The Christie
NHS Foundation Trust

**Board of Directors meeting**
**Thursday 29th June 2023 at 12.45 pm**

**Seminar Room 4/5, Education Centre**

**Agenda**

**David Fitzgerald, Director – Policy and Strategy, NHS Cancer Programme, NHS England**

**Clinical presentation:** Bloods closer to home / Homecare, Claire Adams, Head of SACT services, Jackie Wrench, Divisional Manager, Networked services

| | | | | | Page |
|---|---|---|---|---|---|
| **Public items** | | | | | |
| **21/23** | **Standard business** | | | | |
| a | Apologies | | | Chair | |
| b | Declarations of interest | | | Chair | |
| c | Minutes of previous meeting – 25th May 2023 | | * | Chair | 2 |
| d | Action plan rolling programme, action log & matters arising | | * | CEO | 9 |
| **22/23** | **Board assurance** | | | | |
| a | Board assurance framework 2023/24 | | * | CEO | 12 |
| b | Workforce Assurance Committee summary report to Board – May 2023 | | * | Committee Chair | 18 |
| **23/23** | **Key Reports** | | | | |
| a | Trust report | | * | CEO | 22 |
| b | Integrated performance, quality & finance report | | * | COO | 30 |
| c | Annual compliance with the CQC requirements | | * | ECN | 67 |
| d | The Christie Strategy 2023 – 2028 implementation plan | | * | DoS | 78 |
| **24/23** | **Approvals** | | | | |
| a | Annual report, financial statements and quality accounts (incl Annual governance statement / Statement on code of governance) | | # | CEO | |
| b | Fit & Proper Persons Policy | | * | CEO | 80 |
| **25/23** | **Any other business** | | | Chair | |

**Date and time of the next meeting**
Thursday 28th September 2023 at 12:45pm

| | | | |
|---|---|---|---|
| CEO | Chief Executive Officer | * | paper attached |
| COO | Chief Operating Officer | v | verbal |
| EDoF | Executive Director of Finance | p | presentation |
| ECN | Executive Chief Nurse | # | separate pack |
| DoS | Director of Srategy | | |

The Christie
NHS Foundation Trust

**Public meeting of the Board of Directors**
**Thursday 25th May 2023 at 12.45 pm**
**Seminar Room 4 & 5, Education Centre**

**Present:** Chair: Chris Outram (CO), Chairman
Roger Spencer (RS), Chief Executive Officer
Kathryn Riddle (KR), Non-Executive Director
Dr Jane Maher (JM), Non-Executive Director
Robert Ainsworth (RA), Non-Executive Director
Alveena Malik (AM), Non-Executive Director
Tarun Kapur (TK), Non-Executive Director
Grenville Page (GP), Non-Executive Director
Prof Kieran Walshe (KW), Non-Executive Director
Prof Chris Harrison (CJH), Deputy CEO
Bernie Delahoyde (BD), Chief Operating Officer
Prof Janelle Yorke (JY), Executive Chief Nurse
Dr Neil Bayman (NB), Executive Medical Director
Sally Parkinson (SP), Interim Executive Director of Finance
Prof Fiona Blackhall (FB), Director of Research
Eve Lightfoot (EL), Director of Workforce
John Wareing, Director of Strategy
Prof Richard Fuller, Director of Education

**Minutes:** Louise Westcott, Company Secretary

**In attendance:** Jo D'Arcy, Assistant Company Secretary
Dr Kantappa Gajanan, Staff Governor

**Clinical presentation:** Aseptic Suite & research including the patient pathway, Damian Child, Director of Pharmacy / Ev Dolan, Lead Nurse Research / Lydia Sutherland, lead pharmacist in clinical trials / Helen Donavon, Lead Nurse CRF / Deirdre Lehwald / Sian O'Boyle

ED introduced herself & colleagues who will talk about clinical trials, the patient pathway and the role of the aseptic suite.

LS gave an overview of the clinical trials pharmacy team – there are 27 pharmacists, technicians & assistants. The team set up & oversee the ongoing management of trial drugs. Treatments needing aseptic preparation will need additional capacity.

The aseptic treatment workflow was illustrated in a diagram from cycle prescription to collection with several steps along the way. The process is complex and has several checks included. It requires good coordination to deliver safe treatment in a timely way.

SO noted that she has been with the Trust for 6 months and how much she loves working here and that the team are growing. The team showed a pre prepared video about the aseptic process and how the drugs are processed ready for delivery. Preparation can take between 15 & 120 minutes for a single drug. Multiple checks are built into the process. The video exemplified the complexity of the production of the products and the time required for each drug.

TK asked how many people are involved. SO replied that there are multiple prep rooms manned by different people and then assembly, checkers, a release coordinator, and pharmacist.

KW noted the complexity of the prep for trials and asked why drugs don't arrive more treatment ready as with standard chemotherapy. DC noted that most drugs require a similar process but Baxter's do this at scale for the chemotherapy. The difference is that trials are much smaller

volumes so require a more labour-intensive process. Standard chemotherapy drugs are batched by Baxter and processed at scale. SB noted that there are limits on expiry dates for the trials drugs – often 24 hour expiry. They have to be patient specific.

DL noted that the drugs can't be processed until the patient is assessed on the day for suitability.

JM asked about the multiple contamination steps and what the evidence base is for how much you need. DC noted that there are national standards as well as an evidence base. We are dictated to around how we process the drugs.

CH asked DC to talk about quality assurance processes and the assurance we get as a Board that we are delivering to the requirements. DC noted that we are externally inspected by the regional pharmaceutical assurance team who use the same framework as the MHRA and they look at the whole quality management system. A high-risk rating was given when our isolators were failing a couple of years ago. We have been reinspected and the external team gave us a low-risk rating at the last inspection. We are rebuilding the unit and working on IT software solutions to support a more efficient process. This is being put through Trust process for approval.

GK asked where we will be in 5 years' time to look to reduce the carbon footprint of the process. DC responded that we must look at a proper plan to deliver our ambitions and future proof us. We are looking at redesign of workflows and possible new clean rooms to increase output. The service is 5 days a week with some cover on weekends, so this is also something that needs discussion.

DL noted that there is a whole team, and the teams all came in and worked across the recent bank holidays.

HD noted the additional types of drugs that are delivered on the CRF and showed a video of the process once the drugs arrive on the ward.

CO thanked the team for the insight into the workings of the unit and increasing the Boards knowledge of the process and what goes into the delivery of trial drugs.

| Item | | Action |
|---|---|---|
| **16/23** | **Standard business** | |
| **a** | **Apologies** | |
| | None received | |
| **b** | **Declarations of Interest** | |
| | RA noted his role as Director of the Pharmacy Company. | |
| **c** | **Minutes of the previous meeting – 27th April 2023** | |
| | The minutes were accepted as a correct record. | |
| **d** | **Action plan rolling programme, action log & matters arising** | |
| | All items from the rolling programme are noted on the agenda. | |
| **17/23** | **Board Assurance** | |
| **a** | **Board assurance framework 2022/23** | |
| | RS noted the BAF 2023/24 opening position. The risks against the approved annual objectives are reflected in the new framework. This will be continuously reviewed, and assurance assigned against the risks through the assurance committees and reported back to Board.<br>GP noted that there should be more consideration of KPI's in the assurance column. Target risk scores will be added in as the framework develops. | |

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| **b** | **Audit Committee summary report to Board – April 2023** | |
| | GP noted the report and noted that a verbal update was given at the last meeting. The key reports are noted. Pharmacy was considered and the main activity was the year end accounts and annual reports. The committee were highly satisfied and had feedback from external and internal auditors. | |
| **c** | **PSIRF feedback / discussion following training** | |
| | JY noted the Board have all done their training around PSIRF and asked if there are any questions. We are fully compliant with the training, and it was noted that the information is very interesting. JY added that any further discussion is welcome with her and the team. | |
| **18/23** | **Key Reports** | |
| **a** | **Trust report** | |
| | RS reported that we have received the CQC inspection report and have been given a Good rating. Further details will follow. The required submission has been made against the IR(ME)R regulation in radiotherapy and we have had confirmation that this was well received.<br>RS noted that the submission of a balanced revenue ICB plan has been achieved. There were problems in coming to this point and this is good progress.<br>Our financial performance is also shown in the report at month 1.<br>It was noted that the ICP have published their strategy. There is a governance & leadership review of the ICB under way as well as a financial recovery plan. We've previously been asked to look at the outputs of this and requirements set out by the ICB. We did this at the Board time out in May and confirmed this with the ICB in line with the requirement.<br>CO asked about CIP and what we have in the plan. Our plan is £12.4m CIP that gets us to an £8m deficit. There is also the additional requirement of the system gap as well as the challenge of achieving better than plan.<br>GP asked about the overspend on capital and backlog maintenance, is there a distinction between what is revenue and what is capital. SP noted that the definition can add to the value or maintain the value, this will be reviewed through the year.<br>KW asked about the deficit position and the funding for additional activity. Do we need to plan for not getting this income or will this resolve. SP and RS are discussing this, we must maintain the link between what we do and what we get paid for. RS added that the importance of the position is not about the scale but we need to ensure that money for cancer is spent on cancer. We're working with the ICB on this.<br>CO noted the progress on education and research and congratulations were extended on the successful completion of the Paterson building. CO asked for updates on the move of staff into the building and how this is reported. TK noted that the workforce committee intend to look at this. | |
| **b** | **Integrated performance, quality & finance report** | |
| | BD outlined the month 1 performance.<br>There were no SI incidents, no Never Events, no Major and 14 Moderate incidents and 4 risks at 15+<br>There have been 2 cases of C.diff with no lapses in care, 1 case of MRSA with no lapses in care, 6 cases of E-Coli and 9 cases of Covid nosocomial infections. | |

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| | Mandated training is at 89.3%, PDR compliance was at 84.7% and sickness was 3.9% overall.<br>Performance against some targets is still low and we continue to monitor them closely.<br>Access targets - 18 Weeks was at 96.5%, 62 day performance was at 71.7%, 24 day performance achieved 73.5% and 31 day performance was at 97.9%. Some of this is down to the industrial action and 3 bank holidays.<br>There were 34 x 104-day waiters, this is impacted by the strikes and the bank holidays and is being focused on and 1 patient was a 52 week wait for complex reasons. There were 2 cancelled operations on the day, both rebooked.<br>Referrals were within the predicted range in month.<br>A breakdown of the mandatory training was shown as well as the areas that are below 80% who have risk assessments in place.<br>BD noted the gaps between headcount and establishment are improving.<br>In terms of the financial position, we achieved a £415k deficit against £607k expected deficit.<br>Capital performance to month 1 is £191k above the NHSEI plan. The 2023/24 CIP will be reported at month 2.<br>BD noted that activity information will be reported from Month 2.<br>Questions were invited.<br>CO asked about cancelled operations. The numbers were high in March due to a clinician being snowed in and day cases being cancelled. The April cancellations were due to an admin error and an overrun.<br>JM asked about the moderate incidents and trends. JY noted that this was a busy month and the numbers are within a normal range. GP asked about links with incidents. JY noted that thematic reviews are undertaken when similar incidents are seen. PSIRF will give us a national process to do this.<br>RA asked about the RCA's as outcome. JY noted that this is the lag in reporting and they will appear next month.<br>**Report noted** | |
| **c** | **Risk Management Strategy and Policy 2021-2024 annual review** | |
| | JY presented the annual update on implementation of the strategy as well as an internal audit and the MIAA audit. Good progress is being made and we are on time for the actions from MIAA. We have decided to bring the review of the strategy forward by 12 months to ensure we reflect the PSIRF requirements.<br>No questions received. Actions approved. | |
| **d** | **CQC update** | |
| | Current position was outlined;<br>CQC Medical Services inspection in October 2022 and a Well Led Review in November 2022.<br>The CQC report was published 12th May 2023 with an overall rating of 'good'. This coincided with International Nurses Day and allowed discussion & questions at the nurse open forum on that day.<br>CQC Radiotherapy inspection IR(ME)R (April 2023). A large submission was sent in and interviews will now be set up.<br>An action plan is to be submitted by 5th June in response to the full report in relation to 7 Must Do's and 4 Should Do's. | |

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| | There is additional work beyond the action plan on speaking up, raising concerns, visibility and access. This is a focus and priority as well as addressing the regulatory must do's. Several sessions have taken place with leaders and other staff across the organisation about the report led by RS with other execs in attendance.<br>A Grand Round is taking place tomorrow to discuss the must and should do's.<br>The action planning – Must Do's were outlined;<br>• …ensure effective assurance process for fit an proper persons checks (5)<br>• …ensure staff complete mandatory training… receive training, supervision and appraisal (18(2)a)* – includes safeguarding training (18(1)(2)a)<br>• …ensure that policies are reviewed and ratified in a more timely manner (17(1))<br>• …ensure that serious incidents and mortality reviews are investigated in a timely manner and learning is shared (12(2)b)<br>There is a focus on the quality of these reviews as well as the timeliness.<br>• …ensure an effective process to manage complaints… in particular, timeliness of responses (16(2))<br>• …ensure patient risk assessments are consistently completed and reviewed (12(1)(2)ab)<br>This relates to inpatient ward risk assessments.<br>• …ensure safe and proper management of medicines… including antimicrobial documentation (12(1)(2)g)<br>This relates to documentation around antimicrobials.<br>** Numbers refer to relevant regulations*<br>The action planning – Should Do's are;<br>• …continue to make improvements in culture… support staff when raising concerns and act on them in a timely way<br>• …continue to develop and promote fundamental strategies such as EDI and take action to improve staff engagement especially [for] those with particular equality characteristics<br>• …consider monitoring delayed discharges or transfers of care<br>This related to patients designated as 'no right to reside', this is not a particular issue for us and at the time of inspection we had 1 patient that was categorised in this way.<br>• …ensure there is an effective process to provide information in an accessible format for users with information and communications needs<br>There has been good work around this and we have made good progress.<br>JY showed the Board an example of the format of the template we need to complete. This includes the actions we will take.<br>JY outlined the actions against each regulation to achieve assurance on the must do's. The specific actions were talked through for all 7 Must Do's.<br>JY gave specific examples of the digital improvements we have made to support clinical staff in recording of information to meet standards. Focus has also been given to documentation, specifically around antimicrobial delivery.<br>AM asked if we met our internal timelines for complaints and how we manage these realistically to give the best response. JY noted these are managed closely and the team stay in touch with the complainant throughout.<br>Policy review dates are all being reviewed against expiry dates and we are | |

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| | looking at a better way of monitoring compliance with reviews. Policies are allocated to a role and responsible committee.<br>GP asked if this is in job descriptions. JY noted that this changes often so it's the area not the individual that is allocated responsibility.<br>In relation to training, the mandatory training threshold is 80% and where this is not achieved a risk assessment must be in place for the area. A new dashboard shows the breakdown to enable better management.<br>Safequarding training has been reviewed to ensure the correct training is aligned to roles.<br>The appraisal process is being reviewed and an alternative process is being piloted. Supervision has also been reviewed and expanded to more roles.<br>JY noted that there is an implementation plan with evidence behind the questionnaire that is also being developed.<br>AM asked about the should do's.<br>RS responded that this is also extremely important and there has been a lot of engagement work with staff since publication of the report. RS noted the responsibility to get this right. The opportunity to raise questions and respond in the correct way is paramount. We are discussing and arranging the opportunity to do more around culture to ensure we can do even better. We have commissioned an independent review of culture to identify what we can do to improve and learn. Informal and formal sessions are arranged. RS noted that this is really important, and we are keen to find some additional assurance around this to put in additional Board sessions to do this. This would look at the must / should do's as well as the way our assurance systems may pick up potential regulatory breach risks going forward.<br>AM noted that the should do's are key and have the potential for impact on reputation.<br>CO noted that we must hear from staff in this whole process with culture. Assurance Committee chairs need to look at the possible changes.<br>KW noted the authentic response as the Board is key. AM noted that this isn't just about tying this to the CQC.<br>JM noted that she was very impressed with how the executive have used this as a learning experience and a positive way forward. CO agreed.<br>Report endorsed by the Board. | |
| **19/23** | **Approvals** | |
| **a** | **NHS Provider License conditions: self-certification declarations** | |
| | RS noted the self-certifications against the provider licence. The declarations indicate that we are compliant.<br>Board approved the signing of the self-certifications. | |
| **20/23** | **Any other business** | |
| | CO noted that this is KR's last meeting as a NED after serving for 9 years. KR has been a hugely positive influence as well as the senior independent director. CO expressed thanks for her support around freedom to speak up and her support to other board colleagues.<br>KR thanked everyone for a fantastic 9 years and a huge amount of learning from the executives. KR noted that regulators should think more carefully about the impact of their words on patients and staff. She commented that this board has | |

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| | intelligence, integrity, courage and ambition and she knows this will be used to progress the research, care and education. | |
| | **Date and time of the next meeting** | |
| | Thursday 29th June 2023 at 12:45pm | |

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**Agenda item 21/23d**

**Meeting of the Board of Directors - June 2023**

**Action plan rolling programme after May 2023 meeting**

| Month | From Agenda No | Issue | Responsible Director | Action | To Agenda no |
|---|---|---|---|---|---|
| **June 2023** | Annual reporting cycle | Integrated performance & quality report and finance report | COO | Monthly report | 23/23b |
| | Annual reporting cycle | Annual reports from audit, quality and workforce assurance committees | Committee chairs | Assurance | 22/23c |
| | Annual reporting cycle | Annual compliance with the CQC requirements | ECN | Declaration / approval | 23/23d |
| | Annual reporting cycle | Annual report, financial statements and quality accounts (incl Annual governance statement / Statement on code of governance) | EDoF&BD | Approve | 24/23a |
| | | | | | |
| **July 2023 - no meeting** | | Integrated performance & quality report and finance report | COO | Monthly report | By email |
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| **August 2023 - no meeting** | | Integrated performance & quality report and finance report | COO | Monthly report | By email |
| | | | | | |
| **Sep-23** | Annual reporting cycle | Integrated performance & quality report and finance report | COO | Monthly report | |
| | | Greater Manchester Cancer update | GM Cancer lead | Report | |
| | | | | | |
| **October 2023** | Annual reporting cycle | 6 monthly review of annual objectives / review of strategy | DCEO | Interim review & update | |
| | | Christie role in addressing healthcare inequalities | DCEO | Report | |
| | | Integrated performance & quality report and finance report | COO | Monthly report | |
| | | Freedom to speak up guardian | FTSUG | Annual report | |
| | | | | | |
| **November 2023** | Annual reporting cycle | Integrated performance & quality report and finance report | COO | Monthly report | |
| | | | | | |
| **December 2023 - no meeting** | | Integrated performance & quality report and finance report | COO | Monthly report | By email |
| | | | | | |
| **January 2024** | Annual reporting cycle | Integrated performance report | COO | Monthly report | |
| | | | | | |
| | | | | | |
| **February 2024 - no meeting** | | Integrated performance & quality report and finance report | COO | Monthly report | By email |

| Month | From Agenda No | Issue | Responsible Director | Action | To Agenda no |
|---|---|---|---|---|---|
| | | | | | |
| **March 2024** | Annual reporting cycle | Corporate planning (corporate objectives / BAF 2023/24) | Executive directors | Approve next year's BAF | |
| | Annual reporting cycle | Letter of representation & independence | Chair | Directors to sign | |
| | Annual reporting cycle | Register of directors interests | Chair | Report for approval | |
| | Annual reporting cycle | Integrated performance & quality report and finance report | COO | Monthly report | |
| | Annual reporting cycle | Declaration of independence (non-executive directors only) | Chair | For completion by NEDs | |
| | | 5 year strategy 2023-29 - year 1 review | DCEO | | |
| | | Digital Update | EMD/Dep CEO | Update | |
| | | Workforce update | DoW | Quarterly review | |
| | | Annual reporting cycle | Chair | Approve | |
| | | | | | |
| **April 2024** | Annual reporting cycle | Integrated performance & quality report and finance report | COO | Monthly report | |
| | | Register of matters approved by the board | CEO | April 2022 to March 2023 | |
| | Annual reporting cycle | Annual Corporate Objectives | CEO | Review 2022/23 progress | |
| | Annual reporting cycle | Risk Management strategy 2021-24 | CN&EDoQ | Annual Review | |
| | | Modern Slavery Act update | CEO | Approve | |
| | | Board effectiveness review | Chairman | Undertake survey | |
| | | Freedom to speak up Guardian report | FTSUG | Quarterly update | |
| | | | | | |
| **May 2024** | Annual reporting cycle | Integrated performance & quality report and finance report | COO | Monthly report | |
| | Provider licence | Self certification declarations | EDoF&BD | To approve the declarations | |
| | | Responsible Officer report | EMD | Medical Appraisal & Revalidation Annual report | |
| | Annual reporting cycle | Annual compliance with the CQC requirements | ECN | Declaration / approval | |
| | Annual reporting cycle | Risk Management strategy 2021-24 annual review | CN&EDoQ | Annual Review | |
| | | | | | |

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**Agenda item: 21/23d**

**Action log following the Board of Directors meetings held on**

**Thursday 25th May 2023**

| No. | Agenda | Action | By who | Progress | Board review |
|---|---|---|---|---|---|
| | | No actions noted in the minutes | | | |

The Christie
NHS Foundation Trust

**Agenda Item 22/23a**

**Thursday 29th June 2023**

**Board Assurance Framework 2023/24**

| | |
|---|---|
| Subject / Title | Board Assurance Framework 2023/24 |
| Author(s) | Louise Westcott, Company Secretary |
| Presented by | Louise Westcott, Company Secretary |
| Summary / purpose of paper | This paper provides the Board with the closing position of the Board Assurance Framework 2023/24 that summarises the risks to achievement of the corporate objectives.<br>The cover paper gives detail of the updates. |
| Recommendation(s) | To note the Board Assurance Framework (BAF) 2023/24 |
| Background papers | Board assurance framework 2022/23. Corporate objectives 2023/24, operational plan and revenue and capital plan 2022/23. |
| Risk score | N/A |
| Link to:<br>➢ Trust strategy<br>➢ Corporate objectives | • Trust's strategic direction<br>• Divisional implementation plans<br>• Our Strategy<br>• 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<br>ECN Executive chief nurse<br>EDoF Executive director of finance<br>EMD Executive medical director<br>COO Chief operating officer<br>DoW Director of workforce<br>DCEO Deputy chief executive officer |

The Christie
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**Agenda Item 22/23a**

**Board of Directors meeting**

**Thursday 29th June 2023**

# Board Assurance Framework 2023/24

## 1 Introduction

The board assurance framework (BAF) 2022/23 was presented to the Board of Directors and Workforce Assurance Committee in May.

## 2 Updates to risks

The risks in the 2023/24 framework have been reviewed to reflect the annual objectives against each of the 8 agreed corporate objectives. The executive directors and the company secretary have reviewed the risks and added in the target risk scores for each risk.

## 3 Suggested updates

There are no other suggested updates to the risks identified in the Board Assurance Framework this month.

## 4 Recommendation

To note the Board Assurance Framework (BAF) 2023/24 that reflects the risks to achievement of the corporate objectives and note assurance levels assigned by the Assurance Committees.

