The Christie
NHS Foundation Trust

Board of Directors meeting
Thursday 31st October 2024 at 12.45 pm

Trust Meeting Room

Agenda

Patient story / clinical presentation: Nutrition & Dietetics – Lorraine Gillespie, Dietetic Manager & Specialist Oncology Dietitian and a patient **30 mins**

Public items		Decision		Lead	Page	Timing
30/24	**Standard business**					
a	Apologies			Chair		
b	Declarations of interest			Chair		
c	Minutes of previous meeting – 26th September 2024	Approve	*	Chair	2	5 mins
d	Action plan rolling programme, action log & matters arising	Review	*	CEO	9	
31/24	**Performance & finance**					
a	Trust report	Review	*	Execs	12	15 mins
b	Value Improvement Programme Progress Report	Review	*	COO	20	5 mins
32/24	**Culture**					
a	Freedom to speak up guardian annual report	Review	*	FTSUG	24	15 mins
33/24	**Governance (regulatory / statutory compliance)**					
a	Board assurance framework	Review	*	CEO	34	5 mins
b	Reports from Committees • Workforce Assurance Committee September 2024 • Quality Assurance Committee September 2024	Review	*	Committee chair	41 46	15 mins
c	Emergency Preparedness & Resilience Response statement of compliance	Approve	*	COO	51	5 mins
34/24	**Any other business**					

Papers for information only
Integrated performance, quality & finance report month 6 *

Date and time of the next meeting
Thursday 28th November 2024 at 12:45pm

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

The Christie
NHS Foundation Trust

Public meeting of the Board of Directors
Thursday 26th September 2024 at 12.45 pm
Trust Meeting Room

Present:	Chair:	Edward Astle (EA), Chairman Roger Spencer (RS), Chief Executive Officer Tarun Kapur (TK), Non-Executive Director Robert Ainsworth (RA), Non-Executive Director Alveena Malik (AM), Non-Executive Director Grenville Page (GP), Non-Executive Director Sarah Corcoron (SC), Non-Executive Director Dr Diana Tait (DT), Non-Executive Director Roy Dudley-Southern (RDS), Non-Executive Director Prof Chris Harrison (CJH), Deputy CEO Vicky Sharples (VS), Executive Chief Nurse Sally Parkinson (SP), Executive Director of Finance Dr Neil Bayman (NB), Executive Medical Director Eve Lightfoot (EL), Director of Workforce John Wareing (JW), Director of Strategy Prof Rikki Goddard-Fuller (RGF), Director of Education Prof Fiona Blackhall (FB), Director of Research Claire McPeake (CM), Interim Chief Operating Officer Tom Thornber (TT), Director of Strategy
Minutes:		Louise Westcott (LW), Company Secretary
In attendance:		Jo D'Arcy, Assistant Company Secretary Jeanette Livings, Director of Comms

Clinical presentation: Acute Oncology Service – Annie Dewberry, Associate Chief Nurse, Sabrina Scott, AACU ward manager, Laura Bradley, Advanced Clinical Practitioner and Sophia McGough, Senior Sister & hotline manager and a Jane a regular patient.

AD introduced the team and noted that acute oncology is continuing to grow. Acute ambulatory care is noted as a model that reduces the need for patients to attend A&E's at other hospitals.

Challenges include advances in cancer therapy, disease progression and toxicities.

As a tertiary centre, we have 80% outpatient activity and 201 beds including 23 additional acute assessment beds. Since AACU has been established it has seen a 39% increase in activity.

SS - AACU is part of the Acute Admissions inpatient unit. There are 11 spaces, it is a nurse led unit, and the team work very well together, the service has increased the number of days to 7 days, it is very busy.

Patients come from a number of places including outpatients, via the hotline and deteriorating patients, as well as planned transfusions. There are many ways into the unit.

There are currently around 760 attendances a month, 81% of these are discharged. This is very good and avoids unnecessary admission.

LB – introduced herself and noted that in April 2021 there were 221 attendances, and 14% admissions. In June 2024 there were 601 attendances, and 13.8% admissions

These would otherwise have been admitted somewhere else in the system or to one of our beds.

Average numbers per month keep rising year on year.

There is a higher attendance early in the week, and the unit is now getting increasing numbers on a Saturday because of activity in other parts of the organisation.

The breakdown of patients seen across the month was outlined.

In terms of clinical presentation, the staff find incidental PE's in many patients. There are some surgical patients, patients with SACT treatment issues, IR toxicity from immunotherapy, reactions and AKI's etc. There is a very broad range of issues, and they are all treated and safely discharged where necessary.

Top admissions are generally due to being generally unwell, issues with electrolytes, sepsis, blood transfusions, drains, and incidental PE's.

Patient feedback was shared. Jane shared how safe and confident she is coming through the AACU, they are like a family to her and she is 100% better when she leaves. She expressed confidence in her care and noted that she comes for planned electrolyte infusions.

These patients would otherwise be pushed into their local A&E's so we take all of our patients now unless it is clinically required or patient choice.

DT noted that when working in a clinic it is amazing to have this service as it helps to avoid problems for other patients in outpatients. DT asked about the growth in the service and the pressures. From a nurses perspective, there has been great flexibility and nurses like to work over weekends and only 1 member of staff has left in 5 years. There is a list of nurses who want to come and work on the unit. The patients are triaged throughout the day and patients are sent home throughout the day and pressures are spread across the day. Nurses feedback is excellent.

Patient flow team and hotline work very closely and there is excellent cross working.

TT thanked the team for his care on the unit and fed back that this was excellent.

SS noted that the move from the old Patient Admission & Treatment (PAT) suite has been a major improvement. The PAT suite used to have a list of patients from all over the Trust, people were waiting in the waiting area, the patient experience was poor. The change to the triage system is significant and the unit look after all acute patients and this works much better for the clinical teams.

The unit is less ambulatory than it was originally due to the nature of the patients.

Continuity of care and links to the primary treatment team are good and there is greater contact with clinicians on the ACU. As time goes there is more and more awareness and connections have been made.

RDS asked about authority to introduce new supportive medicines. LB noted that the team have full authority to do this and prescribe where needed. The team do that well and follow up with patients once they are discharged home.

The team can prescribe following calls to the Hotline.

NB noted that there is nowhere else in GM and few others in the country that can provide this expert service. We are leading the way on managing some of these issues such as immunotherapy toxicity. The clinicians and patients are very fortunate to have this service as clinicians in other Trusts couldn't do this.

The impact on reduction in inpatient stays is significant. This supports the system who do not have to admit our patients to their hospitals. We are also supporting primary care and allowing them to do other things. This is the model for care of cancer patients in the future.

GP – in terms of next 2 or 3 years, what's next for this service and what are barriers with primary care, and the opportunities to strengthen links.

Looking at dedicated clinical support line manned by an oncologist so GP's / A&E staff can contact an expert.

Barriers are around discharge process and improving this. We are looking at other primary care service links like to diabetic support etc, these pressures do impact our patients.

EA thanked the team for taking the time to come and speak to the Board.

Item		Action
24/24	**Standard business**	
a	**Apologies**	
	No apologies noted	
b	**Declarations of Interest**	
	None noted.	
c	**Minutes of the previous meeting – 27th June 2024**	
	The minutes were accepted as a correct record.	
d	**Action plan rolling programme, action log & matters arising**	
	All items from the rolling programme are complete or noted on the agenda. It was noted that information has been shared with the Board since the last meeting through the Trust Report and Integrated Performance Report.	
25/24	**Performance & Finance**	
a	**Trust Report**	
	• Despite system pressures, overall performance is very good for both quality and performance standards. • Key patient quality indicators for August show no significant adverse variances or issues for escalation. • Challenging activities in the system, our cancer waiting times are all being achieved in this context. Considerable work to achieve this. • Financial performance is better than plan at month 6. • Value improvement programme was highlighted, good progress has been made. • Overall very good performance at month 6. • Broader system is in a very difficult place and has a deteriorating position. • Our role in the system was stressed particularly related to the presentation heard today relating to the AACU. • Questions invited • RDS asked about delays in the earlier part of the pathway and how that impacts patients and our service. • RS noted that this is closely monitored, harm reviews are undertaken. Cancer Alliance is reviewing themes in the harm reviews. No firm evidence of impact on stage of presentation yet. We contribute to this process. • We are working on predictive work to focus attention in areas where there are delays. It's the early diagnosis phase where delays are seen. • Query around the transfer of clinical haematology from Mid Cheshire and the funding. • In a process of discovery around this, finance is part of the discussion and this will move over time. • CDEL limit restrictions –is this causing patient safety issues? • We have been careful to allocate CDEL and there is no current impact on patient safety. There may start to be an impact on productivity as we move to	

	next year. This will become an issue if the CDEL restrictions continue and Board will need to consider the position. • EA asked whether any patient safety risks need escalating. The risk relating to Aseptic's in Pharmacy has been closely managed and this risk is reducing. • Noted that the way we manage operational risk is very detailed and scrutinised to ensure mitigations are tested and assurances regularly received. Impact of financial pressures needs close scrutiny in terms of safety impact. • QAC will look at associated risks around diagnostics as detailed in the top risks. • Further detail is contained in the Integrated Performance, Quality & Finance report. • National infection levels queried. We are hitting all thresholds apart from MRSA, this will be reported to QAC. • New ward accommodation is in the process of being operationalised. This will support patient experience.	
b	**Value Improvement Programme**	
	• Financial plan submitted for £7m surplus including VIP target of £21.4m? Productivity gains make up a significant part in this target. • Workplan is outlined to deliver target in year. • By end of month 6 have delivered ??m recurrently (75% achieved). We are overachieving on the non-recurrent target. • The £1.5m shortfall that will be delivered by the end of month 6. • The focus is now on next year's transformation schemes. • We are the only Trust in GM to deliver VIP target by this point in the year. • Next years will be more difficult. • Impact of anticipated nursing industrial action will put pressure on achievement of VIP targets for next year. • Level of efficiency required is extremely high in future. • PwC have requested more from us. • Board noted congratulations to the organisation on achievement so far.	
26/24	**Culture**	
a	**Health Inequalities self-assessment**	
	• Board received detail on the background on health inequalities at a Board planning session last December. • This has been a strategic priority for over 20 years. • The Trust strategy is to seek to address access to cancer care across GM. • Self-assessment process highlighted the considerable number of activities that are going on across the Trust. • There are a number of actions outlined with timescales. • Cross-overs with Inclusive Culture plans and health inequalities work. • This will come back to a future meeting to report on progress. • Question around variation in outcomes across the population. • There is more work on this, particularly on access to clinical research and	

	trials. • Lung health checks is a good example in the shift to earlier diagnosis and the improvement in outcomes for patients from more deprived backgrounds. Evidence now shows earlier stage diagnosis in the deprived areas than other areas. • Inclusive culture work will support work on health inequalities. • Further work is required to understand ethnicity and cancer incidence for specific diseases. • Role as an Anchor Institute is key. • Need action on health inequalities through clarity on our remit as an organisation and identifying what we can do. • Improved outcomes need to be demonstrated. GM outcomes are improving and the rate of improvement is better than the national rate. • Everything we do should be seen through an inequalities lens. • Disparities in access across GM have been addressed through provision of radiotherapy in the North East and North West sectors as well as through improvements with MDT working. • Early interventions / prevention are a focus of the Cancer Alliance. • Early diagnosis and access are huge issues. There are additional requirements for patients from deprived areas who need additional support to get the same treatment outcomes. • Senior adult oncology service is an example of filling the gaps for this group that younger patients don't experience.	
b	**Cultural audit**	
	• This provides an update on progress with the work around culture following the cultural audit last year. • The paper documents where the work has got to and the next steps that have been agreed by the Trust. • Board supported and noted the direction of this work.	
27/24	**Strategy**	
a	**Trust Planning 2025/26**	
	• Paper provides a summary of the session held in July 2024 to look at approaches to planning and the themes that came from this. • Overall approach to delivery, VIP for the year etc all discussed. • Planning is now more detailed for 2025/26. • Dependencies outlined including draft ICB planning framework. • Feedback from the session is part of the development of the next session on 4th October.	
28/24	**Governance (regulatory / statutory compliance)**	
a	**Board assurance framework 2024/25**	
	• The updated BAF was discussed outlining the risks to achievement of the strategic objectives. • Board asked to feedback on any changes or updates required based on assurance committee discussions.	

	• Rolling programmes have been updated to reflect deep dives into specific risks, where the Board are the responsible committee the rolling programme also covers consideration of those risks. • The score for the risk relating to PSIRF has increased following discussion at the latest QAC, this relates to the external changes and impact on learning. • The BAF is not used in the operational committees but is used through the assurance committees. It is visible at the Risk & Quality Governance Committee. • Updates to BAF to be summarised on the cover paper for future versions.	LW
b	**Reports from Committees**	
	Workforce Assurance Committee June 2024	
	• TK noted that staff story's now link to the culture work and there were real examples of what the divisions are doing and comments made about spreading good practice across divisions. • The People & Culture Plan was looked at and there was discussion around exit interviews and how these are encouraged and captured more consistently. • Resident doctors feedback was discussed. • Response of the organisation to the riots was acknowledged. • Potential impact of future industrial action by nurses was acknowledged. • Future approach with the FTSUG was discussed linking this to culture.	
	Quality Assurance Committee June 2024	
	• SC thanked KW as previous chair. • Board noted the work around duty of candour and education with staff on this. • Learning and how this is shared are a focus as well as risk, complaints etc. PSIRF and the cultural shift required for the NHS was discussed and will be monitored as it becomes business as usual. • Looking at improvements around metrics and in the other intelligence.	
	Audit Committee July 2024	
	• Key issues were reviewed on a digital outage, high assurance received on actions taken. • Joint meeting reviewed and signed off accounts. • Audit process went very smoothly and relationships with the finance team were praised. No major concerns outlined. • Deep dive on Digital Services, key issue around data security and cyber. There has been a massive increase in cyber attacks and assurance was received on the work being done to address the risk. Medium assurance due to the ever evolving nature of cyber attacks.	
c	**Governance Review action plan update**	
	• Summary of the actions taken to respond to the actions outlined as a result of an external review into our assurance processes by GGI. • This highlights the work done and actions that will continue to be undertaken to continuously improve governance.	

d	**GM ICB System**	
	• As a provider in the ICS the Board are required to look at the GM Sustainability Plan • At the current financial run rate the system were significantly underperforming and interventions have therefore been made supported by PwC. • Monthly provider oversight meeting takes place with CEO/DoF attendance. • Board have approved a Financial Sustainability Statement. • ICB Undertakings – formal action from NHSE in all 4 areas outlined – governance, leadership, finance, performance. A Board has been established to monitor actions outlined. • Multiple plans have been developed that intersect. Sustainability plan has a big part to play in this. • ICP needs to set out its 5-year ambition. • Focus on health & wellbeing of staff. • Joint forward plan required to address how ICB strategy will be delivered alongside constitutional requirements. • No structural change anticipated. • Shift from short term to long term responses for health is required but measures are still on the acute requirements. • Board must focus on the organisations financial sustainability. Board to receive updates at future meetings.	SP
29/24	**Any other business**	
	• No further items raised.	
	Date and time of the next meeting	
	Thursday 31st October 2024 at 12:45pm	
	Papers for information only	
	Integrated performance, quality & finance report Quality Strategy update	

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Agenda item 30/24d

Meeting of the Board of Directors - October 2024
Action plan rolling programme after September 2024 meeting

