The Christie
NHS Foundation Trust

Board of Directors meeting
Thursday 29 January 2026 at 2.00pm
Trust meeting room

Agenda

Patient story / clinical presentation: Greater Manchester Aseptic project / CRF trials – Ev Dolan, Assoc Chief Nurse R&I / Dr Fiona Thistlethwaite, Director CRF / patient / John Wareing, Director of Strategy

30 mins

	Public items	**Decision**		**Lead**	**Page**	**Timing**
01/26	**Standard business**					
a	Apologies			Chair		
b	Declarations of interest			Chair		
c	Minutes of previous meeting – 27 November 2025	Approve	*	Chair	2	5 mins
d	Action plan rolling programme, action log & matters arising	Review	*	CEO	9	
02/26	**Performance & finance**					
a	Trust report	Review	*	Execs	12	5 mins
b	Integrated performance quality & finance report	Review	*	COO	18	5 mins
c	Value Improvement Programme update	Review	*	COO	63	10 mins
e	Review of annual objectives	Review	*	CEO	71	5 mins
03/26	**Planning**					
a	Future Christie update	Review	*	DFC	78	10 mins
b	Financial & operational planning	Delegate authority	*	EDoF	83	5 mins
04/26	**Governance (regulatory / statutory compliance)**					
a	Reports from committees (November 2026 meetings)					
	• Workforce Assurance Committee	Review	*	Committee chair	85	10 mins
	• Quality Assurance Committee				88	
	• Senior Management Committee				91	
b	Board assurance framework	Review	*	CEO	95	5 mins
05/26	**Any other business**					
	For information					
	Reflections on the meeting					
	Date and time of the next meeting					
	Thursday 26th March 2026 at 2:00pm					

D/CEO	Deputy / Chief Executive Officer
DFC	Director of Future Christie
COO	Chief Operating Officer
DoE	Director of Education

*	paper attached
v	verbal
p	presentation

The Christie
NHS Foundation Trust

Public meeting of the Board of Directors
Thursday 27th November 2025 at 12.45 pm
Trust Meeting Room

Present:	Chair:	Prof Joe Rafferty (JR), Chair Roger Spencer (RS), Chief Executive Officer Tarun Kapur (TK), Non-Executive Director 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 Amanda Oates (AO), Non-Executive Director Marisa Logan-Ward (MLW), Non-Executive Director Sarah Corcoran (SC), Non-Executive Director Prof Chris Harrison (CJH), Executive Director / Deputy CEO Claire McPeake (CM), Chief Operating Officer Vicky Sharples (VS), Chief Nurse and Executive Director of Quality Sally Parkinson (SP), Executive Director of Finance Dr Neil Bayman (NB), Executive Medical Director Eve Lightfoot (EL), Director of Workforce John Wareing (JW), Director of Strategy Prof Adrian Bloor (AB), interim Director of Future Christie Prof Fiona Blackhall (FB), Director of Research Prof Rikki Goddard-Fuller (RGF), Director of Education Jeanette Livings (JL), Deputy Director of Communications
Minutes:		Louise Westcott (LW), Company Secretary
In attendance:		Jo D'Arcy (JD), Assistant Company Secretary

Clinical presentation: The Christie Breast Cancer Service, Dr Caroline Wilson & Dr Alexandra Lewis, Acute Oncology & Breast Medical Oncology consultants, Dr Carmel Anandadas, Clinical Oncologist, Suzanne Frank Specialist Breast Cancer Pharmacist and Joanne, a patient

AL noted that she works from Christie @ Macclesfield. She described the way the Breast service is structured and what it involves and is made up of. The multidisciplinary team were described, including consultants, nurses, trainees, pharmacists & administrators.

Joanne described her experience as a patient. She found a lump, was diagnosed and was referred to Macclesfield. The tumour was aggressive, so the team advised chemotherapy first followed by surgery and radiotherapy. The plan was clear and there were people to talk to. Joanne described Macclesfield being very convenient as she lives in Buxton. She met the same nurses every time she came to site, the unit is small and so that was very important in terms of making it less scary. She stressed the importance of physiotherapy to help prepare her for radiotherapy post-surgery – that was particularly helpful. Radiotherapy starts in December and Joanne will then take Herceptin and bisphosphonates.

CW thanked Joanne and stressed the importance of the other centres for patients. CW described the HER-2 SACT service – this has been lifted out of the service to provide for this group of patients with a streamlined service. Every patient has their treatment designed by CW and all their related support is done by the team and controlled by the service. The service is protocolised which standardises treatment and allows for less consultant time – chemo nurses can follow the protocols, letters are also standardised. Breast surgeons are doing all on treatment imaging. Feedback from patients is being requested through a questionnaire. Initial feedback has been very positive. Audits of the service show good efficacy and comparable patient flow – streaming more patients through treatment with fewer consultants.

200 patients through the service so far, dedicated admin for the service. The service is expanding to new areas.

AL described the current activity, with a pressure on the service due to increased survival and lots of new treatments coming online. Recruitment is difficult at consultant level and the workforce must be adapted to respond to this.

The complexity of breast cancer treatment pathways was illustrated with contact with multiple teams, surgical, radiotherapy and SACT.

Innovations were described including protocolised pathways to reduce appointments, use of patient feedback (ePROMs) and standard administrative letters. Specialised regional virtual clinics were described as well as the use of pathway coordinators and good patient information at all steps. The team noted that there is a gap with an early breast cancer nursing service.

The Breast Pathway Navigator project was described to improve clinical productivity. Looking at equity of access and sharing workload across all consultants. The coordinators are arranging genomic testing and patient questionnaires to support decisions on treatment. They check in with patients after 6 months to ensure ongoing support is going well.

The early breast cancer pathway described from referral to treatment to discharge and follow up.

SF described the approval of adjuvant abemaciclib by NICE in July 2022. This has a huge impact on additional support to patients for an extra 2 years after discharge. There are toxicities that need to be monitored. Arranging the service has taken 2 years because of the extent of the requirement. We now have dedicated teams – phlebotomy, pharmacy, administrators, and the digital team. Much of the follow up is done over the phone and through ePROMs. Patients are seen face to face initially and when they need to be, dependant on their toxicities etc. Work has been done to work out whether patients need a phone call or can receive a text & prescription based on their ePROMs forms. Team are being used appropriately to see the patients that most need them. The service has been cited as an exemplar, and the clinic model has been taken internationally. There is a very high level of patient satisfaction. The service is delivered equitably across the whole region.

A further drug has now been approved called adjuvant ribiociclib – this is a 3-year treatment course requiring an ECG at the start and in the first month and is suitable for a wider group of patients. The service is being designed currently to address this new therapy.

The joint breast / endocrine clinic was described that supports women on follow up treatment that can have major impact on patients in the longer term. 10 GP's have been employed to further support patients.

The SACT sustainability plan was described.

The radiotherapy service was described and the issues that were facing the standard of care. We now have state of the art equipment and techniques. We are recruiting to all breast cancer trials and they can be delivered close to home in our various centres. The workforce is a limiting factor and this is developing. Audit data is very good, fractionation rates are low, and the machines are the best. We have excellent techniques for DIBH and there are advanced planning capabilities, we are pioneering and establishing the breast proton service. We are open to every breast radiotherapy trial in the country, the technique is being spread across the world because of our work. An ACP has been trained, and a PhD student has gone through the service. This is all happening with a 40% increase in demand.

Future aspirations were described, such as the migration to AI planning which is better for patients but takes longer. Plans will become more complex as advice on reduction in surgery and increase in radiotherapy is recommended.

Major technical developments have been delivered in the last 5 years, and there is a resource gap. The complexity and numbers are increasing and ongoing investment is key to maintain momentum and sustainability.

NB thanked the team for the excellent description of the service we deliver. What the breast team are doing is innovative and delivered alongside huge pressures in demand and drug approvals – the number of patients impacted in this service is huge and its extremely hard to keep up. This is truly delivering the best care closer to home, using virtual appointments – this is neighbourhood oncology being delivered now.

GP asked about the psychological support provided by The Christie and what other services are relied upon. Joanne felt this support came from the nurses as well as Macmillan and Maggie's. She also got support from other patients that she met while having treatment. The nurses responded to questions and concerns when they came up. The gaps in support are mitigated through talks prior to treatment, patient information etc. We also have a psych-oncology service.

JR thanked the team for their presentation and the infectious enthusiasm for improvement and excellence.

DT commented on the huge job of coordination required to deliver this service.

RS noted the lack of expertise in the wider system for breast cancer. The workforce issues are significant.

The leadership of the team has changed which has driven this significant development in the service.

Discussion took place on our place in the workforce problems and how we can support a pipeline of clinicians. NB noted the good practice we have in areas such as radiology. RGF described the increased focus on flexibility in the training of the future. NB described the recognition of MAHSC chair posts.

Item		Action
37/25	**Standard business**	
A	**Apologies**	
	Tom Thornber, Director of Future Christie	
b	**Declarations of Interest**	
	No declarations made relating to the items on the agenda	
c	**Minutes of the previous meeting – 23rd October 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.	
38/25	**Performance & Finance**	
a	**Trust Report**	
	• There are no adverse variances against objectives at month 7 and we are on plan for performance requirements. • We are a positive outlier regionally and nationally both financially and in respect to the national standards. • We have had notification from the CQC of an IR(ME)R inspection, the last one was 2 years ago. • The ICB has stood down the oversight arrangements with us. The ICB are in a deteriorating financial position. • Research set up times were discussed. We have a 60-day internal target to meet the overall 150-day national set-up target. This is a new requirement. Sponsors	

	could take up to a year previously. We are benchmarking and currently about 30% of studies meet 60 days, digital systems and staff are being put in to get to an aspiration of 80%. Capacity is being addressed across the Trust to deliver this. • Further information will come to future Boards. Escalations are coming nationally, associated with research finances. • The specified committee for overall operational & financial issues will be amended to the most senior committee which is the Board of Directors. • The IR(ME)R inspection does not have a direct relationship to our overall CQC rating. There is a self-assessment process followed by a visit. This is part of our overall safety assessment. Report noted	LW
b	**Integrated performance quality & finance report**	
	• CM outlined the report that aligns to the NHS Oversight Framework. • The executive summary notes the exceptions and what we are doing. • CM thanked colleagues for their feedback on the report through a session with the NEDs. • The report shows a high reporting, low harm culture. • We are delivering a surplus plan, and our capital spend is slightly over plan which is intentional. • Cancer pathway performance exceeds the standards alongside growth in demand. Haematology activity has been integrated, and we are delivering the faster diagnostic standard. • VTE assessment has been under the target, this has been looked at in QAC with a detailed report there. Further detail is coming back to that committee. • Cancer waits have also been discussed in depth at QAC. • Vacancy rate remains a focus, and this is looked at through the WAC. • There was discussion on the risk relating to unintended blood products. Mitigations are in place and the score has been continuously reviewed and has fluctuated. The aim is to put in a digital fix that may take up to 2 years to deliver. The R&QG committee are reviewing this and the effectiveness of the mitigations at their next meeting.	
c	**Value Improvement Programme update**	
	• Paper shows the monthly update. • Delivered for 2025/26 and are now working on 2026/27. We are required to produce a submission in December and are working to a rolling programme of VIP rather than in year. • A self-assessment has been undertaken against the NHSE grip & control checklist (HFMA good practice). This enables Trusts to provide assurance. 70% assessed as green and 2% as red. We are scored overall at 98% compliance. • The areas assessed as red are around a non-clinical recruitment freeze and a 6-facet estate survey. • We are ensuring that we have evidence against the self-assessment. • PwC insisted on a grip & control assessment 2 years ago that came through the Audit Committee. Query as to whether this should come through Audit Committee. Agreed that this will be added to the rolling programme.	LW/JD

	• Breakdown of VIP shows non-recurrent achievement, discussion around whether this is a problem. We will always rely on some non-recurrent VIP with good grip & control. The risks relating to non-recurrent are less for us than in other organisations. • Most other organisations have a freeze on non-clinical staff. We will not be doing this. The Board noted: • Plans for 2026/27 VIP	
39/25	**Planning**	
a	**Future Christie update**	
	• AB presented the Future Christie update which is a transformation platform built around the patient, clinician and whole hospital. • Our International advisory panel had a presentation from MD Anderson. They spoke about their use of data and analytics. They have been doing this since 2019 and we can learn from the successes they have had. We would like to invite them to speak to Board in the future. • We are getting an external view on what good looks like. We are at the foundation stages of this work. • Ambient Voice Technology (AVT) is going forward, we have some work to do on governance to ensure we do this right. There's a lot of clinical support for this. • Electronic Patient Record (EPR), the process to move to an outline business case (OBC) is going well. Lots of workshops are taking place across the organisation and engagement is very high. • Board will see more on EPR in between now and February when the OBC will come to Board. Progress is going well. • AM noted that its great to get advice from those who have already done things and asked about management of the risks. • AB noted that we will be looking at this help around our data strategy and how we progress. We will look at the assurance routes for this that address risk. • There was comment about the EDI impact that needs careful consideration. It was noted that we will look at detailed assessments of each element of the programme as we introduce new things. • Discussion took place on the impacts on EDI, both positive and negative. • Timelines for approval of the posts described are realistic and the process of approval internally is progressing. • We must be very aware of the procurement challenge around EPR, and we are taking the best advice on this to ensure we are doing everything right. We anticipate there may still be some challenge. • The programmes of work have the impact on our workforce / culture at the forefront of our thought, we are engaging with staff and will look at the baseline situation to enable us to compare impact as the EPR project progresses. This will come through WAC. • We know the EPR impact will inevitably cause a dip in staff satisfaction – we are focused on digital education and change management support. • There was challenge & discussion around how we make sure we get the best value from consultants on the assessments they undertake that have already	

	been done in other organisations. • We must be very clear about what we need, and we must also have an external view. We must be aware of what we can do internally and what we cannot. The timing and context of doing some of the big things like EPR must also be considered by Board.	
40/25	**Governance (regulatory / statutory compliance)**	
a	**Reports from Committees (October 2025)**	
i	**Audit Committee**	
	GP noted the report in the papers – this was reported verbally at the last meeting. EPRR and Sustainability reports were received and assurance received on progress.	
ii	**Senior Management Committee**	
	RS noted the most recent report that shows progress of items through the committee structure to Board and the assurance committees. No items to escalate.	
b	**Board Assurance Framework**	
	• BAF has been updated to show the current position against the strategic risks. • Changes to the risk scores are outlined in the cover paper with explanations. • The NICE approval risk score relates to the Breast service that was discussed in the earlier presentation. This is anticipated to reduce in the coming months. • The ribociclib service is now available for breast patients – the unanticipated element is the existing patients that need to be accommodated. Complete implementation is underway, and the operational risk score will be reduced. This increased risk score reflects our ability to be agile and implement NICE recommendations with these unanticipated consequences. • The score relating to VIP refers to 2026/27. • It was noted that the 2025/26 VIP risk achieved its target score and was superseded by the risk for the following financial year. This has been noted in previous Board meetings.	
c	**Advanced Foundation Trust authorisation**	
	• JW presented the paper that describes the new programme for advanced foundation trusts (AFT). • The guidance also includes reference to establishing Integrated Health Organisation's and only AFTs can establish an IHO. • We are pursuing the opportunity to apply for reapplication as an AFT. • The guidance is out for consultation, we will prepare for reapplication in the meantime. • The Board will have more discussion on developing plans at Board Planning days including on Friday 5th December. • RDS asked about why the 8 initial Trusts have been identified for the AFT Programme. The Regional offices have chosen these organisations initially. • Guidance suggests the qualification requirements. • Discussions are ongoing with others in the system around this.	

	• This will help support the future ambitions of the organisation.	
	Reflections of the meeting	
	The presentation was excellent. Good meeting with lots of discussion and challenge.	
41/25	**Any other business**	
	• TK's last meeting, thanks extended to him for his ongoing support and wisdom over the last 9 years. TK thanked the Board for his time at The Christie and for the support of the team.	
	For information	
	Christie Higher Education Institution (HEI) project update	
	Noted.	
	Date and time of the next meeting	
	Thursday 29th January 2025 at 12:45pm	

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Agenda item 01/26d

Meeting of the Board of Directors - 29 January 2026
Action plan rolling programme after November 2025 meeting

C Culture P Performance S Strategy G Governance

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
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	02/26e
	Annual reporting cycle	P	Integrated performance report	COO	Monthly report	02/26b
		S	Future Christie update	DFC	Review	03/26a
		P	Value Improvement Programme	COO	Review	02/26c
	Planning session		Board planning	Chair	Planning cycle - 16th January	N/A
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 - 5 year plan approval	Chair	Board Development programme	N/A
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	
		G	National Job Matching Profiles for Nursing and Midwifery	DoW	Review	
	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		
	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 2025-26 annual review	ECN	Annual Review	
May 2026 - no meeting Planning & Development Day	Annual reporting cycle	P	Integrated performance & quality and finance report	COO	Monthly report	By email
	Planning session	S	Planning			

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
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	Planning session	S	Service Review day with senior leadership teams			
August 2026 - no meeting		P	Integrated performance & quality and finance report	COO	Monthly report	By email
September 2026		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance & quality and finance report	COO	Monthly report	
		P	Value Improvement Programme	COO	Review	
		S	Future Christie update	DFC	Review	
October 2026		C	Patient story	CEO	To hear a patient story	Board presentation
		P	Integrated performance & quality and finance report	COO	Monthly report	
		P	Value Improvement Programme	COO	Review	
		S	Future Christie update	DFC	Review	
		P	EPRR Compliance statement	COO	Approve	
		G	Regulatory preparedness update	ECN	Review	
		C	Freedom to speak up guardian	FTSUG	Annual report	
	Planning & Development Day	S	Board Planning & Development	Chair	Board development programme - externally facilitated	N/A
November 2026		C	Patient story	CEO	To hear a patient story	
	Annual reporting cycle	P	Integrated performance & quality and finance report	COO	Monthly report	
		S	Strategy update	DoS	Six month review	
		P	Value Improvement Programme	COO	Review	
		S	Future Christie update	DFC	Review	
		S	Higher Education Institute update	DoE	Note	
		S	Annual Sustainabiltiy Report - Boards responsibility for Carbon Net Zero	DCEO	Note approval by Audit Committee	
December 2026 - no Board meeting		P	Integrated performance & quality and finance report	COO	Monthly report	By email
	Planning & Development / Council	S	Board planning			
		S	Council / Board - strategy update			

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Agenda item: 01/26d

Action log following the Board of Directors meetings held on

Thursday 27 November 2025

No.	Agenda	Action	By who	Progress	Board review
1	38/25c	Review of VIP self-assessment against NHSE grip & control checklist to be added to Audit Committee rolling programme for February.	LW	Complete	N/A

Meeting of the Board of Directors

Thursday 29th January 2026

Subject / Title	Trust report
Author(s)	Executive Directors
Presented by	Roger Spencer, Chief Executive
Summary / purpose of paper	This report brings together the key issues for the Board of Directors in relation to our performance, strategy, workforce, the Greater Manchester system landscape, the regulatory landscape and other pertinent matters within the scope of the board's responsibilities.
Recommendation(s)	The board is asked to review the contents of the paper.
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** ➢ **Strategic Objectives**	1. To deliver safe, effective & equitable care 2. To deliver excellent financial and operational performance 3. To provide integrated clinical, research and education services 4. To be an excellent place to work and attract the best staff 5. To transform our services to improve access and reduce health inequalities 6. To provider leadership within the wider NHS cancer system
Acronyms or abbreviations contained in the report	NHSE NHS England FDS Faster Diagnosis Standard PDR personal development review GM Greater Manchester VIP Value Improvement Programme EPR electronic patient record AI Artificial Intelligence NIHR National Institute for Health & Care Research

The Christie NHS Foundation Trust

Trust Report

January 2026 (December data)

Introduction

The Christie continues to perform well, strategically well positioned, with no current issues requiring escalation and a projected achievement of annual objectives across all strategic domains.

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

Board Capability

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

Our self-assessment of full compliance against the NHS England provider capability domains was made at our September 2025 Public Board and submitted to NHSE by their October 2025 deadline. The table below summarises the position with all domains rated Green, with no escalation required.

NHSE Board capability domain	Relevant Indicators	Evidence	RAG rating
1. Strategy & Leadership	Oversight Framework segment; national ranking	NOF Segment 1, Q2 ranked 7th nationally NHS Acute & Specialist Trusts.	
2. Quality of Care	62-day cancer standard; Faster Diagnosis Standard; nurse staffing	62-day and FDS remain above target. Nurse staffing consistently at/above safe 1:8 ratio.	
3. Workforce	Sickness absence; PDR compliance; training compliance	Sickness 4.8% (lowest in GM). PDR compliance (87.2%) and mandatory training compliance (95.1%)	
4. Partnerships & System Role	GM Collaborative contributions; national audits	Leadership in Cancer Alliance. Lead GM aseptic programme. OECI reaccreditation confirms global top-tier status.	
5. Financial Sustainability	Monthly surplus; VIP delivery	Surplus (£5.56m) on plan; value improvement plan target achieved.	
6. Improvement & Innovation	Clinical trial set-up; AI pilots; EPR milestones	Research set-up below 60-days. Digital/AI projects and Future Christie milestones progressing to plan.	

Operational Performance – Month 9 Position

The Trust's national ranking and Segment 1 status confirm our continued strong external assurance of our leadership and capability.

The Christie continues to perform strongly across all domains. We are in Segment 1 of the NHS Oversight Framework, the highest possible rating, and at Q2 are ranked 7th nationally among acute and specialist providers. This position reinforces our international standing as one of the top 25 global cancer centres as reported at the September 2025 board meeting.

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

Strategic Objectives – Month 9 Position

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

Strategic Objective 1: Safe, Effective and Equitable Care

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

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

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

Strategic Objective 2: Excellent Financial and Operational Performance

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

- Status: Green
- BAF Risks: 2 ≥15
- Committee Oversight: Board of Directors
- Executive Lead: Executive Director of Finance

At Month 9, the Trust is delivering a financial surplus of £5.56 million, in line with plan. The Value Improvement Plan for 2025/26 has been achieved, and operational performance remains compliant against all major cancer standards, including the 62-day, 31-day and Faster Diagnostic Standard (FDS) metrics.

The NHSE Medium Term Planning Framework for the period 2026/27 to 2028/29 sets performance targets and requirements for NHS organisations, introduces a new operating model, and emphasizes local autonomy through a neighborhood health approach. It aims to return the NHS to better health by reducing waiting times and restoring access to local care.

We made our first plan submission to NHSE in December. We have now received feedback on this first submission and are required to respond to this in the final draft that needs to be submitted to the NHSE Regional office by 11th February.

The plan contains;

- 3-year revenue and 4-year capital plan return.
- 3-year workforce return.
- 3-year operational performance and activity return.
- Integrated planning template showing triangulation and alignment of plans.
- Board assurance statements confirming oversight of process.

