The Christie
NHS Foundation Trust

Board of Directors meeting
Thursday 25th September 2025 at 12.45 pm
Trust meeting room

Agenda

Patient story / clinical presentation: *'A 360-degree view of The Christie's National Peritoneal Tumour Centre'* - Omer Aziz, Colorectal Surgeon & Rebecca Halstead, Clinical Nurse Specialist and a patient
30 mins

	Public items	Decision		Lead	Page	Timing
26/25	**Standard business**					
a	Apologies			Chair		
b	Declarations of interest			Chair		
c	Minutes of previous meeting – 26th June 2025	Approve	*	Chair	2	5 mins
d	Action plan rolling programme, action log & matters arising	Review	*	CEO	8	
27/25	**Performance & finance**					
a	Trust report	Review	*	Execs	12	
b	Integrated performance quality & finance report	Review	*/p	COO	24	20 mins
c	Financial planning	Review	*	EDoF	63	
d	Value Improvement Programme update	Review	*	COO	68	
28/25	**Planning**					
a	OECI accreditation report	Review	*	DCEO	73	15 mins
b	Future Christie	Review	*	DFC	78	
29/25	**Governance (regulatory / statutory compliance)**					
a	Reports from committees • Workforce Assurance Committee – June 2025 • Quality Assurance Committee – June 2025 • Audit Committee – June & July 2025	Review	*	Committee chair	82	15 mins
b	Board assurance framework	Review	*	CEO	103	
c	Board capability self-assessment	Review	*	CEO	113	20 mins
d	Board assessment statement on Winter Planning	Approve	*	COO	129	
30/25	**Any other business**					
	Reflections on the meeting					
	Date and time of the next meeting Thursday 23rd October 2025 at 12:45pm					

D/CEO	Deputy / Chief Executive Officer
EDoF	Executive Director of Finance
DFC	Director of Future Christie
COO	Chief Operating Officer

*	paper attached
v	verbal
p	presentation

The Christie
NHS Foundation Trust

Public meeting of the Board of Directors
Thursday 26th June 2025 at 12.45 pm
Trust Meeting Room

Present:	Chair:	Tarun Kapur (TK), Non-Executive Director Roger Spencer (RS), Chief Executive Officer Alveena Malik (AM), Non-Executive Director Grenville Page (GP), Non-Executive Director Roy Dudley-Southern (RDS), Non-Executive Director Dr Diana Tait (DT), Non-Executive Director Prof Chris Harrison (CJH), Executive Director / Deputy CEO Vicky Sharples (VS), Executive Chief Nurse Claire McPeake (CM), 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
Minutes:		Louise Westcott (LW), Company Secretary
In attendance:		Jo D'Arcy, Assistant Company Secretary Geraldine Vesey

Clinical presentation: PLACE assessment – Rosie Gill, Soft Facilities Manager and Brian Turner, patient assessor

RG introduced herself and Brian who has been participating in the assessment for a number of years. The focus is in improving the environment in non-clinical areas – all areas a patient will see.

PLACE stands for Patient Led Assessment of the Care Environment and was introduced in 2013 to replace PEAT, giving patients a stronger voice.

The premise of the assessments is that good environments matter and that every NHS patient should be cared for with compassion and dignity in a clean, safe environment. Where standards fall short, they should be able to draw it to the attention of managers and hold the service to account. PLACE assessments provide motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced.

The assessments involve patient assessors going into hospitals as part of teams to assess how the environment supports the provision of clinical care, assessing non-clinical aspects of healthcare premises that covers cleanliness, disability & how well are the needs of patients with accessibility needs are being met, food & hydration, dementia, privacy, dignity & wellbeing and condition, appearance & maintenance.

Recruitment and training of patient assessors is the responsibility of those organisations undertaking assessments.

The assessments take place every year, and results are published to help drive improvements in the care environment. The results show how hospitals are performing both nationally and in relation to other hospitals providing similar services. PLACE assessments focus exclusively on the environment in which care is delivered and do not cover clinical care provision or how well staff are doing their job.

A training session is planned for 2-3 weeks before assessment. The site is split into a number of areas and a team of 2 staff & 2 patient assessors are allocated to each area, an independent assessor from another trust, will also participate.

Assessments are detailed and the scoring is completed into a spreadsheet and sent off to NHSE.

RG outlined the detailed elements within each part of the assessment. Disability and dementia are new areas in the assessment. Actions around dementia have been identified and a group has been put together to address actions.

RG outlined the process followed on the day of assessment.

BT introduced himself and gave a summary of his background. He was a patient and has had contacts with the Trust since 2009. BT explained that he is involved in lots of ways and has been doing the PLACE assessments for many years. He does it to put something back to help the organisation. He outlined that he knows other Trusts well too so can also compare to other places. He has a good idea of what the priorities are and what a patient needs to have.

Results from 2024 – ward 12 works are to be completed and ward 11 will be done next. Reception desks in radiology come out as substandard and that will be addressed by the ASIC development. Bare walls have been covered through work with the Art room lead. New signage for all toilets are going in, that are dementia friendly. A survey on accessibility is being undertaken in September.

RS thanked BT for his dedication in helping us which is very much appreciated.

GP asked about communal areas and patients with family / carers, does the assessment include the concession areas that family use as they are not always clean and always very busy.

RG responded that we are looking at future investment in the M&S area to address the issues around patient flow / capacity / space for wheelchairs etc.

TT asked what changes have been seen over the years and how the charity has helped. RG noted that The Charity support the work in the garden and other aspects but there is a big change with the dementia challenge as patients can be on any ward. Other languages in signage are also being looked at.

AM asked about dignity, particularly for some communities we care for and which sites this covers. RG noted that we cover Macclesfield, but the other Trusts (Salford/Oldham) do their own assessments. RG to share the dignity assessment details with AM.

Item		Action
20/25	**Standard business**	
a	**Apologies**	
	Prof Joe Rafferty (JR), Chair, Prof Fiona Blackhall (FB), Director of Research, Sarah Corcoron (SC), Non-Executive Director, Jeanette Livings (JL), Director of Communications	
b	**Declarations of Interest**	
	None noted.	
c	**Minutes of the previous meeting – 24th April 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.	
21/25	**Performance & Finance**	
a	**Trust Report**	
	• The new Performance Assessment Framework has been introduced; our indicative assessment is presented. This goes live in Q2. Contributing metrics are outlined. Performance will be assessed against this framework. • Most activities are on plan, and this is not reflected in the broader system. • Quality indicators are all stable and no issues to escalate. • Financial position is outlined at month 2. • SP noted that we don't have parameters around the indicators yet for the new assessment framework – some will be relative, and some are absolute. • Our current assessment under the previous system oversight framework is still published as a '2' but the indicative assessment in the new framework is '1' – the best possible. **Approved**	
b	**Integrated performance quality & finance report**	
	• Focus on 62-day cancer standard and VIP recurrent shortfall • Strong performance in workforce, finance, and 31-day cancer metrics • Quality and safety culture evident with emphasis on timelier incident management **62 Days;** • Standard sets out what a Patients' Rights are and is NHS Performance • Standardised Data Collection across all Trusts • Defined Standards and Pathways • Specificity for Cancer Types • Patient Choice and Clinical Judgement involved • The national priority for 2025/26 is to improve performance against the headline 62-day cancer standard to 75% by March 2026 • Internally, we receive on average 1400 referrals per month – most are on a 31-day pathway • Approx 1/3 of patients referred are on a 62-day pathway (up to 400 a month) • Patients on a 62-day pathway are referred from secondary care and should be referred within the first 38 days of the pathway • Patients > 38 days, average of 51.7 days (60%) • Patients > 62 days, average of 94.4 days • We aim to see all patients within 24 days from receipt of referral. • Performance has dipped from April 2025 – there was then a spike in referrals after year end performance assessment that created further delay. • Theatre capacity and radiotherapy access are internal issues. We support other Trusts across the system to try and improve the overall pathway for patients on 62-day pathways.	

	• There is wraparound care for every patient and a designated CNS for each patient to support patients through their pathway • Other providers are dealing with an increasingly large number of patients with suspected cancer, only a small proportion of those have a cancer diagnosis. • As we take patients from a very large population, we have to keep pace with supporting colleagues across many providers (9 main providers). • Changes in the broader NHS highlighted as a complicating factor. There are things that can be done in the pathways regardless through more cooperation (single queue of patients). • Noted that we are also getting requests from outside of GM to treat patients that creates an additional pressure. • We can better design models of care to treat patients more quickly and this aligns to Future Christie work. • Working with Stockport to support delayed pathways.	
c	**Value Improvement Programme update**	
	• Target is £25.3m (5.6% of total expenditure) plus £6m (corporate saving) – delivery phased over 12 months. • Month 2 we are on plan. • Mid-point assessment done in June. Delivered £20.7m (2nd best in NW), still need to do impact assessments on the £2m outstanding. • From September we will be looking at next year's VIP. • Benchmarking being undertaken to identify more schemes, hugely challenging for the teams.	
22/25	**Strategy**	
a	**Strategic & annual objectives 2025/26 & draft BAF**	
	• Amended strategic objectives and the resultant annual objectives were discussed at the May Board session. • Now 6 objectives from the previous 8. These relate to the broader strategy. • Strategic risks have been identified and a draft BAF presented. • Risk appetite statement presented and if approved will be published. Reflects an open approach to risk relating to innovation. **Approved** • Noted that the presentation from the objectives to the strategic risks that make up the BAF is very helpful.	
23/25	**Culture**	
a	**Future Christie programme progress report**	
	• The summarised focus of the programme was described – a bold transformation programme to modernise cancer care – digitally, clinically & culturally • Outputs – clinician / patient / intelligent hospital • Push and pull factors outlined • Transformation, strategy and service delivery all intersect. • Digital and transformation functions are to be unified to better use resources already in place.	

	• Clinically led programme, centrally supported, locally delivered to enact change at scale and pace. Deliverables outlined; • Launch unified roadmap and launch patient portal • Develop business case for new EPR – current EPR will not deliver what we need so we are initiating the process for an outline business case for a replacement EPR. • Implementation of AI contouring in radiotherapy • Risk assessed schemes • Question around how we time the implementation of a new EPR based on the pace of developments and when we make the move. We know certain fixed points and have a line of sight of some elements that help with the decision on timing. • What is the outcome we hope to achieve – fewer and more significant changes. • Looking at how this impacts on the aims within the strategy e.g. health inequalities, culture etc and links to the 4 themes of the strategy. • Where are we capturing secondary and primary care in the work – the Cancer Alliance is our link. • Communication with the wider organisation in underway, linked to the culture challenge. • Issue of back up for over reliance on an electronic system was raised and is being considered.	
24/25	**Governance (regulatory / statutory compliance)**	
a	**Reports from Committees**	
i	**Audit committee – May 2025**	
	• The meeting focused on the production of the Annual Report & Accounts (AR&A) so there was confidence in what was being signed. **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. • This is the final version of the 2024/25 BAF – details what has changed in the transition from this version of the BAF to the next iteration presented earlier.	
c	**Annual compliance with the CQC requirements**	
	• Annual position and planning outlined. • Quarterly meeting takes place with our CQC inspector and there is an open dialogue. • Summary of the must and should do's outlined as well as the IR(M)ER inspection. • Approach that we are taking outlined – Excellence in Action noted as well as CODE and Quality Mark – both based on CQC standards. • Workforce being engaged including mock inspections and this will also include the Board. Mock interviews will be rolled out. • Review and approve paper.	

	• Energy and commitment clear, are there any areas we are worried about. • Staff have responded very well and are keen to showcase how good they are. **Approved**	
d	**Annual report and accounts 2024/25 (approved at joint assurance committee)**	
	The joint assurance committee approved the AR&A through delegated authority yesterday. External auditors were extremely complimentary of the accounts and process. Noted.	
25/25	**Any other business**	
	• No items noted	
	Date and time of the next meeting	
	Thursday 25th September 2025 at 12:45pm	
	Papers for information only	
	Integrated performance, quality & finance report	

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

C Culture P Performance S Strategy G Governance

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
September 2025		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance & quality and finance report	COO	Monthly report	27/25b
		P	Value Improvement Programme	COO	Review	27/25d
		S	Future Christie update	DFC	Review	28/25b
October 2025		C	Patient story	CEO	To hear a patient story	Board presentation
		P	Integrated performance & quality and finance report	COO	Monthly report	
		P	Value Improvement Programme	COO	Review	
		S	Future Christie update	DFC	Review	
		P	EPRR Compliance statement	COO	Approve	
		G	CQC Well-led update	ECN	Review	
		C	Health inequalities		Review	
		C	Freedom to speak up guardian	FTSUG	Annual report	
	Planning & Development Day	S	Board Planning & Development	Chair	Board development programme - externally facilitated	N/A
November 2025		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance & quality and finance report	COO	Monthly report	
		S	Strategy update	DoS	Six month review	
		P	Value Improvement Programme	COO	Review	
		S	Future Christie update	DFC	Review	
		S	Annual Sustainabiltiy Report - Boards responsibility for Carbon Net Zero	DCEO	Note approval by Audit Committee	For information
December 2025 - no Board meeting		P	Integrated performance & quality and finance report	COO	Monthly report	By email
	Planning & Development / Council	S	Board planning			
		S	Council / Board - strategy update			
January 2026		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Interim review of annual objectives	CEO	Review progress	
	Annual reporting cycle	P	Integrated performance report	COO	Monthly report	
		S	Future Christie update	DFC	Review	
		P	Value Improvement Programme	COO	Review	
February 2026 - no Board meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
	Annual reporting cycle	G	Letter of representation & independence	Chair	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	Board development & planning	Chair	Board Development programme	N/A

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
March 2026		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance & quality and finance report	COO	Monthly report	For information
	Annual reporting cycle	G	Annual reporting cycle	Executive directors	Approve	
		S	Future Christie update	DFC	Review	
		P	Value Improvement Programme	COO	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 and finance report	COO	Monthly report	
		G	Register of matters approved by the board	CEO	Note April 2023 to March 2024	
	Provider licence	G	Self certification declarations	CEO	To approve the declarations	
	Annual reporting cycle	S	Annual Corporate Objectives review / BAF	CEO	Review progress	
		G	Modern Slavery Act statement (in Trust Report	CEO	Approve	
		P	Trust Strategy Update	DoS	Review	
		C	Freedom to speak up Guardian report	FTSUG	6 monthly update	
	Annual reporting cycle	P	Risk Management strategy 2024-25 annual review	ECN	Annual Review	
May 2026 - no meeting	Annual reporting cycle	P	Integrated performance & quality and finance report	COO	Monthly report	By email
Planning & Development Day		S	Planning			
June 2026		C	Patient story	CEO	To hear a patient story	
	Annual reporting cycle	P	Integrated performance & qualityand finance report	COO	Monthly report	
	Annual reporting cycle	G	Annual reports from audit, quality and workforce assurance committees	Committee chairs	Assurance	
	Annual reporting cycle	G	Annual compliance with the CQC requirements	ECN	Declaration / approval	
		P	Value Improvement Programme	COO	Review	
		S	Annual objectives / BAF 2026/27		Approve	
	Annual reporting cycle	G	Annual report, financial statements and quality accounts (incl Annual governance statement / Statement on code of governance)	EDoF	Approve	
July 2026 - no meeting		P	Integrated performance & quality and finance report	COO	Monthly report	By email
Planning & Development Day		S	Service Review day with senior leadership teams			
August 2026 - no meeting		P	Integrated performance & quality and finance report	COO	Monthly report	By email

Board activities over the next 6 months

Month	Activities
September 2025	CQC well-led mock interviews Board of Directors meeting • Provider capability self-assessment • EPR strategic outline case
October 2025	Board Planning Day • Strategy & objectives and 3–5 year planning • Board development session
	Board of Directors meeting • CQC planning and preparation for well-led / comprehensive inspection • Emergency Preparedness Resilience & Response • Freedom to Speak Up
November 2025	Board of Directors meeting • Strategy update • Annual sustainability report
December 2025	Board Planning Day • Joint meeting with Council of Governors • Planning • Board development
January 2026	Board of Directors meeting • Review annual objectives
February 2026	Board Planning Day • Planning • Board Development

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Agenda item: 26/25d

Action log following the Board of Directors meetings held on

Thursday 26th June 2025

No.	Agenda	Action	By who	Progress	Board review
1	16/25b	Board to be updated on Higher Education Institute (HEI) options ahead of formal approvals	RGF	Work progressing	November Board of Directors

The Christie
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Meeting of the Board of Directors
25th September 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 FDS Faster diagnosis standard GM Greater Manchester PALS Patient advice & liaison ICB Integrated Care Board ICS Integrated Care System VIP Value Improvement Programme RAG Red, Amber, Green BMA British Medical Association

The Christie
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Trust Report
September 2025 (August data)

Board Scorecard

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

1 best / 5 worst

Executive Summary

- We are in segment 1 of the NHS Oversight Framework and ranked 3/135 in the acute & specialist ranking in Q1 2024/25.
- Patient quality indicators for August show no significant adverse variances and no issues for escalation.
- Performance in August for the 62-day cancer standard was compliant at 74.5%.
- 4 operational risks are scored at 15 or above on the risk register.
- Cumulative financial performance at the end of August (M5) is on plan at a £3.1m surplus.
- Key financial performance indicators at the end of M5 indicate one adverse variance; the level of recurrent VIP is £1.4m underdelivered, this is offset by an equivalent over delivery of non-recurrent schemes in year. Whilst the capital plan is £1.2m ahead of budget, this is a phasing issue and not of concern.
- Workforce indicators for August show a slight increase in sickness absence rates from the previous month.
- PDR performance and mandatory training performance is better than the required thresholds.
- NHSE planning guidance has been issued
- NHSE Provider capability self-assessment to be submitted by 22nd October.

Quality of Care

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

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.

4 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. The risks are detailed in the Integrated Performance, Quality and Finance Report.

Our quality of care has recently been externally assessed by our patients, our staff, NHS England and by a team representing the global healthcare community.
Judged one of the Best Hospitals in England (as judged by our patients)

- Providing excellent overall quality of care by our patients, with the second-best score (9.2/10) for overall care of all hospitals in England, according to the National Inpatient Survey.
- Providing excellent cancer care, with one of the top scores in England (9.2/10) according to our patients in the National Cancer Patient Survey
- The Christie NHS Foundation Trust - Care Quality Commission

One of the Best Hospitals in England (as judged by our staff)

- In the best performing category and either first or second best in our peer group for all aspects of the NHS people promise, according to the recently published National Staff Survey, which assesses compassion, inclusivity, staff recognition, staff voice, safety, health, learning, flexible working, and teamwork.
- One of the highest scores for a specialist hospital for staff engagement and morale in the National Staff Survey.
- NHS Staff Survey 2024 Benchmark Report

One of the Best Performing Hospitals Nationally (as judged by NHS England)

- In the top performing (Tier 1) category of all hospitals in England, according to NHS England
- The 3rd best performing of all hospitals in England, according to the recently published national performance assessment, which takes into account quality of care, waiting times and financial control
- Home - NHS England Data Dashboard

One of the Best Cancer Centres Globally (as judged by the global healthcare community)

- In the exclusive top tier of cancer centres in Europe, according to a recent external international audit, which reaffirmed our position as an accredited comprehensive cancer centre of excellence.
- In the top 25 global cancer centres according to the latest international ranking data, which evaluates facilities, outcomes, and international reputation.
- OECI reaccreditation

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 August against the 2 key cancer standards was;

- 62-day standard: Performance was compliant at 74.5%
- Faster Diagnosis Standard (FDS): Performance was 87.5% 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 98.5% against a target of 96%.

Financial Performance

Revenue: Financial performance is in line with plan as illustrated in the table below. The Trust is reporting a £3.1m surplus in line with the plan as illustrated below:

Month 05 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(470,197)	(195,682)	(197,289)	(1,607)
Other Income	(81,151)	(33,574)	(31,799)	1,775
Pay	266,431	109,492	108,087	(1,405)
Non Pay (incl drugs)	258,610	108,803	109,509	706
Operating (Surplus) / Deficit	**(26,307)**	**(10,961)**	**(11,492)**	**(530)**
Finance expenses/ income	23,089	9,620	10,206	586
(Surplus) / Deficit	**(3,218)**	**(1,341)**	**(1,285)**	**55**
Exclude impairments/ charitably funded capital donations	(4,282)	(1,784)	(1,839)	(55)
Adjusted financial performance (Surplus) / Deficit	**(7,500)**	**(3,125)**	**(3,125)**	**0**

Capital: The capital plan for 2025-26 is £51.1m, subject to confirmation by NHS England. At M5 the actual spend is £4.6m against the plan of £3.4m, a variance of £1.2m which is due to phasing.

Value Improvement Programme: The Trust has made good progress against the target of £25.3m with the full target identified at the end of M5:

- £1.1m of the identified schemes are fully developed but still need to be implemented by Divisions
- Recurrent schemes totalling £11.2m have been identified against a recurrent target of £12.6m, leaving £1.4m of the 25/26 recurrent target unidentified. This is offset by an equivalent over delivery of non-recurrent schemes in year.
- Any under delivery against the recurrent target which remains at the end of the year will be carried forward into the 26/27 planning cycle.
- Integrated planning with workforce, operational performance, and activity planning has already commenced for the 26/27 VIP Programme.

KPIs: Variances from the planned financial performance against key measures. As shown in the table, there are no other significant variances:

Measure of Financial Performance	Red / Amber / Green rating
Planned surplus/deficit	£7.5m Surplus
Variance year-to-date to financial plan	0
Level of confidence in delivery of financial plan	Amber

Workforce

Our workforce performance indicators show mandatory training compliance and personal development plan rates are both above (better than) thresholds at 94.4% and 87.6% respectively. Sickness absence rates have increased slightly in August to 4.7% (threshold of 4.25%). The overall all year turnover is 11.3%. These issues and the associated plans for improvement have been considered by the Workforce Assurance Committee.

Following updated guidance from NHS England, the Trust has strengthened its approach to tackling sexual misconduct by aligning with the revised Sexual Safety Charter Assurance Framework. Full details of this review have been presented to the Workforce Assurance Committee. HIVE - Sexual safety charter

We've refreshed our approach to Personal Development Reviews (PDRs), moving away from a checklist-driven process to a more person-centred conversation.

The NHS Annual Staff Survey 2025 will launch on the 5th October As part of our preparations, we will be holding a dedicated staff engagement event on Wednesday 17 September. This session will showcase changes made in response to previous feedback and offer practical tips for boosting participation. It will also include a live Q&A with the Executive Team, reinforcing our commitment to listening and acting on staff feedback.

Research

We do not consistently meet the national 60-day benchmark for clinical trial set up. The division is revising its processes to ensure they are streamlined and implementing a new Local Portfolio Management system. In future the current performance with be reported in the IPFQR.

Education

The Christie Institute of Cancer Education is preparing for seeking higher education status. The Board will receive a proposal for consideration in November 2025.

Strategic and Service Developments

The Ward refurbishment programme continues with activity shifting to Ward 11 following completion of Ward 12. Design development continues for Ward 10 which will follow once Ward 11 is completed in early 2026.

The Advanced Scanning & Imaging Centre (ASIC) project team continue to push forward design development activity (RIBA Stage 4) which will run until November 2025 and will underpin the development of the Contract Sum. This design stage includes stakeholder engagement workshops working closely with clinical and estate team members.

There has been significant focus on the development of the decant workstream which will underpin the delivery of the new ASIC project. Governance arrangements and communications plans are being established for the decant as work packages are finalised for review, approval and taken forward as formal projects.

The LinAc Accelerator Replacement Programme is progressing with LinAc 4 recently decommissioned with building work to refurbish the area now commenced. The new LinAc 4 will be operational in December 2025. Staff training on the new equipment is scheduled to commence in October 2025.

The temporary modular building located off Oak Road between the Proton Beam Therapy Centre (PBTC) and the Energy Centre is being dismantled and will be fully removed by mid November 2025.

The Nuclear Medicine Refurbishment Project continues as pace and involves the replacement of mechanical & electrical services, refurbishment of W.C's, reception, treatment & laboratory spaces. Work commenced January 2025 and is being delivered over six phases and is on programme to complete in November 2025.

Future Christie

Future Christie is our whole-organisation transformation programme, aligning with the Christie 2028 Strategy to deliver personalised care, empowered staff, an intelligent hospital, and a culture of change.

Key progress this quarter:

- **Patient Portal** – rollout expanded, improving access to appointments and information; integration with the NHS App planned for Q1 2026.
- **AI Deployment** – radiotherapy auto-planning and ambient AI pilots reducing documentation burden and freeing clinical time.
- **EPR** – Strategic Outline Case presenting to the private board; work on the Outline Business Case will follow pending board decision.
- **JAC (Joint Analytics for Cancer)** – paper to the Board for awareness, highlighting foundations for real-time insight and intelligent hospital capability. Item 28/25b
- **Staff engagement** – strong participation across Board away days, Hive Leaders Forum, Grand Round, and divisional/clinical forums, embedding a culture of change.

Forward look:

- Development of the **EPR OBC**.
- Expansion of **patient portal adoption** and compliance with NHS App standards.
- Progression of **data preparedness** for JAC and Intelligent Hospital.
- Broader evaluation of **AI pilots** and automation opportunities.

Following the promotion of Alistair Reid-Pearson to a new role at the Greater Manchester Mental Health NHS Foundation Trust, Matthew Barker-Hewitt has been appointed as interim CIO. Responsibility and accountability, including SIRO, for the CIO and the digital team has moved to the Director of Future Christie.

Regulatory update

The Annual Members meeting took place on 11th September where the Annual report and accounts 2024/25 were presented to the members. The meeting can be watched back here Annual members' meeting

The Trust has been asked to produce a Board assessment statement for Winter Planning 2025/26, which will be reviewed by the Quality Assurance Committee in September and sent to Board for approval and then submitted by the end of the month.

NHS Oversight Framework (NOF) 2025/26

Following publication of the NHS Oversight Framework 2025/26 in June, the Quarter 1 position for 2025/26 has now been validated utilising published Q1 data and the Trust has been placed in segment 1. Our ranking in the acute and specialist league table is 3/134. ThHome - NHS England Data Dashboard These are the first published measures under the new framework.

Assessing Provider Capability – self assessment

As part of the Oversight Framework, NHS England will assess NHS trusts'* capability, using this alongside providers' NOF segments to judge what actions or support are appropriate at each trust. Assessing provider capability: guidance for NHS trust boards. As a key element of this, NHS boards will be asked to assess their organisation's capability against a range of expectations across 6 areas derived from The Insightful Provider Board.

Our self-assessment is set out for Board consideration in September and highlights evidence against each of the 6 domains.

NHSE Planning Framework

On 8 September, NHSE formally published the Planning framework for the NHS in England The Framework is designed to support the development of five-year plans covering the period 2026/27 to 2030/31 and is intended as a guide for local leaders responsible for shaping medium-term plans.

All organisations are required to prepare credible, integrated five-year plans and demonstrate how financial sustainability will be secured over the medium term. This means developing plans that:

- build and align across time horizons, joining up strategic and operational planning
- are co-ordinated and coherent across organisations and different spatial levels
- demonstrate robust triangulation between finance, quality, activity and workforce

National expectations and an indicative timetable for plan development are described as follows:

- Phase one will run to the end of September. During this period, NHSE England and DHSC will work together to translate the 10YHP and spending review outcome into specific multi-year priorities and allocations.
- Phase two will launch at the end of September / early October with the publication of multi-year guidance and financial allocations. This will enable ICBs and providers to fully develop their medium-term plans and take them through board assurance and sign off processes in December.