C Culture P Performance S Strategy G Governance

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
October 2024		C	Patient story	CEO	To hear a patient story	Board presentation
		P	Integrated performance & quality report and finance report	COO	Monthly report	For information
		P	EPRR Compliance statement	COO	Approve	33/24c
		C	Freedom to speak up guardian	FTSUG	Annual report	32/24a
Planning & Development Day		S	Planning with Divisional leadership teams			04/10/2024
		S	Strategy deep dive - system role / sustainability			
November 2024		C	Patient story	CEO	To hear a patient story	
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	
		S	Strategy update	DoS	Six month review	
		S	Clinical Outcomes Strategy review	EMD	Review	
		S	Inclusive Culture strategy	DoW	Approve	
		P	Digital Strategy update	DCEO / CIO	Annual Review	
	Annual reporting cycle	P	Interim review of annual objectives	CEO	Review progress	
		S	Annual Sustainabiltiy Report - Boards responsibility for Carbon Net Zero	DCEO	Approve	
December 2024 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
Planning & Development / Council of Governors Day		S	Board planning			
		S	Council / Board - strategy update			
January 2025		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance report	COO	Monthly report	For information
		P	Benchmarking	DCEO	Review	
		P	International strategy	DCEO	Review	
		S	Review of Trust strategy & annual objectives 2023-2029	DoS	Report	
		P	Value Improvement Programme	COO	Review	
		P	Sustainability Annual Report	DCEO	Report	
February 2025 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
	Annual reporting cycle	G	Letter of representation & independence	Chair	Circulate	By email
	Annual reporting cycle	G	Register of directors interests / FPPT annual declaration	Chair		
	Annual reporting cycle	G	Declaration of independence (non-executive directors only)	Chair		
Planning & Development Day		S	Planning			
		S	Strategy deep dive			

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
March 2025		C	Patient story	CEO	To hear a patient story	
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	
	Annual reporting cycle	G	Annual reporting cycle	Executive directors	Approve	
		P	Research & Innovation Strategy Update	DoR	Annual review	
		C	Culture Audit review	DCEO/DoW	Approve	
		G	Annual BAF review / risk deep dive	CEO	Review	
		C	Staff survey initial results	DoW	Note	
		P	Health inequalities performance review	DCEO	Review	
	Annual reporting cycle	G	FPPT Compliance report	Chair	Approve annual compliance	
April 2025		C	Patient story	CEO	To hear a patient story	
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	
		G	Register of matters approved by the board	CEO	Note April 2023 to March 2024	
	Provider licence	G	Self certification declarations	CEO	To approve the declarations	
	Annual reporting cycle	S	Annual Corporate Objectives review / BAF 2023/24	CEO	Review 2023/24 progress	
		G	Modern Slavery Act statement	CEO	Approve	
		G	Standing Financial Instructions (SFI's)	DoF	Approve	
		G	Board effectiveness review	Chairman	Undertake survey	
		C	Freedom to speak up Guardian report	FTSUG	6 monthly update	
	Annual reporting cycle	P	Risk Management strategy 2024-25 annual review	ECN	Annual Review	
May 2025 - no meeting	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	By email
Planning & Development Day						
		S	Planning			
June 2025		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	For info section
	Annual reporting cycle	G	Annual reports from audit, quality and workforce assurance committees	Committee chairs	Assurance	Joint Audit/Quality
	Annual reporting cycle	G	Annual compliance with the CQC requirements	ECN	Declaration / approval	
		P/S	Education Strategy Update	DoE	Review	
		G	Board effectiveness review	Chair	Report	
		P	Value Improvement Programme	COO	Review	
	Annual reporting cycle	G	Annual report, financial statements and quality accounts (incl Annual governance statement / Statement on code of governance)	EDoF	Approve	
July 2025 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
Planning & Development Day		S	Service Review day with senior leadership teams			
August 2025 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
September 2025		C	Patient story	CEO	To hear a patient story	
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	
		C/P	Health inequalities self -assessment	DCEO	Review	
		P	Value Improvement Programme	COO	Review	
		P	Quality Strategy update	ECN	Review	
Development session		S	Strategy / planning			

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Agenda item: 30/24d

Action log following the Board of Directors meetings held on

Thursday 26th September 2024

No.	Agenda	Action	By who	Progress	Board review
1	28/24a	Updates to the Board Assurance Framework to be summarised on the cover paper	LW	Complete	Updated in October Board papers
2	28/24d	Board to receive updates on financial sustainability in each meeting	SP	Ongoing	Updated in October Board papers

The Christie
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Agenda item: 31/24a

Meeting of the Board of Directors
31st October 2024

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

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Trust Report
October 2024 (September data)

Board Scorecard

Corporate objective	Indicators	Tolerances			Current month	Year to date
All	CQC rating	N/A			Good	Good
All	SOF Rating	N/A			2	2
Quality of Care & Performance						
1,6	Proportion of incidents that are low/no harm (%)	90%+			96.4%	N/A
1,6	31 day compliance (%)	96%			98.1%	N/A
1,6	Patients meeting the faster cancer diagnosis standard (%)	75%			90.0%	N/A
1,6	MRSA bacteraemia infection (attributable) (N)	TBC			0	2
1,6	Clostridium difficile infection (attributable) (N)	TBC			4	24
Finance and Use of Resources						
6	Financial sustainability / liquidity (days)	>21	21 to 14	<14	92	92
6	Overall financial position (% variance to control total)	0% below plan	0 - 10% below plan	>10% below plan	0.0%	0.0%
6	Recurrent VIP performance (% achieved)				75%	75%
6	Current cash balance (£'000)				£123,683	£123,683
6	Exchequer capital spend to date (variance to plan %)	within 10%	10 to 20%	>30%	10%	13%
6	Average length of time debt is outstanding	<15	>16 - 20	>20	11	11
6	Public Sector Payment Policy - trade creditors paid within 30 days (number and volume)	>95%	95 - 85%	<85%	99%	99%
People and Culture						
7	PDRs completed (%)				87.2%	86.9%
7	Mandatory training (%)	>80%		<79%	93.7%	93.5%
7	Voluntary turnover in first 2 years (%)	**<31%**		**>32%**	42.11%	47.25%
Research						
4	New trails open per month (N)	>10	9-10	<8	**15**	**90**
4	No. patients consented into studies (N)	>250	200-249	<199	**160**	**1329**
4	Christie Sponsored research: new studies opening (N)	>2	1	0	2	**7**
4	Research patient experience - % strongly agree they would participate in research again	90%	75-89%	<75%	**24 (92%)**	**33 (85%)**
Education						
3	Undergraduate placement activity	>135		<135	**144**	N/A
3	CPD activity (internal & external)	>440	340-440	<340	**780**	N/A
System						
1,6	62 days (%)	>70%		<69.9%	**74.0%**	N/A
1,6	Priority patients not admitted (deferred)	0		>1	**0**	**0**
Digital						
4	Customer Satisfaction score of "Good"	>95%	85-94%	<85%	**97.3%**	**97.4%**

Executive Summary

- We remain rated overall as Good by the CQC.
- We continue to be in segment 2 of the System Oversight Framework.
- Key patient quality indicators for September show no significant adverse variances there was one issue for escalation relating to a never event. We remain a high reporting, low harm organisation.
- Performance in September for the 62-day consolidated cancer standard was 74% which is better than the operating plan standard of 70%.
- Eight corporate risks are scored at 15 or above on the risk register.
- Cumulative financial performance at the end of September (Month 6) is a (£4.3m) surplus against a planned (£3.5m) surplus. This is a favourable variance of (£0.8m) to plan.
- Key financial performance indicators in month 6 show one adverse variance which is the level of recurrent VIP identified being £10.5m identified so far against a £14m annual target.
- Workforce indicators for September show a slight increase in sickness absence rates.
- PDR performance has worsened slightly from August's position. Mandatory training has remained at the same level as August's position and remains well above the set standard.
- The NHS Staff Survey 2024 is now live. All staff are encouraged to be part of this and take a few minutes to fill in the survey.
- NHS England has published a new national policy framework on sexual misconduct. This builds on the first ever Sexual Safety Charter launched last year, which we have signed up to.
- Christie Education projects and events continue to support our aims and objectives.
- Capital schemes are progressing to plan across the Trust.
- Monday 21st October was the launch of a public consultation to inform the 10-Year Health Plan for the NHS

Quality of Care

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

Pressure ulcers and falls were in line with internally set trajectory in September.

There were 17 complaints in September, higher than the monthly average. The number of contacts with the Patient Advice and Liaison Service (PALS) service in September was 29 which is lower than the previous month.

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

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

1. Risk of not achieving the financial plan including the value improvement programme in 2024/25 (16)
2. Limitation on equipment & facilities to deliver planned activity or progress developments due to insufficient capital funding (CDEL) (16)
3. There is a risk that patients awaiting stem cell treatments may experience delays (16)
4. Risk of delayed patient treatment due to extended turnaround times in histopathology results (16)
5. Financial and Operational Risk to The Christie in relation to Transfer of Mid-Cheshire Foundation Trust Clinical Haem in 2025 (16)
6. Risk to treatment delivery due to workforce recruitment & retention (15)
7. Breach of 28 day Faster Diagnosis Standard for haematology patients (15)
8. Risk of disruption to operations & patient safety due to out-of-date evacuation plans (16)

Operational Performance

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

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

The 62-day standard is a barometer of how well the system is performing with cancer pathways. Compliance at the end of September against the 2 key cancer standards was;

- The 62-day consolidated standard was 74% against a threshold of 70%.
- We achieved 90% against the 75% threshold for the Faster Diagnosis Standard which measures initial referral to diagnosis.

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

- We have continued to achieve the 31-day standard for treatment to start within 31 days of the decision to treat at 98.1% against a target of 96%.

During September there were 2 operations cancelled on the day for non-clinical reasons.

Our vaccination campaign for Flu and COVID-19 is now underway, with many staff already visiting the onsite hub to get their jabs. The 2024-25 campaign commenced on Thursday 3 October. Staff are able to have both jabs at the same appointment, or at two separate appointments.

Financial Performance

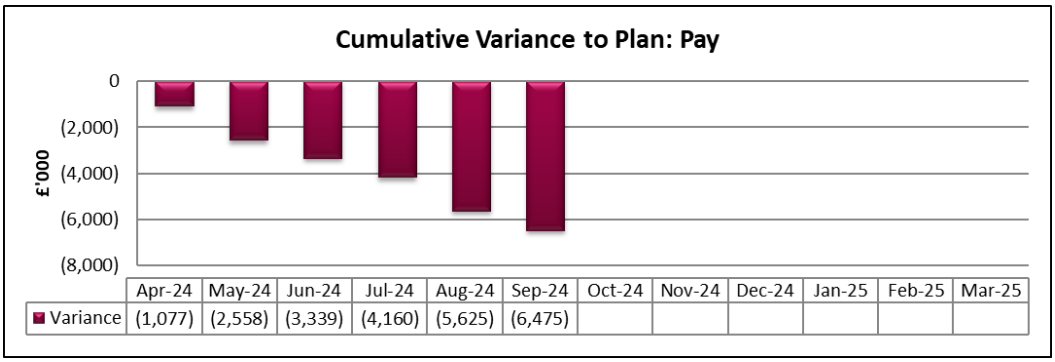
Revenue: Financial performance is ahead of plan by (£0.8m) as illustrated in the table below. The Trust is reporting a (£4.3m) surplus against a (£3.5m) planned surplus position. The better than plan position is primarily due to :-

- pay underspends arising from vacancies
- over-achievement of clinical income to-date.

Month 6 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(423,369)	(211,670)	(216,406)	(4,736)
Other Income	(75,495)	(37,703)	(35,871)	1,832
Pay	231,872	115,858	109,382	(6,475)
Non Pay (incl drugs)	241,409	120,699	126,874	6,175
Operating (Surplus) / Deficit	**(25,584)**	**(12,816)**	**(16,020)**	**(3,204)**
Finance expenses/ income	30,932	15,463	17,769	2,307
(Surplus) / Deficit	**5,349**	**2,646**	**1,749**	**(897)**
Exclude impairments/ charitably funded capital donations	(12,355)	(6,174)	(6,068)	106
Adjusted financial performance (Surplus) / Deficit	**(7,006)**	**(3,528)**	**(4,319)**	**(791)**

The pay underspend of (£6.5m) is illustrated in the graph below :-

- (£2.3m) relates to income backed services, including GM Cancer, R&I and Charity-funded posts, which has an equivalent reduction in income.
- The balance on the Trust pay underspend in M06 is mainly due to vacancies predominantly in clinical posts, most noticeably scientific, technical and therapeutic (£1.8m) and consultants (£1.4m).



Capital: The capital plan for 2024-25 has been agreed at £18.4m. The Trust has spent £5.7m to M06, which is 86% year to date against the capital plan, primarily on:

- TIF ward refurbishment
- Ongoing digital projects
- Small replacement assets

Value Improvement Programme. The annual VIP target of £21.4m is split into a £14m recurrent target and a £7.4m non-recurrent target. The level of recurrent VIP identified to date is £10.5m giving a recurrent shortfall of £3.5m. The level of non-recurrent VIP identified to date is £9.1m, over plan by (£1.7m). Year to date, £10.7m has been delivered against a target of £10.7m.

KPIs: Variances from the planned financial performance against key measures include capital expenditure and the level of recurrent VIP delivered to date. As shown in the table, there are no other significant variances:

Measure of Financial Performance	Red / Amber / Green rating
Revenue: Trust Control Total compared to plan	£0.8m ahead of plan
Capital: Capital expenditure against plan	£0.9m **under** plan

Measure of Financial Performance	Red / Amber / Green rating
VIP identified (recurrent) against target of £14m	£10.5m identified
Debtor days compared to 15-day target	11 days
Cash balance	£123.7m
Better Payment Practice Code (95% target)	99%

GM financial and operational planning 2025/26
The 2025/26 planning cycle has commenced, both within GM ICB and also internally within the Christie. GM have issued draft planning guidance and timetables which provide limited information but emphasises the triangulation of activity, workforce and finances and suggests commissioning decisions will follow.

The Trust held an awayday at the beginning of October to launch the value improvement programme (VIP) for 2025/26, this provided time and space to discuss how we will continue to deliver high quality patient care at an increased level on the current year in terms of workforce recruitment, infrastructure etc.

Activity and resource planning templates have been issued to divisions to return in November; these will capture the activity increases associated with new indications, NICE guidance and general growth in activity levels. Divisions will estimate the level of new resources (pay and non-pay budgets) associated with efficient delivery of this increased activity.

The next part of the process is the internal challenge and collation of this information to form an expenditure plan. In parallel, the Trust will hold discussions with both GM ICB and specialised commissioners to inform the income assumptions. The result of this work will form the basis of the Trust's 2025/26 financial and operational plan; progress will be regularly reported to Board.

The second of the Board and senior leadership Annual Planning sessions took place in October. The Board discussed a number of issues including;

- Developing plans for the future delivery model of The Christie
- The development of the 2025/25 Value Improvement Plans

Based on the discussion, further work on the 'Future Christie' programme will take place in the coming months. This will refine the scope and key deliverables required and be presented to a forthcoming Board meeting.

The session on Value Improvement received presentations demonstrating improvement activity across a range of areas (e.g. eProms, Theatres) and considered key themes and areas of opportunity for 2025/26. This will be worked up further as part of the Operational Plan.

Workforce

Our workforce performance indicators show mandatory training compliance and personal development plan rates are both above (better than) thresholds at 93.7% and 87.2% respectively. Sickness absence rates increased slightly in September to 4.74% (threshold of 3.4%). The overall turnover for the Trust has reduced from last month to 12.12%. These issues and the associated plans for improvement have been considered by the Workforce Assurance Committee.

