Gillian Hobson,
Staff Side Chair
(Partnership Officer)



Inclusive strategy model

What do we mean by Inclusive Culture? A positive and welcoming environment where harmony and collaboration is promoted amongst people of all backgrounds and experiences, and differences are respected and embraced.

Our model

- Compassionate and skilled individual leaders, effective at coaching and curious questions
- Collective leadership with a sense of community and accountability; focus on relationships, resilience and improvement.
- Ability to notice, challenge and unpack inequity and injustice and drive honest dialogue
- Create psychologically safe, engaged and inclusive teams committed to making a difference.
- Improved visibility and voice of diverse leaders

- Collaborative learning and joined-up thinking across teams.
- Effective staff networks
- Safe spaces for open dialogue and normalised conversations about protected characteristics, discrimination, power, privilege.
- Ability for all to challenge inequality through respectful, appropriate conversations
- Foster understanding of protected characteristics
- Engage colleague voices to impact meaningful change and generate a sense of belonging.
- Focus on patient voice and outreach activity

- **Colleagues –** improved experience and retention:
  - Celebrate our diversity
  - Remove inequality and address issues: attraction and recruitment, career progression and upskilling, bullying and harassment, board representation.
- **Patients –** improved experience of care:
  - Entry and access to service and treatment (incl. digital inclusion and structural barriers)
  - Health inequalities and social value activity.

Tell our stories to bring experiences to life.

- EHIAs for policy and process
- EDI Steering Group that influences improvement
- Clear local/divisional accountability mechanisms
- Focus on getting equality data and using it well to uncover issues and drive change
- Establish a continuous improvement mindset
- Reasonable adjustments normalised
- People policies which meet the needs of the people who use them

Our ambitions

1 Purposeful and compassionate leadership

We will develop leaders who are role models, who act purposefully and compassionately to embed equality, diversity, inclusion principles. Our leaders will create safe environments where everyone feels respected and valued, and they actively support a sense of belonging.

2 Harnessing connectivity and conversation

We will help to create conditions to bring people together across boundaries to generate real conversation and connection. We will promote respectful communication and positive relationships to ensure everyone feels psychologically safe and empowered to share concerns, opinions, and ideas.

3 Improving experience and outcomes

We will improve experience and outcomes for colleagues and patients and reduce inequalities for people with protected characteristics.

4 Effective governance, policy, systems and data

We will embed a strong system of Equality Diversity and Inclusion governance including accountability, authority, responsibility and reporting for compliance with the Equality Act 2010 and the Public Sector Equality Duty at individual, team, service and organisational levels.

Our ambitions are underpinned by 6 shaping culture themes

Diverse teams and cultural diversity

Bringing together team members from diverse backgrounds and cultures which drives innovative ideas and better team performance.

Creating safe spaces and sense of belonging

Creating safe spaces where diverse colleagues feel a sense of belonging and are valued and respected for their unique perspectives and contributions; where everyone can be their authentic selves.

Equal opportunity and bias training

Tackling hidden biases and making fair decisions, we create a fair environment for all.

Inclusive language and open dialogue

Using inclusive language and promoting open conversations are crucial parts of an inclusive work culture to make sure that everyone's perspectives are heard and appreciated. This results in improved decision-making and inspires innovative thinking.

Inclusion initiatives and leadership roles

Putting resources into inclusion efforts and supporting diverse leaders are key steps championed by the Board and senior leaders.

Colleague wellbeing and feedback

Actively listening to colleagues and addressing their unique needs, enhancing satisfaction and retention.

What we've achieved so far…

Purposeful and compassionate leadership

- Series of EDI events attended by our Board and Executive Sponsors
- Race awareness training for Investigation Officers and Executive leaders
- Positive action for BAME colleagues to access leadership training, building capability of diverse leaders at earlier career points
- Leaders who advocate our Respectful Resolution Framework, supporting psychologically safe conversations and reducing bullying, harassment and abuse in the workplace
- The Real World Leader behavioural assessment for incoming leaders to raise awareness of their purpose and impact
- Increased focus on compassionate leadership and listening in our education provision
- Introduction of Leading the Way category in our values and behaviours framework to make it clear what we support, value and foster.

Harnessing connectivity and conversation

- Celebrate diversity at key points annually, e.g. Black History Month, Ramadan, Neurodiversity Week, Armed Forces Week, Pride and International Women's Day
- Established and promoted 8 new EDI Staff Network Groups based on colleague feedback.
- EDI Champions in each division to support colleagues on EDI issues in the workplace
- Signed the Armed Forces Covenant and obtained the Defence Employer Recognition Bronze and Silver awards
- Formed a new EDI Steering Group, providing a voice for colleagues to challenge and promote EDI.
- Bring people together to build understanding of lived experience and provide support e.g. menopause café, Schwartz Rounds
- New opportunities for connection and listening at Trust induction and 6 months into employment.

Improving experience and outcomes

- Manager Recruitment and Selection training to minimise bias and ensure consistency of approach
- Improved range and access to colleague health and well-being services to manage a range of physical and mental health conditions
- Comprehensive induction and onboarding programme for all colleagues, including international recruits, in line with our NHS EDI Improvement Plan High Impact Actions 2 and 5.
- Launched our Patient Experience Engagement Strategy which includes our commitment in implementing the Accessible Information Standard.
- Physical spaces to meet diverse needs and practical requirements, e.g. room for expressing milk, prayer space, shabbat kitchen
- Community engagement and widening participation work with local job centre, housing association, schools and other groups in Greater Manchester to provide training and improve employability.
- New ways of delivering services to meet the diverse needs of patients, create tailored experiences and improve clinical outcomes, e.g. use of Card Medic app to communicate across language barriers, skin tone assessment training guide, and a multi-disciplinary outpatient facility for older patients.

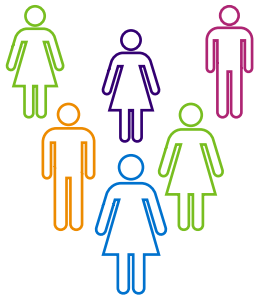
Effective governance, policy, systems and data

- Introduced a robust process for Equality and Health Inequality Analysis (EHIA) in 2023, which informs our decision making and service delivery.
- Achieved the Radius Stage 1 Employee Network Leadership Graduate Programme which provides a recognition of our commitment and support for our EDI Staff Network Groups.
- Introduced EDI Divisional Implementation Plans and EDI Coordinator model, supported by Divisional Boards
- Continue to make improvements in our contractual requirements for NHS England and the government
- New Patient Registration Form and Protected Characteristics Board to improve our patient data capture.
- More joined-up ways of working across the Trust on staff data and policy, exploring opportunities to innovate.

1. Purposeful and compassionate leadership

Our ambition

We will develop leaders who are role models, who act purposefully and compassionately to embed equality, diversity and inclusion principles.
Our leaders will create a safe environment where everyone feels respected and valued, and they actively support a sense of belonging.



We will achieve this by:

- Working across boundaries (GM/nationally) to draw on innovation, programmes and opportunities that advance our compassionate leadership practice.
- Leadership communities of practice and networks to improve culture with collective accountability. Focus on effective team working and psychological safety.
- Introducing a leadership and management competency framework, and activity to develop leaders in line with this.
- A leadership culture of curiosity, collaboration, self-awareness and reflection, where leaders are skilled and ready to have conversations about diversity and inequity. Creating spaces and learning opportunities for this to emerge and become habitual.
- Ensuring that our leaders have EDI objectives included in their performance and annual appraisals processes as evidenced in the NHS EDI Improvement Plan High Impact Action 1.
- Embedding the EDI Divisional Implementation Framework through local leadership, improving practice for colleagues and patients.
- Demonstrating our commitment to review Board and senior management diversity appointments from Band 8a upwards and set targets in line with the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).
- A mentoring and sponsorship programme for Black, Asian and Minority Ethnic (BAME) colleagues, supported by senior leaders.
- Demonstrating our commitment to anti racism by achieving the Bronze and Silver level of the GM Anti Racist Framework.

We will measure success by evidencing:

- Engagement with leadership learning activities and evidence that this is improving how leaders role model and create psychological safety in teams.
- Colleague stories (positive and constructive) are captured and shared, providing real insight into the lived experience of our workforce from multiple perspectives. Indication that this is continually improving.
- HR metrics and case work indicate ongoing improvement in retention and engagement.
- The number of leaders involved in mentoring and sponsorship programmes for BAME colleagues annually.
- Our WRES and WDES data provides evidence of improvement in the diversity of our workforce
- Regular assessment and assurance that all parts of the Trust are actively engaged in the EDI Divisional Implementation Framework and are using it to deliver change.
- Successfully completion of the Bronze and Silver level of the GM Anti Racist Framework
- EDI objectives are an ongoing part of Board level appraisal and assessment criteria. Leaders and Executive Sponsors regularly engage in EDI activities.

2. Harnessing connectivity and conversation

Our ambition

We will help to create conditions to bring people together across boundaries to generate real conversation and connection.
We will promote respectful communication and positive relationships to ensure everyone feels psychologically safe and empowered to share concerns, opinions, and ideas.

We will achieve this by:

- Organising a series of different events and learning activities to raise awareness of EDI issues, barriers and opportunities, creating safe spaces for open dialogue, listening and conversations.
- Focusing on building skillsets, relationships and environments where colleagues are comfortable to bring their best selves to work, and feel equipped and empowered to tackle discrimination, promote inclusion and reduce inequalities.
- Taking a positive and proactive approach in supporting the health, safety and wellbeing of our colleagues and volunteers
- Developing a Patient and Carer Engagement Group that supports co production of our activities around policy and service development programmes or projects.
- Committing to working collaboratively with our strategic partners and stakeholders from the voluntary and community sectors to increase awareness of the barriers in accessing our services.
- Valuing and celebrating diversity in all its forms, promoting how diversity strengthens our ability to work together and achieve more successful outcomes for colleagues and patients.

We will measure success by evidencing:

- Monitoring level of engagement, conversation themes and impact from colleague events.
- Iterative review of how our culture 'feels' via different research methodologies, using this insight to shift focus accordingly
- Triangulating data from HR metrics, staff survey, freedom to speak up and other indicators to give assurance that this activity is cumulatively having a positive impact on retention and engagement.
- Colleagues feel supported and confident to raise bullying, harassment and abuse concerns which are dealt with in a timely manner as referenced in the NHS EDI Improvement Plan High Impact Action 6.
- An annual review of the EDI Staff Network Groups to assess impact and engagement.
- The Patient and Carer Engagement Group feel that they influence decision-making processes and are helping to address health inequalities in access to our services

3. Improving experience and outcomes

Our ambition

We will improve experience and outcomes for colleagues and patients and reduce inequalities for people with protected characteristics.

We will achieve this by:

- Reviewing our recruitment and selection processes and set targets to improve representation in senior leadership roles from Band 8c upwards, in line with the NHS EDI Improvement Plan High Impact Action 2.
- Increase the range and quality of practical EDI learning for managers, e.g. disability awareness and reasonable adjustment training.
- Achieving Level 3 Disability Confident Leaders Accreditation
- Analysing and reporting on patient equality monitoring data to inform understanding of health inequality for under-represented groups
- Taking a positive and proactive approach in supporting the health, safety and wellbeing of our patients and colleagues, ensuring that our work has a positive impact in addressing health inequalities in our services and relationship with communities.
- Building partnerships with the voluntary sector and communities to increase awareness and understanding the barriers and cultural needs of patients in delivering services and reduce the impact of health inequalities
- Collaborative approach to improving patient experiences, working across boundaries to assess technology and digital solutions that support implementation of the Accessible Information Standard. This includes training colleagues to support patient needs.

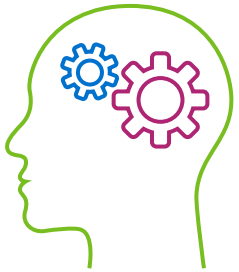
We will measure success by evidencing:

- Regular analysis of equality data and feedback from surveys and conversations (colleagues and patients), with evidence of incremental improvements.
- Improved diversity of job applicants, appointment and retention rates, monitored through our WRES and WDES data.
- Active partnerships with the voluntary and community sectors to reduce health inequality in delivering our services.
- The Accessible Information Standard actions are implemented, and patients have a positive experience of accessing services.
- Ongoing improvements in the quality and quantity of protected characteristic data captured from our patients; with associated improvements to service delivery and patient experience.
- Our Patient Experience Engagement Plan continues to meet the needs of our patients in consultation with the Patient and Carer Engagement Group, monitored via annual review.
- Patient stories (positive and constructive) are captured and shared, providing real insight into the lived experience of our service from multiple perspectives.

4. Effective governance, policy, systems and data

Our ambition

We will embed a strong system of Equality Diversity and Inclusion governance including accountability, authority, responsibility and reporting for compliance with the Equality Act 2010 and the Public Sector Equality Duty at individual, team, service and organisational levels.



We will achieve this by:

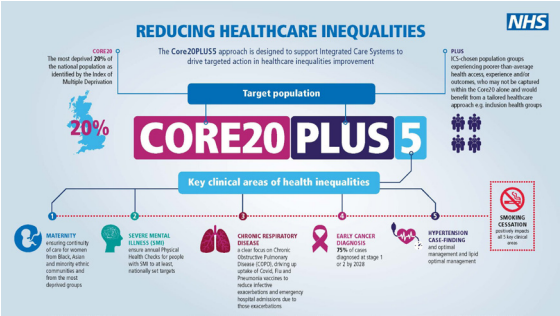
- Embedding and expanding the Equality and Health Inequality Analysis process to better understand the potential impacts of the decisions we make on colleagues, patients and services, by protected characteristics and social inclusion groups.
- Committing to achieve the Greater Manchester Anti Racist Framework bronze and silver accreditation.
- Ensuring that our Board and Committee reports include EDI considerations to ensure that are transparent and robust.
- Integrating the EDI Divisional Implementation Framework into divisional business planning processes.
- Developing management systems that aligns with the strategy, vision and purpose of the organisation at board level and throughout all divisional structures and functions.
- Developing an EDI dashboard to monitor and measure impact of the strategy.

We will measure success by evidencing:

- Organisational decision-making and continuous improvement informed by listening to the lived experience and voice of our EDI Staff Network Groups, and our EHIA process.
- Improvement of metrics within all our plans aligned to legislative and regulatory requirements.
- Improved compliance rates of equality data for colleagues, volunteers and patients, enabling a better understanding of any barriers or issues. Evidence that effective action is taken based on this insight.
- Equality conversations and decisions routinely happening in board and committee meetings via minutes and reports.
- Assurance that the EHIA process remains effective through an annual audit.

Reducing health inequalities

Health inequalities are described as unfair and avoidable differences in health between different groups in society and their access to health care services. They arise because of the conditions in which we are born, grow, live, work and age which can influence how we think, feel and act and can impact both our physical and mental health and wellbeing.



- Addressing health inequalities is a key part of the NHS Long Term Plan. Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population, the 'Core20PLUS', and identifies '5' focus clinical areas including cancer diagnosis as one of the areas that requiring accelerated improvement.
- The National Healthcare Inequalities Improvement Programme has developed a Core20PLUS Ambassador Programme with a third cohort being recruited for 2024/25. Our ambassadors selected on the programme will be supported to enhance their knowledge, skills and insights to tackle healthcare inequalities and form local, regional and national networks with others who seek to improve healthcare inequalities.
- This approach is incorporated within our strategic themes of 'Local and specialist care', 'The Christie experience', 'Best outcomes' and 'Leading cancer care'.
- The Christie has a long-standing approach of promoting geographical equity of access to our services. We deliberately focus our cancer care improvements in more deprived parts of Greater Manchester and Cheshire, and in populations with particular needs.
- Our radiotherapy networked services were placed in Oldham and Salford specifically to meet the needs of the more deprived and ethnically diverse communities in the north of the conurbation and the new cancer centre in Macclesfield is located to address the needs of a population of older people.
- Our chemotherapy network has equally been developed to address the needs of communities across Greater Manchester and Cheshire, focussing on increasing access in underserved areas such as Wigan.
- We have worked with and through the Cancer Alliance (and its previous manifestations) to support improvements in cancer care across our communities including improvements in prevention and screening services and initiatives with local authorities to address the wider determinants of health.

The Christie has a long-standing approach of promoting geographical equity of access to our services.

What we've achieved so far…

We will adhere to our duties set out in legislation, regulation and accreditation schemes.

Legislation

- The Equality Act 2010
- The Public Sector Equality Duty (PSED)
- Human Rights Act 1998
- Gender Pay Gap
- Ethnicity Pay Gap (voluntary)
- Disability pay gap (voluntary)

NHS regulation

- Equality Delivery System 2022 (EDS)
- Workforce Race Equality Standard (WRES)
- Workforce Disability Equality Standard (WDES)
- Accessible Information Standard (AIS)
- Sexual Orientation Monitoring Information Standard (SOMIS)

Accreditation schemes

- Armed Forces Covenant
- Defence Employer Recognition Scheme
- Disability Confident Employer Scheme

Governance and leadership

We will embed a strong system of Equality Diversity and Inclusion governance including accountability, authority, and responsibility for compliance with the Equality Act 2010 and the Public Sector Equality Duty at individual, team, service and organisational levels.

Governance structures

Organisational

- **Workforce Assurance Committee**
- **Senior Management Committee**
- **Patient Experience Committee**

Divisional

- **Divisional Boards**
- **Divisional Triumvirates**
- **EDI Coordinators and Champions**

EDI steering group

- **EDI Staff Network Groups**
- **EDI Staff Networks**
  - Women
  - Ability and Wellbeing
  - Parents and Carers
  - Armed Forces Covenant
  - Faith and Belief
  - Neurodiversity
  - Rainbow (formerly LGBTQ+)
  - Ethnic Diversity

Executive leadership functions

- **Director of Workforce**
  Inclusive culture for staff
- **Chief Nurse and Executive Director of Quality**
  Inclusive culture for patients
- **Executive Medical Director**
  Health data and outcomes
- **Director of Strategy**
  Health inequalities

Relationship to other strategies

To implement our Inclusive Culture Strategy, we must align our thinking and connect our strategy ambitions. Our Inclusive Culture Strategy has been aligned to other organisational and NHS strategies.

***we'll ensure activity remains aligned to any subsequent plans**

The Christie People and Culture plan

Our People and Culture plan sets out our focus areas to improve how we attract, recruit, develop, retain, support and reward our people and teams.

Our Values and Behaviours

Our Values and Behaviours shape the way we work.

NHS People Promise

This is a promise we must all make to each other – to work together to improve the experience of working in the NHS for everyone.

Our Trust Strategy 2023-2028

This focuses on the four themes of our vision: leading cancer care, The Christie experience, local and specialist care, and best outcomes.

NHS EDI Improvement Plan

Published by NHS England in June 2023 it sets out actions to address the prejudice and discrimination that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce.

