The Christie
NHS Foundation Trust

Board of Directors meeting
Thursday 26th June 2025 at 12.45 pm
Trust meeting room

Agenda

Patient story / clinical presentation: PLACE assessment – Rosie Gill, Soft Facilities Manager and Brian Turner, patient assessor

30 mins

	Public items	**Decision**		**Lead**	**Page**	**Timing**
20/25	**Standard business**					
a	Apologies			Chair		
b	Declarations of interest			Chair		
c	Minutes of previous meeting – 24th April 2025	Approve	*	Chair	2	5 mins
d	Action plan rolling programme, action log & matters arising	Review	*	CEO	9	
21/25	**Performance & finance**					
a	Trust report	Review	*	Execs	13	
b	Integrated performance quality & finance report	Review	*/p	COO	22	20 mins
c	Value Improvement Programme update	Review	*	COO	54	
22/25	**Strategy**					
a	Strategic & annual objectives 2025/26 & draft BAF	Approve	*	CEO	59	10 mins
23/25	**Culture**					
a	Future Christie programme progress report	Review	*****/p	DFC	72	10 mins
24/25	**Governance (regulatory / statutory compliance)**					
a	Reports from committees • Audit Committee – April 2025	Review	*	Committee chair	75	5 mins
b	Board assurance framework	Review	*	CEO	82	5 mins
c	Annual compliance with the CQC requirements	Approve	*	ECN	93	5 mins
d	Annual report and accounts 2024/25	Approve	#	CEO		2 mins
25/25	**Any other business**					

Date and time of the next meeting
Thursday 25 September 2025 at 12:45pm

D/CEO	Deputy / Chief Executive Officer
DFC	Director of Future Christie
ECN	Executive Chief Nurse
COO	Chief Operating Officer

*	paper attached
v	verbal
p	presentation

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Public meeting of the Board of Directors
Thursday 24th April 2025 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 Corcoran (SC), Non-Executive Director
Roy Dudley-Southern (RDS), Non-Executive Director
Prof Chris Harrison (CJH), Executive Director / Deputy CEO
Vicky Sharples (VS), Executive Chief Nurse
Claire McPeake (CM), Interim Chief Operating Officer
Sally Parkinson (SP), Executive Director of Finance
Dr Neil Bayman (NB), Executive Medical Director
Prof Rikki Goddard-Fuller (RGF), Director of Education
Eve Lightfoot (EL), Director of Workforce
John Wareing (JW), Director of Strategy
Tom Thornber (TT), Director of Future Christie
Prof Fiona Blackhall (FB), Director of Research

Minutes: Louise Westcott, Company Secretary

In attendance: Jo D'Arcy, Assistant Company Secretary
Geraldine Vesey, Comms Manager
Darren Buckley, Siemens Health engineers
Jane Kimberley, Freedom to Speak Up Guardian (to 3rd March)
Fi Jenkinson, Freedom to Speak Up Guardian (from 3rd March)

Clinical presentation: Haematology, with a focus on Christie@ Macclesfield and the overarching Haematology strategy - Faye Sharpley, Clinical Director for Haematology and David**,** a patient.

FS introduced herself and David her patient who she sees at Macclesfield.

Haematology is unique and doesn't fit the model that solid tumours do. Haematologists are clinicians and laboratory specialists. Haematologists are doctors of blood disorders – covers cancers and non-cancers. Some patients are treated with bone marrow transplant which is stem cells. Most of the time is spent in the laboratory, haematologists also provide advice and guidance to GPs and medics.

Haematology has expanded from the main site to Tameside, Macclesfield and now Leighton. Initially 4 consultants, now 14 + 1 specialist doctor on main site plus other staff.

The Christie Haematology service acts as a tertiary referral centre serving 3.2 million people. The main site currently sees approximately 500-600 new patients, 12-13,000 follow up patients and admits around 1000 patients per year. 4500 outpatient SACT deliveries per year. Outpatient haematology services are provided by the Haematology and Transplant Day Unit (HTDU) and the ambulatory care facility, they provide level 3 care. Inpatient services for both adults and Teenage and Young Adult (TYA) patients are provided by the 31 bedded Palatine Treatment Ward, and the 4 bedded Withington Ward. Currently 14 consultants, 1 specialist doctor, & 8 Resident Doctors (SpR/IMT)

Tameside – serves approx. 250,000 people. Provides lowest level of haematology care and has no IP beds. Approximately 450 new patients, 5000 follow-up patients, 530 SACT treatment deliveries

per year. There are also 6 chemo chairs, and it's staffed by 2 consultants, 1 ANP, 2 CNS's and 1 HCA.

Macclesfield serves a population of 450,000 people. New building provides 400 new OP and 4000 FU appts, lots of chemo delivered in 16 chairs - 1700 treatments per year and no beds. Level 2 care. There are 3 consultants, 1 ANP, 1 CNS and 1 HCA.

Leighton serves a population of 320,000 people. Delivers 1,100 new appts, 10,000 FU's and 1800 SACT deliveries per year. There are 10 chemotherapy chairs and no haematology beds and delivers level 2a care. Busy unit – there are 5 consultants, 2 ANPs and 3 CNS's.

Planned expansion of the service is due to benefits for patients in local area, who can now access Christie quality care closer to home. Can also appoint to posts where previously organisations have struggled to staff these services. FS outlined how we are now impacted by the FDS target, and this is now improving under Christie management. Patients can now more easily be referred for transplant, CAR-T or trials. Looking to reduce healthcare inequalities by working in these areas and providing more stability for the service. Allows collaboration with local agencies.

Risks include workforce – people don't want to be haematologists, very difficult to recruit. We now also have to address the FDS as we didn't have to do this previously as a tertiary centre. Reliance on DGH infrastructure – for example scanning. Capacity at other sites is limited and can be difficult. Non-malignant haematology also being looked after at other sites and there is an impact on other services like pharmacy, hotline and inpatient services.

FS outlined how the whole department were asked about strengths and weaknesses as well as opportunities and threats. These were summarised.

Other sites fit into the overall Trust strategy for providing local & specialist care. Haematology strategy focuses on optimising each site as a 'centre of excellence' – they are all different. Macclesfield example – bid for money as 'Centre of Ageing Excellence' to offer trials to older populations. Tameside want to treat lymphoma patients to reduce pressure on main site. Leighton – looking at focus of cellular therapy and to provide more capacity.

Things that would help were outlined – better public engagement in local areas, media/comms to raise profile of the centres, better assessment of outcomes to prove success.

Aspirations were outlined – taking on the service at Stepping Hill – this may be less of a risk as they have an existing workforce, there are questions around whether we have reached our limit, and whether this will increase pressure on the main site.

FS introduced David who was previously being treated at East Cheshire, was diagnosed by the Christie at Macclesfield and was very unwell on diagnosis. He has seen changes to the way the service is delivered.

David described being diagnosed with Myeloma whilst he was an inpatient. Felt Faye was more like a friend than a doctor and was very clear about what was happening and what could be done. Constant monitoring and always someone to answer questions – all treatments on time apart from one and apology given when that happened. Constant updates around movement of treatment from infusions to tablets. Given a choice as to whether to continue with consultant appointments or move to appointments with the senior pharmacist, Hannah, this has been the case for a while and that's working very well. Bloods, telephone consultation every 4 weeks and then every 8 weeks, Great feedback from Hannah. Always feels there is time for him to talk. Very happy with the care, cannot fault the treatment from Christie at Macclesfield.

Questions.

TT asked about the move to phone consultations. David described that this is much easier and less problematic for parking, travel etc. Always starts the call with reassurance to allay fears.

CH asked how long it takes to get to Macclesfield and The Christie main site. David said takes 20 mins to get to Macclesfield and his family can collect drugs for him from there. Would take about 45 mins to get to travel to the main site.

CH asked FS about workforce issues and lack of haematologists and what could be done. FS noted there are more training numbers, but lots are retiring. Haematologists don't have to be the medical registrar so this may help, need more engagement at medical trainee level.

Noted that the situation of cover is better than in previous times.

GP asked about when trainees can be made aware of haematology as a specialty. FS responded that this could happen at medical school but more can be done. Agreed that we can help to influence this.

EA thanked FS and David for coming to present to Board.

Item		Action
14/25	**Standard business**	
a	**Apologies**	
	Dr Diana Tait (DT), Non-Executive Director, Jeanette Livings (JL), Director of Communications	
b	**Declarations of Interest**	
	None noted.	
c	**Minutes of the previous meeting – 27th March 2025**	
	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.	
15/25	**Performance & Finance**	
a	**Trust Report**	
	• RS confirmed that we continue to achieve the cancer waiting time targets. • Quality indicators are all stable and no issues to escalate. • Financial position has been achieved and we finished the year having exceeded the plan against a very difficult system position. Closing position is a £15m surplus, £7m better than plan. • Noted the new Oversight Framework will start to be tested in Q1. New metrics will be reported going forward. Using the new framework would put us in segment 1 (best possible). • Significant increase in challenge coming in the system. Delivery of performance going forward will continue to be very difficult. • FDS target pressure has increased with takeover of the Leighton service. Impact is being managed and is anticipated to improve. • Query about presentation of FDS performance to show where the issues are. Validation of activity is taking place. • Haematology patients are being moved around the network to be given the next available appointment to make things more efficient for patients. • Discussion on impact of changes in the system of NHSE / ICB oversight and providers being asked to take on more responsibility. Haematology is a good example of this. Discussions continue nationally. We need to be agile.	CM

	• TK noted that we have concluded the process for the replacement of EA, Joe Rafferty has been appointed. • In the process of recruitment for a new non-executive director to replace TK. • Board approved the Modern Slavery statement for 2025/26 noting that Audit Committee oversees compliance with this through MIAA internal audits **Approved**	
b	**Planning update 2025/26**	

	• Financial & operational plan approved March 25.
	  ○ Revenue £7.5m
	  ○ Capital £51m (incl £15m performance capital)
	  ○ VIP £25m (5.9%)
	• Letter 7th April from NHSE CEO Jim Mackey asking all providers to reduce corporate costs by 50% by December 2025.
	• This equates to £6m for us. Delivery plan by end of May with full savings by Dec 2025. Hugely challenging. Based on a corporate services return.
	• Board requested to approve delivery plan in May
	• Staff in scope were clarified – procurement, finance, HR, digital, quality & governance, corporate development and comms & marketing.
	• Non-pay changes have been made – catering, taxi use etc.
	• Context – huge numbers of staff are being made redundant in the system and we are not suggesting this at this point.
	• There are opportunities for our education function in this.
	• Discussions are taking place across the system around reduction and consolidation.
	• Corporate vacancies have been paused and all vacancies will go through a vacancy control panel process.
	• This is part of a much bigger picture in the NHS, we have an immediate challenge but there will be more to come.
	• Messaging to staff is very difficult and the impact may be seen in future feedback. This is an unprecedented situation.	

c	**Standing Financial Instructions (SFI's)**	
	• SP noted the updated SFI's and detailed scheme of delegation (DSoD) that have been scrutinised by the Audit Committee. • Changes made are in line with new procurement guidelines and committee name changes and these are highlighted in the paper. • Board were asked to approve the SFI's and DSoD based on changes and amendments agreed through Audit Committee **Approved**	
16/25	**Strategy**	
a	**Risk Management Strategy annual review**	
	• Paper closes off previous strategy prior to move to the new strategy. • Summary tables indicate actions are closed and new strategy now in place and has started reporting from this month.	

	• Board acknowledged good progress. • Review of new strategy will come to a future meeting.	
b	**Annual corporate objectives**	
	• Paper summarises annual objectives completed in the previous year (2024/25). No issues to escalate to Board. Some items roll into this year e.g. OECI accreditation. • May Planning Day will look at next years corporate and annual objectives. • Health inequalities self-assessment was discussed, and ongoing work is identified in an action plan. This will be reported to a future Board. • Timeframes for progress with Higher Education Institute (HEI) status outlined, by Q2/Q3 this year will understand move to new set up for education function and then procurement will begin to get an HEI partner. Noted that the Office for Students is not taking new applications now. • Board to be updated on options ahead of formal approvals	RGF
c	**Future Christie update**	
	• Approach to organisational change and planning for 2025/26 – need to increase the pace of change with total adoption of schemes across the Trust. • Focused resource on fewer but significant changes – must remove current practices and have universal application. • Timeframes outlined for real time patient interface; patient correspondence available on the same day. This is very challenging and looking at short term impact – within 3 months. • Acknowledgement of requirement to make change and staff need to be supported to deliver. • Looking for a Future Christie Medical Director and an Associate Director of Transformation to deliver this. • Marsden collaboration outlined – service collaboration focus e.g. remote support for SACT, ANP models of development, Pharmacy SACT screening collaboration to catalyse roll out. • De risk change by collaborative approach and commitment to innovate and provide leadership going forward. • Looking at engaging private partnerships to escalate innovation. • Some clarity around how things will look in the next 5 years but subject to national impact.	
17/25	**Culture**	
a	**Freedom to Speak Up Guardian report**	
	• Jane Kimberley introduced herself as FTSUG for a cover period, Fi Jenkinson is now in post. • JK will maintain competency to cover for FJ when she starts in the role. • Contacts were outlined by time over 5 years – year on year increase seen that's in line with national picture from this period. Contacts have increased for identifiable reasons over time e.g. covid / CQC / culture audit. • Concerns were summarised with 48% relating to attitudes & behaviours / 31% relating to policies, procedures and processes. This is about robust and fair application. Training being put in to support improvement.	

	• Manager training / PSIRF also really helping with culture to support freedom to speak. • Latest staff survey results show an improvement – much better in some questions. Have a consistent high ranking comparably. Work we have done has shown an impact. • Gaps in who is speaking up looked at with aim to address these. Inclusive Culture Strategy and FTSU action plan will focus on this work. More FTSU champions in these staff groups happening. • Achievements outlined – guide for managers will be launched soon, embedding of PSIRF principles & culture, freedom to speak up month where activities focussed on listening and the progression of Respectful Resolutions. • Benchmarking shows good improvement & consistency – setting example to empower staff, importance of listening and supporting managers & leaders, targeting barriers to speaking up, sharing positive experiences will help continue this progress. • Comment that improvement is great. Is there an aspiration to achieve a particular level of feedback. Year on year improvement would be good. • Acknowledgement of external factors impacting these results – financial constraints coming will likely have a negative impact. • Response to concerns are appropriate, we have had very good feedback for some cases, some are more complex but generally positive. It feels like leadership are taking this very seriously. • Expectations of the process and whether we message this well to staff discussed. May need to do more to manage expectations and this will be part of the focus going forward – this is what it can do / options that may come out of the concern being raised outlined. Want to give clear options for staff on what the process can do. • RS thanked JK for stepping in while we went through the recruitment process and for doing a fantastic job. • Noted that the level of improvement in staff survey is excellent.	
18/25	**Governance (regulatory / statutory compliance)**	
a	**Reports from Committees**	
i	**Workforce Assurance Committee – March 2025**	
	• TK summarised the report noting that assurance levels are medium for many areas as work is in progress. • Role essential training – management of data has been an issue so move to old system has delayed progress. This is not about the delivery of training to staff but the recording. **Noted**	
ii	**Quality Assurance Committee – March 2025**	
	• SC summarised the report. • Alert the Board on patient demographics / data quality – low assurance as slow progress and some unknowns about what is missing. Committee have asked for this to come back for further scrutiny on progress. • New operational risk on the aseptic unit, action plan provided good assurance and will be monitored.	

	Noted	
iii	**Audit committee – April 2025**	
	• Formal report to next committee. • End of year governance is underway. Reviews of reports and accounts are all on track and no delays are anticipated. • Head of Internal Audit review for last year was substantial. • Good progress on internal audit actions – iQemo action highlighted. Review required for next meeting. Noted that management actions / timeframes must be realistic. • Supply chain discussed, senior team looking at issues impacted by global factors. • Agreed by committee that not having a separate Finance & Investment Committee is the correct approach and the full Board should continue to see this detail. **Noted**	
b	**Board Assurance Framework**	
	• Updates and amendments outlined in the paper including changes to risk scores and additions of detail in controls, gaps and assurances. • Q4 risk scores added • Legal & regulatory risk has been disaggregated but there is scope to further narrow the risk definitions • May Planning Day will include the risk to annual objectives for the coming period.	
c	**Register of matters approved by the Board**	
	• Summary of the matters approved by Board in 2024/25 noted and approved. **Approved**	
d	**Self-certification declarations**	
	• Noted and approved **Approved**	
e	**Trust nomination of Charity Trustee**	
	• Noted and approved **Approved**	
19/25	**Any other business**	
	• No items noted	
20/25	**Date and time of the next meeting**	
	Thursday 26th June 2025 at 12:45pm	
	Papers for information only	
	Integrated performance, quality & finance report	

The Christie NHS Foundation Trust

Agenda item 20/25d

Meeting of the Board of Directors - June 2025
Action plan rolling programme after April 2025 meeting

C Culture P Performance S Strategy G Governance

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
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	21-25b
	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	24-25c
		P	Value Improvement Programme	COO	Review	21-25b
	Annual reporting cycle	G	Annual report, financial statements and quality accounts (incl Annual governance statement / Statement on code of governance)	EDoF	Approve	separate pack
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			

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
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			
November 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
		S	Strategy update	DoS	Six month review	
		S	Inclusive Culture strategy	DoW	Approve	
		P	Digital Strategy update	DCEO / CIO	Annual Review	
	Annual reporting cycle	P	Interim review of annual objectives	CEO	Review progress	
		S	Annual Sustainabiltiy Report - Boards responsibility for Carbon Net Zero	DCEO	Note approval by Audit Committee	For information
December 2025 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
Planning & Development / Council of Governors Day		S	Board planning			
		S	Council / Board - strategy update			
January 2026		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance report	COO	Monthly report	For information
		P	Value Improvement Programme	COO	Review	
February 2026 - 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 2026		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	Trust Strategy Update	DoS	Review	
		C	Culture update	DCEO/DoW	Approve	
		G	BAF review	CEO	Review	
		C	Staff survey initial results	DoW	Note	
	Annual reporting cycle	G	FPPT Compliance report	Chair	Approve annual compliance	
April 2026		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 2024/25	CEO	Review progress	
		G	Modern Slavery Act statement	CEO	Approve	
		G	Standing Financial Instructions (SFI's)	DoF	Approve	
		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	

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
May 2026 - no meeting	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	By email
		G	BAF review	CEO	Review	
Planning & Development Day		S	Planning			

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Agenda item: 20/25d

Action log following the Board of Directors meetings held on Thursday 24th April 2025

No.	Agenda	Action	By who	Progress	Board review
1	15/25a	Show breakdown of FDS performance to show where delays are in haematology	CM	Complete	Trust Report June Board
2	16/25b	Board to be updated on Higher Education Institute (HEI) options ahead of formal approvals	RGF	Work progressing	To be presented prior to approvals

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Agenda 21/25a

Meeting of the Board of Directors
Thursday 26th June 2025

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

The Christie
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Trust Report
June 2025 (May data)

Board Scorecard

Current National Oversight Framework (NOF) Score	**2**				
CQC Rating	**Good**				
	Indicative scoring (PAF)				
Indicator	**2024/25**	**Q1 25/26**	**Q2 25/26**	**Q3 25/26**	**Q4 25/26**
Operating priorities (elective / cancer)	**1**				
Outcomes	**1**				
Quality & inequalities (experience/workforce/safety/inequalities)	**1**				
Productivity & value for money (finance & efficiency/productivity)	**1**				

1 best 5 worst

Executive Summary

- We are rated Good overall by the CQC.
- We are in segment 2 of the System Oversight Framework.
- Patient quality indicators for May show no significant adverse variances and no issues for escalation. We remain high reporting and low harm.
- Performance in May for the 62-day consolidated cancer standard was 68.5% which is below the operating plan standard of 75%, we do not anticipate achieving the standard for Q1.
- 6 operational risks are scored at 15 or above on the risk register.
- Cumulative financial performance at the end of May (Month 02) is a (£1.2m) surplus against a planned (£1.3m) surplus. This is an adverse variance of £0.1m to plan.
- Key financial performance indicators in month 02 show one material adverse variance to plan; the level of **recurrent** VIP delivered being £8.6m identified so far against a £12.6m annual target.
- Workforce indicators for May show a decrease in sickness absence rates from the previous month.
- PDR performance and mandatory training performance is over the required thresholds.
- Capital schemes are progressing to plan across the Trust.
- New NHSE Performance Assessment Framework delivery metrics outlined

Quality of Care

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

Pressure ulcers and falls were in line with internally set trajectory in May. There were 12 complaints in May which is slightly below average. The number of contacts with the Patient Advice and Liaison Service (PALS) service in May was 44 which is higher than average.

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.

6 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. There is a risk of a patient inadvertently receiving an unintended blood component or product (15)
3. There is a risk to treatment delivery due to the Aseptic service's workforce recruitment and retention (15)
4. Breach of trust compliance target 28-day Faster Diagnosis Standard (FDS) for patients with a possible haematology malignancy (15)
5. There is a risk to patient safety & experience due to issues relating to lack of visibility of virology blood tests sent externally to MFT (15)
6. There is a risk to patient safety & experience due to issues relating to requesting & resulting of blood tests sent externally to MFT (15)

Operational Performance

The 62-day standard is a barometer of how well the system is performing with cancer pathways, a third of all our patient referrals are relevant to this standard. Currently 25% of patients have already exceeded a 62 day wait before referral to the Christie. The Trust compliance at the end of May against the 2 key cancer standards was;

- 62-day consolidated standard: Performance was 68.5% with a requirement to reach the 75% target by March '26. We are embedding a structured, accountable recovery programme for 62 days with an objective to achieve the standard by the close of quarter 2. There are three areas of strategic focus:
    - End to end pathway redesign – mapping and removing delays with closer working with our system partners
    - Capacity and productivity. Maximising theatre use and making best use of mutual aid
    - Digital and data maturity – tracking of pathways, optimised operational dashboards with early breach warnings
- Faster Diagnosis Standard (FDS): Performance was 82.6% against the 80% threshold 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 97.9% against a target of 96%.

During May there were 4 operations cancelled on the day for non-clinical reasons. They were all rebooked within 28 days.

Financial Performance

Revenue: Financial performance is broadly in line with plan as illustrated in the table below; £1.2m surplus against a £1.3m planned surplus position.

Month 02 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(466,475)	(77,746)	(75,987)	1,759
Other Income	(80,458)	(13,367)	(12,891)	477
Pay	264,174	43,159	42,194	(965)
Non Pay (incl drugs)	256,452	43,569	42,048	(1,521)
Operating (Surplus) / Deficit	**(26,307)**	**(4,384)**	**(4,636)**	**(252)**
Finance expenses/ income	23,089	3,848	4,229	381
(Surplus) / Deficit	**(3,218)**	**(536)**	**(407)**	**129**
Exclude impairments/ charitably funded capital donations	(4,282)	(714)	(759)	(45)
Adjusted financial performance (Surplus) / Deficit	**(7,500)**	**(1,250)**	**(1,166)**	**84**

The variances in the figures above are likely to be as a result of phasing of the plan. Further analysis will be undertaken at the end of the first quarter (month 3).

Capital: The capital plan for 2025-26 is £51.1m, subject to confirmation by NHS England. At month 2 the expenditure is £1.2m against the in-month plan of £0.6m, this is not a material variance and relates to phasing differences between the plan and actual expenditure.

Value Improvement Programme. The annual VIP target of £25.3m is split into a £12.7m recurrent target and a £12.6m non-recurrent target. The level of recurrent VIP identified to date is £8.6m, which reduces to £7.2m after applying a RAG risk rating, giving a recurrent shortfall of £4.1m (£5.5m shortfall against RAG rated value).

The level of non-recurrent VIP identified to date is £13.7m, exceeding plan by £1.1m. Year to date, £4.2m has been delivered against a target of £4.2m.

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

Measure of Financial Performance	Red / Amber / Green rating
Revenue: Trust Control Total compared to plan	£0.1m over plan
Capital: Capital expenditure against plan	£0.6m over plan
VIP identified (recurrent) against target of £12.6m	£8.6m identified (£7.2m RAG rated)
Debtor days compared to 15-day target	13 days
Cash balance	£118.4m
Better Payment Practice Code (95% target)	98%

Workforce

Our workforce performance indicators show mandatory training compliance and personal development plan rates are both above (better than) thresholds at 93.9% and 87.4% respectively. Sickness absence rates have decreased slightly in May to 4.11% (threshold of 4.25%). The overall all year turnover is 11.45%. These issues and the associated plans for improvement have been considered by the Workforce Assurance Committee.

The staff network groups have been running several Lunch and Learn sessions during June to continue with our theme from the recent EDI celebration event, 'Embracing our commUNITY'. Topics included ‘Unseen struggles: hidden disabilities in the workplace’ and ‘Keeping the faith’.

June is international lesbian, gay, bisexual and transgender (LGBTQ+) Pride Month. Throughout the month, members of the Rainbow LGBTQ+ staff network group will be using HIVE to share their personal stories about what Pride means to them, some of the history around the importance of Pride and resources and support for those that would like more information or to be involved.

There are also several activities going on throughout the month. Everyone is welcome at all of these, so please drop by. See HIVE - LGBTQ+ Pride Month at The Christie for more details.