Following nominations, shortlisting and judging, the results of 2024 Christie Colleague Awards were announced on Thursday 10 October at a ceremony in the Auditorium, attended by our finalists and their nominators. Hosted by Chief Executive Roger Spencer and Non-executive Director Tarun Kapur, the evening was an opportunity to recognise and celebrate some of the fantastic staff we have here at The Christie. Thank you to everyone involved

and congratulations to all of the deserving finalists. Details of all the winners and finalists can be found here.

The NHS Staff Survey 2024 is now live. It's our ambition that everybody working at The Christie feels listened to and has opportunities to provide feedback. The annual NHS Staff Survey is a key listening mechanism and an important way for you to share how you feel about working here. All staff are encouraged to be part of this and take a few minutes to fill in the survey.

Many of you shared views last year. A snapshot of key areas that were important to you, and the work that has been happening can be found here.

The survey should take no longer than 20 minutes to complete. Every colleague who completes their survey online will be offered the opportunity to be entered into a prize draw to win one of four £50 Love2Shop vouchers as a way of saying thanks for your time. There will also be team prizes for those with the highest response rates and most improved response rates from last year.

At the Christie we are committed to creating a safe place where staff come to work every day to provide compassionate care and support to others. There is absolutely no place for sexual misconduct or abuse of any kind within the NHS and we will not allow it to be tolerated. This week NHS England has published a new national policy framework on sexual misconduct. This builds on the first ever Sexual Safety Charter the NHS launched last year, which the Christie has signed up to. As part of our commitment to the Charter we will soon be launching our own sexual safety policy, training and reporting systems to make it easier for staff to come forward to report serious issues.

Every October, the National Guardian's Office highlights the importance of NHS staff having a voice that counts through its Speak Up Month campaign. For Speak Up Month 2024, the theme has been 'listen up' and has focussed on the role listening plays in encouraging people to feel confident to speak up. Throughout October, we have been highlighting stories, training, activities and more content related to listening on HIVE.

Allied Health Professionals (AHPs) Day took place on 13th October where we celebrated our AHP staff. AHPs are people from 15 different professions who provide holistic support and care to people at all stages of their lives. We have seven of those professions at The Christie: diagnostic and therapeutic radiographers, operating department practitioners, physios, dietitians, speech and language therapists and occupational therapists. AHPs are there to help our patients live their lives as fully as possible, both while they're with us and beyond their cancer diagnosis and treatment.

Research

We are delighted to announce that 5 Christie Consultants have been recruited to the National Institute Health and Care Research (NIHR) Manchester BioMedical Research Centre (BRC) new Clinical Research Investment Scheme (CRIS). This is through matched funding from The Christie Research 2030 Charity Funding Programme. The aim of CRIS is to invest in and increase the capacity of research qualified healthcare professionals focusing on experimental medicine and early phase translational research.

Congratulations to: -

- Laura Forker- Consultant Clinical Oncologist
- Safwaan Adam- Consultant Endocrinologist
- Kathryn Banfill- Consultant Clinical Oncologist
- Emma Searle- Consultant Haematologist
- Paul Sutton- Consultant Colorectal Pelvic and Peritoneal Surgeon

Rachel Chown joined the team on 7th October in the new role of Associate Director – Integrated Research and Education Strategy. Within this role her responsibilities and

portfolio will span both R&I and Education, with a particular focus on where our divisions interface which will include our clinical academic pipeline, fellowship scheme, strategic funding bids for both research and education, international partnerships, and the development of our clinical and research staff.

Breast Cancer Awareness Month:

1. The Personalised Disease Monitoring in Metastatic Breast Cancer study, part funded by The Christie Charity has been selected for presentation at San Antonio Breast Cancer Symposium Dec 2024
2. The BCAN-RAY study to identify women at increased risk of breast cancer without a strong family history is progressing well with 600/750 women consented through 8 GP surgeries. We have identified, as with many projects, that recruitment is low in areas of high ethnic diversity. In response we have engaged with the Black community (young black women are more likely to develop aggressive BC and to die from their disease) through two community sessions (so far) and have recruited two women of Black heritage to be advisors for a project funded by GM Cancer to test novel processes for risk assessment in the community setting. We plan to start recruitment in Q1 2025 and will continue the engagement processes to try and further reduce inequalities.
3. Phase 2 ILS FAKTION study **-** We previously demonstrated through our phase 2 ILS FAKTION, on which we were also the top recruiters, that capivasertib (AZD) improved survival in women with ER+ MBC. The phase 3 follow on study was also positive leading to approval for licence in the US and UK NICE appraisal for routine use in the NHS is anticipated for March 2025.

The Muslim Cancer Support Group, the first in the North and 2nd in the UK was launched in October. This is a collaboration between Maggie's and The Christie NHS Foundation Trust steered by Shahfaz Saaed, R and I Division patient experience manager.

Lorraine Turner, Nurse Consultant and Doctoral Researcher attended a Breast & cervical cancer awareness event at Fatima Women's Association in Oldham on 17th October to represent the Christie and help answer any concerns and queries.

Chelsey Wheeler, Research Nurse Team Lead and her team hosted a successful study day on 1st October - A Spotlight on Early Breast Cancer.

Education

Christie Library and Knowledge Service underwent a recent national review by NHSE. The highly positive review commended a raft of areas of good practice and innovation incorporating support for clinical care, workforce and external academic outputs. The appointment of a clinical librarian and accompanying outreach worked was particularly highlighted as was the evident integration within Christie Education and the wider Trust.

Library and Knowledge colleagues have continued their contribution to staff, patients, carers and our local community. To celebrate World Mental Health Day, The Christie Library and Knowledge Service partnered with Manchester City Council Libraries to giveaway thousands of new books to Christie staff, patients and visitors on our main and Christie@ sites.

As part of our commitment to high quality education informed healthcare, our first 'Lead Registrar' appointment has been made. Developed from the Royal College of Physicians 'Chief Registrar Programme', this senior resident doctor post works between Education and Medical Director Teams, developing joint service-education initiatives focused on safe patient care alongside opportunities to develop strategic and leadership experience. Dr Fiona Wilson, a Clinical Oncology Specialist Registrar, takes up this inaugural position.

A key part of Christie Education's strategy relates to our external impact in international health professions education academia. Rikki Goddard-Fuller has been elected as joint program chair (with the VP of the American Medical Association) for the 2026 Ottawa

conference, the leading global health professions' assessment and evaluation health conference.

Strategic and Service Developments

Pathology JV Re-procurement - the procurement process continues with the competitive dialogue sessions and we intend to issue the final statement of requirements during Q3. We are dovetailing this process with plans to develop new pathology facilities. We anticipate making a contract award during Q4.

The long-term estate option for new pathology facilities at the Withington site has been identified. The trust is continuing dialogue with The Christie Charity as to its role in funding and delivering the project.

The new 20-bedroom ward in the former Trust Administration and Digital floors is complete and known as Wards 14 and 15. The first stage of the ward moves from Ward 12 is schedule for Saturday 19th October 2024. In parallel, proposals are being developed to undertake a minor refurbishment to the remaining wards in this financial year and additional works on Ward 12.

Planning Permission for the next major strategic development, the Advanced Scanning and Imaging Centre (ASIC) development was received in December 2023. The Outline Business Case (OBC) was approved by the Trust's Board in September. The next stage is to engage with NHS England and HM Treasury to seek agreement to funding for the scheme to progress.

The replacement of the Superficial Treatment unit remains ongoing. Proposals to replace the remaining pharmacy robot continue to be developed as well as the first phase of the multi-year linear accelerator replacement programme.

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

Regulation and Governance

Change NHS: a health service fit for the future

Monday 21st October was the launch of a public consultation to inform the 10-Year Health Plan. As part of this launch, The Christie welcomed a ministerial visit from Andrew Gwynne MP, Parliamentary Under-Secretary for Public Health and Prevention, to our Withington site on Friday 18th October to see a number of our services including supportive oncology, ePROMs and proton beam therapy and hear from our clinicians and patients about the care and treatment we provide.

The consultation portal at change.nhs.uk is now open until the end of the year and the government is keen to hear all views, experiences and ideas to help shape immediate steps and long-term changes as part of this new 10-Year Health Plan for the NHS. The Trust will be submitting an organisational response and health and care workers are also encouraged to use the portal to describe their role and experiences and give their views. The final version of the plan is expected to be published in Spring 2025.

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Agenda item 31/24b

Meeting of the Board of Directors
Thursday 31st October 2024

Subject / Title	Value Improvement Programme (VIP) 2024/25
Author(s)	Jo Bolger Leece Assistant Director: Value Improvement Programme Claire McPeake; Chief Operating Officer (Interim)
Presented by	Claire McPeake Chief Operating Officer (Interim)
Summary / purpose of paper	This paper provides: • An overview of the Value Improvement Programme (VIP) with a month 6 position. • A summary of progress against actions from the paper previously presented to senior management committee in September • Overview of what focus on engagement and ownership has taken place to ensure financial sustainability for the future. • Outcomes from the Value Improvement Conference held on 4th October
Recommendation(s) (assure/alert/advise)	The Board of Directors are asked to note: • The content of the report; and • The associated actions identified to improve delivery.
Background papers	N/A
Risk score / BAF reference	Risk 3629 / Board Assurance Framework: Risk 1, Risk 6, Risk 7, Risk 9, Risk 10
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
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 Investment and Capital Planning Committee: ICPC Transformation, Performance and Improvement Group: TPIG

Agenda item 31/24b

Meeting of the Board of Directors
Thursday 31st October 2024

Value Improvement Programme (VIP)

1.0 Background and Introduction

The Christie strategy 2023 to 2028 sets out how we will continue to deliver our mission - to care, discover and teach - through the 4 themes of our vision: leading cancer care, the Christie experience, local and specialist care and best outcomes.

A key enabler of our strategy is ensuring financial sustainability to support and drive innovation and improvement, while continuing to invest in our capital and services. In line with the rest of Greater Manchester (GM), The Christie must achieve a challenging cost improvement target. To address this, as previously presented to the board, we have developed a high-level framework aligned with our Trust ambitions, focusing on delivering value for money through transformation.

In September, we presented a paper detailing the Trust's financial position, and progress in delivering our Value Improvement Programme (VIP). Recognising the need to inject capacity and pace into the VIP plans to meet our financial forecast, several improvement interventions were described and are being supported.

This paper describes the current position of VIP at month 6 and outlines the outcomes and actions being taken based on the recommendations.

2.0 Month 6 Financial Overview: VIP

In 24/25 as at M6, the Trust's year to date (YTD) surplus is £4.3m, £0.8m ahead of plan. The Trust is still forecasting a planned surplus of £7m assuming the delivery of the VIP target.

As at M6, the Trust has made good progress and £10.6m of VIP has been delivered with a number of schemes still to be delivered.

Summary	Performance as at M6
Full year forecast outturn £7.0m surplus	M6 YTD Position £4.3m surplus £0.8m favourable to plan
24/25 VIP Plan £21.4m	M6 VIP Identified (YTD) £19.6m
Target VIP M6 £10.7m	Delivered VIP M6 £10.7m

3.0 Governance and assurance

- Alongside an internal review of the governance and framework for VIPs, Greater Manchester commissioned PWC to conduct a financial review across the entire GM region. The outcomes of this review and the actions being taken in response to the recommendations were presented to the audit committee in October. The Trust is in a strong position regarding 'grip and control' guidance, with any outstanding actions being reviewed by the Transformation and Performance Improvement Group (TPIG).
- The TPIG, chaired by the Chief Operating Officer as the VIP SRO, continues to receive reports from enabling workstreams via highlight reports. These reports outline transformation objectives, progress against key milestones, and any risks that need to be escalated.
- The NHS IMPACT Clinical and Operational Excellence Programme has provided access to learning resources, improvement networks, analytics, and working guides shared by NHS England. Each workstream has been tasked with reviewing their services against best practices. This approach aims to identify and assess opportunities for The Christie by leveraging the best clinical and operational practices from across the country to support further local improvements.
- The Finance team are developing opportunity packs for divisions, which will include expenditure, income, model hospital metrics, and other available benchmarking data. These packs are intended to help divisions identify where VIP opportunities exist.

This blend of improvement guides, analytics, and networks, along with additional resources planned for the coming months, is proving beneficial in enhancing current leadership and expertise. It supports the delivery of sustainable, value-driven improvements, ensuring the best and most effective care for our patients.

4.0 Engagement and developing capacity and capability.

In response to developing capacity and capability, a survey conducted by finance to budget holders and feedback from clinical teams, a Value Maker Programme has been designed to support developing capacity and capability. Between November – April a number of training and awareness sessions for clinical teams and budget holders linking directly to national support from One Finance and Proud to be Ops are being scheduled to promote Finance and Clinical Education (FACE). These will include:

- Understanding budget management
- How to write a business case
- Demystifying finance in the NHS for clinicians
- Quality Impact Assessment (QIA) 'pop up' sessions
- Value improvement/waste reduction workshops for front line staff
- Measures for improvement

As part of the Trust Board away day, we hosted a Value Maker Conference. Through a mix of sharing best practices and group work, we launched our 2025/26 VIP. The event focused on:

- Identifying how we create and deliver value from our patients' perspectives
- Applying methods to identify and reduce 'waste' in our current processes, providing opportunities for improvement

- Celebrating success with clinical presentations on ePROMs and theatre improvements
- A Market Place for networking, showcasing patient-level costing, digital solutions including RPA, and the estates' Green Net Carbon VIP. Additionally, we highlighted how ePROMs enhance patient experience and, consequently, improve productivity.

The event saw strong attendance, with over 80 staff members, including Board members, participating. There was excellent engagement and support, leading to requests from clinical teams for additional bespoke sessions for broader staff. Approximately 20 improvement ideas emerged from the group work, all of which, along with the value analysis, are being incorporated into this year's VIP.

5.0 Next Steps

Divisions have already been identifying ideas for improvement and have developed their VIP pipeline ideas. They will be asked to submit details of the progress in identifying VIP schemes and the associated values for the 2025/2026 financial year as per the following timescales:

- **Communication with divisional accountable officers -** outlining expectations and timescales – end of October
- **Opportunity packs –** November
- **Submission 1, first Cut - Deadline 13th December 2024** - Expectation is that VIP has been identified and has been added to the 'tracker'
- **Final deadline - Deadline cop 21st February 2025** - Expectation is that VIP will be fully identified with a Green Risk Rating – plans and Quality Impact Assessments will be completed and are being managed against delivery.
- **Finance and clinical education (FACE)** launched in November.
- **Risk management –** a review and update of the VIP risk, with updated mitigating controls and action plans is being carried out.

6.0 Recommendation

The Board of Directors are asked to note the content of the report and the associated actions identified to improve delivery.

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Agenda item 32/24a

Meeting of the Board of Directors

Thursday 31st October 2024

Subject / Title	Freedom to Speak Up report - 1st April 2024 to 30th September 2024
Author(s)	Sue Mahjoob, Freedom to Speak Up Guardian
Presented by	Sue Mahjoob, Freedom to Speak Up Guardian
Summary / purpose of paper	This paper provides an update on Freedom to Speak Up activity within the Trust …
Background papers	Previous six month Freedom to Speak Up report
Risk score / BAF reference	N/A
EDI impact/considerations	FTSUG attends EDI network steering group meetings
Link to: ➢ Trust strategy ➢ Corporate objectives	Achievement of corporate objectives The Christie People and Culture plan
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	FTSUG – Freedom To Speak Up Guardian NGO - National Guardian's Office EDI – Equality, Diversity and Inclusion NHSE – NHS England

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Agenda item 32/24a

Meeting of the Board of Directors
Thursday 31st October 2024

Freedom to Speak Up report 1st April 2024 to 30th September 2024

1. Background

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

This report presents the six-monthly update on activity to the Board of Directors.

