The Christie NHS Foundation Trust

Board of Directors meeting
Thursday 25th April 2024 at 12.45 pm

Seminar Room 4/5, Education Centre

Agenda

Patient story / clinical presentation: Haematology Ambulatory Care, Hanna Simpson, Clinical Nurse Specialist, Prof Adrian Bloor, Consultant Haematologist, patient **30 - 40 mins**

	Public items	**Decision**		**Lead**	**Page**	**Timing**
12/24	**Standard business**					
a	Apologies			Chair		
b	Declarations of interest			Chair		
c	Minutes of previous meeting – 28th March 2024		*	Chair	2	5 mins
d	Action plan rolling programme, action log & matters arising		*	CEO	9	
13/24	**Strategy and forward planning**					
a	Annual Corporate Objectives review & Board assurance framework 2023/24	Review	*	CEO	12	15 mins
14/24	**Performance & finance**					
a	Trust report	Note	*	Execs	25	15 mins
b	Risk Management Strategy 2024/24 annual review	Note	*	ECN	35	10 mins
15/24	**Culture**					
a	Freedom to Speak Up Guardian report	Note	*	FTSUG	41	20 mins
16/24	**Governance (regulatory / statutory compliance)**					
a	Board assurance framework 2024/25 incl Risk Appetite Statement	Note/ Approve	*	CEO	57	10 mins
b	Modern Slavery Act statement	Approve	*	CEO	65	
c	Reports from Committees - Quality Assurance March 2024	Note	*	Committee chair	67	5 mins
d	Framework for Board & Committee allocation	Approve	*	CEO	74	
e	Self-certification declarations	Approve	*	CEO	78	5 mins
f	Register of matters approved by the board	Approve	*	CEO	83	
g	Board effectiveness review	Notice		Chair		
17/24	**Any other business**					

Papers for information only

	Integrated performance, quality & finance report Month 12		*			

Date and time of the next meeting

Thursday 27th June 2024 at 12:45pm

D/CEO	Deputy / Chief Executive Officer	*	paper attached
ECN	Executive Chief Nurse	v	verbal
FTSUG	Freedom to Speak Up Guardian	p	presentation

The Christie
NHS Foundation Trust

Public meeting of the Board of Directors
Thursday 28th March 2024 at 12.45 pm
Paterson Meeting Room G-103

Present:	Chair:	Edward Astle (EA), Chairman Roger Spencer (RS), Chief Executive Officer Tarun Kapur (TK), Non-Executive Director Robert Ainsworth (RA), Non-Executive Director Alveena Malik (AM), Non-Executive Director Grenville Page (GP), Non-Executive Director Prof Kieran Walshe (KW), Non-Executive Director Dr Diana Tait (DT), Non-Executive Director Prof Chris Harrison (CJH), Deputy CEO Bernie Delahoyde (BD), Chief Operating Officer Theresa Plaiter (TP), Interim Chief Nurse Sally Parkinson (SP), Executive Director of Finance Dr Neil Bayman (NB), Executive Medical Director Eve Lightfoot (EL), Director of Workforce John Wareing (JW), Director of Strategy Prof Rikki Goddard-Fuller (RGF), Director of Education Prof Fiona Blackhall, Director of Research Claire McPeake (CM), Interim Chief Operating Officer
Minutes:		Louise Westcott (LW), Company Secretary
In attendance:		Jo D'Arcy, Assistant Company Secretary Will Blair (WB), Sustainability Manager Vicky Sharples, to be Exec Chief Nurse from May 2024

Clinical presentation: The Christie Clinical Research Facility – Rebecca Shearer (RSh), NIHR Manchester CRF Operations Lead / Prof Fiona Thistlethwaite (FT), Director Christie CRF / Jasmin David (JD), patient

RSh outlined the role of the CRF and the way it is structured & funded. It delivers experimental & early-stage trials as well as complex phase 3 trials. The facility is housed in the Trust. The Christie is 1 of 6 CRFs in Manchester and the biggest. Looking to provide opportunities for all to take part in research. There is patient representation at all levels within the governance structure.

The team are split across clinical, laboratory & operations. The role of the ACPs was highlighted as key to expanding cover from a medical perspective. The unit is reliant on a multidisciplinary group of professionals. The facilities were described, 10 beds & 26 treatment chairs, Monday-Friday 24hr care.

Gold CODE accreditation has been awarded and a further accreditation is being prepared for now.

The portfolio of trials was described, commercial 76% / non-commercial 24% - non-commercial are not charged to use the facility. Over 170 funders.

FT introduced Jasmin and asked her to describe her story. Jasmin was employed as a specialist nurse in haematology. She was diagnosed with breast cancer and had radiotherapy, chemotherapy and surgery. Jasmin was diagnosed with metastatic disease in 2019 and the cancer was in her bones and lungs. She was told she would have 10 months to live. Jasmin has 2 children in their early 20's. She was referred to the CRF and a new study was identified that could be an option. Jasmin decided to take part in the trial as a first in human study. She wanted to take part as felt there may be a chance it would help her, but it would also help future patients.

Jasmin described that the CRF are like a family, they are available to speak to / email anytime. Initial side effects were difficult, but this has improved. The trial has been very successful and there is now no evidence of cancer. The team give incredible peace of mind and are very approachable.

Jasmin talked about challenges, coming for lots of investigations, regular treatments, lots of bloods, waiting in between and long infusions. It was easy enough as Jasmin lives close by, but this would be difficult if the patient lived a long way from the hospital.

Jasmin was asked about improvements – she said that after 6pm she was moved to a different ward and staff had to hand over care, it would be better to stay.

FT noted that we try to learn from all of our patients and thanked Jasmin who supports the unit with patient input for other things as well.

RSh noted that feedback is overwhelmingly positive but there are some small negatives such as waiting times and the TV's not working.

RSh described the delivery of CSTD's where drugs are prepared within the CRF to be delivered to patients avoiding using aseptics and giving a better patient experience. Point of care testing is about to be introduced on the CRF, a capital award has been received from NIHR – this allows decision making to be made earlier in the day to allow drugs to be prepared. Lab bloods are done alongside the point of care testing.

The unit is closed at weekends and some patients need to be transferred to haematology, the aim is to open 24/7 eventually and the benefits & challenges are being explored. This would be done gradually. There would be some risk around other patients using the facility over the weekend where there is capacity.

TK noted that his tour showed an extremely high functioning unit with upbeat staff / patients.

KW asked about the Shaughnessy report and the fear that trials are moving away and asked what the performance is like for set up times etc. FT noted that we deliver the trials, but the disease groups recruit the patients. We're working on improvement to time to trial performance. Turnaround has really improved.

KW asked about the commercial activity return and what it has enabled. FB noted that we've over established staff and looked at weekend working etc. We are set up differently to other units. We are fuelling our own research through commercial income.

GP asked about whether all commercial income comes from pharma. RSh noted that they the vast majority do.

EA thanked everyone for their presentation and for taking time to speak to the Board.

Item		Action
06/24	**Standard business**	
a	**Apologies**	
	No apologies noted	
b	**Declarations of Interest**	
	None noted.	
c	**Minutes of the previous meeting – 25th January 2024**	
	The minutes were accepted as a correct record.	
d	**Action plan rolling programme, action log & matters arising**	
	All items from the rolling programme are complete or noted on the agenda.	

07/24	**Strategy and forward planning**	
a	Draft Green Plan	
	• CH presented the draft Green Plan. The components of the plan are laid out in the paper. This is a requirement. There has been extensive engagement on the plan. • WB attended and summarised the process that has been followed to arrive at the plan based on requirements and through wide engagement through the Trust. • GP asked how dependent the plans are on capital investment. CH responded that all developments must have an impact assessment undertaken around sustainability and we have previously accessed additional sustainability funding (£9m). • Decarbonisation assessments are underway, to access additional funding going forward we must have this plan. • TK asked about how agile we are to change and how we manage the additional cost of this way of working. EL noted that there is a cultural aspect to this, and we are looking to have apprenticeships through an organisation that looks at clinical sustainability. • AM asked how you get staff on board. WB noted the Green Ward competition that linked this to better patient care & financial savings worked well. Social aspects of environmental impact bring people on board and training is underway to educate staff on this impact. • One of our nurses has won a prize for National Sustainability Nurse of the Year. One of the physicists has done nationally recognised work on the environmental impact of linear accelerators. • This is important for staff & patients. Must be realistic about what is achievable. • Progress will be monitored through an assurance committee. This is coming back for final approval. Noted	**LW/CH**
08/24	**Performance & finance**	
a	**Trust report**	
	• RS noted that key quality indicators for February show no significant adverse variances other than in the cancer waits. 62-day performance is under target, impacted by late referrals. We anticipate achievement of the required 70% by year end. • The GM ICS has significant financial issues, and we are part of this. At the end of the financial year, we anticipate a position forecast surplus of £6.8m. This is extremely positive in the context of the system position. • We are in a financial turnaround and £14.1m deficit plan is forecast for next year. We are forecasting a 9% growth next year and are currently being told there is no growth funding. We will break even if we get paid for the activity we do. • CDEL is overprescribed and has not yet been agreed. We are suggesting we deliver an element of productivity. Other Trusts are not in this position. • Board discussed the situation in GM and processes for resolution of contracting disputes that should be resolved locally where possible.	

	• Initial feedback on the national staff survey is covered later on the agenda. • The 2 SI's were noted. NB assured the Board that there are no trends and these are going through Trust process. Noted	
b	**Research & Innovation Strategy progress**	
	• FB outlined the current progress on the R&I strategy. The focus is on operational capabilities and the workforce as well as research activity. • The strategy shows what is needed to deliver research going forward in terms of infrastructure. • The assessment shows an honest review. Certain objectives are challenging and will take more time. The direction of travel is clear and progressing to plan. • DT asked if the programme was overambitious and whether the delay in progress in some areas will impact the next 12 months. FB noted that the strategy has focused the division on what they need to work towards, there is an aspect of this being uncomfortable and ambitious but achievable. The network is the best performing across the CRN footprint and we are still pushing to be innovative and better. • GP asked about health inequalities and how the strategy reflects these priorities. FB noted the aim to provide research to all. There has been analysis of deprivation and protected characteristics that will be reported on. We are looking at capturing more data on this. A patient experience manager has been appointed to progress this work. • The Board discussed the financial impact to the NHS of research and the benefits of patients having treatment paid for through trials and not the NHS. • More information will be fed back on priority 3 in the next report. • The Board commended the ambition of the strategy and looked forward to more updates. **Action** Noted	**FB**
09/24	**Culture**	
a	**Cultural Audit Outcome and Next Steps**	
	• The paper outlines the work that's been undertaken to better understand the culture and what is needed to improve. The board recognised that this is not an end point and work will be on going to address issues raised. There was appreciation of the approach. • The themes are things that our staff have told us and they are mainly practical. The range of activities we already have in place is broad and comprehensive, but we need to improve the communication of these offerings. • Board responsibilities are outlined, and further detail will come back to the Board. • The Board agreed they need to make a commitment to always consider the impact of their decisions on the staff. • Board noted the work undertaken to distil policies into more focused and accessible formats. • Communication to staff was discussed as well as consistency of implementation of their responsibilities.	**CH**

	• Communication, consistency, policies, and Board overview of culture were discussed. Communications and consistency are key going forward, the Board agreed to review once this has been better understood. Approved	**LW**
b	**NHS Staff survey results 2023**	
	• EL noted that the report gives a high-level set of results from the 2023 survey. There is a programme of work that is planned to further analyse the results, the free text comments from the survey will also be sent in coming weeks that will give us more information. • Overall, the scores are very good. Engagement & morale scores are slightly lower. Confidence in raising concerns is a key focus. • In terms of benchmarking, we have better scores in all domains than The Royal Marsden. • There will be engagement through the divisions to identify priorities, further benchmarking will also be undertaken. The detailed analysis will be presented to the WAC in June. The results are also discussed at the Workforce Committee. • Speaking up is a focus and the results align to the Culture Audit. The work will interrelate. NEDs expressed concern at the decline and our low position within our benchmarked group. • Response rates were discussed, and it was agreed that the additional culture audit helps to triangulate the feedback. It does enable us to look at hotspots and themes and year on year progress by area. • We compare very well across Greater Manchester. • Discussion took place on the lower satisfaction with the appraisal process; we focus support on continuous conversations and enabling line managers to be well supported and trained. This will be picked up in the analysis and actions. • TK noted the Workforce Assurance Committee will focus on certain themes. • NB noted that we need to look behind the figures and differentials in different staff groups, we understand more about what this means from the culture work and engagement with individual groups. • The culture audit gives us a much better understanding of what this means and how we can improve and the actions we can take. Noted	
10/24	**Governance (regulatory / statutory compliance)**	
a	**GGI assurance review action plan**	
	• The Board noted their previous discussions on the work and the progress that has taken place. Many improvements have already been implemented and other agreed actions are in the process of completion. • The Board noted that the improvements will all be in place by the end of Q2 2024/25. • Further discussion was had around the development of terms of reference for the committees. Noted	

b	**Board assurance framework 2023/24**	
	• RS noted the updated BAF that reflects the position at month 11. The intention is to present an updated format for next year with a reviewed set of risks. • It was noted that many risk scores have reduced at this point in the year. Noted.	
c	**Fit & Proper Persons Compliance report**	
	• The Chair presented the report that formally notes the position of compliance against the F&PPT framework. No issues have been raised on any of the Board members. • Approved to submit. **Action**	**LW**
d	**Reports from Committees**	
	Quality Assurance January 2024	
	• The minutes are in the papers. An item was escalated to the previous Board meeting on the lost to follow up risk. The risk score has reduced following mitigations put in place.	
	Audit Committee February 2024	
	• Cyber security controls were discussed and noted. • There was a presentation on actions required following a MIAA audit on the radiotherapy delivery system, Mosaiq and a delay in the implementation of the agreed actions. • A further review of other outstanding actions on the tracker is coming back to the next meeting. • Preparation of the annual accounts is in progress and will come through the next meeting. • GP noted that external audit noted that engagement with exec leads and engagement & challenge in meetings was excellent.	
	Workforce Assurance Committee March 2024	
	• TK noted that the NEDs visited the catering department and the Senior Catering Manager presented to the Committee on the improvements they are making for patients & staff. • Violence & aggression standards were looked at - medium assurance given. • Safe staffing report was discussed, high assurance was given. Board discussed the importance of this report and noted the position / assurance. • Effectiveness outcome report was very helpful, and improvements will be made as a result.	
e	**Annual reporting cycle 2024/25**	
	• The Board approved the cycle for the coming year. There may be adjustments because of the planning timetable changing.	
11/24	**Any other business**	
	• EA noted that this is BD's last meeting and noted that staff have huge affection & respect for her. EA thanked BD from the Board for her contribution. BD asked that the team keep on the great work and keep innovating.	

	Date and time of the next meeting	
	Thursday 25th April 2024 at 12:45pm	
	Papers for information only	
	Integrated performance, quality & finance report	

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Agenda item 12/24d

Meeting of the Board of Directors - April 2024

Action plan rolling programme after March 2024 meeting

C Culture P Performance S Strategy G Governance

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
April 2024		C	Patient story	CEO	To hear a patient story	
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	In papers
		G	Register of matters approved by the board	CEO	Note April 2023 to March 2024	16/24f
	Provider licence	G	Self certification declarations	CEO	To approve the declarations	16/24e
	Annual reporting cycle	S	Annual Corporate Objectives review / BAF 2023/24	CEO	Review 2023/24 progress	13/24a
		G	Modern Slavery Act statement	CEO	Approve	16/24b
		G	Board effectiveness review	Chairman	Undertake survey	16/24g
		C	Freedom to speak up Guardian report	FTSUG	6 monthly update	15/24a
	Annual reporting cycle	P	Risk Management strategy 2023-24 annual review	ECN	Annual Review	14/24b
May 2024 - no meeting	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	By email
Planning & Development Day		S	Charity / Trust joint meeting			
		S	Planning			
June 2024		C	Patient story	CEO	To hear a patient story	
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	
	Annual reporting cycle	G	Annual reports from audit, quality and workforce assurance committees	Committee chairs	Assurance	
	Annual reporting cycle	G	Annual compliance with the CQC requirements	ECN	Declaration / approval	
		P	Education Strategy Update	DoE	Review	
		P	Quality Strategy annual update	ECN	Review	
		G	Board effectiveness review	Chair	Report	
		P	Value Improvement Programme	COO	Review	
	Annual reporting cycle	G	Annual report, financial statements and quality accounts (incl Annual governance statement / Statement on code of governance)	EDoF	Approve	
July 2024 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
Planning & Development Day		S	Service Review day with senior leadership teams			
August 2024 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
September 2024		C	Patient story	CEO	To hear a patient story	
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	
		G	Standing Financial Instructions (SFI's)	DoF	Approve	
		C/P	Health inequalities self -assessment	DCEO	Review	
		P	Green Plan	DCEO	Approve	
		P	Value Improvement Programme	COO	Review	
		P	Digital Strategy Update	DCEO / CIO	Annual Review	

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
October 2024		C	Patient story	CEO	To hear a patient story	
		P	Integrated performance & quality report and finance report	COO	Monthly report	
		S	EDI Strategy	DoW	For approval	
		C	Culture audit review	DCEO	Review	
		C	Freedom to speak up guardian	FTSUG	Annual report	
Planning & Development Day		S	Planning with Divisional leadership teams			
		S	Strategy deep dive - system role / Cancer Alliance			
November 2024		C	Patient story	CEO	To hear a patient story	
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	
		S	Strategy update	DoS	Six month review	
		S	Clinical Outcomes Strategy review	EMD	Review	
	Annual reporting cycle	P	Interim review of annual objectives	CEO	Review progress	
		S	Boards responsibility for Carbon Net Zero	DCEO	Report	
December 2024 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
Planning & Development / Council of Governors Day		C	Board planning / culture training			
		S	Council / Board - strategy update			
January 2025		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance report	COO	Monthly report	For information
		P	Benchmarking	DCEO	Review	
		P	International strategy	DCEO	Review	
		S	Review of Trust strategy & annual objectives 2023-2029	DoS	Report	
		P	Value Improvement Programme	COO	Review	
		P	Sustainability Annual Report	DCEO	Report	
February 2025 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
	Annual reporting cycle	G	Letter of representation & independence	Chair	Circulate	By email
	Annual reporting cycle	G	Register of directors interests / FPPT annual declaration	Chair		
	Annual reporting cycle	G	Declaration of independence (non-executive directors only)	Chair		
Planning & Development Day		S	Planning			
		S	Strategy deep dive			
March 2025		C	Patient story	CEO	To hear a patient story	
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	
	Annual reporting cycle	G	Annual reporting cycle	Executive directors	Approve	
		P	Research & Innovation Strategy Update	DoR	Annual review	
		C	Culture Audit review	DCEO/DoW	Approve	
		G	Annual BAF review / risk deep dive	CEO	Review	
		C	Staff survey initial results	DoW	Note	
		P	Health inequalities performance review	DCEO	Review	
	Annual reporting cycle	G	FPPT Compliance report	Chair	Approve annual compliance	

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Agenda item: 12/24d

Action log following the Board of Directors meetings held on

Thursday 28th March 2024

No.	Agenda	Action	By who	Progress	Board review
1	07/24a	Green Plan to be monitored through an assurance committee and to come back to Board for approval	LW/CH	Added to rolling programme for Board and on rolling programme for Audit	Board September 2024 Audit October 2024
2	08/24a	External benchmarks as well as progress against internal ambition to be included in new R&I Strategy update	FB	To be included in the report to Board in March 2025	Board March 2025
3	09/24a	Culture Audit to come back to Board	CH	Board responsibilities outlined in paper to Board	Board (part 2) April 2024
4	10/24	Submit Fit & Proper Persons annual return following approval to submit	LW	To be submitted by end of April 2024	N/A

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Agenda Item 13/24a

Meeting of the Board of Directors
Thursday 25th April 2024

Subject / Title	Review of corporate objectives and board assurance framework 2023/24
Author(s)	Louise Westcott, Company Secretary
Presented by	Chief Executive Officer
Summary / purpose of paper	This paper outlines the progress against the corporate objectives and the corresponding final board assurance framework position for 2023/24.
Recommendation(s)	The board are asked to note: • the update on progress against the corporate objectives for 2023/24 and the year-end position of the risks associated with those objectives as set out in the Board Assurance Framework.
Background papers	Corporate objectives, board assurance framework 2022/23
Risk score	N/A
Link to: ➢ Trust strategy ➢ Corporate objectives	• Trust's strategic direction • Divisional implementation plans • Key stakeholder relationships
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	BAF Board assurance framework ECN Executive Chief nurse EDoF Executive director of finance EMD Executive medical director COO Chief operating officer DoW Director of workforce NHSE NHE England

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Agenda item 13/24a

Meeting of the Board of Directors
Thursday 25th April 2024

Review of corporate objectives and board assurance framework 2023/24

1. Introduction

This paper outlines the progress against the annual objectives for 2023/24 (appendix 1). These objectives and the reporting for each were approved at the April 2023 Board of Directors meeting.

2. Background

Each year we agree a set of corporate objectives within the framework of our strategy. The board should note that the objectives set here are those of The Christie for its various activities. As entities with their own identities (within the overall Christie umbrella), Christie Private Care (CPC), Christie Pathology Partnership (CPP) and The Christie Charity have their own objectives which are managed by the Joint Venture Boards and The Christie Charity Board respectively.

Monitoring of the objectives has been through the performance report and consolidated updates to the board. Assurance is managed through the board assurance framework. This paper describes the end of year position.

3. Board assurance framework 2023/24

The board assurance framework (BAF) 2023/24 was presented to the Board and Quality Assurance Committee in March. This is attached at appendix 2. Further review of the board assurance framework has taken place by the executive team since the board meeting as part of the review of the progress against the annual objectives.

The following updates have been made to the BAF since it was presented to Board in March;

- The year-end risk score position has been added to all risks;
- Adjustments have been made to these risk scores to reflect achievement / non achievement of 2023/24 performance targets;

All the risks identified are scored 12 or under at year end.

3. Recommendation

The board of directors are asked to;

- Note the update on progress against the annual objectives for 2023/24 and the year-end position of the Board Assurance Framework.

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Executive Objectives 2023/24

1. To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer.						
	BAF	**Annual objective**	**Reporting**	**Timescale**	**Director**	**Progress**
1.1	1.3 1.4 1.5 6.1	Publish all information required under the NHS Code of Governance for Provider Trusts – including relevant oversight framework metrics (See below)	Trust Annual Report & Accounts and other governance documents prepared and reported to board with appropriate audit opinion	30.6.23	CS	Complete
1.2	1.3 1.4 1.5	Publish information on our quality of care in 2022/23 in our annual Quality Report and Accounts	Annual Quality Report prepared and reported to board with appropriate audit opinion	30.06.23	ECN	Complete
1.3	8.3	Publish information on Environmental, Social and Governance (ESG) indicators in our board reports and website and incorporate into annual report	Annual report to board – incorporated into Annual Report	30.06.23	DCEO	Complete Draft Green Plan developed
1.4	6.1	Publish relevant metrics as set out in the NHS oversight metrics for 2023/24 when published (or 2022/23 metrics if 2023/24 not published by NHSE))	Monthly report to board	Monthly	COO	Complete
1.5	1.2	Publish information on clinical outcomes in line with the 2023/24 milestones in our Clinical Outcomes Strategy	Annual report to Quality Assurance Committee	31.3.24	EMD	Report to QAC in June 2024
1.6	7.1 7.4	Publish progress with EDS 2022 self-assessment action plan	Effective web site page – six monthly report to Workforce Assurance Committee	6 monthly	DoW	Complete
1.7	1.2 2.1 5.3	Publish self-assessment and action plan for health inequalities based on socio-economic deprivation, ethnicity, and other community characteristics	Effective web site page – six monthly report to Board	6 monthly	DCEO	In development – rolled into 2024/25

1. To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer.						
	BAF	**Annual objective**	**Reporting**	**Timescale**	**Director**	**Progress**
1.8	N/A	Ensure that all board and sub-committee papers contain appropriate impact statements including for health inequalities and EDI	Board and committee papers contain appropriate impact assessment statements	31.08.23	CS	Complete
1.9	1.6	Publish CQC report and action plan when available and implement agreed actions	Action plan developed, published, submitted to CQC within required timescales and reported to Board Action plan implemented and reported to board	30.11.23	ECN	Complete
1.10	N/A	Develop our external website to ensure it provides up to date information on our quality of care	Reporting to Quality Assurance Committee	31.3.24	DCEO	Complete

2. To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey						
	BAF	**Annual objective**	**Reporting**	**Timescale**	**Director**	**Progress**
2.1	2.1 2.2 2.3	Implement 2023/24 (year 1) milestones of Research & Innovation division strategy	Six monthly report to Quality Assurance Committee Annual report to board Effective web site page	31.3.24	DRI	Complete
2.2	N/A	Ensure plan for relocation of research teams into Paterson facility implemented	Regular reporting to Quality Assurance Committee	31.3.24	DRI	Complete
2.3	2.1 2.2 2.3	Implement refreshed leadership and management structure for Research & Innovation division	Six monthly reporting to Quality Assurance Committee	31.3.24	DRI	Complete

3. To be an international leader in professional and public education for cancer care						
	BAF	**Annual objective**	**Reporting**	**Timescale**	**Director**	**Progress**
3.1	3.1 3.2 3.3	Implement the 2023/24 milestones of the Christie Education strategy	Six monthly report to Workforce Assurance Committee Annual report to Board Effective web site page	31.3.24	DE	Complete
3.2	3.1 3.2 3.3	Implement refreshed leadership and management structure for Education division	Six monthly reporting to Workforce Assurance Committee	31.3.24	DE	Complete
3.3	3.3	Confirm future organisational governance arrangements for Christie Education and relationship to Education Sector	Six monthly reporting to Workforce Assurance Committee Report to Board	31.3.24	DCEO/ DE	Complete

4. To integrate our clinical, research and educational activities as an internationally recognised and leading comprehensive cancer centre						
	BAF	**Annual objective**	**Reporting**	**Timescale**	**Director**	**Progress**
4.1	4.1	Ensure the website carries accurate, up to date information on our comprehensive cancer centre status	Six monthly reporting to Audit Committee	31.3.24	DCEO	Complete
4.2	4.1	Prepare for and secure reaccreditation with the OECI as a Comprehensive Cancer Centre	Achievement of reaccreditation	TBC	DCEO	Initial data response being collated
4.3	4.1 4.2	Develop our network of international relationships through the OECI by participating in OECI working groups	Reporting of attendance / involvement in working groups	31.3.24	DCEO	On going participation reported through Trust Report
4.4	4.3	Secure agreement on new governance arrangements for MCRC partnership with University of Manchester and CRUK	Agreement in place and reported to board	31.3.24	DCEO	Ongoing discussions taking place

4. To integrate our clinical, research and educational activities as an internationally recognised and leading comprehensive cancer centre						
	BAF	Annual objective	Reporting	Timescale	Director	Progress
4.5	4.2	Promote the reputation of The Christie internationally by supporting attendance and scholarly contributions at prestigious international professional and corporate events.	Reporting of attendance at international meetings	31.3.24	DCEO	Complete
4.6	4.2	Continue to develop partnerships in Kenya and Uganda, and others as appropriate	Include in regular international programme reports to board of directors	31.3.24	DCEO	Complete
4.7	4.2	Increase range and uptake of activity made available internationally though the School of Oncology	Six monthly reporting to Workforce Assurance Committee	31.3.24	DE	Complete
4.8	1.4	Develop a Patient and Public Involvement & Engagement plan	Annual report to the Quality Assurance Committee	31.3.24	DCEO	Complete

5. To promote equality, diversity & sustainability through our system leadership for cancer care						
	BAF	Annual objective	Reporting	Timescale	Director	Progress
5.1	5.1 5.2 5.3	Provide direction and guidance as chair of GM cancer board and represent cancer at Trust Provider Collaborative	Reporting to Board of attendance /involvement	31.3.24	CEO	Complete
5.2	5.1	Participate as part of senior leadership team of Greater Manchester Cancer	Reporting to Board of attendance/involvement	31.3.24	DoS	Complete
5.3	5.1	Fully implement the GM Cancer operating model	Regular reporting to Board	31.3.24	CEO	Complete
5.4	5.1	Continue transfer of management and accountability of local outpatient oncology care (including systemic therapy) – contracts to be held by The Christie NHS FT	Regular reporting to Management Board and Board	31.3.24	COO	Complete

5. To promote equality, diversity & sustainability through our system leadership for cancer care						
	BAF	Annual objective	Reporting	Timescale	Director	Progress
5.5	5.2	Develop and increase local systemic anti-cancer therapy delivery in line with agreed plan	Regular reporting to Management Board and Board	31.3.24	COO	Complete
5.6	5.3	Development of governance arrangements for Christie led & hosted trials at the networked centres	Regular reporting to Management Board and Board	31.3.24	DoR	Complete

6. To maintain excellent operational, quality and financial performance						
	BAF	Annual objective	Reporting	Timescale	Director	Progress
Quality of Care						
6.1	6.6	Implement 2023/24 (year three) milestones of our 2022/24 Quality Strategy	6 monthly report to Quality Assurance Committee	6 monthly	ECN	Complete
6.2	1.1 1.4 6.1	Implement the 2023/24 milestones of our Patient Experience plan To include CODE accreditation programme To include The Christie Quality Mark	6 monthly report to Quality Assurance Committee	6 monthly	ECN	Complete
6.3	1.1	Implement the 2023/24 milestones of the Trust Risk Management Strategy	Annual report to Board	31.3.24	ECN	Complete
Operational Performance						
6.6	6.1 6.6	Achieve the agreed operational activity plan for 2023/24	Monthly performance reports to management board & board	Monthly	COO	Complete
6.7	6.1	Achieve relevant national targets set out in 2023/24 NHS planning guidance	Monthly performance reports to management board & board	Monthly	COO	Exception of 62 days / FDS
6.8	6.3 6.5	Implement Year 1 milestones of the Digital Strategy	Six monthly reporting to Audit Committee	31.3.24	DCEO	Complete

6. To maintain excellent operational, quality and financial performance						
	BAF	Annual objective	Reporting	Timescale	Director	Progress
Financial Performance						
6.9	6.2 6.4 6.6	Achieve the Trust's 2023/24 revenue plan	Monthly financial performance reports to management board & board	Monthly	EDoF	Complete
6.10	6.2 6.6	Achieve the Trust's 2023/24 capital plan	Monthly financial performance reports to management board & board	Monthly	EDoF	Complete
6.11	6.2 6.6	Achieve the agreed level of cost-improvement and efficiency	Monthly financial performance reports to management board & board	31.3.24	COO	Complete
6.12	6.2 6.6	Develop the Trust group structure to deliver the Trust strategy	Regular reports to Board	31.3.24	EDoF	In development
Strategy						
6.13	6.6	To achieve the year 1 milestones of the overall Christie Strategy	Six monthly reports to Board	31.3.24	All	Complete

7. To be an excellent place to work and attract the best staff						
	BAF	Annual objective	Reporting	Timescale	Director	Progress
7.1	7.1	Achieve year 1 milestones of The Christie People & Culture Plan 2023/26	Regular reporting to Workforce Assurance Committee	31.3.24	DoW	Partially complete – reported to WAC
7.2	7.1 7.4	Achieve Equality, Diversity and Inclusion (EDI) plan 2023/24 objectives	Regular reporting to Workforce Assurance Committee	31.3.24	DoW	Partially complete – reported to WAC
7.3	7.1	Implement updated Mandatory Training policy	Regular reporting to Workforce Assurance Committee	31.3.24	DoW	Complete
7.4	7.1	Implement updated personal development plan (PDR) policy	Regular reporting to Workforce Assurance Committee	31.3.24	DoW	Complete

7.5	7.1	Implement framework for Respectful Resolution programme	Regular reporting to Workforce Assurance Committee	31.3.24	DoW	Complete

8. To play our part in the local health care economy and community						
	BAF	**Annual objective**	**Reporting**	**Timescale**	**Director**	**Progress**
8.1	5.1 8.2	Contribute to GM System working	Regular reports to Board	31.3.24	DoS	Complete
8.2	8.3	Achieve 2023/24 milestones for Trust Sustainability Plan	Six monthly reports to Audit Committee	31.3.24	DCEO	Complete
8.3	8.3	Achieve 2023/24 milestones for Carbon Zero objective	Six monthly reports to Audit Committee	31.3.24	DCEO	Complete
8.4	8.2	Participate in Anchor institutions initiative	Six monthly reports to Board	31.3.24	DoS	Complete
8.5	8.1	Regularly engage local residents regarding the Trust's plans	Continued meetings of the Neighbourhood Forum reported through Management Board as part of capital reporting	31.3.24	EDoF	Complete

