

Board of Directors meeting
Thursday 22nd October 2026 at 2.00pm
Paterson Meeting Room 104/105

Agenda

Patient story / clinical presentation: Experience of care and treatment - Abdul Kaiyum, patient
30 mins

Public items	Decision		Lead	Page	Timing
25/26 Standard business					
a Apologies			Chair		
b Declarations of interest			Chair		
c Minutes of previous meeting – 24 th September 2026	Approve	*	Chair	2	5 mins
d Action plan rolling programme, action log & matters arising	Review	*	CEO	10	
26/26 Performance & finance					
a Trust report	Review	*	Execs	13	
b Integrated performance quality & finance report	Review	*	COO	20	15 mins
c Value Improvement Programme update	Review	*	COO	65	
10 Minute Break					
27/26 Strategy					
a Regulatory preparedness update	Review	*	ECN	70	15 mins
b Developing the strategic framework – process and approach	Review	*	DoS	74	5 mins
29/26 Governance (regulatory / statutory compliance)					
a Reports from committees (Oct 2026 meetings)					
• Quality Assurance Committee		*			
• Workforce Assurance Committee	Review	*	Committee chair	76	10 mins
• Strategy & Transformation Assurance Committee		v			
• Senior Management Committee		*			
b Board assurance framework	Review	*	CEO	91	10 mins
c EPRR compliance statement	Approve	*	COO	101	10 mins
d Inquiry self-assessments	Review	*	ECN	107	20 mins
30/26 Any other business					
Reflections on the meeting					
Items for information					
Feedback from September patient story	Note	*	Execs	114	

Date and time of the next meeting
Thursday 26th November 2026 at 2:00pm

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

* paper attached
v verbal
p presentation



**Public meeting of the Board of Directors
Thursday 24th September 2026 at 2.00 pm
Trust Meeting Room**

Present: Chair: Prof Joe Rafferty (JR), Chair
Roger Spencer (RS), Chief Executive Officer
Alveena Malik (AM), Non-Executive Director
Amanda Oates (AO), Non-Executive Director
Dr Marisa Logan-Ward (MLW), Non-Executive Director
Sarah Corcoran (SC), Non-Executive Director
Roy Dudley-Southern (RDS), Non-Executive Director
Dr Diana Tait (DT), Non-Executive Director
Jim Hughes (JH), Non-Executive Director
Grenville Page (GP), Non-Executive Director
Eve Lightfoot (EL), Director of Workforce
John Wareing (JW), Director of Strategy
Claire McPeake (CM), Chief Operating Officer
Vicky Sharples (VS), Chief Nurse and Executive Director of Quality
Sally Parkinson (SP), Executive Director of Finance
Dr Neil Bayman (NB), Executive Medical Director & DCEO
Prof Adrian Bloor (AB), Director of Future Christie

Minutes: Louise Westcott (LW), Company Secretary

In attendance: Jo D'Arcy, Assistant Company Secretary
Dr Farouk Vawda, member of the public
James Bromfield, member of the public
Michael Reed, representing Amnesty International

Clinical presentation: Scanning experience, Justine Carson (JC)

JC introduced herself and expressed her gratitude for her treatment at The Christie.

JC outlined her experience of first having breast cancer in 2021 and after treatment being declared cancer free. In 2023 scans revealed the cancer was back and had spread and was at stage 4. 3 years later she is stable and having 3 monthly scans. She is awaiting scan results at present.

JC explained that she lives well and her care is underpinned by scanning to decide on her next line of treatment. Bloods always remain in the normal range, so scans are the way to understand changes. She described living in 3-month cycles. The period between scans allows some 'normal' life. Have had 3 monthly scans for 3 years.

JC described her experience of the scanning facility (Pat Seed dept) getting much busier. She described the pathway through the department for a CT scan as taking around 3 hours. The need to drink liquid an hour before whilst sitting in the waiting room. Carers often having to stand as there are no seats. The need to complete a questionnaire and have a cannula fitted. New patients don't always know what they need to do and there isn't always someone to ask.

The new scanning centre is designed with patient dignity and capacity in mind and should address many of the current issues. However, JC expressed her worry about the interim period.

There are areas that can be improved now. The communication around a scan is confusing, at the follow up review, the scan request is submitted, and this is sometimes then undertaken too near to the review appointment or even afterwards.

As a patient JC described wanting to have 3 monthly scans. She explained that there is no clear directive as to who to chase for scan appointments, and that she doesn't get texts for scans currently. The booking and communication needs to be more streamlined.



JC noted that she went for her last scan at Bolton and she was in and out in 15 minutes. She was asked to drink water before she arrived and then went straight in and didn't have to sit in the waiting room. She then had the cannula removed after the scan.

RS updated the Board on the planned scanning build (ASIC's). The fundraising is underway for the project, and this is on track. The cost is around £100m. We are confident that we can build the new facilities in a complicated part of the site and we are making good progress with this.

We need to have a modernised process of looking after patients through this scanning experience. A team are looking at communication with patients, booking and effectiveness of flow through the service. There is work underway and we need even more patient involvement in this.

CM thanked JC for describing the experience. CM noted that patients shouldn't be sat waiting and we need to be streamlining the experience with the patient at the heart of this.

VS asked about privacy and dignity and asked how it feels for the patients. JC noted that it can be extremely helpful to speak to others in the waiting room and that's good. Toilet access and water are not available easily. It's not clear for patients what they should do in terms of completing questionnaires and what to wear for the scan.

AM thanked JC for her feedback and asked about the Bolton experience. JC noted that she was asked to go for an earlier appointment at Bolton and it was very easy, no waiting, very slick and a good experience.

NB noted that doing the whole procedure built around the patient versus the service is where we need to be and what we are working on.

DT noted that the timing of scan appointments and review appointments is crucial for the patient. The scans have to be reported, and this timeframe must be taken into account.

JC described that the period between a scan and the review must be as short as possible as this is when she allows herself to worry and that's very difficult.

GP asked about JC's anxiety and how this is supported by The Christie. JC noted that when you're first diagnosed, the initial focus is on staying alive and the oncologist is focused on treatment. As this progressed it did feel that things were difficult particularly around medical menopause. Help with finance and benefits etc is also very important. Communication of the support that the secondary breast cancer team can provide was only discovered some way in to care. It's difficult to find out what support exists.

AB asked about 'scanxiety' and whether making results available ahead of an appointment would be useful. JC responded that she would need to have the option to call someone immediately if there was an issue.

AB asked about signposting to other services and the ideal of there being one place to go to that sends you to the right place. JC noted that if the sign posting doesn't help then this would add more frustration, it must result in resolution to the issue.

NB recognised that waiting for scans then review is recognised as an issue nationally. Patient stratified follow up is recommended that tracks when patients should be having scans and then the follow up. This is being rolled out and we are trying to pilot this starting with colorectal cancer patients. Technology has advanced to support this.

JR thanked JC. JC noted that she thinks this is a brilliant thing for the patients to speak to Board.

JR thanked JC for all her feedback, good and bad. Our focus is on our desire to make this better for patients, and we will continue working to improve and will respond to this feedback. We know about these things but need to continue to help patients in the interim period before the new centre opens.



RS thanked JC for her support to the Charity in their fundraising efforts and there's significant progress.

CM confirmed that we don't have a lack of capacity for CT but we do have many issues with communication and booking of scans.

MLW noted what a fantastic patient experience story this is and we must respond to this. Feedback on the issues raised will come back to Board and be fed back to Justine.

We must take some of the administrative burden away from patients.

NB noted that PSFU will allow booking of the scans and appointments before a patient leaves their appointment.

Item		Action
20/26	Standard business	
a	Apologies	
	Prof Rikki Goddard-Fuller (RGF), Director of Education, Fiona Blackhall (FB), Director of Research, Jeanette Livings (JL), Director of Communications, Dan Bate (DB), Non-Executive Director, Nick Williams (NW), Non-Executive Director	
b	Declarations of Interest	
	No declarations made relating to the business of the meeting.	
c	Minutes of the previous meeting – 25th June 2026	
	The minutes were accepted as a correct record.	
d	Action plan rolling programme, action log & matters arising	
	All items from the rolling programme are complete or noted on the agenda.	
21/26	Performance & Finance	
a	Trust Report	
	- There are no adverse variances against our objectives at month 5 and we are on green in all 6 NHS oversight framework domains. There is no adverse performance to note. We remain in segment 1 and are currently ranked 9th nationally. - The good performance is in the context of difficulties in the NHS overall. - We are trying to support colleagues in the Northern Care Alliance, and are looking to provide mutual aid where possible. - The AFT process is progressing and will conclude with a Board to Board with NHSE on 30th September. We will find out the outcome around the end of October. - RS drew attention to the requirement around contacting patients to let them know we have received their referral. This is being implemented. - RS noted that there is a requirement on the Trust set out in NHSE's operating guidance to use the federated data platform (FDP). Significant concerns have been raised with us around the use of the platform. These concerns have been raised with NHSE as they hold the contract. - NB noted that the FDB hosts several products. The one we have been using is the patient stratified follow up product. We have been using this with colorectal patients. This tracks scans needed and schedules appointments. It makes sure scans aren't missed and appointments are in the correct timeframes. This helps	



	release capacity in the system. • There is a national expectation that we use this product with other patient groups. • We're looking at a further product around Single Queue Diagnostics with PET-CT scanning. This looks at the capacity in the whole system to schedule appointments as quickly as possible and use all available capacity. • These products do process patient data and concerns have been raised around the FDP that have been escalated. • JH noted the positives and asked about assurances around IG safeguards and whether the data for Christie patients stays within the Christie. • NB noted that there are signed data processing schedules and a data processing agreement. The data can only be accessed by someone at the Christie. The data is not accessible outside of the organisation or anyone other than the clinicians. • AM asked about the workforce's response to the use of the FDP. • NB noted that our use of FDP is limited and there's been no real response from workforce up to now. We are considering this with the use of technology in changing care, particularly with AVT and EPR. • EL noted that we engage and involve staff in the roll out of new technology to involve them in the design of new processes. We are also engaging unions. • AB noted that we can't stay still and we must change to better serve patients. AVT has had a mixed response from clinicians but its much better for patients and we must always bring everyone back to this. • VS noted that staff tell us that our systems aren't working for them so there's an appetite to change and move to better systems. There's an imperfect system currently.	
b	Integrated performance quality & finance report	
	• CM outlined the most recent available published position (Q1 2026/27) showing good results – segment 1 and 9/134 in the acute & specialist league-table. • Predicted to stay in segment 1 and be within the top 10 in Q2. • The headline performance was outlined – we have exceeded or on plan for 62 days / FDS / 18-week RTT and finance & activity. • We are focusing on internal pathways as well as supporting system partners with referrals to us. • Compliance and patient volumes were outlined showing compliance across all requirements in line with our plan. • Board noted the month 5 financial position including liquidity. This was noted as on plan and further detail will be considered at the next meeting. • Integrated delivery plan outlines delivery and transformation programmes. • The GM planning hub meetings have started, and planning activities involve all relevant staff across the Trust. • An NHSE submission is required after the Board session on 2nd October. • The full year VIP plan is achieved at month 5 and is forecast to be fully delivered in month 6. Attention is now focused on developing the 2027/28 programme, supported by full governance, executive oversight and established routes for monitoring delivery, risk and mitigation. • The process for mid-year review was outlined including the requirement for self-	



	certification submissions as well as meeting with NHS Regional teams. - GP noted that some metrics are in segment 3 or 4. What action has been taken to address these. - CM noted that trial set up is 3 and smoking cessation is 4. - Trial set up – working with R&I, improvements are being made but this won't impact until Q4. - Smoking cessation – we have predominantly provided an OP service; this is an inpatient metric. We have changed the service to focus on inpatients and are correcting our data for this quarter. We've seen a marked improvement but won't see the impact until Q3/4. - AO asked about the agency decrease and annual leave and what controls are in place for this. EL to feed back.	EL
c	Value Improvement Programme update	
	- CM noted the paper shows the monthly update and position for 2026/7. - Aiming to close 2026/27 programme next week and the focus is then on 2027/28 from October onwards. - The programme was balanced across the year. We are well ahead of the requirements. - The paper gives a breakdown of the approach, governance arrangements, quality impact assessments and the framework that is in place - DT asked about the quality impact assessments on VIP schemes and how this works. Can more detail come through QAC - Every scheme has a QIA and this must be done before the scheme is accepted. The ECN and EMD must sign off the assessments. These are reported through Risk & Quality Governance and are kept dynamic. Assessments are revisited throughout the life of the schemes. - A worked example to be brought through QAC. - DT asked if there is an appetite for VIP schemes and how do staff feel. - CM noted that staff are still engaged in the process. Ideas summits are held with all staff, and they are very engaged in this process. - Divisions do not always agree, and challenge exists in these discussions. House keepers are a very helpful group with ideas and there is good engagement from across staff groups. - VIP schemes are very much clinically led and have finance support. - MLW asked about the wait for biopsy results and felt that histology turnaround times should be part of the diagnostic waiting information. - CM noted that we've had a risk on the risk register around this. This is a dynamic report, and this will be considered as part of future reporting. - AO asked about the compounding effect of risks should things culminate at the same time. - VS noted that infection control thresholds are set by NHSE and they are stretch targets. C Diff threshold is 35 and is a very tough target. We have a robust review process with learning response. E-coli/klebsiella and gram-negative bacterium – all difficult to achieve thresholds. Our activity is increasing and the target is decreasing. - There is a lot of work to do in this area. We have issues that we are addressing	CM/VS CM



	and there's a piece of improvement work taking place. • VS offered to provide more information on infection prevention & control for any individuals who want to know more. • SC noted that she is satisfied with the systems in place and governance relating to these issues and this has been reviewed and assurance received at the Quality Assurance Committee.	
22/26	Strategy	
a	Strategy refresh engagement plan	
	• JW noted the process set out to refresh the strategy over the coming months. • We are 3 years into an existing 5 year strategy (2023-28) and this is the right time to refresh this. • Neighbourhood Oncology plans etc need to be reflected, as well as reflections from the 10 year health plan. • We need to look at digital transformation, new care models etc in the refreshed strategy. • There are opportunities for Board to input into and guide this process. • JH asked what the steering group / Strategy & Transformation Assurance Committee relationship will be. • JW noted that this is the engine room for development and will be fed back into assurance and Board structure. • Board noted the planned timeframes for development of the refreshed strategy.	
23/26	Governance (regulatory / statutory compliance)	
a	Reports from Committees (June-Aug 2026)	
i	Audit Committee	
	• GP noted the report and invited questions. • The formal process to submit annual accounts has been completed. • DSPT internal audit reviewed – assessed as meeting standards, acknowledged that there are on going issues to focus on with cyber that continue into the next assessment. • Deep dive on supply chain and report from Pharmacy noted and showed acknowledgement of global impacts on supply chain. • Undertook a review of the Fuller enquiry response and this showed we had what was needed in place • FPPT reviewed and compliance noted • Next meeting will review EPRR self-assessment • External tender process undertaken in August to appoint external auditors with input from Governors. Grant Thornton have been appointed. • Questions invited. None received	
ii	Workforce Assurance Committee	
	• AO noted that the risks relating to Workforce have been redescribed • Medical devices medium assurance is coming to the next meeting for further assurance • Committee will review medium assurance items.	



iii	Quality Assurance Committee	
	- SC noted that the committee is having good discussions. - Medium assurance items are coming back for further review. - IPC has been a focus as previously discussed.	
iv	Senior Management Committee	
	- Report shows the business of the SMC aligned to the work of the Board. - The committee has been renamed Management Board and the agenda realigned to reflect feedback from the Well-led Developmental review. - No items for escalation. - Most recent meeting (Sept) noted the recent national enquiries that have been published. VS noted that a full review will be coming back in October. - Self-assessments have been completed against the Amos, Ockenden and Thirlwall reviews. Strong assurance has been seen alongside some improvements. - The improvements will be aligned to the well-led outputs and one set of recommendations produced. - Noted that Thirlwall recommendations are being worked through including Board level safeguarding training. Our implementation of Martha's Rule supports our assurance against the recommendations. - Great conversations have taken place around curiosity and questioning that test our assumptions. - GP noted that in person training for safeguarding would be a preference. - JR asked about how we describe when the police should be contacted. VS responded that we act in partnership with other agencies and do not hesitate to contact the police. We have examples of this in recent cases. - SC reminded colleagues that she is NED at The Countess of Chester – there are conversations about protective processes for staff. - Further information to come back to Board in October.	
b	Board Assurance Framework	
	- Latest BAF presented. - RS noted that a number of the risks have been redescribed to better reflect the current position of risks against delivery of strategic objectives. - The risks are all assigned to a committee and many are being reviewed through the next round of assurance committees. - AB noted that Board assurance around cyber requires a bigger discussion and this will be done through assurance committees. - Training opportunities has been circulated to Board around cyber. We are also linking with MFT on cyber. The new CIO has a strong cyber background. - Request to receive a cyber report direct to Board possibly with external input.	AB
c	Winter Assurance checklist	
	- Assurance statement has been completed and shows full assurance. - Prevention and vaccination section is different as a specialist centre - Board asked to sign off the statement ahead of the submission. - RDS noted that he was disappointed to see no reference to El Nino and the	



	potential impact this may have on supply chains • CM noted that this is picked up through EPRR. The winter preparedness is around flow and provision of care ahead of winter. • CM noted that EPRR is being picked up through Audit Committee. • VS noted the specific risk around storage of fluids is being addressed through the new Director of Pharmacy. • Deep dive on EPRR and supply chain take place through Audit Committee and are on the rolling programme. • RS noted that we have experience around supply of medicines and take national advice around stockpiling of medicines. • Approved for submission	
24/26	Any other business	
	Trust admin is moving to the ground floor of Paterson building from 19 th October.	
	Reflections of the meeting	
	SC noted that as a virtual participant it was difficult to hear some voices in the room. The participants appreciated the break in the agenda.	
	Date and time of the next meeting	
	Thursday 22 nd October 2026 at 2pm	



Meeting of the Board of Directors - 22nd October 2026
Action plan rolling programme after September 2026 meeting

C Culture P Performance S Strategy G Governance

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
October 2026		C	Patient story	CEO	To hear a patient story	Board presentation
		P	Integrated performance & quality and finance report	COO	Monthly report	26/26b
		P	Value Improvement Programme	COO	Review	26/26c
		S	Strategic Framework	DoS	Review	27/26b
		P	EPRR Compliance statement	COO	Approve	29/26c
		G	Regulatory preparedness update	ECN	Review	27/26a
		G	Inquiry self-assessments	ECN	Review	29/26d
	Planning & Development Day	S	Board Planning & Development	Chair	Board development programme	N/A
November 2026		C	Patient story	CEO	To hear a patient story	
	Annual reporting cycle	P	Integrated performance & quality and finance report	COO	Monthly report	
		S	Strategy update	DoS	Six month review	
		P	Value Improvement Programme	COO	Review	
		S	Higher Education Institute update	DoE	Note	
		C	Freedom to speak up guardian	FTSUG	Annual report	
		S	Annual Sustainability Report - Boards responsibility for Carbon Net Zero	DCEO	Note approval by Audit Committee	
December 2026 - no Board meeting		P	Integrated performance & quality and finance report	COO	Monthly report	By email
	Planning & Development / Council	S	Board planning			
		S	Council / Board - strategy update			
January 2027		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Interim review of annual objectives	CEO	Review progress	
	Annual reporting cycle	P	Integrated performance report	COO	Monthly report	
		P	Value Improvement Programme	COO	Review	
February 2027 - no Board meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
	Annual reporting cycle	G	Letter of representation & independence	Chair	Circulate	By email
	Annual reporting cycle	G	Register of directors interests / FPPT annual declaration	Chair		
	Annual reporting cycle	G	Declaration of independence (non-executive directors only)	Chair		
	Planning & Development Day	S	Board development & planning	Chair	Board Development programme	N/A
March 2027		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance & quality and finance report	COO	Monthly report	
		P	Value Improvement Programme	COO	Review	
	Annual reporting cycle	S	Annual reporting cycle	Executive directors	Approve	
		C	Staff survey initial results	DoW	Review	
	Annual reporting cycle	G	FPPT Compliance report	Chair	Approve annual compliance	

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
April 2027		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance & quality and finance report	COO	Monthly report	
		G	Register of matters approved by the board	CEO	Approve	
	Provider licence	G	Self certification declarations	CEO	To approve the declarations	
		G	Modern Slavery Act statement (in Trust Report)	CEO	Approve	
		C	Freedom to speak up Guardian report	FTSUG	6 monthly update	
	Annual reporting cycle	P	Risk Management strategy 2026-27 annual review	ECN	Approve	
May 2027 - no meeting Planning & Development Day	Annual reporting cycle	P	Integrated performance & quality and finance report	COO	Monthly report	By email
	Planning session	S	Planning			
June 2027		S	Green Plan refresh	DoS	Approve	
		C	Patient story	CEO	To hear a patient story	
	Annual reporting cycle	P	Integrated performance & quality and finance report	COO	Monthly report	17/26b
	Annual reporting cycle	G	Annual reports from audit, quality and workforce assurance committees	Committee chairs	Assurance	At joint meeting
	Annual reporting cycle	G	Annual compliance with the CQC requirements	ECN	Declaration / approval	17/26d
		P	Value Improvement Programme	COO	Review	17/26c
		S	Annual objectives / BAF		Approve	18/26b/c
	Annual reporting cycle	G	Annual report, financial statements and quality accounts (incl Annual governance statement / Statement on code of governance)	EDoF	Approve	18/26e
July 2027 - no meeting Planning & Development Day		P	Integrated performance & quality and finance report	COO	Monthly report	By email
	Planning session	S	Service Review day with senior leadership teams			
August 2027 - no meeting		P	Integrated performance & quality and finance report	COO	Monthly report	By email
September 2027		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance & quality and finance report	COO	Monthly report	
		P	Value Improvement Programme	COO	Review	
		S	Strategy update	DoS	Review	
	Planning & Development Day	S	Board Planning & Development	Chair	Board development programme	



Action log following the Board of Directors meetings held on

Thursday 24th September 2026

No.	Agenda	Action	By who	Progress	Board review
1	Patient story	Address feedback from patient story on improvement work in radiology.	CM	Feedback followed up across multiple areas	Response included in October Board pack
2	21/26b	Provide more detail on agency decrease and annual leave controls to AO.	EL	Complete	N/A
3	21/26c	Quality Impact Assessment worked example from a VIP scheme to be brought to QAC	CM/VS	Added to QAC agenda	December QAC
4	21/26c	Consider reporting of histology turnaround times data	CM	Review of reporting underway	November IPQFR
5	23/26b	Cyber report to Board with external input	AB	Options under consideration aligned to Board training	Board development session



Meeting of the Board of Directors

Thursday 22nd October 2026

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



Trust Report

October 2026 (September data)

Introduction

We continue to perform and project achievement of annual objectives across all domains. There are three areas of local operational escalation outlined in the IPQFR.

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

The NHS Oversight Framework 2026/27 outlines how we are assessed [NHS England » NHS Oversight Framework 2026/27](#). Trust monthly reporting reflects this framework.

Board Capability

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

The [NHS England provider capability](#) domains were assessed as 'Green' for 2025/26.

The table below summarises the position with all domains rated Green, with no escalation required.

NHSE Board capability domain	Relevant Indicators	Evidence	RAG rating
1. Strategy & Leadership	Oversight Framework segment; national ranking	NOF Segment 1, Q1 ranked 9 th nationally NHS Acute & Specialist Trusts.	Green
2. Quality of Care	62-day cancer standard; Faster Diagnosis Standard; nurse staffing	62-day and FDS remain above target. Nurse staffing consistently exceeding the minimum target of 80% planned levels	Green
3. Workforce	Sickness absence; PDR compliance; training compliance	Sickness 5.04% (lowest in GM). PDR compliance (89.79%) and mandatory training compliance (95.01%)	Green
4. Partnerships & System Role	GM Collaborative contributions; national audits	Leadership in Cancer Alliance. Lead GM aseptic programme. OECl reaccreditation confirms global top-tier status.	Green
5. Financial Sustainability	Monthly surplus; VIP delivery	Surplus (£3.79m) on plan; value improvement plan target achieved.	Green
6. Improvement & Innovation	Clinical trial set-up; AI pilots; EPR milestones	Research set-up below 60-days. Digital/AI projects and Future Christie milestones progressing to plan.	Green



The Trust was selected as part of the second wave of organisations invited to seek AFT status, reflecting operational, quality and financial performance and consistent placement in Segment 1 of the NHS Oversight Framework.

The Trust has completed submission of a Board Memorandum and supporting evidence to NHS England and a Board to Board assessment took place on 30th September as the final step in the process. We await NHS England's decision on our application.

Operational Performance – Month 6 Position

We continue to perform strongly across all domains. We are in Segment 1 of the NHS Oversight Framework, and at Q1 are ranked 9th nationally among acute and specialist providers. Our international standing ranks us as one of the top 25 global cancer centres as reported at the September 2025 board meeting. Our overall NHSE provider capability rating is assessed as 'Green' for 2025/26.

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

Strategic Objectives – Month 6 Position

Progress against the 2026/27 annual milestones of each of our six strategic objectives is currently rated Green, with risks actively managed and oversight of risks assigned to committees or the board and tracked through the Board Assurance Framework.

Strategic Objective 1: Safe, Effective and Equitable Care

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

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

There were no significant adverse quality variances in September. One operational risk currently scores above 12 and risks are monitored via the Risk & Quality Governance Committee, with mitigation plans in place.

Safe staffing was maintained, with nurse staffing consistently exceeding the minimum target of 80% planned levels.

Incident reporting remains within expected limits, with 97% of reported incidents resulting in low or no harm. Healthcare-associated infections remain an area of focus, with E. coli, Klebsiella and P. aeruginosa bloodstream infections above the year-to-date trajectories and targeted improvement actions in place.

Our staff flu vaccination programme started on 5th October, initial uptake has been good, and work continues to encourage staff to get their vaccination.

The October Public Board papers includes a paper responding to patient feedback from the September Board meeting relating to scanning and associated experiences.

Smoking cessation performance remains below the required position, with revised processes in place and data being quality assured to support improvement. Histopathology turnaround times



remain an operational concern and continue to require active management and oversight to improve performance.

Strategic Objective 2: Excellent Financial and Operational Performance

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

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

At Month 6, the Trust is delivering a financial surplus of £3.79 million, in line with plan. The principal financial risk remains recurrent efficiency delivery, although the full value has been identified the recurrent target has been offset by non-recurrent delivery.

Operational performance remains compliant against all major cancer standards, including the 62-day, 31-day and Faster Diagnostic Standard (FDS) metrics.

October is Cyber Security Awareness Month, highlighting the role we all play in keeping NHS systems, information and services safe. Cyber security is about protecting the digital systems and information we all rely on. At The Christie, this includes everything from patient records and clinical systems to email, devices and other digital tools used across the Trust.

Strategic Objective 3: Integrated Clinical, Research and Education Services

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

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

R&I continues to make strong progress in improving research study set-up. In September, 100% of studies were set up within 90 days; however, all new studies entering the pathway achieved the standard, with the overall position affected by a small number of legacy studies.

We have submitted an outline application for a National Institute of Healthcare Research (NIHR) biomedical research centre (BRC) funding opportunity. Our application is to host a Cancer North BRC that unites the North's leading cancer centres in the UK's largest cancer research partnership. The bid includes partners from Manchester, Liverpool, Leeds, Sheffield and Newcastle. The DHSC will confirm designation and funding for BRC's in September 2027.

Progressive improvement in external quality markers of education include those related to NOF ratings, National Education & Training Survey 81.5% (72.6% 2022) and National Training Survey 78.2% (75.4% 2023). Undergraduate learner experience within the Christie remains stable with overall satisfaction scores of 91-99% across disciplines. Workforce Education activity updates include a 37% increase in colleagues accessing CPD funding for education opportunities with WRES data demonstrating equal access/activity for racially minoritised staff.

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

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



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

Workforce indicators remain strong. Mandatory training compliance stands at 95.01%, and PDR completion is at 89.79%. Sickness absence is currently at 5.04%, the lowest in Greater Manchester. The Christie continues to be rated in the top category nationally for compassionate and inclusive culture, staff engagement, safe & healthy, morale and flexibility, as confirmed by the NHS Staff Survey 2025.

The NHS Staff Survey 2026 launched on 5th October giving colleagues the opportunity to share their views on working life at The Christie, including their wellbeing, development and what it's like to work here. The survey is run independently by Picker, with responses handled confidentially and anonymously. Feedback helps us better understand colleagues' experiences and identify areas for improvement.

Strategic Objective 5: Transform Services and Reduce Inequalities

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

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

Our Future Christie transformation programme remains on track. The Patient Portal has been successfully rolled out, connected to the NHS App. The capital programme is progressing to plan and remains within budget.