Full plan submissions include updated versions of these plus the five-year narrative plan. The Board will review the plans prior to submission and delegate authority for final sign off at the January Board.

Strategic Objective 3: Integrated Clinical, Research and Education Services

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

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

We are working towards the national 60-day benchmark for Research trial set-up times which have improved. Further process improvements are taking place to sustain and further improve this position.

A proposal to establish a credentialled education suite and achieve Higher Education status was shared at the November 2025 Board of Directors. This represents a strategic opportunity to strengthen our academic partnerships and reinforce our position as a centre of excellence in cancer education. Work to develop new academic programmes and delivery partnerships in support of this proposal is well underway.

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

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

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

Workforce indicators remain strong. Mandatory training compliance stands at 95.1%, and PDR completion is at 87.2%. Sickness absence is currently at 4.8%, the lowest in Greater Manchester. The Christie continues to be rated in the top category nationally for compassionate and inclusive culture, staff engagement, morale and flexibility, as confirmed by the NHS Staff Survey 2024.

The November and December rounds of industrial action by resident doctors resulted in minimal disruption to services, thanks to robust operational planning and contingency measures. The current strike mandate has expired, with a national re-ballot underway that could extend action into the summer. While national discussions continue around a potential resolution, this remains an active risk on the Trust's Risk Register.

The Trust continues to prioritise sexual safety for staff and patients. We are working on new requirements published in December. The trust is demonstrating strong compliance against its commitments to the NHS Sexual Safety Charter.

The national staff survey closed on the 28th November with a 47% response rate. This compares with a 48% response rate in 2024. NHS England has indicated that national

publication of the 2025 Staff Survey results is expected in Spring 2026, although exact dates have not yet been confirmed.

Strategic Objective 5: Transform Services and Reduce Inequalities

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

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

Our Future Christie transformation programme remains on track. The Patient Portal has been successfully rolled out, and development of a business case for a new electronic patient record (EPR) is underway. The capital programme is progressing to plan and remains within budget.

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

Strategic Objective 6: Leadership Within the Wider NHS Cancer System

The Christie's leadership role within the regional and international cancer system is recognised and expanding, reinforcing our strategic influence.

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

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

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

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

National Policy Developments

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

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

- This guidance sets out the finance business rules for integrated care boards (ICBs) and NHS trusts and foundation trusts ('NHS trusts') that will apply from 1 April 2026. The finance business rules include relevant statutory financial duties and other financial policy requirements set by NHS England and the Department of Health and Social Care (DHSC) that apply to ICBs and NHS trusts, as well as setting out how the impact of surpluses and deficits are managed in future years. https://www.england.nhs.uk/publication/nhs-finance-business-rules-from-2026-27-guidance-for-integrated-care-boards-and-nhs-trusts/

- The 2025/26 Q2 segmentation results and public performance dashboard are now live, including NHS league tables for acute, mental health, community and ambulance trusts. A more detailed version is available to NHS staff via the Model Health System. https://www.england.nhs.uk/publication/nhs-oversight-framework-nhs-trust-performance-league-tables-process-and-results/

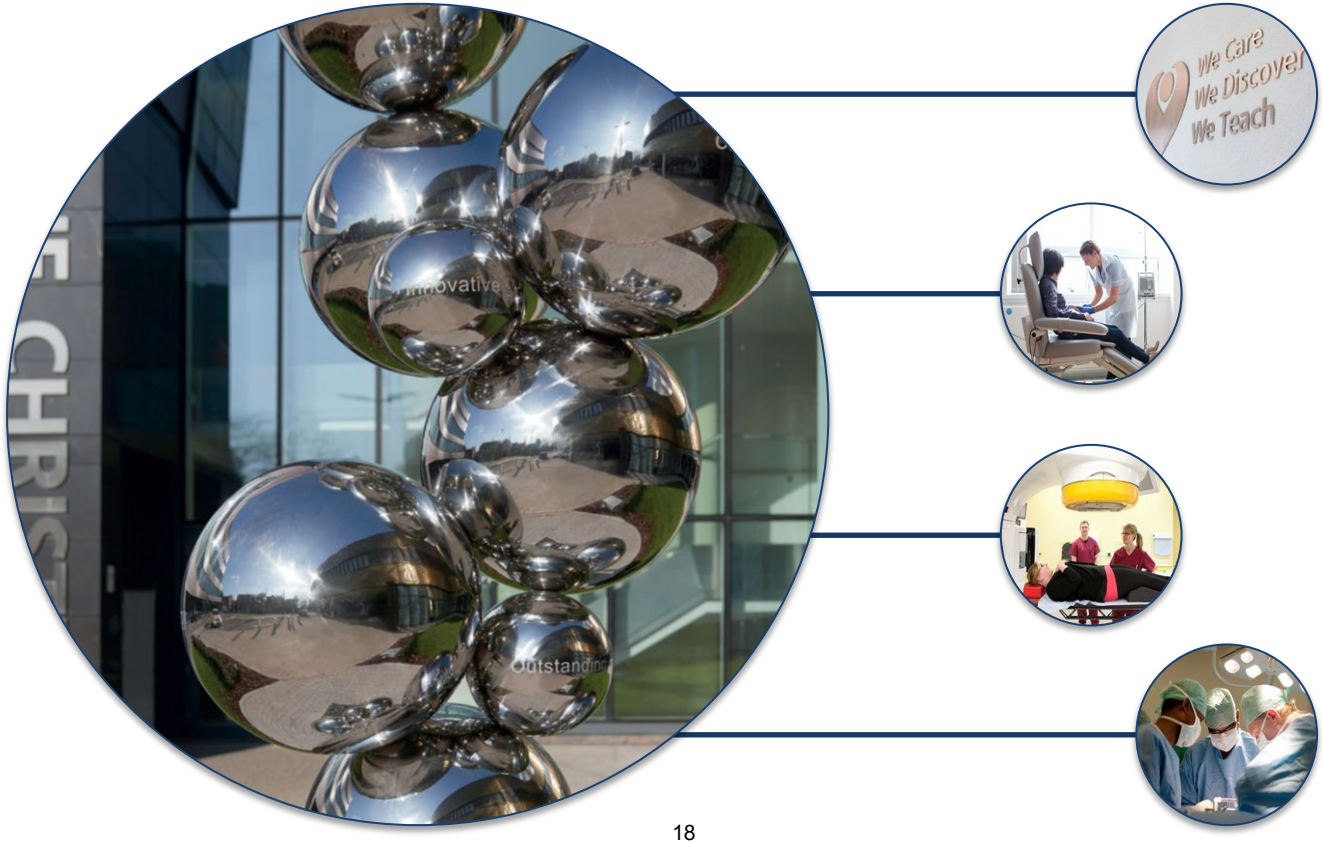
- NHSE has written to trusts and ICBs with an update and new actions for all organisations delivering NHS care. This includes requiring trusts and ICBs to complete a new sexual misconduct audit by Monday 2 February 2026. The letter is accompanied by supporting documentation on improving chaperoning guidance and a downloadable checklist for primary care providers. https://www.england.nhs.uk/long-read/an-update-on-actions-to-prevent-sexual-misconduct-in-the-nhs/

- The ICO has set out their public sector approach. Following feedback, the ICO has added a clearer definition of organisations in scope and the circumstances under which a fine may be issued. https://ico.org.uk/about-the-ico/our-information/policies-and-procedures/public-sector-approach/

Recommendation

To note that The Christie continues to perform well and is strategically well positioned and has declared full compliance with the NHSE Board capability domains.

The Christie NHS Foundation Trust



EXECUTIVE SUMMARY

NHS
The Christie
NHS Foundation Trust

Strategy and Leadership The Trust remains compliant with the NHS Oversight Framework and continues to demonstrate strong governance through regular risk reviews and escalation processes. However, research and innovation KPIs are below national averages, with leadership focus on process efficiency and stakeholder engagement to maintain strategic positioning as a leading cancer centre

Safety Incident reporting culture is robust, with 96% of incidents resulting in low/no harm and 18% being near misses, which reflects proactive risk identification.

IPC MRSA remains above trajectory, while E.coli and Klebsiella trends are improving. Sustained focus on IPC fundamentals and compliance monitoring continues to prevent future spikes and maintain patient safety

Workforce Agency spend remains stable at £0.3m per month, however bank spend has increased slightly, and clinical pay costs are steady. This suggests workforce stability with some ongoing reliance on temporary staffing. Continued monitoring of workforce resilience and strategies to reduce agency dependency while maintaining safe staffing levels is ongoing.

Financial Sustainability The Trust is delivering a £5.65m surplus in line with plan, and strong liquidity (£117.2m cash), meeting Better Payment Practice Code targets. However, the £1.3m shortfall in recurrent VIP savings is being compensated for with non-recurrent schemes. Focus remains on identifying recurrent efficiencies and controlling upward trends in drug expenditure.

Service Improvement Clinical outcomes remain within expected ranges, and trial recruitment in haematology has improved. However, research set-up timelines and amendment implementation are below target with continued focus to support improvement**.** Cancer and access standards, long term SPC indicates positive special cause variation, but the service remains fragile during pressure periods

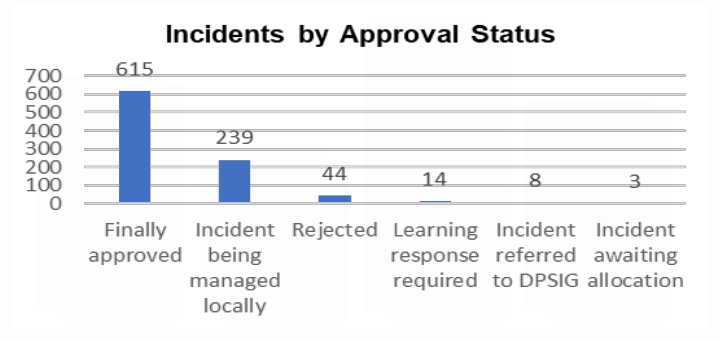
Overall Assessment The Trust demonstrates strong financial control, positive safety culture, and compliance with governance frameworks. Key challenges remain in IPC performance, research efficiency, and recurrent cost improvement delivery. Strategic priorities focus on risk reduction, operational efficiency, and sustainable financial planning to maintain excellence and resilience.

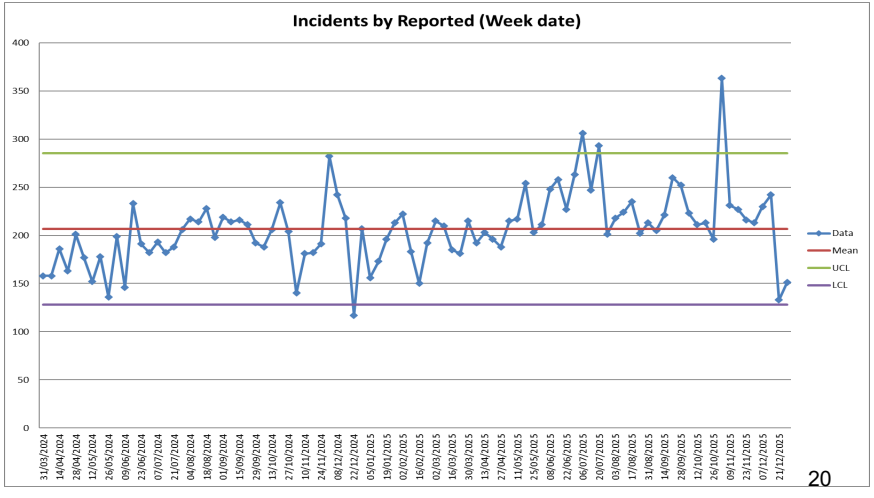
A forecast of performance against the NHS Oversight Framework (from Q3 2025/26), will be presented in future reports.

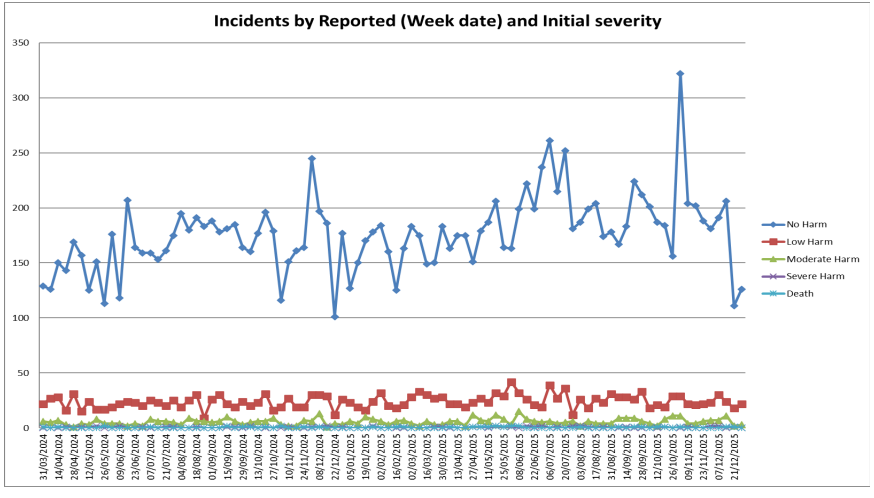
Incident Reporting

A total of 923 incidents were reported to DCIQ in December 2025.

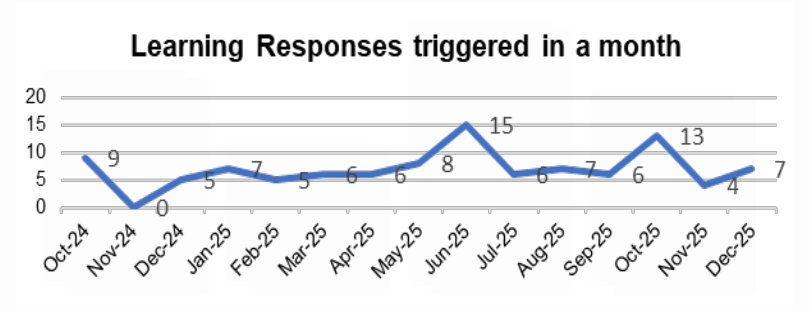
- At the time of reporting, 67% of incidents have been finally approved. 5% of incidents have been rejected for reasons such as duplication and incidents which involve care provided by an external trust.
- 96% of all incidents reported resulted in low/no harm.
- 18% of incidents were reported to be a 'near miss', evidencing a positive reporting culture.
- Reporting trends in December were within the expected limits.



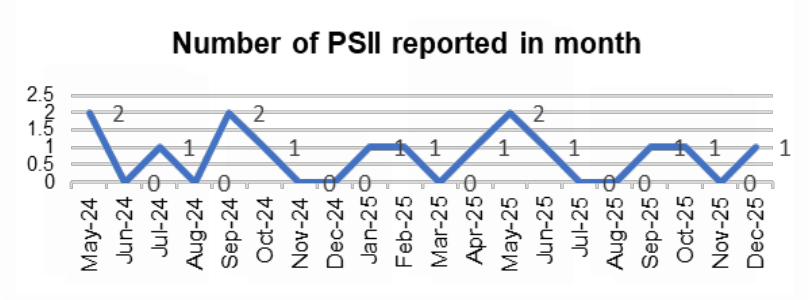




Incidents identified that require a Learning Response



- Learning responses are triggered when an opportunity for new learning is identified.
- Potential learning responses are discussed and agreed at the PSIRF delivery group which is held weekly and attended by the patient safety team and divisional governance teams.
- 7 Learning responses were triggered locally and via the divisional PSIGs in December 2025:
- 2 triggered for presentation to the ERG
- 5 triggered for a local learning response



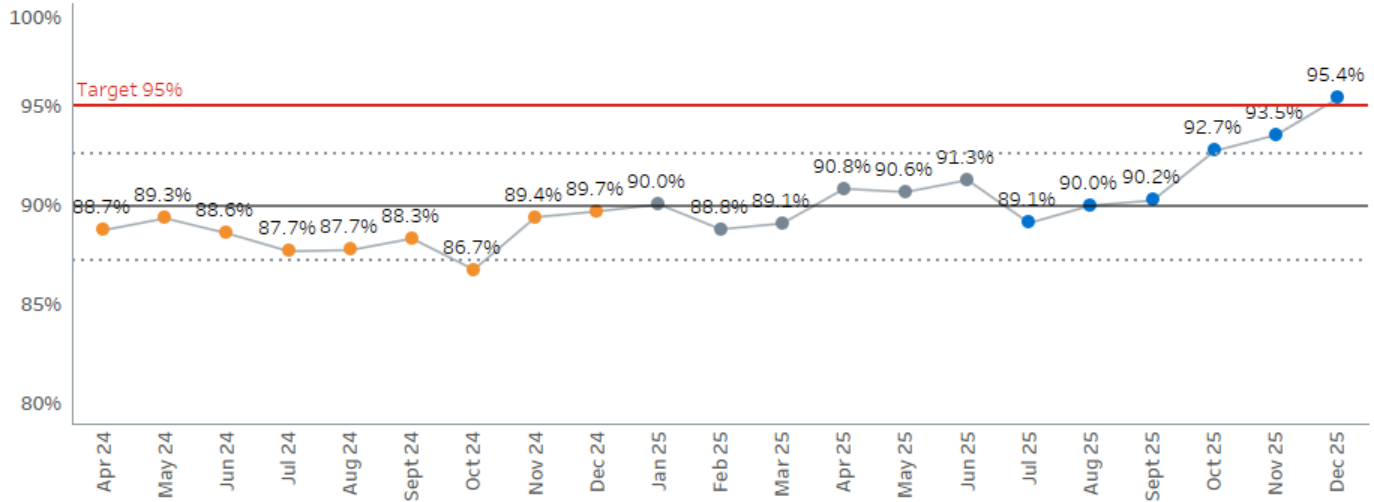
- Patient Safety Incident Investigations (PSII) are triggered when there is a significant opportunity for learning and improvement. PSIIs are extensive investigations which result in specific outcomes recommended by trained investigators.
- 1 PSII was reported in December 2025:
- I18893 - WLE carried out to right scar site on crown of scalp, no WLE carried out at intended site of melanoma to left parietal scalp (wrong site surgery)

Integrated Performance Report - Patient Care Metrics Summary

NHS
The Christie
NHS Foundation Trust

Metric	Month	Measure	Target	Variation	Assurance
Sepsis - screening (presenting as an emergency)	December	91.00%	90.00%		
Sepsis - timely treatment with IV antibiotics (established inpatients)	December	95.00%	90.00%		
VTE Assessment Within 14 Hours of Admission	December	95.38%	95.00%		
Falls per 1000 bed days	December	4.7	3.8		
Pressure sores per 1000 bed days	December	0.4	0.5		
Category 3 pressure ulcers	December	0.0	0.0		
Hospital Cancelled Operations on the day for non clinical reasons	December	5.0	0.0		

VTE Assessment Within 14 Hours of Admission



Icons

Improving

Failing

Summary

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

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

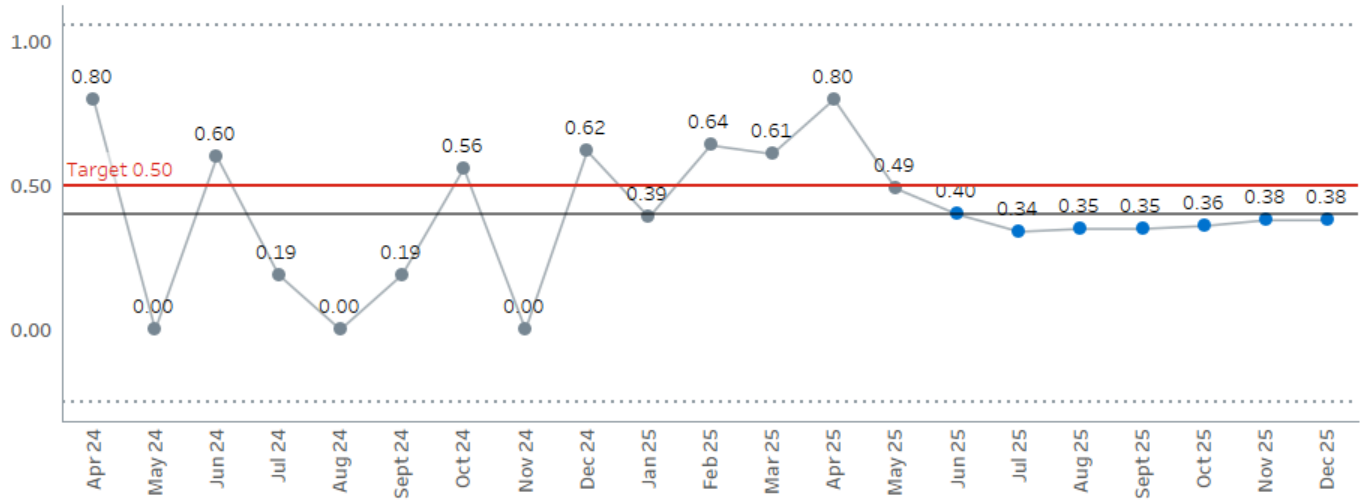
Understanding the performance

From early 2025 onward, the trend shows steady and sustained improvement, rising from 89–91% in spring 2025 to 92–94% by late summer. Performance surpasses the 95% target in November and December 2025, reaching a peak of 95.4%.This upward trajectory suggests that recent interventions—such as strengthened ward workflow, improved digital prompts, or targeted education—are having a positive and cumulative effect. The reduction in variation during 2025 indicates more reliable processes and greater compliance across clinical areas. Sustaining above-target performance will require maintaining current practice, continuing oversight and addressing any pockets of underperformance.

Actions (SMART)

Achieve and maintain ≥95% VTE assessment completion for three consecutive months by Q2 2026.