NHS Regional Blueprint

This document has previously been circulated to Board members and is on the NHS Futures website with restricted access.

Trust Provider Collaborative

Provider Collaboratives have been established for a number of years to support joint working across the sector. Appendix 1 provides an update on the strategic priorities of the GM Trust Provider Collaborative (TPC). TPC has agreed to work together on eight priorities that are intended to bring system wide benefits (cash and non cash releasing). Whilst contributing to all the priorities, the Christie is providing leadership support to the GM Aseptic programme. Membership of the Collaborative and our contribution to the eight priorities provides positive evidence to support our key elements of the Provider Capability Assessment.

The Board is asked to review the priorities and note the commitments made to each of the priorities.

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Overview of position by Trust on the TPC Strategic Priorities

July 2025

Introduction

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- Discussions commenced in 2024/25 to review the key Strategies Priorities for GM Trust Provider Collaborative working

- At the January 2025 TPC CEO meeting it was agreed a set of priorities should be agreed by the end of the financial year

- Draft priorities were considered on the 14th February, with an agreed set being signed off at the 14th March TPC

- Since then, implementation plans have been developed for each. However, it should be recognised that the priorities are all at different stages of development currently.

ASK: Each Board to review the list of priorities and the commitments as of July 2025 for their Trust and ensure processes are in place keep updated on progress of these

TPC Strategic Delivery Plan Priorities (3 yrs)

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Transform corporate services

- 1.**Transforming people services:** deliver digitally enabled people services at the level where they will benefit the most from scale and have the greatest impact, focusing on Recruitment, OH, Chatbot and ESR
- **Transforming financial transactional services (2.Ledger and 3.Procurement):** Deliver Single ledger system and service across all GM Trusts. Establish an integrated service delivery model for procurement via a phased implementation approach to service integration
- 4.**Transforming other transactional corporate services:** deliver collaborative approaches on cluster and GM levels as appropriate in areas such as: BI, legal, governance and risk, estates & facilities

Innovation to support delivery of clinical services

- 5.**Pathology:** Single collaborative model, delivered from appropriate number of sites across GM relating to demand with a residual service at all sites to support urgent requirements
- 6.**Single queue approaches**: GM wide approach to scaling up the implementation of single queue diagnostics
- 7.**Digital convergence and interoperability**: deliver digital convergence and enhanced intra operability across GM and at cluster level
- 8.**Aseptics hub:** Single service operating as a hub and spoke model for the whole of GM

Summary of Trust commitments July 2025 – corporate services

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Priority	Status	Trust sign up to commitment requested								
	Commitment requested to date	Bolton	The Christie	MFT	NCA	Stockport	Tameside	WWL	GMMH	Pennine Care
Transforming People Services: Chatbot	Implementation following joint procurement exercise as early adopter sites									
Transforming People Services: Recruitment	Support the move to a single recruitment model from Q4 25/6 (with phased implementation)									
Transforming People Services: Occupational Health	Support consistent approach to occupational health across GM									
Procurement service delivery	Join a GM hub and spoke model, with implementation 1 April 2026					*	*			
Ledger harmonisation	Work towards a single ledger									
Transforming other transactional corporate services	Support opportunities to be explored and delivered through TPC Director Group work plans									

*But do support joining at a later date following collaboration across the two trusts

Summary of Trust commitments July 2025 - clinical support services

NHS
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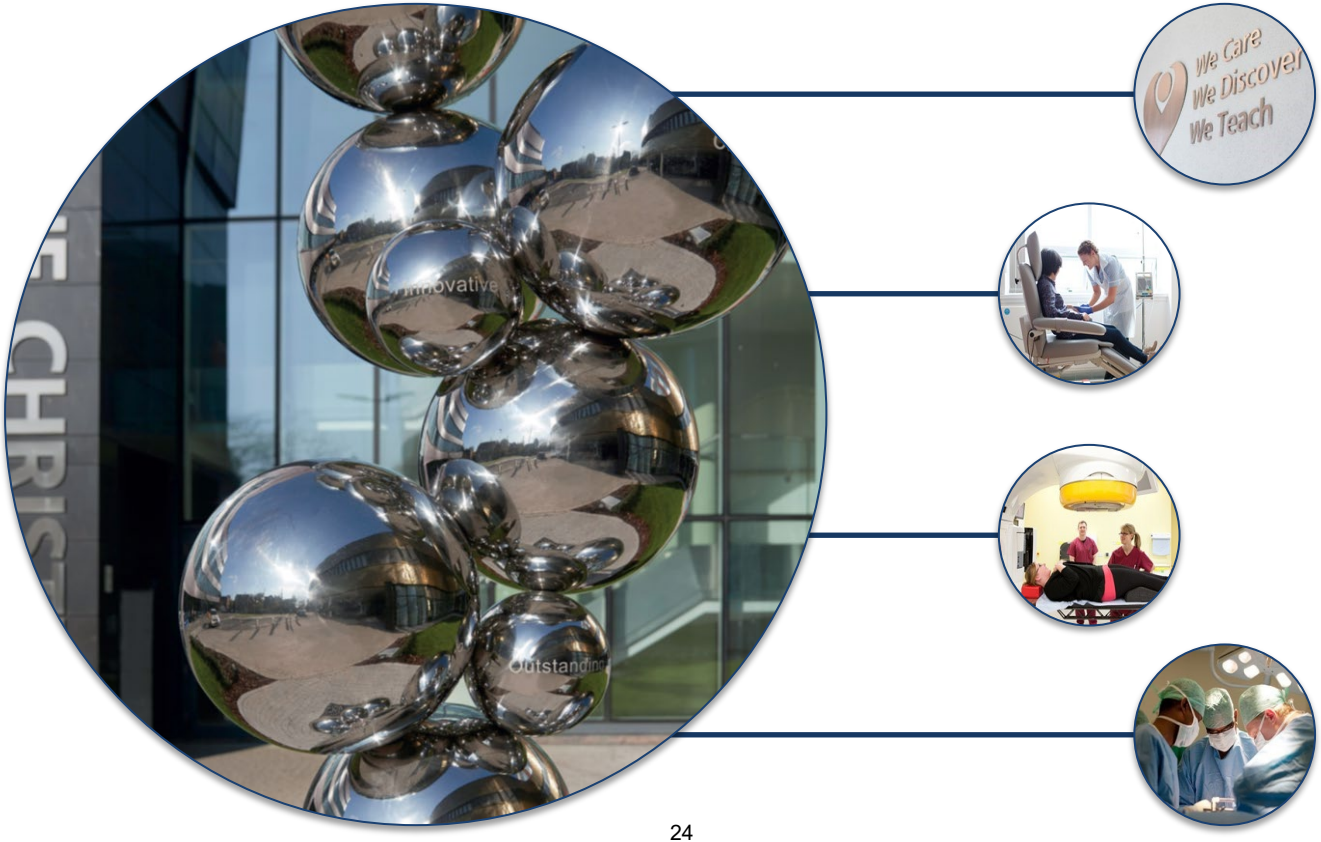
Priority	Status	Trust sign up to commitment requested								
	Commitment requested to date	Bolton	The Christie	MFT	NCA	Stockport	Tameside	WWL	GMMH	Pennine Care
Single Queue Diagnostics	Support development of a focused programme of work									
Aseptics hub	Support development of a single service operating as a hub and spoke model for GM									
Pathology	Support continued NCA \ MFT Pathology Service Collaboration, with a view to potentially joining a single model in the future	*								
Digital: EPR convergence	Work towards potential convergence on a single EPR in the next 3 years (subject to appropriate procurement processes)									

*May consider at a later date

Out of scope

The Christie NHS Foundation Trust



EXECUTIVE SUMMARY

The Christie NHS Foundation Trust

Safety

- In August 2025 5 Incidents met the criteria of a Notifiable Safety Incident, triggering statutory Duty of Candour. All 5 incidents demonstrated compliance with the DOC criteria demonstrating a pro-active approach to transparency and candour.
- At the Trust-wide risk level, four risks remain scored at 15+, indicating areas of heightened strategic concern. These are detailed on **slide 8** and continue to be actively monitored through our governance structures to ensure appropriate mitigation and escalation.
- Staffing levels have consistently met required acuity thresholds, maintaining a 1:7 nurse-to-patient ratio, with occasional extension to 1:8, which remains within national guidance. While there has been an increase in reported patient safety incidents, thematic review confirms these are not linked to staffing levels, suggesting other contributory factors are at play and warrant further exploration.
- There were 4 cases of C-Difficile, 2 cases of MSSA, 7 cases of E-Coli and 2 cases of Klebsiella reported in August that were deemed attributable to the Trust. All instances of HCAI have been assessed and improvement in place; the rise in E coli and Klebsiella may reflect broader environmental and system factors rather than direct clinical practice **(see slide 17)**

Performance

- The Trust is performing strongly against national standards and year end operational ambitions, particularly in the 31-day standard, RTT and faster diagnosis, which are critical indicators of patient access and service efficiency.
- Targeted improvement work both internally and across the wider system is underway for the 24-day and 62-day pathways, with breach reviews informing actionable changes.
- The referral growth trajectory signals a need for strategic workforce and capacity planning, especially in Haematology and other high-growth specialties.
- The low number of long-waiters and proactive resolution reflects effective backlog management and inter-Trust coordination.

HR

- While staff absence in August showed a slight improvement, reducing to 4.8%, it remains above the target of 4.25%, indicating continued pressure on workforce capacity and resilience. This sustained variance suggests a need to further understand underlying drivers—whether seasonal, operational, or wellbeing-related—and to assess the impact on service delivery and team morale.
- Performance Development Review (PDR) completion and mandatory training compliance both dipped marginally compared to July. Although training compliance remains high, the downward trend across these key workforce indicators may signal early signs of operational strain or shifting priorities. It's important to monitor whether this is a temporary fluctuation or part of a broader pattern, and to consider targeted interventions to maintain momentum in staff engagement and development

Finance

- At the end of Month 5, we have achieved a year-to-date surplus of (£3.1m), fully aligned with the planned position, indicating strong financial discipline and effective budgetary control. This achieving plan indicates that operational and financial risks are being well-managed, with no unexpected pressures impacting the bottom line at this stage.
- Capital expenditure to date stands at £4.6m, exceeding the revised NHSE plan by £1.2m. While this overspend reflects accelerated investment, it is concentrated in strategically important areas: the ASIC scheme, estates backlog reduction, digital transformation, and essential asset replacement across all divisions. These investments are critical to maintaining service resilience, improving infrastructure, and enabling future operational efficiencies.

Oversight Framework 25/26

The Christie NHS Foundation Trust

The new NHS Oversight Framework 2025/26 describes a consistent and transparent approach to assessing ICBs and NHS trusts and foundation trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement. The initial data below shows the Trust's rankings based on the first cut of data (the Access to services module is not currently being populated for specialist cancer Trusts). Metrics have been grouped into domains and will be scored individually and across each domain, with Trust's being segmented into an overall score for comparison against other Trusts. The information is to be publicised on the Model Hospital platform.

Select a trust

The Christie NHS Foundation Trust (RBV)

View the glossary page

Average score

1.51

Trusts are scored on up to 30 measures of performance (metrics).

Scores range from 1.00 (high performing) to 4.00 (low performing).

How has average score been calculated?

Trust in financial deficit?

No

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

How is financial deficit applied?

Segment

1 - High performing

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

Some of the more challenged trusts may be referred to the Recovery Support Programme and therefore allocated to a fifth segment.
How has segment been calculated?

Trust rank

3 out of 134

Each trust receives a rank based first on their segment and then their average score within that segment. Ranks range from 1 (The segment one trust with the lowest average score) to 134 (The segment four trust with the highest average score)
How has rank been calculated?

Focussed performance areas

Access to services	(Blank)
Finance and productivity	2 - Above average
Effectiveness and experience of care	1 - High performing
Patient safety	1 - High performing
People and workforce	1 - High performing

Average score by trust rank placement

View full league table

Oversight Framework 25/26

The Christie NHS Foundation Trust

Segment	Finance and productivity domain segment
1 - High performing	2 - Above average

Return to overview

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric score	Rank	Average value	Standard
Finance and productivity	Finance	Combined finance	Q1 2025/26		score	1.00			
Finance and productivity	Finance	Planned surplus/deficit	2025/26	1.39	percent	1.00	5 out of 134	-1.62	0
Finance and productivity	Finance	Variance year-to-date to financial plan	Month 3 2025	-0.37	percent	2.00	98 out of 134	0.00	
Finance and productivity	Productivity	Implied productivity level	To M12 2024/25 vs 2023/24	1.64	percent	2.92	86 out of 134	2.91	

Segment	Effectiveness and experience domain segment
1 - High performing	1 - High performing

Return to overview

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric score	Rank	Average value	Standard
Effectiveness and experience	Effective flow and discharge	Average number of days from discharge ready date to actual discharge date (including zero days)	Jun-25	0.30	days	1.34	15 out of 126	0.70	
Effectiveness and experience	Patient experience	CQC inpatient survey satisfaction rate	2023		score	1.00			

Oversight Framework 25/26

The Christie NHS Foundation Trust

Segment	Patient safety domain segment
1 - High performing	1 - High performing

Return to overview

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric score	Rank	Average value	Standard
Patient safety	Patient safety	NHS Staff survey - raising concerns sub-score	2024	6.93	out of 10	1.11	6 out of 134	6.42	
Patient safety	Patient safety	Number of MRSA infections	Jul 24 - Jun 25	3.00	count	2.63	55 out of 134	3.00	0
Patient safety	Patient safety	Rate of C-Difficile infections	Jul 24 - Jun 25	1.04	rate	2.11	26 out of 134	1.22	1
Patient safety	Patient safety	Rate of E-Coli infections	Jul 24 - Jun 25	1.05	rate	2.22	34 out of 134	1.16	1

Segment	People and workforce domain segment
1 - High performing	1 - High performing

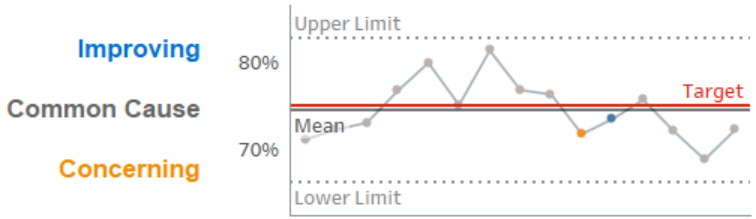
Return to overview

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric score	Rank	Average value	Standard
People and workforce	Retention and culture	NHS staff survey engagement theme sub-score	2024	7.52	out of 10	1.02	2 out of 134	6.88	
People and workforce	Retention and culture	Sickness absence rate	Q4 2024-25	4.38	percent	1.38	22 out of 134	5.21	

Integrated Performance, Quality & Finance Report - New Reporting Guidance

SPC Charts

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



SPC Rules

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

- a data point is part of a series of 6 or more points in an upward or downward trend
- a data point is part of a series of 6 or more points above or below the mean
- a data point is part of a series of 3 points that are approaching the control limits
- a single data point is outside the control limits

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

Interpreting Performance Icons

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

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

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

Interpreting Assurance Icons

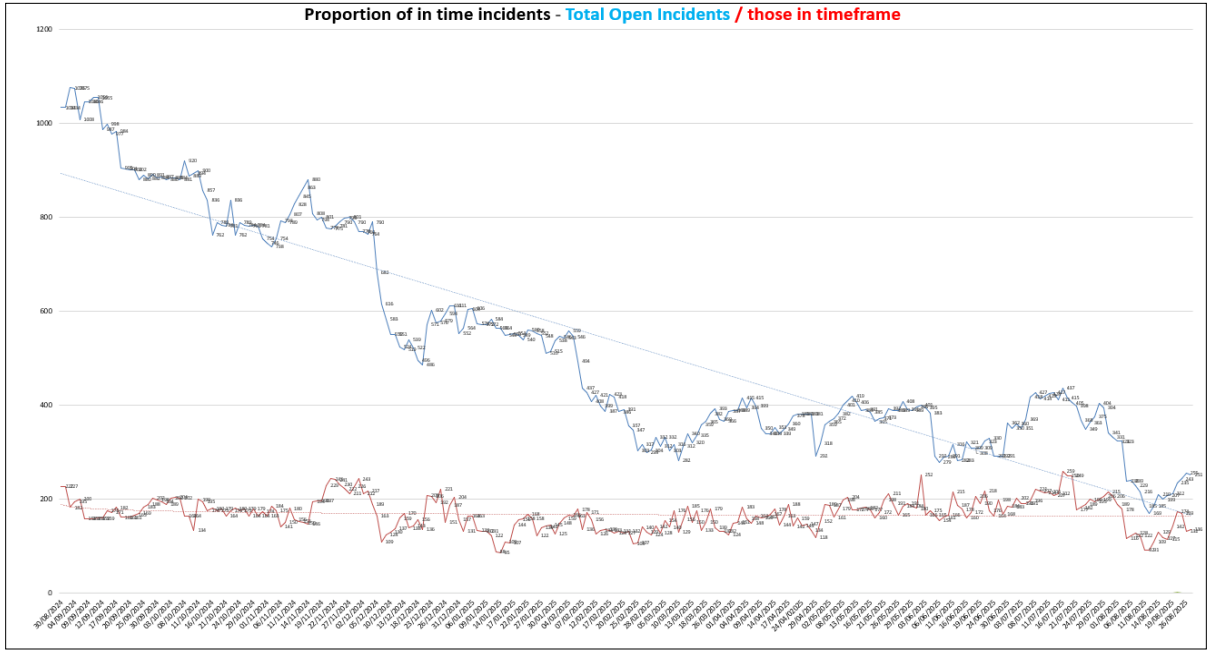
No Target There is **no** set target for this data

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

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

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

Incident Management



At the time of reporting, 52% of incidents were managed locally within 10 calendar days, 48% 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.

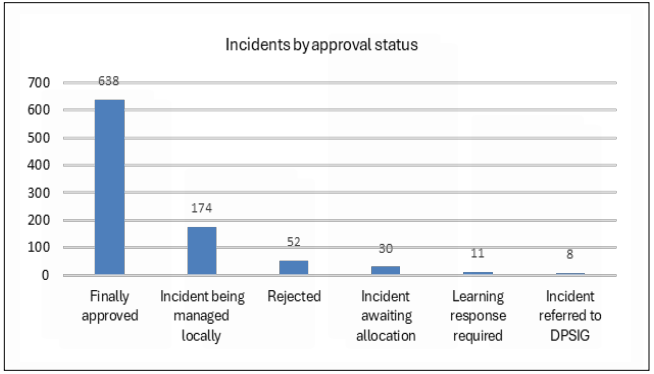
Dashboards have been developed for each division to show live incident management progress that can be utilised to highlight areas that require further support/ education.

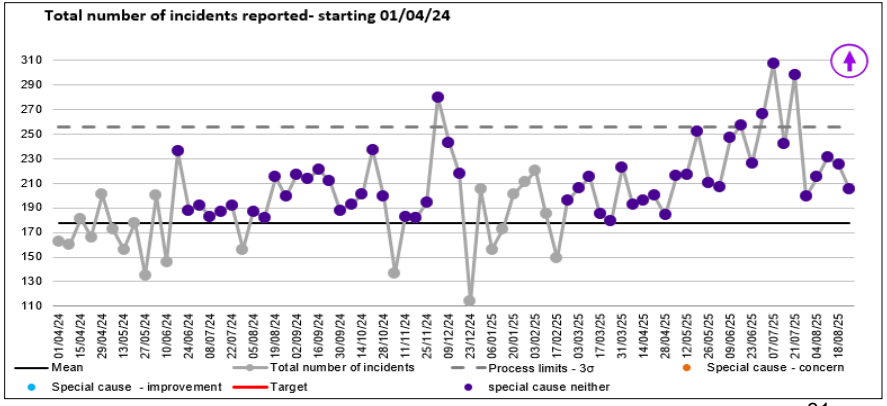
Ongoing work with the divisional teams to ensure timely management of incidents. 30

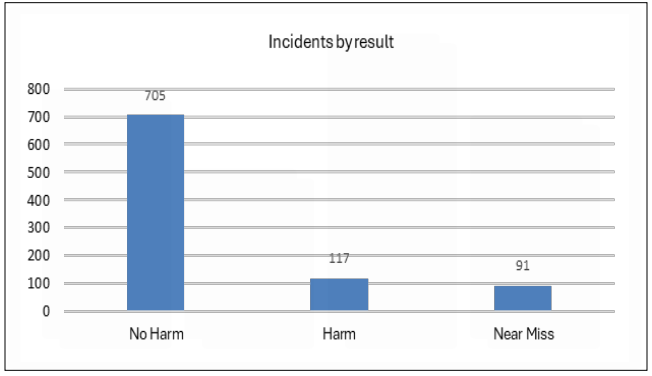
Incident Reporting

A total of 913 incidents were reported to DCIQ in August 2025.

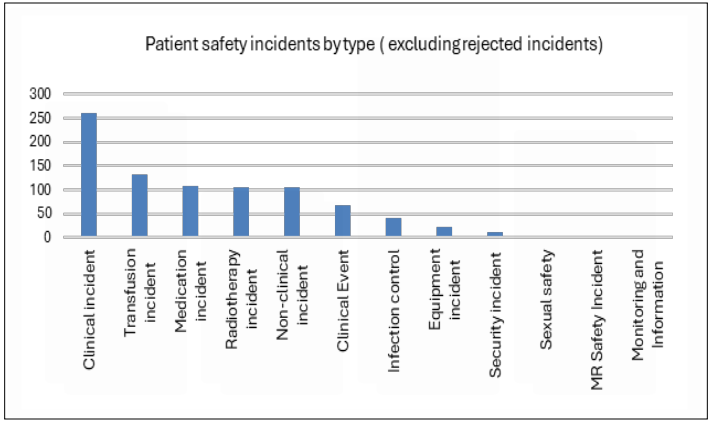
- At the time of reporting, 70% of incidents have been finally approved. 6% of incidents have been rejected for reasons such as duplication and incidents which involve care provided by an external trust. .
- 87% of incidents reported resulted in no harm
- 10% of incidents were reported to be a 'near miss', evidencing a positive reporting culture
- Reporting trends in August were within the expected limits, with a decrease in incidents reported from last month.





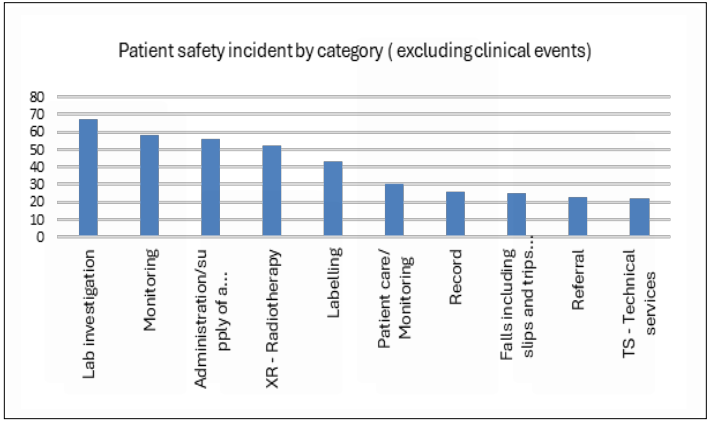


Incident Reporting



In August 2025, 89% of all incidents reported (812/913) 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), 68 (9%) were clinical events, this category includes cardiac arrests, known complications and events recorded for monitoring purposes.



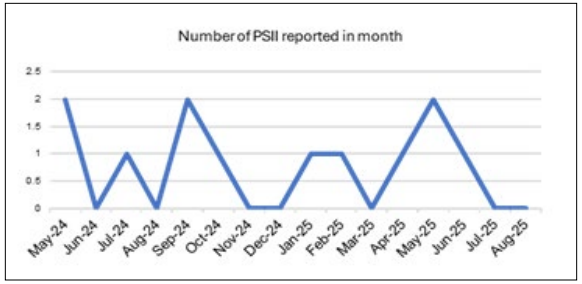
The remaining 699 incidents were categorised in the DCIQ system, and the chart shows the top 10 categories identified.

Lab investigation/labelling - high volume of reports noted due to challenges encountered with meeting sampling labelling requirements for the order comms system.

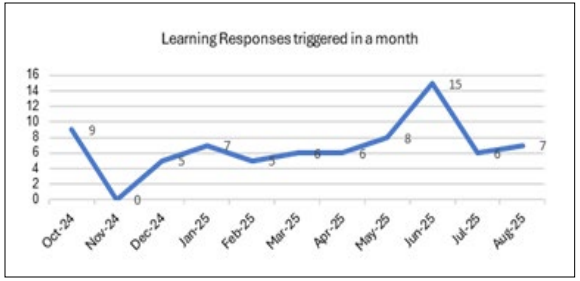
Monitoring – near miss/no harm incidents relating to omitted vital signs during the blood transfusion administration process. Individual clinical areas are reviewing these incidents to devise an action plan to improve practice.

32

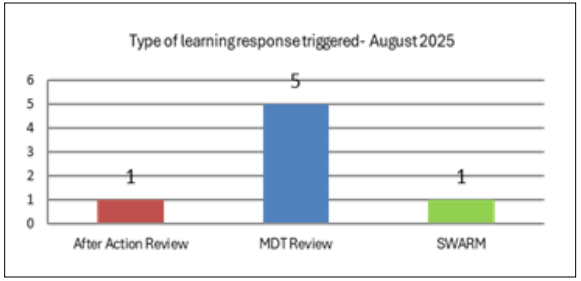
Incidents identified that require a Learning Response



- 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.
- No PSIIs were reported in August 2025.



- 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.
- 7 Learning responses were triggered locally and via the divisional PSIGs in August 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
- 5 MDT reviews ,1 SWARM, and 1 After action review were triggered in August 2025.

Operational Risks

Risks with a current risk score of 15 and above.

Risks with a current risk score of 15 and above:

Risk ID	Risk	Risk Register	Type	Subtype	Risk owner	Date opened	Initial rating	Current likelihood	Current consequence	Current rating	Target rating	Movement	Next Review Date
135	There is a risk that patients may experience harm due to significant delays in the management of patients with colorectal and penile cancers.	Trustwide	Clinical Risk	Patient Safety / Outcomes Risk	Tracey Jones	22/07/2025	12	4	4	16	8	↑	29/09/2025
357	There is a risk of a patient inadvertently receiving an unintended blood component or product	Trustwide	Clinical Risk	Patient Safety / Outcomes Risk	Sharon Jackson	16/06/2023	10	3	5	15	5	↑	31/08/2025
389	Not Identifying and Delivering 25/26 recurrent VIP programme impacting on financial sustainability and ability to treat patients	Trustwide	Financial Risk	Financial Management / Waste Reduction Risk	Claire Mcpeake	30/10/2024	16	4	4	16	16	→	31/08/2025
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	Clinical Risk	Patient Safety / Outcomes Risk	Ruth Elizabeth Clout	14/05/2025	15	5	3	15		→	29/08/2025

- As of the current reporting period, 4 risks have a score of 15 and above.
- In August only 2/4 risks were reviewed within the required trust timescales and so were compliant with the trust's risk review process.
- All risks with a current rating of ≥8 require monthly review via the 'Risk Review' tab in DCIQ , including documented justification for any changes in risk scores.