2. Activity

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

The FTSUG is a member of the Equality and Diversity (EDI) steering group and has held a session with EDI champions to explain the role and how they can signpost and support staff to speak up.

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

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

The weekly briefing is used to share information on Freedom to Speak Up activity.

Promotion of speaking up is supported by activity during October, Freedom to Speak Up month.

3. Culture

3.1 Cultural audit

Progress is being made on priorities identified following the cultural audit. These are wide ranging and include leadership development and training, staff health and wellbeing and staff communications. It is articulated that cultural change is something all staff own and have a responsibility to make happen and that it is important that everyone feels supported, valued and able to contribute ideas and get feedback on these. This is the foundation for a positive speaking up and listening culture.

3.2 Values and Behaviours

The Values & Behaviours framework articulates what our culture looks and feels like when we are operating at our best and includes that we demonstrate integrity by listening to others and taking ownership of our actions. A Values & Behaviours dashboard has been developed which brings together how we see people behaving based on staff survey responses and enables comparison of departments with the average or other departments. This is currently being rolled out across the Trust.

3.3 Staff survey

"We each have a voice that counts" is an element within the 2023 NHS Staff Survey that is focused on speaking up with 4 questions that contribute to the sub-score "Raising concerns". A more detailed report, which provided comparison with other specialist trusts, the results by division, staff grouping, protected characteristics and information from the questions added by the Trust has been shared with divisions to help with their action planning. A report was presented to the Workforce Assurance Committee in the Summer which provided a deeper analysis and Trust response on the speaking up questions.

A staff survey dashboard has been developed which will enable divisions to review their results in more depth in a more accessible way.

The divisions have developed priority action plans for presentation at Workforce Committee. This provides an opportunity to share ideas and information. Divisions have been asked to consider action they can take to support speaking up, given the fall in results for the "Raising concerns" questions.

3.4 Patient Safety Incident Response Framework (PSIRF)

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

4. National guidance and reports

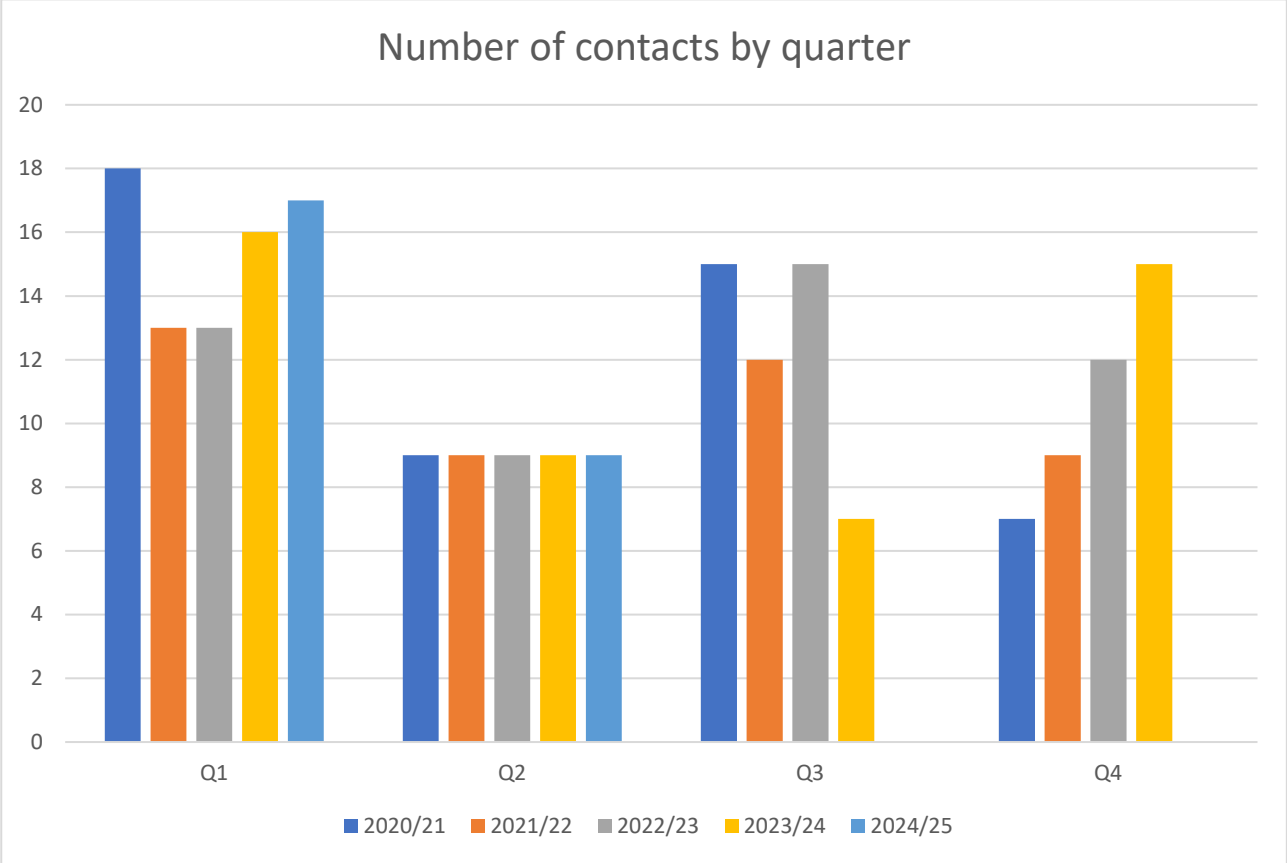
Throughout the last six months the following report was issued and reviewed.

- National Guardians Office Listening to the silence : Freedom to Speak Up in the NHS staff survey 2023

The report highlighted the National Guardian's Office observations from the staff survey nationally.

5. Contacts

5.1 Number of contacts by quarter



5.2 Type of contact

The table below describes the activity from 1st April 2024 to 30th September 2024. Descriptions of concerns are recorded as described by the staff member and concerns can have more than one issue.

Quarter	Number of contacts	Issue category	Description	Action
2024/25 Q1	17	Attitudes and behaviour (x12)	Behaviour of colleague (x7) Behaviour of manager (x5)	Anonymous joint concern (manager/colleague) (x 7) – combined approach; joint response sent via FTSUG, conversations with staff members willing to speak directly with senior manager. Actions in place Staff member decided not to proceed (x1) Staff member raised with more senior manager (x2) Staff member in formal HR process (x2)
		Policies, procedures and	Concern re doctor rotas and weekend shifts (x1)	Response part of wider review with action plan

		processes (x3)	HR Investigation handling (x2)	Staff member waiting for outcome of investigation before making decision to proceed (x2)
		Service change (x5)	Organisation and prioritising of workload (x1)	Joint concern response
			Communication re room change and organisation of work (x2)	Conversation with senior manager to share concern and follow up action
			Communication re change of service (x1)	Staff member raised with senior manager
			Proposed change in job delivery without discussion (x1)	Discussed with senior manager
		Quality and safety (x2)	Doctor rotas and weekend shifts (x1)	Response part of wider review with action plan
			Potential health and safety equipment risk (x1)	Raised with manager, equipment changed
		Other (x1)	Lack of equity in accessing activities at Christie@sites (x1)	Satellite sites considered when planning activity, checks made that this was happening.
2024/25 Q2	9	Attitudes and behaviour (x9)	Behaviour of manager unsupportive (x2)	Staff member raised with manager (x1) Staff member decided not to take further (x1)
			Behaviour of manager (x2)	Staff member raised with the manager (x1) Staff member decided not to take further (x1)
			Behaviour of colleague (x3)	Raised with manager (x3)
			Racist behaviour by colleague (x1)	Staff member raised formally (x1)
			Team culture (x1)	

		Policies, procedures and processes (x2) Performance capability (x1)	Concern re colleague behaviour not dealt with well (x1) Changes to working patterns (wfh, condensed hours) (x1) Lack of communication and support when performance reviewed causing uncertainty (x1)	Open conversations within team (x1) Staff member did not proceed (x1) Staff member decided not to proceed (x1) Staff member had conversation with manager (x1)

5.3 Summary

In summary, over the last six months, 60% of concerns (as a percentage of number of issues) have had an element relating to attitudes and behaviours and includes 7 members of staff in Q1&2 raising this as part of their joint concern.

14% related to policies, procedures and processes and 14% related to service change.

There are similar levels of concerns raised about colleague behaviour as manager behaviour and 1 person reported that the manager did not deal with the situation well when a concern was raised about a colleague's behaviour. Communication about reasons for changes in service is not always as comprehensive as it could be resulting in staff feeling unsupported or disregarded. These factors reinforce the need to ensure that managers have access to guidance, training and support to enable them to deal with concerns effectively and develop effective communication skills.

Concerns relating to policies, procedures and processes are varied but highlight how the conduct of investigations has to be robust and fair to maintain confidence.

6. Who is raising the concern

A review of who is raising concerns and how they are raised helps to identify if there are groups of staff who are not speaking up. There would be a benefit in reviewing how staff are encouraged to raise concerns and what channels they use for those groups where there are low numbers contacting the FTSUG.

6.1 Number of FTSUG contacts by staff group

Staff group	Q1&2 23/24	Q3&4 23/24	Q1&2 24/25	Total for 18 months
Additional clinical services	0	3	2	5
Additional professional, scientific and technical	3	1	1	5
Administrative and clerical	6	10	10	26
Allied health professionals	8	1	8	17

Estates and ancillary	1	2	1	4
Healthcare scientists	0	1	0	1
Medical and dental	1	1	1	3
Nursing and midwifery	5	2	3	10
Students	0	0	0	0
Unknown	1	1	0	2
Total				73

Staff group	Total number (18 months)	% of total number of contacts	Staff numbers by group 2024	% of total number of staff
Additional clinical services	5	7%	141	4%
Additional professional, scientific and technical	5	7%	416	11%
Administrative and clerical	26	36%	1165	30%
Allied health professionals	17	23%	429	11%
Estates and ancillary	4	6%	290	8%
Healthcare scientists	1	1%	202	5%
Medical and dental	3	4%	330	9%
Nursing and midwifery	10	14%	913	24%
Unknown	2	3%	0	0
	73		3886	

6.2 Demographics

From April 2024, all contacts are asked to provide their demographic information at their first meeting with the FTSUG. 15 provided this information and going forward, as more data is collected, the data can be compared with the overall workforce demographics to identity gaps.

Age	25-35	6
	35-44	6
	45-54	2
	55-64	1
Ethnicity	White British	10
	White European	2
	White other	1
	African	1
	White and Black Caribbean	1
Disability	Yes	3
Religion	Christian	9
	No religion	6

6.3 Role

Role	Q1&Q2 2023/2024	Q3&Q4 2023/2024	Q1&2 2024/2025
Senior leader	4%	0	0
Manager	36%	36%	27%
Worker	56%	59%	73%
Anonymous	4%	5%	0
Denominator – number of cases	25 (1 anonymous)	22 (1 anonymous)	26

6.4 Method of speaking up

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

Method	Q1&Q2 2023/2024	Q3&Q4 2023/2024	Q1&Q2 2024/2025
Face to face	15	9	13
MS Teams	6	7	12
Telephone	1	5	1
Form on intranet	1	0	0
Email	2	1	0

7. FTSU plan

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

The FTSU plan for 2024/2025 was developed in conjunction with activity following the cultural audit, the launch of PSIRF and feedback from staff via the staff survey to ensure that it meets the ambition to progress improvements in speaking up culture.

Over the six months the deliverables achieved were:

- Raising awareness of FTSUG and the speaking up and listening message at team meetings, via HIVE and team brief and in person attendance at staff induction as part of the Values & Behaviours session
- Development of posters and daily programme of items to support October’s Freedom to Speak Up
- FTSUG presentation at the EDI champions meeting to provide knowledge and understanding of FTSU and how to support it
- Feedback on Datix a mandatory requirement so all staff can review the outcomes of an incident they report and are able to challenge outcomes
- Embedding of Respectful Resolutions which includes a tool to aid speaking up

In progress:

- Anonymous reporting for inappropriate behaviours
- Development of an animated version of the FTSU policy
- Development of guide to support managers who receive a concern

8. National Freedom to Speak Up month

October is National Freedom to Speak month and the focus for organisations is Listening and the role it plays in encouraging speaking up. Each day for October, there is a different activity linked to listening promoted via the weekly bulletin. Activity includes links to short videos from staff highlighting the benefits of listening in helping the organisation improve, guides, policies and training.

9. Freedom to Speak Up Training

The National Guardian’s Office, in association with Health Education England launched Freedom to Speak Up e-learning training divided into three modules, Speak Up for all staff, Listen Up for

managers at all levels and Follow Up for Senior leaders. The Speak Up module is part of the Trust mandatory training programme and 96.05% of staff are compliant.

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

10. FTSU service effectiveness

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

15 contacts replied in Q1 and Q2 2024/2025.

All said they would speak up again, 14 said they were made to feel they did the right thing in raising their concern, 1 did not know.

11 said they felt very well supported, 3 said quite well.

14 said they understood very well what would happen once they raised a concern, 1 did not know.

All said they were communicated with very well.

9 said they were informed of learning that happened as a result, 5 said there was no learning.

12 respondents said they felt they did not suffer disadvantageous or demeaning behaviour as a result of speaking up, 2 said yes and 1 replied they didn't know.

The 2 people who said yes to detriment commented:

The person, who I am raising concern and complaint about, continues the behaviour that does not align with Christie Values. This behaviour continues to escalate.

I spoke up about my manager and although the process is anonymous I feel that the manager is aware I was involved and is angry with me. It's early days but I am concerned that I will not be treated fairly because of this.

However, they both have said they would speak up again.

Comments made:

The comments are reproduced in their entirety so that complete transparency is maintained to provide assurance that the service is delivering the required standard of support for the staff.