Pressure Sores per 1000 Bed Days



Icons

Improving

Hit & Miss

Summary

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

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

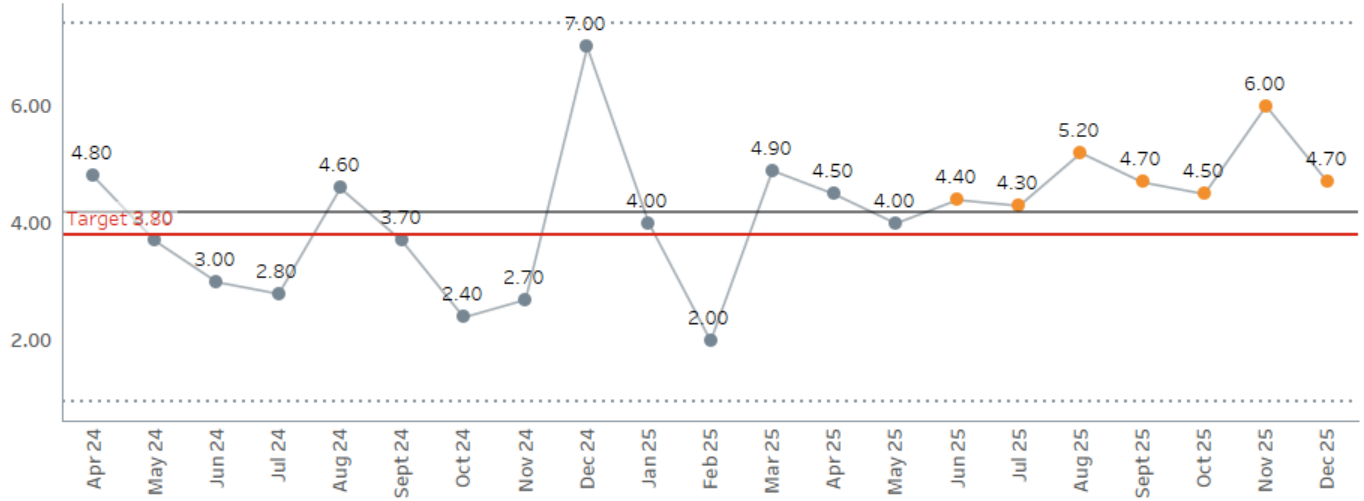
Understanding the performance

- Sustained low numbers of pressure ulcers
- Evidences improvement work related to skin assessment and pressure ulcer prevention having impact

Actions (SMART)

- Continue to monitor practice via ward area monthly quality audits (mini-CODE)
- Continue education from tissue viability team

Falls per 1000 Bed Days



Icons

Concerning

Hit & Miss

Summary

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

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

Understanding the performance

- Since June 2025 we have seen increase in falls however, below national average of 6.8 falls per 1000 OBD
- Thematic review completed; falls associated with increased complexity of patient cohort, especially inpatients

Actions (SMART)

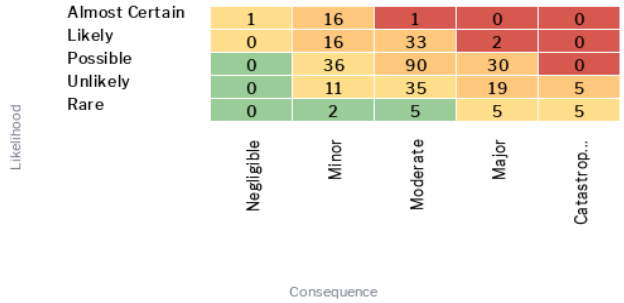
Falls improvement group set up, chaired by Deputy Chief Nurse, initial focus on:

- Enhanced Therapeutic Observations of Care standards
- Use of falls prevention equipment (pressure sensors, low rise beds)
- Patient and staff education
- Improving assessment process with therapy involvement

Risk Profile

New	New longer than 3 days	Active	Due next 30 days	Overdue
1 Risks	1 Risks	312 Risks	184 Risks	26 Risks

Risks Matrix



Risks by Level

Current rating	# Risks
Low	7
Moderate	93
High	209
Extreme	3

- In December 2025 there were 312 open risks recorded in DCIQ
- Of the 312 risks open, 67% (n= 209) were rated as high
- 1 risk was rated 'extreme (≥15)
- 92% of all active risks reviewed within planned timeframes (26 risks were overdue scheduled review

Trust wide risk register

The Christie NHS Foundation Trust

Risk ID	Risk	Risk Register	Type	Subtype	Status	Risk owner	Date opened	Initial rating	Current likelihood	Current consequence	Current rating	Target rating	Movement	Next Review Date
101	There is a risk to the Trust's ability to demonstrate compliance and adherence to it's regulatory and statutory requirements under PSIRF	Trustwide	External Risk	Strategic Planning Risk	Active	Katerina Pearson	10/03/2025	16	3	3	9	6	→	02/02/2026
339	There is a risk that a patient may develop a DVT if their VTE assessment is not completed	Trustwide	Clinical Risk	Patient Safety / Outcomes Risk	Active	Annie Dewberry, Liz Perry	28/03/2025	9	3	3	9	3	→	30/01/2026
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	Active	Claire Mcpeake	30/10/2024	16	3	3	9	16	→	30/11/2025
496	There is a risks that patients may experience delays to their care and treatment due to limited medical resources within the anaesthetic service	Trustwide	Clinical Risk	Patient Safety / Outcomes Risk	Active	Lauren Oswald, Tracey Jones	23/07/2025	9	4	4	16	6	→	25/01/2026
514	There is a risk that patients may experience harm due to significant delays in the management of patients with colorectal cancers.	Trustwide	Clinical Risk	Patient Safety / Outcomes Risk	Active	Tracey Jones	05/09/2025	16	3	4	12		→	31/01/2026
530	There is a risk that may impact patient safety due to non-compliance with mandatory training	Trustwide	Workforce Risk	Workforce Performance Risk	Active	Mr David Smithson	22/09/2025	12	4	3	12	6	→	13/02/2026

Risk ID	Risk	Risk Register	Type	Subtype	Status	Risk owner	Date opened	Initial rating	Current likelihood	Current consequence	Current rating	Target rating	Movement	Next Review Date
617	There is a risk of a patient coming to harm due to unclear and non-standardised operational processes for clinical correspondence	Networked Services Risk Register	Clinical Risk	Patient Safety / Outcomes Risk	Active	Suzanne MacGregor	19/12/2025	9	5	2	10	6	↑	19/01/2026

The Trust wide risks are defined as those that need impact Trust wide or need organisation wide involvement to resolve. Associate Director of Governance hold responsibility for this; agreeing new risk and overseeing controls, reviews and actions.

The Christie NHS Foundation Trust

Movement of extreme risks

Risks with a current risk score of 15 and above:

Risk ID	Risk	Risk Register	Type	Subtype	Status	Risk owner	Date opened	Initial rating	Current likelihood	Current consequence	Current rating	Target rating	Movement	Next Review Date
496	There is a risks that patients may experience delays to their care and treatment due to limited medical resources within the anaesthetic service	Trustwide	Clinical Risk	Patient Safety / Outcomes Risk	Active	Lauren Oswald, Tracey Jones	23/07/2025	9	4	4	16	6	↔	25/01/2026

- As of the current reporting period, 1 risk has a score of 15 and above.
- In December, extreme risks were reviewed within the required trust timescales and so were compliant with the trust's risk review process.
- 2 risks were downgraded in December (ID 236&562)

Risks downgraded from extreme:

Risk ID	Risk	Risk Register	Type	Subtype	Status	Risk owner	Date opened	Initial rating	Current likelihood	Current consequence	Current rating	Target rating	Movement	Next Review Date
236	Risk of harm to patients caused by potential microbiological contamination because of ASU facility limitations	Pharmacy	Operational Risk	Business Continuity Risk	Active	Dawn Gillibrand	21/03/2025	9	3	3	9		↓	10/01/2026
562	Risk of patient harm (metastatic disease), poor patient experience & reputational harm, due to failure to comply with NICE guidance to offer Ribociclib treatment to eligible breast cancer patients	Networked Services Risk Register	Clinical Risk	Capacity Planning Risk	Active	Mrs Caroline Rogers	10/10/2025	15	4	3	12	3	↓	16/01/2026

Safe Staffing

The Christie NHS Foundation Trust

		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	16546	13835	5064	5.7
	Total monthly ACTUAL	15840	13154		
	Average Fill Rate %	95.7%	95.1%		
Care Staff	Total monthly PLANNED	9881	7198	5064	2.9
	Total monthly ACTUAL	8138	6448		
	Average Fill Rate %	82.4%	89.6%		
ALL Staff	Total monthly PLANNED	26427	21033	5064	8.6
	Total monthly ACTUAL	23978	19602		
	Average Fill Rate %	90.7%	93.2%		

Registered Nurses	DAY			NIGHT			Cumulative count over the month of patients at 23:59 each day	CHPPD (Care Hours Per Patient Per Day)
	Hours Planned	Hours Actual	% Fill Rate	Hours Planned	Hours Actual	% Fill Rate		
Critical Care Unit	2267	1868	82.4%	2144	1831	85.4%	156	23.7
Palatine Ward	3035	2848	93.8%	2516	2385	94.8%	912	5.7
Ward 10	2041	1900	93.1%	1660	1527	92.0%	733	4.7
Ward 11	1851	1753	94.7%	1472	1506	102.3%	597	5.5
Ward 12	1878	1815	96.6%	1566	1645	105.0%	850	4.1
Ward 4	1853	2005	108.2%	1488	1504	101.1%	766	4.6
Ward 2	1485	1480	99.7%	1161	1015	87.4%	522	4.8
Acute Assessment Unit	2136	2171	101.6%	1828	1741	95.2%	528	7.4
TOTAL	16546	15840	95.7%	13835	13154	95.1%	5064	5.7

Registered Nursing Associates	DAY			NIGHT		
	Hours Planned	Hours Actual		Hours Planned	Hours Actual	
Critical Care Unit						
Palatine Ward		103				
Ward 10						
Ward 11						
Ward 12		16				
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%	156	0.0
Palatine Ward	1063	862	81.1%	977	838	85.8%	912	1.9
Ward 10	1505	1256	83.5%	774	707	91.3%	733	2.7
Ward 11	1605	1329	82.8%	1219	1183	97.0%	597	4.2
Ward 12	2057	1637	79.6%	1374	1259	91.6%	850	3.4
Ward 4	1694	1314	77.6%	1322	1127	85.2%	766	3.2
Ward 2	929	844	90.9%	831	748	90.0%	522	3.0
Acute Assessment Unit	1028	896	87.2%	701	586	83.6%	528	2.8
TOTAL	9881	8138	82.4%	7198	6448	89.6%	5064	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

Integrated Performance Report - Friends & Family Test & Patient Experience

NHS
The Christie
NHS Foundation Trust

Metric	Month	Measure	24/25 Avg	Variation	Assurance
Inpatient Response Rate	December	40.60%	34.00%		
Inpatient Recommended Score	December	96.40%	97.00%		
Outpatient Recommended Score	December	92.90%	96.00%		
Number of new complaints	December	12	13		
Number of PALS	December	51	37		

Healthcare Associated Infections

The Christie NHS Foundation Trust

HCAIs against thresholds 2025-26 – HOHA & COHA only

Indicator	Threshold	Position	Year so far (as at month 9)	Threshold adjusted to month 9	Difference
C.*Difficile*	≤ 52	Below trajectory	28	39	-11
E.coli BSI	≤ 43	Above trajectory	45	32	+13
Klebsiella spp. BSI	≤ 24	Above trajectory	27	18	+9
P.Aeruginosa BSI	≤ 8	Below trajectory	4	6	-2

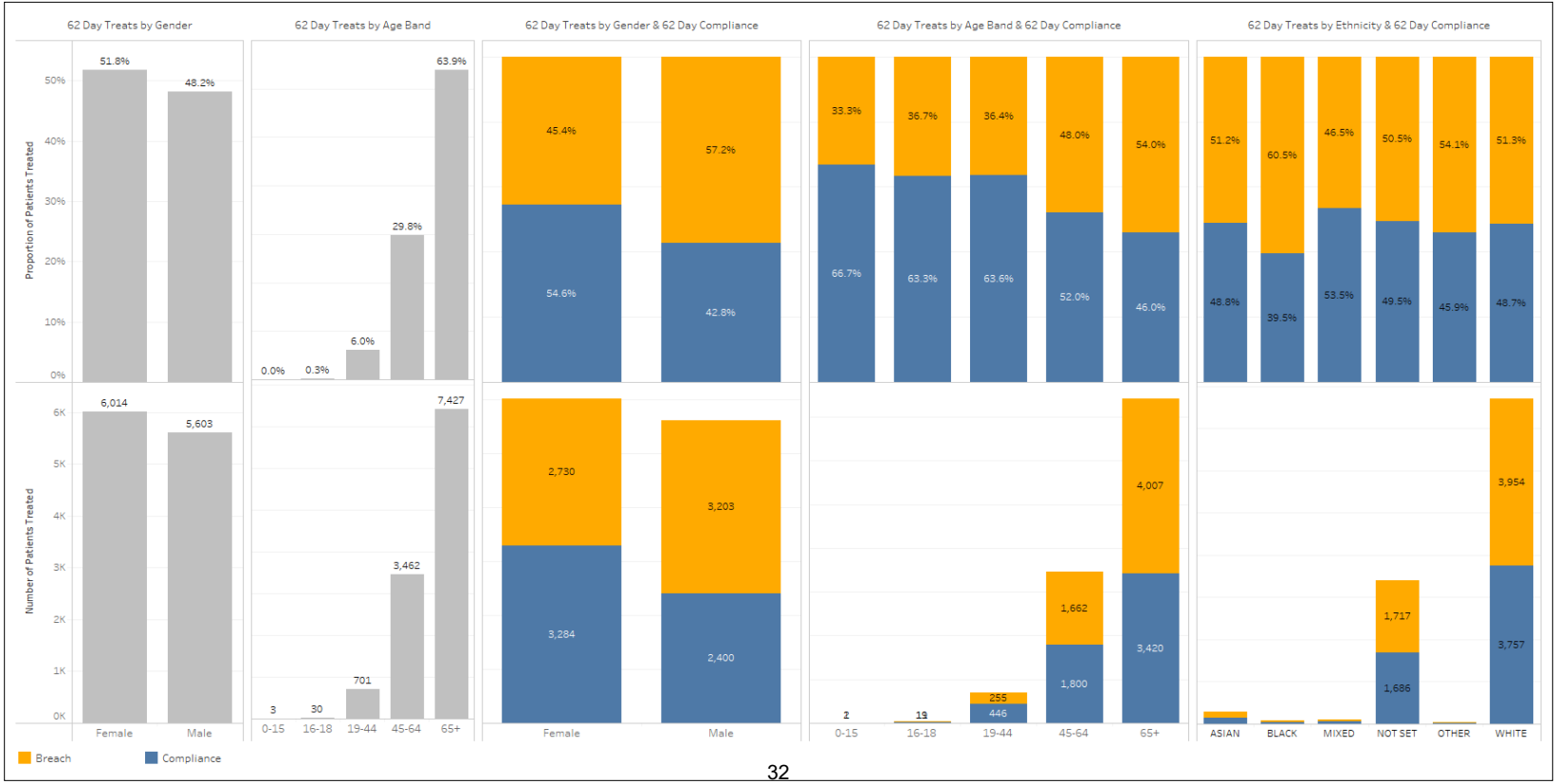
HCAIs being monitored

Indicator	Target	Position	Year so far (as at month 9)	Threshold adjusted to month 9
MRSA BSI	Zero tolerance	Above trajectory	2	-
MSSA BSI	No target	No target	17	-

There have been no further spikes in E.coli and Klebsiella hence the difference is now gradually reducing each month. The Trust held a well-attended IPC summit in October with NHSE representation. The summit focused on the thresholds and on the importance of the fundamentals of IPC practice for clinical staff.

Cancer Standards – Health Inequalities Analysis

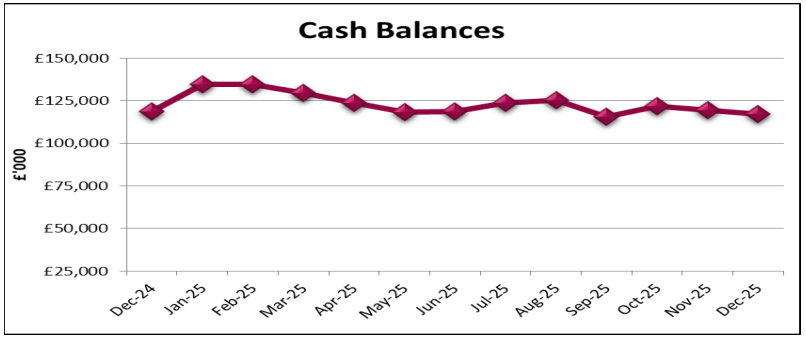
62 Day Treatments between 01/04/2023 – 31/12/2025 analysed by gender, age and ethnicity.



Finance (Executive Summary)

This report outlines the M9 consolidated financial performance of The Christie NHS Foundation Trust and its wholly owned subsidiary The Christie Pharmacy Ltd.

Month 09 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(470,558)	(352,861)	(355,390)	(2,528)
Other Income	(81,320)	(60,968)	(61,700)	(732)
Pay	267,333	199,638	196,097	(3,541)
Non Pay (incl drugs)	258,589	194,636	200,704	6,067
Operating (Surplus) / Deficit	**(25,957)**	**(19,555)**	**(20,289)**	**(735)**
Finance expenses/ income	22,739	17,142	17,949	808
(Surplus) / Deficit	**(3,218)**	**(2,413)**	**(2,340)**	**73**
Exclude impairments/ charitably funded capital donations	(4,282)	(3,212)	(3,311)	(99)
Adjusted financial performance (Surplus) / Deficit	**(7,500)**	**(5,625)**	**(5,651)**	**(26)**



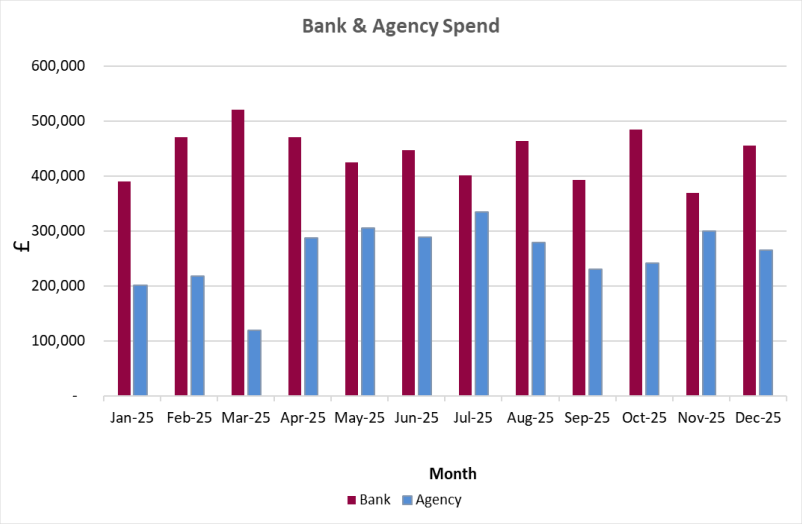
I&E

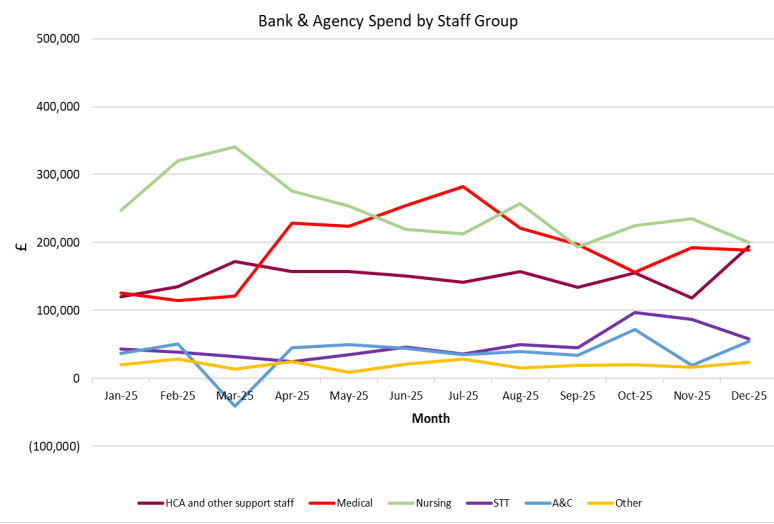
- The Trust is reporting a surplus at the end of month 09 of (£5.65m) against a YTD plan of (£5.63m), which gives a YTD variance of (£0.02m).
- Identified in-year VIP is £25.3m against a target of £25.3m. The VIP shortfall against the recurrent VIP target is £1.3m (RAG rated shortfall £1.3m), where £11.4m has been identified against a target of £12.6m (90% of recurrent target identified). Non-recurrent identified VIP is £13.9m against a target of £12.6m, overachieving by (£1.3m).

Balance sheet / liquidity

- The cash balance as at 31st December 2025 is £117.2m, with a forecast yearend balance of £109.3m.
- Capital spend for 2025-26 was £16.6m, this was £0.5m 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)

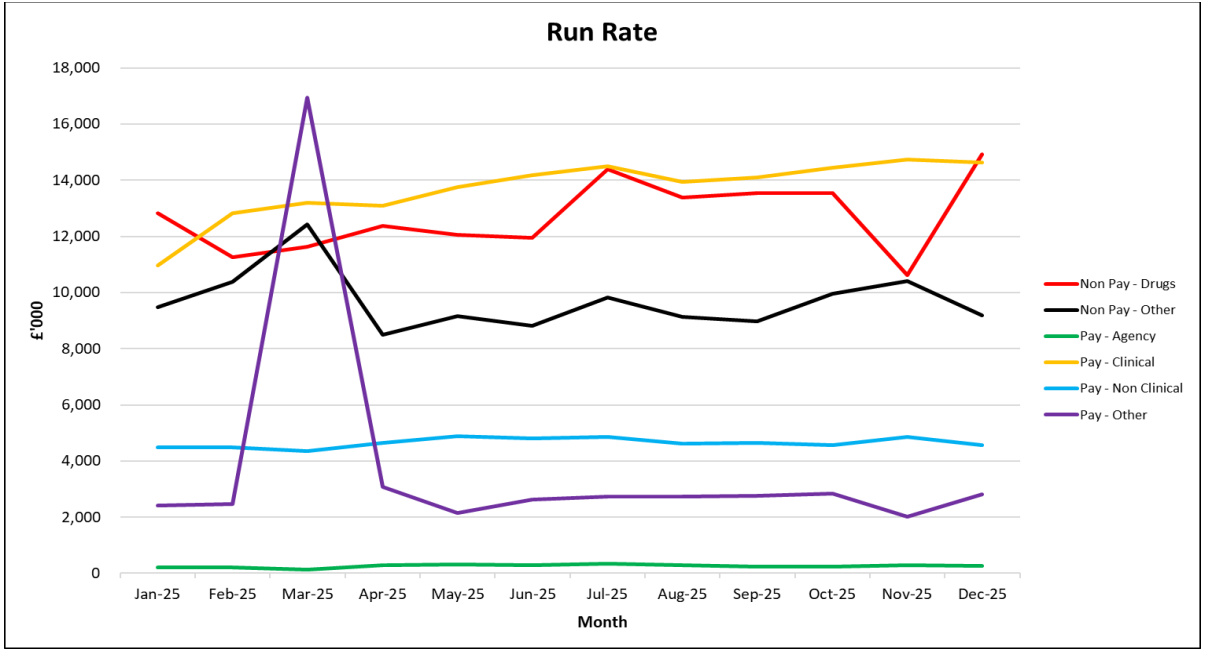




Agency spend in month 09 is £0.3m, £2.5m YTD, in line with month 08. The spend is predominantly on medical agency.