Confirmation of NHS pay award 2025/26
All NHS staff will receive pay rises for the second consecutive year. These awards will be backdated to 1 April 2025.

Staff can visit the relevant link for your staff group for more details:

- Agenda for change staff
- Resident doctors
- Other doctors and dentists

Pay award by staff groups for England

Staff Group / Contract	PRB Recommendation for Basic Pay	Range of Basic Pay Uplifts	Estimated Average Basic Pay Uplift
Consultants	4%	4%	4%
Resident Doctors	4% + £750	5.1% - 6.0%	5.4%
SAS Doctors (Specialty & Specialist)	4%	4%	4%
Agenda for Change	3.6%	3.6%	3.6%
ESMs & VSMs	3.25%	3.25%	3.25%

At present, we are awaiting confirmation as to when these changes will be processed and reflected in staff pay. We will share further updates as soon as we have them.

Upcoming publication of new national job profiles for nursing roles
The NHS staff council and its job evaluation subgroup (JEG) have completed a review of the national job matching profiles for nursing and midwifery and have published new profiles. The changes are largely updated language and providing additional narrative examples of the factor levels. The updated profiles also have a 'new look' to make them easier to understand for those who are not trained in job evaluation.

We have created a task and finish group to manage implementation. Membership includes HR staff, nurse senior managers and staff side colleagues. Once published, the new profiles may have implications for how roles are banded across nursing posts. Key points to be aware of:

- **No immediate change to your role or banding**: Your current duties, responsibilities, and pay band remain in place unless formally reviewed through the usual job evaluation processes.
- **Possible banding reviews**: Some posts may be reviewed locally in light of the new profiles. If a review is considered appropriate, you will be fully informed and supported throughout the process.
- **Support and guidance**: We are working closely with HR and staff side representatives to ensure a clear and fair approach to any local implementation. Further guidance will be shared as soon as the national profiles are published.

In the meantime, if you have any questions or concerns, please speak to your line manager or union representative.

Research

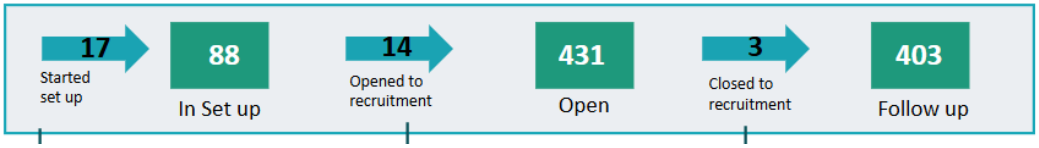
National targets for set up of clinical trials are becoming increasingly important and is a key focus of the divisions work over the coming quarter. Weekly huddles have been implemented which allows us to focus on how we can improve our study set up process by becoming more efficient and also ensuring our trial set up activity is given the priority it requires. This includes a balance of 'quick win' changes and focus on process change. As part of this piece of work, and the move to a new Local Portfolio Management system called EDGE, we will be visiting some external organisations including The Marsden to learn about their processes, benchmark our practices and inform our set up metrics.

The Breast team achieved a **30-day set up time** on a study with Pfizer, this was applauded by the company as gold standard, and we are reviewing this project timeline as part of our wider set-up work.

Our pipelines remain stable with consistent number of trials entering set up, active recruitment and follow-up each month. Below shows the data for May 2025, showing 88 studies in set up.

Study portfolio details – April 2025

Data extract from 06/05/2025.



The R&I Division had 20 posters showcased at the RDF forum in May across a variety of topics including implementation of PSIRF, student sandwich placements and sustainability process, and our successful implementation of the National funding contract for commercial research.

A consultation process is being developed for planning to operate our Clinical Research Facility (CRF) as a 24/7 service. This is being completed in stages and will involve agreement and arrangement of weekend medical cover.

On June 18th, alongside Cancer Research UK and The University of Manchester we announced the appointment of Professor Samra Turajlic as the Director of the Cancer Research UK Manchester Institute. Professor Turajlic has been an independent research group leader at the Francis Crick Institute since 2019 and is a consultant medical oncologist at The Royal Marsden NHS Foundation Trust. She is expected to take up her new position in September 2025. samra-turajlic-appointed-new-director-of-cruk-manchester-institute

Education

The first of the monthly Education drop in's took place on June 12th focusing on supporting Christie colleagues and their line managers to access a growing portfolio of professional development opportunities and engagement events. Christie Institute for Cancer Education team members were able to engage with a wide range of colleagues and signpost events and CPD.

The latest WRES education data shows progressive growth in racially minoritised staff groups accessing professional development/CPD education.

The Christie's ambition to achieve HEI (Higher Education Institution) recognition continues to make excellent progress with extremely positive engagement/interest with potential partner HEIs in our pre-procurement phase. There is active development work in setting up a wholly owned subsidiary to support commercial education activity (including HEI plans) and build

further opportunity and impact for The Christie/Christie Charity. This proposal will be explored in more detail at the June Charity Board.

Continued scholarly highlights include The Christie Library team have named authorship on a major systematic review paper of treatment toxicity in Breast Cancer and invited platform contributions at the forthcoming international ASME and AMEE Education conferences. At a local level, The Christie undergraduate education team were delighted to receive confirmation of a further, student nominated award for the quality of our undergraduate medical education, reflecting the brilliant work of all colleagues who contribute to supporting students.

Strategic and Service Developments

Work continues on the refurbishment of Ward 12. As this project moves closer to completion, attention will move to the refurbishment of Ward 11.

The ASIC project team has concluded a key design stage (RIBA Stage 3) including a full review of the project cost plan. The team will continue to focus on detailed design development, supporting decant activity, commencement of supply chain engagement and the development of a target cost.

Linear accelerator 11 is being installed in the newly refurbished area, planned to be operational by the end of June.

Future Christie Project

Overview "Future Christie is our bold transformation programme to modernise cancer care—digitally, clinically, and culturally. We're building a world-leading, intelligent cancer centre where patients access care in real-time, clinicians are supported by cutting-edge tools, and data drives every decision. It's not just about technology, it's about reimagining how The Christie delivers care, connects services, and leads innovation across the NHS."

Building the team - We have appointed Sarah Mcgovern a very capable leader who has a fantastic track record in organisation transformation to the role Associate Director of Transformation. The role will be key to delivering the scale and pace of change required to meet the ambitions of the organisation.

Approach to Change - Through a workshop with members of the Senior Management committee we are revising the leadership and coordination of transformation resource in the organisation with the aim to deliver a coordinated vision, faster execution and higher impact.

- A unified, clinically led, high-impact transformation
- Fewer, more strategic changes with visible outcomes
- Whole-organisation approach rooted in engagement and pace of change
- Strong clinical and operational leadership guiding digital and service change
- Centralised transformation and digital support function

Programs of work – The Future Christie Patient - Initial roll out of the Christie patient portal has commenced with a cohort of patients who will be able to access their letters, consultant appointments and Electronic patient reported outcomes.

Future Christie Clinician - Initiation of the strategic outline case to procure the latest generation of Electronic Patient record

Intelligent Hospital - The Christie has signed the MOU for joining the national Federated Data Platform. This will provide a sustainable basis of storing, interrogating data across the NHS and public sector

Regulation and Governance

Performance Assessment Framework

NHS England has developed an updated Assessment Framework which will replace the previous Oversight Framework, setting out how success and areas for improvement will be identified, and how organisations will be rated. This will apply to trusts who provide services, and to integrated care boards (ICB) who have the responsibility to assess population need and arrange services to meet those needs. This updated framework was subject to a public consultation in summer 2024 and extensive engagement with the NHS took place between December 2024 and January 2025.

Key changes that have been made since consultation;

1. Segmentation decisions will be based only on the delivery metrics (outlined below) and will not be adjusted for organisational capability. This is so there is full transparency for the public about how their local NHS is performing.
2. Providers scores will not be adjusted for system considerations, i.e. their delivery scores cannot be moderated for system performance, instead the extent to which they are collaborating will be included in a separate capability rating which will be used to inform NHSE's regulatory response
3. Overrides have been included for finance which means organisations in deficit/or that score a 4 in finance domain have their overall segment score limited to 3
4. The introduction of segment 5 which is effectively the category for the organisations needing the most intensive support informed by a diagnostic review
5. NHSE have removed the detail of their approach to organisational capability for both ICB and Providers as they wish to complete and test their work on this as they finalise the improvement approach. This will be done in Q1.

The delivery metrics or indicators that make up the assessment (below) will be outlined in the monthly Integrated Performance, Quality & Finance Report from the end of Q1.

Indicator / delivery metrics	Indicative scoring
Operating priorities	
Elective	**1**
Proportion of incomplete patient pathways waiting over 52 weeks	
Proportion of incomplete patient pathways waiting less than 18 weeks	
Estimated days to clear all incomplete pathways with no new clock starts (Clearance time)	
Cancer	
Proportion of urgent referrals to receive a definitive diagnosis within 4 weeks	
Proportion of patients treated for cancer within 62 days of referral	
Outcomes	
Percentage of Healthcare Workers involved with direct patient care taking up flu vaccination	**1**
Average number of days between discharge ready date and actual date of discharge	
Proportion of inpatients making a supported attempt to quit smoking though an in-house tobacco dependence treatment service	
Emergency rate of readmissions within 30 days of discharge (Banding)	
Proportion of patients waiting more than 6 weeks for a diagnostic test or procedure	
Summary Hospital Mortality Indicator	
Quality & inequalities	
Experience	**1**
National CQC inpatient survey overall experience rating	
Workforce	
National Education and Training Survey - Level of satisfaction with overall experience	
All staff leaver rate	
Sickness absence rate	
NHS Staff Survey engagement sub-score	
Safety	
NHS Staff Survey raising concerns sub-score	
CQC safe domain inspection rating	

Indicator / delivery metrics	Indicative scoring
Percentage of hospital spells where a new pressure ulcer has been acquired	
Rate of inpatients to suffer a new hip fracture	
12 month rolling count of MRSA cases	
12 month rolling count of C.Difficile cases as a proportion of trust threshold	
12 month rolling count of e.coli cases as a proportion of trust threshold	
Inequalities	
Under 18, elective 18 week performance	
Productivity & value for money	
Finance & efficiency	**1**
Planned surplus / deficit as a proportion of turnover	
Year to date variance to plan	
Delivery confidence level (Derived from plan and YTD variance)	
Productivity	
Implied rate of productivity compared with baseline	

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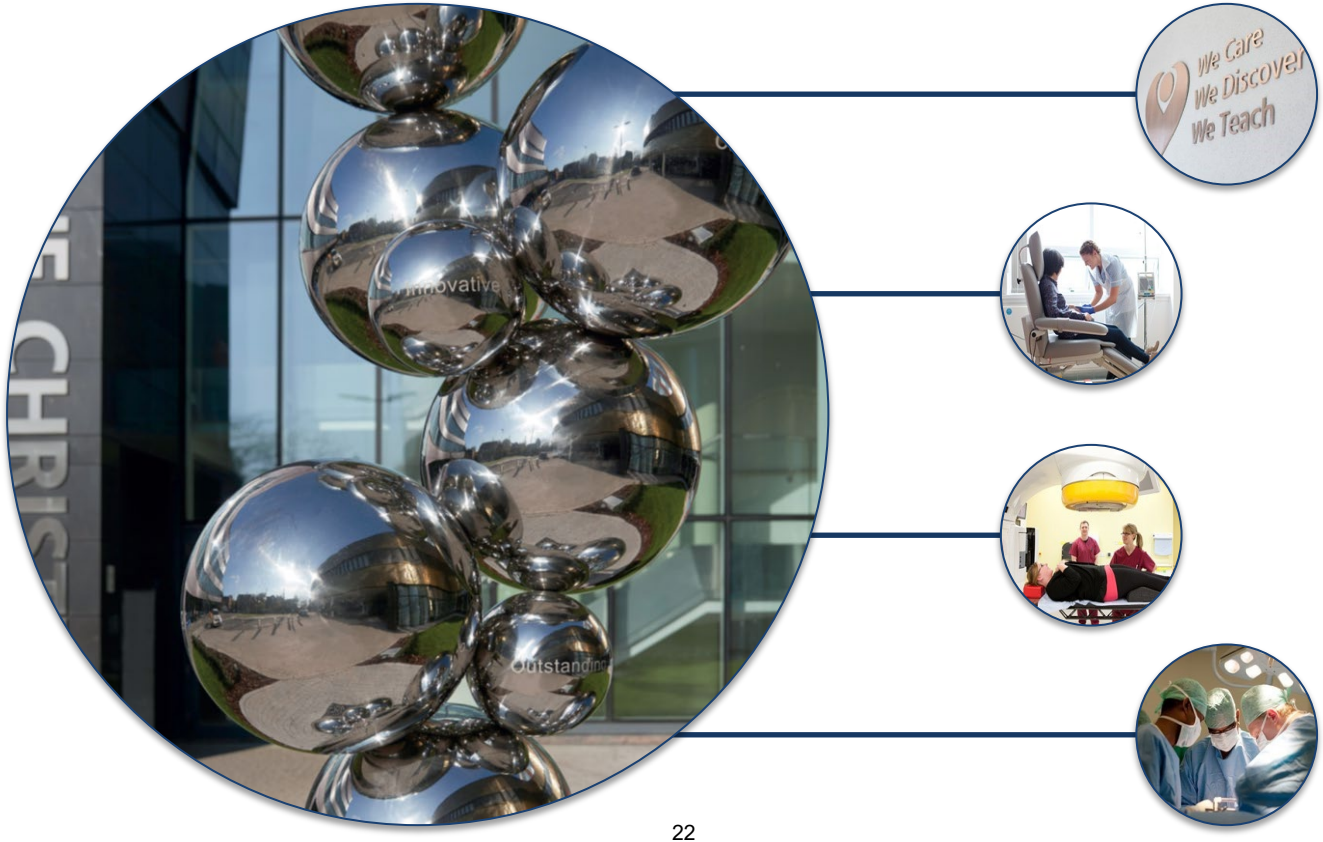

EXECUTIVE SUMMARY

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

Safety

- 2 incidents in May were identified as meeting the criteria of a notifiable safety incident and so required statutory duty of candour.
- There are 6 Trust level risks scored at 15+. Details of these can be found on slide 8.
- 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 4 cases of C-Difficile, 5 cases of E-Coli, 3 cases of Klebsiella. 1 case of Pseudomonas, 3 cases of MSSA, and 1 case of MRSA reported in May that were deemed attributable to the Trust. No lapses in care were identified.

Performance

- In May the combined 62-day performance subject to validation was at 68.5% which is below the 25/26 stretch target set at 75%. The combined 31-day performance was 97.9% which is above the standard of 96%. The internal 24-day performance was below our internal standard at 67.4%. All 62 and 24-day breaches are reviewed to ensure any delays are understood and plans can be implemented to mitigate any future delays. The Trust's RTT 18-week performance is well above standard at 95.1%. The Trust achieved the 80% faster diagnosis stretch target in May with a compliance score of 82.6%.
- There were two patients waiting over 52 weeks at the end of May. Both patients are on complex pathways and their pathways contain significant patient-initiated delays.
- Referral numbers in May remained at a consistent level with April and above the 24/25 average. Referral levels are expected to be routinely above the 24/25 average due to the increase in Haematology referrals following the service takeover from Mid Cheshire.

HR

- Staff absence reduced slightly in May to a position of 4.11% against a target of 3.4%.
- PDR performance decreased slightly from April's position. Mandatory training slightly improved and remains well above the set standard.

Finance

- The Trust is reporting a surplus at the end of M02 of (£1.2m) against a M01 YTD plan of (£1.3m), which gives a month 02 variance of £0.1m under plan.
- Capital spend for 2025-26 was £1.2m, this was (£0.6m) above the revised plan submitted to NHSE.
- The Trust has incurred £1.2m on capital schemes at month 2 2025-26, overspending by £0.6m against the revised plan submitted to NHSE.

SUMMARY DASHBOARD

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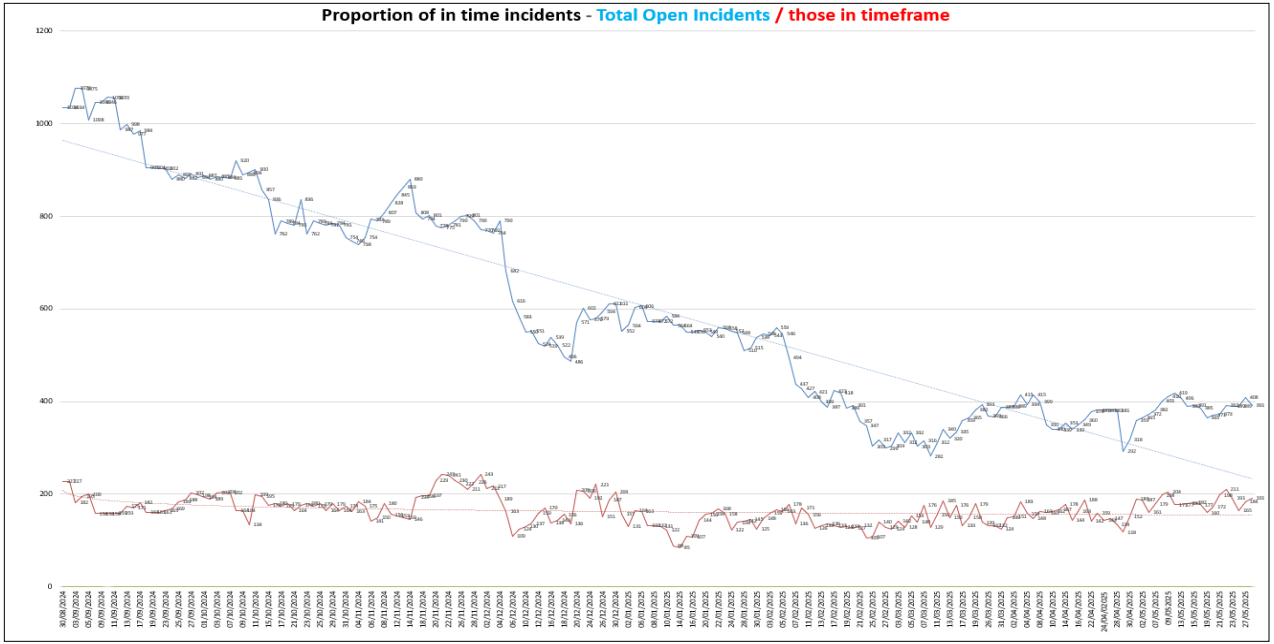
Indicator	Threshold / Standard 25/26	Apr-25	May-25	YTD
Patient Safety Incident Investigations Reported	-	1	2	3
Never Events	0	0	0	0
Radiation Incidents Reported (IRMER Reportable)	0	2	2	4
Radiation Incidents Reported (IRMER Reportable - Grade 2 or above)	0	0	0	0
Sepsis - timely treatment with IV antibiotics (established inpatients)	90%	82.1%	93.7%	-
Sepsis - screening (presenting as an emergency)	90%	97.0%	97.7%	-
Number of Trust-Wide Risks Grade 15 or Above	-	7	6	-
28 Day Faster Diagnosis Standard	80%	94.7%	82.6%	-
62 Day Compliance	75%	72.1%	68.5%	-
24 Day Compliance	85%	72.2%	67.4%	-
31 Day Compliance	96%	99.1%	97.9%	-
18 Weeks Compliance - Incomplete Pathways	92%	95.1%	95.1%	-
Patients waiting >52 Weeks	0	0	2	2
Patients waiting >62 days at end of month (62 Day Classic)	80	115	127	-
Patients waiting >104 days at end of month (All 62 Day Targets)	-	53	52	-
Length Of Stay (Elective & Non-Elective Inpatients)	-	6.71	7.44	-
Patients Discharged Beyond Ready for Discharge Date	-	8	6	14
Patients Discharged Beyond Ready for Discharge Date - Total Bed Days Lost (days counted in the month of discharge)	-	161	220	381
Patients Discharged Beyond Ready for Discharge Date - Average Bed Days Lost (days counted in the month of discharge)	-	20.1	36.7	-
Hospital Cancelled Operations on the day for non clinical reasons	0	4	4	8
Hospital Cancelled Operations on the day for non clinical reasons - NOT rebooked within 28 days	0	0	0	0
Complaints Received	13 (24/25 Avg)	13	12	25
PALS Contacts	37 (24/25 Avg)	31	44	75
MRSA	0	0	1	1
C-Difficile - All Attributable Cases (Pre & Post 48 Hours)	Awaiting 25/26 Target	4	4	8
C-Difficile - Attributable Cases Due To Lapse In Care	0	0	0	0
MSSA Bacteraemia - Attributable	Awaiting 25/26 Target	4	3	7
E-Coli - Attributable		4	5	9
Klebsiella Species - Attributable		1	3	4
Pseudomonas Aeuriginosa - Attributable		1	1	2
Staff Sickness	3.4%	4.18%	4.11%	-
Staff Mandatory Training	>80%** / <80%	93.5%	93.9%	-
Staff PDRs	-	87.6%	87.4%	-

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

Incident Management



At the time of reporting, 46% of incidents were managed locally within 10 calendar days, 54% of incidents are overdue management and closure.

Divisions continue to hold divisional patient safety improvement groups (DPSIG) meetings on a weekly basis which provide oversight on a divisional level of all incidents, emerging themes and potential risks to patient safety. The DPSIG process is supported by the patient safety team via the PSIRF delivery group.

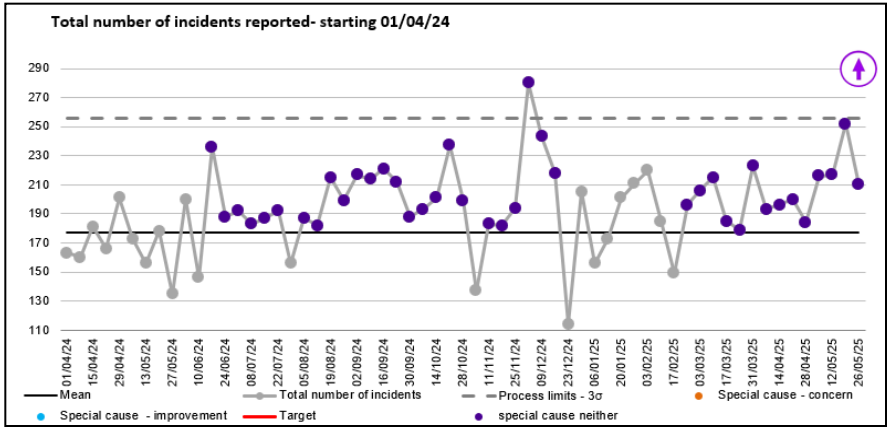
Dashboards have been developed for each division to show live incident management progress that can be utilised to highlight areas that require further support/ education.

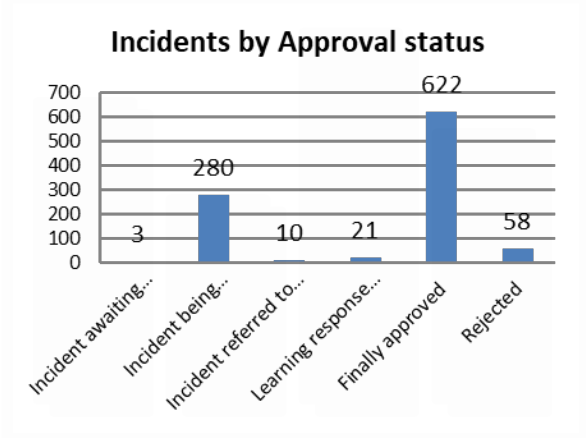
Ongoing work with the divisional teams to ensure timely management of incidents 25

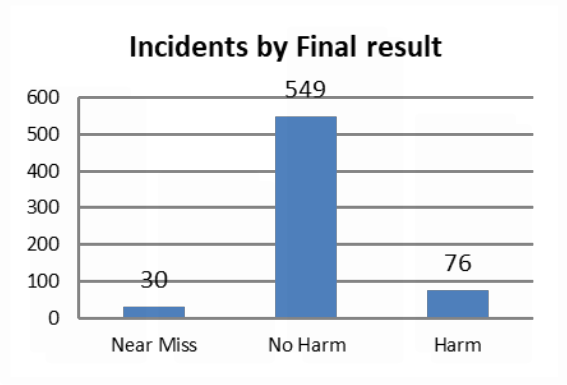
Incident Reporting

A total of 994 incidents were reported to DCIQ in May 2025.