The Christie
NHS Foundation Trust

Agenda Item 38/24a

Meeting of the Board of Directors

Thursday 28th November 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 of Directors 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.
Updates to note in month	• 2024/25 MIAA Audit outcomes added where relevant • Updates to assurance level added where relevant • No changes have been made to any risk score or mitigations since the October meeting • As discussed in Audit Committee (October 24), an over-arching risk is being written relating to supply chain. This will be included in the next report once agreed. • Operational risks scoring 15 & above are detailed in the report
Recommendation(s) (assure / **alert** / advise)	The Board of Directors 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. • Note the operational risks scoring 15 and above
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 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	16	16			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	16	16			8	16
RISK 2	**Learning from patient safety incidents**	If we are unable to fully implement the new Patient Safety Incident Response Framework (PSIRF) there is a risk that we will miss opportunities to learn lessons and improve patient safety leading to preventable patient harm.	Quality Assurance Committee	15	6	15			1	15
RISK 7	**Ineffective Greater Manchester system-wide cancer pathways**	If diagnostic, MDT and referral processes at local hospitals across the GM system are not efficient there is a risk that we receive patients on 62-day pathways late leading to them not being treated within 62 days.	Quality Assurance Committee	25	16	12			5	12
RISK 11	**Cyber attack**	If we or our suppliers 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	12	12			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	12	12			4	12
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	Board of Directors	25	20	10			2	10
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	16	9			5	9
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	9	9			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	9	9			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	9	9			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	9	9			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	8	8			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	8	8			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	Quality Assurance Committee	10	8	8			4	8

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 Nov-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	Exec Medical Director
		Responsible Committee	**Quality Assurance Committee**
		Assurance Level	Medium
		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	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	3	3	9	3	3	9			0			0	2	2	4

RISK 2	Learning from patient safety incidents	Date Risk Opened	Current Risk Score
Description	**If we are unable to fully implement the new Patient Safety Incident Response Framework (PSIRF) there is a risk that we will miss opportunities to learn lessons and improve patient safety leading to preventable patient harm.**	Apr-24 Date of Last Review Nov-24	15
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	Exec Chief Nurse
		Responsible Committee	**Quality 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	The Trust has invested in external training for the patient safety strategy with 2 cohorts in November and January respectively covering all components of the patient safety strategy. The patient safety team are hosting training for incident handlers to ensure management of incidents across teams is standardised. Improvement workstreams have been established to implement recommendations following the publication of learning responses. Review through Patient Safety & Experience Committee and Risk & Quality Governance. Introduction of new DATIX system	New ways of working require new skills across the organisation and resource at a team level to manage incidents.	Level 1 – Data and management reports • PSIRF reports to Patient Safety Committee / Risk & Quality Governance / Senior Management Committee • ERG□ 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 - incident 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	5	15	2	3	6	3	5	15			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 Nov-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	Workforce Director
		Responsible Committee	**Workforce Assurance Committee**
		Assurance Level	High
		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	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 - Divisional Recruitment Nov 24 - limited assurance	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	3	3	9	3	3	9			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 Nov-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**	4	3	**12**	4	3	**12**			**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 Nov-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**	4	4	**16**	4	4	**16**			**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 Nov-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** Medium 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**	3	3	**9**	3	3	**9**			**0**			**0**	3	2	**6**

RISK 7	Ineffective Greater Manchester system-wide cancer pathways	Date Risk Opened	Current Risk Score
Description	**If diagnostic, MDT and referral processes at local hospitals across the GM system are not efficient there is a risk that we receive patients on 62-day pathways late leading to them not being treated within 62 days.**	Apr-24 Date of Last Review Nov-24	**12**
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 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	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	4	4	16	4	3	12			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 Nov-24	**8**
Associated Corporate Objectives	To maintain excellent operational, quality and financial performance.	Executive Lead Responsible Committee Assurance Level Risk Appetite	Deputy Chief Executive **Audit Committee** 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	4	2	8	4	2	8			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 Nov-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	Chief Operating Officer **Workforce 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	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) Pay awards agreed at national level for junior doctors August 2024	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	4	4	16	3	3	9			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 Nov-24	**10**
Associated Corporate Objectives	To maintain excellent operational, quality and financial performance.	Executive Lead	Exec Director of Finance
		Responsible Committee	**Board of Directors**
		Assurance Level	High
		Risk Appetite	Averse

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
	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 October planning session with senior leaders focused on VIP delivery for 24/25 & 25/26.	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	5	4	20	2	5	10			0			0	2	1	2

RISK 11	Cyber attack	Date Risk Opened	Current Risk Score
Description	**If we or our suppliers 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 Nov-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	Medium
		Risk Appetite	Averse

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
	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 Data Protection Toolkit assessment (DPST) - Substantial assurance July 2024	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	3	4	12	3	4	12			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 Nov-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

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
	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. Regular reporting to Board. Inclusive Culture work taking forward actions and approach for the Trust.	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 • Board development session on Inclusive Culture facilitated by NHS Providers expert Sept 2024□ 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	2	4	8	2	4	8			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 Nov-24	**8**
Associated Corporate Objectives	To be an excellent place to work and attract the best staff	Executive Lead	Exec Medical Director
		Responsible Committee	**Quality Assurance Committee**
		Assurance Level	
		Risk Appetite	Cautious

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
	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**	4	2	**8**	4	2	**8**			**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 Nov-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	High
		Risk Appetite	Averse

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
	Engagement in national updates and regulatory briefings. Designated leads for statutory requirements across the Trust reporting into committee structure. Membership of NHS Providers. Exec Team engagement in national briefings. Close working with regulators, GM ICS / ICB and NHSE. Exit criteria clear from NHSE around move back to SOF 1.	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 • MIAA role specific training audit (CQC Reg 19) - Limited assurance Oct 24□	None identified	Take MIAA checklists / advisory notes to appropriate assurance committees Agreed exit criteria from SOF 2 to SOF 1 agreed and being monitored for compliance to specified timeframes.	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**	4	4	**16**	4	4	**16**			**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 Nov-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

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
	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**	3	3	**9**	3	3	**9**							1	2	**2**

Summary of Operational Risks (15+) November 2024

Description	Score	Controls	Responsible Committee
2024/25 Capital Envelope (CDEL) Restrictions	**16**	Manage capital priorities 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 hadn't accepted this proposal.	Board of Directors
Not identifying and delivering 2025/26 recurrent VIP programme impacting on financial sustainability and ability to treat patients	**16**	• Divisions to increase level of recurrent VIP schemes identified in order to achieve Trust VIP target • Workshops for staff – ideas generation • Promotion of staff do you have an idea process for ownership. • Clinician sessions – understanding value. • Seek ideas from other sites. (site visits and GM CIP) • Incorporate PWC recommendations into planning	Divisional Boards
Risk of delayed patient treatment due to extended turnaround times in histopathology results	**16**	• Substantive Consultant posts to be worked up and costed then any required funding to be taken to CPP Board in a growth case once the capacity and demand work has been undertaken • Scope the possibility of support from the CPOC Charity for a Consultant Histopathologist post to audit the effectiveness of the GI specialist and appendiceal work and make recommendations for the future workforce requirements	Christie Pathology Partnership Board
Financial and operational risk to The Christie in relation to transfer of Mid-Cheshire Foundation Trust Clinical Haematology in 2025	**16**	• 1 x locum recruited but has since withdrawn for another job. Further locum interview planned for November • Working with Cheshire & Mersey ICB regarding funding gap	Senior Management Committee
There is a risk to the Trust's ability to demonstrate compliance and adherence to its regulatory and statutory requirements	**15**	• Patient Safety team contacting individual handlers to support closure of incidents. Starting with oldest reported. • Improvement in number of overdue incidents	Risk & Quality Governance Committee
There is a risk that patients awaiting stem cell treatments may experience delays	**16**	Advertisement and recruitment for Band 7 and Band 6 WTE ongoing. Previous appointed applicant for Band 7 declined.	Christie Pathology Partnership Board

Description	Score	Controls	Responsible Committee
Risk of inadequate evacuation planning and response leading to patient and staff safety hazards, reputational damage, and financial penalty.	**15**	Following a review of the plans and feedback provided to the Estates & Facilities and Health & Safety teams, a decision has been made to establish a task and finish group to expedite the process and ensure that the relevant key indicators, as required by NHSE and best practices, are included.	EPRR Board / Senior Management Committee
Risk to Treatment Delivery due to Workforce Recruitment & Retention in Aseptics	**15**	Recruitment continuing. Still at 45% vacancy. Progress being made but currently remains risk until staff in post and trained.	CSSS Divisional Board / TCP Board

The Christie
NHS Foundation Trust

Agenda Item 38/24b

Meeting of the Board of Directors

Thursday 28th November 2024

Subject / Title	Audit Committee report – November 2024
Author(s)	Assistant Company Secretary Committee Chair
Presented by	Committee Chair
Summary / purpose of paper	This paper provides the board with a summary of the items considered by the Audit Committee at their October meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions
Background papers	Audit Committee papers – October 2024
Risk score	Board Assurance Framework (BAF) references noted within the report
EDI impact / considerations	Ensure governance arrangements provide assurance and appropriate oversight of EDI requirements for the organisation
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.	EPRR emergency preparedness, resilience & response NED non-executive director KPI key performance indicator EDI equality diversity inclusion SFI standing financial instructions GT Grant Thornton

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Agenda item 38/24b

Meeting of the Board of Directors

Thursday 28th November 2024

Audit Committee report – October 2024

1 Introduction

The Audit Committee took place on 17th October 2024. The meeting was quorate. The following summary gives the Board information on the items that were considered by the committee at their meeting under the headings of Assure / Alert / Advise.

2 Audit Committee agenda items

The items listed in Appendix 1 of the report were all presented to the Audit Committee in October 2024. Following discussion, the items are presented to Board for information and action where appropriate.

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

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

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

3 Recommendation

The Board are asked to note the summary report from the Audit Committee in October 2024.

The Christie NHS Foundation Trust

Appendix 1

Agenda item	BAF ref	CQC regulation reference	Assurance rating given	Key points and associated actions (where applicable)
Assure				
35/24a	8	N/A	Medium	**Deep Dive – BAF risk number 8: (i) Emergency Preparedness, Resilience, and Response (EPRR) Committee annual report and (ii) EPRR Assurance Process Statement of Compliance** • EPRR core standards have changed each year for the last 3 years in response to major incidents (Arena bombing and the Covid-19 pandemic), they would not ordinarily change. • The Trust's 2023-24 self-assessment indicated 76% compliance, but after NHSE's 'check and challenge' process, this was downgraded to 1% due to inadequate evidence for several standards. A significant amount of the drop in score related to the policies and procedures and not the Trust's operational capability. • Full time dedicated EPRR lead now in place. Self re-assessment completed following work completed and re-assessed externally as 61% compliant (overall rating of non-compliant). • Important to focus on the level of risk to the Trust, which has not changed, this is about understanding and evidencing the self-assessment. Dynamic EPRR risk assessment now in place to monitor and provide a better structure. • Medium assurance was agreed based solely on the significant progress made towards the completion of the required work to meet the required EPRR standards, whilst recognising the further work required. **No actions**
35/24b	8, 14	N/A	Medium / High	**Sustainability annual report** • NED department visit prior to the committee meeting; good discussion in relation to some of the areas of sustainability work undertaken within the Trust demonstrating how the sustainability strategy impacts on all areas of the Trust. • Mandatory report completed in accordance with the NHS Standard Contract Service Conditions 2024/25, providing a summary of the progress on delivery of the Trust's Green Plan, report has been through the relevant governance process. • Now working to new a Green Plan, finance needs to be addressed as to how the Trust will fund Net Zero. Staffing resource will be challenging in terms of people and finance to be able to deliver the Green Plan, heavily reliant on

Agenda item	BAF ref	CQC regulation reference	Assurance rating given	Key points and associated actions (where applicable)
				funding. • Due to the Trust winning their bid for the low carbon skills fund, this now positions the Trust for future funding. 700 bids across the UK across and the whole of the public sector were submitted, The Christie were the only one that won. We are seen as a leading organisation and sharing our knowledge with others as to how the bid was won. • High assurance agreed based on the progress being made in delivery of the work plan and medium assurance agreed in terms of the context of achieving overall decarbonisation and in recognition of the external factors and challenges. **No actions**
35/24c	10, 14	N/A	High	**The Christie Pharmacy Company six monthly report** • Sharp increase in prescription turnaround times since May (increase in staffing level from April) and September saw 93% of target achieved. When the new inpatient pharmacy replacement robot project starts, there will be an impact to some extent to prescription turnaround times but not expecting to be majorly affected. Also looking at extended opening hours to accommodate if required. Delivery plan for the new inpatient pharmacy replacement robot project is in progress, the risk will be agreed as part of this project planning. • Number of risks reduced from 5 down to 3, target risk score aimed to be achieved for the business continuity plan actions, the risk in relation to medicines shortage is an external issue. • Highlights on the risk mitigations in place requested for future reports and whether in certain circumstances consideration needs to be given to agreeing to tolerate a level of risk above target where it is demonstrated all appropriate action is being taken. Current risk to shortages of stock to the Trust is based on the ability to store medications, this will become a separate risk register entry to be able to escalate as necessary. Can add risks that are then dependent on this risk such as certain medications that may present a higher risk than the overall risk. It was agreed that it was important to disaggregate risks where an individual component was high risk. **Action:** Further detail on risk mitigations in place to be incorporated into future six monthly reports to the committee.
35/24d	10, 14	N/A	High	**Executive Director of Finance Report** • A snapshot of KPIs included in the Trust report provided; arranging for procurement training to be provided to Board members and from there can identify what KPIs Board members would like to see.

Agenda item	BAF ref	CQC regulation reference	Assurance rating given	Key points and associated actions (where applicable)
				• Annual report and accounts finalised and published, Annual Members' Meeting held in September. Now working on this year's accounts. • No ex-gratia payments in reporting period, some historic debts written off based on the legal costs which would be involved in trying to recover salary overpayments. Finance Team are working with the Research and Development team to reduce the R&I aged debtors. New processes are being considered and will be implemented to assist with the debt collection process. There are historic invoices which are being reviewed and may need to be written off. These will be reported in future report updates. **Action:** • Coverage of how Directors insurance is accounted for to be included as part of next year's report.
36/24e	8, 14	15	High	**CQC Regulation 15 Premises and equipment compliance report** • 2000 audits are undertaken each month to comply with national cleaning standards on a risk-based approach. Work in close liaison with the Infection Prevention and Control team. • 130 deep cleans are also completed per month, operating on a 24/7 basis. • Cleaning charter displayed in all relevant areas and training programme in place for staff. • Security is provided through an in-house team 24/7, 365 days a week. Low level of incidents. Regular and irregular patrols in place as well as CCTV. • Estates maintenance system in place for management of tasks. • Comply with EDI assessments wherever possible. • Robust policies in place which are compliant with Healthcare Technical Memorandums. • Compliant with Trust SFIs when obtaining quotes and strive for value for money. • Committee members agreed a fully comprehensive report and high assurance provided. **No actions**
Alert				
36/24a	N/A	N/A	N/A	**Board Assurance Framework** • Based on committee discussion, request for operational review of supply chain risk identified. • Consideration to be given to EPRR risk being escalated to the BAF and incorporating the current risk relating to

Agenda item	BAF ref	CQC regulation reference	Assurance rating given	Key points and associated actions (where applicable)
				weather or for EPPR to be reviewed and description to be broadened. **Action:** • Operational review of supplier chain risk to be requested. • EPRR risk to be reviewed and description broadened.
43/24	N/A	N/A	N/A	**External audit contract renewal** • External audit contracts are normally awarded on a 3 year plus 1 + 1 year basis. • Last time the Trust went out to tender only Grant Thornton tendered. Still need to go out to tender but have the option to extend for the second year with GT this was proposed to committee members with going out to tender next year. **Committee approved, to take up to 2025/26 accounts.**
Advise				
No items to report.				

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

- There was 1 patient safety incident investigation triggered in October, details of which can be found on slide 5. There were 6 incidents in total reported in October which require a learning response, 1 was reported with the classification of severe harm, 3 reported as moderate harm, and 2 were reported as low / no harm. Details of each incident can be found on slide 6. All the incidents are still progressing through to full root cause analysis. One never event was reported in month, details of which can be found on slide 5.
- There are 8 Trust level risks scored at 15+. Details of these can be found on slides 11&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 7 cases of C-Difficile, 5 cases of E-Coli, 2 cases of Klebsiella, 1 case of MSSA and 2 cases of Pseudomonas reported in October that were deemed attributable to the Trust. No lapses in care were identified.

Performance

- In October the new combined 62-day performance subject to validation was at 80.8% which is above the new standard of 70%. The new combined 31-day performance was 98.5% which is above the new standard of 96%. The internal 24-day performance was below standard at 76.9%. 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 98.0%. The Trust achieved the 75% faster diagnosis standard in October with a compliance score of 81.3%.
- There were no patients waiting over 52 weeks at the end of October.
- Referral numbers in October rose from the September position and cumulatively remain high in comparison to the 23/24 average.

HR

- Staff absence rose slightly from September to a position of 5.07% against a target of 3.4%.
- PDR performance reduced slightly from September's position. Mandatory training maintained the same position as September and remains well above the set standard.

Finance

- The Trust is reporting a surplus at the end of M7 of (£4.5m) against a M7 YTD plan of (£4.1m), which gives a month 7 variance of (£0.4m) better than plan.
- Capital performance to month 7 was (£1.3m) below the revised plan submitted to NHSE&I in June 24. The Trust has spent 85% year to date of the capital plan.
- Capital spend to month 7 was £1.3m below the revised plan submitted to NHSE&I in June 24. This is lower than the plan position due to timing in the anticipated completion of the first linear accelerator.
- The Trust has incurred £7.7m on capital schemes to month 7, primarily on the TIF ward refurbishment as well as ongoing digital projects and small replacement assets. The Trust has spent 85% year to date of the capital plan.

SUMMARY DASHBOARD

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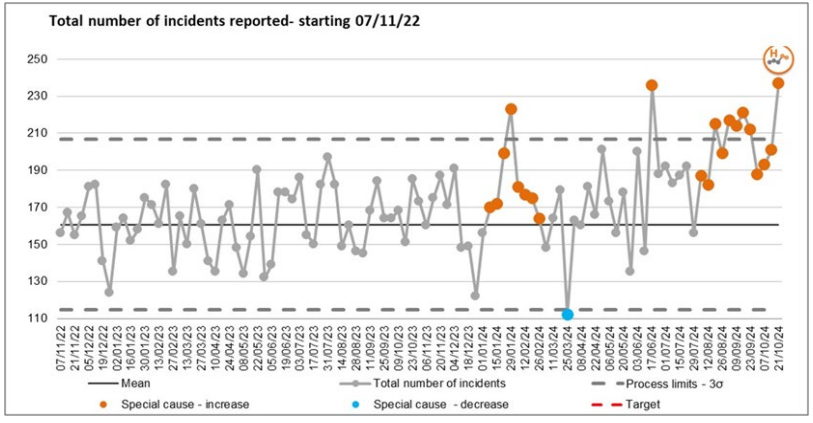
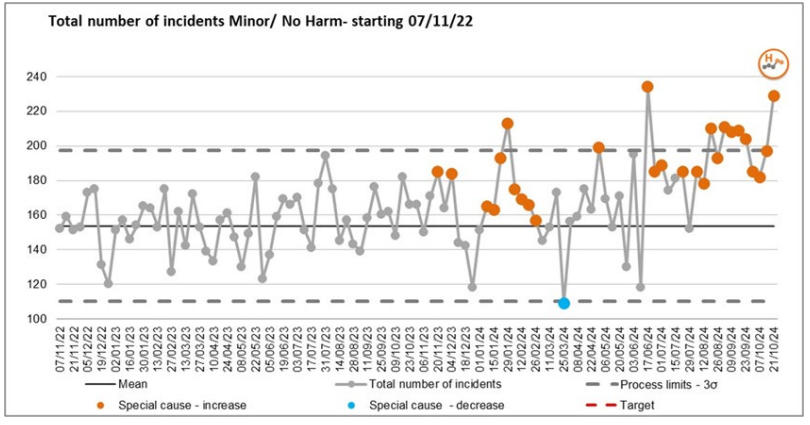
Indicator	Threshold / Standard 24/25	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	YTD
Patient Safety Incident Investigations	-	1	2	1	0	0	3	1	8
Never Events	0	0	0	0	0	0	1	0	1
Radiation Incidents Reported (IRMER Reportable)	0	1	3	1	3	1	2	2	13
Radiation Incidents Reported (IRMER Reportable - Grade 2 or above)	0	0	0	0	0	0	0	0	0
Number of Pressure Ulcers (Post admission - Grade 2 or above) - Rate per 1000 occupied bed days	0.5	0.8	0.0	0.6	0.2	0.0	0.2	0.6	0.3
Inpatient Falls Resulting in Harm (Grade 2 or above) - Rate per 1000 occupied bed days	3.8	4.7	3.6	3.0	2.9	4.5	3.5	2.3	3.8
Sepsis - timely treatment with IV antibiotics (established inpatients)	90%	90.0%	87.0%	96.4%	94.4%	92.4%	91.4%	93.0%	-
Sepsis - screening (presenting as an emergency)	90%	94.9%	100.0%	100.0%	97.5%	96.9%	98.1%	97.4%	-
Number of Trust-Wide Risks Grade 15 or Above	-	6	6	9	13	8	8	8	-
28 Day Faster Diagnosis Standard	75%	81.3%	75.0%	100.0%	91.7%	86.4%	90.0%	81.3%	-
62 Day Compliance	70%	71.2%	72.1%	72.4%	76.7%	79.7%	75.0%	80.8%	-
24 Day Compliance	85%	71.5%	72.2%	74.6%	78.2%	78.5%	72.8%	76.9%	-
31 Day Compliance	96%	99.2%	99.6%	99.2%	99.1%	99.3%	98.6%	98.5%	-
18 Weeks Compliance - Incomplete Pathways	92%	98.4%	98.7%	98.1%	98.0%	97.9%	97.9%	98.0%	-
Patients waiting >52 Weeks	0	0	0	0	0	0	0	0	0
Patients waiting >62 days at end of month (62 Day Classic)	80	129	119	100	95	93	101	108	-
Patients waiting >104 days at end of month (All 62 Day Targets)	-	47	51	42	49	49	42	43	-
Length Of Stay (Elective & Non-Elective Inpatients)	-	7.81	6.39	6.39	7.16	6.54	6.76	7.29	-
Patients Discharged Beyond Ready for Discharge Date	-	14	2	7	18	13	6	14	74
Patients Discharged Beyond Ready for Discharge Date - Total Bed Days Lost (days counted in the month of discharge)	-	213	15	90	296	97	33	108	852
Patients Discharged Beyond Ready for Discharge Date - Average Bed Days Lost (days counted in the month of discharge)	-	15.2	7.5	12.9	16.4	7.5	5.5	7.7	-
Hospital Cancelled Operations on the day for non clinical reasons	0	3	2	0	0	2	2	13	22
Hospital Cancelled Operations on the day for non clinical reasons - NOT rebooked within 28 days	0	0	0	0	0	0	0	0	0
Complaints Received	12 (23/24 Avg)	12	14	8	21	10	17	15	97
PALS Contacts	35 (23/24 Avg)	32	67	39	37	44	29	42	290
MRSA	0	0	2	0	0	0	0	0	2
C-Difficile - All Attributable Cases (Pre & Post 48 Hours)	<52	2	3	4	6	5	4	7	31
C-Difficile - Attributable Cases Due To Lapse In Care	0	0	0	0	0	0	0	0	0
MSSA Bacteraemia - Attributable	No Target	1	2	3	1	0	2	1	10
E-Coli - Attributable	<57	6	4	4	1	3	4	5	27
Klebsiella Species - Attributable	<25	1	2	2	1	2	5	2	15
Pseudomonas Aeuriginosa - Attributable	<8	2	0	0	1	1	2	2	8
Staff Sickness	3.4%	4.57%	4.39%	4.47%	4.80%	4.49%	4.65%	5.07%	-
Staff Mandatory Training	>80%** <80%	92.7%	92.7%	93.2%	93.7%	93.8%	93.7%	93.7%	-
Staff PDRs	-	84.6%	85.7%	85.3%	86.6%	88.0%	87.2%	87.1%	-