**Corporate objective 1 - To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer**

| Number | Principal Risks | Exec Lead | Likelihood | Impact | Key Control established | Key Gaps in Controls | Current Risk Score | Assurance | Gaps in assurance | Actions to address gaps | Risk appetite (Averse / Cautious / Eager) | Responsible committee | Assurance level achieved (High / Medium / Low) | Opening Position | Position at end of Q1 | Position at end of Q2 | Position at end of Q3 | Position at end of Q4 | Target risk score | Target date for completion |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1.1 | Not meeting national requirements of Patient Safety Incident Response Framework (PSIRF) | ECN | 2 | 4 | Associate Chief Nurse for Quality and Patient Safety and Associate Medical Director for Patient Safety leading training and implementation programme. Progress monitored through Risk & Governance Committee and Quality Assurance Committee. Updates presented to ICB | None identified | **8** | Monitoring of reporting requirements through reports / asurance committee rolling programmes | None identified | | Averse | Quality | | **8** | | | | | **2** | Year end |
| 1.2 | Lack of data to fully understand equity of access to services & its impact on outcomes | COO | 4 | 3 | Project established to address data quality gap with clinical leadership. | Incomplete data set | **12** | Local audit of compliance reported to Executive Team. MIAA audit re GM cancer Q3 | None identified | Regular review and reporting to executive team | Cautious | Quality | | **12** | | | | | **4** | Year end |
| 1.3 | Risk to patients and reputational risk to trust of exceeding healthcare associated infection (HCAI) standards | ECN | 2 | 3 | Patients with known or suspected HCAI are isolated. Medicines management policy contains prescribing guidelines to minimise risk of predisposition to C-Diff & other HCAI's. RCA undertaken for each known case. Review of harm undertaken. Induction training & bespoke training if issues identified. Close working with NHS England at NIPR meetings. Clinical advisory group in place. Following national guidance. IPC BAF in place | None identified. | **6** | Levels reported through performance report to Management Board and Board of Directors and quarterly to NHS Improvement. MIAA audit planned Q2 | None identified | | Averse | Quality | | **6** | | | | | **6** | Year end |
| 1.4 | Failure to learn from patient feedback (patient satisfaction survey / external patient surveys / complaints / PALS) | ECN | 2 | 2 | Monthly patient satisfaction survey undertaken and reported through performance report. Negative comments fed back to specific area and plans developed by ward leaders to address issues. Action plans developed and monitored from national surveys. Complaints and PALs procedures in place. Action plans monitored through the Patient Experience Committee | None identified | **4** | Management Board and Board of Directors monthly Integrated performance and quality report. National survey results presented to Board of Directors. MIAA audit complaints Q1 / risk management Q4 | None identified | | Averse | Quality | | **4** | | | | | **2** | Year end |
| 1.5 | Risk of exceeding the thresholds for harm free care indicators (falls, pressure ulcers, venous thromboembolism) | ECN | 2 | 4 | All falls with low harm come through Friday-Focus and moderate/above through ERG. Falls prevention group operational. Training required for all nursing/HCA staff. All hospital acquired pressure ulcers reviewed through Friday-Focus. Monitoring of VTE assessment compliance through Thrombosis Committee. | Risk assessments for falls and skin assessment not always completed in a timely manner | **8** | QI project evaluating introduction of bedside handover to improve compliance with risk assessments.<br>Risk assessment compliance added to CWP and monitored daily.<br>Regular reports to Quality Assurance committee.<br>MIAA audit risk management Q4 | None identified | | Averse | Quality | | **8** | | | | | **2** | Year end |
| 1.6 | Lack of preparedness for a CQC inspection leading to a poor performance | ECN | 2 | 4 | Assessment against standards ongoing. Timetable of mock inspections being arranged. Looking at Trust wide requirements. Assessment of assurance process to ensure all regualtions assessed. | Full understanding of CQCs new approach to inspection | **8** | Good rating 2023. MIAA audit - risk management Q4 | None identified | Engagement in CQC's regulation updates | Averse | Quality | | **8** | | | | | **4** | Year end |
| | | | | | | | | | | | | | | | | | | | | |

**Corporate objective 2 - To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey**

| | Principal Risks | Exec Lead | Likelihood | Impact | Key Control established | Key Gaps in Controls | Current Risk Score | Assurance | Gaps in assurance | Actions to address gaps | Risk appetite (Averse / Cautious / Eager) | Responsible committee | Assurance level achieved (High / Medium / Low) | Opening Position | Position at end of Q1 | Position at end of Q2 | Position at end of Q3 | Position at end of Q4 | Target risk score | Target date for completion |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.1 | Risk to research profile and patient access to trials through reduced funding & changes to funding streams | DoR | 3 | 4 | Regular dialogue with national funding organisations on potential impact; open dialogue with strategic pharma partners; strong academic investment strategy to retain and attract world leading academics. Reporting to NHSE/I as and when required. Engaging in national webinars and updates. Sign up to regulators alerts - legislative changes assimilated into local processes as they arise. Any associated risks discussed and communicated. Levels of risk and mitigation reported through Research Division Board and Christie Research Strategy Committee. Approved Research & Innovation Strategy. | Oversight of potential legislative impact | **12** | Reports to Quality Assurance Committee. MIAA audit of The Christie sponsored research Q2 | None identified | Regular discussion and review of legislative changes through CRSC | Cautious | Quality | | 12 | | | | | **4** | Year end |
| 2.2 | Risk of not meeting year 1 deliverables of the Research & Innovation Strategy | DoR | 3 | 4 | Approved Research & Innovation Strategy. | External factors / pipeline of high quality researchers | **12** | Reports to Quality Assurance Committee. MIAA audit of The Christie sponsored research Q2 | None identified | Recruitment & retention plans linked to Trust plan | Cautious | Quality | | 12 | | | | | **6** | Year end |
| 2.3 | Risk of not meeting externally set research targets in the changing national landscape | DoR | 3 | 3 | Monitoring & reporting of targets. Delivery of the approved R&I strategy | None identified | **9** | Reports to Quality Assurance Committee. MIAA audit of The Christie sponsored research Q2 | None identified | | Cautious | Quality | | 9 | | | | | **3** | |
| 2.4 | Protected time for staff for the delivery of research | DoR | 3 | 3 | Recruitment & Retention Trust wide group in operation reporting to the workforce committee. Divisional oversight of recruitment activity and vacancies discussed at the monthly service review meetings. | External factors / pipeline of high quality researchers | **9** | Reports to Quality Assurance Committee showing delivery of research ambitions | None identified | | Cautious | Quality | | 9 | | | | | **6** | |
| | | | | | | | | | | | | | | | | | | | | |

**Corporate objective 3 - To be an international leader in professional and public cancer education**

| | Principal Risks | Exec Lead | Likelihood | Impact | Key Control established | Key Gaps in Controls | Current Risk Score | Assurance | Gaps in assurance | Actions to address gaps | Risk appetite (Averse / Cautious / Eager) | Responsible committee | Assurance level achieved (High / Medium / Low) | Opening Position | Position at end of Q1 | Position at end of Q2 | Position at end of Q3 | Position at end of Q4 | Target risk score | Target date for completion |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3.1 | Risk to delivery of the School of Oncology strategy due to reduction in demand | DoE | 3 | 3 | Review the deliverables and prioritise in line with financial investment available. Maximise the potential of external income. Refresh the School of Oncology focus on integration of objectives with clinical and research divisions. Work with finance to review funding options, develop business cases for high priority initiatives and look at alternative funding sources. School of oncology board reports to Management Board. | Continuing inability to deliver all strategic objectives due to difficulty in accessing curent investment funds to deliver new initiatives. | **9** | Reporting to Workforce Assurance Committee and Board | None identified | | Cautious | Workforce | | 9 | | | | | **3** | Year end |
| 3.2 | External factors / pipeline of high quality clinical and teaching staff | DoE | 3 | 3 | Monitoring of workforce numbers / turnover. Active recruitment and investment in Christie pipeline. | External factors / pipeline of high quality oncologists | **9** | Reporting to Workforce Assurance Committee and Board | None identified | | Cautious | Workforce | | 9 | | | | | **3** | Year end |
| 3.3 | Lack of progress with organisational governance arrangements for Christie Education | DoE | 3 | 3 | Project group in place. Plans established and resourse identified. | External factors | **9** | Reporting to Workforce Assurance Committee and Board | None identified | | Cautious | Workforce | | 9 | | | | | **3** | Year end |

**Corporate objective 4 - To integrate our clinical, research and educational activities as an internationally recognised and leading comprehensive cancer centre**

| | Principal Risks | Exec Lead | Likelihood | Impact | Key Control established | Key Gaps in Controls | Current Risk Score | Assurance | Gaps in assurance | Actions to address gaps | Risk appetite (Averse / Cautious / Eager) | Responsible committee | Assurance level achieved (High / Medium / Low) | Opening Position | Position at end of Q1 | Position at end of Q2 | Position at end of Q3 | Position at end of Q4 | Target risk score | Target date for completion |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4.1 | Lack of evidence to show progress against the ambition to be leading comprehensive cancer centre | DoR | 2 | 3 | Reaccreditation by OECI - reinspection due. Baseline measures identified and presented to Board of Directors. Looking at how we can be part of International Benchmarking. MCRC Strategy. Designated as the most technologically advanced cancer centre in the world outside North America. In segment 1 (System oversight framework). | Availability of comprehensive data with which to compare ourselves | **6** | Updates to Board Time Outs / Board of Directors meetings | None identified | | Cautious | Board | | 6 | | | | | **2** | Year end |
| 4.2 | Lack of progress with The Christie's international ambitions and partnerships | DoR | 3 | 3 | International Board in place. Monitoring of progress reported through regular engagement and meetings | External factors | **9** | Updates to Board of Directors | None identified | | Cautious | Board | | 9 | | | | | **3** | Year end |
| 4.3 | Failure to establish new governance arrangements for MCRC partnership | DCEO | 3 | 4 | Partnership Board in place. Good relationships established with partners. Paterson replacement complete and in use. | None identified | **12** | Updates to Board of Directors | None identified | | Cautious | Board | | 12 | | | | | **9** | Year end |

**Corporate objective 5 - To promote equality, diversity & sustainability through our system leadership for cancer care**

| | Principal Risks | Exec Lead | Likelihood | Impact | Key Control established | Key Gaps in Controls | Current Risk Score | Assurance | Gaps in assurance | Actions to address gaps | Risk appetite (Averse / Cautious / Eager) | Responsible committee | Assurance level achieved (High / Medium / Low) | Opening Position | Position at end of Q1 | Position at end of Q2 | Position at end of Q3 | Position at end of Q4 | Target risk score | Target date for completion |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 5.1 | Inability to fully implement the 2023/24 Greater Manchester Cancer operating model | CEO | 3 | 4 | CEO chairs Manchester Cancer Board. Director of Strategy attendance at key meetings. Christie Strategy 2023-28 approved | None identified | **12** | Reports to Management Board and Board of Directors | None identified | | Averse | Quality | | 12 | | | | | 9 | Year end |
| 5.2 | Failure to implement 2023/24 objectives of the SACT strategy | COO | 3 | 4 | Strategy on track but constrained by other trusts. Expansion on Withington site. | None identified | **12** | Regular reports to Management Board and Board of Directors | None identified | | Averse | Quality | | 12 | | | | | **3** | Year end |
| 5.3 | Inequity of access for patients to Christie trials due to delays in implementing governance arrangements for Christie led & hosted trials at the networked centres | DoR/COO | 3 | 4 | Research & Innovation Strategy approved. Approval for the trust to further expand the management of local oncology and chemeotherapy services across GM. Focus on improved digital access e.g. appointments / ePROMs and Shared Decision Making. Chemotherapy services in locations across GM & Cheshire - strategy on track but constrained by other trusts. | Workforce and engagement from other trusts. | **12** | Regular reports to Quality Assurance Committee and Board of Directors | None identified | | Averse | Quality | | 12 | | | | | **9** | Year end |

**Corporate objective 6 - To maintain excellent operational, quality and financial performance**

| | Principal Risks | Exec Lead | Likelihood | Impact | Key Control established | Key Gaps in Controls | Current Risk Score | Assurance | Gaps in assurance | Actions to address gaps | Risk appetite (Averse / Cautious / Eager) | Responsible committee | Assurance level achieved (High / Medium / Low) | Opening Position | Position at end of Q1 | Position at end of Q2 | Position at end of Q3 | Position at end of Q4 | Target risk score | Target date for completion |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 6.1 | Key performance targets not achieved | COO | 3 | 4 | Executive led monthly divisional performance review meetings. Integrated performance & quality report to Management Board and Board of Directors monthly. Weekl;y performance reporting via trust operational group. Escalation internally & across GM of delays impacting waiting time targets. Monitoring cancer waiting time standards through GM Cancer & IPR. | None identified | **12** | Executive Team monitor activity weekly. Integrated performance report to Management Board, Quality Assurance Committee and Board of Directors. | None identified | | Cautious | Audit / Quality | | 12 | | | | | **4** | Year end |
| 6.2 | Change in financial regime resulting in inability to deliver the Trust's strategic plan. | EDoF | 4 | 4 | Participating at national level and ICS (Greater Manchester) level to influence the new financial framework and its implementation. 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. | Changes in national funding arrangements and delegation of commissioning functions. | **16** | To continue to report through Managment Board and Board of Directors via financial reports and updates. Executive Team monitor activity weekly. MIAA audit - CIP Q2 / financial systems Q3 / Critical Apps Q3 | None identified | External advice sought on new models of working | Cautious | Audit | | 16 | | | | | **4** | Year end |
| 6.3 | Digital programme unable to support delivery of operational objectives | COO | 3 | 4 | CWP (clinical web portal) on stable platform. Review of digital programme and to align ditial strategy with Service strategies. Key projects moving forward e.g.Order comms. EPMA, ePROMs, clinical outcomes. Progress and objectives set/reviewed by Quarterly Digital board. | Internal capability & expertise to support system going forward. | **12** | Reports to Management Board & Board of Directors. MIAA audit - Data Protection Toolkit (DPST) Q4 | None identified | | Cautious | Audit | | 12 | | | | | **4** | Year end |
| 6.4 | Not delivering the objectives of our commercial partnerships resulting in negative financial / patient experience or reputational impact | EDoF | 3 | 3 | Partnership Boards in place. Review of contract arrangemnts for CPP. TCP - Internal and external auditors in place. MIAA governance audit gave significant assurance. KPI's reported via partnerhip board structure. | None identified | **9** | Close contact with partners & management of joint incidents. Regular reports to Board and Audit Committee | None identified | | Averse | Audit / Board | | 9 | | | | | **3** | Year end |
| 6.5 | Reputational damage, service disruption and financial loss due to cyber-attack. | COO | 3 | 5 | Risk committee regular reporting on cyber security alerts established. Digital Programme progression of key cyber security improvement projects continues. Digital Board reporting. NHS Digital linked monitoring tools being deployed. Internal scanning tools deployed. External summary reports provided. Regular testing and reporting of security vulnerabilities. Staff training mandatory. Cyber incident response support established via NHS Digital. Cyber essential assessment underway. | The Trust does not currently have cyber security insurance. | **15** | Data Security and Protection Toolkit submissions with audits undertaken. Digital board reporting. Board level Senior Information Risk Owner in place.MIAA audit - Data Protection Toolkit (DPST) Q4 | None identified | | Averse | Audit | | 15 | | | | | **15** | Year end |
| 6.6 | Not implementing the in year objectives of the Trust strategy and its underpinning plans (Quality / Patient Experience / Risk Management / Operational) | DCEO | 3 | 4 | Strategy / plans approved and reported through assurance committees | None identified | **12** | Published Trust Strategy | None identified | | Averse | Board | | 12 | | | | | **4** | Year end |

**Corporate objective 7 - To be an excellent place to work and attract the best staff**

| | Principal Risks | Exec Lead | Likelihood | Impact | Key Control established | Key Gaps in Controls | Current Risk Score | Assurance | Gaps in assurance | Actions to address gaps | Risk appetite (Averse / Cautious / Eager) | Responsible committee | Assurance level achieved (High / Medium / Low) | Opening Position | Position at end of Q1 | Position at end of Q2 | Position at end of Q3 | Position at end of Q4 | Target risk score | Target date for completion |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 7.1 | Failure to achieve the year 1 milestones of the People and Culture Plan 2023/26 | DoW | 3 | 4 | Plan approved and actions underway against each element of the plan | None identified | **12** | Workforce Assurance Committee reports. MIAA audit EDS 22 Q4. | None identified | | Averse | Workforce | Medium | 12 | | | | | **4** | Year end |
| 7.2 | Risk of negative impact on delivery of services and staff engagement levels due to Trustwide staffing gaps in some occupations and ability to recruit and retain | DoW | 4 | 3 | Recruitment & Retention Trust wide group in operation reporting to the workforce committee. Commenced programme of work with an external organisation to develop our recruitment offer, advertising and brand. Commenced a programme of recruiting international nurses over a 6 month period. Quarterly oversight of Trust wide vacancies and recruitment activity presented to the workforce committee. Divisional oversight of recruitment activity and vacancies discussed at the monthly service review meetings. Turnover analysis and exit interview data presented and discussed six monthly at the workforce committee. | National staff shortages impacting recruitment | **12** | National staff survey 2021 results. Reports to Management Board . Agency spend. Workforce Committee Oversight. MIAA audit - sickness absence Q1 | None identified | | Averse | Workforce | Medium | 12 | | | | | **6** | Year end |
| 7.3 | Management of Board succession and appointment of new Chair / NEDs | DoW/CS | 3 | 3 | External search agency appointed to undertake Chair recruitment process. Plan outlined for future requirements to replace NEDs as they come to end of term. | None identified | **9** | Nominations Committee decisions reported to Council of Governors. Adgherence to Fit & Proper Persons regulation - report to Audit Committee. Use of external search partner. | None identified | | Averse | Audit | Medium | 9 | | | | | **9** | Year end |
| 7.4 | Race/Disability discrimination impacting staff experience and therefore patient care | DoW | 3 | 3 | Staff networks established, Board development sessions planned across the year focussing on discrimination. EDI programme board monitors delivery of the EDI plan, monitoring of risks and WRES/WDES action plans. EDS2022 progress against plans monitored at the Management Board. Workforce Assurance Committee oversight of progress. | None identified | **9** | Reports to Workforce Committee, Management Board and Workforce Assurance committee. Staff story at each Workforce Assurance Committee. MIAA audit EDS 22 Q4. | None identified | | Averse | Workforce | Medium | 9 | | | | | **6** | Year end |

| Corporate objective 8 - To work with others in promoting a sustainable environment and eliminating health inequalities | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Principal Risks | Exec Lead | Likelihood | Impact | Key Control established | Key Gaps in Controls | Current Risk Score | Assurance | Gaps in assurance | Actions to address gaps | Risk appetite (Averse / Cautious / Eager) | Responsible committee | Assurance level achieved (High / Medium / Low) | Opening Position | Position at end of Q1 | Position at end of Q2 | Position at end of Q3 | Position at end of Q4 | Target risk score | Target date for completion |
| 8.1 | Impact on our ability to obtain planning approval for future capital developments. | EDoF | 2 | 3 | Close working with Manchester City Council (MCC) planning and development issues as well as implementation of the Trust's green travel plan. Strategic planning framework approved which includes current and future requirements for travel to site. Regular communication with residents through the Neighbourhood Forum and newsletters and with local councillors. Agreement by MCC of strategic development plan and delivery of the Trust's 5 year Capital Plan delivery | None identified | **6** | Monitored through Management Board & Board of Directors. Capital programme shared with MCC and Board of Directors. | None identified | | Cautious | Board | | 6 | | | | | **3** | Year end |
| 8.2 | Not able to progress our role as an Anchor Institution | DoS | 2 | 3 | Engagement in relevant GM meetings | None identified | **6** | Monitored through Board of Directors. | None identified | | Cautious | Board | | 6 | | | | | **3** | Year end |
| 8.3 | Failure to progress towards achievement of the NHS net zero Carbon targets through failure to achieve the annual milestones for The Christie set out in the Sustainable Development Management Plan | DCEO | 4 | 2 | Progress against SDMT plan regularly reported to Sustainability Committee and to Management Board as part of Integrated Performance Report. Progress against objectives overseen and reviewed by DCEO as Trust Net Zero lead. Board training on net zero Carbon arranged for November 2022 | None identified | **8** | Progress against SDMT plan regularly reported to Board of Directors as part of Integrated Performance Report. Annual Report to Board of Directors. Oversight by Audit Committee | None identified | | Cautious | Audit | | 8 | | | | | **4** | Year end |
| 8.4 | Reduced ability to provide services and support to patients due to national / global influences (supplies / fuel costs / strikes etc) | DCEO | 3 | 3 | Group in place to review supply chain. Close working with unions. Business continuity plans in place. Planning meetings in place around strike acton and incident management approach used. | Global position. Lack of control for supply chain e.g. radioisotopes | **9** | Reports to Audit Committee | None identified | | Cautious | Audit | | 9 | | | | | **3** | Year end |
| 8.5 | Failure to adapt to climate change & other environmental factors e.g., floods / extreme temps / new pathogen | DCEO | 3 | 3 | Business continuity planning process in place. Plans tested and reviewed. | Uncertainty around what / when | **9** | Sustainable Development Plan in place and reported to Audit Committee | None identified | | Cautious | Audit | | 9 | | | | | 3 | Year end |

The Christie
NHS Foundation Trust

**Agenda Item 22/23b**

**Meeting of the Board of Directors**
**Thursday 29th June 2023**

| | |
|---|---|
| Subject / Title | Workforce Assurance Committee Report – May 2023 |
| Author(s) | Company Secretary Office |
| Presented by | Committee Chair |
| Summary / purpose of paper | This paper provides the board with a summary of the assurance items considered by the Workforce Assurance Committee at their May meeting and any subsequent actions required by the Board. |
| Recommendation(s) | To note the report and any actions |
| Background papers | Workforce Assurance Committee papers 19th May 2023 |
| Risk score | BAF references noted within the report |
| Link to:<br>➢ Trust strategy<br>➢ Corporate objectives | • Trust's strategic direction<br>• Divisional implementation plans<br>• Our Strategy<br>• 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. | EDG Ethnic Diversity Group<br>BAF Board Assurance Framework<br>WRES Workforce race equality standard<br>WDES Workforce disability equality standard<br>FTSU freedom to speak up |

The Christie
NHS Foundation Trust

**Agenda item 22/23b**

**Meeting of the Board of Directors**
**Thursday 29th June 2023**

**Workforce Assurance Committee report – May 2023**

## 1 Introduction

The Workforce Assurance Committee took place on 19th May 2023. The following summary gives the Board information on the items that were considered, and any actions required by the Board.

## 2 Quality Assurance Committee agenda items

The items listed below were all presented to the Workforce Assurance Committee for assurance in May.

| | |
|---|---|
| **Agenda item** | The Christie People Plan |
| **BAF reference** | 7.1 – 7.4 |
| **Assurance rating given** | Medium |

**Key points and associated action (where applicable):**
The plan was launched in January 2023 along with the values and behaviours framework, it is a 3-year plan to 2026. A summary was provided on the progress against the year 1 objectives of the plan. In terms of the areas not currently on track at moment, detail was provided on the following areas and the action plans in place:

- Mandatory training
- Inclusive recruitment
- Exit interviews
- Respect campaign
- Consultant and clinical development programmes

The remaining areas of the plan are on track with good progress.

| | |
|---|---|
| **Agenda item** | Sickness analysis/wellbeing update |
| **BAF reference** | 7.1 |
| **Assurance rating given** | High |

**Key points and associated action (where applicable):**
Details provided on a 5-year comparison showing an increase in activity. Long term sickness equates to 10% of the overall figure. The Trust position mirrors that of both a regional and national trend, both inside and outside of the NHS. An overview of the HR advisory support for managers was presented. The top 2 reasons for long term sickness were described (stress/anxiety and musculoskeletal) along with the principal reason for short term sickness (cough / cold / flu / ENT). Assurance from a procedural perspective that managers know what they are doing and audits in place to support relevant policies.
Additional support to managers is also in place and an overview of this support was provided.

| | |
|---|---|
| **Agenda item** | Staff survey results |
| **BAF reference** | 7.1-7.4 |
| **Assurance rating given** | Medium |
| **Key points and associated action (where applicable):**<br>An overview of the position for the latest staff survey results was given. A table was presented showing where scores have moved up compared to 2021 on 3 of the people promise elements but cannot ignore the areas where the Trust has not improved and these were described. A comparison with GM and national data was shown representing where we fall as a Trust in relation to the responses around the grounds for experiencing discrimination questions in the survey. We resulted in the worst overall against 2 out of 6 questions and there was a discussion on this. The areas of focus in the local staff survey, the action planning and central initiatives were described. As part of a deeper dive on the results, the Engagement and OD Manager, HR Business Partners and Divisional Leads are working together to analyse divisional data. Divisions are required to set meaningful, achievable actions. Other notable activity included an overview of the enhanced Corporate Induction, the Band 5-6 pilot leadership development programme in GM for BME colleagues, 'EDI in Education' activity to explore inequality and access issues in education, and leadership behaviours focus for senior roles.<br>Medium assurance assigned with the knowledge that things are progressing. | |

| | |
|---|---|
| **Agenda item** | Guardian of Safe Working Hours Report |
| **BAF reference** | 7.2 |
| **Assurance rating given** | Medium |
| **Key points and associated action (where applicable):**<br>An overview of the papers was provided noting that these are exception reports from trainee doctors when they are asked to work longer than their contracted hours. For 2021/22, there were a total of 23 exception reports in year. The numbers are reasonably low and compare well nationally, difficult to ascertain if under reporting but it is reviewed at the junior doctor forum and attendance at the forums has improved. Included in the data were details around vacancies and gaps in shifts to be covered by locums, this often relates to a regional or national picture and not a local one.<br>Discussion to be held as to whether future reports are for assurance purposes or to be listed as a governance item. | |

| | |
|---|---|
| **Agenda item** | Safe Staffing Six Monthly Report |
| **BAF reference** | 7.2 |
| **Assurance rating given** | High |
| **Key points and associated action (where applicable):**<br>At the time of the report, a big recruitment drive had taken place, and this has made an impact as to how lead nurses have reviewed safe care. The report also detailed how challenges have been addressed. There was a call within the report for more healthcare assistants so that registered nurses can focus on their skills. Feedback from nurses is that patients are more complex and staying as inpatients for longer. Overall nurses feel the establishment is safe, a group of ward managers also recently recruited so a strong team in place. | |

| | |
|---|---|
| **Agenda item** | Freedom to Speak Up - Board assessment |
| **BAF reference** | N/A |
| **Assurance rating given** | Medium |
| **Key points and associated action (where applicable):** | |

| |
|---|
| Presentation to the Committee on the FTSU guide for leaders and the reflection and planning tool. The reflection and planning tool is provided to help organisations identify strengths and gaps in individuals, leadership team and the organisation, the tool consists of 8 principles with statements for reflection. The Trust is required to review the statements, score itself against them and identify high level areas of focus.<br>An overview and description of all 8 principles was provided. In terms of action planning, the plan has been drawn up by EL, SM and the NED FTSU lead and was provided to the Committee for discussion.<br>Discussion led to the requirement for sufficient time to be allocated to go through the plan in more detail with the suggestion of a Board session once the assessment is finalised. |

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 reports received for assurance by the Workforce Assurance Committee in May 2023.

Assurance level descriptions:

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

The Christie
NHS Foundation Trust

**Agenda item 23/23a**

**Meeting of the Board of Directors**
**Thursday 29th June 2023**

| | |
|---|---|
| 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. It incorporates existing reports and responds to the feedback from the Board Time Out in July 2022. |
| Recommendation(s) | The board is asked to note the contents of the paper. |
| Background Papers | Integrated Performance, Quality and Finance Report<br>Finance Report |
| Risk Score | See Board Assurance Framework |
| Link to:<br>➢ Trust's Strategic Direction<br>➢ Corporate Objectives | Achievement of corporate plan and objectives |
| You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box. | CEO Chief Executive Officer<br>MCRC Manchester Cancer Research Centre<br>NHSI NHS Improvement<br>JFP Joint Forward Plan<br>CQC Care Quality Commission<br>GM Greater Manchester<br>ICB Integrated Care Board<br>ICS Integrated Care System<br>CIP Cost Improvement Programme<br>WRES workforce race equality scheme<br>WDES workforce disability equality scheme<br>IR(ME)R Ionising radiation medical exposure regulations |

The Christie
NHS Foundation Trust

**Agenda item 23/23a**

**Meeting of the Board of Directors**
**Thursday 29th June 2023**

**Trust Report**

## Introduction

**Executive Summary**

- We have four high risks on the risk register all of which have controls and mitigation in place – these are overseen the by risk committee with assurance provided by the three board assurance committees
- Financial performance is strong with a cumulative £415k deficit against a £607k deficit plan and no significant variances in financial metrics
- GM Integrated Care Board submitted a balanced plan for revenue at the beginning of May
- Operational performance is strong other than for the 62-day referral to treatment standard which we have not met mainly because of referrals being received late in this pathway
- The quality of care remains high with no significant adverse variances in indicators of the effectiveness, safety, or patient experience of our services
- Our workforce indicators show good performance other than the staff absence rate which is slightly above the target threshold
- We are assessing the ongoing impact of industrial action on our patients.
- Research & Innovation have launched their strategy with staff and seen very good performance against internal performance indicators as well as an increase in the capacity of the aseptic service for delivery of trials
- Christie education continues to develop and provide support to staff across the Trust
- GM ICS are progressing work following their external review of leadership and governance
- The action plan developed following the CQC inspection is being progressed and we are awaiting the report following the inspection of the IR(ME)Regulation

This report brings together the key issues for the Board of Directors in relation to our performance, strategy, workforce, and the Greater Manchester system landscape, the regulatory landscape and other pertinent matters within the scope of the board's responsibilities.

This format consolidates information provided in a range of routine reports for the board and responds to requests from board members for regular and structured reporting of key system and regulatory developments.

## Risks

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

1. Risk of not achieving the financial plan including the cost improvement programme.
2. Risk of prolonged disruption to services, due to a severe cyber security incident.
3. Risk of delayed cancer referral and treatments due to not meeting 24 / 62-day targets.
4. Risk of patients being lost to follow up.

*See details in Integrated Performance, Quality and Finance Report*
*Responsible Executive Director - Chief Nurse*
*Responsible Assurance Committee – Quality/Audit/Workforce depending on risk*

## Financial Performance

Financial performance is ahead of plan. The Trust is reporting a £875k deficit against £1,340k expected deficit planned position. This is mainly due to interest received being above planned levels and a pay underspend due to vacancies and industrial action. Capital expenditure is on plan.

As shown in the table there are no significant variances from the planned financial performance against key measures other than the level of recurrent CIP delivered to date. Whilst Divisions are working up cost improvement schemes, the level of these assessed as delivering is currently low.

| **Measure of Financial Performance** | Red / Amber / Green rating |
|---|---|
| Revenue: Trust Control Total compared to plan | £875k deficit |
| Capital: Capital expenditure against plan | £7k over plan |
| CIP achieved (recurrent) against target of £6.4m | £0.7m identified |
| Debtor days compared to 15-day target | 11 days |
| Cash balance | £142,842k |

**2023/24 Planning**
The Trust is part of the Greater Manchester Integrated Care System (GM ICS) and as such, must plan for its revenue and capital expenditure to fit within the cumulative capital and revenue limit for the GM ICS.