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

The Trust's Electronic Patient Record (EPR) Programme continues to progress following Board approval of the Outline Business Case in February 2026. The programme is currently working towards submission of a Full Business Case later in 2026.

Strategic Objective 6: Leadership Within the Wider NHS Cancer System

The Christie's leadership role within the regional and international cancer system is recognised and expanding.

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

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



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

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

National Policy Developments

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

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

1. Health Bill: provider autonomy and structural reform

On 9 September, the Department of Health and Social Care published further policy detail and impact assessments supporting the Health Bill. The Bill provides for the abolition of NHS England, changes to integrated care boards and provider governance, and a revised foundation trust model. It also establishes the legislative basis for advanced foundation trust status and integrated health organisation contracts.

Relevance to The Christie: This is directly relevant to the Trust's advanced foundation trust ambitions. The Trust continues to demonstrate strong governance, financial sustainability, quality, productivity and partnership working, while assessing the opportunities and risks associated with greater autonomy and any future integrated health organisation arrangements.

2. Revised NHS oversight framework and provider league tables

On 10 September, NHS England published the first segmentation results under the revised 2026/27 NHS Oversight Framework. The framework now uses updated metrics and fixed thresholds to determine provider segments, making movement between segments more transparent. A financial override continues to prevent trusts in deficit from being placed above segment 3.

The Christie was placed in **segment 1** and ranked joint 9th nationally in the acute trust league table, with an average metric score of 1.81.

Relevance to The Christie: The result provides positive external assurance regarding the Trust's performance and supports our case for earned autonomy and advanced foundation trust status.

3. Resident doctor employment arrangements

Updated guidance issued on 25 September requires trusts to implement the national resident doctor agreement consistently. It establishes substantive contracts as the default for locally



employed doctors, sets out arrangements for examination fee reimbursement and asks trusts to put proportionate monitoring arrangements in place to provide Board assurance on implementation. National monitoring will also be undertaken through the Resident Doctor Industrial Relations Committee.

Relevance to The Christie: The Trust is aligning our medical workforce policies, contracts and recruitment processes with the national guidance.

4. Patient confidentiality and unauthorised access to records

On 25 September, NHS England instructed NHS organisations to adopt a zero-tolerance approach to unauthorised, inappropriate or unjustifiable access to confidential patient information. The guidance states that unauthorised access will, in almost all cases, constitute gross misconduct and should be addressed accordingly. Immediate implementation was requested, supported by appropriate leadership, workforce and information governance arrangements.

Relevance to The Christie: An assessment has been undertaken around our access controls, audit arrangements, staff communications, investigation procedures and disciplinary policies to reflect the strengthened national position. This was presented to the Quality Assurance Committee in October with an associated action plan.

5. Patient experience excellence framework

On 17 September, NHS England published Achieving excellent patient experience. The framework positions experience alongside safety and clinical effectiveness as a core component of quality. It emphasises compassionate, inclusive and person-centred care, the systematic use of patient and staff experience, action to address inequalities and stronger leadership accountability. A self-assessment tool has been provided, with a national delivery plan expected in spring 2027.

Relevance to The Christie: The framework provides an opportunity to review how patient, carer and staff experience is incorporated into quality governance, service improvement and Board reporting and this is being reflected in Trust policy and assured through QAC.

6. Mandatory learning disability and autism training

On 14 September, the Care Quality Commission reiterated that appropriate learning disability and autism training is a regulatory requirement. It noted that uptake remains variable and that many larger providers and NHS trusts still have further work to do. The Oliver McGowan Code of Practice sets out how registered providers are expected to meet the requirement.

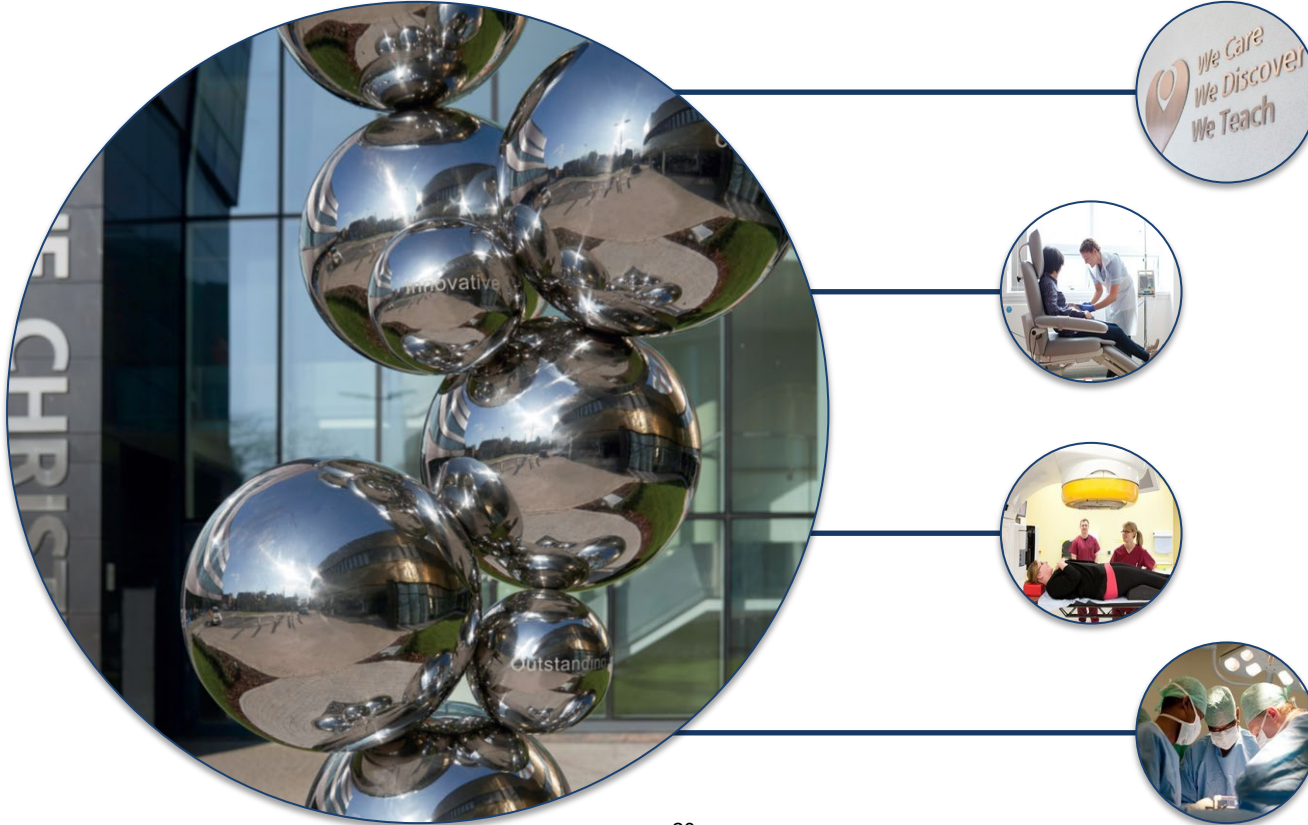
Relevance to The Christie: The Trust continues to maintain compliance with the mandatory training requirement, including completion rates, training quality and how learning is applied in oncology services.

7. NHS productivity measurement

On 8 October, NHS England published the methodology for calculating NHS productivity growth in 2026/27. The measure compares changes in provider activity with changes in workforce and other resource inputs. NHS England acknowledges that productivity provides only a partial view of performance and should be considered alongside quality, outcomes, safety and financial measures.

Relevance to The Christie: Work has been undertaken to understand how our activity and resources are reflected in the national methodology.





EXECUTIVE SUMMARY

Quality & Safety (slides 3-14): Incident reporting remains within expected limits, with 97% of reported incidents resulting in low or no harm. There is 1 extreme risk on the operational risk register of NWS division related to regional provision of radio-pharmacy. Healthcare-associated infections remain an area of focus; the Trust is above trajectory against nationally monitored HCAs and associated improvement plans are in place.

Finance (slides 15-19): The Trust is on plan at month 6, reporting a £3.79m surplus and full identification of the £25.3m in-year VIP requirement, with cash at £103m. Capital expenditure is £2.7m above plan.

Access & Performance (slides 20-29) : Cancer standards remain positive, with September performance above target for 62 days, FDS, 31 days and 18 weeks, while no patients were waiting over 52 weeks. The areas requiring continued management are 24-day internal pathway performance at 77.2% against the 85% target, exposure to late inter-provider transfers, and length of stay remaining above the 2025/26 average

Workforce (slides 30-38): Mandatory training is meeting target at 95.01%, but appraisal compliance is marginally below target at 89.79%. Sickness, turnover and vacancy rates remain above their respective thresholds, with material variation between directorates subject to focused local management.

Outcomes (slides 39-40): Current 30-day post-SACT mortality remains within the expected range and is consistent with published NDRS rates for both The Christie and the national position.

Research (Slides 41-42): Research pathway performance requires further attention, with 20 of 51 in-scope studies meeting the 90-day standard and 31 studies awaiting recruitment at the reported point. The high number of open studies without a first patient recruited is being checked to confirm the accuracy of recruitment data and the underlying operational position.

Overall Assessment: The overall position is good, with the financial plan maintained, most major access standards achieved and clinical outcomes remaining within expected parameters. The principal areas requiring management attention are, the internal 24-day cancer pathway, workforce capacity and attendance indicators, and research set-up and recruitment performance.

Exceptions to note: Areas requiring continued focus are smoking cessation performance, research study set-up times against the NOF measure, and histopathology turnaround times. Actions are being progressed across all three areas, with strengthened oversight of performance and delivery



A total of 1050 incidents were reported to DCIQ in September 2026.

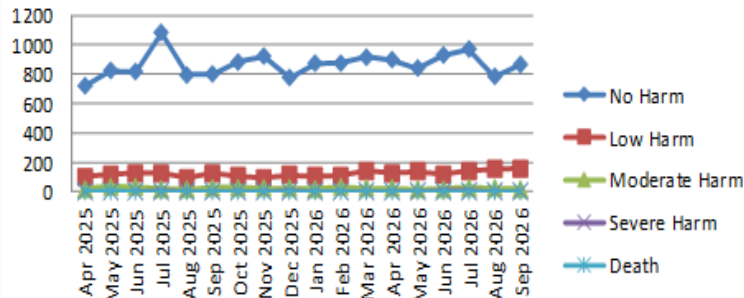
At the time of reporting, 68% of incidents have been finally approved. 3% of incidents have been rejected for reasons such as duplication and incidents which involve care provided by an external trust.

97% of all incidents reported resulted in low/no harm.

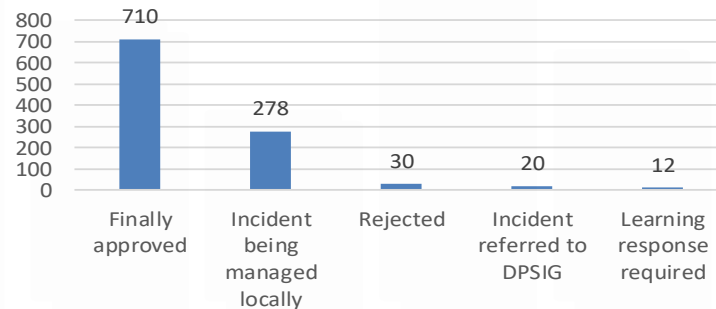
13% of incidents were reported to be a 'near miss', evidencing a positive reporting culture.

Reporting trends in September were within the expected limits.

Incidents by Reported (month) and Initial Severity



Incidents by Approval Status

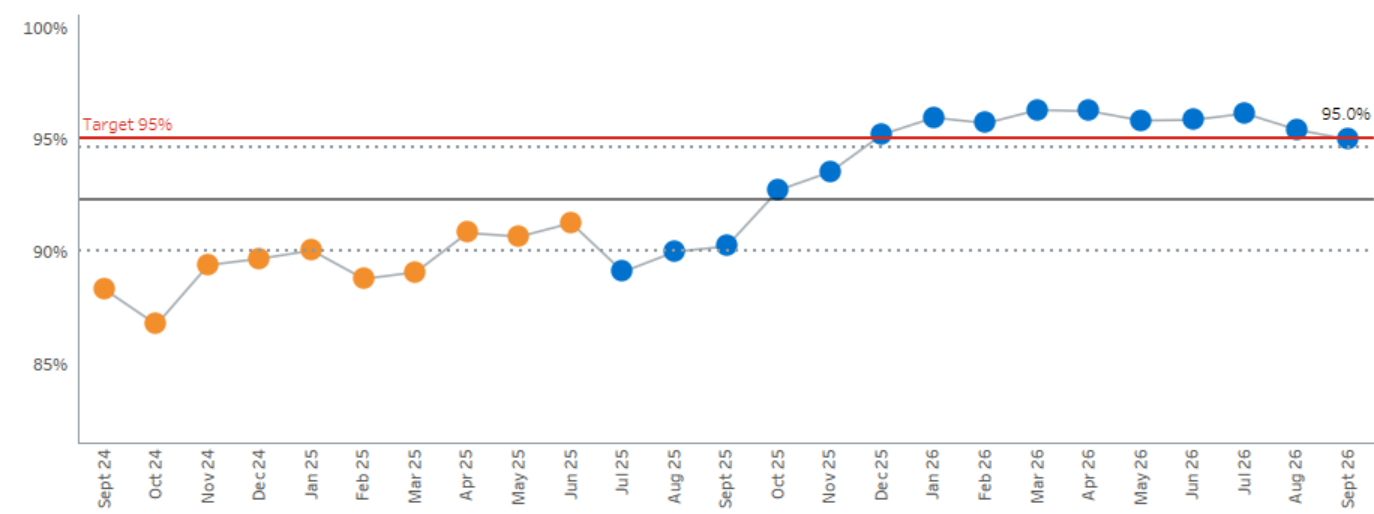


Integrated Performance Report - Patient Care Metrics Summary

Metric	Month	Measure	Target	Variation	Assurance
Sepsis - screening (presenting as an emergency)	September	94.00%	90.00%		
Sepsis - timely treatment with IV antibiotics (established inpatients)	September	90.00%	90.00%		
VTE Assessment Within 14 Hours of Admission	September	94.97%	95.00%		
Falls per 1000 bed days	September	4.7	3.8		
Pressure sores per 1000 bed days	September	1.0	0.5		
Category 3 pressure ulcers	September	0.0	0.0		
Hospital Cancelled Operations on the day for non clinical reasons	September	11.0	0.0		



VTE Assessment Within 14 Hours of Admission



Icons

Improving

Failing

Summary

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

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

Understanding the performance

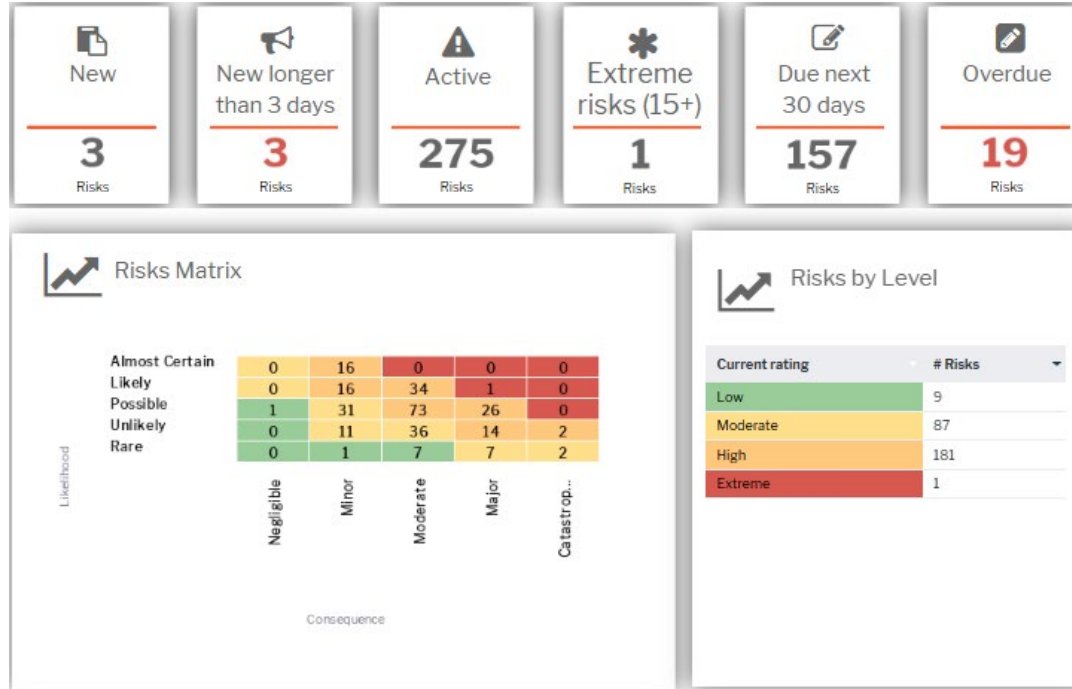
Performance has improved from c.87-90% to 95%, with a sustained upward trend since autumn 2025, indicating that recent process changes are having a consistent impact against the 95% standard. Variation earlier in the period caused by inconsistent completion within 14 hours at the point of admission, linked to workflow, ownership, or timing of assessment. As time progresses, consistently hitting above target will ensure the process moves from an assurance phase of failing to passing.

Actions (SMART)

Implement new form checklist in CWP, monitored daily, with compliance reported at ward level.
Weekly exception reporting at operational management group.
Sustained performance ≥95% for three consecutive months by embedding real-time tracking and targeted support to outlier areas.



Risk Profile



- In September 2026 there were 275 open risks recorded in DCIQ
- Of the risks open, 65% (n=181) were rated as high
- 1 risk was rated as being 'extreme' – (602) Supply of Radio pharmacy Products to NW Region – Divisional Register.
- 90% of all active risks were reviewed within planned timeframes (27 risks were overdue scheduled review)



Trust wide risk register

Risk ID	Risk	Risk register	Type	Date opened	Initial rating	Current likelihood	Current consequence	Previous Rating	Current rating	Target rating	Movement	Trend	Next Review Date
267	Risk of; Ineffective management and application of procedural and clinical documents due to fragmented document control systems.	Trust wide	Operational Risk	28/02/2019	15	4	3	12	12	3	↔	↗	11/11/2026
514	There is a risk that patients may experience harm due to significant delays in the management of patients with colorectal cancers.	Trust wide	Clinical Risk	05/09/2025	16	3	4	12	12	8	↔	↗	23/10/2026
530	There is a risk that may impact patient safety due to non- compliance with mandatory training	Trust wide	Workforce Risk	22/09/2025	12	3	3	12	9	6	↓	↗	31/12/2026
548	If the Trust does not deliver the 2026/27 recurrent Value Improvement Programme (VIP) target due to the challenging scale of savings, then there is risk of limited capacity to invest in and improve patient care, leading to reduced ability to achieve	Trust wide	Financial Risk	30/09/2025	12	3	4	16	12	8	↓	↗	04/11/2026
630	Risk that the Aseptic unit will be unable to deliver required capacity during a period of recovery following shutdown due to a recognised inability to maintain required operational & safety standards	Trust wide	Operational Risk	26/01/2026	20	3	4		12	4	↔	↗	30/09/2026
703	If we fail to maintain and improve robust patient administration systems and processes, there will be adverse clinical and financial outcomes	Trust wide	Clinical Risk	19/06/2026	12	4	3		12		↔	↗	30/07/2026

- Two risks have been closed on the Trust Wide Register :

Risk ID	Risk	Risk register	Type	Date opened	Initial rating	Current likelihood	Current consequence	Previous Rating	Current rating	Target rating	Movement	Trend	Next Review Date
101	There is a risk to the Trust's ability to demonstrate compliance and adherence to it's regulatory and statutory requirements under PSIRF	Trust wide	External Risk	10/03/2025	16	3	3		9	6	↔	↗	14/08/2026
640	(Business continuity risk) Failure of back up isolator resulting in inability to produce trial / critical medications.	Trust wide	Operational Risk	11/02/2026	15	3	4	15	12	5	↓	↗	30/09/2026



Integrated Performance Report - Safer Staffing

WARD	Day Reg Fill Rate	Night Reg Fill Rate	CHPPD - Registered	Day Unreg Fill Rate	Night Unreg Fill Rate	CHPPD - Unregistered	Month total inpatients at 23:59 each day	CHPPD - Overall
Oncology Critical Care Unit	82%	90%	24.2	138%	52%	4.5	152	28.7
Palatine Ward	89%	94%	6.1	76%	118%	1.9	857	8.0
Ward 10	85%	85%	4.2	64%	90%	2.3	778	6.4
Ward 11	98%	99%	5.4	87%	115%	4.2	586	9.6
Ward 12	100%	97%	3.9	92%	114%	3.1	818	7.0
Ward 4 and 4a	97%	102%	4.1	99%	135%	3.6	790	7.7
Ward 2	99%	96%	4.1	109%	92%	2.4	593	6.5
Acute Assessment Unit	88%	97%	6.4	78%	97%	2.7	566	9.1
TOTAL	91%	95%	5.4	87%	108%	2.9	5,140	8.3

Care Hours Per Patient Day (CHPPD) = $\frac{\text{Hours of registered ward-based staff} + \text{Hours of non-registered ward based staff}}{\text{Total number of inpatients at 23.59}}$

Understanding the performance

Whilst HCA vacancies remain, a number of new starters commenced in post during September. A centralised recruitment model will be implemented from October to support timely filling of ongoing vacancies. Ongoing demand for enhanced observations of care has contributed to reduced fill rates in some areas. Safe staffing is maintained through daily workforce reviews, proactive redeployment of staff, and senior nurse oversight.



Integrated Performance Report - Friends & Family Test & Patient Experience

Metric	Month	Measure	25/26 Avg	Variation	Assurance
Inpatient Response Rate	September	34.90%	34.00%		
Inpatient Recommended Score	September	96.24%	97.00%		
Outpatient Recommended Score	September	95.72%	96.00%		
Number of new complaints	September	22	17		
Number of PALS	September	91	48		



HCAIs against thresholds 2026-27 – HOHA & COHA only

Indicator	Threshold	Position	YTD	Threshold adjusted to month 6	Difference
<i>C.Difficile</i>	≤ 35	Above trajectory	34	17	+17
E.coli BSI	≤ 43	Above trajectory	36	21	+15
Klebsiella spp. BSI	≤ 24	Above trajectory	22	12	+10
P.Aeruginosa BSI	≤ 8	Above trajectory	7	4	+3

HCAIs being monitored

Indicator	Target	Position	YTD	Threshold adjusted to month 6
MRSA BSI	Zero tolerance	Below trajectory	0	-
MSSA BSI	No target	No target	15	-

HCAI Surveillance, Learning and Improvement Assurance

Surveillance and oversight: Continuous monitoring of all reportable HCAIs with routine reporting and escalation through governance structures.

Learning response (PSIRF): All cases are subject to proportionate learning responses to identify contributory factors and assess if avoidable.

Improvement actions: Targeted interventions (e.g. antimicrobial stewardship, device care, hygiene standards) are implemented and tracked.

Embedding learning: Themes are shared across teams to support sustained improvement and prevent recurrence.

Please note: all cases are reviewed by the Infection Prevention and Control team along with divisional colleagues to identify opportunities for learning. The trust delivered a second IPC summit in July 2026 covering a broad range of IPC topics including the core foundations of good IPC practice such as bare below the elbows and hand hygiene. The summit included representation from NHS E and UKHSA.



Christie CODE Quality Assurance Programme

CODE = Care, Observation, Documentation, Experience

CODE (Care Observation Documentation Experience) and Quality Mark current accreditation status

September 2026

Ward/dept	CODE outcome	Last inspection date
Palatine Ward	Gold	July 2026
Withington Ward	Gold	September 2026
Ward 2	Gold	October 2025
Ward 4	Green	March 2026 (due sept 2026)
Ward 10	Gold	December 2025
Ward 11	Gold	November 2025
Ward 12	Gold	July 2026
CRF	Gold	June 2026
AAU	Gold	May 2026
Ward/dept	Quality Mark outcome	
Outpatients	Gold	October 2025
Ambulatory Care	Gold	September 2026
Christie at Macclesfield	Gold	September 2026
Christie at Oldham	Gold	September 2026
Christie at Salford	Gold	September 2026
Christie at Tameside	Gold	July 2026
Withington radiotherapy	Gold	November 2022
Integrated procedure unit	Gold	January 2026

The CODE (inpatients) Quality Mark (non-ward-based areas) Quality Scheme Tool translates gathered/observed evidence against standards into an overall colour-rated status for the ward

Gold status = 10 or more gold standards, no red standards

Green status = All standards green or gold

Red status = One or more standards red

- Networked sites at Macclesfield, Oldham, Salford and Tameside along with Withington radiotherapy will be re-accredited in 2026.
- Care quality assurance monthly audit process (mini-CODE) and quality improvement programme forms basis of annual assessment process.

Note: Satellite sites at Macclesfield, Oldham, Salford and Tameside along with Withington radiotherapy will be revalidated in 2026. CODE assurance and sustainability established through the monthly mini-CODE inspections. This process has been reviewed and updated in May 2026.



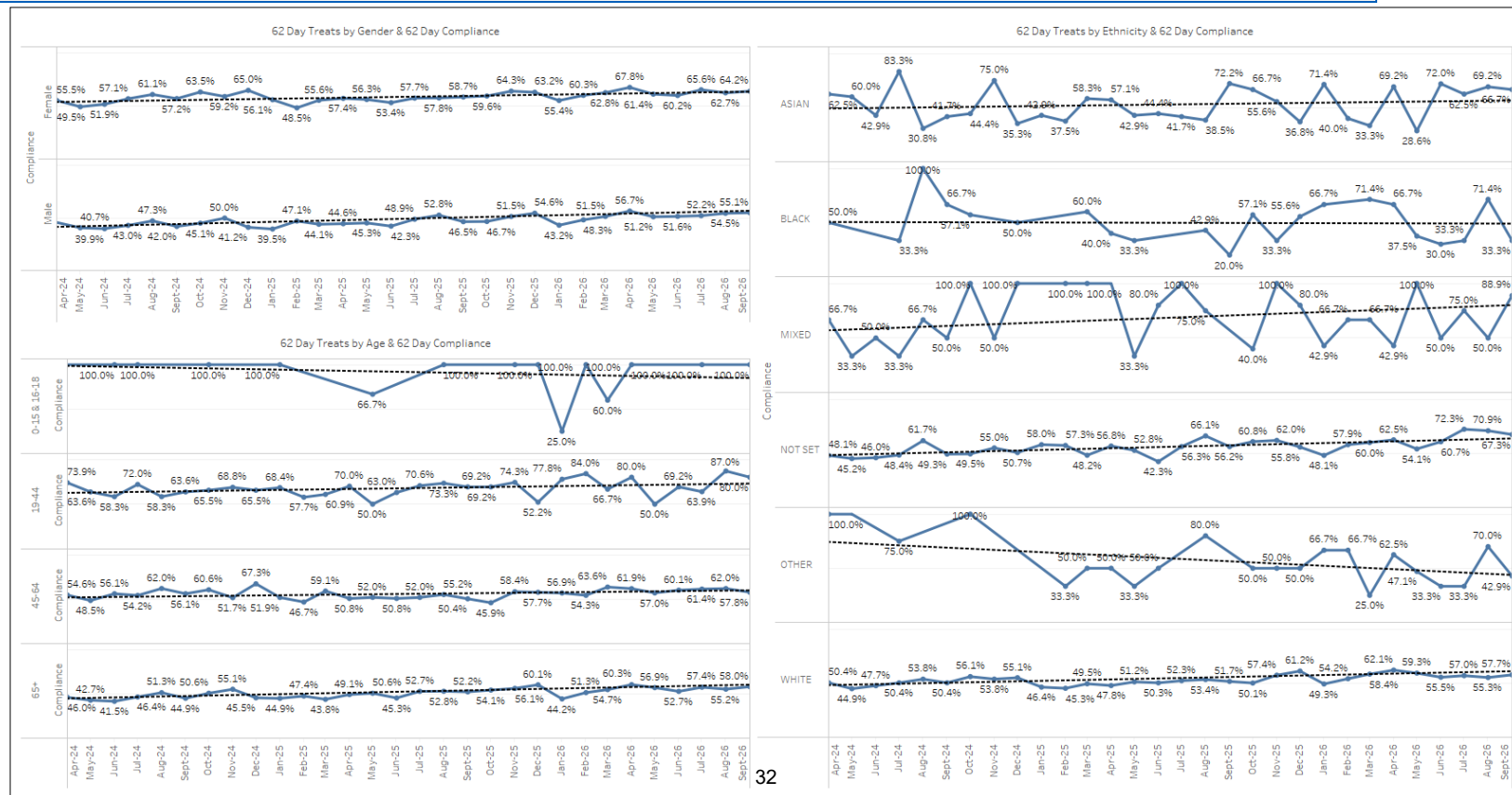
Cancer Standards – Health Inequalities Analysis

62 Day Treatments between 01/04/2023 – 30/09/2026 analysed by gender, age and ethnicity.



Cancer Standards – Health Inequalities Analysis

62 Day Treatments between 01/04/2023 – 30/09/2026 analysed by gender, age and ethnicity.



What is the NWLMDS?