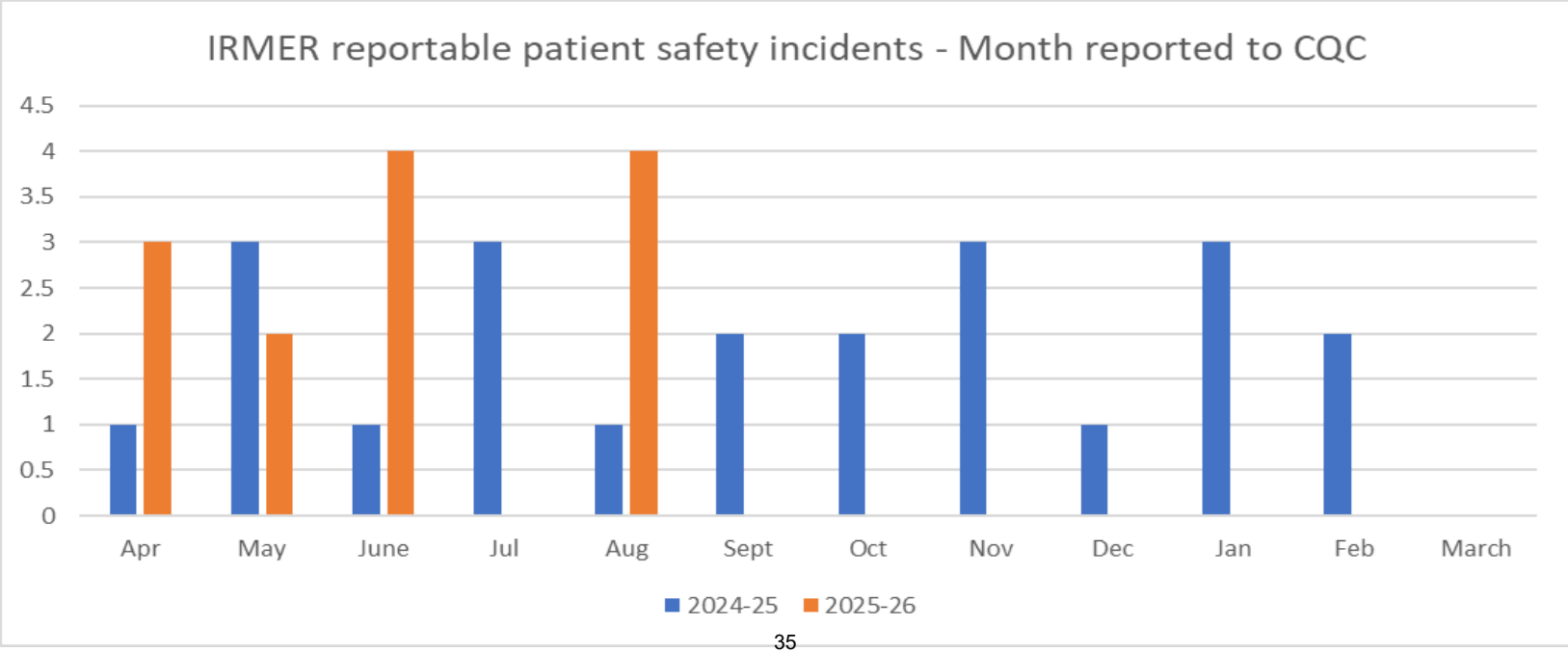
Risks downgraded from extreme in August:

Risk ID	Risk	Risk Register	Type	Subtype	Risk owner	Date opened	Initial rating	Current likelihood	Current consequence	Current rating	Target rating	Movement	Next Review Date
108	Breach of trust compliance target 28- day Faster Diagnosis Standard (FDS) for patients with a possible haematology malignancy	Haematology Teenage and Young Adults	Clinical Risk	Patient Experience Risk	Chloe Read	12/03/2025	12	3	3	9	9	↓	29/10/2025
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	Clinical Risk	Patient Experience Risk	Ruth Elizabeth Clout	20/08/2024	12	5	2	10	6	↓	27/10/2025
204	Risk to Treatment Delivery due to ASU Workforce Recruitment & Retention	Pharmacy	Operational Risk	Business Continuity Risk	Anna Mcnicholas	19/03/2025	9	4	3	12	6	↑	20/09/2025
236	Risk of microbiological contamination or delivery of service in ASU due to facility limitations	Pharmacy	Operational Risk	Business Continuity Risk	Dawn Gillibrand	21/03/2025	9	3	3	9		→	20/09/2025

Radiation Incidents

There were 4 IRMER reportable incidents reported to IRMER CQC in August 2025.

Of the four reported incidents, one occurred in April and was documented during the annual routine treatment dose and activity audit. This incident was reported to IRMER in August.



35

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	16358	13619	5080	5.5
	Total monthly ACTUAL	15461	12723		
	Average Fill Rate %	94.5%	93.4%		
Care Staff	Total monthly PLANNED	9666	6660	5080	2.9
	Total monthly ACTUAL	8657	6223		
	Average Fill Rate %	89.6%	93.4%		
ALL Staff	Total monthly PLANNED	26024	20279	5080	8.5
	Total monthly ACTUAL	24118	18946		
	Average Fill Rate %	92.7%	93.4%		

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	2099	1833	87.3%	2059	1715	83.3%	142	25.0
Palatine Ward	2980	2826	94.8%	2483	2303	92.8%	911	5.6
Ward 10	2133	1924	90.2%	1715	1570	91.5%	747	4.7
Ward 11	1928	1909	99.0%	1514	1503	99.3%	773	4.4
Ward 12	1760	1904	108.2%	1454	1459	100.3%	686	4.9
Ward 4	1913	1818	95.0%	1543	1491	96.6%	804	4.1
Ward 2	1398	1290	92.3%	1046	1001	95.7%	464	4.9
Acute Assessment Unit	2147	1957	91.2%	1805	1681	93.1%	553	6.6
TOTAL	16358	15461	94.5%	13619	12723	93.4%	5080	5.5

Registered Nursing Associates	DAY			NIGHT		
	Hours Planned	Hours Actual		Hours Planned	Hours Actual	
Critical Care Unit						
Palatine Ward						
Ward 10		23				
Ward 11						
Ward 12		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	0	0	100.0%	0	0	100.0%	142	0.0
Palatine Ward	1205	1055	87.6%	986	873	88.5%	911	2.1
Ward 10	1625	1387	85.4%	816	738	90.4%	747	2.8
Ward 11	1536	1380	89.8%	990	930	93.9%	773	3.0
Ward 12	1796	1590	88.5%	1155	1284	111.2%	686	4.2
Ward 4	1683	1480	87.9%	1433	1281	89.4%	804	3.4
Ward 2	765	719	94.0%	565	471	83.4%	464	2.6
Acute Assessment Unit	1056	1046	99.1%	715	646	90.3%	553	3.1
TOTAL	9666	8657	89.6%	6660	6223	93.4%	5080	2.9

**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.*

Positive feedback received…..

"To reception team, thank you for bringing smiles and a welcoming atmosphere, you are the first faces and impression we get on our visits. Keep doing what you do."

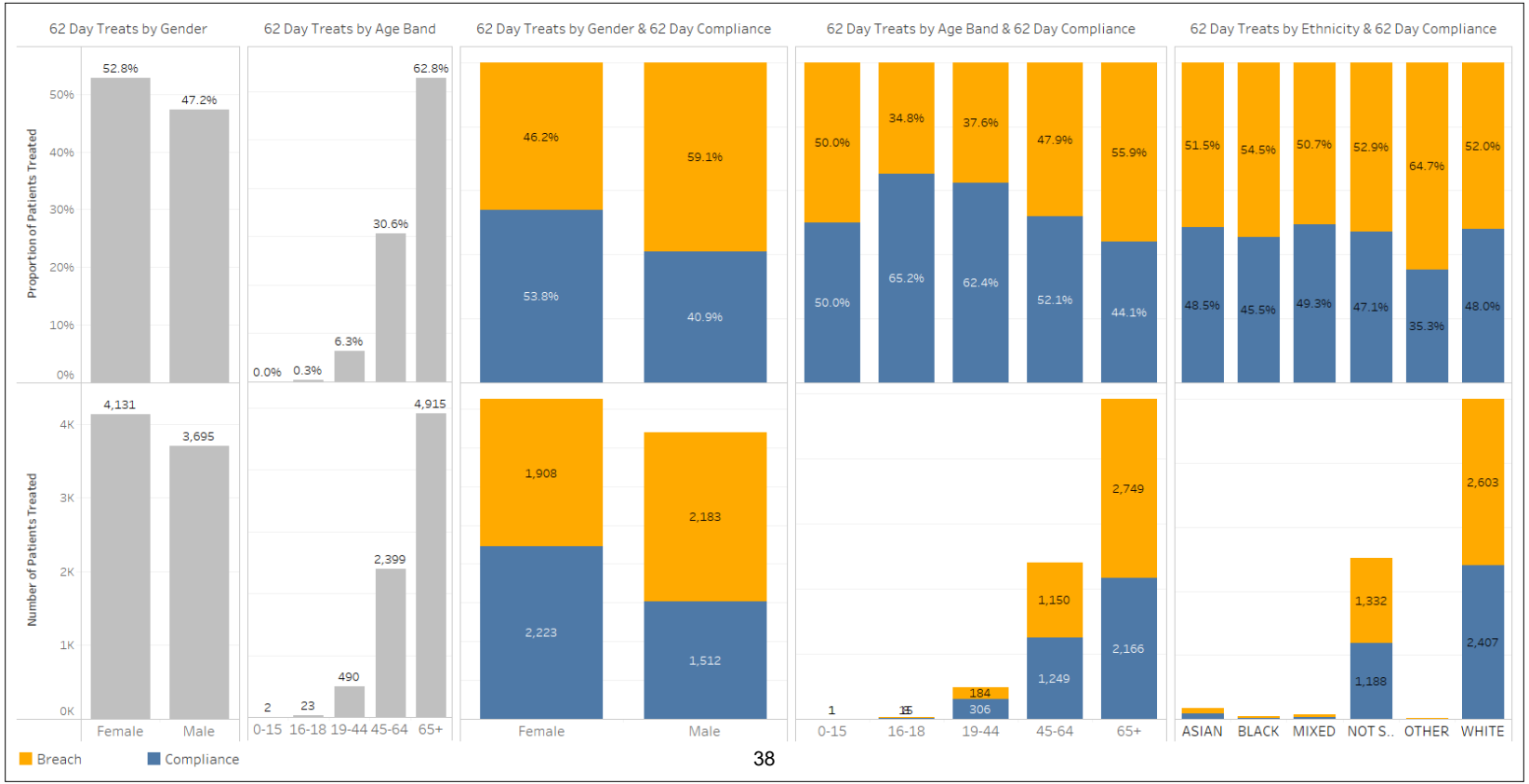
"All the staff at The Christie Oldham have been superb. The reception staff always have lovely smiles to greet us, whatever the time and are so kind and friendly. The radiology team have all treated me with kindness, concern and respect and I could not have received better treatment at all. Our grateful thanks to the whole team who deliver such a great service you are all doing such a wonderful job."

"To the radiotherapy legends. Thank you for the last 6 weeks, you have made being radiated a little more of a somewhat "enjoyable" experience, you're amazing! I appreciate you all".

"I would like to say a big thank you to you and everyone who was involved in my journey with you, everyone made me feel at ease. You are all amazing with so much care and compassion, I really couldn't have asked for anymore.
So please say a big thank you. I really appreciate everything the whole team have done".

Cancer Standards – Health Inequalities Analysis

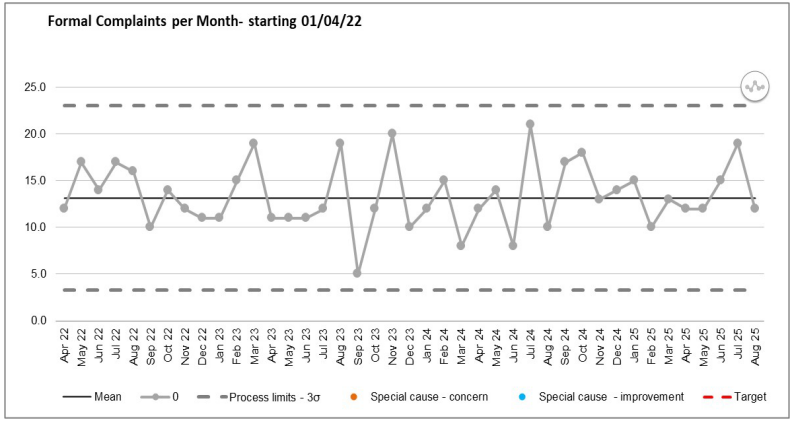
62 Day Treatments between 01/04/2023 – 31/08/2025 analysed by gender, age and ethnicity.

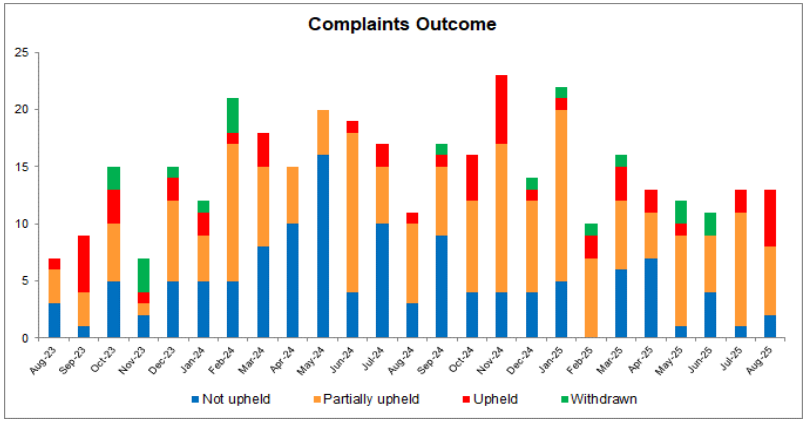


Cancer Standards – Health Inequalities Analysis

62 Day Treatments between 01/04/2023 – 31/08/2025 analysed by gender, age and ethnicity.

Complaints





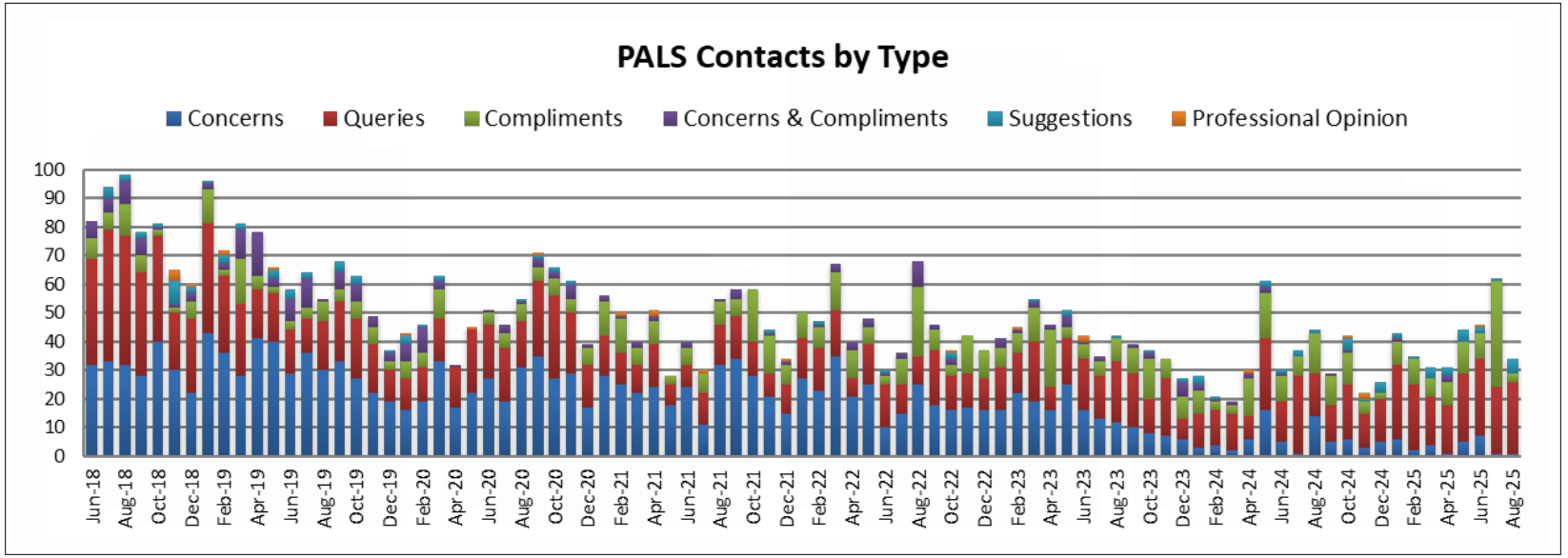
12 new complaints received in August 2025.

13 complaints were closed in August 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 was referred to the PHSO in August 2025. 4 active cases in total with the PHSO. All are still under investigation.

PALS



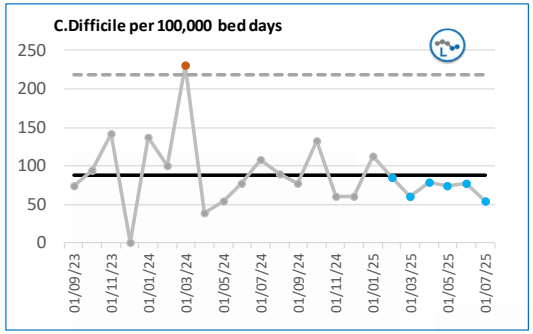
34 new PALS contacts have been received in August 2025.

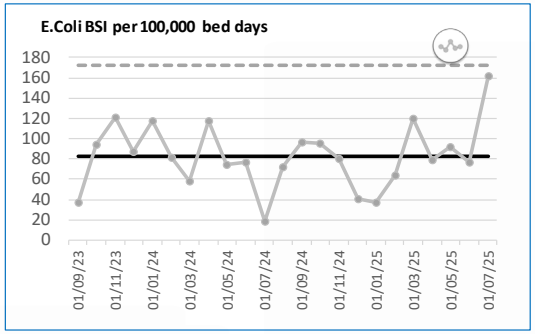
Only 1 of those raised concerns about their experience at The Christie but did not wish to proceed with a formal complaint. The other reasons for contacting PALS are captured in the graph.

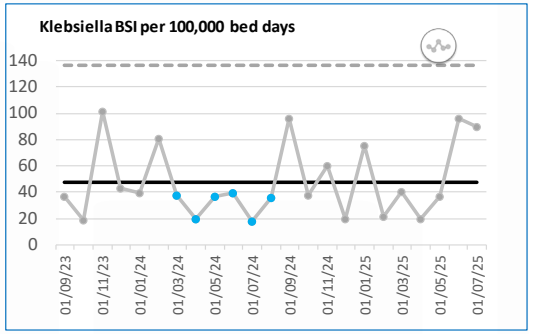
Healthcare Associated Infections

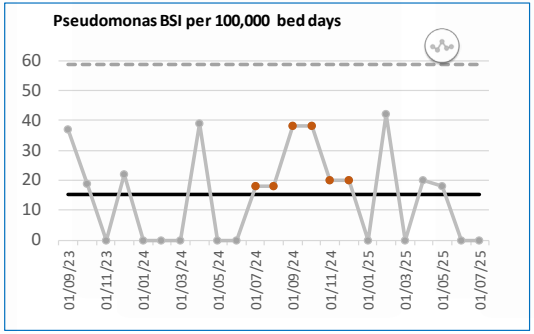
The Christie NHS Foundation Trust

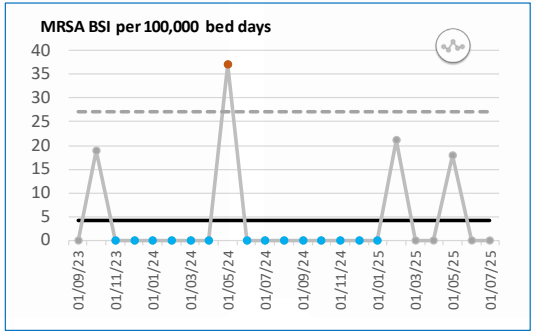
HCAIs per 100,000 bed days – rolling 12 months

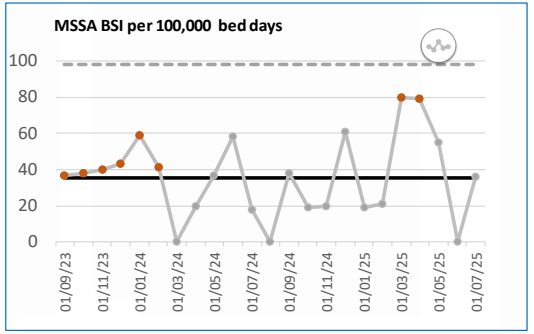












All cases reviewed through IPC team and reported through NIPR.

Healthcare Associated Infections

NHS
The Christie
NHS Foundation Trust

HCAIs against thresholds 2025-26 – HOHA & COHA only

Indicator	Threshold	Position	Year so far (as at month 4)	Threshold adjusted to month 4	Difference
C.*Difficile*	≤ 52	Below trajectory	15	17	- 2
E.coli BSI	≤ 43	Below trajectory	22	14	+ 8
Klebsiella spp. BSI	≤ 24	Below trajectory	14	8	+ 6
P.Aeruginosa BSI	≤ 8	Below trajectory	2	3	-1

HCAIs being monitored

Indicator	Target	Position	Year so far (as at month 4)	Threshold adjusted to month 4
MRSA BSI	Zero tolerance	Above trajectory	1	-
MSSA BSI	No target	No target	9	-

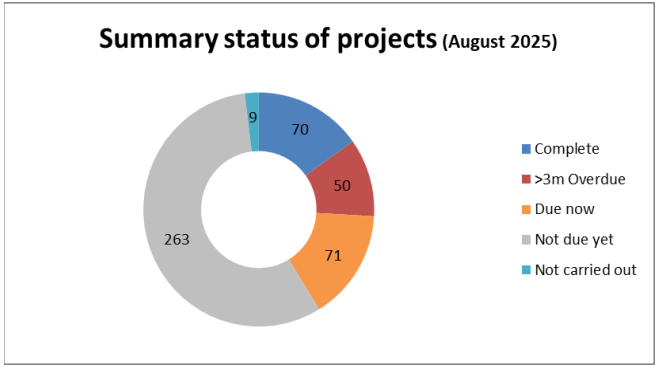
Re. the increase in E.coli and Klebsiella; there is an ongoing thematic analysis looking at the disease groups associated with the positive cases. The current IPC Improvement Plan incorporates initiatives looking to improve performance across all of the HCAI thresholds.

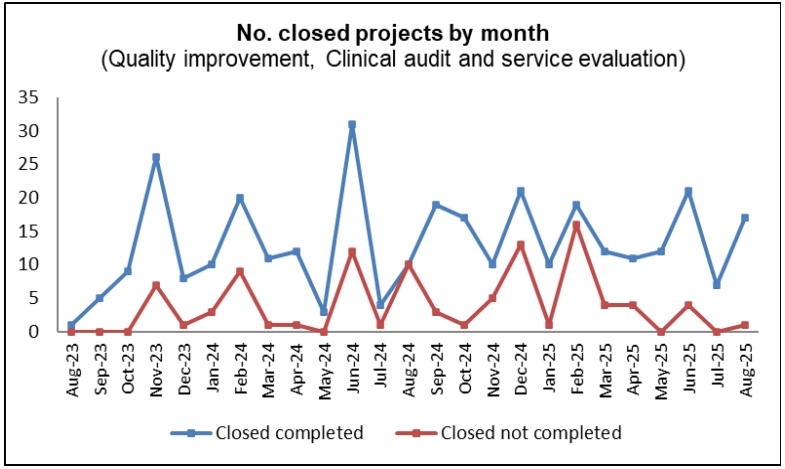
Quality Improvement & Clinical Audit

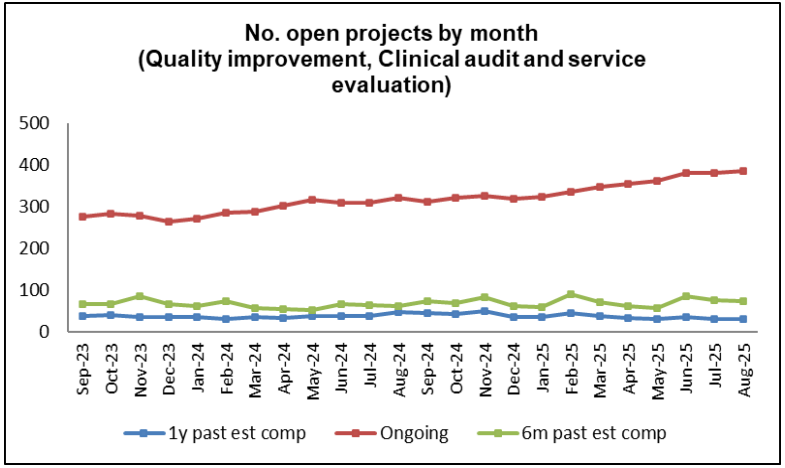
The Christie NHS Foundation Trust

QICA programme – Quality Improvement and Clinical Audit Including service evaluations and patient surveys. Figures include all agreed Trust priority projects. Projects with 'Individual interest' priority are not included here.

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





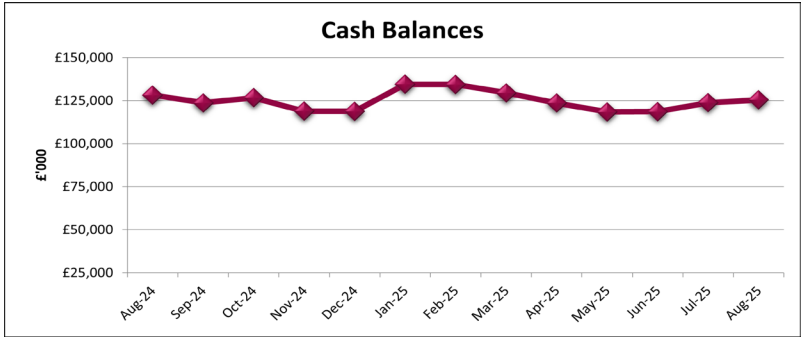


Finance (Executive Summary)

NHS
The Christie
NHS Foundation Trust

This report outlines the M5 consolidated financial performance of The Christie NHS Foundation Trust and its wholly owned subsidiary The Christie Pharmacy Ltd.