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	Target date for implementation	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	1	2	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	**2**	Monitoring of reporting requirements through reports / asurance committee rolling programmes. Plan approval at Management Board January 2024	None identified	Team progressing implementation of PSIRF. Detail & dates in September 23 Board paper	September Board paper	Averse	Quality	High	**8**	8	8	8	2	**2**	Year end
1.2	Lack of data to fully understand equity of access to services & its impact on outcomes	COO	2	2	Project established to address data quality gap with clinical leadership. Go live date of July 2023 for identified projects. Impact assessed in January 2024.	Incomplete data set	**4**	Local audit of compliance reported to Executive Team. MIAA audit re GM cancer Q3	Published information on website	Regular review and reporting to executive team. System changes identified	Publication in April 2024	Cautious	Quality	Mediu m	**12**	12	12	12	4	**4**	Year end
1.3	Risk to patients and reputational risk to trust of exceeding healthcare associated infection (HCAI) standards	ECN	1	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.	**3**	Levels reported through performance report to Management Board and Board of Directors and quarterly to NHS Improvement. MIAA audit planned Q2 - moderate assurance	None identified	Actions relating to IPC BAF identified with target dates - full report to Sept 23 QAC	Monthly assessment of progress	Averse	Quality	High	**6**	6	6	6	3	**3**	Year end
1.4	Failure to learn from patient feedback (patient satisfaction survey / external patient surveys / complaints / PALS)	ECN	1	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	**2**	Management Board and Board of Directors monthly Integrated performance and quality report. National survey results presented to Board of Directors. MIAA audits - complaints Q1 - substantial assurance / risk management Q4. CQC Inpatient survey results. National Cancer Patient Experience Survey results	None identified	Team progressing implementation of PSIRF	September 23 / January 24 Board papers	Averse	Quality	High	**4**	4	4	4	2	**2**	Year end
1.5	Risk of exceeding the thresholds for harm free care indicators (falls, pressure ulcers, venous thromboembolism)	ECN	1	2	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. Continuous assessment of progress against thresholds.	Risk assessments for falls and skin assessment not always completed in a timely manner	**2**	QI project evaluating introduction of bedside handover to improve compliance with risk assessments. Risk assessment compliance added to CWP and monitored daily. Regular reports to Quality Assurance committee. MIAA audit risk management Q4 Year-end performance shows better than target performance	None identified	Continuous monitoring through monthly reports. Escalations in place where appropriate.	Monthly assessment of progress	Averse	Quality	High	**8**	8	8	8	2	**2**	Year end
1.6	Lack of preparedness for a CQC inspection leading to a poor performance	ECN	1	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. GGI review & actions. Assessment of impact of new regulatory approach undertaken.	Full understanding of CQCs new approach to inspection	**4**	Good rating 2023. MIAA audit - risk management Q4	None identified	Engagement in CQC's regulation updates / webinars re new assessment framework. Review of compliance against 2022 Must Do actions underway	Regular engagement meetings in diary	Averse	Quality	High - for completion of action plans	**8**	8	8	4	4	**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	Target date for implementation	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	2	2	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. Quarterly review of impact and risk score.	Oversight of potential legislative impact	**4**	Reports to Quality Assurance Committee. MIAA audit of The Christie sponsored research Q2 - limited assurance	None identified	Regular discussion and review of legislative changes through CRSC & Divisional Board	Monthly meetings review progress	Cautious	Quality	High	**12**	12	12	12	4	**4**	Year end
2.2	Risk of not meeting year 1 deliverables of the Research & Innovation Strategy	DoR	3	2	Approved Research & Innovation Strategy. 6 monthly assessment of progress.	External factors / pipeline of high quality researchers	**6**	Reports to Quality Assurance Committee. MIAA audit of The Christie sponsored research Q2 - limited assurance	None identified	Recruitment & retention plans linked to Trust plan	Some activity rolled into 24/25 - identified through Baord report March 24	Cautious	Quality	High	**12**	12	12	12	6	**6**	Year end
2.3	Risk of not meeting externally set research targets in the changing national landscape	DoR	1	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 - limited assurance	None identified	Monitoring through R&I divisional meetings	Monthly meetings review progress	Cautious	Quality	High	**9**	9	9	9	3	**3**	year-end
2.4	Protected time for staff for the delivery of research	DoR	2	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	**6**	Reports to Quality Assurance Committee showing delivery of research ambitions	None identified	Working with Workforce Team on job planning - on going process	Monthly meetings review progress	Cautious	Quality	High	**9**	9	9	9	6	**6**	Year-end

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	Target date for implementation	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 Christie Education strategy due to reduction in demand	DoE	2	2	Review the deliverables and prioritise in line with financial investment available. Maximise the potential of external income. Refresh the Christie Education 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. Active monitoring of regulated education funding tariffs (NHS WT&E, previously HEE) and funding opportunities.Balanced focus on maximising opportunities for Christie Workforce through People Development Group.	Continuing inability to deliver all strategic objectives due to difficulty in accessing current investment funds to deliver new initiatives.	**4**	Reporting to Workforce Assurance Committee and Board Creation/launch of Executive Education Oversight Group to scrutinise opportunities for alternative legal/financial vehicles for Christie Education	None identified	Market/competitor analysis undertaken. Expansion of external sub-brand activity. Relaunch of observerships scheme. Use of growth funding to appoint new posts.	Divisional Board to manage timelines of actions	Cautious	Workforce	Medium	**9**	9	9	4	4	**4**	Year end
3.2	External factors / pipeline of high quality clinical and teaching staff	DoE	3	1	Monitoring of workforce numbers / turnover. Active recruitment and investment in Christie pipeline.	External factors / pipeline of high quality oncologists	**3**	Reporting to Workforce Assurance Committee and Board	None identified	Active recruitment practices / investment	Divisional Board to manage timelines of actions	Cautious	Workforce	Medium	**9**	9	9	6	3	**3**	Year end
3.3	Lack of progress with organisational governance arrangements for Christie Education	DoE	2	2	Project group in place. Plans established and resourse identified. Project progress reported to Board of Directors.	External factors	**4**	Reporting to Workforce Assurance Committee and Board	None identified	Project group identified actions and timelines, reported through Education Board.	Divisional Board to manage timelines of actions	Cautious	Workforce	Medium	**9**	9	9	4	4	**4**	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	Target date for implementation	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	1	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	**2**	Updates to Board Time Outs / Board of Directors meetings	None identified	OECI project lead appointed and coordinating OECI reaccreditation application.	Deadline for submission of data	Cautious	Board		**6**	6	6	6	2	**2**	Year end
4.2	Lack of progress with The Christie's international ambitions and partnerships	DCEO	1	3	International Board in place. Monitoring of progress reported through regular engagement and meetings	External factors	**3**	Updates to Board of Directors	None identified	International Board actions identified and plans in place	Managed through International Board	Cautious	Board	High	**9**	9	9	9	3	**3**	Year end
4.3	Failure to establish new governance arrangements for MCRC partnership	DCEO	3	3	Partnership Board in place. Good relationships established with partners. Paterson replacement complete and in use.	None identified	**9**	Updates to Board of Directors	None identified	MCRC meetings identified way forward	Regular meetings	Cautious	Board		**12**	12	12	12	9	**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	Target date for implementation	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	3	CEO chairs Manchester Cancer Board. Director of Strategy attendance at key meetings. Christie Strategy 2023-28 approved	None identified	**9**	Reports to Management Board and Board of Directors	None identified	GM Cancer Board monitoring progress and sharing & reviewing progress through regular meetings	Annual objectives assessed at 6 and 12 months	Averse	Board		**12**	12	12	12	9	**9**	Year end
5.2	Failure to implement 2023/24 objectives of the SACT strategy	COO	1	3	Strategy on track but constrained by other trusts. Expansion on Withington site. 6 monthly assessment of progress. Bolton activity agreed & transferring from April 2024	None identified	**3**	Regular reports to Management Board and Board of Directors. Six monthly assurance reports to Quality Assurance Committee.	None identified	SACT team report to Board on progress June 2023. On going assessments of demand and response in place	SACT Board manages action progress and reports through Management Bd	Averse	Quality	Mediu m	**12**	12	12	12	3	**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	3	Research & Innovation Strategy approved. Approval for the trust to further expand the management of local oncology and chemotherapy 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.	**9**	Regular reports to Quality Assurance Committee and Board of Directors	None identified	Working with other Trusts to understand issues and actions. Monitored through R&I / SACT boards	SACT Board manages action progress and reports through QAC	Averse	Quality	High	**12**	12	12	12	9	**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	Target date for implementation	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	2	Executive led monthly divisional performance review meetings. Integrated performance & quality report to Management Board and Board of Directors monthly. Weekl;y performance reporting via trust operational group. Escalation internally & across GM of delays impacting waiting time targets. Monitoring cancer waiting time standards through GM Cancer & IPR.	Impact of ongoing Industrial Action leading to delays in referrals	**6**	Executive Team monitor activity weekly. Integrated performance report to Management Board, Quality Assurance Committee and Board of Directors.	None identified	Weekly monitoring through Executive Team, actions discussed and escalated as appropriate. Weekly escalation meeting with divisions / execs	Monthly review of annual targets	Cautious	Quality	Mediu m	**12**	12	12	15	6	**6**	Year end
6.2	Change in financial regime resulting in inability to deliver the Trust's strategic plan.	EDoF	1	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.	**4**	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 - moderate assurance / financial systems Q3 - substantial assurance / Critical Apps Q3 - moderate assurance	None identified	External advice sought on new models of working. Close working with national & regional team	Monthly assessment of progress towards annual plan	Cautious	Audit	High	**16**	16	16	16	4	**4**	Year end
6.3	Digital programme unable to support delivery of operational objectives	COO	1	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. Projects on plan. Roll out to clinical areas in early 2024/25.	Internal capability & expertise to support system going forward.	**4**	Reports to Management Board & Board of Directors. MIAA audit - Data Protection Toolkit (DPST) Q4	None identified	Progress and objectives set/reviewed by Quarterly Digital board. Esaclations through Management Board.	Monthly assessment of progress towards annual plan	Cautious	Audit	Mediu m	**12**	12	12	12	4	**4**	Year end
6.4	Not delivering the objectives of our commercial partnerships resulting in negative financial / patient experience or reputational impact	EDoF	1	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	**3**	Close contact with partners & management of joint incidents. Regular reports to Board and Audit Committee	None identified	Issues outlined and escalated through Boards	Regular assessment of progress towards annual plan	Averse	Audit / Board	High	**9**	9	9	9	3	**3**	Year end
6.5	Reputational damage, service disruption and financial loss due to cyber-attack.	COO	3	4	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.	**12**	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	Actions identified through MIAA DSPT review. Progress monitored on target dates through divisional meetings.	Monthly review of identified actions	Averse	Audit	Mediu m	**15**	15	12	12	12	**12**	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	1	4	Strategy / plans approved and reported through assurance committees. 6 monthly assessment reported to Board.	None identified	**4**	Published Trust Strategy	None identified	Objectives monitored through appropriate divisional board	Annual objectives assessed at 6 and 12 months	Averse	Board		**12**	12	12	12	4	**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	Target date for implementation	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	2	3	Plan approved and actions underway against each element with regular updating and reporting	None identified	**6**	Workforce Assurance Committee reports. MIAA audit EDS 22 Q4.	None identified	Target dates for all elements of the plan identified	Monthly review of identified actions	Averse	Workforce	Medium	**12**	12	12	12	6	**6**	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	2	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	**6**	National staff survey 2021 results. Reports to Management Board . Agency spend. Workforce Committee Oversight. MIAA audit - sickness absence Q1 - substantial assurance	None identified	Recrutiment and retention workplan in place - monitored through Workforce Assurance Committee	Regular assessment of progress towards annual plan	Averse	Workforce	High	**12**	12	12	12	6	**6**	Year end
7.3	Management of Board succession and appointment of new Chair / NEDs	DoW/CS	1	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. New Chair successfully appointed to start October 2023. Process for recruitment of 2 NEDs commenced July 2023. One NED appointed from Jan 23, Second appointment to be completed by April 24.	None identified	**3**	Nominations Committee decisions reported to Council of Governors. Adherence to Fit & Proper Persons regulation - report to Workforce Assurance Committee and Board on compliance. Use of external search partner. New Chair / 2 NED appointments	None identified	NED recruitment underway and plans outlined for further recruitment with timelines. Skill mix assessment updated and Board discussion undertaken as part of Dec Planning session.	Year end review of succession plan to determine future NED requirements	Averse	Board	Medium	**9**	9	9	9	3	**3**	Year end
7.4	Race/Disability discrimination impacting staff experience and therefore patient care	DoW	2	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	**6**	Reports to Workforce Committee, Management Board and Workforce Assurance committee. Staff story at each Workforce Assurance Committee. MIAA audit EDS 22 Q4.	None identified	WRES / EDS2022 action plans identify actions & timelines	Regular assessment of progress towards annual plan	Averse	Workforce	Medium	**9**	9	9	9	6	**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	Target date for implementation	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	1	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	**3**	Monitored through Management Board & Board of Directors. Capital programme shared with MCC and Board of Directors.	None identified	MCC aware of current and future plans and timelines. Planning team engaged in discussions alongside Neighbourhood Forum	Dates in line with capital plan	Cautious	Board	Medium	**6**	6	6	6	3	**3**	Year end
8.2	Not able to progress our role as an Anchor Institution	DoS	1	3	Engagement in relevant GM meetings	None identified	**3**	Monitored through Trust report to Board of Directors.	None identified	Continued attendance at relevant GM meetings	6 monthly review of progress	Cautious	Board		**6**	6	6	6	3	**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 (SDMT)	DCEO	1	4	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	**4**	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	Actions outlined in SDMT with annual objectives	Annual milestones monitored monthly	Cautious	Audit	Mediu m	**8**	8	8	8	4	**4**	Year end
8.4	Reduced ability to provide services and support to patients due to national / global influences (supplies / fuel costs / industrial action)	COO	5	2	Industrial Action - close working with unions. Business continuity plans in place. Planning meetings in place around strike acton and incident management approach used. Management of demand. Risk assessments undertaken.	Impact of ongoing Industrial Action	**10**	Reports to Management Board and Board of Directors	Impact of ongoing Industrial Action	Detailed planning of patient demand and catch up. Staff cover planned. Liaision with unions and national team.	On going dependent on mandate to take action	Averse	Board	Mediu m	**9**	9	20	20	10	**10**	Year end
		DCEO	1	3	Group in place to review supply chain.	Global position. Lack of control for supply chain e.g. radioisotopes	**3**	Reports to Audit Committee	None identified	Escalations in place for supply issues through procurement team.	As appropriate dependent on issue	Cautious	Audit		**9**	9	9	9	3	**3**	Year end
8.5	Failure to adapt to climate change & other environmental factors e.g., floods / extreme temps / new pathogen	DCEO	1	3	Business continuity planning process in place. Plans tested and reviewed.	Uncertainty around what / when	**3**	Sustainable Development Plan in place and reported to Audit Committee	None identified	EPRR lead out to advert	Appointment to be made by end November 2023	Cautious	Audit	Medium	**9**	9	9	9	3	**3**	Year end

The Christie
NHS Foundation Trust

Agenda item 14/24a

Meeting of the Board of Directors
Thursday 25th April 2024

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

The Christie
NHS Foundation Trust

Trust Report
for March 2024

Executive Summary

- Key quality indicators for March show no significant adverse variances or issues for escalation.
- We have reported a better than target rate of both falls and pressure ulcers at year end.
- Performance in March for the 62-day consolidated cancer standard was 74.5% which is above the operating plan standard of 70%.
- Four corporate risks are scored at 15 or above on the risk register.
- Cumulative financial performance at the end of March (Month 12) is a £6.8m surplus against a planned £8m deficit. This is a positive variance of £14.8m to plan.
- Planning for 2024/25 continues with both of the Trust's main commissioners supported by the PwC turnaround team.
- Key financial performance indicators in month 12 show no adverse variances other than the level of recurrent efficiency achieved, £2.0m against a year-end target of £6.4m.
- Workforce indicators for March show a slight decrease in sickness absence rates
- The annual staff vaccination programme completed 31st March. Our compliance rates remained the highest in Greater Manchester
- We are updating the project arrangements following approval of actions from the cultural audit engagement process and communications are planned in April 2024
- We remain rated overall as Good by the CQC
- We continue to be in segment 2 of the System Oversight Framework.
- Our governance review, with a particular focus on assurance about the CQC fundamental care standards, is complete and the actions agreed are progressing as planned.
- Capital schemes are progressing to plan across the Trust.
- New CQC single assessment framework is now in place, we are assessing ourselves against the quality statements as preparation for a future inspection.
- We are in a pre-election period or 'purdah' ahead of local elections in May.

Quality of Care

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

We have achieved a better than internal target rate of both falls and pressure ulcers at year end. Our target was internally set and significantly below the national average for both areas.

There were 8 complaints in March which is below the monthly average. The number of contacts with the Patient Advice and Liaison Service (PALS) service in March was 19, lower than the previous month.

Nurse staffing numbers met the levels to ensure appropriate levels of safety and care with indicative staffing to maintain a 1:8 nurse to patient ratio which is nationally recommended.

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. Limitation on equipment & facilities to deliver planned activity or progress developments due to insufficient CDEL (20)
2. Risk of not achieving the financial plan including the value improvement programme in 2024/25 (20)
3. Risk that patients may experience harm due to significant delays in the management of patients with penile cancer (16)
4. Risk of delayed cancer referral and treatments due to not meeting 24 / 62-day targets (15).

Operational Performance

The 2024/25 NHSE Planning Guidance 2 Christie applicable cancer metrics;

- 62 day cancer standard
- 28 day Faster Diagnostic Standard (FDS)

The 62-day standard is a barometer of how well the system is performing with cancer pathways.

Compliance at the end of March against the 2 key cancer standards was;

- The 62-day consolidated standard was 74.5% against a threshold of 70%. This level of performance has been driven by referral delays from other Trusts as the result of industrial action.
- We have missed the 75% threshold for the Faster Diagnosis Standard which measures initial referral to diagnosis. This is for a very small number of patients (average 12 per month), that we have taken over from district general hospital haematology services. This pathway is being redesigned and we expect to be compliant in Q1 2024/25.

The majority of Christie referred patients are monitored via the 31-day standard (decision to treat to treatment start).

- We have continued to achieve the 31-day standard for treatment to start within 31 days of the decision to treat at 98.5% against a target of 96%.

During March there were 6 operations cancelled on the day for non-clinical reasons, all were rebooked within 28 days. 4 of these were as a result of an IT outage that impacted a number of Trust systems for 2 days at the end of the month.

The final position for seasonal vaccinations among frontline staff show that we have the highest rate of compliance for both Covid-19 (41%) and Flu (58%) vaccinations in Greater Manchester.

Transition to the new version of our risk management and incident system, DATIX-DCIQ continues following its launch on Monday 4th March. The Patient Safety Team are leading the implementation of DATIX and continue to provide various methods of support throughout this process including virtual and in-person drop-in sessions. The roll out has gone very well with minimal issues.

The Patient Safety Incident Response Framework (PSIRF) was implemented nationally on Tuesday 2nd April with a Trust wide launch led by the Patient Safety Team supported by the Chief Nurse and Medical Director.

The Fuller Inquiry has conducted a questionnaire survey of Trusts. The first phase of the Inquiry, on matters relating to Maidstone and Tunbridge Wells NHS Trust, concluded in November 2023 with the publication of the Phase 1 Report. Phase 2 of the Inquiry will look at the broader national picture and consider if procedures and practices in other hospital and non-hospital settings, where deceased people are kept, safeguard the security and dignity of the deceased.

A True for Us review of the "Independent Inquiry into the issues raised by the David Fuller Case" was presented at Risk and Quality Governance on 10th April 2024.

Financial Performance

Revenue: Year-end financial performance finished ahead of plan as described in the table below. The Trust had a year-end surplus of £6.8m against an £8.0m planned deficit position. This is due to:

- pay underspends arising from vacancies
- interest received on the Trust's cash balances above planned levels
- income to negate the costs of industrial action
- inclusion of £6.3m of commercial profit from the Trust's Joint Venture

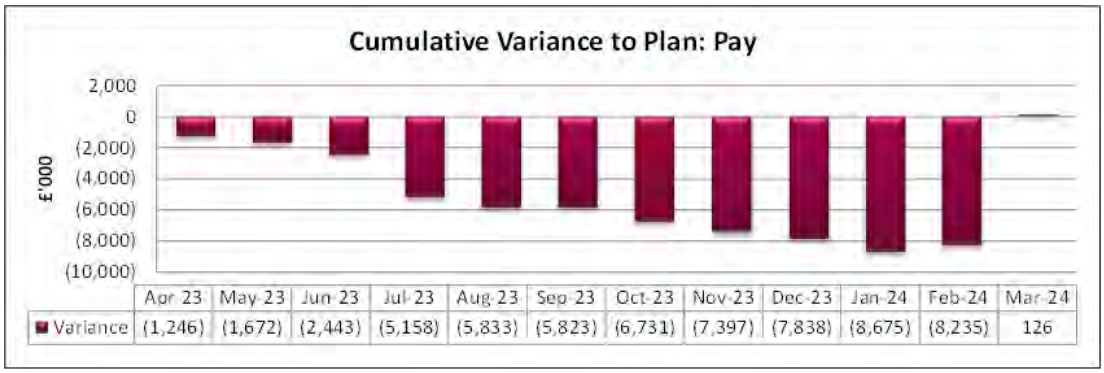
The significant variances in clinical income and non-pay are both related to the overspend (and associated over achievement of income) in relation to pass through drugs.

Month 12 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(373,973)	(373,973)	(406,452)	(32,478)
Other Income	(68,922)	(68,922)	(65,716)	3,206
Pay	212,392	212,392	212,518	126
Non Pay (incl drugs)	218,455	218,455	236,586	18,131
Operating (Surplus) / Deficit	**(12,048)**	**(12,048)**	**(23,064)**	**(11,016)**
Finance expenses/ income	28,723	28,723	17,170	(11,554)
(Surplus) / Deficit	**16,675**	**16,675**	**(5,894)**	**(22,569)**
Exclude impairments/ charitably funded capital donations	(8,637)	(8,637)	(903)	7,734
Adjusted financial performance (Surplus) / Deficit	**8,038**	**8,038**	**(6,797)**	**(14,835)**

The cumulative pay position is an overspend of £0.1m which is illustrated in the graph below; it includes:

- £8.1m notional pension contributions expenditure which have an equivalent offset in the income position

- £(5.7)m pay expenditure underspend relating to services with associated and equivalent income, including GM Cancer, R&I and The Christie Charity
- £(2.5)m Trust pay underspend



Capital: The Trust's capital outturn position was in line with the plan with £33.2m expenditure on areas such as backlog maintenance programme, linear accelerators and CT scanner replacements, Digital Services Electronic Health Records projects, final works on the Paterson scheme, Proton treatment planning system and the TIF ward refurbishment.

Cost improvement: The annual CIP target of £12.5m was delivered in full at year end but predominantly through non-recurrent measures; this will create associated pressures for 2024/25. The final level of recurrent CIP identified was under plan at £2.0m compared to a target of £6.4m. Whilst divisions have been working on the delivery of cost improvement schemes, this has been significantly impacted by the management of industrial action.

KPIs: 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:

Measure of Financial Performance	Red / Amber / Green rating
Revenue: Trust Control Total compared to plan	£6.8m surplus
Capital: Capital expenditure against plan	£0.1m under plan
CIP identified (recurrent) against target of £6.4m	£2.0m identified
Debtor days compared to 15-day target	11 days
Cash balance	£137m
Better Payment Practice Code (95% target)	96%

GM Recovery: The GM system has been supported by the PwC turnaround team in the delivery of 2023/24 outturn which was in line with the final agreed figure of £180m deficit.

2024/25 planning: PwC are also supporting the GM system with the 2024/25 planning round. The Trust is forecasting significant levels of growth in services arising from referral demand and implementation of NICE guidance. This is causing significant pressure on the Trust's commissioners to fund this growth with on-going conversations with the Trust's two main commissioners, GM Integrated Care Board (ICB) and specialised commissioning.

Workforce

Our workforce performance indicators show mandatory training compliance and personal development plan rates are both above (better than) thresholds at 92.6% and 84.9% respectively. Sickness absence rates have decreased slightly in March to 4.21% (threshold of 3.4%). The overall all year turnover has reduced from a starting position in April 23 of

17.93% to a year end position of 13.65%. These issues and the associated plans for improvement have been considered by the Workforce Assurance Committee.

Staff are reminded that they can access a range of key information including Trust workforce policies, information on Health & Wellbeing, recruitment resources and information on leadership and PDRs through this link MeetWorkforceTeam - 1 (pagetiger.com).

The Workforce Committee commissioned a trial of the Real-World Leader (RWL) tool. The RWL is an evidence-based tool designed for senior level recruitment and promotion. It is very different to traditional selection tools, assessing proven behaviours and what leaders choose to enact, rather than personality or other traits. The tool supports the assessment of candidates against the Trust's values and behaviours framework.

The tool has been trialled at the Christie for all senior posts (8c and above). 16 behavioural assessments have been undertaken during the trial. Feedback from recruiting managers has been positive. The Committee approved the continuation of the tool and supported a mandate to use for all recruitment to posts at 8c and above. Further work was also agreed to increase the capacity of assessors with a view to extending to 8b posts in the future.

The BMA junior doctors have secured a further 6-month mandate for strike action. The mandate also includes action short of strike (ASOS). Current information suggests (not confirmed by BMA) that junior doctors are unlikely to announce any dates for action until after the BMA Junior Doctors Conference on 27th April.

SAS doctors also have a current strike mandate. BMA SAS mandate is until 18th June. There is a possibility of SAS doctors taking concurrent action with junior doctors. The BMA have announced that consultants voted to accept the offer made by government.

The workforce risk continues to be assessed by the Workforce Committee. Staff retention continues to improve. Based on the healthy pipeline, reducing vacancies, and improving retention, the Workforce Committee has reviewed the risk and reduced the score to 9.

The Christie Leadership Development Programme is built around our Leadership Framework. These dimensions are fundamental to leaders at every level, enabling them to support the development of high performing teams and the delivery of high-quality services to our patients. Aimed at line manager and supervisors in band 4-7 roles (clinical and non-clinical), this 6-month programme supports staff to build their leadership skills further. Two cohorts will run this year and are now fully subscribed.

We continue to recognise the remarkable contribution of our staff and volunteers who have worked at The Christie for 10, 20, 30 and 40 years. Our series of celebration events will continue on 30th April and 21st May. In April 26 staff will receive their 10-year recognition award and in May, we will celebrate 5 staff reaching 20 years' service, 1 reaching 30 years and 2 reaching 40 years. We congratulate staff on this tremendous service milestone and thank them for their contribution to our success. Full details of these achievements will be communicated following the events.

Culture

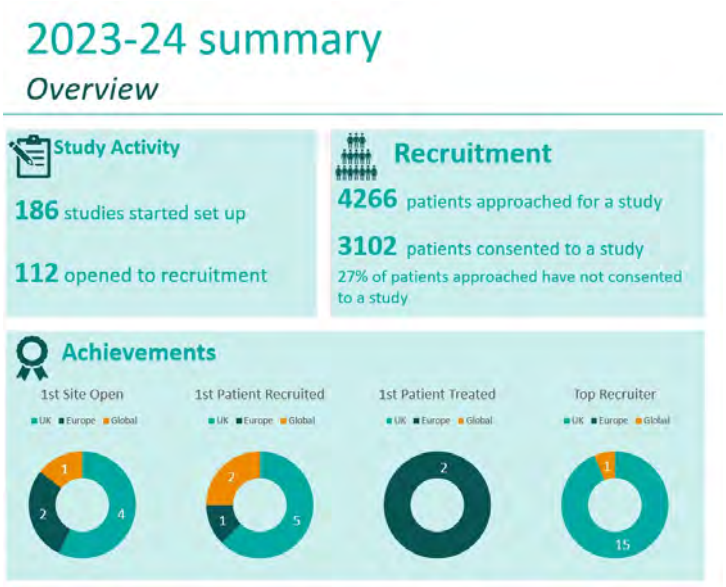
The cultural audit outcomes and engagement process have now been discussed by our Management Board and Board of Directors, who have given approval for the actions to be implemented. We are in the process of updating the project arrangements with an oversight group. The communications plan for the next steps of the cultural audit implementation will focus on using the divisional cascade via the senior management committee and service divisions. We are also developing the "continuing the conversation" approach set out in the plan discussed by the Board of Directors. On behalf of the board the CEO will be

communicating the next steps to all staff via the staff intranet and internal communication routes including team briefing. The aim is to incorporate implementation of the cultural audit plan into normal business. The specific role of the board is to be discussed separately and then reported and confirmed at a future public meeting.

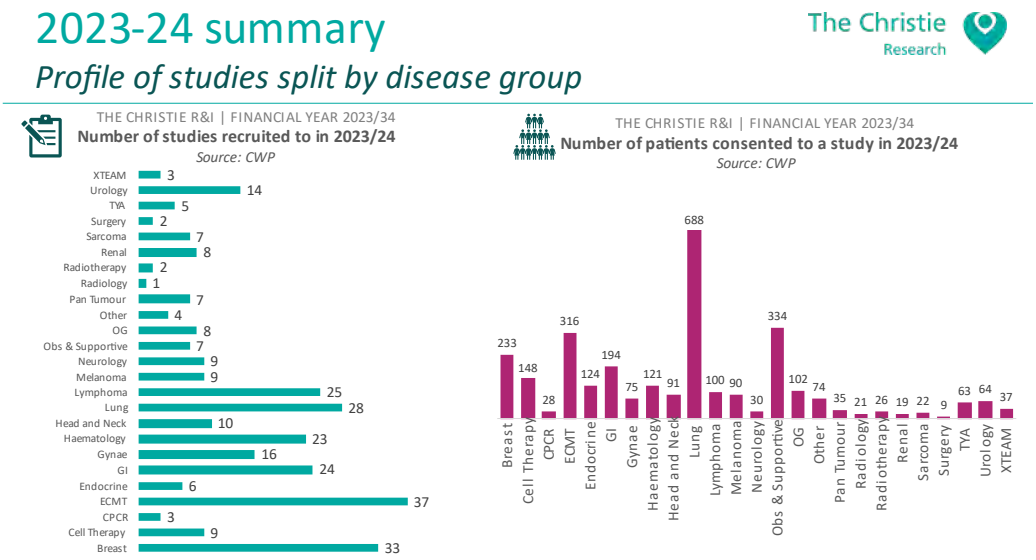
Research

The R&I team are focused on improving Study Set Up times to reduce our average time to set up, post the Lord O'Shaughnessy Review . Work is ongoing to review our processes, work with partners and implement changes.

It is noted that we have been successful in achieving UK top recruiter position and first patient recruited for some of our trials.



Our research is distributed in the following disease groups.



R&I Aged Debt is reducing, after a peak in December 2023. In addition, we have also focussed on addressing invoices due, which has added to the Aged Debt. We now have an Industry Partnerships Manager, who will support the building of relationships with our Commercial Sponsors, which will include discussions on prompt payment of invoices.

As part of a wide strategic partnership with the UK Government, Moderna has established the Vaccine Innovation Fund, a multimillion-pound fund to invest in sustaining and enhancing the UK's capabilities in vaccine research beyond the immediate crisis of the pandemic. We will be submitting a bid which will address challenge one: To develop capacity and capability in clinical trials pharmacy with a focus on developing and testing novel models for delivering clinical trials of advanced therapy medicinal products (ATMPs)

Professor Fiona Blackhall, Director Research and Innovation, is one of two new Cluster leads at Manchester BioMedical Research Centre.

In the Greater Manchester Cancer Awards 2024, we have been shortlisted for a number of awards:-

- Commitment to Equality- **RAPID- RT- Co- Designing an inclusive study to collect and utilise real world data to evaluation patient outcomes after changes in standard of care radiotherapy practice-** The University of Manchester, The Christie NHS Foundation Trust, VOCAL
- Early Career Researcher- **Alicia Marie Conway-** CRUK National BioMarker Centre, University of Manchester, The Christie NHS Foundation Trust
- Team Science- **Manchester PMP Accelerator Team-** University of Manchester, The Christie NHS Foundation Trust, Wellcome Trust, Centre for Cell Matrix, Manchester Cancer Research Centre, Centre for Applied Pharmacokinetic Research. **BRAINantomy**- optimising cognition in brain cancer survivors- The University of Manchester, The Christie NHS Foundation Trust, Manchester University NHS Foundation Trust and, **The Manchester CUP Research Group-** The University of Manchester, CRUK, Manchester Institute Cancer Biomarker Centre, The Christie NHS Foundation Trust

Teams are continuing to move into the Paterson, with Observational and Haematology teams now moved in, with Lymphoma and Head & Neck to follow.

Education

Christie Education and workforce colleagues continue to work closely to develop a refreshed, comprehensive suite of education, training and career development resources around leading and improving, supporting key elements of the cultural audit action plan. An integrated suite of EDI focused activity is well underway as part of our joint working, supporting the launch of new staff network groups through a series of education EDI events.

Christie Education events has completed its annual review, reporting 50 events to nearly 5000 local and global colleagues in the last calendar year as part of our wider Education portfolio. Gateway C launches across NHS Scotland in April 2024 and have also launched a new workstream commissioned by RM Partners, providing a range of bespoke education resources.

In respect of international partnerships, a Memorandum of Understanding between The Christie and Peter Mac (Melbourne) is due to be signed in mid-April. Education collaboration forms a cornerstone of this agreement, with a commitment from both partners that we focus on accessible and impactful opportunities for **all** staff, through shared online learning, collaborative action learning sets/networks and exchange opportunities. An early outcome of the partnership has been the establishment of two joint clinical fellowships between both organisations, spending one year in Manchester and one year in Melbourne. For the 2024-2025 round, the partnership is supporting two fellowships across radiation/clinical oncology and trials/medical oncology.

Our international education programme looks forward to visitors from Greece (as part of our partnership with HeSMO) and we are really pleased to welcome radiation oncology colleagues from the Ukraine in May who will be undertaking a Christie observership and sharing learning with us about radiotherapy in the Ukraine in the lecture presentation on May 9th. More details to follow on the event!

International

In April 2024 the Trust signed a framework partnership agreement with Peter MacCallum Cancer Centre, Australia's only public health service solely dedicated to caring for people affected by cancer. 'Peter Mac' is a world leading research, education and treatment centre. The agreement outlines areas for collaboration including education and training, research and clinical services.

Strategic and Service Developments

Pathology JV Re-procurement – initial bidder submissions have now been received in line with the procurement timetable. An evaluation process is now underway in line with the tender documents following which the Dialogue process will commence.

Work continues on the formation of a 20-bedroom ward in the former Trust Administration and Digital floors. Internally, the partitions are complete and work on the decorations and finishes such as the wall cladding and floor finish has commenced with the mechanical and electrical work progressing. Externally, the external cladding to the steel frame has commenced and the windows installed. Several risks were identified in respect of the delivery of the project and these continue to be managed.

Work on the refurbishment of the existing Art Room has commenced and is scheduled to complete in May 2024. The structural alterations are complete as well as some of the mechanical and electrical works. Externally, the new ramps in the garden are formed and are awaiting the completion of the handrails and final surface. This project is funded by The Christie Charity and the art service has been moved to a temporary location to allow the service to continue during the works.