The [National Waiting List Minimum Data Set](#) is a weekly return at patient level which focuses on the number of patients currently on an open referral to treatment pathway. This is effectively a measure of how many patients are currently awaiting treatment at each Trust. Several data points are submitted for each patient which cover all the relevant pathway dates and waiting times can be calculated. Patient demographics are also included within the return including Ethnicity Code which is based on the national data set.

What are we submitting?

The Ethnicity code field is currently being completed on the weekly return using the available data we have within our master patient index. The data is extracted live and so is as timely as possible. As the weekly return includes patients registered on a pathway up to the previous Sunday, this provides a challenge to ensure ethnicity data is captured at the point of registration. The return is a snapshot each week and whilst some patients will appear in multiple returns, there is a short window to update the ethnicity code and therefore report correctly. There are no opportunities to backdate the data.

Each return contains approximately between 3500 – 4000 records. The breakdown of the ethnicity coding in the latest August return is below;

		Return Week Ending	
		19/04/2026	30/09/2026
Ethnicity Category		%	%
A	White - British	44.4%	48.3%
B	White - Irish	0.7%	0.6%
C	White - Any other White background	1.1%	1.2%
D	Mixed - White and Black Caribbean	0.2%	0.2%
E	Mixed - White and Black African	0.3%	0.3%
F	Mixed - White and Asian	0.2%	0.1%
G	Mixed - Any other mixed background	0.2%	0.3%
H	Asian or Asian British - Indian	0.4%	0.6%
J	Asian or Asian British - Pakistani	1.0%	1.3%
K	Asian or Asian British - Bangladeshi	0.1%	0.2%
L	Asian or Asian British - Any other Asian background	0.5%	0.7%
M	Black or Black British - Caribbean	0.2%	0.3%
N	Black or Black British - African	0.8%	0.9%
P	Black or Black British - Any other Black background	0.1%	0.1%
R	Other Ethnic Groups - Chinese	0.4%	0.3%
S	Other Ethnic Groups - Any other ethnic group	1.4%	1.8%
Z	Not stated	5.9%	42.7%
99	Not Set	42.4%	0.0%

Next Steps & Measuring Progress

The table shows that the initial investigation into the weekly returned a compliance that was roughly in line with our overall MPI analysis that shows that we have recorded ethnicity data for approximately 55% of our patients.

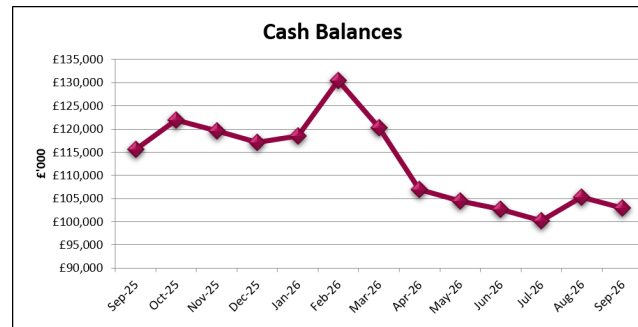
To improve this percentage, we implemented a more robust process of capturing the data using any available sources and means at the point of referral. This will include checking the Greater Manchester Care Record for each patient who has one and contacting referring Trust's. As the subsequent weeks show these processes have started to yield a significant improvement in the weekly return coverage.

As the data shows, whilst there has been a large reduction in the numbers of missing data items, there has been a corresponding large increase in the 'Not Stated' category. To ensure 100% accuracy with the recording these records are also being reviewed and we should see a reduction in this category until it reaches its nationally comparable level.



This report outlines the M6 consolidated financial performance of The Christie NHS Foundation Trust and its wholly owned subsidiary The Christie Pharmacy Ltd.

Month 06 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(506,088)	(253,026)	(257,861)	(4,835)
Other Income	(95,367)	(47,221)	(44,274)	2,947
Pay	287,883	143,446	140,733	(2,713)
Non Pay (incl drugs)	285,333	142,687	146,373	3,686
Operating (Surplus) / Deficit	(28,240)	(14,114)	(15,029)	(915)
Finance expenses/ income	25,292	12,646	13,248	602
(Surplus) / Deficit	(2,948)	(1,468)	(1,781)	(313)
Exclude impairments/ charitably funded capital donations	(4,552)	(2,276)	(2,008)	268
Adjusted financial performance (Surplus) / Deficit	(7,500)	(3,744)	(3,789)	(45)



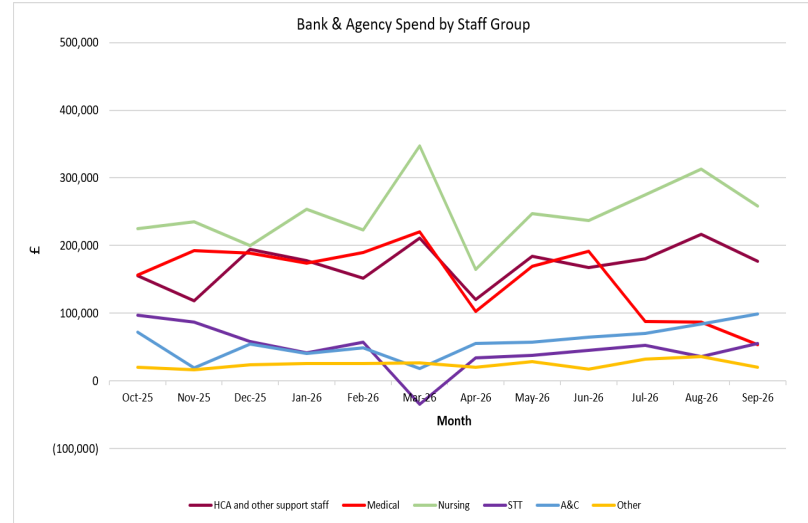
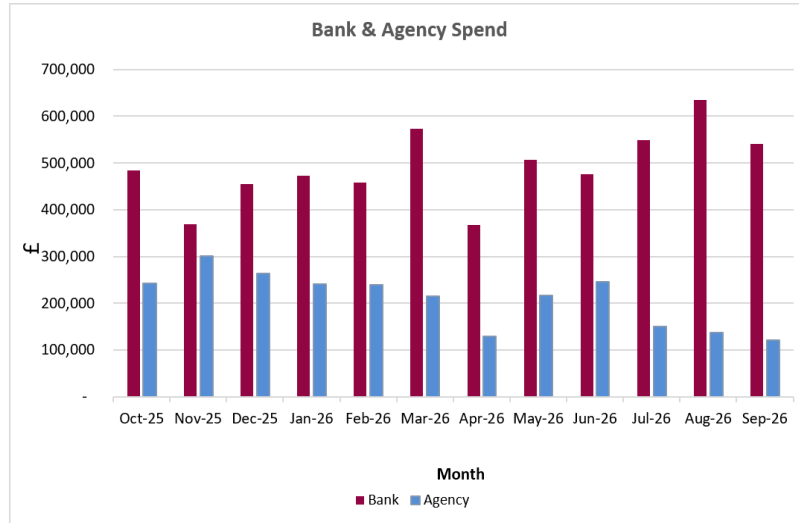
I&E

- The Trust is reporting a surplus at the end of month 06 of (£3.79m) against a YTD plan of (£3.74m), which gives a YTD positive variance of (£0.05m).
- Identified in-year VIP is £25.3m against a target of £25.3m. The VIP shortfall against the recurrent VIP target is £1.5m (RAG rated shortfall of £1.8m), where £11.1m has been identified against a target of £12.6m (88% of recurrent target identified). Non-recurrent identified VIP is £14.2m against a target of £12.6m, overachieving by (£1.5m).

Balance sheet / liquidity

- The cash balance as at 30th September 2026 is £103m with a forecast for the 31st March 2027 of £88.3m.
- Capital spend for month 05 is £10.8m, this was £2.7m above the plan submitted to NHSE.
- Targets have been achieved against payment of creditors paid within the 30-day Better Payment Practice Code target.

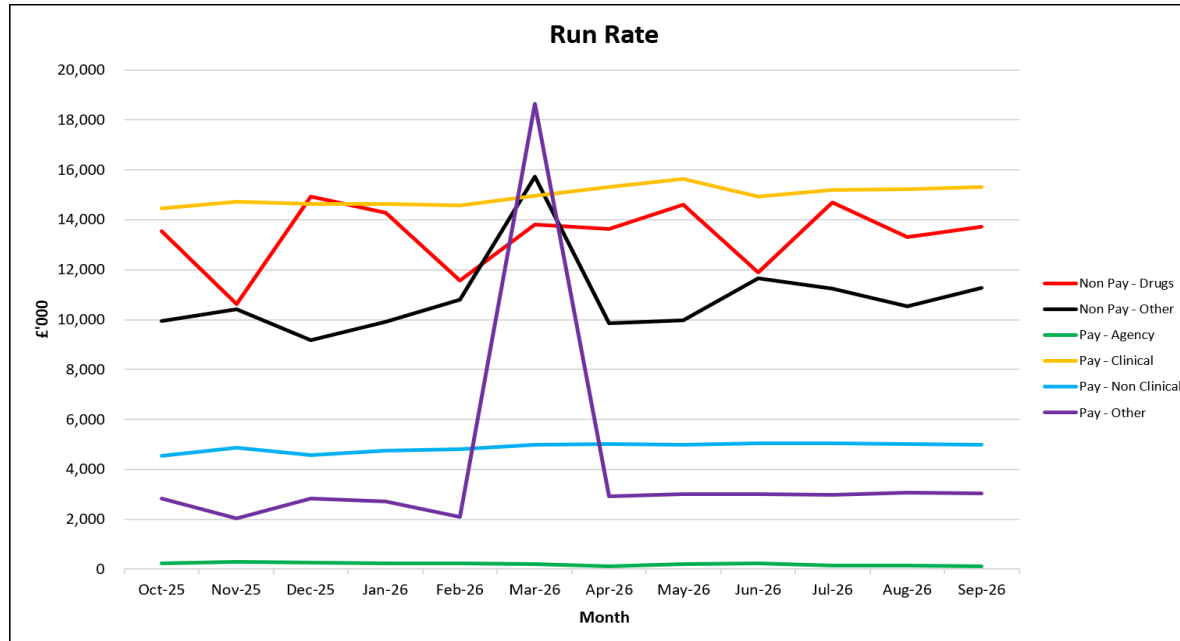




Agency spend in month 06 is £0.12m, a decrease of (£0.02m) from month 05. The spend is predominantly on medical agency.

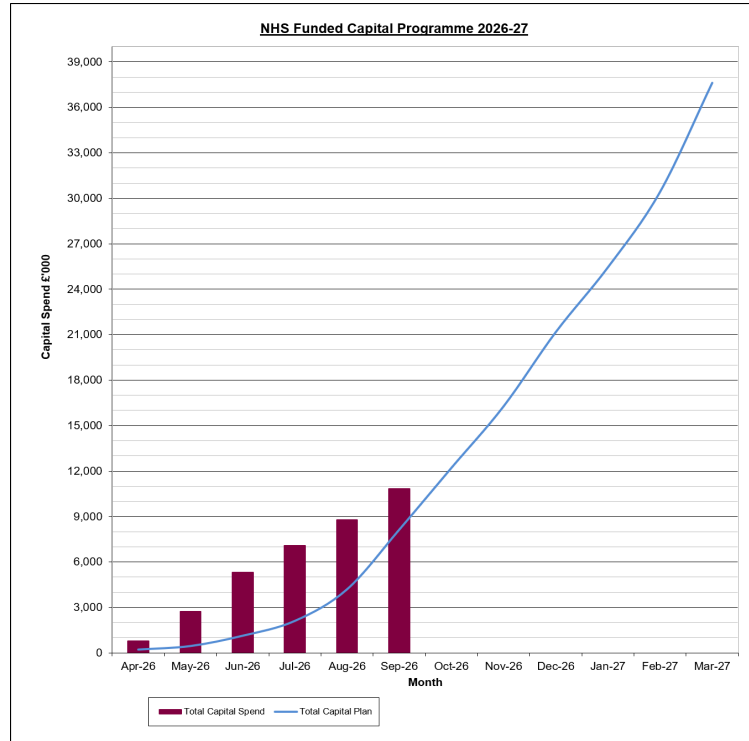
Alongside this, bank spend in month 06 is £0.54m, a decrease of (£0.1m) from month 05.





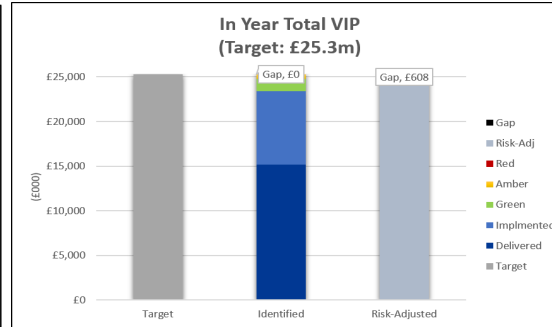
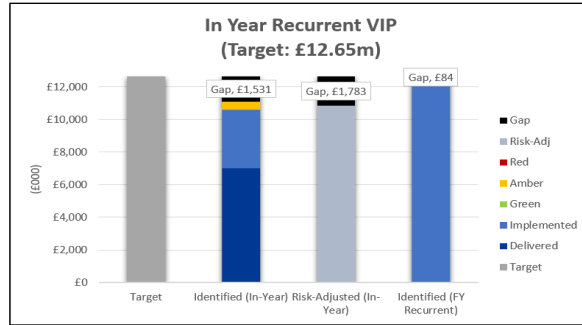
- Drugs spend in month 06 is £13.7m, an increase of £0.4m from month 05 driven by an increase in cost and volume drug expenditure.
- Non-Pay – Other spend in month 06 is £11.3m, an increase of £0.7m from month 05 due to non-recurrent increases in non-clinical spend
- Key elements of 'Non-Pay Other' spend consist of clinical supplies and services, premises and infrastructure costs and R&I costs.
- Pay – Agency spend in month 06 is £0.1m, in line with month 05.
- Pay – Clinical spend in month 06 is £15.3m, an increase of £0.1m from month 05.
- Pay – Other spend in month 06 is £3.0m, a decrease of (£0.1m) from month 05.





The 2026-27 Capital plan is £37.6m The Trust has incurred £10.8m to the end of month 06 on capital schemes overspending by £2.7m against the 2026-27 plan.





Total In year CIP

- Total identified VIP schemes reported are £25.3m (£14.2m non recurrent / £11.1m recurrent).
- Risk adjusted identified schemes value £24.7m, leaving £0.6m unidentified.

Recurrent

- Schemes totalling £11.1m have been identified recurrently against a recurrent target of £12.6m.
- This leaves £1.5m of the recurrent target unidentified, RAG rated unidentified £1.8m.



Annual						Year To Date		
	Target (£000)	Identified (£000)	Unidentified (£000)	Risk-Adjusted Identified (£000)	Risk-Adjusted Unidentified (£000)	Target (£000)	Delivered (£000)	Variance (£000)
Total VIP	25,298	25,298	0	24,690	608	12,650	12,650	0
Recurrent VIP	12,649	11,118	1,531	10,866	1,783	6,325	4,510	1,814
Non-Recurrent VIP	12,649	14,180	(1,531)	13,825	(1,176)	6,325	8,140	(1,814)

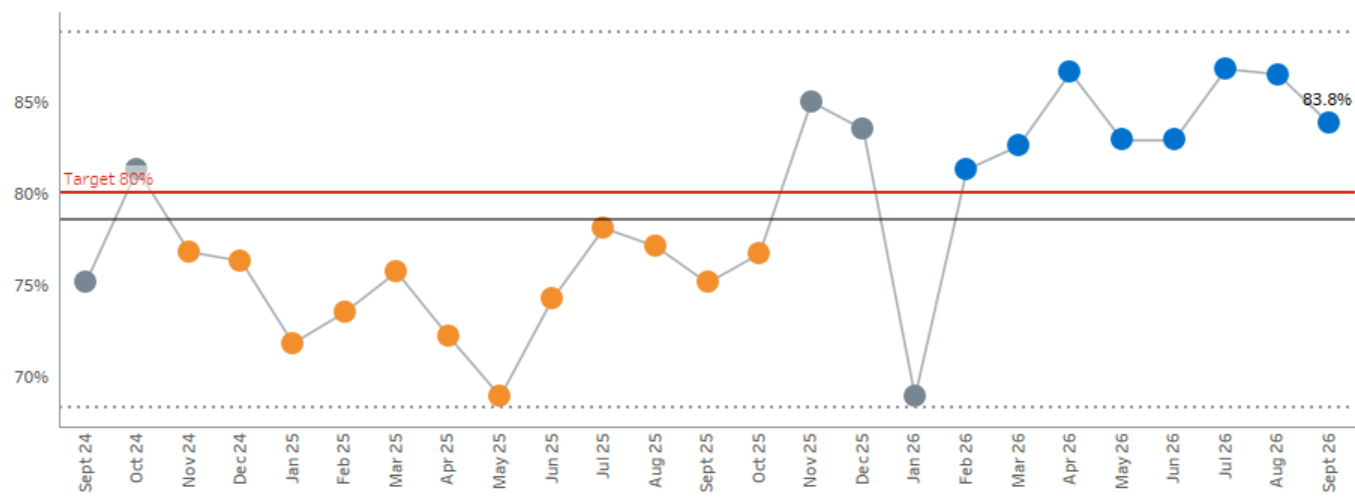


Integrated Performance Report - Cancer Standards Summary

Metric	Month	Measure	Target	Variation	Assurance
18 weeks	September	96.80%	92.00%		
24 day (Internal Target)	September	77.20%	85.00%		
28 Day FDS	September	94.70%	80.00%		
31 day	September	99.00%	96.00%		
62 Day	September	83.80%	80.00%		
Waiting >52 Weeks	September	0.00%	0.00%		



Percentage of patients treated for cancer within 62 days of referral



Icons

Improving

Hit & Miss

Summary

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

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

Understanding the performance

September performance is 83.8%, remaining above the Trust's 80% 2026/27 ambition, although lower than the recent July/August position shown on the chart. Performance has remained above the 80% ambition since April, representing a sustained improvement from the lower and more variable position during 2024/25. Improvement has been delivered alongside continued growth in referrals and treatment activity; average internal treatment waits have also reduced during 2026. Performance remains sensitive to late inter-provider transfers, demand growth and tumour-site variation. Around 25-30% of monthly 62-day treatments are received after day 38, making upstream pathway performance important to the overall position. The key internal control is the 24-day receipt-to-treatment interval. The independent review found the overall trajectory "Likely to Deliver, with Conditions", with sustained 85% delivery dependent partly on upstream conditions and strengthened provider relationships.

Actions (SMART)

Maintain 62-day performance at or above the 80% 2026/27 ambition each month, with variance from trajectory reviewed through established performance governance.

Improve the 24-day receipt-to-treatment measure, using daily PTL management to identify at-risk pathways early and escalate patients approaching the internal control point.

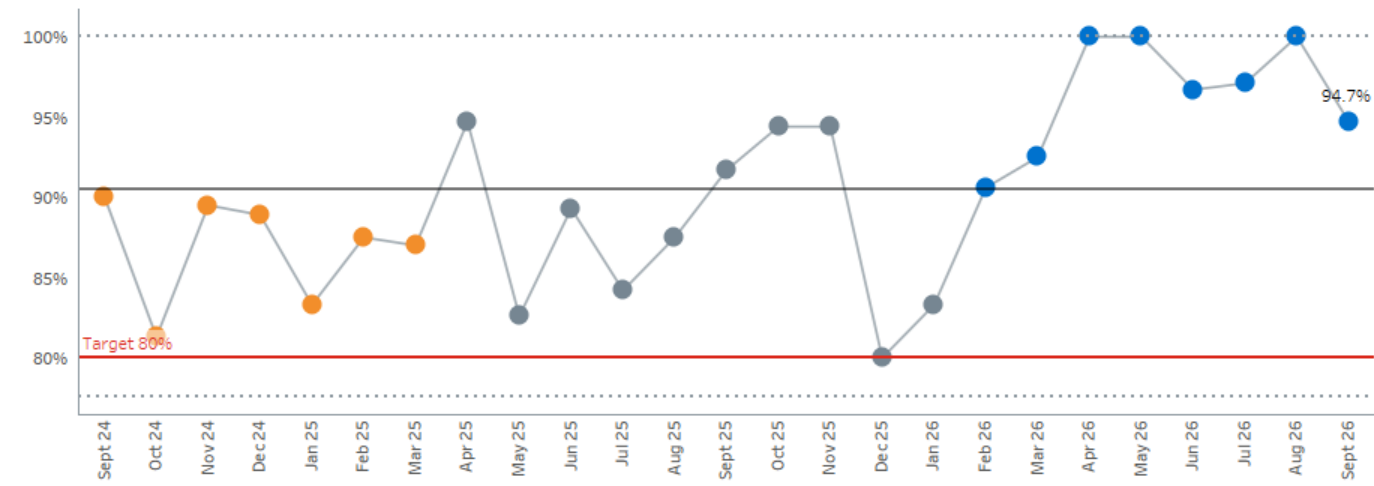
Target improvement at the tumour sites contributing most to breaches, with particular focus on urology, which has accounted for approximately a quarter of 62-day breaches.

Monitor late inter-provider transfers and escalate recurring referral delays with referring providers, strengthening cross-provider management of the end-to-end pathway rather than treating 62-day performance solely as an internal Christie issue.

Track delivery against the trajectory towards 85%, demonstrating measurable impact from improvement interventions on the 24-day measure, breach reduction and overall 62-day performance, rather than reporting action completion alone



Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks



Icons

Improving

Hit & Miss

Summary

Improving

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

Hit or Miss

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

Understanding the performance

Performance is 94.7% in September 2026, comfortably above the 80% target, following 100% in August. The SPC chart indicates an improving pattern, with performance consistently above the target since the December 2025 low point.

Performance has been above 90% from February 2026 onwards, reaching 100% in April, May and August. The wider cancer waiting-times position is also positive: the Trust has maintained the Faster Diagnosis Standard for 28 consecutive months, despite increasing referral demand.

Actions (SMART)

Monthly: review every urgent referral exceeding 28 days, recording the reason for delay, pathway stage and corrective action.

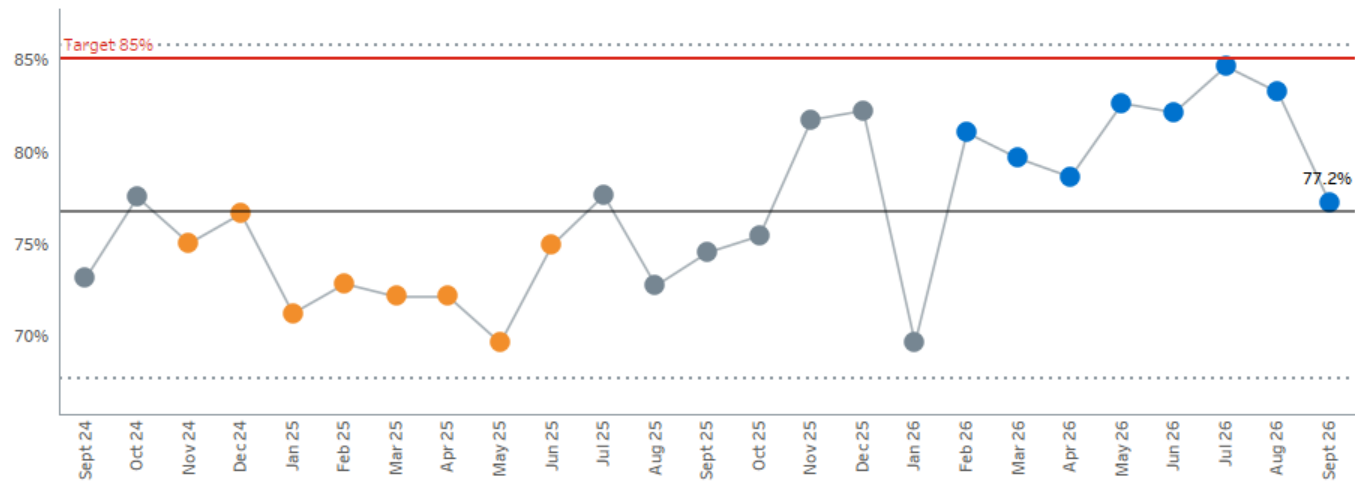
Monthly: maintain performance above the 80% standard, with any deterioration or emerging SPC signal reviewed through the appropriate performance governance route.

By November 2026: confirm that all relevant pathways have clear PTL visibility of current status, next action, diagnostic requirement and breach risk, consistent with the Trust's cancer pathway principles.

By November 2026: complete a focused review of recurring causes of >28-day pathways and agree pathway-specific actions where a controllable theme is identified.

Quarterly: review demand, diagnostic capacity and pathway performance together so that increasing referral volumes or capacity constraints are identified before they affect delivery.

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



Icons

Improving



Hit & Miss



Summary

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

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

Understanding the performance

September performance is 77.2%, remaining 7.8 percentage points below the 85% internal target despite improvement across much of 2026. The SPC identifies an improving signal, but target achievement remains "hit and miss", meaning current performance is not yet consistently reliable.

Performance reached close to the 85% target in July before reducing in August and September, demonstrating that the required level has been approached but not yet sustained.

The 24-day IPT-to-treatment measure is the Trust's primary internal control for the 62-day pathway, allowing patients at risk of delay to be identified before the overall pathway becomes unrecoverable.

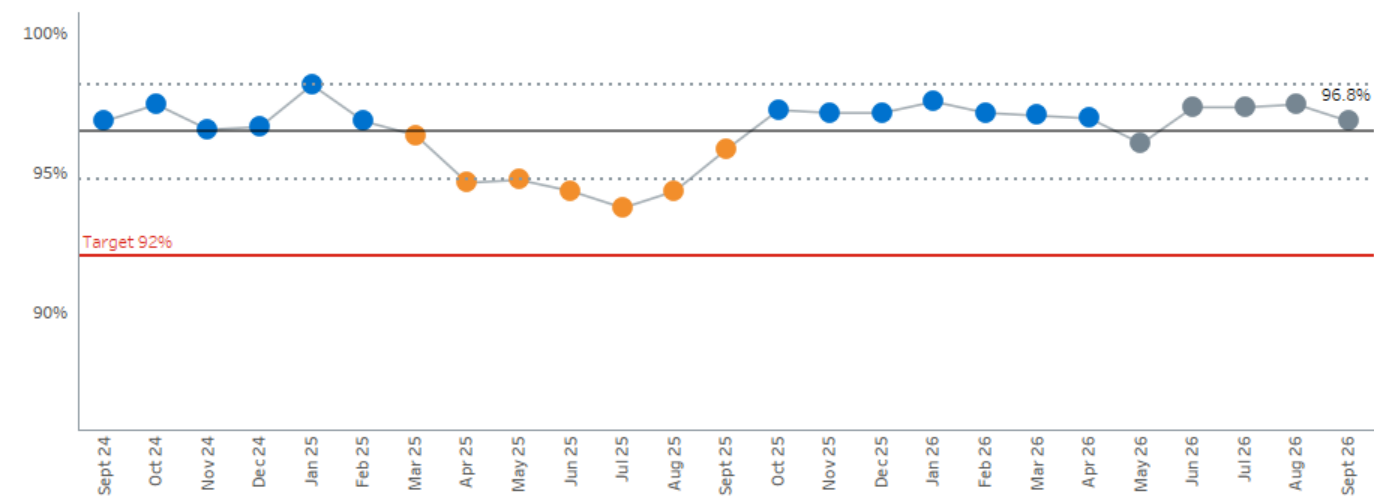
Known contributors to internal delay include booking/scheduling, diagnostics, MDT decision-making, treatment readiness and capacity, with late inter-provider transfers reducing the time available for treatment.

Actions (SMART)

- Weekly: review all patients approaching or exceeding the 24-day IPT control point, confirming treatment date, cause of delay, named owner and recovery action.
- Weekly: analyse 24-day breaches by tumour site and delay reason, escalating recurring booking, diagnostic, MDT, treatment-readiness or capacity constraints through the appropriate operational route.
- Monthly through OPIG: report the number and proportion exceeding 24 days, principal breach themes and whether agreed interventions are reducing breaches.
- For next IPM: agree and report a dated recovery trajectory to ≥85%, with named owners against the principal causes of delay and measurable evidence of progress. This is consistent with the existing divisional IPM approach.
- Escalate exceptions: identify late inter-provider transfers and pathways where capacity or treatment readiness places delivery at risk, with partner escalation where the cause sits upstream and internal corrective action where it sits within Christie control.