At the beginning of May, after a prolonged planning process, GM Integrated Care Board (GM ICB) submitted a balanced plan for revenue. Delivery of the revenue plan remains a significant challenge and includes "system savings" of £123m (which remains in the ICB plan and haven't been allocated to individual providers) with no current identified mitigation. This is in addition to significant levels of cost improvement plans (CIP) in individual provider plans. Whilst there are organisations in balance and some with deficits, this is a planning assumption and should the system deliver the revenue plan, the expectation would be for deficit plans to improve.

The Christie NHS FT 2023/24 revenue plan is a £8m deficit. At a high level, this deficit is created by activity in excess of contracted activity plus inflation costs in excess of that funded in tariff. The challenge for the Trust will be to identify and deliver cost improvements (in addition to the CIP already included in the plan) or receive funding for activity delivered to close this £8m gap.

Management Board and Divisions have been briefed on the Trust and GM's overall financial plan; CIP targets have been allocated to individual Divisions.

*Financial details are provided in the Integrated Performance, Quality and Finance Report*
*Responsible Executive Director – Finance Director*
*Responsible Assurance Committee – Audit*

**Operational Performance**
Overall performance remains strong apart from the 62-day referral to treatment standard. The May 62-day position has deteriorated slightly from March to 66.9% compliance (subject to validation). We have continued to achieve the 31-day standard for treatment to start within 31 days of the decision to treat.

Activity is higher than last year's levels across all lines at month 2. Four operations were cancelled on the day for non-clinical reasons in May, all have been rebooked.

*Performance details are in the Integrated Performance, Quality and Finance Report*
*Responsible Executive Director – Chief Operating Officer*
*Responsible Assurance Committee – Quality Assurance*

**Quality of Care**
The reported metrics confirm that the quality of care at The Christie continues to be maintained despite the pressures of recent years.

Safer staffing numbers have met the required acuity levels to ensure appropriate levels of safety and care for our patients. Indicative staffing, in line with nursing establishments, is set to maintain a

1:6 nurse to patient ratio. On occasion this has been extended to 1:8 which is in line with recommended national staffing ratios. While we have seen an increase in patient safety incidents, following thematic review, these were not related to nurse staffing ratios.

There were 20 in-patient falls in May, only one of these was moderate harm, with 3 being minor harm and 16 no harm. This equates to 4 falls per 1000 occupied bed days (last year's performance was 3.6, with the national average around 6.6). There were three category 2 pressure ulcers that developed during admission in May. There were no category 3 & 4 pressure ulcers acquired during hospital admission. This equates to 0.4 pressure ulcers per 1000 occupied bed days (last year's performance was 0.4).

We continue to report cases of a range of infections although other than for C Difficile there are no national standards or thresholds. Although we continue to have patients with C Difficile, reflecting community prevalence of infection and the vulnerability of our patients, audits show that in no case has infection been the result of a lapse in the standards of care. There were no cases of hospital acquired nosocomial COVID-19 infections in May. There were no MRSA Bacteraemia in May.

There were 11 formal complaints in May which is below the monthly average, the number of contacts with the Patient Advice and Liaison Service (PALS) service increased from 46 in April to 51 in May. No serious incidents were reported in May. There were 7 incidents reported in month with the classification of moderate and none with the classification of major all of which are going through to full root cause analysis. Our post treatment mortality rates remain within the expected very low limits.

*See details in Integrated Performance, Quality and Finance Report*
*Responsible Executive Directors - Chief Nurse and Medical Director*
*Responsible Assurance Committee – Quality Assurance*

**Workforce**
Our summary workforce performance indicators continue to show overall good performance. The mandatory training compliance is at 92.09% and personal development plan rates are at 84.5%.

Sickness absence rates have reduced in May but are still slightly above the threshold of 3.4%. The annual adjusted turnover rate is at 14.03%. These issues and the associated plans for improvement have been considered by the new Workforce Assurance Committee.

In June 2023 panel interviews were held to interview 2 candidates for the Director of Finance role. The process was supported by an external search agency and the panels' decision was to permanently appoint Sally Parkinson as the Director of Finance.

Our 2023 WRES and WDES data was submitted to the WDES/ WRES data collection framework in May, in line with national requirements.

The Christie has been accredited as Veteran Aware. This means it takes active note of the needs of the Armed Forces Community and met standards laid down by the Veterans Covenant Healthcare Alliance (VCHA), a national NHS team.

The Trust will be celebrating Armed Forces Week (19-24 June). There'll be an opportunity to hear from reservists on site at Withington and find out about the support available to veterans and reservists, and their families, on our Engagement Stall. This work is part of our ongoing commitment to supporting and celebrating patients and staff in the armed forces community.

NHS England has published the first NHS workforce equality, diversity and inclusion (EDI) improvement plan – a key milestone in the 75th year of the NHS. It sets out six high impact actions for NHS organisations, addressing inequalities across the nine protected characteristics as prescribed in the Equality Act 2010. The plan supports the objectives of the forthcoming Long Term

Workforce Plan by setting out actions to improve the culture of our workplaces and the experiences of our workforce, benefiting retention and the attraction of new talent to the NHS.

The six high impact changes are reflected in the current Christie EDI Plan, but further work will be undertaken to ensure our objectives are fully aligned and support the NHS England plan.

We continue to manage the impact of industrial action. Junior doctors took action for three days from 14th to 17th June. Additionally, members of the Unite union held a 24-hour strike from 14th to 15th June. The Royal College of Nursing (RCN), the Society of Radiographers (SOR) and the BMA (for consultants and Juniors) are all currently balloting their members about further strike action. It is anticipated we will know the outcome of these ballots at the end of June onwards.

The Workforce Risk continues to be assessed by the Workforce Committee. We currently have 441 vacancies across the Trust (12% vacancy rate). Of these vacancies 226 are in the latter stages of the recruitment process, where offers have been made or start dates have been agreed. The vacancy gap has increased by 2% since March. This reflects an increased establishment because of growth allocated to deliver extra activity. However, based on the relatively healthy pipeline the Workforce Committee has reviewed the risk and maintained the score at 12.

*See details in Integrated Performance, Quality and Finance Report*
*Responsible Director - Director of Workforce*
*Responsible Assurance Committee – Workforce Assurance Committee*

**Research**
The American Society of Clinical Oncology (ASCO) hosts the largest oncology conference attended by 45,000 delegates annually. Manchester research came almost entirely from The Christie NHS Foundation Trust, with 60 Christie investigators presenting 40 original abstracts accepted (3 investigators from elsewhere in Manchester presented 3 abstracts). There were 6 oral abstracts (which are the most prestigious), 9 poster-discussion abstracts and 24 posters, with 5 abstracts presented in electronic format only.

Dr David Thomson, Consultant in Clinical Oncology gave the oral presentation of the randomised Phase 3 NIMRAD trial of nimorazole added to radiotherapy in patients with head and neck cancers. Dr Matt Krebs, Consultant in Medical Oncology gave the poster discussion of the Phase 2a MIST3 trial of bemcentinib and pembrolizumab in patients with mesothelioma. Professor Mark Saunders gave the poster discussion of the Phase 3 SOLSTICE trial of trifluridine or tipiracil plus bevacizumab compared with capecitabine plus bevacizumab for patients with colorectal cancer. Many of our Clinical Fellows also played leading roles in the presentation of posters, which is great experience for them and reflects well on The Christie.

Professor Juan Valle, MB ChB MSc FRCP has recently retired from his role as Professor at the University of Manchester, Institute of Cancer Sciences and Honorary Consultant specialising in Hepato-pancreato-biliary (HPB) cancers and Neuroendocrine Tumours at the Department of Medical Oncology, The Christie NHS Foundation Trust. Having completed his medical training in Sheffield, he worked his way towards Manchester, starting at The Christie in 1995 as a Research Fellow. He was made Consultant in 2000 and Professor in 2014. Juan's primary focus was leading practice-changing clinical trials. In 2010 he led the Phase 3 randomised ABC-02 trial which compared gemcitabine alone with cisplatin and gemcitabine in patients with advanced biliary cancers. This established a global standard of care for these patients, which has only recently been improved upon. Juan took many national and international leadership roles as well as working in partnership with patient charities and advocates. Juan is taking up the role of Chief Medical Officer at the Cholangiocarcinoma Foundation.

*Responsible Director - Director of Research*
*Responsible Assurance Committee - Quality*

**Education**
Christie Education continues with a series of engagement activities focusing on its three key strategic goals:

- Attain recognition as a leader for excellence in the design, delivery and development of cancer care education and training for the current and future workforce.
- Achieve global impact as a key opinion leader through educational leadership, outreach and partnership.
- Grow as a forward-thinking, inclusive educational organisation with a reputation and demonstrable impact of educational scholarship (research, enterprise, transformation and innovation).

An external review of branding and marketing has been commissioned to ensure Education better understands, aligns to, and creates opportunities with target audiences, current and future partners. This has included high level work in partnership with Healthcare UK and the Department of International Trade with potential clients in Latin America and Southeast Asia.

Our Gateway C platform now provides specialist, impactful cancer education to primary care colleagues across three of the four nations, with its recent expansion to Scotland and Wales, supporting education and patient care with a growing number of GP colleagues locally, regionally, and nationally.

*Responsible Director - Director of Education*
*Responsible Assurance Committee – Quality Assurance Committee*

**Digital**
Paul Baxter from the Digital Services team has been named Individual of the Year at the NHS England Cyber Associates Network (CAN) Awards, held virtually on 8th June. The CAN Awards recognise innovation in cyber security among 2,000 digital experts working in the NHS and social care to help protect against cyber-attacks and maintain patient safety. Paul was also a finalist in the Cyber Leader of the Year category.

*Responsible Executive Director – Chief Operating Officer*
*Responsible Assurance Committee – Audit Committee*

**Strategic and Service Developments**
The Paterson project has entered the operational phase and the transfer of the University of Manchester and CRUK staff from Alderley Park is complete on schedule. Attention is focusing on the moves from the Trust site into the Paterson and the first move has been completed. The established governance meetings will continue until the final account is settled and all staff are transferred but this is a significant and pivotal achievement.

The outpatient pharmacy and new dispensing robot on the Withington site is complete and being commissioned to open in July 2023.

Works have commenced on the formation of a 20-bedroom ward in the former Trust Administration and Digital floors with the final decommissioning and temporary access works. Several other schemes are at pre-construction and construction stages including the replacement of radiotherapy equipment in Oldham and Salford, the replacement of two CT scanners in radiology and the charity funded Art Room renovation.

The design and engagement for the proposed Advanced Scanning and Imaging Centre development along Wilmslow Road continues with the scheme being well received during consultation sessions. We are currently appointing the main contractor and beginning to develop the designs and cost plan together with the various decants which need to complete before demolition works can commence.

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

*Responsible Director – Director of Finance*
*Responsible Assurance Committee – Board*

**Greater Manchester System**
The Carnall Farrar review of leadership and governance has now been formally published by the ICB. The report makes a number of recommendations in support on its organisational development. Two immediate actions have been identified:

- the development of the Joint Forward Plan (JFP) and
- the development and clarification of the GM operating model

*The Greater Manchester Joint Forward Plan*
The 2022 Health & Care Act requires Integrated Care Boards to develop a 5-year Joint Forward Plan with local 'partner NHS Trusts'. The Plan is designed to respond to the Integrated Care Partnerships strategy as well as setting how NHS services will be arranged to meet the 'local population's physical and mental health needs'. NHS England has published guidance (see NHS England » Guidance on developing the joint forward plan) on the content and timescales for the development of the Plan. GM has produced a draft document in advance of a submission deadline of 30 June.

The GM approach to the JFP plan is based on the six missions outlined in the Integrated Care Partnership's strategy, namely

- Strengthening our communities
- Helping people stay well and detecting illness earlier
- Helping people get into, and stay in, good work
- Recovering core NHS and care services
- Supporting our workforce and our carers
- Achieving financial sustainability

From a cancer perspective GM has, through the Cancer Alliance, developed an annual plan to address a number of priorities, including current operational performance/faster diagnosis, early diagnosis, tackling variation in care and developing personalised care. Alongside this there is a significant amount of support to patient engagement and involvement. Oversight of the GM Cancer Plan delivery is the responsibility of the GM Cancer Board.

Whilst the JFP is designed to cover a 5-year timeframe, the Cancer Plan has a one to two year horizon. Importantly a number of the key elements of the GM Cancer Pan are identified within the JFP, particularly faster and early diagnosis.

*Responsible Director – Director of Strategy, with Chief Operating Officer for system performance issues and Deputy CEO for strategic issues. The CEO is the chair of the Greater Manchester Cancer Alliance Board.*
*Responsible Assurance Committee – Board*

**Regulation**
We were notified on 21st April of a CQC inspection of our radiotherapy service for compliance with the Ionising radiation medical exposure regulations (IR(ME)R). We have made our data submission and it has been considered by the CQC, we are now awaiting their report.

Following our CQC inspection in October and November 2022 the final inspection report was published on 12th May and we were rated as 'Good' overall. The Management Board have considered the report and the 'must' and 'should' do's that have been identified and an action plan

required by our regulator has been submitted by the CQC's deadline. Prof Janelle Yorke presented the action plan to the Greater Manchester Quality & Performance Committee on 7th June and oversight monitoring is via the Specialist Commissioners routine quality meetings. We also continue to meet with the CQC through our regular engagement meetings.

The actions from the inspection are being communicated across the organisation and discussed in key forums, and progress monitored through the Board of Directors. The Independent Culture Review that has been commissioned following the report has been communicated and focus groups and 1:1 meetings with staff will get underway from July 2023. This will give us a more detailed assessment of the issues and advise us on how we can ensure a healthy culture which promotes engagement and diversity.  The terms of reference are published here.

*Responsible Director – Executive Chief Nurse and Deputy CEO*
*Responsible Assurance Committee - Board*

The Christie NHS Foundation Trust

# EXECUTIVE SUMMARY

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

**Safe**

- No serious incidents were reported in May. There were 7 incidents reported in month with the classification of moderate, details of which can be found on slide 7. All the incidents are still progressing through to full root cause analysis. No never events were reported in month.
- There are 4 Trust level risks scored at 15+. Details of these can be found on slide 12.
- Safer staffing numbers have met the required acuity levels to ensure appropriate levels of safety and care for our patients. Indicative staffing, in line with nursing establishments, is set to maintain a 1:6 nurse to patient ratio. On occasion this has been extended to 1:8 which is in line with recommended national staffing ratios. While we have seen an increase in patient safety incidents, following thematic review, these were not related to nurse staffing ratios.

**Responsive**

- Performance against the 62 day standard has not been met with a performance of 66.9%, subject to validation. The 62 day unvalidated upgrade performance is also below the standard with a performance of 71.9%. The internal 24 day target is also below standard and is at 75.5%. All 62 and 24 day breaches are reviewed to ensure any delays are understood and plans can be implemented to mitigate any future delays. All 31 day targets and 18 week RTT standards have been achieved in May subject to validation. Performance against the CWT thresholds is constantly monitored and action plans are in place to improve performance going forward.
- The one patient waiting over 52 weeks at the end of May is an 18 week patient who's pathway includes several postponements due to patient choice.
- Referral numbers in May increased from April and are higher than May 2022.

**Effective**

- There were 3 cases of C-Difficile, 4 cases of E-Coli, 2 cases of Klebsiella and 1 case of MSSA in May that were deemed attributable to the Trust. No lapses in care have been identified.
- There were no cases of hospital acquired nosocomial Covid-19 infections in May.
- Staff absence levels reduced from April to a position of 3.8% against a target of 3.4%.
- PDR performance has been maintained whilst there has been an improvement in the mandatory training performance which is above the set standard.

**Well – Led**

- The Trust is reporting a month end deficit of £875k compared to expected £1,340k deficit. The main reason for an improved position relates to interest received being higher than plan and continued underspends on pay whilst growth vacancies are recruited to.
- Capital expenditure is £7k over the NHSI plan mainly due to the spend on backlog maintenance. The cash balance is £134,652k.
- Performance for month 2 was an overspend of £7k above the plan submitted to NHSE&I.
- The Trust has incurred £926k on capital schemes to month 2, primarily on the backlog maintenance programme, the Linac replacements and the TIF ward.

# SUMMARY DASHBOARD

NHS
The Christie
NHS Foundation Trust

## Safe

| Indicator | Threshold / Standard 23/24 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 | YTD |
|---|---|---|---|---|---|---|---|
| Serious Incident Reported | - | 2 | 1 | 1 | 0 | 0 | 0 |
| Never Events | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Radiation Incidents Reported (IRMER Reportable) | 0 | 2 | 0 | 0 | 0 | 0 | 0 |
| Radiation Incidents Reported (IRMER Reportable - Grade 2 or above) | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| Number of Pressure Ulcers (Post admission - Grade 2 or above) - Rate per 1000 occupied bed days | 0.4 (22/23 Avg) | | | | 0.2 | 0.4 | - |
| Inpatient Falls Resulting in Harm (Grade 2 or above) - Rate per 1000 occupied bed days | 3.6 (22/23 Avg) | | | | 2.6 | 4 | - |
| VTE Assessments Completed | 95.0% | 97.8% | 98.0% | 98.6% | 98.0% | 98.3% | - |
| Sepsis - timely treatment with IV antibiotics (established inpatients) | 90.0% | 97.1% | 97.4% | 89.2% | 96.9% | 95.1% | - |
| Sepsis - screening (presenting as an emergency) | 90.0% | 93.7% | 94.2% | 94.8% | 95.0% | 95.3% | - |
| Number of Corporate Risks Grade 15 or Above | - | 4 | 4 | 4 | 4 | 4 | - |
| Safe Staffing (% of planned hours vs actual hours across all inpatient areas) | - | 92.2% | 86.0% | 88.1% | 82.7% | 87.4% | - |

## Responsive

| Indicator | Threshold / Standard 23/24 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 | YTD |
|---|---|---|---|---|---|---|---|
| 62 Day Compliance | 85.0% | 66.50% | 79.40% | 71.90% | 71.70% | 66.90% | - |
| 62 Day Compliance - Upgrades | 85.0% | 78.00% | 79.10% | 77.80% | 65.90% | 71.90% | - |
| 62 Day Compliance - Screening | 90.0% | 77.80% | 100.00% | 100.00% | 75.00% | 72.70% | - |
| 24 Day Compliance | 85.0% | 72.40% | 86.50% | 77.00% | 73.50% | 75.50% | - |
| 31 Day Compliance | 96.0% | 96.90% | 98.30% | 97.70% | 97.90% | 97.50% | - |
| 31 Day Compliance - Subsequent Drug Therapy | 98.0% | 99.20% | 100.00% | 99.60% | 100.00% | 100.00% | - |
| 31 Day Compliance - Subsequent Radiotherapy | 94.0% | 99.00% | 99.50% | 99.30% | 99.00% | 99.30% | - |
| 31 Day Compliance - Subsequent Surgery | 94.0% | 99.00% | 100.00% | 98.40% | 98.80% | 100.00% | - |
| 18 Weeks Compliance - Incomplete Pathways | 92.0% | 97.10% | 96.70% | 96.50% | 96.50% | 96.91% | - |
| Patients waiting >52 Weeks | 0 | 2 | 1 | 1 | 1 | 1 | 2 |
| Patients waiting >104 days at end of month (All 62 Day Targets) | - | 38 | 45 | 34 | 34 | 42 | 76 |
| Length Of Stay (Elective & Non-Elective Inpatients) | 6.8 | 6.58 | 7.30 | 7.06 | 7.77 | 7.10 | - |
| Hospital Cancelled Operations on the day for non clinical reasons | 0 | 1 | 1 | 12 | 2 | 4 | 6 |
| Cancelled Operations due to COVID Reasons | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Hospital Cancelled Operations on the day for non clinical reasons - NOT rebooked within 28 days | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| Complaints Received | 14 (22/23 Avg) | 11 | 15 | 19 | 11 | 11 | 22 |
| PALS Contacts | 44 (22/23 Avg) | 41 | 45 | 55 | 46 | 51 | 97 |
| Inquests | - | 3 | 2 | 0 | 2 | 5 | 7 |
| Coroner Request | - | 5 | 1 | 7 | 11 | 12 | 23 |

# SUMMARY DASHBOARD

NHS
The Christie
NHS Foundation Trust

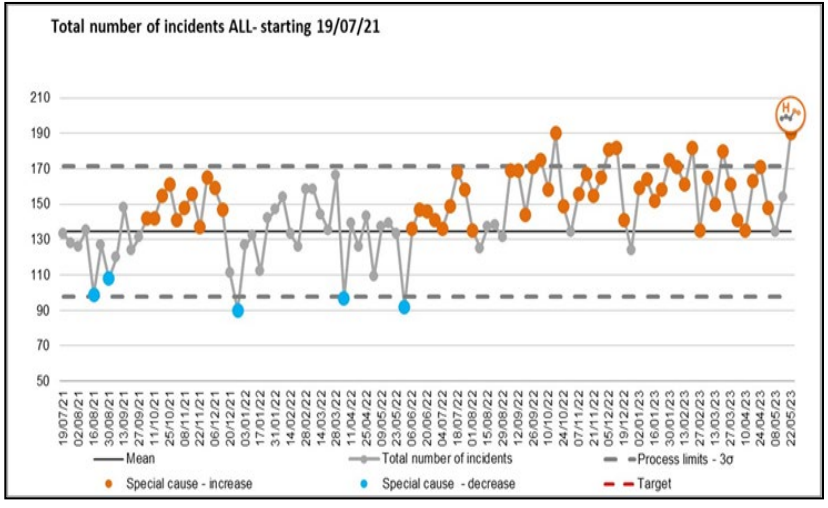
## Effective

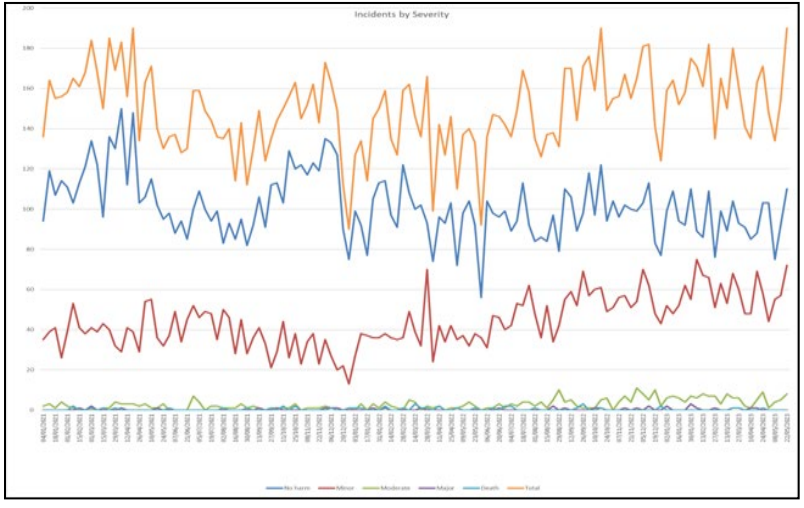
| Indicator | Threshold / Standard 23/24 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 | YTD |
|---|---|---|---|---|---|---|---|
| MRSA | 0 | 0 | 1 | 1 | 1 | 0 | 1 |
| C-Difficile - All Attributable Cases (Pre & Post 48 Hours) | 51 | 5 | 4 | 6 | 2 | 3 | 5 |
| C-Difficile - Attributable Cases Due To Lapse In Care | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| MSSA Bacteraemia - Attributable | 25 | 2 | 2 | 5 | 1 | 1 | 2 |
| E-Coli - Attributable | 58 | 4 | 4 | 8 | 5 | 4 | 9 |
| Klebsiella Species - Attributable | 17 | 4 | 2 | 1 | 4 | 2 | 6 |
| Pseudomonas Aeuriginosa - Attributable | 10 | 1 | 2 | 0 | 1 | 0 | 1 |
| COVID infections - Hospital Aquired | 0 | 0 | 0 | 8 | 9 | 0 | 9 |
| Palliative Radiotherapy 30 Day Suvival Rate | - | 90.3% | 86.3% | 87.0% | 94.2% | - | - |
| Final Chemotherapy 30 Day Survival Rate | - | 99.4% | 99.4% | 99.2% | 99.0% | - | - |
| Surgery 30 Day Survival Rate | - | 100.0% | 100.0% | 100.0% | 100.0% | - | - |
| Staff Sickness | 3.4% | 4.56% | 4.89% | 4.23% | 3.94% | 3.81% | - |
| Staff Mandatory Training | >80%** <80% | 88.5% | 87.8% | 88.1% | 89.4% | 92.1% | - |
| Staff PDRs | - | 84.5% | 84.0% | 86.0% | 84.7% | 84.5% | - |

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

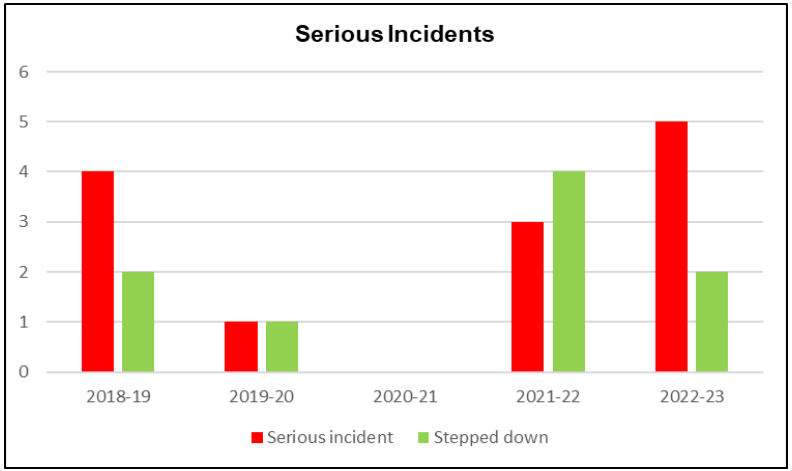
****Infection targets currently set at 22/23 totals whilst waiting on confirmation of 23/24 targets**

# Incident Reporting



# Serious Incidents and Never Events




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

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

**Serious incidents**
There were 0 serious incidents identified in May.

# Incidents identified that require a Learning Response

NHS
The Christie
NHS Foundation Trust

## May 2023 – Incidents reviewed at ERG

| Reference | Description | Reported Harm Level |
|---|---|---|
| W77588 | Delay in arranging radiotherapy after surgery | Moderate |
| W77551 | Scanned letter not forwarded to Consultant. | Moderate |
| W77602 | Delayed penile surgery | Moderate |
| W77906 | Chemotherapy dose reduction did not happen as planned | Moderate |
| W77793 | Delayed penile surgery | Moderate |
| W77794 | Patient had surgery for penile surgery – only part of the procedure could be completed -patient requires additional procedure as consequence | Moderate |
| W77795 | Patient had surgery for penile surgery – only part of the procedure could be completed -patient requires additional procedure as consequence | Moderate |