Planning Permission for the next major strategic development, the Advanced Scanning and Imaging Centre (ASIC) development was received in December 2023. The current actions are the completion of the current design stage and the development of the Treasury compliant Full Business Case.

Our Carbon Energy Fund Scheme is a key project in our sustainability aspirations and puts us a step closer towards achieving the NHS Net Zero targets. All major works are complete and the scheme is anticipated to be fully operational in the summer 2024. This project is a key part of the Trust and NHS aspiration to reach Net Zero in the future.

The replacement of the Superficial Treatment unit and the CT SIM2 have both commenced and are due to complete in May 2024.

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

Regulatory

CQC Update

It is almost a year since we received our CQC inspection report and rating of 'good' . Following this, we held a number of events to ensure a wide range of staff were able to input into our action plan detailing how we would meet the 'must do' actions. This was

submitted to the CQC and shared with our Board, the Greater Manchester Integrated Care Board and NHS England Specialised Commissioning team.

We completed our action plan in October 2023 and now, as part of our best practice activity, there is a lot of work to review the 'must do' actions identified. Our Quality and Safety team continue to lead this work and have quarterly engagement meetings with our CQC relationship manager, looking at new regulations and methodologies.

This evolving process involves analysing data that is relevant to the new CQC single assessment framework which includes an ongoing monitoring of trust information and data. This retains the 5 key questions of safe, effective, caring, responsive to people's needs and well-led and the 4 point rating scale.

Under each of the 5 key questions are a set of quality statements which the CQC assesses services against using the evidence gathered both off site and during an on-site inspection to make an assessment. You can read more information about the new CQC assessment approach and quality statements on the CQC website here. To date, no trusts have had a full inspection under this approach.

Pre-election guidance
NHS England have written to Trusts about the pre-election guidelines that have been published here NHS England » Pre-election guidance for NHS organisations Spring 2024. The guidelines describe the fact that we are in a pre-election period or 'purdah' for the upcoming May local elections. This means that NHS organisations must take additional care and consideration of their role in terms of the matters considered at their meetings, visits to the Trust, media, requests for information and marketing amongst other things.

During the pre-election period, there should be:

- no new announcements of policy or strategy
- no announcements on large and/or contentious procurement contracts
- no participation by NHS representatives in debates and events that may be politically controversial, whether at national or local level.

These restrictions apply in all cases other than where postponement would be detrimental to the effective running of the local NHS, or wasteful of public money. Communications activities necessary for operational delivery purposes should continue as normal.

NHSE reminded Trusts that the Nolan Principles of Public Life apply to every member of NHS staff. For those in leadership positions – particularly executive and non-executive directors of NHS organisations – there is a particular responsibility to model and champion these principles. This means being, and being seen to be, scrupulously impartial, and to avoid any impression that public office in the NHS or public resources are being used for private or political gain.

Agenda item 14/24b

Meeting of the Board of Directors

25th April 2024

Subject / Title	Risk Management Strategy and Policy 2021-2024 annual review
Author(s)	Ben Vickers, Head of Risk and Patient Safety Specialist
Presented by	Theresa Plaiter, Chief Nurse and Executive Director of Quality
Summary / purpose of paper	This paper provides an update on progress against the Risk Management Strategy and Policy for 2021-24
Recommendation(s)	The Board are asked to note the progress against the 3 objectives in the strategy and the response to the recommendations of the MIAA Audit.
Background papers	Risk Management Strategy and Policy 2021-2024 MIAA Risk management Audit 2024
Risk score	n/a
Link to: ➢ Trust strategy ➢ Corporate objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness.
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.	MIAA Mersey Internal Audit Agency CODE Care, Observation, Documentation, Experience CRF Clinical Research Facility PSIRF Patient Safety Incident Response Framework

Agenda item 14/24b

Board of Directors

Risk Management Strategy and Policy 2021-2024 annual review

1) Introduction

The Risk Management Strategy and Policy 2021-2024 replaced the previous policy 2017-2020. The updated document was developed through extensive consultation with a broad range of staff from across the organisation and was approved by the Risk & Quality Governance Committee and the Management Board.

2) Purpose of Report

As part of the Trusts system for internal control around Risk Management, The Board of Directors are asked to review the Risk Management Strategy annually. The Board are asked to note the progress against the 3 objectives and the response to the recommendations of the MIAA Audit.

3) Background

The Trust has a holistic approach to Risk Management across the organisation, which embraces financial, corporate, reputational, clinical, non-clinical and project risks. The Trust takes all reasonable steps in the management of risk with the overall objective of protecting patients, staff and its assets.

The primary concern is the provision of a safe environment together with having systems and processes in place to identify, assess, evaluate, and assign responsibilities to manage risks within the Trust. This is achieved by ensuring that risk management and corporate governance is an integrated process through which the organisation will identify, assess, analyse, and manage risks and incidents at every level of the organisation and aggregate the results at a corporate level.

Strategic risks and risks to the achievement of the corporate objectives are presented to the Board through the Board Assurance Framework and assurance on their management is monitored through the assurance committees.

The reporting of risks, and progress against associated actions, are reported through the Trust governance structures, including the relevant assurance committee and the Board of Directors.

The Patient Safety and Risk Team undertook an audit of compliance with the Risk Management Strategy in March 2024, the audit findings and recommendations are due to be presented to the Risk & Quality Governance Committee in May 2024.

An update on progress against the three objectives of the Risk Management Strategy are detailed in figure 1.

In February 2024, MIAA undertook a review of Risk Management Core Controls. As a mandated review, MIAA do not assign a level of assurance. They recommended one management action; Terms of Reference for Risk & Quality Governance Committee were past their due date for renewal, these are to be ratified at the May 2024 Committee.

Delivery against the 3 objectives of the Risk Management Strategy 2021-2024 (as of April 2023)

Figure 1

Objective	Progress
1) Increase involvement, knowledge and accountability of all staff in the risk management process and integrated governance	Training needs analysis completed Risk management training rolled out to risk owners. Level 2 of the Patient Safety Syllabus is now essential to role for all staff managing incidents or risks. Quality Mark expanded to include Christie @ sites. This now includes Radiotherapy and Proton Beam on the Withington site, and Macclesfield, Salford and Oldham satellite sites. Christie CODE expanded – Ward 2 and Clinical Research Facility (CRF) have now achieved gold accreditation
2) Greater insight, transparency and triangulation of data	Patient Safety Incident Response Framework (PSIRF) is now operationalised from 1 April 2024. This included the publication of patient safety incident response plan and policy to external facing website, ICB and NHSE. Datix DCIQ is operational, supporting the Trust in compliance with Learning From Patient Safety Events (LFPSE) since 4 March 2024. The Enterprise Risk Management Module is due to go live by 31 May 2024. Level 1 of the Patient Safety Syllabus is now mandatory for all staff and monitored through Patient Safety Committee. The Trust Corporate Induction now includes a session on Patient Safety & Risk for all staff who join The Christie. Work is in its early stages to adopt data into the Data Warehouse to improve insights into legacy and contemporaneous risk and incident data.
3) Refine and improve processes and systems to build effective risk management	Audit of risk registers, including compliance with risk review dates, and confirmation of associated risk assessments – Completed March 2024. Learning for improvement bulletin well established – review includes learning from complaints alongside incidents.

Action plan to continue improvement against the 3 Risk Management Objectives, and address learning identified from both the internal risk audit, and the MIAA audit:

Figure 2

No	Issue	Action required (reference to detail)	Action Lead responsibility	Deadline Date	Expected Evidence of Completion/RAG
1	Review Risk Management Strategy 2021-2024	Undertake a review of the current Risk Management Strategy to address the following Areas: 1. Divisional governance arrangements for risk assessment and acceptance prior to adding to risk registers 2. Roles & Responsibility of risk oversight at Divisional and Board Level 3. Review and ratify risk appetite statement of the Board 4. Publish risk appetite statement on Trust website 5. Align the Board Assurance Framework (BAF) to the revised Risk Management Strategy	Theresa Plaiter, Executive Chief Nurse & Director of Quality	May 2024	Revised Risk Management Strategy 2024-2027 in place *This action has been delayed due to Datix DCIQ implementation for incident module overrunning by 6 months.*
2	Risk Management Thresholds and Assurance Reporting	To undertake a review of the current risk thresholds and management / oversight of risks at a Service, Divisional or Trust Wide Level. 1. Review the standard risk reporting produced by the Patient Safety and Risk Team to ensure robust assurance and accountability is obtained at Risk & Quality Governance Committee 2. Review the definitions of “Corporate Risk Register”, “Top 5 Trust wide Risks” and “Key Risks Report”	Ben Vickers, Head of Risk & Patient Safety Specialist	May 2024	*This action has been delayed due to Datix DCIQ implementation for incident module overrunning by 6 months.*

No	Issue	Action required (reference to detail)	Action Lead responsibility	Deadline Date	Expected Evidence of Completion/RAG
		3. Confirm accountable roles for risk management and oversight at a divisional level 4. Confirm process for escalation of risks 5. Confirm process for interconnected / risk dependencies and decision making on where to oversee such risks *e.g. a digital risk in a clinical setting or an operational risk with a proposed digital solution unknown to stakeholders.*			
3	The Trust should ensure its risk assessment form is reviewed and updated, to ensure compliance with best practice in the management of risk.	Update current Risk Assessment form; 1) Within divisional governance arrangements form to be assessed prior to adding to Risk Register 2) Revised format to include additional fields: Hazards, Impact, Contributing Factors. To be included in DATIX Cloud Risk Module.	Ben Vickers, Head of Risk & Patient Safety Specialist	May 2024	New risk assessment in place and Datix DCIQ supporting. *This action has been delayed due to Datix DCIQ implementation for incident module overrunning by 6 months.*
4	Undertake Bi-Annual internal Risk Management Audit Q2 and Q4 of each financial year to measure compliance with current policy at divisional level.	Q2 of 2022-2023 – Completed Q4 2022-2023 Completed Q2 – 20232024 July 2023	Ben Vickers, Head of Risk & Patient Safety Specialist	March 2023 – Recurrent Action.	Findings to be presented to R&QG Committee May 2024.

No	Issue	Action required (reference to detail)	Action Lead responsibility	Deadline Date	Expected Evidence of Completion/RAG
5	Risk Management Training for Risk Owners	1. Add to Christie Learning Zone. 2. 181 Risk Owners in Datix as numerator 3. Monitor compliance through ERG and Risk and Quality Governance Committee.	Ben Vickers, Head of Risk & Patient Safety Specialist	1 & 2 completed	

The Christie
NHS Foundation Trust

Agenda item 15/24a

Meeting of the Board of Directors
Thursday 25th April 2024

Subject / Title	Freedom to Speak Up report - 1st October 2023 to 31st March 2024
Author(s)	Sue Mahjoob, Freedom to Speak Up Guardian
Presented by	Sue Mahjoob, Freedom to Speak Up Guardian
Summary / purpose of paper	This paper provides an update on Freedom to Speak Up activity within the Trust to the Board of Directors
Recommendation(s)	To note the contents of the report
Background papers	Previous 6 monthly reports to Board of Directors.
Risk score	
Link to: ➢ Trust strategy ➢ Corporate objectives	Achievement of corporate objectives The Christie People and Culture plan
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.	FTSUG – Freedom To Speak Up Guardian NGO- National Guardian's Office EDI – Equality, Diversity and Inclusion NHSE – NHS England

Board of Directors
Thursday 25th April 2024
Freedom to Speak Up report 1st October 2023 to 31st March 2024

1. Background

The Freedom To Speak Up Guardian's role is to support staff to effectively raise concerns, address barriers to speaking up and foster a positive speaking up culture so that concerns raised are viewed as an opportunity for learning and improvement.

The National Guardians Office recommends that this report is presented on a regular basis to the Board. This is the six-monthly update on activity to the Board of Directors.

2. Activity

To highlight the importance of speaking up and listening, The Freedom to Speak Up Guardian (FTSUG) continues to attend meetings and induction in person. Attendees are sent an electronic booklet which includes further information on Freedom to Speak Up.

The local induction pack template provides details on the role of the FTSUG and reference to speaking up and listening.

Videos relating to staff speaking up experience are included within digital placements: specialist radiotherapy clinical placement, nursing and proton beam.

Team Brief is used to share information on Freedom to Speak Up activity.

Promotion of speaking up is supported by the Freedom to Speak Up champions.

3. Culture

3.1 Cultural audit

The report following the external audit on culture has been shared with staff for feedback and priorities for additional work are being developed. One area of focus relates to staff being able to speak up, share concerns about patient safety and putting forward ideas for improvement.

3.2 Staff survey results

"We each have a voice that counts" is an element within the 2023 NHS Staff Survey that is focused on speaking up with 4 questions that contribute to the sub-score "Raising concerns".

In addition, the Trust added questions to ascertain what would support staff to speak up as well as their experiences of speaking up with the option to provide comments to explain reasons for their answer.

The survey results are being considered alongside the cultural audit report when developing the action for improving staff confidence in both speaking up and feeling that action will be taken as a result. This will enable a co-ordinated approach to cultural development and progress will be reported to the Workforce Assurance Committee.

3.3 Trust board self assessment

The Christie Trust Board undertook the NHSE self assessment to evaluate existing arrangements for Freedom to Speak Up and adherence to principles to develop a healthy speaking up culture. They reflected on their role in supporting a positive speaking up culture.

3.4 Patient Safety Incident Response Framework (PSIRF)

The Christie has gone live with PSIRF which sets out the approach to responding to patient safety incidents with an emphasis on the system and culture. PSIRF recognises a culture of strong psychological safety underpins openness and transparency in incident reporting and promotes respectful investigations with meaningful system-based learning.

4. National guidance and reports

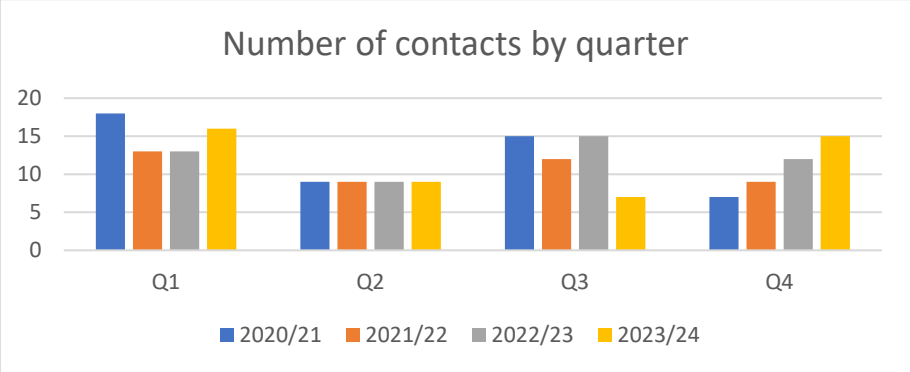
Throughout the last six months the following report and guidance were issued and reviewed. Any learning identified and progress with actions are monitored by the Workforce Committee.

a. National Guardians Office Annual report

b. National Guardian's Office Recording Cases and Reporting Data Guidance

5. Contacts

5.1 Number of contacts by quarter



5.2 Type of contact

The table below describes the activity from 1st October 2023 to 31st March 2024. Descriptions of concerns are recorded as described by the staff member and concerns can have more than one issue.

Quarter	No. of contacts	Issue category	Description	Action
2023/24 Q3	7	Attitudes and behaviour (x2)	Colleague behaviour	Anonymous - advice given on options
			Manager behaviour	Feedback forwarded on staff member's behalf to inform exit interview
		Policies, procedures and processes (x6)	Requesting information on support available during a disciplinary	Information provided
			No standard application of HR policies	Feedback forwarded on staff member's behalf to inform exit interview
				Information provided

Quarter	No. of contacts	Issue category	Description	Action
			Application of sick leave policy HR investigation process not followed Confidentiality not maintained Insufficient advice and support in resolving pension concern	 Response to concern provided by Deputy Director of Workforce Concern shared with senior manager, meeting arranged Senior management and HR involvement to resolve
2023/24 Q4	15	Attitudes and behaviour (x12)	Behaviour of manager (x5) Behaviour of colleague (x5) Lack of support from management to address capacity concerns Attitude of manager makes it difficult to raise concerns	Staff member discussed with more senior manager (x3) Staff member to raise under HR policy (x2) Mediation session undertaken (x1) Concern discussed with manager (x1) Decision on how to proceed yet to be made (x3) Staff discussion with senior management Meeting held with involved staff to identify way forward
		Policies, procedures and processes (x3)	Programme for training not planned or supportive Inconsistent information provided re rules for Covid Rigid processes causing upset	Meeting held with involved staff to identify way forward Up to date information provided Meeting with more senior manager
		Quality and safety (x1)	Process to be launched did not have up to date information but staff member was not	Conversation with senior manager and information updated

Quarter	No. of contacts	Issue category	Description	Action
			able to raise directly with manager	
		Service change (x1)	Unable to find information on service change as manager not available	Conversation took place with more senior manager

5.3 Type and method of raising concern

A review of the type of concerns and how they are raised are below. The small number of concerns means that one case can affect the overall percentage.

Category	Q3&Q4 2022/2023	Q1&Q2 2023/2024	Q3&Q4 2023/2024
Patient safety/quality	3%	11%	4%
Worker safety/wellbeing	9%	5%	0%
Attitudes and behaviours	40%	60%	36%
Policies, procedures and processes	29%	14%	36%
Denominator – number of issues	35	37	25

There is a cross section of staff who speak up. Anonymous reporting could be an indicator of lack of confidence in raising a concern.

Role	Q3&Q4 2022/2023	Q1&Q2 2023/2024	Q3&Q4 2023/2024
Senior leader	7%	4%	0
Manager	44%	36%	36%
Worker	37%	56%	59%
Anonymous	11%	4%	5%
Denominator – number of cases	27 (3 anonymous)	25 (1 anonymous)	22 (1 anonymous)

To make it easy for staff to speak up, there are a number of ways to speak with the FTSUG and staff choose the method that works best for them.

Method	Q3&Q4 2022/2023	Q1&Q2 2023/2024	Q3&Q4 2023/2024
Face to face	14	15	9
MS Teams	4	6	7
Telephone	4	1	5
Form on intranet	2	1	0
Email	3	2	1

5.4 Summary

In summary, over the last six months, 36% of concerns (as a percentage of number of issues) have had an element relating to attitudes and behaviours. This compares with 60% for the previous six months. 36% related to policies, procedures, and processes (14% previously).

There are similar levels of concerns raised about colleague behaviour as manager behaviour. Contacts are likely to opt to have conversation with manager to resolve their concern, acting

formally using appropriate HR policy is the other option. This reinforces the need to ensure that managers have access to guidance, training and support to enable them to deal with concerns effectively.

Concerns relating to policies, procedures and processes are varied but highlight how inequitable application of policies or confusing communication leads to dissatisfaction.

The safety concern demonstrates the benefit of staff feeling able to raise their concern directly with managers in ensuring patient safety.

There was 1 concern raised anonymously and advice for options to proceed were given.

6. FTSU plan

The Freedom to Speak Up plan describes the aims and action to promote, develop and support the culture, values and behaviour to meet the ambition that "we are comfortable to speak up."

The FTSU plan for 2024/2025 has been developed to meet the ambition to progress improvements in speaking up culture. To help encourage staff to engage with the plan it has been made more visually appealing and is being shared with divisions for their support and identification of action to achieve the deliverables.

The action plan from the FTSU plan 2023/2024 has been updated and is included as Appendix 1.

Over the six months the deliverables achieved were:

- Raising awareness of FTSUG and the speaking up and listening message at team meetings, via HIVE and team brief and in person attendance at staff induction as part of the Values and Behaviours session
- Development of posters and presence on Engagement hub to support Freedom to Speak Up month. The focus was Breaking Barriers to speaking up
- Launch of Patient Safety Incident Response Framework (PSIRF) which includes speaking up within the domain of staff engagement
- The inclusion of the Freedom to Speak Up training in the Leadership at The Christie guide as part of its recommendations

In progress:

- Anonymous reporting for inappropriate behaviours
- Review of staff survey results in combination with the cultural audit
- Development of an animated version of the FTSU policy
- Divisional engagement with the FTSU annual plan to develop action to achieve deliverables

7. National Freedom to Speak Up month

October was National Freedom to Speak month and the focus for organisations is Breaking Barriers. Posters encouraging speaking up and action already taken to support all colleagues to speak up were promoted. There was a presence at the Engagement Hub and promotion via HIVE.

8. Annual review – Freedom to Speak Up policy

The annual review of the Freedom to Speak Up policy consists of two parts and was presented to Workforce Committee.

a. *Freedom to Speak Up Audit* - an effectiveness audit was undertaken to review the formal cases raised during 2023 to ensure they were managed in accordance with the policy.

b. *Qualitative review* – a review of actions taken to support the implementation of the policy and to promote and further develop a positive culture that enables people to feel safe to speak up about anything that concerns them. The review has been undertaken against 4 key themes which underpin the Trust's Freedom to Speak Up plan 2023/24.
    - Raising Awareness
    - Ensuring a positive raising concerns culture
    - Support
    - Learning

All concerns raised have been managed in accordance with the Trust policy. The qualitative assessment shows that considerable work has been undertaken to contribute to creating a culture where staff know how to and feel safe to speak up.

9. Freedom to Speak Up Training

The National Guardian's Office, in association with Health Education England launched Freedom to Speak Up e-learning training divided into three modules, Speak Up for all staff, Listen Up for managers at all levels and Follow Up for Senior leaders. The Speak Up module is part of the Trust mandatory training programme and 94.05 of staff are compliant.

The leadership training modules reference FTSU training which supports managers to deal with concerns.

10. FTSU service effectiveness

10.1 Feedback from staff contacts

The NGO requires that Guardians ask those who contact the FTSUG if they would speak up again or have experienced detriment. Additional questions are asked about support and communication. Respondents are asked for their personal characteristics. The feedback tool is completed via a link so that responses are anonymous. The questionnaire is sent when a case is closed and not all cases are closed in the quarter they are reported.

7 contacts replied in Q3 and Q4 2023/2024.

All said they would speak up again and were made to feel they did the right thing in raising their concern.

5 said they felt very well supported, 2 said quite well.

7 said they understood very well what would happen once they raised a concern.

6 said they were communicated with very well, 1 quite well.

3 said they were informed of learning that happened as a result, 3 said there was no learning and 1 said no.

6 respondents said they felt they did not suffer disadvantageous or demeaning behaviour as a result of speaking up, 1 replied they didn't know.

Comments made:

- Really supportive and a great opportunity to discuss concerns informally with the opportunity to raise formally.
- The support from Sue was great but I did not feel confident in taking the concern further and making it more formal.
- It made me confident enough to raise a concern if it was ever to occur again. Sue made me feel at ease and gave me sound knowledge and advice about my situation.

- Pleased I raised my concerns as I didn't feel my immediate manager was listening / prepared to act on concerns
- I would speak to Sue again, she was very helpful and empathetic and has continued to check in.
- It was very helpful to have someone who was impartial but still very supportive.

Suggestions for improvement of the FTSU service:-

- Raise awareness of team more and educate staff on options to take concerns forward more openly. I wonder if staff members are aware of options as I wasn't until I spoke up and asked.
- Although the speak up service is helpful as it makes you feel understood when raising concerns, I still feel there is no choice but to leave the Christie or the department I work in due to the people I am working with.
- Not sure if this is for freedom to speak up to do, but there is no process for managers to follow after a concern is raised with the team. I feel like it was still a little too easy for the managers to brush the concern off.

10.2 Equality monitoring information

Contacts were asked to provide information on their personal characteristics. Further work is required to make the collection of this information more robust, in parallel with the Trust's overall focus on monitoring activity by protected characteristics.

Age	Do you have a disability	Sex	Ethnicity	Religion	Sexual Orientation
35- 44	No	Female	White: British	No religion	Heterosexual
55 - 64	No	Female	White: British	Christian	Heterosexual
25 - 34	Yes	Female	Asian or Asian British: Pakistani		Heterosexual
25 - 34	No	Female	White: British	Christian	Heterosexual
25 - 34	No	Female	White: British	No religion	Heterosexual
25 - 34	Yes	Female	White: British	No religion	Heterosexual
25 - 34	No	Female	White: British	No religion	

11. Conclusion

The Board of Directors is asked to note the detail in the report and receive a further update in six months' time.

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Appendix 1
Freedom to Speak Up plan deliverables for 2023/2024

Deliverable	Comment	Timescale
Raising awareness		
Deliver regular communications to staff on how to raise concerns	Examples: Promotion of updated FTSU policy Items in Team brief HIVE banners Attendance at team meetings Attendance at face to face staff induction	Team briefing - Monday 4 Septembe Team briefing Monday 13 Februar FTSU_Make_a_difference_HIVE banner.pdf Team briefing Monday 05 June 202
Promote speaking up cases and share learning	Posters on display and advertised via HIVE on corridors	Sept 2023 FTSU_Make_a_difference_A4_V5.pdf
Support national FTSU month	Posters produced and activity on Engagement stall during October – theme breaking barriers HIVE banner with link to HIVE page	October 2023 FTSU_Breaking_Barriers_A1 posters.pdf
Ensuring a positive raising concerns culture		
Refresh NHSI board self-assessment of leadership and governance arrangements in relation to speaking up	For discussion at Workforce Assurance Committee followed by the Trust board	Board session held 8th Dec 23 to discuss
Update Trust policy to meet requirements of refreshed national Freedom to Speak Up policy and ensure it is easy to access	Policy updated and published	April 2023
Promotion of the NGO HEE e-learning and monitor compliance	Promoted via team brief and referenced in Trust training.	March 2024

Deliverable	Comment	Timescale
as part of the Trust essential training programme	New staff sent link to training following induction. Referenced in Leadership at the Christie guide	HIVE - Leadership at The Christie (xchristie.nhs.uk)
Use of staff survey results to highlight areas or staff groupings that require additional focus	Initial analysis complete To consider priorities from Globis culture survey	May 2024
Work with the Patient Safety Specialist and the Risk team to highlight FTSU messages within the implementation of the NHS Patient Safety Strategy and support improvement in the confidence of staff raising clinical concerns	Implementation of Patient Safety Strategy ongoing. FTSU captured within the domain of staff engagement within Patient Safety Incident Response Framework (PSIRF) Development of process for staff feedback following an incident response to be captured within domain of staff engagement within Patient Safety Incident Response Framework (PSIRF) Trustwide shared learning being reviewed as part of PSIRF implementation Staff ability to identify rationale for reporting an incident so they are involved in the incident management process Feedback on Datix mandatory so all staff can review the outcomes of the incident they report and are able to challenge outcomes	March 2024
Identify indicators of a healthy speaking up culture	Link with HR metrics and culture work undertaken by the Organisational Development team. Tool developed to report on culture metrics and includes numbers of FTSU cases FTSU considered alongside Trust organisational development work on psychological safety in teams Leadership guide produced which highlights the leadership training offers and leadership expectations to support psychological safety	December 2023 HIVE - Leadership at The Christie (xchristie.nhs.uk)
Promote Respectful Resolutions package which provides tools and training to address bullying and harassment and includes a tool to aid speaking up	Respectful Resolutions launched	March 2024

Deliverable	Comment	Timescale
Support		
Enhance and promote support arrangements for staff and managers involved in raising a concern	Respectful Resolution package purchased which includes a tool for speaking up and other guides. Speaking up support scheme promoted with HR, TU and Occupational Health colleagues As part of the breaking barriers focus, consideration is being given to identifying support that would be of benefit to staff with protected characteristics - to include working with EDI champions and the staff networks	March 2024
Enhance communication about zero tolerance approach to detriment	Referenced in updated FTSU policy	January 2024
Understand views on detriment and measure effectiveness of support	Additional questions added to staff survey 2023	March 2024
Learning		
Continue with listening exercise with the staff network groups	Ethnic diversity video complete and promoted Offer extended to staff networks. Neither networks proceeded. Conversation about how networks will operate going forward and how the Trust gets views and engagement is ongoing.	March 2024 Action closed waiting conclusion of wider Trust discussion
Contribute to a FTSU/ patient safety culture exercise to ascertain views on culture and suggestions to improve confidence to raise a patient safety concern	Questions asked within 2023/2024 staff survey. Globis independent culture review - development of priorities	March 2024
Identify further triangulation of information and use to identify areas for improvement	Triangulation of patient safety concerns FTSUG joining HR TU regular meetings	January 2024 1. Raising Concerns. Board Paper 081223 I
Share good practice more widely by developing a series of posters	Posters on display and advertised via HIVE on corridors	July 2023

Deliverable	Comment	Timescale
that highlight examples of speaking up and outcomes		 FTSU_Make_a_difference_A4_V5.pdf  FTSU_Make_a_difference_HIVE banner.p

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Freedom to Speak Up plan

2024/2025

Making speaking up business as usual

Raising awareness • Ensuring a positive Freedom to Speak Up culture
Support • Learning

MAKE A DIFFERENCE
ACT WITH KINDNESS
CONNECT WITH PEOPLE

Introduction

Delivering the **Freedom to Speak Up plan**

The Christie People and Culture plan 2022-2025 sets out how we will value, support and develop our staff to create a thriving and sustainable workforce. It has six themes, each of which has an ambition.

One theme relates to engaging our people and has a focus on supporting people to have the confidence and knowledge of how to speak up. This Freedom to Speak Up plan describes our aims and action to promote, develop and support the culture, values and behaviour that will meet the ambition that we are comfortable to speak up.

People and Culture Plan 2022-2025
Theme 1 – Engaging our people

NHS and NHS people promise	Ambition	Area of focus Priority area	Further focus
Belonging to the NHS: We each have a voice that counts	People feel proud to work here, feel supported and recognised. We are comfortable to speak up and enjoy coming to work	Culture, values and behaviours	• Listening communication and engagement • Reward and recognition • Building confidence to speak up

The Freedom to Speak Up plan has four themes:

Raising Awareness

Raising awareness helps ensure that the message of speaking up safely is shared with all staff. Awareness will support two of the main reasons people do not speakup– Fear (of detriment or consequences) and Futility (nothing is done).(source staff survey 23) Raising awareness is everyone's business.

We want our staff:-

- To know how to raise concerns
- To feel confident in doing so and know that speaking up will not impact adversely on them
- To feel that they are listened to
- To know that something will be done in response to concerns that are raised

Support

The main barriers (as per the staff survey 23) for those raising concerns are Fear (of detriment or consequences) and Futility (nothing is done). Being open and honest with staff throughout the process and providing feedback, as far as might be appropriate to do so, can help to alleviate these worries. Feedback is vital so that those raising concerns understand how their disclosure has been handled and is dealt with.

Appropriate support should be offered to staff raising concerns, and those who have concerns raised against them, throughout the process, not just at the point of them raising a concern. Staff should not suffer detriment as a result of speaking up.

Ensuring a positive Freedom to Speak Up culture

A positive speaking up culture is one where people feel safe and confident to:

- Share their thoughts, experiences, improvement ideas and concerns
- Participate in health and wellbeing conversations
- Call out incivility, discrimination or bullying

Learning

Sharing the learning and providing ongoing opportunity for reflective practice, via appropriate channels depending on the nature and confidentiality of the concern will support a positive Freedom to Speak Up culture. Learning and ideas for improvement are also gained from reviewing guidance and reports from external sources such as the National Guardian's Office and NHS England.

Deliverables

The following are the deliverables for 2024/2025.

Raising Awareness
Of the importance of speaking up and how to do this

Deliverables 2024/25
- Regular communications to staff on how to raise concerns and share improvement ideas recognising the multiple ways in which staff can speak up
- Support and engagement for national FTSU month
- EDI champions and Patient Safety champions have knowledge and understanding of Freedom to Speak Up
- Promotion of the Freedom to Speak Up policy and the key messages in different formats to improve accessibility
- Divisional engagement and activity.

Ensuring a positive speaking up culture
Staff feel able and safe to speak up

Deliverables 2024/25
- Refreshed NHSE board self-assessment of leadership and governance arrangements in relation to speaking up
- Speaking up highlighted as an important element when implementing the Patient Safety Incident Response Framework (PSIRF) and clear mechanisms for raising, investigating and escalating clinical concerns to build confidence of staff
- Staff survey results and cultural audit informing activity to support a positive raising concerns culture
- Management development and training to support managers to create cultures within their teams where staff feel able to speak up, raise concerns and share improvement ideas
- Targeting barriers to speaking up, particularly for those with protected characteristics.

Support
Staff feel supported both during and after raising a concern

Deliverables 2024/25
- Review feedback from those who raised a concern to share learning
- Promotion and continued implementation of Respectful Resolutions package which provides tools and training to address bullying and harassment and supports speaking up.

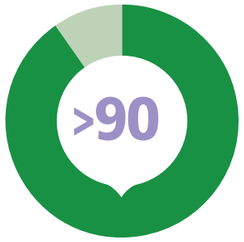
Learning
The organisation learns and shares learning from concerns raised

Deliverables 2024/25
- Promotion and discussion of speaking up cases and shared learning
- Triangulation of FTSU information, patient safety concerns and employee relations matters
- Introduction of anonymous reporting for attitudes and behaviours and triangulate information with other sources of information

Measurement of the plan

We will know we have made a positive difference when:

There is a year-on-year improvement in the national staff survey scores for questions relating to speaking up.



Feedback from staff who have raised concerns say they would raise a concern again (>90%)

Qualitative staff feedback across the organisation indicates positive experience

The underpinning action plan to achieve the deliverables will be monitored via the Workforce Committee.

Keep up-to-date with all our news from the latest Christie developments to charity events.