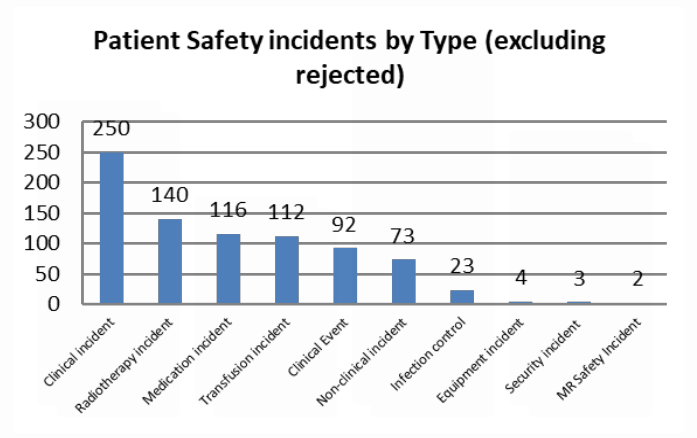
- At the time of reporting, 63% of incidents have been finally approved. 6% of incidents have been rejected for reasons such as duplication and incidents which involve care provided by an external trust.
- Reporting trends in May were within trust expected limits.
- 84% of incidents reported resulted in no harm
- 5% of incidents were reported to be a 'near miss', evidencing a positive reporting culture





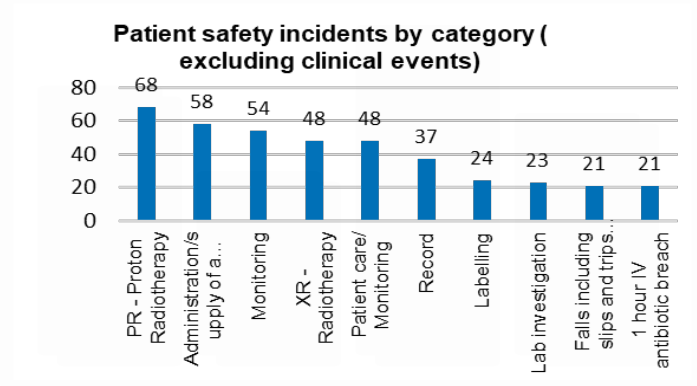


Incident Reporting



In May 2025, 87% of all incidents reported (864/994) were classed as 'Incidents affecting a patient' and therefore reported to LFPSE (Learning from Patient Safety Events).

The chart shows that of these (excluding rejected), 92 (11%) were clinical events, this category includes cardiac arrests, known complications and events recorded for monitoring purposes.



The remaining 723 incidents were categorised in the DCIQ system, and the chart shows the top 10 categories identified.

Administration/ supply of a medicine- These incidents are broken down into further sub-categories and monitored through the Medicines Safety Priority group- MTSIG.

Proton Radiotherapy - High reporting by the radiotherapy directorate is typical due to the requirement to report radiotherapy error and near misses (RTE) to NHS England.

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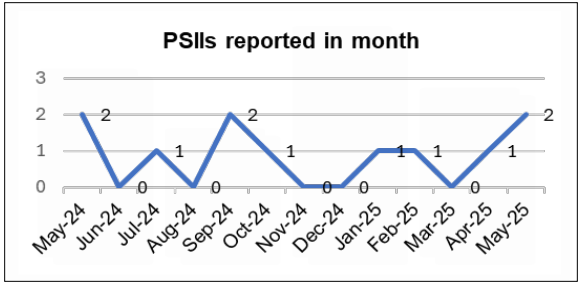
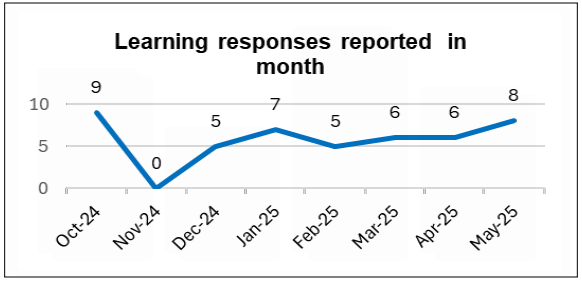
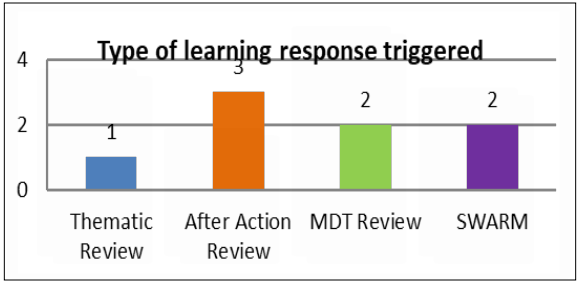
Incidents identified that require a Learning Response







- Learning responses are triggered when an opportunity for new learning is identified.
- Potential learning responses are discussed and agreed at the PSIRF delivery group which is held weekly and attended by the patient safety team and divisional governance teams.
- 8 learning responses were triggered both locally and via the divisional PSIGs in May 2025.

- SWARM and After-Action Reviews are favoured locally in clinical teams; feedback suggests that these are easily established and engage a wide range of staff quickly.
- MDTs are favoured when a more in-depth review is required, and feedback suggests these have replaced the RCA under the SI framework.
- Thematic reviews are triggered least but are labour intensive to complete, considering common factors across a tranche of incidents to develop action learning / recommendations
- 2 MDT reviews ,2 SWARMs, 3 After action reviews and 1 themed review was triggered in May 2025.

- Patient Safety Incident Investigations (PSII) are triggered when there is a significant opportunity for learning and improvement. PSIIs are extensive investigations which result in specific outcomes recommended by trained investigator.
- 2 PSIIs were reported in May 2025:
- I12075 – fluid balance monitoring and care in the last days of life
- I12226 – missed opportunity to identify and treat immune related myositis

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Operational Risks

The Christie NHS Foundation Trust

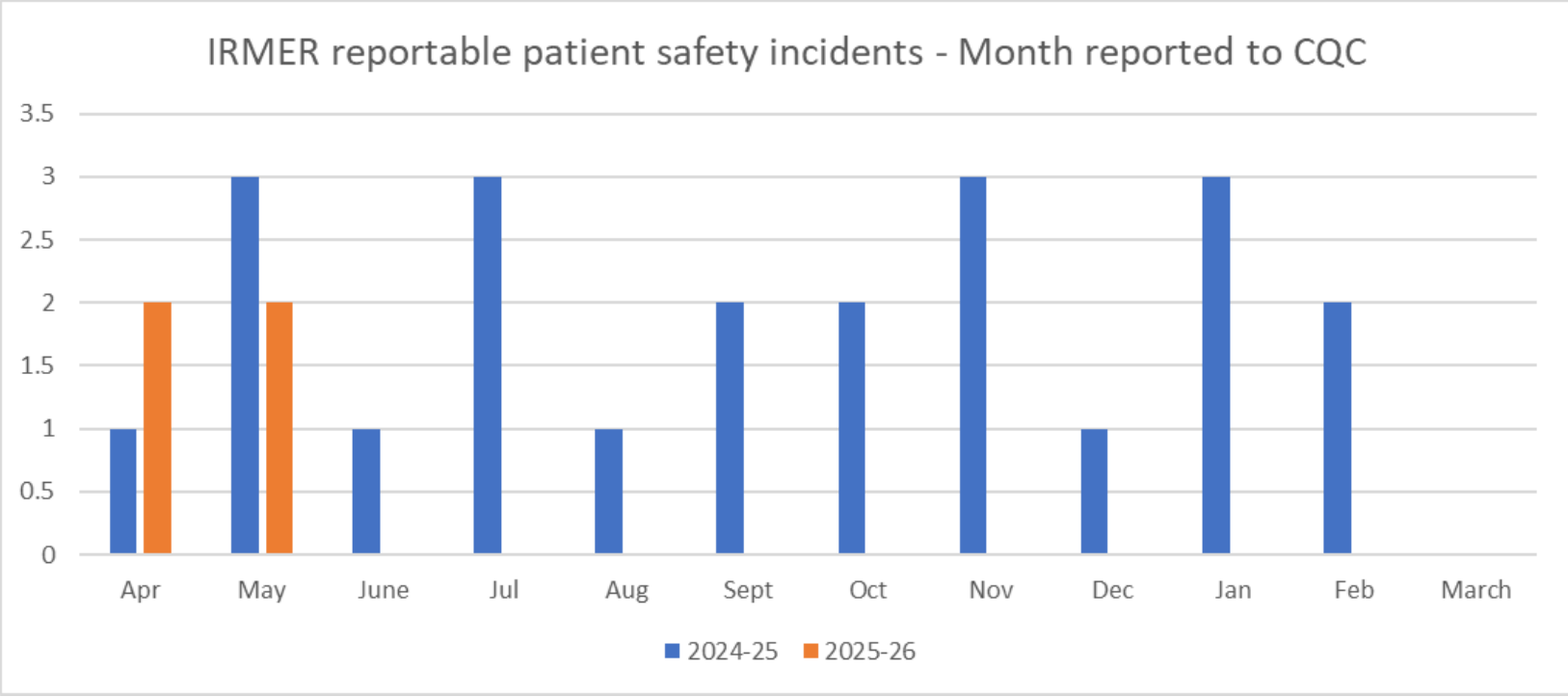
Risks with a current risk score of 15 and above.

Risk ID	Risk	Risk Register	Subtype	Risk owner	Date opened	Initial rating	Current rating	Target rating	Movement	Next Review Date	Review comments
108	Breach of trust compliance target 28- day Faster Diagnosis Standard (FDS) for patients with a possible haematology malignancy	Haematology Teenage and Young Adults	Patient Experience Risk	Chloe Read	12/03/2025	12	15	9	↑	12/06/2025	
194	Risk to patient safety & experience due to issues relating to lack of visibility of virology blood tests sent externally to MFT	Haematology Teenage and Young Adults	Patient Experience Risk	Ruth Elizabeth Clout	20/08/2024	12	15	6	↑	30/05/2025	
204	Risk to Treatment Delivery due to ASU Workforce Recruitment & Retention	Pharmacy	Business Continuity Risk	Anna Mcnicholas	19/03/2025	9	15	6	↑	16/06/2025	Risk increased after divisional board on 11th April - the risks of not having sufficient staff to do roles which enable dispensing to occur.
357	There is a risk of a patient inadvertently receiving an unintended blood component or product	Trustwide	Patient Safety / Outcomes Risk	Sharon Jackson	16/06/2023	10	15	5	↑	18/05/2025	
389	Not Identifying and Delivering 25/26 recurrent VIP programme impacting on financial sustainability and ability to treat patients	Trustwide	Financial Management / Waste Reduction Risk	Claire Mcpeake	30/10/2024	16	16	16	↔	01/04/2025	
453	There is a risk to patient safety and experience due to issues relating to how results appear from blood tests sent externally to Manchester Foundation Trust (MFT).	Haematology Teenage and Young Adults	Patient Safety / Outcomes Risk	Victoria Burns	14/05/2025	15	15	6	↔	27/06/2025	

- As of the current reporting period, six risks have a score of 15 or higher.
- There has been no change in the outstanding risk scores since last month.
- In May, none of the identified extreme risks were reviewed within the required trust timescales or in accordance with the trust's risk review process, which mandates monthly reviews through the 'Risk Review' tab and includes documented justification for any changes in risk scores.
- 1 new risk, with a score of 15, was opened on the Haematology: Teenage and Young Adult risk register (ID 453)

Radiation Incidents

There were 2 IRMER reportable incidents reported to IRMER CQC in May 2025.



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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	16787	13648	5252	5.7
	Total monthly ACTUAL	16737	13360		
	Average Fill Rate %	99.7%	97.9%		
Care Staff	Total monthly PLANNED	10921	7405	5252	3.2
	Total monthly ACTUAL	9793	6772		
	Average Fill Rate %	89.7%	91.5%		
ALL Staff	Total monthly PLANNED	27708	21053	5252	8.9
	Total monthly ACTUAL	26530	20132		
	Average Fill Rate %	95.7%	95.6%		

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	2430	2225	91.6%	2308	2008	87.0%	168	25.2
Palatine Ward	3219	3080	95.7%	2556	2271	88.8%	918	5.8
Ward 10	2280	2033	89.2%	1776	1634	92.0%	766	4.8
Ward 11	2147	2115	98.5%	1655	1602	96.8%	852	4.4
Ward 12	1612	1846	114.5%	1397	1507	107.9%	612	5.5
Ward 4	1882	1856	98.6%	1497	1525	101.9%	804	4.2
Ward 2	975	1444	148.1%	556	1031	185.4%	537	4.6
Acute Assessment Unit	2242	2138	95.4%	1903	1782	93.6%	595	6.6
TOTAL	16787	16737	99.7%	13648	13360	97.9%	5252	5.7

Registered Nursing Associates	DAY			NIGHT		
	Hours Planned	Hours Actual		Hours Planned	Hours Actual	
Critical Care Unit						
Palatine Ward						
Ward 10						
Ward 11		15				
Ward 12						
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	382	340	89.0%	0	11	100.0%	168	2.1
Palatine Ward	1330	1167	87.7%	1195	1110	92.9%	918	2.5
Ward 10	1861	1401	75.3%	917	768	83.8%	766	2.8
Ward 11	1769	1612	91.1%	1373	1244	90.6%	852	3.4
Ward 12	1918	1841	96.0%	1553	1441	92.8%	612	5.4
Ward 4	1724	1562	90.6%	1207	1092	90.5%	804	3.3
Ward 2	784	681	86.9%	338	374	110.7%	537	2.0
Acute Assessment Unit	1153	1189	103.1%	822	732	89.1%	595	3.2
TOTAL	10921	9793	89.7%	7405	6772	91.5%	5252	3.2

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 recently passed away and family wanted to pass on their gratitude and thanks to everyone at The Christie for the precious time that her treatment gave them all. At the time of her passing her cancer was stable and she died due to frailty and was pain free. The patient was diagnosed with cancer at 78 and the family were fearful that she would not be offered treatment as an older person. However, this could not have been further from the truth, she received treatment that gave her nearly two years that the family would not have had. Everyone at the Christie who treated the patient with the utmost care and respect and the family don't know how they would have coped without the help and advice received."

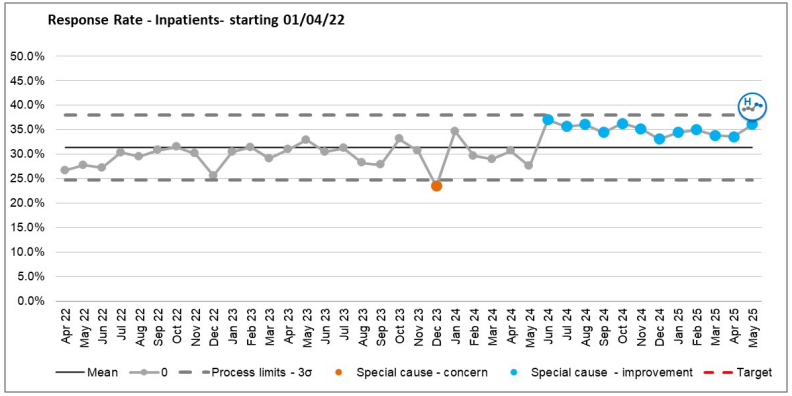
"Compliment the smoking cessation team, last week or week before they called patient and provided him with free inhaler to help him stop smoking, they gave him great hints and tips to help with giving up smoking and he feels inspired."

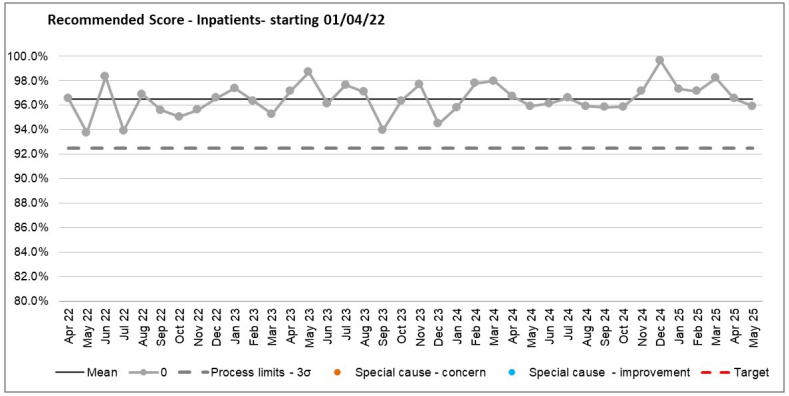
"We cannot speak highly enough about the support and care provided by all at the AAU. The staff were very thorough in their treatment and assessment. They admitted the patient to the ward overnight and fundamentally changed her pain relief with positive results so far. Everyone there was so kind and pleasant to her."

Friends & Family Test

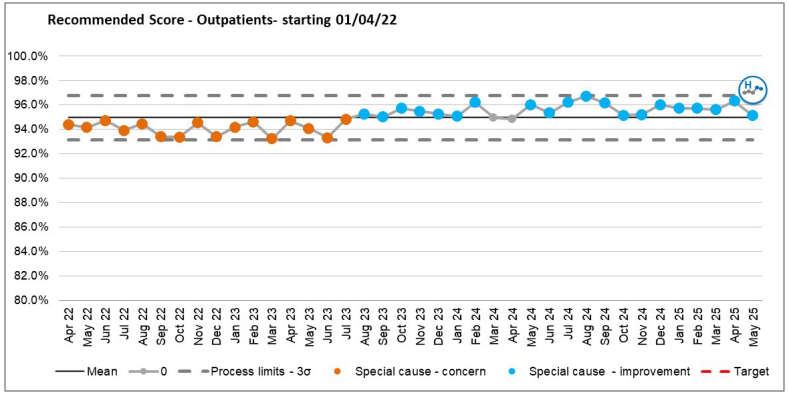
The Christie NHS Foundation Trust

Monthly Summary

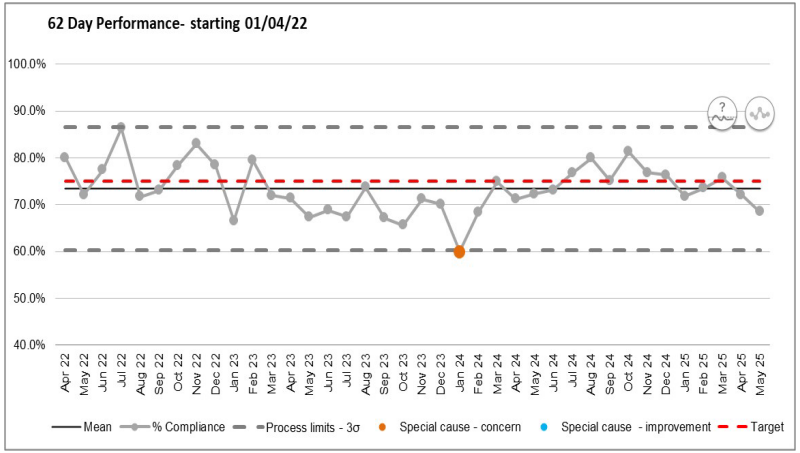


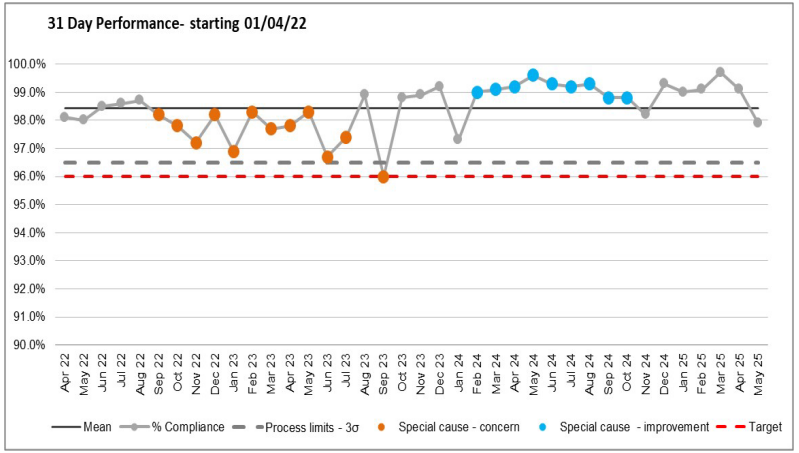


The Inpatient response rate continues to show improvement in recent months. Both the recommended percentage scores for Outpatients and Inpatients remain high with Outpatients maintaining a sustained period of high performance.



Cancer Standards





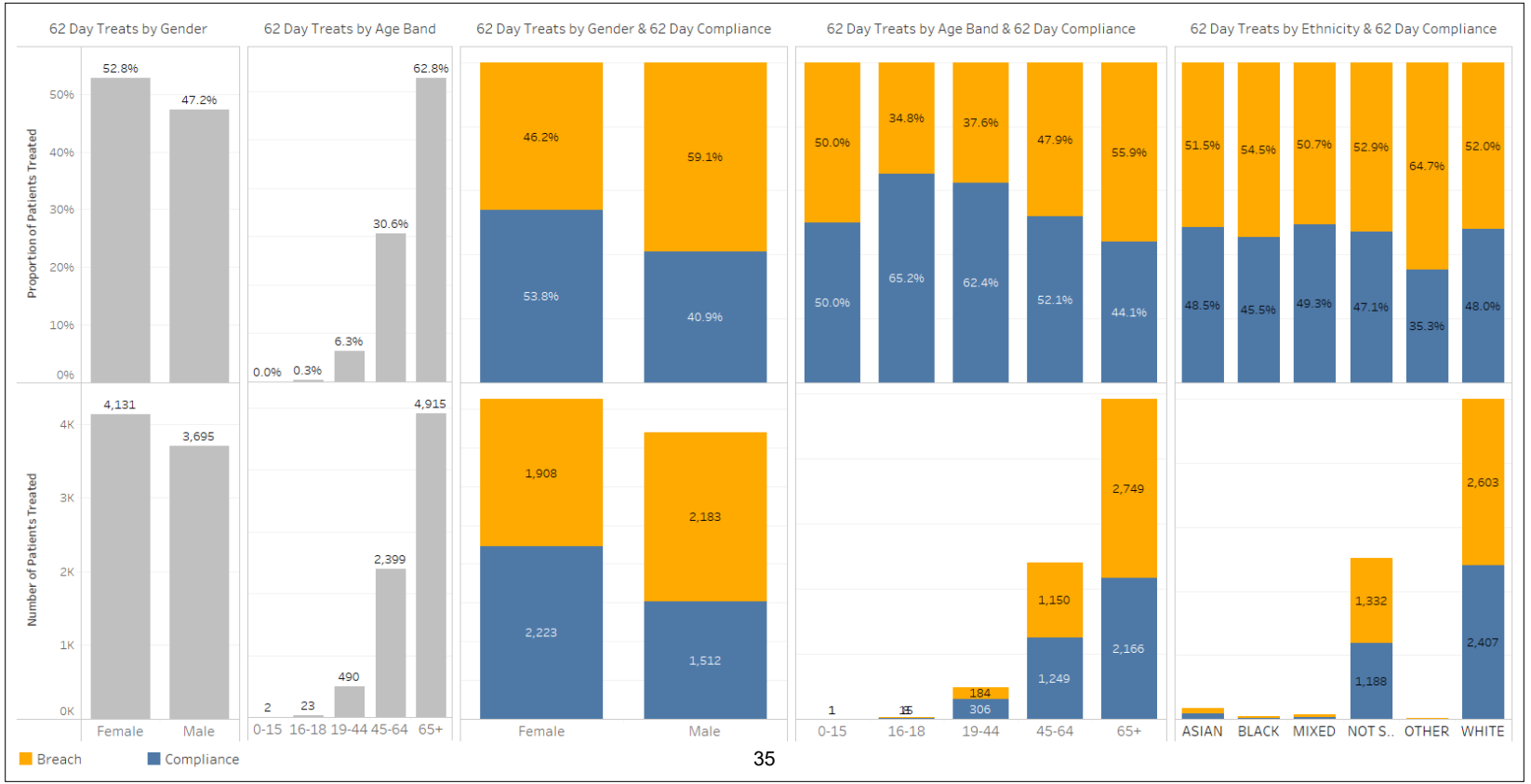
National Standard	25/26 Standard	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
62 Day	75%	72.3%	73.1%	76.7%	79.9%	75.1%	81.3%	76.8%	76.3%	71.8%	73.5%	75.7%	72.1%	**68.5%**
28 Day FDS	80%	75.0%	100.0%	91.7%	86.4%	90.0%	81.3%	89.5%	88.9%	83.3%	87.5%	87.0%	94.7%	**82.6%**
24 Day Internal	85%	72.5%	74.9%	78.2%	78.8%	73.1%	77.5%	75.0%	76.6%	71.2%	72.8%	72.1%	72.2%	**67.4%**
31 Days	96%	99.6%	99.3%	99.2%	99.3%	98.8%	98.8%	98.2%	99.3%	99.0%	99.1%	99.7%	99.1%	**97.9%**
18 Weeks - Incomplete	92%	97.6%	97.1%	97.2%	97.1%	96.8%	97.4%	96.5%	96.6%	98.1%	96.8%	96.3%	95.1%	**95.1%**

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 75% 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 – 31/05/2025 analysed by gender, age and ethnicity.