# Learning - Patient Safety Incidents

The Christie NHS Foundation Trust

**Agreed learning and revised severity outcome following executive reviews May 2023**

| Ref | Description | Root cause | Learning | Outcome |
|---|---|---|---|---|
| **W73898** | Delays in patient receiving Herceptin treatment at Christie SLA site. | Herceptin was not prescribed due to a dual prescription problem between the Christie and Christie SLA site iQemo systems. | • No dual prescribing or mid-way cycles changing from 1 system to another.<br>• Clinician to attend weekly metastatic clinical meetings.<br>• Retrospective audit to be undertaken: 1. HER2+ Neo-adjuvant patients between Jul – Dec 22<br>• Pathology reports checked, and previous annotations amended to reflect Her2 2+ FISH amplified (positive) | Moderate |
| **W75610** | Patient monitoring plan not followed after prescription of a COX2 inhibitor. | A prescribed plan for daily bloods to detect deterioration in renal function that was not followed. This plan was not communicated by the medical and nursing staff to the next shift. | • Ward managers to discuss in ward meetings the necessary information that should be handed over and on the daily huddle.<br>• Daily huddle to be moved to teams so all staff can access from different devices.<br>• Learning shared with junior doctors.<br>• Doctors to be reminded to use weekend handover and alertive for tasks due. | Minor |

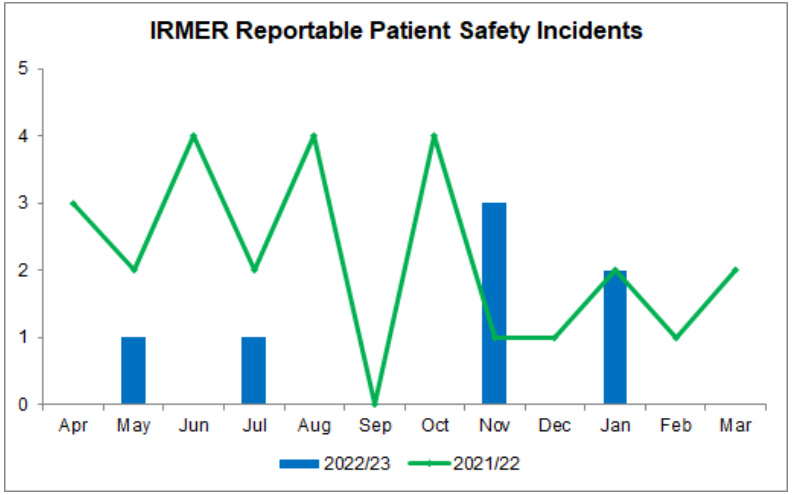
# Learning - Patient Safety Incidents

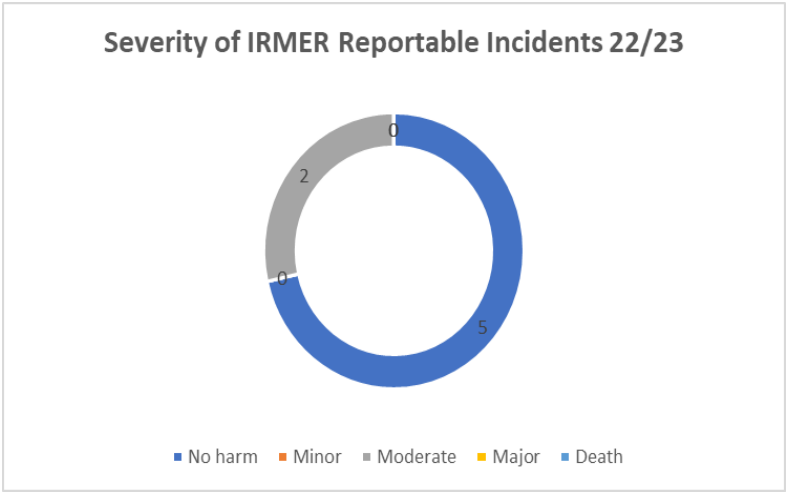
NHS
The Christie
NHS Foundation Trust

**Agreed learning and revised severity outcome following executive reviews May 2023**

| Ref | Description | Root cause | Learning | Outcome |
|---|---|---|---|---|
| **W75799** | Patient was discharged twelve days post-surgery without input from physiotherapy in the discharge planning process. | Nursing and medical staff were not fully aware of the multi-disciplinary team input into this patient's care and the information available to them was not considered prior to discharge. | • To liaise with the Discharge Manager to look at ways of sharing best practice with regards to safe discharge, with the MDT<br>• Ensure that the ward daily huddle is used to check all MDT are in agreement with the discharge plan. | Minor |
| **W76005** | Methicillin- Resistant Staphylococcus Aureus (MRSA) Bacteraemia identified on an inpatient. This was classified as a Hospital Onset Hospital Acquired (HOHA) | MRSA Bacteraemia was likely to be related to the central venous access device (CVAD) infection, which could have potentially been avoided by sufficient suppression treatment. | • Sharing learning trust wide around the use of suppression treatment.<br>• In addition to training already provided, face to face level 2 IPC Education programme to be considered.<br>• MRSA Policy to be reviewed alongside new guidance<br>• IPCT Surveillance to be strengthened, by the development of a ward round tool | Minor |

# Radiation Incidents



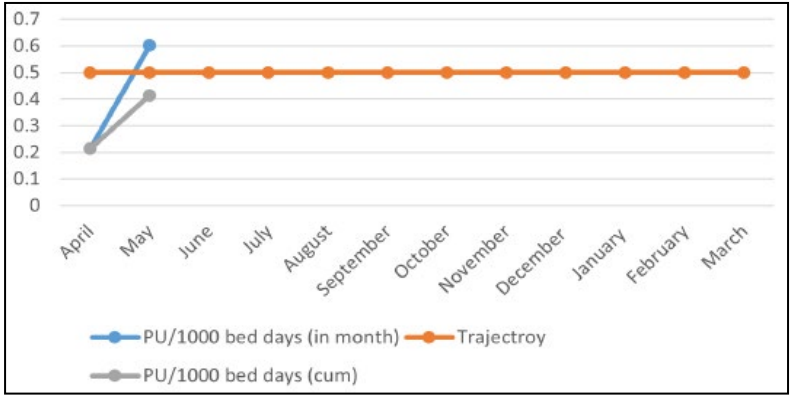




There were 0 IRMER reportable patient safety incidents in May 2023. There have been 0 reportable incidents YTD.

# Harm Free Care

The Christie NHS Foundation Trust

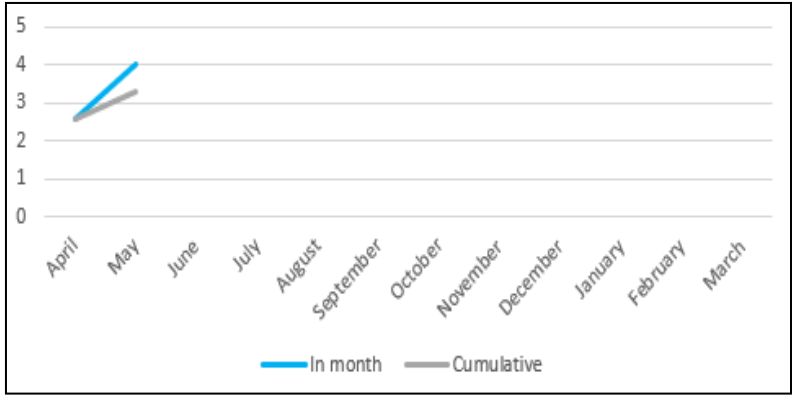
## Pressure ulcers per 1000 occupied bed days




The were three category 2 pressure ulcers that developed during admission in May.

There were no category 3 & 4 pressure ulcers acquired during hospital admission. This equates to 0.4 pressure ulcers per 1000 occupied bed days (last years performance was 0.4)

## Falls per 1000 occupied bed days




There were 20 in-patient falls in May - only one of these were of moderate harm, with 3 being minor harm and 16 no harm.

This equates to 4 falls per 1000 occupied bed days (last years performance was 3.6, with the national average around 6.6)

40

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

# Corporate Risks

NHS
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**There are 4 Trust-wide 15+ risks in May**

| Description | Score | Controls |
|---|---|---|
| Financial Risk 2023-24 (ID 3378) | 16 | M1 outturn better than plan (by £200k); CIP reporting will commence from M2 |
| Post clinic appointments processes are contributing to a risk to patients being lost to follow up (ID 3299) | 15 | T&F group is ongoing and review of all patients with no ongoing appointment is happening, those with open referrals are also being reviewed and closed where appropriate. currently waiting for waiting list module within care flow to be added to our test system and has been escalated with system C and our digital teams |
| Risk to delayed cancer referral and treatments due to not meeting 24 / 62 day target (ID 2407) | 15 | In addition to existing mitigations:<br><br>Treatment capacity in healthy position. Opening of Oldham 2 creates increased capacity for first definitive patients with ICDs. Capacity to treat these patients at Withington from June 23. |
| Risk of prolonged disruption to services, due to a severe cyber security incident. (ID 3218) | 15 | Cyber Essentials Plus postponed with assessors until the end of June.<br>Cyber Essentials (self assessment) undertaken and achieved.<br>Risk score review meeting currently to take place in July.<br>Separate risk for Disaster Recovery linked to service BCPs raised as the plans need improvement with dependent systems listed and assessed. |

# 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 | 17286 | 13409 | 4944 | 5.5 |
| | Total monthly ACTUAL | 14887 | 12150 | | |
| | Average Fill Rate % | 86.1% | 90.6% | | |
| Care Staff | Total monthly PLANNED | 9955 | 5470 | 4944 | 2.7 |
| | Total monthly ACTUAL | 8388 | 4881 | | |
| | Average Fill Rate % | 84.3% | 89.2% | | |
| ALL Staff | Total monthly PLANNED | 27241 | 18879 | 4944 | 8.2 |
| | Total monthly ACTUAL | 23275 | 17032 | | |
| | Average Fill Rate % | 85.4% | 90.2% | | |

| 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 | 2427 | 2151 | 88.6% | 2164 | 1784 | 82.4% | 114 | 34.5 |
| Palatine Ward | 3160 | 2587 | 81.9% | 2698 | 2153 | 79.8% | 858 | 5.5 |
| Ward 10 | 2434 | 1853 | 76.1% | 1575 | 1520 | 96.6% | 680 | 5.0 |
| Ward 11 | 1894 | 1782 | 94.1% | 1487 | 1503 | 101.1% | 861 | 3.8 |
| Ward 12 | 1986 | 1936 | 97.5% | 1655 | 1518 | 91.7% | 831 | 4.2 |
| Ward 4 | 1925 | 1935 | 100.5% | 1582 | 1540 | 97.4% | 834 | 4.2 |
| Ward 2 | 879 | 719 | 81.8% | 460 | 449 | 97.6% | 222 | 5.3 |
| Acute Assessment Unit | 2583 | 1925 | 74.5% | 1790.5 | 1684 | 94.0% | 544 | 6.6 |
| TOTAL | 17286 | 14887 | 86.1% | 13409 | 12150 | 90.6% | 4944 | 5.5 |

| Registered Nursing Associates | DAY | | | NIGHT | | |
|---|---|---|---|---|---|---|
| | Hours Planned | Hours Actual | | Hours Planned | Hours Actual | |
| Palatine Ward | | 17 | | | | |
| Ward 12 | | 12 | | | 41 | |
| Ward 4 | | 82 | | | 150 | |

| 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 | 620 | 315 | 50.8% | 12 | 12 | 95.8% | 114 | 2.9 |
| Palatine Ward | 1261 | 1138 | 90.3% | 840 | 806 | 95.9% | 858 | 2.3 |
| Ward 10 | 1901 | 1272 | 66.9% | 723 | 431 | 59.6% | 680 | 2.5 |
| Ward 11 | 1576 | 1271 | 80.6% | 897 | 829 | 92.4% | 861 | 2.4 |
| Ward 12 | 1394 | 1298 | 93.1% | 897 | 845 | 94.2% | 831 | 2.6 |
| Ward 4 | 1675 | 1684 | 100.6% | 1136 | 1073 | 94.4% | 834 | 3.3 |
| Ward 2 | 376 | 341 | 90.6% | 253 | 242 | 95.5% | 222 | 2.6 |
| Acute Assessment Unit | 1153.5 | 1070.5 | 92.8% | 713 | 646 | 90.6% | 544 | 3.2 |
| TOTAL | 9955 | 8388 | 84.3% | 5470 | 4881 | 89.2% | 4944 | 2.7 |

Safer staffing numbers have met the required acuity levels to ensure appropriate levels of safety and care for our patients.

# Patient Experience

NHS
The Christie
NHS Foundation Trust

## Positive feedback received…..

*“I wanted to write to inform you of the amazing care given by Dr. Adam, Dr. Arthur and the entire endocrinology department. Although we have received some excellent care in the past, the team at the Endo Dept are something else! Me and my wife have been regular visitors here over this year and the care is consistently excellent.”*

*“You have all made this horrific journey so much more bearable. Keep doing what you are doing as it really does make a difference every day. We can't thank you all enough. What great team ward 11 is."*

*“Department 25 is only small but what a soothing environment, so relaxing and such nice decorative touches and a TV. Refreshments available too.”*

*"I wanted to email your team about the Christie and tell you about the wonderful care that my father has been receiving there. On my visits, taking my father to the hospital for appointments, all the staff have been friendly and approachable, and nothing has seemed too much of a difficulty or a barrier to care. The ward clerk I spoke to from the Palatine ward was friendly, helpful, and caring. They all put my father, and mother, at ease during a worrying time for them. What also was striking, I noted, was the lovely atmosphere of the hospital and the tangible feelings of things as precious as hope and dignity that is evidently present as soon as you walk through the door.”*

# Friends & Family Test

NHS
The Christie
NHS Foundation Trust

## Monthly Summary

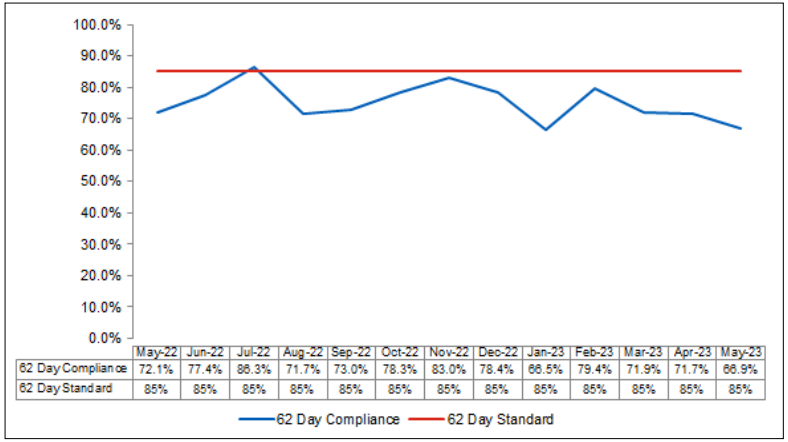
| | INPATIENT & DAYCASE RESPONSES | | | | | | Total Number of people eligible to respond | Total Responses | Response Rate | % Recommended |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1 - Very Good | 2 - Good | 3 - Neither Good nor Poor | 4 - Poor | 5 - Very Poor | 6 - Don't Know | | | | |
| Apr-23 | 207 | 27 | 4 | 0 | 2 | 1 | 780 | 241 | 30.9% | 97.10% |
| May-23 | 280 | 20 | 1 | 2 | 0 | 1 | 926 | 304 | 32.8% | 98.68% |
| YTD Total | 487 | 47 | 5 | 2 | 2 | 2 | 1706 | 545 | 31.95% | 97.98% |

| | OUTPATIENT RESPONSES | | | | | | Total responses | % Recommended |
|---|---|---|---|---|---|---|---|---|
| | 1 - Very Good | 2 - Good | 3 - Neither Good nor Poor | 4 - Poor | 5 - Very Poor | 6 - Don't Know | | |
| Apr-23 | 1348 | 165 | 38 | 19 | 10 | 18 | 1598 | 94.68% |
| May-23 | 1336 | 166 | 52 | 18 | 13 | 12 | 1597 | 94.05% |
| YTD Total | 2684 | 331 | 90 | 37 | 23 | 30 | 3195 | 94.37% |

| Ward name | INPATIENT & DAYCASE RESPONSES - BY WARD | | | | | | Total Number of people eligible to respond | Total responses for each ward | Response rate for each ward |
|---|---|---|---|---|---|---|---|---|---|
| | 1 - Very Good | 2 - Good | 3 - Neither Good nor Poor | 4 - Poor | 5 - Very Poor | 6 - Dont Know | | | |
| 04 Ward (Dept 52) | 16 | 0 | 0 | 0 | 0 | 0 | 86 | 16 | 18.6% |
| 10 Ward-Surg Onc Unit (Dept 4) | 38 | 4 | 1 | 0 | 0 | 1 | 140 | 44 | 31.4% |
| 11 Ward (Dept 4) | 3 | 1 | 0 | 0 | 0 | 0 | 78 | 4 | 5.1% |
| 12 Ward (Dept 4) | 3 | 3 | 0 | 0 | 0 | 0 | 85 | 6 | 7.1% |
| The BMR Unit (Dept 16) | 16 | 1 | 0 | 0 | 0 | 0 | 44 | 17 | 38.6% |
| Endocrine Ward (Dept 63) | 12 | 0 | 0 | 0 | 0 | 0 | 22 | 12 | 54.5% |
| Haematology Day Unit (Dept 26) | 63 | 4 | 0 | 1 | 0 | 0 | 143 | 68 | 47.6% |
| Integrated Procedure Unit (Dept 2) | 121 | 7 | 0 | 1 | 0 | 0 | 240 | 129 | 53.8% |
| Palatine Ward (Dept 27) | 8 | 0 | 0 | 0 | 0 | 0 | 88 | 8 | 9.1% |
| Total | 280 | 20 | 1 | 2 | 0 | 1 | 926 | 304 | 32.8% |

# Cancer Standards

## 62 Day / 31 Day / 18 Weeks




| | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 62 Day Compliance | 72.1% | 77.4% | 86.3% | 71.7% | 73.0% | 78.3% | 83.0% | 78.4% | 66.5% | 79.4% | 71.9% | 71.7% | 66.9% |
| 62 Day Standard | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |

| | | | 62 Days | | | |
|---|---|---|---|---|---|---|
| | | | 62 Classic | | Upgrades | |
| | | | Pts | Acc Num | Pts | Acc Num |
| 62 Compliance | (CaRP Rec) | Total Timeframe | 208 | 78.5 | 119 | 48 |
| FULL Christie Compliance | > 38 Days | <= 62 Days | 30 | 30 | 9 | 9 |
| FULL Christie Breach | <= 38 Days | > 62 Days | 10 | 10 | 4 | 4 |
| 50% Shared Breach | > 38 Days | > 62 Days, Treat > 24 Days | 32.0 | 16.0 | 19.0 | 9.5 |
| 50% Shared Compliance | <= 38 Days | <= 62 Days | 45.0 | 22.5 | 51.0 | 25.5 |
| FULL Referring Provider Breach | > 38 Days | > 62 Days, Treat <= 24 Days | 91 | 91 | 36 | 36 |
| | | | | | | |
| TOTAL Compliances | | | 75.0 | 52.5 | 60.0 | 34.5 |
| TOTAL Breaches | | | 42.0 | 26.0 | 23.0 | 13.5 |
| % Compliance | | | | 66.9% | | 71.9% |

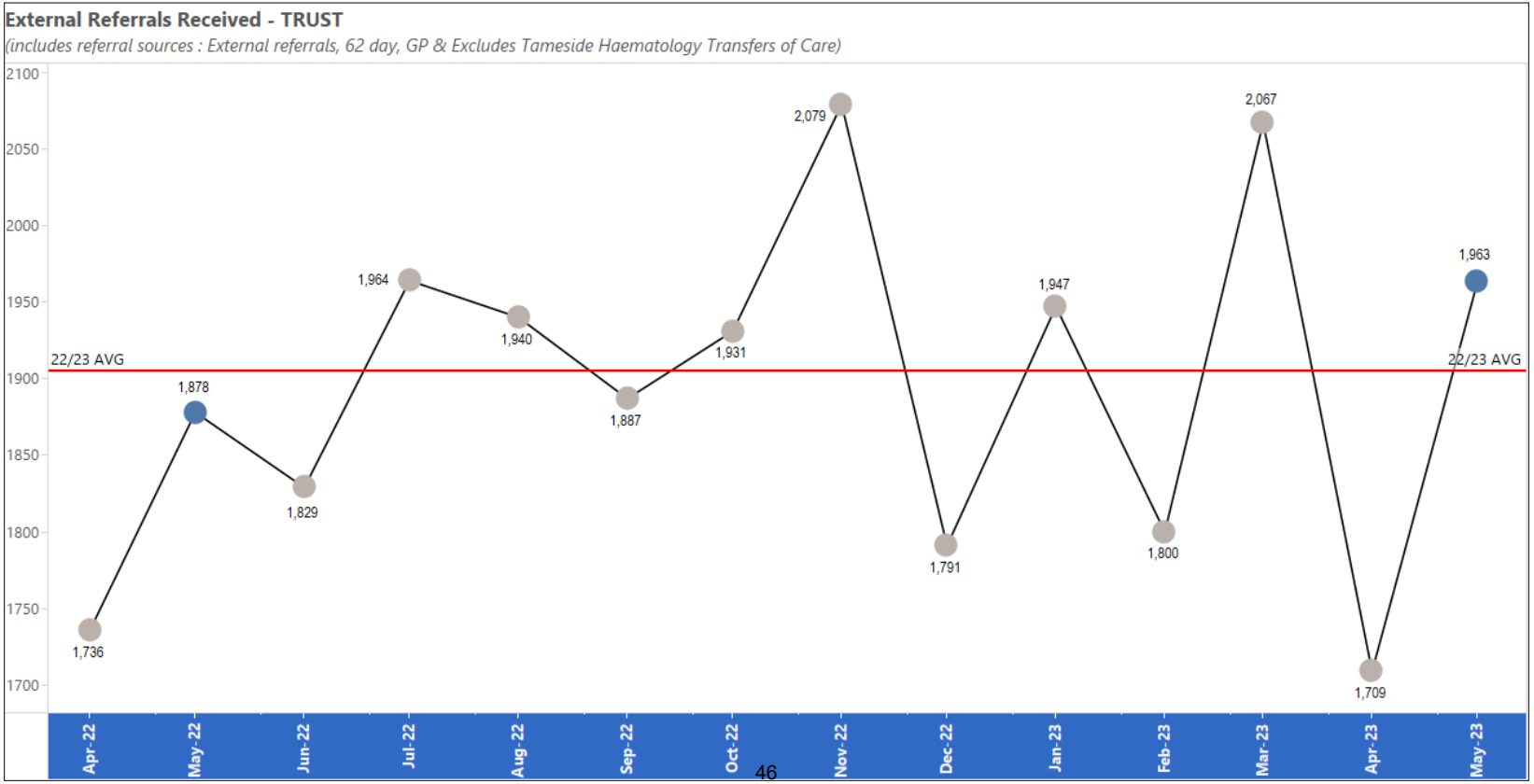
| National Standard | Standard | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 62 Day | 85% | 72.10% | 77.40% | 86.30% | 71.70% | 73.00% | 78.30% | 83.00% | 78.40% | 66.50% | 79.40% | 71.90% | 71.70% | 66.90% |
| 62 Day Upgrades | 85% | 80.40% | 75.00% | 86.30% | 84.30% | 86.50% | 84.40% | 83.00% | 82.00% | 78.00% | 79.10% | 77.80% | 65.90% | 71.90% |
| 62 Day Screening | 90% | 50.00% | 100.00% | 83.30% | 57.10% | 50.00% | 88.90% | 50.00% | 83.30% | 77.80% | 100.00% | 100.00% | 75.00% | 72.70% |
| 24 Day Internal | 85% | 80.40% | 80.60% | 89.70% | 79.90% | 82.40% | 87.60% | 84.10% | 82.30% | 72.40% | 86.50% | 77.00% | 73.50% | 75.50% |
| 31 Days | 96% | 98.00% | 98.50% | 98.60% | 98.70% | 98.20% | 97.80% | 97.20% | 98.20% | 96.90% | 98.30% | 97.70% | 97.90% | 97.50% |
| 31 Day Subsequent Drug | 98% | 99.60% | 99.50% | 100.00% | 100.00% | 99.60% | 100.00% | 99.70% | 99.20% | 99.20% | 100.00% | 99.60% | 100.00% | 100.00% |
| 31 Day Subsequent XRT | 94% | 99.40% | 99.20% | 99.80% | 99.60% | 99.60% | 99.20% | 99.50% | 99.60% | 99.00% | 99.50% | 99.30% | 99.00% | 99.30% |
| 31 Day Subsequent Surgery | 94% | 100.00% | 100.00% | 100.00% | 100.00% | 99.10% | 99.10% | 99.10% | 100.00% | 99.00% | 100.00% | 98.40% | 98.80% | 100.00% |
| 18 Weeks - Incomplete Pathways | 92% | 98.30% | 98.60% | 97.90% | 97.30% | 97.60% | 98.10% | 98.40% | 96.70% | 97.10% | 96.70% | 96.50% | 96.50% | 96.91% |

45

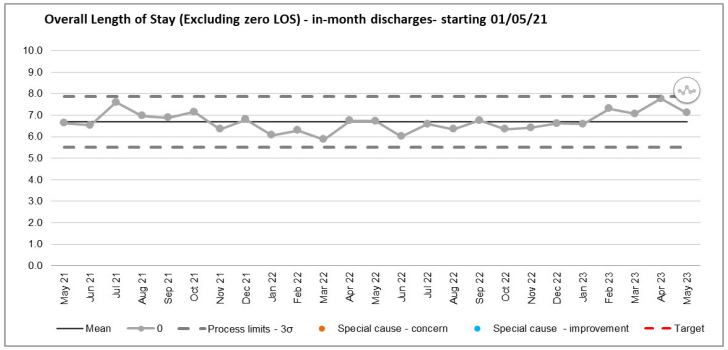
***All target positions are subject to validation and are correct as of the time of reporting.***

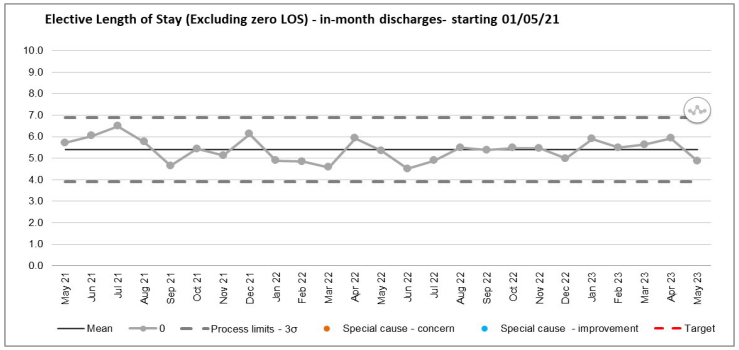
# Referrals Analysis

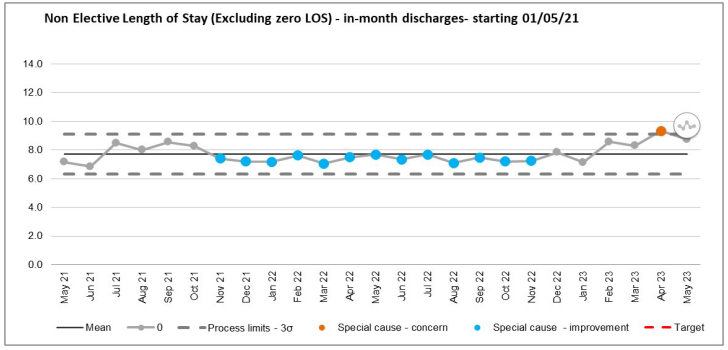
The Christie NHS Foundation Trust

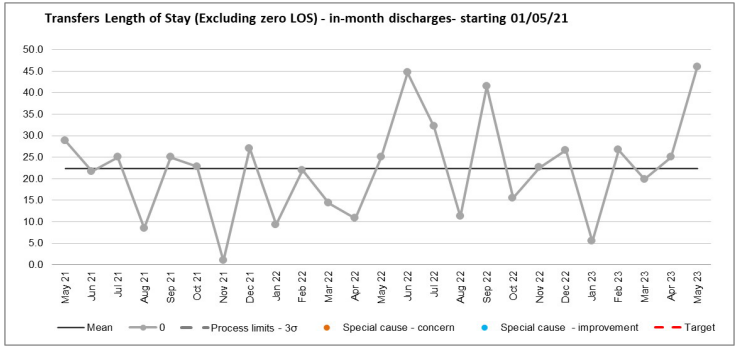


# Length of Stay



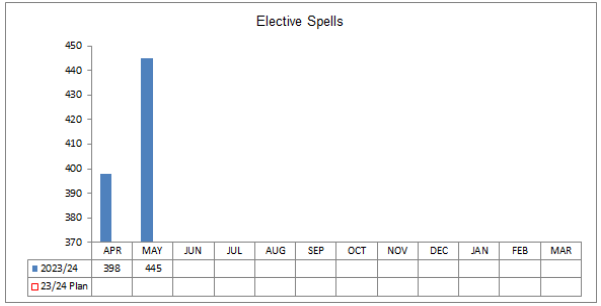



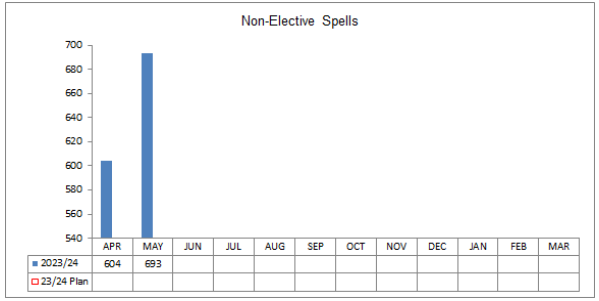



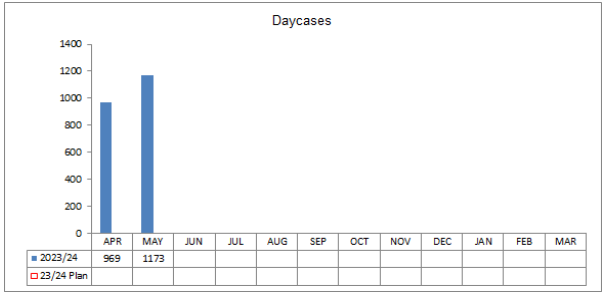

Elective, non-elective, and overall length of stay continues to be well within control limits. There has been a slight raise in transfer patients due to the discharge in May of one long stay patient.