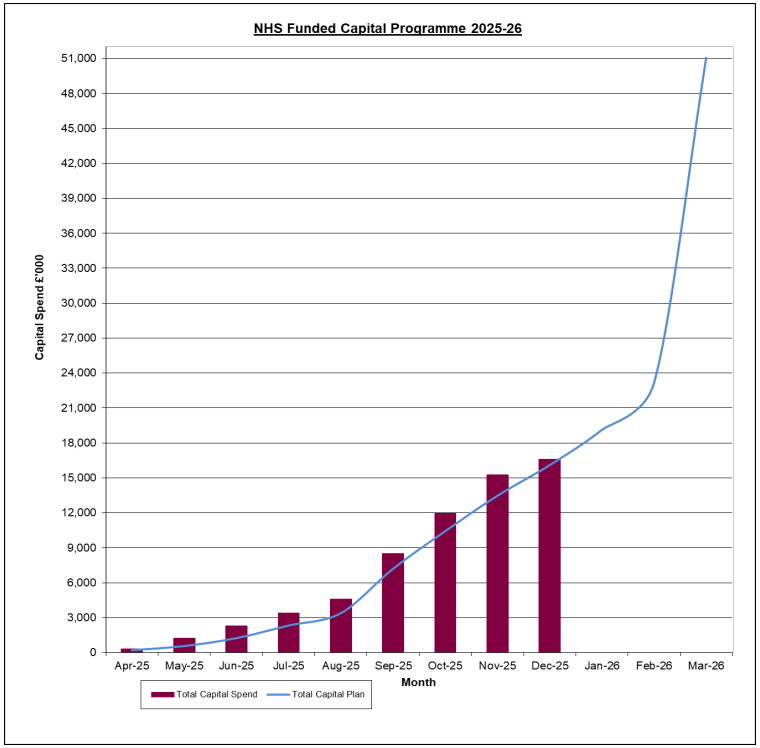
Alongside this, bank spend in month 09 is £0.5m and £3.9m YTD, an increase of £0.1m from month 08.

Finance (Expenditure)



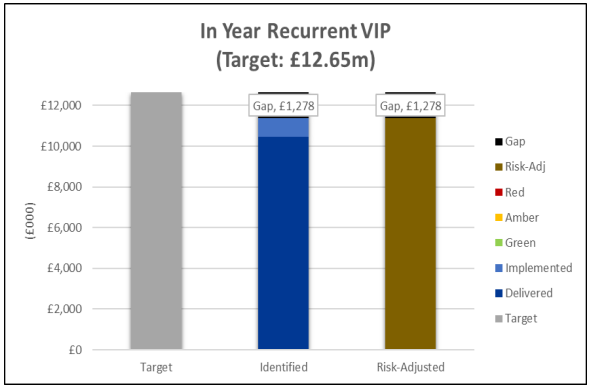
- Drugs spend in month 09 is £15.0m, an increase of £4.3m from month 08 driven by an increase in cost and volume drug expenditure and a £1.9m prior year non-recurrent credit in month 08.
- Non-Pay – Other spend in month 09 is £9.2m, a decrease of £1.2m from month 08 driven by decreased spend clinical 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 09 is £0.3m, in line with month 08.
- Pay – Clinical spend in month 09 is £14.7m, in line with month 08.
- Pay – Other spend in month 09 is £2.8m, an increase of £0.8m from month 08 driven by partial release of annual leave accrual in line with Trust policy in month 08

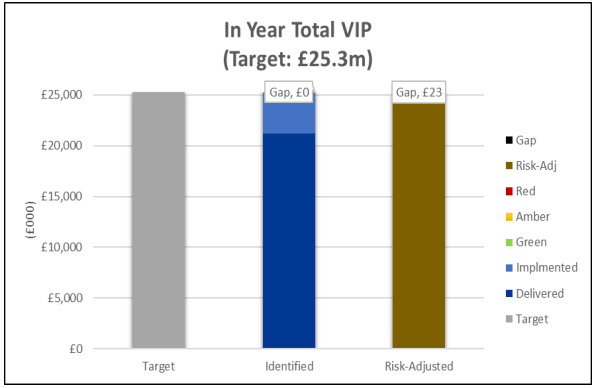
Finance (Capital)



The Trust has incurred £16.6m up to month 09 on capital schemes overspending by £0.5m 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 (£13.9m non recurrent / £11.4m recurrent).
- Risk adjusted identified schemes value £25.3m, leaving £0.0m unidentified.

Recurrent

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

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

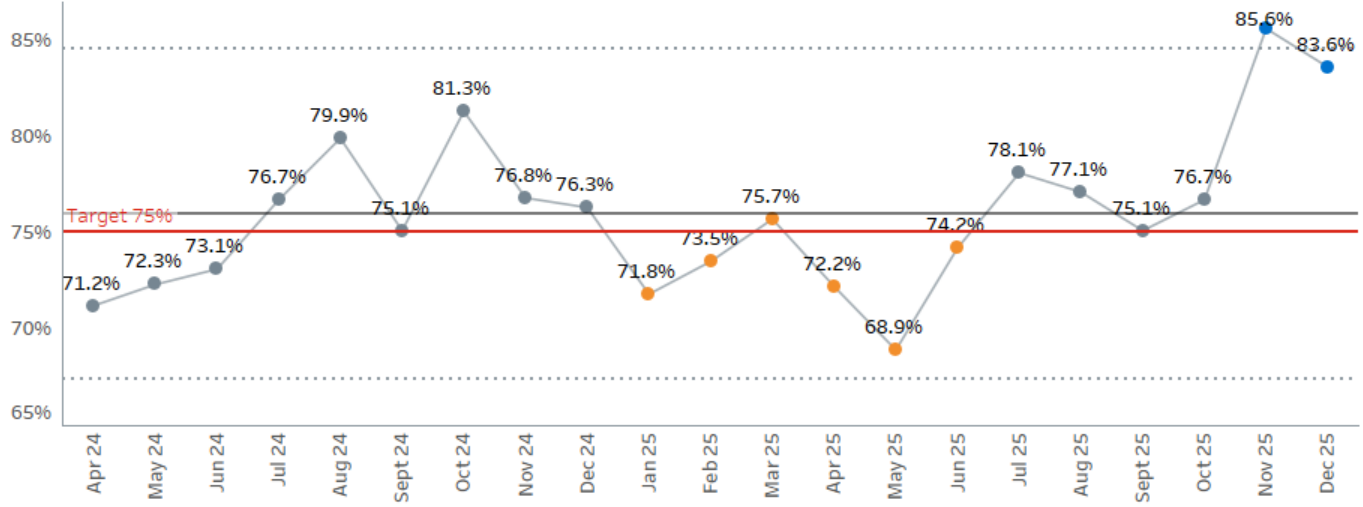
	Annual					Year To Date		
	Target £0	Identifed £0	Unidentified £0	Risk-Adjusted Identified £0	Risk-Adjusted Unidentified £0	Target £0	Delivered £0	Variance £0
Total VIP	**25,298**	**25,298**	**0**	**25,275**	**23**	**18,848**	**18,848**	**0**
Recurrent VIP	12,649	11,371	1,278	11,371	1,278	9,487	8,484	1,003
Non-Recurrent VIP	12,649	13,927	(1,278)	13,903	(1,254)	9,361	10,364	(1,003)

Integrated Performance Report - Cancer Standards Summary

NHS
The Christie
NHS Foundation Trust

Metric	Month	Measure	Target	Variation	Assurance
18 weeks	December	96.90%	92.00%		
24 day (Internal Target)	December	82.20%	85.00%		
28 Day FDS	December	81.60%	80.00%		
31 day	December	98.70%	96.00%		
62 Day	December	83.60%	75.00%		
Waiting >52 Weeks	December	0.00%	0.00%		

Percentage of patients treated for cancer within 62 days of referral



Icons

Improving

Hit & Miss

Summary

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

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

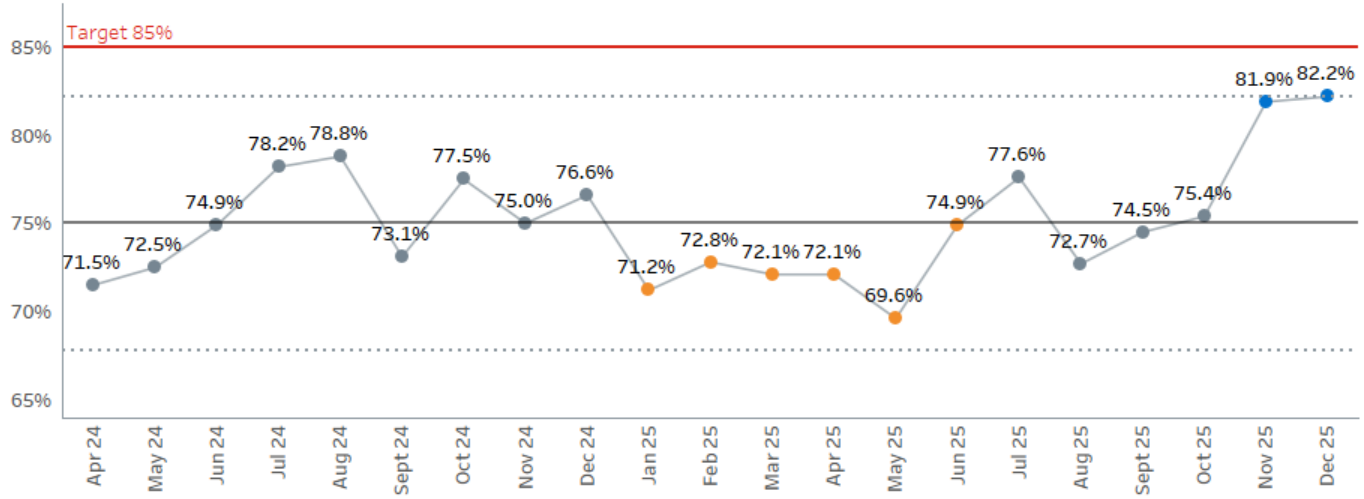
Understanding the performance

Variable performance noting the changing targets required over the 20 month period shown.
A significant recovery and upward trend from mid-2025.
Evidence of special-cause improvement, indicating recent changes are taking effect.

Actions (SMART)

Introduce a rapid-access escalation protocol for patients approaching Day 50, ensuring early intervention before breaches occur.
Reduce the number of >62-day patients on the PTL by 15% over the next 12 weeks.
Achieve and sustain at least 80% compliance by Q2 2026.

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



Icons

Improving

Failing

Summary

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

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

Understanding the performance

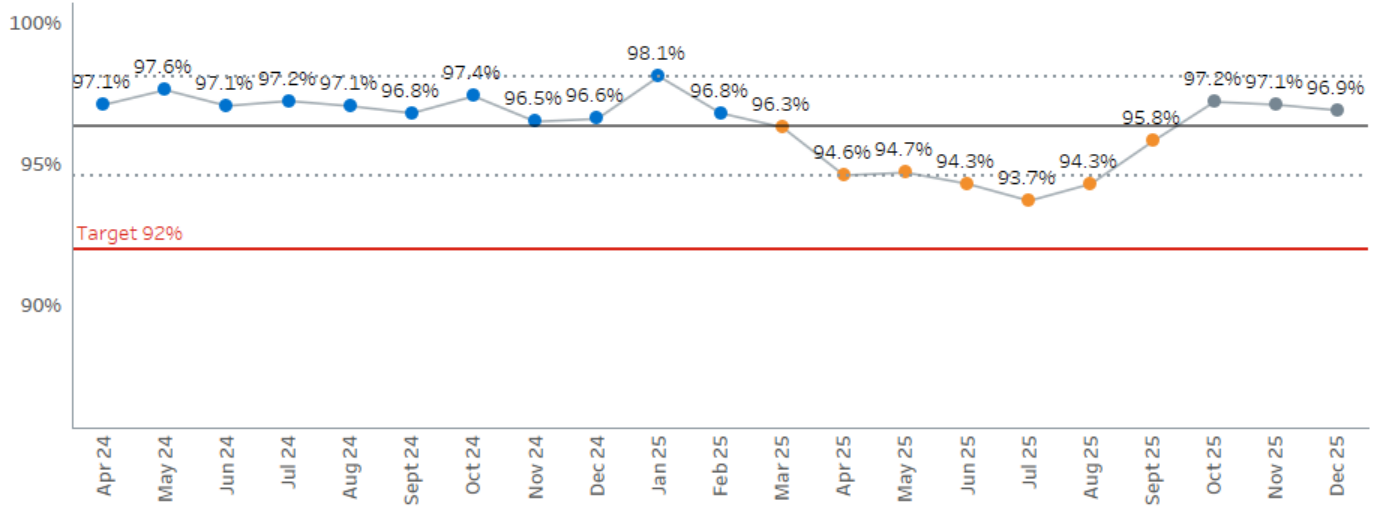
A gradual upward trajectory is visible after the low point in March. By Oct–Dec 2025, performance climbs above 80%, with December achieving 82.2%, the strongest performance in the year. While not yet reaching the 85% target, the consistent improvement suggests that earlier interventions are beginning to have an effect, with pathway delays reducing and flow stabilising. In summary, performance is improving but fragile. The service is trending in the right direction but remains vulnerable to operational pressures, and achieving the 85% target will require continued focus on pathway optimisation, capacity resilience, and proactive oversight of bottlenecks.

Actions (SMART)

Increase treatment capacity at peak demand times

Strengthen proactive breach monitoring

Percentage of patients treated within 18 weeks



Icons

Common Cause

Passing

Summary

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

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

Understanding the performance

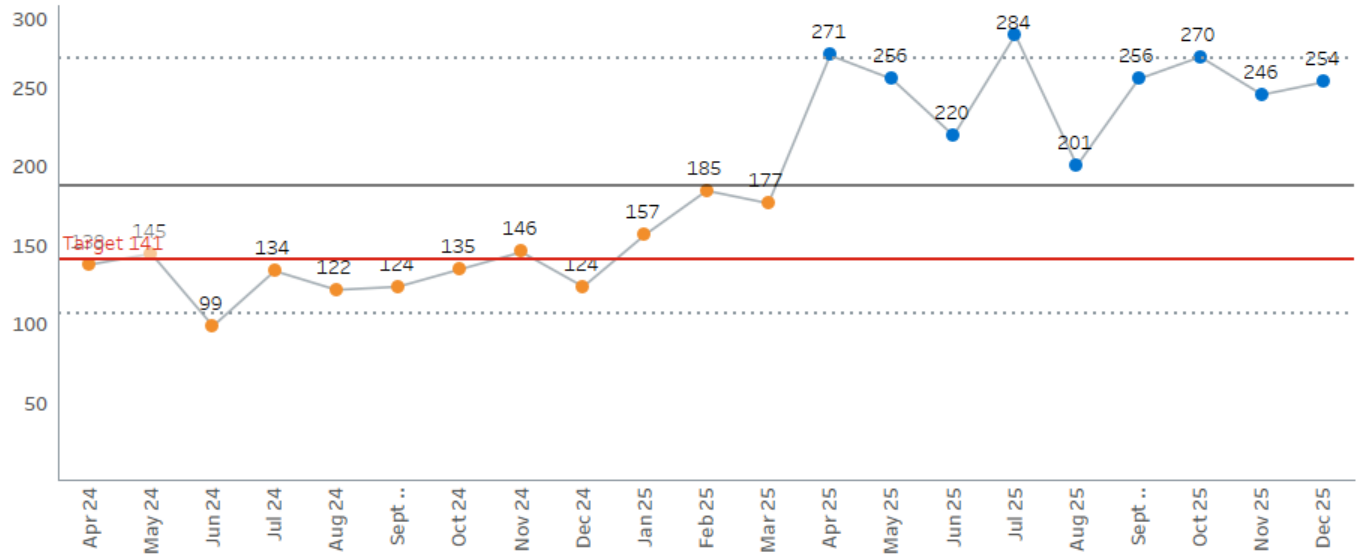
Actions (SMART)

Integrated Performance Report - External Referrals Received Summary

NHS
The Christie
NHS Foundation Trust

Metric	Month	Measure	24/25 Avg	Variation	Assurance
External Referrals Received - ALL Specialties	December	2,230	2,067		
External Referrals Received -Clinical Oncology	December	967	978		
External Referrals Received -Haematology	December	254	141		
External Referrals Received -Medical Oncology	December	584	549		
External Referrals Received -Surgical Specialties	December	384	365		

External Referrals Received - Haematology



Icons

Improving

Hit & Miss

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)	December	7.5	7.0		
Inpatient LOS - Elective Patients (excluding zero LOS)	December	6.8	5.8		
Inpatient LOS - Non-Elective Patients (excluding zero LOS)	December	7.8	7.9		
Inpatient LOS - Transfer Patients (excluding zero LOS)	December	22.7	17.1		

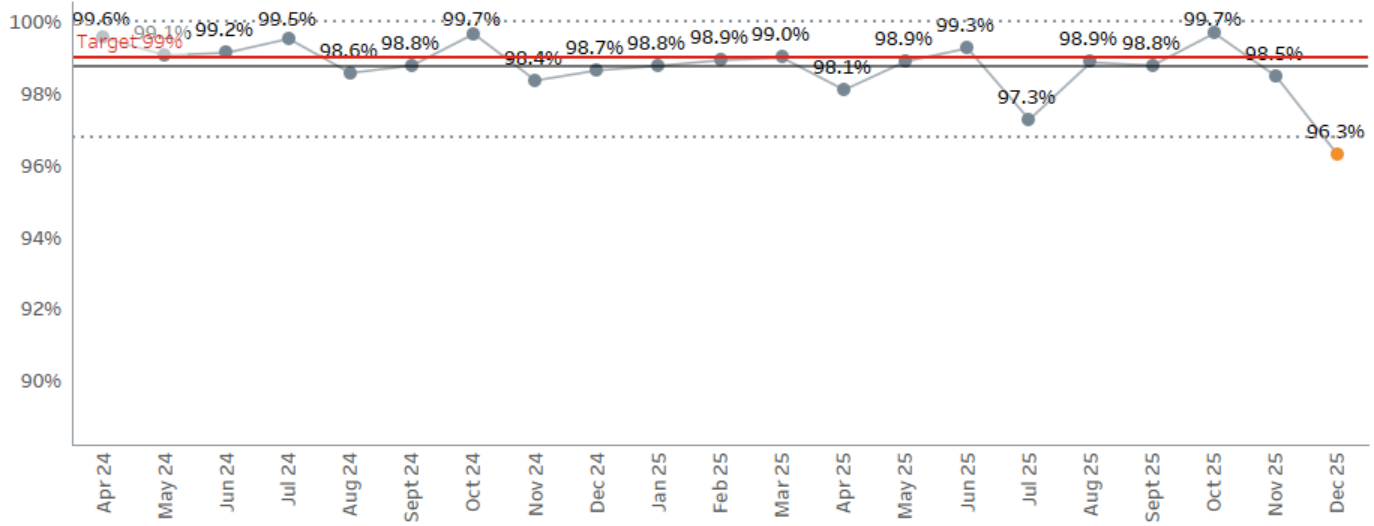
Integrated Performance Report - Diagnostic 6 Week Waiting Times Summary

The Christie NHS Foundation Trust

Metric	Month	Measure	Target	Variation	Assurance
Magnetic Resonance Imaging	December	96.30%	99.00%		
Computed Tomography	December	99.20%	99.00%		
Non-obstetric Ultrasound	December	100.00%	99.00%		
Dexa Scan	December	100.00%	99.00%		
Cardiology - Echocardiography	December	100.00%	99.00%		
Flexi Sigmoidoscopy	December	100.00%	99.00%		
Cystoscopy	December	93.80%	99.00%		
Barium Enema	December	100.00%	99.00%		
Colonoscopy	December	100.00%	99.00%		
Gastroscopy	December	100.00%	99.00%		
DM01 Return - All Scans	December	98.40%	99.00%		

*Lastest month figures are taken from the National Waiting List Weekly Return. Historical data trends are based on monthly DM01 figures. Latest data is refreshed with DM01 data once submitted.

MRI 6 Week Waiting Time Compliance



Icons

Concerning

Hit & Miss

Summary

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

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

Understanding the performance

The MR 6-week waiting time compliance has remained consistently high throughout the reporting period, generally staying above 98% and frequently at or close to 100%. This indicates strong performance in meeting the national diagnostic standard. However, the SPC chart highlights two points of concern: A drop to 97.3% in April 2025, which falls outside the typical performance range and is marked as a concerning data point. In practical terms this is a total of 5 patients

Actions (SMART)

Aim to restore monthly compliance to ≥ 98% for the next 6 consecutive months.
Reduce number of radiotherapy/brachy scans on the MR scanners and maximise the utilisation of the proton MR scanner

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.

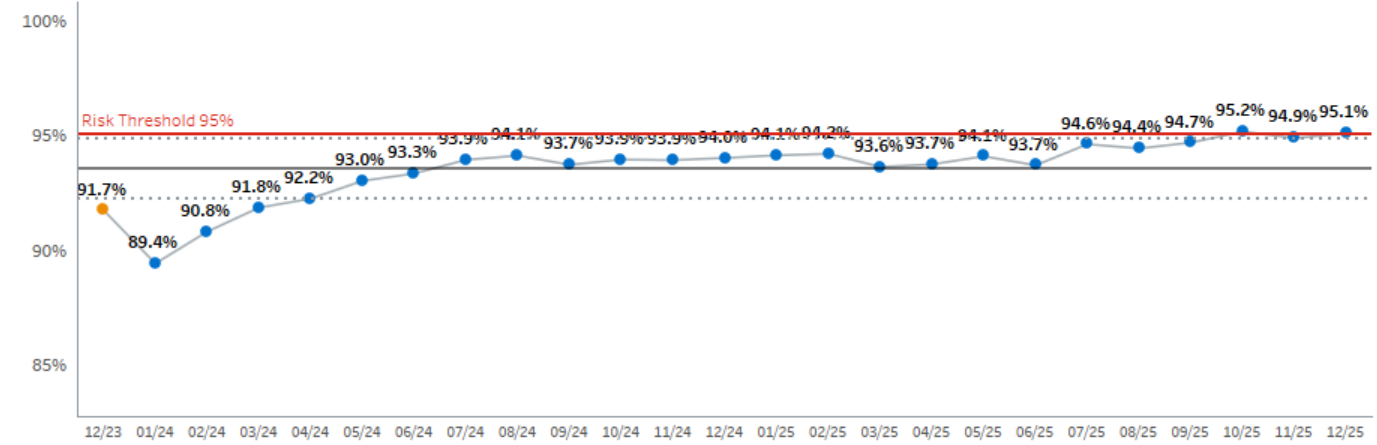
Metric - the KPI metric
Measure - the value of the **Metric** as of the end of the **Month**
Target - the Trust defined minimum or maximum limit for each **Metric**
Mean - the average of the **Measure**s over the past 12 months

Metric	Month	Measure	Risk Threshold / Target	Mean	Performance	Assurance
Appraisal	December 2025	**87.18%**	90.00%	87.67%		F
Mandatory Training	December 2025	**95.08%**	95.00%	93.52%	H	F
Absence	December 2025	**5.34%**	4.25%	4.74%	H	?
All Turnover	December 2025	**11.14%**	11.00%	12.04%	L	F
Voluntary Turnover	December 2025	**8.82%**	9.00%	9.76%	L	?
Vacancy Rate	December 2025	**6.16%**	5.00%	8.53%	L	F

Our People - Mandatory Training and Appraisal Compliance

The Christie: All Directorates

Mandatory Training



Performance	Assurance
Improving	Failing

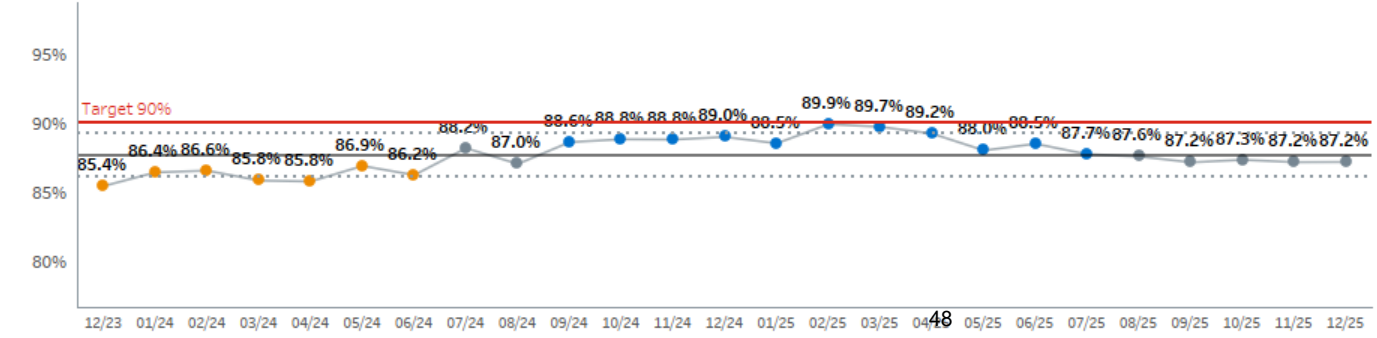
Summary

- There are **3,094** outstanding modules.