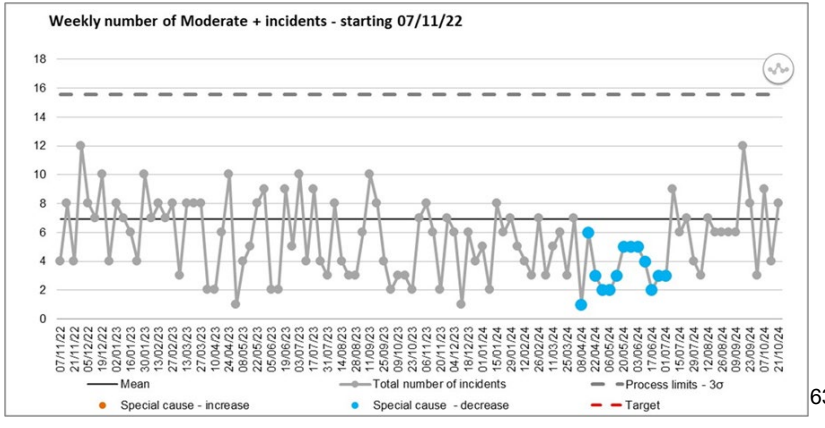
***Compliance if <80% & risk assessment in place*

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

Incident Reporting



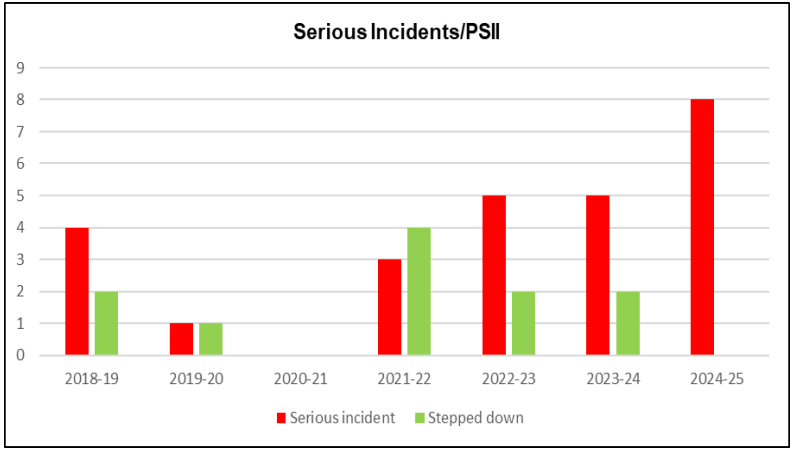




Special cause decrease can be noted for reported weekly moderate incidents (post triage) , this reflects the change in incident grading in the new Datix system from March 2024 .'Near miss' incidents can now be submitted (graded as no harm) which previously were submitted as moderate in severity.

63

Serious Incidents and Never Events



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

No Never Events were identified in October 2024:

Patient Safety Incident Investigations (PSII's) triggered
There was one PSII triggered in October 2024

5900 – Patient was prescribed Filgrastim as part of chemotherapy regime on iQEMO but this was not provided to patient upon discharge. Patient was neutropenic on review and has subsequently been admitted to another hospital with sepsis.

Incidents identified that require a Learning Response

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October 2024 – RCA/learning response to be presented to ERG		
Reference	**Description**	**Reported Harm Level**
4424	Missed diagnosis CT performed 19/08- this was first identifiable from 2021 but not reported on our scan reports now causing chest wall invasion, rib invasion and pathological fracture of the ninth posterolateral rib	Severe Harm
3080/3151	2 incidents of C-diff PCR and toxin positive stool taken (hospital onset, hospital acquired)	No harm/Low Harm
3003	Staff member scratched her right inner wrist (did not bleed) on a cannula needle that she used in a failed attempt to cannulate a patient known to have HIV.	Low Harm
5441	Patient given venetoclax and azacitidine - patient's bloods showed white cell count at 73 go ahead was given when protocol states that WBC should be <25.	Moderate Harm
5489	5 day chemo regime was missed given chemo over a weekend.	Moderate Harm
5949	Emergency Sepsis pathway antibiotic breach by 7hrs 18mins due to delay in initial recognition and clinical decision to commence IVAB antibiotic cover	Moderate Harm

Learning – Patient Safety Incidents

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Agreed learning and revised severity outcome following executive reviews October 2024

Ref	Description	Learning	Outcome
2955	A patient, who consented to a trial in February 2024 and underwent screening blood tests, was accepted into the trial. Three months later, in June 2024, the research team was informed by a doctor that the patient had tested positive for Hepatitis B, a result that had not been previously reported to the Research Team.	• MFT and Christie SOP to align with each other to ensure both highlight what results are deemed as significant that need escalating. MFT SOP to include back-up person to notify if team are unobtainable. • CWP not flagging positive Hep B result as abnormal result. • Virology forms not being fully completed with teams' details in order that MFT have required information to escalate result with Christie. • ICNet platform not identified positive result	Moderate Harm
2121	The patient had regular CT scans every 3-4 months, all of which showed no evidence of metastatic disease. However, during a clinic visit on 23/05/24, the patient was admitted for pain management. An urgent CT scan revealed significant progressive nodal disease that had been present but unreported in the scans from April and January 2024.	• All reporting errors to be recorded on Datix. • Recorded errors to be monitored by radiology governance and annual error rate report to be produced. • To be discussed at REALM • Highlighting to referrers the important of updating clinical history if changed since scan was requested	Moderate Harm
3416	A patient attended for treatment, reporting dizziness and headaches. After contacting the Hotline, she was advised to keep her appointment. A SACT nurse requested a medical review, suspecting vestibular neuritis, and patient was directed to her pre-scheduled GP appointment that same day. Later that evening, patient attended Bolton ED, experienced a seizure, and subsequently passed away. (RIP)	• Locate/purchase Otoscope equipment to keep on ORTC. • Ensure that all new fellows have access to Alertive on mobile/desktop devices and understand when/how to use. • Produce induction document for ORTC fellows. • Induction to be reviewed. • Establish ownership of Alertive	Clinical Event-Known Complication

Learning – Patient Safety Incidents

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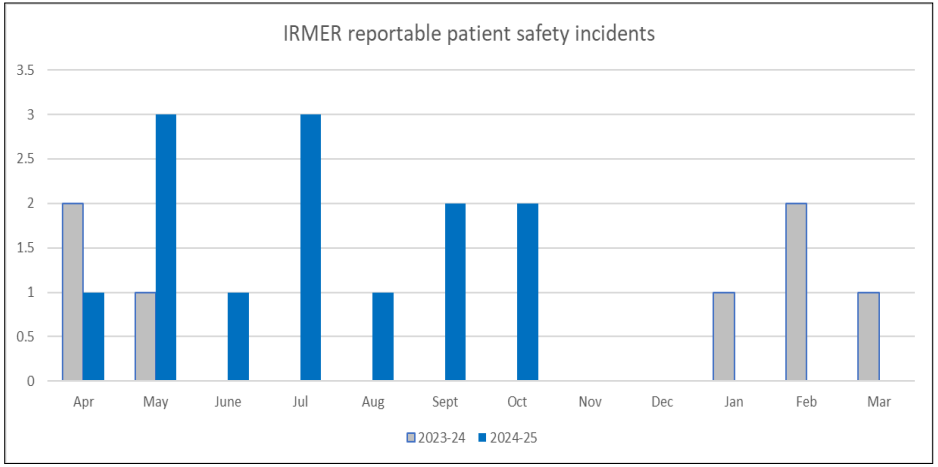
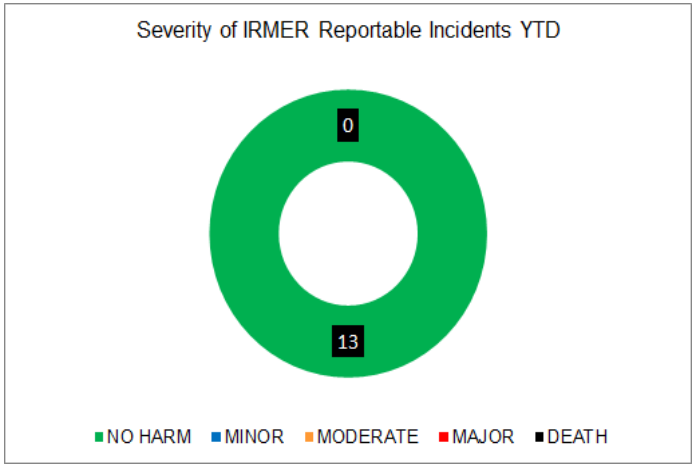
Agreed learning and revised severity outcome following executive reviews October 2024

Ref	Description	Learning	Outcome
1874/2 129	The Trust had 2 cases of MRSA BSI in May 24' both believed to be associated to line infections	• Responsibilities and acknowledgement of laboratory results including out of hours • To Review MRSA Policy to be in line with national guidance • IPC assurances – escalate to IPCC	Low Harm
4021	A cluster of incidents involved the transcription of prescriptions onto new drug charts, allowing medications to be administered without a prescriber's signature. In total, 12 incidents were reported: 7 instances involved registered nurses transcribing and administering medications without a medical signature, while 5 instances involved transcriptions counter-signed by the medical team	• Reinforce Medicines Practice Operational Policy (MPOP) and who is permitted to prescribe medicines on drug chart. • Trust wide audit on same day of incident to ascertain if Trust wide opportunity for learning. • Escalated to Ward Managers, Lead Nurses and Senior IP Clinical Educator for immediate sharing and communication via email/huddle/verbally ensuring SIEPS model and promoting psychological safety. • Read and Sign Document Implemented by Senior Clinical Educator reinforcing the above NMC Code of Professional standards of practice and behaviour. • Reflective discussions with nursing teams fostering SIEPS model to promote psychological safety culture. • Clinical Supervision/PNA/Coaching support provided, and support services signposted as required. • Professional accountability scenario added to Medications Management Day. • Q&S Lead Nurse and NMP Lead disseminated communications of vigilance in prescribing and transcribing. • Prescribing/transcribing of medicines poster (circulated. • Trust wide audit of Prevalence of transcribing inpatient drug charts – supported by QICA team and snap tool	No Harm

Radiation Incidents





There were two IrMER reportable incidents reported in Oct 2024:

5617 – no harm
5781 – no harm

Harm Free Care

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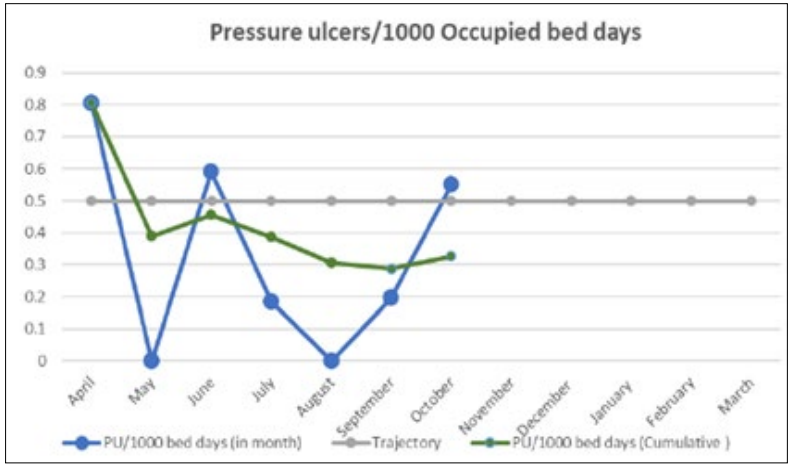
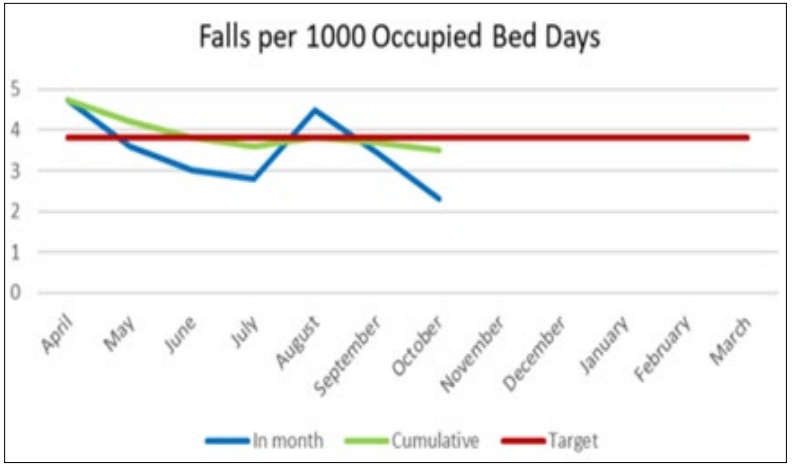
Pressure ulcers per 1000 occupied bed days



The ambition for 2024/25 is to maintain previous good performance of less than 0.5/1000bed occupied days a month. 0.55 reported in October – although overall remains at 0.32 overall year to date.

1 category 2 pressure ulcer was identified in October
2 deep tissue injuries were identified in October

Falls per 1000 occupied bed days



13 IP Falls in October, below mean of 20.

2.3 falls per 1000 OBD, within ambition of less than 3.8 (national mean 6.63)

3 low harm falls, no moderate + falls

77 % Falls no harm

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

Operational Risks

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There are 8 Trust-wide 15+ risks in October

Description	Score	Controls
24/25 Capital Envelope Restrictions	**16**	Manage capital priorities 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 hadn't accepted this proposal.
Not Identifying and Delivering 25/26 Recurrent VIP programme impacting on financial sustainability and ability to treat patients **NEW RISK**	**16**	• Divisions to increase level of recurrent VIP schemes identified in order to achieve Trust VIP target • Workshops for staff – ideas generation • Promotion of staff do you have an idea process for ownership. • Clinician sessions – understanding value. • Seek ideas from other sites. (site visits and GM CIP) • Incorporate PWC recommendations into planning
Risk of delayed patient treatment due to extended TAT in histopathology results	**16**	• Substantive Consultant posts to be worked up and costed then any required funding to be taken to CPP Board in a growth case once the capacity and demand work has been undertaken • Scope the possibility of support from the CPOC Charity for a Consultant Histopathologist post to audit the effectiveness of the GI specialist and appendiceal work and make recommendations for the future workforce requirements
Financial and Operational Risk to The Christie in relation to Transfer of Mid-Cheshire Foundation Trust Clinical Haem in 2025	**16**	• 1 x locum recruited but has since withdrawn for another job. Further locum interview planned for Nov.

Operational Risks

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There are 8 Trust-wide 15+ risks in October		
Description	**Score**	**Controls**
There is a risk to the Trust's ability to demonstrate compliance and adherence to its regulatory and statutory requirements	**15**	• Patient Safety team contacting individual handlers to support closure of incidents. Starting with oldest reported. • Improvement in number of overdue incidents
There is a risk that patients awaiting stem cell treatments may experience delays	**16**	Advertisement and recruitment for Band 7 and Band 6 WTE ongoing. Previous appointed applicant for Band 7 declined.
Risk of inadequate evacuation planning and response leading to patient and staff safety hazards, reputational damage, and financial penalty.	**15**	Following a review of the plans and feedback provided to the Estates & Facilities and Health & Safety teams, a decision has been made to establish a task and finish group to expedite the process and ensure that the relevant key indicators, as required by NHSE and best practices, are included.
Risk to Treatment Delivery due to Workforce Recruitment & Retention in Aseptics	**15**	Recruitment continuing. Still at 45% vacancy. Progress being made but currently remains risk until staff in post and trained.

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	16885	13788	5348	5.2
	Total monthly ACTUAL	15125	12935		
	Average Fill Rate %	89.6%	93.8%		
Care Staff	Total monthly PLANNED	10308	6452	5348	2.5
	Total monthly ACTUAL	7710	5523		
	Average Fill Rate %	74.8%	85.6%		
ALL Staff	Total monthly PLANNED	27193	20240	5348	7.7
	Total monthly ACTUAL	22835	18458		
	Average Fill Rate %	84.0%	91.2%		

Registered Nurses	DAY			NIGHT			Cumulative count over the month of patients at 23:59 each day	CHPPD (Care Hours Per Patient Per Day)
	Hours Planned	Hours Actual	% Fill Rate	Hours Planned	Hours Actual	% Fill Rate		
Critical Care Unit	2285	2056	90.0%	2225	1863	83.7%	186	21.1
Palatine Ward	3216	2878	89.5%	2545	2290	90.0%	910	5.7
Ward 10	2285	1770	77.5%	1512	1490	98.5%	827	3.9
Ward 11	1931	1737	90.0%	1615	1573	97.4%	823	4.0
Ward 12	1891	1736	91.8%	1592	1581	99.3%	735	4.5
Ward 4	1783	1752	98.3%	1453	1435	98.8%	826	3.9
Ward 2	1188	1215	102.3%	984	977	99.3%	483	4.5
Acute Assessment Unit	2306	1981	85.9%	1862	1726	92.7%	558	6.6
TOTAL	16885	15125	89.6%	13788	12935	93.8%	5348	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		11				
Ward 4						
Ward 2						
Acute Assessment Unit						

Care Staff	DAY			NIGHT			Cumulative count over the month of patients at 23:59 each day	CHPPD (Care Hours Per Patient Per Day)
	Hours Planned	Hours Actual	% Fill Rate	Hours Planned	Hours Actual	% Fill Rate		
Critical Care Unit	672	73	10.9%	11	23	209.1%	186	0.5
Palatine Ward	1217	1062	87.3%	949	821	86.5%	910	2.1
Ward 10	1854	1246	67.2%	890	743	83.5%	827	2.4
Ward 11	1568	1215	77.5%	1131	990	87.5%	823	2.7
Ward 12	1248	1308	104.8%	1103	1000	90.7%	735	3.1
Ward 4	1748	1302	74.5%	1253	1058	84.4%	826	2.9
Ward 2	746	513	68.8%	356	314	88.2%	483	1.7
Acute Assessment Unit	1255	991	79.0%	759	574	75.6%	558	2.8
TOTAL	10308	7710	74.8%	6452	5523	85.6%	5348	2.5

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**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

NHS
The Christie
NHS Foundation Trust

Positive feedback received…..

"Patient daughter attended with her father to acute ambulatory care and wants to give thanks to all the staff for the treatment and support, care received was superb, she is grateful to The Christie staff throughout the hospital who are professional, patient and dedicated and kind. Staff also went the extra mile to ensure she was ok despite her not being the patient."

"Family member wished to say that the nursing staff on AAU and ward 10 have been exceptional and just completely faultless."

"Thank you all for the wonderful, caring and professional treatment I received under your care. I cannot thank you enough for looking after me so kindly."