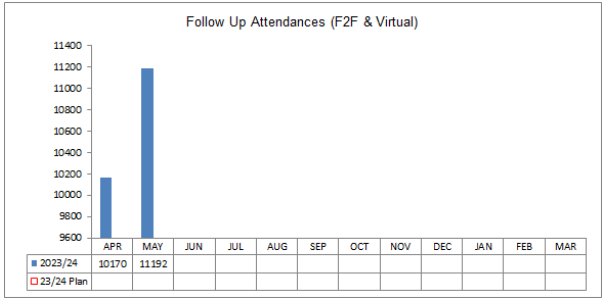
# Activity

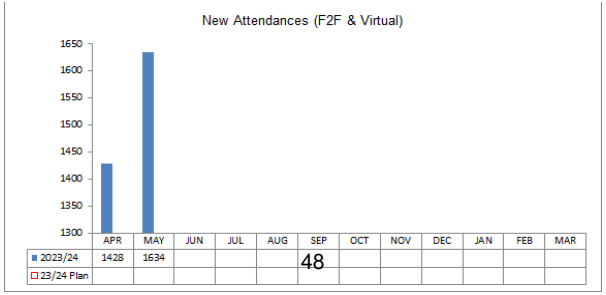
**Plan data for some activity lines will be available in June.*

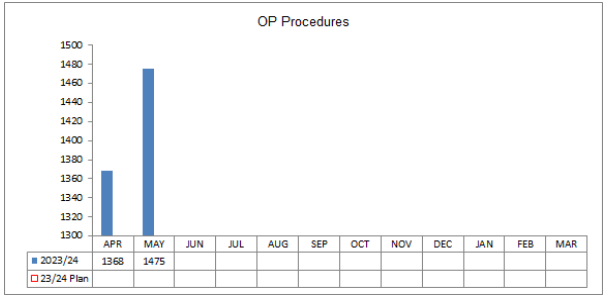


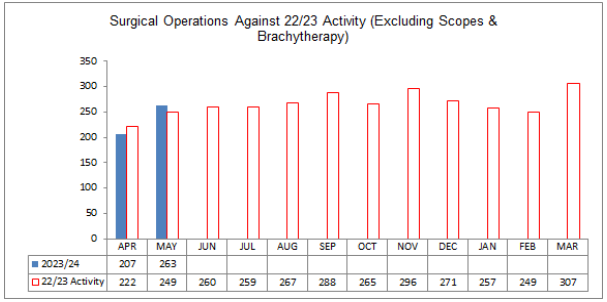




48

# Activity

*Plan data for some activity lines will be available in June.*

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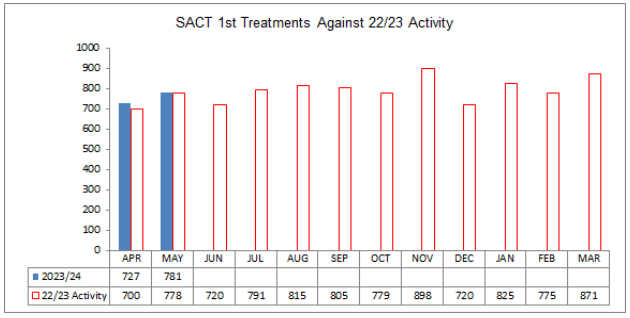
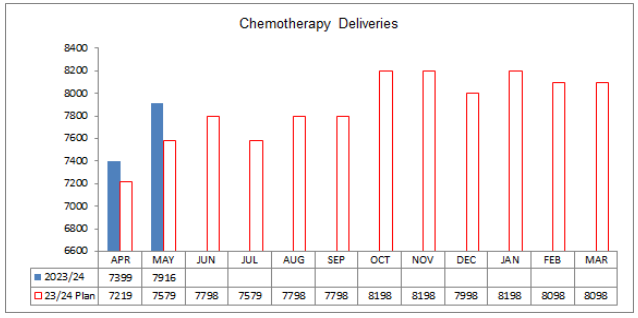
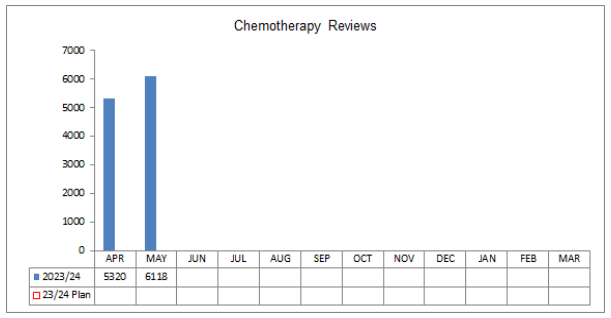


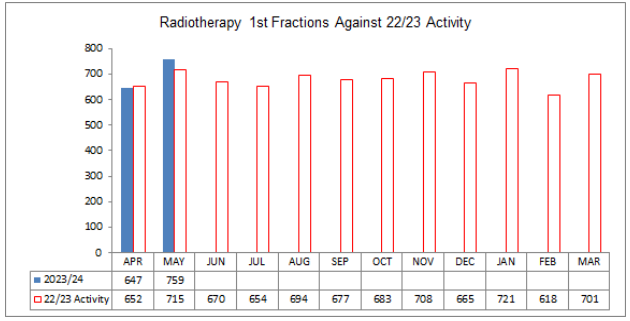

| | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2023/24 | 727 | 781 | | | | | | | | | | |
| 22/23 Activity | 700 | 778 | 720 | 791 | 815 | 805 | 779 | 898 | 720 | 825 | 775 | 871 |



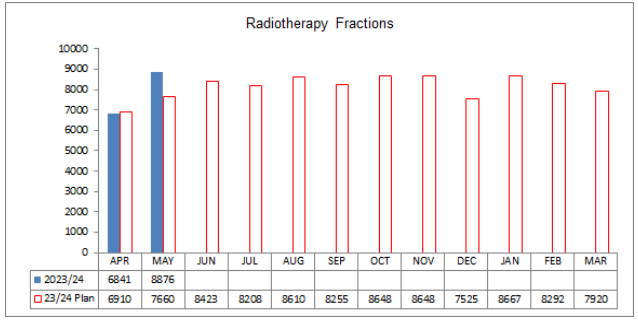

| | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2023/24 | 7399 | 7916 | | | | | | | | | | |
| 23/24 Plan | 7219 | 7579 | 7798 | 7579 | 7798 | 7798 | 8198 | 8198 | 7998 | 8198 | 8098 | 8098 |



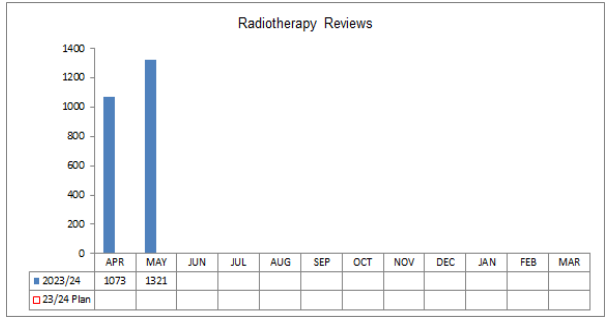

| | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2023/24 | 5320 | 6118 | | | | | | | | | | |
| 23/24 Plan | | | | | | | | | | | | |




| | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2023/24 | 647 | 759 | | | | | | | | | | |
| 22/23 Activity | 652 | 715 | 670 | 654 | 694 | 677 | 683 | 708 | 665 | 721 | 618 | 701 |



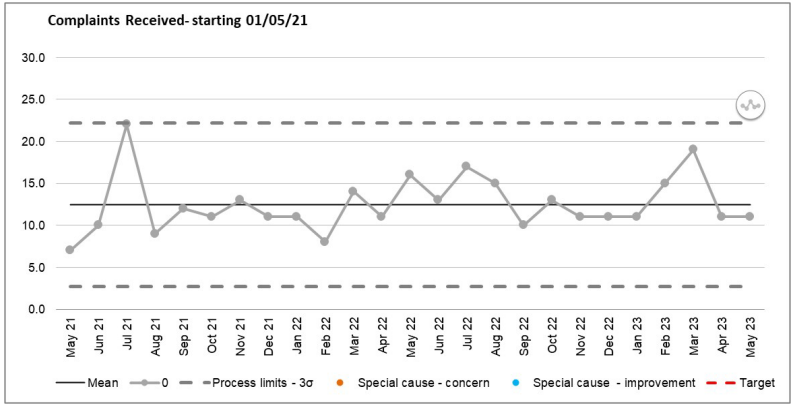

| | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2023/24 | 6841 | 8876 | | | | | | | | | | |
| 23/24 Plan | 6910 | 7660 | 8423 | 8208 | 8610 | 8255 | 8648 | 8648 | 7525 | 8667 | 8292 | 7920 |




| | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2023/24 | 1073 | 1321 | | | | | | | | | | |
| 23/24 Plan | | | | | | | | | | | | |

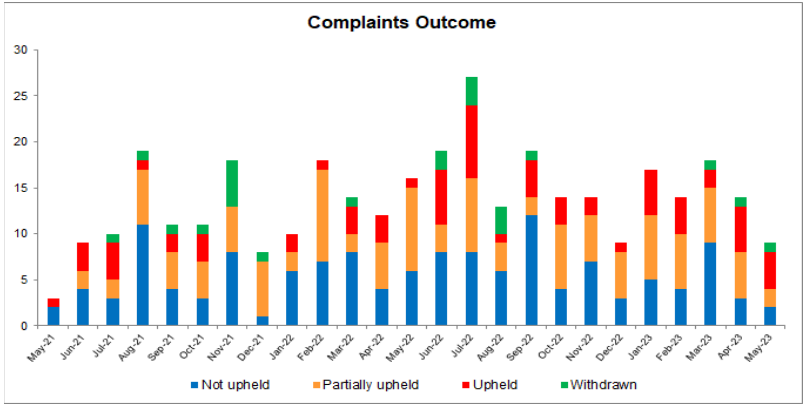
SACT 1st Treatments, 1st Fractions & Surgical Operations do not form part of the 23/24 activity plan and are used as supplementary guides to productivity. The figures are monitored against the previous year's month for comparison.

# Complaints



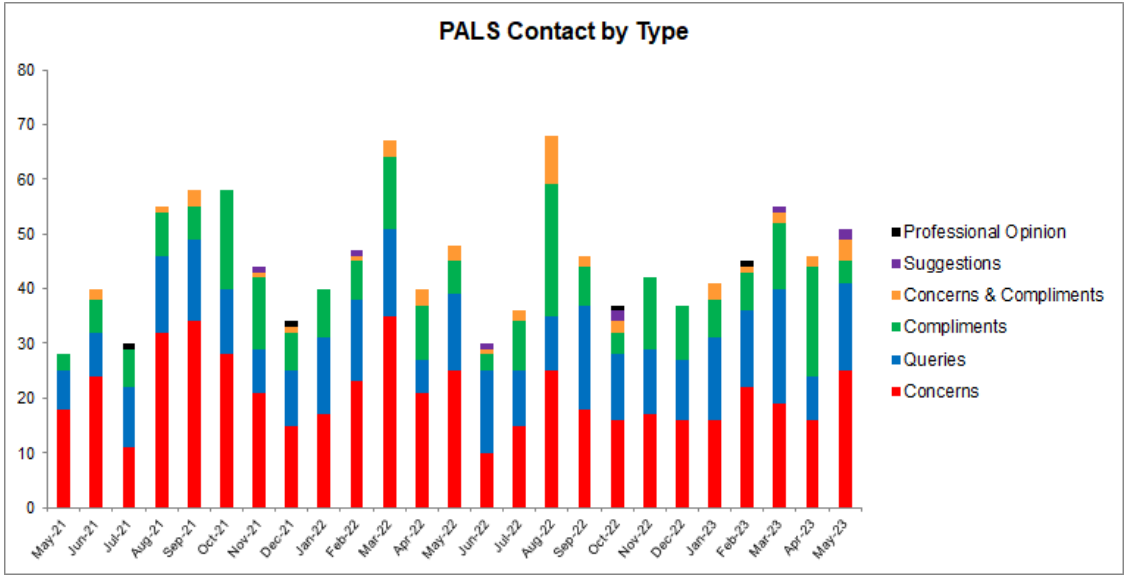

11 new complaints received in May 2023

9 complaints were closed in May 2023




**Ombudsman Cases**
Complainants have the right to refer their case to the Parliamentary and Health Service Ombudsman (PHSO) if they are not satisfied it has been resolved by the Trust. 1 case was referred to the PHSO in May 2023. 4 cases remain under investigation.

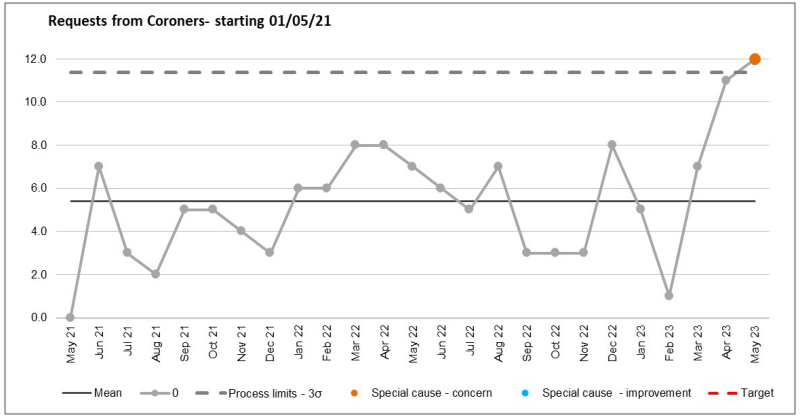
# PALS

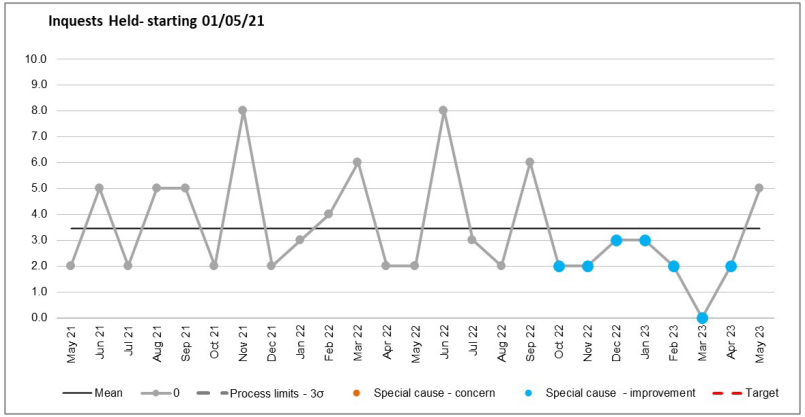



51 PALS contacts have been received in May 2023.

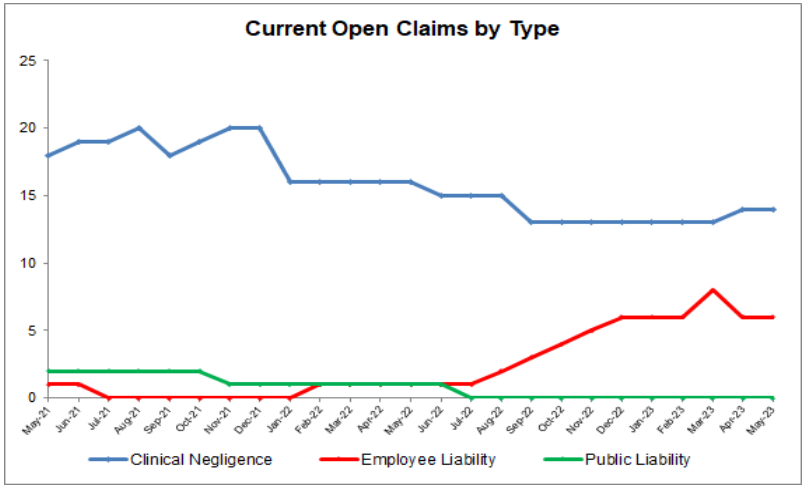
25 of those raised concerns about their experience at The Christie but did not wish to take them down the formal complaints route. The other reasons for contacting PALS are captured in the graph.

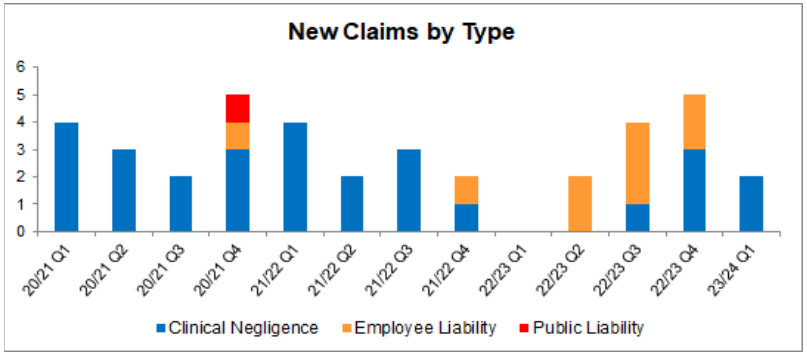
# Inquests


Requests from Coroners- starting 01/05/21
12.0
10.0
8.0
6.0
4.0
2.0
0.0
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22
Oct 22
Nov 22
Dec 22
Jan 23
Feb 23
Mar 23
Apr 23
May 23
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


Inquests Held- starting 01/05/21
10.0
9.0
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22
Oct 22
Nov 22
Dec 22
Jan 23
Feb 23
Mar 23
Apr 23
May 23
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

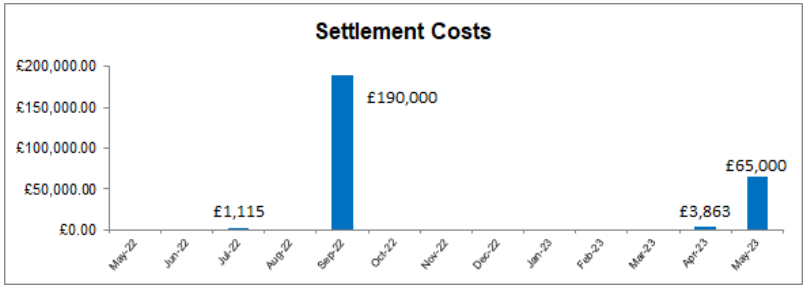
# Claims




1 new 'Clinical Negligence' claim received in May 2023.

1 Clinical Negligence Claim settled in May 2023.



# Healthcare Associated Infections

NHS
The Christie
NHS Foundation Trust

| Curent Month | Community Onset - Indeterminate Acquisition (COIA) | Community Onset - Community Acquired (COCA) | Community Onset - Healthcare Acquired (COHA) | Healthcare Onset - Healthcare Acquired (HOHA) | Lapses in Care | Area(s) Occurred |
|---|---|---|---|---|---|---|
| Clostridium Difficile | 1 | 3 | | 3 | 0 | (W2x1) (W11x1) (W12x1) |
| E.coli Bacteraemia | | 3 | 2 | 2 | 0 | (W2x1) (PWx1) (AAUx2) |
| Klebsiella spp. | | | | 2 | 0 | (W11z1) (W12x1) |
| Pseudomonas aeruginosa bacteraemia | | | | | 0 | |
| MSSA Bacteraemia | | 2 | 1 | | 0 | (IPUx1) |
| MRSA Bacteraemia | | | | | 0 | |

| YTD | Community Onset - Indeterminate Acquisition (COIA) | Community Onset - Community Acquired (COCA) | Community Onset - Healthcare Acquired (COHA) | Healthcare Onset - Healthcare Acquired (HOHA) | Lapses in Care |
|---|---|---|---|---|---|
| Clostridium Difficile | 1 | 3 | | 5 | 0 |
| E.coli Bacteraemia | | 6 | 4 | 5 | 0 |
| Klebsiella spp. | | | 3 | 3 | 0 |
| Pseudomonas aeruginosa bacteraemia | | | | 1 | 0 |
| MSSA Bacteraemia | | 2 | 1 | 1 | 0 |
| MRSA Bacteraemia | | | 1 | | 0 |

| Organism | COVID 19 first positive 3 – 7 days from admission (HO-iHA) | COVID 19 first positive 8 – 14 days from admission (HO-pHA) | COVID 19 first positive 15 or more days from admission (HO-dHA) | TOTAL | Lapses in care |
|---|---|---|---|---|---|
| COVID-19 | | | | 0 | 0 |

| Organism | Number of Cases | Area(s) Occurred | Lapses in care |
|---|---|---|---|
| CPE colonisation / infection | 0 | | 0 |

There were 3 cases of C-Difficile, 4 cases of E-Coli, 2 cases of Klebsiella and 1 case of MSSA in May that were deemed attributable to the Trust. No lapses in care have been identified.