- The Face to Face training compliance % for December is **86.6%**

- The online training compliance % for December is **95.9%**

Appraisal



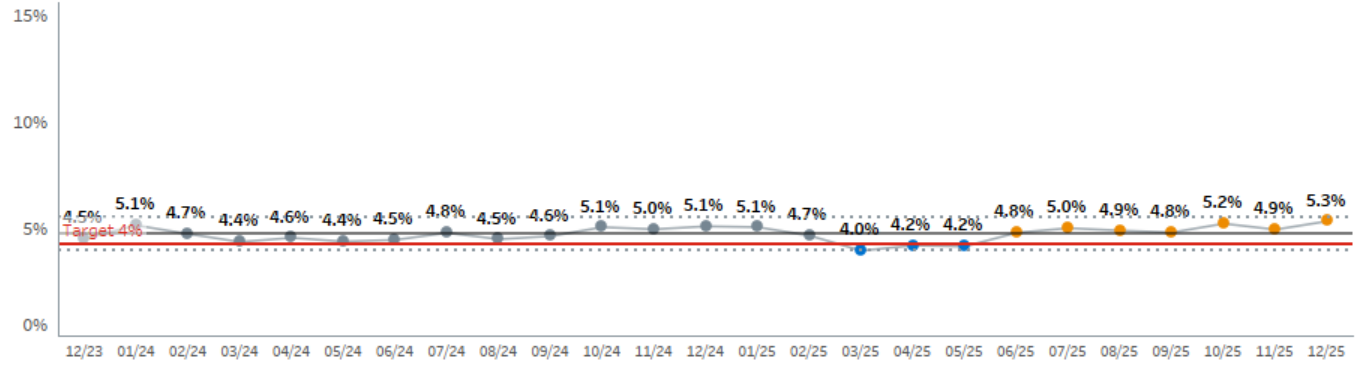
Performance	Assurance
Common Cause	Failing

Summary

- There are **453** outstanding appraisals.

Our People - Sickness Absence

All Absence



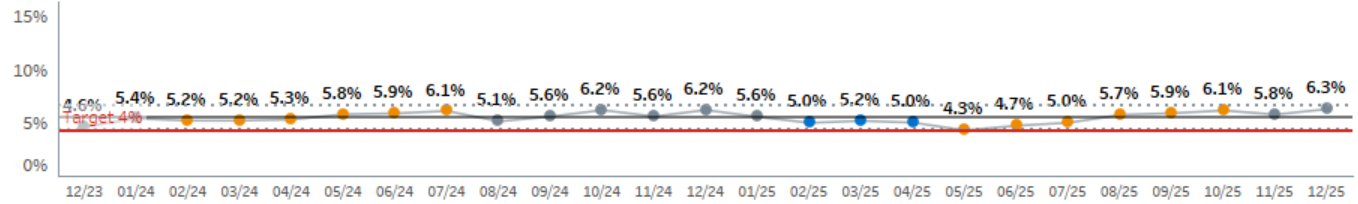
Performance	Assurance
Concerning	Hit & Miss

Summary

- The rolling yearly sickness absence % is **4.8%** as of December.

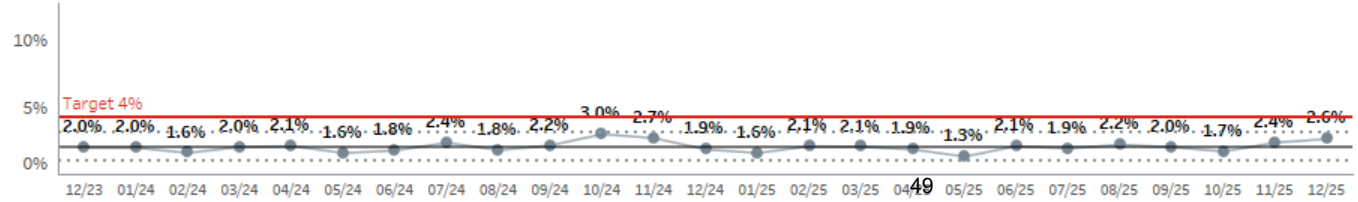
- There were **203** absences still open at the end of December.

Nursing and Midwifery



Performance	Assurance
Common Cause	Failing

Medical and Dental

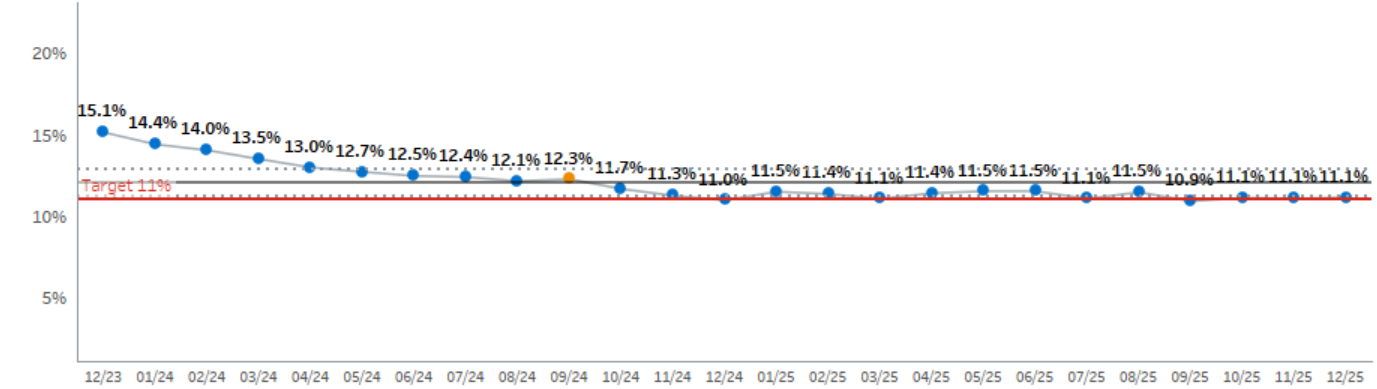


Performance	Assurance
Common Cause	Passing

Our People - Turnover

The Christie: All Directorates

All Turnover



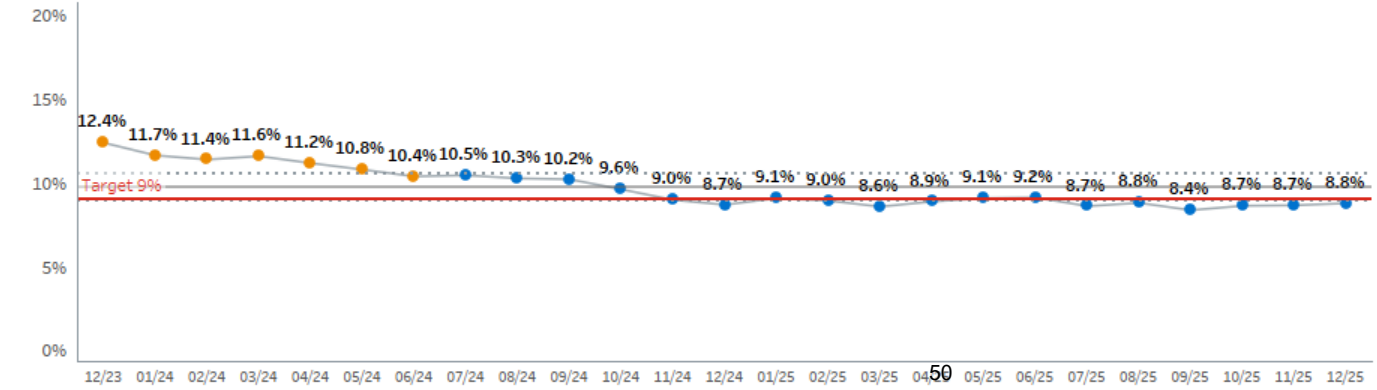
Performance	Assurance
Improving	Failing

Summary

- 38 colleague(s) left the Trust in December.

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

Voluntary Turnover



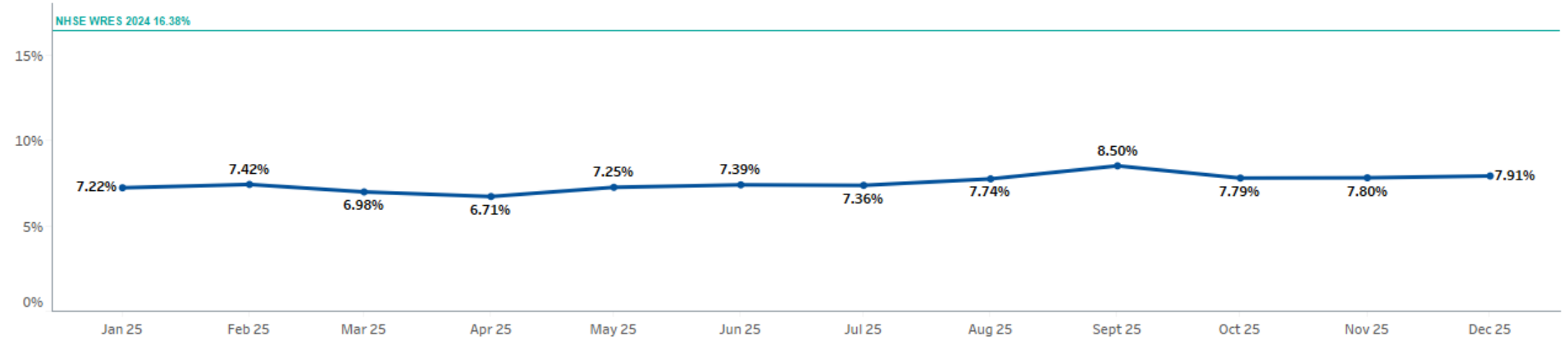
Performance	Assurance
Improving	Hit & Miss

Summary

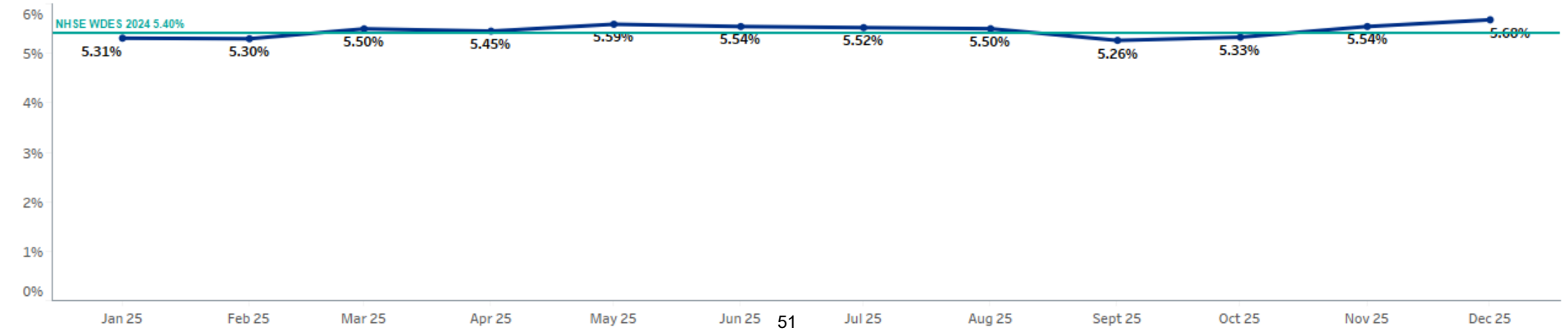
- The top voluntary leaving reason was **Voluntary Resignation - Relocation**.

Our People - Senior Management Representation

Senior Management (Band 8A - VSM) BAME %

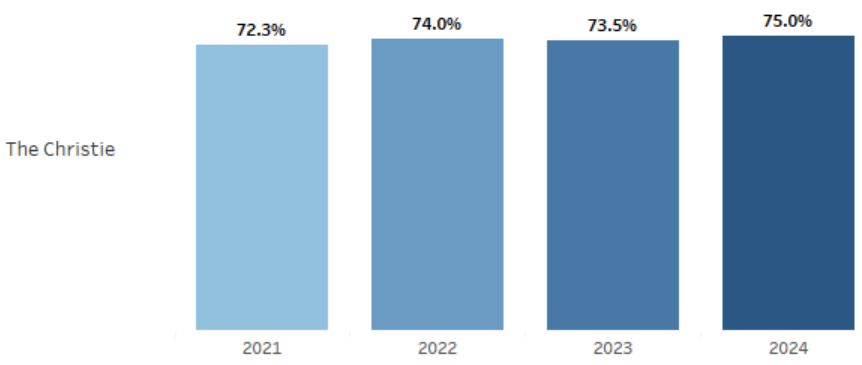


Senior Management- (Band 8A - VSM) Disability %



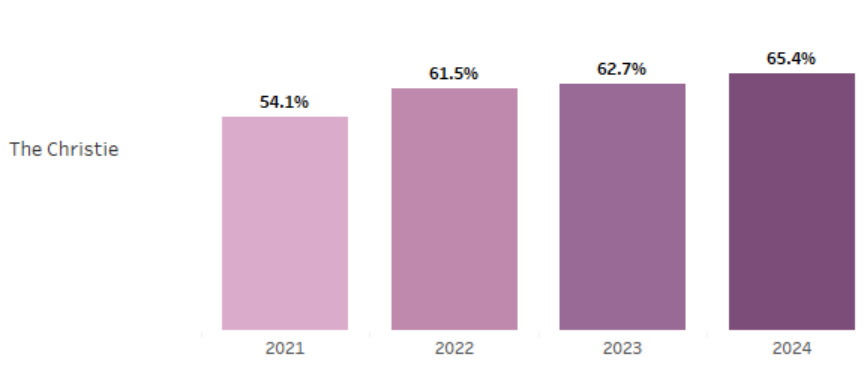
Our People - Staff Survey

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%

Oversight Framework 2025/26

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 data below relates to Q2 (Access to services module data has been excluded for specialist cancer Trusts whilst the national team work on a different way of displaying this data). Metrics have been grouped into domains and will be scored individually and across each domain, with Trust's being segmented into an overall score for comparison against other Trusts. The information is to be publicised on the Model Hospital platform.

Select a trust

The Christie NHS Foundation Trust (RBV)

View the glossary page

Average score

1.59

Higher by 0.08 from previous quarter

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

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

How has average score been calculated?

Trust in financial deficit?

No

No change from previous quarter

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

How is financial deficit applied?

Segment

1 - High performing

Previous quarter's segment: 1

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

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

7 out of 134

Previous quarter's rank: 3 out of 134

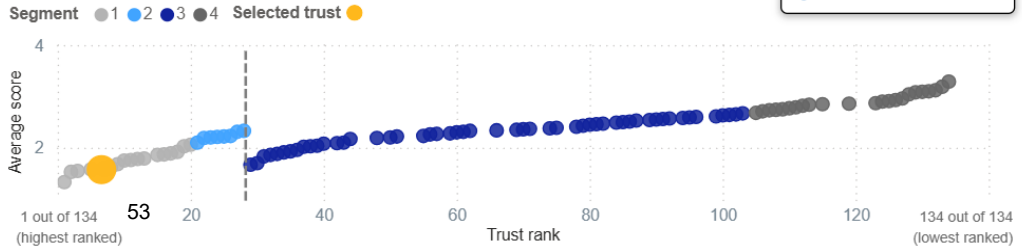
Each trust receives a rank based first on their segment and then their average score within that segment. Ranks range from 1 (the segment one trust with the lowest average score) to 134 (the segment four trust with the highest average score).
How has rank been calculated?

Performance domains

Access to services	(Blank)
Finance and productivity	3 - Below average
Effectiveness and experience	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 2025/26

The Christie NHS Foundation Trust

Quarter	Segment	Finance and productivity domain segment
Q2 2025/26	1 - High performing	3 - Below average

Return to overview

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
Finance and productivity	Finance	Planned surplus/deficit	2025/26	1.39	%	0.00 →	1.00	5 out of 134	-1.54	0
Finance and productivity	Finance	Variance year-to-date to financial plan	Month 6 2025	0.00	%	0.37 ↑	1.00	46 out of 134	0.00	
Finance and productivity	Finance	Combined finance	Q2 2025/26		score		1.00			
Finance and productivity	Productivity	Implied productivity level	Q1 2025/26 vs Q1 2024/25	-0.84	%	-2.48 ↓	3.39	107 out of 134	1.77	

Quarter	Segment	Effectiveness and experience domain segment
Q2 2025/26	1 - High performing	1 - High performing

Return to overview

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
Effectiveness and experience	Effective flow and discharge	Average number of days from discharge ready date to actual discharge date (including zero days)	Sep-25	0.03	days	-0.27 ↑	1.24	11 out of 125	0.78	
Effectiveness and experience	Patient experience	CQC inpatient survey satisfaction rate	2024		score		1.00			

Oversight Framework 2025/26

NHS
The Christie
NHS Foundation Trust

Quarter	Segment	Patient safety domain segment
Q2 2025/26	1 - High performing	1 - High performing

Return to overview

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
Patient safety	Patient safety	Number of MRSA bacteraemia cases	Oct 24 - Sep 25	2.00	count	-1.00 ↑	2.33	39 out of 134	3.00	0
Patient safety	Patient safety	Proportion of E. coli bacteraemia	Oct 24 - Sep 25	1.28	rate	0.23 ↓	3.39	100 out of 134	1.18	1
Patient safety	Patient safety	NHS Staff survey - raising concerns sub-score	2024	6.93	out of 10	0.00 →	1.11	6 out of 134	6.42	
Patient safety	Patient safety	Proportion of C. difficile infections	Oct 24 - Sep 25	0.98	rate	-0.06 ↑	1.00	1 out of 134	1.18	1

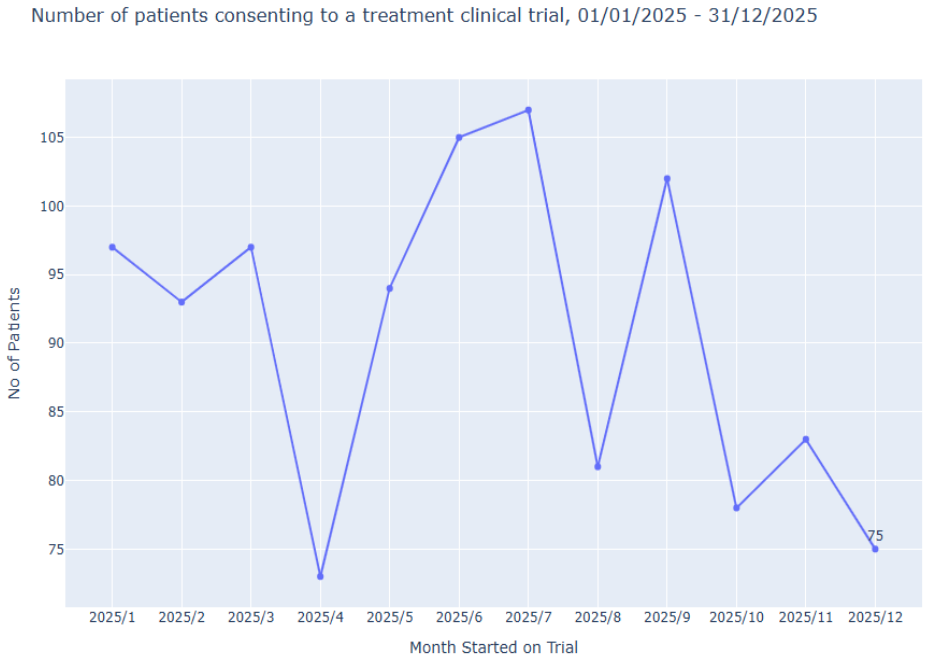
Quarter	Segment	People and workforce domain segment
Q2 2025/26	1 - High performing	1 - High performing

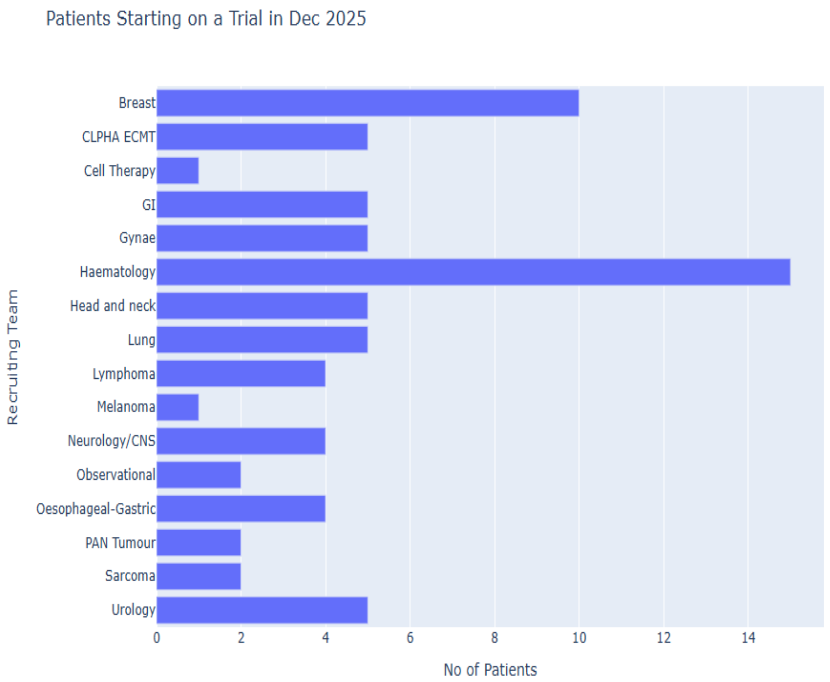
Return to overview

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
People and workforce	Retention and culture	Sickness absence rate	Q1 2025/26	4.24	%	-0.14 ↑	1.68	41 out of 134	4.72	
People and workforce	Retention and culture	NHS staff survey engagement theme sub-score	2024	7.52	out of 10	0.00 →	1.02	2 out of 134	6.88	

Clinical Outcomes

Clinical Trial Entries



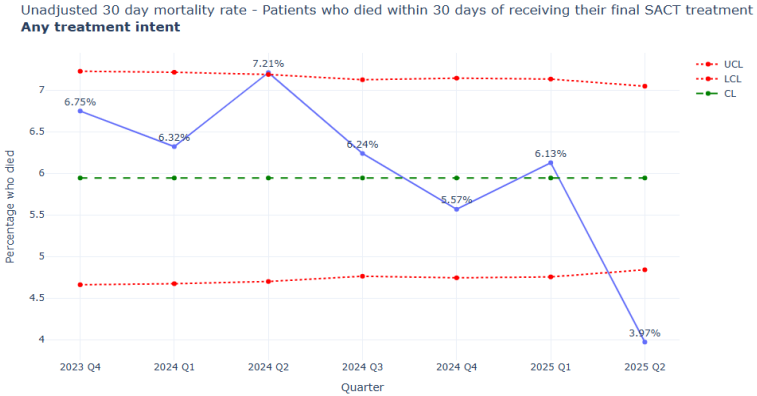


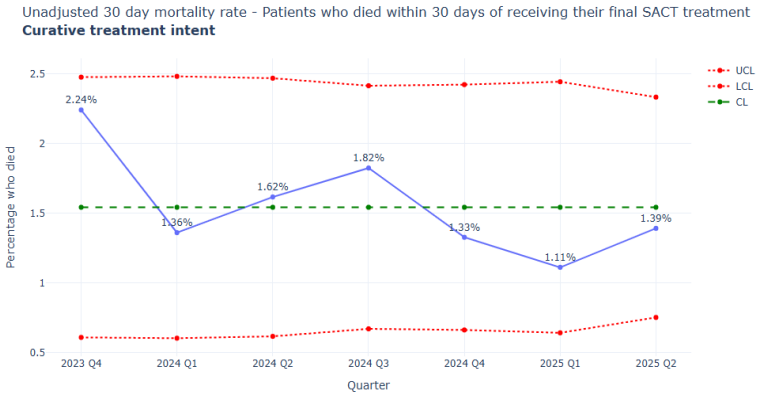
During Dec 2025 there was an increase in recruitment to Haematology trial.