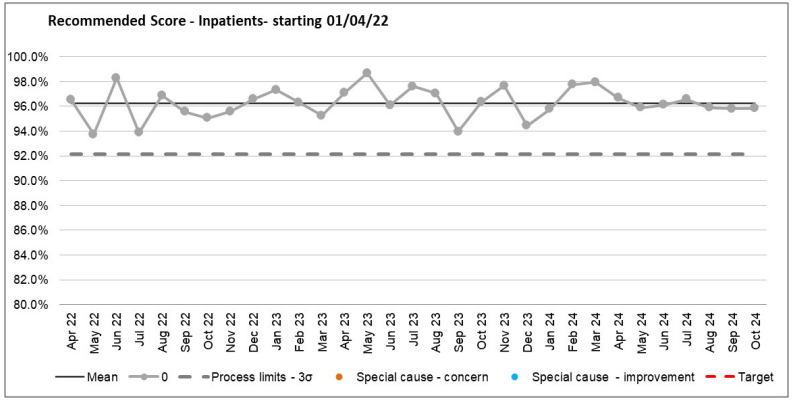
"I just wanted to pass on my thanks and appreciation to everyone involved. All of the staff went over and above what they had to do. The nursing staff on the Treatment Unit stayed well beyond the end of their shift. And the staff on Ward 12 took me on when they were already pulled out on a busy ward with very ill patients."

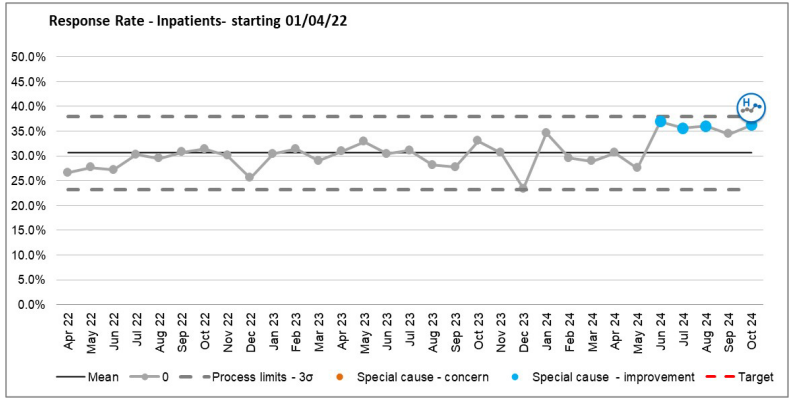
"I want to express my gratitude for the speed that I was admitted to your hospital. The care and compassion I have received from all disciplines of staff has been second to none. The cleanliness of my room and en-suite are of a high standard and the food has always been hot and tasty. People are always quick to complain about our NHS but I have nothing but praise. Please pass on my gratitude to all those concerned."

Friends & Family Test

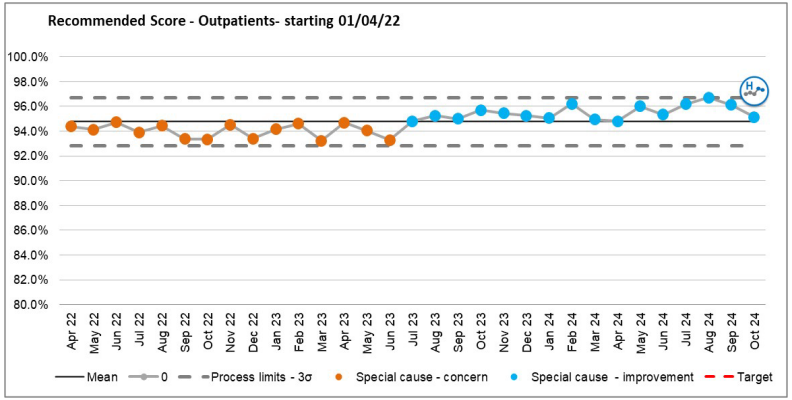
The Christie NHS Foundation Trust

Monthly Summary

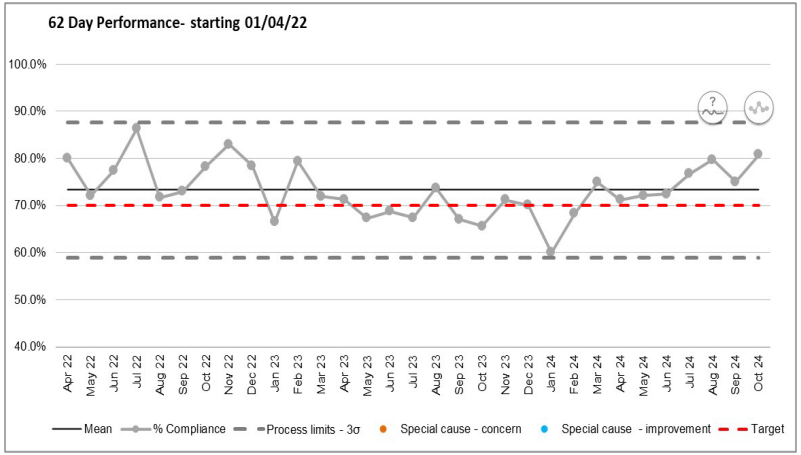


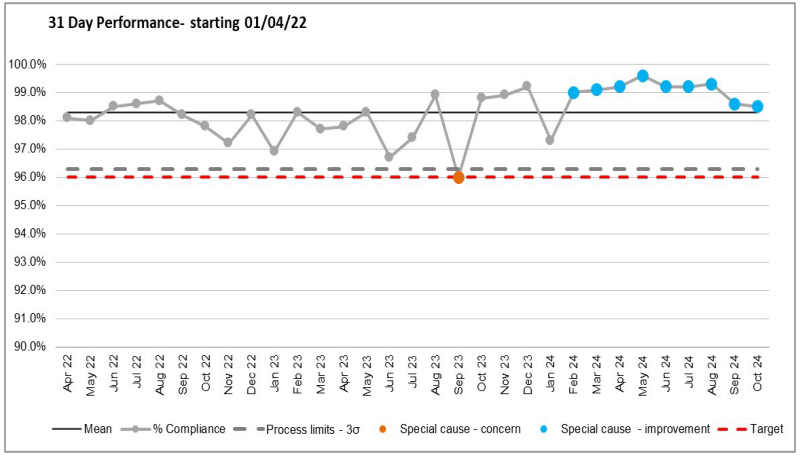


The Inpatient response rate continues to show improvement in recent months. Both the recommended percentage scores for Outpatients and Inpatients remain high with Outpatients maintaining a sustained period of high performance.



Cancer Standards





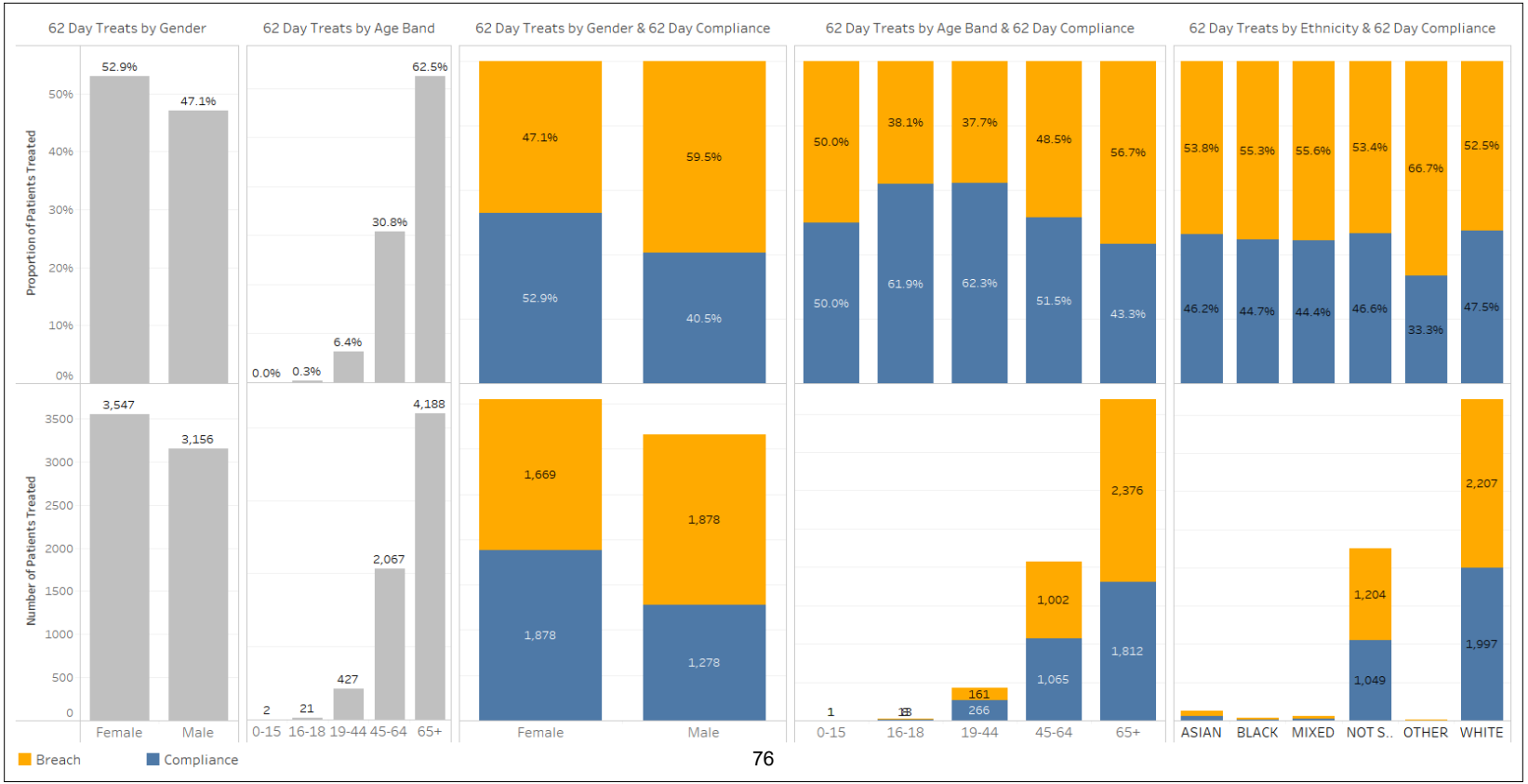
National Standard	Standard	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
62 Day	70%	65.6%	71.2%	70.1%	60.0%	68.3%	74.9%	71.2%	72.1%	72.4%	76.7%	79.7%	75.0%	**80.8%**
28 Day FDS	75%	85.0%	66.7%	81.8%	52.9%	60.0%	55.0%	81.3%	75.0%	100.0%	91.7%	86.4%	90.0%	**81.3%**
24 Day Internal	85%	68.3%	69.6%	73.2%	63.7%	71.7%	76.4%	71.5%	72.2%	74.6%	78.2%	78.5%	72.8%	**76.9%**
31 Days	96%	98.8%	98.9%	99.2%	97.3%	99.0%	99.1%	99.2%	99.6%	99.2%	99.2%	99.3%	98.6%	**98.5%**
18 Weeks - Incomplete	92%	97.7%	97.2%	97.2%	97.3%	98.0%	98.0%	98.4%	98.7%	98.1%	98.0%	97.9%	97.9%	**98.0%**

As of October 2023, all 62-day standards are merged into one 62-day standard and all 31-day standard types are merged into 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 01/04/2023 – 31/10/2024 analysed by gender, age and ethnicity.

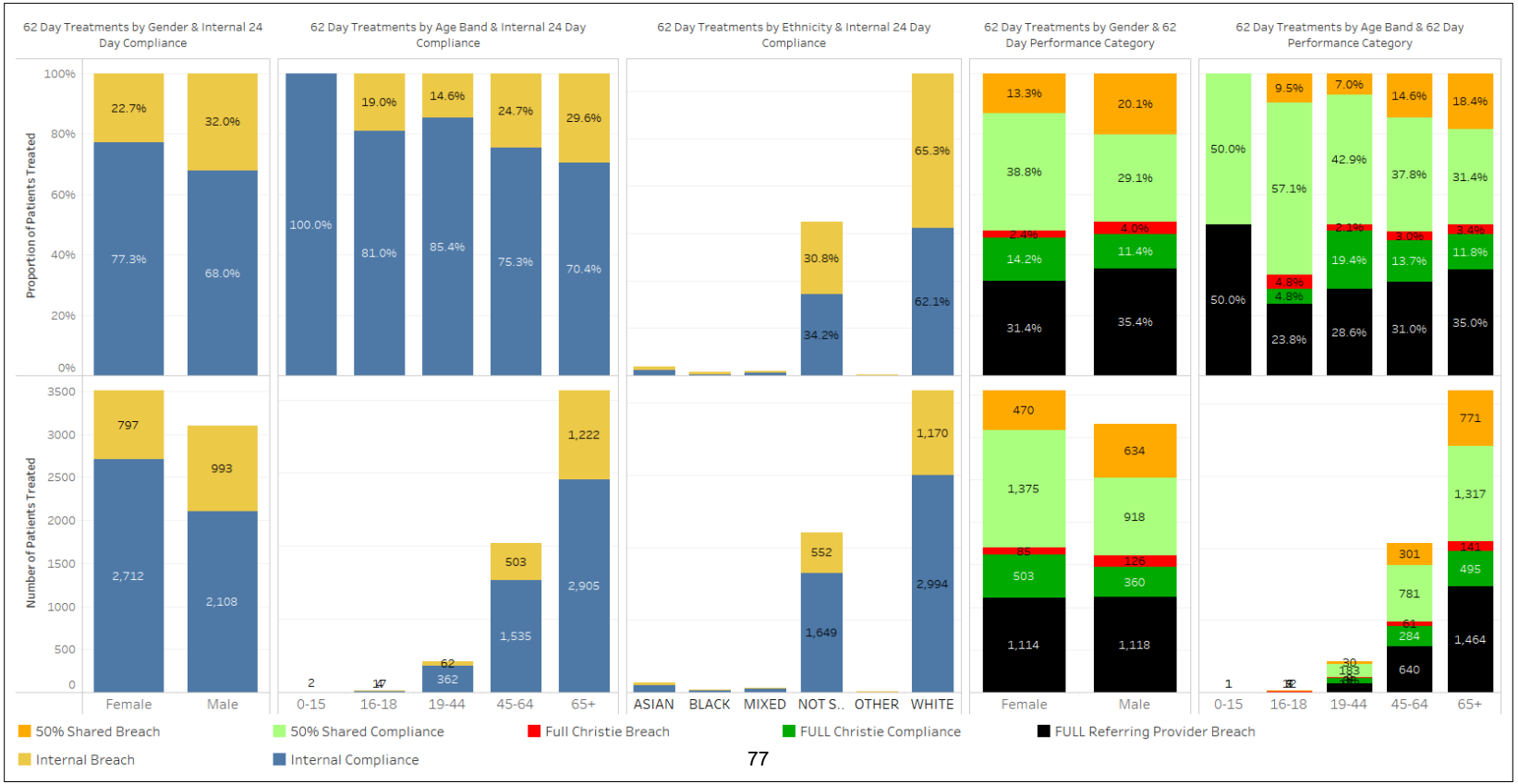
The Christie NHS Foundation Trust



Cancer Standards – Health Inequalities Analysis

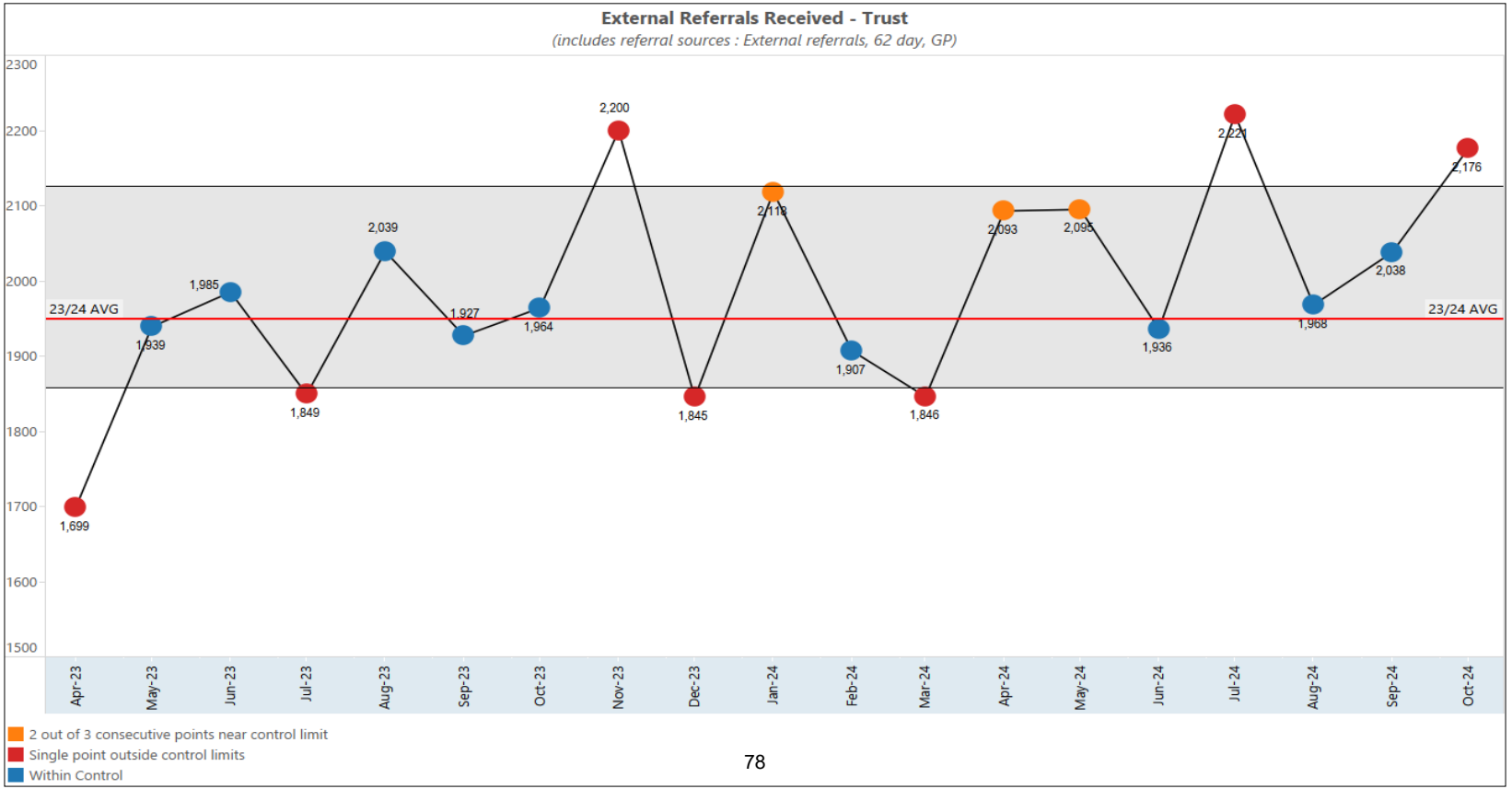
62 Day Treatments between 01/04/2023 – 31/10/2024 analysed by gender, age and ethnicity.