NHS
The Christie
NHS Foundation Trust



Cancer Standards – Health Inequalities Analysis

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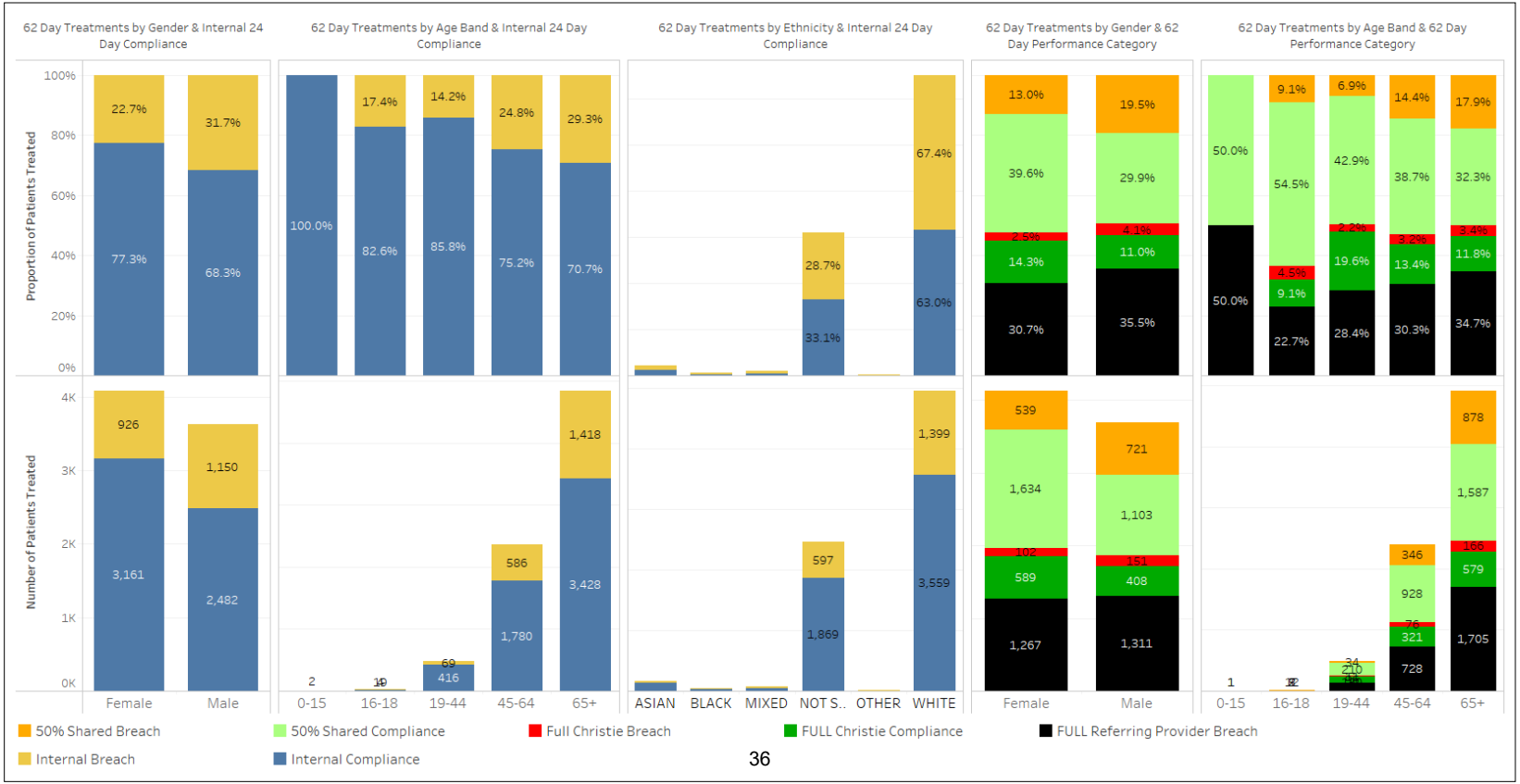
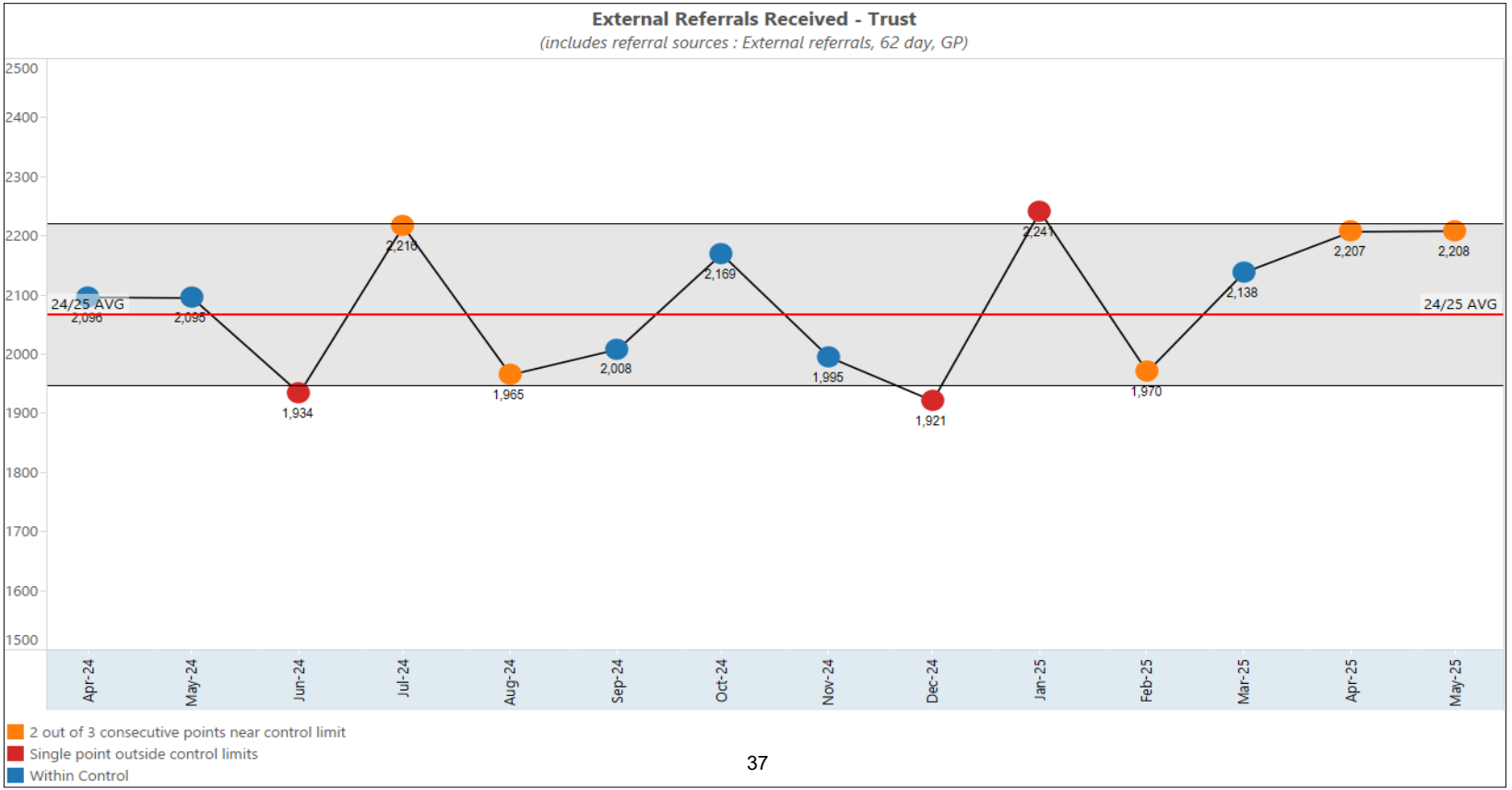
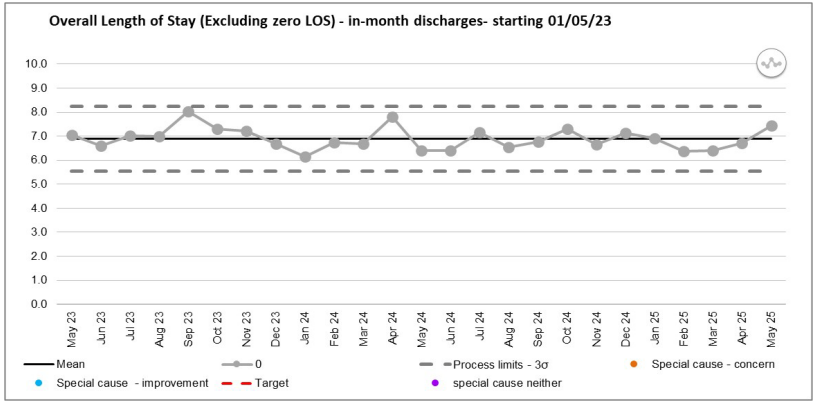
The Christie NHS Foundation Trust



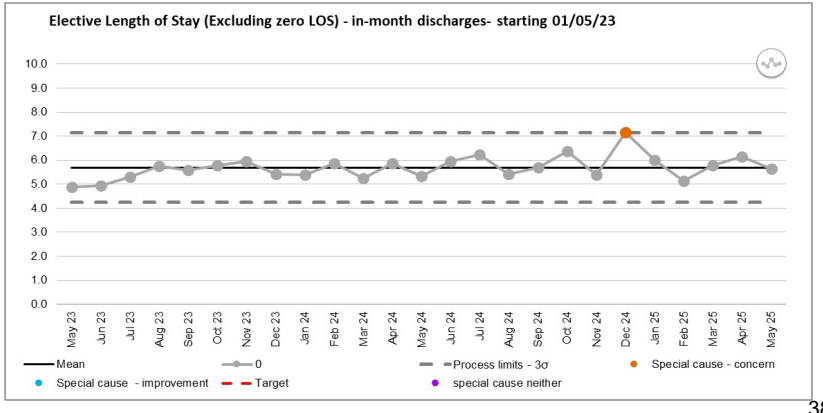
Referrals Analysis

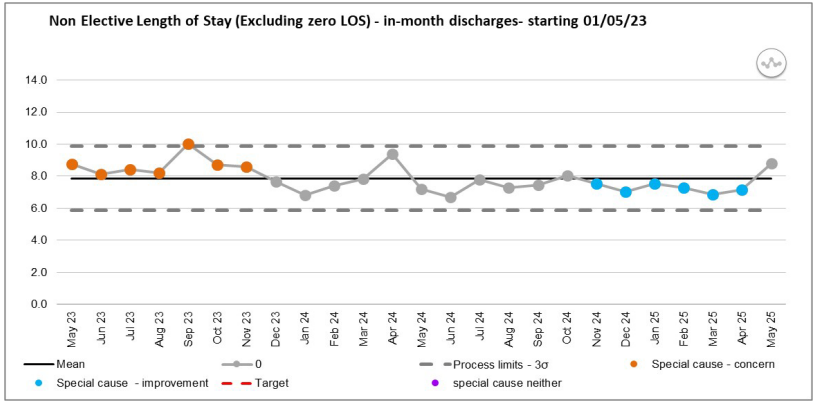


Length of Stay



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





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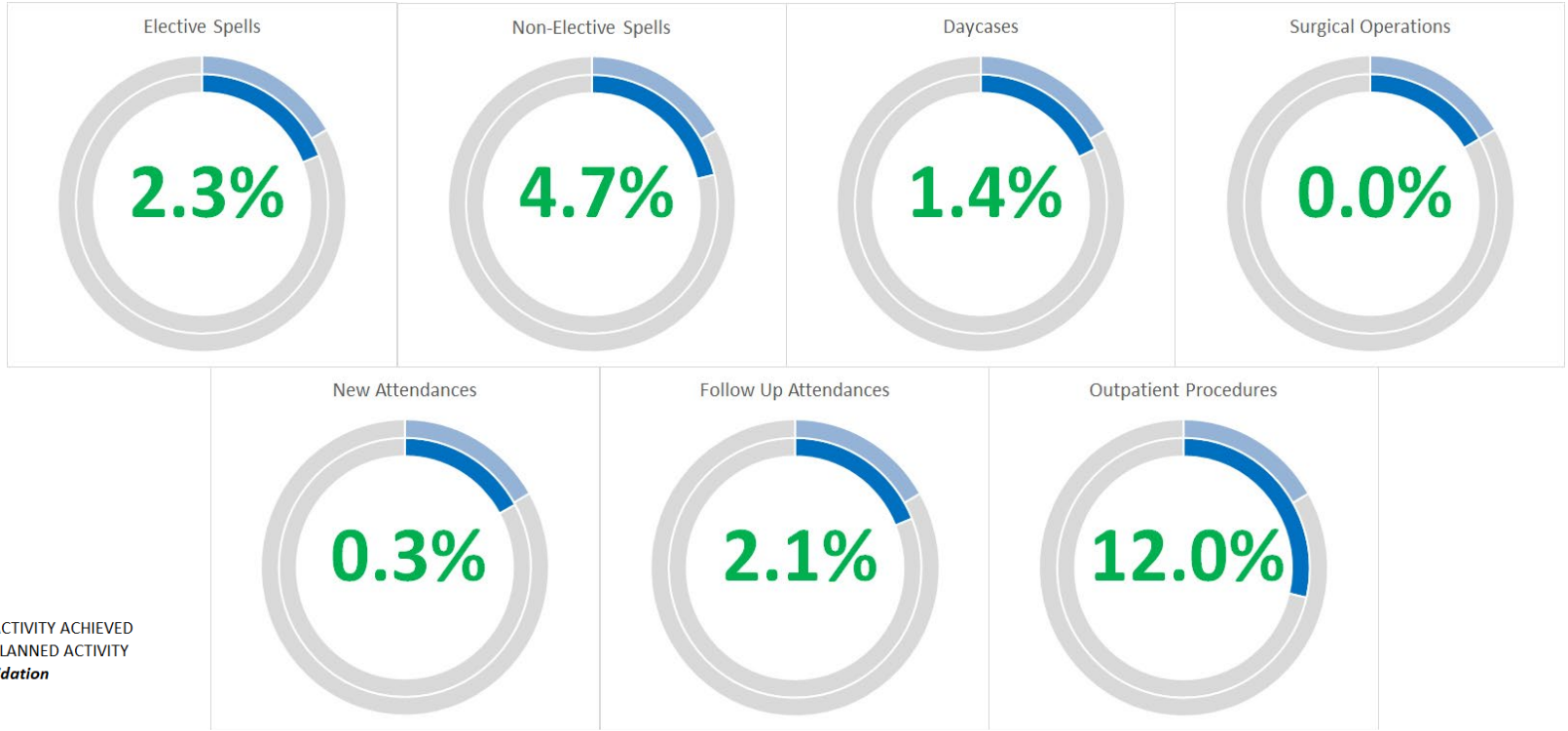
Activity – YTD Progress

Trust level activity



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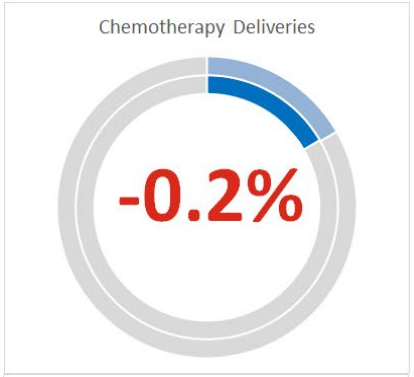
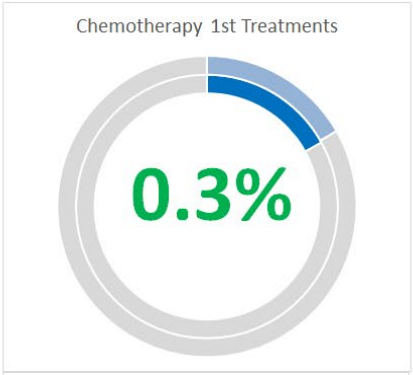
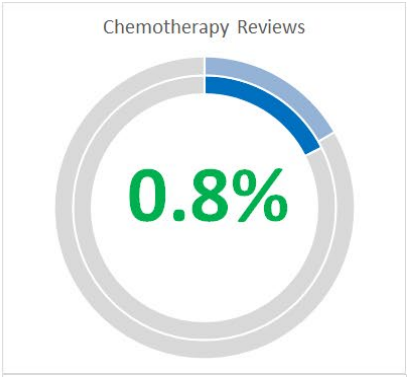
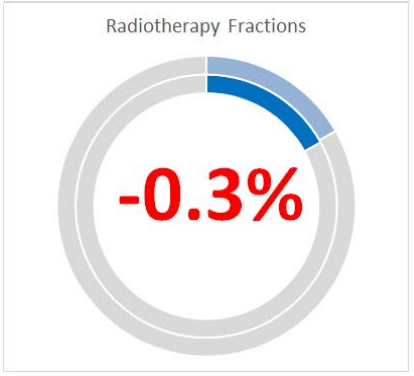
*25/26 plan information will be available at month 3. YTD performance has been compared with months 1&2 plan data from 24/25 as a guide

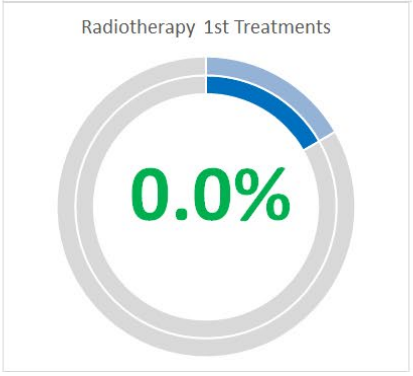
Activity – YTD Progress

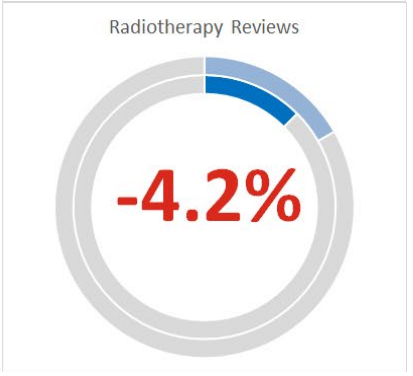








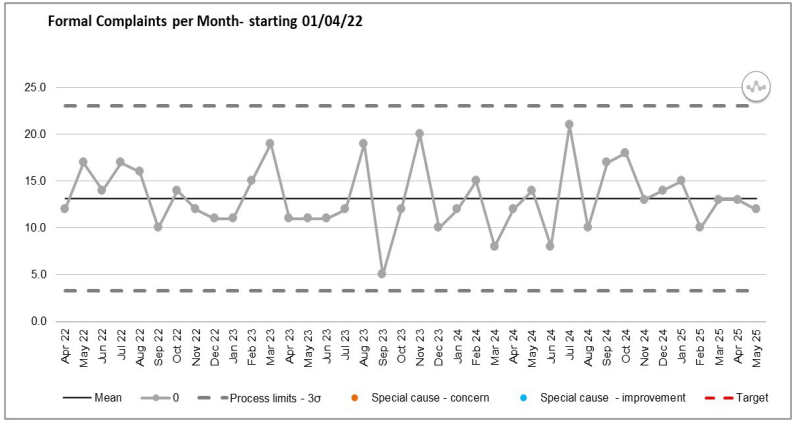


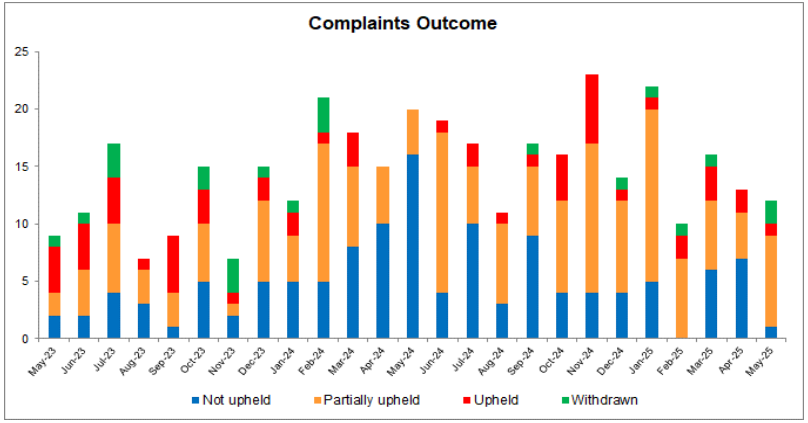


SACT 1st Treatments, 1st Fractions & Surgical Operations do not form part of the 24/25 activity plan and are used as supplementary guides to productivity. The figures are monitored against the previous year's month for comparison.

YTD ACTIVITY ACHIEVED
YTD PLANNED ACTIVITY
subject to validation

Complaints





12 new complaints received in May 2025.

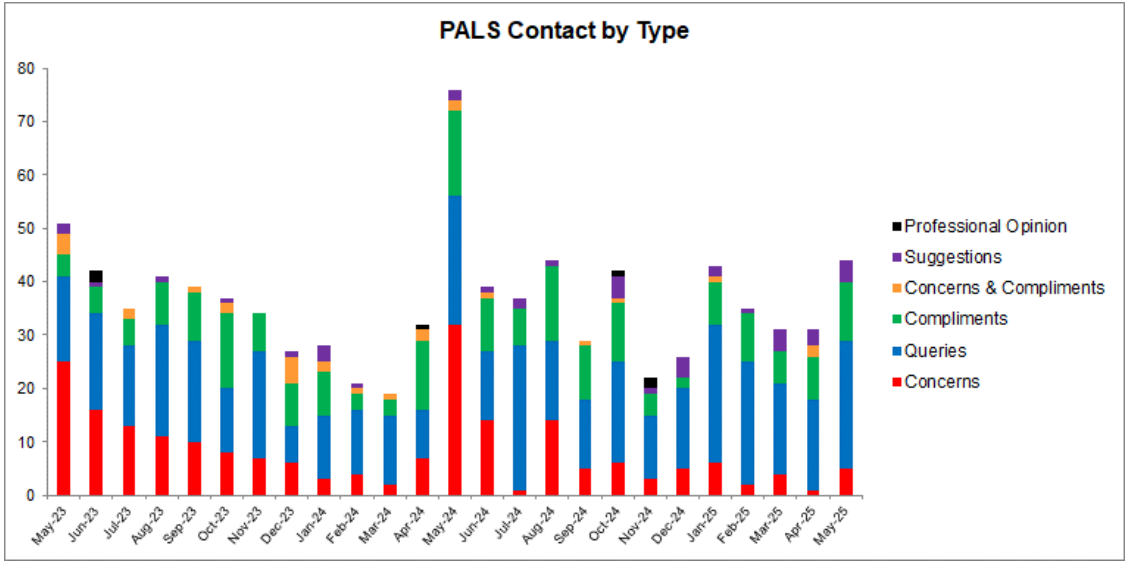
12 complaints were closed in May 2025.

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 May 2025. 3 active cases in total with the PHSO.

PALS



44 new PALS contacts have been received in May 2025.

5 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

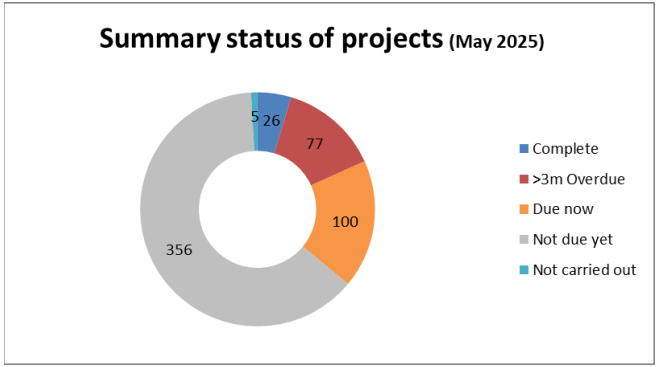
All cases reviewed through IPC team and reported through NIPR.

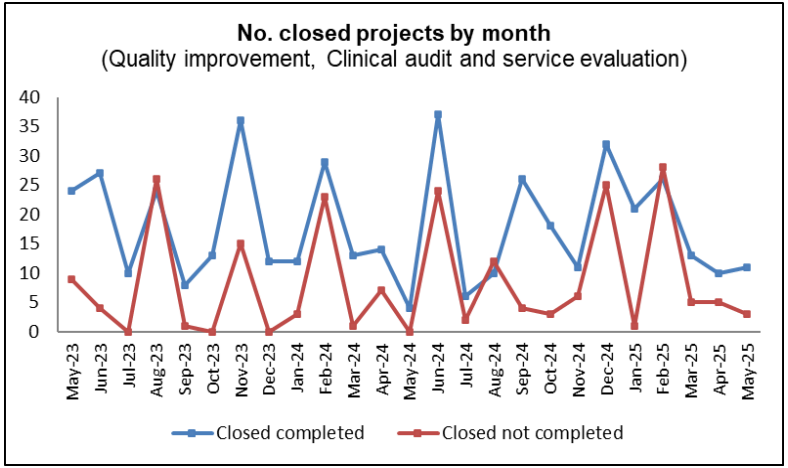
Quality Improvement & Clinical Audit

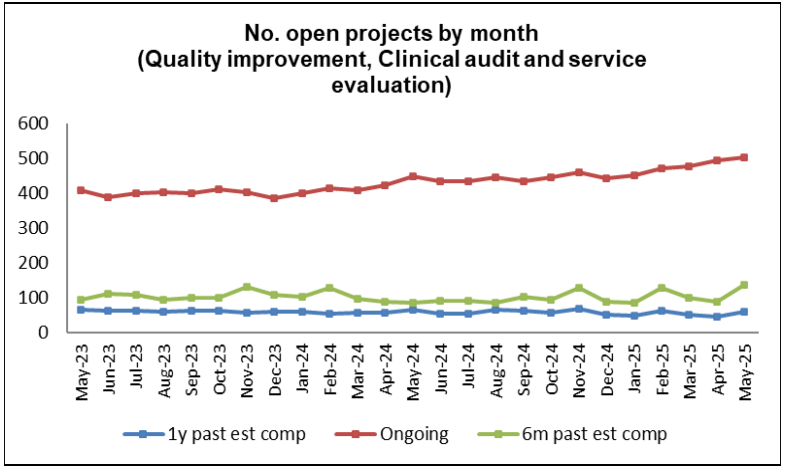
The Christie NHS Foundation Trust

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

Our sickness absence target has been revised, it is now **4.25% for 2025**

Our sickness absence rates have increased post Covid. This mirrors a trend in the NHS and across other sectors nationally. The previous absence target of 3.4% is no longer realistic.