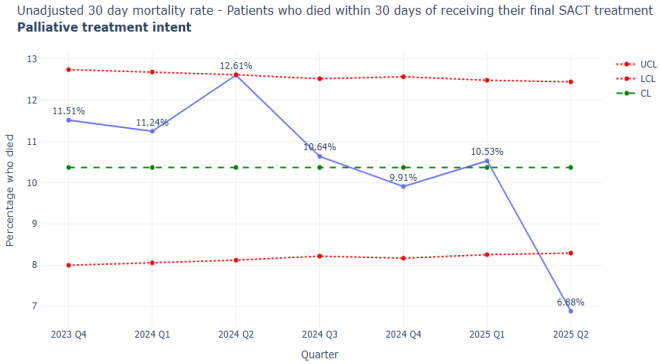
Clinical Outcomes

The Christie NHS Foundation Trust

30-Day SACT Mortality







The control line shows the 30-day mortality rate over the entirety of time frame shown: 01/10/2023 – 30/09/2025
The UCL and LCL are the upper and lower confidence limits (respectively) around the CL. 95% Confidence limits.

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

Research & Innovation

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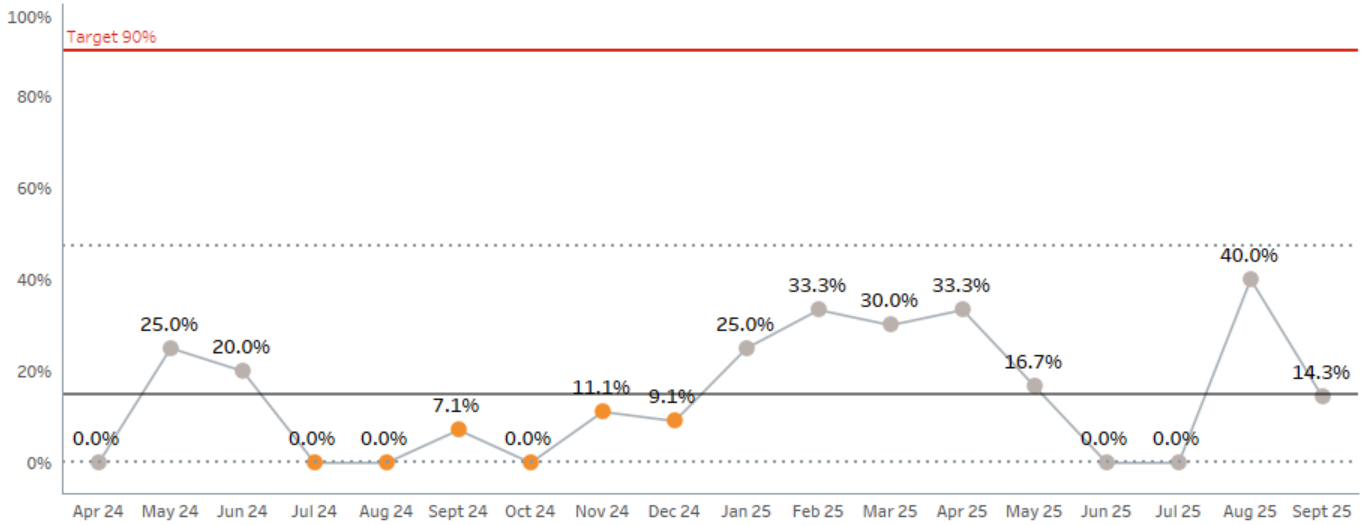
Area Shown: All

Metric	Month	Measure	Target	Mean	Variation	Assurance
Study opened within 60 days of HRA approval	September 2025	**14.29%**	90.00%	14.72%		
First participant recruited within 30 days of study opening	September 2025	**14.29%**	90.00%	25.47%		
Study amendment processed within 30 days	September 2025	**39.45%**	90.00%	45.69%		

Proportion of commercial contract studies open to recruitment within 60 days of HRA approval letter



Icons

Common Cause

Failing

Summary

Nationally, this KPI is not meeting the target level. The Christie is performing below the national average.

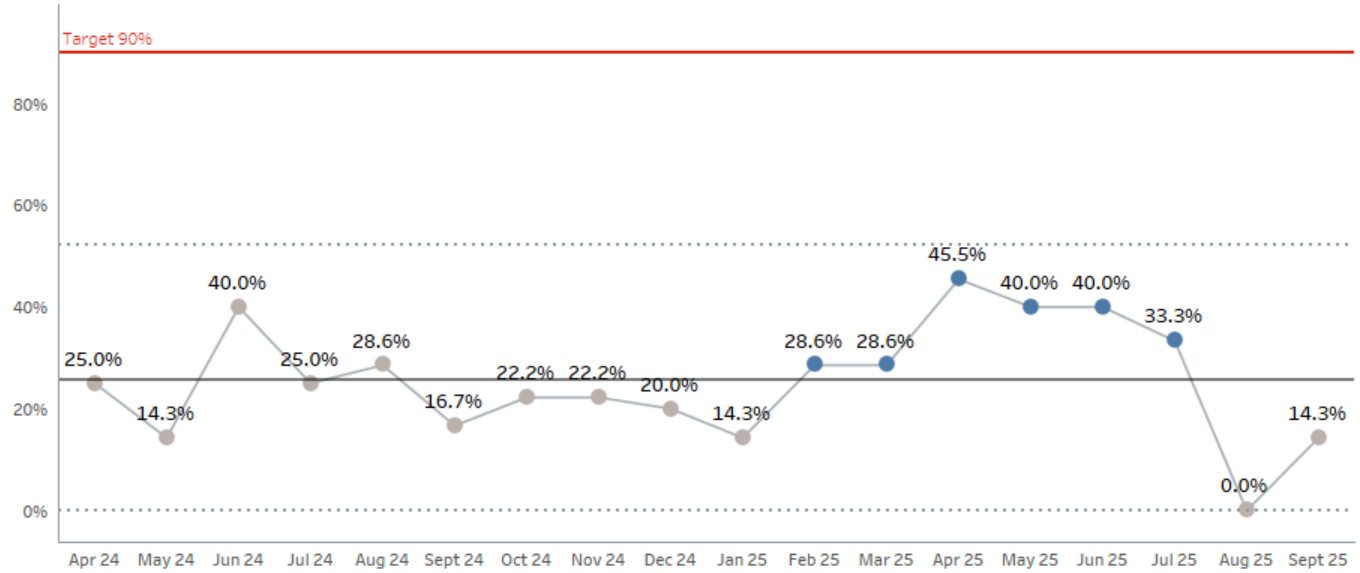
Understanding the performance

14% of studies that received HRA approval in September 2025 were opened to recruitment within 60 days. In October, the UK CRD reported the latest figure for this KPI as 20% nationally and an average of 27% over the same period. Nationally the data is still evolving and in January 2026 we should align to the national reporting to give a more accurate picture.
Set-up is a complex process with multiple stakeholders so granular data and broad actions will be required for improvement.
December two studies achieved; 1st in Europe and 1st in UK (ALlight and ALE1006)

Actions (SMART)

- Escalation meeting – incorporate granular performance data into meeting to formalise issues with performance and determine agreed actions.
- Develop process for ‘Commercial Site Selection Letter of Intent’ trial and measure effect on set-up times
- Implementation of EDGE to further streamline the process with additional reporting abilities.

Proportion of commercial contract studies recruiting first participant within 30 days



Icons

Common Cause

Failing

Summary

Nationally, this KPI is not meeting the target level. The Christie is performing below the national average.

Understanding the performance

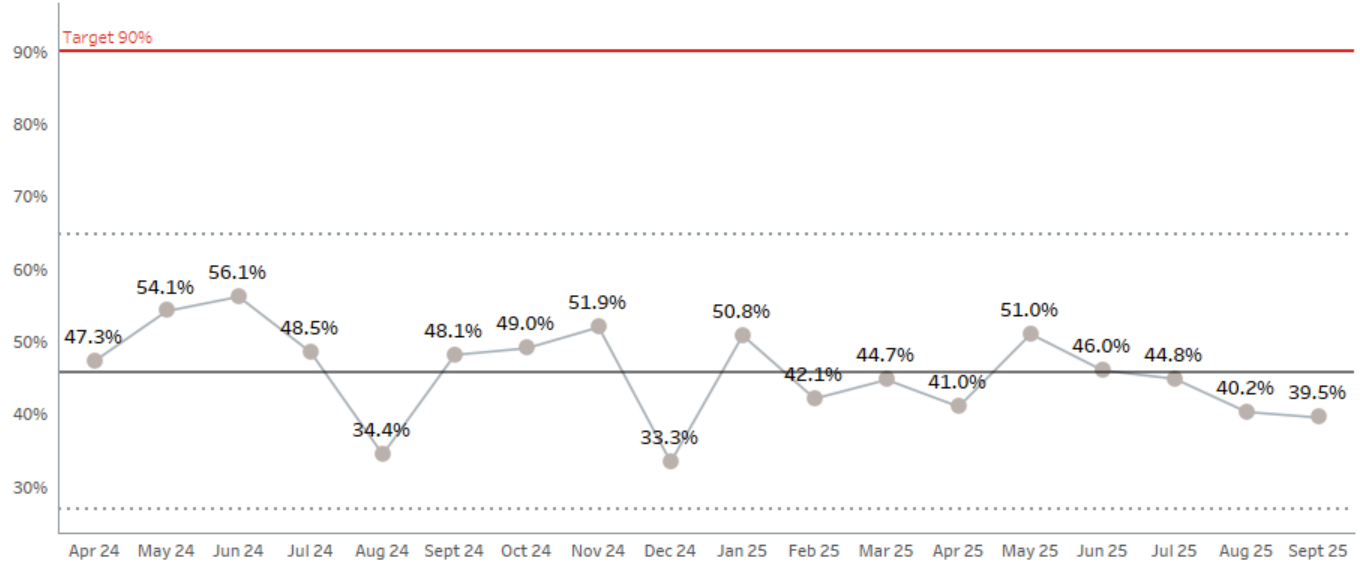
14% of studies that opened to recruitment in August 2025 have recruited a participant within 30 days. This is within the expected range based on the performance since April 2024.

In October, the UK CRD reported the latest figure for this KPI as 0% and an average of 38% over the same time period.

Actions (SMART)

- Develop a set of granular data which can provide meaningful indicators as to why the KPI is not met.

Proportion of Amendments processed within 35 days



Icons

Common Cause

Failing

Summary

Nationally, the target is 35 days for implementation for amendments. The Christie is performing below this target.

Understanding the performance

This is not a national measured and published KPI so cannot be benchmarked. 57% of all amendments completed in December were implemented within 35 days. The number is 64% for amendments which do not have resource implications and 27.3% for those that do have resource implications.

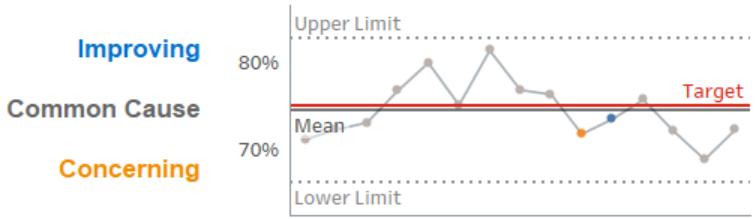
Actions (SMART)

- Escalation meeting – incorporate granular performance data into meeting to formalise issues with performance and determine agreed actions.
- Set-up a working group for amendment implementation
- Implementation of EDGE to further streamline the process with additional reporting abilities.

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.

The Christie NHS Foundation Trust

Agenda item 02/26c

Meeting of the Board of Directors
Thursday 29th January 2026

Subject / Title	Value Improvement Programme (VIP)
Author(s)	Jo Bolger Leece, Assistant Director for Value Improvement
Presented by	Claire McPeake Chief Operating Officer
Summary / purpose of paper	This report provides: • An overview of progress in developing the 2026/27 VIP plan, including the integration of NHS IMPACT principles and specialty-led improvement reviews. • Assurance that programme delivery is supported by robust Quality Impact Assessment (QIA) governance, clinical engagement, and alignment with national and local strategic priorities. • A summary of how the VIP plan aligns to planning submission for the Medium Term Operational Planning triangulating with performance, activity, workforce and finance. **Executive Summary** The Value Improvement Programme (VIP) 2025/26 delivered its annual financial improvement target of £25.3 million. Identification of the 2026/27 VIP are well underway, with an enhanced focus on recurrent financial sustainability, clinical-led specialty reviews, and embedding data-driven improvement across operational and clinical services. Governance oversight remains robust through the Operational Performance Improvement Group (OPIG), with clear escalation routes to senior management and the Board. While risks remain (notably workforce capacity and demand growth), the strengthened infrastructure and culture of improvement position the Trust well for continued delivery and regulatory assurance.
Recommendation(s)	The Board is asked to: 1. Note the position, XX 2. Support continued focus on recurrent efficiency delivery, ensuring sustainability beyond 2025/26. 3. Endorse the approach to Quality Impact Assessment (QIA) of the VIP schemes 4. Acknowledge ongoing risks (workforce, demand, and financial sustainability) and endorse continued mitigation through oversight and benchmarking (GIRFT, Model Health System). 5. Receive further updates on specialty review outputs and 2026/27 planning progress at the February Board.

Background papers	VIP reports to Board 2025
EDI Impact	Achievement of the value improvement target is expected to advance equity, improve access, or reduce disparities for one or more protected or disadvantaged groups
Risk score	Risk 3629 – Score 12 Board Assurance Framework: Risk 1, Risk 6, Risk 7, Risk 9, Risk 10
Link to: ➢ **Trust strategy** ➢ **Strategic objectives**	Executive objective: 1. To deliver safe, effective & equitable care 2. To deliver excellent financial and operational performance
Acronyms or abbreviations used in the paper	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 02/26c

Board of Directors
Thursday 29th January 2026

Value Improvement Programme (VIP)

1.0 Background and Introduction

National planning guidance sets out clear expectations for providers to deliver financial sustainability, recurrent cost improvement, productivity gains and reduced unwarranted variation over the next five years as part of their Cost Improvement Programme (CIP).

The Christie's response to these requirements is delivered through our Value Improvement Programme (VIP) which is the Trust's overarching, organisation-wide approach to CIP, efficiency and improvement. VIP is fully aligned to the Five-Year Integrated Delivery Plan, ensuring that financial, operational, workforce and digital plans are coherent, realistic and mutually reinforcing.

The Medium-Term Operational Planning Guidance, NHS Planning Framework and Provider Oversight Framework collectively require providers to:

- Deliver recurrent CIPs and operate within allocated resources
- Achieve a minimum 2% annual productivity improvement
- Reduce unwarranted variation using GIRFT, Model Hospital and national standards
- Align activity, workforce and financial plans
- Strengthen system collaboration to support the left shift
- Ensure digital transformation delivers measurable productivity benefits
- Maintain strong financial governance, grip and control

The Christie's Value Improvement Programme (VIP) provides the structured, organisation wide mechanism through which these requirements will be delivered. This paper provides:

- An overview of progress in developing the 2026/27 VIP plan, including the integration of NHS IMPACT principles and specialty-led improvement reviews.
- A summary of how the VIP plan aligns to planning submission for the Medium-Term Operational Planning triangulating with performance, activity, workforce and finance.
- Assurance that programme delivery is supported by robust Quality Impact Assessment (QIA) governance, clinical engagement, and alignment with national and local strategic priorities.

2.0 2026/27 Value Improvement Programme (VIP)

The Trust has successfully achieved its Value Improvement Programme (VIP) target for 2025/26 financial target, demonstrating assurance to the Board and system partners that The Christie continues to deliver sustainable value in alignment with national expectations and local strategic priorities.

Planning for the 2026/27 VIP is underway, building on the success of 2025/26. The focus will be on delivering sustainable, recurrent efficiencies while maintaining high-quality, patient-centred care. The programme continues to follow NHS IMPACT principles, promoting data-driven and clinically led improvement.

2.1 Key areas of progress:

- **Scheme identification:** Divisions are identifying schemes and reporting weekly to the Chief Operating Officer their position, which is also reported nationally.
- **Delivery planning:** Detailed implementation plans, milestones, and performance measures will be completed by March 2026.
- **Governance:** An updated Quality and Equality Impact Assessments process based on learning from last year will ensure changes remain safe and fair.
- **Engagement:** The HIVE system provides staff with access to FAQ, resources, and operational excellence programmes are being expanded to develop staff capacity and capability.
- **Specialty reviews:** Clinically led reviews have commences using GIRFT and Model Health System data to identify opportunities, reduce variation, and drive improvement, aligning our clinical strategy to the NHS 10 year plan, and medium term planning guidance.
- **Productivity and efficiency**: opportunity packs have been developed to support us to benchmark, reduce variation, improving workforce planning, and reduce reliance on temporary staffing.
- **Procurement, digital, and estates:** Ongoing work to optimise resource use, improve flow, and support sustainable service delivery continues with the development of Ambient Voice Technology (AVT)
- **Culture and capability**: NHS IMPACT training and coaching will help embed continuous improvement into everyday practice.

2.2 VIP performance

2026/27 Identified VIP- Transactable Savings

Division: All (Directorate: All)

Headlines

Target	Identified: Recurent	Identified: Non-Recurent	Unidentified: Gap to Target
£25,298,000	£6,156,582	£2,710,000	£16,431,418
No.of Plans Outstanding	**No.of Plans Not Required**	**No. of Plans In Progress**	**No. of Plans Submitted**
6	2	16	1
No.of QIA's Outstanding	**No.of QIA's Not Required**	**No. of QIA's In Progress**	**No. of QIA's Submitted**
6	12	7	0
Delivered / Implemented	**Green (of which remaining)**	**Amber (of which remaining)**	**Red (of which remaining)**
£0	£3,053,007	£1,873,000	£3,940,575

The Trust is working to submit a compliant Value Improvement Plan in line with national planning requirements as part of the agreed planning submission deadlines. At the time of writing, the Trust has identified £8.9m of value improvement, with further schemes in development.

By the point of submission on 12th February, the Trust expects to have 100% of the required value improvement identified. This will be delivered through a combination of productivity

schemes and transactional efficiencies, which are currently being fully scoped and costed to ensure robustness and deliverability.

As a result of additional governance, support and performance interventions now in place, the Trust anticipates that the remaining gap will be closed and identified, and compliant plan will be achieved within the required timescales.

3.0 National Requirements and Organisational Commitments

A clear understanding of the Trust's position against national requirements is essential for assurance that our VIP financial sustainability and productivity commitments are both credible and deliverable. The NHS Operational Planning Guidance places a strengthened emphasis on recurrent efficiency, productivity, grip and control, and system collaboration.

The Christie's response is delivered through our Value Improvement Programme (VIP), which provides the overarching framework for delivering our Five-Year Integrated Delivery Plan to ensure a coherent approach to improvement in the following areas:

3.1 Recurrent CIP Delivery and Financial Sustainability

National guidance requires providers to deliver recurrent CIPs, reduce underlying deficits and minimise reliance on non-recurrent measures. The Trust is committed to delivering a recurrent and sustainable CIP programme aligned to the Five-Year Integrated Delivery Plan.

Delivery will be supported through our Quality Management System, strengthened organisational grip and control, and improved improvement capability across all divisions. VIP will ensure that opportunities are identified through national productivity packs, local opportunity analysis and benchmarking against Model Hospital, GIRFT and wider best practice. We will support the delivery of high-impact schemes and ensure improvements are embedded and sustained with robust benefits realisation.