Percentage of patients treated within 18 weeks



Icons

Common Cause

Passing

Summary

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

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

Understanding the performance

September performance is 96.8%, remaining 4.8 percentage points above the 92% target. Performance has remained above the 92% target throughout the period shown, including during the deterioration seen between April and August 2025. The SPC identifies common-cause variation, indicating no significant deterioration or improvement in the underlying process. The measure is classified as “passing”, indicating that the current process is capable of consistently delivering the 92% target. Recent performance has remained broadly stable at around 96–97%, therefore the priority is to sustain delivery rather than initiate a recovery programme.

Actions (SMART)

Weekly: continue PTL oversight of patients approaching 18 weeks, with a named plan and escalation for pathways at risk of exceeding the standard.

Monthly: review 18-week performance and exception themes by specialty to identify any emerging deterioration before this affects overall compliance.

Monthly: monitor waiting-list size, demand and available capacity alongside the headline percentage to ensure current performance remains sustainable.

By next IPM: identify any recurrent causes of 18-week breaches and confirm a named owner and corrective action for material themes.

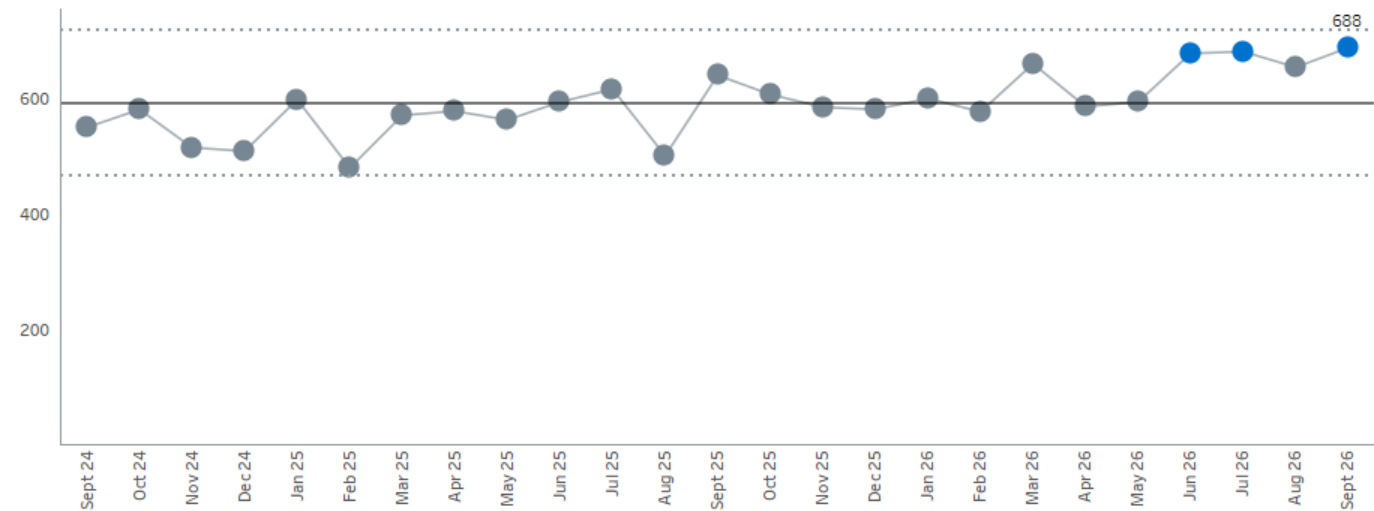
Ongoing: maintain performance at ≥92%, escalating through divisional performance arrangements if the SPC position changes or performance moves towards the target.

Integrated Performance Report - External Referrals Received Summary

Metric	Month	Measure	Variation	Assurance
External Referrals Received - ALL Specialties	September	2,383		
External Referrals Received -Clinical Oncology	September	961		
External Referrals Received -Haematology	September	267		
External Referrals Received -Medical Oncology	September	688		
External Referrals Received -Surgical Specialties	September	398		



External Referrals Received - Medical Oncology



Icons

Common Cause

No Target

Summary

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

No Target There is no set target for this data

Understanding the performance

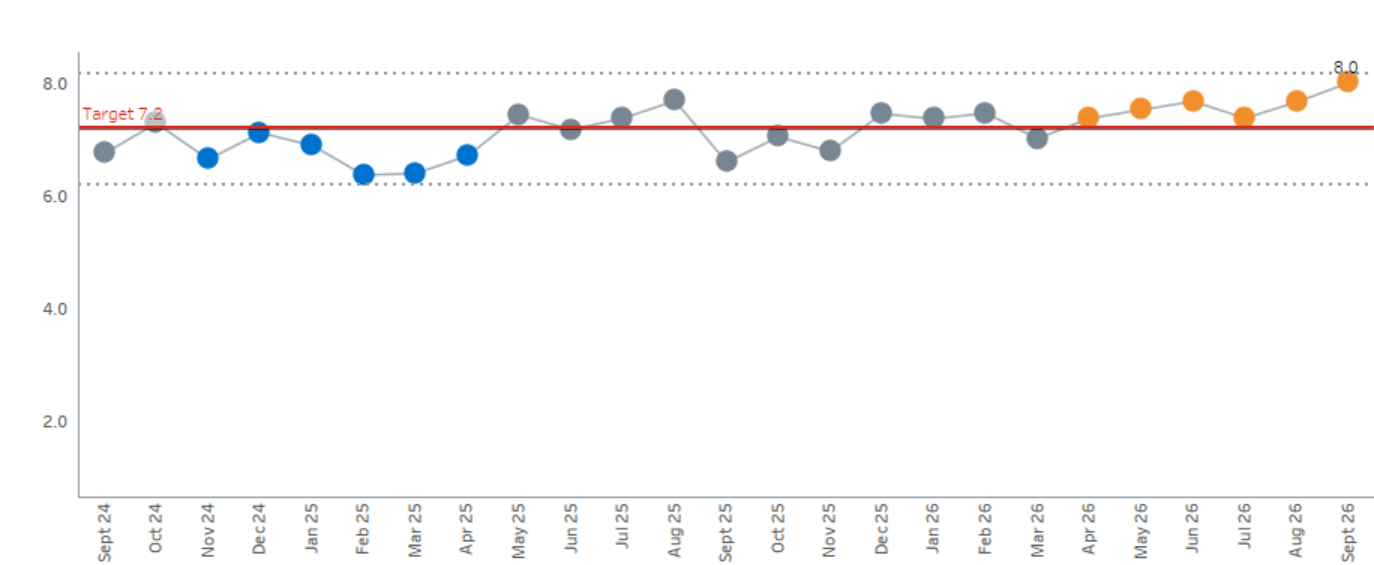


Integrated Performance Report - Inpatient Length of Stay Averages

Metric	Month	Measure	25/26 AVG	Variation	Assurance
Inpatient LOS - All Patients (excluding zero LOS)	September	8.0	7.2		
Inpatient LOS - Elective Patients (excluding zero LOS)	September	7.5	6.2		
Inpatient LOS - Non-Elective Patients (excluding zero LOS)	September	8.3	7.9		
Inpatient LOS - Transfer Patients (excluding zero LOS)	September	22.5	20.3		



LOS averages - All patients (excluding zero LOS)



Icons

Concerning

Hit & Miss

Summary

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

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

Understanding the performance

A trend of 6 consecutive months where length of stay has been above the 25/26 average has triggered an alert in the data. After investigations there doesn't appear to be any underlying issue and the months that are above average are more than often caused by a small number of patients that were discharged in month with a long length of stay.

Actions (SMART)

Integrated Performance Report - Diagnostic 6 Week Waiting Times Summary

Metric	Month	Measure	Target	Variation	Assurance
Magnetic Resonance Imaging	September	99.40%	99.00%		
Computed Tomography	September	99.70%	99.00%		
Non-obstetric Ultrasound	September	100.00%	99.00%		
Dexa Scan	September	100.00%	99.00%		
Cardiology - Echocardiography	September	100.00%	99.00%		
Flexi Sigmoidoscopy	September	100.00%	99.00%		
Cystoscopy	September	100.00%	99.00%		
Barium Enema	September	100.00%	99.00%		
Colonoscopy	September	100.00%	99.00%		
Gastroscopy	September	100.00%	99.00%		
DM01 Return - All Scans	September	99.70%	99.00%		



Tobacco Dependence

REFERRAL TO IN HOUSE SERVICE	SEEN BY IN HOUSE SERVICE FOLLOWING REFERRAL	TObACCO DEPENDENCE CARE PLAN	NATIONAL CODE	JULY	AUGUST	SEPTEMBER	Q2
N	N	Quit attempt with behavioural intervention and licensed medication – recommended NHS INTERVENTION	70	2	4	1	7
		VBA (very brief advice) only (refusal of opt-out offer of treatment)	10	17	2	6	25
				2	1	4	7
		Unsuported quit attempt with nicotine	60	1			1
		Unsuported quit attempt without nicotine	50	1	1		2
	Y	Quit attempt with behavioural intervention and licensed medication – recommended NHS INTERVENTION	70			1	1
Y	Y	Quit attempt with behavioural intervention and licensed medication – recommended NHS INTERVENTION	70	12	15	8	35
		Smoking reduction (a supported attempt to reduce the number of cigarettes smoked, with or without the use of nicotine)	20	1	2		3
		Supported temporary abstinence (support to remain smokefree whilst in hospital, no follow-up care)	30		1		1
		VBA (very brief advice) only (refusal of opt-out offer of treatment)	10	12	12	7	31
		Quit attempt with behavioural intervention and nicotine containing vapes (or unlicensed nicotine containing products) only	80	1	3		4
					3	14	17
		Unsuported quit attempt with nicotine	60	1			1
		Unsuported quit attempt without nicotine	50	1	1		2
	N	No care plan (VBA (very brief advice) or treatment) provided - unable to provide VBA due to medical or other condition	97	1			1
		Quit attempt with behavioural intervention and without pharmacotherapy	90		3	2	5
		Quit attempt with behavioural intervention and licensed medication – recommended NHS INTERVENTION	70		1		1
		VBA (very brief advice) only (refusal of opt-out offer of treatment)	10		1		1
Quit attempt with behavioural intervention and nicotine containing vapes (or unlicensed nicotine containing products) only			80	1		1	1
Grand Total				53	50	43	146
		% of smokers referred to service		56.6%	84.0%	72.1%	70.5%
		% of referred patients seen by the service		96.7%	95.2%	100.0%	97.1%
		% of seen patients referred, seen, and received a supported quit attempt (codes 70,80,90) - NOF METRIC		44.8%	52.5%	32.3%	44.0%
REFERRAL TO IN HOUSE SERVICE	SEEN BY IN HOUSE SERVICE FOLLOWING REFERRAL	TObACCO DEPENDENCE CARE PLAN	NATIONAL CODE	OCTOBER	NOVEMBER	DECEMBER	Q3
N	N	VBA (very brief advice) only (refusal of opt-out offer of treatment)	10	3			3
Y	Y	Quit attempt with behavioural intervention and licensed medication – recommended NHS INTERVENTION	70	4			4
		Supported temporary abstinence (support to remain smokefree whilst in hospital, no follow-up care)	30	1			1
		VBA (very brief advice) only (refusal of opt-out offer of treatment)	10	8			8
Y	N	VBA (very brief advice) only (refusal of opt-out offer of treatment)	10	1			1
Grand Total				16			16
		% of smokers referred to service		81.3%			81.3%
		% of referred patients seen by the service		100.0%			100.0%
		% of seen patients referred, seen, and received a supported quit attempt (codes 70,80,90) - NOF METRIC		30.8%			30.8%

There are several metrics related to Tobacco Dependence measured via a national monthly upload.

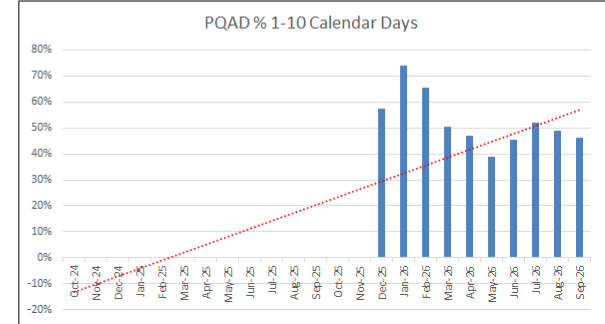
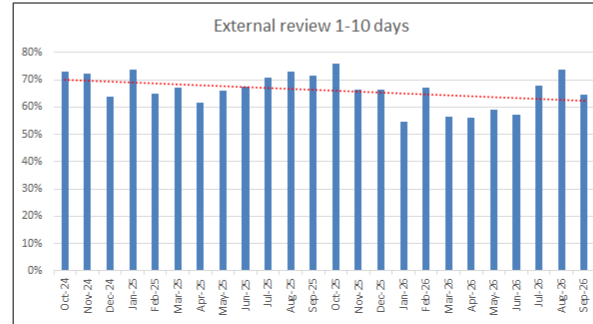
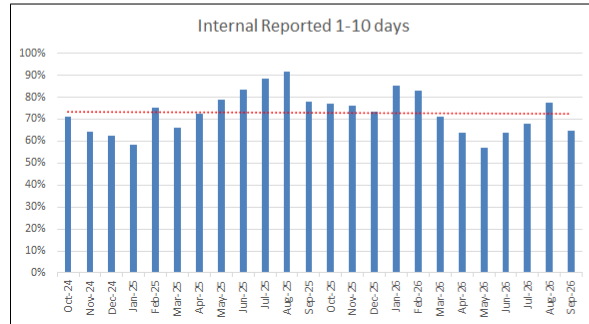
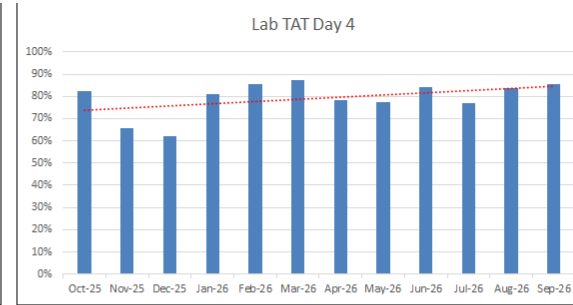
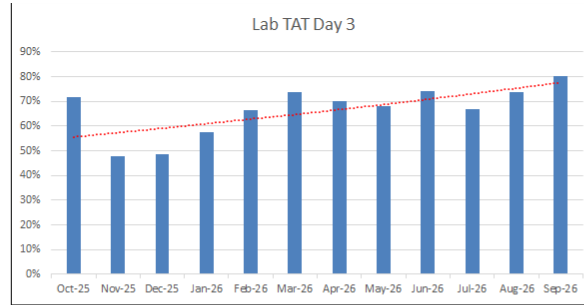
The metric highlighted is part of the National Operating Framework and is measured on a 12 monthly rolling basis.

The Trust implemented changes to our processes in July to improve performance and the current data up to 11th October is displayed above. Work is ongoing to quality check the data before the next upload.

*Data is subject to change as of the date reported due to ongoing quality checks prior to national upload.



Pathology Turnaround Times



Area Selection

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

Division
The Christie

Directorate
All Directorates

Summary Table

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

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

Metric	Month	Measure	Risk Threshold / Target	Mean	Performance	Assurance
Appraisal	September 2026	89.79%	90.00%	88.77%		
Mandatory Training	September 2026	95.01%	95.00%	94.47%		
Absence	September 2026	5.04%	4.10%	4.88%		
All Turnover	September 2026	11.78%	11.00%	11.47%		
Voluntary Turnover	September 2026	9.53%	9.00%	9.14%		
Vacancy Rate	September 2026	9.77%	5.00%	7.98%		

Our People - Divisional Overview

The Christie: All Directorates

Appraisal (Target: 90%)	
	September
Strategy	58.3%
Corporate Development	78.6%
GM Cancer	81.8%
Finance & Procurement	83.5%
Estates & Facilities	85.0%
Performance	85.2%
Quality & Standards	86.8%
The Christie Institute for Cancer Education	88.2%
Workforce	88.7%
Research & Innovation	89.9%
Clinical Support & Specialist Surgery	90.2%
Clinical Networked Services	91.7%
Digital Services	91.9%

Mandatory Training (Target: 95%)	
	Septemb..
Clinical Support & Specialist Surgery	93.7%
Clinical Networked Services	94.8%
The Christie Institute for Cancer Education	94.8%
GM Cancer	95.1%
Workforce	95.2%
Strategy	95.6%
Digital Services	96.3%
Estates & Facilities	96.4%
Research & Innovation	96.7%
Corporate Development	97.1%
Quality & Standards	97.6%
Finance & Procurement	98.6%
Performance	99.0%

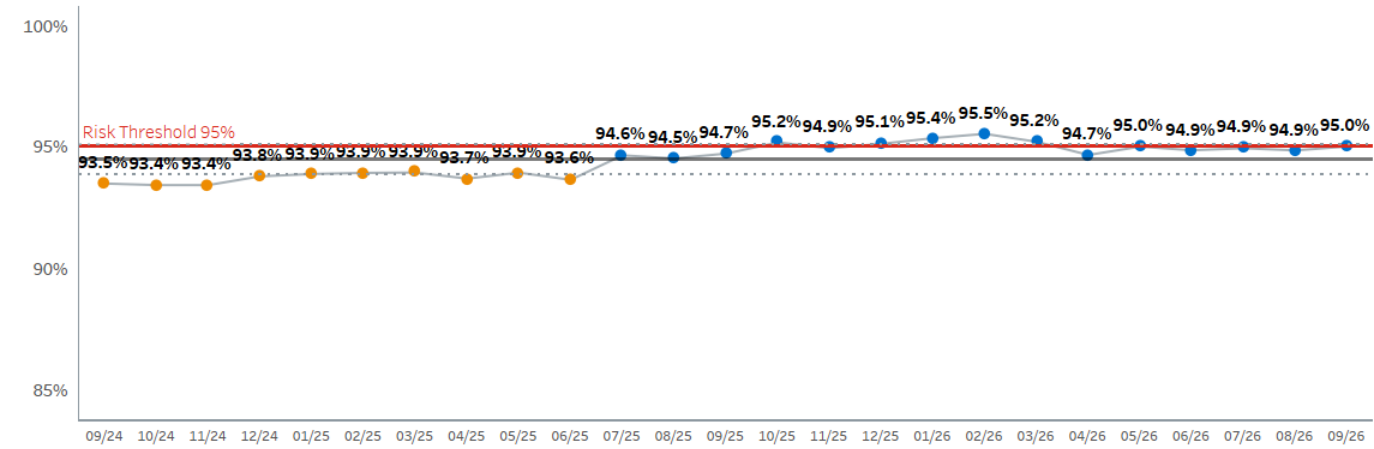
Sickness (Target 4.1%)	
	September
Strategy	8.9%
Performance	8.3%
Estates & Facilities	7.5%
Clinical Support & Specialist Surgery	6.2%
Workforce	6.2%
Clinical Networked Services	4.7%
Digital Services	4.2%
Finance & Procurement	4.0%
Research & Innovation	3.8%
GM Cancer	2.0%
The Christie Institute for Cancer Education	1.5%
Corporate Development	0.6%
Quality & Standards	0.3%

All Turnover (Target: 11%)	
	September
Performance	21.1%
GM Cancer	14.6%
Research & Innovation	13.7%
Finance & Procurement	13.2%
Quality & Standards	12.4%
Clinical Support & Specialist Surgery	12.3%
The Christie Institute for Cancer Education	12.2%
Digital Services	12.0%
Clinical Networked Services	11.2%
Estates & Facilities	9.6%
Workforce	8.5%
Corporate Development	0.0%
Strategy	0.0%

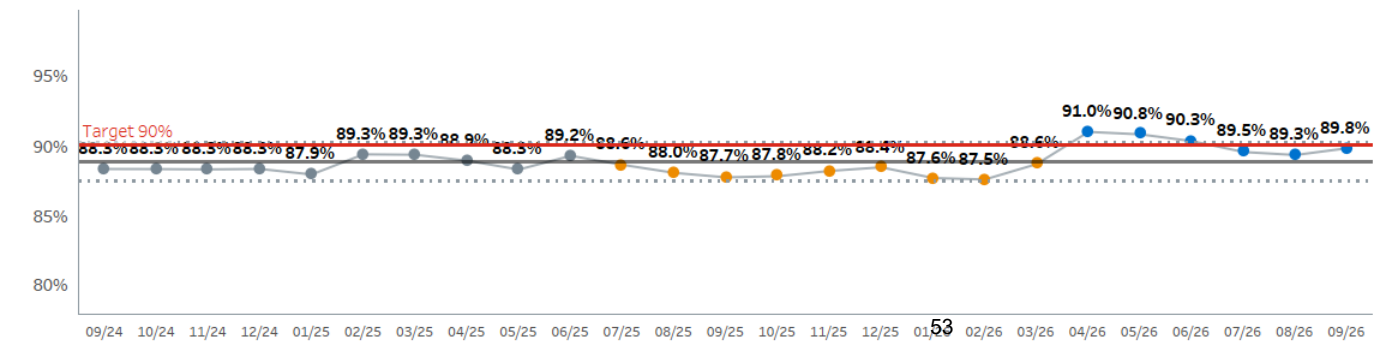
Our People - Mandatory Training and Appraisal Compliance

The Christie: All Directorates

Mandatory Training



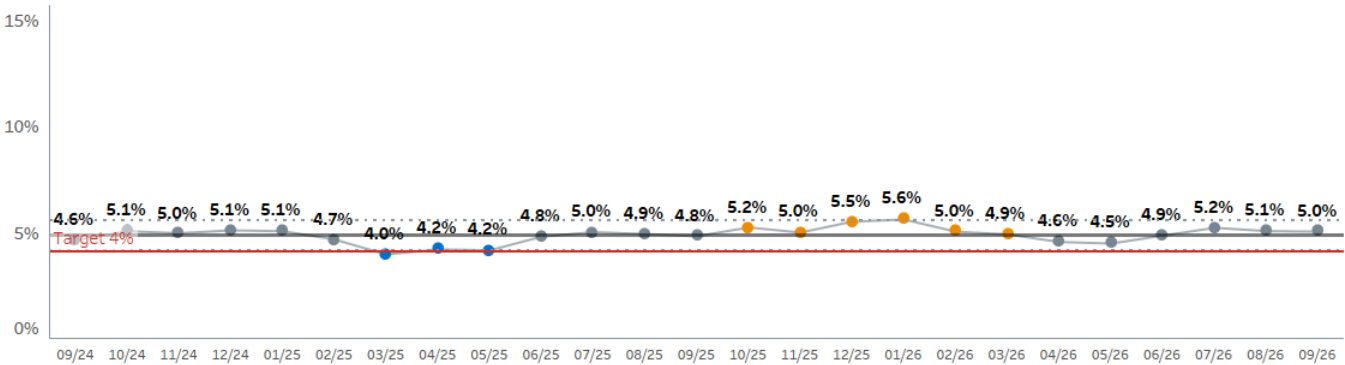
Appraisal



Performance	Assurance
Improving 	Hit & Miss 
Summary	
- There are 3,370 outstanding modules. - The Face to Face training compliance % for September is 86.1% - The online training compliance % for September is 95.8%	
Performance	Assurance
Improving 	Hit & Miss 
Summary	
- There are 368 outstanding appraisals.	

Our People - Sickness Absence

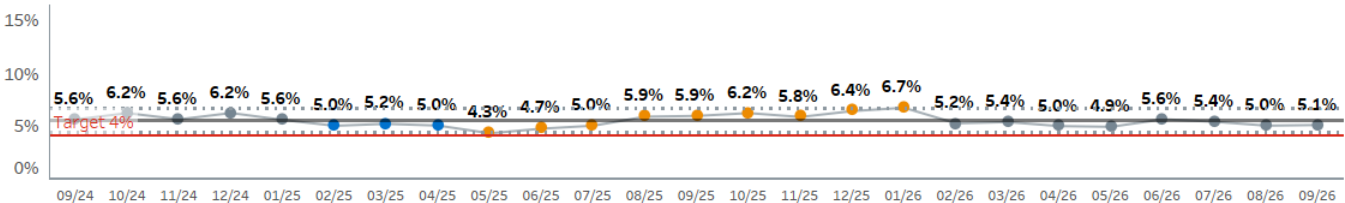
All Absence



Performance	Assurance
Common Cause 	Failing 

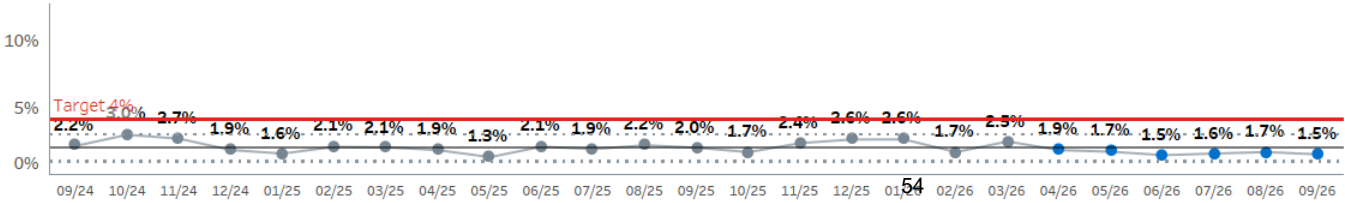
Summary
- The rolling yearly sickness absence % is 5.0% as of September.
- There were 228 absences still open at the end of September.