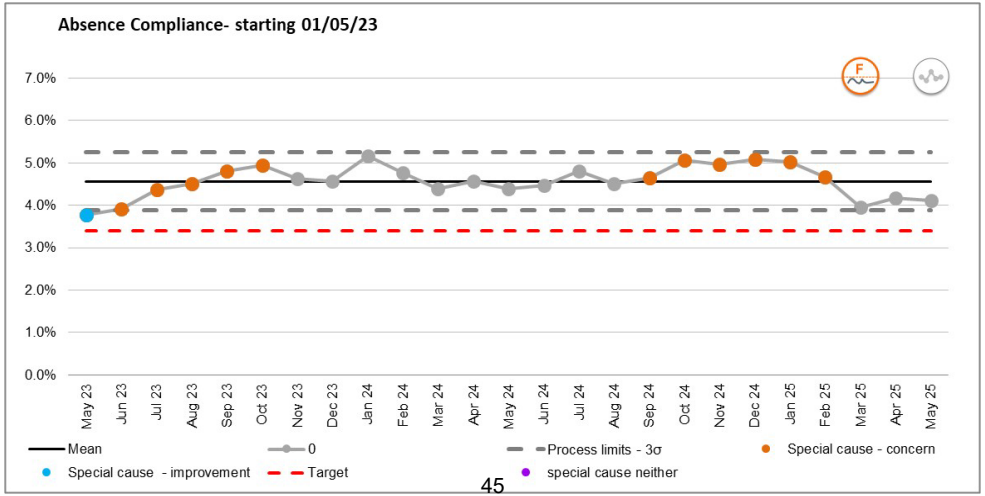
Last updated: 10/06/2025

Performance | Absence

Monthly Sickness %	Yearly Sickness %	Absences Ended	Long Term	Short Term
4.11%	4.62%	471	40	431

Trust Overview

Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
4.47%	4.80%	4.50%	4.64%	5.06%	4.96%	5.10%	5.06%	4.66%	3.95%	4.18%	4.11%



HR Metrics – Mandatory Training

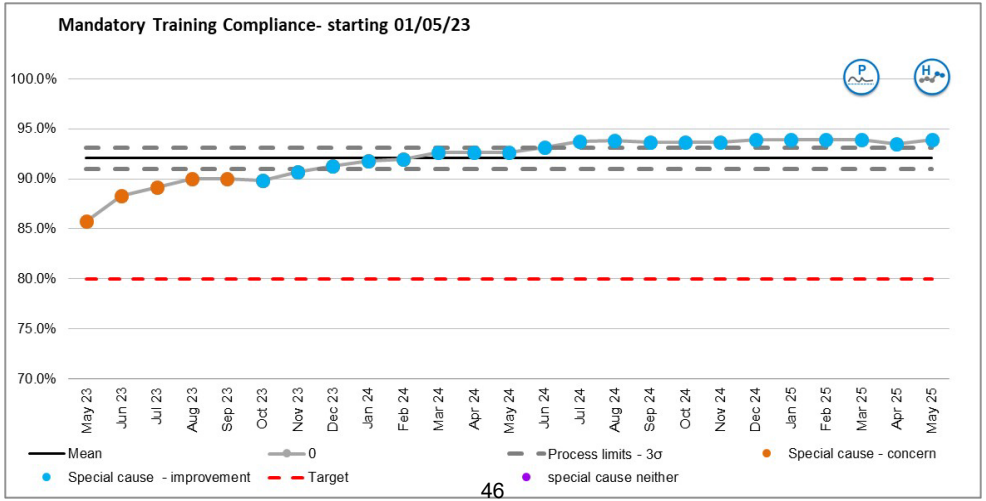
The Christie NHS Foundation Trust

Performance | Mandatory Training

Overall Compliance	Modules Outstanding	F2F Compliance	Online Compliance
93.88%	3,725	84.96%	94.76%

Trust Compliance

Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
93.19%	93.73%	93.79%	93.68%	93.66%	93.62%	93.95%	93.91%	93.94%	93.95%	93.48%	93.88%



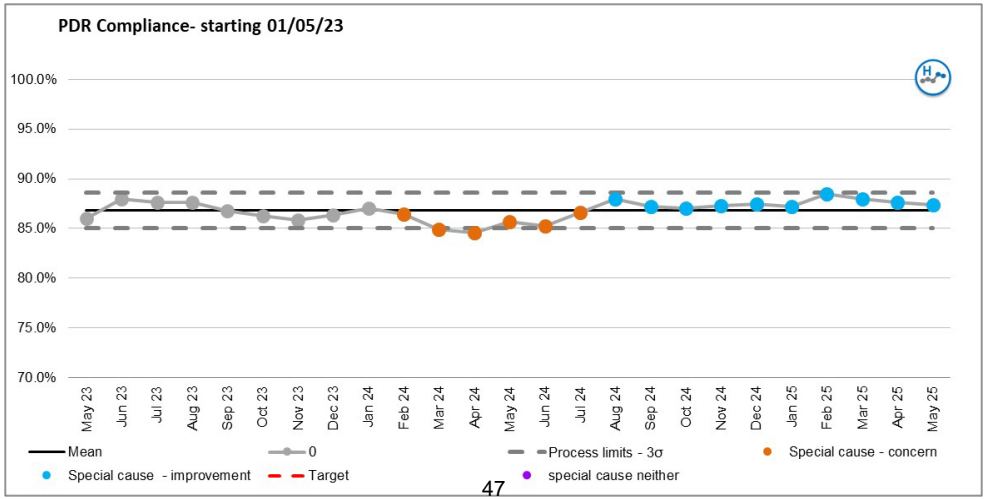
HR Metrics - PDR

The Christie NHS Foundation Trust

Performance | Appraisal

Overall Compliance	Expired Appraisals	Appraisals Due Soon
87.39%	423	564

Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
85.28%	86.63%	87.95%	87.18%	87.05%	87.27%	87.46%	87.22%	88.49%	87.93%	87.59%	87.39%



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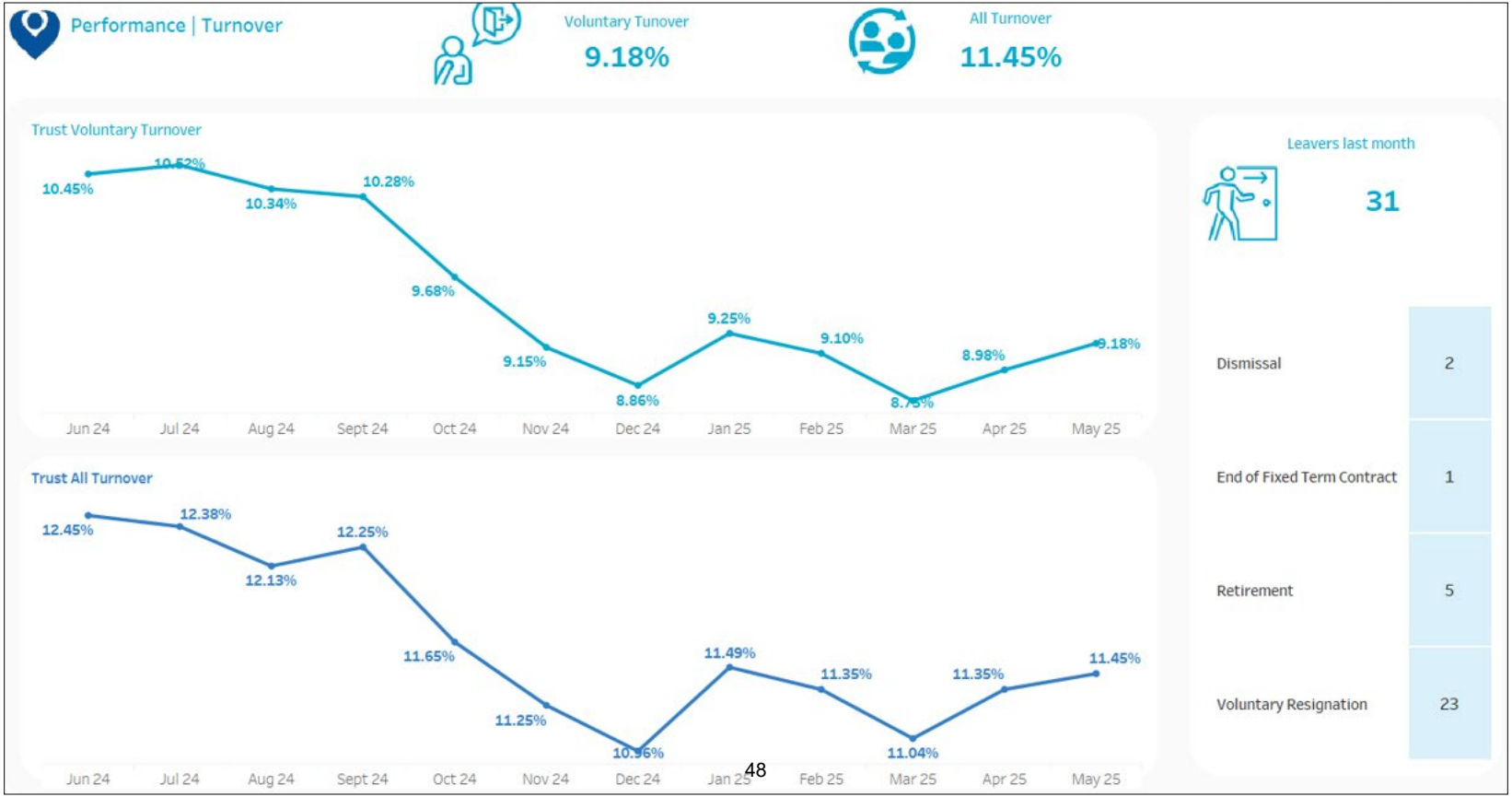
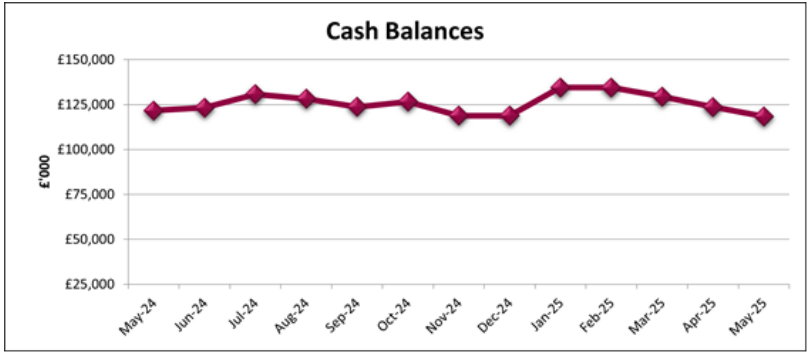
Workforce Metrics - Turnover



Finance (Executive Summary)

Month 02 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(466,475)	(77,746)	(75,987)	1,759
Other Income	(80,458)	(13,367)	(12,891)	477
Pay	264,174	43,159	42,194	(965)
Non Pay (incl drugs)	256,452	43,569	42,048	(1,521)
Operating (Surplus) / Deficit	**(26,307)**	**(4,384)**	**(4,636)**	**(252)**
Finance expenses/ income	23,089	3,848	4,229	381
(Surplus) / Deficit	**(3,218)**	**(536)**	**(407)**	**129**
Exclude impairments/ charitably funded capital donations	(4,282)	(714)	(759)	(45)
Adjusted financial performance (Surplus) / Deficit	**(7,500)**	**(1,250)**	**(1,166)**	**84**



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

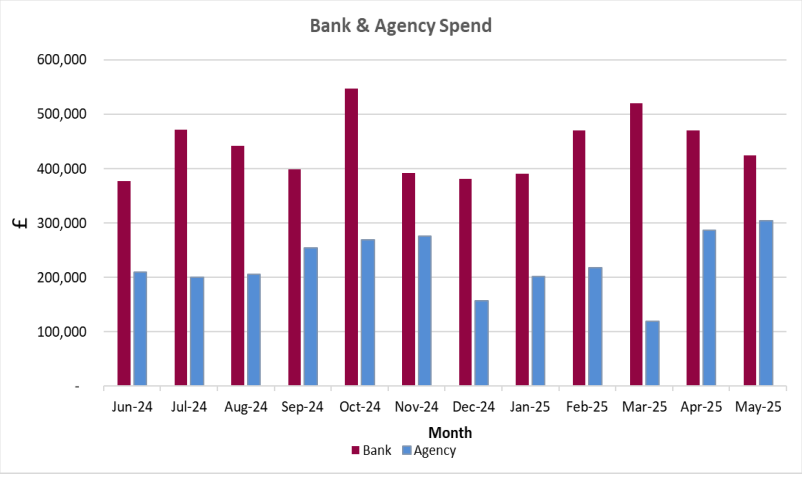
I&E

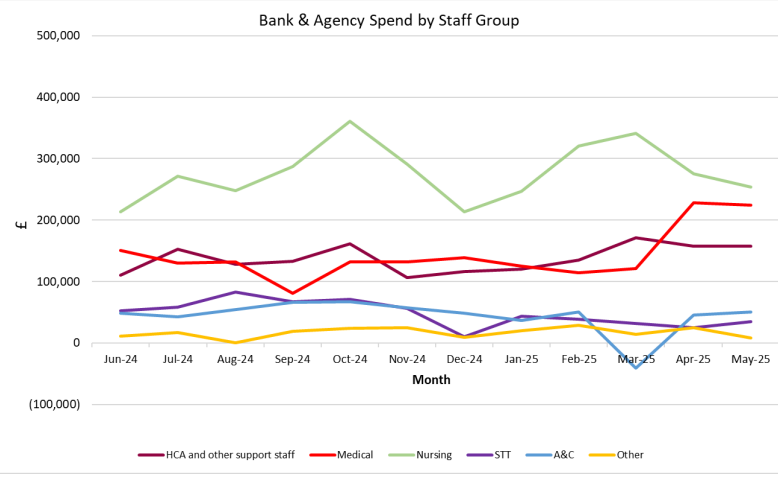
- The Trust is reporting a surplus at the end of M02 of (£1.2m) against a M01 YTD plan of (£1.3m), which gives a month 02 variance of £0.1m under plan.
- Identified in-year VIP is £22.3m against a target of £25.3m. The VIP shortfall against the recurrent VIP target is £4.1m, where £8.6m has been identified against a target of £12.6m (68% of recurrent target identified). Non-recurrent identified VIP is £13.7m against a target of £12.6m, overachieving by (£1.1m).

Balance sheet / liquidity

- The cash balance is £118.4m.
- Capital spend for 2025-26 was £1.2m, this was (£0.6m) above the revised plan submitted to NHSE.
- Targets have been achieved against payment of creditors paid within the 30-day Better Payment Practice Code target.

Finance (Expenditure)

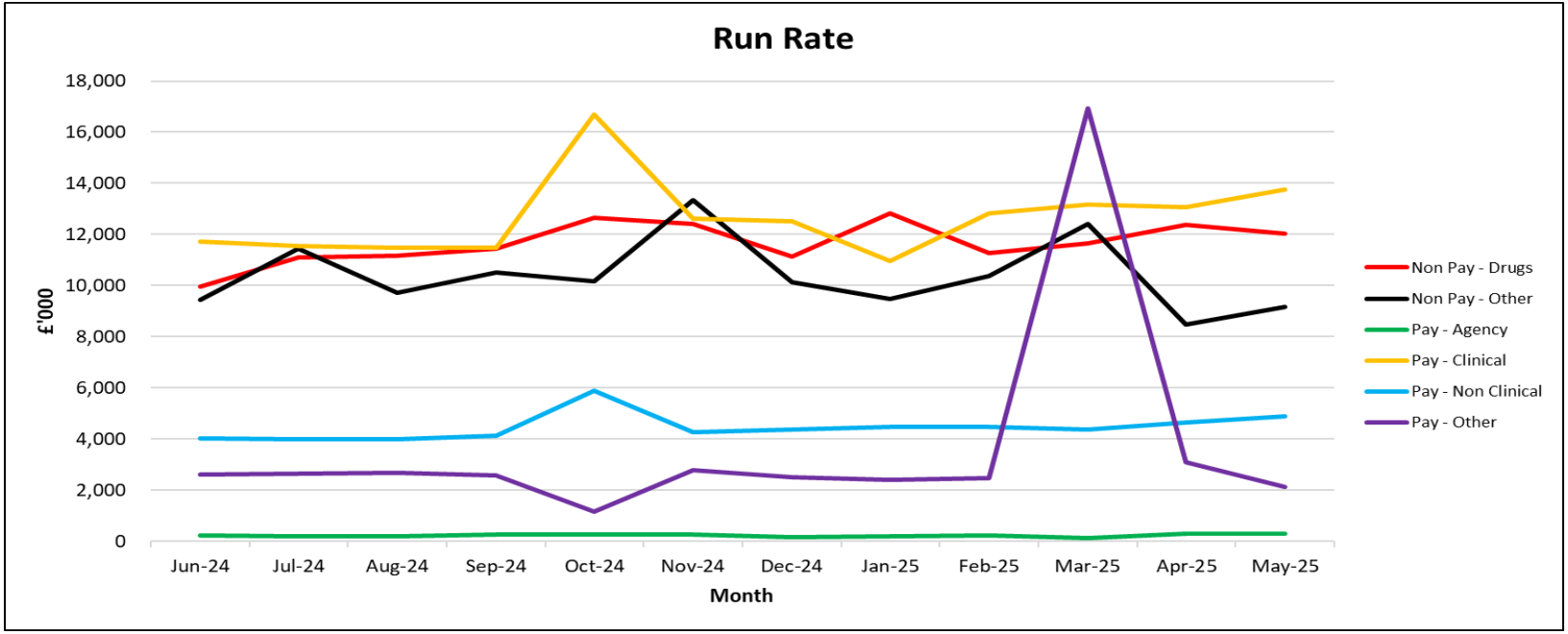




Agency spend in month 02 is £0.3m, £0.6m YTD. The spend is predominantly on medical agency with increases in month on nursing agency and scientific, technical and therapeutic agency compared to month 01.

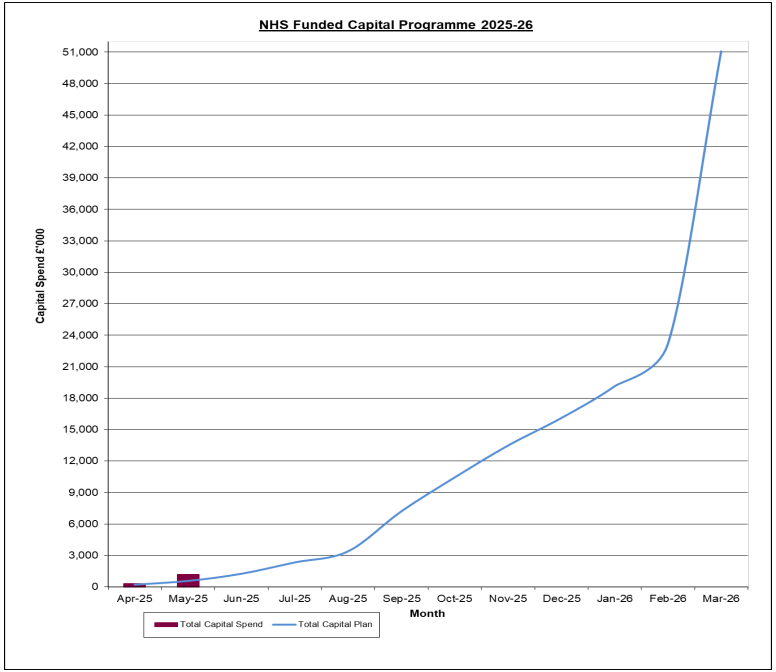
Alongside this, bank spend decreased in month 02 by (£0.1m) compared to month 01, giving £0.4m in month 02 and £0.9m YTD.

Finance (Expenditure)



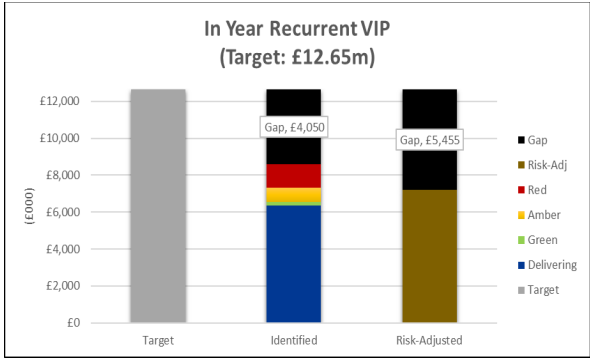
- Drugs spend in month 02 is £12.0m, a decrease from month 01 of £0.4m linked to fluctuations in pass through drug spend
- Pay – Clinical spend in month 02 is £13.8m, an increase from month 01 of £0.7m driven by year to date pay accrual correction and increase in CSSS pay.
- Pay – Agency spend in month 02 is £0.3m, consistent with month 01
- Pay – Other spend in month 02 is £2.1m, a decrease from month 01 of (£1.0m) driven by year to date pay accrual correction
- Non Pay – Other spend in month 02 is £9.2m, an increase of £0.7m from month 01 is driven by increased spend on clinical supplies & services.
- Key elements of 'Non-Pay Other' spend consist of clinical supplies and services, premises and infrastructure costs and R&I costs.

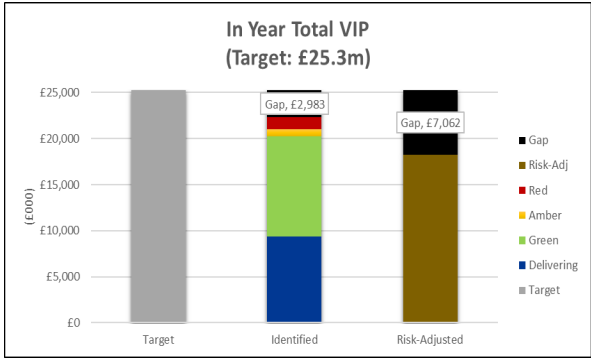
Finance (Capital)



The Trust has incurred £1.2m on capital schemes at month 2 2025-26, overspending by £0.6m against the revised plan submitted to NHSE.

Finance (VIP)





Total In year VIP

- Total identified VIP schemes reported are £22.3m (£13.7m non recurrent / £8.6m recurrent).
- Risk adjusted identified schemes value £18.2m, leaving £7.1m unidentified.

Recurrent

- Schemes totalling £8.6m have been identified recurrently against a recurrent target of £12.6m
- This leaves £4.0m of the recurrent target delivered.

Delivering	Green	Amber	Red	Unidentified
100%	75%	50%	25%	0%

	Annual					Year To Date		
	Target (£000)	Identifed (£000)	Unidentified (£000)	Risk-Adjusted Identified (£000)	Risk-Adjusted Unidentified (£000)	Target (£000)	Delivered (£000)	Variance (£000)
Total VIP	**25,298**	**22,315**	**2,983**	**18,236**	**7,062**	**4,216**	**4,216**	**0**
Recurrent VIP	12,649	8,599	4,050	7,194	5,455	2,108	1,199	909
Non-Recurrent VIP	12,649	13,716	(1,067)	11,041	1,608	2,108	3,017	(909)

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Agenda item 21/25c

Meeting of the Board of Directors

Subject / Title	Value Improvement Programme (VIP) 2025/26
Author(s)	Jo Bolger Leece, Assistant Director for Value Improvement
Presented by	Claire McPeake Chief Operating Officer
Summary / purpose of paper	This paper provides: • An overview of the Value Improvement Programme (VIP) with a month 2 position and a mid month position for month 3. • A summary of progress • Actions being taken to achieve VIP target • Assurance that a focus on engagement and ownership remains and governance is in place to manage risk.
Recommendation(s)	The committee is asked to note: • The content of the report and • The associated actions identified to improve delivery.
Background papers	NA
Risk score	Risk 3629 – Score 16
Link to: ➢ Trust strategy ➢ Corporate objectives	Executive objective: 1 -To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer. 6 - To maintain excellent operational, quality and financial performance Board Assurance Framework: Risk 1, Risk 6, Risk 7, Risk 9, Risk 10
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	Value Improvement Programme: VIP Quality Impact Assessment: QIA Equality Impact Assessment: EIA NHS England: NHSE Getting it Right First Time (GIRFT) Model Health System (MHS) Clinical Advisory Group (CAG)

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Agenda item 21/25c

Board of Directors

Value Improvement Programme (VIP)

1.0 Background and Introduction

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

A key enabler of our strategy is ensuring financial sustainability to support and drive innovation and improvement, while continuing to invest in our capital and services. In line with the rest of the NHS, in 2025/26 the Christie must achieve a challenging cost improvement target of £25.3m. To address this, as previously presented to the board, a framework was developed and aligned with our Trust ambitions, focusing on delivering improved outcomes for patients by getting the basics right, daily management, ensuring the services we provide are equitable and seeking innovative approaches to improve productivity and efficiency.