Month 05 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(470,197)	(195,682)	(197,289)	(1,607)
Other Income	(81,151)	(33,574)	(31,799)	1,775
Pay	266,431	109,492	108,087	(1,405)
Non Pay (incl drugs)	258,610	108,803	109,509	706
Operating (Surplus) / Deficit	**(26,307)**	**(10,961)**	**(11,492)**	**(530)**
Finance expenses/ income	23,089	9,620	10,206	586
(Surplus) / Deficit	**(3,218)**	**(1,341)**	**(1,285)**	**55**
Exclude impairments/ charitably funded capital donations	(4,282)	(1,784)	(1,839)	(55)
Adjusted financial performance (Surplus) / Deficit	**(7,500)**	**(3,125)**	**(3,125)**	**0**



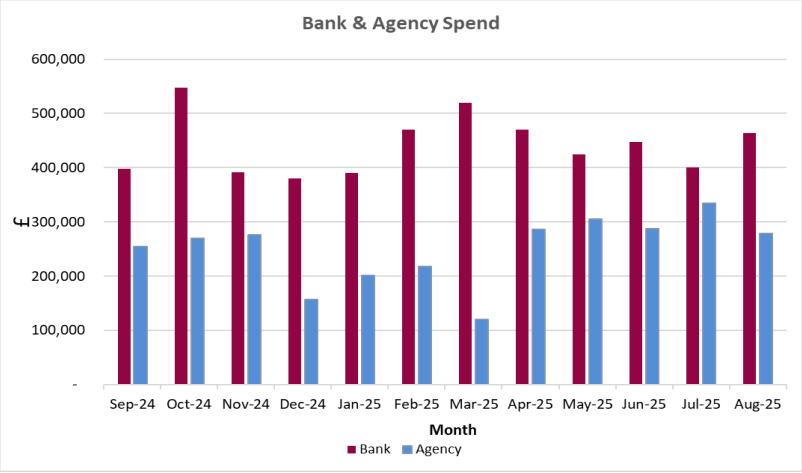
I&E

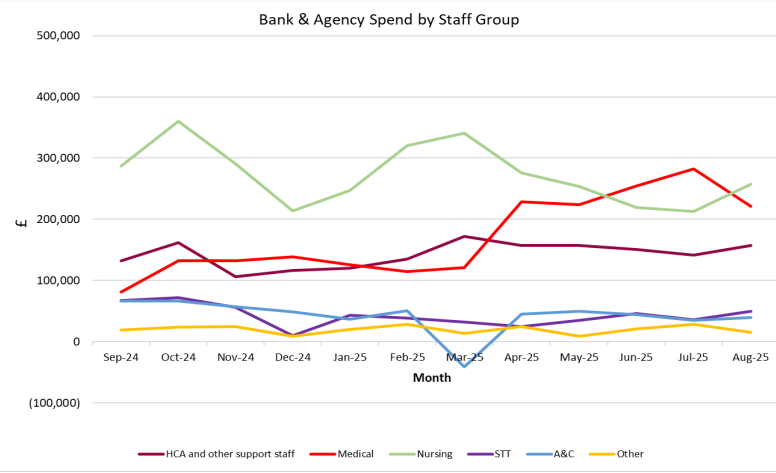
- The Trust is reporting a surplus at the end of month 05 of (£3.1m) against a YTD plan of (£3.1m), which gives a YTD variance of £0.0m.
- Identified in-year VIP is £25.3m against a target of £25.3m. The VIP shortfall against the recurrent VIP target is £1.5m (Rag rated shortfall £1.8m), where £11.2m has been identified against a target of £12.6m (88% of recurrent target identified). Non-recurrent identified VIP is £14.1m against a target of £12.6m, overachieving by (£1.5m).

Balance sheet / liquidity

- The cash balance is £125.4m.
- Capital spend for 2025-26 was £4.6m, this was £1.2m 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)

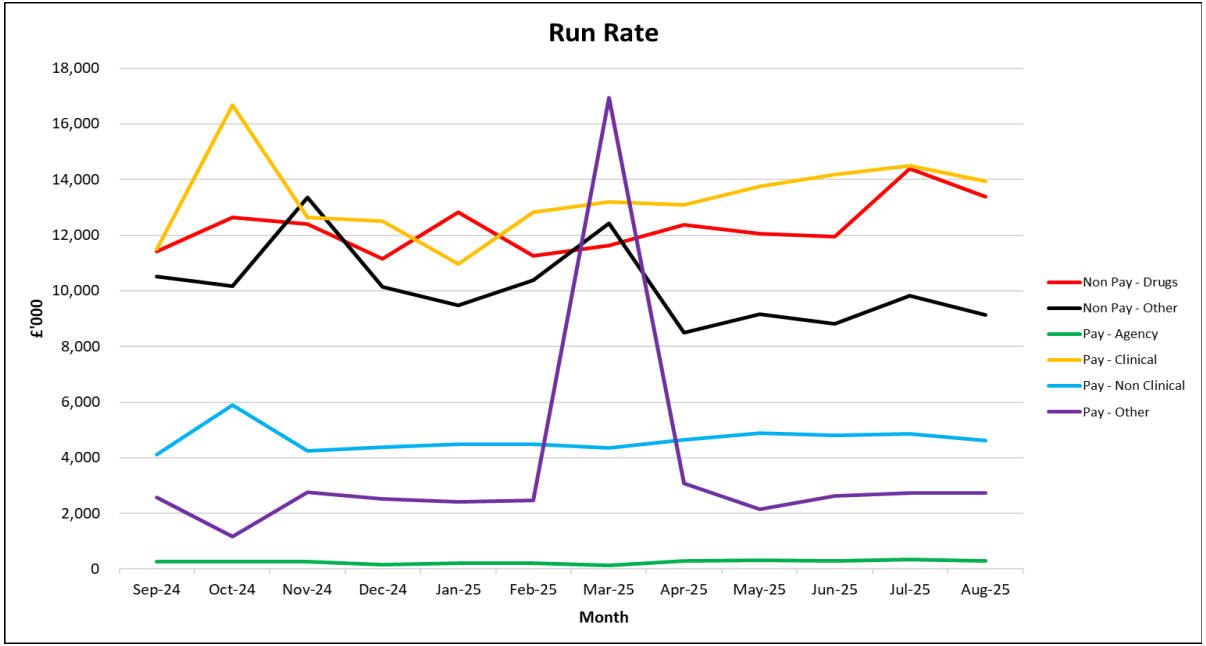




Agency spend in month 05 is £0.3m, £1.5m YTD. The spend is predominantly on medical agency and is in line with month 04 spend of £0.3m.

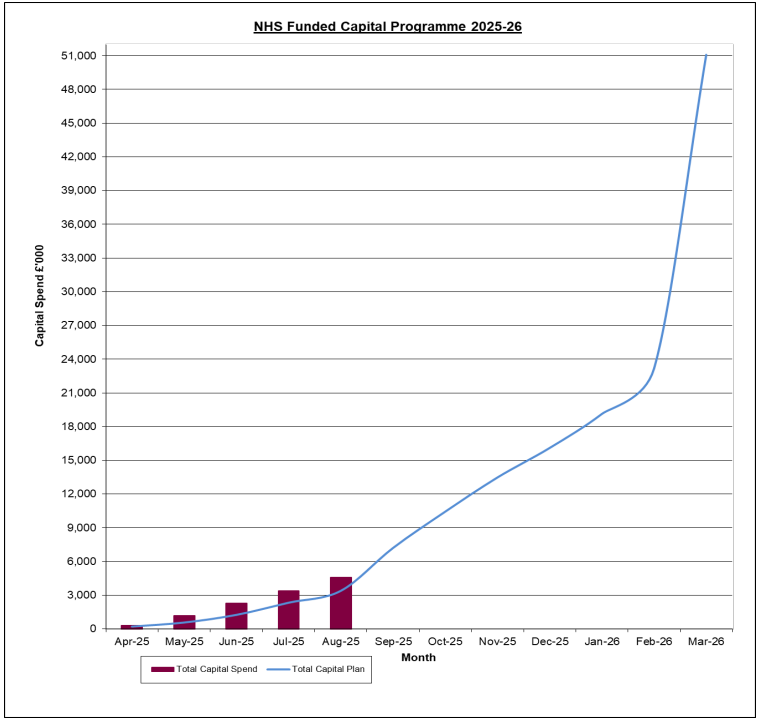
Alongside this, bank spend in month 05 is £0.5m and £2.2m YTD, an increase of £0.1m from month 04.

Finance (Expenditure)



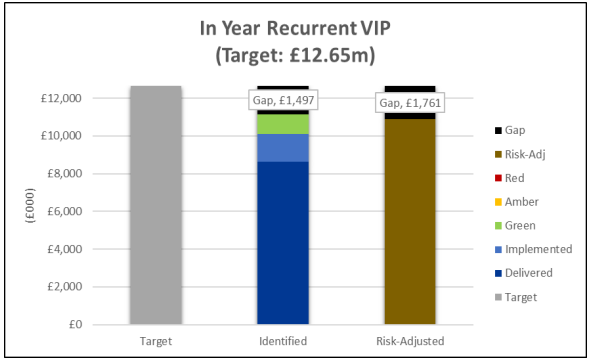
- Drugs spend in month 05 is £13.4m, a decrease from month 04 of £1.0m linked to fluctuations in pass through drug spend.
- Non-Pay – Other spend in month 05 is £9.1m, a decrease of £0.7m from month 04 driven by decreased spend on premises & clinical supplies and services.
- Key elements of 'Non-Pay Other' spend consist of clinical supplies and services, premises and infrastructure costs and R&I costs.
- Pay – Agency spend in month 05 is £0.3m, consistent with month 04.
- Pay – Clinical spend in month 05 is £13.9m, a decrease from month 04 of £0.6m driven by year to date correction at category level in month 04.

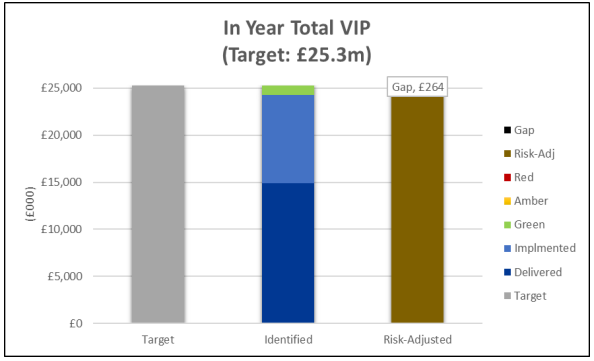
Finance (Capital)



The Trust has incurred £4.6m up to month 05 on capital schemes overspending by £1.2m against the 2025-26 plan. Capital expenditure is primarily on the ASIC scheme, the estates backlog programme, digital projects and a significant operational asset replacement programme across all divisions.

Finance (CIP)





Total In year CIP

- Total identified VIP schemes reported are £25.3m (£14.1m non recurrent / £11.2m recurrent).
- Risk adjusted identified schemes value £25.0m, leaving £0.3m unidentified.

Recurrent

- Schemes totalling £11.2m have been identified recurrently against a recurrent target of £12.6m
- This leaves £1.5m of the recurrent target unidentified.

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

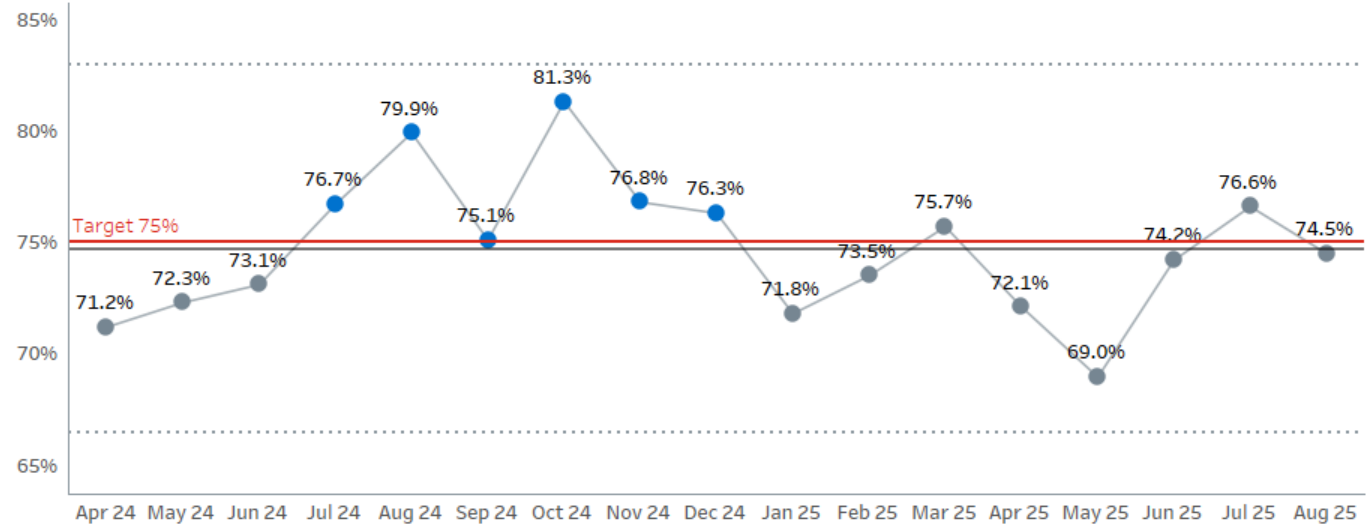
	Annual					Year To Date		
	Target (£000)	Identifed (£000)	Unidentified (£000)	Risk-Adjusted Identified (£000)	Risk-Adjusted Unidentified (£000)	Target (£000)	Delivered (£000)	Variance (£000)
Total VIP	**25,298**	**25,298**	**0**	**25,034**	**264**	**10,312**	**10,312**	**0**
Recurrent VIP	12,649	11,152	1,497	10,888	1,761	5,270	4,077	1,193
Non-Recurrent VIP	12,649	14,146	-1,497	14,146	-1,497	5,042	6,235	-1,193

Integrated Performance Report - Cancer Standards Summary

NHS
The Christie
NHS Foundation Trust

Metric	Month	Measure	Target	Variation	Assurance
18 weeks	August	94.50%	92.00%		
24 day (Internal Target)	August	70.80%	85.00%		
28 Day FDS	August	87.50%	80.00%		
31 day	August	98.50%	96.00%		
62 Day	August	74.50%	75.00%		
Waiting >52 Weeks	August	0.04%	0.00%		

Percentage of patients treated for cancer within 62 days of referral



Icons

Common Cause

Hit & Miss

Summary

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

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

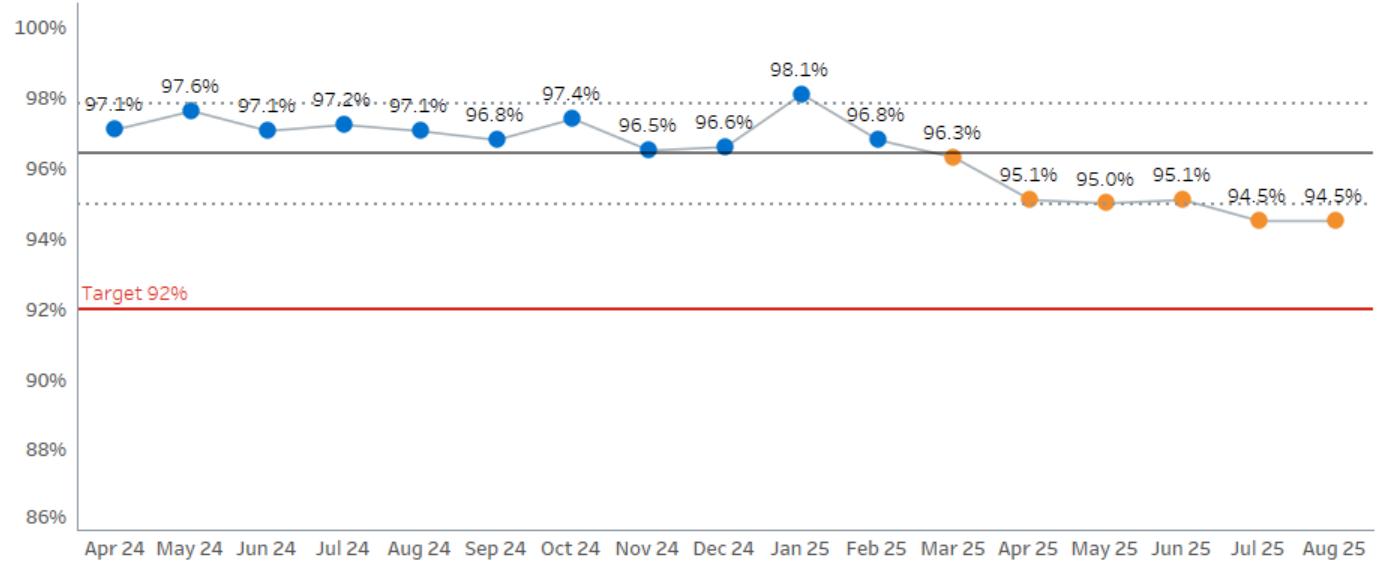
Understanding the performance

The data illustrates monthly performance from April 2024 to August 2025 against the national target of 75% for treating cancer patients within 62 days of referral.
The performance shows common cause variation, indicating natural fluctuations rather than special cause events.
Above Target: Several months (e.g., July 2024: 79.9%, October 2024: 81.3%, July 2025: 76.6%) exceeded the 75% target, demonstrating capability to meet standards.
Below Target: Notably, May 2025 marks a significant dip in line with multiple bank holiday periods,
Recent Performance: The last three months (June–August 2025) hovering just below the year end ambition.
This pattern suggests that while the system can meet the target, consistency remains a challenge.

Actions (SMART)

Specific -Conduct root cause analysis for the dip in May 2025 to identify operational bottlenecks or staffing/resource issues.
Standardise referral triage protocols to reduce delays in treatment pathways.
Measurable - Track weekly compliance rates to identify early signs of deviation.
Set a short-term goal to achieve ≥75% for three consecutive months.
Achievable - Implemented a rapid escalation process for cases approaching the 62-day threshold.
Introduce weekly ops reviews for complex cases to manage any barriers
Relevant - Ensure all interventions support the national cancer strategy and local ICS goals.
Time-bound - Complete root cause analysis and implement corrective actions by end of October 2025.
Review impact of changes by December 2025, aiming for sustained improvement into Q4.

Percentage of patients treated within 18 weeks



Icons

Concerning

Passing

Summary

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

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

Understanding the performance

The data demonstrates 18 week (referral to treatment RTT) performance from April-24 to August 25.
The year end recovery ambition set within the Operating plan is 65%, with the constitutional standard being 92%
We continue to perform above the standard, but have seen a decrease in performance since April '25 when the Leighton haematology service was transferred.

Actions (SMART)

Specific - Prioritise patients approaching 40+ weeks.
Measurable – achieve 95% performance consistently
Achievable - Increase outpatient capacity by X clinics per week.
Relevant - Aligns with NHS England RTT recovery priorities. Supports patient safety and experience.
Time-bound - Weekly monitoring of progress via PTL (Patient Tracking List).
Monthly review at operational performance meetings

Integrated Performance Report - Friends & Family Test

NHS
The Christie
NHS Foundation Trust

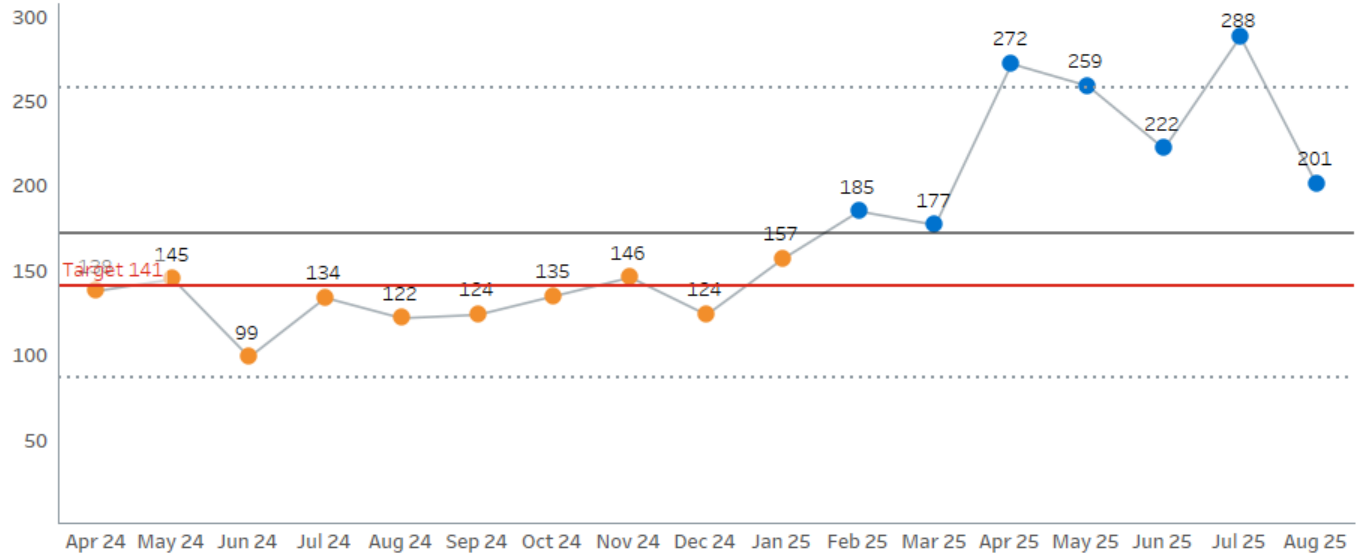
Metric	Month	Measure	Target	Variation	Assurance
Inpatient Response Rate	July	32.49%			
Inpatient Recommended Score	July	96.71%			
Outpatient Recommended Score	July	95.81%			

Integrated Performance Report - External Referrals Received Summary

The Christie NHS Foundation Trust

Metric	Month	Measure	24/25 Avg	Variation	Assurance
External Referrals Received - ALL Specialties	August	1,935	2,067		
External Referrals Received -Clinical Oncology	August	843	978		
External Referrals Received -Haematology	August	201	141		
External Referrals Received -Medical Oncology	August	502	549		
External Referrals Received -Surgical Specialties	August	364	365		

External Referrals Received - Haematology



Icons

Hit & Miss

Improving

Summary

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

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

Understanding the performance

The current change in performance against the 24/25 average is due to the Mid Cheshire hospital Haematlogy service takeover in April. Additional Two Week Wait patients as well as non-cancer Haematology referrals are being accepted and therefore there has been a step change in the baseline number. By the end of 25/26 a new consistent average will be seen and the performance and assurance icons will reflect that.

Integrated Performance Report - Inpatient Length of Stay Averages

The Christie NHS Foundation Trust

Metric	Month	Measure	Target	Variation	Assurance
Inpatient LOS - All Patients (excluding zero LOS)	August	7.7	7.0		
Inpatient LOS - Elective Patients (excluding zero LOS)	August	7.1	5.8		
Inpatient LOS - Non-Elective Patients (excluding zero LOS)	August	8.2	8.0		
Inpatient LOS - Transfer Patients (excluding zero LOS)	August	14.3	16.9		

Integrated Performance Report - Summary

Area Selection

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

Division
The Christie

Directorate
All Directorates

Summary Table

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

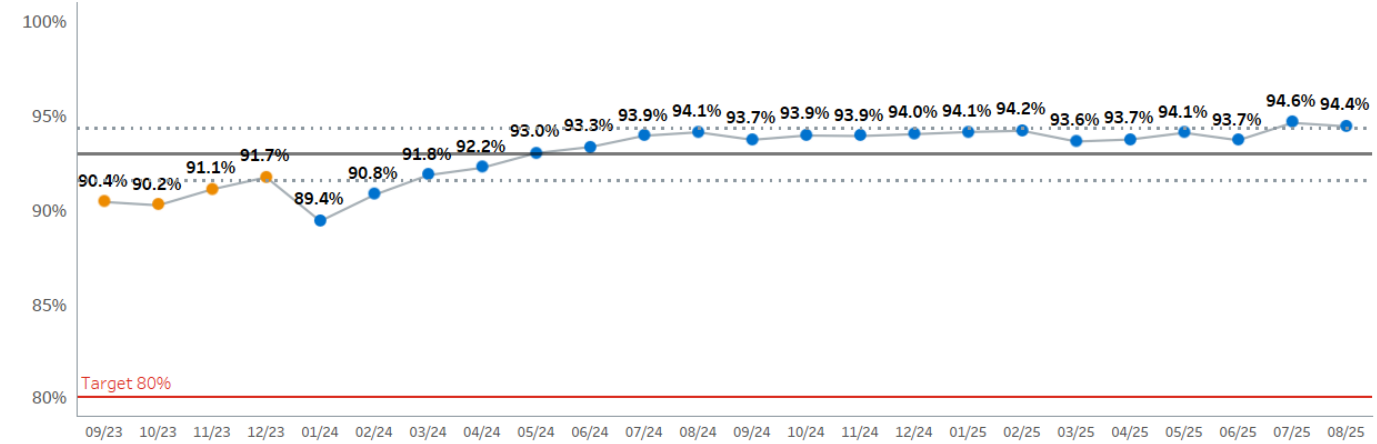
Metric - the KPI metric
Measure - the value of the **Metric** as of the end of the **Month**
Target - the Trust defined minimum or maximum limit for each **Metric**
Mean - the average of the **Measure**s over the past 12 months

Metric	Month	Measure	Target	Mean	Performance	Assurance
Appraisal	August 2025	**87.57%**	80.00%	87.38%		
Mandatory Training	August 2025	**94.42%**	80.00%	92.92%		
Absence	August 2025	**4.78%**	4.25%	4.68%		
All Turnover	August 2025	**11.31%**	Null	12.53%		
Voluntary Turnover	August 2025	**8.91%**	Null	10.28%		
Vacancy Rate	August 2025	**6.60%**	5.00%	9.40%		

Our People - Mandatory Training and Appraisal Compliance

The Christie: All Directorates

Mandatory Training



Performance	Assurance
Improving	Passing

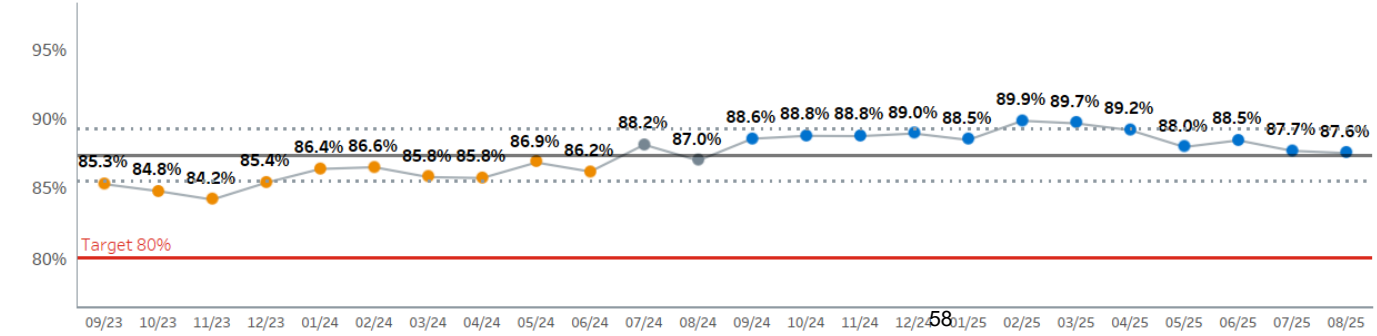
Summary

- There are **3,435** outstanding modules.

- The Face to Face training compliance % for August is **86.8%**

- The online training compliance % for August is **95.2%**

Appraisal



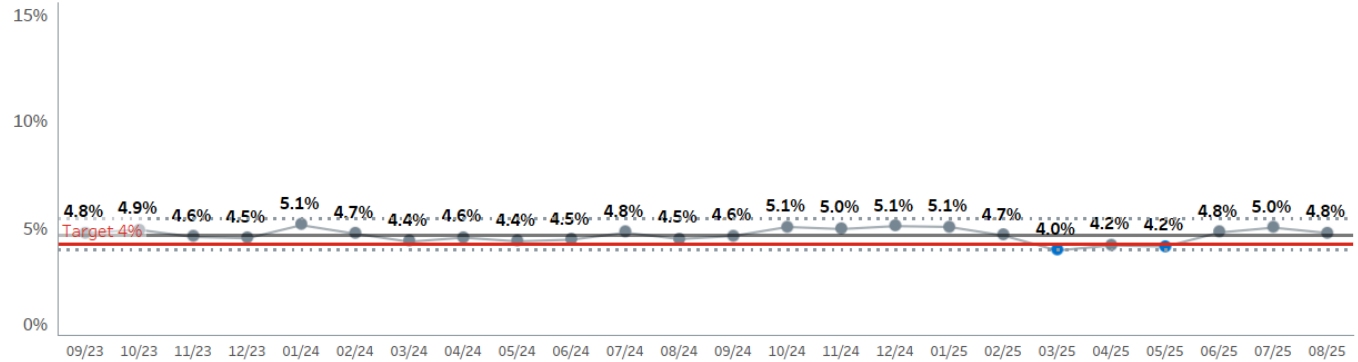
Performance	Assurance
Improving	Passing

Summary

- There are **429** outstanding appraisals.