NHS
The Christie
NHS Foundation Trust

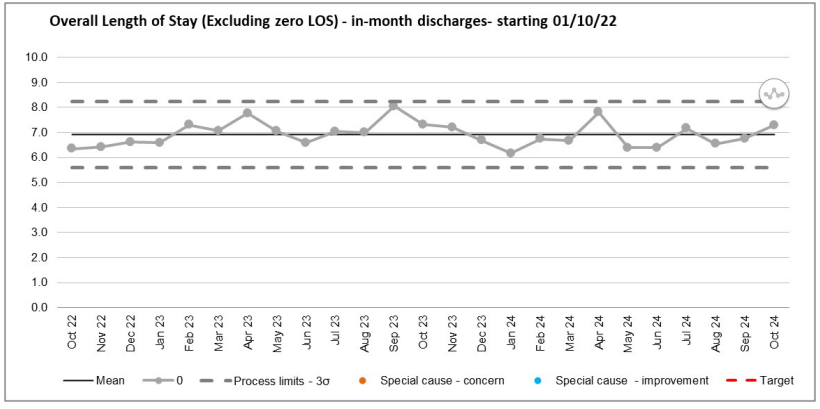


Referrals Analysis

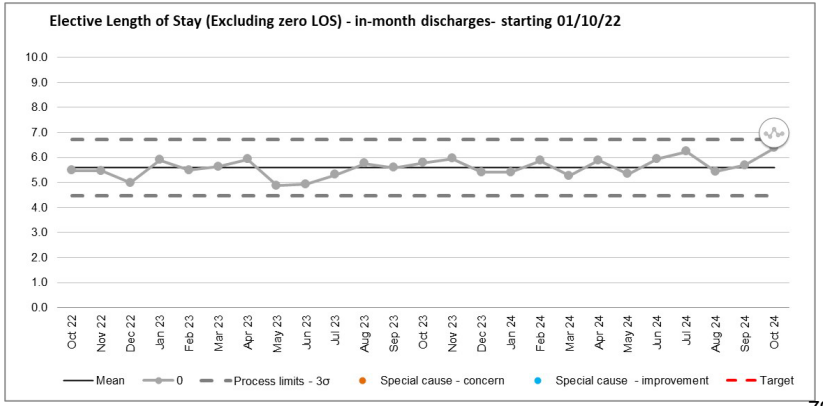
The Christie NHS Foundation Trust

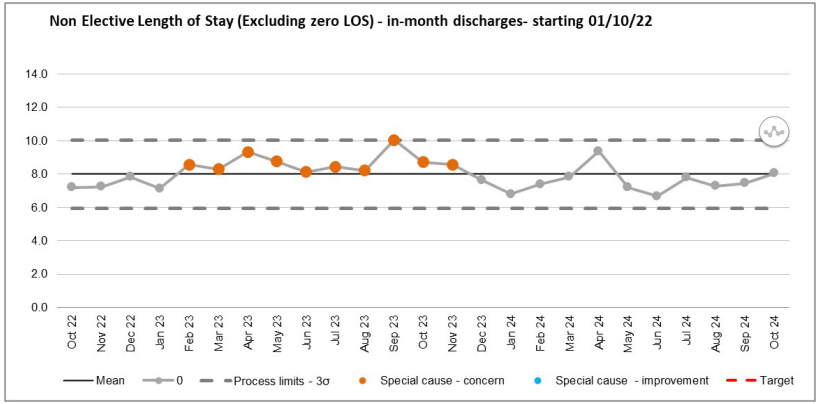


Length of Stay



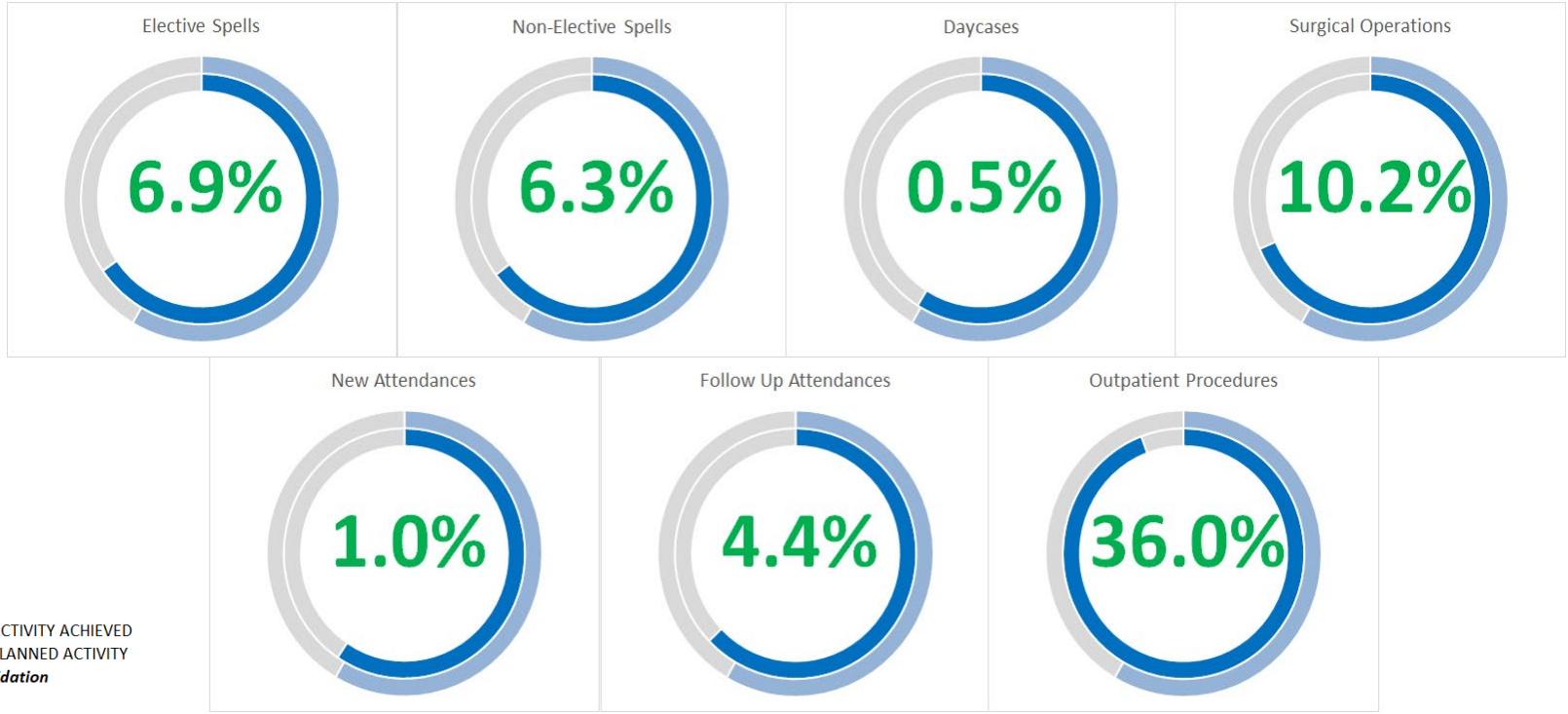
Overall length of stay, elective and non-elective spells continue to be well within control limits.



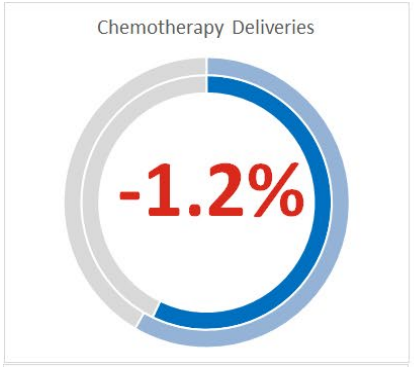


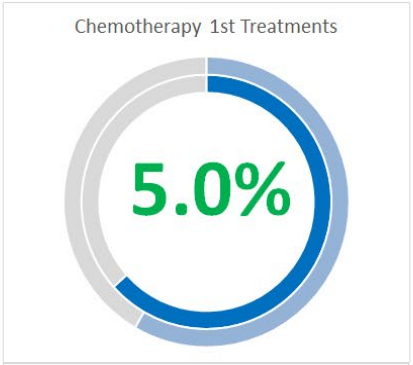
Activity – YTD Progress

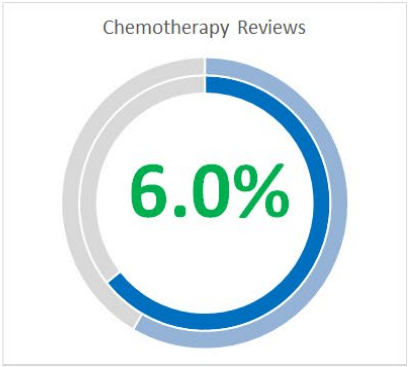
Trust level activity - progress against YTD plan

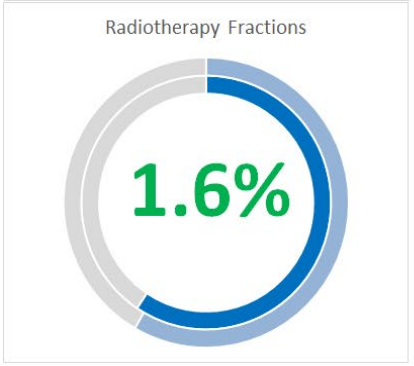


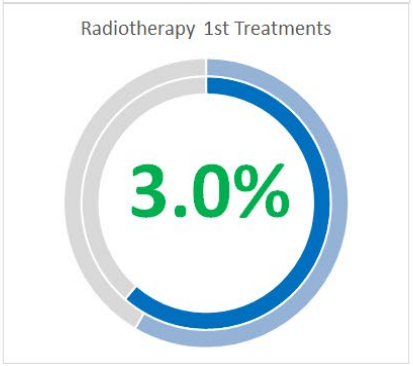
Activity – YTD Progress

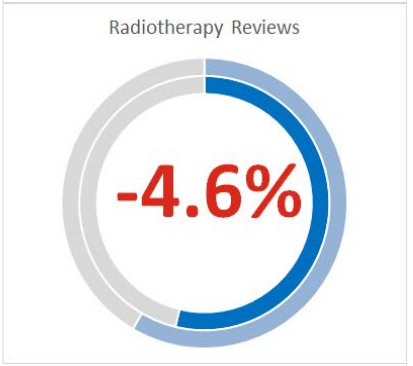








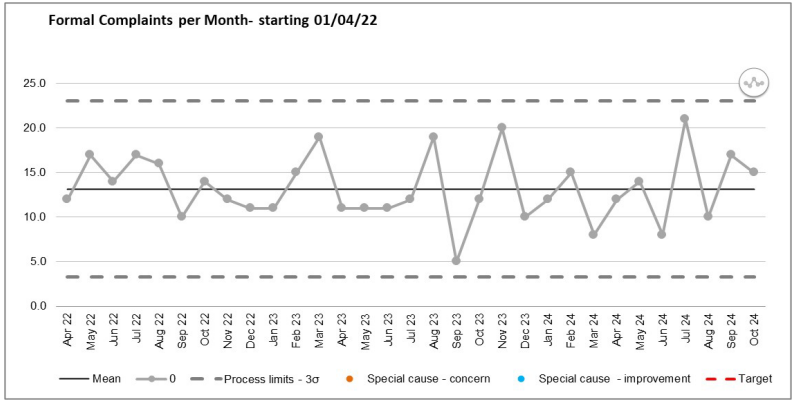




SACT 1st Treatments, 1st Fractions & Surgical Operations do not form part of the 24/25 activity plan and are used as supplementary guides to productivity. The figures are monitored against the previous year's month for comparison.

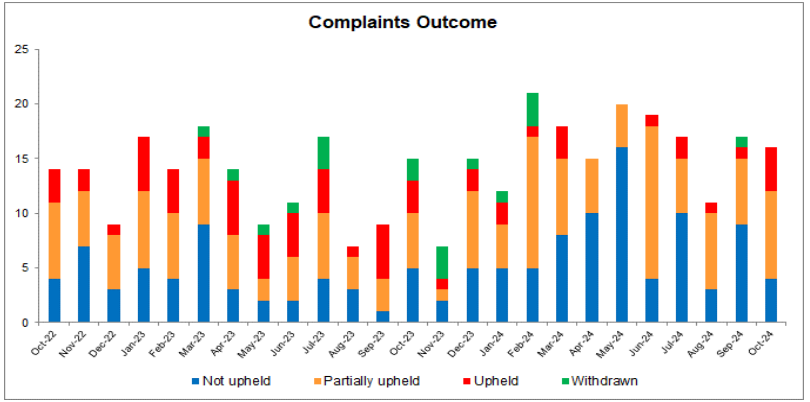
YTD ACTIVITY ACHIEVED
YTD PLANNED ACTIVITY
subject to validation

Complaints



15 new complaints received in October 2024

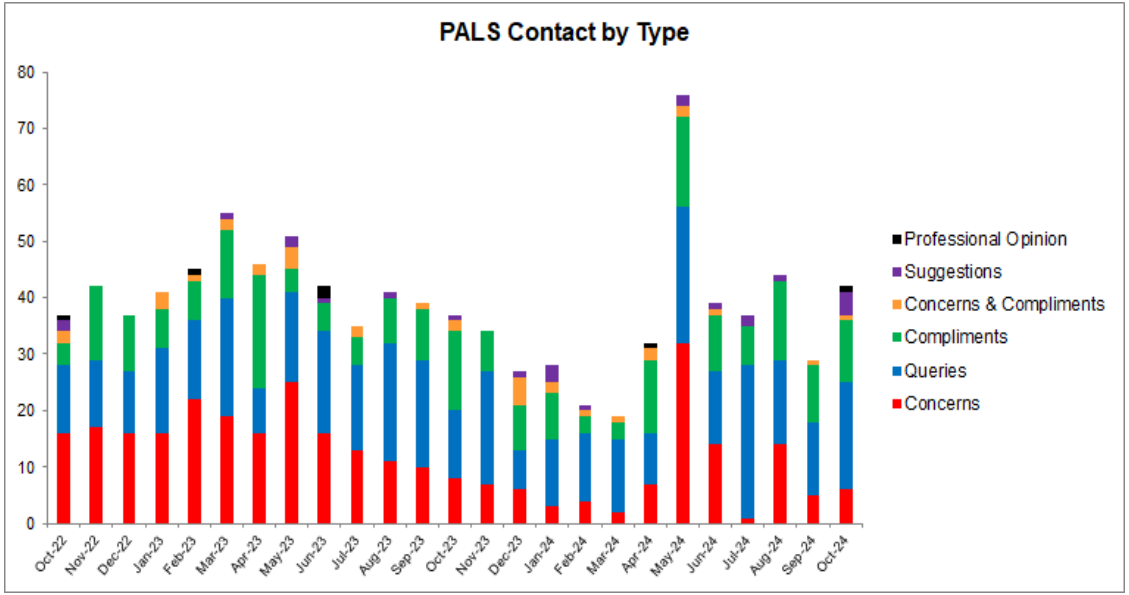
16 complaints were closed in October 2024



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 October 2024. 3 active cases in total with the PHSO.

PALS



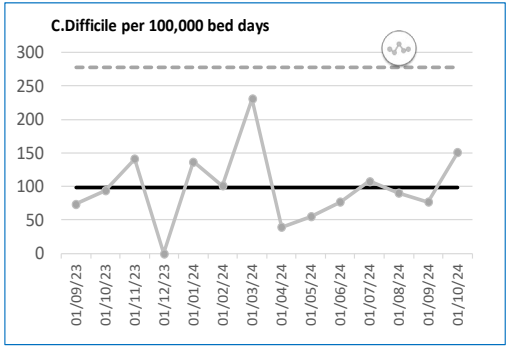
42 PALS contacts have been received in October 2024.

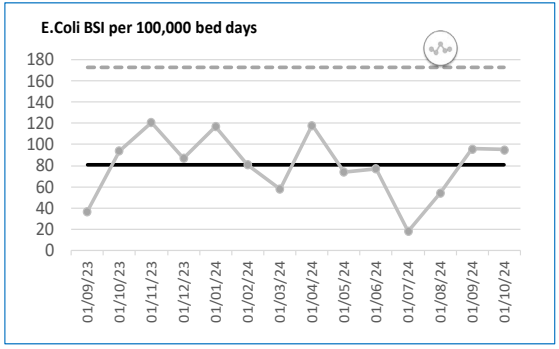
6 of those raised concerns about their experience at The Christie but did not wish to proceed with a formal complaint. The other reasons for contacting PALS are captured in the graph.

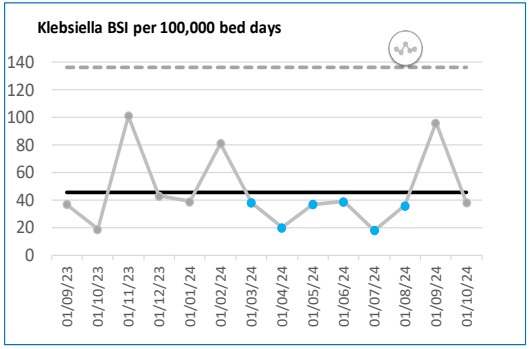
Healthcare Associated Infections

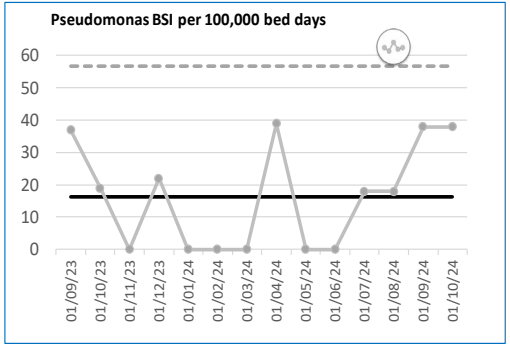
The Christie NHS Foundation Trust

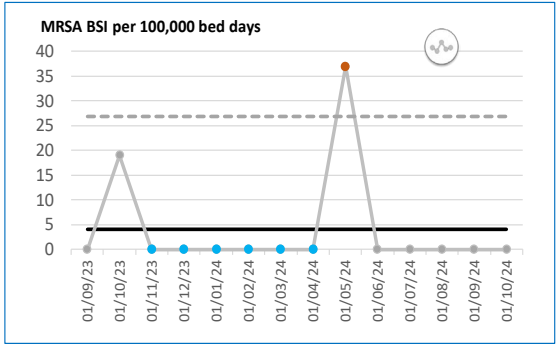
HCAIs per 100,000 bed days – rolling 12 months

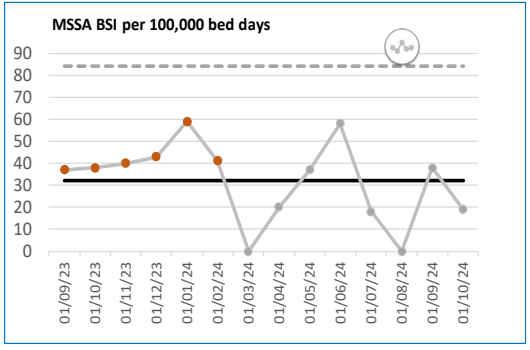












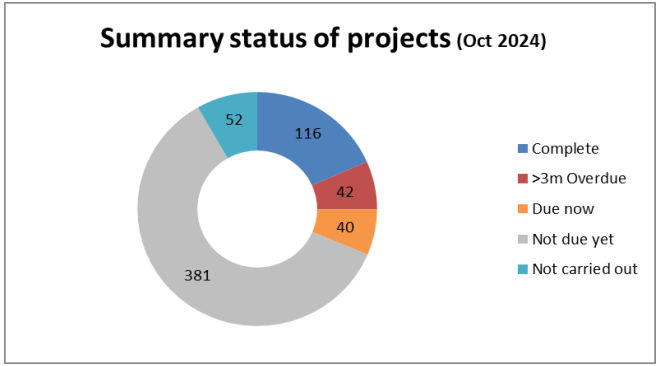
All cases reviewed through IPC team and reported through NIPR.