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Agenda Item 16/24a

Board of Directors meeting

Thursday 25th April 2024

Subject / Title	Board Assurance Framework 2024/25
Author(s)	Louise Westcott, Company Secretary
Presented by	Louise Westcott, Company Secretary
Summary / purpose of paper	This paper provides the Board with the Board Assurance Framework 2024/25 that summarises the top strategic risks aligned to achievement of the corporate objectives. The paper also outlines the Risk Appetite Statement for 2024/25
Recommendation(s)	To note the Board Assurance Framework (BAF) 2024/25 and approve the Risk Management Statement for 2024/25
Background papers	Corporate objectives 2024/25, operational and revenue and capital plan 2024/25.
Risk score	N/A
Link to: ➢ Trust strategy ➢ Corporate objectives	• Trust's strategic direction • Divisional implementation plans • Our Strategy • Key stakeholder relationships
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	BAF Board assurance framework ECN Executive chief nurse EDoF Executive director of finance EMD Executive medical director COO Chief operating officer DoW Director of workforce DCEO Deputy chief executive officer

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Agenda Item 16/24a

Board of Directors meeting

Thursday 25th April 2024

Board Assurance Framework 2024/25

1 Introduction

The Board of Directors reviewed a set of draft risks for the 2024/25 Board Assurance Framework (BAF) in March 2024. The approach to the development of the BAF 2024/25 is in line with recommendations from the 2023 Good Governance Improvement Review and taking account of the 2024 MIAA Assurance Framework review.

2 Updates to Risks

The BAF 2024/25 outlines the top strategic risks for the organisation and aligns to the achievement of the corporate objectives. Each risk identified in the BAF 2024/25 is assigned to the Board or an assurance committee for assurance and has an executive lead. The summary view of the BAF outlines what the risks are and orders them by current risk score to enable the Board to easily assess which are the highest strategic risks. Each risk is described and has an inherent, current and target risk score and a risk appetite identified. Controls, assurance, gaps and actions with timeframes will be outlined for each risk. It is noted that the information in the BAF 2024/25 will be further reviewed by the company secretary and executive directors and more information added for month 2.

3. Risk Appetite Statement

A Board approved risk appetite statement supports the Board Assurance Framework, particularly the identified appetite against each risk that is outlined in the BAF. The statement is published on our website. The Board need to review this annually.

The recommended statement for 2024/25 is;

The Christie NHS Foundation Trust recognises that its long-term sustainability depends upon the delivery of its strategic objectives and its relationships with patients, staff, the public and strategic partners. It operates within a low overall risk range. It will not accept risks that have a likelihood of a detrimental impact on patient or staff safety or compliance and regulatory objectives.

However, The Christie NHS Foundation Trust has a marginally higher risk appetite to take considered risks in terms of its impact on the strategic, reporting and operations objectives in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment. The highest risk appetite relates to our pursuance of innovation and transformation objectives.

4 Recommendation

The Board are asked to;

- note the Board Assurance Framework (BAF) 2024/25 that represents the key strategic risks for the organisation in year and aligns to the risks to achievement of the corporate objectives.
- Approve the Risk Appetite Statement for 2024/25

BOARD ASSURANCE FRAMEWORK 2024/25 OVERVIEW OF RISKS

RISK No.	Risk Title	Risk Description	Responsible Committee	Inherant Risk Score	Q1	Q2	Q3	Q4	Target Risk Score	Current Risk Score
RISK 5	**Impact of the system capital allocation framework**	If the capital planning and allocation system does not enable full use of our charitable and commercial reserves there is a risk that we may not be able to fund our capital and asset replacement programmes leading to delays, cancellations or reprioritising of planned projects and equipment not being replaced when needed.	Board of Directors	**25**					**5**	**20**
RISK 7	**Ineffective GM system-wide cancer pathways**	If diagnostic, MDT and referral processes at local hospitals across the GM system are not efficient there is a risk that we receive patients on 62-day pathways late leading to them not being treated within 62 days.	Quality Assurance Committee	**25**					**5**	**15**
RISK 9	**Industrial action**	If there is ongoing industrial action, there is a risk of business disruption leading to delayed or cancelled care	Workforce Assurance Committee	**25**					**5**	**15**
RISK 11	**Cyber attack**	If we are subjected to a cyber-attack there is a risk of loss of data and operational disruption leading to patient care being delayed or cancelled	Audit Committee	**25**					**4**	**12**
RISK 4	**Changes in quality regulation**	If the CQC or other regulatory body changes their approach to regulation there is a risk that we will not be able to demonstrate compliance leading to us being assessed as not meeting the fundamental care standards.	Board of Directors	**15**					**4**	**12**
RISK 10	**Financial balance**	If we do not achieve the planned activity levels and our target efficiency savings there is a risk that we won't achieve financial balance leading to us having to repay the difference to our agreed plan in the following year	Audit Committee	**15**					**2**	**12**
RISK 3	**Recruitment and retention of skilled staff**	If we are unable to maintain current levels of skilled staff there is a risk that they will not have the time or expertise required for excellent care and communication leading to a reduction in the standards of patient safety and experience.	Workforce Assurance Committee	**20**					**4**	**10**
RISK 1	**New technologies and increased standards of care**	If there are changes to NICE guidance or other advances in practice that we have not anticipated (diagnostic, therapeutic, care) there is a risk that there will be a delay in their introduction leading to a delay in patients obtaining the benefits of new treatments.	Quality Assurance Committee	**20**					**4**	**9**
RISK 6	**Insufficient contractual support for networked cancer care provision**	If the GM system does not continue to support local provision of cancer care with contractual and funding flow changes there is a risk that we are unable to devolve more systemic therapy, clinical trials and radiotherapy treatments to local communities leading to persistence or increases in inequalities in provision to economically deprived and ethnically diverse communities.	Quality Assurance Committee	**12**					**6**	**9**
RISK 8	**Extreme weather events**	If there is an extreme weather event (heat wave, freeze, floods etc) due to climate change there is a risk of business disruption (increased staff absence, increased patient non-attendance and equipment malfunction) leading to delayed or cancelled care.	Audit Committee	**16**					**4**	**8**
RISK 12	**Ineffective response to cultural audit**	If our response to the cultural audit is insufficient there is a risk that a negative culture will persist in some specific parts of our organisation leading to an increase in the number of staff reporting a poor experience.	Workforce Assurance Committee	**16**					**2**	**8**
RISK 13	**Insufficient data on patient protected characteristics**	If we are unable to capture data on the protected characteristics of our patients there is a risk we will be unable to assess any inequalities in access, experience or outcomes leading to lack of focus in addressing health inequalities	Workforce Assurance Committee	**10**					**4**	**8**
RISK 14	**Legal and statutory compliance**	If we do not maintain an awareness of and respond to changing statutory and legal requirements there is a risk that we will fail to comply leading to being sanctioned for being in regulatory or statutory breach.	Audit Committee	**25**					**4**	**8**
RISK 2	**Not learning from patient safety incidents**	If we are unable to fully implement the new Patient Safety Reporting Framework (PSIRF) there is a risk that we will miss opportunities to learn lessons and improve patient safety leading to preventable patient harm.	Quality Assurance Committee	**12**					**1**	**6**

RISK 1	New technologies and increased standards of care	Date Risk Opened	Current Risk Score
Description	**If there are changes to NICE guidance or other advances in practice that we have not anticipated (diagnostic, therapeutic, care) there is a risk that there will be a delay in their introduction leading to a delay in patients obtaining the benefits of new treatments.**	Apr-24 Date of Last Review Apr-24	**9**
Associated Corporate Objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer	Executive Lead Responsible Committee Assurance Level Risk Appetite	Exec Medical Director **Quality Assurance Committee** Cautious

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

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	4	**20**			**0**			**0**			**0**			**0**	2	2	**4**

RISK 2	Not learning from patient safety incidents	Date Risk Opened	Current Risk Score
Description	**If we are unable to fully implement the new Patient Safety Reporting Framework (PSIRF) there is a risk that we will miss opportunities to learn lessons and improve patient safety leading to preventable patient harm.**	Apr-24 Date of Last Review Apr-24	**6**
Associated Corporate Objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer	Executive Lead Responsible Committee Assurance Level Risk Appetite	Exec Chief Nurse **Quality Assurance Committee** Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	Training programme led by Exec Chief Nurse & Medical Director. Review through Patient Safety & Experience Committee and Risk & Quality Governance. Introduction of new DATIX system	None identified	Level 1 – Data and management reports • PSIRF reports to Patient Safety Committee / Risk & Quality Governance / Senior Management Committee • ERG Level 2 – Management team and committee scrutiny • Review compliance through QAC • Level 3 – External assurances • MIAA review • Updates presented to ICB	None identified		Year End	Year End

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

RISK 3	Recruitment and retention of skilled staff	Date Risk Opened	Current Risk Score
Description	**If we are unable to maintain current levels of skilled staff there is a risk that they will not have the time or expertise required for excellent care and communication leading to a reduction in the standards of patient safety and experience.**	Apr-24 Date of Last Review Apr-24	**10**
Associated Corporate Objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey. To be an international leader in professional and public cancer education.	Executive Lead Responsible Committee Assurance Level Risk Appetite	Workforce Director **Workforce Assurance Committee** Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	Recruitment & retention Trust-wide group reporting to Workforce Committee. International Nurse recruitment programme.	National staff shortages impacting recruitment	Level 1 – Data and management reports • Divisional oversight of recruitment through Service & Operatonal Review meetings • Level 2 – Management team and committee scrutiny • Review compliance through WAC • F&PP Compliance report to WAC / Board Level 3 – External assurances • National staff survey • MIAA audit	None identified		Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	5	**20**			**0**			**0**			**0**			**0**	2	2	**4**

RISK 4	**Changes in quality regulation**	Date Risk Opened	Current Risk Score
Description	**If the CQC or other regulatory body changes their approach to regulation there is a risk that we will not be able to demonstrate compliance leading to us being assessed as not meeting the fundamental care standards.**	Apr-24 Date of Last Review Apr-24	**12**
Associated Corporate Objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey. To be an international leader in professional and public cancer education.	Executive Lead Responsible Committee Assurance Level Risk Appetite	Exec Chief Nurse **Board of Directors** Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	Self assessments underway against 2022 must do actions and well-led quality indicators. Attendance at CQC briefings / NHS Providers briefings	Lack of national understanding of the detail of the new inspection regime	Level 1 – Data and management reports • Self assessment against 2022 Must Do's • Self assessment against Well Led quality indicators Level 2 – Management team and committee scrutiny • QAC /WAC review of CQC regulations • Level 3 – External assurances • GGI review • Globis Culture Audit	Full review of well-led quality indicators to indentify gaps	Plan in development for full review of well led	Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	3	**15**			**0**			**0**			**0**			**0**	4	1	**4**

RISK 5	**Impact of the system capital allocation framework**	Date Risk Opened	Current Risk Score
Description	**If the capital planning and allocation system does not enable full use of our charitable and commercial reserves there is a risk that we may not be able to fund our capital and asset replacement programmes leading to delays, cancellations or reprioritising of planned projects and equipment not being replaced when needed.**	Apr-24 Date of Last Review Apr-24	**20**
Associated Corporate Objectives	To promote equality, diversity & sustainability through our system leadership for cancer care	Executive Lead Responsible Committee Assurance Level Risk Appetite	Exec Director of Finance **Board of Directors** Eager

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	Alternative proposals put forward by GM ICB indicate allocation options linked to existing or nationally calculated depreciation. Participation at local and national level (NHSE / GM ICB) to influence allocation. Development of mitigating financial strategies. Identification & implementation of new models of working.	National / local funding rules / arrangements. Cap on CDEL	Level 1 – Data and management reports • Monthly finance reports Level 2 – Management team and committee scrutiny • summary of progress with capital plan/strategy implementation at Board / Planning Days • Regular reporting to Senior Management Committee & Board of Directors Level 3 – External assurances •	None identified		Year End	Year End

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

RISK 6	**Insufficient contractual support for networked cancer care provision**	Date Risk Opened	Current Risk Score
Description	**If the GM system does not continue to support local provision of cancer care with contractual and funding flow changes there is a risk that we are unable to devolve more systemic therapy, clinical trials and radiotherapy treatments to local communities leading to persistence or increases in inequalities in provision to economically deprived and ethnically diverse communities.**	Apr-24 Date of Last Review Apr-24	**9**
Associated Corporate Objectives	To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey. To promote equality, diversity & sustainability through our system leadership for cancer care	Executive Lead Responsible Committee Assurance Level Risk Appetite	Chief Operating Officer **Quality Assurance Committee** Cautious

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	Participating in GM ICS meetings. Work with GM Cancer Alliance and pathway leads across the system. Exec attendance at system meetings. Working with GM / Cheshire Trusts to develop pathways	GM ICB decisions on funding	Level 1 – Data and management reports • GM Cancer Board • Level 2 – Management team and committee scrutiny • Reports to Senior Management Committee & Board of Directors Level 3 – External assurances • MIAA	None identified		Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	3	**12**			**0**			**0**			**0**			**0**	3	2	**6**

RISK 7	Ineffective GM system-wide cancer pathways	Date Risk Opened	Current Risk Score
Description	**If diagnostic, MDT and referral processes at local hospitals across the GM system are not efficient there is a risk that we receive patients on 62-day pathways late leading to them not being treated within 62 days.**	Apr-24 Date of Last Review Apr-24	**15**
Associated Corporate Objectives	To promote equality, diversity & sustainability through our system leadership for cancer care To maintain excellent operational, quality and financial performance.	Executive Lead Responsible Committee Assurance Level Risk Appetite	Chief Operating Officer **Quality Assurance Committee** Cautious

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	Executive led monthly divisional performance review meetings. Integrated performance & quality report to Management Board and Board of Directors monthly. Weekl;y performance reporting via trust operational group. Escalation internally & across GM of delays impacting waiting time targets. Monitoring cancer waiting time standards through GM Cancer & IPR.	Impact of ongoing Industrial Action leading to delays in referrals	Level 1 – Data and management reports • repors to Senior Management Committee and Board□ •□ Level 2 – Management team and committee scrutiny • 6 monthly review by QAC□ •□ Level 3 – External assurances • MIAA review of 62 days / Cancer Alliance□ •□	None identified		Year End	Year End

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

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

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	What we have in place to prevent the risk materialising (reduce likelihood): Sustainable Development Management Plan (SDMP) - with aims to reduce system wide emissions within direct NHS control (NHS Carbon Footprint) by 80% by 2028-2032 What we have in place to reduce the impact of the risk if it materialises (reduce impact): Business Continuity Plan (BCP) - sections on extreme weather conditions	In development - Climate Change Adaptation Plan (CCAP) - adapt normal business processes to changed environment	Level 1 – Data and management reports •SDMP compliance •BCP compliance and effectiveness Level 2 – Management team and committee scrutiny •Quarterly Net Zero and Climate Adaptation Committee (NZACAC) advises Executive Director •Annual SDMP report to MB and BoD (Assurance Scrutiny by Quality Assurance Committee) •Statutory disclosures in Trust Annual Report •Regular briefing of governors through DSC Level 3 – External assurances •Internal audit of compliance with NHS requirements •NHSE review of plans and progress	None identified	•Developing methodology to assess carbon footprint in collaboration with other Trusts •Developing a CC •Annual Report - Check what audit scrutiny this receives	Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	4	**16**			**0**			**0**			**0**			**0**	4	1	**4**

RISK 9	Industrial action	Date Risk Opened	Current Risk Score
Description	**If there is ongoing industrial action, there is a risk of business disruption leading to delayed or cancelled care**	Apr-24 Date of Last Review Apr-24	**15**
Associated Corporate Objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey. To be an international leader in professional and public cancer education.	Executive Lead Responsible Committee Assurance Level Risk Appetite	Chief Operating Officer **Workforce Assurance Committee** Cautious

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	Close working with unions. Business continuity plans in place. Planning meetings in place around strike acton and incident management approach used. Management of demand. Risk assessments undertaken.	Impact of ongoing Industrial action	Level 1 – Data and management reports • Review of incidents from periods of action□ • BCP compliance & effectiveness□ Level 2 – Management team and committee scrutiny • Reports to Senior Management Committee□ •□ Level 3 – External assurances • External reporting on impact to ICB□ •	None identified	Detailed planning of patient demand and catch up. Staff cover planned. Liaision with unions and national team	Year End	Year End

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

RISK 10	**Financial balance**	Date Risk Opened	Current Risk Score
Description	**If we do not achieve the planned activity levels and our target efficiency savings there is a risk that we won't achieve financial balance leading to us having to repay the difference to our agreed plan in the following year**	Apr-24 Date of Last Review Apr-24	**12**
Associated Corporate Objectives	To maintain excellent operational, quality and financial performance.	Executive Lead	Exec Director of Finance
		Responsible Committee	**Audit Committee**
		Assurance Level	
		Risk Appetite	Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	Review additional resource requested from Divisions to identify further potential mitigations to close financial gap and achieve break even. 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	Commissioning intentions. Funding growth	Level 1 – Data and management reports • Monthly Divisional scrutiny of financial position • Level 2 – Management team and committee scrutiny • Reports to Senior Management Committee, Audit Committee and Board of Directors • Level 3 – External assurances • MIAA review of financial systems • External audit of Annual Accounts	None identified		Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	3	5	**15**			**0**			**0**			**0**			**0**	2	1	**2**

RISK 11	**Cyber attack**	Date Risk Opened	Current Risk Score
Description	**If we are subjected to a cyber-attack there is a risk of loss of data and operational disruption leading to patient care being delayed or cancelled**	Apr-24 Date of Last Review Apr-24	**12**
Associated Corporate Objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey. To be an international leader in professional and public cancer education.	Executive Lead	Deputy Chief Executive
		Responsible Committee	**Audit Committee**
		Assurance Level	
		Risk Appetite	Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	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 23/24	The Trust does not currently have cyber security insurance.	Level 1 – Data and management reports • Regular updates from NHS Digital - Vulnerability Monitoring Service • Level 2 – Management team and committee scrutiny • Reports to Senior Management Comittee and Audit Committee • Level 3 – External assurances •Cyber Essentials + accreditation July 2023 • MIAA undertaking Data Protection Toolkit assessment (DPST)	None identified		Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	5	**25**			**0**			**0**			**0**			**0**	2	2	**4**

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

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	Plan developed through extensive engagement with staff following production of Globis Culture Audit and approved by Board. Board responsibilities outlined. Work commenced to implement agreed actions and continue to communicate with staff	None identified	Level 1 – Data and management reports • Culture oversight group • Divisional action plans from staff survey Level 2 – Management team and committee scrutiny • Reporting to Workforce Committee, Workforce AssuranceCommittee and Board of Directors Level 3 – External assurances • Globis culture audit • Annual CQC Staff Survey 2023	None identified		Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	4	**16**			**0**			**0**			**0**			**0**	1	2	**2**

RISK 13	**Insufficient data on patient protected characteristics**	Date Risk Opened	Current Risk Score
Description	**If we are unable to capture data on the protected characteristics of our patients there is a risk we will be unable to assess any inequalities in access, experience or outcomes leading to lack of focus in addressing health inequalities**	Apr-24 Date of Last Review Apr-24	**8**
Associated Corporate Objectives	To be an excellent place to work and attract the best staff	Executive Lead	Exec Medical Director
		Responsible Committee	**Workforce Assurance Committee**
		Assurance Level	
		Risk Appetite	Cautious

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	Collation of existing data into a report for publication on the website. Areas of poor data quality identified and group established to identify actions to improve	Lack of data from national spine	Level 1 – Data and management reports • published data • review by Exec Team monthly Level 2 – Management team and committee scrutiny • Integrated Performance report to Senior Management Committee and Board of Directors • Level 3 – External assurances • Submissions to NHSE •	None identified		Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	2	**10**			**0**			**0**			**0**			**0**	2	2	**4**

RISK 14	**Legal and statutory compliance**	Date Risk Opened	Current Risk Score
Description	**If we do not maintain an awareness of and respond to changing statutory and legal requirements there is a risk that we will fail to comply leading to being sanctioned for being in regulatory or statutory breach.**	Apr-24 Date of Last Review Apr-24	**8**
Associated Corporate Objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey. To be an international leader in professional and public cancer education. To integrate our clinical, research and educational activities as an internationally recognised and leading comprehensive cancer centre	Executive Lead	Exec Director of Finance
		Responsible Committee	**Audit Committee**
		Assurance Level	
		Risk Appetite	Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	Engagement in national updates and regulatory briefings. Membership of NHS Providers. Exec Team engagement in national briefings. Close working with regulators, GM ICS and NHSE	None identified	Level 1 – Data and management reports • Regular reports to Executive Team • Monthly IPQFR Level 2 – Management team and committee scrutiny • Board self-assessments April 2024 • Board reporting on regulatory changes Level 3 – External assurances • CQC Inspection Reports (IR(M)ER) • SOF Rating 2	None identified		Year End	Year End

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

NHS
The Christie
NHS Foundation Trust

Agenda item 16/24b

Meeting of the Board of Directors
Thursday 25th April 2024

Subject / Title	Modern Slavery statement 2024/25
Author(s)	Executive Directors
Presented by	Roger Spencer, Chief Executive
Summary / purpose of paper	The Modern Slavery Act 2015 (the Act) establishes a duty for commercial organisations to prepare an annual slavery and human trafficking statement. This is a statement of the steps the organisation has/is taking to ensure that slavery and human trafficking is not taking place in any of its supply chains or in any part of its own business. Part of the requirement of the Act is to produce a statement that is approved by the board and published on the website. Christie contracts include specific clauses relating to the Act and when undertaking formal procurement exercises, we include an assessment where bidder responses are assessed on a PASS/FAIL basis. Assurance around our procurement arrangements are reviewed by our internal auditors and reported to Audit Committee. This was last undertaken in 2023 with a particular focus on commercial partnerships. The updated statement for 2024/25 is appended to this report for approval. Following Board approval, the statement will be published on the trust website.
Recommendation(s)	The Board are asked to approve the updated Modern Slavery statement for 2024/25. Following Board approval, the statement will be published on the trust website.
Background Papers	https://www.gov.uk/government/collections/modern-slavery-bill NHS Terms and Conditions clauses 10.1.16 and 10.1.17
Risk Score	2/3 (6)
EDI impact / considerations	Adherence to the Act ensures that The Trust is ensuring there is no modern slavery or human trafficking in any part of our business and in so far as is possible we require our suppliers to hold a similar ethos.
Link to: ➢ Trust's Strategic Direction ➢ Corporate Objectives	To promote equality, diversity & sustainability through our system leadership for cancer care To be an excellent place to work and attract the best staff To integrate our clinical, research and educational activities as an internationally recognised and leading comprehensive cancer centre
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	

The Christie
NHS Foundation Trust

SLAVERY AND HUMAN TRAFFICKING STATEMENT

Introduction from the Board
We are committed to improving our practices to combat slavery and human trafficking.

Organisations Structure
The Christie is a specialist cancer centre serving a population of 3.2 million across Greater Manchester and Cheshire. We are an NHS Foundation Trust with approximately 3,700 employees and an annual turnover of approximately £429m.

Our business
We are a specialist cancer centre and we treat approximately 60,000 patients a year. We are a world pioneer in the care, treatment and research of cancer. We operate out of our main site in Withington, South Manchester and have radiotherapy centres at Salford, Oldham and Macclesfield as well as chemotherapy and outpatient services at sites across 14 other sites in Greater Manchester and Cheshire. We also provide chemotherapy service and treatment in patients' homes.

Our policies on slavery and human trafficking
We are committed to ensuring that there is no modern slavery or human trafficking in any part of our business and in so far as is possible we require our suppliers to hold a similar ethos.

The Christie NHS Foundation Trusts' guidance on Modern Slavery is to:

- Comply with legislation and regulatory requirements
- Make suppliers and service providers aware that we promote the requirements of the legislation
- Consider modern slavery factors when making procurement decisions
- Develop awareness of modern slavery issues

We will:

- Aim to include modern slavery conditions or criteria in specification and tender documents wherever possible,
- Evaluate specifications and tenders with appropriate weight given to modern slavery points,
- Encourage suppliers and contractors to take their own action and understand their obligations to the requirements.

Trust staff must:

- Contact and work with the Procurement department when looking to work with new suppliers so appropriate checks can be undertaken.

Procurement staff will:

- Undertake awareness training where possible.
- Aim to check and draft specifications to include a commitment from suppliers to support the requirements of the Act.
- Will not award contracts where suppliers do not demonstrate their commitment to ensuring that slavery and human trafficking are not taking place in their own business or supply chains.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ending 31 March 2025.

SIGNATURE:

POSITION: Chief Executive Officer, The Christie NHS Foundation Trust
DATE: 25th April 2024

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Agenda Item 16/24c

Board of Directors

Thursday 25th April 2024

Subject / Title	Reports from Board Committees
Author(s)	Committee secretaries
Presented by	Committee Chairs
Summary / purpose of paper	For the board to note the discussions held at the following meetings: • Quality Assurance Committee draft minutes March 2024
Recommendation(s)	To note
Background papers	Full papers from the Quality Assurance, Audit and Workforce Assurance Committees
Risk score	See Board Assurance Framework Corporate Objective 1 - 7
Link to: ➢ Trust strategy ➢ 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.	

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DRAFT

Meeting of the Quality Assurance Committee
Thursday 21st March 2024 at 1.00pm
Education Centre Seminar Room 4/5 and MS Teams
Minutes

Present

Chair:	Kieran Walshe (KW) Chair	Non-Executive Director
Members:	Alveena Malik (AM)	Non-Executive Director
	Tarun Kapur (TK)	Non-Executive Director
In attendance:	Theresa Plaiter (TP)	Interim Chief Nurse & Executive Director of Quality
	Eve Lightfoot (EL)	Director of Workforce
	Louise Westcott (LW)	Company Secretary
	Phil Higham (PH)	Patient Experience & Improvement Lead
	Ben Vickers (BV)	Patient Safety Specialist & Head of Risk
	Zoe Gale (ZG)	CQC Project Lead
	Joanne Woolley (JW)	Clinical Audit Manager
	James Fortune-Clubb (JFC)	Health and Safety Manager
	Matt Bilney (MB)	Associate Chief Nurse
	Vidya Kasipandian (VK)	Associate Medical Director
	Linda Allen (LA)	Lead Safeguarding Nurse
Minutes:	Jo D'Arcy (JD)	Assistant Company Secretary

Agenda item		**Action**
09/24	**Standard Business**	
a	**Apologies for absence**	
	Neil Bayman, Diana Tait, Simon Davies	
b	**Declarations of interest**	
	None declared	
c	**Minutes of the last meeting**	
	The minutes of the last meeting held on Thursday 18th January 2024 were accepted as a correct record.	
d	**Rolling programme, action log and matters arising**	
	• **Rolling programme** – all items on the agenda with the exception of the Health and Safety annual report to come to the June meeting following presentation to the Health and Safety Committee for approval. • **Action Log** – reference to action for agenda item 2/24g, TP confirmed following review at the service and operational reviews, the risk score has been reduced to a 12 due to the mitigation in place and the recruitment in progress to Band 3 & 5 posts.	
e	**Board assurance framework (BAF)**	
	LW noted to the Committee that the extract of the BAF presented details the relevant risks to the Committee. The cover paper highlights the changes to risk scores since the BAF was last seen by the Committee. Nothing to bring to the Committee's attention. Committee **noted** and **accepted** the BAF.	
f	**Committee Terms of Reference (ToR)**	

	LW confirmed the ToR has been reviewed following the GGI recommendations, there may be some further amendments following review at the Committee Chairs & Exec Leads meeting in April. Updates have been made in line with compliance monitoring of regulations undertaken by the Committee. Need to look at strengthening the wording around research governance. **Actions:** • ToR and internal audit plan to be added to the agenda for discussion at the Committee Chairs & Exec Leads meeting in April. • Assurance Committee ToRs to be sent to all Non-Executive Directors. **Approved**	**JD** **JD**
10/24	**Assurance**	
a	**Safeguarding Vulnerable People Annual Report**	
	LA presented the report to the Committee noting the following key points: • Report covers safeguarding activity from 1st Jan to 31st Dec 2023. • Positive position in relation to training compliance, all areas of safeguarding training are above the Trust target compliance rate of 80%. • Team structure outlined, team have trained approximately 1200 staff since March 2023, training well received by staff and received good feedback. Training required to be completed every 3 years so number of sessions reduced for now. • Overview of the achievements were summarised and covered the NHSE & NHSI - Learning Disability Standards Review, Oliver McGowan e-learning, Safeguarding adults Level 3 training – A Whole Family Approach and Safeguarding Newsletters. Feedback on training in most cases was better or the same level as other organisations, 100% across the board from patients. • Oliver McGowan eLearning became mandatory from March 2023, Trust is at 86% compliance. Looking at options for part 2 of the training. • Safeguarding newsletters are produced monthly and are based on hot topics at the time, both locally and nationally. Sent to all clinical areas. • In the plan for last year, the team planned to roll out Safeguarding Supervision and Safeguarding Link Workers, only a small team and currently carrying a vacancy so not being able to progress but this is currently in the process of being arranged. • Future aspirations – capacity training for all staff to be made mandatory to enhance knowledge. It should be a person who knows the patient best doing the training and capacity assessments. Working with the Digital team on a web form for recording DoLS requirements. To also look at adding in audits around capacity, DoLS and chaperones and look at how best to influence any changes. The Committee discussion led to: • NEDs confirming informative visit to the department ahead of the meeting. • Confirmation that refresher training is in place and the requirement is for this to be done every 3 years, compliance is monitored through ESR. • AM offered to send details to team on safer recruitment (new legislation) for consideration as part of safeguarding which goes beyond DBS checks. • Volunteers are required to undertake a DBS check and completed training, this used to be face-to-face but has been online since Covid, will consider a move back to face-to-face. • Committee discussion led to high assurance being agreed. **Noted** **Assurance level agreed (CQC Regulation 13): High** LA left the meeting.	

b	**Patient Safety Quarterly Report October - December 2023**	
	BV presented the report to the Committee noting the following key points: • Dip in incident reporting due to the Christmas period falling during reporting period. • Slight increase in safety incidents. 1 SI panel. All patient safety alerts acted on in required timeframe. • Seeing a higher number of incidents being reduced in severity following review via the PSIG triage process. • Duty of Candour statutory duty compliance currently stands at 62%. • Administration remains the highest incident rate, the majority of which relates to medicines. • 1 SI in the quarter relating to a surgical complication. • SI Panel held in the quarter, details are in the report. This case is going to an inquest in May. The post mortem has taken place, the outcome has been challenged by the family and the inquest re-opened by the coroner. • Patients falls and pressure ulcers below national average. • Mortality report data compliant for the quarter. The Committee discussion led to: • Duty of Candour statutory duty compliance, this figure fluctuates. There is no timeframe within the statute but need to monitor as an organisation. 40% represents around 12 cases. Each case is different and all cases are looked at ERG and RQGC. Small numbers have a big impact on the percentage compliance. There is also a need to be sensitive to a patient or relative's needs, the timing of the discussion needs to be right. Sometimes the outcome of the investigation is that no harm was caused. • Good engagement and learning from the teams on managing pressure ulcers. • Committee discussion led to high assurance being agreed. **Noted** **Assurance level agreed (BAF risk 1.1, 1.3, 1.5, CQC Regulation 12, 20): High**	
c	**Patient Experience & Clinical Effectiveness Quarterly Report October - December 2023**	
	PH presented the report to the Committee noting the following key points: • 44 complaints in quarter, quite high for the Trust. Had a lot of complaints remaining open so were taking longer to respond, a lot of effort on working to reduce this with the divisions, now returned to normal limits and continuing to monitor. Daily meetings with divisions and forms part of ERG to raise any concerns on open complaints. • PHSO feedback – monitored monthly. No further contacts since the last peak in cases, 4 cases formally open with PHSO and 1 at assessment stage, no feedback since the last meeting. • Friends and family test feedback remains positive at 96%. • JW covered the clinical effectiveness part of report; short staffed for over a year and sadly lost a team member due to ill health. In the process of recruiting, this has impacted greatly on the team. In a good position in relation to the number of reports completed, also a high level of reports closed down but not completed. Capacity to undertake follow ups is currently reduced. The Committee discussion led to: • JW has taken early retirement and is working part time, another team member also working one day less a week so this has also reduced the capacity within the team. Recruitment is challenging but gives the opportunity to look at things differently. PH thanked JW and the team for their hard work given the circumstances.	

	• Committee discussion led to high assurance being agreed. **Noted** **Assurance level agreed (BAF risk 1.4, CQC Regulation 9, 10, 12, 16): High**	
d	**Health and Safety Quarterly Report July - September 2023**	
	JFC presented the report to the Committee noting the following key points: • Large part of the report has been re-formatted with the intention to be fully formatted by the next report. Data now presented over a longer period of time, vast majority within stipulated limits, exceptions noted as moving and handling and verbal and physical abuse which was due to a peak in instances with explanations within the report. • Need to consider if as a Trust willing to accept the associated instances. The Committee discussion led to: • If stayed within limits, doesn't show improvement. The limits should not be seen as targets and want to see improvement. Challenging in terms of improvements as numbers are very low. Need to be clear that there is learning from the incidents. • Changes to the report will help to assess the data and move forward. Through the Health & Safety Committee, staff inoculation incidents are looked at and there is active work with occupational health and the ICPC Team, will evolve as the report format progresses. Staff injuries also go through ERG. • Health & Safety Executive (HSE) inspections and interventions are done proactively on different themes, HSE wrote to all NHS trusts a year ago on topics of focus that they will look at if a visit takes place. Topics discussed at Health & Safety Committee and work done through Task and Finish Group. HSE current programme of work ends next month. • Committee discussion led to high assurance being agreed. **Noted** **Assurance level agreed (BAF risk 7.3, CQC Regulation 15): High** JFC left the meeting.	
11/24	**Governance**	
a	**Briefing from the Risk and Quality Governance Committee**	
	TP presented the briefing to the Committee confirming that the slide provided summarises the January and February minutes which are also provided in the papers: • 1 risk at 25 and 1 at 20, specifically around finance and SP presenting later on the agenda around this. • No escalations from sub committees and approvals went through as planned. • Lost to follow up risk reduced to 12. **Noted**	
b	**Audit Recommendation Tracker Report**	
	TP provided an update on the recommendations: • Risk management strategy – number of actions from previous audit, most are complete with some superseded as working on new risk model for Datix. Overview of outstanding actions provided. • Complaints – ties in with work on Datix, all actions are on track. Looking at how complaints training can be improved and the wider learning and learning from good practice. **Noted**	

c	**Annual Quality Improvement and Clinical Audit plan 2024/25**	
	JW presented the plan to the Committee noting the following key points: • Main opportunities for this year – should be able to use PSIRF and NHS impact as drivers for quality improvement work. • Work to identify audits that are national priorities. QI projects also required nationally and core audit programme. • National surveys as required. • Rest of programme - non-core and based on local risks, patient involvement and service priorities. Number of projects around service outcomes, these are used to present at conferences by clinicians. • Structured data has increased the strength of the relationship with the clinical data outcome team and managing governance around access to data. The Committee discussion led to: • Impressive, full programme. • Some look more research based rather than improvement, triage meetings take place where R&I, analytics, IG and clinicians attend, can be some challenge. • Service evaluation projects to be looked at to see if can reduce the amount of follow up to allow time to focus on other projects. **Noted**	
d	**Quality Assurance Committee - Effectiveness Review Outcome Report**	
	KW opened out for comment to the Committee: • Priorities noted as good for the Committee as well as the work between the Committees. • Time management for the Committee meetings is improving. • Challenges noted as appropriate by the Committee. • Governors have been invited to attend meetings. • Attendance by other staff discussed, welcomed for those to be invited to observe to familiarise with the work of the Committee. • Medical leaders who Chair sub Committees and those who express interest in leadership also welcomed. • Wellbeing of staff is important, need to think about the impact of decisions that involve more work. **Noted**	
e	**Quality Assurance Committee – Draft Annual Report**	
	• LW informed the Committee that the report is a statutory requirement and required to be approved at the joint assurance committee in June. • No amendments identified, report to go to the joint assurance committee for approval in June. **Approved**	
f	**Capital risk update – risk 3628 2024/25 restricted capital envelope**	
	SP presented the update to the Committee noting the following key points: • The risk relates to the ability to spend capital. • Content and risk description described: o GM ICB delegated capital spend limit ('CDEL'). o each provider within the system allocated CDEL. o total initial GM 24/25 capital bids = £430m, CDEL limit = £157m. o GM prioritisation of capital schemes led by the ICB.	