***Definitions***

*COCA - Cdiff: Is not categorised HOHA and the patient has not been discharged from the same reporting organisation in the 84 days prior to the specimen date (where day 1 is the specimen date)*

*E.coli, Klebs, Pseudo, MSSA, MRSA: Is not categorised HOHA and the patient has not been discharged from the same reporting organisation in the 28 days prior to the specimen date (where day 1 is the specimen date)*

*COIA - Symptoms commenced within first two days of admission and has been an inpatient in the trust in the past 4 weeks*

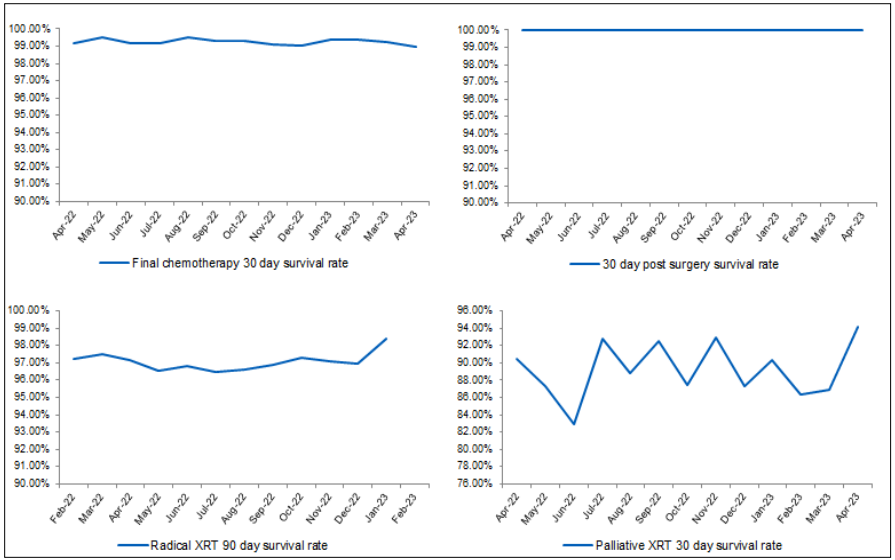
*COHA - Symptoms commenced within first two days of admission and inpatient in the past 12 weeks (but not past 4 weeks)*

*HOHA - Symptoms commenced within first two days of admission (No admission in past 12 weeks)*

# Mortality Indicators & Survival Rates

The Christie NHS Foundation Trust

## Survival Rates




## Inpatient Deaths – Onsite Deaths

| | | May-23 |
|---|---|---|
| Number of NHS Christie onsite deaths | Elective/planned admission | 3 |
| | Non Elective/emergency admission | 28 |
| | TOTAL | **31** |
| Number of deaths that have triggered Structured Casenote Review (SCR) Note: screening is ongoing so further triggers may be identified | Mortuary screened triggers (including reported to the coroner) - 1 | **6** |
| | Bereaved families raised concern – 0 | |
| | Medical Triggers - 5 | |
| | Nursing Triggers - 1 (inc in family concern) | |
| | COVID-19 - 0 | |
| | (note there may be more than one trigger) | |

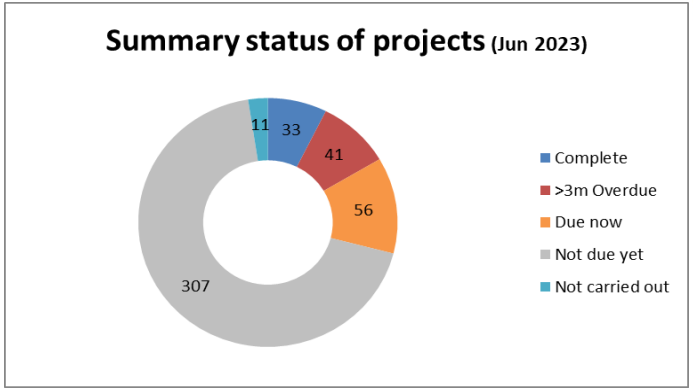
The Christie process for learning from deaths follows the 2017 NHSI guidance. All in-patient deaths are screened and where flagged by one or more triggers an independent structured case note review (SCR) is undertaken. Reviews are discussed by the Mortality Surveillance Group and the findings and actions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

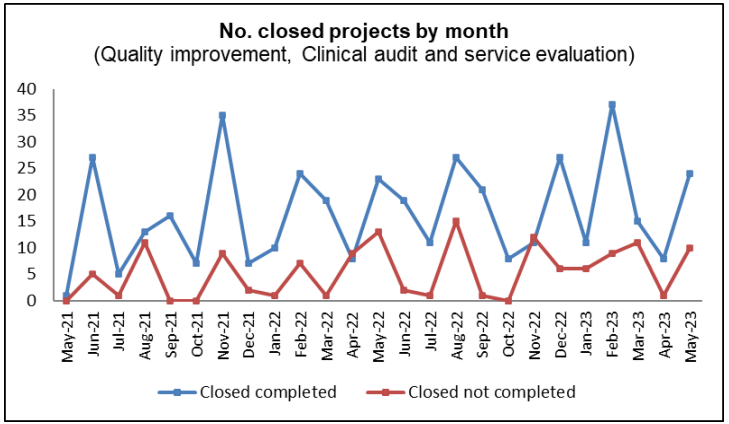
# Quality Improvement & Clinical Audit

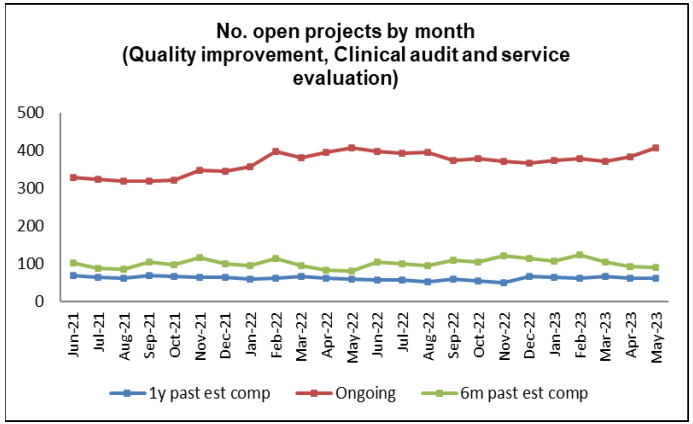
The Christie NHS Foundation Trust

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

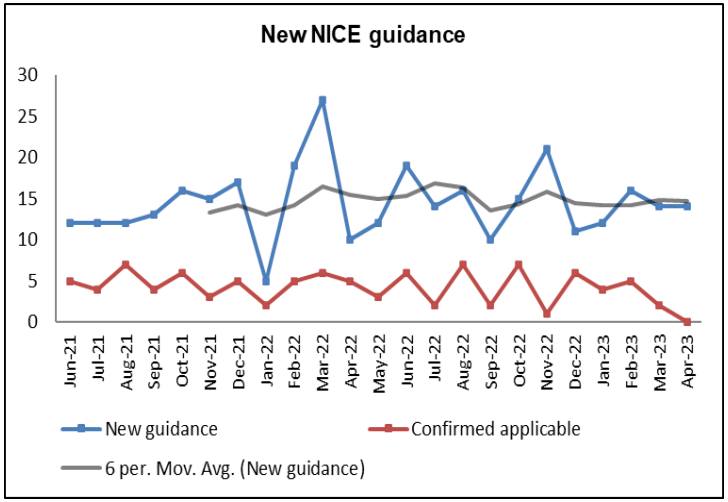
Reminders are sent mid-quarter which lead to increased number of closed projects

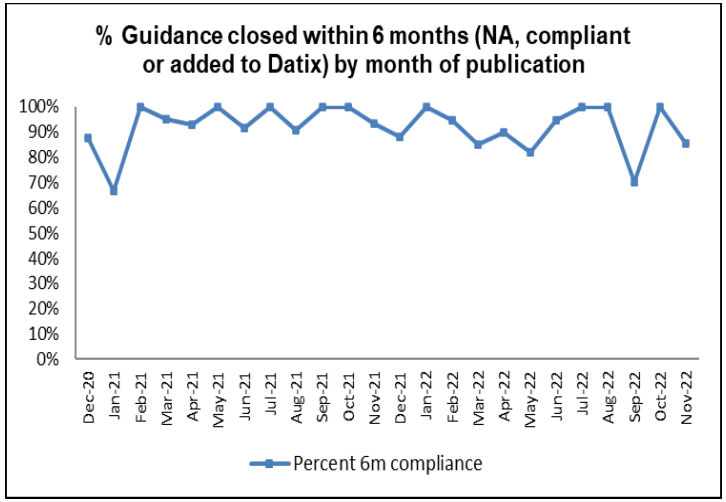


# NICE Guidance




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

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

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

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

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

# HR Metrics (Sickness)

NHS
The Christie
NHS Foundation Trust

**3.81%**
Monthly Absence

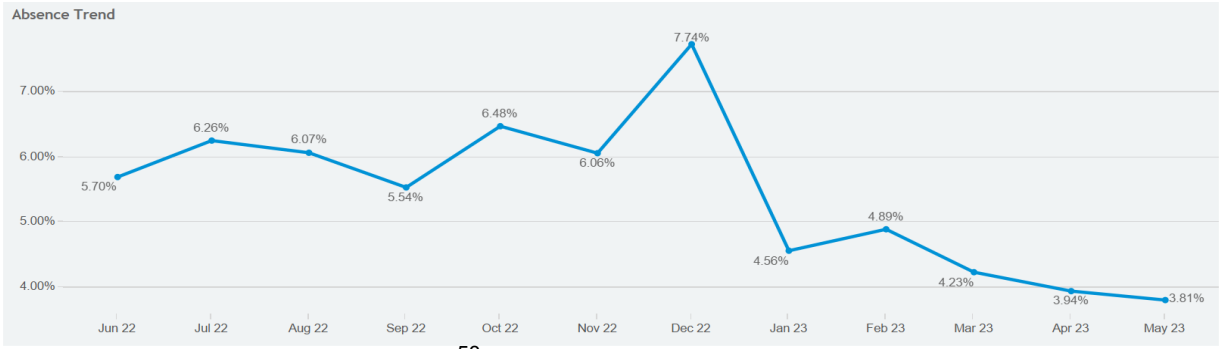
**5.43%**
Yearly Absence

**273**
Returned Last Month

**88**
No. of Employees on Long Term Sick

**283**
No. of Employees on Short Term Sick

| Division | Jun 22 | Jul 22 | Aug 22 | Sep 22 | Oct 22 | Nov 22 | Dec 22 | Jan 23 | Feb 23 | Mar 23 | Apr 23 | May 23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Christie Medical Physics & Engineering | 1.29% | 2.02% | 1.93% | 3.05% | 2.55% | 1.70% | 3.07% | 3.24% | 2.45% | 2.26% | 1.67% | 2.32% |
| Clinical Networked Services | 4.43% | 4.98% | 4.10% | 4.29% | 5.27% | 4.70% | 5.50% | 4.67% | 3.68% | 4.27% | 3.82% | 3.50% |
| Clinical Support & Specialist Surgery | 5.23% | 5.60% | 5.48% | 4.76% | 4.91% | 6.79% | 8.23% | 5.66% | 5.05% | 5.00% | 4.92% | 5.51% |
| Corporate Development | 0.62% | 1.42% | 2.04% | 1.86% | 1.71% | 0.89% | 2.77% | 0.55% | 0.52% | 0.29% | 0.00% | 0.00% |
| Digital Services | 2.33% | 2.89% | 1.23% | 1.78% | 4.69% | 4.99% | 4.25% | 1.80% | 1.55% | 1.65% | 1.83% | 2.53% |
| Education (School of Oncology) | 3.93% | 2.69% | 1.57% | 1.86% | 1.57% | 0.51% | 3.72% | 4.60% | 3.35% | 1.42% | 1.86% | 0.93% |
| Estates & Facilities | 9.38% | 9.20% | 10.08% | 9.86% | 11.02% | 12.52% | 13.49% | 11.11% | 8.97% | 9.79% | 8.93% | 5.89% |
| Finance & Business Development | 1.24% | 0.71% | 1.28% | 1.47% | 2.86% | 4.45% | 3.91% | 2.75% | 1.83% | 2.43% | 1.88% | 3.43% |
| GM Cancer | 5.56% | 4.24% | 3.59% | 1.50% | 1.08% | 0.22% | 3.47% | 3.78% | 1.36% | 0.00% | 0.35% | 0.86% |
| Medical Director's Office | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |
| Performance | 2.93% | 4.48% | 3.39% | 8.53% | 5.17% | 11.12% | 6.47% | 4.01% | 4.32% | 7.10% | 7.40% | 9.78% |
| Quality & Standards | 8.04% | 8.57% | 5.83% | 3.41% | 6.01% | 6.71% | 9.36% | 7.96% | 6.44% | 5.78% | 4.25% | 5.93% |
| Research & Innovation | 3.23% | 4.69% | 4.04% | 3.65% | 4.46% | 4.08% | 5.24% | 4.42% | 3.13% | 3.73% | 3.73% | 3.62% |
| Strategy | 0.00% | 0.00% | 4.80% | 7.93% | 6.00% | 6.00% | 8.28% | 3.70% | 0.00% | 0.00% | 2.19% | 0.00% |
| Trust Administration | 1.11% | 0.00% | 5.80% | 6.43% | 5.85% | 6.21% | 7.07% | 6.42% | 6.21% | 5.85% | 6.65% | 6.88% |
| Workforce | 2.02% | 3.03% | 2.99% | 2.33% | 2.82% | 4.48% | 3.83% | 1.75% | 0.93% | 1.40% | 0.52% | 0.35% |

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# HR Metrics - Mandatory Training)

The Christie NHS Foundation Trust

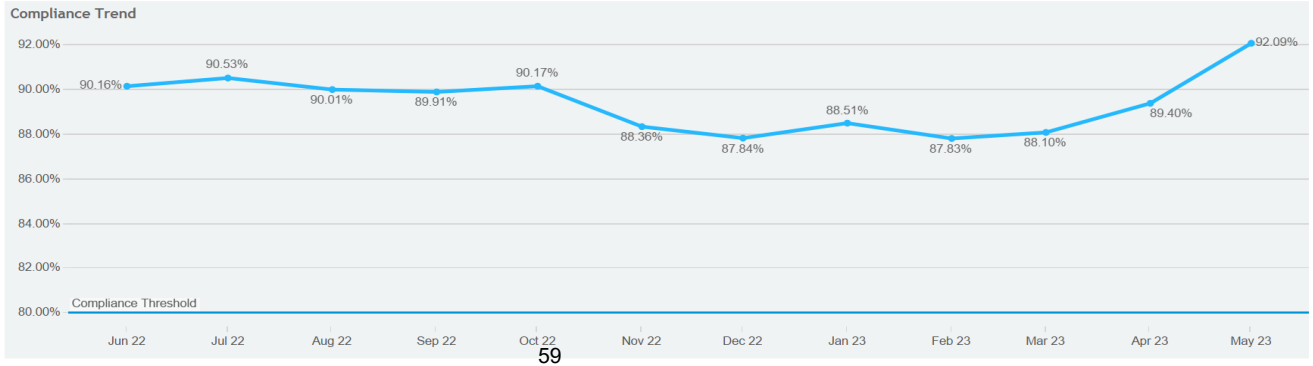
**92.09%**
Compliance

**3,195**
Outstanding Modules

**82.15%**
Face to Face

**93.26%**
Online

| Division | Jun 22 | Jul 22 | Aug 22 | Sep 22 | Oct 22 | Nov 22 | Dec 22 | Jan 23 | Feb 23 | Mar 23 | Apr 23 | May 23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Christie Medical Physics & Engineering | 94.58% | 94.71% | 94.92% | 93.08% | 94.94% | 95.48% | 95.55% | 95.37% | 94.95% | 95.06% | 96.03% | 96.20% |
| Clinical Networked Services | 88.65% | 89.92% | 89.07% | 89.47% | 89.85% | 87.27% | 87.11% | 87.62% | 87.45% | 85.86% | 87.06% | 90.07% |
| Clinical Support & Specialist Surgery | 86.78% | 86.38% | 85.75% | 84.91% | 85.29% | 83.59% | 82.47% | 83.39% | 81.15% | 81.96% | 84.99% | 88.93% |
| Corporate Development | 98.78% | 95.36% | 95.42% | 97.93% | 98.17% | 96.94% | 95.76% | 96.19% | 95.58% | 95.71% | 96.12% | 100.00% |
| Digital Services | 93.41% | 92.23% | 92.37% | 94.14% | 93.50% | 96.24% | 95.22% | 94.86% | 96.21% | 98.97% | 98.35% | 98.55% |
| Education (School of Oncology) | 96.73% | 96.79% | 94.70% | 95.27% | 96.38% | 95.09% | 93.86% | 93.91% | 94.14% | 94.81% | 94.11% | 96.06% |
| Estates & Facilities | 93.05% | 94.28% | 93.79% | 94.13% | 92.61% | 92.98% | 92.97% | 93.65% | 93.13% | 95.21% | 93.98% | 94.46% |
| Finance & Business Development | 96.63% | 97.26% | 98.39% | 99.39% | 98.39% | 98.74% | 98.25% | 97.14% | 97.75% | 99.67% | 97.93% | 99.11% |
| GM Cancer | 84.24% | 78.57% | 77.66% | 79.12% | 77.89% | 82.20% | 81.66% | 82.66% | 80.54% | 86.04% | 87.44% | 92.97% |
| Medical Director's Office | 92.86% | 92.86% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% |
| Performance | 97.71% | 96.70% | 96.15% | 95.88% | 96.57% | 94.74% | 93.91% | 95.03% | 96.39% | 95.06% | 95.32% | 93.38% |
| Quality & Standards | 91.90% | 93.10% | 97.47% | 93.51% | 93.27% | 88.80% | 89.07% | 92.26% | 92.17% | 92.86% | 94.08% | 93.04% |
| Research & Innovation | 93.41% | 94.21% | 94.56% | 94.43% | 94.19% | 93.42% | 92.88% | 94.20% | 93.53% | 93.57% | 94.32% | 96.53% |
| Strategy | 91.96% | 93.57% | 90.26% | 90.91% | 90.91% | 90.21% | 85.57% | 95.49% | 93.22% | 93.85% | 94.17% | 98.26% |
| Trust Administration | 91.18% | 92.86% | 92.44% | 92.86% | 98.74% | 95.88% | 95.88% | 97.99% | 98.33% | 93.15% | 93.56% | 96.04% |
| Workforce | 90.82% | 89.12% | 86.81% | 88.10% | 89.61% | 88.17% | 89.12% | 88.84% | 92.94% | 91.61% | 92.72% | 96.12% |



# HR Metrics - PDR

NHS
The Christie
NHS Foundation Trust

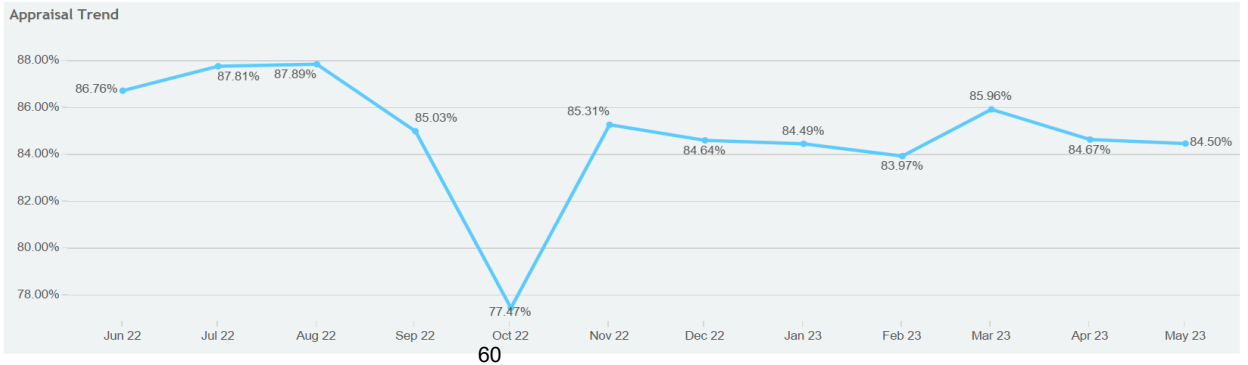
**84.50%**
Compliance

**429**
Expired

**367**
Due Soon (3 Months)

**68.44%**
Predicted Compliance
(If the Due Soon were to expire)

| Division | Jun 22 | Jul 22 | Aug 22 | Sep 22 | Oct 22 | Nov 22 | Dec 22 | Jan 23 | Feb 23 | Mar 23 | Apr 23 | May 23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Christie Medical Physics & Engineering | 91.25% | 89.67% | 87.08% | 86.13% | 83.75% | 84.58% | 89.58% | 88.84% | 88.07% | 90.00% | 90.46% | 92.08% |
| Clinical Networked Services | 88.51% | 90.48% | 91.18% | 88.47% | 74.31% | 86.45% | 86.04% | 83.43% | 81.33% | 80.90% | 81.24% | 86.22% |
| Clinical Support & Specialist Surgery | 83.57% | 85.04% | 86.23% | 83.70% | 72.34% | 82.72% | 83.83% | 84.59% | 84.94% | 87.08% | 85.64% | 82.19% |
| Corporate Development | 89.47% | 89.19% | 88.24% | 96.88% | 96.97% | 96.97% | 93.94% | 88.57% | 75.68% | 100.00% | 100.00% | 100.00% |
| Digital Services | 83.70% | 87.64% | 83.91% | 74.71% | 79.31% | 87.06% | 84.27% | 91.11% | 89.36% | 93.62% | 93.75% | 89.69% |
| Education (School of Oncology) | 83.05% | 80.70% | 74.14% | 61.02% | 77.78% | 92.06% | 87.30% | 92.19% | 90.48% | 92.31% | 94.03% | 89.39% |
| Estates & Facilities | 80.58% | 81.93% | 82.70% | 78.15% | 79.24% | 84.32% | 83.05% | 83.40% | 82.68% | 84.28% | 80.60% | 72.10% |
| Finance & Business Development | 94.29% | 94.29% | 95.59% | 90.91% | 88.89% | 95.24% | 87.30% | 90.63% | 88.89% | 96.67% | 89.06% | 95.24% |
| GM Cancer | 61.29% | 58.06% | 62.50% | 65.63% | 66.67% | 63.64% | 61.76% | 57.14% | 53.85% | 71.79% | 61.90% | 65.96% |
| Medical Director's Office | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 0.00% | 0.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% |
| Performance | 86.96% | 87.50% | 87.50% | 87.50% | 86.96% | 91.30% | 91.30% | 91.30% | 90.91% | 91.30% | 82.61% | 72.73% |
| Quality & Standards | 92.31% | 92.31% | 96.15% | 82.14% | 78.57% | 75.00% | 79.31% | 82.76% | 76.67% | 87.10% | 78.79% | 82.35% |
| Research & Innovation | 93.33% | 92.70% | 91.51% | 90.97% | 88.21% | 87.96% | 82.01% | 82.08% | 87.02% | 90.71% | 88.24% | 85.37% |
| Strategy | 66.67% | 75.00% | 62.50% | 50.00% | 37.50% | 37.50% | 30.00% | 33.33% | 30.00% | 30.00% | 30.00% | 50.00% |
| Trust Administration | 80.00% | 80.00% | 86.67% | 86.67% | 76.47% | 80.00% | 80.00% | 66.67% | 80.00% | 85.71% | 92.86% | 92.86% |
| Workforce | 90.20% | 92.45% | 94.34% | 89.66% | 93.22% | 91.67% | 87.93% | 94.92% | 98.28% | 94.74% | 91.38% | 98.28% |

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# Workforce Metrics - Turnover

The Christie NHS Foundation Trust

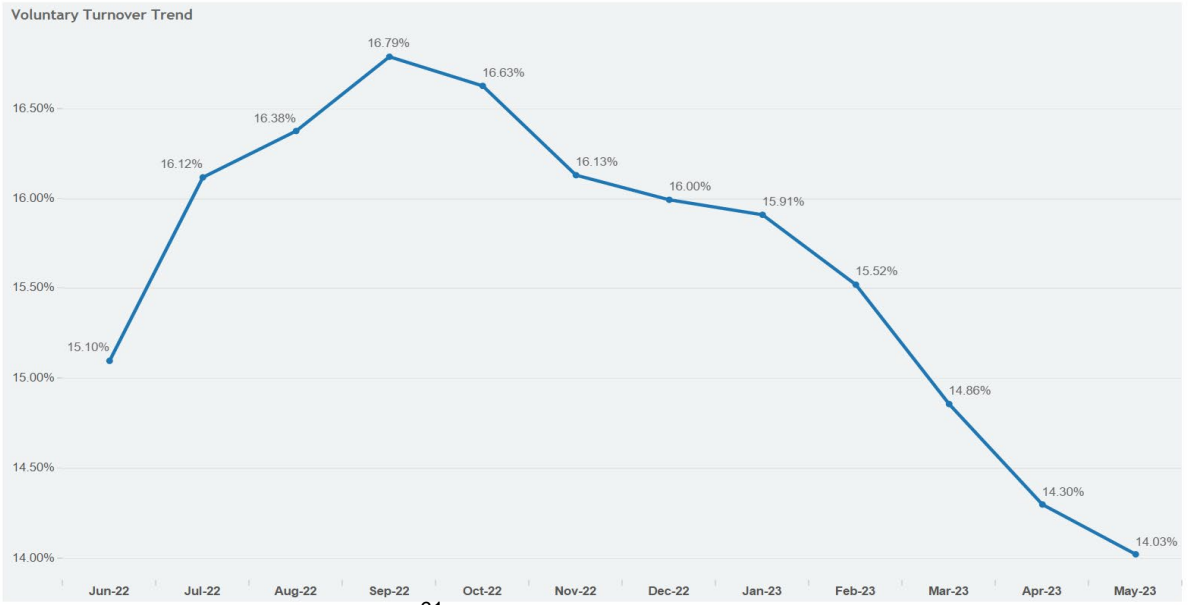
**37**
Leavers

**14.03%**
Voluntary Yearly Turnover

**17.67%**
All Yearly Turnover

**3,439**
Headcount

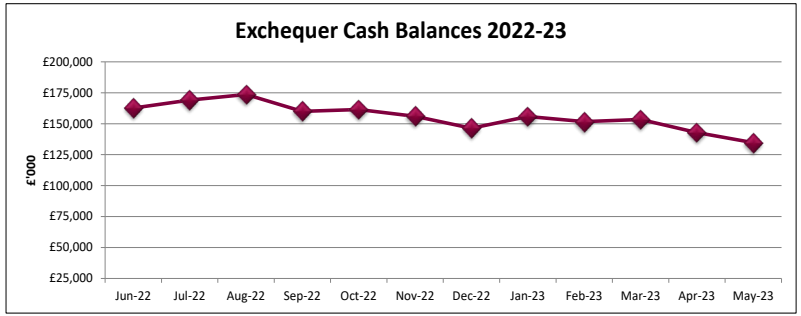
| | Jun 22 | Jul 22 | Aug 22 | Sep 22 | Oct 22 | Nov 22 | Dec 22 | Jan 23 | Feb 23 | Mar 23 | Apr 23 | May 23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dismissal | 1 | 4 | | 1 | | 1 | 1 | 1 | 1 | 1 | | 2 |
| End of Fixed Term Contract | 7 | 10 | 18 | 14 | 5 | 1 | | 1 | 2 | 1 | 7 | 2 |
| Redundancy | | 1 | | | | | | | | | | |
| Retirement | 3 | 7 | 4 | | 7 | 3 | 3 | 5 | 3 | 10 | 5 | 4 |
| Voluntary Resignation | 24 | 63 | 50 | 53 | 31 | 25 | 28 | 37 | 26 | 30 | 28 | 29 |
| Others | | | 1 | | 1 | | 1 | 2 | 1 | 35 | 1 | |
| Grand Total | 35 | 85 | 73 | 68 | 44 | 30 | 33 | 46 | 33 | 77 | 41 | 37 |



# Finance (Executive Summary)

The Christie NHS Foundation Trust

| | YTD Budget | YTD Actual | Variance |
|---|---|---|---|
| | £'000 | £'000 | £'000 |
| Clinical Income | (62,137) | (61,435) | 701 |
| Other Income | (10,461) | (10,632) | (171) |
| Pay | 34,106 | 32,435 | (1,672) |
| Non Pay (incl drugs) | 36,483 | 36,713 | 230 |
| **Operating (Surplus) / Deficit** | **(2,008)** | **(2,919)** | **(911)** |
| Finance expenses/ income | 5,276 | 5,287 | 11 |
| Joint venture profit | (489) | (76) | 413 |
| **(Surplus) / Deficit** | **2,779** | **2,291** | **(488)** |
| Exclude impairments/ charitably funded capital donations | (1,440) | (1,416) | 24 |
| **Adjusted financial performance (Surplus) / Deficit** | **1,340** | **875** | **(464)** |




This report outlines the month 2 consolidated financial performance of The Christie NHS Foundation Trust and its wholly owned subsidiary The Christie Pharmacy Ltd.

## I&E

- At month 2 the Trust is reporting a month end deficit of £875k compared to expected £1,340k deficit. The main reason for an improved position relates to interest received being higher than plan and continued underspends on pay whilst growth vacancies are recruited to.
- 2023-24 CIP – Identified in year CIP is up to £8.3m (£7.6m non- recurrent / £0.7m recurrent) and is 66% of the in year target of £12.5m.