Our People - Sickness Absence

All Absence



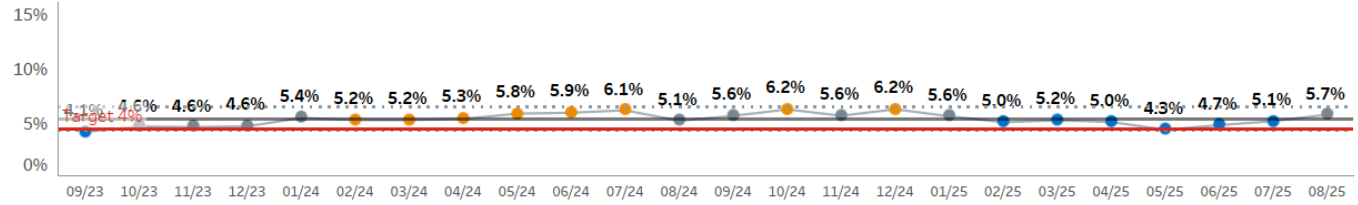
Performance	Assurance
Common Cause	Hit & Miss

Summary

- The rolling yearly sickness absence % is **4.7%** as of August.

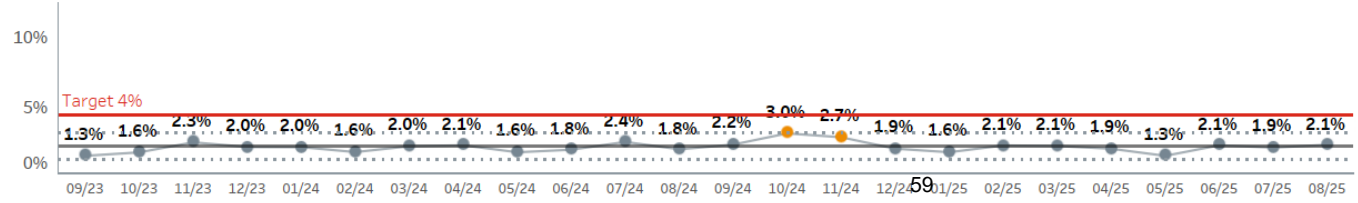
- There were **174** absences still open at the end of August.

Nursing and Midwifery



Performance	Assurance
Common Cause	Hit & Miss

Medical and Dental

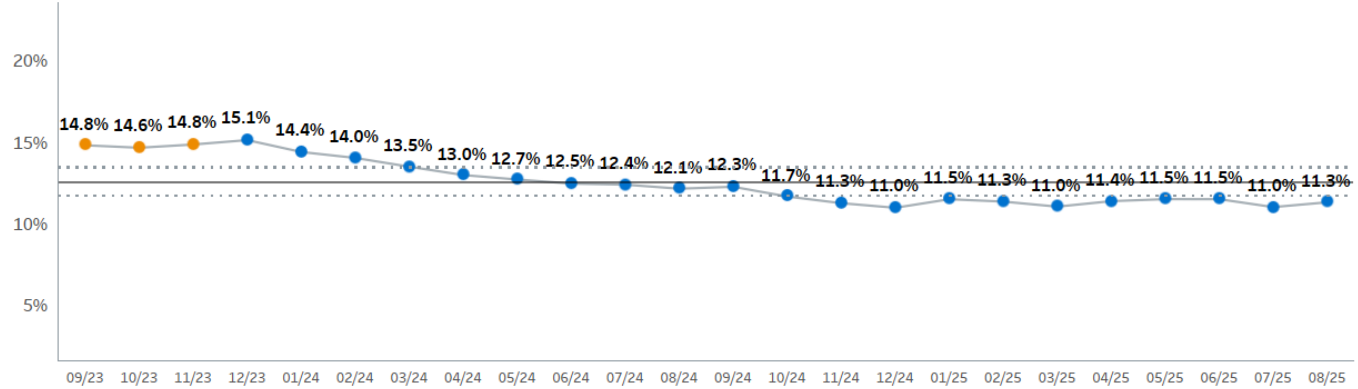


Performance	Assurance
Common Cause	Passing

Our People - Turnover

The Christie: All Directorates

All Turnover



Performance	Assurance
Improving	No Target

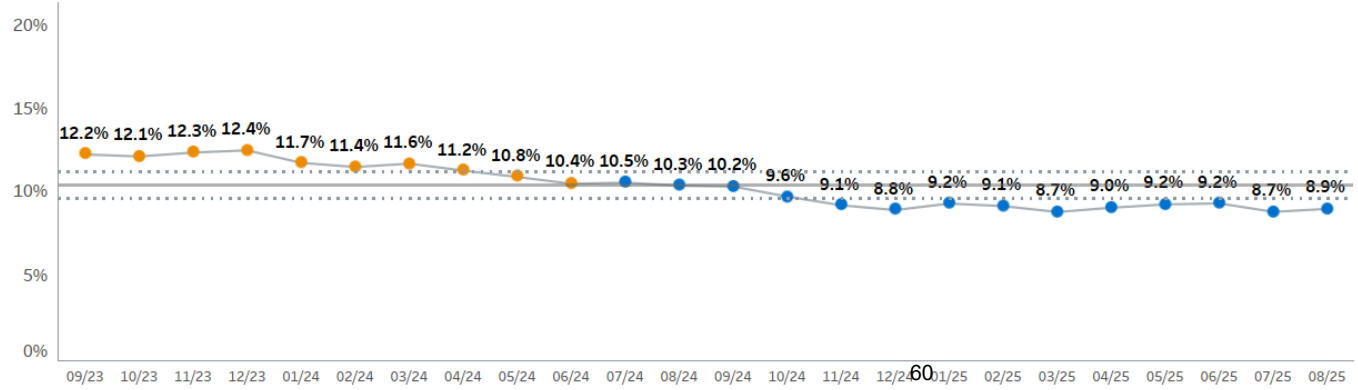
Summary

- **62** colleague(s) left the Trust in August.

- The top non-voluntary leaving reason was **End of Fixed Term Contract**.

- The 12m rolling Turnover % for August for staff with less than 1 year service was **44.97%**

Voluntary Turnover



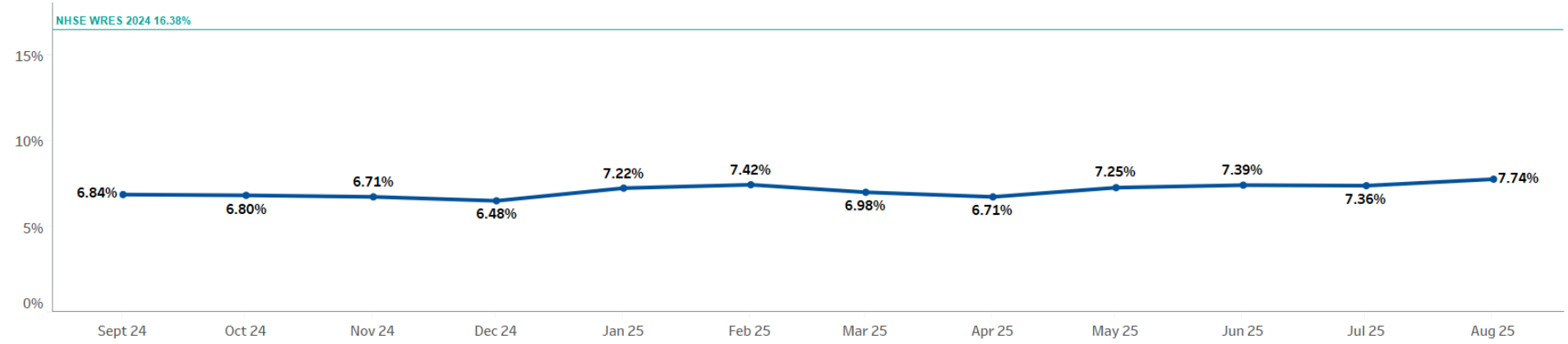
Performance	Assurance
Improving	No Target

Summary

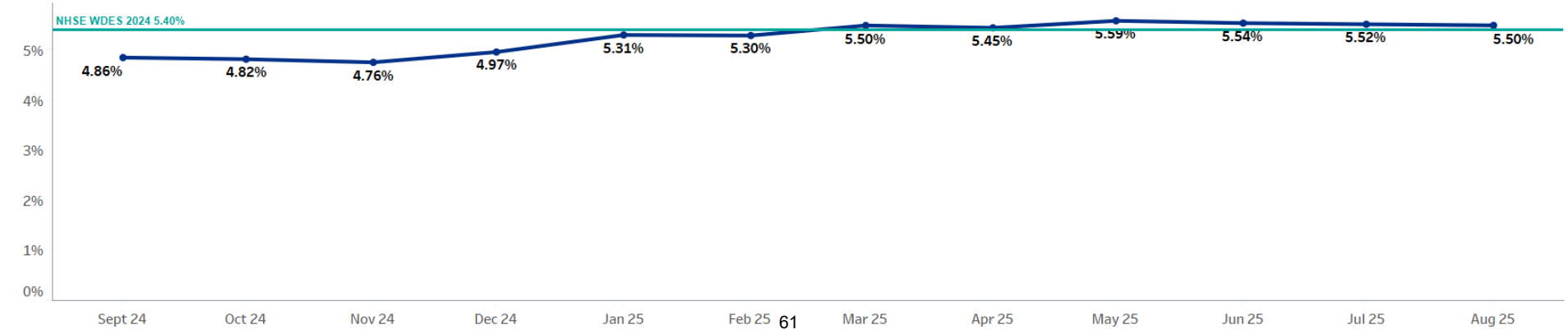
- The top voluntary leaving reason was **Voluntary Resignation - Other/Not Known**.

Our People - Senior Management Representation

Senior Management (Band 8A - VSM) BAME %

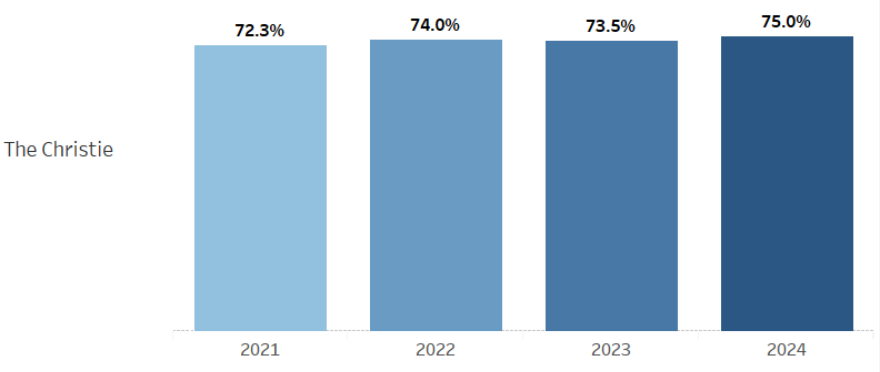


Senior Management- (Band 8A - VSM) Disability %



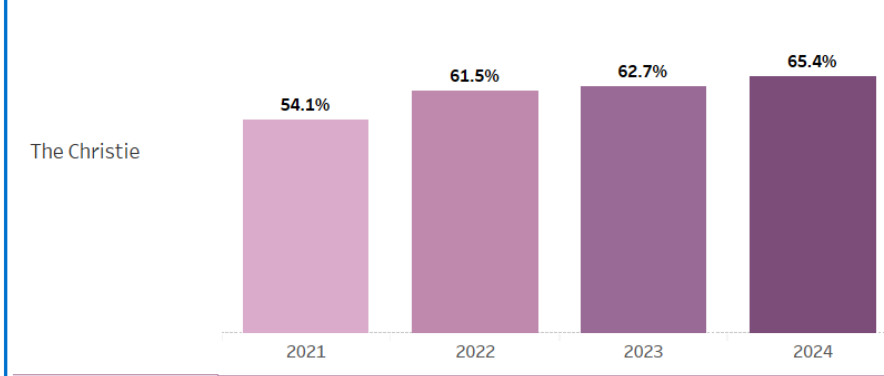
Our People - Staff Survey

Staff Engagement Score



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

Morale Score



	2021	2022	2023	2024
Stressors (HSE index) sub-score	60.4%	66.8%	66.7%	68.1%
Thinking about leaving sub-score	54.0%	62.0%	64.6%	67.1%
Work pressure sub-score	48.0%	55.6%	56.8%	61.1%

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Agenda item 27/25c

Public meeting of the Board of Directors

Thursday 25th September 2025

Subject / Title	Financial Planning
Author(s)	Sally Parkinson, Executive Director of Finance
Presented by	Sally Parkinson, Executive Director of Finance
Summary / purpose of paper	This paper describes key financial planning updates
Recommendation(s)	The Board is asked to note: • assurance letter provided to GM ICB • 2025/26 year-end forecast scenarios • financial planning requirements
Background Papers	None
Risk Score	n/a
EDI impact / considerations	Assessed as part of the individual components of the proposed plan
Link to: ➢ Trust's Strategic Direction ➢ Corporate Objectives	Achievement of corporate plan and objectives
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	GM ICB – Greater Manchester Integrated Care Board DSF – Deficit Support Funding VIP – Value Improvement Plan CDEL – Capital Department Expenditure Limit 10YHP – Ten Year Health Plan NICE – National Institute for Health and Care Excellence GIRFT – Getting It Right First Time PLICS – Patient Level Information and Costing Systems DHSC – Department for Health and Social Care

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Agenda item 27/25c

Public meeting of the Board of Directors

Thursday 25th September 2025

Financial Planning

1. Assurance letter to GM ICB

Each provider in GM has been asked to provide assurance to GM ICB confirming, or otherwise, the delivery of their financial plan. This is intended to provide assurance to NHS England that the cumulative performance of the ICB meets the criteria required to access Deficit Support Funding (DSF). GM ICB set an aggregate 2025/26 financial plan for £200m deficit; the DSF provides cash to fund this deficit.

The Christie's financial plan was to deliver a £7.5m surplus, hence no DSF was required however the assessment is based on the cumulative GM ICB performance so the requirement for the assurance letter from all providers remains.

2. Year-end forecast scenarios

As part of the assurance to GM ICB, each provider was required to model three scenarios to illustrate the potential year-end financial forecasts. The table below summarises the submission:

Forecast (Surplus / Deficit)	£m
Best case	7.5
Most likely	7.5
Worst case	5.3

The worst case reflects the reduction of £2.2m 'cost of capital' funding previously reported to the Board in the M3 and M4 financial reports.

The most likely and best cases assume mitigation of this income reduction, £1m of which has been achieved by M5. The Board will be regularly updated on the most likely financial forecast.

3. Financial planning

In response to the requirements of the Ten Year Health Plan (10YHP) indicating a significant change in the way services are organised, funded and delivered, guidance has now been issued on how NHS providers should plan to address the requirements.

The 'Planning Framework for the NHS in England' was published (in draft form) in August 2025. It signals a return to a longer-term planning cycle commencing this autumn with a requirement to plan for a rolling five-year period. In the years immediately following the Covid-19 pandemic, the NHS received annual funding settlements, making it difficult to focus on long terms strategic planning of services. This new guidance recognises that NHS planning needs to become a continuous, iterative process that supports transformation and fully utilises new science and technology.

All providers are required to prepare credible, integrated five-year plans (20206/27 to 2030/31) which demonstrate how they will be financial sustainability over the medium term.

For context, the table below shows the Christie's financial outturn for the period last five years:

	Adjusted Financial Performance					
	£m					
	2020/21	**2021/22**	**2022/23**	**2023/24**	**2024/25**	**25/26**
Plan (Surplus / Deficit)	-1.1	0.0	0.0	-8.0	7.0	7.5
Actual (Surplus / Deficit)	7.8	0.2	1.4	6.8	15.0	

4. Christie planning process

Our planning process links strategy, delivery and performance management and is, through contract negotiation, agreed with commissioners and triangulated with data from referring organisations.

We have briefed our operational teams on this new long planning requirement. As part of the usual planning process, our divisions model changes in services driven by rising demand, new clinical indications, emerging treatments, NICE approvals, consolidation of services across GM and the productivity gains from the introduction of new equipment.

Several benchmarking data sources are utilised to drive quality and productivity improvements in the delivery of service including the following:

- GIRFT (Getting It Right First Time), a national clinically led NHS England programme designed to improve patient care through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change
- NHS model hospital system, a data-driven improvement tool that supporting improvement in patient outcomes and population health by benchmarked insights across the quality of care, productivity and organisational culture to identify opportunities for improvement.

- Patient Level Information and Costing Systems (PLICS) bring together healthcare activity information with financial information providing detailed information about how resources are used at patient-level e.g. staff, drugs, and diagnostic tests. All acute trusts are required by NHS England to calculate their costs at patient level.

  The Christie costing team have been leading GM ICB in the approach and utilisation of this data to understand variation key cost drivers within specific patient pathways. This is then used to identify opportunities to reduce variation, improve quality ad drive down cost.

It is essential that we plan services to deliver the required thresholds, targets and quality standard described in the NHS Performance Assessment Framework whilst also demonstrating efficiency and actively addressing health inequalities.

This is then modelled in terms of changes in workforce numbers (with equivalent pay budgets) and non-pay budgets to create a total revenue budget requirement with associated productivity and VIP efficiency requirements.

5. Capital and cash

We will need to align our capital requirements with the activity plan to enable the use of the latest technology in delivering care effectively and efficiently manner. Drawing on our five-year rolling capital plan, strategic investments and programmes identified through divisional risk registers we have modelled an associated capital budget and CDEL requirement (permission to deploy cash on capital programmes).

Given the proposed 'capital freedoms', the ability to spend capital above the usual depreciation level in recognition of delivery of a surplus, modelling of cash is vital to ensure the levels of cash are maintained whilst utilising cash balances to deliver strategic and operational capital projects.

For context, the table below shows the level of capital deployed by the Christie from different sources over the last five years:

	£m						
Source	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**	**2025/26 plan**	**TOTAL**
Trust - CDEL	49.1	71.3	68.3	22.3	15.7	49.2	**275.8**
PDC	8.7	3.7	10.1	10.6	1.6	1.9	**36.7**
Charity	6.1	25.2	0.5	0.3	0.3	5.8	**38.2**
Grant						1.1	**1.1**
TOTAL	**64.0**	**100.2**	**78.9**	**33.2**	**17.6**	**58.0**	**351.8**

6. Next steps

Further details regarding the planning process will be described in the Board development day on 3rd October 2025. This will consider the delivery of the Christie strategy in the context of the 10YHP.

The national planning timetable is described below:

- Phase one will run to the end of September with multi-year priorities and allocations issued from NHS England and DHSC
- Phase two will launch at the end of September / early October with the publication of multi-year guidance and financial allocations.
- Providers are required to develop medium-term plans and take them through board assurance and sign off processes in December

7. Recommendation

The Board is asked to note:

- assurance letter provided to GM ICB
- 2025/26 year-end forecast scenarios
- financial planning requirements

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Agenda item 27/25d

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 Month 5 position for the Value Improvement Programme (VIP) and assurance targets for Q2 have been delivered • Set out the proposed approach, benchmarking, alignment and governance arrangements for 2026/27 VIP plan • Outline the next steps
Recommendation(s)	The committee is asked to note: • The content of the report and • The approach to 2026/27
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 27/25d

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 had to achieve a challenging cost improvement target of £25.3m. To address this, a governance framework was developed and aligned with our Trust ambitions. This approach focused 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 Operational 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.

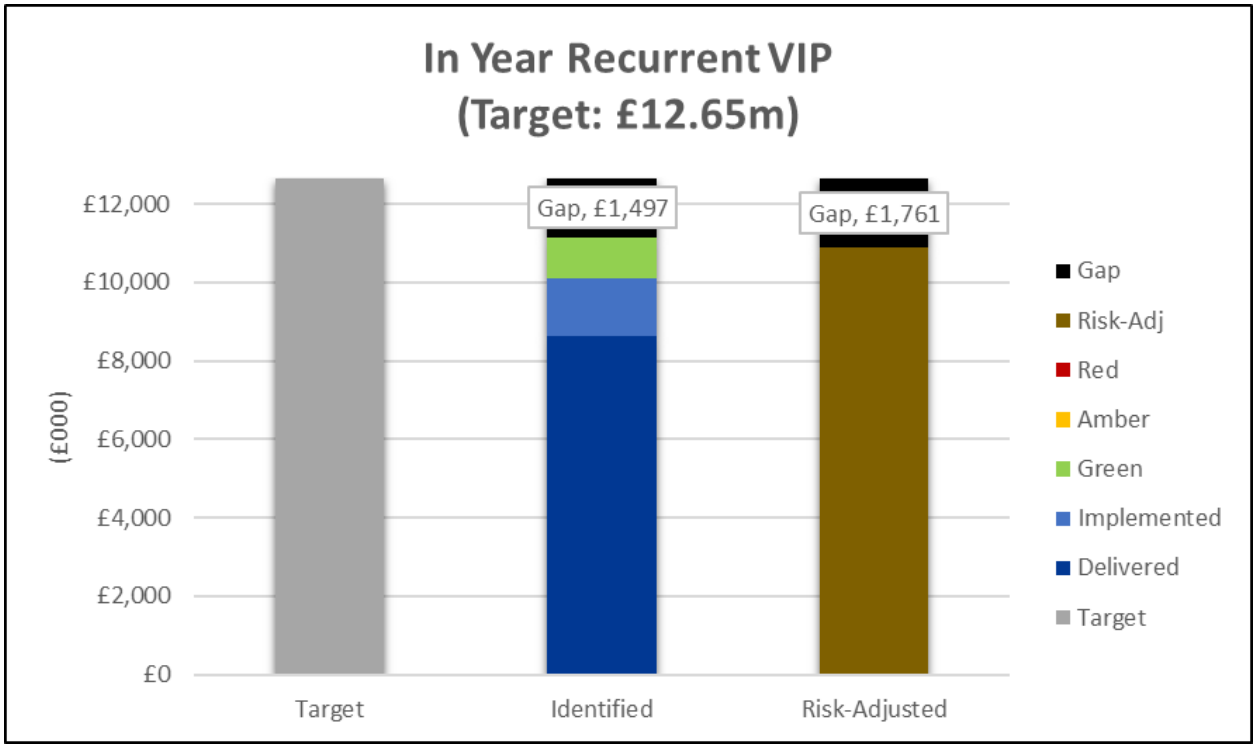
This paper describes the current position of VIP for month 5, and next steps for the launch of the 26/27 programme.

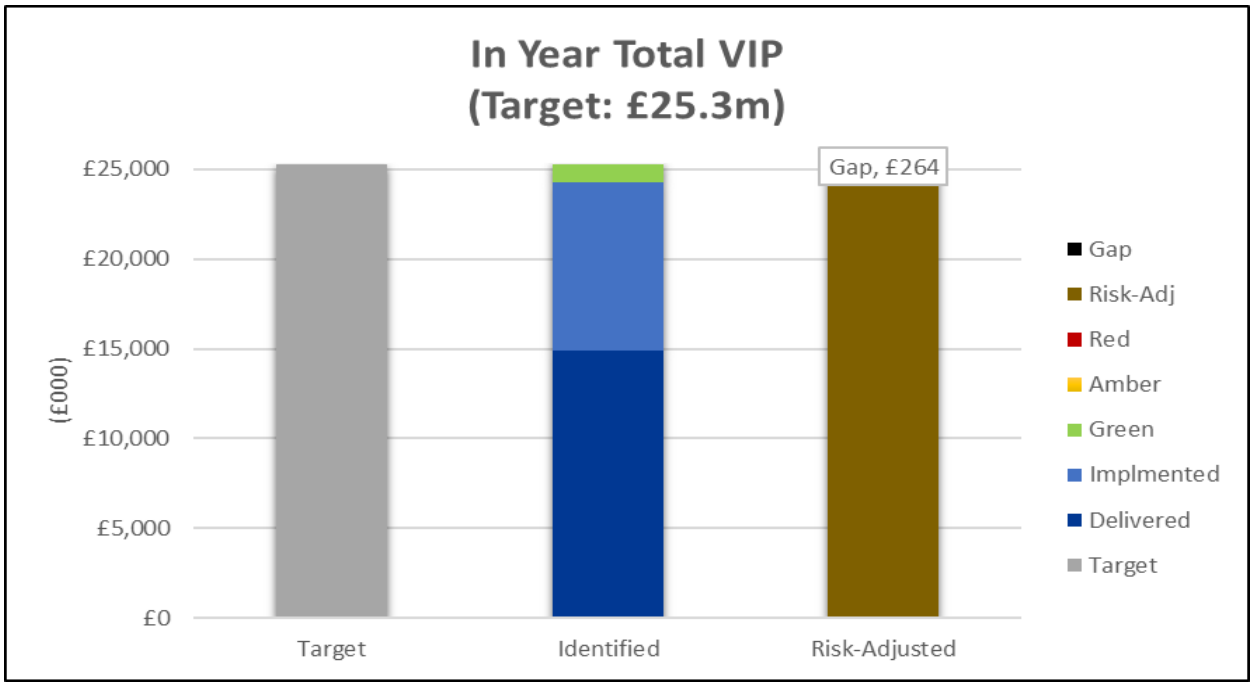
2.0 Financial Overview: VIP month 5

The Trust has made good progress against the target of £25,298,000. The total identified VIP schemes reported at the end of Month 5 are £25.3m (£14.1m non recurrent / £11.2m recurrent) leaving nothing outstanding to be identified against the overall annual VIP target for 25/26.

- £1.1m of the identified schemes are fully developed but still need to be implemented by Divisions
- Recurrent schemes totalling £11.2m have been identified against a recurrent target of £12.6m, leaving £1.5m of the 25/26 recurrent target unidentified. This is offset by an equivalent over delivery of non recurrent schemes in year.
- Any under delivery against the recurrent target which remains at the end of the year will be carried forward into the 26/27 planning cycle.
- Integrated planning with workforce, operational performance, and activity planning has already commenced for the 26/27 VIP Programme.

	Annual					Year To Date		
	Target (£000)	Identifed (£000)	Unidentifled (£000)	Risk-Adjusted Identifled (£000)	Risk-Adjusted Unidentifled (£000)	Target (£000)	Dellvered (£000)	Varlance (£000)
Total VIP	25,298	25,298	0	25,034	264	10,312	10,312	0
Recurrent VIP	12,649	11,152	1,497	10,888	1,761	5,270	4,077	1,193
Non-Recurrent VIP	12,649	14,146	-1,497	14,146	-1,497	5,042	6,235	-1,193





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

3.0 2026/27 Value Improvement Programme (VIP)

The 2026/27 Value Improvement Programme (VIP) has commenced and will build on the progress made in 2025/26. The focus is on strengthening the delivery of recurrent financial efficiencies to ensure a sustainable position for the Trust. The programme is fully aligned to operational plans and continues to embed the principles of NHS Impact, providing a disciplined and evidence-based approach to improvement.

Key enhancements for 2026/27 include:

- Improved use of benchmarking tools: Embedding Model Health System (MHS), Getting It Right First Time (GIRFT), and costing data to drive targeted improvements.
- Operational alignment: Integrating with the Operational Improvement Plan, including digital transformation opportunities through Future Christie.
- Daily management and waste reduction: Driving continuous improvement through divisional ownership and structured improvement methods.
- Breakthrough projects: Delivering high-impact initiatives aligned to strategic priorities, including reducing time away from home, pathway redesign, NHS App adoption, and workforce efficiency.
- Value-based prioritisation: Applying weighted scoring to balance financial impact, outcomes, equity, and patient experience.
- Capability building: Expanding staff training and engagement, linked to Proud2bOps and improvement awareness sessions.
- Clinical leadership: Launching a new programme to reduce unwarranted variation in diagnostic testing.
- Improving how we work alongside our patients to move from patient centred to patient driven service transformation.