Nursing and Midwifery



Performance	Assurance
Common Cause 	Failing 

Medical and Dental

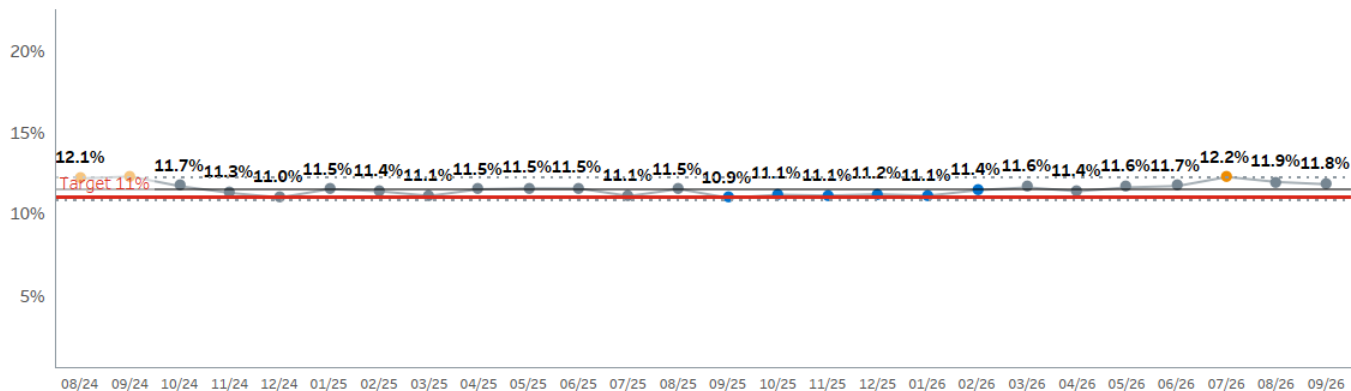


Performance	Assurance
Improving 	Passing 

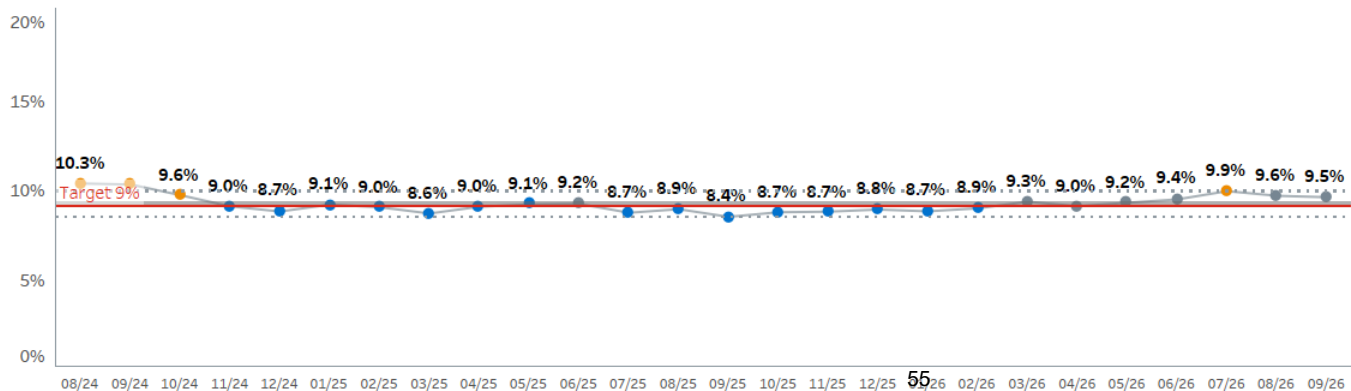
Our People - Turnover

The Christie: All Directorates

All Turnover



Voluntary Turnover



Performance

Common Cause



Assurance

Hit & Miss



Summary

- 44 colleague(s) left the Trust in September.
- The top non-voluntary leaving reason was **End of Fixed Term Contract**.
- #####

Performance

Common Cause



Assurance

Hit & Miss

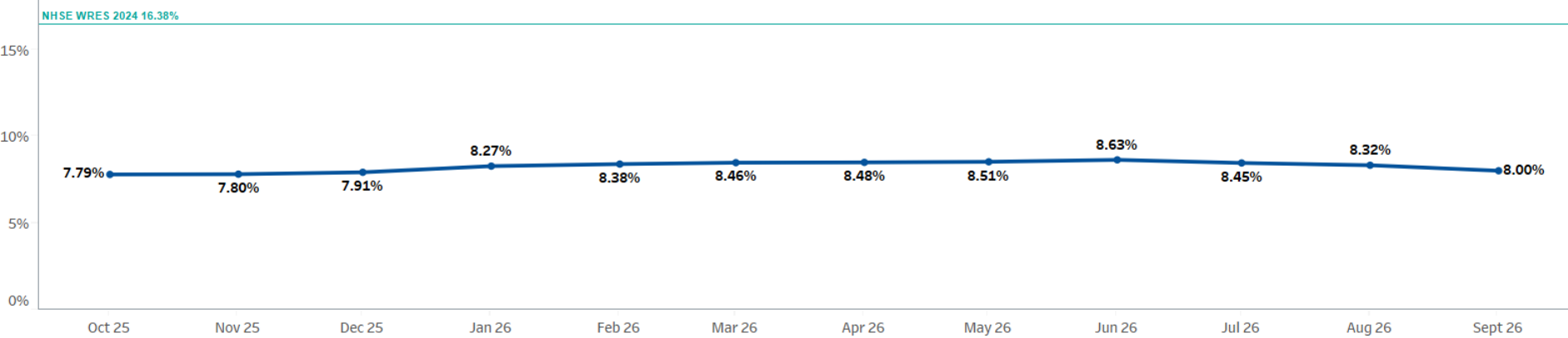


Summary

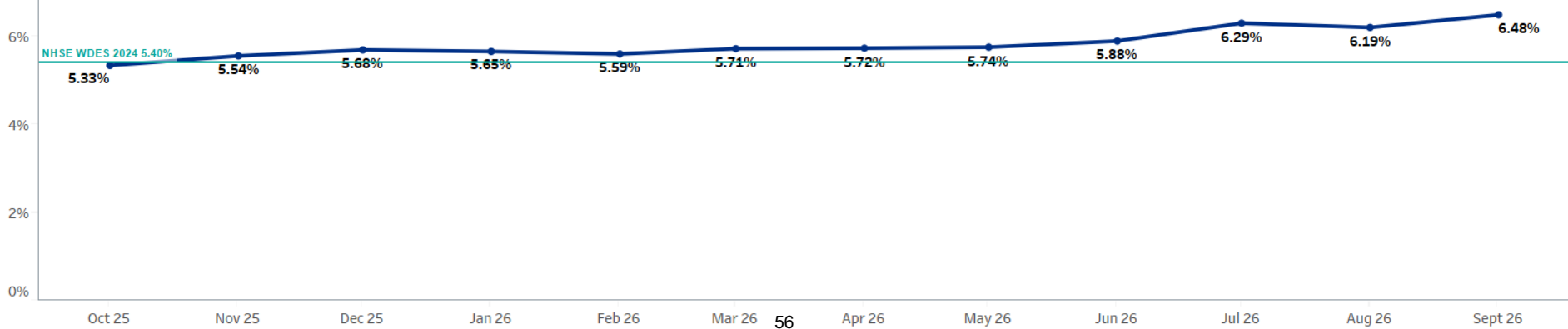
- 30 colleague(s) left the Trust in September for voluntary reasons.
- The top voluntary leaving reason was **Voluntary Resignation - Other/Not Known**.
- The top voluntary leaving reason was **Voluntary Resignation - Promotion**.
- The top voluntary leaving reason was **Voluntary Resignation - Relocation**.

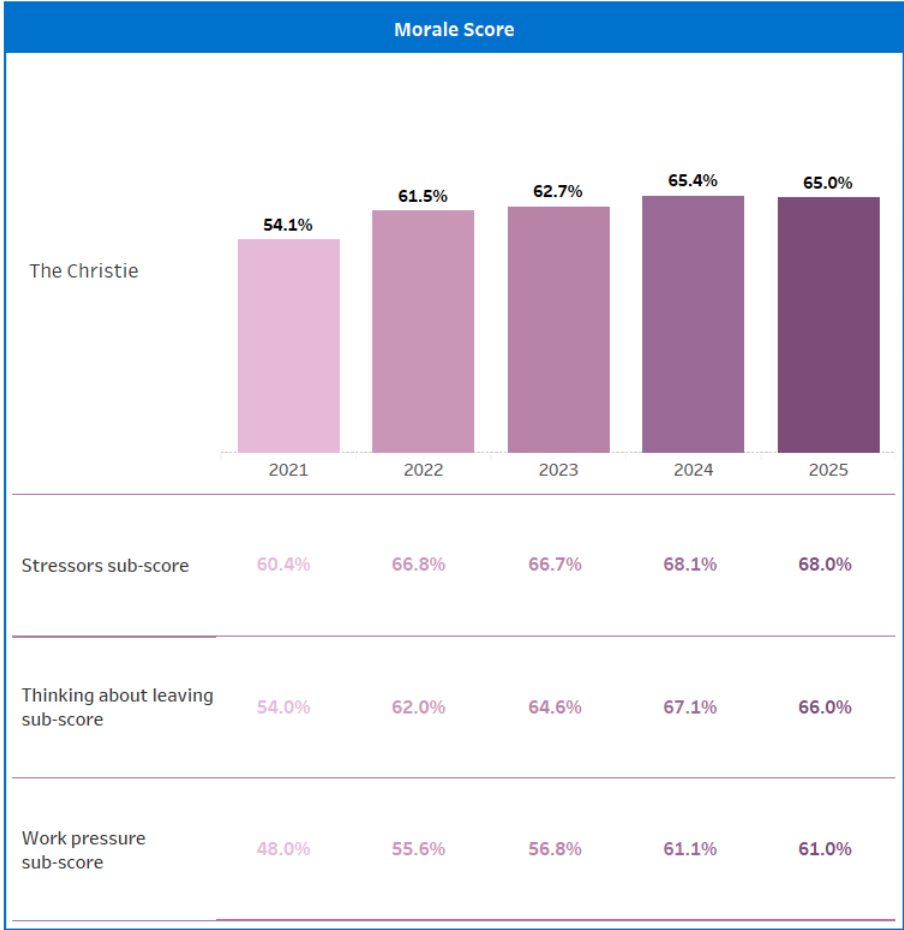
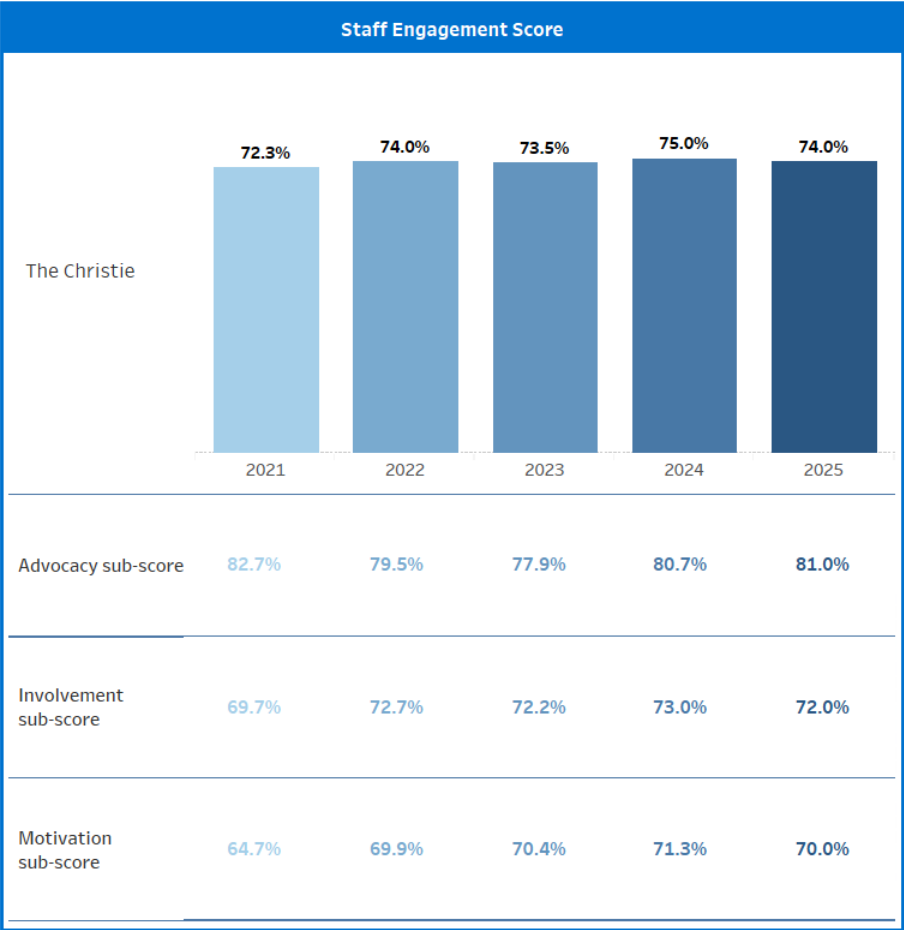
Our People - Senior Management Representation

Senior Management (Band 8A - VSM) BAME %



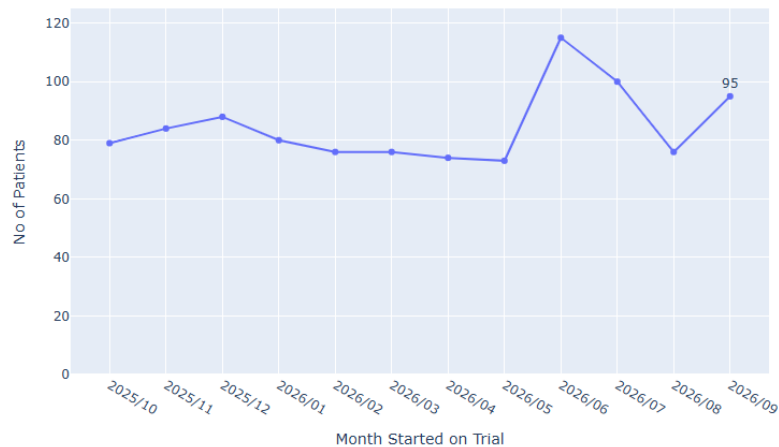
Senior Management- (Band 8A - VSM) Disability %



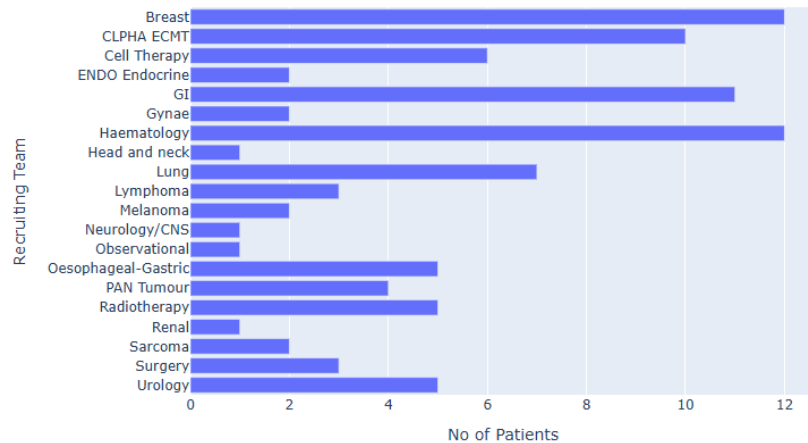


Clinical Trial Entries

Number of patients consenting to a treatment clinical trial, 01/10/25 - 30/09/26

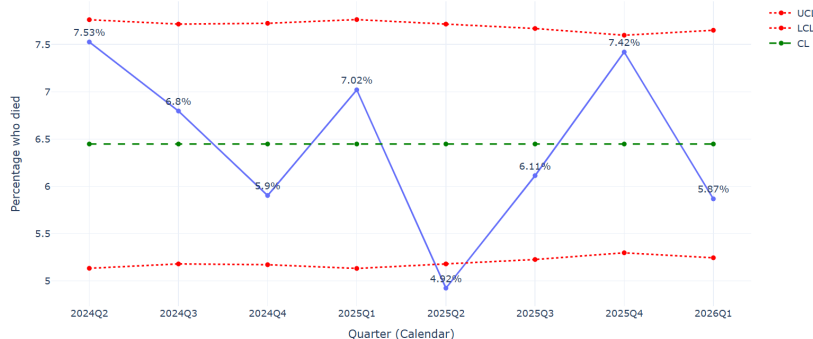


Patients Starting on a Trial in September 2026

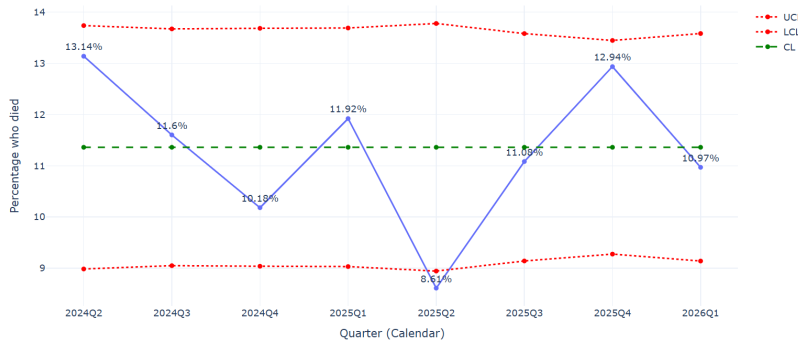


30-Day SACT Mortality

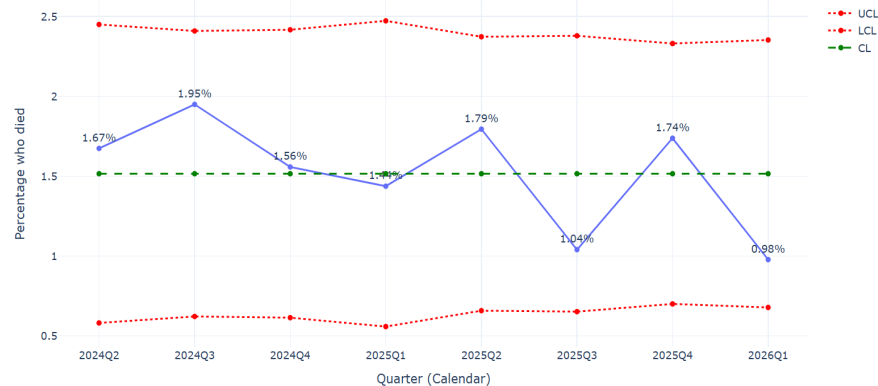
Unadjusted 30 day mortality rate - Patients who died within 30 days of receiving their final SACT treatment
Any treatment intent



Unadjusted 30 day mortality rate - Patients who died within 30 days of receiving their final SACT treatment
Palliative treatment intent



Unadjusted 30 day mortality rate - Patients who died within 30 days of receiving their final SACT treatment
Curative treatment intent



The control line shows the 30-day mortality rate over the entirety of time frame shown (01-04/2024 - 30/03/2026).

The UCL and LCL are the upper and lower confidence limits (respectively) around the CL. 95% Confidence limits.

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

*30-day mortality post-Systemic Anti-Cancer Therapy - Case-Mix Adjusted Rates – NDRS



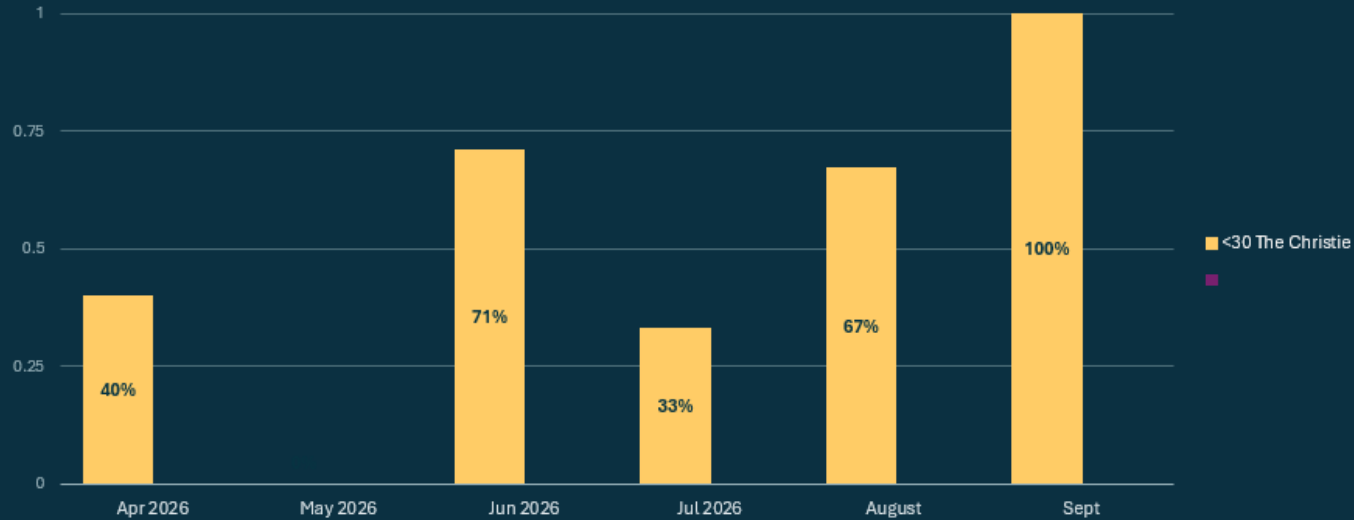
YTD April to Sept 2026

% Studies meeting 30 days

(Data pull 2nd October 2026)



The Christie
NHS Foundation Trust



Notes
0% The Christie in May

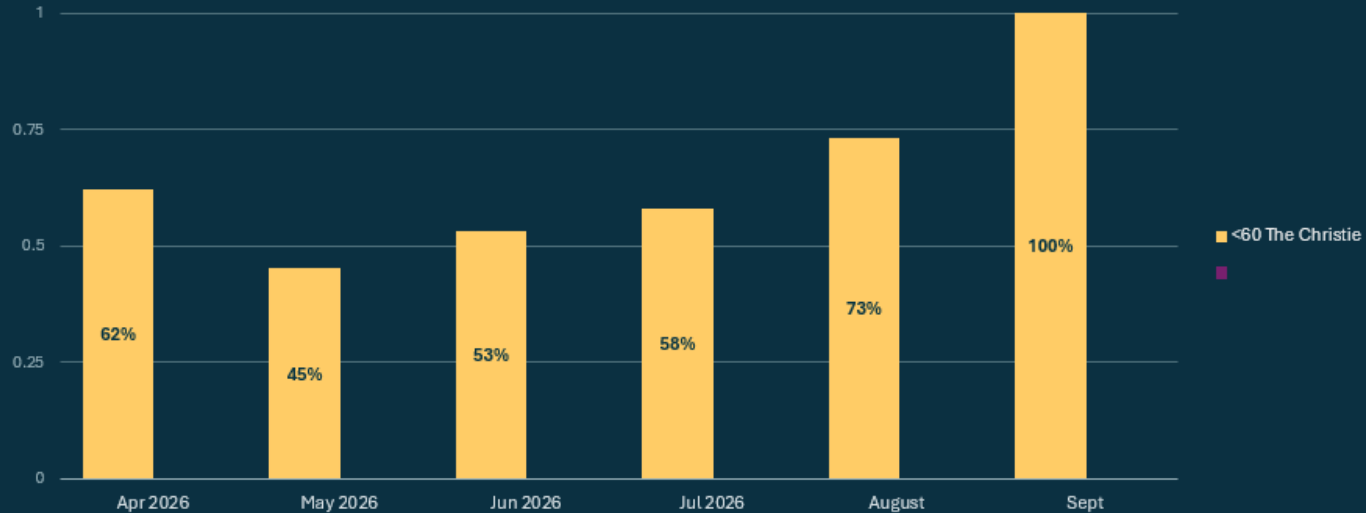


YTD April to Sept 2026

% studies meeting 60 Day pathway (Data pull 2nd October 2026)

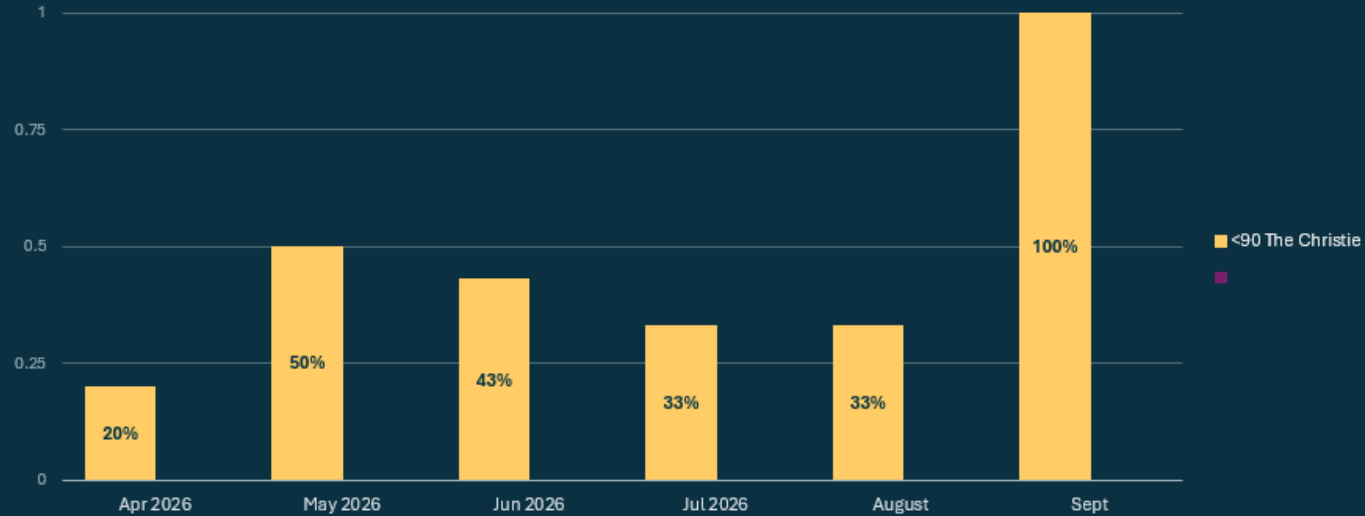


The Christie
NHS Foundation Trust



YTD April to Sept 2026

% Studies meeting 90 days
(Data pull 2nd October 2026)



Oversight Framework 26/27

The NHS Oversight Framework 2026/27 describes a consistent and transparent approach to assessing ICBs and NHS trusts and foundation trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement. The data below relates to Q1 (Access to services module data has been excluded for specialist cancer Trusts whilst the national team work on a different way of displaying this data). Metrics have been grouped into domains and will be scored individually and across each domain, with Trust's being segmented into an overall score for comparison against other Trusts. The information is to be publicised on the Model Hospital platform.

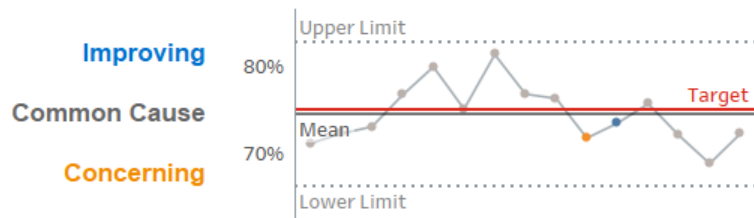
Domain area	Metric	Measured	Q1 26/27 Value	Q1 26/27 Score	DOMAIN SEGMENT	DOMAIN SCORE	Overall Adjusted Segment	Average Metric Score	Status
Effectiveness of care & Population Health	30 day readmission rate band	Annual		2	4	3	1	1.81	New Scoring
	% of inpatients making a supported quit attempt with an in-house tobacco dependence treatment service	Quarterly (Rolling 12 month period)	0% (less than 5%)	4					New Scoring
Experience of care	CQC inpatient survey satisfaction rate	Annual		1	1	1.01			25/26 Continued Scoring
	NHS staff survey advocacy rate	Annual	8.07 (2025 Data Period)	1.02					New Scoring
Finance productivity and innovation	Planned surplus or deficit	Annual	1.26%	1	3	2.61			25/26 Continued Scoring
	Variance to plan year-to-date	Quarterly	0.03	1					25/26 Continued Scoring
	Combined finance score	Quarterly		1					25/26 Continued Scoring
	% of clinical trials set up within 90 days	Quarterly - data cut is taken on the third Friday after the end of each quarter	22.22%	4					New Scoring
	Data Quality Maturity Index	Quarterly - latest monthly position	95.8	1					New Scoring
	Implied productivity growth	Quarterly - year to date figure to latest month vs same period in previous year	not in Q1 dashboard						Contextual
	Relative cost difference (National Cost Collection Index)	Annual	120.38	3.85					New Scoring
Patient safety	Breadth and depth of clinical audit outliers	Quarterly - using latest available data for each audit		1	1	1.36			New Scoring
	NHS staff survey raising concerns sub-score	Annual	6.94	1.07					25/26 Continued Scoring
	% of patients to acquire a new grade 3 or 4 pressure ulcer	Quarterly - latest available data	no data						Contextual
	% of safety incidents resulting in harm	Quarterly - latest month available	not in Q1 dashboard						Contextual
	Number of cases of MRSA in the last 12 months	12-month rolling	1	2					25/26 Continued Scoring
	Rate of c-difficile	12-month rolling (case count) Quarterly (testing data)	0.88	1					25/26 Continued Scoring
	Rate of e-coli	12-month rolling (case count) Quarterly (testing data)	1.63	3					25/26 Continued Scoring
	Rate of inpatient falls that cause harm	Annual	not in Q1 dashboard		Contextual				
People and workforce	Healthcare worker flu vaccination rate	Quarterly (Q2 figure will be directly inherited from Q1 figure as there is no flu vaccination programme in the summer)	53.90%	1.75	1	1.38			New Scoring
	National education and training survey satisfaction rate	Annual	82%	1.61					New Scoring
	NHS staff standards score	Annual	8.03	1.02					New Scoring
	NHS staff survey engagement theme score	Annual	7.44 (2025 Data Period)	1.02					25/26 Continued Scoring
	Sickness absence rate	Quarterly – aggregated monthly figures	5%	1.9					25/26 Continued Scoring
	Temporary staffing cost relative band	Quarterly		1					New Scoring
	Temporary staffing cost relative band - BANK		1	1					New Scoring
	Temporary staffing cost relative band - AGENCY		2	3					New Scoring



Integrated Performance, Quality & Finance Report - New Reporting Guidance

SPC Charts

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



SPC Rules

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



a data point is part of a series of 6 or more points in an upward or downward trend



a data point is part of a series of 6 or more points above or below the mean



a data point is part of a series of 3 points that are approaching the control limits



a single data point is outside the control limits

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

Interpreting Performance Icons



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



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



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

Interpreting Assurance Icons



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



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



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



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

Meeting of the Board of Directors

Thursday 22nd October 2026

Subject / Title	Value Improvement Programme (VIP) 2026/27
Author(s)	Jo Bolger Leece, Assistant Director for Value Improvement
Presented by	Claire McPeake Chief Operating Officer
Summary / purpose of paper	This paper provides: • An overview of the Month 6 position for the Value Improvement Programme (VIP) • A summary of progress in delivery of the full years target • The approach for 27/28 linked to operational planning guidance
Recommendation(s)	The Board of Directors is asked to note: • The content of the report and • The associated actions identified to improve delivery.
Background papers	NA
Risk score	Risk 3629 – Score 12
Link to: ➤ Trust strategy ➤ Corporate objectives	Executive objective: 1 -To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer. 6 - To maintain excellent operational, quality and financial performance Board Assurance Framework: Risk 1, Risk 6, Risk 7, Risk 9, Risk 10
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	Value Improvement Programme: VIP Quality Impact Assessment: QIA Equality Impact Assessment: EIA NHS England: NHSE Getting it Right First Time (GIRFT) Model Health System (MHS) Clinical Advisory Group (CAG)

Meeting of the Board of Directors

Thursday 22nd October 2026

Value Improvement Programme (VIP)

Month 6 2026/27 position and planning for 2027/28

1.0 Purpose

This paper provides the Board with assurance on delivery of the 2026/27 Value Improvement Programme (VIP) and describes the approach and key milestones for developing the 2027/28 programme. It sets out the current position, the strategic and financial importance of delivery, and the governance, quality assurance and improvement arrangements that will support a fully identified and delivery ready programme by the start of the new financial year.