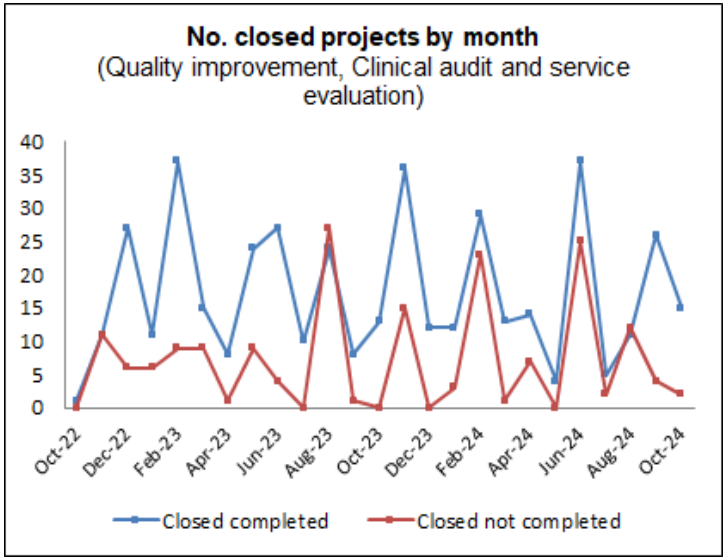
Quality Improvement & Clinical Audit

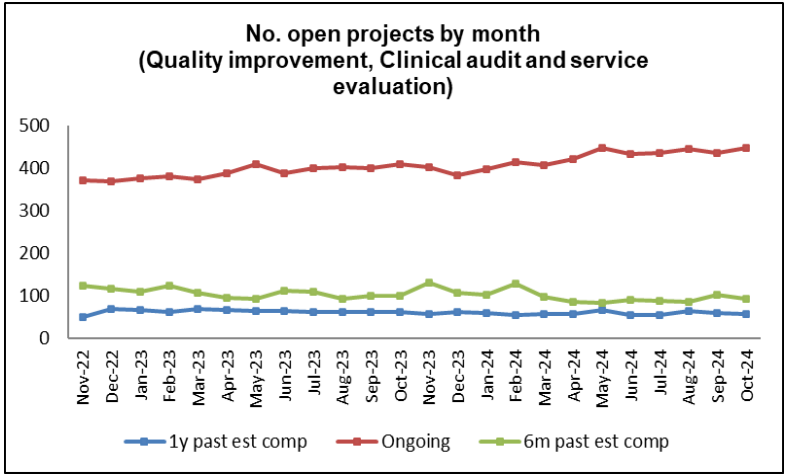
The Christie NHS Foundation Trust

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







HR Metrics Sickness

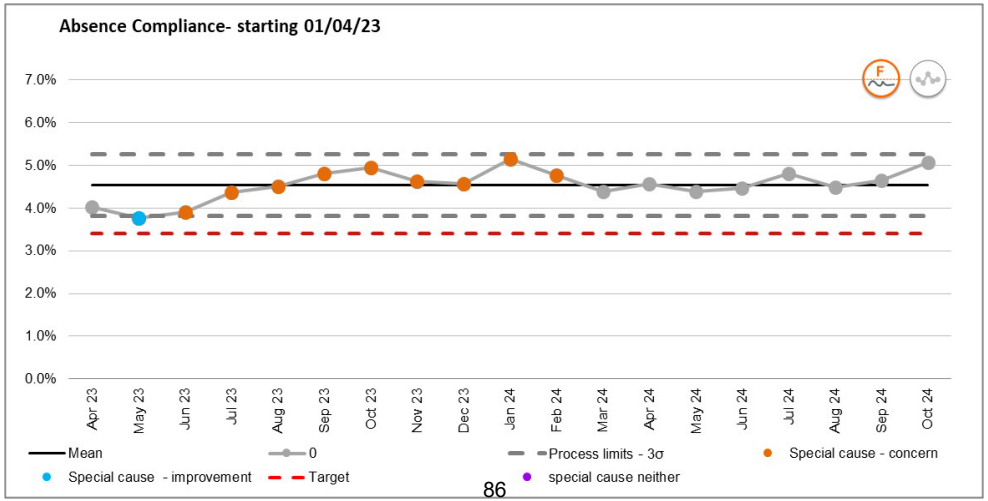
The Christie NHS Foundation Trust

Performance | Absence

Monthly Sickness %	Yearly Sickness %	Absences Ended	Long Term	Short Term
5.07%	4.66%	618	52	566

Trust Overview

Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24
4.63%	4.56%	5.16%	4.77%	4.39%	4.57%	4.39%	4.47%	4.80%	4.49%	4.65%	5.07%



HR Metrics – Mandatory Training

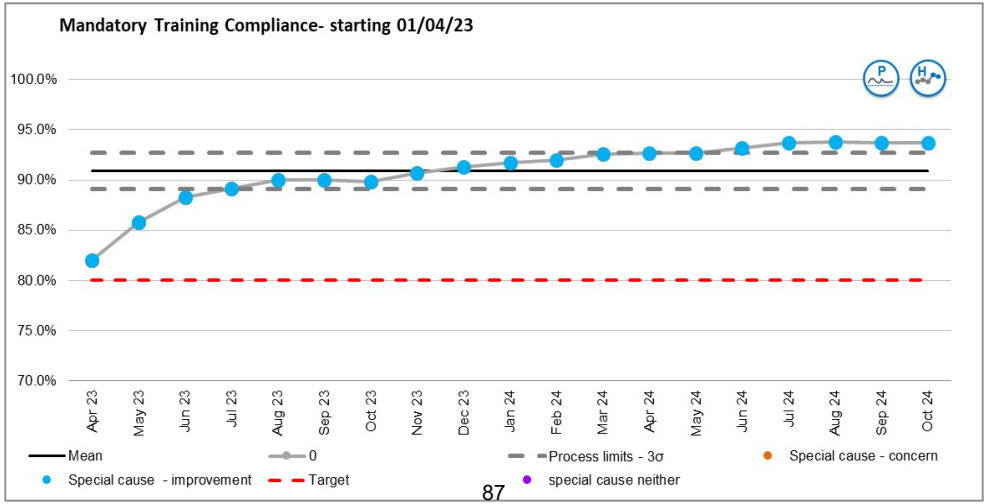
The Christie NHS Foundation Trust

Performance | Mandatory Training

Overall Compliance	Modules Outstanding	F2F Compliance	Online Compliance
93.66%	3,643	82.03%	94.79%

Trust Compliance

Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24
90.68%	91.30%	91.75%	91.96%	92.60%	92.67%	92.68%	93.19%	93.73%	93.79%	93.68%	93.66%



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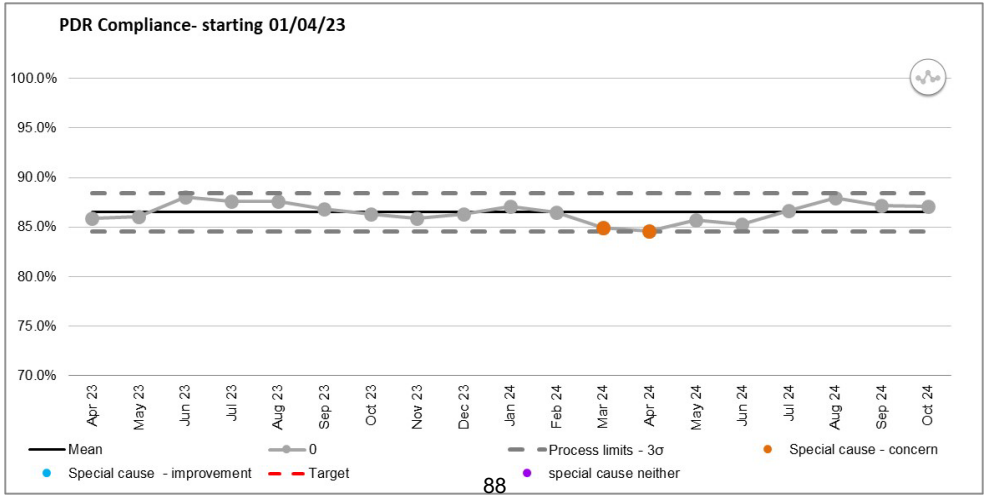
HR Metrics - PDR

The Christie NHS Foundation Trust

Performance | Appraisal

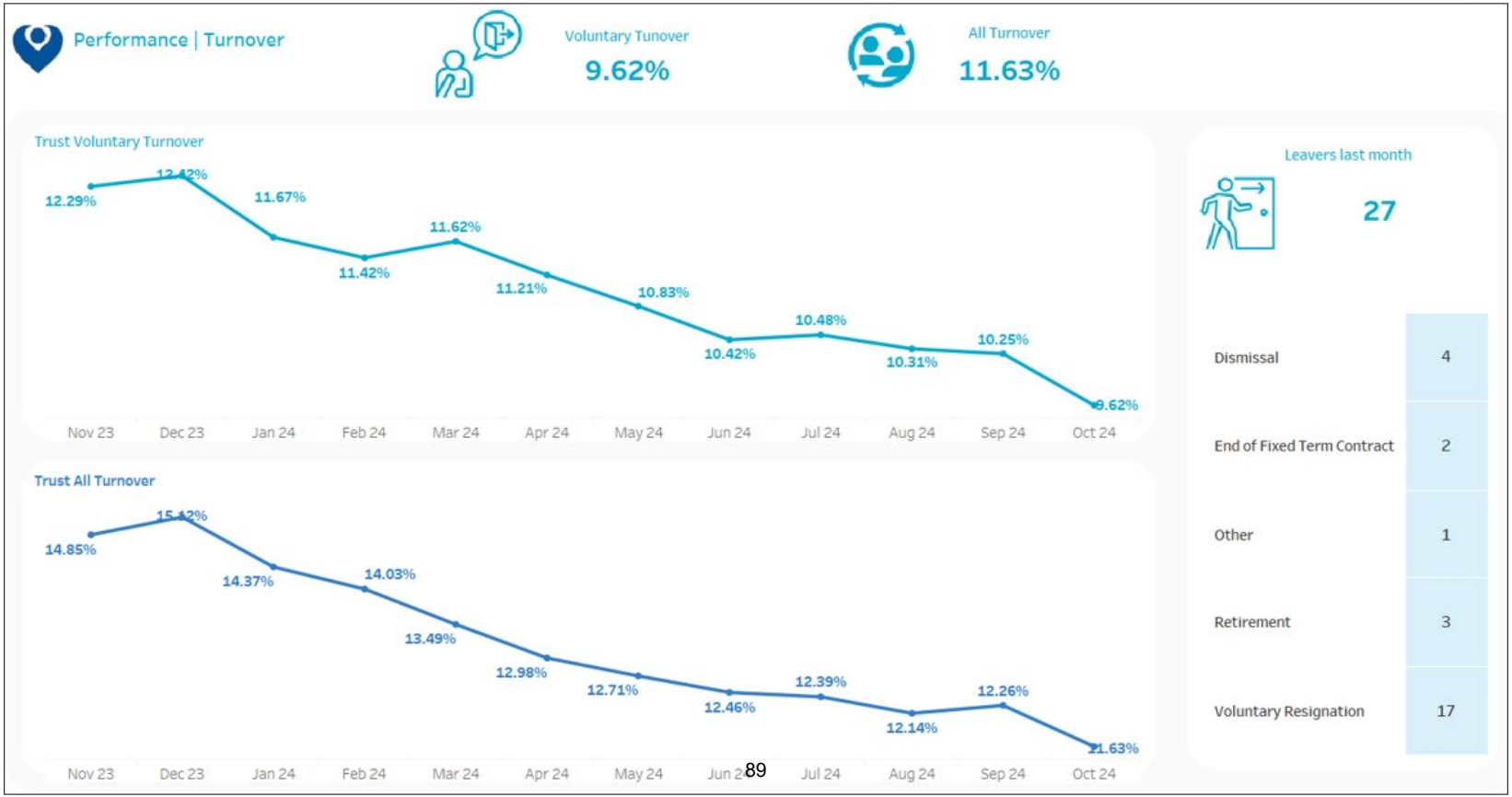
Overall Compliance	Expired Appraisals	Appraisals Due Soon
87.05%	415	635

Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24
85.84%	86.33%	87.04%	86.45%	84.94%	84.61%	85.68%	85.28%	86.63%	87.95%	87.18%	87.05%



Workforce Metrics - Turnover

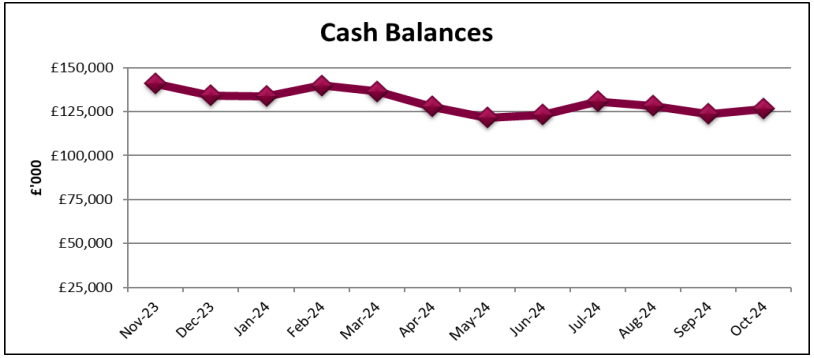
NHS
The Christie
NHS Foundation Trust



Finance (Executive Summary)

The Christie NHS Foundation Trust

Month 7 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(423,907)	(247,263)	(258,578)	(11,315)
Other Income	(77,294)	(44,990)	(43,604)	1,386
Pay	234,288	136,526	133,390	(3,136)
Non Pay (incl drugs)	241,329	140,774	149,701	8,927
Operating (Surplus) / Deficit	**(25,584)**	**(14,953)**	**(19,091)**	**(4,138)**
Finance expenses/ income	30,932	18,040	21,673	3,633
(Surplus) / Deficit	**5,349**	**3,087**	**2,582**	**(505)**
Exclude impairments/ charitably funded capital donations	(12,355)	(7,203)	(7,116)	87
Adjusted financial performance (Surplus) / Deficit	**(7,006)**	**(4,116)**	**(4,534)**	**(418)**



This report outlines the M7 consolidated financial performance of The Christie NHS Foundation Trust and its wholly owned subsidiary The Christie Pharmacy Ltd.

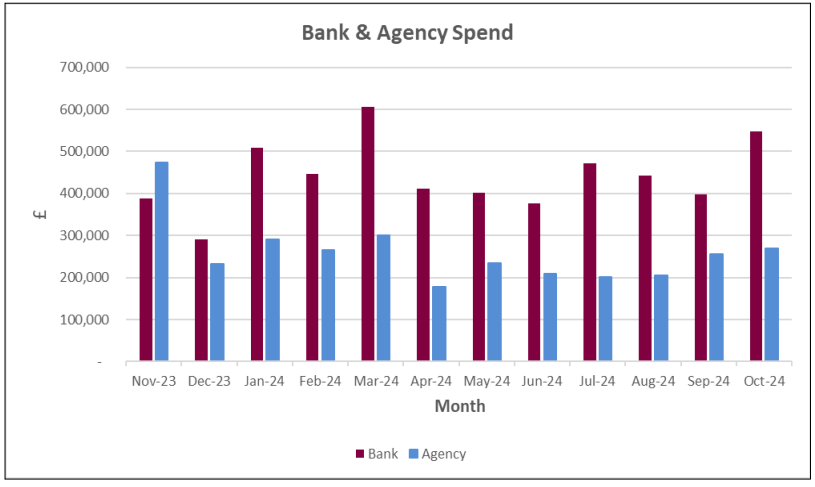
I&E

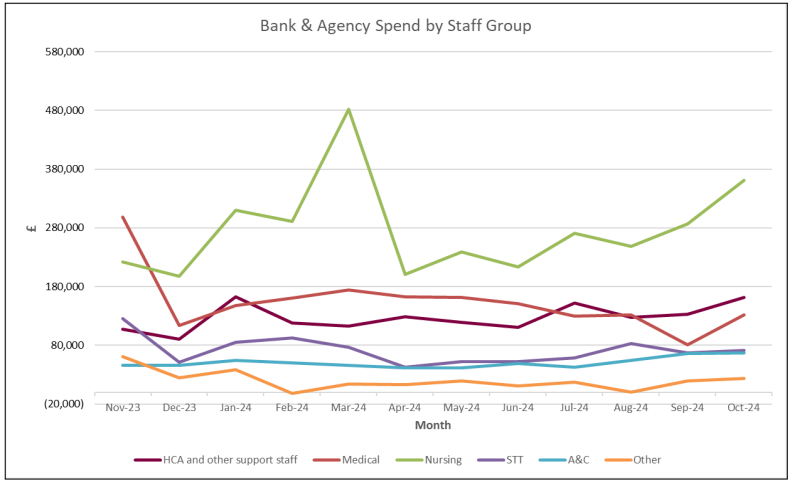
- The Trust is reporting a surplus at the end of M7 of (£4.5m) against a M7 YTD plan of (£4.1m), which gives a month 7 variance of (£0.4m) better than plan.
- In month the Trust reported a surplus position of £0.2m against a plan of £0.6m.
- Identified in year VIP is £19.9m against a target of £21.4m. The VIP shortfall against the recurrent VIP target is £3.5m, where £10.5m has been identified against a target of £14.0m (75% of recurrent target identified). Non-recurrent identified VIP is £9.4m against a target of £7.4m, overachieving by (£2.0m).

Balance sheet / liquidity

- The cash balance is £126.6m.
- Capital performance to month 7 was (£1.3m) below the revised plan submitted to NHSE&I in June 24. The Trust has spent 85% year to date of the capital plan.
- Targets have been achieved against payment of creditors paid within the 30-day Better Payment Practice Code target.

Finance (Expenditure)

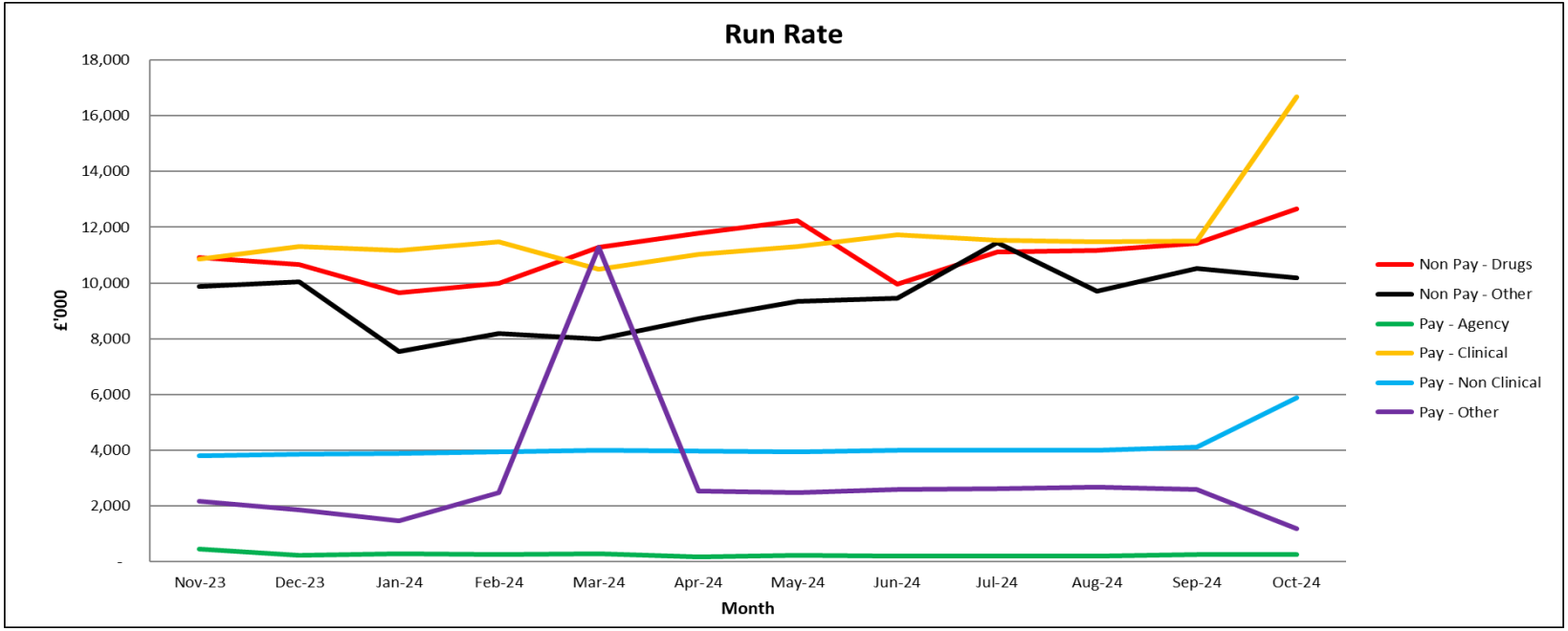




Agency spend in month 7 is £0.3m, £1.6m YTD. The spend is predominantly on medical agency with a decrease in month on nursing agency compared to month 6.

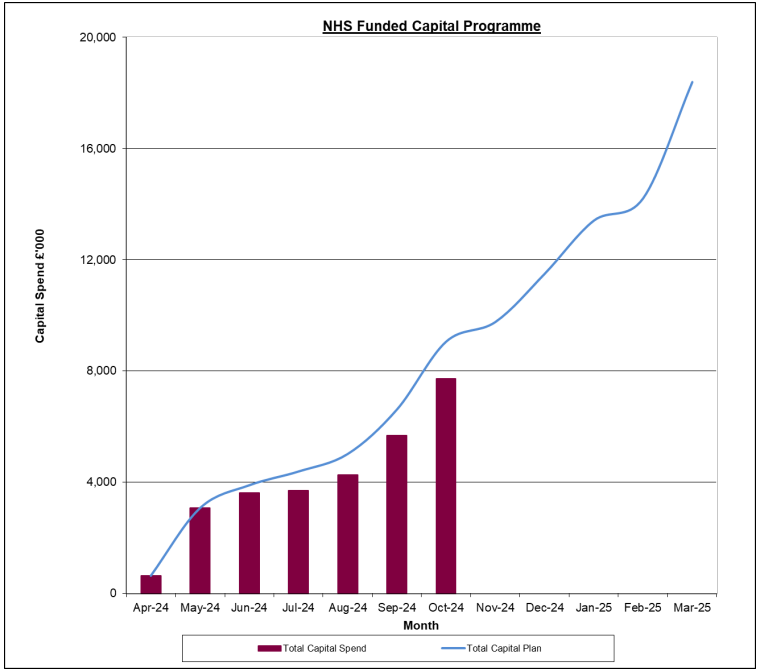
Alongside this, bank spend has increased by £0.1m in month 7 compared to month 6, giving £0.5m in month 7 and £3.0m YTD. The increase in month 7 is predominantly due to back-dated pay award for 2024/25.