- *I feel that I have been well supported and listened to. I continue keeping in touch with Sue as this helps me to manage my stress better.*
- *I felt extremely supported by Sue and felt that she took my concerns seriously. I really appreciated the support and guidance she offered.*
- *Handled well by Freedom to Speak Up.*
- *I am glad I did it because at the time I felt like there was no other option and I wasn't being listened to by anyone in my department. I felt listened to and it allowed me to reflect on the situation. Sue was really friendly and I didn't feel judged at all. I was kept in contact with and although haven't decided to take it further at the moment, I will not hesitate to if future issues resurface.*
- *It was a really good way to raise underlying levels of concerns that can be difficult to find the right person to raise them too. It gave the whole team a way to collectively voice concerns over issues that had happened over an extended period of time and was good to reflect on those feelings and have them heard by someone without initial judgement.*

- *Very supportive, felt comfortable and assured that it would be treated confidentially.*
- *Sue was great, really easy to talk to with impartial advice.*
- *I am glad the process was followed and so far things have started to improve. I don't feel the need to desperately look for a new job at the moment and feel more settled.*
- *At the moment it is still ongoing, but I know I can contact FREEDOM TO SPEAK again*
- *Well handled*
- *n/a as I contacted them for general advice rather than raising a major concern*
- *It was difficult at first to raise any concern as I was not sure of the process but once I took that first step, it felt like the weight of the burden and frustration had lifted.*
- *I would do this again. I think it's a good process. It would be nice to know what the next steps are going to be as this hasn't been communicated by the manager of the person we spoke up about. It would be good to know how they think they can improve the situation. I think it would have been good to receive this feedback form later as the process has only just happened and it's early days.*

Suggestions for improvement of the FTSU service:-

- *I am happy with the service and have no suggestions for improvement.*
- *I don't think it can be - Sue is brilliant in her role and is a credit to the Trust. She has helped me to resolve a long standing issue that has been causing me great stress and anxiety in the work place.*
- *I feel that Freedom to Speak Up should be able to have a say in how a situation is handled rather than purely for advice or passing on concerns only.*
- *No - Sue was quick to respond to our requests and very accommodating when we had to re-organise. She provided quick responses and informed us of all the steps we could take.*
- *I think the process took too long on this occasion, but I understand that was due to circumstances beyond control. I hope that open communications continue between everyone and we can create a good working environment that works for us all*
- *More encouragement is required to boost staff confidence in using the service. Many are unsure how it works and fear it may have a negative impact.*

11. Conclusion

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

The Christie
NHS Foundation Trust

Agenda Item 33/24a

Meeting of the Board of Directors

Thursday 31st October 2024

Subject / Title	Board Assurance Framework 2024/25
Author(s)	Louise Westcott, Company Secretary
Presented by	Louise Westcott, Company Secretary
Summary / purpose of paper	This paper provides the Board of Directors with the Board Assurance Framework 2024/25. The risks outlined impact on achievement of the corporate objectives and the relevant objectives are indicated for each risk. The paper includes a snapshot of the risks ordered by current risk score and a report with the detail relating to each risk. The risks are reviewed alongside the risks on the Trust risk register.
Updates to note in month	• Quarter 2 risk score added for each risk to show change in score over time. • Risk 2 - Learning from patient safety incidents, risk score increased to 15 to reflect discussion at September QAC (see QAC report) • Risk 7 - Ineffective Greater Manchester system-wide cancer pathways – risk score reduced to 12 to reflect achievement of 62 day target • 2024/5 MIAA Audit outcomes added where relevant
Recommendation(s) (assure / **alert** / advise)	The Board of Directors are asked to; • note the Board Assurance Framework (BAF) 2024/25, • assign a level of assurance to items on the agenda of the committee that relate to the risks, • consider if there are any further risks that need to be added to the BAF, • reflect the review of the risk in the BAF for the next meeting.
Background papers	Board assurance framework 2023/24. Corporate objectives 2024/25, operational plan and revenue and capital plan 2024/25.
Risk score	N/A
Link to: ➢ Trust strategy ➢ Corporate objectives	• Trust's strategic direction • Divisional implementation plans • Our Strategy • Key stakeholder relationships
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	BAF Board assurance framework MDT multi-disciplinary team NICE National Institute for Health & Care Excellence PSIRF Patient Safety Incident Response Framework IP(QF)R Integrated Performance Quality & Finance Report GM Greater Manchester

BOARD ASSURANCE FRAMEWORK 2024/25 OVERVIEW OF RISKS

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

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

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

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	4	20	3	3	9	3	3	9			0			0	2	2	4

RISK 2	Learning from patient safety incidents	Date Risk Opened	Current Risk Score
Description	**If we are unable to fully implement the new Patient Safety Incident Response Framework (PSIRF) there is a risk that we will miss opportunities to learn lessons and improve patient safety leading to preventable patient harm.**	Apr-24 Date of Last Review Sep-24	15
Associated Corporate Objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer	Executive Lead	Exec Chief Nurse
		Responsible Committee	**Quality Assurance Committee**
		Assurance Level	Medium
		Risk Appetite	Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	The Trust has invested in external training for the patient safety strategy with 2 cohorts in November and January respectively covering all components of the patient safety strategy. The patient safety team are hosting 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 QAC□ Level 3 – External assurances • MIAA review • Updates presented to ICB	None identified	Full roll out of new Datix - incident module Training programme across the Trust	Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	3	5	15	2	3	6	3	5	15			0			0	1	1	1

RISK 3	Recruitment and retention of skilled staff	Date Risk Opened	Current Risk Score
Description	**If we are unable to maintain current levels of skilled staff there is a risk that they will not have the time or expertise required for excellent care and communication leading to a reduction in the standards of patient safety and experience.**	Apr-24 Date of Last Review Sep-24	9
Associated Corporate Objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey. To be an international leader in professional and public cancer education. To maintain excellent operational, quality and financial performance.	Executive Lead	Workforce Director
		Responsible Committee	**Workforce Assurance Committee**
		Assurance Level	High
		Risk Appetite	Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	Recruitment & retention Trust-wide group reporting to Workforce Committee. Partnership with external provider to deliver our domestic recruitment offer, advertising and brand – social media Staffing levels maintained through coordinated utilisation of bank and agency International Recruitment Programme Christie People and Culture Plan 2023-26 Quarterly oversight of Trust wide vacancies and recruitment activity presented to the workforce committee Divisional oversight of recruitment activity and vacancies discussed at the monthly service review meetings Turnover analysis and exit interview data presented and discussed six monthly at the workforce committee Robust sickness absence management and health and wellbeing offer	National staff shortages impacting recruitment	Level 1 – Data and management reports • Divisional oversight of recruitment through Service & Operatonal Review meetings □ Level 2 – Management team and committee scrutiny • Review compliance through WAC□ • F&PP Compliance report to WAC / Board □ Level 3 – External assurances • National staff survey□ • MIAA audit	None identified	Recruitment of onboarding coordinator	Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	5	20	3	3	9	3	3	9			0			0	2	2	4

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

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

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	3	**15**	4	3	**12**	4	3	**12**			**0**			**0**	4	1	**4**

RISK 5	Impact of the system capital allocation framework	Date Risk Opened	Current Risk Score
Description	**If the capital planning and allocation system does not enable full use of our charitable and commercial reserves there is a risk that we may not be able to fund our capital and asset replacement programmes leading to delays, cancellations or reprioritising of planned projects and equipment not being replaced when needed.**	Apr-24 Date of Last Review Sep-24	**16**
Associated Corporate Objectives	To promote equality, diversity & sustainability through our system leadership for cancer care	Executive Lead Responsible Committee Assurance Level Risk Appetite	Exec Director of Finance **Board of Directors** Eager

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	Alternative proposals put forward by GM ICB indicate allocation options linked to existing or nationally calculated depreciation. Participation at local and national level (NHSE / GM ICB) to influence allocation. Development of mitigating financial strategies. Identification & implementation of new models of working.	National / local funding rules / arrangements. Cap on CDEL	Level 1 – Data and management reports • Monthly finance reports□ Level 2 – Management team and committee scrutiny • summary of progress with capital plan/strategy implementation at Board / Planning Days□ • Regular reporting to Senior Management Committee & Board of Directors□ Level 3 – External assurances • □	None identified	Capital bids collated including level of priority, impact on patient care and activity should the bid not be approved. Manage capital priorities within existing ICB allocation and support the ICB to deliver a compliant capital plan. New models being	Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	5	**25**	4	4	**16**	4	4	**16**			**0**			**0**	5	2	**10**

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

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

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	3	**12**	3	3	**9**	3	3	**9**			**0**			**0**	3	2	**6**

RISK 7	Ineffective Greater Manchester system-wide cancer pathways	Date Risk Opened	Current Risk Score
Description	**If diagnostic, MDT and referral processes at local hospitals across the GM system are not efficient there is a risk that we receive patients on 62-day pathways late leading to them not being treated within 62 days.**	Apr-24 Date of Last Review Sep-24	**12**
Associated Corporate Objectives	To promote equality, diversity & sustainability through our system leadership for cancer care To maintain excellent operational, quality and financial performance.	Executive Lead Responsible Committee Assurance Level Risk Appetite	Chief Operating Officer **Quality Assurance Committee** Cautious

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

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	5	25	4	4	16	4	3	12			0			0	5	1	5

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

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

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	4	16	4	2	8	4	2	8			0			0	4	1	4

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

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	Close working with unions /staff side. Established Business continuity plans in place. Planning meetings in place around strike acton and incident management approach used. Management of patient demand. Risk assessments undertaken. Enhanced rates of pay agreed. National escalation process (For BMA in absence of derogations) Pay awards agreed at national level for junior doctors August 2024	Impact of ongoing Industrial action	Level 1 – Data and management reports • Review of incidents from periods of action□ • BCP compliance & effectiveness□ Level 2 – Management team and committee scrutiny • Reports to Senior Management Committee□ • Reports to Board of Directors□ Level 3 – External assurances • External reporting on impact to ICB	None identified	Detailed planning of patient demand and catch up. Staff cover planned. Further engagement with Regional Union Reps. Restrictions on annual leave/ TOIL during strike action. Reduction in appointments. Closure of elective admissions. Booking of staff via TEMPRE – Direct Engagement. Use of junior medical staff / acting down. Retraining and redeployment. Exploration of mutual aid with MFT	Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	5	25	4	4	16	3	3	9			0			0	5	1	5

RISK 10	Financial balance	Date Risk Opened	Current Risk Score
Description	**If we do not achieve the planned activity levels and our target efficiency savings there is a risk that we won't achieve financial balance leading to us having to repay the difference to our agreed plan in the following year**	Apr-24 Date of Last Review Sep-24	**10**
Associated Corporate Objectives	To maintain excellent operational, quality and financial performance.	Executive Lead	Exec Director of Finance
		Responsible Committee	**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
	Activity plans agreed with Divisions and progress monitored weekly at TOG and monthly at Senior Management Committee. Variable income performance tracked as part of the 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. Trusts VIP programme reviewed by MIAA and all recommendations implemented including developing a VIP SOP, improved governance of VIP schemes and escalating VIP reporting and responsibility to ICPC. VIP delivery at a divisional level monitored via the Trusts Service Operational Review framework October planning session with senior leaders focused on VIP delivery for 24/25 & 25/26.	Commissioning intentions. Funding growth	Level 1 – Data and management reports • Monthly Divisional scrutiny of financial position • Trust Operation Group (TOG) review weekly Level 2 – Management team and committee scrutiny • Reports to Senior Management Committee, Audit Committee and Board of Directors Level 3 – External assurances • MIAA review of financial systems • External audit of Annual Accounts • MIAA review of VIP programme	None identified	VIP Programme recommnedations implemented	Year End	Year End

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

RISK 11	Cyber attack	Date Risk Opened	Current Risk Score
Description	**If we or our suppliers are subjected to a cyber-attack there is a risk of loss of data and operational disruption leading to patient care being delayed or cancelled**	Apr-24 Date of Last Review Sep-24	**12**
Associated Corporate Objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey. To be an international leader in professional and public cancer education.	Executive Lead	Deputy Chief Executive
		Responsible Committee	**Audit Committee**
		Assurance Level	Medium
		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
	Data Security and Protection Toolkit submissions with audits undertaken. Digital board reporting. Board level Senior Information Risk Owner in place. Reviews of risk registers, alerts, reports, actions and observations MIAA audit - Data Protection Toolkit (DPST) Q4 23/24	The Trust does not currently have cyber security insurance.	Level 1 – Data and management reports • Regular updates from NHS Digital - Vulnerability Monitoring Service Level 2 – Management team and committee scrutiny • Reports to Senior Management Comittee and Audit Committee Level 3 – External assurances • Cyber Essentials + accreditation July 2023 • MIAA Data Protection Toolkit assessment (DPST) - Substantial assurance July 2024	None identified	Review of alerts MFA fully rolled out Explore security insurance options	Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	5	25	3	4	12	3	4	12			0			0	2	2	4

RISK 12	Ineffective response to cultural audit	Date Risk Opened	Current Risk Score
Description	**If our response to the cultural audit is insufficient there is a risk that a negative culture will persist in some specific parts of our organisation leading to an increase in the number of staff reporting a poor experience.**	Apr-24 Date of Last Review Sep-24	**8**
Associated Corporate Objectives	To be an excellent place to work and attract the best staff	Executive Lead	Deputy Chief Executive
		Responsible Committee	**Workforce Assurance Committee**
		Assurance Level	Medium
		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
	Plan developed through extensive engagement with staff following production of Globis Culture Audit and approved by Board. Board responsibilities outlined. Work commenced to implement agreed actions and continue to communicate with staff. Advisory Group in place and meetings arranged. Regular reporting to Board. Inclusive Culture work taking forward actions and approach for the Trust.	None identified	Level 1 – Data and management reports • Culture oversight group • Divisional action plans from staff survey Level 2 – Management team and committee scrutiny • Reporting to Workforce Committee, Workforce Assurance Committee and Board of Directors • Board development session on Inclusive Culture facilitated by NHS Providers expert Sept 2024 Level 3 – External assurances • Globis culture audit • Annual CQC Staff Survey 2023	None identified	Implemenetation of agreed action plan Cost additional resource requirments Advisory Group meetings to take place and review progress / report	Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	4	16	2	4	8	2	4	8			0			0	1	2	2

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

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

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	2	**10**	4	2	**8**	4	2	**8**			**0**			**0**	2	2	**4**

RISK 14	Legal and statutory compliance	Date Risk Opened	Current Risk Score
Description	**If we do not maintain an awareness of and respond to changing statutory and legal requirements there is a risk that we will fail to comply leading to being sanctioned for being in regulatory or statutory breach.**	Apr-24 Date of Last Review Sep-24	**16**
Associated Corporate Objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey. To be an international leader in professional and public cancer education. To integrate our clinical, research and educational activities as an internationally recognised and leading comprehensive cancer centre To maintain excellent operational, quality and financial performance.	Executive Lead	Chief Executive Officer
		Responsible Committee	**Audit Committee**
		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
	Engagement in national updates and regulatory briefings. Designated leads for statutory requirements across the Trust reporting into committee structure. Membership of NHS Providers. Exec Team engagement in national briefings. Close working with regulators, GM ICS / ICB and NHSE. Exit criteria clear from NHSE around move back to SOF 1.	None identified	Level 1 – Data and management reports • Regular reports to Executive Team□ • Monthly IPQFR□ Level 2 – Management team and committee scrutiny • Board self-assessments April 2024□ • Board reporting on regulatory changes□ Level 3 – External assurances • CQC Inspection Reports (IR(M)ER)□ • SOF Rating 2 • MIAA role specific training audit (CQC Reg 19) - Limited assurance Oct 24□	None identified	Take MIAA checklists / advisory notes to appropriate assurance committees Agreed exit criteria from SOF 2 to SOF 1 agreed and being monitored for compliance to specified timeframes.	Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	4	**20**	4	4	**16**	4	4	**16**			**0**			**0**	4	2	**8**

RISK 15	Patient confidence in services	Date Risk Opened	Current Risk Score
Description	**There is a risk that adverse events will attract media coverage resulting in a decrease in public confidence in our services**	May-24 Date of Last Review Sep-24	**9**
Associated Corporate Objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey. To be an international leader in professional and public cancer education. To integrate our clinical, research and educational activities as an internationally recognised and leading comprehensive cancer centre To be an excellent place to work and attract the best staff	Executive Lead	Chief Executive Officer
		Responsible Committee	**Board of Directors**
		Assurance Level	
		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
	Adherence to Workforce policies monitored through divisional structures Process in place to identify issues and escalate concerns. Comms plan in place to share patient stories and news on services / developments Website updates	None identified	Level 1 – Data and management reports • Regular reports to Executive Team□ • Monitoring & reporting of clinical / HR events□ Level 2 – Management team and committee scrutiny • Quality Asurance Committee review of clinical cases • Workforce Assurance Committee review of HR cases Level 3 – External assurances • MIAA audits commissioned to review specific issues where appropriate	None identified	Proactive review and response by the senior responsible person of activities that could result in negative publicity	Year End	Year End

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	3	**12**	3	3	**9**	3	3	**9**							1	2	**2**

The Christie
NHS Foundation Trust

Agenda Item 33/24b(i)

Meeting of the Board of Directors
Thursday 31st October 2024

Subject / Title	Workforce Assurance Committee report – September 2024
Author(s)	Assistant Company Secretary Committee Chair
Presented by	Committee Chair
Summary / purpose of paper	This paper provides the board with a summary of the items considered by the Workforce Assurance Committee at their September meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions
Background papers	Workforce Assurance Committee papers – September 2024
Risk score	Board Assurance Framework (BAF) references noted within the report
EDI impact / considerations	Ensure governance arrangements provide assurance and appropriate oversight of EDI requirements for the organisation
Link to: ➢ Trust strategy ➢ Corporate objectives	• Trust's strategic direction • Divisional implementation plans • Our Strategy • Key stakeholder relationships
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	

The Christie
NHS Foundation Trust

Agenda Item 33/24b(i)

Meeting of the Board of Directors
Thursday 31st October 2024

Workforce Assurance Committee report – September 2024

1 Introduction

The Workforce Assurance Committee took place on 19th September 2024. The meeting was quorate. The following summary gives the Board information on the items that were considered by the committee at their meeting under the headings of Assure / Alert / Advise.