4.0 Benchmarking and Assurance

Benchmarking remains central to the VIP, ensuring that improvement opportunities are evidence-based and nationally consistent.

- GIRFT and MHS metrics are directly embedded into the VIP to identify and drive improvement.
- Staff engagement sessions are underway to build understanding of MHS and share learning from other Trusts.
- Updated opportunity packs will be issued to Divisions by November, covering productivity, performance, quality, costing, and benchmarking data.
- Best practice checklist assessments are being conducted to provide assurance on financial management standards.

The Christie continues to report VIP progress weekly to NHSE. As of Q2, the Trust has identified and delivered 100% of its 2025/26 cost improvement target, benchmarking strongly against national peers.

5.0 National Alignment

The Christie's VIP is fully aligned with national expectations and frameworks, supporting our position in Segment One of the NHS Oversight Framework. This requires demonstrable progress against financial and operational metrics, supported by robust governance and delivery.

This includes:

- NHS IMPACT supports embedding leadership behaviours, daily management, and breakthrough change.
- MHS and GIRFT provide data to target unwarranted variation and identifying productivity opportunities.
- System-wide priorities in support of Greater Manchester goals for population health and financial sustainability.
- Robust delivery plans with schemes supported by QIA/EIA and documented assurance processes.

The newly released 2026/27 Operational Planning Framework also reinforces the need for recurrent efficiency, productivity, and recovery delivery. The VIP is designed to meet these expectations while remaining locally responsive and strategically aligned.

6.0 Governance and Oversight

The VIP is underpinned by a comprehensive governance framework that provides assurance to the Board on delivery, risk management, and alignment to national standards:

- Executive Oversight: Co-sponsored by the COO and DoF; reviewed weekly by the Executive Team.
- Board Oversight: Committees receive AAA (Alert, Advise, Assure) reports on progress and risks.
- Operational Governance: OPIG and Service Operational Review meetings provide escalation and monitoring.
- Risk Management: All schemes undergo QIA/EIA; risks are captured on the Corporate Risk Register.
- External Assurance: Use of MHS, GIRFT, and external audit methodology ensures robustness.
- Delivery Risk: Managed through programme oversight, phased milestones, and early escalation.
- Recurrent Focus: Active pipeline development to reduce non-recurrent reliance.
- Workforce Pressures: Addressed through projects to reducing reliance on temporary staffing, recruitment, roster management, job planning.
- Quality Safeguards: Oversight by the Medical Director and Chief Nurse via QIA/EIA.
- Staff Engagement: Regular updates, training, and improvement forums including “Do You Have an Idea?” and HIVE resources.

7.0 Next Steps

Sign off 2025/26 VIP plan as delivered and finalise the 2026/27 VIP pipeline. This includes confirming divisional sign-off as part of the planning framework to submit a compliant plan in line with deadlines. Engagement sessions will also be held including the launch event to promote clinical-financial collaboration, share learning, and generate new ideas.

Agenda item 28/25a

Board of Directors

September 2025

Subject / Title	OECI accreditation
Author(s)	Compliance Lead / OECI Coordinator
Presented by	Professor Chris Harrison
Summary / purpose of paper	The Organisation of European Cancer Institutes (OECI) has reaccredited The Christie for five years from July 2025.
Recommendation(s)	To note: 1. The Organisation of European Cancer Institutes (OECI) has reaccredited The Christie for five years from July 2025. 2. The reaccreditation reaffirms The Christie's status as a leading centre for cancer care in Europe and globally. 3. The findings are in line with other national and international benchmarking data described in the paper
Background papers / source of assurance	The paper provides the board with authoritative external assurance on the integration and quality of clinical care, research and education provided at the Christie as judged against accepted and validated international standards. The full OECI report is available on our Trust publications page under the 'Who we are and what we do' heading.
Risk score / BAF reference	The risk of not achieving reaccreditation has been reduced to 0 (Likelihood 0 x Impact 4) and will be reassessed during the accreditation period.
EDI impact/considerations	No specific impact was identified by the OECI
Link to: ➢ Trust strategy ➢ Corporate objectives ➢ CQC Quality standard ➢ Regulation	OECI accreditation provides assurance in relation to the four areas of: Leading cancer care, The Christie Experience, Local and Specialist Care, Best outcomes
Acronyms and abbreviations	OECI – Organisation of European Cancer Institutes MCRC – Manchester Cancer Research Centre

Agenda item 28/25a

Meeting of the Board of Directors
September 2025

OECI accreditation

Introduction

The Organisation of European Cancer Institutes (OECI) has reaccredited The Christie for a period of five years from July 2025. This follows a rigorous peer-review visit in February 2025 by a team of international cancer experts. Reaccreditation reaffirms The Christie's status as a leading European and global centre for cancer care.

Background

The OECI reaccreditation decision provides the board with a high level of external assurance regarding the integration and quality of clinical care, research, and education delivered at the Christie, as evaluated by experts against recognised and validated international standards.

The OECI is the leading European body that establishes and maintains quality standards for cancer care, research, and education across its member centres. Its mission is to ensure equal access to high-quality, multidisciplinary care; smooth integration of innovation into clinical pathways; and a patient-centred approach to service delivery.

The Christie was the first UK hospital invited to join the OECI in 2008. It was the first UK organisation to be accredited as a comprehensive cancer centre under its strict criteria. We have now been revalidated twice.

Accreditation Process

1. Self-Assessment and Documentation

The Christie provided evidence relating to our governance frameworks, clinical outcomes, research productivity, infrastructure, and education programmes to demonstrate compliance with the stringent OECI standards. These standards offer a validated and reproducible framework for international benchmarking of cancer care.

2. Peer Review Visit

In February 2025, a multinational OECI team carried out on-site evaluations, interviewing executive leadership, clinical and research staff, education providers, and patient representatives to assess operational excellence and patient involvement. The team consisted of senior professionals with direct personal experience and expertise in delivering cancer care.

3. Final Report and Certification

Following detailed feedback, we received the final report and accreditation certificate in August 2025, confirming compliance with all applicable criteria and extending accreditation to July 2030.

Key Findings

The report describes The Christie as “An exemplar Comprehensive Cancer Centre” and makes the following observations

1. Compliance with Standards

We were assessed by the OECI expert audit team as being completely or mostly compliant with 94.8% of the standards, which is all applicable criteria.

2. Excellence in Patient Care and Research

The peer review team rated The Christie as high performing in clinical services quality and research impact, highlighting strong translational links between laboratory discoveries and patient treatments.

3. Comprehensive Education Programmes

The Christie Institute of Cancer Education was commended for its comprehensive continuum of professional development, spanning undergraduate oncology curricula to ongoing learning for general practice and allied professionals.

4. Organisational Culture and Staff Engagement

Reviewers found a highly motivated workforce with clear patient-centred objectives, supported by strong governance structures and a shared commitment to excellence.

5. Progress Since Last Accreditation

The auditors identified measurable advancements in clinical innovation, research impact, and educational outreach since our previous peer review, reinforcing our exemplar status within OECI.

6. Maintaining Accreditation

While assessing us as compliant with the relevant current standards, the visiting expert team recommended certain areas for continued development to ensure ongoing compliance as the standards evolve:

- Increasing, as already planned, capacity in Nuclear Medicine by installing a Total Body PET Scanner, but this also supports our planned Advanced Scanning and Imaging Centre (ASIC) development.
- Developing, as already planned, our digital capability, for example, through the implementation of a new Electronic Patient Record and developing the associated analytic capability, such as the Joint Analytics for Cancer (JAC) initiative

- Further strengthening the Manchester Cancer Research Centre (MCRC), for example, by further integration of the presentation and understanding of the total research spend across the partnership.
- Improving Pathology facilities through the already planned Pathology development.
- Maintaining our ability to recruit staff across all professional groups by building on the high level of engagement and morale through our Inclusive Culture Strategy 2025-2030.
- Working with the Cancer Alliance (Greater Manchester Cancer) to take a more straightforward overview of cancer care quality across the whole pathway to support and develop multidisciplinary team working, oversight and documentation of patient pathways.

Implications and Conclusions

The reaccreditation reaffirms The Christie's status as a leading centre for cancer care in Europe and globally. The findings are in line with other national and international benchmarking data, for example:

We have been recognised by our patients, our staff, and NHS England, and as one of the top hospitals in England, as shown by -

- The second-highest score (9.2/10) for overall care among all hospitals in England, according to the National Inpatient Survey.
- One of the highest scores in England (9.2/10) for overall care in the National Cancer Patient Survey
- In the top-performing category, and either first or second in our peer group across all aspects of the NHS People Promise in the National Staff Survey, which evaluates compassion, inclusivity, staff recognition, staff voice, safety, health, learning, flexible working, and teamwork.
- One of the top two highest scores for a specialist hospital in both staff engagement and morale in the National Staff Survey.
- In the top-performing (Tier 1) category of all hospitals in England, according to NHS England.
- The third-best performing hospital in England, according to the national performance assessment that considers quality of care, waiting times, and financial control.

We have also been recognised by the global healthcare community as one of the world's top Cancer Centres, as demonstrated by -

- Among the top 25 global cancer centres according to the latest international ranking data, which assesses facilities, outcomes, and international reputation.

- In the top tier of cancer centres in Europe, according to the OECI, which has reaccredited us as a comprehensive cancer centre.

Our approach to addressing the issues identified by the audit team is outlined in an action plan that the OECI has approved. Progress with the action plan, including the recommended developments and efforts towards reaccreditation, will be overseen by the Senior Management Committee and reported to the board through SMC escalation reports.

The outcome of the audit reflects the dedication, hard work, expertise, and caring approach of our staff. In their feedback, the OECI auditors specifically noted the strong organisational culture supported by effective governance mechanisms.

Recommendation

The Board of Directors is asked to note:

1. The Organisation of European Cancer Institutes (OECI) has reaccredited The Christie for a period of five years, effective from July 2025.
2. The reaccreditation reaffirms The Christie's status as a leading centre for cancer care in Europe.
3. The findings are in line with other national and international benchmarking data described in the paper

The Christie
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Agenda item 28/25b

Meeting of the Board of Directors

Thursday 25th September 2025

Subject / Title	Future Christie Update
Author(s)	Thomas Thornber, Director of Future Christie
Presented by	Thomas Thornber, Director of Future Christie
Summary / purpose of paper	Provide and update on the progress of Future Christie
Recommendation(s)	To note the progress and the interdependence between the EPR strategic outline case and the Intelligent hospital data plan (Joint Analytics for Cancer - JAC)
Background Papers	Trust Strategy NHS 10 year plan Future Christie Overview
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.	EPR – Electronic patient record JAC – Joint analytics for Cancer PMO – Program management office MCRC – Manchester Cancer Research Centre

Meeting of the Board of Directors

Thursday 25th September 2025

Future Christie Programme: Director's Update

1. Introduction

Future Christie is our whole-organisation transformation programme, designed to modernise cancer care—digitally, clinically, and culturally. This update outlines our underpinning ambitions, the progress made in Year 1, and how current actions directly support our long-term goals.

Note: The Board will also consider the EPR Strategic Outline Case as a substantive item and receive the Intelligent hospital, Joint Analytics for Cancer (JAC) paper for awareness. These items are interdependent and central to the success of Future Christie.

The development and deployment for both these cases will be included in the board planning and away day sessions providing multiple opportunities for further engagement and influencing the case.

2. Underpinning Ambitions of Future Christie

- **Personalised Care for Patients** – access to tailored, digitally enabled care across pathways with clear communication and choice.
- **Empowered Clinicians and Staff** – real-time data, modern systems, reduced duplication, and freed capacity for safe, compassionate, and innovative care.
- **An Intelligent Hospital** – a data-driven, learning organisation integrating care, research, and innovation.
- **A Culture of Change** – embedding consistent improvement, co-design, and staff-led transformation at every level.

These ambitions align with the Christie 2028 Strategy: leading cancer care, best outcomes, Christie experience, and local & specialist care.

3. Context and Drivers

Cancer services face growing pressures:

- **Push factors** – rising incidence, longer survival, workforce availability, treatment complexity, financial constraints.
- **Pull factors** – rising patient/staff expectations, therapeutic advances, new digital technologies.

Future Christie is the coordinated vehicle to meet these challenges.

4. Programme Approach

- **Clinically led** – strong clinical leadership and co-design.
- **Centrally supported** – PMO, analysts, change leads provide standards and delivery capacity.
- **Locally delivered** – divisional transformation teams empowered with resources.
- **Change at pace and scale** – focused strategic priorities with visible outcomes.

5. Year 1 Deliverables and Link to Ambitions

- **Patient Portal** – expanded roll-out supports personalised care.
- **NHS App integration** – planned for Q1 2026, embedding Christie in the wider NHS digital ecosystem.
- **AI deployment** – radiotherapy auto planning and ambient AI reduce burden, supporting empowered clinicians.
- **EPR development** – replacing legacy systems to enable the Intelligent Hospital.
- **JAC business case** – developing real-time analytics capability for insight-driven care and research.

EPR–JAC Interdependence:

- EPR supplies structured, high-quality data.
- JAC transforms data into actionable insights.
- Together, they underpin the Intelligent Hospital vision.

6. Progress Highlights

- Strong engagement across Board, leaders' forums, Grand Round, and divisional/professional forums.
- Alignment of digital and transformation teams under Future Christie.
- Patient Portal roll-out progressing well, expanding access and functionality for patients.
- Active Ambient AI provider engagement to support clinical burden reduction and innovation.
- Staff side engagement on the immediate changes and the long-term approach
- Completion of the EPR Strategic Outline Case.
- Development of plans for Step change in use of data, supported by MCRC partners, Cambridge university and Deloitte. Proposal Joint Analytics for cancer (separate paper)

7. Challenges and Risks

- **Culture of change** – Mitigation: visible leadership, divisional champions, co-design.
- **Legacy systems** – Mitigation: phased EPR transition, critical area prioritisation.
- **Capacity & capability** – Mitigation: invest in PMO through EPR and JAC cases, external expertise, strengthened divisional teams.

- **Financial pressures** – Mitigation: benefits framework, alignment with national funds, focus on high-impact projects.

8. Next Steps (Q3 2025/26)

- Further enhance the engagement approach through multi-channel communications tailored to both staff and patients.
- Develop **EPR Outline Business Case**.
- Expand **Patient Portal** adoption and NHS App compliance.
- Strengthen **Data Preparedness** for JAC and Intelligent Hospital.
- Extend **AI & automation pilots**.
- Maintain strong **engagement** internal and externally.

9. Conclusion

Future Christie is building momentum with visible outcomes in Year 1. Portal expansion, AI pilots, EPR development, and JAC foundations are directly aligned to long-term ambitions: personalised care, empowered staff, an intelligent hospital, and a culture of change.

The EPR and JAC are interdependent enablers of the Intelligent Hospital vision. Sustained leadership, workforce investment, and digital foundations remain essential for success.

Recommendation: The Board is asked to note this update and endorse programme priorities for the next quarter and the further opportunities for further engagement in the developing EPR and Data Strategy.

The Christie
NHS Foundation Trust

Agenda Item 29/25a(i)

Meeting of the Board of Directors
Thursday 25 September 2025

Subject / Title	Workforce Assurance Committee report – June 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 Workforce Assurance Committee at their June meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions.
Background papers	Workforce Assurance Committee papers – 19 June 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
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Agenda Item 29/25a(i)

Meeting of the Board of Directors
Thursday 25 September 2025

Workforce Assurance Committee report – June 2025

1 Introduction

The Workforce Assurance Committee took place on 19 June 2025. The meeting was quorate. The following summary gives the Board information on the items that were considered by the committee at their meeting under the headings of Assure / Alert / Advise.

2 Workforce Assurance Committee agenda items

The items listed in Appendix 1 of the report were all presented to the Workforce Assurance Committee in June 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 Workforce Assurance Committee in June 2025.

Appendix 1

Agenda item	BAF ref	CQC regulation reference	Assurance rating given	Key points and associated actions (where applicable)
16/25a	3, 12	18	High	**Workforce dashboard and risk review**
Assure				• Engagement – some areas above target, healthy position. • Sickness rate – tracking well, rate below last year at 4.13% for April. YTD position is 4.64%, target is 4.25%. • PDR compliance – slight drop to 87.59%. • Mandatory training compliance – stands at 93.48%, divisional performance strong. • Staff turnover – total turnover up (couple of dismissals). Voluntary turnover down (positive). • Establishment against paid FTE gap – moving in the right direction to lower the gap. • Recruitment activity – overactive on recruitment which is positive and helps to recruit to posts when leavers arise. • Staff survey snapshot – overview given which helps to determine risk score. • Workforce risk summary presented, risk in terms of workforce supply remains at a 9 and regularly reviewed at Workforce Committee.
Alert				• No alert points to raise.
Advise				• Next chapter league table – first dashboard presented. 40% of leavers rated the Trust as a five star employer (based on 66 responses). To be developed further as becomes more embedded. • Plans to develop next chapter dashboard further.
Actions				• No actions noted.
16/25b	3	N/A	High	**Bank & agency monitoring report**
Assure				• Compliant with standards and KPIs. • All enhanced rates to be removed, in line with Greater Manchester. • Approval process in place for agency requests. • Extra scrutiny for rosters in place through meetings. • Forecasting staffing report done weekly. • Weekly agency meetings chaired by Deputy Chief Nurse. • Roster KPIs, which will eventually feed into workforce dashboard, are used in service review meetings.
Alert				• No alert points to raise.

Advise				• Price cap compliance – struggling in medical workforce. Escalation process in place if high charges posed from agencies. • Targeted recruitment for some high agency usage areas.
Actions				• No actions noted.
16/25c	3	N/A	High	**Education six monthly report**
Assure				• CPD applications increased continually in relation to funded CPD. • WRES equality in application for CPD – BAME staff slightly more likely to access than White people. • Apprenticeships – 4 pharmacy technicians starting in September. • Expired levy funds - this year have reduced this by 77%. • Work experience – 81 students engaged in structured placements above KPI of 70 per 6 months. • Digital and functional skills – uptake of 38 from Sept 2024 – March 2025, above target. • Evaluation and feedback – PARE evaluation completion rate, regional average matched. PARE positive placement feedback 82.5% positive overall. • Moved to high assurance based on the dashboard presented and assurance provided.
Alert				• No alert points to raise.
Advise				• Preceptorship – take up reduced, possibly due to role vacancy. • Christie care certificate – monitored via a tracker.
Actions				• No actions noted.
16/25d	3	N/A	High	**Divisional recruitment audit update**
Assure				• Actions near completion, further training has been completed with managers. • 150 managers have been trained on recruitment and retention. • Audits implemented internally; pre-employment check standards audits (95% compliance result in March 2025) and vacancy audits.
Alert				• Digital transformation – declaration and conflict of interest processes, on development list for Trac (software provider), Trust has no influence over deployment timescales.
Advise				• Cross referencing to take place with the recruitment and retention policy to new national policy guidance. Policy going to staff forum for approval in June. • Looking at if shortlisted packs can be more digitised.

Actions				• No actions noted.
17/25a	3, 12	18, 19	Strong	**The Christie people and culture plan - year 2 milestone review**
Assure				• Visual representation of milestones shows achievements made and areas on track. In a good position based on where we expected to be for year 2. The areas outstanding are understood.
Alert				• No alert points to raise.
Advise				• No advise points to raise.
Actions				• No actions noted.

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

Assure	• Responsible officer report (annual medical appraisal and revalidation) - good compliance. Two deferrals, not related to non-engagement. Appointed deputy medical director in-year. Visit from high level responsible officer in March (regional team), small number of recommendations made in relation to efficiency of processes which are being reviewed. • Violence reduction prevention policy update - policy with task and finish group stakeholders for consultation review. Summary provided of the changes made to the policy. Trust's violence and aggression risk assessment reviewed and updated. Unacceptable behaviour/discrimination posters ready for publication. Trust wide communication is to be drafted and circulated across the Trust once the policy is approved. Continuation of the task and finish group to monitor effectiveness. • National job profiles for nursing - NHS Staff Council and its job evaluation subgroup (JEG) completed a review of the national job matching profiles for nursing and midwifery roles and updated profiles have been published. Purpose was to check the accuracy of nursing job profiles. Assurance provided on good progress being made. • Internal audit progress report - MIAA supporting the Trust on providing audit recommendation updates via a new report process, example report presented. 2 workforce related reviews with recommendations in place. Presentation of overdue actions (based on original dates agreed), extended deadlines will require approval by Audit Committee before being agreed.
Alert	• No alert points to raise.

Advise	• Board Assurance Framework (BAF) - BAF presented was the closing position for 2024/25, new BAF will be presented to June Board. Risk 3 will remain on the BAF going forward into the new 2025/26 version. Risk 12 will be re-described for the new BAF. Current position regarding industrial action noted. • Guardian of safe working hours quarterly report - seen an increase in exceptions reported by quarter this last year, explanation for this quarter provided. Exceptions relating to patient safety explained. Exception reporting framework is changing and will come in from September on providing guidance to ensure exception reporting is accurate.

The Christie
NHS Foundation Trust

Agenda Item 29/25a(ii)

Meeting of the Board of Directors
Thursday 25 September 2025

Subject / Title	Quality Assurance Committee report – June 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 Quality Assurance Committee at their June meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions.
Background papers	Quality Assurance Committee papers – June 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.	

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Agenda Item 29/25a(ii)

Meeting of the Board of Directors
Thursday 25 September 2025

Quality Assurance Committee report – June 2025

1 Introduction

The Quality Assurance Committee took place on 19 June. The meeting was quorate. The following summary gives the Board information on the items that were considered by the committee at their meeting under the headings of Assure / Alert / Advise.

2 Quality Assurance Committee agenda items

The items listed in Appendix 1 of the report were all presented to the Quality Assurance Committee in June 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 Quality Assurance Committee in June 2025.

The Christie NHS Foundation Trust

Appendix 1

Agenda item	BAF ref	CQC regulation reference	Assurance rating given	Key points and associated actions (where applicable)
16/25a	1, 6	N/A	High	**Bi-annual report of the research governance committee**
Assure				• Training compliance remains high at 96.55%. • PDR compliance improved to 89.64%. • Healthy pipeline in terms of study set up.
Alert				• No alerts to raise.
Advise				• Transitioning from RPEAK to the national Local Portfolio Management System, EDGE. Implementation is planned for Autumn, with support from the national EDGE team during the summer. • A new electronic Trial Master File system, Florence, is being introduced to digitally store trial documents. This will free up physical space and support team expansion. Florence is also used nationally. • Improving clinical trial set-up efficiency is a priority. Weekly huddles are in place to drive process improvements and prioritise trial initiation. External visits (including The Royal Marsden) will help benchmark and refine practices. Executive support is needed to engage service departments. • Quarterly Divisional Service and Operational Reviews (SORs) launched to review each disease group's portfolio, quality, finance, and capacity. These sessions identify issues, celebrate successes, and explore efficiency opportunities.
Actions				• No actions noted.
16/25b	N/A	N/A	High	**Controlled drugs (CD) management and assurance update**
Assure				• Scrutiny of all CD-related incidents, maintenance of medication safety incidents reviewed at Pharmacy Management Group, Divisional Quality Meeting and Trust Safe Medicines Practice Committee with follow-up of any key themes or cause for concern with the relevant clinical areas. • Trust Opioid Safety Task and Finish Group established. • Developed new SOP for destruction of controlled drugs.

Alert				• Challenges in measuring oral liquid CD medicines accurately, spillages not correctly documented, cumulative insignificant small volume discrepancies not being corrected on the opening of each new bottle resulting in a growing discrepancy that becomes more significant over time. This is being monitored closely.
Advise				• Staff to be invited to safe medicines group to look at how to address better controlled drugs practice going forward.
Actions				• Incident data to be analysed to determine if any harm associated incidents relating to controlled drugs management.
16/25c	N/A	N/A	Medium	**Aseptic risk update**
Assure				• Risk to the safe and effective delivery of the Trust's Aseptic Service score has been reduced to 12 based on progress made and NW quality assurance review outcome. There is an 89-point action plan in place with 60 actions completed so far.
Alert				• Risk to treatment delivery due to ASU Workforce recruitment & retention increased from moderate to high with a score of 15.
Advise				• Medium level of assurance agreed with the view to move to a higher level once assurance from the next external review received.
Actions				• Committee to review assurance level associated with aseptic risk following outcome of next external review in December 2025.
16/25e	N/A	12	High	**Infection prevention and control annual report 2024/**
Assure				• IPC Board Assurance Framework reviewed April/May 2025. • Ventilation group commenced in January 2025 informing IPCC. • Collaborative working with other specialist cancer hospitals to streamline processes to standardise patient safety and experience. • A review of the HCAI PSIRF framework with the divisional ACNs has been completed and shared through IPCC.

Alert				• 49% increase (45 to 67) in body fluid exposure incidents, has been a push on reporting. These are monitored at the quarterly Health and Safety Committee. • 11% decrease (2462 to 2196) in vaccination appointments for administration however The Christie had the highest vaccination rates. • PAP policy being worked on. Q4 saw a reduction in incidents reported. • NHSE 5 principles of face fit testing - all records are now uploaded onto ESR however work continues to enable appropriate divisional reporting. • HCAI MRSA, Pseudomonas and Klebsiella were over threshold in the reporting year. CDI and Ecoli were under threshold. All cases are managed through the HCAI PSIRF framework.
Advise				• Mouthcare Matters remains a Quality Ambition for 2025/26. • IPC Annual Audit programme overall results for 2024/25 are 88% compliance. The audit programme tool has been reviewed in line with NHSE guidance. • Antimicrobial pharmacist now in post to progress the AMS strategy. • IPC is involved in the work with regarding the lab system upgrade, this is due to be completed within the next few months.
Actions				• No actions noted.
16/25f (i)	2	12, 20	High	**Patient safety quarterly update**
Assure				• Steady increase in the number of 'near miss' events reported and the proportion of incidents with no/low harm is <3% of all incidents reported, demonstrating a positive patient safety culture of reporting.
Alert				• Escalation to Patient Safety Committee from Patient Safety Priority Groups regarding challenges faced in progressing improvements; started to use quality improvement project proposals.
Advise				• Completed review of all closed actions in DCIQ following learning responses through ERG. Looked at where actions sit, mainly administrative. Building in to DCIQ and adding to hierarchy of controls.
Actions				• No actions noted.
16/25f (ii)	1	9, 10, 12, 16	High	**Patient experience quarterly update**

Assure				• 16 complaints currently open, meeting statutory and local timeframes. 3 open with PHSO, no outcome as yet.
Alert				• No alerts to raise.
Advise				• Out to tender for new FFT provider.
Actions				• No actions noted.
16/25f (iii)	1	9, 10, 12, 16	High	**Clinical effectiveness quarterly update**
Assure				• Summary outcomes of projects generally provide good levels of assurance. • The number of outstanding NICE guidelines has reduced.
Alert				• No alerts to raise.
Advise				• Need to review the process for QICA projects; working with the coding team to ensure triage pointing at the right projects.
Actions				• No actions noted.
16/25f (iv)	N/A	N/A	High	**Health and safety quarterly update**
Assure				• Work ongoing with incident reporting policy for health and safety incidents. • Violence and aggression policy at final stages. • Updated procedural control for moving and handling risk assessments.
Alert				• Lone worker policy going for ratification next week.
Advise				• Revision to risk assessment templates to be made more robust. Hive page developed and designated email address in place.
Actions				• No actions noted.
16/25g	2	N/A	High	**PSIRF bi-annual update**

Assure				• Key themes reviewed and positively in line, have looked at involvement and made great progress in terms of duty of candour and timeframes. • Improvement – project proposals going to patient safety committee. • PSIRF maturity assessment – looked at PSIRF logic model. Runs from 0-3 as to where we are in terms of development.
Alert				• Lone worker policy going for ratification next week.
Advise				• Overarching engagement reviewed – planned area for next 6 months. • Staff involvement – looking at tools that staff can use in their own areas. • Patient safety incident response plan proposal for 2025/26 outlined – deteriorating patient, medicines safety, transfusion safety, lost to follow up/open referrals, end of life care.
Actions				• No actions noted.
16/25h	1	12	Strong	**Learning from deaths**
Assure				• 20 senior medics and 28 nursing reviewers in place. • All 96 SCRs triggered for review have been completed. • No avoidable deaths within the year. • Care scores - majority received excellent/good care, no poor scores. • Good amount of learning gained from deaths with a slight chance of avoidability. • Move to DCIQ has been positive in managing structured case note reviews.
Alert				• No alerts to raise.
Advise				• Highest number of deaths since 2017/18, data confirms the increase is in line with the increases in activity data. • 2 deaths related to patients' history of autism and learning needs; review conducted with safeguarding team.
Actions				• No actions noted.