Key elements of delivery include:

- strengthened forecasting, financial governance and early escalation
- national and local productivity packs to identify opportunities
- benchmarking against GIRFT, Model Hospital and best practice
- for high-impact programmes

3.2 Minimum 2% Productivity Requirement

National expectations require providers to deliver a minimum 2% annual productivity improvement. The Trust is committed to achieving this through VIP, with a focus on pathway redesign, operational efficiency and digital innovation. Priority areas include theatres, outpatients, diagnostics and inpatient flow, where there are opportunities to release capacity and reduce non-value-adding activity.

Our approach will include:

- standardising pathways and reducing variation, including adoption of GIRFT clinic methodology, and peer review outcomes
- improving productivity across outpatient, diagnostic, surgical and inpatient pathways

- deploying digital innovation through Future Christie (EPR, automation, AVT, FDP)
- building operational excellence and QI capability to support continuous improvement

3.3 Reducing Unwarranted Variation

National guidance emphasises the need to reduce variation in clinical practice, length of stay, theatre utilisation and outpatient models of care. The Trust is committed to systematically reducing unwarranted variation across all pathways to improve quality, productivity and patient experience.

This will be achieved through:

- using GIRFT, Model Hospital and internal analysis to identify variation
- standardising clinic templates, MDT processes and follow-up models
- embedding GIRFT clinic methodology where clinically appropriate
- monitoring variation through divisional performance reviews
- expanding Advice & Guidance and shared care
- supporting Single Queue Diagnostics and networked imaging
- using the Federated Data Platform to support pathway optimisation

3.4 Workforce Efficiency and Pay Cost Control

National requirements include reducing agency spend by 30%, optimising skill mix and modernising workforce models. The Trust is committed to maintaining a safe, sustainable and efficient workforce aligned to activity and financial plans, with a clear trajectory to reduce variable pay.

Key areas of focus include:

- strengthened rostering, job planning and deployment
- targeted recruitment and retention initiatives
- reducing administrative burden through automation
- building QI capability to support workforce-led improvement
- aligning workforce capacity to demand through improved modelling

3.5 Digital Transformation as a Productivity Enabler: Future Christie

Digital transformation is a core enabler of improved access, productivity and experience. National guidance requires digital investment to deliver measurable productivity gains. Future Christie is central to this ambition, ensuring that digital programmes are aligned to benefits realisation and productivity plans.

Key priorities include:

- implementation of the new EPR

- deployment of automation and ambient voice technology
- use of the Federated Data Platform to support diagnostics, PIFU and operational decision-making
- alignment of digital programmes with productivity and transformation objectives

3.6 Alignment of Activity, Workforce and Financial Plans

National expectations require providers to ensure that activity, workforce and financial plans are fully aligned, credible and deliverable. The Five-Year Integrated Delivery Plan provides this alignment for The Christie, ensuring that operational, workforce, digital and financial assumptions are coherent and mutually reinforcing.

This includes aligning capital investment with digital and operational priorities, strengthening procurement efficiency and reducing non-pay costs through standardisation and improved governance. VIP will support the delivery of non-pay efficiencies and maintain strong financial resilience through clear risk mitigation, early escalation and robust performance oversight.

- Using FDP for Single Queue Diagnostics and Patient Initiated Follow up, supporting operational decision-making
- Aligning digital programmes with benefits realisation and productivity plans

4. Quality Impact Assessment (QIA)

The NHS Operational Planning Guidance sets a clear expectation that providers must deliver financial sustainability without compromising the quality or safety of care. At The Christie, this principle is embedded within our Value Improvement Programme (VIP), which is designed to deliver efficiency and transformation in a way that protects, and where possible enhances, the quality of services we provide.

To ensure that value improvement activity does not adversely affect patient care, The Christie operates a Quality Impact Assessment (QIA) process aligned to the Equality and Health Impact Assessment (EHIA). This ensures that patient safety, clinical effectiveness, patient and staff experience, and equity are systematically considered as part of all VIP schemes.

The QIA reflects national expectations that quality impacts must be identified, mitigated, monitored and reviewed, providing assurance that decisions remain within organisational risk appetite and quality standards.

The QIA framework ensures that quality considerations are embedded throughout the lifecycle of a scheme, from early development and approval through to implementation, monitoring and post-delivery review. Accountability for the QIA process is embedded within existing clinical and corporate governance arrangements, ensuring that schemes with potential quality impacts receive appropriate scrutiny.

Through this approach, the Trust can provide assurance to the Board that VIP schemes are delivered safely, transparently and in line with national expectations.

5. Recommendations

The Board is asked to:

1. **Note** the overall VIP position and risks
2. **Note** the national requirements for financial sustainability, productivity and transformation and the organisational commitments set out in this paper.
3. **Support** the approach to Quality Impact Assessment as part of the Value Improvement Programme (VIP).
4. **Agree** the alignment of the Five-Year Integrated Delivery Plan with VIP, CIP and productivity priorities.

The Christie
NHS Foundation Trust

Agenda Item 02/26d

Meeting of the Board of Directors
Thursday 29th January 2026

Subject / Title	Review of the Annual Objectives
Author(s)	Louise Westcott, Company Secretary
Presented by	Chief Executive Officer
Summary / purpose of paper	This paper outlines progress against the agreed annual objectives for 2025/26.
Recommendation(s)	The board of directors are asked to; • Review and note the progress with the annual objectives
Background papers	Strategic objectives, Board assurance framework
Risk score	N/A
EDI Impact	Achievement of the annual objectives is expected to advance equity, improve access, or reduce disparities for one or more protected or disadvantaged groups.
Link to: ➢ Trust strategy ➢ Corporate objectives	• Trust's strategic direction • Divisional implementation plans • Key stakeholder relationships
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	BAF Board assurance framework ECN Executive Chief Nurse EDoF Executive Director of Finance EMD Executive Medical Director COO Chief operating officer DoW Director of workforce NHSE NHE England

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Meeting of the Board of Directors
Thursday 29th January 2026

Review of Annual Objectives 2025/26

1. Introduction

This paper outlines progress against the annual objectives for 2025/26 (appendix 1).

2. Background

Our Strategy 2023-28 describes where the Trust wants to be, and the operational plan describes how we will achieve this in year. A simplified set of 6 strategic objectives, annual objectives 2025/26 and revised strategic risks were reviewed at the Board Planning Day in May. The strategic risks form the Board Assurance Framework. This paper updates on progress against the agreed annual objectives.

3. Strategic objectives

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

The 6 strategic objectives and cascade to the annual objectives feed into divisional objectives. Monitoring of the objectives is done through the integrated performance report and reports to board and the assurance committees. Assurance is managed through the board assurance framework and the assurance committees.

Our Strategic Objectives are;

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

The review of the annual objectives has not highlighted any issues for escalation to the Board.

4. Board Assurance Framework (BAF)

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

The BAF will continue to evolve through regular review.

5. Recommendation

The board of directors are asked to;

- Review and note the progress with the 2025/26 annual objectives

Appendix 1: Annual Objectives 2025/26

1. To deliver safe, effective, patient orientated & equitable care							
	BAF risk	Strategy Theme ref	Annual objective	Reporting	Timescale	Director	Progress
1.1	2	TCE BE	Achieve the year 3 actions of the Quality Plan 2023-2026	QAC – March 2026	31.03.2026	ECN	Achieved - complete
1.2	2	BO	Achieve the year 1 actions of the Risk Strategy	QAC – March 2026 / Board of Directors – April 2026	26.03.2026 30.04.2026	ECN	Achieved - complete
1.3	2	TCE BO	Achieve the year 3 actions of Patient Experience and Engagement Plan 2023-2026	QAC – June 2026	31.03.2026	ECN	Achieved – complete. 2026-28 will be in the Quality Plan
1.4	2	TCE	Develop a revised Quality Plan for 2026-29	QAC – March 2026	31.03.2026	ECN	On track. Launch April 2026
1.5	2, 12	TCE BO	Ensure compliance with the CQC regulations & quality standards	QAC / WAC / Board	31.03.2026	ECN	Excellence in action programme continues. No reinspection. IRMER – 2 minor recommendations

2. To deliver excellent financial and operational performance							
	BAF risk	Strategy Theme ref	Annual objective	Reporting	Timescale	Director	Progress
2.1	5,6 10	LCC	Achieve the agreed revenue financial plan including value-improvement programme VIP.	Board of Directors meetings / planning sessions	31.03.2026	EDoF	VIP achieved 2025/26

2. To deliver excellent financial and operational performance							
	BAF risk	Strategy Theme ref	Annual objective	Reporting	Timescale	Director	Progress
2.2	4, 10	LCC	Achieve mandated national targets as per the Performance Assessment Framework (PAF) for 2025/26.	Integrated Performance Quality & Finance Report (IPQFR) to each Board	31.03.2026	COO	On plan to achieve all targets in year
2.3	5	LCC	Achieve the agreed Trust capital plan in 2025/26.	Board of Directors meetings / planning sessions	31.03.2026	EDoF	On plan
2.4	10	LCC	Achieve the nationally mandated corporate services savings.	Board of Directors meetings	31.03.2026	EDoF	On plan
2.5	4, 10	LCC TCE	Ensure compliance with the CQC Regulations & quality standards.	QAC / WAC regular reports	31.03.2026	ECN / DoW	On plan

3. To provide integrated clinical, research and education services							
	BAF risk	Strategy Theme ref	Annual objective	Reporting	Timescale	Director	Progress
3.1	9	LCC BO	Achieve the year 3 actions of the Research Plan	QAC 6 monthly	31.03.2026	DoR	Achieved
3.2	9	LCC	Achieve the year 3 actions of the Education Plan	6 monthly WAC Reports	31.03.2026	DoE	Achieved
3.3	1, 15	LCC	Achieve the year 3 actions of the Clinical Outcomes Plan	QAC	31.03.2026	EMD	Achieved
3.4	9	LCC BO LSP TCE	Achieve the year 3 objectives of the Trust Strategy	Board of Directors	31.03.2026	DoS	Achieved

3. To provide integrated clinical, research and education services							
	BAF risk	Strategy Theme ref	Annual objective	Reporting	Timescale	Director	Progress
3.5	9	LCC	Refresh arrangements and strategy for MCRC in collaboration with new appointments in University and CRUK-MI Director	Board of Directors	31.03.2026	DoR	In progress – discussion with UoM & CRUK continuing following new senior appointment at UoM
3.6	9	LCC	Achieve OECI re-Accreditation as a Comprehensive Cancer Centre	Board of Directors	30.07.2025	DCEO	Complete – achieved

4. To be an excellent place to work and attract the best staff							
	BAF risk	Strategy Theme ref	Annual objective	Reporting	Timescale	Director	Progress
4.1	3, 12	TCE LSC	Achieve the year 1 actions of the Inclusive Culture Strategy	WAC	31.03.2026	DoW	Achieved
4.2	3, 12	TCE	Achieve the year 3 milestones of The Christie People & Culture Plan 2023/26	WAC	31.03.2026	DoW	Achieved – incorporated into Inclusive Culture Strategy
4.3	3, 12	TCE LSC	Achieve the delivery of objectives set in EDS 2025/26.	WAC	31.03.2026	DoW	On track

5. To transform our services to improve access and reduce health inequalities							
	BAF risk	Strategy Theme ref	Annual objective	Reporting	Timescale	Director	Progress
5.1	15, 13	LCC BO	Achieve the year 1 objectives of the Future Christie programme focusing on patient access to information	Board of Directors – every meeting	31.03.2026	DFC	Achieved
5.2	15	LCC TCE BO	Achieve the next steps in our plans to develop modern imaging capability	Board of Directors	31.03.2026	COO	Approvals complete. Decant started.
5.3	13, 2	TCE BO	Achieve year 1 objectives for implementation of new clinical model for acute oncology & inpatient care	Senior Management Committee	31.03.2026	EMD	Achieved
5.4	3, 12	LSC	Achieve the annual health inequalities milestones set out in the Equality and Diversity Plan (Domain 1).	QAC	31.03.2026	DoS	On plan
5.5	4	LSC	Achieve the annual milestones set out in our Green Plan.	Audit Committee October	31.03.2026	DoS	Achieved

6. To provider leadership within the wider NHS cancer system							
	BAF risk	Strategy Theme ref	Annual objective	Reporting	Timescale	Director	Progress
6.1	9, 15	LCC	Contribute to development of proposals for a National Cancer Institute to provide national leadership and coordination of standards of cancer care in England	Board of Directors	31.03.2026	DCEO	Overtaken by publication of National Cancer Plan
6.2	7	LCC LCS	Lead agreed improvements to cancer care pathways across Greater Manchester and Cheshire	Board of Directors	31.03.2026	DoS	Leading GM Aseptic project

KEY:

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

Strategy Themes;

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

The Christie
NHS Foundation Trust

Agenda item 03/26a

Meeting of the Board of Directors

Thursday 29th January 2026

Subject / Title	Future Christie Update
Author(s)	Adrian Bloor, Medical Director of Future Christie
Presented by	Adrian Bloor, Medical Director of Future Christie
Summary / purpose of paper	To update the Board on progress delivered to date within the Future Christie Programme, outline upcoming priorities for Year 1 delivery, and seek endorsement of programme direction and next-stage actions, including: • Deployment of Ambient Voice Technology (AVT) • Advancement of the Electronic Patient Record (EPR) procurement • Implementation of the Joint Analytics for Cancer (JAC) initiative – the foundation of the intelligent hospital vision. The Future Christie Programme continues to deliver significant progress toward building a world-leading, intelligent, and data-driven cancer centre. Over the past quarter, the programme has achieved major milestones across digital transformation, patient engagement, and data integration.
Recommendation(s)	The Board is asked to: 1. Note the ongoing progress made across key Future Christie workstreams. 2. Note the progress made with EPR business case and the timeline for delivery 3. Acknowledge the ongoing challenges and the mitigating actions in place. 4. Note the development of the NHS Federated Data Platform which is aligned to the Future Christie ambitions.
Background Papers	Trust Strategy 2023-2028 NHS 10 year plan Future Christie Overview
Risk Score	See Board Assurance Framework Risk 13 and Risk 15
EDI impact / considerations	The proposals are expected to advance equity, improve access, or reduce disparities for one or more protected or disadvantaged groups. Proposals focus on better communication with patients and staff to streamline care and treatment.

Link to: ➢ Trust's Strategic Direction ➢ Strategic Objectives	1. To deliver safe, effective & equitable care 2. To deliver excellent financial and operational performance 3. To provide integrated clinical, research and education services 4. To be an excellent place to work and attract the best staff 5. To transform our services to improve access and reduce health inequalities 6. To provider leadership within the wider NHS cancer system
Acronyms or abbreviations used in the paper	EPR Electronic patient record JAC Joint analytics for Cancer AI Artificial Intelligence AVT Ambient Voice Technology SQD Single Queue Diagnostics PSFU Patient Stratified Follow up FDP Federated Data Platform

The Christie
NHS Foundation Trust

Agenda item 03/26a

Meeting of the Board of Directors

Thursday 29th January 2026

Future Christie Update

1.0 Future Christie Programs of work

The programme has moved from design into delivery, with progress across all core workstreams:

Electronic Patient Record (EPR):

The program team is finalising an Outline Business Case (OBC) for a new EPR system to be presented to Board in February 2026. Over 140 stakeholders across multiple staff groups have contributed to the engagement workshops defining requirements and pathways, focusing on delivery of patient-centred, data-driven care.

The new EPR will enable real-time patient pathway tracking, structured data capture, clinical decision support, workflow automation, integration with NHS and partner systems, a patient portal, and consolidated records.

Four strategic options are under consideration: maintaining current systems, deploying a core EPR, procuring a comprehensive enterprise EPR, or adopting an enterprise EPR through partnership. The preferred option is a partnership model, sharing a single EPR instance to facilitate efficient patient flows across Greater Manchester and beyond.

Joint Analytics for Cancer (JAC):

A £3m business case was approved to establish the Christie Data Platform, appoint a Chief Data Officer, and undertake foundational data work. Recruitment for key roles is underway. Applications for the Chief Data Officer closed stakeholder panels and interviews scheduled for February 2026.

Patient Portal:

Over 9,000 patients are now registered, accessing appointment details and clinical correspondence electronically. The next phase includes expanding functionality to phlebotomy, supportive care, and radiology appointments, aiming to meet NHS targets for elective appointment visibility.

Ambient Voice Technology (AVT):

AVT has completed technical validation and roll out in Surgery and Haematology will commence on 19th January 2026 with wider implementation at the end of Q2 2026. Regional Transformation Fund support (£2.4m) will enable broader deployment of the technology; areas being investigated include MDT meetings, acute admissions and the hotline.

2.0 Federated Data Platform

The NHS Federated Data Platform (FDP) is a £330 million national initiative to unify data across trusts and integrated care systems, enabling advanced analytics, AI-driven insights, and improved operational efficiency. The Christie will host the Greater Manchester FDP service and integration with FDP underpins the Future Christie vision and the JAC program, creating a single, high-quality data resource.

Initial deployment focuses on Single Queue Diagnostics (SQD) enabling clinicians to request diagnostic tests from external providers, and a digital follow-up tool (Patient Stratified Follow Up - PSFU) providing digital remote monitoring for post-treatment cancer patients, supporting personalised follow up pathways.

The SQD and PSFU platforms have been configured and data sharing arrangements across Greater Manchester Trusts are in place allowing initial roll out during by the end of the current financial year. A project board is being convened to enable deployment at the Christie.

3.0 Strategic Alignment and Benefits

The Future Christie Programme directly supports the Trust Strategy and Corporate Objectives, particularly in improving patient experience, operational excellence, and research capability. It aligns with the NHS Long-Term Plan through digital enablement, data-driven care, and partnership-based innovation.

4.0 Challenges and Mitigations

EPR Programme Risks:

Condensed timescales may limit stakeholder engagement, risking delays or gaps in information. This has been mitigated by excellent engagement at workshops, and the business case development remains on schedule. Procurement plan delays could impact on timelines, and the project team is assessing options.

Patient Portal Risks:

Delayed implementation of enhanced functionality due to requirement for integration with NHS application and plans for the electronic patient record replacement. A prioritisation exercise is planned but additional functionality will not be available until later in 2026. Failure to meet NHS target for elective appointments in the NHS app is being managed via ongoing dialogue with NHS England to define targets and close engagement with operational teams. Significant progress has been made to achieve the target for displaying 70% of outpatient appointments.

AVT Programme Risks:

Cultural change and adapted roles for staff may challenge implementation. Mitigation involves co-designed plans, staff education, and formal consultation with HR. Quality and accuracy of patient communication could be affected by AVT. Mitigation includes phased implementation, post go-live assessment, and robust clinical safety sign-off.

FDP risks

The scope of the SQD and PSFU projects remain uncertain beyond April 2026. Broad utilisation will optimise the benefits however require capacity from operational digital teams to deploy. The PSFU platform will also need integration with the electronic patient record for clinical operability although will require additional scoping and work from the digital teams to deliver.

5.0 Next Steps

- Continue progress with patient portal and AVT deployment.
- Initiate discovery work on the data platform and infrastructure for the JAC program.
- Complete the Outline Business Case for EPR with Deloitte and procurement/legal teams.
- Key dates for board and committee approvals are scheduled throughout January and February 2026, culminating in outline business case approval.
- To work with the FDP team to facilitate deployment of SQD and PSFU.

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Agenda item 03/26b

Board of Directors

Thursday 29th January 2026

Subject / Title	Financial & operational 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 the progress on the financial plan and matters outstanding • delegate authority to the Chief Executive and Executive Director of Finance to submit a compliant plan pending agreement of income with commissioners
Background Papers	Papers to the October and November Board meetings regarding approach to financial planning
Risk Score	BAF Risks 5 / 6 / 10
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

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Agenda item 03/26b

Board of Directors

Thursday 29th January 2026

Financial and operational planning

1. 2026/27 planning

The Board has previously received update papers regarding the approach and progress on financial and operational planning for 2026/27 in its October and November meetings.

The initial plan was submitted mid-December 2025 and was compliant with the performance targets and prescribed financial control total (£7.5m surplus). At this point, we had not had contract offers from either commissioner (NHS England Specialised Commissioning or GM ICB), the income had been included as per calculations from the contracts but not formally agreed with commissioners.

At the time of writing, we still do not have confirmation that the income will be as per the contract and assumed in the plan. We have responded to several queries but are yet to receive formal confirmation.

As such, the Board are requested to, subject to a confirmation of income aligned with the contract and assumed in the plan, delegate authority to the Chief Executive and Executive Director of Finance to submit the compliant plan by the due date of 4th February 2026.

2. Recommendation

The Board is asked to:

- note the progress on the financial plan and matters outstanding
- delegate authority to the Chief Executive and Executive Director of Finance to submit a compliant plan pending agreement of income with commissioners

The Christie
NHS Foundation Trust

Agenda Item 04/26a

Meeting of the Board of Directors
Thursday 29 January 2026

Subject / Title	Workforce Assurance Committee report – November 2025
Author(s)	Jo D'Arcy, Assistant Company Secretary Amanda Oates, Committee Chair
Presented by	Amanda Oates, Committee Chair
Summary / purpose of paper (alert / advise / assure)	This paper provides the Board with a AAA summary of the items considered by the Workforce Assurance Committee at their November meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions required.
Background papers / sources of assurance	Workforce Assurance Committee papers – 20 November 2025
EDI impact / considerations	No direct EDI impact identified: The subject matter has been assessed and found to have no foreseeable implications for equality, diversity, inclusion, or opportunity.
Link to: ➢ Board Assurance Framework ➢ Trust strategy ➢ Corporate objectives ➢ CQC Quality standard ➢ Regulation	• Board Assurance Framework – Risks 3, 4 and 12 • Corporate objective 4 - to be an excellent place to work and attract the best staff • CQC Regulations – 9, 10, 12 and 18
Risk score	N/A
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	EDI – Equality, Diversity & Inclusion MIAA – Mersey Internal Audit Agency PDR – Performance Development Review

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Agenda Item 04/26a

Meeting of the Board of Directors
Thursday 29 January 2026

Workforce Assurance Committee summary report – November 2025

1 Introduction

The committee took place on 20 November 2025. Quoracy met with 4 of 4 members present, including the Chair. All decisions are valid.

2 AAA summary from committee meeting

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

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

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

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

3 Recommendation

The Board are asked to note the summary report from the committee in November 2025.