2 Workforce Assurance Committee agenda items

The items listed in Appendix 1 of the report were all presented to the Workforce Assurance Committee in September 2024. Following discussion, the items are presented to Board for information and action where appropriate.

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

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

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

3 Recommendation

The Board are asked to note the summary report from the Workforce Assurance Committee in September 2024.

The Christie
NHS Foundation Trust

Appendix 1

Agenda item	BAF ref	CQC regulation reference	Assurance rating given	Key points and associated actions (where applicable)
Assure				
16/24a	3, 12	18	High	**Workforce dashboard** • Sickness – more than average sickness relating to coughs, cold, flu absence, decrease not seen over summer period. Still best performing Trust in GM. Divisions have their own plans in reducing absence. • PDRs - compliance at 86.63%. Work ongoing to increase value in PDR for staff. Paper going to Workforce committee on plans. • Upward trend for mandatory training - compliance currently at 93.73%, seen a significant positive impact by staff having to complete the training before starting at the Trust. • Staff turnover – now reduced to 10.5% so promising. Hopeful that culture work is having an impact, improvement on induction and onboarding. • Vacancy factor – 367 FTE vacancies, net improvement due to increase in establishment. August position, establishment has grown further. Keeping pace in terms of recruitment, 350 staff in immediate pipeline. • Workforce risk – overall risk in terms of workforce supply currently at a risk score of 9 (moderate). **Action:** PDR focused review to come to next Workforce Assurance Committee in November 2024.
16/24b	3	N/A	High	**Bank and agency monitoring report** • Managing to continue to meet 3 of the targets set by NHSE, price cap compliance is a challenge, we are above target which is driven by some vacancies in specialist medical areas. A lot of work being done on both non-medical and medical side which has seen some reduction. Working towards compliance will depend on how successful we can be on permanent recruitment. • Looking at ways of attracting middle grade staff, this comes with external competition challenges too. • GM system level conversations are taking place on costs and agency relating to resident doctor spend and looking at applying some consistency on how its approached.

17/24a	3	18, 19	High	**The Christie people and culture plan update** • Now in year 2 of the plan, reviewing in line with the outputs of the cultural audit. • Lots of work around wellbeing undertaken, moved some way in terms of fair recruitment and continuing with community engagement events. Funding to continue with attraction and banding work to attract staff through social media. • Red area on exit process mainly due to take up being low. Divisional roadshows to be undertaken on promoting importance of exit interviews. Will include link to survey which can be completed anonymously. Matter of time before meaningful data can be achieved to enable analysis. **Action**: Exit interview focused review to come to Workforce Assurance Committee in January 2025.
17/24b	12	N/A	Medium	**Enhancing Junior Doctors Working Lives (EJDWL)** • Junior doctors now referred to as resident doctors (effective 19/09/2024). Paper demonstrated the work ongoing in line with the work agenda for the Junior Medical Workforce Strategic Oversight Group (JMWSOG) following previous negative feedback from group of resident doctors. • Overview given on the work of the group. Important as they are the future pipeline. Group takes responsibility for work progressing and will provide a further update in six months. • Work also links to guardian of safe working hours reporting, need to progress through the work of the group. • Medium level assurance until outputs are seen. **Action:** Enhancing resident doctors working lives update to come to workforce assurance committee in January 2025.
17/24c	N/A	N/A	High	**The Christie response to 2024 riots** • NHS were quick to respond and provide guidance to Trusts on how to manage and support staff. Trust worked quickly on messaging to staff and worked with trade unions. Signposting to support for staff. Comms team proactive in external messaging via social media. • Highlighted how staff may experience discrimination by patients and how to seek support. Work ongoing through violence and aggression policy, task force group in place with broad clinical representation – to change name of policy, policy has right steps but not immediately accessible to staff so working on providing guidance to have to hand. • Trust did not have any staff that were involved in any riots from a criminality perspective. • Monitoring will continue through the embedding of the people and culture plan.

18/24b	3	18	High	**Guardian of working hours report** • Quarterly report for March – May 2024, 20 exceptions reported which is high for the Trust, hesitant to use exception reports as a metric for reasons discussed as part of agenda item 17/24b and work involved being progressed through the task force group.
Alert				
No items to report.				
Advise				
No items to report.				

The Christie
NHS Foundation Trust

Agenda Item 34/24b(ii)

Meeting of the Board of Directors
Thursday 31st October 2024

Subject / Title	Quality Assurance Committee report – September 2024
Author(s)	Assistant Company Secretary Committee Chair
Presented by	Committee Chair
Summary / purpose of paper	This paper provides the board with a summary of the items considered by the Quality Assurance Committee at their September meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions.
Background papers	Quality Assurance Committee papers – September 2024.
Risk score	Board Assurance Framework (BAF) references noted within the report.
EDI impact / considerations	Ensure governance arrangements provide assurance and appropriate oversight of EDI requirements for the organisation.
Link to: ➢ Trust strategy ➢ Corporate objectives	• Trust's strategic direction • Divisional implementation plans • Our Strategy • Key stakeholder relationships
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	

The Christie
NHS Foundation Trust

Agenda Item 34/24b(ii)

Meeting of the Board of Directors
Thursday 31st October 2024

Quality Assurance Committee report – September 2024

1 Introduction

The Quality Assurance Committee took place on 19th September 2024. The meeting was quorate. The following summary gives the Board information on the items that were considered by the committee at their meeting under the headings of Assure / Alert / Advise.

2 Quality Assurance Committee agenda items

The items listed in Appendix 1 of the report were all presented to the Quality Assurance Committee in September 2024. Following discussion, the items are presented to Board for information and action where appropriate.

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

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

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

3 Recommendation

The Board are asked to note the summary report from the Quality Assurance Committee in September 2024.

Appendix 1

Agenda item	BAF ref	CQC regulation reference	Assurance rating given	Key points and associated actions (where applicable)
Assure				
25/24a	2	12, 20	Medium	**Patient Safety Quarterly Report April - June 2024** • Reporting now on PSIRF, slight increase in total incidents reporting. 72% of incidents reported in required 48-hour time frame, work to do here noted. At time at reporting there were 1402 open incidents in Datix, now stands at 650. • Duty of candour at 36% compliance at time of completion of the report, significantly improved and now at around 80%. • On right track with PSIRF and will evolve. Actions and recommendations set to a map of improvement work. • Given the change to the landscape in relation to the implementation of PSIRF, the committee discussed and agreed to change the assurance level from high to medium to reflect the change to PSIRF and how this will affect reporting until assurance can be further demonstrated. **Actions:** • Example of cases to demonstrate how PSIRF works to come to the November committee meeting. • BAF risk 2 scoring to be reviewed based on committee discussion and change to assurance level.
25/24b	1	9, 10, 12, 16	Medium	**Patient Experience & Clinical Effectiveness Quarterly Report January- March 2024** • 39 formal complaints in period, average in line with the increase seen since covid. • PHSO referrals – had a spike last year where had 5 complaints referred (1 a year previous to this). 3 currently open and 2 closed, which were upheld in Trust favour. • 97% positive feedback for inpatients and 95% for outpatients. • Committee agreed to change to medium assurance to reflect the linkage to PSIRF and how this will affect reporting as noted above.

25/24c	N/A	N/A	High	**QICA annual report** • Record number of 222 projects completed. Ability to demonstrate impact on QI has increased. Using QI scoring method. QICA team completed projects based on Trust priorities. • Number of incomplete projects similar to last year (planning process under review). • Highlights included the held QICA awards which was a successful event and working on the new NHS impact initiative. **Actions:** • Examples of national clinical audit reports to come to a future meeting for information.
25/24d	N/A	16	High	**Complaints annual report** • Key objectives for this year - full review of process against PHSO standards, work required on new Datix system to get reporting robust and accurate and to work on how we learn from and disseminate the learning from complaints. **Actions:** • Timing and reporting on complaints to be reviewed as part of rolling programme review.
25/24e	N/A	N/A	High	**CQC Adult inpatient survey results** • Positive report, 651 patient responses received. In the majority of sections, the Trust comes out as 'much better'. Nationally, we are one of nine grouped in the high performing, which is long standing and a credit to the Trust. • Results will be reviewed in terms of improvement for the couple of areas where the score not as good. • 4th in national reporting by HSJ. Great achievement for the ward staff who deliver the care to patients.
25/24f	N/A	N/A	High	**National Cancer Patient Experience Survey Results** • Positive results, the challenge is that we do not have control over all areas of the patient experience as we do not own all parts of the pathway. • Many areas noted where we are over the expected rate (positive score). Only one score with a statistical decrease but still about the average. • Looking at a practical way that looks at reviewing the results and considering an in-house survey to help determine areas where we have control in the process across all services involved.

25/24g	1	16	High	**Patient Experience plan update (Deep Dive)** • Multiple areas of work relating to the plan reflected within the report. • Patient and carer group to be established. • Positive work being done in terms of advanced care planning. • Good processes in how patients can provide feedback.
25/24h	N/A	10 & 12	High	**CODE accreditation / Quality Mark update** • Work completed over the last few months to review the process and adding an additional fundamental care standard relating to the care of the deteriorating patient. • Work done to embed relatives and carers in the process, which also aligns to the patient experience plan. • Quality improvements implemented were presented and the vision for driving further improvements outlined including what good look likes in a sustainable way.
25/24i	N/A	N/A	High	**Health and safety quarterly report (April – June 2024)** • Highest categories for reporting are needlesticks and falls. • Two incidents were reported to the HSE under RIDDOR during Q1. • Violence and abuse reporting very low but doing some work to look at against national standards to identify any areas for improvement and use data to identify any hotspot areas. • Work to do on waste management to achieve NHSE targets, challenge due to our levels of high toxicity waste. • Recruitment for new health and safety lead to be progressed and work to further develop report.
Alert				
No items to report.				
Advise				
No items to report.				

The Christie NHS Foundation Trust

Agenda item 33/24c

Meeting of the Board of Directors

Thursday 31st October 2024

Subject / Title	Emergency, Preparedness, Resilience and Response Assurance Process Statement of Compliance
Author(s)	Claire McPeake, Interim Chief Operating Officer / Accountable Emergency Officer Stefano Piscitelli, Head of Emergency Preparedness
Presented by	Claire McPeake, Interim Chief Operating Officer / 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 of 2024-25. 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 in the future.
Recommendation(s) (**assure** / alert / advise)	The Board is asked to approve the contents of the report.
Background papers / source of assurance	• Data • Benchmarking • External assessments • Risks and mitigation • Trajectory and changes over time
Risk score / BAF reference	BAF risk 8
EDI impact/considerations	N/A
Link to: ➢ Trust strategy ➢ Corporate objectives ➢ CQC Quality standard ➢ Regulation	Civil Contingencies Act 2004 NHSE EPRR Framework NHS Standard Contract Service Conditions NHS Act 2006 Health and Social Care Act 2012 Health and Care Act 2022

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.	CCA – Civil Contingencies Act EPRR – Emergency, Preparedness, Resilience and Response LHRP – Local Health Resilience Partnership NHSE – National Health Service England

Agenda item 33/24c

Meeting of the Board of Directors

Thursday 31st October 2024

Emergency, Preparedness, Resilience and Response Assurance Process Statement of Compliance

1. Background

The purpose of this report is to provide the Board of Directors with the annual The Christie NHS Foundation Trust self-assessment against the NHS England Core Standards for Emergency Preparedness Resilience and Response (EPRR) for the period of 2024.

2. Introduction

The Civil Contingencies Act 2004 and the NHS Act 2006 as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022 underpin EPRR within health. Both Acts place EPRR duties on NHS England and the NHS in England. Additionally, the NHS Standard Contract Service Conditions (SC30) requires providers of NHS funded services to comply with NHS England EPRR guidance.

Under the CCA 2004 NHS Providers are Category 1 Responders, which are recognised as being at the core of emergency response and are subject to the full set of civil protection duties including: risk assessment of emergencies, to have in place emergency plans and business continuity management arrangements and a requirement to share information and cooperate with other agencies.

The minimum requirements Specialist Providers must meet are set out in the NHSE Core Standards for EPRR. In line with contractual requirements the Trust is required to provide an annual assurance of compliance with the Core Standards, with a 2024 submission deadline of 30/09/2024 comprising key documents of:

- Statement of compliance
- Associated action plan
- EPRR Core Standards Spreadsheet, which outlines the evidence and RAG rating against each individual standard.

There is a total of 59 standards with an accompanying ‘deep dive’ to gain additional assurance in a specific area. The 2024 ‘deep dive’ topic is Cyber Security, whilst important to undertake, the deep dive does not contribute towards the overall Trust compliance level.

There are 4 levels of 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**

3. Proposal

Updates since the 2023 EPRR Core Standards Submission

The Board of DIirectors are asked to note the following:

Alert

The 2020-21 and 2021-22 EPRR Core Standards submissions were both reduced to consider the impact of the COVID-19 pandemic.

In addition, NHSE made several changes to the standards in 2022-23 which meant comparison with previous years was not equivalent.

Following these amended submissions and significant recent changes to the EPRR landscape, further overarching changes have been made to the 2023-24 EPRR Core Standard submission. This includes several revisions or additions of new evidence requirements to more than 50% of the 59 standards, preventing direct comparison with any submission from the previous 3 years.

The Christie have raised at Local Health Resilience Partnership that the significant changes made to the set of EPRR Core Standards each year over the last 3 consecutive years is in breach of the agreement that only minor amendments will be made annually, and a full review would be conducted in 2018, 2021 and then not again until 2024. Furthermore, that the current submission date of October is out of sync with the financial year, which raises ambiguity around the period of assurance.

2023-24 The Christie Rating – Non-Compliant

The Christie received an overall assurance rating of 'non-compliant,' with compliance achieved in only one standard, resulting in a final score of 1%. The initial submission by The Christie was 76%, which would have resulted in a partially compliant status. However, the Northwest NHSE EPRR Team's ‘check and challenge’ process questioned the evidence for all the standards we had self-assessed as compliant. The final score of 1% was the lowest among all providers in Greater Manchester.

The main feedback focused on policies and plans being outdated and not reflecting the latest guidance and changes in the national Emergency Preparedness landscape.