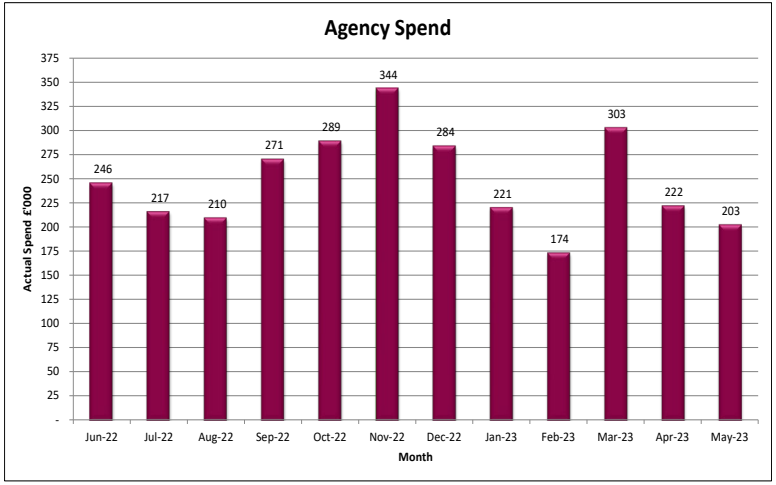
## Balance sheet / liquidity

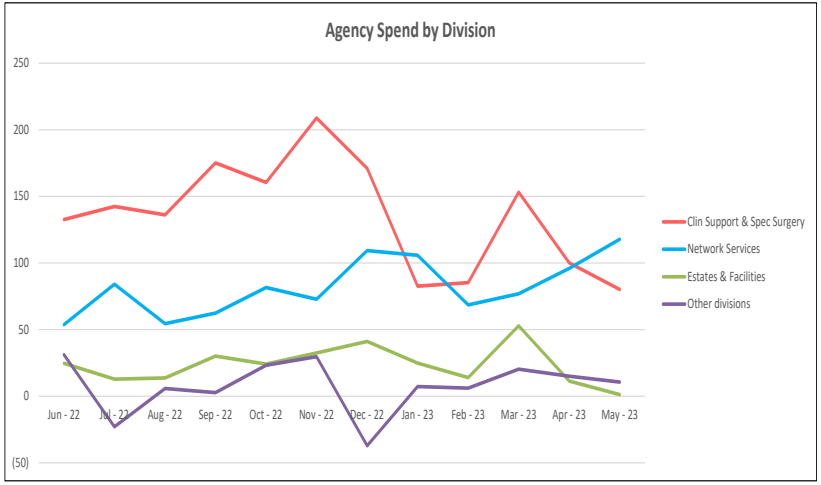
- The cash balance is £134,652k.
- Capital expenditure is £7k over the NHSI plan mainly due to the spend on backlog maintenance.

## Other

- Due to the profiling of TCPC profit it is not included in M2 financial position
- 97% of our trade creditors and 93% of our NHS creditors are paid within the 30 day Better Payment Practice Code target.

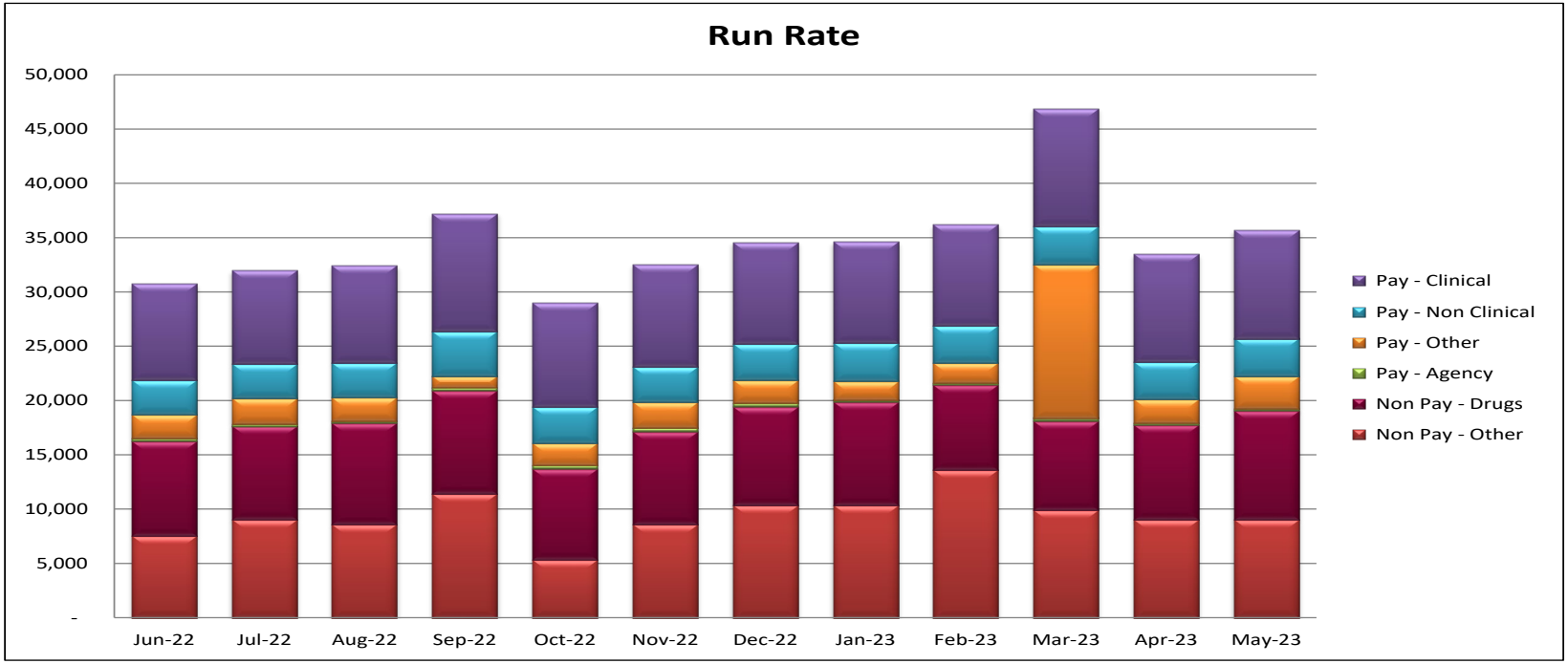
# Finance (Expenditure)




The agency spend is £203k relating to month 2, a decrease of £19k from month 1, mainly due to improvements in CSSS. Alongside this, bank usage has decreased by £35k in month.

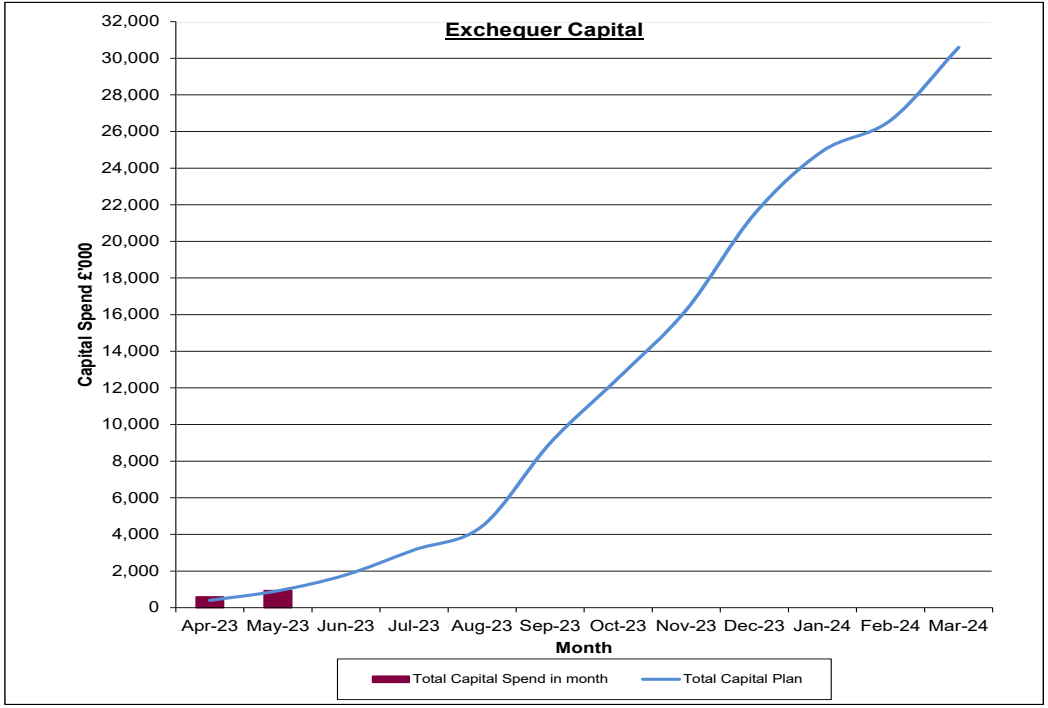
# 5.2 - Finance (Expenditure)




Drug spend in month 2 is £9,971k an increase on month 1 of £1,259k, largely relating to cost and volume drug spend.

Pay Agency spend in month 2 is £203k a decrease from month 1 which was £222k.

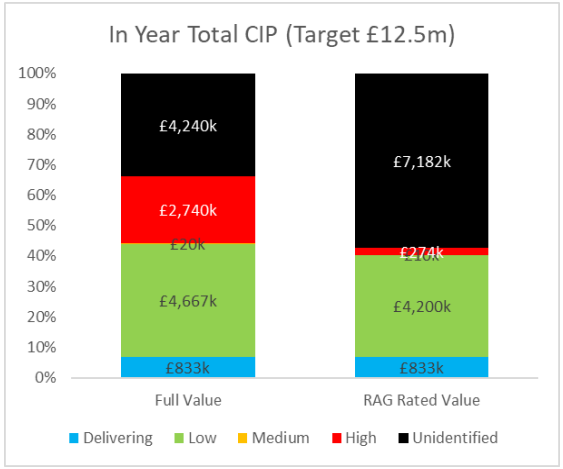
# Finance (Capital)

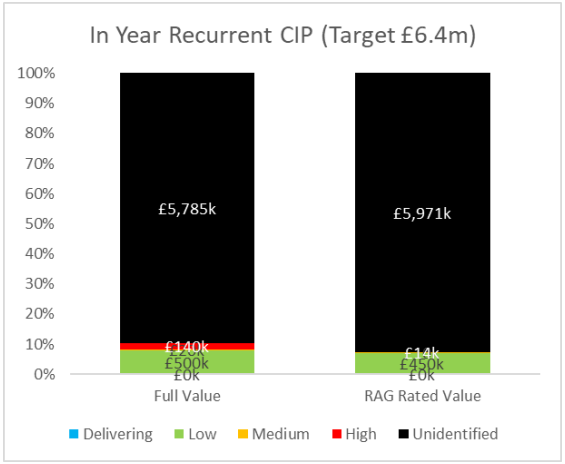



Performance for month 2 was an overspend of £7k above the plan submitted to NHSE&I.

The Trust has incurred £926k on capital schemes to month 2, primarily on the backlog maintenance programme, the Linac replacements and the TIF ward.

# Finance (CIP)




**Total In year CIP**

- Total identified CIP schemes reported are £8.3m (£7.6m non recurrent / £0.7m recurrent)
- This is 66% of the in year target of £12.5m leaving £4.2m unidentified (RAG rated identified value £5.3m leaving £7.2m unidentified).

**Recurrent**

- Schemes totalling £660k have been identified recurrently against a recurrent target of £6.4m
- This leaves £5.8m of the recurrent target unidentified.

| | Annual | | | | | Year to Date | | |
|---|---|---|---|---|---|---|---|---|
| | Target | Identified value | Unidentified Value | Identified RAG Value | Unidentified RAG Value | Target | Delivered | Unidentified |
| **Total CIP** | **£12,500k** | **£8,260k** | **(£4,240k)** | £5,317k | (£7,182k) | **£2,083k** | **£833k** | **(£1,250k)** |
| **Recurrent CIP** | £6,445k | £660k | (£5,785k) | £474k | (£5,971k) | £1,074k | £0k | (£1,074k) |
| **Non-Recurrent CIP** | £6,055k | £7,600k | £1,545k | £4,843k | (£1,212k) | £1,009k | £833k | (£176k) |

The Christie
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**Agenda item 23/23c**

**Meeting of the Board of Directors**
**Thursday 29th June 2023**

| | |
|---|---|
| Subject / Title | Annual update regarding Care Quality Commission (CQC) requirements |
| Author(s) | Chief Nurse & Executive Director of Quality<br>Deputy Chief Nurse<br>Associate Chief Nurse for Quality & Patient Safety<br>Associate Chief Nurse for Quality & Patient Experience<br>Trust CQC Project Lead |
| Presented by | Chief Nurse & Executive Director of Quality |
| Summary / purpose of paper | To assure the Board of Directors of CQC outcomes and preparedness |
| Recommendation(s) | The Board are asked to approve the report. |
| Background papers | Health and Social Care Act 2008 (Regulated Activities) Regulations 2014<br>Care Quality Commission (Registration) Regulations 2009<br>CQC's future role in systems March 2022 |
| Risk score | BAF Risks 1.1 – 1.4 / 2.1 / 2.2 / 4.1 / 5.1 – 5.2 / 6.1 – 6.2 / 7.1 – 7.6 |
| Link to:<br>➢ Trust strategy<br>➢ Corporate objectives | 1. To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer |
| You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box. | CQC - Care Quality Commission<br>ICS - Integrated Care System<br>IPQFR - Integrated performance, quality and finance report<br>KLOE - Key lines of enquiry<br>SACT - Systemic anti-cancer therapy<br>SDM - Shared Decision Making |

The Christie
NHS Foundation Trust

**Agenda item 23/23c**

**Meeting of the Board of Directors**

**Thursday 29th June 2023**

**Annual update regarding Care Quality Commission (CQC) requirements**

## 1. Background

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

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

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

## 2. Engagement activity

Throughout 2022/23, the Trust has continued its regular engagement meetings with the CQC. These are attended by the Executive Chief Nurse & Director of Quality, the Deputy Chief Nurse and a designated CQC inspection manager for the trust. These meetings provide a Trust-wide quality update, with specific responses to trust level service questions raised under the broader CQC principles of Safe, Effective, Caring, Responsive and Well-Led.

These meetings will continue into 2023/24.

## 3. Inspection activity

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

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

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

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

On the 5th June 2023, a comprehensive action plan (Appendix 1) was submitted to the CQC. Progress and compeltion of the actions are being monitored through the Trusts governance and assurance structure, designated weekly action plan meetings and via the routine quality meetings with our Specialist Commissioners.

The report also identifies 4 ‘should do’ actions which the trust is not required to submit an action plan or report to the CQC, but will be undertaking actions to continuing to ensure improvements. That work will be reportde to the Board seperately.

### 3.1 Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection

On the 21st April 2023 the CQC gave notification to inspect the radiotherapy department at the Trust for compliance with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). The inspection was done using the CQC’s new process. This involved completion and submission of a lengthy questionairre followed by discussion with key personnel and meetings with staff where necessary. We have submitted the required data for the inspection and no further meetings were required. The Trust awaits the outcome of the inspection and corresponding report.

## 4. CQCs new regulatory approach and single assessment framework

In 2021 the CQC launched their new strategy ‘A new strategy for the changing world of health and social care: Our strategy from 2021’ which sets out their ambitions under four themes:

- People and communities
- Smarter regulation
- Safety through learning
- Accelerating improvement

As a result, the CQC will be changing how they work and regulate; an approach that will fall into four categories:

- New technology – making it easier to interact and share information
- New policy - a single quality assessment framework for all service types at all levels

- New ways of organising - working in Integrated Assessment and Inspection teams
- New powers - looking at how services work together across a local area with new powers to look at Integrated Care Systems and local authorities

Until the launch of the single assessment framework, the CQCs approach continues to monitor, inspect and rate. The following has been published to date:

- Key questions: Safe, Effective, Caring, Responsive and Well-led
- Quality statements – 34 new quality statements under the 5 key questions
- Evidence categories – 6 evidence categories for each quality statement
    - People's experience of health and care services
    - Feedback from staff and leaders
    - Feedback from partners
    - Observation
    - Processes
    - Outcomes
- How the CQC will assesses services – how assessments will work using the new regulatory approach and scoring

In summer 2023, the CQC has stated that it will launch a phased approach to their new online provider portal, starting with providers being able to submit statutory notifications and improvements as to how the CQC use information received from both providers and the public.

Later in 2023 the CQC will:

- commence assessment in the new way using the single assessment framework which will be supported by new technology
- use the provider portal for all online interactions with providers, including enforcement activity.

Providers will be able to make ongoing amendments to their registration through the provider portal from this point.

## 5. Preparedness

As we enter the post inspection phase, there is an organisational requirement to meet our regulatory requirements, continue to work on our 'should do' and focus on our preparedness for future CQC inspections in line with the principles of the new strategy and single assessment framework summarised above.

On-going engagement with the CQC, preparedness and a programme of self-assessment and mock inspections are in development and aim to ensure compliance and assurance of the Trusts position.

## 6. Conclusion

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

## 7. Recommendation

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

The Christie
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**Appendix 1 - CQC Action Plan**

| Regulated activities | Regulation |
|---|---|
| **Assessment or medical treatment for persons detained under the Mental Health Act 1983**<br>**Diagnostic and screening procedures**<br>**Surgical procedures**<br>**Treatment of disease, disorder or injury** | **Regulation 5**<br>**Fit and proper persons: directors** |
| | **How the regulation was not being met:** |
| | *There were gaps in assurance for requirements of the Fit and Proper Persons Requirement (FPPR).* |

| **Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve** | |
|---|---|
| • Implement a standalone Fit & Proper Persons Policy addressing gaps in assurance.<br>• Update checklist in line with the Fit & Proper Persons Policy.<br>• Include in the annual programme of the Audit Committee and Board of Directors. | |
| **Who is responsible for the action?** | Louise Westcott - Company Secretary |
| **How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?** | |
| • Retain records in individual hard copy files.<br>• Annual audit reporting to Audit Committee for assurance and then to Board. | |
| **Who is responsible?** | Chris Outram - Chair |
| **What resources (if any) are needed to implement the change(s) and are these resources available?** | |
| • No additional resources are needed. | |
| **Date actions will be completed:** | 28 July 2023 |
| **How will people who use the service(s) be affected by you not meeting this regulation until this date?** | |
| • No impact on service users. | |

| Regulated activities | Regulation |
|---|---|
| **Assessment or medical treatment for persons detained under the Mental Health Act 1983** | **Regulation 12**<br>**Safe care and treatment** |
| | **How the regulation was not being met:** |
| | *Serious incidents and mortality reviews were not always investigated in a* |

| | |
|---|---|
| **Diagnostic and screening procedures**<br>**Surgical procedures**<br>**Treatment of disease, disorder or injury** | *timely manner and learning was not always shared across the organisation as required.*<br>*Not all patient risk assessments were consistently completed and reviewed in a timely manner for all patients.*<br>*The service did not ensure the proper and safe management of medicines, including the completion of antimicrobial documentation for safe prescribing in line with the trust policies.* |

**Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve**

Serious incidents and mortality reviews

- Allocation of all incident lead investigators and mortality reviewers for cases reported in the previous 7-days to be confirmed at weekly Executive Review Group and monitored through Risk & Quality Governance Committee.
- Implement a traffic light system to identify and escalate cases at risk of not meeting timeliness requirements.
- Enhance surveillance through the Executive Review Group to ensure compliance with guidance.
- Implementation of the new Datix Mortality software to support timely reviews.
- Increase frequency of Learning for Improvement Bulletin from every 2 months to every month.

Patient Risk assessments

- Align internal policies to national guidelines for falls, nutrition, pressure ulcers and VTE.
- Update ward coordinator checklist to reflect daily monitoring of risk assessments.
- Introduce an alert for patient risk assessments within our electronic patient records.
- Implement ward level view of live risk assessment compliance.
- Include nursing risk assessment requirements in the local induction.
- Continue to measure compliance through bedside handover quality improvement project.

Proper and safe management of medicines, including completion of antimicrobial documentation

- Update of prescriber induction and other training to document clinical indication and duration of all antimicrobials.
- Monitor compliance through ward pharmacists undertaking surveillance of completeness of inpatient antimicrobial prescriptions.

| | |
|---|---|
| **Who is responsible for the action?** | Serious incidents and mortality reviews<br>• Vidya Kasipandian - Associate Medical Director for Quality & Patient Safety<br>Patient Risk assessments<br>• Matt Bilney - Associate Chief Nurse for Quality & Patient Safety<br>Proper and safe management of medicines, including |

| | |
|---|---|
| | <u>completion of antimicrobial documentation</u><br>• Damian Child - Director of Pharmacy |
| **How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?** | |
| <u>Serious incidents and mortality reviews</u><br>• Timeliness of incident investigation and mortality reviews to be included in the quarterly patient safety report to Risk and Quality Governance Committee and to Quality Assurance Committee for board oversight.<br>• Internal audit of learning from deaths is included in the rolling internal audit programme.<br><u>Patient Risk assessments</u><br>• Monitoring of compliance within Divisions by Lead Nurses.<br>• Assurance to Chief Nurse/Corporate Nurses through Lead Nurse meetings.<br>• Annual review of compliance at Patient Safety Committee.<br><u>Proper and safe management of medicines, including completion of antimicrobial documentation</u><br>• Continue a 6 monthly audit programme reporting to the Nosocomial Infection Performance Committee. | |
| **Who is responsible?** | <u>Serious incidents and mortality reviews</u><br>• Neil Bayman - Medical Director<br><u>Patient Risk assessments</u><br>• Janelle Yorke - Executive Chief Nurse & Director of Quality<br><u>Proper and safe management of medicines, including completion of antimicrobial documentation</u><br>• Bernie Delahoyde - Chief Operating Officer |
| **What resources (if any) are needed to implement the change(s) and are these resources available?** | |
| • Time has been identified within the clinical audit programme. | |
| **Date actions will be completed:** | 29 September 2023 |
| **How will people who use the service(s) be affected by you not meeting this regulation until this date?** | |
| • Risk of not continuing to make timely improvements to patient safety and service quality due to delay in sharing learning. | |

| Regulated activities | Regulation |
|---|---|
| **Assessment or medical treatment for persons detained** | **Regulation 16**<br>**Receiving and acting on complaints** |

| | |
|---|---|
| **under the Mental Health Act 1983**<br>**Diagnostic and screening procedures**<br>**Surgical procedures**<br>**Treatment of disease, disorder or injury** | **How the regulation was not being met:**<br>*The trust did not ensure there was an effective process to manage complaints, in particular, ensuring the timeliness of responses.* |

**Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve**

- Report as required by the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.
- Implement a traffic light system to identify and escalate cases at risk of not meeting timeliness requirements.
- Enhance surveillance through Executive Review Group to ensure compliance with national guidelines.
- Immediate learning to be identified through Executive Review Group and shared with divisional governance leads and through Friday Focus.

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| **Who is responsible for the action?** | David Wright - Associate Chief Nurse for Quality & Patient Experience |

**How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?**

- Monitor through the weekly Executive Review Group.
- Continue to provide executive oversight through quarterly report to Patient Experience Committee and Risk & Quality Governance.
- Continue to provide board assurance via the Quality Assurance Committee.
- Internal audit of complaints management is included in the 2023/24 internal audit programme.

| | |
|---|---|
| **Who is responsible?** | Janelle Yorke - Executive Chief Nurse & Director of Quality |

**What resources (if any) are needed to implement the change(s) and are these resources available?**

- No additional resource requirements.

| | |
|---|---|
| **Date actions will be completed:** | 29 September 2023 |

**How will people who use the service(s) be affected by you not meeting this regulation until this date?**

- Risk of not making timely improvements to patient experience and service quality due to delay in sharing learning.

| Regulated activities | Regulation |
|---|---|
| **Assessment or medical treatment for persons detained under the Mental Health Act 1983**<br>**Diagnostic and screening procedures**<br>**Surgical procedures**<br>**Treatment of disease, disorder or injury** | **Regulation 17**<br>**Good governance** |
| | **How the regulation was not being met:** |
| | *Not all policies were reviewed and ratified in a timely manner.* |

**Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve**

- Review all trust policies against expiry dates.
- Review Trust Procedural Documents policy and policy template.
- Develop and implement a Document Management Standard Operating Procedure.

| | |
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| **Who is responsible for the action?** | Matt Bilney – Associate Chief Nurse for Quality & Patient Safety |

**How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?**

- Validation of all policies on the trust document management system (HIVE).
- Monthly reports of "soon to be expired" policies to be managed via the trust Risk & Quality Governance Committee.
- Regular auditing of points within the Document Management Standard Operating Procedures, once developed.

| | |
|---|---|
| **Who is responsible?** | Bernie Delahoyde – Chief Operating Officer |

**What resources (if any) are needed to implement the change(s) and are these resources available?**

- Support from the digital team agreed.

| | |
|---|---|
| **Date actions will be completed:** | 29 September 2023 |

**How will people who use the service(s) be affected by you not meeting this regulation until this date?**

- Risk of staff employing out of date practice as a result of using a policy past its review date.

| Regulated activities | Regulation |
|---|---|
| **Assessment or medical treatment for persons detained under the Mental Health Act 1983**<br>**Diagnostic and screening procedures**<br>**Surgical procedures**<br>**Treatment of disease, disorder or injury** | **Regulation 18**<br>**Staffing** |
| | **How the regulation was not being met:** |
| | *Not all staff had completed mandatory training in accordance with the relevant schedule including safe guarding training. Not all staff had received relevant training, supervision and appraisal to perform their duties competently.* |

**Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve**

Mandatory Training

- Allocate dedicated time for all new starters to attend induction and complete mandatory training before commencing duties.
- Allocate dedicated time for all staff to refresh mandatory training.
- Align our mandatory training including safeguarding training to the Core Skills Training Framework.
- Review and update our Mandatory Training Policy.
- Communicate our mandatory training requirements to all staff.
- Implement a mandatory training dashboard to improve visibility and monitoring of compliance with the mandatory training policy.

Appraisal

- Review our PDR policy, training, tools and processes to improve accessibility.
- Implement a PDR dashboard to improve visibility and monitoring of compliance with the PDR policy.
- Pilot Talent Tool as an alternative approach to PDR.