	○ Christie's capital requirements are being compared to other GM capital projects. ○ RISK: Christie may not be allocated sufficient CDEL to replace key items. of equipment which will impact on our ability to deliver patient care. • CDEL is permission to spend regardless as to whether you have the money. • Mitigations: ○ Divisional capital bids indicated risk, impact on patient care and activity should the bid not be approved. ○ Exec review of all bids before submission to GM. ○ DoF & COO representation at GM capital meetings. ○ lobbying for specialist Trusts providing national services. ○ Additional £6m CDEL secured in 23/24; future essential spend b/f to reduce the risk in subsequent years. ○ Regional / national negotiations for additional CDEL for the Trust. • All schemes have been reviewed. • Unable to confirm how much CDEL the Trust will get allocated. • Risk score is 25, will look to refine based on likelihood but currently out of Trust control, working to mitigate. • Latest position – March planning submission made; £126m over limit. • Trust currently assuming £20.6m but subject to review - likely to reduce. • Trust strategy wouldn't usually allow a risk of 25 to remain as a risk so presented to the Committee to explain the current position and potential impact on patient care. • Main elements for the Trust are the finishing of TIF ward and replacement Linac programme. **Noted**	
12/24	**For information**	
a	**Learning for Improvement Bulletin**	
	Provided for information.	
13/24	**Non-Executive Director feedback from department visit**	
	NEDs visited Safeguarding team prior to the meeting, work of department covered as part of agenda item 10/24a. BV noted for next meeting would like to invite NEDs to visit Q&S Team to discuss work on PSIRF following go-live. **Agreed** **Noted**	
14/24	**Escalations to the Board of Directors**	
	No items identified as requiring escalation to the Board of Directors.	
15/24	**Reflections of the meeting**	
	No comments raised.	
16/24	**Any other business**	
	Noted as TP's last meeting as interim Chief Nurse new Chief Nurse and Executive Director of Quality commences in post in May.	
	Date and time of next meeting: Thursday 13th June 2024, 1pm	

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Agenda item 16/24d

Meeting of the Board of Directors

Thursday 28th March 2024

Subject / Title	Framework for Board & Committee allocation
Author(s)	Louise Westcott, Company Secretary
Presented by	Roger Spencer, Chief Executive
Summary / purpose of paper	This paper describes the allocation of items that the Board are required to review in terms of strategy, performance and compliance and where that activity will take place. This responds to actions identified in the GGI review that were approved by Board in March 2024.
Recommendation(s)	The Board are asked to approve the allocation as described in the framework at appendix 1.
Background Papers	10/24a GGI assurance review action plan Good Governance Improvement – The Christie NHS FT, Enhancing Board Assurance January 2024
Risk Score	See Board Assurance Framework
EDI impact / considerations	Ensure governance arrangements provide assurance and appropriate oversight of EDI requirements for the organisation
Link to: ➢ Trust's Strategic Direction ➢ Corporate Objectives	Achievement of corporate plan and objectives
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	GGI Good Governance Improvement LLP EDI Equality, Diversity, Inclusion QAC Quality Assurance Committee WAC Workforce Assurance Committee TCP The Christie Pharmacy

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Agenda item 16/24d

Board of Directors meeting

Thursday 25th April

Framework for Board / Committee allocation

1 Introduction

At the March 2024 Board of Directors meeting, the Board approved an action plan responding to recommendations made in the GGI governance review 2023 as well as additional actions agreed by the Chair and Executive Directors. This paper outlines the response to certain of these actions and suggests where oversight of key items is reviewed in a framework. A draft of an amended scorecard for Board is also attached.

The actions included;

- Review the Terms of Reference of the assurance committees – Audit, Quality and Workforce
- Review the board's programme of business to ensure an appropriate balance towards strategic items

An additional action was agreed as follows;

- Responsibility for overall strategy and supporting strategies (Quality, finance, digital, workforce, EDI, sustainability, research, education, etc.) to remain with the board with committees seeking assurance on delivery.

2 Background

The Board has allocated oversight for the full range of its responsibilities to one of its assurance committees (Audit, Quality, Workforce) or retained oversight at the full Board. In line with the actions outlined above and as good practice, the allocation of items on the rolling programmes of the Board and its committees has been reviewed. This has been done alongside the review of the Terms of Reference of the assurance committees. This has informed the production of a Board allocation framework (appendix 1).

3 Allocation of key items

Attached at appendix 1 is a summary of the key items that require Board oversight in relation to strategy, performance and assurance. The list of key items describes broad topics and is not exhaustive. For each item the framework indicates where strategy / performance and compliance will be reviewed.

4 Scorecard 2024/25

From month 1 we will be adapting the existing scorecard that is presented in the Integrated Performance, Quality & Finance Report and including it in the Trust Report. This will support the Boards review of many of the items identified. A draft of the adapted scorecard is attached at appendix 2.

5 Recommendation

The Board are asked to approve the allocation as described in the attached Framework (appendix 1) and note the draft scorecard (appendix 2).

Appendix 1

Board Allocation Framework

Item	Strategy	Scorecard	Performance	Compliance	Risk
Patient		Board			Board and specific allocation to Audit / QAC / WAC
Outcomes	Board		Board/QAC	QAC	
Experience	Board		Board	QAC	
Safety	Board		QAC	QAC	
System					
Health Inequalities	Board		Board	QAC	
System working	Board		Board	n/a	
Development					
Projects	Board		Board	Project Board	
Commercial partnerships	Board		Board	Audit (TCP)	
Finances					
Revenue	Board		Board	Audit	
Productivity	Board		Board	Audit	
Capital	Board		Board	Audit	
Culture					
Staff survey	Board		Board/WAC	n/a	
People & Culture Plan	Board		WAC	WAC	
EDI plan	Board		WAC	WAC	
Freedom to Speak Up	Board		WAC	WAC	
Strategy	Board		Board	n/a	
Research	Board		Board	QAC	
Education	Board		Board	WAC	
Digital	Board		Board/Audit	Audit	
Sustainability	Board		Board	QAC	

Key:
TCP – The Christie Pharmacy
WAC – Workforce Assurance Committee
QAC – Quality Assurance Committee
EDI – Equality, Diversity, Inclusion

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Appendix 2

Draft Scorecard 2024/25

Board Scorecard 2024/25

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Source	Corporate objective	Indicators	Frequency	Metric	Threshold / Standard	Tolerances			Current month	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year End cumulative position
Strategy Implementation																						
CJH/JW		Proportion of projects for current year on planned timescale	M	%																		
Performance and Quality of Care																						
NHSE PF	1,6	Total patients waiting more than 52, 78 and 104 weeks to start consultant-led treatment	M	N																		
NHSE PF	1,6	Total elective activity undertaken compared with 2019/20 baseline	M	%																		
NHSE PF	1,6	Total patients waiting over 62 days to begin cancer treatment compared with baseline	M	%																		
NHSE PF	1,6	Proportion of patients meeting the faster cancer diagnosis standard	M	%																		
NHSE PF	1,6	Total patients treated for cancer compared with the same point in 2019/20	M	%																		
NHSE PF	1,6	Outpatient follow-up activity levels compared with 2019/20 baseline	M	%																		
NHSE PF	1,6	National Patient Safety Alerts not completed by deadline	M	N																		
NHSE PF	1,6	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	M	N																		
NHSE PF	1,6	Clostridium difficile infection rate	M	N																		
NHSE PF	1,6	E. coli bloodstream infection rate	M	N																		
Local	5,8	Proportion of records with ethnicity (and other characteristics) recorded	M	%																		
Local	5,8	Proportion of 62 breaches in non-white ethnic groups	M	%																		
Local	5,8	Proportion of 62 breaches by referring hospital	M	%																		
Finance and Use of Resources																						
NHSE PF	6	Financial efficiency - variance from efficiency plan	M	(£'000)																		
NHSE PF	6	Financial stability - variance from break -even standard	M	(£'000)																		
Finance Team	6	Balance sheet sustainability - capital service cover	M	Times		2.5	1.75	1.25														
Finance Team	6	Liquidity - liquidity	M	Days		0	-7	-14														
Finance Team	6	Agency Spend as % of budget	M	%		0%	25%	50%														
Finance Team	6	Overall financial position variance (underspend/overspend against plan - NHSI Control Total)	M	%		<0%	<0 to 3%	>3%														
Finance Team	6	Underperformance against CIP target - full year impact - Full year (M11 target)	M	%		<4%	>4 to 12%	>12%														
Finance Team	6	Underperformance against CIP target - full year impact - Recurrent (M11 target)	M	%		<4%	>4 to 12%	>12%														
Finance Team	6	Exchequer Capital Spend to Date	M	(£'000)																		
Finance Team	6	Current cash balance to Date	M	(£'000)																		
Finance Team	6	Average length of time debt is outstanding	M	Days		<15	>16 to 20	>20														
Finance Team	6	Trade creditors paid cumatively within 30 days	M	%		>95%	90-94%	<90%														
Finance Team	6	Trade creditors paid cumatively within 10 days	M	%		>80%	65-80%	<65%														
People and Culture																						
CJH	7	Proportion of staff survey questions in the top quartile	A	%																		
Workforce Team	7	Sickness absence rate	M	%																		
Workforce Team	7	PDR	M	%																		
Workforce Team	7	Mandatory training	M	%																		
Workforce Team	7	Agency spend against budget	M	%																		
Workforce Team	7	Voluntary turnover	M	%																		
Workforce Team	7	Engagement score	M	%																		
Workforce Team	7	Morale score	M	Score																		

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Agenda item 16/24e

Meeting of the Board of Directors
Thursday 25th April 2023

Subject / Title	NHS Improvement self-certification declarations
Author(s)	Company Secretary
Presented by	Chief Executive
Summary / purpose of paper	NHS foundations trusts are required to undertake the following self-certification declarations: • G6 (systems for compliance with licence conditions) & CoS7 (continuity of service – availability of resources) • FT4 (corporate governance statement) • Training of governors
Recommendation(s)	To approve the declarations
Background papers	NHS Improvement's annual plan review
Risk score	BAF risks under corporate objective 6
Link to: ➢ Trust strategy ➢ Corporate objectives	Strategic objective 6. To maintain excellent operational, quality and financial performance
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.	CoS continuity of service

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Agenda item 16/24e

Meeting of the Board of Directors
Thursday 25th April 2022

NHS Improvement self-certification declarations

1. Introduction

NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services and have complied with governance requirements.

Providers therefore need to self-certify the following after the financial year end:

NHS provider licence condition

- The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6)
- If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service (Condition CoS7)
- The provider has complied with required governance arrangements (Condition FT4)
- Governor training

The aim of self-certification is for providers to carry out assurance that they comply with the conditions.

We are no longer required to return our completed provider licence self-certifications or templates to NHS England. NHS England will contact a select number of NHS foundation trusts to ask for evidence that they have self-certified. This can either be through providing the completed templates or relevant board minutes and papers recording sign-off.

2. Recommendation

The board is asked to note and approve the self-certifications for:

- G6 systems for compliance with licence conditions and CoS7 (continuity of service) – availability of resources (appendix 1)
- FT4 corporate governance statement (appendix 2)
- Governor training (appendix 3)

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates **2023/24** Please complete the explanatory information in cell E36

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Confirmed OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

Confirmed Please fill details in cell E22

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

Confirmed Please fill details in cell E22

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Confirmed Please fill details in cell E22

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

We have achieved a Single Oversight Framework rating of 2 for finance and use of resources (reduced from 1 due to CQC rating - action plan now complete) and achieved our NHSE control total

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Roger Spencer	**Name**	Edward Astle
Capacity	Chief Executive	**Capacity**	Chair
Date	25 April 2024	**Date**	25 April 2024

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

N/A

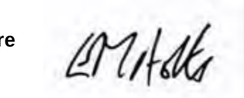
Worksheet "FT4 declaration" **Financial Year to which self-certification relates** **2023/24** P I

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	No material risks identified #
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS England from time to time	Confirmed	No material risks identified #
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	No material risks identified. There are a wide range of controls in place including the Scheme of Delegation and Standing Financial Instructions. There are clear terms of reference for all committes and we undertake an annual committee effectiveness review. All board members are subject to an annual appraisal (the NEDs and the CEO have appraisals led by the chairman, the chairman has an appraisal led by the senior independent NED and the executive directors have appraisals led by the chief executive). There is a clear organisational structure with clear reporting lines. MIAA have conducted their internal audits according to the agreed plan and recommendations agreed and being implemented. These have all been reviewed through the committee structure. In year we asked Good Governance Improvement to undertake a review of our governance and assurance arrangements and actions have been agreed and are being implemented to improve existing arrangements. #
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	There are a range of systems and/or processes in place which evidence the Trust's on-going compliance. The trust holds 8 board of directors meetings per year and receives a monthly Integrated Performance Report structured to reflect performance against key indicators. The trust also holds monthly meetings of its assurance committees (Quality Assurance, Workforce Assurance and Audit) in line with the trust's constitution. The board receives and approves the Annual Plan and receives regular updates from the Executive Director of Finance. The Board Assurance Framework is discussed at each meeting of the board and the assurance committees and has received a green rating from our internal auditors. Further assurance is gained via the external audit opinion, Internal Audit annual plan (approved by the Audit Committee) and the risk & quality governance committee meetings. The clinical divisions feed into monthly management board meetings, attended by senior clinicians and managers, which in turn feeds into the board of directors. In regard to the Single Oversight Framework our finance and use of resources score has again been rated as 2, the reduction from 1 relates to the CQC rating of Good. We have had confirmation that all actions from the must do's in the CQC report are now complete. The overall Head of Internal Audit opinion for the period 1st April 2023 to 31st March 2024 provides Substantial Assurance, that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently. #
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving	Confirmed	No material risks identified. There are a range of systems and/or processes in place which evidence the Trust's on-going complaince with this requirement, including the composition of the board of directors . The quality assurance committee reviews quality of care including approval of the annual clinical audit plan, learning from deaths, reports on patient safety and experience, health & safety and updates from the risk & quality governance committee. We have been rated as Good by the health regulator. Single Oversight Framework - we have been rated as 2 for all of the five themes of:• Quality of care• Finance and use of resources• Operational performance• Strategic change• Leadership and improvement capability (well-led) #
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	There are a range of controls in place to mitigate staffing risks. These include ward staffing reviews, e-rostering for all ward staff and a centralised bank for nursing posts. The board of directors receives a monthly safe staffing update via the integrated performance report. All Board members have been assessed and declared as Fit & Proper under the CQC Regulation 5. #

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature  **Signature** 

Name Roger Spencer **Name** Edward Astle

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A: N/A O

Worksheet "Training of governors" **Financial Year to which self-certification relates** 2023/24

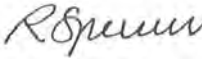
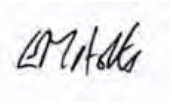
Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Roger Spencer	**Name**	Edward Astle
Capacity	Chief Executive	**Capacity**	Chairman
Date	25.04.2024	**Date**	25.04.2024

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

The Christie
NHS Foundation Trust

Agenda item 16/24f

Meeting of the Board of Directors
Thursday 25th April 2024

Subject / Title	Register of matters approved by the board – 1st April 2023 to 31st March 2024
Author(s)	Company secretary
Presented by	Chief Executive
Summary / purpose of paper	For the board of directors to note the matters approved by the board from 1st April 2023 to 31st March 2024
Recommendation(s)	For the board to note
Background Papers	Complete register from April 2007 (available to directors on request from the company secretary)
Risk Score	n/a
Link to: ➢ Trust's Strategic Direction ➢ Corporate Objectives	Corporate objective 6 - To maintain excellent operational, quality and financial performance
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.	SFI Standing Financial Instructions FT Foundation Trust GM Greater Manchester CQC care quality commission

The Christie
NHS Foundation Trust

Register of matters approved by the board of directors in public– 1st April 2023 to 31st March 2024

Item	Date of meeting	Agenda item	Subject	Remarks/ Follow up
255	27.04.2023	13/23a	Modern Slavery statement 2023/24	Approved
256	27.04.2023	14/23a	Corporate and Annual Objectives 2023/24 & risk appetite statement	Approved
257	25.05.2023	18/23c	Risk Management Strategy and Policy 2021-2024 annual review actions	Approved
258	25.05.2023	19/23a	NHS Provider License conditions: self-certification declarations	Approved
259	29.06.2023	24/23a	Annual report, financial statements, and quality accounts (incl Annual governance statement / Statement on code of governance)	Approved
260	29.06.2023	24/23b	Fit & Proper Persons Policy	Approved
261	28.09.2023	27/23e	Updated Fit & Proper Persons Test Policy	Approved
262	28.09.2023	29/23a	Standing Financial Instructions (SFIs)	Approved
263	28.09.2023	29/23b	Trust proposal of nomination of FT Trustee to Christie Charity Board – Edward Astle	Approved
264	30.11.2023	36/23b	CQC Action Plan	Approved
265	25.01.2024	03/24a	National Cost Collection 2023 Submission	Approved
266	25.01.2024	03/24b	Trust proposal of nomination of FT Trustee to Christie Charity Board – Dr Neil Bayman	Approved
267	28.03.2024	10/24c	Fit & Proper Persons Compliance report	Approved
268	28.03.2024	10/24e	Annual reporting cycle 2024/25	Approved

The Christie NHS Foundation Trust

EXECUTIVE SUMMARY

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

Safety

- No serious incidents were reported in March. There were 7 incidents in total reported in March which require a learning response. All 7 incidents were reported with the classification of moderate. Details of each incident 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 13.
- Safer staffing numbers have met the required acuity levels to ensure appropriate levels of safety and care for our patients. Indicative staffing, in line with nursing establishments, is set to maintain a 1:7 nurse to patient ratio. On occasion this has been extended to 1:8 which is in line with recommended national staffing ratios. While we have seen an increase in patient safety incidents, following thematic review, these were not related to nurse staffing ratios.
- There were 12 cases of C-Difficile, 3 cases of E-Coli and 2 cases of Klebsiella in March that were deemed attributable to the Trust. There were also 3 sperate outbreaks of Covid during February that effected 18 staff and 30 patients. Two lapses in care were identified in March following an RCA that were linked to a period of increased incidence of C-Diff on Ward 4.
- There were no outbreaks of nosocomial Covid-19 during March.

Performance

- In March the new combined 62-day performance subject to validation was at 74.5% which is above the new standard of 70% and a significant improvement on the February position. The new combined 31-day performance was 98.5% which is above the new standard of 96%. The internal 24-day performance is below standard and is at 71.84%. All 62 and 24-day breaches are reviewed to ensure any delays are understood and plans can be implemented to mitigate any future delays. Improvement plans are in place and performance is expected to improve before the end of the financial year. The Trust's RTT 18-week performance is well above standard at 98%. The Trust did not achieve the 75% faster diagnosis standard in March with a compliance score of 55%.
- There were 3 patients waiting over 52 weeks at the end of March. One patient was referred to us extremely late in the pathway and how now been treated. The two other long waits can be attributed to long periods of patient choice to delay the proposed treatment.
- Referral numbers in March decreased slightly from February. Overall referral levels in 23/24 were higher than 22/23 levels with a total of 8 months being above the 22/23 average.

HR

- Staff absence improved from February to a position of 4.21% against a target of 3.4%.
- PDR performance has decreased from February's position whilst mandatory training has improved. Mandatory training performance remains well above the set standard.

Finance

- At year-end The Trust is reporting a year end surplus of (£6,797k) against an annual plan of £8,038k, which gives a positive year end variance of (£14,835k).
- The in month position for month 12 is a surplus of (£1,513k) against a deficit in month plan of £670k which gives a positive in month variance of (£2,183k).
- Performance to month 12 was £2,590k above the original plan submitted to NHSE&I in April 23 but in line with the revised capital plan agreed with GM following the significant variations in approved capital budget sums the Trust has dealt with during 2023-24, which include an additional £5m increase to our plan following an additional transfer of capital envelope from Cheshire & Merseyside ICB.
- The Trust has incurred £33,179k on capital schemes to month 12, primarily on the backlog maintenance programme, the linear accelerators and CT scanner replacements, Digital Services Electronic Health Records projects, final works on the Paterson scheme, the Proton treatment planning system and the TIF ward refurbishment. This includes £278k capital expenditure on the charity funded Art Room refurbishment.

SUMMARY DASHBOARD

NHS
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Indicator	Threshold / Standard 23/24	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	New Standards	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	YTD
Serious Incident Reported	-	0	0	0	2	0	0		0	0	1	2	2	0	7
Never Events	0	0	0	0	0	0	0		0	0	0	0	0	0	0
Radiation Incidents Reported (IRMER Reportable)	0	2	1	0	0	0	0		0	0	0	1	2	1	7
Radiation Incidents Reported (IRMER Reportable - Grade 2 or above)	0	0	0	0	0	0	0		0	0	0	0	1	0	1
Number of Pressure Ulcers (Post admission - Grade 2 or above) - Rate per 1000 occupied bed days	0.5	0.2	0.4	0.2	0.2	0.8	0.6		0.2	0.2	0.4	0.4	0.2	0.4	0.4
Inpatient Falls Resulting in Harm (Grade 2 or above) - Rate per 1000 occupied bed days	3.8	2.6	4	4	0.9	2.9	4.4		9	2.6	4.7	2.5	3.8	3.8	3.2
VTE Assessments Completed	95%	98.0%	98.2%	98.8%	97.8%	98.6%	98.7%		98.3%	98.6%	98.3%	99.2%	98.9%	98.3%	-
Sepsis - timely treatment with IV antibiotics (established inpatients)	90%	96.9%	95.1%	90.2%	92.2%	90.1%	97.7%		93.0%	96.9%	90.0%	88.8%	90.0%	90.2%	-
Sepsis - screening (presenting as an emergency)	90%	95.0%	95.3%	98.7%	96.1%	96.0%	97.1%		95.1%	95.6%	98.3%	96.9%	98.0%	99.1%	-
Number of Corporate Risks Grade 15 or Above	-	4	4	4	4	5	5		5	5	4	5	4	4	-
Safe Staffing (% of planned hours vs actual hours across all inpatient areas)	-	82.7%	87.4%	85.7%	86.5%	84.1%	87.8%		87.1%	87.4%	88.8%	89.0%	88.3%	88.2%	-
28 Day Faster Diagnosis Standard	75%	50.0%	45.5%	52.4%	41.2%	50.0%	53.8%	75%	85.0%	66.7%	81.8%	52.9%	60.0%	55.0%	-
62 Day Compliance	85%	71.3%	67.3%	68.8%	67.4%	73.7%	67.1%								-
62 Day Compliance - Upgrades	85%	67.1%	74.0%	87.7%	74.4%	75.5%	78.7%	70%	65.5%	70.7%	71.0%	59.6%	67.8%	74.5%	-
62 Day Compliance - Screening	90%	75.0%	63.6%	100.0%	58.3%	33.3%	66.7%								-
24 Day Compliance	85%	73.8%	74.6%	75.4%	69.0%	75.5%	70.6%	85%	68.2%	69.2%	73.7%	63.3%	71.5%	75.1%	-
31 Day Compliance	96%	97.8%	98.3%	96.7%	97.4%	98.9%	96.0%								-
31 Day Compliance - Subsequent Drug Therapy	98%	100.0%	100.0%	100.0%	100.0%	98.9%	99.3%	96%	98.7%	98.2%	98.6%	97.4%	99.3%	98.5%	-
31 Day Compliance - Subsequent Radiotherapy	94%	99.2%	99.5%	100.0%	100.0%	98.9%	98.6%								-
31 Day Compliance - Subsequent Surgery	94%	98.8%	100.0%	100.0%	100.0%	98.9%	96.8%								-
18 Weeks Compliance - Incomplete Pathways	92%	96.5%	96.9%	97.4%	96.7%	96.7%	97.8%	92%	97.7%	97.2%	97.2%	97.3%	98.0%	98.0%	-
Patients waiting >52 Weeks	0	1	1	1	1	2	2		1	0	1	1	1	3	15
Patients waiting >62 days at end of month (62 Day Classic)	80	89	84	102	109	105	114		114	136	132	136	119	94	-
Patients waiting >104 days at end of month (All 62 Day Targets)	-	34	42	44	46	40	52		64	58	72	72	45	51	-
Length Of Stay (Elective & Non-Elective Inpatients)	-	7.77	7.1	6.59	7.02	6.99	8.04		7.31	7.21	6.68	6.16	6.74	6.67	-
Patients Discharged Beyond Ready for Discharge Date	-					2	17		14	12	19	8	8	5	85
Patients Discharged Beyond Ready for Discharge Date - Total Bed Days Lost (days counted in the month of discharge)	-	*Reporting commenced last week of Aug*				31	159		263	114	167	211	151	119	1215
Patients Discharged Beyond Ready for Discharge Date - Average Bed Days Lost (days counted in the month of discharge)	-					15.5	9.4		18.7	9.5	8.8	26.4	18.9	23.8	14.3
Hospital Cancelled Operations on the day for non clinical reasons	0	2	4	2	5	9	0		12	5	4	1	5	6	55
Hospital Cancelled Operations on the day for non clinical reasons - NOT rebooked within 28 days	0	0	1	1	1	0	0		0	0	0	0	0	0	3
Complaints Received	14 (22/23 Avg)	11	11	11	12	19	5		12	20	10	12	15	8	146
PALS Contacts	44 (22/23 Avg)	46	51	42	35	42	42		37	34	27	28	21	19	424
Inquests	-	2	5	2	2	1	2		0	4	1	3	1	3	26
Coroner Request	-	11	12	4	3	4	3		3	3	1	6	7	5	62

SUMMARY DASHBOARD

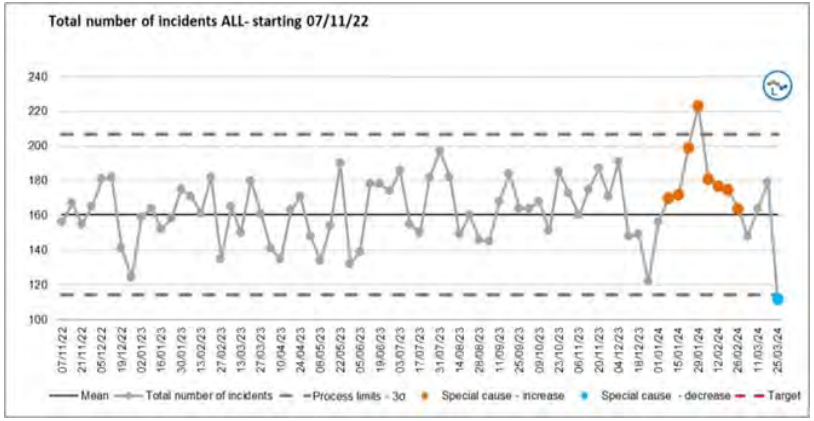
NHS
The Christie
NHS Foundation Trust

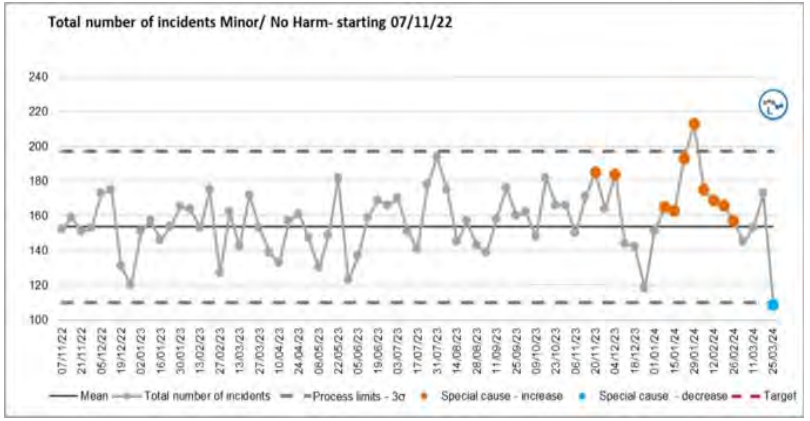
Indicator	Threshold / Standard 23/24	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	YTD
MRSA	0	1	0	0	1	0	0	1	0	0	0	0	0	3
C-Difficile - All Attributable Cases (Pre & Post 48 Hours)	36	2	3	4	4	3	4	5	7	0	7	5	12	56
C-Difficile - Attributable Cases Due To Lapse In Care	0	0	0	0	0	0	0	0	0	0	0	0	2	2
MSSA Bacteraemia - Attributable	25	1	1	1	2	4	2	2	2	2	3	2	0	22
E-Coli - Attributable	29	5	4	7	6	8	2	5	6	4	5	4	3	60
Klebsiella Species - Attributable	14	4	2	0	1	2	2	1	5	2	2	4	2	27
Pseudomonas Aeuriginosa - Attributable	10	1	0	2	1	1	2	1	0	1	0	0	0	9
COVID infections - Hospital Aquired	0	2	1	0	0	8	8	0	0	0	25	30	0	74
Palliative Radiotherapy 30 Day Suvival Rate	-	91.4%	91.2%	91.0%	86.1%	90.9%	90.0%	92.0%	89.1%	91.3%	89.7%	94.4%	-	-
Final Chemotherapy 30 Day Survival Rate	-	98.9%	99.3%	99.5%	99.4%	99.4%	99.3%	99.5%	99.3%	99.4%	99.3%	99.4%	-	-
Surgery 30 Day Survival Rate	-	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	-	-
Staff Sickness	3.4%	4.02%	3.77%	3.88%	4.34%	4.47%	4.77%	4.95%	4.61%	4.47%	5.05%	4.62%	4.21%	-
Staff Mandatory Training	>80%** <80%	83.0%	86.5%	88.8%	89.6%	90.4%	90.0%	89.9%	90.7%	91.3%	91.8%	92.0%	92.6%	-
Staff PDRs	-	85.9%	86.1%	88.0%	87.6%	87.6%	86.8%	86.3%	85.8%	86.3%	87.0%	86.5%	84.9%	-

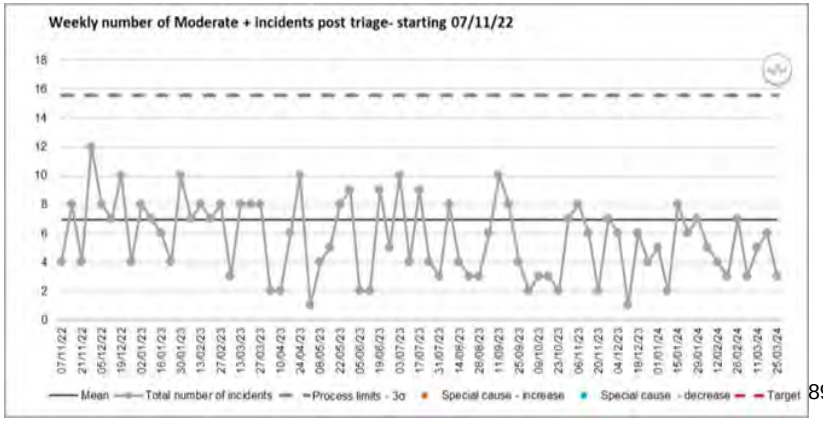
***Compliance if <80% & risk assessment in place*

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

Incident Reporting

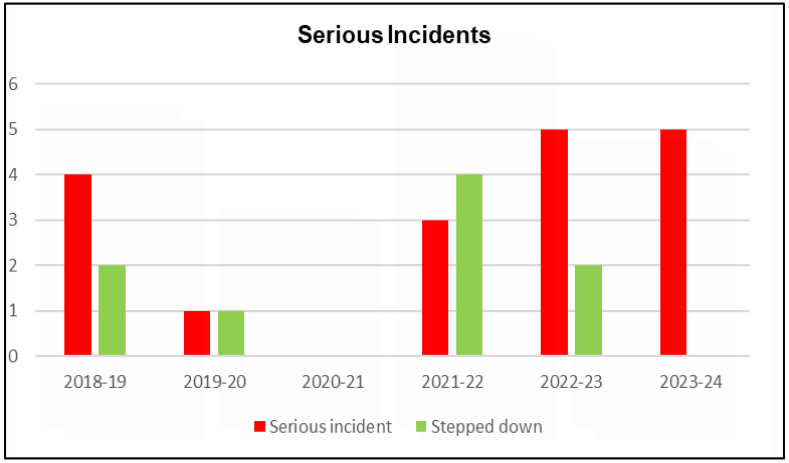






A period reduced incidents can be noted w/c 25th March 24 (115 against average of 150)- likely due to reduced activity over Easter in line with other holidays periods – potential relation to trustwide IT outage on 27th March 24

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 no serious incidents identified in March 2024.