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

Alert	• No further alerts to raise.
Assure	• Board Assurance Framework - Risk 2; score reduced from 9 to 6 due to progress made with PSIRF. Risk has been redescribed in the next version of the BAF. Risk 13; score reduced from 8 to 6 following a review of the impact of this risk and will not appear in the next version of the BAF. • Nutrition and hydration compliance report – assurance gained through the evidence-based report received associated with the policy and CQC requirements. • Quality report – report approved by SMC and QAC, to be published on Trust website by 30 June (completed). • Quality Assurance Committee annual report - approved and to be presented to the joint assurance committee in June (completed). • Internal audit progress report - finalised reviews; PSIRF (substantial assurance) and Risk Management (N/A assurance). PSIRF review - 1 medium and 3 low level recommendations; 3 recommendations have since been completed.
Advise	• Safeguarding vulnerable people annual report 2024/25 – request for future reports to include more assurance on the effectiveness of the process, activity and associated outcomes and impact. Revised safeguarding report to be presented to the committee at the September meeting.

The Christie
NHS Foundation Trust

Agenda Item 29/25a(iii)

Meeting of the Board of Directors
Thursday 25 September 2025

Subject / Title	Audit Committee report – June & July 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 June and July meetings, the June joint assurance committee meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions.
Background papers	Audit Committee papers – June & July 2025 Joint assurance committee papers – June 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 29/25a(iii)

Meeting of the Board of Directors
Thursday 25 September 2025

Audit Committee report – June & July 2025

1 Introduction

The Audit Committee took place on 25 June and 17 July 2025. The joint assurance committee took place on 25 June 2025. The meetings were 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 presented to the Audit Committee in June & July 2025. The items listed in Appendix 2 of the report were presented to the joint assurance committee in June 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 June & July 2025.

The Christie NHS Foundation Trust

Appendix 1 – Audit Committee

June meeting				
Agenda item	**BAF ref**	**CQC regulation reference**	**Assurance rating given**	**Key points and associated actions (where applicable)**
19/25a	4,5,6, 10	N/A	Strong	**Executive director of finance report**
Assure				• Report covered assurance on the finalisation of the annual report and accounts; changes to the audited accounts were highlighted. Accounts prepared on a going concern basis. Healthy cash balance noted. Outcome: total surplus £15m, operating income £543.2m, cash available £129.4m, total assets employed £545.1m. Reconciliation explanation provided to support £15m surplus. Committee accepted the annual accounts. • SFIs updated and amendments noted to the committee. • External auditors highlighted the excellent 'hot' review outcome from the external audit undertaken, no major points identified, highly assuring. • Assurance rating increased from high to strong.
Alert				• No alerts to raise.
Advise				• One redundancy payment of £8k during 2024/25 (no payments in 2023/24). • Losses and special payments for 2024-25 were £171k relating to 45 cases, these related mainly to write off of aged debtors (in 2023-24 there were £36k relating to 78 cases relating to mainly aged debtors).

July meeting				
Agenda item	**BAF ref**	**CQC regulation reference**	**Assurance rating given**	**Key points and associated actions (where applicable)**
25/25a	4, 8	N/A	Medium	**Deep Dive – BAF Risk 4: Digital/Cyber**
Assure				• Reasonable position noted for prevention and detection measures in place.
Alert				• Cyber executive dashboard; covers a number of different standards the Trust is required to comply with. Focuses on measures in place to defend against cyber-attacks, in development and will mature. Response and recovery noted as weak and working on addressing this.

Advise				• Work is progressing to ensure completion of BIAs across the 82 service areas; this is being tracked and monitored by the EPRR committee. • DSPT audit rated as 'approaching standards'. Action plan in place which has been submitted and accepted by NHSE.
Agenda item	**BAF ref**	**CQC regulation reference**	**Assurance rating given**	**Key points and associated actions (where applicable)**
25/25b	4	N/A	High	**The Christie Pharmacy Company (TCP) Six-Monthly Report**
Assure				• Finished the financial year with a surplus of £225K and a clean bill of health from the external auditor. • TCP Board has reduced its meetings to six a year. The operational group which sits below the board is now more robust and effective. TCP finance meetings take place monthly; a role being developed to support this. • Installation of the new robot dispensing system and inpatient dispensary refurbishment successfully completed. Dispensary error rate is below national threshold.
Alert				• Two adverse incidents in year; cold storage failure (£75K loss) and robot damage due to negligence (£33K); appropriate actions taken to prevent re-occurrence.
Advise				• TCP Board approved an improved company pension contribution, matching employee contributions up to a maximum of 8%; this was delivered within the existing budget agreed.
Actions				• Cyber risk to be reassessed. • Reporting to committee to move to a summary escalation format.
Agenda item	**BAF ref**	**CQC regulation reference**	**Assurance rating given**	**Key points and associated actions (where applicable)**
25/25d	4,5,6, 10	N/A	Strong	**Executive director of finance report**
Assure				• Collaborative procurement being implemented across GM to increase robustness and efficiency. Our Head of Procurement is on the implementation group. Comes into place from 1 April 2026. • Finance KPIs presented to the committee for feedback.

Alert	• 60 leavers received overpayments during 2024/25; no trends identified. Continuing with divisional engagement on leaver processes and trying to understand the reasonings through deep dives, will be performance managing against the outcomes.
Advise	• 18 losses and special payments totalling £3,369 (1 April 2025 to 30 June 2025); 16 bad debts write off aged debtor's invoices, £2,969 and two payments for loss of personal effects, £400.
Actions	• Consideration to be given to adding PO and non-PO split as a finance KPI.

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

June meeting	
Advise	• **Audit recommendations tracker and follow up procedure –** procedure developed for use in exceptional circumstances where deadline extensions to audit recommendations are required. Deadline extensions will require executive director approval and assurance committee acceptance before agreement confirmed. Approved extensions by other assurance committees will be seen through the full report to audit committee. Example tracker report provided. Procedure endorsed by the committee. Chairs of the quality and workforce assurance committees are to be advised of this procedure.
	• **Board assurance framework (BAF) 2024/25 -** last view of BAF for 2024/25, next version of BAF to Board in June. Cyber and extreme weather risks to be amalgamated into a service disruption risk. Risk 14 - statutory and legal compliance score reduced from 12 to 8 and to be redescribed for the new BAF. Risk 5 – impact of the system allocation framework, risk has been closed and is redescribed for 2025/26.

July meeting	
Alert	• **iQemo audit recommendations update** - several actions identified from the audit; slow progress to date with reasoning confirmed. 2 long-standing actions remain open; one unresolved for two years. Confirmation to be provided to the committee on the reasoning for the open action relating to the evidencing of regular checks. Confirmation also to be provided on lessons learnt in terms of procurement and performance oversight in relation to the action on lack of 24-hour support from suppliers.
Advise	• **Board assurance framework (BAF) 2025/26 -** BAF updated for 2025/26 with new and re-described risks; committee acknowledged.
Assure	• **Committee Terms of Reference** - reviewed and approved. • **Internal audit progress report** - DSPT review completed; no changes to audit plan; good performance noted. • **Internal audit follow up report Q1 -** 13 recommendations fully implemented, 16 partially implemented, 4 superseded and 7 not yet due

	for follow up (as at 30 June). • **Anti-fraud progress report** – new failure to prevent fraud offence guidance issued; webinars in place which can be attended. MIAA have also issued a briefing guidance which has been circulated to Audit Committee members. MIAA will be completing a gap analysis and putting on some webinars for Execs and NEDs. 5 new referrals so far this year, 1 converted to an investigation and 4 closed. 1 new investigation opened this year; now closed. • **Fraud, bribery and corruption staff survey report 2024/25** - similar result compared to last year, increase of 54% in terms of responses (from 322 to 466). MIAA will continue with comms and provide in person training where possible and also offer virtual training. Overall results were positive. • **2024/25 Assessment: Government Functional Standard GovS 013: Counter Fraud (NHS Requirements) -** the submission for the standard was completed by the required deadline. • **External audit progress update -** Debrief with finance team following completion of the audit to look at if any efficiencies can be gained for next year's audit, positive meeting. Audit recommendations will be followed up.

Appendix 2 – Joint assurance committee

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

Assure	• **Head of internal audit opinion (HOIA) and annual report 2024/25 (accepted at April 2025 Audit Committee) -** substantial assurance opinion noted as reported to Audit Committee in April, assurance rating feeds into the annual governance statement within the annual report and accounts. Committee accepted the audit opinion and annual report.
	• **Audit findings report (ISA260) and the Christie group opinion report 2024/25 -** Work resulted in a clean audit report with no significant findings, agreed action plan in place to be monitored through Audit Committee.
	• **Letter of representation** – approved by the committee for signature.
	• **Auditor's Annual Report 2024/25 -** No significant weaknesses identified, appropriate arrangements in place for each of the arrangements. Good positive report: the recommendations made within the report are for areas of improvement only.
	• **Committee annual reports –** the annual reports of the Audit, Quality and Workforce assurance committees were approved by the committee. Internal and external auditors noted the efficient and effective running of the committees with appropriate challenge.
	• **Annual governance statement (AGS) return –** confirmation of no significant concerns for reporting, approved by the committee.
	• **Annual report and accounts 2024/25 -** final version of the report presented for approval. Minor amendment to the research section noted to remove the reference to 'health' as part of statement to 'occupational health therapists'; this was completed prior to the meeting. The committee approved the report.

The Christie
NHS Foundation Trust

Agenda Item 29/25b

Board of Directors meeting
Thursday 25th September 2025

Subject / Title	Board Assurance Framework
Author(s)	Louise Westcott, Company Secretary
Presented by	Louise Westcott, Company Secretary
Summary / purpose of paper	This paper provides the Board with the 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 risks and mitigations on the Board Assurance Framework, • To assign a level of assurance to discussions in the meeting that relate to the risks.
Background papers	Board assurance framework. Strategic objectives 2025/26, operational plan and revenue and capital plan 2025/26.
Risk score	N/A
Link to: ➢ Trust strategy ➢ 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 29/25b

Board of Directors meeting
Thursday 25th September 2025

Board Assurance Framework

1 Introduction

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

2 Background

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

2 Updates to risks

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

Risk scores have also been updated to show the position at quarter 1 for all risks.

Following the receipt of Organisation of European Cancer Institutes reaccreditation in September 2025, it is recommended that Risk 11 is removed - *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.*

3 Recommendation

The Board are asked;

- To note the risks and controls on the Board Assurance Framework,
- To assign a level of assurance to discussions in the meeting that relate to the risks.

BOARD ASSURANCE FRAMEWORK - 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 6	**NHSE Financial Framework and support for growth**	If the changes in the NHSE financial framework do not maintain the level of income needed to support the planned growth in activity there is a risk that we will not be able to provide optimum care	Board of Directors	Cautious	16		16				4	16	**Reviewed Q2 25/26**
RISK 15	**Technological advancements**	If we do not keep pace with technological advancements, there is a risk that we will not provide the best possible experience to our patients and carers	Board of Directors	Cautious	20		12				4	12	**Reviewed 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		12				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		12				4	12	**Review Q2 25/26**
RISK 13	**Transformational capacity & capability**	If we do not develop transformational capacity & capability, there is a risk that we will not transform services to improve access and reduce health inequalities	Board of Directors	Cautious	20		12				8	12	**Reviewed Q2 25/26**
RISK 2	**Learning from patient safety incidents**	If we do not follow the Patient Safety Incident Response Framework (PSIRF) there is a risk that we will miss opportunities to learn lessons and improve patient safety leading to preventable patient harm	Quality Assurance Committee	Averse	15		9				4	12	**Reviewed Q1 25/26**
RISK 8	**Emergency event**	If there is a serious emergency event (pandemic/cyber-attack/extreme weather event etc) there is a risk of business disruption (increased staff absence, increased patient non-attendance and equipment malfunction) leading to delayed or cancelled care.	Audit Committee	Averse	20	12	10				5	10	**Reviewed Q4 24/25**
RISK 14	**Supply chain**	If there are disruptions to the supply of essential products and services for the treatment and care of our patients there is a risk of service disruption leading to delayed or cancelled care.	Audit Committee	Averse	12	12	12				3	9	**Review Q2 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				6	9	**Reviewed Q2 25/26**
RISK 12	**Staff engagement**	If we do not maintain levels of staff engagement there is a risk that turnover and sickness absence will increase leading to workforce shortages, poor staff experience and a deterioration in the quality of patient care.	Workforce Assurance Committee	Averse	16		8				4	8	**Review Q1 25/26**
RISK 9	**Integrated research, education & service**	If our research, education and clinical services do not operate as an integrated whole there is a risk that we will not secure the benefits of high-quality research and education on patient care and that this will lead to less-than-optimal quality of care.	Board of Directors	Averse	12	8	8				4	8	**Review Q2 25/26**
RISK 1	**New technologies and increased standards of care**	If there are changes to NICE guidance or other advances in practice that we have not anticipated (diagnostic, therapeutic, care) there is a risk that there will be a delay in their introduction leading to a delay in patients obtaining the benefits of new treatments.	Quality Assurance Committee	Cautious	20	6	6				4	6	**Within tolerance**
RISK 10	**Financial balance**	If we do not achieve the operational plan and our planned efficiency savings there is a risk that we won't achieve financial balance.	Board of Directors	Averse	25		5				5	5	**Reviewed Q1 25/26**
RISK 5	**Capital funding**	If we don't receive adequate CDEL there is a risk that we won't deliver the planned improvements resulting in delays in providing the best possible environment & equipment to provide care	Board of Directors	Eager	15		5				5	5	**Reviewed Q2 25/26 / 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	Cautious	12		4				2	2	**Achieved - risk to be removed**

RISK 1	**New technologies and increased standards of care**	Date Risk	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 Sep-25	6
Associated Strategic Objectives	To deliver safe, effective & equitable care	Executive Responsible Assurance Risk Appetite	Exec Medical Director **Quality Assurance** Medium Cautious

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date
Actions	Annual planning process with divisions. The trust has a risk-based process with divisional support to assess applicability and implement relevant guidance. Guidance that is not resolved or on the risk register is monitored and escalated if there are issues	Uncertainty around what / when. External factors	Level 1 – Data and management reports • Review of NICE guidelines through risk-based process with divisional support • risk register in place.□ Level 2 – Management team and committee scrutiny • Review NICE guidelines compliance through QAC and monthly IPQFR□ Level 3 – External assurances • NICE□	None identified	Forward views of upcoming NICE guidelines assessed	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	2	3	6			0			0			0	2	2	4

RISK 2	**Learning from patient safety incidents**	Date Risk	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 Sep-25	12
Associated Strategic Objectives	To deliver safe, effective & equitable care	Executive Responsible Assurance Risk Appetite	Exec Chief Nurse **Quality Assurance** Medium Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	The Trust has undertaken external training for the patient safety strategy covering all components of the patient safety strategy. The patient safety team have/ will continue to host training for incident handlers to ensure management of incidents across teams is standardised. Improvement workstreams have been established to implement recommendations following the publication of learning responses. Review through Patient Safety & Experience Committee and Risk & Quality Governance. Introduction of new DATIX system	New ways of working require new skills across the organisation and resource at a team level to manage incidents.	Level 1 – Data and management reports • PSIRF reports to Patient Safety Committee / Risk & Quality Governance / Senior Management Committee • ERG□ Level 2 – Management team and committee scrutiny • Review compliance through patient safety reports to QAC□ Level 3 – External assurances • MIAA review of PSIRF processes confirms substantial assurance • Updates presented to ICB	None identified	Further focus on involvement and quality improvement - Embed agreed Quality Improvement methodology across the Trust	Reviewed 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
	3	5	15	3	3	9			0			0			0	2	2	4

RISK 3	Recruitment and retention of skilled staff	Date Risk	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 Sep-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	Workforce Director
		Responsible	**Workforce Assurance**
		Assurance	High
		Risk Appetite	Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	Staffing levels maintained through coordinated and risk based utilisation of bank and agency Christie People and Culture Plan 2023-26 Quarterly oversight of Trust wide vacancies and recruitment activity presented to the workforce committee & WAC Divisional oversight of recruitment activity and vacancies discussed at the monthly service review meetings Turnover analysis and 'next chapter' data presented and discussed six monthly at the workforce committee Robust sickness absence management and health and wellbeing offer Connect & reflect sessions in place for new starters within first 3 months of employment Weekly executive led vacancy management panel in place Recruitment of onboarding coordinator Nursing workforce lead appointed	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 and update on compliance with CQC regulation • F&PP Compliance report to WAC / Board • Safe staffing 6 monthly reviews to external standard Level 3 – External assurances • National staff survey • CQC Inpatient survey • OECI accreditation	Actions outlined by MIAA in Nov 24 Divisional Recruitment audit	None identified	Reviewed 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	5	**20**	3	3	**9**			**0**			**0**			**0**	2	3	**6**

RISK 4	Compliance with regulatory standards	Date Risk	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 Sep-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	Exec Chief Nurse
		Responsible	**Board of Directors**
		Assurance	
		Risk Appetite	Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
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	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 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
	5	3	**15**	4	3	**12**			**0**			**0**			**0**	4	1	**4**

RISK 5	Capital funding	Date Risk	Current Risk Score
Description	**If we don't receive adequate CDEL there is a risk that we won't deliver the planned improvements resulting in delays in providing the best possible environment & equipment to provide care**	Jun-25 Date of Last Sep-25	5
Associated Strategic Objectives	To deliver excellent financial and operational performance	Executive Responsible	Exec Director of Finance **Board of Directors**
		Assurance	
		Risk Appetite	Eager

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
	Financial planning includes utilisation of 'capital freedoms' (CDEL) to increase the CDEL allocation to deliver our plan. Capital planning is part of our planning process and based on risk assessment within divisions.	National / local funding rules / arrangements.	Level 1 – Data and management reports • Monthly finance reports□ Level 2 – Management team and committee scrutiny • summary of progress with capital plan/strategy implementation at Board / Planning Days□ • Regular reporting to Senior Management Committee & Board of Directors□ Level 3 – External assurances • ICB allocation	None identified	Capital bids collated including level of risk, 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.	Reviewed Q2 25/26 / Within tolerance

Scoring	Inherent Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	3	5	15	1	5	5			0			0			0	1	5	5

RISK 6	NHSE Financial Framework and support for growth	Date Risk	Current Risk Score
Description	**If the changes in the NHSE financial framework do not maintain the level of income needed to support the planned growth in activity there is a risk that we will not be able to provide optimum care**	Jun-25 Date of Last Sep-25	16
Associated Strategic Objectives	To deliver excellent financial and operational performance	Executive Responsible	Exce Director of Finance **Board of Directors**
		Assurance	
		Risk Appetite	Cautious

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
	Senior team attendance at national and regional meetings to keep updated on policy changes and influence discussions on cancer. Monthly service & operational reviews to ensure efficient delivery of service. Board member attendance at national events to influence policy.	External political factors	Level 1 – Data and management reports • SOR's • Divisional Boards reports Level 2 – Management team and committee scrutiny • SMC reporting□ Level 3 – External assurances • External Audit VfM assessment	None identified	Continued attendance at regional & national events and on going discussions with ICB to understand funding	Reviewed Q2 25/26

Scoring	Inherent Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	4	16	4	4	16			0			0			0	1	4	4

RISK 7	Ineffective Greater Manchester system-wide cancer pathways	Date Risk	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 Sep-25	12
Associated Strategic Objectives	To deliver safe, effective & equitable care To deliver excellent financial and operational performance	Executive Responsible	Chief Operating Officer **Quality Assurance**
		Assurance	
		Risk Appetite	Cautious

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
	Executive led monthly divisional performance review meetings. Integrated performance & quality report to Management Board and Board of Directors monthly. 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	Inherent Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	5	25	4	3	12			0			0			0	4	2	8

RISK 8	Emergency event	Date Risk	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 Sep-25	**10**
Associated Strategic Objectives	To maintain excellent operational, quality and financial performance.	Executive Responsible Assurance Risk Appetite	Director of Strategy **Audit Committee** Medium Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	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) • MIAA Data Protection Toolkit assessment (DPST) - Substantial assurance July 2024	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

	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
Scoring	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	4	**20**	5	2	**10**			**0**			**0**			**0**	5	1	**5**

RISK 9	Integrated research, education & service	Date Risk	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 Sep-25	**8**
Associated Strategic Objectives	To provide integrated clinical, research and education services	Executive Responsible Assurance Risk Appetite	Chief Executive Officer **Board of Directors** Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	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□				Review Q2 25/26

	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
Scoring	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	3	4	**12**	2	4	**8**			**0**			**0**			**0**	1	4	**4**

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

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	Activity plans agreed with Divisions and progress monitored weekly at TOG and monthly at Senior Management Committee. Variable income performance tracked as part of month end financial position and reviewed in the clinical Divisions monthly financial meetings. Development of mitigating strategies including efficiency and transformational programmes. Identification and consideration of new models of working to deliver and finance the Trust's strategic plan. Agreed governance of VIP schemes and escalating VIP reporting and responsibility to SMC. VIP delivery at a divisional level monitored via the Trusts Service Operational Review framework Board has 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	Complete Quality Impact Assessments for all identified schemes	Reviewed Q1 25/26

	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
Scoring	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	5	**25**	1	5	**5**			**0**			**0**			**0**	1	5	**5**

RISK 11	**OECI accreditation**	Date Risk	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 Sep-25	**2**
Associated Strategic Objectives	To provide integrated clinical, research and education services	Executive	Board of Directors
		Responsible	**Board of Directors**
		Assurance	
		Risk Appetite	Cautious

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	OECI accreditation process complete. Final report received showing reaccreditation.	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 accreditation received	None identified		Achieved - risk to be removed

	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
Scoring	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	3	4	**12**	1	4	**4**			**0**			**0**			**0**	1	2	**2**

RISK 12	Staff engagement	Date Risk	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 Sep-25	**8**
Associated Strategic Objectives	To be an excellent place to work and attract the best staff	Executive Responsible	Director of Workforce **Workforce Assurance**
		Assurance	Medium
		Risk Appetite	Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	Inclusive Culture Strategy developed through extensive engagement with staff and approved by Board. Board responsibilities outlined. Service & Operational reviews include 'people & culture' focus for all divisions. Progress reports to WAC. Divisions report staff engagement activity / priorities to Workforce Committee on rolling programme Workforce Assurance committee recieve regular presentations from divisions on cultural activities.	None identified	Level 1 – Data and management reports • Divisional action plans from staff survey • Service & operational reviews Level 2 – Management team and committee scrutiny • Reporting to Workforce Committee, Workforce Assurance Committee and Board of Directors • Board development session on Inclusive Culture facilitated by NHS Providers expert Sept 2024 • Board approved Inclusive Culture Plan Nov 2024 Level 3 – External assurances • Annual CQC Staff Survey 2024	None identified	Implementation of next phase of Inclusive Culture Strategy Extension of People & Culture Plan	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
	4	4	**16**	2	4	**8**			**0**			**0**			**0**	2	2	**4**

RISK 13	Transformational capacity & capability	Date Risk	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 Sep-25	**12**
Associated Strategic Objectives	To transform our services to improve access and reduce health inequalities	Executive Responsible	Director of Future Christie **Board of Directors**
		Assurance	
		Risk Appetite	Cautious

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	Future Christie Director and Medical Director in place. Director of Transformation appointed. Service Planning day with senior leadership team. Communication plan with wider organisation commenced. Alignment of Digital & Transformation under Future Christie. Year 1 objectives on track for delivery - patient portal / expanded AI / EPR outline case / staff engagement	None identified	Level 1 – Data and management reports • Exec review weekly Level 2 – Management team and committee scrutiny • Monthly to SMC and Board Level 3 – External assurances • Deliotte engaged in options appraial for new EPR	External assessment of capability and readiness to be developed	Development of the EPR OBC. Expansion of patient portal adoption and compliance with NHS App standards. Progression of data preparedness for JAC and Intelligent Hospital. Broader evaluation of AI pilots and automation	Reviewed 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
	5	4	**20**	3	4	**12**			**0**			**0**			**0**	2	4	**8**

RISK 14	**Supply chain**	Date Risk	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 Sep-25	**9**
Associated Strategic Objectives	To deliver safe, effective & equitable care To deliver excellent financial and operational performance	Executive Responsible Assurance Risk Appetite	Chief Operating Officer **Audit Committee** Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
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 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**	4	3	**12**			**0**			**0**			**0**	3	1	**3**

RISK 15	**Technological advancements**	Date Risk	Current Risk Score
Description	**If we do not keep pace with technological advancements, there is a risk that we will not provide the best possible experience to our patients and carers**	Jun-25 Date of Last Sep-25	**12**
Associated Strategic Objectives	To transform our services to improve access and reduce health inequalities	Executive Responsible Assurance Risk Appetite	Director of Future Christie **Board of Directors** Cautious

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	Future Christie team leading service change ambitions incorporating technological advances with partners. Engaing with other health providers around effective systems on the market. Development of strategic outline case for new EPR	Recognition of fast moving market	Level 1 – Data and management reports • reports to Board of Directors Level 2 – Management team and committee scrutiny • Execs, SMC and Board reports Level 3 – External assurances • Deliotte engaged in options appraial for new EPR • OECI accreditation	Development of full business cases	Seeking expertise internally & externally around best option - 'expert customer'	Reviewed 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
	5	4	**20**	3	4	**12**			**0**			**0**			**0**	1	4	**4**

The Christie
NHS Foundation Trust

Agenda Item 29/25c

Meeting of the Board of Directors
Thursday 25th September 2025

Subject / Title	**Assessing provider capability – self-assessment**
Author(s)	Louise Westcott, Company Secretary
Presented by	Roger Spencer, Chief Executive Officer
Summary / purpose of paper	This paper outlines the new NHS England process for assessing provider capability through a self-assessment. The guidance also provides a template for the self-assessment that is divided into 6 sections. This self-assessment template is attached to the paper and provides evidence under each heading. The evidence outlined will be compiled alongside the table and submitted to NHSE by mid October
Recommendation(s)	The Board are asked to review the content of the self-assessment and approve this position for submission to NHS by the October deadline.
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.	

Meeting of the Board of Directors
Thursday 25th September 2025

Assessing provider capability – self-assessment

1. Introduction

NHSE has introduced a new requirement for boards to assess themselves against the six domains of The Insightful Board report.

The background to this is described in this paper together with a proposed initial assessment for submission to NHSE by the deadline of October 22nd 2025.