2.0 Strategic and regulatory context

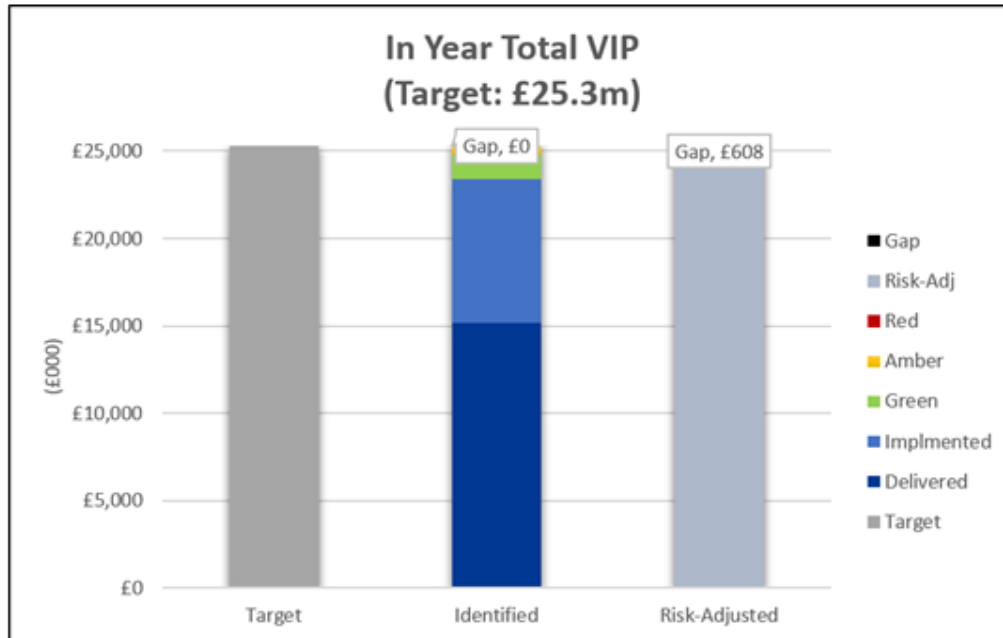
The Christie Five-Year Integrated Delivery Plan 2026–2031 establishes productivity, value and financial sustainability as core components of the Trust’s response to rising demand and delivery of the national medium term planning guidance. Our Value Improvement Programme is how we identify efficiencies, productivity and service improvements and ensure they are translated into planned, measurable delivery, with quality and equity safeguards embedded throughout.

VIP supports the strategic goal of achieving operational excellence and financial sustainability and is integral to the Trust’s financial plan, supporting its position under the NOF Segment 1 status. The programme forms part of the Trust’s integrated approach to improving pathways, reducing unwarranted variation, releasing capacity and directing resources towards the changes that offer the greatest benefit for patients.

3.0 Month 6 VIP position

The Trust has fully identified its 2026/27 Value Improvement Programme (VIP) target of £25.3m. All schemes have now been transacted with the exception of phase 2 of the Theatre Productivity scheme, which remains RAG-rated Green and is progressing as planned. In-year delivery of the programme has relied on £1.5m of over-delivery from non-recurrent schemes to offset a shortfall in recurrent savings; however, the full-year effect of the recurrent VIP schemes has achieved the targeted £12.6m. Consequently, from a VIP delivery perspective, the Trust remains on track to exit the financial year in line with its Medium Term Financial Plan.

Given the successful identification and delivery of the 2026/27 programme, the focus will now shift towards the timely identification, development and delivery of the 2027/28 VIP programme to maintain financial sustainability and support future plan requirements.



Delivering 100%	Green 75%	Amber 50%	Red 25%	Unidentified 0%
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Annual					Year To Date			
	Target (£000)	Identified (£000)	Unidentified (£000)	Risk-Adjusted Identified (£000)	Risk-Adjusted Unidentified (£000)	Target (£000)	Delivered (£000)	Variance (£000)
Total VIP	25,298	25,298	0	24,690	608	12,650	12,650	0
Recurrent VIP	12,640	11,108	1,531	10,866	1,763	6,325	4,510	1,814
Non-Recurrent VIP	12,640	14,190	(1,531)	13,825	(1,176)	6,325	8,140	(1,814)

4.0 Approach to the 2027/28 programme

The Trust is developing the 2027/28 VIP through established integrated planning approach, bringing together activity, workforce, quality, productivity and finance. The approach will continue to embed value improvement within the Trust's Quality Management System and routine operational management, rather than treating it as a stand-alone annual savings exercise.

4.1 Opportunity identification and development

Ideas-generation workshops and pipeline-development meetings with clinical, operational and corporate teams have commenced. Opportunity packs drawing on GIRFT, Model Health System, costing and patient-level information, demand and capacity analysis, and other relevant benchmarking are being developed to signpost opportunities for improvement.

In addition to this:

- Clinically led specialty reviews to identify unwarranted variation, service improvement opportunities and new ways of working.
- A single programme pipeline, with scheme ownership, milestones, expected benefits and dependencies recorded and monitored.
- Early assessment of quality, equality, workforce, operational and financial implications so that schemes are developed as complete service changes rather than financial adjustments in isolation.
- Lessons learned from last year have been captured to ensure continuous improvement.

- Ideas have been shared with other Trusts to ensure schemes are being considered for The Christie.
- The Grip and Control checklist for good financial management has been re-reviewed to ensure we are adopting good practice.

4.2 Value Maker Programme

The established Value Maker Programme continues to develop capacity and capability in improvement skills and strengthens the connection between clinical improvement and financial sustainability. It supports staff to understand value, use improvement methods, interpret benchmarking and financial information, develop credible plans and measure whether intended benefits are being achieved.

The programme will continue to promote shared ownership between clinical, operational and finance colleagues. It will also provide a route to identify and develop local champions, share practical learning and spread successful improvement across the Trust.

4.3 Ideas-generation workshops

Ideas-generation workshops have commenced, with 12-20 ideas for improvement being generated from staff at each session. These aim to support teams to identify waste, reduce unwarranted variation, improve pathways and release capacity. Sessions will combine local knowledge with benchmarking and opportunity data, helping teams translate ideas into defined schemes with clear ownership, patient benefit, measures and next steps. Outputs are added to the central pipeline and progressed through established divisional and programme governance.

4.4 Value Summit

A Trust-wide Value Summit is being planned for early December 2026. The summit will showcase what has been achieved during 2026/27, recognise staff and teams, share learning and strengthen clinical and financial collaboration. It will also be used to generate and accelerate opportunities for 2027/28, connecting successful local improvement with the potential for wider adoption across the Trust.

5.0 Governance, risk and assurance

Scheme and programme confidence is assessed against maturity, ownership, financial validation, quality assurance and deliverability. Risk-adjusted reporting focuses support and escalation on lower-confidence schemes and provides the Board with a realistic view of delivery.

The established governance framework provides weekly scheme level review, Executive Team oversight and national weekly reporting, overseen by the Value Improvement Board. Divisions remain accountable for delivery, with exceptions reviewed through Integrated Performance Management and escalated for executive support or deep dive where required.

Financial validation, benefits tracking, QIA and EHIA review, confidence ratings and defined escalation routes provide assurance that delivery remains controlled and does not compromise quality, safety, experience or equity. Actions arising from the Trust's Grip and Control review are incorporated into programme oversight.

5.1 Quality and equality assurance

All schemes will complete proportionate QIA screening during development, with a full QIA and EHIA approved through the relevant clinical governance arrangements. Required assessments and delivery plans will be completed by February 2027, with post-implementation review used to identify and manage any emerging impact. QIA pop up sessions are held to support clinical teams to complete the assessment.

6.0 Planning timetable and milestones

- **October–November 2026:** opportunity identification and development, including workshops, benchmarking, specialty review, named ownership and pipeline tracking.
- **Early December 2026:** Value Summit to share learning, strengthen clinical and financial collaboration and accelerate further opportunities.
- **By 31 December 2026:** full identification of the gross 2027/28 programme, with scheme owners, provisional values and initial confidence ratings.
- **January–February 2027:** detailed scheme development, financial validation, milestones, required QIAs and EHIA, and confirmation of risks, dependencies and mitigations.
- **By 28 February 2027:** delivery-ready programme, with schemes appropriately risk-rated, quality-assured and exceptions escalated.
- **March 2027:** final governance review, confirmation of reporting arrangements and resolution of remaining delivery dependencies.
- **1 April 2027:** formal delivery and benefits tracking commence.

7.0 Conclusion

The Trust has fully identified the 2026/27 VIP and remains on track to exit the year in line with its Medium Term Financial Plan. The focus is now on developing the 2027/28 programme early, with full identification by the end of December 2026, delivery plans and required quality assurance in place by February 2027, and mobilisation for delivery from 1 April 2027.

Successful VIP delivery is integral to achievement of the Trust's financial plan, supports the finance measures within the NOF, and contributes directly to delivery of the Five-Year Integrated Delivery Plan goal for operational excellence and financial sustainability.

The established governance framework, including weekly scheme-level review, weekly executive and national reporting, Value Improvement Board oversight, devolved accountability, Integrated Performance Management, internal deep dives, QIA and EHIA governance, Grip and Control and national good-practice confidence rating, provides a controlled and improvement-led approach to maintaining financial sustainability while protecting quality and patient outcomes.

8.0 Recommendations

The Board is asked to:

- Note the 2026/27 VIP position and the Trust's forecast exit position.
- Note that VIP delivery is integral to the Trust's financial position, NOF position and Five-Year Integrated Delivery Plan.
- Note the governance and assurance framework, including risk-adjusted confidence assessment, weekly oversight and escalation, Grip and Control, QIA and EHIA governance, Integrated Performance Management and internal deep dives.
- Note the milestones for full identification by the end of December 2026, completion of delivery plans and required QIAs and EHIA by February 2027, and delivery from 1 April 2027.
- Support the continued use of the Value Maker Programme, ideas-generation workshops and early-December Value Summit to strengthen capacity, capability and clinical and financial collaboration.

Agenda item 27/26a

Meeting of the Board of Directors

Thursday 22nd October 2026

Subject / Title	Regulatory preparedness and inspection activity update
Author(s)	Chief Nurse and Executive Director of Quality Compliance Lead
Presented by	Executive Chief Nurse and Director of Quality
Summary / purpose of paper	This paper provides a summary update on Trust wide regulatory preparation and CQC inspection activity
Recommendation(s)	Note the continued progress of the Trust's regulatory preparedness and the ongoing delivery of the Excellence in Action programme, acknowledging staff across clinical and non-clinical areas in evidence mapping, peer mock assessments, and review activities.
Background papers / source of assurance	• Data • Soft intelligence • Benchmarking • External assessments • Risks and mitigation • Trajectory and changes over time
EDI impact / considerations	Positive EDI impact: The proposal is expected to advance equity, improve access, or reduce disparities for one or more protected or disadvantaged groups.
Link to: ➤ Board Assurance Framework ➤ Trust strategy / objectives ➤ NHS Oversight Framework ➤ CQC / Regulation	All
Risk score / BAF reference	BAF Risks 4
Acronyms or abbreviations where they appear in the attached paper, please list them in the adjacent box.	CPP – Christie Pathology Partnership CQC - Care Quality Commission IR(ME)R – Ionising radiation (medical exposure) regulations



**Meeting of the Board of Directors
October 2026**

Executive summary - Regulatory preparedness and inspection activity update

1. Context and background

The Trust continues to make strong progress in its regulatory preparedness through the well-established Excellence in Action programme which has embedded CQC readiness, governance and continuous improvement across the organisation.

2. Scope of the paper

This paper provides an overview of progress in regulatory preparedness, including programme delivery, evidence collation, assurance activities, and external validation. It outlines current levels of readiness against CQC's current key questions and quality statements, 2026/27 inspection activity to date, and planned actions for the remainder of 2026/27.

3. Key insights and assurance

Strong engagement from clinical, corporate and support services, supported by a dynamic evidence matrix and ongoing assurance activity, has demonstrated a high level of readiness against the CQC assessment framework.

Mock assessments have identified a strong culture of safety, quality improvement and person-centred care, with improvement actions being actively addressed.

The Trust maintains a positive regulatory relationship with the CQC through regular engagement and ongoing monitoring activity.

Previous CQC actions arising from the 2025/26 IR(ME)R inspections have been completed and formally closed.

In May 2026, the CQC undertook a routine inspection of The Christie Pathology Partnership LLP (CPP), a Trust joint venture, under the Independent Hospital process; this assessment related solely to CPP and did not include activity undertaken as part of the Trust's CQC registration.

4. Implications

While the Trust is well positioned to demonstrate compliance with CQC requirements, continued focus is required to maintain momentum, strengthen consistency of evidence across all services and respond to future regulatory developments.

5. Next steps or options

Sustain Excellence in Action mock assessment activity and peer review across all sites.

Maintain the dynamic evidence matrix.

Maintain divisional engagement and visibility.

Respond to emerging CQC consultations and adapt to any framework changes.

6. Recommendation

The Board is asked to take assurance from the progress made and the Trust's ongoing preparedness for CQC regulation.



Meeting of the Board of Directors
Thursday 22nd October 2026

Regulatory preparedness and inspection activity update

1. Overview

The Trust continues to make strong progress in its regulatory preparedness programme. Since early 2025, the Trust has delivered Excellence in Action; a structured, organisation wide approach to regulatory preparedness aligned to the CQC assessment framework. The programme underpins the regulatory framework, embedding compliance, governance, and continuous improvement into routine practice.

2. Regulatory preparedness

2.1 Progress to date

- **Evidence matrix and mapping:**

Working alongside the divisions and corporate directorates a dynamic evidence matrix is maintained mapping Trust activities and assurance materials against the CQC key questions and quality statements. This ensures a clear and accessible repository of evidence demonstrating compliance and best practice.

- **Collaborative preparation and the Excellence in Action programme:**

Excellence in Action in its first year focused on staff engagement and promotion through quarterly cycles focused on each of the CQC key questions—Safe, Caring, Responsive, Effective, and Well-Led; linking everyday activity to regulatory expectations with a series of unannounced mock assessments.

Collaborative preparation forms the foundation of the Excellence in Action 2026/27 mock assessment programme. Combining presentations, mock assessments, and staff and patient feedback activities demonstrates learning, knowledge and compliance against the CQC assessment framework. The programme assesses services against each of the CQC key questions, providing an opportunity to evaluate strengths, weaknesses, opportunities and threats. Findings are used to identify areas for quality improvement, share learning and highlight examples of good practice.

This approach supports continuous improvement, strengthens organisational readiness for regulatory assessment and provides assurance that services understand and can demonstrate how they meet regulatory expectations.

Three service level collaborative Excellence in Action mock assessments have been undertaken as far during 2026/27, covering Surgery, anaesthetics and theatres, including ward 10; Radiology and Proton beam therapy. Further service mock assessments are planned for the remainder of the year.

2.2 Assurance

All areas assessed to date have demonstrated a strong safety culture and leadership, engagement in quality improvement, effective partnerships, delivery of person-centred care and responsiveness to people's needs. These are triangulated with existing evidence and governance processes demonstrating a mature approach to regulatory engagement, continuous improvement and assurance that:

- Systems are in place to maintain readiness for regulatory inspection.
- Evidence supporting compliance with the CQC assessment framework is actively maintained and regularly reviewed.
- Services continue to receive independent challenge through mock assessment activity.



- Learning from assessments is translated into local improvement plans and monitored through governance structures.

The Trust maintains its relationship with the CQC through quarterly engagement meetings and responding to regulatory information requests as part of their regulatory oversight.

2.3 Well-led CQC developmental review 2026

The developmental review undertaken by ConsultOne in preparation for our Advanced Foundation Trust (AFT) application outlined a set of suggested improvements. We have taken these recommendations and brought them together with the actions identified through our assessment of the Ockenden, Amos and Thirlwall national inquiries. The overall action plan identifies progress and where assurance against each element will be assessed. This will be presented to Board at a future meeting. It is also noted that NHSE have confirmed that the Board do not need to undertake a separate Board Capability self-assessment in 2026/27 as we have gone through the AFT application process.

3 2026/27 Inspection activity

The CQC undertook a routine inspection of one of the Trust's joint ventures, The Christie Pathology Partnership LLP (CPP), under the Independent Hospital process in May 2026. The scope of the assessment did not include any activity undertaken as part of the Trust's CQC registration and related solely to the activities of CPP. The assessment considered all five CQC key questions and concluded that CPP was in breach of one regulation, for which an action plan was requested. CQC does not rate medical laboratory services.

The Trust has progressed and completed the improvements identified within the 2025/26 CQC IR(ME)R inspections of both the PET-CT and Radiotherapy service with a particular focus on satellite service provision. Both inspections have been formally closed by the CQC.

4 Next Steps

The Trust will continue to engage with the CQC through regular relationship meetings, responding to information requests and maintain momentum through continued delivery of the Excellence in Action programme, informed by staff feedback to support improvement at individual and service level.

- Continue to collate and support the divisions in dynamic evidence mapping for all key questions.
- Ongoing Board and divisional engagement through review days, staff handbooks, and communication campaigns.
- Continued peer review and mock assessment programme to sustain confidence and readiness across all services, across the network sites. These will include a combination of observational assessment, staff, service and patient feedback and service presentations with a focus on quality improvement.
- Engage with CQC consultations on sector specific draft assessment frameworks responding to any changes that may occur during 2026/27.

5 Conclusion

The Trust's structured approach to regulatory preparedness provides clear assurance that systems, evidence, and engagement are in place to demonstrate compliance with the CQC

Assessment Framework. Excellence in Action planned activity will continue to focus on maintaining organisational readiness, strengthening assurance and embedding learning and improvement across all services and network sites.



Agenda item 27/26b

Meeting of the Board of Directors

Thursday 22nd October 2026

Subject / Title	Developing the strategic framework – process and approach
Author(s)	John Wareing, Director of Strategy
Presented by	John Wareing, Director of Strategy
Summary / purpose of paper	As part of the overall strategy refresh the Board will be required to review the current strategic framework. This paper sets out the timeframe and process for this exercise.
Recommendation(s)	The Board of Directors is asked to agree the proposed timetable and process.
Background papers / sources of assurance	22/26a Refreshing the Trust Strategy (Board of Directors 24 September 2026)
Risk score / BAF reference[	N/A
EDI impact / considerations	N/A
Link to Trust strategy / objectives	- All Trust strategic pillars and objectives - Strategy refresh - Strategic portfolio - Organisational capability - Governance and assurance
Acronyms or abbreviations	BRC Biomedical Research Centre

Meeting of the Board of Directors

Thursday 22nd October 2026

1. Background

The current Trust strategy is due to expire in 2028 and, in the context of the developing external landscape, the Board has previously agreed to a high-level timetable of activities to support a process to refresh our Strategy.

Ensuring an effective and comprehensive strategic framework and architecture is in place is a critical success factor for the development and delivery of the refreshed strategy. This will ensure that the delivery of our future priorities and programmes are not only aligned but also sufficiently resourced and governed. This supports the Board being assured that delivery of the strategy is on track.

2. Approach

The forthcoming Board development session (25 November) provides a convenient opportunity for the Board to discuss and debate the development of this framework. This timetable is broadly consistent with that agreed at the September meeting.

The session will be facilitated by the Value Circle and will consider a number of elements of the existing strategy, the work to develop the strategic portfolio and associated governance. Links to the changing external context (eg NHS Plan, NHS Cancer Plan, BRC North, Advanced Foundation Trust and Lead Provider Models) alongside emerging NHS priorities and our current delivery plans will be considered.

In order to ensure that the session can be as productive as possible a series of pre reading materials will be provided to Board members one week prior to the session. The overall aim is to ensure effective discussion and direction such that a strategic framework can be developed. Following the session a revised framework will be developed for approval at the January meeting of the Board.

3. Summary

Developing a refreshed strategy requires the development of an effective strategic framework and it is critical that Board has adequate time to debate and discuss its development.

Agenda Item 29/26a(i)

Meeting of the Board of Directors

Thursday 22nd October 2026

Subject / Title	Quality Assurance Committee report – October 2026
Author(s)	Jo D'Arcy, Assistant Company Secretary Sarah Corcoran, Committee Chair
Presented by	Sarah Corcoran, Committee Chair
Summary / purpose of paper (alert / advise / assure)	This paper provides the Board with a AAA summary of the items considered by the Quality Assurance Committee at their October meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions required.
Background papers / sources of assurance	Quality Assurance Committee papers – 1 st October 2026
EDI impact / considerations	Positive EDI impact. The Committee's work supports safe and equitable care, improved access and reduced health inequalities. Relevant considerations include equitable access to electronic patient records and inclusive engagement with patients, families and staff in service improvement and patient safety learning.
Link to: ➤ Board Assurance Framework ➤ Trust strategy ➤ Corporate objectives ➤ CQC Quality standard ➤ Regulation	• Board Assurance Framework – Risks 1, 2, 4 and 7 • Corporate objective 1 - To deliver safe, effective & equitable care • Corporate objective 3 - To provide integrated clinical, research and education services • Corporate objective 5 - To transform our services to improve access and reduce health inequalities • Corporate objective 6 - To provider leadership within the wider NHS cancer system • CQC Regulations – 9, 10, 12, 13, 14, 16 and 20
Risk score	N/A
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	EDI – Equality, Diversity & Inclusion MIAA – Mersey Internal Audit Agency



**Meeting of the Board of Directors
Thursday 22nd October 2026**

Quality Assurance Committee summary report – October 2026

1 Introduction

The committee took place on 1st October 2026. Quoracy met with 5 of 5 members present, including the Chair. All decisions are valid.

2 AAA summary from committee meeting

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

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

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

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

3 Recommendation

The Board are asked to note the summary report from the committee in October 2026.



Appendix 1

Alert	Assurance rating (if applicable)	Action (to be taken)	By Whom	Target Date
A new assurance report identified gaps in demonstrating a Trust-wide, auditable approach to monitoring access to electronic patient records. While no immediate uncontrolled risk was identified, governance ownership, monitoring arrangements and escalation processes require further clarification.	Low	Ownership and governance responsibilities to be clarified, proposed framework, monitoring arrangements and accountability structure to come to the committee in April 2027 (following presentation through the appropriate governance committee route).	Chief Information Officer Nursing	April 2027

Advise:	Assurance rating (if applicable)
Controlled drugs management and assurance - full assurance could not yet be provided due to identified audit programme gaps resulting from a previous single point of failure within the audit process. Whilst additional controls and mitigation measures are in place and reported patient harm remains low, the committee assigned medium assurance and requested a further progress report in April 2027.	Medium
Mortuary standards assurance report - committee assured that appropriate improvement plans and governance arrangements are in place. Members endorsed continued oversight through six-monthly reporting recognising the safety, governance and regulatory compliance of the service while acknowledging areas requiring further strengthening.	Medium

Assure:	BAF reference	CQC reference	Assurance rating
Digital clinical safety assurance bi-annual report - committee noted the delivery of the previously proposed improvements to digital clinical safety assessment and monitoring processes, recognising the encouraging work and plans in progress.	1, 4		Medium
Ockenden review and Baroness Amos investigation self-assessment – committee received assurance that no significant assurance gaps were identified. An action plan is in place to strengthen arrangements further, including continued development of the public and patient engagement framework and refinement of Martha's Rule implementation.			High
PSIRF priority update and maturity assessment - the Trust continues to make strong progress in embedding PSIRF and delivering its Patient Safety Incident Response Plan. Committee noted evidence of system-wide learning, established governance arrangements including quarterly reporting and a Learning Response Review Group, and positive findings from the maturity assessment. Further work to strengthen patient, family and staff engagement, enhance oversight and resource allocation, and continue embedding a culture of learning and improvement was endorsed.	2		High



Risks discussed (including any new risks identified):

- Risk descriptions for learning from patient safety incidents and the 62 day pathway have been redescribed. The underlying mitigations remain broadly unchanged.
- The revised risks reflect discussions at Board and the review undertaken through the Risk and Quality Governance Committee.

The following agenda items were also discussed during the meeting:

- Approval of previous minutes and a review of actions
- Internal audit progress report and audit recommendation tracker
- Six-monthly research and innovation (R&I) governance assurance report (high assurance)
- Compliance with catering and cleaning standards (CQC regulation 15) (high assurance)
- Integrated governance assurance report (strong assurance)
- Health and safety annual report (medium assurance)
- Board assurance framework (BAF)



Agenda Item 29/26a(ii)

**Meeting of the Board of Directors
Thursday 22nd October 2026**

Subject / Title	Workforce Assurance Committee report – October 2026
Author(s)	Jo D’Arcy, Assistant Company Secretary Amanda Oates, Committee Chair
Presented by	Amanda Oates, Committee Chair
Summary / purpose of paper (alert / advise / assure)	This paper provides the Board with a AAA summary of the items considered by the Workforce Assurance Committee at their October meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions required.
Background papers / sources of assurance	Workforce Assurance Committee papers – 1 st October 2026
EDI impact / considerations	
Link to: ➤ Board Assurance Framework ➤ Trust strategy ➤ Corporate objectives ➤ CQC Quality standard ➤ Regulation	• Board Assurance Framework – Risks 3, 4 and 12 • Corporate objective 4 - to be an excellent place to work and attract the best staff • CQC Regulations – 5, 9, 10, 12 and 18
Risk score	N/A
Acronyms or abbreviations that appear in the attached paper.	EDI – Equality, Diversity & Inclusion MIAA – Mersey Internal Audit Agency



Agenda Item 29/26a(ii)

**Meeting of the Board of Directors
Thursday 22nd October 2026**

Workforce Assurance Committee summary report – October 2026

1 Introduction

The committee took place on 1 October 2026. Quoracy met with 4 of 4 members present, including the Chair. All decisions are valid.

2 AAA summary from committee meeting

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

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

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

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

3 Recommendation

The Board are asked to note the summary report from the committee in October 2026.



Appendix 1

Alert	Assurance rating (if applicable)	Action (to be taken)	By Whom	Target Date
No matters requiring escalation were identified.	N/A	N/A	N/A	N/A

Advise:	Assurance rating (if applicable)
NHS Staff Standards - update on the introduction of the NHS Staff Standards received, a Trust-wide self-assessment was noted as underway. Initial review suggests that the requirements are broadly reflected within existing plans and programmes, although additional data collection requirements may create resource implications. Committee requested that organisational capacity, participant demographics and staff voice data are incorporated into the assessment process to strengthen assurance and support a more comprehensive evaluation. A full gap analysis and improvement plan will be presented to the February meeting for review and assurance.	will be reviewed for assurance rating at next review
Lord Mann Review - update on the Trust's response to the Lord Mann Review received, all eight recommendations considered applicable to the Trust have been assessed through a gap analysis. Progress has been made to strengthen organisational arrangements, including the incorporation of definitions relating to anti-Muslim hostility, antisemitism and racism into relevant policies and guidance. Committee noted that development of measurable EDI objectives for leaders remains a key priority and supported further work to strengthen accountability through the Equality Delivery System and revised EDI action plan. Committee members requested consideration of opportunities to accelerate delivery of key actions, including oversight arrangements for racism investigations, and sought greater alignment between leadership and team-level EDI objectives. A further progress review will be presented to the Committee in April 2027.	N/A

Assure:	BAF reference	CQC reference	Assurance rating
NHS pre-employment checking standards annual assurance report (deep dive) - internal audit testing of 95 employee files identified no anomalies, with no staff commencing employment prior to completion of the required pre-employment checks. Assurance was also received regarding compliance for agency staff and the effectiveness of recruitment controls, including enhanced validation processes. Committee agreed strong assurance that the controls in place support compliance with NHS Employment Check Standards and CQC Regulation 19.	3, 4	19	Strong
Role essential training assurance update - all audit recommendations have been completed, with strengthened governance and oversight arrangements now in place. Compliance continues to improve following significant changes to training requirements, supported by regular monitoring through divisional and executive reporting processes. Whilst a small number of staff groups remain below the compliance target, appropriate risk management and clinical governance arrangements are in place. Committee agreed to increase to high assurance in	3	18	High



respect of the role essential training framework and the progress made in improving compliance, with a further review scheduled for April 2027.			
Resident doctors strategic oversight group (RDSOG) quarterly report and board assurance framework (BAF) - continued improvements in resident doctor experience and workforce measures noted, with the Trust now ranked second in the region following sustained improvement activity. Members were advised that exception reporting remains stable, compliance with rota adherence has improved, and work continues to strengthen workforce planning, training opportunities and competency assessment arrangements.	3, 4	N/A	N/A

Risks discussed (including any new risks identified):

- BAF risks 3, 4 and 12 – discussed as part of papers reviewed during the meeting.
- BAF risk descriptions noted has having been redescribed to sharpen their focus (as presented at Board), scores unchanged.