Incidents identified that require a Learning Response

The Christie NHS Foundation Trust

March 2024 – RCA/learning response to be presented to ERG		
Reference	**Description**	**Reported Harm Level**
W84528	Trial SACT given past expiry date when treatment rearranged	Moderate
W84370	Patient aspirated whilst drinking free fluids. Potential delay in IV antibiotic escalation.	Moderate
W84609	Delayed biopsy sample result - submitted for Whole Genome Sequencing via the North West GLH in Sept/Oct 2022 result not returned until December 2023.	Moderate
W84647	Drug error- Patient prescribed Posaconazole and Venetoclax (contraindicated)	Moderate
430	Inpatient fall resulting in fractured neck of femur	Moderate
W84184	Patient referred with appendix adenocarcinoma. MDT in November 2023 recommended CRS and HIPEC. Difficulty scheduling the case and capacity issues escalated at the time. Patient scheduled for surgery 21/2/24. Pre-operative updated imaging shows disease progression.	Moderate
W83969	Staff injury - fell/tripped backwards. Hit head and hurt back. headache and pins and needles in hands/arms.	Moderate

Learning - Patient Safety Incidents

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Agreed learning and revised severity outcome following executive reviews March 2024

Ref	Description	Root cause	Learning	Outcome
W83323	Potential delays in the prescribing and administration of oral anticoagulation by several days.	No clear plan for anti-coagulation written in the notes on admission which should have been reviewed regularly Patient later deteriorated and died; pulmonary embolisms identified on CT not felt to be due to missed anticoagulant doses	Case study to highlight incident to medical staff and non-medical prescribers. To use incident as a case study on the medicines practice study day. CPF's to disseminate case study to a ward staff. Ensure every ward has the omission of critical medication flow chart displayed. Pharmacy staff to educate staff if critical medication has been omitted and to discuss in pharmacy meeting that medication should be ordered as an urgent item. For wider learning incident to be discussed in the Trust learning bulletin. For wider learning to be discussed at Friday FoCUS	**Death**
W83145	Staff member obtained an injury when a water bottle placed on top of their locker fell onto them, causing a cut on nose, eye swelling and dizziness. Staff member attended A&E and was advised to abstain from work for several days until pain and symptoms improved.	Not all the lockers were installed correctly (some lockers (including the locker involved in the incident) were not secured together	Review procurement/ installation of lockers process with estates / procurement team Trust wide alert to service leads to ensure all lockers are mounted correctly-	**Moderate**

Learning - Patient Safety Incidents

The Christie NHS Foundation Trust

Agreed learning and revised severity outcome following executive reviews March 2024

Ref	Description	Root cause	Learning	Outcome
W81983	A chest drain was inserted and later was removed as the drain was considered to have stopped draining. Pre and Post drain removal chest x-rays showed moderately large residual pleural effusion. A reinsertion of the chest drain was arranged. Patient passed away the day prior to planned reinsertion.	Post chest drain removal it was noted that a pleural effusion remained, this was a similar size to when the patient was first admitted to hospital, and the patient remained stable for 3 days. However, the investigation concluded a reinsertion of a chest drain should have been considered at the point of removal. When escalating for a repeat chest drain, there was a delay in the on-call Radiology Consultant being contacted as Switchboard were unable to locate the on-call Radiology rota. Once contacted, the radiologist attended promptly to assist. Death not related to delay.	Switchboard supervisor made aware of the incident, Radiology team email rota to switchboard weekly and switchboard to ensure information to out of hours team. Weekend plan to include on call Radiologist rota contact details. Establish task and finish group to review chest drain management SOP Revised management of chest drain SOP to be shared across the Medical Workforce Incident to be discussed at the radiology educational meeting Review of chest drain pathway (clinical guidance for insertion of chest drains)	**Moderate**

Learning - Patient Safety Incidents

NHS
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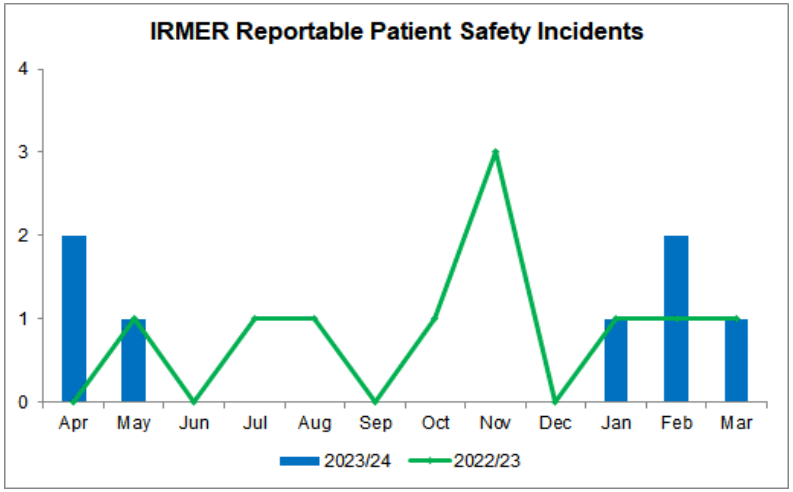
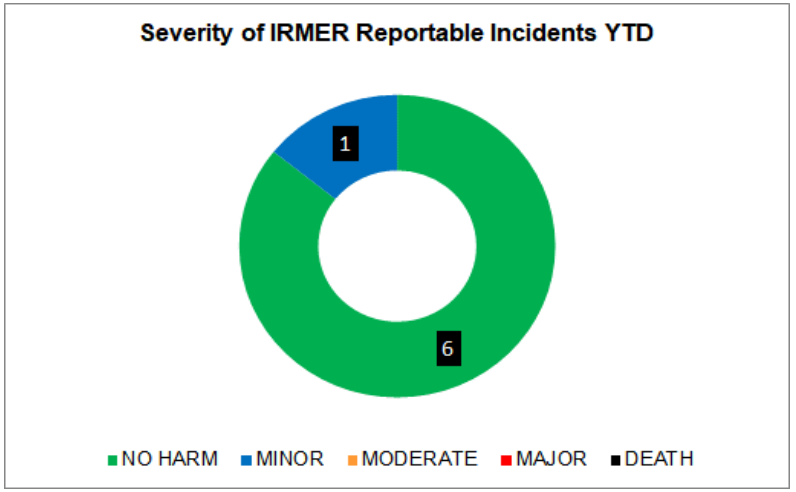
NHS Foundation Trust

Agreed learning and revised severity outcome following executive reviews March 2024

Ref	Description	Root cause	Learning	Outcome
W82860	Following gynaecological surgery at The Christie the patient was referred to both clinical and medical oncology to discuss adjuvant treatment. Following the appointments to discuss adjuvant treatment the patient declined further treatment with oncology and a letter was completed, addressed to the surgical team, regarding the outcome of the consultations and requesting that they organise a follow up appointment with the team here or locally at DGH. Unfortunately, the patient then became lost to follow up. The Surgical team did not receive the letter	Processes were not followed – A CWP message was not annotated at the time of sending the letter to the surgeon. Patient should have been referred back for follow up locally. When a patient completes or declines treatment, they are usually discharged for follow up with the local unit at the DGH. At this point the CareFlow episode would be closed, with comments to explain why, however these episodes were closed, without any explanation	SOP required for internal communication (not referrals) SOP for the management of open referrals and the outpatient waiting list to be ratified and distributed to those staff involved in the process. feedback incident findings at secretarial meetings as now tracked by PTL Testing and implementation of portal for internal/external referrals (external referrals will be implemented first, with internal referrals to follow).	**Moderate**

Radiation Incidents





There was 1 IRMER reportable patient safety incidents in March 2024:
W84728 (no harm)

Harm Free Care

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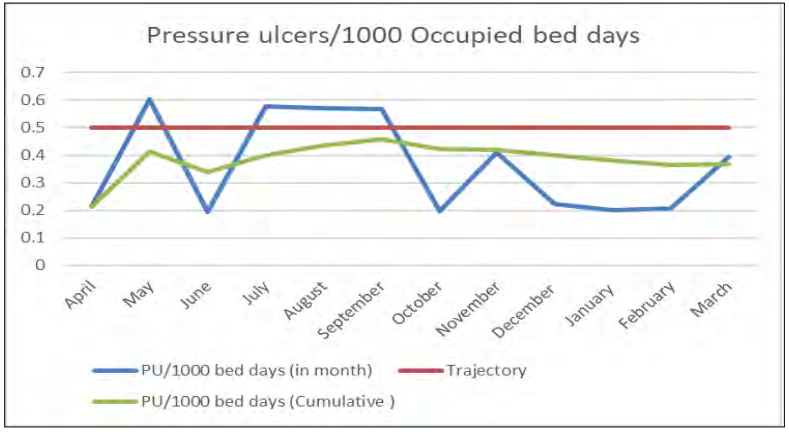
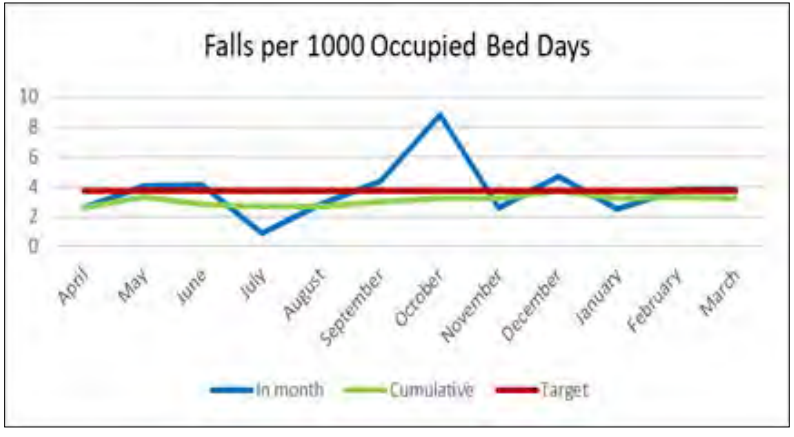
Pressure ulcers per 1000 occupied bed days



0.4 pressure ulcers per 1000 OBD occurred during admission in March 2024 (n=2)
0.36/1000 OBD overall for 2023/24 (n=22) acquired pressure ulcers during admission.
No patients have developed category 3 or 4.
Ambition for 2023/24 is less than 0.5/1000bed occupied days a month) or no more than 26 pressure ulcers (achieved)

Falls per 1000 occupied bed days



3.8 falls per 1000 OBD occurred during March 2024 (n=24)

3.2 falls per 1000 OBD overall for 2023/24

Ambition for 2023/24 is <3.8/1000 OBD (achieved)

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

Corporate Risks

NHS
The Christie
NHS Foundation Trust

There are 4 Trust-wide 15+ risks in March

Description	Score	Controls
24/25 Financial Revenue Risk (Risk ID 3629)	20	Review additional resource requested from Divisions to identify further potential mitigations to close financial gap and achieve break even
Limitation on equipment & facilities to deliver planned activity or progress developments due to insufficient CDEL (25) (Risk ID 3628)	20	Alternative proposals put forward by GM ICB indicate allocation options linked to existing or nationally calculated depreciation. DOF workshop to finalise allocation w/c 3/4/24
There is a risk that patients may experience harm due to significant delays in the management of patients with penile cancers. (Risk ID 3319)	16	Task & Finish group once new penile consultant in post To be linked in with one stop clinic on IPU Radiology engagement at Task and Finish Group
Risk of delayed cancer treatments due to failure to meet 24 / 62 day target (Risk ID 2407)	15	Understand impact on pathway length reduction in XRT on actual 62-day performance Consider prioritising treatment by 62-days, rather than 24-days

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	17077	13285	5037	5.5
	Total monthly ACTUAL	15075	12536		
	Average Fill Rate %	88.3%	94.4%		
Care Staff	Total monthly PLANNED	10299	6035	5037	2.7
	Total monthly ACTUAL	8362	5217		
	Average Fill Rate %	81.2%	86.4%		
ALL Staff	Total monthly PLANNED	27376	19320	5037	8.2
	Total monthly ACTUAL	23437	17753		
	Average Fill Rate %	85.6%	91.9%		

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	2608	1774	68.0%	2054	1632	79.5%	152	22.4
Palatine Ward	3222	2929	90.9%	2524	2410	95.5%	836	6.4
Ward 10	2457	1911	77.8%	1759	1570	89.3%	767	4.5
Ward 11	1816	1813	99.8%	1587	1583	99.7%	843	4.0
Ward 12	1870	1951	104.3%	1567	1677	107.0%	828	4.4
Ward 4	1829	1785	97.6%	1438	1408	97.9%	821	3.9
Ward 2	983	942	95.8%	494	555	112.2%	280	5.3
Acute Assessment Unit	2292	1970	86.0%	1862	1702	91.4%	510	7.2
TOTAL	17077	15075	88.3%	13285	12536	94.4%	5037	5.5

Registered Nursing Associates	DAY			NIGHT		
	Hours Planned	Hours Actual		Hours Planned	Hours Actual	
Critical Care Unit						
Palatine Ward						
Ward 10						
Ward 11						
Ward 12						
Ward 4		60			12	
Ward 2		3			12	
Acute Assessment Unit						

Care Staff	DAY			NIGHT			Cumulative count over the month of patients at 23:59 each day	CHPPD (Care Hours Per Patient Per Day)
	Hours Planned	Hours Actual	% Fill Rate	Hours Planned	Hours Actual	% Fill Rate		
Critical Care Unit	618	233	37.7%	23	12	50.0%	152	1.6
Palatine Ward	1428	1181	82.7%	931	843	90.5%	836	2.4
Ward 10	1901	1327	69.8%	791	570	72.1%	767	2.5
Ward 11	1551	1394	89.9%	1219	1158	95.0%	843	3.0
Ward 12	1628	1529	93.9%	1035	953	92.1%	828	3.0
Ward 4	1588	1427	89.9%	1081	941	87.0%	821	2.9
Ward 2	363	342	94.2%	242	219	90.5%	280	2.0
Acute Assessment Unit	1222	929	76.0%	713	521	73.1%	510	2.8
TOTAL	10299	8362	81.2%	6035	5217	86.4%	5037	2.7

Nursing Associate hours are displayed seperately due to national guidance, however the actual hours are included alongside the Registered Nursing hours. The Trust does not have enough Nursing Associate posts to enable planned established hours.

Patient Experience

NHS
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NHS Foundation Trust

Positive feedback received…..

"Thank you so much for your understanding and kindness it is very much appreciated. A lovely compliment for a few of the staff in MR. A patient attended yesterday evening in tears at the front desk and was helped by numerous members of staff. She dropped cards and chocolates off for them all."

"Sadly my mum lost her battle last week and passed away. She died peacefully and pain free in hospital and I was by her side until the end.
I wanted to thank you personally for the care and friendship you gave to my mum as she thought of you as a friend over the many years she attended the Christie. In 2016 you and your team gave her her life back, we didn't dare to dream she would be with us nearly 8 years later.
You allowed my mum to resume normality and enjoy her life with her friends and family. We will always be eternally grateful."

"Compliment to all the staff involved in her care, who sadly passed away, in her final weeks the patient spent time on wards 11 and 12 and the family want to give eternal thanks to Professor Saunders and Lily and all the supportive care team, the patient found great comfort from them and the care was also extending to the patient's family. The letter also wants to thank all the staff on wards 11 and 12 for the ongoing support and care they provided going above and beyond, they showed compassion to highest level.."

Friends & Family Test

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%
Jun-23	247	24	6	2	3	0	927	282	30.4%	96.10%
Jul-23	223	23	2	1	2	1	810	252	31.1%	97.62%
Aug-23	222	8	3	3	1	0	841	237	28.2%	97.05%
Sep-23	208	25	8	2	4	1	894	248	27.7%	93.95%
Oct-23	237	26	4	4	2	0	827	273	33.0%	96.34%
Nov-23	265	28	5	1	0	1	980	300	30.6%	97.67%
Dec-23	168	19	2	3	4	2	846	198	23.4%	94.44%
Jan-24	295	23	5	5	0	4	960	332	34.6%	95.78%
Feb-24	235	25	2	2	1	1	899	266	29.6%	97.74%
Mar-24	219	21	1	1	1	2	847	245	28.9%	97.96%
YTD Total	2806	269	43	26	20	14	10537	3178	30.16%	96.76%

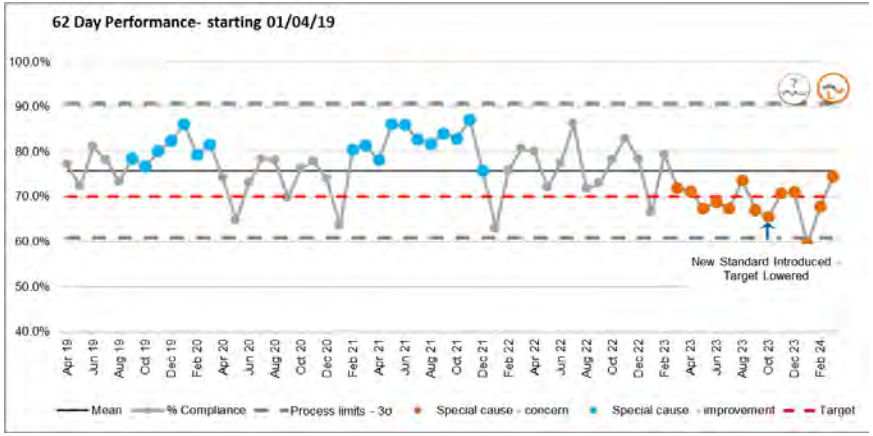
	OUTPATIENT RESPONSES						Total responses	% Recommended
	1 - Very Good	2 - Good	3 - Neither Good nor Poor	4 - Poor	5 - Very Poor	6 - Don't Know		
Apr-23	1348	165	38	19	10	18	1598	94.68%
May-23	1336	166	52	18	13	12	1597	94.05%
Jun-23	1458	181	54	23	21	20	1757	93.28%
Jul-23	1310	148	35	16	13	16	1538	94.80%
Aug-23	1215	167	29	14	10	16	1451	95.24%
Sep-23	1396	140	40	17	5	19	1617	94.99%
Oct-23	1606	170	47	17	7	9	1856	95.69%
Nov-23	1770	227	42	22	11	20	2092	95.46%
Dec-23	1079	144	30	14	9	8	1284	95.25%
Jan-24	1850	200	54	20	19	14	2157	95.04%
Feb-24	1449	146	33	12	6	12	1658	96.20%
Mar-24	1269	116	40	14	9	11	1459	94.93%
YTD Total	17086	1970	494	206	133	175	20064	94.98%

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 - Don't Know			
04 Ward (Dept 52)	11	2	0	0	0	0	87	13	14.9%
10 Ward-Surg Onc Unit (Dept 4)	36	6	0	0	1	0	142	43	30.3%
11 Ward (Dept 4)	4	0	0	0	0	0	69	4	5.8%
12 Ward (Dept 4)	4	1	0	1	0	0	85	6	7.1%
The BMR Unit (Dept 16)	11	1	0	0	0	0	39	12	30.8%
Endocrine Ward (Dept 63)	5	0	0	0	0	0	17	5	29.4%
Haematology Day Unit (Dept 26)	40	2	0	0	0	1	117	43	36.8%
Integrated Procedure Unit (Dept 2)	104	6	1	0	0	1	212	112	52.8%
Palatine Ward (Dept 27)	4	2	0	0	0	0	64	6	9.4%
CTU Inpatient Ward (Dept 1)	0	1	0	0	0	0	15	1	6.7%
Total	219	21	1	1	1	2	847	245	28.9%

Cancer Standards

The Christie NHS Foundation Trust

62 Day / 31 Day / 18 Weeks



National Standard	Standard	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	New Standard	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
62 Day	85%	71.90%	71.3%	67.3%	68.8%	67.4%	73.7%	67.1%							
62 Day Upgrades	85%	77.80%	67.1%	74.0%	87.7%	74.4%	75.5%	78.7%	70%	65.5%	70.7%	71.0%	59.6%	67.8%	74.5%
62 Day Screening	90%	100.00%	75.0%	63.6%	100.0%	58.3%	33.3%	66.7%							
24 Day Internal	85%	77.00%	73.8%	74.6%	75.4%	69.0%	75.5%	70.6%	85%	68.2%	69.2%	73.7%	63.3%	71.6%	75.1%
31 Days	96%	97.70%	97.8%	98.3%	96.7%	97.4%	98.9%	96.0%							
31 Day Subsequent Drug	98%	99.60%	100.0%	100.0%	100.0%	100.0%	98.9%	99.3%							
31 Day Subsequent XRT	94%	99.30%	99.2%	99.5%	100.0%	100.0%	98.9%	98.6%	96%	98.7%	98.2%	98.6%	97.4%	99.3%	98.5%
31 Day Subsequent Surgery	94%	98.40%	98.8%	100.0%	100.0%	100.0%	98.9%	96.8%							
18 Weeks - Incomplete Pathways	92%	96.50%	96.5%	96.9%	97.4%	96.7%	96.7%	97.8%	92%	97.7%	97.2%	97.2%	97.3%	98.0%	98.0%

		Mar
50% Shared Breach		57
50% Shared Compliance		139
Full Christie Breach		9
FULL Christie Compliance		40
FULL Referring Provider Breach		114
Grand Total		359
62 Combined		74.5%
24 Day Compliance		75.07%
31 Day	Breach	7
	Compliance	358
Grand Total		365
31 day - Subsequents	Breach	3
	Compliance	319
Grand Total		322
31 day - Combined	Breach	10
	Compliance	677
Grand Total		687
31 day - Combined		98.5%

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Compliances	2	5	11	7	5	7	17	10	9	9	6	11
Breaches	2	6	10	10	5	6	3	5	2	8	4	9
%	50.0%	45.5%	52.4%	41.2%	50.0%	53.8%	85.0%	66.7%	81.8%	52.9%	60.0%	55.0%

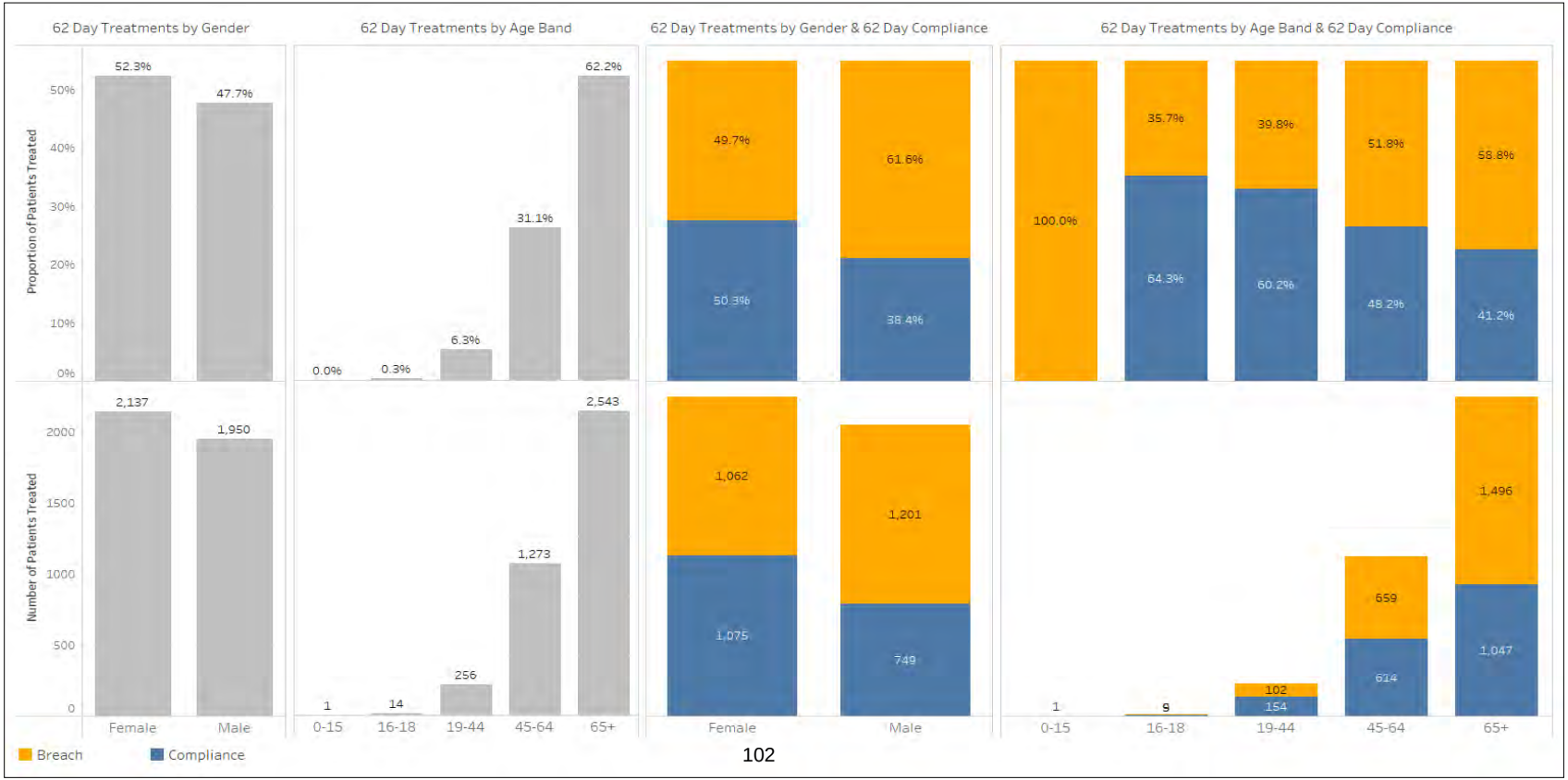
Patients are reported in the month the compliance/breach occurs.

As of October 2023, all 62-day standards are merged in to one 62-day standard and all 31-day standard types are merged in to one combined 31-day standard. The Targets have been lowered from 85% to 70% for the new combined 62-day standard and a new combined target of 96% assigned to the new 31-day combined standard.

Cancer Standards – Health Inequalities Analysis

62 Day Treatments for 2023/24 financial year analysed by gender and age.

The Christie NHS Foundation Trust



Cancer Standards – Health Inequalities Analysis

62 Day Treatments for 2023/24 financial year analysed by gender and age.

NHS
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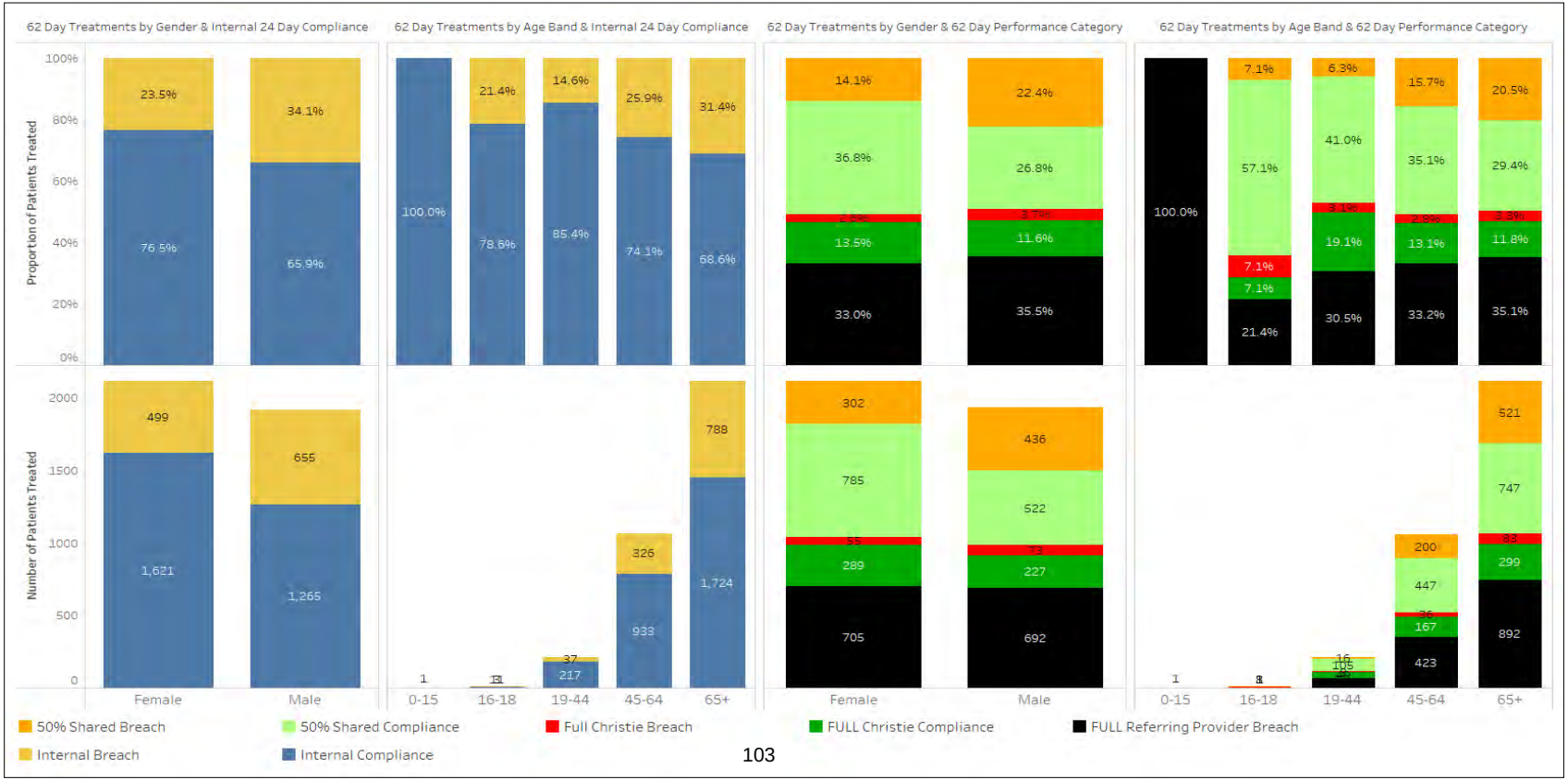
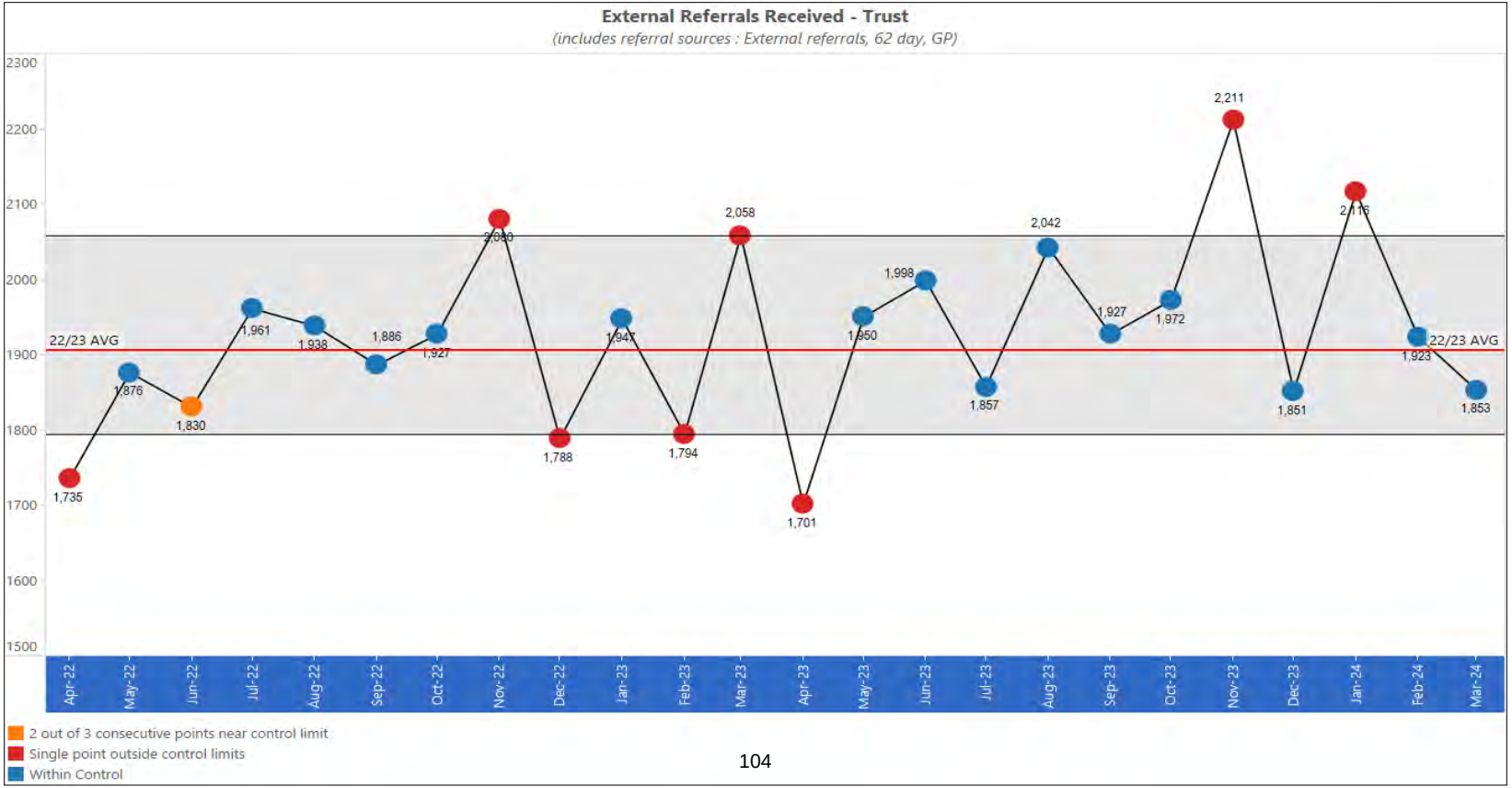
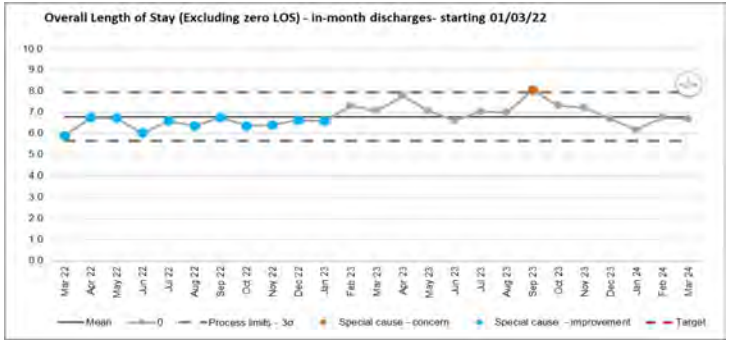
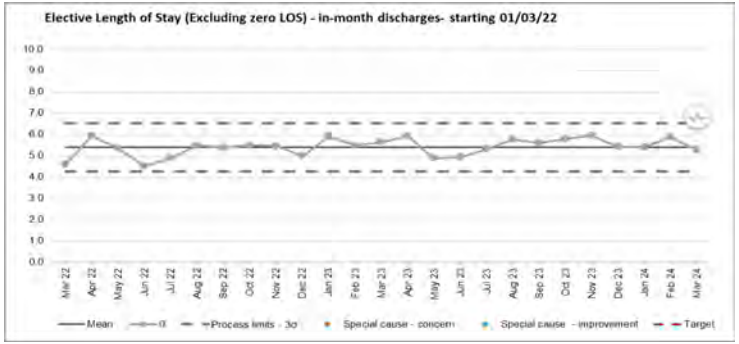


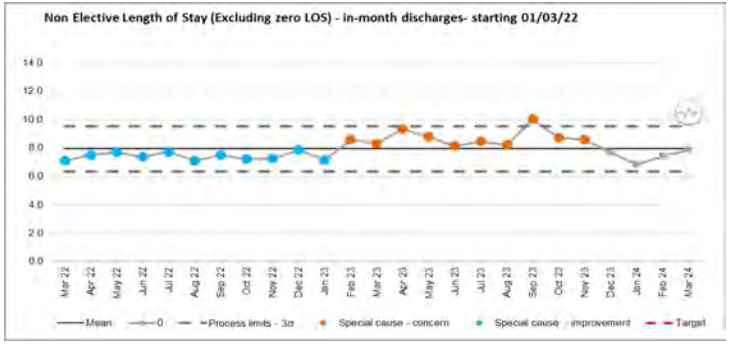
Referrals Analysis

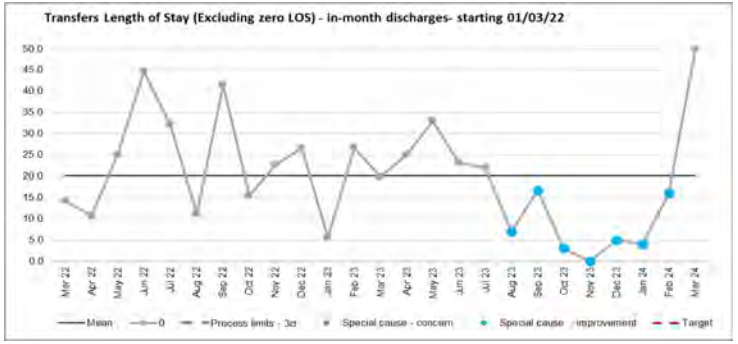


Length of Stay



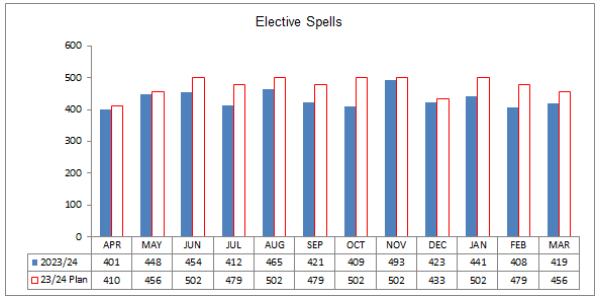




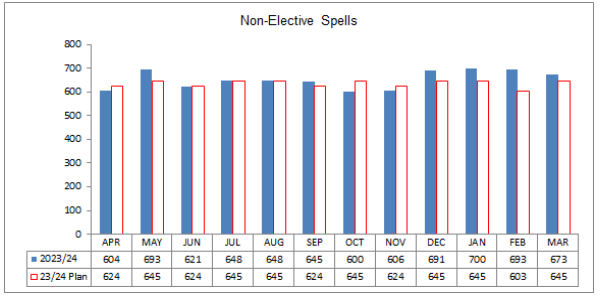


Overall length of stay continues to be well within control limits. The recent spike in transfers relates to the discharge of one patient who was an inpatient for a longer than average period.