Our Value Improvement Programme (VIP) approach at The Christie aims to bring cost and quality together to embed a system and culture where improvement is part of our daily work and we have an approach to empower, engage and support our staff to achieve this.

The target from Greater Manchester ICB is that 100% of the target should be identified by the end of June. Recognising the need to inject capacity and pace into the VIP plans to meet our financial forecast, several improvement interventions have been supported. The VIP position, risks and actions are being tracked weekly.

This paper describes the current position of VIP and outlines the outcomes and actions being taken including the governance around the Quality Impact Assessment (QIA) process.

2.0 Financial Overview: VIP

The Trust has made good progress against the target of £25,298,000. Month 2 progress against plan was achieved and weekly reporting of the VIP position provides us with a real time progress against plans. Using the national risk rating, the VIP position is submitted to NHSE weekly.

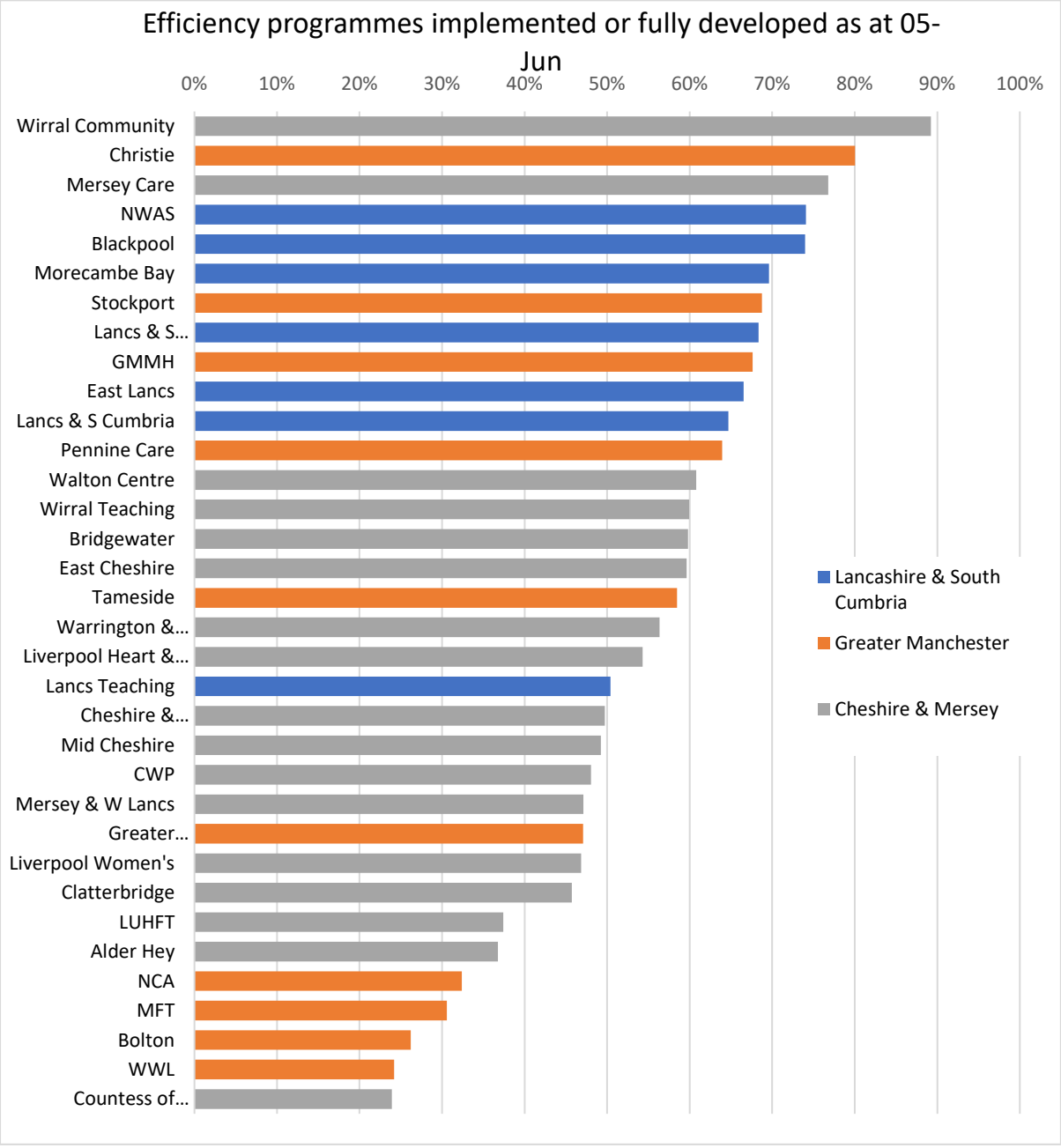
The position as at the 11th June 2025 is £20.7m has been delivered, however a high percentage of this is non recurrent. The gap of unidentified has reduced to £2.1m. There is £2m of schemes allocated as RED which means plans still need to be delivered.

The risk for achievement of the VIP target score remains high for the Trust scoring 16, and mitigating controls and actions are being reviewed weekly.

The risk rated position is based on whether there are plans and QIAs in development or completed. The Christie has achieved 83% either delivered, or risk rated ‘Green’.

Delivered / Implemented	Green (of which remaining)	Amber (of which remaining)	Red (of which remaining)
£20,761,393	£150,000	£226,008	£2,047,049

Once a month, NHSE are also providing a summary of every Trusts position in terms of savings implemented or delivered. The month 2 position is below. The Christie is currently benchmarking well in second place, however we must recognise that the overall position nationally is falling below the target of 100% fully developed by the end of June.



In addition to the VIP target, corporate reduction in growth of £6m is also required.

Work has been ongoing over the last month, and the Trust has successfully identified the £6m through a combination of income and cost improvements alongside re-stating the position in line with the prescribed definitions and taking into account service changes e.g. taking on new services.

3.0 Action being taken to recover the position

Staff communication: We continue to deliver excellent patient care and maintain safe and effective services. In order to support our staff through this financial reset, the frequency and approach to communication and engagement have been re-freshed. A number of sessions have been held to explain the national and local financial position, and what role the Christie has to play in supporting this. These include:

- An exceptional Clinical Advisory Group meeting
- A session for operational staff on the financial position, VIP and their role as operational leaders
- An executive led 'NHS Financial Reset' staff engagement Q&A session which was attended by over 150 staff. This session is available for staff to watch back and continue to ask questions via a new section of FAQ on the VIP pages on HIVE.
- Updated intranet pages on HIVE and encouragement of staff to submit ideas and questions.

Performance: All divisions were allocated VIP targets at the start of the year, and progress is being reviewed against them via reports from a central VIP tracker which records every scheme. Divisions falling below target are subject to additional meetings with the Chief Operating Officer to review recovery actions and provide support.

- All VIP schemes require a:
    - A Quality Impact Assessment (QIA) or checklist
    - plan
    - delivery date
    - lead
    - financial value
    - risk rating based on NHSE risk rating which is reported externally weekly.

QIA: The Quality Impact Assessment (QIA) process was strengthened with a revised checklist based on good practice and the Trust governance has been aligned to this. A Quality Impact Assessment (QIA) is a risk assessment for identifying the anticipated, actual or potential impact of business cases, service changes or VIP schemes. It provides assurance that savings are not being made at the detriment of quality and must be signed off by Clinical and Nursing leads prior to scheme being implemented.

Immediate recovery actions: As part of our efforts to manage resources responsibly, maintain our commitment to avoiding redundancies and ensure we meet our required savings targets, several control measures already present in other Trusts have been adopted over the last 2 months. In addition, a review of each divisions financial performance for month 1 and 2 and a deep dive into schemes risk rated RED indicating they don't have plans developed is taking place to close the gap. This is alongside further review of recommendations of good practice for outpatient, theatres and inpatient services.

4.0 Benchmarking

As part of the VIP approach, seeking best practice, benchmarking and opportunity assessments continue. The Christie is taking part in peer reviews, most recently interventional radiology. The Getting It Right First Time (GIRFT) programme is a national NHS England programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to

support change.

The programme undertakes clinically led reviews of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved. GIRFT is part of an aligned set of programmes within NHS England with the backing of the Royal Colleges and professional associations. GIRFT governance has been revised for the Christie based on national GIRFT Governance recommendations released at the end of the financial year. Outcomes from GIRFT and Model Health System (MHS) are being fed into the VIP programme to ensure areas for improvement can be driven forward to improve care for patients and experiences for staff.

5.0 Next Steps

The focus now must shift from identification to execution. To ensure continued progress and sustainability, the following priorities are

All divisions must ensure 100% scheme identification with Green rating by end of June.
- VIP trajectory to be mapped for full year delivery.
- Maintain a high level of staff engagement to foster ownership and innovation.
- Monitor progress on high-risk (RED) schemes and ensure timely intervention.
- Support robust clinical governance via the enhanced QIA process.
- Prepare for the 2026/27 VIP cycle, with a launch planned for Autumn.

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Agenda Item 22/25a

Meeting of the Board of Directors
Thursday 26th June 2025

Subject / Title	Strategic & Annual Objectives and strategic risks / risk appetite statement
Author(s)	Louise Westcott, Company Secretary
Presented by	Chief Executive Officer
Summary / purpose of paper	For the Board of Directors to receive the refreshed Strategic Objectives and annual objectives for 2025/26 and to consider the updated strategic risks and risk appetite statement.
Recommendation(s)	The board of directors are asked to; • Approve the 2025/26 strategic and annual objectives • Note the strategic risks relating to the strategic and annual objectives for inclusion in a revised Board assurance framework (BAF) following approval of the objectives • Approve the risk appetite statement for publication on the Trust website.
Background papers	Corporate objectives, board assurance framework 2024/25
Risk score	N/A
Link to: ➢ Trust strategy ➢ Corporate objectives	• Trust's strategic direction • Divisional implementation plans • Key stakeholder relationships
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	BAF Board assurance framework ECN Executive Chief nurse EDoF Executive director of finance EMD Executive medical director COO Chief operating officer DoW Director of workforce NHSE NHE England

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Agenda item 22/25a

Meeting of the Board of Directors
Thursday 26th June 2025

Strategic and Annual Objectives 2025/26 & risk appetite statement

1. Introduction

This paper seeks approval of the refreshed strategic and annual objectives for 2025/26 (appendix 1) and outlines the strategic risks relating to achievement of the strategic objectives that will make up the refreshed Board Assurance Framework. The Trust Risk Appetite Statement is also presented for its annual review.

2. Background

Our Strategy 2023-28 describes where the Trust wants to be, and the operational plan describes how we will achieve this in year. We previously described 8 strategic objectives, that have been relatively consistent over the last eight years. This paper describes a simplified set of 6 strategic objectives. The revised strategic objectives, annual objectives 2025/26 and revised strategic risks were reviewed at the Board Planning Day in May. The risks will replace some of the existing BAF risks to form a revised Board Assurance Framework.

3. Strategic objectives

The strategic objectives are a fundamental element in the development of the operational plan and enabling the executives and divisions to align their proposed programme of activity to the Trust's ambitions.

The 6 strategic objectives are detailed at Appendix 1 with the proposed cascade to the annual objectives which will then be fed into divisional objectives. Monitoring of the objectives is done through the integrated performance report and reports to board. Assurance is managed through the board assurance framework and the assurance committees.

The amended Strategic Objectives are;

1. To deliver safe, effective & equitable care
2. To deliver excellent financial and operational performance
3. To provide integrated clinical, research and education services
4. To be an excellent place to work and attract the best staff
5. To transform our services to improve access and reduce health inequalities
6. To provider leadership within the wider NHS cancer system

4. Board Assurance Framework (BAF)

The Board Assurance Framework outlines the risks to achievement of the strategic objectives. The document is regularly reviewed by the company secretary and the executive directors and presented to each Board meeting and assurance committee. The risks within the framework determine the focus of the assurance committees so that the Board can get appropriate assurance against each risk.

The BAF will continue to evolve through regular review. The executive team will undertake a more detailed review of the BAF for the September Board meeting and on a quarterly basis to ensure the risks remain relevant and the target risk scores reflect any changes as the year progresses. The first draft of the updated BAF is appended to this report.

5. Risk Appetite Statement

A Board approved risk appetite statement supports the Board Assurance Framework, particularly the identified appetite against each risk that is outlined in the BAF. The statement is published on our website. The Board need to review this annually. The statement is also contained within the Risk Management Policy for the Trust that is published on the intranet.

The recommended statement for 2025/26 is;

> *The Trust recognises that its long-term sustainability depends upon the delivery of its strategic objectives and its relationships with patients, staff and the public and strategic partners. It operates within a low overall risk range; it will not accept risks that have a likelihood of a detrimental impact on patient/staff safety or to compliance and regulatory objectives.*
>
> *However, the Trust has a marginally higher risk appetite to take considered risks in terms of its impact on the strategic, reporting and operations objectives in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment. The highest risk appetite relates to our pursuance of innovation and transformation objectives.*

6. Recommendation

The board of directors are asked to;

- Approve the strategic and 2025/26 annual objectives
- Note the development of the board assurance framework (BAF) following approval of the objectives
- Approve the risk appetite statement for publication on the Trust website.

Strategic & annual objectives and strategic risks 2025/26

1. To deliver safe, effective, patient orientated & equitable care	
Annual Objectives 2025/26	**Strategic Risks**
• Achieve the year 3 actions of the Quality Plan 2023-2026 • Achieve the year 1 actions of the Risk Strategy • Achieve the year 3 actions of Patient Experience and Engagement Plan 2023-2026 • Develop a revised Quality Plan for 2026-29 • Ensure compliance with the CQC regulations & quality standards	• If we do not follow the Patient Safety Incident Response Framework (PSIRF) there is a risk that we will miss opportunities to learn lessons and improve patient safety leading to preventable patient harm. • If we do not continuously review our compliance with the regulatory standards and take corrective action where needed there is a risk that we will fall below required fundamental standards and quality of care will be reduced. • If there is a serious emergency event (pandemic/cyber-attack/extreme weather event etc) there is a risk of business disruption (increased staff absence, increased patient non-attendance and equipment malfunction) leading to delayed or cancelled care. • 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. • If there are disruptions to the supply of essential products and services for the treatment and care of our patients there is a risk of service disruption leading to delayed or cancelled care.

2. To deliver excellent financial and operational performance	
Annual Objectives 2025/26	**Strategic Risks**
• Achieve the agreed revenue financial plan including value-improvement programme VIP. • Achieve mandated national targets as per the Performance Assessment Framework (PAF) for 2025/26. • Achieve the agreed Trust capital plan in 2025/26. • Achieve the nationally mandated corporate services savings. • Ensure compliance with the CQC Regulations & quality standards.	• If the changes in NHSE financial framework do not maintain the level of income needed to support the planned growth in activity there is a risk that we will not be able to provide care within the required timescales and waiting times will increase. • If we do not continuously review our compliance with the regulatory standards and take corrective action where needed there is a risk that we will fall below required standards and quality of care will be reduced. • If we do not achieve the planned activity levels and our planned efficiency savings there is a risk that we won't achieve financial balance. • If diagnostic, MDT and referral processes at local hospitals across the GM system do not work efficiently there is a risk that we receive patients too late to ensure treatment within 62 days from initial GP referral leading to the 62 day waiting time standard not being achieved • If we don't fit our capital expenditure to the allocated capital funding in 2025/26 there is a risk that we won't deliver the planned improvements resulting in delays in providing the best possible environment & equipment to provide care

3. To provide integrated clinical, research and education services	
Annual Objectives 2025/26	**Strategic Risks**
• Achieve the year 3 actions of the Research Plan • Achieve the year 3 actions of the Education Plan • Achieve the year 3 actions of the Clinical Outcomes Plan • Achieve the year 3 objectives of the Trust Strategy • Refresh arrangements and strategy for MCRC in collaboration with new appointments in University and CRUK-MI Director • Achieve OECI re-Accreditation as a Comprehensive Cancer Centre	• If our research, education and clinical services do not operate as an integrated whole there is a risk that we will not secure the benefits of high-quality research and education on patient care and that this will lead to less-than-optimal quality of care. • If we are unable to secure OECI re-accreditation there is a risk that our international reputation as a leading comprehensive cancer centre will be damaged reducing our attractiveness to researchers, teachers and clinicians.

4. To be an excellent place to work and attract the best staff	
Annual Objectives 2025/26	**Strategic Risks**
• Achieve the year 1 actions of the Inclusive Culture Strategy • Achieve the year 3 milestones of The Christie People & Culture Plan 2023/26 • Achieve the delivery of objectives set in EDS 2056/26.	• If we are unable to maintain appropriate 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. • If we do not maintain levels of staff engagement there is a risk that turnover and sickness absence will increase leading to workforce shortages, poor staff experience and a deterioration in the quality of patient care.

5. To transform our services to improve access and reduce health inequalities	
Annual Objectives 2025/26	**Strategic Risks**
• Achieve the year 1 objectives of the Future Christie programme focusing on patient access to information • Achieve the next steps in our plans to develop modern imaging capability • Achieve year 1 objectives for implementation of new clinical model for acute oncology & inpatient care • Achieve the annual health inequalities milestones set out in the Equality and Diversity Plan (Domain 1). • Achieve the annual milestones set out in our Green Plan.	• If we do not develop transformational capacity & capability, there is a risk that we will not transform services to improve access and reduce health inequalities • If we do not keep pace with technological advancements, there is a risk that we will not provide the best possible experience to our patients and carers

6. To provider leadership within the wider NHS cancer system	
Annual Objectives 2025/26	**Strategic Risks**
• Contribute to development of proposals for a National Cancer Institute to provide national leadership and coordination of standards of cancer care in England • Lead agreed improvements to cancer care pathways across Greater Manchester and Cheshire	

BOARD ASSURANCE FRAMEWORK 2025/26 OVERVIEW OF RISKS

RISK No.	Risk Title	Risk Description	Responsible Committee	Risk Appetite	Inherant Risk Score	Q4 24/25	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	Target Risk Score	Current Risk Score	Target date
RISK 15	**Technological advancements**	If we do not keep pace with technological advancements, there is a risk that we will not provide the best possible experience to our patients and carers	Board of Directors		20						5	15	
RISK 14	**Supply chain**	If there are disruptions to the supply of essential products and services for the treatment and care of our patients there is a risk of service disruption leading to delayed or cancelled care.	Audit Committee	Averse	16						4	12	**Review Q2 25/26**
RISK 7	**Ineffective Greater Manchester system-wide cancer pathways**	If diagnostic, MDT and referral processes at local hospitals across the GM system are not efficient there is a risk that we receive patients on 62-day pathways late leading to them not being treated within 62 days.	Quality Assurance Committee	Cautious	25						8	12	**Reviewed Q3 24/25**
RISK 4	**Compliance with regulatory standards**	If we do not continuously review our compliance with the regulatory standards and take corrective action where needed there is a risk that we will fall below required fundamental standards and quality of care will be reduced.	Board of Directors	Averse	15						4	12	**Review Q1 25/26**
RISK 6	**NHSE Financial Framework and support for growth**	If the changes in the NHSE financial framework do not maintain the level of income needed to support the planned growth in activity there is a risk that we will not be able to provide care within the required timescales and waiting times will increase.	Board of Directors		16						4	12	
RISK 13	**Transformational capacity & capability**	If we do not develop transformational capacity & capability, there is a risk that we will not transform services to improve access and reduce health inequalities	Board of Directors		20						8	12	
RISK 2	**Learning from patient safety incidents**	If we do not follow the Patient Safety Incident Response Framework (PSIRF) there is a risk that we will miss opportunities to learn lessons and improve patient safety leading to preventable patient harm	Quality Assurance Committee	Averse	15						4	9	**Reviewed Q4 24/25**
RISK 3	**Recruitment and retention of skilled staff**	If we are unable to maintain current levels of skilled staff there is a risk that they will not have the time or expertise required for excellent care and communication leading to a reduction in the standards of patient safety and experience.	Workforce Assurance Committee	Averse	20						4	9	**Reviewed Q4 24/25**
RISK 8	**Emergency event**	If there is a serious emergency event (pandemic/cyber-attack/extreme weather event etc) there is a risk of business disruption (increased staff absence, increased patient non-attendance and equipment malfunction) leading to delayed or cancelled care.	Audit Committee	Averse	16						4	8	**Reviewed Q4 24/25**
RISK 12	**Staff engagement**	If we do not maintain levels of staff engagement there is a risk that turnover and sickness absence will increase leading to workforce shortages, poor staff experience and a deterioration in the quality of patient care.	Workforce Assurance Committee	Averse	16						4	8	**Review Q3 & Q4 24/25**
RISK 9	**Integrated research, education & service**	If our research, education and clinical services do not operate as an integrated whole there is a risk that we will not secure the benefits of high-quality research and education on patient care and that this will lead to less-than-optimal quality of care.	Board of Directors		12						4	8	
RISK 1	**New technologies and increased standards of care**	If there are changes to NICE guidance or other advances in practice that we have not anticipated (diagnostic, therapeutic, care) there is a risk that there will be a delay in their introduction leading to a delay in patients obtaining the benefits of new treatments.	Quality Assurance Committee	Cautious	20						4	6	**Within tolerance**
RISK 10	**Financial balance**	If we do not achieve the planned activity levels and our planned efficiency savings there is a risk that we won't achieve financial balance.	Board of Directors	Averse	25						5	5	**Reviewed Q4 24/25**
RISK 5	**Capital funding**	If we don't fit our capital expenditure to the allocated capital funding in 2025/26 there is a risk that we won't deliver the planned improvements resulting in delays in providing the best possible environment & equipment to provide care	Board of Directors	Eager	25						4	4	**Reviewed Q4 24/25 / Within tolerance**
RISK 11	**OECI accreditation**	If we are unable to secure OECI re-accreditation there is a risk that our international reputation as a leading comprehensive cancer centre will be damaged reducing our attractiveness to researchers, teachers and clinicians.	Board of Directors		12						4	4	

RISK 1	New technologies and increased standards of care	Date Risk Opened	Current Risk Score
Description	**If there are changes to NICE guidance or other advances in practice that we have not anticipated (diagnostic, therapeutic, care) there is a risk that there will be a delay in their introduction leading to a delay in patients obtaining the benefits of new treatments.**	Apr-24 Date of Last Review Jun-25	6
Associated Strategic Objectives	To deliver safe, effective & equitable care	Executive Lead	Exec Medical Director
		Responsible Committee	**Quality Assurance Committee**
		Assurance Level	Medium
		Risk Appetite	Cautious

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date
	Annual planning process with divisions. The trust has a risk-based process with divisional support to assess applicability and implement relevant guidance. Guidance that is not resolved or on the risk register is monitored and escalated if there are issues	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	Within tolerance

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	4	20			0			0			0			0			0

RISK 2	Learning from patient safety incidents	Date Risk Opened	Current Risk Score
Description	**If we do not follow the Patient Safety Incident Response Framework (PSIRF) there is a risk that we will miss opportunities to learn lessons and improve patient safety leading to preventable patient harm**	Jun-25 Date of Last Review Jun-25	9
Associated Strategic Objectives	To deliver safe, effective & equitable care	Executive Lead	Exec Chief Nurse
		Responsible Committee	**Quality Assurance Committee**
		Assurance Level	Medium
		Risk Appetite	Averse

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
	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 patient safety reports to 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 Progression with PSIRF implementation, completion of PSIRF training and improved timeframe for incident management. Draft report for MIAA audit of PSIRF processes confirms substantial assurance.	Reviewed Q4 24/25

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	3	5	15			0			0			0			0			0

RISK 3	Recruitment and retention of skilled staff	Date Risk Opened	Current Risk Score
Description	**If we are unable to maintain current levels of skilled staff there is a risk that they will not have the time or expertise required for excellent care and communication leading to a reduction in the standards of patient safety and experience.**	Apr-24 Date of Last Review Jun-25	9
Associated Strategic Objectives	To deliver safe, effective & equitable care To deliver excellent financial and operational performance To be an excellent place to work and attract the best staff	Executive Lead	Workforce Director
		Responsible Committee	**Workforce Assurance Committee**
		Assurance Level	High
		Risk Appetite	Averse

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
	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 Agreement to recruit to the onboarding post on a permanent basis established	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 People & Culture plan updates • F&PP Compliance report to WAC / Board Level 3 – External assurances • National staff survey • MIAA audit - Role Specific Training July 24 - limited assurance / Divisional Recruitment Nov 24 - limited assurance	Actions outlined by MIAA in Nov 24 Divisional Recruitment audit	Recruitment of onboarding coordinator - agreement to recruit to the onboarding post on a permanent basis now established	Reviewed Q4 24/25