The proposed initial assessment is based on information reviewed by our governance system, including board subcommittees over the past 12 months. This includes the Annual Governance Statement and declarations of compliance with the provider licence.

The draft submission, confirming full compliance, is shown in the table in Section 4 of the report. Appendix 1 lists the sources of evidence available to support the assessment for each of the criteria.

Further iterations of the self-assessment will be incorporated into our standard governance process and annual reporting cycle. The board is asked to endorse this initial submission as compliant with the six domains

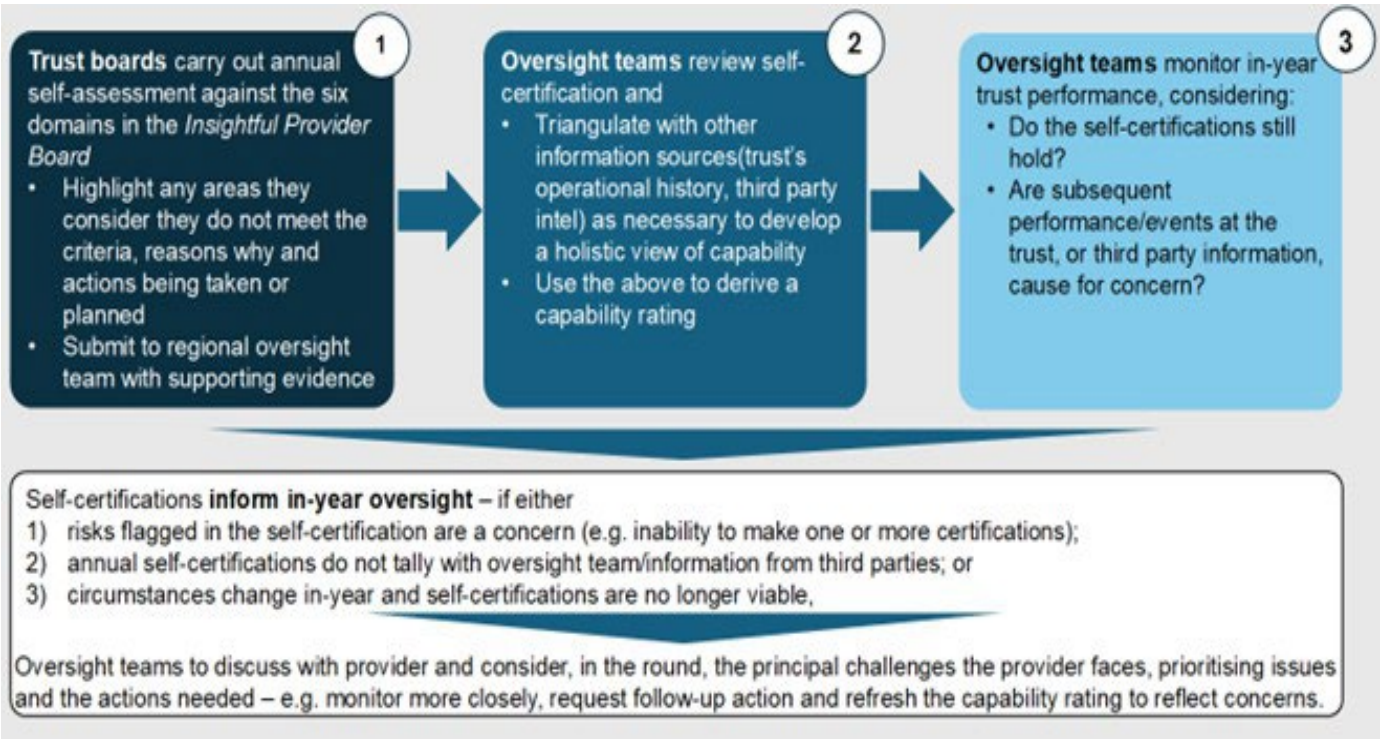
2 Background

NHSE communicated the requirement to submit a self-assessment on 22nd August 2025. As part of the NHS Oversight Framework (NOF), NHS England will assess NHS trusts' capability, using this assessment alongside providers' NOF segments to judge what actions or support are appropriate at each trust. As a key element of this, NHS boards are being asked to assess their organisation's capability against a range of expectations across 6 areas derived from The insightful Provider Board, namely:

- strategy, leadership and planning
- quality of care
- people and culture
- access and delivery of services
- productivity and value for money
- financial performance and oversight

These will inform a self-assessment which is intended to strengthen board assurance and help NHSE oversight teams take a view of NHS trust capability based on boards' awareness of the challenges their organisations face and subsequent actions to address them.

The purpose of this is to focus Boards' attention on a set of key expectations related to their core functions as well as encourage an open culture of 'no surprises' between trusts and oversight teams. NHS England regional teams will then use the assessment and evidence behind it, along with other information, to derive a view of the organisation's capability.



2 The NHS provider trust capability rating

Regional oversight teams will review the trust's submitted self-assessment and consider the statements and evidence. Using a range of considerations, including the historical track record of the trust, its recent regulatory history and any relevant third-party information, the oversight team will decide the trust's capability rating and share this with it, including the rationale for the rating. The ratings and their criteria are set out below;

Rating: Green

- High confidence in management.

Indicative criteria

- No concerns evident from the self-assessment or subsequent performance.
- No concerns arising from third-party information.
- High confidence in the trust's ability to deliver on its priorities based on track record over past 12–24 months.

Rating: Amber–green

- Some concerns or areas that need addressing.

Indicative criteria

- After discussion with the trust, some concerns emerging across more than 1 domain, but these as yet are not affecting quality of care, delivery of core services, finance or the wider reputation of the NHS.
- Trust has prepared plan(s) to address any problems with associated timeframe for delivery.
- Historical issues/track record mean NHS England does not (yet) have full confidence in the board.

Rating: Amber–red

- Material issue needs addressing or failure to address major issues over time.

Indicative criteria

- Issues with self-assessment or subsequent issues across multiple domains.
- Failure to deliver on agreed plans to address a material issue.
- Potentially in breach of licence.

Rating: Red

- Significant concerns arising from poor delivery, governance and other issues.

Indicative criteria

- Material or long-running concerns at the organisation that management has been unable to grip.
- NHS trust in breach of licence or likely to be.

3 Provider capability self-assessment

Board are asked to review the completed self-assessment template at appendix 1 that outlines key evidence against the six areas. In this assessment we are recommending that the Board can confirm that there are no issues that would need highlighting to NHSE in any of the areas.

The evidence relates to the assurance processes that are in place through our committee structure. Evidence relating to each of the 6 areas is reviewed and assessed through an assurance committee or by the Board. We also complete the Annual Governance Statement, self-assessment declarations around compliance with the NHS provider licence conditions, annual Board evaluations and have a comprehensive internal audit plan, external reviews by external auditors, CQC and NHSE.

In future, the intention is that this self-assessment will be done in line with the annual reporting timetable with submission in March. The template that we are required to complete and submitted is shown below.

Provider Capability - Self-Assessment Template

The Board is satisfied that…

Strategy, leadership and planning	• The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners • The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE • The board has the skills, capacity and experience to lead the organisation • The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	**Confirmed**
Quality of care	• Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients • Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	**Confirmed**
People and Culture	• Staff feedback is used to improve the quality of care provided by the trust • Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels • Staff can express concerns in an open and constructive environment	**Confirmed**
Access and delivery of services	• Plans are in place to improve performance against the relevant access and waiting times standards • The trust can identify and address inequalities in access/waiting times to NHS services across its patients • Appropriate population health targets have been agreed with the ICB	**Confirmed**
Productivity and value for money	• Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	**Confirmed**
Financial performance and oversight	• The trust has a robust financial governance framework and appropriate contract management arrangements • Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes • The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	**Confirmed**
	In addition, the board confirms that it has not received any relevant third-party information contradicting or undermining the information underpinning the disclosures above.	**Confirmed**

4 Recommendation

Board is asked to approve that it is satisfied that for each of the 6 areas we can confirm that there are no issues that need escalation to NHSE.

Appendix 1: Assessing provider capability – self-assessment

Self-assessment criteria	Indicative evidence or lines of enquiry	Evidence
Strategy, leadership & planning		
1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners.	• Are the trust's financial plans linked to and consistent with those of its commissioning integrated care board (ICB) or ICBs, in particular regarding capital expenditure? • Are the trust's digital plans linked to and consistent with those of local and national partners as necessary? • Do plans reflect and leverage the trust's distinct strengths and position in its local healthcare economy? • Are plans for transformation aligned to wider system strategy and responsive to key strategic priorities agreed at system level?	Signed commissioning contract with GM ICB Agreed financial plan / planning assumptions consistent with ICB. Capital expenditure considered within system arrangements. Yes - e.g. EPR business case, FDP involvement Operational plan includes patient portal (launched Sept 25) GM ambient voice technology business case submitted Part of GM governance for CIO's (chair meeting) Yes – part of solution to system performance (62 day / Faster Diagnostic Standard). Acute oncology provision, care closer to home, increase in trials, access to specialist care & treatment at Christie centres across GM & Cheshire Clinical haematology provision & improvements in performance & access Yes – plans respond to strategic priorities in Trust Provider Collaborative (TPC), Cancer Alliance & commissioning intentions Examples include new EPR / aseptics, acute oncology, merged cancer & diagnostic alliance

Self-assessment criteria	Indicative evidence or lines of enquiry	Evidence
2. The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHS England.	• Is the trust currently complying with the conditions of its licence? Is the trust meeting requirements placed on it by regulatory instruments – for example, discretionary requirements and statutory undertakings – or is it co-operating with the requirements of the national Performance Improvement Programme (PIP)?	Yes – self-assessments approved at Board. No additional requirements currently
3. The board has the skills, capacity and experience to lead the organisation.	• Are all board positions filled and, if not, are there plans in place to address vacancies? • What proportion of board members are in interim/acting roles? • Is an appropriate board succession plan in place? • Are there clear accountabilities and responsibilities for all areas of operations including quality, delivering access standards, operational planning and finance?	No vacancies on the Board No interim / acting roles on the Board Yes – discussed at Remuneration Committee Yes – clear accountabilities in place for all as outlined in job descriptions
4. The trust is working effectively and collaboratively with its system partners and NHS trust collaborative for the overall good of the system(s) and population served.	• Is the trust contributing to and benefiting from its NHS trust collaborative? • Does the board regularly meet system partners, and does it consider there is an open and transparent review of challenges across the system?	Yes – we host the Cancer Alliance / provide mutual aid across GM. Lead on joint projects and are an active member of the TPC. We lead on the aseptic project. Represented at key system meetings. Work on clinical haematology delivery across the region. Yes, individual director groups meet regularly, and we are represented in each. Meet with the TPC, specialised commissioning, the cancer alliance, other partners outside GM including NW ODN's, Isle of Man, CRUK, UoM, OECI, Federation of Specialist Hospitals, regular Provider Oversight Meeting

Self-assessment criteria	Indicative evidence or lines of enquiry	Evidence
	• Can the board evidence that it is making a positive impact on the wider system, not just the organisation itself – for example, in terms of sharing resources and supporting wider service reconfiguration and shifts to community care where appropriate and agreed?	(POM), MAHSC as method of driving research and transformation etc 62 day performance monitored and action plan to address delayed pathways – reported to Quality Assurance Committee. Christie network of centres provide care closer to home. Aseptic service, mutual aid. Reorganisation of outpatients, work with Clinical Haematology to deliver care at Tameside, Macclesfield and Leighton – discussions with Stockport ongoing. Bloods closer to home service in place across GM & Cheshire, SACT at Home, network of radiotherapy centres (Oldham, Salford & Macclesfield) and systemic anti-cancer therapy delivery across 16 sites in GM & Cheshire MDT for external non-GM patients Gateway C resource provides primary care with information on cancer – commissioned across the UK Centralising of services – procurement
Quality of Care		
5. Having had regard to relevant NHS England guidance (supported by Care Quality Commission	• The trust can demonstrate and assure itself that internal procedures: ○ ensure required standards are achieved (internal and external)	NOF assessment – elements monitored through IPQFR monthly at Senior Management Committee & Board

Self-assessment criteria	Indicative evidence or lines of enquiry	Evidence
information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	○ investigate and develop strategies to address substandard performance plan and manage continuous improvement identify, share and ensure delivery of best practice ○ identify and manage risks to quality of care • There is board-level engagement on improving quality of care across the organisation. • Board considers both quantitative and qualitative information, and directors regularly visit points of care to get views of staff and patients. Board assesses whether resources are being channeled effectively to provide care and whether packages of care can be better provided in the community. • Board looks at learning and insight from quality issues elsewhere in the NHS and can in good faith assure that its trust's internal governance arrangements are robust. • Board is satisfied that current staff training and appraisals regarding patient safety and quality foster a culture of continuous improvement.	Governance review undertaken and actions completed 2022. Established and tested Governance structure – 3 assurance committees. Rolling programmes include BAF risks and assurance around regulatory standards MIAA (internal audit) gap analysis undertaken on Insightful Board guidance and actions being implemented. System meetings on quality & effectiveness of services True for Us reviews on national reports – processed through assurance committees IPC meetings and GM wide improvement work & engagement Internal assessment / compilation of evidence for the well-led domain undertaken 2025. Excellence In Action programme across the Trust and described to Board. Quality Assurance Committee has responsibility for assurance around quality / quality improvement / PSIRF etc – feedback given to Board QAC rolling programme includes BAF risks relating to quality – ongoing review of internal audit plan to include external opinion on problem areas Board review compliance with quality standards (incl all NOF quality standards) through IPQFR at each meeting Regular Exec and NED visits (Board day) scheduled to clinical & non-clinical areas.

Self-assessment criteria	Indicative evidence or lines of enquiry	Evidence
		Patient story in person at each Board meeting alongside clinical presentations Mandatory training compliance reviewed by Board
6. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board.	• Does the board triangulate qualitative and quantitative information, including comparative benchmarks, to assure itself that it has a comprehensive picture of patient experience? • Does the board consider variation in experience for those with protected characteristics and patterns of actual and expected access from the trust's communities? • Is the board satisfied that it receives timely information on quality that is focused on the right matters? • Does the board consider volume and patterns of patient feedback, such as the Friends and Family Test or other real-time measures, and explore whether staff effectively respond to this? • How does the organisation involve service users in quality assessment and improvement and how is this reflected in governance? • Is the board satisfied it is equipped with the right skills and experience to oversee all elements of quality and address any concerns? • Is the board satisfied that the trust has a clear system to both receive complaints from patients and escalate serious and/or re- occurring complaints to the relevant executive decision-makers?	External feedback received through CQC inpatient survey and National Cancer Patient survey – last survey showed excellent scores comparatively. Friends & family / PALS results reported through IPQFR Health inequalities data considered by Board – Trust Strategy focused on care closer to home (for 20+ years) to provide easier access to care & treatment locally. Bloods closer to home in place Data reviewed around protected characteristics and 62 day performance and reported monthly in IPQFR Safety data reported monthly focused on risk Patient experience committee in place with patient representatives Patient experience work / feedback reported to each QAC Governors triangulate patient feedback through Talking to Patients initiative and report through Council of Governors Patients engaged in PLACE assessments Skill mix of Board assessed – includes exec & NED expertise on safety & quality

Self-assessment criteria	Indicative evidence or lines of enquiry	Evidence
		Robust complaints process in place – assessed by QAC, exec level sign off of every complaint response. Learning shared through Patient Experience Committee
People & culture		
7. Staff feedback is used to improve the quality of care provided by the trust.	• Does the board look at the diversity of its staff and staff experience survey data across different teams (including trainees) to identify where there is scope for improvement? • Can the board evidence action taken in response to staff feedback? • Does the board engage with staff forums to continually consider how care can be improved?	WRES & WDES data discussed through WAC. Trainee feedback from National Training survey – feedback and actions discussed through WAC (presented by divisions) WRES/WDES highlights substantial rise in racially minoritised staff engaging with education/development Active review of NETS/NTS and undergraduate experience indicators – ongoing improvement + action planning to support those in training with enhanced experience, supervision etc Staff survey results broken down by area and action plans developed by area / theme and reviewed through divisional boards and reported to SMC/Board. Latest results show very good feedback that has improved year on year for 3 years Workforce Assurance Committee in place that provides Board with assurance on staff risks / issues / feedback and progress Staff Network Groups in place with Exec sponsors – LGBTQ presentation September WAC

Self-assessment criteria	Indicative evidence or lines of enquiry	Evidence
		Divisions provide cultural updates based on staff engagement activity to WAC that includes improvements in care Board clinical presentations at every meeting highlighting advances in care and service developments Admin & clerical forum / Clinical Advisory Group / monthly Service & Operational Reviews / Joint Local Negotiating Committee / Chief Nurse & AHP Forum PLACE assessments and feedback – presented to Board Board planning days with senior leaders and patients / Strategic leaders forum Staff engagement events – finance / Future Christie Regular Grand Round
8. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels.	• Does the trust regularly review skills at all levels across the organisation? • Does the board see and, if necessary, act on levels of compliance with mandatory training?	Mandatory training monitored/managed locally and reported through governance structure to Workforce Assurance Committee Education team work closely with Workforce Team Training needs analysis undertaken Board review compliance through IPQFR at each meeting Dedicated Education Institute – focused on supporting internal staff development, student and trainee education and external education provision to wider cancer professional audience / system improvement through education

Self-assessment criteria	Indicative evidence or lines of enquiry	Evidence
9. Staff can express concerns in an open and constructive environment.	• Does the board engage effectively with information received via Freedom To Speak Up (FTSU) channels, using it to improve quality of care and staff experience? • Are all complaints treated as serious and do complex complaints receive senior oversight and attention, including executive level intervention when required? • Is there a clear and streamlined FTSU process for staff and are FTSU concerns visibly addressed, providing assurance to any others with similar concerns? • Is there a safe reporting culture throughout the organisation? • How does the board know? Is the trust an outlier on staff surveys across peers?	Board receives 6 monthly FTSU reports from the FTSU Guardian to understand issues / themes and actions taken to address Legal & regulatory quarterly report to Board with detail of employment tribunal cases and discussion on actions taken to support staff / address issues PSIRF – patient safety learning responses undertaken & documented Exec review weekly Employee Relations Oversight Group in place All complaint responses are reviewed / signed off by Executive Chief Nurse and CEO Established FTSU process clearly communicated across the organisation – up to date policy in place. Feedback from Staff Survey on FTSU – improved our position in latest results Staff survey feedback shared with Board including local benchmarking and cancer specialist Trust benchmarking
Access & delivery of services		
10. Plans are in place to improve performance against the relevant access and waiting times standards.	• Is the trust meeting those national standards in the NHS planning guidance that are relevant to it? If not, is the trust taking all possible steps towards meeting them, involving system partners as necessary? • Where waiting time standards are not being met or	Trust meets national standards 62 days - work across the system and with Manchester Cancer to tackle delays Full plan in place to achieve year-end ambition & reported to SMC monthly Deep dive on 62 days 6 monthly

Self-assessment criteria	Indicative evidence or lines of enquiry	Evidence
	will not be met in the financial year, is the board aware of the factors behind this? • Is there a plan to deliver improvement?	
11. The trust can identify and address inequalities in access/waiting times to NHS services across its patients.	• The board can track and minimise any unwarranted variations in access to and delivery of services across the trust's patients/population and plans to address variation are in place.	Variation in access has been addressed through the Trusts strategy of care closer to home and opening of radiotherapy centres in sites around GM SACT delivered in 16 locations across GM & Cheshire Provide national specialist services Bloods closer to home Track DNA's per clinic Monitor access (62 days breaches) by protected characteristics and report to Board
12. Appropriate population health targets have been agreed with the integrated care board.	• Is there a clear link between specific population health measures and the internal operations of the trust? • Do teams across the trust understand how their work is improving the wider health and wellbeing of people across the system?	We are a tertiary referral centre and take patients primarily from across GM & Cheshire as well as nationally. Host Cancer Alliance – work on Lung Health Checks / screening programmes Smoking cessation service for all patients Prehabilitation / Supportive Care Anchor organisation work EHIA
Productivity & value for money		

Self-assessment criteria	Indicative evidence or lines of enquiry	Evidence

13. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant.	• Board uses all available and relevant benchmarking data, as updated from time to time by NHS England, to:
	  ○ review its performance against peers
	  ○ identify and understand any unwarranted variations
	  ○ put programmes in place to reduce unwarranted negative variation.
	• The trust's track record of delivery of planned productivity rates.
		Benchmarking data shared with executive team and Board at development sessions / in Board papers
		Performance is good compared to comparative
		Realigned our performance management to align to Insightful Board
		IPQFR reflects Model Hospital
		Quarterly reports on Model Health & GIRFT in development
		VIP reported at every Board meeting
		OECI accreditation received 2025

Financial performance & oversight		
14. The trust has a robust financial governance framework and appropriate contract management arrangements.	• Trust has a work programme of sufficient breadth and depth for internal audit in relation to financial systems and processes, and to ensure the reliability of performance data. • Have there been any contract disputes over the past 12 months and, if so, have these been addressed? • [Potentially more appropriate for acute trusts] Are the trust's staffing and financial systems aligned and show a consistent story regarding operational costs and activity carried out? Has the trust had to rely on more agency/bank staff than planned?	MIAA assurance on financial management Internal audit plan agreed – covers finance, quality, digital External audit – clean audit 2024/25 No contract disputes in last 12 months Health Roster in place. The alignment of ESR & integra is an area of focus with the aim to complete by end of the financial year Trust has recruitment plans that are being accelerated to reduce the bank / agency

Self-assessment criteria	Indicative evidence or lines of enquiry	Evidence
15. Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes.	• Does the board stress-test the impact of financial efficiency plans on resources available to underpin quality of care? • Are there sufficient safeguards in place to monitor the impact of financial efficiency plans on, for example, quality of care, access and staff wellbeing? • Does the board track performance against planned surplus/deficit and where performance is lagging it understands the underlying drivers?	Oversight of Quality impact assessments undertaken on rolling programme for QAC EHIA's look at workforce VIP planning programme closely monitored and reported to Board at each meeting Finance reports to each Board
16. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn.	• Is the board contributing to system-wide discussions on allocation of resources? • Does the trust's financial plan align with those of its partner organisations and the joint forward plan for the system? Would system partners agree the trust is doing all it can to balance its local/organisational priorities with system priorities for the overall benefit of the wider population and the local NHS?	Yes – regular meetings in place Yes

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Agenda item 29/25d

Meeting of the Board of Directors

Thursday 25th September 2025

Subject / Title	Winter Planning 2025/26 Board Assurance Statement (BAS)
Author(s)	Jo Leece – AD Value Improvement Programme Claire McPeake – Chief Operating Officer
Presented by	Claire McPeake – Chief Operating Officer
Summary / purpose of paper (alert / advise / **assure**)	To seek approval from the Quality Assurance Committee for the Board Assurance Statement (BAS) for Winter Planning 2025/26 prior to submission to NHS England by 30 September 2025.
Recommendation(s)	The Board is asked to approve the sign-off of the Board Assurance Statement (BAS) for submission to NHS England by 30 September 2025.
Background papers / source of assurance	• Data • Risks and mitigation
Risk score / BAF reference	BAF risk 8
EDI impact/considerations	EDI impact has been considered
Link to: ➢ Trust strategy ➢ Corporate objectives ➢ CQC Quality standard ➢ Regulation	Links to assurance of regulatory standards
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.	BAS – Board Assurance Statement IPC – Infection, Prevention and Control PPE - Personal Protective Equipment

Agenda item 29/25d

Meeting of the Board of Directors

Thursday 25th September 2025

Winter Planning 2025/26 Board Assurance Statement (BAS)

1. Background

The purpose of the BAS is to ensure the Trust's Board of Directors has oversight that all key considerations in relation to winter planning have been met. The Trust's BAS is required to be submitted to NHS England by 30 September 2025.

2. Process followed for winter plan development

The Trust has developed a comprehensive winter plan for 2025/26 with full input from system partners. The following processes have been completed:

- A Quality and Equality Impact Assessment has been undertaken and reviewed.
- The plan has been tested in a regionally led winter exercise, with lessons learned incorporated.
- Capacity, demand modelling, rotas, and discharge processes have been reviewed to ensure resilience.
- Elective and cancer care plans have been phased to provide operational headroom.
- IPC, PPE, and escalation arrangements are in place.
- Leadership and on-call arrangements have been strengthened.
- Risks to quality and performance have been reviewed with appropriate mitigations identified.

3. Alert / Advise / Assure considerations

Alert

- The Winter Planning 2025/26 Board Assurance Statement (BAS) must be completed, signed by both the CEO and Chair and submitted by 30 September 2025 to the national Urgent and Emergency Care team. Timely completion and sign-off are critical to ensure compliance with national requirements.

Advise

- The BAS includes two key sections:
  - Section A: Describes the Trust's approach to winter planning and its integration with wider strategic planning.
  - Section B: A checklist for Boards to confirm all essential elements are addressed in the 2025/26 Winter Plan.
- Management Approach: the Trust has completed the BAS through coordinated input from planning leads and divisional teams, with oversight from the executive team.

Assure

- A structured process is in place to ensure all checklist items are addressed. Planning is aligned with national guidance and local operational priorities.
- Profile indicates The Christie is a low-risk organisation in terms of the impact of winter.
- Trust escalation plan supports seasonal plan and management of capacity and escalation capacity.

4. Recommendation

The Board of Directors are asked to approve the sign-off of the Board Assurance Statement (BAS) for submission to NHS England by 30 September 2025.

Winter Planning 25/26

Board Assurance Statement (BAS)

NHS Trust

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Provider:	The Christie NHS FT

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.	Yes	
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	AO – Claire McPeake Chief Operating Officer
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	Yes	
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.	NA	

Provider CEO name	Date	Provider Chair name	Date

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Yes	• Staff 25-26 vaccination programme for flu in place (doesn't include covid). • Monthly meetings taking place with relevant stakeholders • Logistics: Vaccinations ordered, identified location. • In the process of identifying and retraining flu champions and booking process. • The vaccination programme will launch first week of October 25 with associated comms and marketing.
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	Yes	• Profile indicates The Christie is a low risk organisation in terms of the impact of winter. Trust escalation plan supports seasonal plan and management of capacity and escalation capacity. • Bed modelling is being updated with benefits from initiatives to reduce patients time away from home. • Escalation plans are in place to manage surges in demand throughout the year.

3.	Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Yes	The review of all rotas is a dynamic process with structures in place to be reactive to changes either in acuity or staffing availability
4.	Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	Yes	Process for proactive management of length of stay and discharge in place. Liaison with social care and community providers.
5.	Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	Capacity and demand for elective and cancer delivery is modelled in line with seasonal variation in line with referral patterns from secondary care
Infection Prevention and Control (IPC)			
6.	IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Yes	Seasonal winter virus policy is in place, winter vaccination programme is in place, IPC improvement plan, will carry on usual surveillance via ward managers meetings and IPC team walk around. SLA being reviewed with laboratory services.
7.	Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	Yes	Fit testing is taking place and is part of the IPC improvement plan. Individual data is recorded on the ESR, however ESR doesn't provide the percentage compliance for the Trust. Local records are held. PPE stock is available.
8.	A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	Yes	Outbreak Policy has recently been reviewed by the EPRR committee to enact patient cohorting plan if required.
Leadership			
9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	A robust on call system is in place and staff receive Trust specific training before being placed on the rota with the EPRR lead

10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	No	The OPEL framework is not applicable as a tertiary organisation with no accident and emergency provision. We have an internal escalation process that mirrors the OPEL framework to manage increases in demand or acuity
Specific actions for Mental Health Trusts			
11.	A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	NA	
12.	Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	NA	