Assure

2024-25 Compliance Anticipated Final Compliance as of October 2024

The Trust is expecting to achieve a compliance rating of 62.71% - Non-Compliant

The Christie NHS Foundation Trust receiving a rating of 'non-compliant' should not be perceived as a poor assurance rating. As a Trust, The Christie is delivering against the vast majority of NHS Core Standards for EPRR, and significant improvements have been made compared to last year's 1% compliance. The score also indicates that there are opportunities for the Trust to further improve over time through the implementation and monitoring of effective action plans.

Level of Compliance	Standards	Comments
Full compliance	36 standards	A significant improvement compared to the single standard that achieved compliance in 2023/2024.
Partial compliance	23 standards	A detailed action plan has been drafted to convert the partial compliance status to full compliance by the year 2025/2026
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 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 and confirmed trust visit on the 17th of October 2024.

4. Recommendation

The Board of Directors are asked to note and approve The Christie EPRR statement of compliance for 2024-25, with assurance of delivery of actions and future improved compliance through the Christie EPRR governance structure.

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NHS Foundation Trust

Greater Manchester Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2024-2025

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.

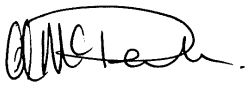
Following self-assessment, the organisation has been assigned as an EPRR assurance rating of ***Non-compliant*** against the core standards.

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

Claire McPeake



Date signed: *27/09/2024*.

17/10/2024	*31/10/2024*	*July 2025*
Date (to be) presented at Audit Committee	Date (to be) presented at Public Board	Date to be published in organisation's Annual Report

The Christie NHS Foundation Trust

EXECUTIVE SUMMARY

The Christie NHS Foundation Trust

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

Safety

- There were 3 patient safety incident investigations triggered in September, details of which can be found on slide 5. There were 5 incidents in total reported in September which require a learning response, one was reported with the classification of severe harm, one reported as moderate harm, and 3 were reported as low / no harm. Details of each incident can be found on slide 6. All the incidents are still progressing through to full root cause analysis. One never event was reported in month, details of which can be found on slide 5.
- There are 8 Trust level operational risks scored at 15+. Details of these can be found on slides 11&12.
- Safer staffing numbers have met the required acuity levels to ensure appropriate levels of safety and care for our patients. Indicative staffing, in line with nursing establishments, is set to maintain a 1:7 nurse to patient ratio. On occasion this has been extended to 1:8 which is in line with recommended national staffing ratios. While we have seen an increase in patient safety incidents, following thematic review, these were not related to nurse staffing ratios.
- There were 4 cases of C-Difficile, 4 cases of E-Coli, 5 cases of Klebsiella, 2 cases of MSSA and 2 cases of Pseudomonas reported in September that were deemed attributable to the Trust. No lapses in care were identified.

Performance

- In September the new combined 62-day performance subject to validation was at 74% which is above the new standard of 70%. The new combined 31-day performance was 98.1% which is above the new standard of 96%. The internal 24-day performance was below standard at 70.7%. All 62 and 24-day breaches are reviewed to ensure any delays are understood and plans can be implemented to mitigate any future delays. Improvement plans are in place and performance is expected to improve before the end of the financial year. The Trust's RTT 18-week performance is well above standard at 98.1%. The Trust achieved the 75% faster diagnosis standard in September with a compliance score of 90%.
- There were no patients waiting over 52 weeks at the end of September.
- Referral numbers in September rose from the August position and cumulatively remain high in comparison to the 23/24 average.

HR

- Staff absence rose slightly from August to a position of 4.74% against a target of 3.4%.
- PDR performance reduced slightly from August's position. Mandatory training has also reduced slightly from August's position but remains well above the set standard.

Finance

- The Trust is reporting a surplus at the end of M6 of (£4.3m) against a M6 YTD plan of (£3.5m), which gives a month 6 variance of (£0.8m) better than plan.
- Capital performance to month 6 was (£0.9m) below the revised plan submitted to NHSE&I in June 24. The Trust has spent 86% year to date of the capital plan.
- Capital spend to month 6 was £0.9m below the revised plan submitted to NHSE&I in June 24. This is lower than the plan position due to the TIF Ward position.
- The Trust has incurred £5.7m on capital schemes to month 6, primarily on the TIF ward refurbishment as well as ongoing digital projects and small replacement assets. The Trust has spent 86% year to date of the capital plan.

SUMMARY DASHBOARD

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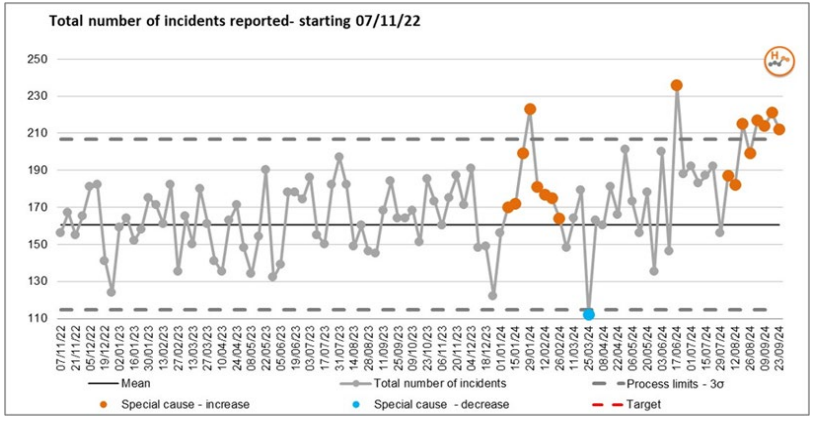
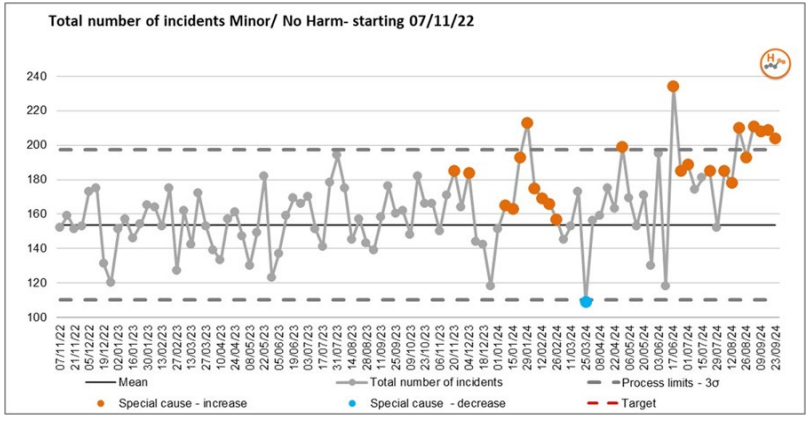
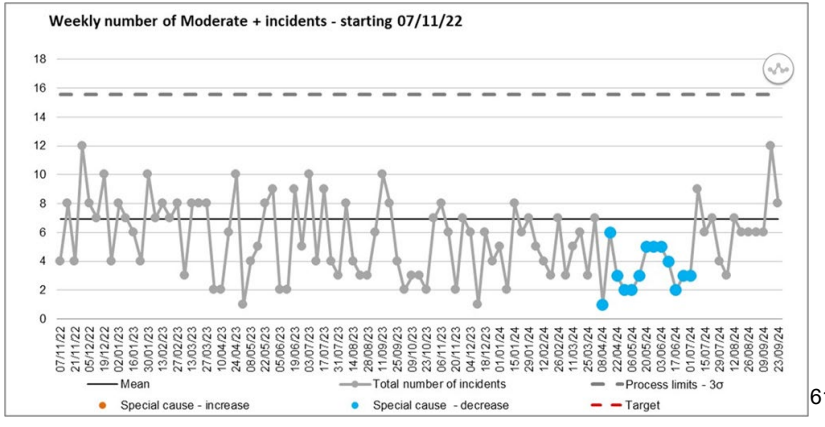
Indicator	Threshold / Standard 24/25	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	YTD
Patient Safety Incident Investigations	-	1	2	1	0	0	3	7
Never Events	0	0	0	0	0	0	1	1
Radiation Incidents Reported (IRMER Reportable)	0	1	3	1	3	1	2	11
Radiation Incidents Reported (IRMER Reportable - Grade 2 or above)	0	0	0	0	0	0	0	0
Number of Pressure Ulcers (Post admission - Grade 2 or above) - Rate per 1000 occupied bed days	0.5	0.8	0.0	0.6	0.2	0.0	0.2	0.3
Inpatient Falls Resulting in Harm (Grade 2 or above) - Rate per 1000 occupied bed days	3.8	4.7	3.6	3.0	2.9	4.5	3.5	3.8
Sepsis - timely treatment with IV antibiotics (established inpatients)	90%	90.0%	87.0%	96.4%	94.4%	92.4%	91.4%	-
Sepsis - screening (presenting as an emergency)	90%	94.9%	100.0%	100.0%	97.5%	96.9%	98.1%	-
Number of Trust-Wide Risks Grade 15 or Above	-	6	6	9	13	8	8	-
28 Day Faster Diagnosis Standard	75%	81.3%	75.0%	100.0%	91.7%	86.4%	90.0%	-
62 Day Compliance	70%	71.2%	72.1%	72.4%	76.6%	79.7%	74.0%	-
24 Day Compliance	85%	71.5%	72.2%	74.6%	78.1%	78.4%	70.7%	-
31 Day Compliance	96%	99.2%	99.6%	99.2%	99.1%	99.3%	98.1%	-
18 Weeks Compliance - Incomplete Pathways	92%	98.4%	98.7%	98.1%	98.0%	97.9%	98.1%	-
Patients waiting >52 Weeks	0	0	0	0	0	0	0	0
Patients waiting >62 days at end of month (62 Day Classic)	80	129	119	100	95	93	101	-
Patients waiting >104 days at end of month (All 62 Day Targets)	-	47	51	42	49	49	42	-
Length Of Stay (Elective & Non-Elective Inpatients)	-	7.81	6.39	6.39	7.16	6.54	6.76	-
Patients Discharged Beyond Ready for Discharge Date	-	14	2	7	18	13	6	60
Patients Discharged Beyond Ready for Discharge Date - Total Bed Days Lost (days counted in the month of discharge)	-	213	15	90	296	97	33	744
Patients Discharged Beyond Ready for Discharge Date - Average Bed Days Lost (days counted in the month of discharge)	-	15.2	7.5	12.9	16.4	7.5	5.5	-
Hospital Cancelled Operations on the day for non clinical reasons	0	3	2	0	0	2	2	9
Hospital Cancelled Operations on the day for non clinical reasons - NOT rebooked within 28 days	0	0	0	0	0	0	0	0
Complaints Received	12 (23/24 Avg)	12	14	8	21	10	17	82
PALS Contacts	35 (23/24 Avg)	32	67	39	37	44	29	248
MRSA	0	0	2	0	0	0	0	2
C-Difficile - All Attributable Cases (Pre & Post 48 Hours)	<52	2	3	4	6	5	4	24
C-Difficile - Attributable Cases Due To Lapse In Care	0	0	0	0	0	0	0	0
MSSA Bacteraemia - Attributable	No Target	1	2	3	1	0	2	9
E-Coli - Attributable	<57	6	4	4	1	3	4	22
Klebsiella Species - Attributable	<25	1	2	2	1	2	5	13
Pseudomonas Aeuriginosa - Attributable	<8	2	0	0	1	1	2	6
Staff Sickness	3.4%	4.56%	4.39%	4.45%	4.75%	4.44%	4.74%	-
Staff Mandatory Training	>80%** <80%	92.7%	92.7%	93.2%	93.7%	93.8%	93.7%	-
Staff PDRs	-	84.6%	85.7%	85.3%	86.6%	88.0%	87.2%	-

Incident Reporting



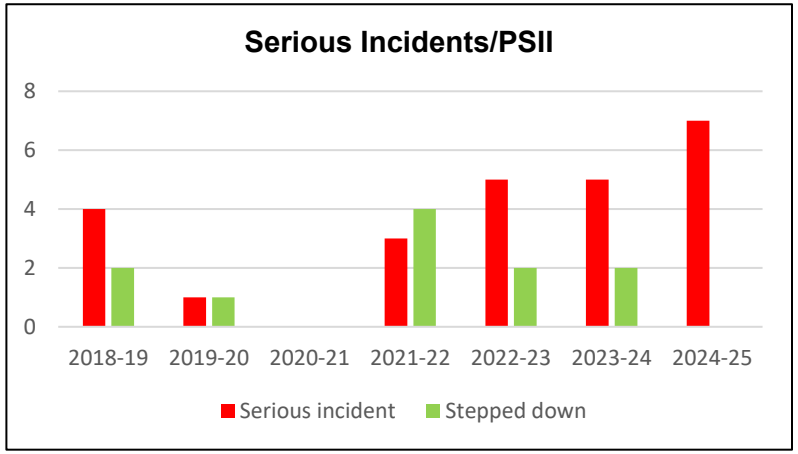




Special cause decrease can be noted for reported weekly moderate incidents (post triage) , this reflects the change in incident grading in the new Datix system from March 2024 .'Near miss' incidents can now be submitted (graded as no harm) which previously were submitted as moderate in severity.

61

Serious Incidents and Never Events



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

1 Never Event was identified in September 2024:

5456 -insulin not measured using insulin syringe. Incorrect insulin dose given for management of hyperkalaemia (100 units/250ml dextrose instead of prescribed 10 units/250ml dextrose).

Patient Safety Incident Investigations (PSII's) triggered
There were 3 PSIIs triggered in September 2024

3721 - wrong blood in tube
4964 - 10-month delay in scheduling of examination and biopsy for ?malignancy - advanced disease identified
5456 - Never event- insulin not measured with insulin syringe - as above.