Supervision

- Align supervision requirements to professional standards for Agenda for Change roles / Postgraduate medical training grades / local employed doctors (SAS + Consultants).

| | |
|---|---|
| **Who is responsible for the action?** | Mandatory Training & Appraisal<br>• David Smithson - Deputy Director of Workforce<br>Supervision<br>• Ellie McManus - Head of Workforce Education |

**How are you going to ensure that the improvements have been made and are**

| sustainable? What measures are going to put in place to check this? | |
|---|---|
| • Regular reporting and review of compliance with the policies at the service and operational review meetings.<br>• Executive oversight through Workforce Committee.<br>• Continue to provide board assurance via Workforce Assurance Committee.<br>• Commission internal audit (MIAA) to review our processes. | |
| **Who is responsible?** | Eve Lightfoot - Director of Workforce |
| **What resources (if any) are needed to implement the change(s) and are these resources available?** | |
| • Prioritise resources to release staff to meet training requirements.<br>• Additional resources required for the MIAA audit will be identified. | |
| **Date actions will be completed:** | 31 October 2023 |
| **How will people who use the service(s) be affected by you not meeting this regulation until this date?** | |
| • Risk of staff not having the full skills and development needed to undertake their roles effectively. | |

NHS
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**Agenda item 23/23d**

**Meeting of the Board of Directors**
**Thursday 29th June 2023**

| | |
|---|---|
| Subject / Title | The Christie Strategy 2023 – 2028 implementation plan |
| Author(s) | John Wareing, Interim Director of Strategy |
| Presented by | John Wareing, Interim Director of Strategy |
| Summary / purpose of paper | The attached document is the implementation plan for the aims and objectives of the Trust Strategy for 2023 – 2028. The plan outlines where each aim or objective fits with the corporate objectives and shows the year 1 milestones for each aim. |
| Recommendation(s) | Members of the Board are asked to note the implementation plan for the 2023 – 2028 Trust Strategy and the year 1 milestones identified against each aim. |
| Background papers | The Trust Strategy 2023-2028 (agenda item 08-23a) |
| Risk score | N/A |
| Link to:<br>➢ Trust strategy<br>➢ Corporate objectives | The Trust Strategy 2023-2028<br>All Corporate Objectives |
| You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box. | None |

## Strategic Development Objectives 2023 - 2028

| # | Trust Priority | Reducing Inequalities | Improving Outcomes | Reducing waits | Strategic Development Aim / Objective | Director Lead 2023/24 | 1. Demonstrate excellent / equitable patient outcomes, safety, experience | 2. International Leader in R&I | 3. International leader in prof. and public education | 4. Integrate clinical, resaerch & education, be internatinoally recognised CCC | 5. Leadership in local network | 6. Excellment operations, quality and finance | 7. Place to Work & Attract staff | 8. Local heath care economy / community | Enabling Strategy | Milestone 2023/4 | 2024/5 | 2025/6 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SD1 | Leading Cancer Care | √ | √ | | Realise the potential of the Paterson development - seamless integration of research with clinical care | DRI | √ | √ | | | | | | | R&I Strategy | * Ensure plan for relocation of research teams into Paterson facility is implemented by 31/3/24 (AO 2.2, DRI Q4) | | |
| SD2 | Leading Cancer Care | | √ | | Grow pipeline of Christie leaders with regional, national and international influence through an active model of staff development | DE | | | | | | | √ | √ | People & Culture<br>R&I Strategy<br>Education Strategy | *Identify potential future leaders and potential opportunities Q1-Q4 | | |
| SD3 | Leading Cancer Care | √ | | √ | Accelerate research delivery through efficiencies and innovation - tomorrow's treatments to patients faster | DRI | √ | √ | | | | √ | | | R&I | * Implement refreshed leadership and management structure for Research & Innovation division by 31/3/24 (AO 2.3, DRI, Q4) | | |
| SD4 | Leading Cancer Care | √ | | | Create sustainable opportunities for our staff to work within international partnerships to tackle cancer inequalities locally and globally | DCEO | | | | | | | √ | | International<br>People & Culture<br>Education Strategy | * Promote the reputation of The Christie internationally by support attendance and contributions at prestigious international professional and corporate events. (AO 4.5, DCEO, Q4)<br>* Continue to develop partnerships in Kenya and Uganda, and others as appropriate (AO 4.6, DCEO, Q4)<br>* Increase range and uptake of training made available internationally though the School of Oncology (AO 4.7, DE, Q4)<br>* Submit charity business case for investment in Global Cancer Leaders (International, RC/JM, Q1) | | |
| SD5 | Leading Cancer Care | √ | √ | | Amplify accessible and inclusive cancer care education and training for Christie staff, external colleagues and patients | DE | | | | | | | √ | | Education Strategy<br>International | * Develop expansive portfolio of innovative (cancer) education and training programmes with a strong focus on personalised learning and development linked to clinical / system need. Continue to develop, promote and position a distinctive Christie Education and Training brand internally and externally that facilitates current and future goals | | |
| SD6 | Christie Experience | | | √ | Improve in-patient experience and efficiencies through emerging / next generation ward environments | COO | √ | | | | | √ | | | [Patient Experience]<br>[Capital]<br>[R&I] | * Complete two new (TIF) wards (Capital, COO, Q?) | | |
| SD7 | Christie Experience | √ | √ | | Establish system-wide Christie Research Outreach - access to research for every patient across Greater Manchester | DRI | √ | | | √ | | | | | R&I Strategy<br>Clinical Outcomes Strategy<br>Digital Strategy | * Undertake baseline assessment of current position | | |
| SD8 | Christie Experience | √ | √ | √ | Personalise the Christie out-patient experience embedding digital healthcare tools | COO | √ | | | | | | | | Digital Strategy<br>[Patient Experience] | * Progress first year of Digital Strategy | | |
| SD9 | Christie Experience | √ | √ | | Embed cancer partnerships beyond GM by building on the success of national service networks and hosting Operational Delivery Networks | DoS | | | | | | | | | | *Q1-Q4 support the development of the NE Radiotherapy and TYA Networks | | |
| SD10 | Christie Experience | √ | | | Grow active patient and public engagement opportunities across cancer education priorities | DE | | | √ | | √ | | | | Education Strategy<br>[Patient Experience]<br>[PPIE] | *Promote Patient engagement with cancer education priorities through internal fora (e.g. carers' education) and develop detailed timeline for utilisation of James Lind Association methodologies | | |
| SD11 | Local & Specialist | √ | √ | √ | Lead a single Christie non-surgical oncology service with equitable care for all patients across GM | COO | √ | | | | | √ | | | SACT<br>Digital Strategy | * Transfer management and accountability of local outpatient / SACT oncology care to The Christie (AO 5.4, COO, Q4) | | |
| SD12 | Local & Specialist | √ | √ | √ | Collaborate with system partners to improve access to cancer diagnosis and treatment targeting areas of greatest need | DCEO | √ | | | | | √ | | | | * Publish self-assessment and action plan for health inequalities based on socio-economic deprivation, ethnicity, and other community characteristics (AO 1.7, DCEO, Q1, Q2, Q3, Q4) | | |
| SD13 | Local & Specialist | √ | √ | | Develop a comprehensive supportive oncology service with system leadership and incorporating education and research | COO | √ | | | √ | | | | √ | [Service Strategy]<br>Education Strategy<br>R&I Strategy | Develop initial plans for implementation | | |
| SD14 | Local & Specialist | √ | √ | √ | Establish a Christie Advanced Cancer Scanning Centre for state-of-the-art diagnostics and increasing system capacity | DoF | √ | | | | | | | | Capital<br>Digital Strategy<br>People & Culture | * Complete business case for new Centre (Capital, COO, Q3) | | |
| SD15 | Local & Specialist | √ | √ | √ | Work with partner organisations to integrate a sustainable next-generation cancer pathology service in cytogenetics, histopathology and blood sciences | COO | √ | √ | | | | √ | | √ | [Service Strategy] | * Commence re-procurement process for new pathology partner ([Service?], [Lead Director], Q1)<br>* Publish ITT for re-procurement ([Service?], [Lead Director], Q3) | Confirm new pathology partner ([Service?], [Lead Director], Q3)<br>Mobilise new service ([Service?], [Lead Director], Q4) | |
| SD16 | Best Outcomes | | | √ | Drive improvements in quality, safety and patient experience through real-time data for 'data-enhanced clinicians' | ECN | √ | | | √ | | | | | Clinical Outcomes Strategy<br>Digital Strategy<br>Patient Experience Strategy<br>Quality Strategy | * Pilot a minimum viable product for real time data monitoring (Clinical Outcomes, EMD, Q1)<br>* Launch the Clinical Outcomes Fellowship (Clinical Outcomes, EMD, Q3) | | |
| SD17 | Best Outcomes | | √ | | Develop a secured-data environment with regional/national capability in collaboration with research partners | COO | | | | √ | | | | | R&I Strategy<br>Digital Strategy | *To have completed the initial use cases and roll out wider proposals for research use | | |
| SD18 | Best Outcomes | | √ | | Accelerate the use of real world data and improving outcomes through launching a multidisciplinary Clinical Outcomes & Data Unit (CODU) | EMD | √ | | | √ | | | | | Clinical Outcomes Strategy<br>Digital Strategy | * Establish a core set of clinical outcomes across the Trust and a monitoring system, (Clinical Outcomes, EMD, Q1)<br>* Establish a CODU Steering Group and a Clinical Forum, (Clinical Outcomes, EMD, Q2)<br>* Establish clear governance regarding the access, use and sharing of real world data (Clinical Outcomes, EMD, Q1) | | |
| SD19 | Best Outcomes | √ | | | Work in partnership with the GM Cancer Alliance to establish and report cancer equality metrics and KPI | DCEO | √ | | | | √ | | | | Clinical Outcomes Strategy<br>Digital Strategy | * Baseline assessment of current equity metrics | | |
| SD20 | Best Outcomes | √ | | | Improve outcomes for older patients with cancer through the Christie Senior Adult Oncology service | COO | √ | | | | | | | | Clinical Outcomes Strategy<br>[Service Strategy] | * Complete review of pilot and business case for the Service ([Service?], COO, Q3) | | |

The Christie
NHS Foundation Trust

**Agenda item 24/23b**

**Meeting of the Board of Directors**
**Thursday 29th June 2023**

| | |
|---|---|
| Subject / Title | The Fit & Proper Persons Policy |
| Author(s) | Louise Westcott, Company Secretary |
| Presented by | Roger Spencer, Chief Executive Officer |
| Summary / purpose of paper | The Fit & Proper Persons Policy outlines the Trusts responsibilities and processes around CQC Regulation 5: Fit & Proper Persons to ensure the Trust has clear guidance around the requirements. |
| Recommendation(s) | The Board are asked to approve the Fit & Proper Persons Policy and note the requirement to review the policy in line with the review date. |
| Background papers | The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 5: Fit and Proper Persons Requirement |
| Risk score | 8 (2/4) |
| Link to:<br>➢ Trust strategy<br>➢ Corporate objectives | Trust Strategy 2023-2028<br>Corporate objective 7 – To be an excellent place to work and attract the best staff |
| You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box. | None |

The Christie
NHS Foundation Trust

# FIT & PROPER PERSONS POLICY

| | | | |
|---|---|---|---|
| Document reference: | | Version: | V01 |
| Document owner: | Company Secretary | Document author: | Company Secretary |
| Accountable committee: | Board of Directors | Date approved: | 29th June 2023 |
| Ratified by: | Document Ratification Committee | Date ratified: | May 2023 |
| Date issued: | 29th June 2023 | Review date: | June 2027 |
| Target audience: | Board directors, board members and equivalents, including any other individuals who are members of the board, irrespective of their voting rights or if in interim positions. | Equality impact assessment: | 5th April 2023 |

**Key points**

- To outline the requirements & processes in place to ensure those who have director level responsibility for the quality and safety of care, and for meeting the fundamental standards, comply with the Fit & Proper Persons regulation and are therefore fit and proper to carry out their role.

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## 1. ASSOCIATED DOCUMENTS

- Recruitment and selection policy and procedure
- Disciplinary Policy
- Code of Conduct (Management of Conflicts of Interest)

## 2. INTRODUCTION

### 2.1 Statement of intent

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 5 recommends that a statutory Fit and Proper Person's Requirement (FPPR) be imposed on health service bodies. This policy outlines the application of this test for new appointments and existing post holders. In addition, where the Trust engages an interim at a senior level equivalent to the posts in Section 2.6, the same process and FPPR test will apply if they are employed or registered as an external worker.

### 2.2 Equality Impact Analysis

As part of its development, this policy was analysed to consider its effect on different groups protected from discrimination by the Equality Act 2010. The requirement is to consider if there are any unintended consequences for some groups, and to consider if the policy will be fully effective for all protected groups. This analysis has been undertaken and recorded using the Trust's e-tool, and appropriate measures taken to remove barriers or advance equality in the delivery of this policy.

### 2.3 Good Corporate Citizen

As part of its development, this policy was reviewed in line with the Trust's Corporate Citizen ideals. As a result, the document is designed to be used electronically to reduce any associated printing costs.

### 2.4 The Christie Commitment

We aim to reward our staff who are committed and motivated to do their best for patients every day. The Trust's principles and behaviours describe what our patients and their families or carers can expect from us, and what our staff can expect from each other.

The Trust's behaviours are;
We always give the best quality care
We treat everybody with compassion, dignity and respect
We listen to our patients and each other
We work together as one Christie team
We share knowledge and learning
We support staff to develop to their full potential
We look for new ideas and better ways of working
We promote a fair culture
We provide a safe, clean and tidy environment

All staff are expected to behave in a way that reflects the Trust's principles and behaviours.

### 2.5 Purpose

The purpose of this policy is to ensure the Trust complies with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 5: Fit and Proper Persons Requirement.

The regulations have been integrated into the Care Quality Commission's (CQC's) registration requirements and falls within the remit of their regulatory inspection approach.

### 2.6 Scope

This policy and procedure apply to all board appointments i.e., executive and non-executive directors and those other directors who are recognised as part of the Trust board. This includes permanent, interim, and associate positions whether employed or registered as an external worker.

The following posts are subject to the arrangements outlined in this policy:

a) the Chair of the Trust,
b) Non-Executive Directors appointed to the Board of Directors (including Associate Non-Executive Directors),
c) the Chief Executive of the Trust,
d) Executive Directors who can vote at the Board of Directors,
e) non-voting Directors who attend the Board of Directors.

## 3. DEFINITIONS

| Term | Meaning |
|---|---|
| Chief Executive | The person who has delegated responsibility from the Board of Directors for the management of governance arrangements within the Trust and is ultimately responsible for ensuring that the Trust meets its obligations with regards to the safe and effective delivery of services. This is delegated to responsible individuals within the Trust. |
| Trust Chair | Chairs the Board of Directors and Council of Governors. The chair has an ambassadorial role, as well as encompassing leadership, strategy, independent oversight and assurance. |
| Executive Director | Very senior manager, employee and member of the Board of Directors. Have legal responsibilities to The Christie as a Director. The Board of Directors is collectively responsible for promoting the success of The Christie and supervising The Christie's affairs. |
| Non-Executive Director | Member of the Board of Directors. Have the same general legal responsibilities to The Christie as any other Director. The Board of Directors is collectively responsible for promoting the success of The Christie and supervising The Christie's affairs. |
| Trust | The Christie NHS Foundation Trust |
| Fit & Proper Person | As defined by Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (see section 5 for full details) |
| Regulated activity | The regulated activities of an NHS organisation are detailed in the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. Each organisation have their regulated activities described in their CQC registration. |

## 4. DUTIES

### 4.1 Trust Chair

It is the responsibility of the Chair to discharge the requirement placed on the Trust, to ensure that all directors satisfy the Fit and Proper Person Requirements, both on appointment and on an ongoing basis, and to ask the Company Secretary to undertake an annual review of compliance on their behalf.

The Trust Chair will be assured by the Company Secretary that all Non-Executive Directors meet the definition of the Fit and Proper Persons requirements under the Health and Social Care Act 2008 (Regulated Activities) Regulations and act as necessary and proportionate to ensure that the position in question is held by an individual who meets such requirement.

If a director becomes 'unfit' the Chair will be responsible for ensuring that the regulator is notified.

### 4.2 Senior Managers and individuals as applicable

#### 4.2.1 Chief Executive

The Chief Executive will be assured by the Director of Workforce on appointment that all Executive and Non-Board Directors meet the definition of the Fit and Proper Persons requirement under the Health and Social Care Act 2008 (Regulated Activities) Regulations and act as necessary and proportionate to ensure that the position in question is held by an individual who meets such requirement.

The Chief Executive is responsible for on going appraisal of the executive directors.

If the individual becomes 'unfit' the Chief Executive must notify the Chair who will be responsible for ensuring that the regulator is notified.

#### 4.2.2 Director of Workforce

The Director of Workforce will be responsible for ensuring that all recruitment and selection processes to Executive and Non-Board Directors and subsequent recruitment checks comply with the Fit and Proper Persons requirements under the Health and Social Care Act 2008 (Regulated Activities) Regulations.

The Director of Workforce will be responsible for ensuring that all Executive and Non-Board Directors complete a Fit and Proper Persons self- declaration at commencement of employment.

The Director of Workforce will advise on the process where an Executive or Non-Board Directors is deemed unfit- this will ordinarily result in the Disciplinary Policy being applied.

#### 4.2.3 Company Secretary

The Company Secretary will be responsible for ensuring that all recruitment and selection processes to Non- Executive Director positions and subsequent recruitment processes comply with the Fit and Proper Persons requirements under the Health and Social Care Act 2008 (Regulated Activities) Regulations.

The Company Secretary will ensure that annual declarations are completed and stored appropriately for all relevant directors.

The Company Secretary will hold evidence relating to the fit & proper persons regulation on all relevant individuals and ensure that this is available for inspection by the CQC when required.

The Company Secretary will undertake an annual review of compliance on behalf of the Chair to be reported to the Audit Committee.

#### 4.2.4 Board Director & Non-Board Directors

All Board and Non-Board Directors positions will complete a Fit and Proper Persons self-declaration at appointment and annually thereafter.

All Board Directors and Non-Board Directors are required to declare to their line manager and to the Director of Workforce (for Executives/Non-Board) and Company Secretary (for Non-Executives) should they, prior to the commencement of their appointment or during the course of their employment/ tenure, become 'unfit'.

### 4.3 Committees in level of hierarchy

#### 4.3.1 Board of Directors

The Board of Directors are responsible for approval of the fit & proper persons policy in line with the review date and receiving a report from the Audit Committee on compliance annually.

### 4.3.2 Audit Committee

The Audit Committee are responsible for receiving assurance on compliance with this policy annually and reporting this to the Board of Directors.

## 5. FIT & PROPER PERSONS REGULATION

Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (referred to as the 2014 Regulations) places a duty on NHS providers not to appoint a person, or allow a person to continue to be, an Executive Director or equivalent or a Non-Executive Director under given circumstances. This means Executive/Non-Executives should not be appointed/continue to hold office unless they:

a) are of good character
b) hold the required qualifications and have the competence, skills and experience required for the relevant office for which they are employed
c) are, by reason of their physical and mental health, after any reasonable adjustments if required, capable of properly performing their work
d) can supply relevant information as required by schedule 3 of the act, i.e. documentation to support the FPPR
e) have not been responsible for or privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying out regulated activity (or providing a service elsewhere which if provided in England would be a regulated activity).

### 5.1 Good Character

When assessing a person being 'of good character' NHS providers are required to take account of Schedule 4 of the 2014 Regulations, namely:

a) whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence, and
b) whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

The CQC's definition of good character is not the objective test of having no criminal convictions but instead rests upon a judgement as to whether the person's character is such that they can be relied upon to do the right thing under all circumstances.

The CQC names the following as features 'normally associated' with good character that should be taken into account when applying FPPR to an individual, in addition to those specified in part 2 of schedule 4:

- Honesty
- Trustworthiness
- Integrity
- Openness
- Ability to comply with the law
- A person in whom the public can have confidence in prior employment history, including reason for leaving
- If the individual has been subject to any investigations or proceedings by a professional or regulation body
- Any breaches of the The Seven Principles of Public Life (Nolan Principles)
- Any breaches of the duties imposed on directors under the Companies Act
- The extent to which the director has been open and honest with the Trust
- Any other information which may be relevant, such as disciplinary action taken by an employer.

### 5.2 Unfit

Under Schedule 4 part 1 of the regulations, Executive/Non-Executive Directors are deemed 'unfit' and prevented from holding the office and for whom there is no discretion if:

a) the person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged
b) the person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland
c) the person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40)
d) the person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it
e) the person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006 (legislation.gov.uk)
f) the person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

### 5.3 Requirement for standard / enhanced DBS check

In January 2018 the CQC issued revised guidance for providers and CQC inspectors in respect of Regulation 5 of the 2014 Regulations. Specifically, the CQC made a minor change to its guidance to make it explicit that they expect providers to undertake an "enhanced Disclosure and Barring Service (DBS) check for directors to check that they are not on the children's and / or safeguarding barred list where they meet the eligibility criteria". However, Executive/Non-Executive Directors are only eligible for such an enhanced DBS check if the role that they take falls within the definition of a "regulated activity" as defined by the Safeguarding Vulnerable Groups Act 2006.

Only those Board members who are required to undertake regulated activities will be required to have an Enhanced DBS check. Where a role does not undertake regulated activity, a standard DBS check will be required. However, all Board members will be required to make a declaration annually that they meet the FPPR.

## 6. PROCEDURE

### 6.1 New Appointments

Where a post is subject to FPPR, candidates will be notified as part of the Trust's recruitment process. It is important when making appointments that consideration is given to the values of the organisation and the extent to which the candidate fits with these values. It is therefore expected that the interview process will incorporate competency-based questions.

Where an interim is sourced by an agency the recruitment agency will be made aware of the FPPR process and must confirm that they have undertaken the necessary checks.

Executive search companies will also be required to confirm compliance with the FPPR and provide relevant evidence for inspection by the Trust.

The Trust's comprehensive pre-employment checking processes are determined by the NHS employment standards and include the following:

1. Proof of identity / address
2. Evidence of the right to work in the UK
3. Disclosure and Barring Service (DBS) check as relevant to the role
4. Occupational Health Clearance as relevant to the role
5. Evidence of a values-based interview process
6. Proof of qualifications / professional registration applicable to role

7. A check of employment history. Specifically, this includes validating a minimum of three years continuous employment including details of any gaps in service.
8. Two references one of which must be the most recent employer.

In addition, the following registers will be checked:

a) Disqualified directors
b) Bankruptcy and insolvency
c) Removed Charity Trustees

The Chair will be responsible for ensuring compliance supported by the Workforce Team and the Company Secretary. A sign off form will be completed at appointment and will be retained on the post holder's personal file for the purposes of audit (Appendix 1).

The FPPR requires new employees to complete a Fit and Proper Person's Declaration form (Appendix 2) on appointment and then annually. This form will be included with the application pack and form part of the application process for the position.

Where specific qualifications are deemed by the Trust as necessary for a role, the Trust will make this clear and will only appoint those individuals that meet the required specification; including any requirements to be registered with a professional body.

Where the Trust considers that an individual can be appointed to a role based on their qualification, skills and experience but there is an expectation that they will be required to develop specific competencies to undertake the role within a specified timescale, any such discussions or recommendations will be recorded in minutes of the Nominations Committee for Non-Executive Director appointments or for other Board appointments where confirmation of appointment is discussed.

If the candidate has a disability, wherever possible, reasonable adjustments will be made to enable the individual to carry out the role that they have been appointed to.

The Council of Governors is responsible for the appointment and removal of the Chair and the Non-Executive Directors, drawing on the recommendations of the Council of Governors Nominations Committee. In respect of Executive Directors, this responsibility will be discharged by the Board of Directors.

### 6.2 Care Quality Commission (CQC)

The CQC will cross-check notifications about new Directors against other information that they hold or have access to, to decide whether the Trust should look further into the individual's fitness. The CQC will also have regard to any other information that they hold or obtain about Directors, in line with current legislation on when convictions, bankruptcies or similar matters are to be considered 'spent'.

Where a director is associated with serious misconduct or responsibility for failure in a previous role, the CQC will have regard to the seriousness of the failure, how it was managed, and the individual's role within that. There is no time limit for considering such misconduct or responsibility. Where any concerns about an existing Director come to the attention of the CQC, they may also ask the Trust to provide the same assurances.

Should the CQC use their enforcement powers to ensure that all Board Directors are fit and proper for their role, they will do this by imposing conditions on the Trust's registration to ensure that the Trust takes the appropriate action to remove the Board Director.

## 7. CONSULTATION PROCESS

Consultation has been undertaken with staff side representatives and the Director of Workforce as well as MIAA as internal auditors. A check is undertaken against the content of this policy against a checklist developed by MIAA and this is assessed through the Audit Committee. Comparison has also been done with other Trust Fit & Proper Person Policies. The policy has been approved by Staff Forum and ratified by the Document Ratification Committee.

## 8. DISSEMINATION, IMPLEMENTATION & TRAINING

### 8.1 Dissemination

This document has been disseminated by posting the ratified document on the intranet and shared with the Workforce Team for inclusion in their raft of policies.

### 8.2 Implementation

The Policy will be implemented upon ratification by the Document Ratification Committee.

### 8.3 Training/Awareness

The policy will be owned and updated by the Company Secretary and Director of Workforce and used in all Board level and very senior manager recruitment. The responsible committee is the Staff Forum.

## 9. PROCESS FOR MONITORING EFFECTIVE IMPLEMENTATION

Compliance with the policy will be monitored through annual audit by the Company Secretary's office and reported through the Audit Committee against MIAA's checklist. Evidence is maintained in personnel files for inspection by the CQC.

## 10. REFERENCES (IF APPLICABLE)

- Health and Care Act 2022 (legislation.gov.uk)
- Care Act 2014 (legislation.gov.uk)
- Companies Act 2006 (legislation.gov.uk)
- Companies Act 2006 (legislation.gov.uk)
- Employment standards and regulation | NHS Employers
- Safeguarding Vulnerable Groups Act 2006 (legislation.gov.uk)
- Standards of conduct, performance and ethics | (hcpc-uk.org)
- Principles in practice - Committee on Standards in Public Life (blog.gov.uk)
- CQC regulation-5-fit-proper-persons-directors

## 11. VERSION CONTROL SHEET

| Version | Date | Author | Status | Comment |
|---|---|---|---|---|
| 1.0 | December 2022 | Louise Westcott | Approved | Feedback from parent committee and document |

| | | | | |
|---|---|---|---|---|
| | | Company Secretary | | ratification committee (DRC) reflected in final version |
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## 12. APPENDICES

**Appendix 1:**

The Christie NHS Foundation Trust

**Board of Directors' recruitment**
**Chairman sign off form**

| | |
|---|---|
| **Recruiter (delete as appropriate)** | **Nominations committee NED led interview panel** |

**SUCCESSFUL CANDIDATE**

| | | | |
|---|---|---|---|
| **Name of Candidate:** | | | |
| **Job Title:** | | | |
| **Line Manager:** | | | |
| **Start Date** | | | |
| **Salary:** | | **Hours:** | |
| **Permanent / Fixed Term:** | | **Fixed Term End Date:** | |
| **Appropriate additional approvals received (non-executives only)** | | **Date:** | |
| **All pre-employment checks complete (see attached checklist)** | | | |

| | | | |
|---|---|---|---|
| **Name:** | | | |
| **Title:** | Chair | | |
| **Signature:** | | **Date:** | |

**Appendix 2:**

The Christie
NHS Foundation Trust

## Fit and Proper Person Declaration

In line with the requirement for Directors of an NHS Foundation Trust to be a fit and proper person, I hereby declare

| Declaration | Confirmed |
|---|---|
| I am of good character by virtue of the following: | |
| • I have not been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence | |
| • I have not been erased, removed or struck-off a register of professionals maintained by a regulator of health or social care. | |
| • I have not been sentenced to imprisonment for three months or more within the last five years | |
| • I am not an undischarged bankrupt | |
| • I am not the subject of a bankruptcy order or an interim bankruptcy order | |
| • I do not have an undischarged arrangement with creditors | |
| • I am not included on any barring list preventing them from working with children or vulnerable adults | |
| I have the qualifications, skills and experience necessary for the position I hold on the Board | |
| I am capable of undertaking the relevant position, after any reasonable adjustments under the Equality Act 2010 | |
| I have not been responsible for any misconduct or mismanagement in the course of any employment with a CQC registered provider | |
| I am not prohibited from holding the relevant position under any other law. e.g. under the Companies Act or the Charities Act. | |
| | |
| **Signed** | |
| **Name** | |
| **Position** | |
| **Date** | |