Finance (Expenditure)



- Drugs spend in month 7 is £12.6m, an increase from month 6 of £1.2m.
- Pay – Clinical spend in month 7 is £16.7m, an increase from month 6 of £5.1m as a result of the pay award backdated to April 24. .
- Pay – Agency spend in month 7 is £0.3m, consistent with month 6.
- Key elements of 'Non-Pay Other' spend consist of clinical supplies and services, premises and infrastructure costs and R&I costs.

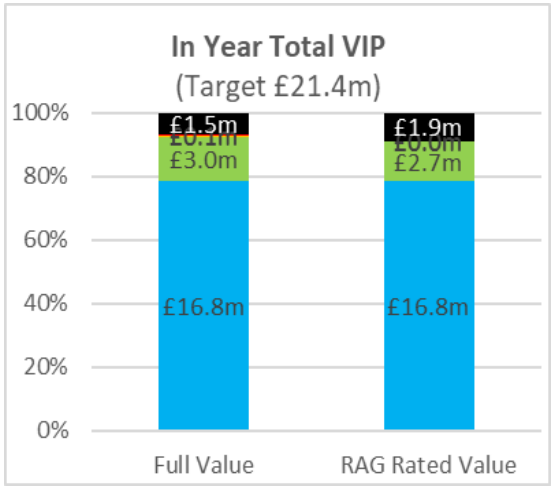
Finance (Capital)

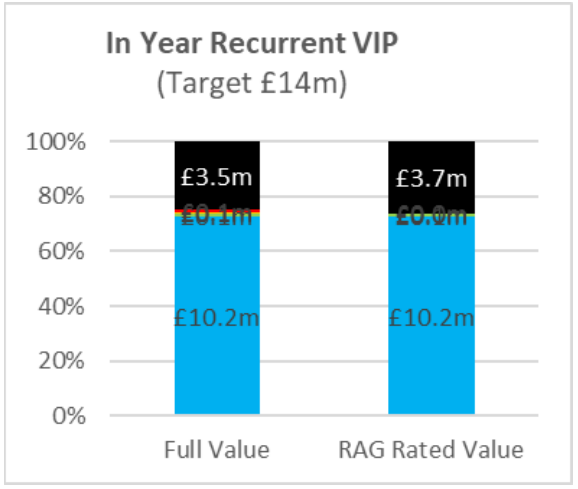


Capital spend to month 7 was £1.3m below the revised plan submitted to NHSE&I in June 24. This is lower than the plan position due to timing in the anticipated completion of the first linear accelerator.

The Trust has incurred £7.7m on capital schemes to month 7, primarily on the TIF ward refurbishment as well as ongoing digital projects and small replacement assets. The Trust has spent 85% year to date of the capital plan.

Finance (CIP)





Total In year CIP

- Total identified VIP schemes reported are £19.9m (£9.4m non recurrent / £10.5m recurrent).
- Risk adjusted identified schemes value £19.5m, leaving £1.9m unidentified.

Recurrent

- Schemes totalling £10.5m have been identified recurrently against a recurrent target of £14.0m.
- This leaves £3.5m 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**	**£19,935k**	**£1,461k**	**£19,487k**	**£1,909k**	**£12,502k**	**£12,502k**	**(£0k)**
Recurrent VIP	£13,996k	£10,495k	£3,501k	£10,329k	£3,667k	£8,183k	£5,931k	(£2,252k)
Non-Recurrent VIP	£7,400k	£9,440k	(£2,040k)	£9,158k	(£1,758k)	£4,319k	£6,571k	£2,252k

NHS
The Christie
NHS Foundation Trust

Meeting of the Board of Directors
Monday 28th November 2024

Subject / Title	Annual Sustainability Report
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 24/25, the Trust must provide an annual summary of progress on delivery of Green Plan. This is the final annual report for The Christie Sustainable Development Management Plan 2022-2024
Recommendation(s)	For note Audit Committee scrutiny (October 2024) and approval
Background papers	Sustainable Development Management Plan (2021-2024) Green Pan (2024-2027)
Risk score	9
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.	IPPC - Intergovernmental Panel on Climate Change SDMP - Sustainable Development Management Plan CQC – Care Quality Commission

NHS
The Christie
NHS Foundation Trust

Meeting of the Board of Directors
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Annual Sustainability Report

1. Introduction and background

1.1 Climate Change

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

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.

1.2 Climate Change 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.

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.

1.5 Delivering a Net Zero NHS

On 1 July 2022, the NHS became the first health system to embed net zero into legislation, through the Health and Care Act 2022. The Delivering a Net Zero National Health Service report is now issued as statutory guidance. The report was launched to mobilise NHS staff and set an ambitious, evidence-based route map and date for the NHS to reach net zero.

The statutory targets are 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, with interim 80% reduction targets by 2028-2032 and 2036-39 respectively.

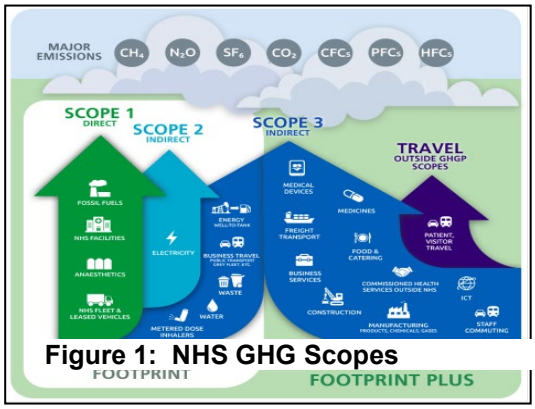
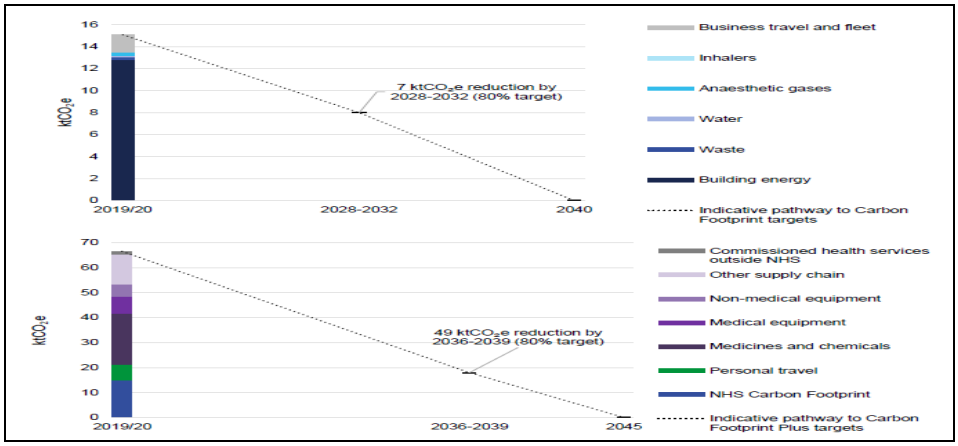


Figure 1: NHS GHG Scopes

Trust Carbon Footprint Plus Baseline

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**

Trust Carbon Footprint Plus Net Zero Trajectories



1.6 Staff Feedback

Introduction

The NHS staff survey now includes questions around sustainability. These are added by the Trust as local questions and so results cannot be compared with other Trusts.

Aim

To help support the delivery of Green Plan commitments and inform leadership of workforce climate knowledge.

How important do you think it is for the Trust to take action against climate change?

Option	2022	2023
Very important	55%	51%
Quite important	27%	27%
Quite unimportant	6%	7%
Very unimportant	6%	6%
Don't know	6%	9%

To what extent do you agree that the Trust actively consider the environmental impact in decision?

Option	2022	2023
Strongly agree		12%
Agree to some extent		43%
Disagree to some extent		14%
Strongly disagree		8%
Don't know		23%

At work do you feel it is easy to do things that would support the environment?

Option	2022	2023
Strongly agree	10%	9%
Agree to some extent	46%	50%
Disagree to some extent	28%	26%
Strongly disagree	16%	15%
Don't know	1%	1%

To what extent do you think you would benefit from training to raise your awareness of climate?

Option	2022	2023
Strongly agree	22%	18%
Agree to some extent	52%	55%
Disagree to some extent	14%	15%
Strongly disagree	10%	11%
Don't know	2%	1%

The survey shows a need for training to increase the understanding of the climate crisis with 19% unaware of the impact it will have on the delivering of healthcare. Furthermore, 73% of staff indicate that they would benefit from climate training.

1.7 Care Quality Commission

The Care Quality Commission (CQC) has implemented a new regulatory approach that includes a quality statement on environmental sustainability. Through the CQC regulatory approach, inspectors may consider how providers have made efforts to become more environmentally sustainable.

The environmental sustainability quality statement, under well-led, will look at any negative impact of providers activities on the environment, how they are acting to reduce it and supporting people to do the same.

In addition to this, climate change adaptation will be assessed in the quality statement 'safe environments' and within 'Governance, management and sustainability'. Within these quality statements steps taken to adapt to the effects of climate change will be looked at e.g., adverse weather plans.

2 The Christie Sustainable Development Management Plan (2021-2024)

Introduction

All NHS organisations in performing their obligations under the NHS Standard Contract 24/25 must take all reasonable steps to minimise its adverse impact on the environment and to deliver the commitments set out in Delivering a 'Net Zero' National Health Service. Furthermore, they must maintain and deliver a Green Plan (formerly Sustainable Development Management Plan), approved by its Governing Body.

The Trust Board approved Sustainable Development Management Plan (SDMP) 2021-2024 in June 2021 to commence work on the ambitions within Delivering a Net Zero NHS.

The plan was developed using the NHS Sustainable Development Assessment Tool (SDAT). The SDAT evolved from the Good Corporate Citizen (GCC) Self-Assessment Tool, which has been widely used by NHS providers and commissioners since 2008. The SDAT covered ten modules with four cross-cutting themes, namely Governance & Policy, Core responsibilities, Procurement and Supply chain, and Working with Staff, Patients & Communities.

- Corporate Approach
- Asset Management & Utilities
- Travel and Logistics
- Adaptation
- Capital Projects
- Green Space & Biodiversity
- Sustainable Care Models
- Our People
- Sustainable use of Resources
- Carbon / GHGs

An organisation's sustainable journey is usually very unique therefore this approach to the modules allowed users to demonstrate their progress in a way that mirrors an individual organisations journey. However, as part of the wider Greener NHS programme regional deliverables were also developed as part of the Regional Memorandum of Understanding 2023/2024.

This is the final annual report for the SDMP 2023-2024, and outstanding actions have been reviewed for consideration in The Christie Green Plan 2024-2027.

2.1 Key Highlights 23/24

Experimental Cancer Medicine Team

The Experimental Cancer Medicine Team (ECMT) have used an innovative approach to decrease unnecessary waste within clinical trials, improving sustainability whilst providing critical medical

supplies to countries in need. The ECMT is a research team who host early-phase clinical trials, working closely with pharmaceutical companies who sponsor these trials which run worldwide. These companies provide the team with trial consumables to support the collection of vital research samples such as blood bottles, needles, plasters, specimen collection pots and packaging.

An audit in 2019 demonstrated substantial waste being generated within the trust due to over-supply and expiry of these consumables, alongside sponsor requests to destroy them. This waste was predominantly sent for disposal due to a lack of guidance and oversight of how to manage excess supplies. A parallel survey showed the same issue reflected across the UK.

In 2023, ECMT joined forces with InterCare, a charity who provide medical aid to over 100 clinics in Africa. Now, excess supplies are sorted, so as many items as possible are donated or reused around the trust. To date, over 10,000 supplies have been donated from The Christie alone. Where donation/re-use is not feasible, items are recycled where possible to further reduce the environmental impact of the waste.

To encourage this work further, a Clinical Trials Sustainability Working Group (CTSWG) with members from other disease-specific research teams, trials pharmacy and the Clinical Research Facility has been established by staff within ECMT to focus efforts on improving sustainable practices across the whole division. A preliminary piece of work by this group was the production of a 'consumables destruction guide' to advise the division on reuse (within the trust) and donation excess supplies.

Furthermore, a group within ECMT, in collaboration with the Digital Cancer Research Team (University of Manchester) have developed an online platform (TREETOPS) to enable clinical trial sites worldwide to assess the sustainability of their processes. TREETOPS allows sites to answer questions to receive a low, medium or high impact score, and receive advice on how to improve their sustainability of their processes. This data will be collected to enable oversight of the global landscape of this issue for further engagement work with sponsors.

Figure 1: Members of the Experimental Cancer Medicine Team at The Christie accepting their Bionow 2023 Social Impact Award

This work falls outside of the day-to-day remit of this team and is driven by a passion to improve the sustainability within the division; in March 2024 the team won the BioNow Social Impact Award, highlighting the importance of this work beyond The Christie.

There is an international lack of guidance to support clinical trial sites to practically reduce waste and work more sustainability. The work by ECMT is leading the way to improve this for The Christie and beyond, this clearly aligns with the behaviour "We care for each other and our environment" both through the reduction of waste and the redistribution to those in need.

NHS Forest Awards 2023

The 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

Figure 2: The Christie Gardener - Phill Walker

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.

The Christie PEASS (Prostate Easy Access Support Service)

In the past patients living with, or after, a diagnosis of prostate cancer have been reviewed at regular intervals by their clinical team at a hospital or community clinic. There is strong evidence that symptoms and concerns are managed more quickly and effectively if patients report them as and when they occur, rather than waiting for a routine appointment. The PEAS changed the way the Trust follows up some of our prostate cancer patients.

Patients who have been enrolled onto The Christie PEASS pathway will no longer have routine follow-up clinic appointments. They are able to contact your PEASS team directly as and when they need to, if they have any symptoms or worries. Also, previously patients would have three samples of blood taken. Through working with Bloods Closer to Home team this has been reduced one sample. This means less appointments and reducing resource use.

Patients are empowered to manage their own health during and after cancer treatment. Many things can be done without the involvement of your clinical team, such as physical activity and healthy eating. Patient in the scheme are not yet being discharged and will have easy access to their PEASS team if they have any worries or concerns. This new service has fully embraced the principles of sustainable healthcare (Patient Empowerment, Prevention, Lean Pathways and Low Carbon Alternatives).

Patients are empowered to manage their own healthcare by having control over when they need face to face appointments. They are also empowered to manage their own health as a means of preventing additional health impacts through exercise and healthy eating. By reducing unnecessary appointments and blood samples this has produce a leaner service to manage resources better. Also, by reducing patient travel it has lowered the environmental impact and avoided patients having to make unnecessary journeys.

2.2 Corporate Approach
Introduction

Sustainable healthcare is only achievable if the principles of sustainability are embedded across the organisation. It is essential that all staff, governors and stakeholders are held accountable for delivering the goals set in our SDMP. This means ensuring our policies, strategies, procedures and business cases reflect our ambition for sustainable healthcare, and that operationally all activity across the Trust ensures the delivery of our goals.

Aim

To ensure that sustainability is embedded within organisational strategy and processes, and that we deliver, monitor and report on progress supported by a nominated Trust board level net zero carbon lead.

Tracking Progress

Ref	Module title	X-Cutting Theme	Action	Responsible person	Target implementation date	Status
CA6	Corporate Approach	Governance & Policy	Trust Board supported with sustainability training	Sustainability Manager	Mar-23	Implemented
CA7	Corporate Approach	Governance & Policy	Develop Sustainability Impact Assessment (SIA) for use in all business cases.	Sustainability Manager/Head of Capital/Assistant Director of Finance	Oct-22	Implemented
CA8	Corporate Approach	Governance & Policy	Mandatory Sustainability Impact Assessment (SIA) for all business cases. This will include requirement for discussion of the SIA at the approving committee.	Director of Finance & Business Development	Mar-23	Requires Action
CA9	Corporate Approach	Governance & Policy	Develop key indicator reports for the Trust board against all modules to be submitted on a six monthly basis. Once reports are approved by theTrust board the will be made available to staff on the intranet.	Sustainability Manager/Head of facilities	Oct-22	Implemented
CA10	Corporate Approach	Governance & Policy	Annual report format updated to include updates across all ten modules of the Sustainable Development Assessment Tool. Once report is approved by the Trust board it will be made available to staff on the intranet.	Sustainability Manager/Head of facilities	Mar-23	Implemented
CA12	Corporate Approach	Governance & Policy	Completed interim review of Sustainable Development Management Plan (2021-2024)	Sustainability Manager	Mar-23	Implemented
CA13	Corporate Approach	Governance & Policy	Commence full review of the Sustainable Development Management Plan (2021-2024)	Sustainable Development Committee	Mar-23	Implemented
CA15	Corporate Approach	Core responsibilities	Identify training gaps for Sustainable Development Committee leads	Sustainability Manager	Oct-22	Implemented
CA16	Corporate Approach	Core responsibilities	Implement training requirements for Sustainable Development Committee leads	Head of facilities	Mar-23	Implemented
CA17	Corporate Approach	Procurement and Supply chain	Develop Sustainable procurement policy	Head of procurement	Mar-23	Requires Action

2.3 Our People
Introduction

Every single staff member has a part to play in delivering our strategy, and making sure we educate and engage them is paramount to success. Staff need to understand the impact they have and how even small changes can make a difference to the organisation both in a positive and negative context.

Aim

To support staff to improve sustainability at work and empower them to make sustainable choices.

Tracking Progress

Ref	Module title	X-Cutting Theme	Action	Responsible person	Target implementation date	Status
OP1	Our People	Governance & Policy	Develop a communication and marketing stratergy	Deputy Director of Corporate Affairs and Engagement	Mar-22	Implemented
OP2	Our People	Core responsibilities	Develop a section on Trust intranet dedicted to sustainability	Deputy Director of Corporate Affairs and Engagement	Mar-22	Implemented
OP3	Our People	Core responsibilities	Sustainability awareness included in staff annual survey	Deputy Director of Workforce	Oct-22	Implemented
OP4	Our People	Core responsibilities	Develop sustainability induction package for new starters	Sustainable Development Committee	Mar-23	Implemented
OP5	Our People	Core responsibilities	Develop training and awareness raising programme opportunities to increase knowledge and understanding of sustainability amongst our staff.	Deputy Director of Workforce/Sustainability M	Mar-23	Implemented

2.4 Capital Projects

Introduction

The built environment contributes around 40% to the UK's total carbon footprint, so tackling the construction, refurbishment and decommissioning of buildings is a key part of our carbon reduction plans. Our Estate is constantly evolving and expanding to cope with increasing pressures, but we need to ensure that sustainability is considered in all stages of the projects.

Aim

To reduce the environmental impact of building works during design, refurbishment, construction, operation and decommissioning stages.

Tracking Progress

Ref	Module title	X-Cutting Theme	Action	Responsible person	Target implementation date	Status
CP1	Capital Projects	Core responsibilities	Full review of NHS Net Zero requirements on capital developments. This is will include: • Reviewing and understanding the commitments set out in Delivering a 'Net Zero' National Health Service. • Reviewing and understanding the implications of the NHS Operational Planning and Contracting Guidance requirement that all NHS organisations must ensure all new builds and refurbishment projects are delivered to net zero carbon standards. • Engagement with Greater Manchester Health and Social Care Partnership and the wider NHS to define what the NHS Net Zero requirements means for healthcare facilities. • Baselining with other NHS providers. • Exploring funding options available for the Delivering a 'Net Zero' National Health Service commitments • Assessment of capital costs required to deliver Net Zero Carbon	Dircetor of capital	Mar-24	Requires Action
CP3	Capital Projects	Core responsibilities	Sustainable capital projects plan/process in place to; • Ensure any designed scheme advisers need to provide idea of the energy usage • Every scheme needs to justify why it is not sub metered • Challenge long term requirement of all developments in the business case and if flexibly design can be incorporated.	Head of capital	Dec-23	In Progress
CP5	Capital Projects	Core responsibilities	Incorporate sustainability into handover process to communicate and induct staff into the new building or area, on the way it works and designed to support them to make energy efficiency decisions	Head of capital	Mar-23	In Progress

2.5 Asset Management and Utilities

Introduction

Our Estate activities are intensive and constant. Utilities represent a substantial cost and environmental impact to the organisation, so it is essential that we accurately measure and reduce consumption through efficiencies, new technologies, and increased staff awareness.

Aim

To embed energy and water efficient technologies and practices throughout our Estate and services and deliver year-on-year reductions in consumption.