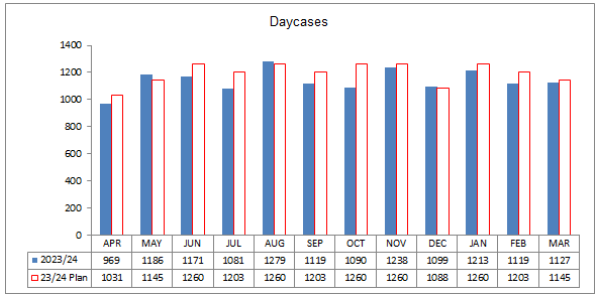
Activity



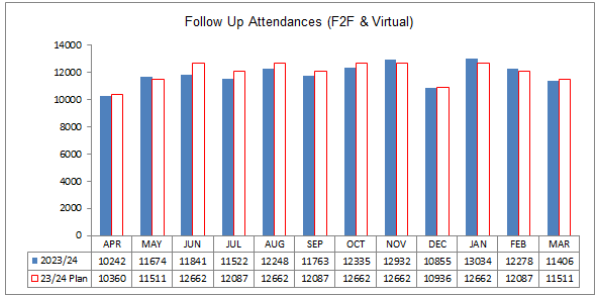
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	401	448	454	412	465	421	409	493	423	441	408	419
23/24 Plan	410	456	502	479	502	479	502	502	433	502	479	456



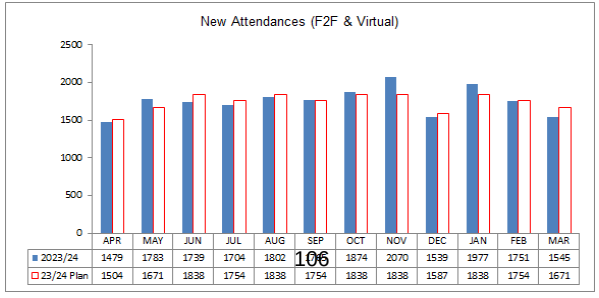
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	604	693	621	648	648	645	600	606	691	700	693	673
23/24 Plan	624	645	624	645	645	624	645	624	645	645	603	645



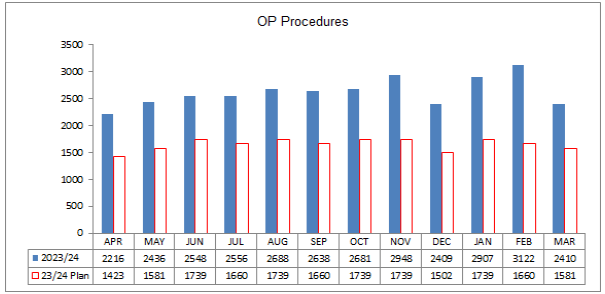
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	969	1186	1171	1081	1279	1119	1090	1238	1099	1213	1119	1127
23/24 Plan	1031	1145	1260	1203	1260	1203	1260	1260	1088	1260	1203	1145



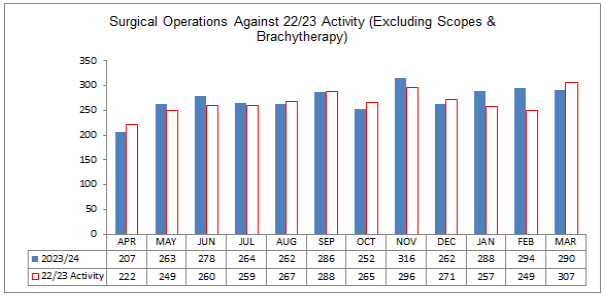
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	10242	11674	11841	11522	12248	11763	12335	12932	10855	13034	12278	11406
23/24 Plan	10360	11511	12662	12087	12662	12087	12662	12662	10936	12662	12087	11511



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	1479	1783	1739	1704	1802	1706	1874	2070	1539	1977	1751	1545
23/24 Plan	1504	1671	1838	1754	1838	1754	1838	1838	1587	1838	1754	1671

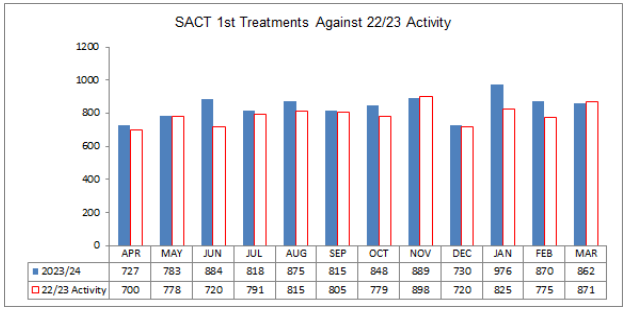


	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	2216	2436	2548	2556	2688	2638	2681	2948	2409	2907	3122	2410
23/24 Plan	1423	1581	1739	1660	1739	1660	1739	1739	1502	1739	1660	1581

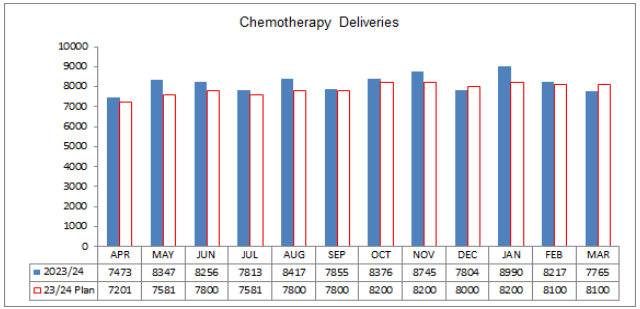


	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	207	263	278	264	262	286	252	316	262	288	294	290
22/23 Activity	222	249	260	259	267	288	265	296	271	257	249	307

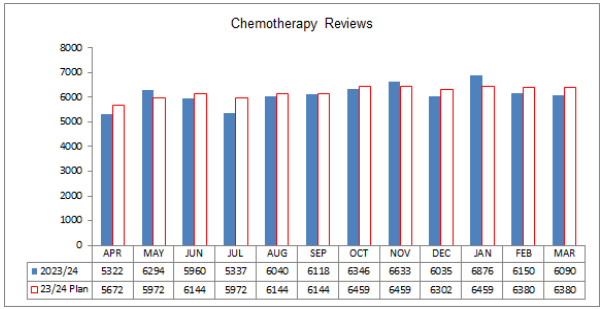
Activity



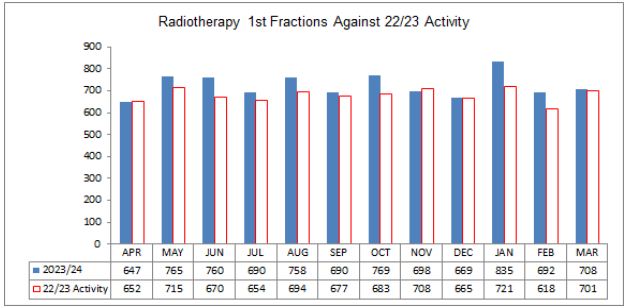
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	727	783	884	818	875	815	848	889	730	976	870	862
22/23 Activity	700	778	720	791	815	805	779	898	720	825	775	871



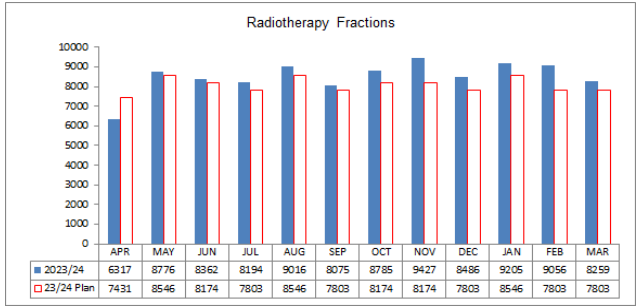
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	7473	8347	8256	7813	8417	7855	8376	8745	7804	8990	8217	7765
23/24 Plan	7201	7581	7800	7581	7800	7800	8200	8200	8000	8200	8100	8100



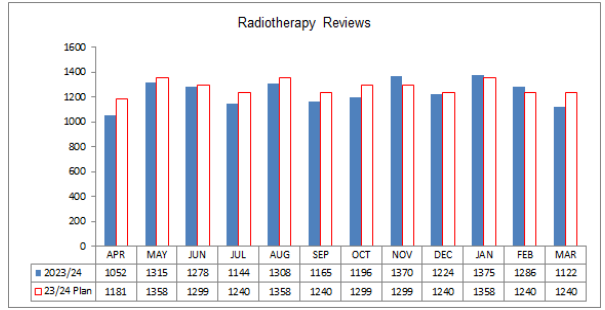
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	5322	6294	5960	5337	6040	6118	6346	6633	6035	6876	6150	6090
23/24 Plan	5672	5972	6144	5972	6144	6144	6459	6459	6302	6459	6380	6380



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	647	765	760	690	758	690	769	698	669	835	692	708
22/23 Activity	652	715	670	654	694	677	683	708	665	721	618	701



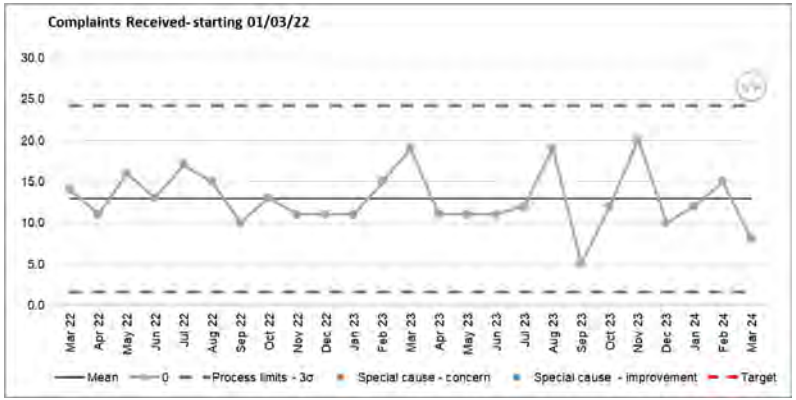
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	6317	8776	8362	8194	9016	8075	8785	9427	8486	9205	9056	8259
23/24 Plan	7431	8546	8174	7803	8546	7803	8174	8174	7803	8546	7803	7803

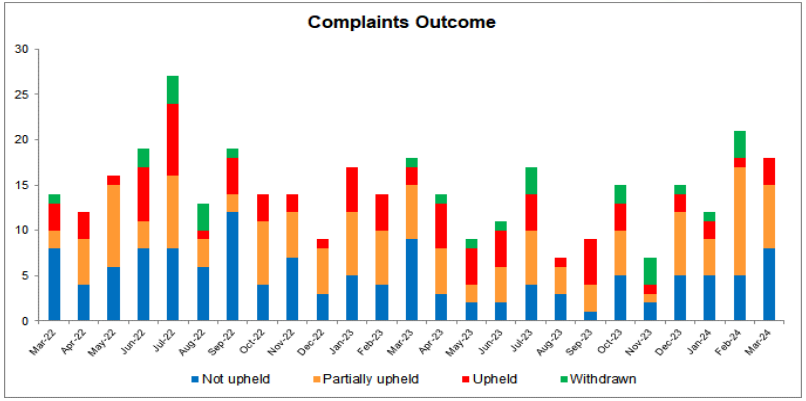


	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	1052	1315	1278	1144	1308	1165	1196	1370	1224	1375	1286	1122
23/24 Plan	1181	1358	1299	1240	1358	1240	1299	1299	1240	1358	1240	1240

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



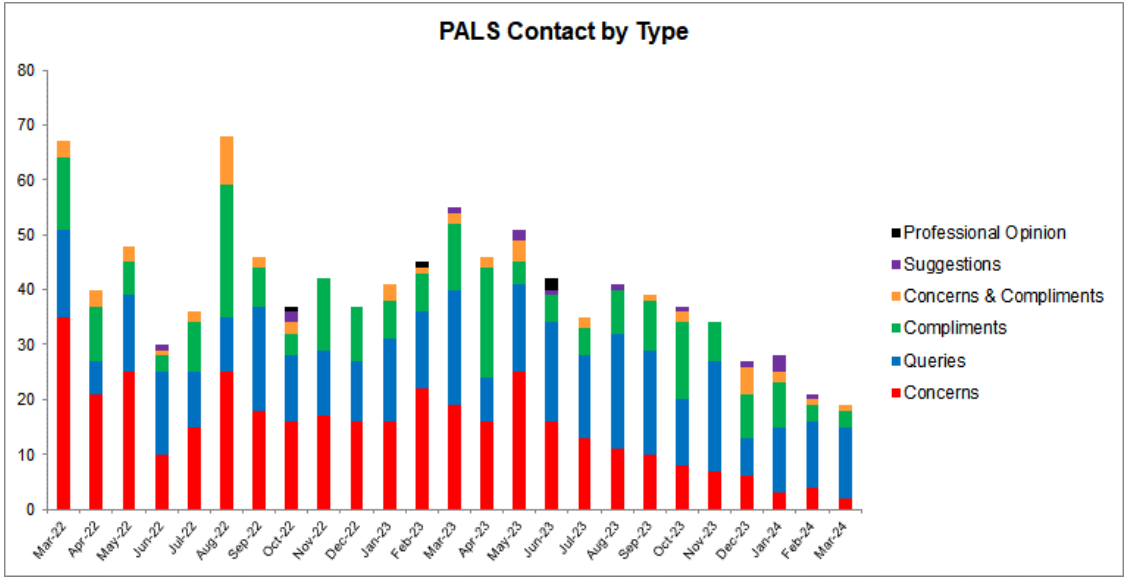


8 new complaints received in March 2024

18 complaints were closed in March 2024

Ombudsman Cases
Complainants have the right to refer their case to the Parliamentary and Health Service Ombudsman (PHSO) if they are not satisfied it has been resolved by the Trust. 0 cases were referred to the PHSO in March 2024. 5 active cases in total with the PHSO.

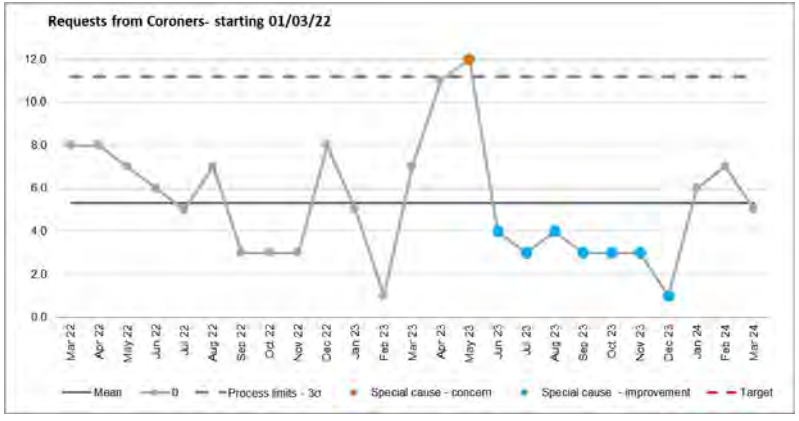
PALS

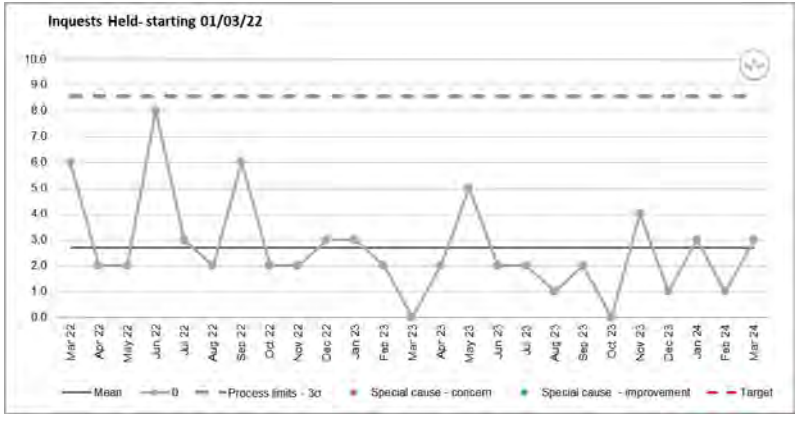


19 PALS contacts have been received in March 2024.

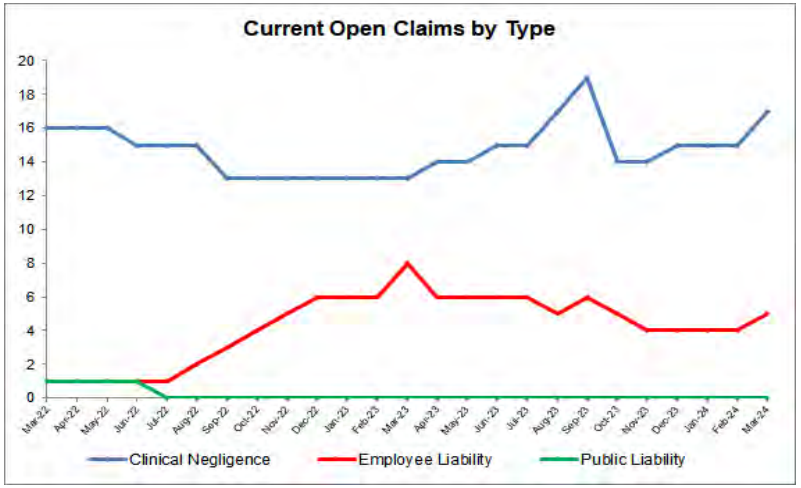
2 of those raised concerns about their experience at The Christie but did not wish to proceed with a formal complaint. The other reasons for contacting PALS are captured in the graph.

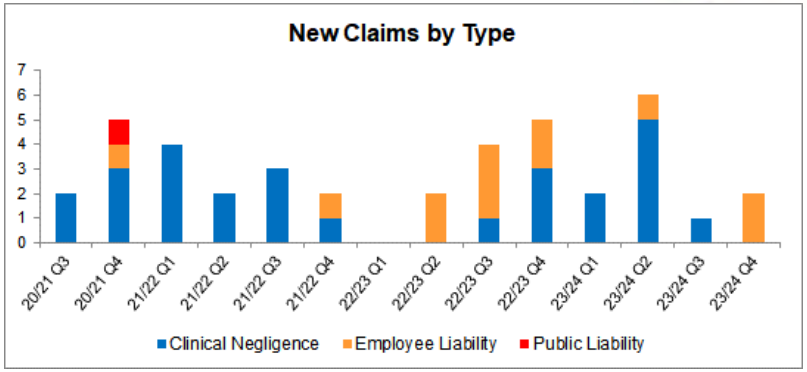
Inquests


Requests from Coroners- starting 01/03/22
12.0
10.0
8.0
6.0
4.0
2.0
0.0
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
Jun 23
Jul 23
Aug 23
Sep 23
Oct 23
Nov 23
Dec 23
Jan 24
Feb 24
Mar 24
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


Inquests Held- starting 01/03/22
10.0
9.0
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
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
Jun 23
Jul 23
Aug 23
Sep 23
Oct 23
Nov 23
Dec 23
Jan 24
Feb 24
Mar 24
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

Claims





2 new claims received in March 2024.
1 CNST claim re-opened.
0 claims closed in March 2024.

Healthcare Associated Infections

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	8	4	2	(W4 X1) (PW X2) (AAU X3) (W11 X2) (W12 x3) (W10 x1)
E.coli Bacteraemia		2	2	1	0	(IPU X1) (PW X1) (W4 X1)
Klebsiella spp.		1	1	1	0	(IPU X1) (W11 X1)
Pseudomonas aeruginosa bacteraemia					0	
MSSA Bacteraemia					0	
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	9	17	25	31	2
E.coli Bacteraemia		38	28	32	0
Klebsiella spp.		13	13	14	0
Pseudomonas aeruginosa bacteraemia		6	4	5	0
MSSA Bacteraemia		7	11	11	0
MRSA Bacteraemia		1	2	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 (YTD)	Lapses in care
COVID-19	30	24	20	74	0

Organism	Number of Cases (YTD)	Lapses in care
CPE colonisation / infection	10	0

There were 12 cases of C-Difficile, 3 cases of E-Coli and 2 cases of Klebsiella in March that were deemed attributable to the Trust. There were also 3 sperate outbreaks of Covid during February that effected 18 staff and 30 patients. Two lapses in care were identified in March following an RCA that were linked to a period of increased incidence of C-Diff on Ward 4.

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

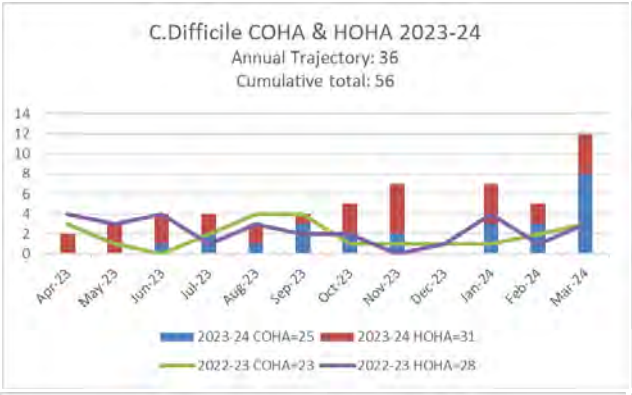
COHA - Symptoms commenced within first two days of admission and inpatient in the past 12 weeks (but not past 4 weeks)

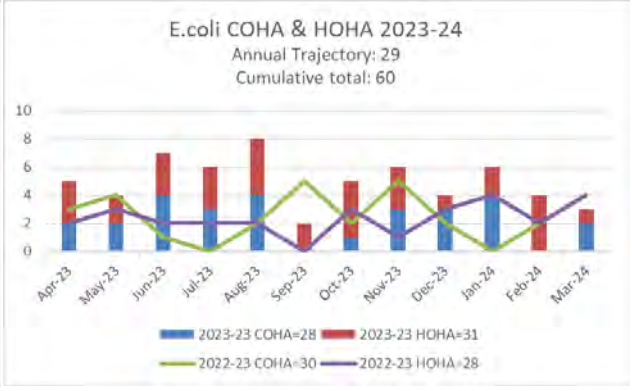
HOHA - Symptoms commenced within first two days of admission (No admission in past 12 weeks)

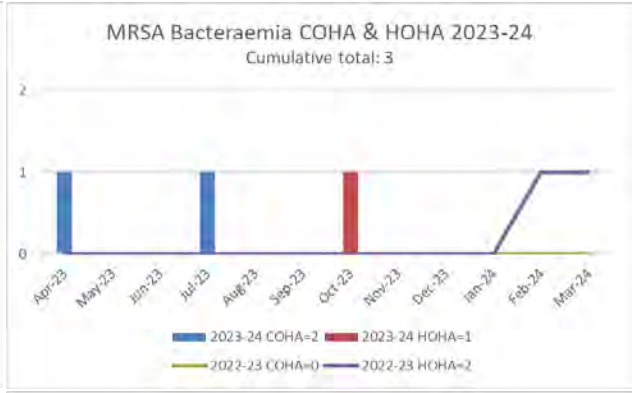
Healthcare Associated Infections

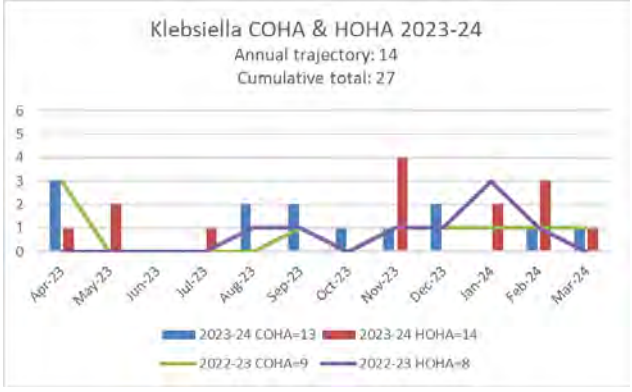
NHS
The Christie
NHS Foundation Trust

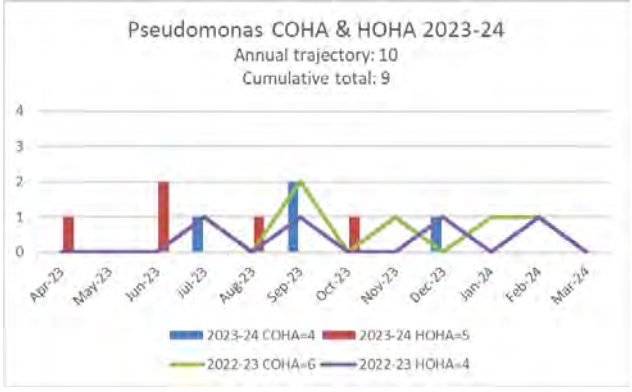
Alert Organisms

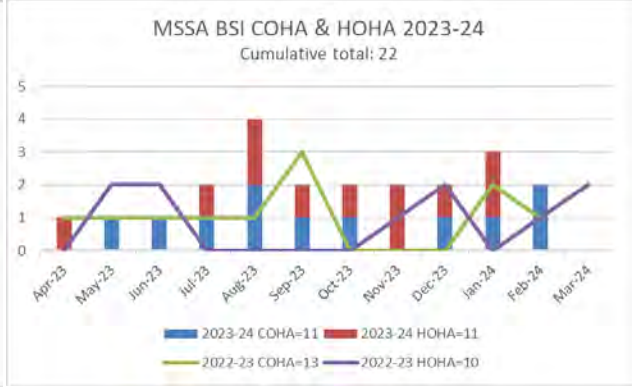










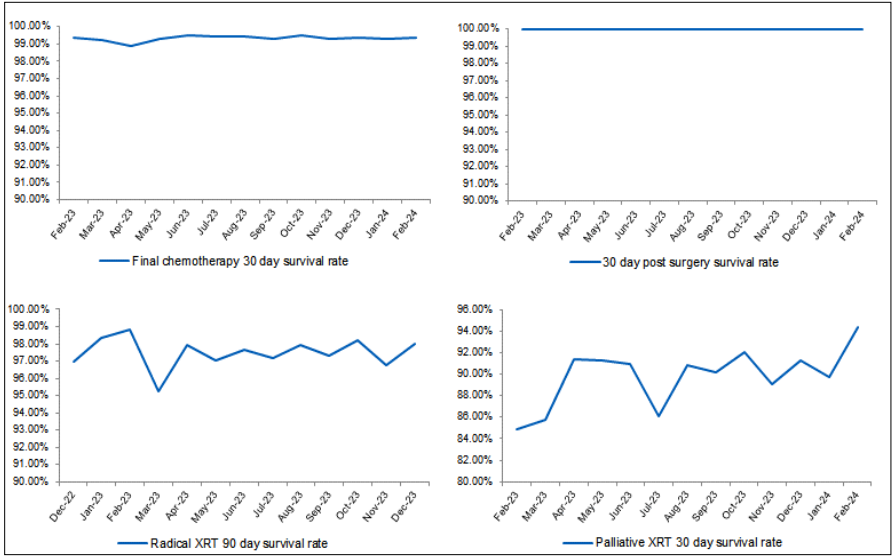


All cases reviewed through IPC team and reported through NIPR. Two lapses in care identified in March – linked to Period of Increased Incidence of C-Diff on Ward 4. Involved in GM and North-West region work to understand increasing trends across the area.