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	5	20			0			0			0			0			0

RISK 4	Compliance with regulatory standards	Date Risk Opened	Current Risk Score
Description	**If we do not continuously review our compliance with the regulatory standards and take corrective action where needed there is a risk that we will fall below required fundamental standards and quality of care will be reduced.**	Jun-25 Date of Last Review Jun-25	**12**
Associated Strategic Objectives	To deliver safe, effective & equitable care To deliver excellent financial and operational performance To be an excellent place to work and attract the best staff	Executive Lead 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 completion
Actions	Self assessments underway against 2022 must do actions and well-led quality indicators. Attendance at CQC briefings / NHS Providers briefings Engagement in national updates and regulatory briefings. Designated leads for statutory requirements across the Trust reporting into committee structure. Policies and procedures in place e.g. conflicts of interest, SFI's, Document ratification processes. Membership of NHS Providers to recieve most up to date advice and guidance. Exec Team engagement in national briefings. Close working with regulators, GM ICS / ICB and NHSE. Attendance at system level and national meetings. Leads identified internally for each statutatory requirement e.g. health & safety / IRMER / CQC etc	Lack of national understanding of the detail of the new inspection regime External political factors	Level 1 – Data and management reports • Self assessment against 2022 Must Do's□ • Self assessment against Well Led / Safety quality indicators Level 2 – Management team and committee scrutiny • QAC /WAC review of CQC regulations - all on rolling programmes□ • Board level training on new CQC assessment framework Feb 24 • Board reporting on regulatory changes□ • Work of the 3 assurance committees Level 3 – External assurances • GGI review□ • Globis Culture Audit • CQC Inspection Reports (IR(M)ER) • SOF Rating 2 • MIAA role specific training audit (CQC Reg 19) - Limited assurance Oct 24□ • MIAA data quality audit Oct 24 - moderate assurance	Full review of well-led quality indicators to indentify gaps	Plan in development for full review of well led / safety	Review Q1 25/26

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	3	**15**			**0**			**0**			**0**			**0**			**0**

RISK 5	Capital funding	Date Risk Opened	Current Risk Score
Description	**If we don't fit our capital expenditure to the allocated capital funding in 2025/26 there is a risk that we won't deliver the planned improvements resulting in delays in providing the best possible environment & equipment to provide care**	Jun-25 Date of Last Review Jun-25	**4**
Associated Strategic Objectives	To deliver excellent financial and operational performance	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 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. All high capital risks included and delivered in capital plan 24/25	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 • ICB allocation	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	Reviewed Q4 24/25 / Within tolerance

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	5	**25**			**0**			**0**			**0**			**0**			**0**

RISK 6	NHSE Financial Framework and support for growth	Date Risk Opened	Current Risk Score
Description	**If the changes in the NHSE financial framework do not maintain the level of income needed to support the planned growth in activity there is a risk that we will not be able to provide care within the required timescales and waiting times will increase.**	Jun-25 Date of Last Review Jun-25	**12**
Associated Strategic Objectives	To deliver excellent financial and operational performance	Executive Lead Responsible Committee Assurance Level Risk Appetite	Exce Director of Finance **Board of Directors**

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
Actions	Senior team attendance at national and regional meetings to keep updated on policy changes and influence discussions on cancer.	External political factors	Level 1 – Data and management reports • Level 2 – Management team and committee scrutiny • □ Level 3 – External assurances • □			

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	4	**16**			**0**			**0**			**0**			**0**			**0**

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 Jun-25	**12**
Associated Strategic Objectives	To deliver safe, effective & equitable care To deliver excellent financial and operational performance	Executive Lead Responsible Committee Assurance Level Risk Appetite	Chief Operating Officer **Quality Assurance Committee** Cautious

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
	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.	NHS pressures leading to delays in referrals from other Trusts	Level 1 – Data and management reports • 62 / 31 / 24 day reports to Senior Management Committee and Board□ • Service & Operational Review feedback Level 2 – Management team and committee scrutiny • 6 monthly review by QAC□ Level 3 – External assurances • MIAA review of 62 days / Cancer Alliance□	Evidence of progress in underperforming parts of the pathway	Supporting cancer improvement plans in GM Cancer Pathway improvement workstream in GM Cancer	Reviewed Q3 24/25

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	5	25			0			0			0			0			0

RISK 8	Emergency event	Date Risk Opened	Current Risk Score
Description	**If there is a serious emergency event (pandemic/cyber-attack/extreme weather event etc) there is a risk of business disruption (increased staff absence, increased patient non-attendance and equipment malfunction) leading to delayed or cancelled care.**	Apr-24 Date of Last Review Jun-25	**8**
Associated Strategic Objectives	To maintain excellent operational, quality and financial performance.	Executive Lead Responsible Committee Assurance Level Risk Appetite	Director of Strategy **Audit Committee** Medium Averse

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
	No ability to reduce likelihood as an organisation, however we do have a Sustainable Development Management Plan (SDMP) - with aims to reduce system wide emissions within direct NHS control (NHS Carbon Footprint) by 80% by 2028-2032 Business Continuity Plans (BCP) - regularly tested and reviewed Extreme weather plan approved & published on intranet Data Security and Protection Toolkit submissions with audits undertaken. Digital board reporting. Board level Senior Information Risk Owner in place. Reviews of risk registers, alerts, reports, actions and observations MIAA audit - Data Protection Toolkit (DPST) Q4 23/24	The Trust does not currently have cyber security insurance.	Level 1 – Data and management reports • SDMP compliance • BCP compliance and effectiveness • Approved Extreme weather plan • Regular updates from NHS Digital - Vulnerability Monitoring Service Level 2 – Management team and committee scrutiny • Emergency Planning & Resilience Committee - reporting of regular testing of BCP's • Quarterly Net Zero and Climate Adaptation Committee (NZACAC) advises Executive Director • Annual SDMP report to MB and BoD (Assurance Scrutiny by Quality Assurance Committee) • Statutory disclosures in Trust Annual Report • Reports to Senior Management Comittee and Audit Committee□ Level 3 – External assurances • Internal audit of compliance with NHS requirements • NHSE review of plans and progress - agreement of current compliance (as in self-assessment)	Not at 100% compliance for self-assessment / external assessment	Developing methodology to assess carbon footprint in collaboration with other Trusts Developing a CC Annual Report - Check what audit scrutiny this receives Review of cyber alerts	Reviewed Q4 24/25

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	4	16			0			0			0			0			0

RISK 9	Integrated research, education & service	Date Risk Opened	Current Risk Score
Description	**If our research, education and clinical services do not operate as an integrated whole there is a risk that we will not secure the benefits of high-quality research and education on patient care and that this will lead to less-than-optimal quality of care.**	Jun-25 Date of Last Review Jun-25	**8**
Associated Strategic Objectives	To provide integrated clinical, research and education services	Executive Lead Responsible Committee Assurance Level Risk Appetite	Chief Executive Officer **Board of Directors**

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
	Research / Education / CODU plans all approved and being monitored through divisional boards and SMC		Level 1 – Data and management reports • Divisional Board reports Level 2 – Management team and committee scrutiny • Regular reports on progress to Board and assurance committees□ Level 3 – External assurances • OECI accreditation□				

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	3	4	12			0			0			0			0			0

RISK 10	Financial balance	Date Risk Opened	Current Risk Score
Description	**If we do not achieve the planned activity levels and our planned efficiency savings there is a risk that we won't achieve financial balance.**	Apr-24 Date of Last Review Jun-25	5
Associated Strategic Objectives	To maintain excellent operational, quality and financial performance.	Executive Lead Responsible Committee Assurance Level Risk Appetite	Exec Director of Finance **Board of Directors** High Averse

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	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 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. Board has recieved monthly financial report showing performance	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 recommendations implemented	Reviewed Q4 24/25

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	5	25			0			0			0			0			0

RISK 11	OECI accreditation	Date Risk Opened	Current Risk Score
Description	**If we are unable to secure OECI re-accreditation there is a risk that our international reputation as a leading comprehensive cancer centre will be damaged reducing our attractiveness to researchers, teachers and clinicians.**	Jun-25 Date of Last Review Jun-25	4
Associated Strategic Objectives	To provide integrated clinical, research and education services	Executive Lead Responsible Committee Assurance Level Risk Appetite	Board of Directors **Board of Directors**

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
	OECI accreditation process complete. Draft report received showing accreditation received.	None identified	Level 1 – Data and management reports • Reports to Board Level 2 – Management team and committee scrutiny • Reports to Board Level 3 – External assurances • OECI review undertaken	None identified		

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	3	4	12			0			0			0			0			0

RISK 12	Staff engagement	Date Risk Opened	Current Risk Score
Description	**If we do not maintain levels of staff engagement there is a risk that turnover and sickness absence will increase leading to workforce shortages, poor staff experience and a deterioration in the quality of patient care.**	Jun-25 Date of Last Review Jun-25	8
Associated Strategic Objectives	To be an excellent place to work and attract the best staff	Executive Lead Responsible Committee Assurance Level Risk Appetite	Director of Workforce **Workforce Assurance Committee** Medium Averse

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	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. Regular reporting to Board. Inclusive Culture work taking forward actions and approach for the Trust.	None identified	Level 1 – Data and management reports • 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 • Board approved Inclusive Culture Plan Nov 2024 Level 3 – External assurances • Globis culture audit • Annual CQC Staff Survey 2023 & 2024	None identified	Implemenetation of agreed action plan Cost additional resource requirments	Review Q3 & Q4 24/25

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	4	16			0			0			0			0			0

RISK 13	Transformational capacity & capability	Date Risk Opened	Current Risk Score
Description	**If we do not develop transformational capacity & capability, there is a risk that we will not transform services to improve access and reduce health inequalities**	Jun-25 Date of Last Review Jun-25	**12**
Associated Strategic Objectives	To transform our services to improve access and reduce health inequalities	Executive Lead Responsible Committee Assurance Level Risk Appetite	Director of Future Christie **Board of Directors**

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
	Future Christie Director and Clinical lead in place. Associate Director of Transformation appointed		Level 1 – Data and management reports • Level 2 – Management team and committee scrutiny • □ Level 3 – External assurances • □			

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	4	20			0			0			0			0			0

RISK 14	Supply chain	Date Risk Opened	Current Risk Score
Description	**If there are disruptions to the supply of essential products and services for the treatment and care of our patients there is a risk of service disruption leading to delayed or cancelled care.**	Nov-24 Date of Last Review Jun-25	**12**
Associated Strategic Objectives	To deliver safe, effective & equitable care To deliver excellent financial and operational performance	Executive Lead Responsible Committee Assurance Level Risk Appetite	Chief Operating Officer **Audit Committee** Averse

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
	Pharmacy - TCP procurement team work closely with regional & national drug procurement teams. Mutual aid MOU in place in NW. Management with clinicians to avoid imapct on care Medical Physics - close relationship with national supply chains and management of demand based on availability of radioactive materials. BCP in place for Radiopharmacy to maintain supplies and regular discussions with supplier of FDG for the PETCT scanner. Procurement - policies & processes in place for management of supplies incl escalations & triggers / communication.	National / international shortages / supply issues	Level 1 – Data and management reports • Regular reports to relevant committee • Monitoring & review by management team□ Level 2 – Management team and committee scrutiny • Reports to The Christie Pharmacy Company Board and Audit Committee, via Trust Drug & Therapeutics Committee • Esclations from Risk & Quality Governance to Senior Management Committee Level 3 – External assurances • MIAA audits commissioned to review specific issues where appropriate	None identified	Review of alerts	Review Q2 25/26

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	4	16			0			0			0			0			0

RISK 15	Technological advancements	Date Risk Opened	Current Risk Score
Description	**If we do not keep pace with technological advancements, there is a risk that we will not provide the best possible experience to our patients and carers**	Jun-25 Date of Last Review Jun-25	**15**
Associated Strategic Objectives	To transform our services to improve access and reduce health inequalities	Executive Lead Responsible Committee Assurance Level Risk Appetite	Director of Future Christie **Board of Directors**

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
	Future Christie team leading work with partners to procure best systems.		Level 1 – Data and management reports • reports to Board of Directors Level 2 – Management team and committee scrutiny • □ Level 3 – External assurances • □			

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	5	20			0			0			0			0			0

The Christie
NHS Foundation Trust

Agenda Item 23/25a

Meeting of the Board of Directors
Thursday 26th June 2025

Subject / Title	**Future Christie Programme Progress Report**
Author(s)	Thomas Thornber, Future Christie Programme Director
Presented by	Thomas Thornber, Future Christie Programme Director
Summary / purpose of paper	To provide the Board with an update on the Future Christie Programme
Recommendation(s)	Board are asked to; • Note the Future Christie vision and primary objectives • Note progress to date • Endorse the planning for July Away Day to align Future Christie goals • Support preparation for digital correspondence go-live in September
Background papers	Board Planning Day update May 2025
Risk score	N/A
Link to: ➢ Trust strategy ➢ Strategic objectives	• Christie Strategy 2023-28 • Strategic 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.	

Meeting of the Board of Directors
Thursday 26th June 2025

Future Christie Programme Progress Report

1. Future Christie: Vision

"Future Christie is our bold transformation programme to modernise cancer care — digitally, clinically, and culturally. We're building a world-leading, intelligent cancer centre where patients access care in real-time, clinicians are supported by cutting-edge tools, and data drives every decision. It's not just about technology—it's about reimagining how The Christie delivers care, connects services, and leads innovation across the NHS."

2. Objectives

Future Christie Patient
Objective: Empower every patient with personalised, proactive, and digitally supported care that enhances autonomy, improves outcomes, and reduces the burden of treatment through seamless access, communication, and support across their cancer journey.

Future Christie Clinician
Objective: Enable clinicians to deliver the best care through intelligent systems, streamlined pathways, and collaborative decision-making—freeing up time for compassionate, expert-led interaction and innovation in treatment.

Intelligent Hospital
Objective: Transform The Christie into a data-driven, adaptive, and integrated healthcare environment—using digital platforms, automation, and predictive insights to optimise care delivery, resource use, and organisational learning.

3. Key Achievements Since May 2025

Leadership and Governance

- Medical Director – Future Christie: Appointed Professor Adrian Bloor
- Director of Transformation/Delivery: Appointed Sarah Mcgovern
- Digital and Transformation Workshop outputs. Alignment of the Transformational and digital capability of the organisation

Engagement and Culture

- July Service Away Day focus on Future Christie and the care and service model changes required.

4. Current Priorities

Programme Delivery

- Establish core PMO infrastructure to support delivery across workstreams.
- Preliminary work on ePROMS and real-time digital correspondence in progress.
- Develop communications and engagement plan
- Developing partnership with Royal Marsden to align digital transformation approaches.

Technology and Data
- Christie Patient platform roll out initiated
- Continue technical assessments for EPR
- Review commercial patient platform options.

Culture and Capability
- Identify approach to digital skills training for staff.
- Engagement with staff and patient groups. Organisational patient group in setup

5. Upcoming Milestones

Milestone	Target Date
Medical Director appointed	June 2025
Director of Transformation start	September 2025
Service away Day	July 2025
EPR procurement process launch	Q3 2025
Real-time patient correspondence live	September 2025
Future Christie delivery roadmap agreed	End Q2 2025

6. Risks and Mitigations

Risk	Mitigation
Future Christie Leadership and transformation capacity and capability	MD post and AD post appointed.
Staff and patient engagement	Comms plan and organisational patient forum in development.
Capacity to change	Alignment of digital and transformation for focused capacity on fewer changes. Engage commercial and industrial partners to support.
Alignment to organisational decision making and delivery	Standing item on SMC and Board. Developing governance framework for sub programs.

7. Recommendations for The Board

- Note the Future Christie vision and primary objectives
- Note progress to date.
- Endorse the planning for July Away Day to align Future Christie goals.
- Support preparation for digital correspondence go-live in September.

The Christie
NHS Foundation Trust

Agenda Item [xx/25]

Meeting of the Board of Directors
Thursday 26th June 2025

Subject / Title	Audit Committee report – April 2025
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 April meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions.
Background papers	Audit Committee papers – April 2025
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.	

The Christie
NHS Foundation Trust

Agenda item [xx/25]

Meeting of the Board of Directors
Thursday 26th June 2025

Audit Committee report – April 2025

1 Introduction

The Audit Committee took place on 22nd April. 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 Alert / Advise / Assure.

2 Audit Committee agenda items

The items listed in Appendix 1 of the report were all presented to the Audit Committee in April 2025. 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:

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

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

3 Recommendation

The Board are asked to note the summary report from the Audit Committee in April 2025.

Appendix 1

The following agenda items were discussed at the meeting but did not require an assurance level assigning:

Anti-fraud annual report 2024/25	**Alert**	• N/A
	Advise	• 13 fraud referral queries in-year; 2 referrals became formal investigations; 1 referral remains open for further analysis. The remaining 11 were either no fraud identified or did not meet the criminal threshold to commence an investigation and were passed, where appropriate, to HR to consider further action. • Fraud valued at £1,026.60 identified from one investigation and a further £362.64 prevented by the Finance team.
	Assure	• Overview of completed activities provided. • Counter Fraud Functional Standard Return – Trust received an all 'green' rating across the 13 assessed components.
Standing Financial Instructions (SFIs) and Scheme of Delegation	**Alert**	• N/A
	Advise	• N/A
	Assure	• SFIs updated to meet latest procurement regulations. • The provision of delegated authority from the Board to the joint assurance committee to sign off the annual report and accounts in June included. • Documents have been reviewed by Finance, Procurement and HR teams. • The committee endorsed the SFIs and Scheme of Delegation
	Actions	• Check to be undertaken in relation to section 2 of the SFIs to confirm alignment with the Audit Committee Terms of Reference. • Responses to other second order questions to be provided.
Unaudited accounts – review	**Alert**	• N/A
	Advise	• Summary of unaudited accounts provided to the committee.
	Assure	• The Committee felt assured of the work and actions to date in the preparation for the successful completion and submission of the statutory annual report and accounts.

	Actions	• Going concern to be advised as part of summary report to Board. • Clarification in respect of note 11.2 regarding gross and net assets to be provided.
Annual governance statement – draft for approval	**Alert**	• Cyber security and resiliency bill to come out later in the year (predicted June/July). The new Data Security and Protection Toolkit will have a key focus on cyber and a resiliency element for other key function areas other than IT, noted this will be key for focussing on when looking at the processes around end-to-end systems.
	Advise	• Discussion on the top risks, confirmation provided on blood transfusion risk. Consideration suggested for further inclusion of strategic and cyber risks within the content. To review and include expansion on how risk content in the statement has been arrived at and include section on cyber.
	Assure	• The committee endorsed the annual governance statement.
	Actions	• To review and include expansion on how risk content in the statement has been arrived at and consider inclusion of strategic and cyber risks. • Forthcoming cyber security and resiliency bill to be alerted to Board through summary report.
Board assurance framework 2024/25	**Alert**	• N/A
	Advise	• Legal & statutory risk (BAF 14) discussed: now refined to DHSC/NHSE and CQC. Risk still incorporates significant and variable components, need to assess whether all for Audit Committee. Discussion as to whether the risk would be more appropriately placed as responsibility under Board. Risk score of 12 seems high given controls in place, may need to consider separating out between the internal risk and external risk. • Discussion on supply chain risk and impact of tariffs. Noted that the position on tariffs changes on a daily basis, need to await guidance to come through.
	Assure	• N/A
	Actions	• To progress the review of BAF risk 14 through ongoing review and development. • Supply chain risk in relation to tariffs to be kept under review and advised as part of summary report to Board.
Declarations of	**Alert**	• N/A

interest 2024/25 six monthly update	**Advise**	• Discussion on need to continue with advice to staff on what they can and cannot accept. • Move to annual assurance report process agreed through committee discussion with reporting by exception if required.
	Assure	• Year-end compliance at 91% for decision making staff, good position given tolerance allowed for starters and leavers. For this financial year already at 60% compliance. • Regular comms in place, staff do raise queries when unsure.
	Actions	• Rolling programme to be updated to reflect move to annual reporting for declarations of interest.
Audit committee annual report – draft for approval	**Alert**	• N/A
	Advise	• Discussion on report and updates suggested, recorded as actions.
	Assure	• The committee endorsed the report, subject to the changes noted.
	Actions	Committee annual report to be updated to include: • Specify Audit Committee's overarching role in that it discharges through the joint assurance committee at the end of the year. • Reference to the committee reporting back to the Council of Governors through the summary reports to Board in year to also be included. • In forward look section - add in focus on end-to-end systems, reference to in-year review of audit plan and potential to add in a digital related review and inclusion of deep dives.
Audit committee effectiveness outcome report 2024/25	**Alert**	• N/A
	Advise	• Committee discussion on the 'what do you think we could do better' section of the report. • More responses encouraged for future reviews.
	Assure	• Positive outcome in terms of effectiveness scoring (92.2%).
	Actions	• Committee effectiveness outcome reports to be added to the next committee chairs and exec leads meeting to enable review of training needs. • Consideration to be given to making effectiveness review questions more specific and splitting between executive and non-executive for future years.

Internal audit progress report	**Alert**	• N/A
	Advise	• Board reporting review: noted gaps identified are being addressed in line with new guidance just released. With reference to the absence of a finance committee, noted that the Trust addresses finance and planning detail through its private Board and Board planning days. • Assurance Framework: actions to be added to the tracker.
	Assure	• Finalised 4 reviews; PSIRF (reported to Quality Assurance Committee with substantial assurance), Assurance framework (full report provided to Audit Committee), risk management and Board reporting. • Encouragement noted on PSIRF review outcome.
Internal audit follow up report 2024/25	**Alert**	• Biobank review – 2 medium recommendations outstanding, overview given. Extensions requested for end of April 2025 for SLA recommendation and July 2025 for assurance report recommendation, committee discussion led to agreement to requested extensions.
	Advise	• 81 recommendations due for completion by the 31 March 2025; 50 fully implemented, 23 partially implemented, 4 actions now superseded and 4 not due for completion. Reasoning and justification on the partially completed recommendations discussed.
	Assure	• New standard operating procedure in progress for formalising the extension process with MIAA.
	Actions	• Ownership for iQemo actions to be reviewed with management with an update to be brought to the July Audit Committee. • Summary report to Board to advise on message that audit recommendation timeframes for completion need to be achievable and delivered, and managers will be held to account for completion delays.
Head of internal audit opinion 2024/25	**Alert**	• N/A
	Advise	• Discussion on opinion given the number of limited assurance reviews, confirmed the outcome was borderline between substantial and moderate noting it was a risk-based plan, and the Trust had alerted MIAA to risk areas to review and worked responsively with MIAA as part of the reviews.
	Assure	• Substantial assurance opinion provided with detail on how the conclusion has been reached through work undertaken in-year, management responses and the assurance framework.

Internal audit plan 2025/26	**Alert**	• End to end systems and processes to be considered for inclusion in the plan. • Consideration of a review based on the Trust's preparedness for the new cyber regulation due to come in, consider at a later date following publication of guidance and Trust response.
	Advise	• Noted as a flexible plan that can be amended at a later date if required.
	Assure	• The committee approved the plan.
	Actions	• End to end systems and Trust's preparedness for the new cyber regulation to be kept under review and considered for MIAA audit review later in the year.
Internal audit charter	**Alert**	• N/A
	Advise	• N/A
	Assure	• Charter acknowledged by the committee.
External audit plan 2024/25	**Alert**	• N/A
	Advise	• Overview of the plan and the 3 mandated significant risks provided. • Following completion of draft accounts, materiality has increased. • VFM initial risk assessment done, nothing identified at this stage.
	Assure	• N/A
	Actions	• Further information on GT strategic investigation to be provided to Audit Committee NED members.

The Christie
NHS Foundation Trust

Agenda Item 24/25b

Board of Directors meeting
Thursday 26th June 2025

Subject / Title	Board Assurance Framework 2024/25
Author(s)	Louise Westcott, Company Secretary
Presented by	Louise Westcott, Company Secretary
Summary / purpose of paper	This paper provides the Board with the closing position of the Board Assurance Framework that summarises the risks to achievement of the corporate objectives. The cover paper gives detail of the updates.
Recommendation(s)	• To note the closing position for the Board Assurance Framework 2024/25, • To assign a level of assurance to discussions in the meeting that relate to the risks, • To note that a full review of the refreshed annual objectives and resultant strategic risks has taken place and will form the next iteration of the BAF.
Background papers	Board assurance framework. 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 ECN Executive chief nurse EDoF Executive director of finance EMD Executive medical director COO Chief operating officer DoW Director of workforce DCEO Deputy chief executive officer

The Christie
NHS Foundation Trust

Agenda Item 24/25b

Board of Directors meeting
Thursday 26th June 2025

Board Assurance Framework 2024/25

1 Introduction

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

2 Background

As part of the annual review of the objectives a draft set of amended strategic objectives and annual objectives were considered by the Board at their May Planning Day. A full review was undertaken by the company secretary and executive directors of the strategic risks associated with these refreshed objectives.

2 Updates to risks

All risks in the current version of the framework have been reviewed to reflect the current position and close off risks that may no longer be relevant or amend risk descriptions to reflect the current risk. Risk scores have also been updated to show the position at month 1 for all risks.

The following risks will be removed or replaced in the next iteration of the BAF.

- **Risk 6** - *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*.

  This risk has changed in the new financial year and is described in the updated framework

- **Risk 11** - *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.*

  The risk description relating to cyber has been amended for the refreshed BAF to describe business disruption from several causes including cyber.

- **Risk 12** - *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.*

  This risk has changed and a new risk relating to staff engagement will replace it.

- **Risk 13** - *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*

  Risk score reduced from 8 (4x2) to 6 (3x2) to reflect the assessment of the risk. This risk has been removed as it is monitored as an operational risk.