The following agenda items were also discussed during the meeting:

- Approval of previous minutes and a review of actions
- Internal audit progress report and recommendation tracker
- Director of Workforce report
- Workforce dashboard and risk review (high assurance)
- Sickness absence assurance report (high assurance)
- Medical devices training audit progress update (medium assurance)
- Resident doctors payroll accuracy report (high assurance)
- Responsible Officer report - annual medical appraisal and revalidation



Agenda Item 29/26a(iii)

Meeting of the Board of Directors

Thursday 22nd October 2026

Subject / Title	Strategy & Transformation Assurance Committee report – October 2026
Author(s)	Jo D’Arcy, Assistant Company Secretary Dr Jim Hughes, Committee Chair
Presented by	Dr Jim Hughes, Committee Chair
Summary / purpose of paper (alert / advise / assure)	This paper provides the Board with a AAA summary of the items considered by the Strategy & Transformation Assurance Committee at their October meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions required.
Background papers / sources of assurance	Strategy & Transformation Assurance Committee papers – 1 st October 2026
EDI impact / considerations	No adverse EDI impacts were identified from the report itself; individual programmes will require appropriate equality and health inequalities assessment as they develop.
Link to: ➤ Board Assurance Framework ➤ Trust strategy ➤ Corporate objectives ➤ CQC Quality standard ➤ Regulation	• Board Assurance Framework – Risks 13 & 15 • Corporate objectives: 1. To deliver safe, effective & equitable care 2. To deliver excellent financial and operational performance 3. To provide integrated clinical, research and education services 4. To be an excellent place to work and attract the best staff 5. To transform our services to improve access and reduce health inequalities 6. To provider leadership within the wider NHS cancer system
Risk score	N/A
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	BAF – Board Assurance Framework EDI – Equality, Diversity & Inclusion MIAA – Mersey Internal Audit Agency



Agenda Item 29/26a(iii)

Meeting of the Board of Directors

Thursday 22nd October 2026

Strategy & Transformation Assurance Committee summary report – October 2026

1 Introduction

The committee took place on 1st October 2026. Quoracy met with 4 of 5 members present, including the Chair. All decisions are valid.

2 AAA summary from committee meeting

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

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

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

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

3 Recommendation

The Board are asked to note the summary report from the committee in October 2026.



Appendix 1

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

Advise:	Assurance rating (if applicable)
Project portfolio update report - The committee reviewed the Trust's transformation portfolio and noted that governance and portfolio management processes are established and operating effectively, supported by the Strategic Portfolio Management Office and defined programme oversight arrangements. The committee agreed a medium assurance rating, recognising that arrangements continue to mature and that further work is required to strengthen reporting on critical paths, dependencies, benefits realisation, workforce capacity and risk impacts. The committee also requested that future reporting embeds consideration of health inequalities and support effective non-executive assurance through a portfolio development session.	Medium
Christie Neighbourhood Cancer Centre (CNCC) (Christie @ Leighton) update - The committee reviewed the development progress and received assurance that appropriate governance arrangements are in place to support the development of the Outline Business Case. The committee agreed a medium assurance rating, recognising that further work is required to confirm affordability, secure funding arrangements, test capacity and utilisation assumptions, and demonstrate interdependencies with related strategic programmes. The committee also requested that learning from Christie at Macclesfield and consideration of health inequalities be reflected in the Outline Business Case.	Medium
EPR programme assurance update - The committee reviewed progress of the programme and noted that governance arrangements, programme leadership and joint working structures with Manchester University NHS Foundation Trust are being established. The committee agreed a medium assurance rating, recognising that the programme remains in development, with further work underway to finalise the Full Business Case, resource and affordability assessments, data governance arrangements and independent external assurance. The committee noted the scale and complexity of the programme and the importance of maintaining appropriate oversight of delivery, partnership and information governance risks.	Medium

Assure:	BAF reference	CQC reference	Assurance rating
Committee Terms of Reference approved with a review date of 6 months.	N/A	N/A	N/A

<u>Risks discussed (including any new risks identified):</u>
BAF risks 13 and 15; deep dives to be added to the agenda for December 2026

The following agenda items were also discussed during the meeting:

- Formation and establishment of the committee



- Partnership report
- Transformation capacity and capability assurance framework
- Board assurance framework (BAF)



Meeting of the Board of Directors

Thursday 22nd October 2026

Subject / Title	Senior Management Committee report – September 2026
Author(s)	Louise Westcott, Company Secretary
Presented by	Roger Spencer, Committee Chair
Summary / purpose of paper (alert / advise / assure)	This paper provides the Board with a AAA summary of the items considered by the Senior Management Committee at their September meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions required.
Background papers / sources of assurance	Senior Management Committee papers – September 2026
EDI impact / considerations	The report has a neutral to positive indirect EDI impact. The committee's oversight of governance, risk management, internal control and declarations of interest supports fair, transparent and consistent decision-making across the organisation.
Link to: ➤ Board Assurance Framework ➤ NHS Oversight Framework ➤ Strategic objectives ➤ Regulation	• Board Assurance Framework • Strategic objectives • NHS Oversight Framework • CQC Regulations
Risk score	N/A
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	EDI – Equality, Diversity & Inclusion MIAA – Mersey Internal Audit Agency PDR – Performance Development Review

Meeting of the Board of Directors

Thursday 22nd October 2026

Senior Management Committee – AAA Report (September 2026)

September 2026

ASSURE

- Performance reporting was reviewed by exception with no significant constitutional, workforce, patient experience, agency or bank staffing exceptions identified. The VIP programme is expected to close by month end, reducing associated operational risk.
- A comprehensive improvement plan is in place for controlled drugs following limited assurance from Risk and Quality Committee, with Management Board scheduled to review progress in six months.
- Significant strategic programmes continue to progress, including the Advanced Foundation Trust assessment, Leighton Development programme, implementation of the Trust-wide inpatient model of care, and rollout of Ambient Voice Technology across clinical services.
- The Equality Delivery System submission, Winter Assurance Checklist (subject to final clarification), and Sustainability Annual Report were approved, with no significant concerns identified.
- Management Board approved progression of several major capital investments, including ASIC decant replacement, MRI scanner replacement and, in principle, the data centre replacement programme.

ALERT

- Organisational performance ranking within the National Oversight Framework has fallen from 2nd place at the end of Q4 to 9th place. Further analysis and targeted interventions are being developed.
- IPC performance is approaching the year-to-date threshold and requires continued monitoring.
- Research performance against the NIHR 90-day study set-up target remains below standard, requiring urgent improvement to achieve Q3 expectations. Data quality issues within NIHR reporting are also being addressed.
- Clinical support capacity has been identified as the principal risk to successful rollout of Ambient Voice Technology, particularly across Network Services where user numbers are expected to exceed 200 staff.
- The current referral and booking process continues to present patient safety risks. Management Board agreed that implementation of a standardised referral model should be accelerated and that delay due to further consultation should be avoided.

ADVISE

- Note the proposed partnership with Manchester University NHS Foundation Trust to join the Epic electronic patient record platform, creating a shared care record and joint optimisation of cancer pathways. A full business case is expected in November 2026 with Board consideration planned for December 2026. Monthly scrutiny will continue through Management Board.

- Support continued oversight of implementation of the new inpatient model of care, with monthly progress reports to be provided until business-as-usual arrangements are achieved.
- Note development of a new Christie centre at Mid Cheshire (Leighton), with a formal business case expected in October 2026 to support delivery of neighbourhood oncology services closer to home.
- Support further work to strengthen critical care planning, particularly in anticipation of increasing complex oncology and cell therapy activity, ensuring future business cases fully consider critical care impacts.
- Note that Management Board is progressing actions arising from the Well-Led Review, including communications modernisation, education and training improvements, and updates to Management Board Terms of Reference aligned to Advanced Foundation Trust ambitions.

Overall conclusion: Management Board received assurance that core performance remains stable and strategic programmes are progressing. Attention is required in relation to organisational performance ranking, research trial set-up performance, IPC performance and operational risks associated with referral management and digital transformation programmes.

Board of Directors meeting

Thursday 22nd October 2026

Subject / Title	Board Assurance Framework
Author(s)	Louise Westcott, Company Secretary
Presented by	Louise Westcott, Company Secretary
Summary / purpose of paper	This paper provides the Board with the Board Assurance Framework that summarises the risks to achievement of the strategic objectives. The cover paper gives detail of the updates.
Recommendation(s)	• To note the risks and controls relating to the strategic risks on the Board Assurance Framework, • To note that updates will be made to the risks that are the responsibility of the Board following discussion. • To scrutinise and review the assigned risks, controls and assurances and confirm any changes for Board approval.
Background papers	Board assurance framework. Strategic objectives 2025/26, operational plan and revenue and capital plan 2025/26.
Risk score	N/A
Link to: ➤ Trust strategy ➤ Strategic objectives	• Trust's strategic direction • Divisional implementation plans • Our Strategy • Key stakeholder relationships
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	BAF Board assurance framework ECN Executive chief nurse EDoF Executive director of finance EMD Executive medical director COO Chief operating officer DoW Director of workforce DCEO Deputy chief executive officer WAC Workforce Assurance Committee



**Board of Directors meeting
Thursday 22nd October 2026**

Board Assurance Framework

1 Introduction

The board assurance framework (BAF) outlines the risks to achievement of the strategic objectives and is presented to each Board and assurance committee meeting. The framework details the risk description, controls and gaps, responsible committee, risk appetite and target risk score. The overview shows changes in risk scores over time.

2 Background

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

3 Updates to risks

All risks in the framework have been reviewed to reflect the current position. Risk descriptions, controls, gaps and assurances have been updated where appropriate

Risk 10 - If we do not deliver our planned efficiency savings there is a risk that we won't achieve our financial plan – risk score reduced from 15 (3/5) to 5 (1/5) to reflect achievement of the 2026/27 value improvement target.

5 Recommendation

The Board are asked;

- To note the risks and controls relating to the strategic risks on the Board Assurance Framework,
- To note that updates will be made to the risks that are the responsibility of the Board following discussion.
- To scrutinise and review the assigned risks, controls and assurances and confirm any changes for Board approval.



BOARD ASSURANCE FRAMEWORK - OVERVIEW OF RISKS

RISK No.	Risk Title	Risk Description	Responsible Committee	Risk Appetite	Inherent Risk Score	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	Q1 26/27	Q2 26/27	Target Risk Score	Current Risk Score	Review /Target date
RISK 15	Technological advancements	If we do not keep pace with technological advancements, there is a risk that we will not provide the best possible experience to our patients and carers	Strategy & Transformation Assurance Committee	Cautious	20	12	12	12	12	12	12	8	12	Review Q3 2026/27
RISK 7	Ineffective Greater Manchester system-wide cancer pathways	There is a risk that The Christie cannot achieve its strategic objective of delivering timely and equitable specialist cancer care because of increasing demand and dependencies on external providers across the end-to-end cancer pathway, leading to delayed commencement of treatment, failure to	Quality Assurance Committee	Cautious	25	12	12	12	12	12	12	8	12	Reviewed Q1 2026/27
RISK 4	Compliance with regulatory standards	If the Trust is unable to consistently comply with regulatory, statutory & licensing requirements due to changes in regulatory expectations, service complexity, workforce pressures or weaknesses in governance & assurance arrangements, this could result in patient safety concerns, regulatory action, reputational damage & failure to achieve the Trust's strategic objectives	Board of Directors	Averse	15	12	12	12	12	12	12	4	12	Reviewed Q2 2026/27
RISK 13	Transformational capacity & capability	If we do not develop transformational capacity & capability, there is a risk that we will not transform services to improve access and reduce health inequalities	Strategy & Transformation Assurance Committee	Cautious	20	12	12	12	12	12	12	8	12	Review Q3 2026/27
RISK 14	Supply chain	If there are disruptions to the supply of essential products and services for the treatment and care of our patients, there is a risk of service disruption leading to delayed or cancelled care.	Audit Committee	Averse	12	9	9	9	12	12	12	8	12	Reviewed Q2 2026/27
RISK 8	Emergency event	If there is a serious emergency event (pandemic/cyber-attack/extreme weather event etc) there is a risk of business disruption (increased staff absence, increased patient non-attendance and equipment malfunction) leading to delayed or cancelled care.	Audit Committee	Averse	20	10	10	10	10	10	10	10	10	Review Q3 2026/27
RISK 2	Learning from patient safety incidents	If quality governance, assurance and organisational learning arrangements are not sufficiently effective to identify, escalate, investigate and respond to quality and patient safety concerns, then opportunities to learn and improve may not be consistently recognised or embedded, resulting in avoidable harm, variation in care quality, reduced	Quality Assurance Committee	Averse	15	12	12	9	9	9	9	4	9	Review Q3 2026/27
RISK 3	Recruitment and retention of skilled staff	If the organisation fails to maintain effective workforce resourcing supply and retention strategies, then it will face shortages leaving us at risk of delivering our integrated delivery plan.	Workforce Assurance Committee	Averse	20	9	9	9	9	9	9	6	9	Review Q3 2026/27
RISK 6	NHSE Financial Framework and support for growth	If the changes in the NHSE financial framework do not adequately fund efficient patient care & growth in activity there is a risk that we will not be able to deliver our integrated delivery plan	Board of Directors	Cautious	16	16	16	16	8	8	8	4	8	Review Q3 2026/27
RISK 12	Staff engagement	If leadership fails to actively model and foster an inclusive, compassionate and psychologically safe workplace this could result in poor behaviour and poor department/divisional cultures. Leads to risk to patient care and safety.	Workforce Assurance Committee	Averse	16	8	8	8	8	8	8	4	8	Review Q3 2026/27
RISK 9	Integrated research, education & service	If our research, education and clinical services do not operate as an integrated whole there is a risk that we will not secure the benefits of high-quality research and education on patient care and that this will lead to less-than-optimal quality of care.	Board of Directors	Averse	12	8	8	8	8	8	8	4	8	Reviewed Q4 2025/26
RISK 1	New technologies and increased standards of care	If there are changes to NICE guidance or other advances in practice that we have not anticipated (diagnostic, therapeutic, care) there is a risk that there will be a delay in their introduction leading to a delay in patients obtaining the benefits of new treatments.	Quality Assurance Committee	Cautious	20	6	6	12	6	6	6	4	6	Review Q3 2026/27
RISK 10	Financial balance	If we do not deliver our planned efficiency savings there is a risk that we won't achieve our financial plan	Board of Directors	Averse	25	5	5	15	15	15	15	5	5	Relates to VIP 2026/27
RISK 5	Capital funding	If we're not allocated adequate CDEL (ICB plus surplus) there is a risk that we won't deliver the planned strategic developments impacting on patient care and efficiency	Board of Directors	Eager	15	5	5	5	5	5	5	5	5	Review Q3 2026/27 / Within tolerance

RISK 1	New technologies and increased standards of care					Date Risk Opened	Current Risk Score								
Description	If there are changes to NICE guidance or other advances in practice that we have not anticipated (diagnostic, therapeutic, care) there is a risk that there will be a delay in their introduction leading to a delay in patients obtaining the benefits of new treatments.					Apr-24	6								
						Date of Last Review									
						Aug-26									
Associated Strategic Objectives	To deliver safe, effective & equitable care					Executive Lead Responsible Committee	Exec Medical Director Quality Assurance Committee								
						Assurance Level	Medium								
						Risk Appetite	Cautious								
Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date									
	Annual planning process with divisions. The trust has a risk-based process with divisional support to assess applicability and implement relevant guidance. Guidance that is not resolved or on the risk register is monitored and escalated if there are issues Model for delivery of upcoming NICE guidance established and in place	Uncertainty around what / when. External factors. Issue with breast cancer treatment - scale of impact	Level 1 – Data and management reports • Review of NICE guidelines through risk-based process with divisional support • risk register in place.□ Level 2 – Management team and committee scrutiny • Review NICE guidelines compliance through QAC and monthly IPQFR□ Level 3 – External assurances • NICE□	None identified	None identified	Review Q3 2026/27									
Scoring	Inherent Risk			Q1 26/27		Q2 26/27		Q3 26/27		Q4 26/27		Target Risk			
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	4	20	2	3	6	2	3	6				2	2	4

RISK 2	Learning from patient safety incidents						Date Risk Opened	Current Risk Score										
Description	If quality governance, assurance and organisational learning arrangements are not sufficiently effective to identify, escalate, investigate and respond to quality and patient safety concerns, then opportunities to learn and improve may not be consistently recognised or embedded, resulting in avoidable harm, variation in care quality, reduced regulatory assurance, reputational damage and failure to achieve the Trust's strategic objectives						Jun-25	9										
							Date of Last Review											
							Aug-26											
Associated Strategic Objectives	To deliver safe, effective & equitable care						Executive Lead	Exec Chief Nurse										
							Responsible Committee	Quality Assurance Committee										
							Assurance Level	Medium										
							Risk Appetite	Averse										
Actions	Key Control established	Key Gaps in Controls	Assurance		Gaps in	Actions to address	Target date for											
	The Trust has undertaken external training for the patient safety strategy covering all components of the patient safety strategy. The patient safety team have/ will continue to host training for incident handlers to ensure management of incidents across teams is standardised. Improvement workstreams have been established to implement recommendations following the publication of learning responses. Review through Patient Safety & Experience Committee and Risk & Quality Governance. Introduction of new DATIX system	New ways of working require new skills across the organisation and resource at a team level to manage incidents.	Level 1 – Data and management reports • PSIRF reports to Patient Safety Committee / Risk & Quality Governance / Senior Management Committee • ERG Level 2 – Management team and committee scrutiny • Review compliance through patient safety reports to QAC Level 3 – External assurances • MIAA review of PSIRF processes confirms substantial assurance • Updates presented to ICB • MIAA Health & Safety - substantial assurance		Embed quality improvement methodology across the Trust	Embed agreed Quality Improvement methodology across the Trust by Q4 26/27	Review Q3 2026/27											
Scoring	Inherent Risk			Q1 26/27			Q2 26/27			Q3 26/27			Q4 26/27			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	3	5	15	3	3	9	3	3	9							2	2	4

RISK 3	Recruitment and retention of skilled staff					Date Risk Opened	Current Risk Score								
Description	If the organisation fails to maintain effective workforce resourcing supply and retention strategies, then it will face shortages leaving us at risk of delivering our integrated delivery plan.					Apr-24	9								
						Date of Last Review									
						Aug-26									
Associated Strategic Objectives	To deliver safe, effective & equitable care To deliver excellent financial and operational performance To be an excellent place to work and attract the best staff					Executive Lead	Workforce Director								
						Responsible Committee	Workforce Assurance Committee								
						Assurance Level	High								
						Risk Appetite	Averse								
Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for									
	Staffing levels maintained through coordinated and risk based utilisation of bank and agency Christie People and Culture Plan 2023-26 Quarterly oversight of Trust wide vacancies and recruitment activity presented to the workforce committee & WAC Divisional oversight of recruitment activity and vacancies discussed at the monthly service review meetings Turnover analysis and 'next chapter' data presented and discussed six monthly at the workforce committee Robust sickness absence management and health and wellbeing offer Connect & reflect sessions in place for new starters within first 3 months of employment Weekly executive led vacancy management panel in place Recruitment of onboarding coordinator Nursing workforce lead appointed Completion and reporting to WAC of progress against the 10 point plan to improve resident doctors lives.	National staff shortages impacting recruitment.	Level 1 – Data and management reports • Divisional oversight of recruitment through Service & Operational Review meetings Level 2 – Management team and committee scrutiny • Review compliance through WAC People & Culture plan updates and update on compliance with CQC regulation • F&PP Compliance report to WAC / Board • Safe staffing 6 monthly reviews to external standard Level 3 – External assurances • National staff survey • CQC Inpatient survey • OECl accreditation • MIAA Bank & Admin audit - Moderate assurance	None identified	None identified	Review Q3 2026/27									
Scoring	Inherent Risk			Q1 26/27		Q2 26/27		Q3 26/27		Q4 26/27		Target Risk			
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	5	20	3	3	9	3	3	9	L	I	Score	2	3	6

RISK 4	Compliance with regulatory standards					Date Risk Opened	Current Risk Score											
Description	If the Trust is unable to consistently comply with regulatory, statutory & licensing requirements due to changes in regulatory expectations, service complexity, workforce pressures or weaknesses in governance & assurance arrangements, this could result in patient safety concerns, regulatory action, reputational damage & failure to achieve the Trust's strategic objectives					Jun-25	12											
						Date of Last Review												
						Aug-26												
Associated Strategic Objectives	To deliver safe, effective & equitable care To deliver excellent financial and operational performance To be an excellent place to work and attract the best staff					Executive Lead	Exec Chief Nurse											
						Responsible Committee	Board of Directors											
						Assurance Level	Medium											
						Risk Appetite	Averse											
Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for												
	Self assessments underway against 2022 must do actions and well-led quality indicators. Attendance at CQC briefings / NHS Providers briefings Engagement in national updates and regulatory briefings. Designated leads for statutory requirements across the Trust reporting into committee structure. Policies and procedures in place e.g. conflicts of interest, SFI's, Document ratification processes. Membership of NHS Providers to receive most up to date advice and guidance. Exec Team engagement in national briefings. Close working with regulators, GM ICS / ICB and NHSE. Attendance at system level and national meetings. Leads identified internally for each statutory requirement e.g. health & safety / IRMER / CQC etc Excellence in action programme underway.	External political factors	Level 1 – Data and management reports • Self assessment against 2022 Must Do's • Self assessment against Well Led / Safety quality indicators Level 2 – Management team and committee scrutiny • QAC /WAC review of CQC regulations - all on rolling programmes • Board level training on new CQC assessment framework Feb 24 • Board reporting on regulatory changes • Work of the 3 assurance committees • Board capability self-assessment Level 3 – External assurances • CQC Inspection Reports (IR(M)ER) • NOF Rating 1 (Q1 26/27 rated 9/134 acute & specialist trusts) • MIAA role specific training audit (CQC Reg 19) - Limited assurance Oct 24 • MIAA data quality audit Oct 24 - moderate assurance • OECI accreditation • MIAA Medical devices Training - limited assurance • MIAA Key Financial systems - substantial assurance • MIAA Health & Safety - substantial assurance • External well-led development review, Audit One	None identified	Plan in development for full review of all domains (1 per quarter) Actions relating to role specific training data reporting and compliance - reporting to WAC March 26	Reviewed Q2 2026/27												
Scoring	Inherent Risk			Q1 26/27			Q2 26/27			Q3 26/27			Q4 26/27			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	3	15	4	3	12	4	3	12	4	1	4	4	1	4	4	1	4

RISK 5	Capital funding	Date Risk Opened	Current Risk Score															
Description	If we're not allocated adequate CDEL (ICB plus surplus) there is a risk that we won't deliver the planned strategic developments impacting on patient care and efficiency	Jun-25	5															
Associated Strategic Objectives	To deliver excellent financial and operational performance	Date of Last Review																
		Aug-26																
		Executive Lead	Exec Director of Finance															
		Responsible	Board of Directors															
		Assurance Level	High															
		Risk Appetite	Eager															
Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for												
	Financial planning includes utilisation of 'capital freedoms' (CDEL) to increase the CDEL allocation to deliver our plan. Capital planning is part of our planning process and based on risk assessment within divisions. NHSE rules for 26/27 allow greater freedom with CDEL / capital spend	National / local funding rules / arrangements.	Level 1 – Data and management reports • Monthly finance reports Level 2 – Management team and committee scrutiny • summary of progress with capital plan/strategy implementation at Board / Planning Days • Regular reporting to Senior Management Committee & Board of Directors Level 3 – External assurances • ICB allocation - maximum capital freedoms	None identified	None identified	Review Q3 2026/27 / Within tolerance												
Scoring	Inherent Risk			Q1 26/27			Q2 26/27			Q3 26/27			Q4 26/27			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	3	5	15	1	5	5	1	5	5							1	5	5

RISK 6	NHSE Financial Framework and support for growth					Date Risk Opened	Current Risk Score											
Description	If the changes in the NHSE financial framework do not adequately fund efficient patient care & growth in activity there is a risk that we will not be able to deliver our integrated delivery plan					Jun-25	8											
Associated Strategic Objectives	To deliver excellent financial and operational performance					Date of Last Review		Exec Director of Finance										
						Aug-26												
						Executive Lead	Responsible		Assurance Level	Risk Appetite								
						High	Cautious											
Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for												
	Senior team attendance at national and regional meetings to keep updated on policy changes and influence discussions on cancer. Monthly service & operational reviews to ensure efficient delivery of service. Board member attendance at national events to influence policy. 2026/27 contract signed	External political factors	Level 1 – Data and management reports • SOR's • Divisional Boards reports Level 2 – Management team and committee scrutiny • MB reporting Level 3 – External assurances • External Audit VIM assessment • Signed contract for 26/27 in line with activity • MIAA Key Financial systems - substantial assurance	None identified	Continued attendance at regional & national events and on going discussions with ICB to understand funding	Review Q3 2026/27												
Scoring	Inherent Risk			Q1 26/27		Q2 26/27			Q3 26/27			Q4 26/27			Target Risk			
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	4	16	2	4	8	2	4	8							1	4	4

RISK 7	Ineffective Greater Manchester system-wide cancer pathways					Date Risk Opened	Current Risk Score											
Description	There is a risk that The Christie cannot achieve its strategic objective of delivering timely and equitable specialist cancer care because of increasing demand and dependencies on external providers across the end-to-end cancer pathway, leading to delayed commencement of treatment, failure to achieve cancer waiting time standards and adverse impacts on patients and the organisation.					Apr-24			12									
						Date of Last Review												
						Aug-26												
Associated Strategic Objectives	To deliver safe, effective & equitable care To deliver excellent financial and operational performance					Executive Lead			Chief Operating Officer									
						Responsible			Quality Assurance									
						Assurance Level			Medium									
						Risk Appetite			Cautious									
Actions	Key Control established		Key Gaps in Controls		Assurance		Gaps in		Actions to address		Target date for							
	Executive led monthly divisional performance review meetings. Integrated performance & quality report to Management Board and Board of Directors monthly. Weekly performance reporting via trust operational group. Escalation internally & across GM of delays impacting waiting time targets. Monitoring cancer waiting time standards through GM Cancer & IPQFR.		NHS pressures leading to delays in referrals from other Trusts		Level 1 – Data and management reports • 62 / 31 / 24 day reports to Senior Management Committee and Board • Service & Operational Review feedback Level 2 – Management team and committee scrutiny • 6 monthly review by QAC Level 3 – External assurances • MIAA review of 62 days / Cancer Alliance • The PSC Independent assessment and assurance of 62-Day Standard in the 5 year Integrated Delivery Plan - Likely to Deliver with conditions		Evidence of progress in underperforming parts of the pathway		Pathway improvement workstream in GM Cancer - reporting on progress 6 monthly to QAC		Reviewed Q1 2026/27							
Scoring	Inherent Risk			Q1 26/27			Q2 26/27			Q3 26/27			Q4 26/27			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	5	25	4	3	12	4	3	12							4	2	8

RISK 8	Emergency event					Date Risk Opened	Current Risk Score											
Description	If there is a serious emergency event (pandemic/cyber-attack/extreme weather event etc) there is a risk of business disruption (increased staff absence, increased patient non-attendance and equipment malfunction) leading to delayed or cancelled care.					Apr-24	10											
						Date of Last Review												
						Aug-26												
Associated Strategic Objectives	To maintain excellent operational, quality and financial performance.					Executive Lead	Chief Operating Officer											
						Responsible	Audit Committee											
						Assurance Level	Medium											
						Risk Appetite	Averse											
Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for												
	No ability to reduce likelihood as an organisation, however we do have an Annual Assurance process that is externally reviewed to develop our Statement of Compliance Adaptations to existing buildings / equipment to manage temperature rises. GM approach. Business Continuity Plans (BCP) - regularly tested and reviewed Extreme weather plan approved & published on intranet Data Security and Protection Toolkit submissions with audits undertaken. Digital board reporting. Board level Senior Information Risk Owner in place. Reviews of risk registers, alerts, reports, actions and observations MIAA audit - Data Protection Toolkit (DPST) 2024/25 approaching standards (new assessment) - improvement plan submitted to NHSE, actions completed (pending MIAA audit review) - reported to July 26 Audit Committee.DPST 2025/26 - assurance rating of low risk	The Trust does not currently have cyber security insurance.	Level 1 – Data and management reports • SDMP compliance • BCP compliance and effectiveness • Approved Extreme weather plan • Regular updates from NHS Digital - Vulnerability Monitoring Service Level 2 – Management team and committee scrutiny • Emergency Planning & Resilience Committee - reporting of regular testing of BCP's • Quarterly Net Zero and Climate Adaptation Committee (NZACAC) advises Executive Director • Annual SDMP report to MB and BoD (Assurance Scrutiny by Quality Assurance Committee) • Statutory disclosures in Trust Annual Report • Reports to Senior Management Committee and Audit Committee • Annual Assurance Report and Statement of Compliance- substantial compliance Level 3 – External assurances • Internal audit of compliance with NHS requirements • NHSE review of plans and progress - agreement of current compliance (as in self-assessment) • MIAA Data Protection Toolkit assessment (DPST) - Substantial assurance July 2024 / met standards for 2024/5 (new assessment) / low risk 2025/26	Not at 100% compliance for self-assessment / external assessment	Developing methodology to assess carbon footprint in collaboration with other Trusts Developing a CC Adaptation plan in development for future developments	Review Q3 2026/27												
Scoring	Inherent Risk			Q1 26/27			Q2 26/27			Q3 26/27			Q4 26/27			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	4	20	5	2	10	5	2	10							5	2	10