Mortality Indicators & Survival Rates

The Christie NHS Foundation Trust

Survival Rates



Inpatient Deaths – Onsite Deaths

		Mar-24
Number of NHS Christie onsite deaths	Elective/planned admission	3
	Non Elective/emergency admission	15
	TOTAL	**18**
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) - 2	**3**
	Bereaved families raised concern – 1	
	Medical Triggers - 1	
	Nursing Triggers - 1 (inc in family concern)	
	(note there may be more than one trigger)	

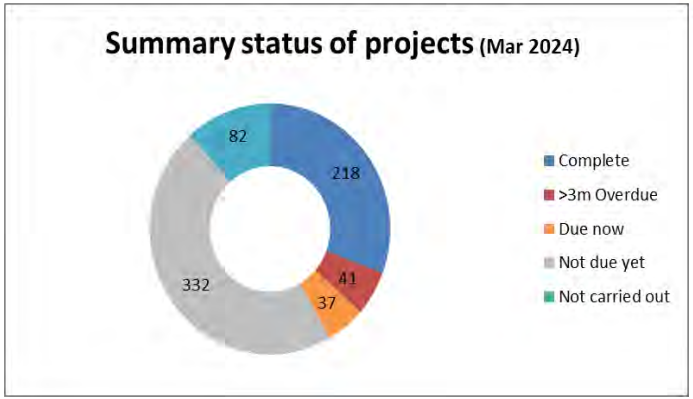
The Christie process for learning from deaths follows the 2017 NHSI guidance. All in-patient deaths are screened and where flagged by one or more triggers an independent structured case note review (SCR) is undertaken. Reviews are discussed by the Mortality Surveillance Group and the findings and actions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

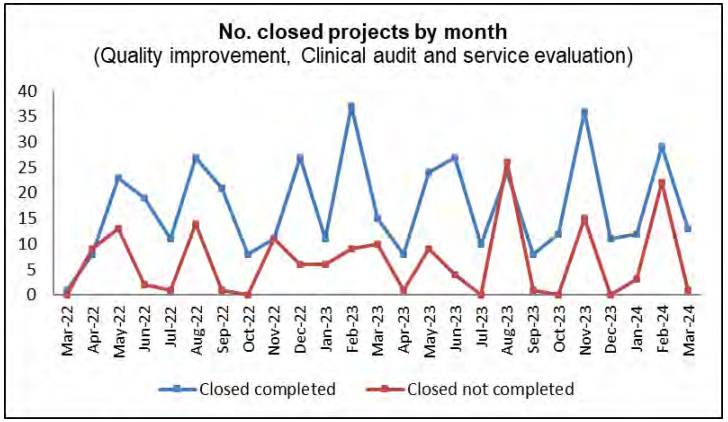
Quality Improvement & Clinical Audit

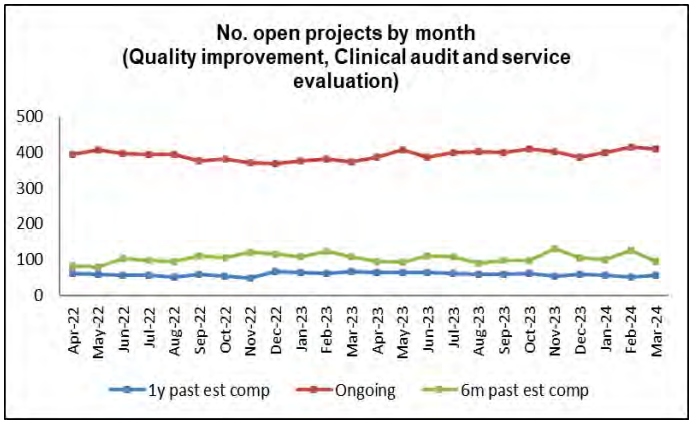
The Christie NHS Foundation Trust

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







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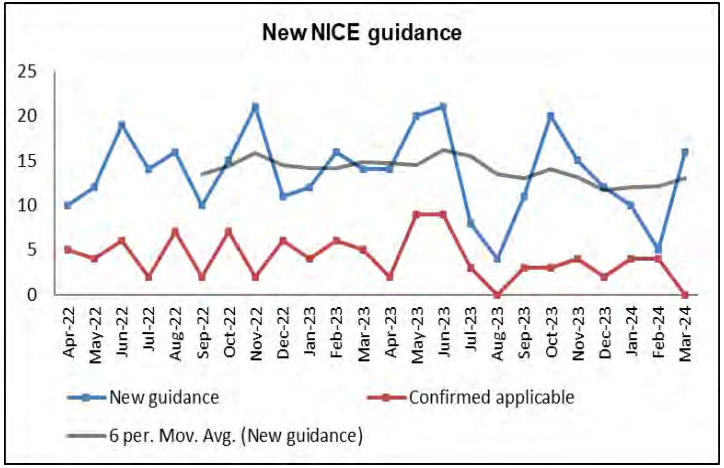
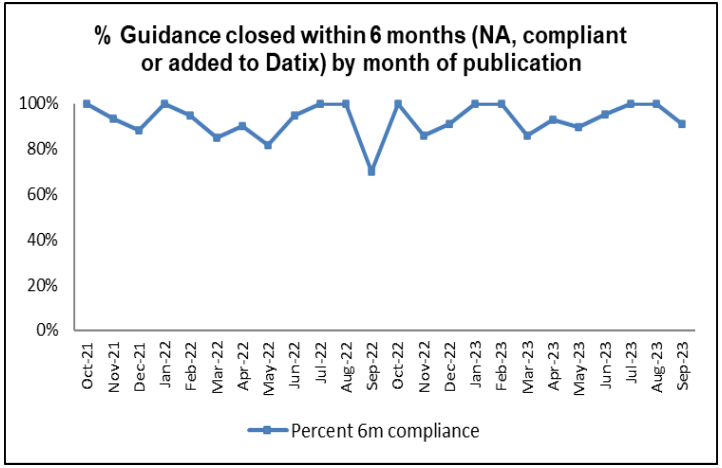
NICE Guidance





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

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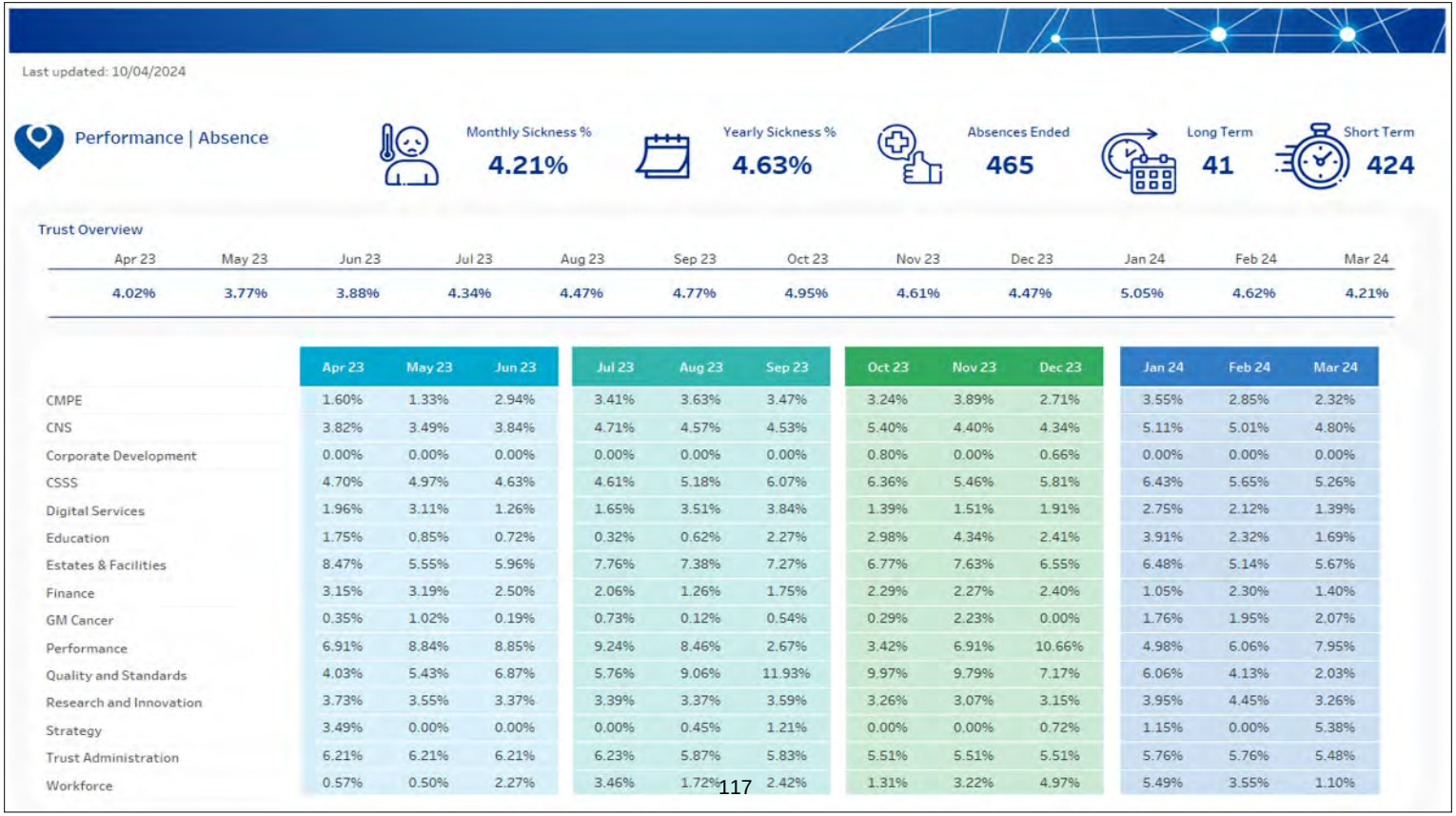
HR Metrics Sickness

The Christie NHS Foundation Trust



Last updated: 10/04/2024

Performance | Absence

Monthly Sickness %	Yearly Sickness %	Absences Ended	Long Term	Short Term
4.21%	4.63%	465	41	424

Trust Overview

Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
4.02%	3.77%	3.88%	4.34%	4.47%	4.77%	4.95%	4.61%	4.47%	5.05%	4.62%	4.21%

	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
CMPE	1.60%	1.33%	2.94%	3.41%	3.63%	3.47%	3.24%	3.89%	2.71%	3.55%	2.85%	2.32%
CNS	3.82%	3.49%	3.84%	4.71%	4.57%	4.53%	5.40%	4.40%	4.34%	5.11%	5.01%	4.80%
Corporate Development	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.80%	0.00%	0.66%	0.00%	0.00%	0.00%
CSSS	4.70%	4.97%	4.63%	4.61%	5.18%	6.07%	6.36%	5.46%	5.81%	6.43%	5.65%	5.26%
Digital Services	1.96%	3.11%	1.26%	1.65%	3.51%	3.84%	1.39%	1.51%	1.91%	2.75%	2.12%	1.39%
Education	1.75%	0.85%	0.72%	0.32%	0.62%	2.27%	2.98%	4.34%	2.41%	3.91%	2.32%	1.69%
Estates & Facilities	8.47%	5.55%	5.96%	7.76%	7.38%	7.27%	6.77%	7.63%	6.55%	6.48%	5.14%	5.67%
Finance	3.15%	3.19%	2.50%	2.06%	1.26%	1.75%	2.29%	2.27%	2.40%	1.05%	2.30%	1.40%
GM Cancer	0.35%	1.02%	0.19%	0.73%	0.12%	0.54%	0.29%	2.23%	0.00%	1.76%	1.95%	2.07%
Performance	6.91%	8.84%	8.85%	9.24%	8.46%	2.67%	3.42%	6.91%	10.66%	4.98%	6.06%	7.95%
Quality and Standards	4.03%	5.43%	6.87%	5.76%	9.06%	11.93%	9.97%	9.79%	7.17%	6.06%	4.13%	2.03%
Research and Innovation	3.73%	3.55%	3.37%	3.39%	3.37%	3.59%	3.26%	3.07%	3.15%	3.95%	4.45%	3.26%
Strategy	3.49%	0.00%	0.00%	0.00%	0.45%	1.21%	0.00%	0.00%	0.72%	1.15%	0.00%	5.38%
Trust Administration	6.21%	6.21%	6.21%	6.23%	5.87%	5.83%	5.51%	5.51%	5.51%	5.76%	5.76%	5.48%
Workforce	0.57%	0.50%	2.27%	3.46%	1.72%	2.42%	1.31%	3.22%	4.97%	5.49%	3.55%	1.10%

HR Metrics – Mandatory Training

The Christie NHS Foundation Trust

Last updated: 10/04/2024

Performance | Mandatory Training

Overall Compliance	Modules Outstanding	F2F Compliance	Online Compliance
92.60%	4,633	82.57%	94.16%

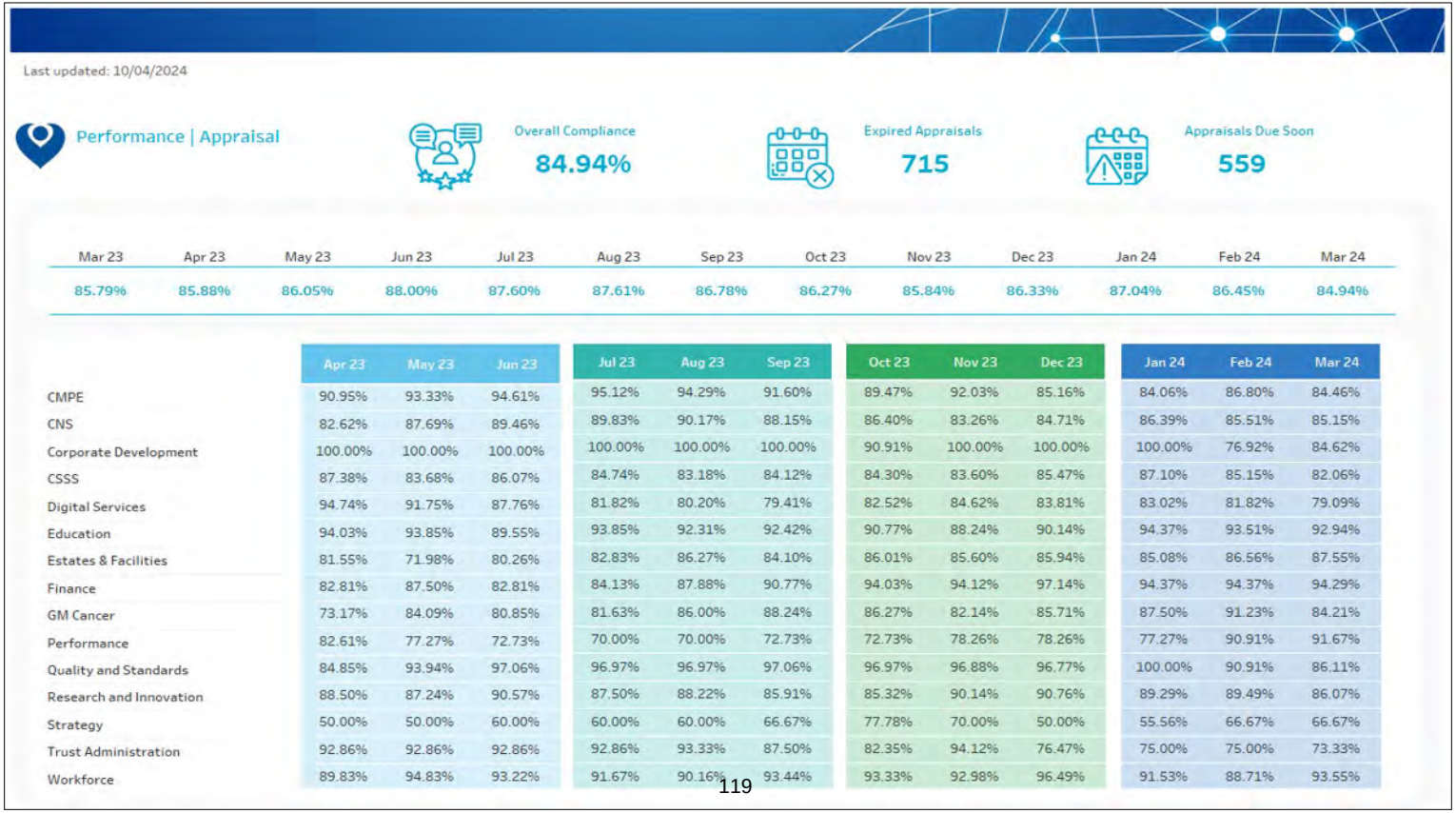
Trust Compliance

Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
82.95%	86.45%	88.84%	89.62%	90.39%	90.02%	89.85%	90.68%	91.30%	91.75%	91.96%	92.60%

	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
CMPE	89.67%	92.12%	92.41%	93.13%	94.00%	94.58%	93.65%	94.11%	94.42%	93.31%	93.94%	94.72%
CNS	80.40%	83.44%	85.91%	87.48%	88.69%	87.88%	88.12%	89.07%	89.45%	90.02%	90.41%	91.13%
Corporate Development	90.00%	95.71%	97.14%	97.59%	98.32%	98.88%	99.44%	98.32%	98.88%	98.90%	99.45%	100.00%
CSSS	78.73%	82.57%	85.67%	86.57%	86.53%	86.24%	85.97%	87.70%	88.62%	89.10%	89.20%	89.67%
Digital Services	91.27%	93.78%	95.51%	94.89%	95.64%	94.24%	95.84%	95.20%	92.88%	94.98%	94.47%	96.46%
Education	91.09%	94.27%	93.99%	94.80%	94.37%	95.42%	92.90%	94.26%	95.89%	98.43%	98.96%	98.62%
Estates & Facilities	85.06%	89.75%	92.81%	92.02%	93.25%	93.89%	91.56%	90.73%	93.29%	94.14%	94.24%	94.27%
Finance	93.04%	97.47%	97.78%	98.79%	98.48%	98.36%	98.22%	97.74%	98.64%	97.54%	98.78%	98.87%
GM Cancer	78.55%	88.61%	92.84%	88.60%	88.99%	90.18%	93.06%	92.15%	94.91%	95.31%	92.73%	94.01%
Performance	89.54%	91.03%	92.31%	96.70%	94.81%	91.43%	92.86%	98.57%	97.71%	96.98%	99.45%	98.08%
Quality and Standards	86.04%	87.92%	90.21%	91.23%	90.29%	89.76%	90.60%	91.30%	91.90%	92.95%	91.65%	94.39%
Research and Innovation	88.93%	92.42%	94.80%	95.08%	96.24%	95.28%	95.86%	95.59%	95.53%	95.71%	95.74%	96.34%
Strategy	81.06%	87.12%	87.88%	88.64%	91.55%	92.13%	92.13%	95.71%	95.00%	91.94%	92.75%	94.93%
Trust Administration	89.09%	91.40%	92.31%	92.76%	91.67%	90.84%	89.35%	91.63%	90.49%	91.60%	90.48%	93.61%
Workforce	87.93%	91.24%	92.87%	90.01%	95.62%	97.26%	96.83%	97.53%	96.57%	94.59%	96.00%	96.11%

HR Metrics - PDR

The Christie NHS Foundation Trust



Last updated: 10/04/2024

Performance | Appraisal

Overall Compliance
84.94%

Expired Appraisals
715

Appraisals Due Soon
559

Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
85.79%	85.88%	86.05%	88.00%	87.60%	87.61%	86.78%	86.27%	85.84%	86.33%	87.04%	86.45%	84.94%

	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
CMPE	90.95%	93.33%	94.61%	95.12%	94.29%	91.60%	89.47%	92.03%	85.16%	84.06%	86.80%	84.46%
CNS	82.62%	87.69%	89.46%	89.83%	90.17%	88.15%	86.40%	83.26%	84.71%	86.39%	85.51%	85.15%
Corporate Development	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	90.91%	100.00%	100.00%	100.00%	76.92%	84.62%
CSSS	87.38%	83.68%	86.07%	84.74%	83.18%	84.12%	84.30%	83.60%	85.47%	87.10%	85.15%	82.06%
Digital Services	94.74%	91.75%	87.76%	81.82%	80.20%	79.41%	82.52%	84.62%	83.81%	83.02%	81.82%	79.09%
Education	94.03%	93.85%	89.55%	93.85%	92.31%	92.42%	90.77%	88.24%	90.14%	94.37%	93.51%	92.94%
Estates & Facilities	81.55%	71.98%	80.26%	82.83%	86.27%	84.10%	86.01%	85.60%	85.94%	85.08%	86.56%	87.55%
Finance	82.81%	87.50%	82.81%	84.13%	87.88%	90.77%	94.03%	94.12%	97.14%	94.37%	94.37%	94.29%
GM Cancer	73.17%	84.09%	80.85%	81.63%	86.00%	88.24%	86.27%	82.14%	85.71%	87.50%	91.23%	84.21%
Performance	82.61%	77.27%	72.73%	70.00%	70.00%	72.73%	72.73%	78.26%	78.26%	77.27%	90.91%	91.67%
Quality and Standards	84.85%	93.94%	97.06%	96.97%	96.97%	97.06%	96.97%	96.88%	96.77%	100.00%	90.91%	86.11%
Research and Innovation	88.50%	87.24%	90.57%	87.50%	88.22%	85.91%	85.32%	90.14%	90.76%	89.29%	89.49%	86.07%
Strategy	50.00%	50.00%	60.00%	60.00%	60.00%	66.67%	77.78%	70.00%	50.00%	55.56%	66.67%	66.67%
Trust Administration	92.86%	92.86%	92.86%	92.86%	93.33%	87.50%	82.35%	94.12%	76.47%	75.00%	75.00%	73.33%
Workforce	89.83%	94.83%	93.22%	91.67%	90.16%	93.44%	93.33%	92.98%	96.49%	91.53%	88.71%	93.55%

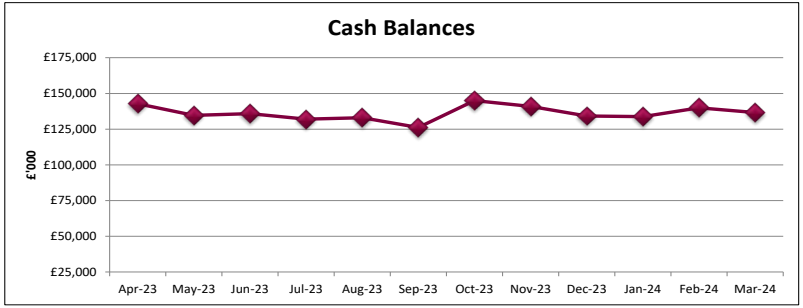
Workforce Metrics - Turnover

The Christie NHS Foundation Trust

Finance (Executive Summary)

The Christie NHS Foundation Trust

Month 12 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(373,973)	(373,973)	(406,452)	(32,478)
Other Income	(68,922)	(68,922)	(65,716)	3,206
Pay	212,392	212,392	212,518	126
Non Pay (incl drugs)	218,455	218,455	236,586	18,131
Operating (Surplus) / Deficit	**(12,048)**	**(12,048)**	**(23,064)**	**(11,016)**
Finance expenses/ income	28,723	28,723	17,170	(11,554)
(Surplus) / Deficit	**16,675**	**16,675**	**(5,894)**	**(22,569)**
Exclude impairments/ charitably funded capital donations	(8,637)	(8,637)	(903)	7,734
Adjusted financial performance (Surplus) / Deficit	**8,038**	**8,038**	**(6,797)**	**(14,835)**



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

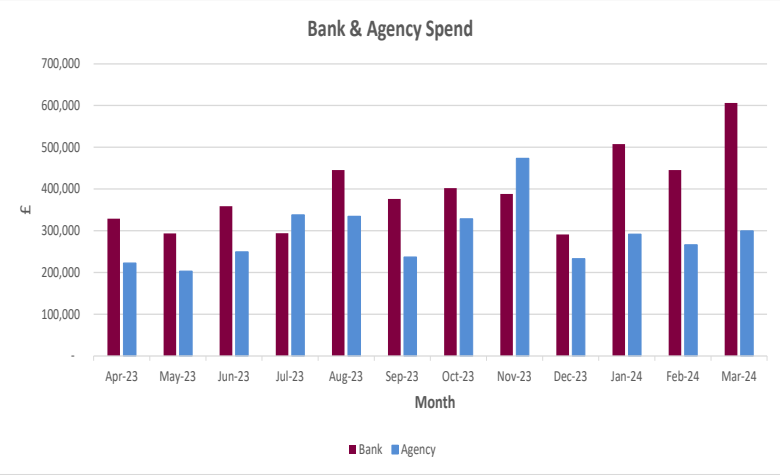
I&E

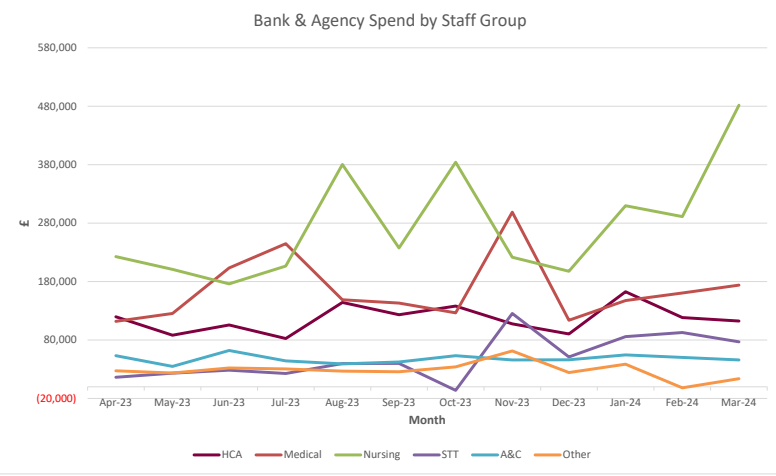
- The Trust is reporting a year end surplus of (£6,797k) against an annual plan of £8,038k, which gives a positive year end variance of (£14,835k).
- The in month position for month 12 is a surplus of (£1,513k) against a deficit in month plan of £670k which gives a positive in month variance of (£2,183k).
- 2023-24 CIP – CIP was delivered inline with overall target of £12.5m, although under recovery against the recurrent target by £4.5m was offset by over recovery of non recurrent schemes by the same amount.

Balance sheet / liquidity

- The cash balance is £136,607k.
- Year end capital expenditure is in line with the revised CDEL envelope agreed with GM
- Targets have been achieved against payment of our NHS creditors paid within the 30-day Better Payment Practice Code target.

Finance (Expenditure)

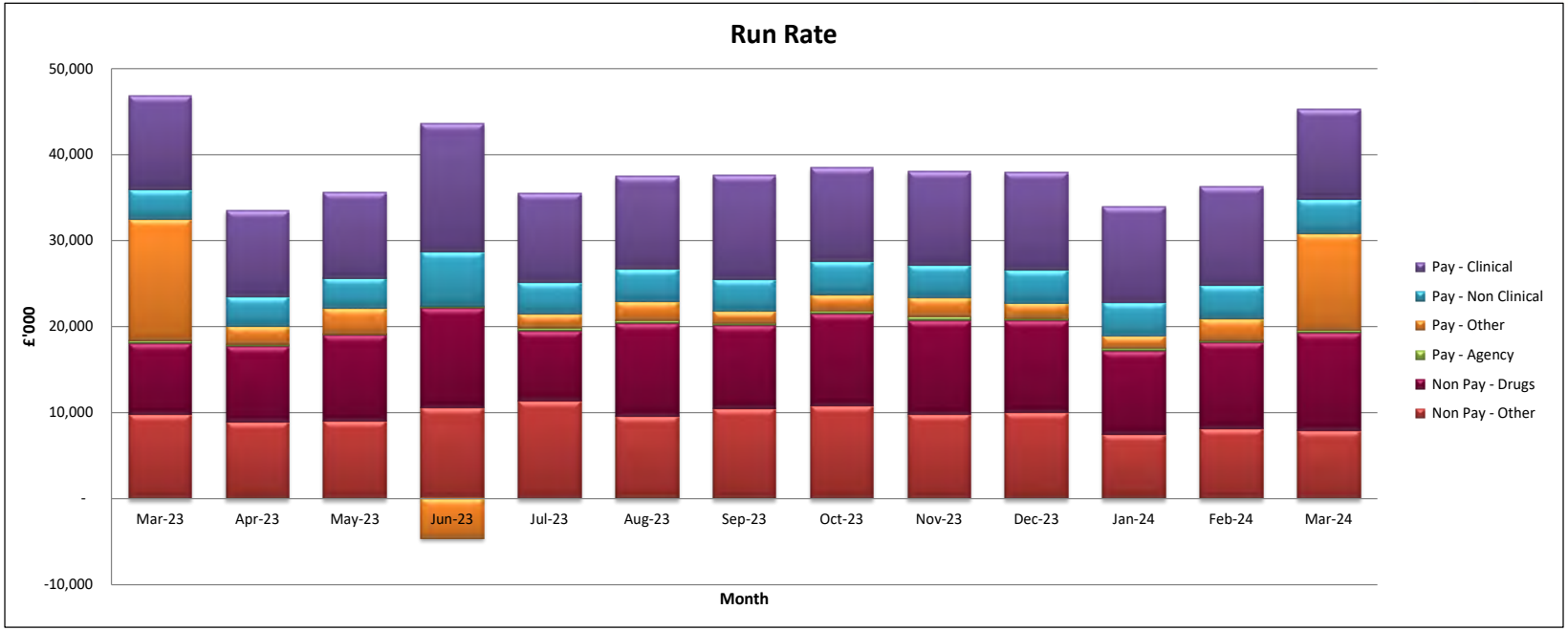




The agency spend is £300k in month 12, an increase of £33k from month 11. This is mainly due to an increase on Clinical Nursing agency spend.

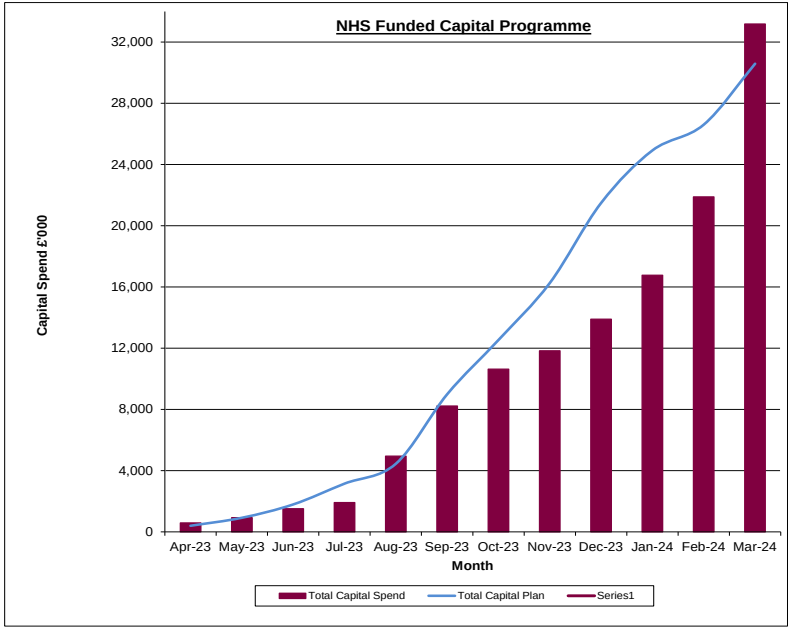
Alongside this, bank usage has increased by £161k in month compared to month 11, largely driven by higher spend on nursing within surgical theatres, relating to backpay on working time directive payments.

5.2 - Finance (Expenditure)



- Drugs spend in month 12 is £11,289k, an increase from month 11 of £1,290k.
- Pay – Clinical spend in month 12 is £10,498k.
- Pay – Other spend includes notional spend of £8.1m in relation to pension contributions, this is offset entirely with income resulting in nil impact to the Trust position.
- Pay – Agency spend in month 12 is £298k, an increase of £32k from month 11.
- Key elements of 'Non-Pay Other' spend consist of clinical supplies and services, premises and infrastructure costs.

Finance (Capital)

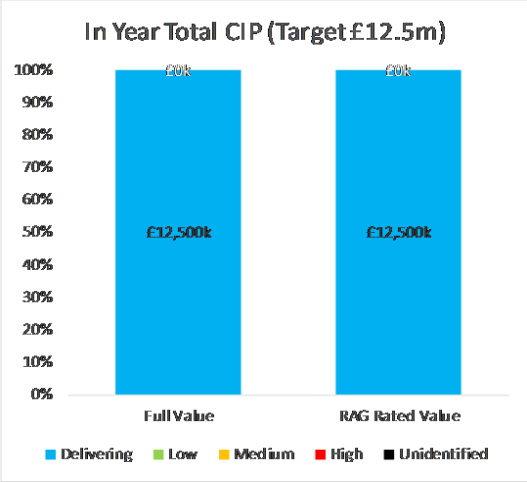


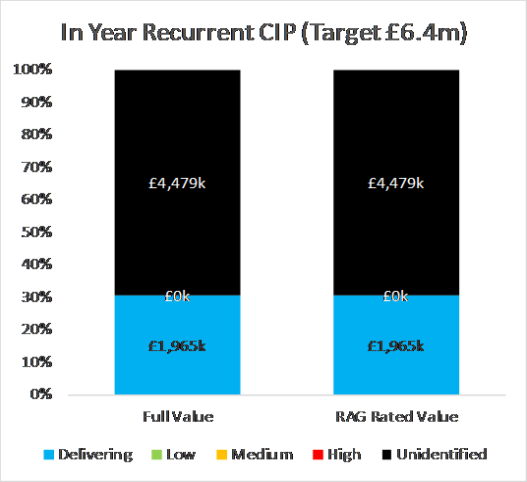
	Original Plan Apr-23 £k	Revision £k	Revised plan/ forecast o/s £k		Year to date- original plan £k	Year to date - actual £k	Year to date - variance £k
Annual depreciation charge 2023-24	**21,370**	**1,630**	**23,000**		**21,370**	**22,730**	**(1,360)**
GM capital plan control total - Trust own cash	**19,820**	**2,592**	**22,412**		**19,820**	**22,253**	**(2,433)**
PDC capital funded schemes	**10,083**	**526**	**10,609**		**10,083**	**10,609**	**(526)**
Loan and lease funded schemes	**686**	**(686)**	**0**		**686**	**0**	**686**
Total annual capital programme under CDEL	**30,589**	**2,432**	**33,021**		**30,589**	**32,862**	**(2,273)**
ASIC development	**0**	**0**	**0**		**0**	**0**	**0**
Art room refurbishment	**0**	**278**	**278**		**0**	**278**	**(278)**
Other Charity/ Grant Funded	**0**	**39**	**39**		**0**	**39**	**(39)**
Charity funded programme	**0**	**317**	**278**		**0**	**317**	**(317)**
Total Trust Annual Capital Programme	**30,589**	**2,749**	**33,299**		**30,589**	**33,179**	**(2,590)**

Performance to month 12 was £2,590k above the original plan submitted to NHSE&I in April 23 but inline with the revised capital plan agreed with GM following the significant variations in approved capital budget sums the Trust has dealt with during 2023-24, which include an additional £5m increase to our plan following an additional transfer of capital envelope from Cheshire & Merseyside ICB.

The Trust has incurred £33,179k on capital schemes to month 12, primarily on the backlog maintenance programme, the linear accelerators and CT scanner replacements, Digital Services Electronic Health Records projects, final works on the Paterson scheme, the Proton treatment planning system and the TIF ward refurbishment. This includes £278k capital expenditure on the charity funded Art Room refurbishment.

Finance (CIP)





Total In year CIP

- Total identified CIP schemes reported are £12.5m (£10.5m non recurrent / £2m recurrent).
- Risk adjusted identified schemes value £12.5m leaving £0 unidentified.

Recurrent

- Schemes totalling £2m have been identified recurrently against a recurrent target of £6.4m.
- This leaves £4.5m 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**	**£12,500k**	**£0k**	£12,500k	£0k	**£12,500k**	**£12,500k**	**£0k**
Recurrent CIP	£6,445k	£1,965k	(£4,479k)	£1,965k	(£4,479k)	£6,445k	£1,965k	(£4,479k)
Non-Recurrent CIP	£6,055k	£10,534k	£4,479k	£10,534k	£4,479k	£6,055k	£10,534k	£4,479k