- **Risk 14** - *If we do not maintain an awareness of and respond to changing statutory and legal requirements (DHSC/NHSE/CQC) there is a risk that we will fail to comply leading to being sanctioned for being in regulatory or statutory breach.*

  Risk score reduced from 12 (3x4) to 8 (2x4) to reflect the Trust responses to updated statutory & legal requirements. This risk has been redescribed to better reflect the current risk.

- **Risk 15** - *There is a risk that adverse events will attract media coverage resulting in a decrease in public confidence in our services*

  Risk score reduced from 6 (3x2) to 4 (2x2) to reflect the outcome of recent high profile employment tribunals. The review of risks agreed that this risk is no longer significant enough to be included in the BAF and can be reconsidered if this position changes.

The following risks have been redescribed to reflect the current risk and the updated risk will be described in the amended framework.

- **Risk 2** - *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.*

  Risk score reduced from 9 (3x3) to 6 (2x3) to reflect progress made with PSIRF implementation, completion of PSIRF training and improved timeframe for incident management. MIAA audit of PSIRF processes confirms substantial assurance. The risk is redescribed for the next version of the BAF and the new description reflects that PSIRF is now business as usual.

- **Risk 4** - *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*

  Risk score reduced from 12 (4x3) to 9 (3x3) to reflect the work done around the new assessment framework & roll out of Excellence in Action. New description is around review and corrective action to maintain standards.

- **Risk 5** - *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.*

  Risk now reflects the new financial year and resultant risk relating to capital.

- **Risk 8** - *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.*

  Risk description now relates to business disruption from many potential threats including cyber, weather, pandemic etc.

- **Risk 10** - *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.*

  Risk redescribed to reflect 2025/26 financial rules.

The following risks will remain unchanged;

- **Risk 1 -** *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.*
- **Risk 3** - *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*.
- **Risk 7** - *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*.
- **Risk 16** - *If we can't maintain supply of essential products for the treatment and care of our patients there is a risk that their treatment and care will be adversely impacted or delayed.*

3 Recommendation

The Board are asked;

- To note the closing position for the Board Assurance Framework 2024/25,
- To assign a level of assurance to discussions in the meeting that relate to the risks,
- To note that a full review of the refreshed annual objectives and resultant strategic risks has taken place and will form the next iteration of the BAF.

BOARD ASSURANCE FRAMEWORK 2024/25 OVERVIEW OF RISKS

RISK No.	Risk Title	Risk Description	Responsible Committee	Risk Appetite	Inherant Risk Score	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	Target Risk Score	Current Risk Score	Target date
RISK 7	**Ineffective Greater Manchester system-wide cancer pathways**	If diagnostic, MDT and referral processes at local hospitals across the GM system are not efficient there is a risk that we receive patients on 62-day pathways late leading to them not being treated within 62 days.	Quality Assurance Committee	Cautious	25	16	12	12	12	8	12	**Reviewed Q3 24/25**
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	Averse	25	12	12	12	12	4	12	**Reviewed Q4 24/25**
RISK 16	**Supply chain**	If we can't maintain supply of essential products for the treatment and care of our patients there is a risk that their treatment and care will be adversely impacted or delayed	Audit Committee	Averse	16	N/A	N/A	12	12	4	12	**Review Q2 25/26**
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	Averse	15	12	12	12	12	4	9	**Review Q1 25/26**
RISK 3	**Recruitment and retention of skilled staff**	If we are unable to maintain current levels of skilled staff there is a risk that they will not have the time or expertise required for excellent care and communication leading to a reduction in the standards of patient safety and experience.	Workforce Assurance Committee	Averse	20	9	9	9	9	4	9	**Reviewed Q4 24/25**
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	Quality Assurance Committee	Cautious	12	9	9	9	9	6	9	**Review Q1 25/26**
RISK 14	**Legal and statutory compliance**	If we do not maintain an awareness of and respond to changing statutory and legal requirements (DHSC/NHSE/CQC) there is a risk that we will fail to comply leading to being sanctioned for being in regulatory or statutory breach.	Audit Committee	Averse	20	16	16	12	12	4	8	**Review Q1 25/26**
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	Averse	16	8	8	8	8	4	8	**Reviewed Q3 24/25**
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	Averse	16	8	8	8	8	4	8	**Review Q3 & Q4 24/25**
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	Averse	15	6	15	12	9	4	6	**Reviewed Q4 24/25**
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	Cautious	10	8	8	8	8	4	6	**Within tolerance**
RISK 1	**New technologies and increased standards of care**	If there are changes to NICE guidance or other advances in practice that we have not anticipated (diagnostic, therapeutic, care) there is a risk that there will be a delay in their introduction leading to a delay in patients obtaining the benefits of new treatments.	Quality Assurance Committee	Cautious	20	9	9	6	6	4	6	**Within tolerance**
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	Averse	25	20	12	12	5	5	5	**Reviewed Q4 24/25**
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	Averse	12	9	9	6	6	4	4	**Reviewed Q4 24/25**
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	Eager	25	16	16	12	4	4	4	**Reviewed Q4 24/25 / Within tolerance**

RISK 1	New technologies and increased standards of care	Date Risk Opened	Current Risk Score
Description	**If there are changes to NICE guidance or other advances in practice that we have not anticipated (diagnostic, therapeutic, care) there is a risk that there will be a delay in their introduction leading to a delay in patients obtaining the benefits of new treatments.**	Apr-24	6
		Date of Last Review	
		Jun-25	
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

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date
	Annual planning process with divisions. The trust has a risk-based process with divisional support to assess applicability and implement relevant guidance. Guidance that is not resolved or on the risk register is monitored and escalated if there are issues	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	Within tolerance

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	2	3	6	2	3	6			0

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	6
		Date of Last Review	
		Jun-25	
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

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
	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. Progression with PSIRF implementation, completion of PSIRF training programme across the Trust and improved timeframe for incident management.	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 patient safety reports to QAC□ Level 3 – External assurances • MIAA audit of PSIRF processes confirms substantial assurance. • Updates presented to ICB	None identified	Full roll out of new Datix - incident module	Reviewed Q4 24/25

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	3	4	12	3	3	9			0

RISK 3	Recruitment and retention of skilled staff	Date Risk Opened	Current Risk Score
Description	**If we are unable to maintain current levels of skilled staff there is a risk that they will not have the time or expertise required for excellent care and communication leading to a reduction in the standards of patient safety and experience.**	Apr-24 Date of Last Review Jun-25	9
Associated Corporate Objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey. To be an international leader in professional and public cancer education. To maintain excellent operational, quality and financial performance.	Executive Lead Responsible Committee Assurance Level Risk Appetite	Workforce Director **Workforce Assurance Committee** High Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for 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 Agreement to recruit to the onboarding post on a permanent basis established	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 People & Culture plan updates□ • F&PP Compliance report to WAC / Board □ Level 3 – External assurances • National staff survey□ • MIAA audit - Role Specific Training July 24 - limited assurance / Divisional Recruitment Nov 24 - limited assurance	Actions outlined by MIAA in Nov 24 Divisional Recruitment audit	Recruitment of onboarding coordinator - agreement to recruit to the onboarding post on a permanent basis now established	Reviewed Q4 24/25

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	3	3	9	3	3	9			0

RISK 4	Changes in quality regulation	Date Risk Opened	Current Risk Score
Description	**If the CQC or other regulatory body changes their approach to regulation there is a risk that we will not be able to demonstrate compliance leading to us being assessed as not meeting the fundamental care standards.**	Apr-24 Date of Last Review Jun-25	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	Exec Chief Nurse **Board of Directors** High Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	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. Board session completed in February 2025 with Hempsons to discuss approach and preparation. Evidence collated by Q&S team against well-led. Saftey evidence being collated. Excellence In Action programme designed and rolled out across the organisation. Mock inspections being undertaken.	None identified	Level 1 – Data and management reports • Self assessment against 2022 Must Do's□ • Self assessment against Well Led quality indicators • Excellence in Action Level 2 – Management team and committee scrutiny • QAC /WAC review of CQC regulations - all on rolling programmes□ • Board level training on new CQC assessment framework Feb 24 Level 3 – External assurances • GGI review□ • Globis Culture Audit • CQC Inspection Reports (IR(M)ER)	None identified	Safety' evidence being collated. Mock inspections planned and being arranged. Evidence to be collated for other key questions and quality statements (effective / caring / responsive to peoples needs)	Review Q1 25/26

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	4	3	12	4	3	12			0

RISK 5	Impact of the system capital allocation framework	Date Risk Opened	Current Risk Score
Description	**If the capital planning and allocation system does not enable full use of our charitable and commercial reserves there is a risk that we may not be able to fund our capital and asset replacement programmes leading to delays, cancellations or reprioritising of planned projects and equipment not being replaced when needed.**	Apr-24 Date of Last Review Jun-25	4
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** High Eager

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	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. All high capital risks included and delivered in capital plan 24/25	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 • ICB allocation	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	Reviewed Q4 24/25 / Within tolerance

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	4	3	12	1	4	4			0

RISK 6	Insufficient contractual support for networked cancer care provision	Date Risk Opened	Current Risk Score
Description	**If the GM system does not continue to support local provision of cancer care with contractual and funding flow changes there is a risk that we are unable to devolve more systemic therapy, clinical trials and radiotherapy treatments to local communities leading to persistence or increases in inequalities in provision to economically deprived and ethnically diverse communities.**	Apr-24 Date of Last Review Jun-25	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

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
	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 review□	GM ICB confirmations of commissioning intentions 25/26	Highlighting financial / operational / risks at provider oversight meetings	Review Q1 25/26

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	3	3	9	3	3	9			0

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 Jun-25	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

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
	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.	NHS pressures leading to delays in referrals from other Trusts	Level 1 – Data and management reports • 62 / 31 / 24 day reports to Senior Management Committee and Board□ • Service & Operational Review feedback Level 2 – Management team and committee scrutiny • 6 monthly review by QAC□ Level 3 – External assurances • MIAA review of 62 days / Cancer Alliance□	Evidence of progress in underperforming parts of the pathway	Supporting cancer improvement plans in GM Cancer Pathway improvement workstream in GM Cancer	Reviewed Q3 24/25

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	3	4	12	4	3	12			0

RISK 8	Extreme weather events	Date Risk Opened	Current Risk Score
Description	**If there is an extreme weather event (heat wave, freeze, floods etc) due to climate change there is a risk of business disruption (increased staff absence, increased patient non-attendance and equipment malfunction) leading to delayed or cancelled care.**	Apr-24 Date of Last Review Jun-25	8
Associated Corporate Objectives	To maintain excellent operational, quality and financial performance.	Executive Lead Responsible Committee Assurance Level Risk Appetite	Director of Strategy **Audit Committee** Averse

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
	What we have in place to prevent the risk materialising (reduce likelihood): No ability to reduce likelihood as an organisation, however we do have a 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 Plans (BCP) - sections on extreme weather conditions, regularly tested and reviewed Extreme weather plan approved & published on intranet	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 • Approved Extreme weather plan Level 2 – Management team and committee scrutiny • Emergency Planning & Resilience Committee - reporting of regular testing of BCP's / extremem weather plan • 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 Level 3 – External assurances • Internal audit of compliance with NHS requirements • NHSE review of plans and progress - agreement of current compliance (as in self-assessment)	Not at 100% compliance for self-assessment / external assessment	•Developing methodology to assess carbon footprint in collaboration with other Trusts •Developing a CC •Annual Report - Check what audit scrutiny this receives	Reviewed Q3 24/25

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	4	2	8	4	2	8			0

RISK 10	Financial balance	Date Risk Opened	Current Risk Score
Description	**If we do not achieve the planned activity levels and our target efficiency savings there is a risk that we won't achieve financial balance leading to us having to repay the difference to our agreed plan in the following year**	Apr-24 Date of Last Review Jun-25	5
Associated Corporate Objectives	To maintain excellent operational, quality and financial performance.	Executive Lead Responsible Committee Assurance Level Risk Appetite	Exec Director of Finance **Board of Directors** High Averse

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	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 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. Board has recieved monthly financial report showing performance. Acheivement of 2024/25 plan.	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 - substantial assurance • External audit of Annual Accounts • MIAA review of VIP programme	None identified	VIP Programme recommendations implemented	Reviewed Q4 24/25

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	3	4	12	3	4	12	1	5	5			0

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 Jun-25	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 Responsible Committee Assurance Level Risk Appetite	Executive Medical Director **Audit Committee** Medium Averse

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	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, review for 2024/25 underway.	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	Reviewed Q4 24/25

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	3	4	12	3	4	12			0

RISK 12	Ineffective response to cultural audit	Date Risk Opened	Current Risk Score
Description	**If our response to the cultural audit is insufficient there is a risk that a negative culture will persist in some specific parts of our organisation leading to an increase in the number of staff reporting a poor experience.**	Apr-24 Date of Last Review Jun-25	8
Associated Corporate Objectives	To be an excellent place to work and attract the best staff	Executive Lead Responsible Committee Assurance Level Risk Appetite	Director of Workforce **Workforce Assurance Committee** Medium Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
Actions	Plan developed through extensive engagement with staff following production of Globis Culture Audit and approved by Board. Board responsibilities outlined. Work commenced to implement agreed actions and continue to communicate with staff. Advisory Group in place and meetings arranged. 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 • Board approved Inclusive Culture Plan Nov 2024□ Level 3 – External assurances • Globis culture audit□ • Annual CQC Staff Survey 2023 / 2024	None identified	Implemenetation of agreed action plan Cost additional resource requirments Advisory Group meetings to take place and review progress / report	Review Q3 & Q4 24/25

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	2	4	8	2	4	8			0

RISK 13	Insufficient data on patient protected characteristics	Date Risk Opened	Current Risk Score
Description	**If we are unable to capture data on the protected characteristics of our patients there is a risk we will be unable to assess any inequalities in access, experience or outcomes leading to lack of focus in addressing health inequalities**	Apr-24 Date of Last Review Jun-25	6
Associated Corporate Objectives	To be an excellent place to work and attract the best staff	Executive Lead Responsible Committee Assurance Level Risk Appetite	Exec Medical Director **Quality Assurance Committee** Medium Cautious

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
Actions	Collation of existing data into a report for publication on the website. Areas of poor data quality identified and group established to identify actions to improve.	Lack of data from national spine	Level 1 – Data and management reports • published data□ • review by Exec Team monthly□ Level 2 – Management team and committee scrutiny • Integrated Performance report to Senior Management Committee and Board of Directors□ Level 3 – External assurances • Submissions to NHSE • MIAA - Data Quality audit Oct 24 - moderate assurance	Outcomes from planned improvements not yet demonstrated in performance	Reports to be tailored to ensure they accurately reflect our services / patient group	Within tolerance

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	4	2	8	4	2	8			0

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 (DHSC/NHSE/CQC) there is a risk that we will fail to comply leading to being sanctioned for being in regulatory or statutory breach.**	Apr-24 Date of Last Review Jun-25	8
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 Responsible Committee Assurance Level Risk Appetite	Chief Executive Officer **Audit Committee** High Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
Actions	Engagement in national updates and regulatory briefings. Designated leads for statutory requirements across the Trust reporting into committee structure. Policies and procedures in place e.g. conflicts of interest, SFI's, Document ratification processes. Membership of NHS Providers to recieve most up to date advice and guidance. Exec Team engagement in national briefings. Close working with regulators, GM ICS / ICB and NHSE. Attendance at system level and national meetings. Leads identified internally for each statutatory requirement e.g. health & safety / IRMER / CQC etc	Uncertainty around what / when. External political factors	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□ • Work of the 3 assurance committees 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□ • MIAA data quality audit Oct 24 - moderate assurance	SOF rating - currently 2	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.	Review Q1 25/26

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	3	4	12	3	4	12			0

RISK 15	Patient confidence in services	Date Risk Opened	Current Risk Score
Description	**There is a risk that adverse events will attract media coverage resulting in a decrease in public confidence in our services**	May-24 Date of Last Review Jun-25	4
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 Responsible Committee Assurance Level Risk Appetite	Chief Executive Officer **Board of Directors** High Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
Actions	Policies and procedures e.g. management of claims External legal advice where necessary Outcomes of legal cases 2024/25	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	Reviewed Q4 24/25

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	3	2	6	3	2	6			0

RISK 16	Supply chain	Date Risk Opened	Current Risk Score
Description	**If we can't maintain supply of essential products for the treatment and care of our patients there is a risk that their treatment and care will be adversely impacted or delayed**	Nov-24 Date of Last Review Jun-25	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 maintain excellent operational, quality and financial performance.	Executive Lead Responsible Committee Assurance Level Risk Appetite	Chief Operating Officer Audit Committee Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
Actions	Pharmacy - TCP procurement team work closely with regional & national drug procurement teams. Mutual aid MOU in place in NW. Management with clinicians to avoid imapct on care Medical Physics - close relationship with national supply chains and management of demand based on availability of radioactive materials. BCP in place for Radiopharmacy to maintain supplies and regular discussions with supplier of FDG for the PETCT scanner. Procurement - policies & processes in place for management of supplies incl escalations & triggers / communication.	National / international shortages / supply issues	Level 1 – Data and management reports • Regular reports to relevant committee • Monitoring & review by management team Level 2 – Management team and committee scrutiny • Reports to The Christie Pharmacy Company Board and Audit Committee, via Trust Drug & Therapeutics Committee • Esclations from Risk & Quality Governance to Senior Management Committee Level 3 – External assurances • MIAA audits commissioned to review specific issues where appropriate	None identified	Review of alerts	Review Q2 25/26

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			N/A			N/A	4	3	12	4	3	12			0

The Christie
NHS Foundation Trust

Agenda item 24/25c

Meeting of the Board of Directors
Thursday 26th June 2025

Title	Care Quality Commission (CQC) Trust Annual Update against standards and preparedness.
Author	Chief Nurse & Executive Director of Quality
Presented by	Chief Nurse & Executive Director of Quality
Purpose of paper	To provide the Board of Directors an update the Trust's annual position and preparedness against the CQC regulatory standards.
BAF reference	BAF Risks 4 and 14
Link to: ➢ Trust strategy ➢ Corporate objectives ➢ Regulation	Trust strategy CQC regulations (all key questions and quality statements)
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	CQC - Care Quality Commission

The Christie
NHS Foundation Trust

Agenda item 24/25c

Meeting of the Board of Directors

Thursday 26th June 2025

Care Quality Commission (CQC) Trust Annual Update against standards and preparedness.

1. Purpose

1.1 The purpose of this report is to provide an annual update on Trust position and preparation against the CQC regulatory assessment framework.

2. Background

2.1 In July 2022, the CQC launched its single assessment framework (name changed to assessment framework, January 2024) for health and social care providers outlining how quality and performance is assessed. The assessment framework is based on 5 key questions; is the service Safe, Caring, Responsive, Effective and Well led. Each key question has underlying quality statements, of which there are 34 in total. Expressed as 'we' statements, quality statements are commitments providers should live up to, to deliver high-quality person-centred care. The CQC gain insight into services through ongoing data gathering from national data collections, information from providers, which they request via email currently and feedback from engagement activities.

2.2 Six evidence categories have been identified relating to each of the 34 quality statements.

These are:

- People's experience of health and care services
- Feedback from staff and leaders
- Feedback from partners (e.g. commissioners and other local providers)
- Observation
- Processes
- Outcomes

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

- 4 = Over 87% (outstanding)
- 3 = 63 to 87% (Good)

- 2 = 39 to 62% (requires improvement)
- 1 = 25-38% (inadequate)

2.4 CQC will continue to provide an overall rating using the existing scale: Outstanding, Good, Required Improvement and Inadequate.

2.5 Current provider ratings will remain in place until the next assessment

3. Engagement activity

3.1 Throughout 2024/25, the Trust has continued its regular engagement meetings with the CQC. These are attended by the Executive Chief Nurse & Director of Quality, the Deputy Chief Nurse and a designated CQC inspection manager for the Trust, other people are also invited as required. These meetings provide a Trust wide quality update, with specific responses to questions raised under the CQC key questions; Safe, Effective, Caring, Responsive and Well-Led.

3.2 There is also an open channel of communication between the local CQC inspection Manager and the Chief Nurse throughout the year, all interactions are documented on a Trust tracker and all documents are provided with a unique CQC code and logged by CQC and Trust.

4. Inspection activity

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

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

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

- The Trust must ensure staff complete mandatory training, including safeguarding training in accordance with the relevant schedule and receive relevant training, supervision and appraisal to perform their duties competently. (Regulation 18 (1)(2)(a)
- The Trust must ensure that policies are reviewed and ratified in a more timely manner. (Regulation 17 (1))
- The Trust must ensure that serious incidents and mortality reviews are investigated in a timely manner and learning is shared across the organisation as required. (Regulation 12 (2)(b))
- The Trust must ensure there is an effective process to manage complaints, in particular, ensuring the timeliness of responses. (Regulation 16 (2))

- The Trust must ensure there is an effective process to manage the administration of the fit and proper persons checks. (Regulation 5)
- The Trust must ensure that patient risk assessments are consistently completed and reviewed in a timely manner for all patients. (Regulation 12 (1)(2)(a)(b))
- The service must ensure the proper and safe management of medicines, to include the completion of antimicrobial documentation for safe prescribing in line with Trust policies. (Regulation 12(1)(2)(g))

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

4.4 The report also identifies 4 'should do' actions which the Trust is not required to submit an action plan or report to the CQC. Work continues to ensure improvements against these actions, this is reported seperately to board.

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

4.5 Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection

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

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

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

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

5. Preparedness – Excellence in Action

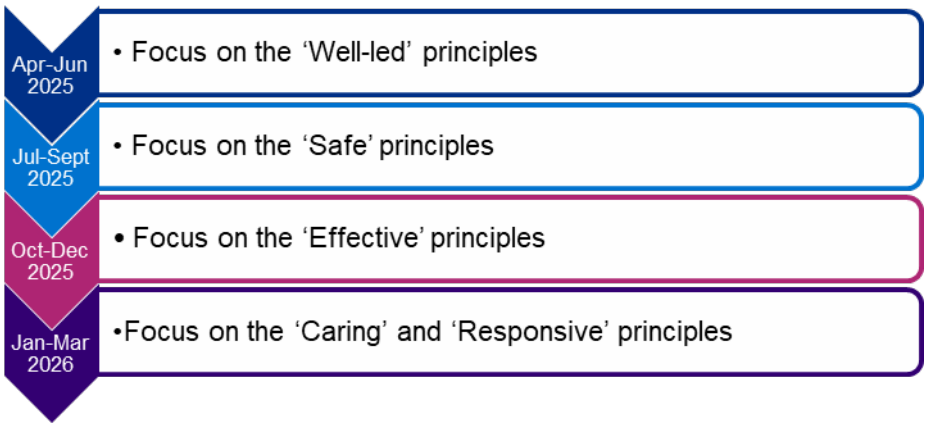
5.1 The Trusts internal quality inspection programme CODE (Care, Observation, Documentation, Experience), which is mapped to the CQCs fundamental standards of care, continued through 2024/25, with the introduction of a monthly 'mini CODE' that monitors the sustainability of the quality outcome and fundamentals of person centred care. These commenced Q4, 2024/25.

5.2 More focused preparedness commenced at the beginning of 2025. To date this has included:

- At the February 2025 board away day Hempsons solicitors, who have expertise in NHS regulation, presented to the board of directors an overview of the CQC single assessment framework.
- The compliance team have developed an evidence matrix to organise how we organise the information pertinent to each quality statement.
- The compliance team have led a process to map evidence and sources of evidence to each of the well-led quality statements and its relevant evidence categories, with engagement from teams Trust wide.
- We have carried out a 'well-led' review day with the Chief Nurse, compliance team and Hempsons solicitors, who are supporting us in this process
- Launched 'Excellence in Action' which is a trust wide annual programme of work to promote, engage and demonstrate how our everyday work meets the standards set out in the CQCs regulatory framework, helping us to deliver high-quality, person-centred care.

5.3 Excellence in Action

- During 2025-26 each quarter will focus on different key questions. There are 34 quality statements which sit under 5 key questions. The schedule for the key questions can be found below:



The programme has two arms and is based on a rolling quarterly approach to:

1. Gather, map and review available evidence and identify potential gaps
2. Promote and engage a key question and its relevant quality statements.

The aim of this is to enhance the understanding of all staff on what we do on a daily basis to meet our regulatory requirements and engage staff with the language and terminology used within the assessment framework. The approach also involves and supports staff to feel more confident in a continual regulatory assessment process and showcase and evidence the excellence we action as business as usual and how this aligns with the Trusts strategy, mission, values and behaviours.

Our approach to the engagement of Excellence in Action includes:

- Staff engagement - examples include engagement stands, presenting at Trust forums, divisional, directorate and service meetings.
- Communications - examples include Trust wide cascades and weekly briefings, HIVE pages, a staff handbook focussing on the key questions and quality statements and questions to staff on how each key question is demonstrated. Working in partnership with division, directorate and service leads to support staff if there are gaps identified.
- Mock inspections – this will include unannounced inspections of clinical areas as well as mock interviews. The inspecting teams will be made up of a cross section of staff groups, disciplines and grades.
- Preparatory Interviews with senior leaders and Board members to support confidence in the assessment process.

6. Conclusion

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

The Trust has a structured method of regulatory assessment preparation and engagement.

7. Recommendation

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