Appendix 1

Alert	Assurance rating (if applicable)	Action (to be taken)	By Whom	Target Date
Mandatory training compliance – assurance increased from low to medium. Further assurance sought on how the plan addresses sustainability of thresholds being met and the monitoring of areas that fall in and out of the threshold.	Medium	Further update to come back to the committee in June.	Deputy Director of Workforce	June 2026
Role essential training: • Low assurance on staff completion of training through information provided. • Transfer of data to ESR – good progress being made with a completion date set for December 2025.	Low Medium	Further updates to come back to the committee in January and March.	Assistant Director of Education	March 2026
National training survey – actions noted as high level within the report, a more granular level of detail on the actions sought for assurance as part of a further update in March.	Medium	Progress update to come back to the committee in March	Director of Education	March 2026

Advise:	Assurance rating (if applicable)
Improving resident doctors' working lives 10-point plan: progress noted but external reporting issues persist, to be resolved through lead employer (not the Trust) and NHSE. Further update to committee in June.	N/A
Consistency on completion of EDI section on cover papers to be improved, noted by all committee members for future reports.	N/A

Assure:	BAF reference	CQC reference	Assurance rating
• Workforce dashboard – voluntary turnover down to 8.5% (12% in 2023); vacancy rate 6.7%; sickness 4.9%, PDR compliance 87.2%. Threshold review welcomed.	3, 4, & 12	18	High
• Admin bank review (MIAA) – high assurance provided; the majority of the recommendations have been completed.	3	N/A	High
• Nurse staffing bi-annual report - establishment slightly above requirement which is a positive. Mitigations in place for higher falls linked to complexity.	3 & 4	9, 10 & 12	High

Risks discussed (including any new risks identified):

- Workforce supply risk remains at 9; regularly reviewed by Workforce Committee.
- Previous low assurance for mandatory training compliance escalated to Trust risk register.
- Patient safety risk due to staffing noted in the guardian of safe working hours report, this was resolved.

The following agenda items were also discussed during the meeting:

- Approval of previous minutes and a review of actions
- Board assurance framework (BAF) 2025/26
- Internal audit recommendation tracker

The Christie
NHS Foundation Trust

Agenda Item 04/26a

Meeting of the Board of Directors
Thursday 29 January 2026

Subject / Title	Quality Assurance Committee report – November 2025
Author(s)	Jo D'Arcy, Assistant Company Secretary Sarah Corcoran, Committee Chair
Presented by	Sarah Corcoran, Committee Chair
Summary / purpose of paper (alert / advise / assure)	This paper provides the Board with a AAA summary of the items considered by the Quality Assurance Committee at their November meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions required.
Background papers / sources of assurance	Quality Assurance Committee papers – 26 November 2025
EDI impact / considerations	No direct EDI impact identified: The subject matter has been assessed and found to have no foreseeable implications for equality, diversity, inclusion, or opportunity.
Link to: ➢ Board Assurance Framework ➢ Trust strategy ➢ Corporate objectives ➢ CQC Quality standard ➢ Regulation	• Board Assurance Framework – Risks 1, 2, 4 and 7 • Corporate objective 1 - To deliver safe, effective & equitable care • Corporate objective 3 - To provide integrated clinical, research and education services • Corporate objective 5 - To transform our services to improve access and reduce health inequalities • Corporate objective 6 - To provider leadership within the wider NHS cancer system • CQC Regulations – 9, 10, 12, 16 and 20
Risk score	N/A
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	EDI – Equality, Diversity & Inclusion MIAA – Mersey Internal Audit Agency PDR – Performance Development Review

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Agenda Item 04/26a

Meeting of the Board of Directors
Thursday 29 January 2026

Quality Assurance Committee summary report – November 2025

1 Introduction

The committee took place on 26 November 2025. Quoracy met with 4 of 5 members present, including the Chair. All decisions are valid.

2 AAA summary from committee meeting

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

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

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

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

3 Recommendation

The Board are asked to note the summary report from the committee in November 2025.

Appendix 1

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

Advise:	Assurance rating (if applicable)
Quality plan – Committee noted the extension of the current plan approved at Risk & Quality Governance Committee with the new draft plan to be presented to the committee in January followed by approval in February and to Quality Assurance Committee in March. The committee agreed there is a high level of assurance based on the report and discussion.	High
Discharge management MIAA review – Review received moderate assurance, identifying 1 high, 3 medium, and 2 low-risk recommendations. Timescales for completion discussed. Valuable learning from the review noted. A progress update will be brought to the committee in June.	N/A

Assure:	BAF reference	CQC reference	Assurance rating
Cancer waiting times - current performance shows strong compliance, with FDS above standard and 62-day RTT improving. 25–30% of referrals arriving after day 38 continue to impact delivery, prompting efforts to strengthen partnerships and leverage the new EPR, alongside mutual aid to reduce delays. Overall performance noted as excellent, and confidence remains high for upcoming pathways.	4, 7	N/A	High
National cancer patient experience survey and adult inpatient survey 2024 results – Committee noted the excellent results across both surveys. Identification of improvements given the great results commended.	N/A	N/A	High
Annual reports for Complaints, Claims, Quality Improvement & Clinical Audit - the reports confirmed the Trust is meeting regulatory requirements with no breaches. Complaints continue to rise year-on-year, outpacing activity, prompting efforts to resolve more issues through PALS. Claims remain low.	4	16	High

Risks discussed (including any new risks identified):

- No risks to highlight to Board.

The following agenda items were also discussed during the meeting:

- Approval of previous minutes and a review of actions
- Committee terms of reference
- Medicines safety – annual update
- Integrated governance assurance report
- Patient experience plan update
- VTE assurance update
- Board assurance framework (BAF) 2025/26
- Internal audit progress report and audit recommendation tracker

The Christie
NHS Foundation Trust

Agenda Item 04/26a

Meeting of the Board of Directors
Thursday 29th January 2026

Subject / Title	Senior Management Committee report – November / December 2025
Author(s)	Louise Westcott, Company Secretary
Presented by	Committee Chair
Summary / purpose of paper	This paper provides the Board with a summary of the items considered by the Senior Management Committee at their November & December meetings in a triple A format.
Recommendation(s)	To note the report and any actions.
Background papers	Senior Management Committee papers – November & December 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 ➢ Strategic 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.	CAG Clinical Advisory Group CQC Care Quality Commission WRES workforce race equality standard WDES workforce disability equality standard EPR electronic patient record PET positron emission tomography BAF Board Assurance Framework EPRR emergency preparedness, resilience & response

The Christie
NHS Foundation Trust

Agenda Item 04/26a

Meeting of the Board of Directors
Thursday 29th January 2026
Senior Management Committee report November & December 2025

NOVEMBER MEETING

Items Considered were:

- Approval of previous meeting minutes and review of actions
- Mandatory training compliance and associated risks
- Risk register cleansing, training, and calibration
- Clinical Advisory Group (CAG) role and engagement
- Value Improvement Plan update
- Future Christie Programme updates, including Patient Portal, Ambient AI, and EPR
- Financial planning
- IPC and Flu ipdate
- Strategy update
- Business cases -

See also the Trust Report and Integrated Performance Quality & Finance Report

ALERT

Anaesthetic Rota Delays (Risk Score 16)

A new extreme risk affecting CSSS and Network Services; operational impact noted and requires urgent mitigation.

Regulatory Pressures – IR(ME)R Inspection

Organisation placed on notice; self-assessment underway with a 5 December submission and 18 December site visit. High scrutiny, no serious concerns.

Aseptic Unit Contamination Risk (Score 15)

Risk remains high pending results; continues to pose a significant safety and operational impact across services.

ADVISE

Strengthen Risk Management Capability

Risk Register Owners need improved calibration and consistency in scoring; training programme ongoing and must be prioritised.

Improve Compliance Hotspots

Despite 95% overall mandatory training compliance, pockets of low compliance persist; divisions advised to implement strengthened governance and consequences for non-compliance.

Enhance Workforce Support & Supervision

Growth of the supervision pool, registrar training, and identification of consultants lacking clinical supervision (due January 2026) remain critical workforce priorities.

ASSURE

Cancer Pathway Recovery Ahead of Target

62-day recovery performance at 75%, above trajectory planned for March 2026.

Financial Position Stable

Year-to-date £4.4m surplus delivered on plan; capital investment ahead of plan supporting digital and infrastructure improvements.

Regulatory Feedback Positive

Recent CQC visit to TCPC completed with positive verbal feedback and no issues identified, demonstrating strong quality and safety culture.

DECEMBER MEETING

Items Considered were:

- Approval of previous meeting minutes and review of actions
- Mandatory training compliance and associated risks
- Risk register cleansing, training, and calibration
- Clinical Advisory Group (CAG) role and engagement
- Value Improvement Plan update
- Future Christie Programme updates, including Patient Portal, Ambient AI, and EPR
- Financial planning
- IPC and Flu update
- Strategy update
- Business cases;
    - AlignRT Advanced system for four linear accelerators
    - Replacement of RayStations applications servers
    - Replacement of Virtual Simulation (vSim) in Radiotherapy
    - Remodelling of CRF
    - Telephony equipment renewal
- Contract awards;
    - Re-roofing and replacement / refurbishment of existing AHU ventilation
    - Main Contractor for the refurbishment of Ward 11
    - Replacement of Virtual Simulation (vSim) in Radiotherapy
    - Aseptically-prepared Systemic Anti-Cancer Therapies (SACT)
    - Telephony equipment renewal

ALERT

62-Day Cancer Performance Deterioration

January performance is tracking below target, increasing pressure on the rest of the quarter and delivery of the required trajectory.

Research Performance Below National Expectations

Research metrics continue to underperform; delays in support services (radiology, pathology, Aseptic) are impacting study setup times. Improvement actions in place.

Clinical Correspondence & Operational Risks

Escalation discussions highlighted ongoing issues with clinical correspondence pathways & booking/referral processes. Histopathology turnaround times require continued monitoring.

ADVISE

Well-led review

An independent well-led review that includes stakeholder engagement has been initiated. SMC members will be interviewed. Focus groups, questionnaires, document reviews and 1:1 interviews underway.

EPR Programme – Strategic Direction Emerging

Options appraisal concluded that a partnership model is the preferred approach. Full business case returning February 2026.

Neighbourhood Oncology – Strategic Shift in Care Model

Emerging model (Systemwide SACT, Ambulatory Acute Oncology, Supportive Oncology) aligns with national cancer strategy and will require workforce, digital and governance redesign.

ASSURE

Risk Profile Improving

Active risks reduced to 312, with overdue risks cut from 80+ to 26, reflecting improved oversight and responsiveness.

Anaesthetic Staffing Position Stabilising

Use of agency cover has improved anaesthetic staffing sufficiently to lower the related risk score.

CQC Preparedness Strong

Mock inspections, evidence mapping and action plans are progressing well across key clinical areas, with good engagement reported. “What We’re Proud Of/Working On” updates to be circulated.

The Christie
NHS Foundation Trust

Agenda Item 04/26b

Board of Directors meeting
Thursday 29th January 2026

Subject / Title	Board Assurance Framework
Author(s)	Louise Westcott, Company Secretary
Presented by	Louise Westcott, Company Secretary
Summary / purpose of paper	This paper provides the Board with the Board Assurance Framework that summarises the risks to achievement of the strategic objectives. The cover paper gives detail of the updates.
Recommendation(s)	• To note the risks and controls relating to the strategic risks on the Board Assurance Framework, • To note that updates will be made to the risks that are the responsibility of the Board following discussion.
Background papers	Board assurance framework. Strategic objectives 2025/26, operational plan and revenue and capital plan 2025/26.
Risk score	N/A
Link to: ➢ Trust strategy ➢ Strategic objectives	• 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 04/26b

Board of Directors meeting
Thursday 29th January 2026

Board Assurance Framework

1 Introduction

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

2 Background

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

2 Updates to risks

All risks in the framework have been reviewed to reflect the current position. Controls, gaps and assurances have been updated. Quarter 3 risk scores have been added for all risks.

Risk 3 – Recruitment & retention of skilled staff – addition of reference in key controls to 10-point plan to improve resident doctors lives.

3 Recommendation

The Board are asked;

- To note the risks and controls relating to the strategic risks on the Board Assurance Framework,
- To note that updates will be made to the risks that are the responsibility of the Board following discussion.

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	16	16		4	16	**Reviewed Q2 25/26**
RISK 10	**Financial balance**	If we do not achieve the operational plan and our planned efficiency savings there is a risk that we won't achieve financial balance on NHS activity.	Board of Directors	Averse	25		5	5	15		5	15	**Reviewed Q2 - achieved VIP 25/26. From Q3 - focus on VIP 26/27**
RISK 15	**Technological advancements**	If we do not keep pace with technological advancements, there is a risk that we will not provide the best possible experience to our patients and carers	Board of Directors	Cautious	20		12	12	12		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	12	12		8	12	**Reviewed Q3 25/26**
RISK 4	**Compliance with regulatory standards**	If we do not continuously review our compliance with the regulatory standards and take corrective action where needed there is a risk that we will fall below required fundamental standards and quality of care will be reduced.	Board of Directors	Averse	15		12	12	12		4	12	**Reviewed Q4 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	12	12		8	12	**Reviewed 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	6	12		4	12	**Review Q3 25/26**
RISK 8	**Emergency event**	If there is a serious emergency event (pandemic/cyber-attack/extreme weather event etc) there is a risk of business disruption (increased staff absence, increased patient non-attendance and equipment malfunction) leading to delayed or cancelled care.	Audit Committee	Averse	20	12	10	10	10		5	10	**Review Q3 25/26**
RISK 2	**Learning from patient safety incidents**	If we do not follow the Patient Safety Incident Response Framework (PSIRF) there is a risk that we will miss opportunities to learn lessons and improve patient safety leading to preventable patient harm	Quality Assurance Committee	Averse	15		12	12	9		4	9	**Reviewed Q2 25/26**
RISK 14	**Supply chain**	If there are disruptions to the supply of essential products and services for the treatment and care of our patients, there is a risk of service disruption leading to delayed or cancelled care.	Audit Committee	Averse	12	9	9	9	9		3	9	**Review Q3 25/26**
RISK 3	**Recruitment and retention of skilled staff**	If we are unable to maintain current levels of skilled staff there is a risk that they will not have the time or expertise required for excellent care and communication leading to a reduction in the standards of patient safety and experience.	Workforce Assurance Committee	Averse	20		9	9	9		6	9	**Reviewed Q4 25/26**
RISK 12	**Staff engagement**	If we do not maintain levels of staff engagement there is a risk that turnover and sickness absence will increase leading to workforce shortages, poor staff experience and a deterioration in the quality of patient care.	Workforce Assurance Committee	Averse	16		8	8	8		4	8	**Reviewed Q2 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	8	8		4	8	**Reviewed Q2 25/26**
RISK 5	**Capital funding**	If we don't receive adequate CDEL there is a risk that we won't deliver the planned improvements resulting in delays in providing the best possible environment & equipment to provide care	Board of Directors	Eager	15		5	5	5		5	5	**Reviewed Q3 25/26 / Within tolerance**

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 Review Jan-26	**12**
Associated Strategic Objectives	To deliver safe, effective & equitable care	Executive Lead	Exec Medical Director
		Responsible Committee	**Quality Assurance Committee**
		Assurance Level	Medium
		Risk Appetite	Cautious

	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. Issue with breast cancer treatment - scale of impact	Level 1 – Data and management reports • Review of NICE guidelines through risk-based process with divisional support • risk register in place. Level 2 – Management team and committee scrutiny • Review NICE guidelines compliance through QAC and monthly IPQFR Level 3 – External assurances • NICE	Complete adherence to NICE guidelines relating to a specific breast cancer treatment	Forward views of upcoming NICE guidelines assessed	Review Q3 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**	2	3	**6**	2	3	**6**	4	3	**12**			**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 Jan-26	**9**
Associated Strategic Objectives	To deliver safe, effective & equitable care	Executive Lead	Exec Chief Nurse
		Responsible Committee	**Quality Assurance Committee**
		Assurance Level	Medium
		Risk Appetite	Averse

	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 improvement - Embed agreed Quality Improvement methodology across the Trust	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
	3	5	**15**	3	4	**12**	3	4	**12**	3	3	**9**			**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 Jan-26	**9**
Associated Strategic Objectives	To deliver safe, effective & equitable care To deliver excellent financial and operational performance To be an excellent place to work and attract the best staff	Executive Lead	Workforce Director
		Responsible Committee	**Workforce Assurance Committee**
		Assurance Level	High
		Risk Appetite	Averse

	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 Completion and reporting to WAC of progress against the 10 point plan to improve resident doctors lives.	National staff shortages impacting recruitment.	Level 1 – Data and management reports • Divisional oversight of recruitment through Service & 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 • MIAA Bank & Admin audit - Moderate assurance	Actions outlined by MIAA in Nov 24 Divisional Recruitment audit	None identified	Reviewed Q4 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**	3	3	**9**	3	3	**9**			**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 Jan-26	**12**
Associated Strategic Objectives	To deliver safe, effective & equitable care To deliver excellent financial and operational performance To be an excellent place to work and attract the best staff	Executive Lead	Exec Chief Nurse
		Responsible Committee	**Board of Directors**
		Assurance Level	Medium
		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 Excellence in action programme underway.	External political factors	Level 1 – Data and management reports • Self assessment against 2022 Must Do's • Self assessment against Well Led / Safety quality indicators Level 2 – Management team and committee scrutiny • QAC /WAC review of CQC regulations - all on rolling programmes • Board level training on new CQC assessment framework Feb 24 • Board reporting on regulatory changes • Work of the 3 assurance committees • Board capbility self-assessment Level 3 – External assurances • CQC Inspection Reports (IR(M)ER) • NOF Rating 1 (Q1 rated 3/134 acute & specialist trusts) • MIAA role specific training audit (CQC Reg 19) - Limited assurance Oct 24 • MIAA data quality audit Oct 24 - moderate assurance • OECI accreditation	Full review of well-led quality indicators to indentify gaps	Plan in development for full review of all domains (1 per quarter) Actions relating to role specific training data reporting and compliance	Reviewed Q4 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**	4	3	**12**	4	3	**12**			**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 Jan-26	5
Associated Strategic Objectives	To deliver excellent financial and operational performance	Executive Lead	Exec Director of Finance
		Responsible	**Board of Directors**
		Assurance Level	High
		Risk Appetite	Eager

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	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 - maximum capital freedoms	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 Q3 25/26 / 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
	3	5	**15**	1	5	**5**	1	5	**5**	1	5	**5**			**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 Jan-26	16
Associated Strategic Objectives	To deliver excellent financial and operational performance	Executive Lead	Exec Director of Finance
		Responsible	**Board of Directors**
		Assurance Level	
		Risk Appetite	Cautious

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	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	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**	4	4	**16**	4	4	**16**	4	4	**16**			**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 Jan-26	12
Associated Strategic Objectives	To deliver safe, effective & equitable care To deliver excellent financial and operational performance	Executive Lead	Chief Operating Officer
		Responsible	**Quality Assurance**
		Assurance Level	Medium
		Risk Appetite	Cautious

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	Executive led monthly divisional performance review meetings. Integrated performance & quality report to Management Board and Board of Directors monthly. Weekly performance reporting via trust operational group. Escalation internally & across GM of delays impacting waiting time targets. Monitoring cancer waiting time standards through GM Cancer & 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 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	5	**25**	4	3	**12**	4	3	**12**	4	3	**12**			**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 Jan-26	**10**
Associated Strategic Objectives	To maintain excellent operational, quality and financial performance.	Executive Lead	Chief Operating Officer
		Responsible	**Audit Committee**
		Assurance Level	Medium
		Risk Appetite	Averse

	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 an Annual Assurance process that is externally reviewed to develop our Statement of Compliance Adaptations to existing buildings / equipment to manage temperature rises. GM approach. Business Continuity Plans (BCP) - regularly tested and reviewed Extreme weather plan approved & published on intranet Data Security and Protection Toolkit submissions with audits undertaken. Digital board reporting. Board level Senior Information Risk Owner in place. Reviews of risk registers, alerts, reports, actions and observations MIAA audit - Data Protection Toolkit (DPST) 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 • Annual Assurance Report and Statement of Compliance- substantial compliance Level 3 – External assurances • Internal audit of compliance with NHS requirements • NHSE review of plans and progress - agreement of current compliance (as in self-assessment) • MIAA Data Protection Toolkit assessment (DPST) - Substantial assurance July 2024	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 Adaptation plan in development for future developments	Review Q3 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**	5	2	**10**	5	2	**10**	5	2	**10**			**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 Jan-26	**8**
Associated Strategic Objectives	To provide integrated clinical, research and education services	Executive Lead	Chief Executive Officer
		Responsible	**Board of Directors**
		Assurance Level	High
		Risk Appetite	Averse

	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 OECI accreditation achieved and reported to Board Business case for expansion of CRF going to January Board.		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	None identified	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
	3	4	**12**	2	4	**8**	2	4	**8**	2	4	**8**			**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 on NHS activity.					Apr-24 Date of Last Jan-26	15
Associated Strategic Objectives	To maintain excellent operational, quality and financial performance.					Executive Lead	Exec Director of Finance
						Responsible	Board of Directors
						Assurance Level	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 2025/26 VIP achieved from month 6 - focus on 2026/27	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 Q2 - achieved VIP 25/26. From Q3 - focus on VIP 26/27

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

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 Jan-26	8
Associated Strategic Objectives	To be an excellent place to work and attract the best staff					Executive Lead	Director of Workforce
						Responsible	Workforce Assurance
						Assurance Level	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. Strategic Leaders Forum - scheduled across the year Divisional plans in place for events and meetings across the year	None identified	Level 1 – Data and management reports • Divisional action plans from staff survey • Service & operational reviews Level 2 – Management team and committee scrutiny • Reporting to Workforce Committee, Workforce Assurance Committee and Board of Directors • Board development session on Inclusive Culture facilitated by NHS Providers expert Sept 2024 • Board approved Inclusive Culture Plan Nov 2024 Level 3 – External assurances • Annual CQC Staff Survey 2024	None identified	Implementation of next phase of Inclusive Culture Strategy Extension of People & Culture Plan	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	4	16	2	4	8	2	4	8	2	4	8			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 Jan-26	**12**
Associated Strategic Objectives	To transform our services to improve access and reduce health inequalities	Executive Lead	Dir of Future Christie
		Responsible Committee	**Board of Directors**
		Assurance Level	Medium
		Risk Appetite	Cautious

	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 opportunities Development of external partnerships for delivery of ambitions.	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**	3	4	**12**	3	4	**12**			**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 Jan-26	**9**
Associated Strategic Objectives	To deliver safe, effective & equitable care To deliver excellent financial and operational performance	Executive Lead	Chief Operating Officer
		Responsible Committee	**Audit Committee**
		Assurance Level	
		Risk Appetite	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 Q3 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**	3	3	**9**	3	3	**9**	3	3	**9**			**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 Jan-26	**12**
Associated Strategic Objectives	To transform our services to improve access and reduce health inequalities	Executive Lead	Dir of Future Christie
		Responsible Committee	**Board of Directors**
		Assurance Level	
		Risk Appetite	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 Year 1 objectives on track for delivery - patient portal / expanded AI / EPR outline case / staff engagement	Recognition of fast moving market	Level 1 – Data and management reports • reports to Board of Directors Level 2 – Management team and committee scrutiny • Execs, SMC and Board reports Level 3 – External assurances • 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**	3	4	**12**	3	4	**12**			**0**	1	4	**4**