Tracking Progress

Sustainable Development Management Plan

Ref	Module title	X-Cutting Theme	Action	Responsible person	Target implementation date	Status
AM1	Asset Management & Utilities	Governance & Policy	Commence implementation of carbon and energy fund project to bring guaranteed savings and a reduction in carbon footprint	Head of facilities/Energy Manager	Jul-23	Implemented
AM2	Asset Management & Utilities	Core responsibilities	Conduct water use survey to identify options to reduce water usage through best practice efficiency standards and new innovations.	Technical manager for hard facilities/Energy Manager	Mar-23	Requires Action

2.6 Carbon and Greenhouse Gases

Introduction

Every activity that is undertaken across our organisation generates a carbon footprint. Monitoring and minimising our emissions is vital if we are to reach the ambitious reduction targets set in the Delivering a Net Zero NHS Report and the GM Environment Plan. The Trust has recorded annual reductions in its carbon footprint but more work needs to be done with staff, contractors, and procurement to agree a metric and support a trend of improvement.

Aim

To measure our carbon emissions, identify hotspots and take targeted action to reduce this year-on-year.

Tracking Progress

Ref	Module title	X-Cutting Theme	Action	Responsible person	Target implementation date	Status
C1	Carbon / GHGs	Governance & Policy	To set a carbon footprint baseline figure for this SDMP	Sustainability manager	Oct-22	Implemented
C2	Carbon / GHGs	Governance & Policy	To set interim targets for carbon reduction to identify how we can meet net-zero commitments.	Sustainable Development Committee	Mar-23	Requires Action
C3	Carbon / GHGs	Governance & Policy	Develop air condition and ventilation management process (See action AM1)	Energy Manager	Sep-23	Requires Action
C4	Carbon / GHGs	Core responsibilities	Public sector decarbonisation scheme project	Energy Manager	Feb-23	Implemented
C5	Carbon / GHGs	Core responsibilities	Through a new sustainable health care committee explore options to reduce use of desflurane and sevoflurane anaesthetic gases.	Sustainable health care committee	Oct-22	Implemented
C6	Carbon / GHGs	Procurement and Supply chain	Transfer electricity purchase into 100% renewable energy tariffs	Energy Manager	Mar-22	Requires Action
C7	Carbon / GHGs	Procurement and Supply chain	Purchase Hydrotreated Vegetable Oils as fuel for stand-by generators	Energy Manager	Dec-23	Requires Action
C8	Carbon / GHGs	Working with Staff, Patients & Communities	Engagement with GMHSCP and wider NHS to define carbon trajectories for the Estate and explore opportunities for external funding to support further carbon reduction schemes.	Sustainability Manager	Mar-23	In Progress

Building Energy Carbon Footprint

Resource		2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Gas	Use (kWh)	44,988,718	46,274,930	36,792,367	27,188,907	32,079,912	32,079,912
	tCO_2e	8,276	9,614	7,645	6,070	6,854	9,322
Oil	Use (kWh)	0	0	0	0	3,455	3,455
	tCO_2e	0	0	0	0	1	1
Coal	Use (kWh)	0	0	0	0	0	0
	tCO_2e	0	0	0	0	0	0
Electricity	Use (kWh)	10,661,428	10,113,690	12,548,996	20,836,718	20,127,033	20,127,033
	tCO_2e	3,018	3,196	3,616	5,832	5,264	5,016
Green Electricity	Use (kWh)	0	29,307	28,106	27,050	26,000	26,000
	tCO_2e	0	0	0	0	0	0
Total Energy CO2e		11,294	12,810	11,260	11,902	12,118	14,339

Water Use

Water	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
m3	95,049	120,389	85,274	151,863	117,696	128,205
tCO_2e	33	41	13	23	21	23

2.7 Green Space and Biodiversity
Introduction

Sustaining and improving green space helps combat climate change through carbon storage, supports local biodiversity, reduces noise pollution, improves air quality and act as solutions to cooling overheated cities. But the benefits are not just environmental; having access to outdoor space has been proven to improve both mental and physical wellbeing which is hugely important for our patients and also our staff.

Aim

To maximise the quality and benefits from our green spaces and reduce biodiversity loss by protecting and enhancing natural assets.

Tracking Progress

Ref	Module title	X-Cutting Theme	Action	Responsible person	Target implementation date	Status
GS1	Green Space & Biodiversity	Governance & Policy	Develop a biodiversity strategy for approval by Trust board	Technical manager for hard facilities/Head of capital	Mar-23	In Progress
	Green Space & Biodiversity	Working with Staff, Patients & Communities	Explore possible collaboration options with Greater Manchester Health and Social Care Partnership	Technical manager for hard facilities/Head of capital	Mar-23	Implemented
GS4	Green Space & Biodiversity	Core responsibilities	Complete a tree register for the Withington Site	Technical manager for hard facilities	Mar-23	Implemented

2.8 Sustainable Use of Resources
Introduction

Procurement constitutes the largest proportion of our carbon footprint and how we purchase and use our resources accounts for significant impacts on the environment. We are working to procure more efficiently and sustainably, reduce unnecessary waste, and move away from a throwaway culture.

Aim

To take an innovative approach to driving out waste, delivering year on year reductions in cost and volumes.

Tracking Progress

Ref	Module title	X-Cutting Theme	Action	Responsible person	Target implementation date	Status
SU1	Sustainable use of Resources	Core responsibilities	Review opportunities for reusable personal protective equipment	Lead Nurse Infection Control	Mar-23	In Progress
SU2	Sustainable use of Resources	Core responsibilities	Develop and implementation of a non-clinical plastics plan to remove the use of single use plastics where there is a viable and lower carbon option.	Sustainable Development Committee	Jun-23	Requires Action
SU3	Sustainable use of Resources	Core responsibilities	Develop a clinical plastics plan to remove the use of single use plastics where there is a viable and lower carbon option.	Sustainable health care committee/Lead Nurse Infection Control	Mar-23	Requires Action
SU4	Sustainable use of Resources	Procurement and Supply chain	Membership of WARP-IT (a customisable online peer to peer reuse network)	Requisition & Supplies Manager	Mar-22	Implemented
SU5	Sustainable use of Resources	Procurement and Supply chain	No longer purchase single-use plastic cutlery, plates or single-use cups made of expanded polystyrene or oxo-degradable plastics	Head of procurement/Catering Manager/Requisition & Supplies Manager	Mar-22	Implemented
SU6	Sustainable use of Resources	Working with Staff, Patients & Communities	Commence waste management projects in departments to identify avoidable waste	Sustainability manager/Waste minimisation officer	Oct-22	In Progress
SU7	Sustainable use of Resources	Working with Staff, Patients & Communities	Address the over-use of non-sterile gloves through education and training.	Lead Nurse Infection Control	Mar-23	In Progress
SU8	Sustainable use of Resources	Working with Staff, Patients & Communities	Staff have access to initiatives and discount schemes that allow them to procure more sustainable products.	Deputy Director of Workforce	Mar-23	Implemented

2.9 Sustainable Care Models

Introduction

We need to embed sustainability into the heart of clinical pathways; helping to integrate healthcare services so they are more efficient, support patients in receiving care closer to home, and improve the general health and wellbeing of our population to reduce hospital admissions.

Aim

To deliver the best quality of care while being mindful of its social, environmental and financial impact and take a whole systems approach to the way it is delivered.

Tracking Progress

Ref	Module title	X-Cutting Theme	Action	Responsible person	Target implementation date	Status
SC1	Sustainable Care Models	Governance & Policy	Awareness training for the Trust board net zero carbon lead on the role of sustainable care models	Sustainability manager	Mar-23	Implemented
SC2	Sustainable Care Models	Core responsibilities	Formation of a committee that will bring clinical leads together to help develop sustainable care models. This will include looking at areas such as anaesthetic gases and procurement.	Medical Director/Chief Nurse	Mar-22	Implemented
SC3	Sustainable Care Models	Core responsibilities	Explore training opportunities for clinicians to develop sustainable healthcare skills in the context of the NHS.	Sustainability manager	Mar-22	Implemented
SC4	Sustainable Care Models	Core responsibilities	Implementation of training for clinicians to develop sustainable healthcare skills in the context of the NHS.	Medical Director/Chief Nurse	Mar-23	In Progress
SC5	Sustainable Care Models	Working with Staff, Patients & Communities	Participation in the Centre for Sustainable Healthcare Green Ward competition	Chief Nurse	Mar-22	Implemented

Anaesthetic Gases Emissions

Anaesthetic gases	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Desflurane tCO2e	321	237	143	73	15	8
Isoflurane tCO2e	1	4	0	0	0	0
Sevoflurane tCO2e	16	23	21	22	22	22
Nitrous Oxide pure tCO2e (Manifold)	26	18	26	35	35	22
Nitrous Oxide pure tCO2e (Cylinders)	1	0	0	11	0	0
Nitrous oxide mixed tCO2e (Manifold)	0	0	17	17	5	14
Nitrous oxide mixed tCO2e (Cylinders)	12	8	16	11	11	14
Total anaesthetic gases tCO2e	378	290	224	170	88	80

2.10 Climate Change Adaptation

Introduction

The Trust has a statutory requirement to be resilient against the threats of a changing climate and adapt now. We need to take appropriate action to prevent or minimise the damage of increasing temperatures and extreme weather events across our estate so that our staff and patients are safe, and that we can continue to deliver our services.

Aim

To ensure that our whole organisation is prepared to deal with the effects of climate change, particularly extreme weather events, and continue to invest in adaptation and mitigation measures.

Tracking Progress

Ref	Module title	X-Cutting Theme	Action	Responsible person	Target implementation date	Status
A1	Adaptation	Governance & Policy	A Climate Change Risk Assessment to be added to Trust risk register and reviewed annually.	Health, safety and emergency planning lead/Sustainability Manager	Oct-22	Implemented
A2	Adaptation	Governance & Policy	Develop an Adaptation Plan for approval by Trust board	Health, safety and emergency planning lead/Sustainability Manager	Mar-23	Requires Action

2.11 Travel and Logistics

Introduction

As a Trust with multiple sites and the need to provide some elements of patient transport, the transport of goods and services, as well as staff, patients and visitors has a significant impact on the environment. We need to reduce the impact of these activities by eliminating unnecessary journeys, and promoting sustainable and active travel methods, leading to cost savings and health benefits.

Aim

To encourage sustainable and active travel wherever possible and reduce carbon and air quality impacts of our organisation and supply chain.

Tracking Progress

Sustainable Development Management Plan

Ref	Module title	X-Cutting Theme	Action	Responsible person	Target implementation date	Status
TL1	Travel and Logistics	Governance & Policy	Complete a green fleet baseline review (19/20)	Deputy Director of Workforce/Sustainability Manager	Oct-22	Implemented
TL2	Travel and Logistics	Governance & Policy	Cut business mileages and Trust fleet air pollutant emissions by 20% by 2023/24.	Director of Finance & Business Development/Deputy Director of Workforce	Mar-24	Requires Action
TL3	Travel and Logistics	Governance & Policy	Review Expenses Travel and Subsistence Policy in line commitment to reduce emissions from fleet by 20% by 2023/24.	Deputy Director of Workforce	Oct-22	Implemented
TL4	Travel and Logistics	Governance & Policy	End all domestic flights for business travel, including reimbursement for domestic flights	Director of Finance & Business Development	Mar-22	Implemented
TL5	Travel and Logistics	Core responsibilities	Assessment to ensure staff have access to facilities for video/teleconferencing to support homeworking, reduce business miles between sites and from attending external meetings.	Chief Information Officer	Oct-22	Implemented
TL6	Travel and Logistics	Core responsibilities	Continued implementation of the Green Travel Plan (2014-2030)	Sustainability Manager	Mar-22	Implemented
	Travel and Logistics	Procurement and Supply chain	A strategy in place to ensure that at least 90% of the Trust fleet uses low-emissions engines (including 25% ultra-low emissions) by 2028.	Head of procurement/Sustainability Manager	Mar-23	In Progress
TL7	Travel and Logistics	Procurement and Supply chain	All new Trust leased or purchased vehicles must be zero emission vehicles.	Head of procurement/Requisition & Supplies Manager	Mar-23	Requires Action
TL8	Travel and Logistics	Procurement and Supply chain	Engagement with GMHSCP to develop target for reducing the environmental impact (GHGs and Air pollution) of the logistics associated with the delivery of goods and services to site .	Head of procurement	Mar-24	In Progress

Green Travel Plan

As part of the agreement for Christies strategic planning framework (SPF) the Trust produced a Green Travel Plan to support site development. The GTP aims to support all site employees in a move away from single occupancy vehicles (SOV).

The modal shift is based on the following targets for staff using sustainable travel:

- Medium term (2024) – 52%
- Long term (2030) – 60%

The tables below detail the process for conducting the 2023 survey and the results: -

Table 1: Staff survey statistics

	2013	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**
Nº of staff surveyed	789	1682	1781	3758	3527	3565	3538	3721	3795	3735	4284
Returns	394	650	599	1330	1428	1474	1560	1591	1556	1442	1898
Non returns	395	1032	1118	2339	2099	2091	1978	2130	2239	2293	2386
Response rate	49%	39%	34%	35%	40%	41%	44%	43%	41%	39%	44%

Table 2: Modal Split results

Method of commute	**Baseline** 2013 (%)	2014 (%)	2015 (%)	2016 (%)	2017 (%)	2018 (%)	2019 (%)	2020 (%)	2021 (%)	2022 (%)	2023 (%)
N/A - Working from home								13.07	13.07	9.50	6.22
Walk	14.00	12.62	14.02	14.51	13.94	14.25	15.00	11.57	13.24	13.66	13.70
Bicycle or motorcycle	6.30										
Bicycle		6.15	6.68	8.72	7.28	6.85	6.79	6.91	7.07	7.98	7.27
Motorcycle		0.15	0.67	0.08	0.91	0.54	0.38	0.31	0.32	0.21	0.21
Bus	6.90	7.23	11.52	9.32	7.42	8.48	9.62	7.42	6.68	7.63	8.06
Train	1.00	1.23	1.00	0.75	1.96	1.02	1.03	0.82	0.58	0.83	1.16
Metrolink	1.80	0.62	0.83	1.88	2.52	3.60	3.46	1.57	2.06	3.12	4.16
Car share/passenger	4.80										
Car share		2.92	5.34	4.36	2.80	3.60	2.12	1.45	1.35	1.66	1.69
Lift share *		2.77	3.01	2.18	2.10	2.10	5.83	2.14	2.76	1.94	2.74
Park & ride transport		0.00	0.67	1.42	1.12	1.22	1.28	0.31	1.16		
Drive (SOV)	61.90	66.31	56.26	56.77	59.94	58.34	54.49	54.43	51.48	53.47	54.79
Unknown	3.40										
Total Sustainable Travel	34.80	33.69	43.74	43.22	40.05	41.66	45.51	45.57	48.29	46.53	45.21

*A staff member giving a lift to another colleague who is not a car driver and therefore a car has not been removed from the road. Whilst this is encouraged under the Green Travel Plan this situation will not afford the same benefits as the defined car sharing situation.

A full report on the 2023 progress on the Green Travel Plan (2014-2030) can be found here.

3. Greener NHS Data Collection 23/24

Introduction

The Greener NHS Team developed a Memorandum of Understanding outlining deliverables and targets for the 2023/24. Wherever possible, Greener NHS are making use of existing sources of data and pre-developed metrics to minimise the burden of collection. However, Greener NHS need to fill the gaps and to improve the quality, completeness, and timeliness of existing data.

Aim

The Greener NHS Data Collection has been created understand progress on the deliverables.

Data from the collection is reported back via the Greener NHS Dashboard and other Greener NHS Support Tools to:

- support benchmarking;
- show progress against deliverables; and
- aid further planning exercises.

The process has helped develop an understanding of the data and metrics needed to underpin the delivery of the NHS' Net Zero ambitions and provide the basis for accountability at The Public Board, The NHS Sustainability Board and Regional level.

Tracking Progress

Greener NHS Deliverables	Greener NHS Data Collections				Comments
	Q1	Q2	Q3	Q4	
Q1. Does your organisation purchase 100% of its electricity from renewable sources?	No	No	No	No	Market forces has forced some of our suppliers to change procurement strategies to maintain supply
Q 2. Have you addressed nitrous oxide waste including waste from nitrous oxide and oxygen mixed?	In Progress	In Progress	In Progress	In Progress	Work on decommission nitrous manifold commenced. Decommissioning of Entonox manifold not approved as is still used in endoscopy and Haematology.
Q3. Does your organisation purchase or lease solely vehicles (under 3.5 tonnes) that are ultra-low emission vehicles (ULEVs) or zero emission vehicles (ZEVs)?	No	No	No	No	No but green fleet assessment has been completed and fleet decarbinisation group formed.
Q4. Does your organisation's salary sacrifice scheme for vehicles allow for the purchase of only ULEVs or ZEVs?	In Place	In Place	In Place	In Place	Now in place
Q5. What travel-related schemes do you operate across your organisation?	In Place	In Place	In Place	In Place	All relevant schemes implemented
Q6. Which local transport partners does your organisation work closely with?	In Place	In Place	In Place	In Place	Manchester City Council, Transport for Greater Manchester and bus providers
Q7. Please select number of sites to be added to enter. What facilities does your organisation offer for people who arrive by a mode of active travel?	In Progress	In Place	In Place	In Place	Staff facilities in place on main site.
Q8. At the site where you have the largest food service, how does your organisation measure the total amount of food waste produced?	In Place	In Place	In Place	In Place	At present the information is recorded manually at both ward and kitchen level.
Q9. Does your organisation have a digital meal ordering system for patients installed, as recommended by the Independent Review of NHS Hospital Food, to enable more accurate meal planning and reduce food waste?	No	No	No	No	No and we do not plan to in the next 12 months. It is under consideration as an additional option to ordering at point of service, undertaking patient satisfaction surveys, and reviewing various cost proposals so cannot confirm that this will be implemented within next 12 months.
Q10. In your food service, have you 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?	In Place	In Place	In Place	In Place	Yes, we have reviewed menus once and implemented the changes: Catering have reviewed your menu once and have made changes to make some menu options healthier and lower carbon
Q11. How are you managing the inclusion of the minimum of 10% on Net Zero and Social Value in every tender?	In Progress	In Progress	In Progress	In Progress	Included in every tender, with requirements embedded in our contract management approach, but no defined KPIs for each contract.
Q12. How are you managing the inclusion of the Carbon Reduction Plan (CRP) requirements in new procurements over £5million/annum? (outside of procurement via frameworks)	N/A	N/A	N/A	In Place	Process in place for new procurements over £5million/annum
Q13a. Do you participate in a walking aids return and reuse scheme?	No	No	No	In Place	Agreement to add notices and labels to be created to encourage people to return to their local hospital.
Q14. Does your organisation have a nominated lead who is accountable for adaptation planning and management?	In Place	In Place	In Place	In Place	Sustainability Manager/ Net Zero and Climate Adapatation Board
Q15. Does your organisation have a long-term climate change adaptation plan separate from your business continuity plan?	No	No	No	No	CCRA completed and adapatation training attended. Included on the new Green Plan.

5. Challenges and Risks

5.1 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 Green 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:

5.2 Organisation Vision

Although significant progress has been made in the last year, 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.

5.3 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 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.

5.4 Finance

Budget constraints and access to financial capital is limited, if the Christie 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 is no dedicated funding to support the delivery of the Green Plan actions.

5.5 Heat Decarbonisation

All NHS trusts and NHS foundation trusts are to have an HDP, identifying and prioritising the phasing out of existing systems by 31st March 2024. It is also a mandatory requirement that a HDP is in place to secure public sector decarbonisation funding bids. The Trust was awarded LCSF Grant of £246,000 to deliver an HDP. The project will involve multiple stakeholders and has a completion date of 21/02/2025. This is a challenging deadline that must be met to achieve compliance and help the Trust position us for future public sector decarbonisation bids.

5.5 Travel & Transport

Currently the Trust is not on track to meet the commitments within the GTP, and this could potentially impact development of site and our net zero targets. GTP will require review and updating, this will also include lining it up with the NHS Transport and Travel Strategy.

5.6 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. A long-term climate change adaptation plan should list and prioritise adaptation actions over a minimum of three years.

5.7 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.

6. 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. It is essential we build upon the work already achieved and deliver the actions within the Green Plan (2024-2027). There may be many challenges but there are also opportunities to deliver a service that delivers socially, financially and environmentally.

7. Recommendation

The Board of Directors are asked to note the scrutiny given to the report by Audit Committee at its October meeting and approval of the plan.