RISK 9	Integrated research, education & service										Date Risk Opened		Current Risk Score					
Description	If our research, education and clinical services do not operate as an integrated whole there is a risk that we will not secure the benefits of high-quality research and education on patient care and that this will lead to less-than-optimal quality of care.										Jun-25		8					
											Date of Last Review							
											Aug-26							
Associated Strategic Objectives	To provide integrated clinical, research and education services										Executive Lead		Chief Executive Officer					
											Responsible		Board of Directors					
											Assurance Level		High					
											Risk Appetite		Averse					
Actions	Key Control established		Key Gaps in Controls		Assurance		Gaps in assurance		Actions to address gaps		Target date for implementation		Target date for completion					
	Research / Education / CODU plans all approved and being monitored through divisional boards and MB OECI accreditation achieved and reported to Board Business case for expansion of CRF approved at January 2026 Board. Well-led review undertaken to assure on governance				Level 1 – Data and management reports • Divisional Board reports Level 2 – Management team and committee scrutiny • Regular reports on progress to Board and assurance committees Level 3 – External assurances • OECI accreditation • Well-led developmental review 2026		None identified		None identified				Reviewed Q4 2025/26					
Scoring	Inherent Risk			Q1 26/27			Q2 26/27			Q3 26/27			Q4 26/27			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	3	4	12	2	4	8	2	4	8							1	4	4

RISK 10	Financial balance					Date Risk Opened	Current Risk Score								
Description	If we do not deliver our planned efficiency savings there is a risk that we won't achieve our financial plan					Apr-24 Date of Last Review Aug-26	5								
Associated Strategic Objectives	To maintain excellent operational, quality and financial performance.					Executive Lead Responsible Assurance Level Risk Appetite	Exec Director of Finance Board of Directors High Averse								
Actions	Key Control established	Key Gaps in Controls	Assurance		Gaps in	Actions to address	Target date for								
	Activity plans agreed with Divisions and progress monitored weekly at TOG and monthly at Senior Management Committee. Variable income performance tracked as part of month end financial position and reviewed in the clinical Divisions monthly financial meetings. Development of mitigating strategies including efficiency and transformational programmes. Identification and consideration of new models of working to deliver and finance the Trust's strategic plan. Agreed governance of VIP schemes and escalating VIP reporting and responsibility to MB. VIP delivery at a divisional level monitored via the Trusts Service Operational Review framework	Commissioning intentions. Funding growth. Impact of cost increases (power/medicines etc) as a result of global factors (war in Middle East)	Level 1 – Data and management reports • Monthly Divisional scrutiny of financial position • Trust Operation Group (TOG) review weekly Level 2 – Management team and committee scrutiny • Reports to Senior Management Committee, Audit Committee and Board of Directors Level 3 – External assurances • MIAA review of financial systems • External audit of Annual Accounts • MIAA review of VIP programme • MIAA Key Financial systems - substantial assurance		None identified	Complete Quality Impact Assessments for all identified schemes as they arise	Relates to VIP 2026/27								
Scoring	Inherent Risk			Q1 26/27		Q2 26/27		Q3 26/27		Q4 26/27		Target Risk			
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	5	25	3	5	15	3	5	15				1	5	5

RISK 12	Staff engagement					Date Risk Opened	Current Risk Score								
Description	If leadership fails to actively model and foster an inclusive, compassionate and psychologically safe workplace this could result in poor behaviour and poor department/divisional cultures. Leads to risk to patient care and safety.					Jun-25	8								
Associated Strategic Objectives						To be an excellent place to work and attract the best staff		Date of Last Review							
								Aug-26							
		Executive Lead	Director of Workforce												
		Responsible	Workforce Assurance												
		Assurance Level	Medium												
		Risk Appetite	Averse												
Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for									
	Inclusive Culture Strategy developed through extensive engagement with staff and approved by Board. Board responsibilities outlined. Service & Operational reviews include 'people & culture' focus for all divisions. Progress reports to WAC. Divisions report staff engagement activity / priorities to Workforce Committee on rolling programme Workforce Assurance committee receive regular presentations from divisions on cultural activities. Strategic Leaders Forum - scheduled across the year Divisional plans in place for events and meetings across the year	None identified	Level 1 – Data and management reports • Divisional action plans from staff survey • Service & operational reviews Level 2 – Management team and committee scrutiny • Reporting to Workforce Committee, Workforce Assurance Committee and Board of Directors • Board development session on Inclusive Culture facilitated by NHS Providers expert Sept 2024 • Board approved Inclusive Culture Plan Nov 2024 Level 3 – External assurances • Annual CQC Staff Survey 2024 / 2025	None identified	Implementation of next phase of People & Culture Plan - reporting to WAC June 2026	Review Q3 2026/27									
Scoring	Inherent Risk			Q1 26/27		Q2 26/27		Q3 26/27		Q4 26/27		Target Risk			
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	4	16	2	4	8	2	4	8				2	2	4

RISK 13	Transformational capacity & capability					Date Risk Opened	Current Risk Score								
Description	If we do not develop transformational capacity & capability, there is a risk that we will not transform services to improve access and reduce health inequalities					Jun-25	12								
						Date of Last Review									
						Aug-26									
Associated Strategic Objectives	To transform our services to improve access and reduce health inequalities					Executive Lead	Dir of Future Christie								
						Responsible Committee	Strategy & Transformation								
						Assurance Level	Medium								
						Risk Appetite	Cautious								
Actions	Key Control established	Key Gaps in Controls	Assurance		Gaps in	Actions to address	Target date for								
	Future Christie Director and Medical Director in place. Director of Transformation appointed. Service Planning day with senior leadership team. Communication plan with wider organisation commenced. Alignment of Digital & Transformation under Future Christie. Year 1 objectives on track for delivery - patient portal / expanded AI / EPR outline case / staff engagement Strategic projects scoped and resource described - use of commercial partner to provide short term resource where identified as necessary. Transformation Committee meeting weekly. External assessments commissioned for AFT application process - financial / Well-led / content of application	None identified	Level 1 – Data and management reports • Exec review weekly Level 2 – Management team and committee scrutiny • Monthly to MB and Board • Board approved EPR OBC • Transformation Committee reporting Level 3 – External assurances • Deloitte engaged in options appraisal for new EPR • MIAA Key Financial systems - substantial assurance • PWC undertaking assessment of financial modelling • AuditOne Well-led review / assessment of AFT application		External assessment of capability and readiness to be developed	Year 1 objectives on track for delivery - patient portal / expanded AI / EPR outline case / staff engagement	Review Q3 2026/27								
Scoring	Inherent Risk			Q1 26/27		Q2 26/27		Q3 26/27		Q4 26/27		Target Risk			
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	4	20	3	4	12	3	4	12				2	4	8

RISK 14	Supply chain					Date Risk Opened	Current Risk Score								
Description	If there are disruptions to the supply of essential products and services for the treatment and care of our patients, there is a risk of service disruption leading to delayed or cancelled care.					Nov-24	12								
						Date of Last Review									
						Aug-26									
Associated Strategic Objectives	To deliver safe, effective & equitable care To deliver excellent financial and operational performance					Executive Lead	Chief Operating Officer								
						Responsible Committee	Audit Committee								
						Assurance Level	Medium								
						Risk Appetite	Averse								
Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for									
	Pharmacy - TCP procurement team work closely with regional & national drug procurement teams. Mutual aid MOU in place in NW. Management with clinicians to avoid impact on care Medical Physics - close relationship with national supply chains and management of demand based on availability of radioactive materials. BCP in place for Radiopharmacy to maintain supplies and regular discussions with supplier of FDG for the PETCT scanner. Procurement - policies & processes in place for management of supplies incl escalations & triggers / communication.	National / international shortages / supply issues - may result in price increases	Level 1 – Data and management reports • Regular reports to relevant committee • Monitoring & review by management team Level 2 – Management team and committee scrutiny • Reports to The Christie Pharmacy Company Board and Audit Committee, via Trust Drug & Therapeutics Committee • Escalations from Risk & Quality Governance to Senior Management Committee Level 3 – External assurances • MIAA audits commissioned to review specific issues where appropriate	None identified	Continuous review of alerts March 2026 - Comprehensive review undertaken of all aspects of supply chain risk in the context of escalated conflict in the Middle East	Reviewed Q2 2026/27									
Scoring	Inherent Risk			Q1 26/27		Q2 26/27		Q3 26/27		Q4 26/27		Target Risk			
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	3	4	12	4	3	12	4	3	12				4	2	8

RISK 15	Technological advancements										Date Risk			Current Risk Score				
Description	If we do not keep pace with technological advancements, there is a risk that we will not provide the best possible experience to our patients and carers										Jun-25			12				
											Date of Last Review Aug-26							
Associated Strategic Objectives	To transform our services to improve access and reduce health inequalities										Executive Lead			Dir of Future Christie				
											Responsible Committee			Strategy & Transformation Assurance Committee				
											Assurance Level			Medium				
										Risk Appetite			Cautious					
Actions	Key Control established			Key Gaps in Controls			Assurance			Gaps in			Actions to address			Target date for		
	Future Christie team leading service change ambitions incorporating technological advances with partners. Engaging with other health providers around effective systems on the market. Development of strategic outline case for new EPR Year 1 objectives on track for delivery - patient portal / expanded AI / EPR outline case / staff engagement			Recognition of fast moving market			Level 1 – Data and management reports • reports to Board of Directors Level 2 – Management team and committee scrutiny • Execs, MB and Board reports Level 3 – External assurances • Deloitte engaged in options appraisal for new EPR • OECl accreditation			Development of full business cases			EPR business case to Board July 2026. Seeking expertise internally & externally around best option - 'expert customer'			Review Q3 2026/27		
Scoring	Inherent Risk			Q1 26/27			Q2 26/27			Q3 26/27			Q4 26/27			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	4	20	3	4	12	3	4	12							2	4	8

Agenda item: 29/26c

Meeting of the Board of Directors

Thursday 22nd October 2026

Subject / Title	Emergency Preparedness, Resilience and Response (EPRR) – Annual Assurance Statement of Compliance
Author(s)	Claire McPeake (Accountable Emergency Officer) Dom Healey (Head of Emergency Preparedness)
Presented by	Claire McPeake (Accountable Emergency Officer)
Summary / purpose of paper	The purpose of this paper is to present the Board of Directors with the annual self-assessment of The Christie NHS Foundation Trust against the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) for the period 1 October 2025 – 30 September 2026. The paper seeks approval of the EPRR Statement of Compliance and outlines the Trust's current compliance status, recent improvements, and the action plans in place to achieve full compliance.
Recommendation(s)	The Board of Directors is asked to note and approve the contents of this report and the attached Statement of Compliance.
Background papers / source of assurance	• Self-assessment data against NHS England EPRR Core Standards • Benchmarking and external assessments • Risk register entries and mitigation plans
EDI impact/considerations	Positive EDI impact. Emergency preparedness and business continuity arrangements support the safety of all patients, staff and visitors. Plans, communications, evacuation arrangements and exercises should remain inclusive and accessible, taking account of differing mobility, disability, sensory, communication and language needs.
Link to: ➤ Board Framework ➤ Trust strategy	Assurance ➤ Board Assurance Framework: Risks 4, 8 ➤ Civil Contingencies Act 2004 ➤ NHSE EPRR Framework ➤ NHS Standard Contract Service Conditions



➤ Strategic objectives ➤ NHS Oversight Framework ➤ CQC Quality standard ➤ Regulation	➤ NHS Act 2006 ➤ Health and Social Care Act 2012 ➤ Health and Care Act 2022
Risk score	N/A
Acronyms or abbreviations that appear in the attached paper.	CCA – Civil Contingencies Act EPRR – Emergency, Preparedness, Resilience and Response LHRP – Local Health Resilience Partnership NHSE – National Health Service England



Meeting of the Board of Directors

Thursday 22nd October 2026

Emergency Preparedness, Resilience and Response (EPRR) – Annual Assurance Statement of Compliance

1. Background

Emergency Preparedness, Resilience and Response (EPRR) is a statutory requirement for NHS providers. The duty arises from the Civil Contingencies Act 2004, the NHS Act 2006, the Health and Social Care Act 2012, and the Health and Care Act 2022.

The NHS England EPRR Framework and the NHS Standard Contract (Service Condition 30) provide the operational obligations for NHS-funded providers. As a Category 1 responder, The Christie NHS Foundation Trust is required to:

- Assess emergency risks affecting the organisation and wider system.
- Maintain robust emergency and business continuity plans.
- Share information and cooperate with local and national partner agencies.

The NHS England EPRR Core Standards set the minimum benchmark for compliance across the NHS. Each year providers must complete a self-assessment and submit an assurance return to NHS England.

2. Introduction

This paper presents The Christie NHS Foundation Trust's annual self-assessment against the NHS England EPRR Core Standards for the period 1 October 2025 – 30 September 2026.

The submission consists of three key components:

- A Statement of Compliance, signed by the Accountable Emergency Officer.
- An improvement plan, addressing any partially compliant standards.
- The completed EPRR Core Standards spreadsheet, detailing evidence and RAG ratings.

For 2026/27 there are 59 standards. The national framework defines four levels of organisational compliance:

Full	Substantial	Partial	Non-Compliant
Compliant with all standards	The organisation is 89-99% compliant.	The organisation is 77-88% compliant	The organisation is compliant with 76% or less

This report sets out the Trust's current compliance position and the improvement work that continues to be taken forward.



3. Assurance Position

This paper provides the committee with assurance on the Trust's compliance position following the 2026/27 self-assessment.

The Trust's overall compliance rating has improved significantly:

- **2023** – 1% (non-compliant)
- **2024** – 61% (non-compliant)
- **2025** – 89% (substantial)
- **2026** – 91% (substantial)

This trajectory demonstrates a step change in the Trust's approach to EPRR and reflects the maturity of governance, training and exercising now in place.

The Board are asked to note the following:

Alert

Two domains remain partially compliant. Importantly, each of these areas is already subject to active improvement plans and mitigation measures, meaning that the overall risk to the Trust is being effectively managed.

- Warning and informing – resilience for out-of-hours communications remains limited. However, the Trust has established a pool of trained spokespeople to provide cover, ensuring a reasonable level of resilience while work continues to strengthen the model.
- Duty to maintain plans (Countermeasures) – further development is required in relation to protective and countermeasure planning. This work is in hand and will be progressed through the EPRR Committee to ensure timely delivery.

In addition, third-party business continuity assurance continues to be a key area of focus. A structured programme of engagement with critical suppliers and the Digital team is already in progress and is providing greater visibility and control over these risks.

Advise

The Trust has delivered a strong programme of training and exercising. Training has been designed to meet the Minimum Occupational Standards for Health Commanders, with compliance across the on-call cohort reaching 80%.

Exercises have tested key risks on the Trust risk register, including cyber security, radiological response and evacuation. Business Continuity and Communications exercises have also taken place in the last 12 months. The Trust has also participated in a multi-agency and national exercise: *Exercise Chaffinch* (national cyber attack).

No major incidents or critical incidents have been declared in the last 12 months. One business continuity incident was declared following an outage in the Radiopharmacy.

Lessons identified through incidents and exercises have been captured, debriefed, and translated into actions. Completed actions include new training packages, updated policies and infrastructure improvements. Ongoing actions are monitored by the EPRR Committee, demonstrating evidence of an embedded learning cycle.



Assure

The Trust is now assessed as 91% compliant with the NHS England Core Standards for EPRR. This represents substantial compliance and is a significant improvement compared to previous years. The majority of domains are fully compliant, with only two areas of partial compliance, all of which are under active management through improvement plans.

This provides assurance to the Board that the Trust has robust governance, a functioning learning cycle, and a clear trajectory towards full compliance.

Level of Compliance	Standards	Comments
Full compliance	54 standards	A maintenance of standards compared to the 53 standards that achieved compliance in 2025.
Partial compliance	6 standards	A detailed action plan has been drafted to convert the partial compliance status to full compliance by the year 2027.
Non-compliance	Zero	

Actions to address the partially compliant standards are in place and outlined in an action plan. The action plan will be overseen by the Christie EPRR Committee to ensure delivery, with assurance to the trust Risk and Quality Governance Committee and Audit Committee via committee minutes. Cascade of actions will be undertaken through the Christie EPRR governance structure.

In addition, external oversight, and peer review of provider EPRR self-assessments and associated action plans are provided through the Local Health Resilience Partnership. It should be noted that Greater Manchester's Integrated Care Board will review the Christie EPRR Core Standard submission during an official visit in October 2026 – the date is currently being finalised.

4. Recommendation

In light of the progress made and the outcome of the 2026/27 EPRR Core Standards assurance process, the Board of Directors is asked to consider and approve the following:

- Note the Trust's current assurance position, with a compliance rating of 91% against the NHS England EPRR Core Standards, representing substantial compliance.
- Approve the attached Statement of Compliance, which formally records the Trust's position and will be submitted to NHS England as required.
- Endorse the improvement plans that are in place to address the two remaining areas of partial compliance: communications resilience and countermeasures.
- Support the continuation of the Trust's structured programme of training, exercising and third-party business continuity assurance, which is critical to maintaining progress and embedding resilience across the organisation.
- Agree to receive a further update at the conclusion of the 2026/27 assurance cycle, ensuring that the Board is kept fully informed of ongoing improvements and risks.



Greater Manchester Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2026-2027

STATEMENT OF COMPLIANCE

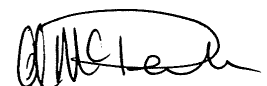
The Christie NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool.

Where areas require further action, The Christie NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Substantial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.



Signed by the organisation's Accountable Emergency Officer

30/09/2026

Date signed

15/10/2026

Date of Board/governing body meeting

22/10/2026

Date presented at Public Board

Date published in organisations Annual Report

Agenda item 29/26d

Meeting of the: Board of Directors
Thursday 22nd October 2026

Subject / Title	Learning from National Inquiries: Integrated Assurance, Oversight and Action Plan
Author(s)	Vicky Sharples, Chief Nurse and Executive Director of Quality
Presented by	Vicky Sharples, Chief Nurse and Executive Director of Quality
Summary / purpose of paper	To provide the Board with integrated assurance on the Trust's response to the Ockenden, Amos and Thirlwall reviews. To provide an opportunity to explore the Board's curiosity, challenge and triangulation of intelligence and how this can further strengthen oversight and early identification of risk.
Recommendation(s)	• Note the assurance provided by the Trust's existing governance, safeguarding, workforce, patient safety and learning arrangements • Note the targeted areas for further strengthening and the associated delivery timescales • Maintain curiosity and constructive challenge, particularly where intelligence is incomplete, inconsistent or indicates emerging risk
Background papers / source of assurance	• Ockenden and Amos review and Trust self-assessment • Thirlwall Inquiry report and Trust response
EDI impact/considerations	The reviews reinforce the importance of inclusive listening and ensuring that concerns can be raised and acted upon by all patients, families and staff. Strengthening patient and family voice, co-production and analysis of experience by protected characteristic and deprivation will support the identification of unequal experiences, barriers to access and opportunities to reduce health inequalities. No adverse equality, diversity or inclusion impacts have been identified.
Link to: ➤ Board Assurance Framework ➤ Trust strategy / objectives ➤ NHS Oversight Framework ➤ CQC Quality standard ➤ Regulation	BAF risks 2,3, 4 and 12 The Christie Quality Strategy 2026–2028 CQC regulations 9,10,12,13,16,17,18,20
Risk score	N/A
Acronyms or abbreviations that appear in the attached paper.	



Learning from National Inquiries

Integrated assurance, oversight and action
plan

Ockenden • Amos • Thirlwall 2026



The reviews converge on one central requirement: Boards must listen, triangulate weak signals, act promptly and evidence sustained improvement.

Strong current assurance

- Established Board and committee PSIRF
- Mortality governance
- Safeguarding governance
- Mortuary compliance
- Patient and staff voice
- Safe staffing and workforce controls

Priority strengthening

- Strengthen evidence of impact and sustainability of improvement
- Improve triangulation of intelligence
- Increase visibility of feedback outcomes

Board Focus

- Maintain curiosity and challenge
- Seek evidence of outcomes, not activity
- Maintain oversight of national guidance

Overall position:

No Major assurance gaps

Targeted action needed

Actions through 2027



How the inquiries align

Ockenden

Maternity services review

Amos

National maternity and
neonatal investigation

Thirlwall

Leadership, governance
and safeguarding inquiry

Shared lessons

Listen and act on concerns	Visible, accountable leadership	Psychological safety and speaking up
Learning from harm and complaints	Meaningful quality intelligence	Compassion, candour and equity

Thirlwall adds specific emphasis on suspected deliberate harm, safeguarding and police escalation, and controls for high-risk medicines.



What provides assurance now

Board oversight	Quality Assurance Committee, Workforce Assurance Committee and Board reporting
Triangulated intelligence	Incidents, mortality, complaints, patient feedback, audit, safeguarding, workforce and speaking up
Independent escalation	Martha's Rule, Freedom to Speak Up, safeguarding and formal governance routes
Learning systems	PSIRF, clinical audit, quality improvement and structured learning dissemination
Workforce controls	Establishment reviews, job planning, daily staffing oversight, competency and training assurance
External assurance	Well-Led review, Fuller assurance, Human Tissue Authority and internal audit activity



Consolidated improvement actions

Key improvement priorities

- Strengthen inclusive patient & family voice to improve equity and experience
- Strengthen evidence of the impact and sustainability of improvement actions
- Enhance visibility of improvement resulting from staff concerns
- Strengthen safeguarding arrangements relating to suspected deliberate harm including police reporting
- Strengthen triangulation of intelligence to support assurance to move from “Are we assured?” to “What is the intelligence telling us, where should we look more closely, and what difference are our actions making?”

Outstanding actions are scheduled for completion between November 2026 and June 2027. Progress will be monitored through the relevant executive and assurance committees. Completed actions will move into routine monitoring to confirm that improvements are embedded and sustained.



Considerations for Board

Be curious

- Look beyond headline assurance and seek out weak signals, variation and emerging themes
- Ask “what are we not seeing?” and where intelligence may be incomplete

Triangulate

- Connect patient and family voice, staff voice, safety, outcomes, workforce and operational intelligence
- Explore where different sources align or tell a different story

Act

- Ensure intelligence leads to timely escalation, intervention and improvement
- Maintain focus on areas of greatest risk, inequality or uncertainty

Seek impact

- Challenge for evidence of outcomes, not simply activity or action completion
- Ask whether improvement is embedded, sustained and making a measurable difference

Keep listening

- Create visibility of what patients, families and staff are telling the organisation
- Ensure feedback is heard, acted upon and visibly connected to improvement



Board of Directors meeting

Thursday 22nd October 2026

Subject / Title	Feedback from September Patient Story	
Author(s)	Claire McPeake, Chief Operating Officer Vicky Sharples, Executive Chief Nurse	
Presented by	N/A	
Summary / purpose of paper	This paper provides the Board with a response to the feedback from the patient story heard at the September Public Board meeting	
Recommendation(s)	To note the feedback to the issues raised	
Background papers	Patient story – 24 th September 2026 Public Board of Directors meeting	
Risk score	N/A	
Link to: ➤ Trust strategy ➤ Strategic objectives	- Trust's strategic direction - Divisional implementation plans - Our Strategy - Key stakeholder relationships	
Acronyms or abbreviations where they appear in the attached paper.	CT	Computed Tomography
	CM	Claire McPeake
	CRIS	clinical radiology information system
	CWP	clinical web portal
	EPR	electronic patient record
	DNA	did not attend

Meeting of the Board of Directors
Thursday 22nd October 2026
Feedback from September Patient Story

Patient Experience Review: Diagnostic Imaging and Related Services

Following the patient story presented at the Public Board, a review has been undertaken to consider the issues raised and identify opportunities to improve patient experience across the diagnostic imaging pathway and related support services.

Diagnostic Imaging

1. Cannulation, Intravenous Contrast and Post-Scan Safety

The patient compared their experience of CT scanning at The Christie with that at another NHS provider, highlighting a preference for the shorter process experienced elsewhere, where intravenous access was removed immediately after the scan.

The review confirmed that The Christie's approach reflects established clinical safety protocols associated with the administration of intravenous contrast, including appropriate post-scan monitoring where required. Subsequent discussion with the other provider confirmed that the process described by the patient was not consistent with that organisation's standard protocol and is being reviewed locally.

Board assurance: The Christie will maintain its current clinical safety arrangements. Learning relates to improving patient understanding of why post-scan observation and retention of intravenous access may be necessary for patient safety.

2. Information Provided Prior to Scanning

The review identified an opportunity to strengthen patient communications regarding preparation for imaging investigations.

Patients asked to drink water before a scan can do so before travelling to The Christie, whereas patients requiring oral contrast must attend site, complete the required safety checks and consume the contrast on-site.

Board assurance: Patient information materials are being reviewed to ensure clearer guidance regarding preparation requirements, reducing unnecessary time spent on site and improving the patient experience.

3. Coordination of Scans and Follow-Up Appointments

The patient story highlighted challenges associated with coordinating imaging appointments and subsequent clinical follow-up.

Current processes are constrained by the use of multiple systems (CRIS, CareFlow and CWP) that do not fully integrate, limiting the ability to coordinate diagnostic and outpatient appointments as a single pathway.

Board assurance: Radiology and care coordinator teams are developing interim solutions to improve appointment coordination pending the implementation of the new Electronic Patient Record (EPR), which is expected to provide improved functionality in this area.

4. Psycho-Oncology Service: Access and Waiting Times

As of 8 October 2026, 24 patients were awaiting a first appointment with the Psycho-Oncology Service, with a current routine waiting time of approximately 12 weeks.

All referrals are clinically triaged and prioritised according to assessed need. Referrals awaiting a first appointment are reviewed weekly through established operational management arrangements and escalated where necessary.

The longest-standing referral dates from June 2026; however, the patient concerned was offered an appointment in September 2026 and did not attend.

Board assurance: The service maintains oversight of waiting lists, clinical prioritisation and capacity. Waiting times, demand, capacity and any associated clinical risks continue to be reviewed through weekly operational management processes.

5. Support for Patients Experiencing Medically Induced Menopause

Patients whose treatment is expected to result in medically induced menopause receive counselling and information as part of their treatment pathway. This includes discussion of potential physical and psychological effects, provision of written information, practical advice and referral to additional support services where appropriate.

Patients may also access specialist services, including psychosexual support, complementary therapies and the Trust's Ovarian Suppression Service. Concerns can be revisited and addressed throughout the patient's treatment journey.

Board assurance: Appropriate information, support and onward referral pathways are in place for patients affected by treatment-induced menopause.

6. Maggie's Centre Financial Advice

Feedback regarding a patient's experience of seeking financial advice has been shared with Maggie's. Maggie's has apologised and advised that specialist financial advice services are not always available on site, with patients therefore signposted to alternative support services where required.

Board assurance: Work is underway through the communications and patient experience teams to develop a clearer directory of support services to improve patient navigation and access to advice.

7. CT Scanning Department Environment

Concerns were raised regarding toilet availability and access to drinking water within the CT scanning department.

The Estates Team has apologised for recent maintenance issues affecting toilet facilities and has confirmed that ongoing monitoring and timely repairs will continue. The department has also confirmed that drinking water remains available within the waiting area and will ensure the dispenser is operational at all times.

Board assurance: Actions have been taken to address environmental concerns raised by the patient and to maintain an appropriate environment for patients attending for imaging.

Key Learning and Actions

The review identified the following areas for action:

Diagnostic imaging

- Maintaining safe clinical practice while improving patient understanding of safety-related processes.
- Strengthening patient communications regarding scan preparation requirements.
- Improving appointment coordination within existing system constraints while longer-term digital solutions are implemented.

Access to Psycho-Oncology Services

- Continued monitoring of capacity, waiting lists and associated clinical risks through weekly operational review of waiting lists, triage arrangements, capacity and risks, with escalation where required.

Menopause Support

- Continue to reinforce available support pathways and ensure patients are routinely reminded of services that can be accessed as their needs evolve.

Access to Financial Advice and Support

- Provide clear patient information and signposting by updating the website as part of ongoing user research work.
- Information on Maggie's has been updated on our website to reflect their services.

Patient Environment and Facilities

- Maintain proactive monitoring and timely maintenance of patient facilities, including toilets and water dispensers, and ensure operational checks form part of routine departmental management.

Following the patient story presented to the Board, the patient has been contacted by the Breast Care Team to ensure that any outstanding concerns are addressed and that her feedback informs appropriate improvements to the service.