Incidents identified that require a Learning Response

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September 2024 – RCA/learning response to be presented to ERG		
Reference	**Description**	**Reported Harm Level**
430	Themed Review of Falls in Palatine Ward	Low harm/no harm
3523	Patient being treated for ICI mediated myasthenia gravis (MG), myositis and myocarditis patient was given stat tazocin and gentamicin -aminoglycosides contraindicated in patients with MG. Patient acutely deteriorated requiring CCU admission. RIP.	Severe harm
4777	PET scan performed November 23- report was not downloaded onto CWP therefore not reviewed – report showed possible signs of a new malignancy.	Moderate
3746	Themed Review of incidents regarding accessibility of Hotline service	Low harm/no harm
3080/3151	C-diff PCR and toxin positive stool sample (HOHA)	No harm

Learning – Patient Safety Incidents

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Agreed learning and revised severity outcome following executive reviews September 2024

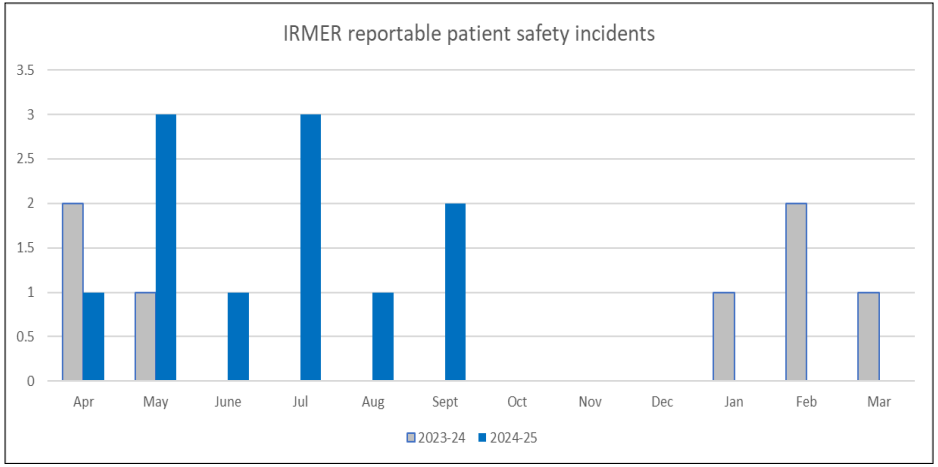
Ref	Description	Learning	Outcome
2188 - MDT	Deranged electrolytes resulted in a patient being admitted to the Oncology Critical Care Unit (OCCU). Concerns were raised that the patient's potassium levels were not optimised prior to the OCCU admission.	• Escalate to pathology manager for review. • To be highlighted to all ward staff. Informal checking of prescription charts by ward leaders.	Moderate
2379 - MDT	Tissue collected from patients who had received a radionuclide tracer was not handled in accordance with the clinical trial protocol requirements in place to mitigate exposure to radioactive material.	• Manuals review process to be assessed. • Feedback to the trial sponsor the importance of ensuring manuals applicable to different cohorts are clear and easily distinguishable. • Review tracer dose in all tissue samples and produce a guidance document. • Ensure samples pathway document is developed for this trial to guide services/teams' practice around regulated areas e.g. radiation. • All services to confirm a local SOP/work instruction is in place for radiation management which specifically refers to flexibility that may be required for research context.	No Harm
3504 - MDT	Inappropriate discharge of patient with poor prognosis.	• Reminders to clinical groups to be proactive in ensuring discussion with patient/family has taken place prior to Rapid Discharge request • Review of Vancomycin guidance in Micro Guide. Reminder to clinical teams where to find the guide. • Reminder to ward staff to complete Kardex regarding O2 use	Moderate

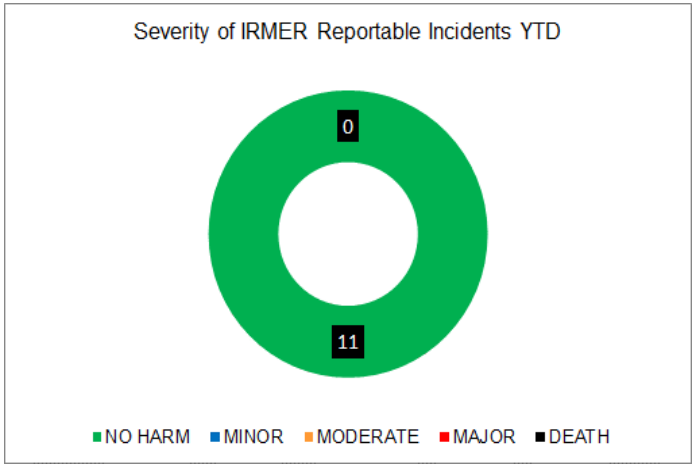
Learning – Patient Safety Incidents

The Christie NHS Foundation Trust

Agreed learning and revised severity outcome following executive reviews September 2024			
Ref	**Description**	**Learning**	**Outcome**
1647 After Action Review	Delayed review of deteriorating outpatient due to patient being under multiple teams.	• Reiterate process of Alertive escalation and parental team responsibilities for surgical specialities	Moderate
2432 MDT	Patient deterioration thought to be due to an error in insulin prescription and administration.	• A crib sheet to be developed and circulated around inpatient wards. • Review if a risk should be raised.	Moderate

Radiation Incidents





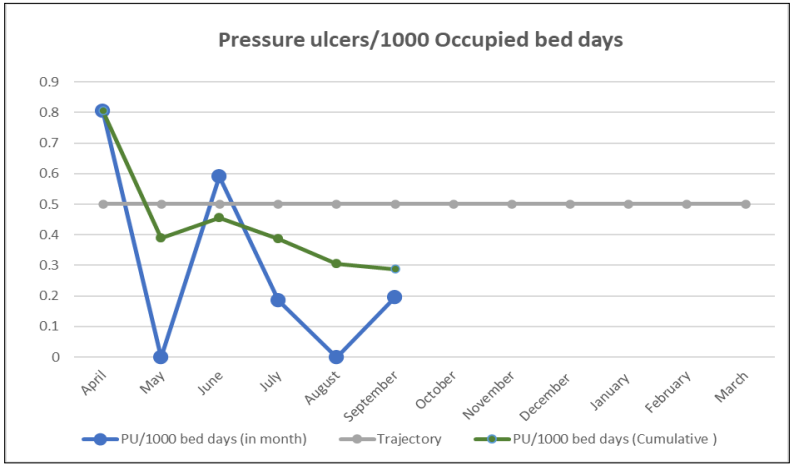
There was two IrMER reportable incident reported in September 2024:

5160 – no harm – equipment error
5312 – no harm – equipment error

Harm Free Care

The Christie NHS Foundation Trust

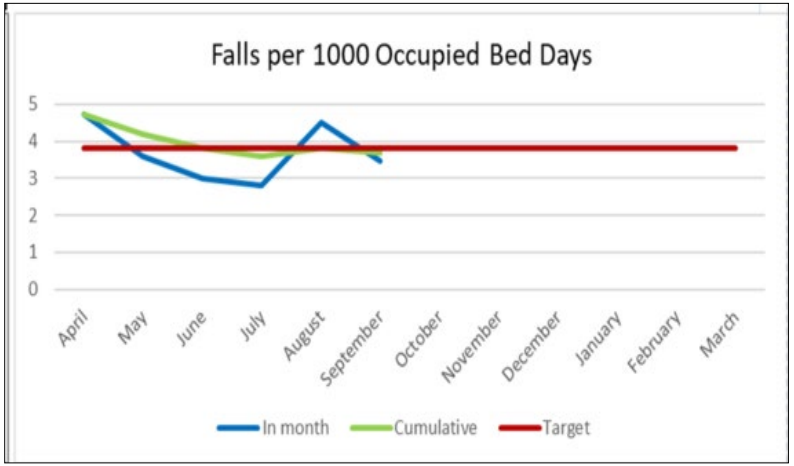
Pressure ulcers per 1000 occupied bed days



The ambition for 2024/25 is to maintain previous good performance of no less than 0.5/1000 occupied bed days a month.

One pressure ulcer was identified in September (0.2/1000 occupied bed days)

Falls per 1000 occupied bed days



18 IP Falls in September, below target mean of 20.

3.5 falls per 1000 OBD, below target of 3.8.

5 low harm falls, 0 moderate

72 % no harm.

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

Operational Risks

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There are 8 Trust-wide 15+ risks in September		
Description	**Score**	**Controls**
24/25 Capital Envelope Restrictions (Risk ID 3628)	16	Manage capital priorities within existing ICB allocation and support the ICB to deliver a compliant capital plan. Current proposal from NHSE to support system revenue plan involves further reduction to capital envelope. At the time of updating the GM ICB hadn't accepted this proposal.
Delivery of 24/25 Recurrent VIP Plan(Risk ID 3742)	16	Support Identification and delivery of VIP: Opportunity packs for divisions Review of model hospital opportunities Incorporate PWC recommendations into value improvement plan Completed 'Grip and control' checklists adding actions for assurance Staff ideas generation
Risk of delayed patient treatment due to extended TAT in histopathology results (Risk ID 3688)	16	Continuing recruitment process and exploring locum agencies
Financial and Operational Risk to The Christie in relation to Transfer of Mid-Cheshire Foundation Trust Clinical Haem in 2025 (Risk ID 3697)	16	Recruit to all required medical posts either as NHS Locum or substantively

Operational Risks

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There are 8 Trust-wide 15+ risks in September

Description	Score	Controls
There is a risk to the Trust's ability to demonstrate compliance and adherence to its regulatory and statutory requirements in relation to the timeliness of incident management(Risk ID 3662)	16	Daily data reported to divisions and overseen at PSIRF delivery group & ERG.
There is a risk that patients awaiting stem cell treatments may experience delays(Risk ID 3752)	16	Review capacity plan within stem cell services
Risk of inadequate evacuation planning and response leading to patient and staff safety hazards, reputational damage, and financial penalty (Risk ID 3737)	15	Formalising partnerships with external emergency services, including fire, police, and ambulance services, to ensure they are integrated into the evacuation plan. Mutual aid agreements being put in place to provide additional resources or support in large-scale evacuation scenarios. This will ensure that, in case of an emergency, external agencies are prepared to assist in patient transport or provide backup care facilities
Risk to Treatment Delivery due to Workforce Recruitment & Retention in Aseptics (Risk ID 2959)	15	Coaching training for managers and mediation for selected staff to reduce conflict and internal disputes

Safe Staffing

The Christie NHS Foundation Trust

		DAY	NIGHT	Cumulative count over the month of patients at 23:59 each day	CHPPD (Care Hours Per Patient Per Day)
		Hours	Hours		
Registered Nurses	Total monthly PLANNED	16145	12655	5037	5.2
	Total monthly ACTUAL	14375	12031		
	Average Fill Rate %	89.0%	95.1%		
Care Staff	Total monthly PLANNED	10139	6408	5037	2.7
	Total monthly ACTUAL	7958	5839		
	Average Fill Rate %	78.5%	91.1%		
ALL Staff	Total monthly PLANNED	26284	19063	5037	8.0
	Total monthly ACTUAL	22333	17870		
	Average Fill Rate %	85.0%	93.7%		

Registered Nurses	DAY			NIGHT			Cumulative count over the month of patients at 23:59 each day	CHPPD (Care Hours Per Patient Per Day)
	Hours Planned	Hours Actual	% Fill Rate	Hours Planned	Hours Actual	% Fill Rate		
Critical Care Unit	2178	1923	88.3%	2065	1683	81.5%	149	24.2
Palatine Ward	3039	2814	92.6%	2430	2277	93.7%	873	5.8
Ward 10	2234	1706	76.4%	1481	1372	92.6%	755	4.1
Ward 11	1868	1742	93.3%	1460	1417	97.1%	818	3.9
Ward 12	1839	1680	91.4%	1472	1475	100.2%	813	3.9
Ward 4	1714	1720	100.4%	1460	1430	97.9%	787	4.0
Ward 2	989	882	89.2%	494	615	124.5%	307	4.9
Acute Assessment Unit	2284	1908	83.5%	1793	1762	98.3%	535	6.9
TOTAL	16145	14375	89.0%	12655	12031	95.1%	5037	5.2

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

Care Staff	DAY			NIGHT			Cumulative count over the month of patients at 23:59 each day	CHPPD (Care Hours Per Patient Per Day)
	Hours Planned	Hours Actual	% Fill Rate	Hours Planned	Hours Actual	% Fill Rate		
Critical Care Unit	594	222	37.4%	57	56	100.0%	149	1.9
Palatine Ward	1103	762	69.1%	774	678	87.6%	873	1.6
Ward 10	1925	1531	79.5%	1147	1084	94.5%	755	3.5
Ward 11	1590	1136	71.4%	975	864	88.6%	818	2.4
Ward 12	1429	1387	97.1%	1002	865	86.3%	813	2.8
Ward 4	1822	1480	81.2%	1442	1345	93.3%	787	3.6
Ward 2	461	439	95.2%	276	276	100.0%	307	2.3
Acute Assessment Unit	1215	1001	82.4%	735	671	91.3%	535	3.1
TOTAL	10139	7958	78.5%	6408	5839	91.1%	5037	2.7

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

Patient Experience

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Positive feedback received…..

“Patient grateful for the surgeon's expertise - both surgically and during consultations. The approach gave the patient courage to be brave and positive at one of the toughest times in their life and for that she will always be thankful.”

“Patient emailed regarding his positive experience from the car park staff, to the porters, to the reception staff, who were all helpful. His consultant did an excellent job of explaining the way forward with an exemplary mix of empathy , humour and professionalism. All in all, he had 10 out of 10 experience at the trust."

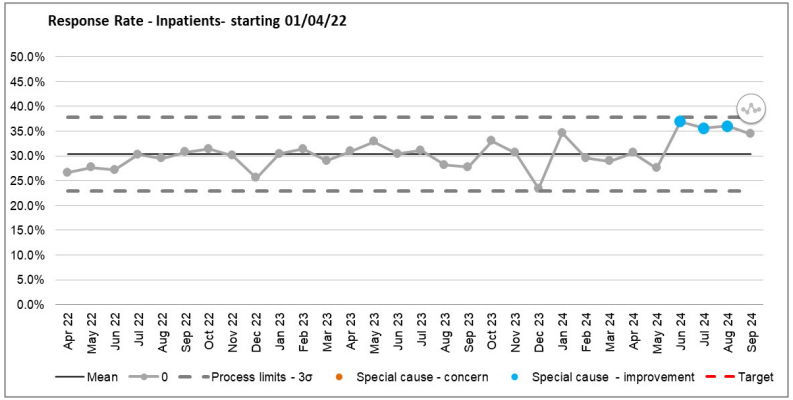
“Patient wanted to pass on huge thanks to staff member in the information centre, who when the patient arrived to collect a wig voucher spent time to talk through the hair loss journey and how it can affect people, the patient was glad for the staff members kind and empathetic words. Also huge thanks to staff member in the wig room who knew exactly what would suit the patient.”

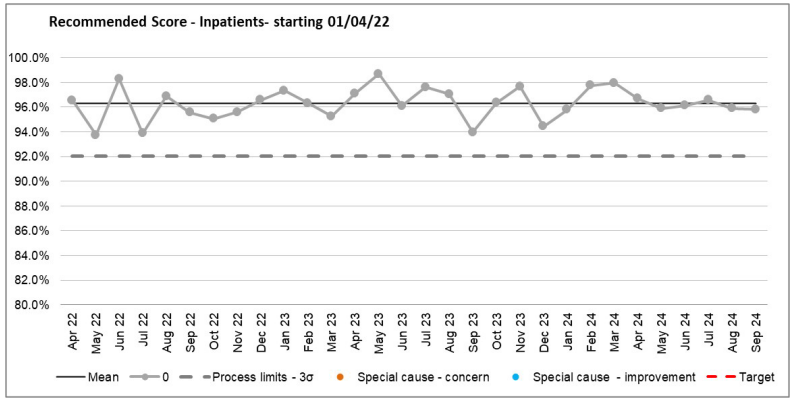
“Positive feedback regarding pharmacist who was fantastic with patient's family who were collecting a prescription for their mum as it was new treatment the family said it was daunting as they did not know what to expect with new regimen and lot of info to digest. Pharmacist took family into a side room and went through each drug explained how and when to take it and went through the side effect management, patient and friendly and very knowledgeable and answered all questions and made a positive impact on their day.”

Friends & Family Test

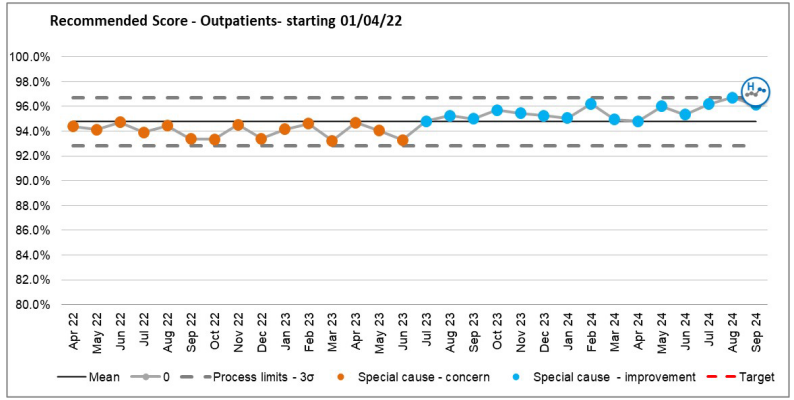
The Christie NHS Foundation Trust

Monthly Summary

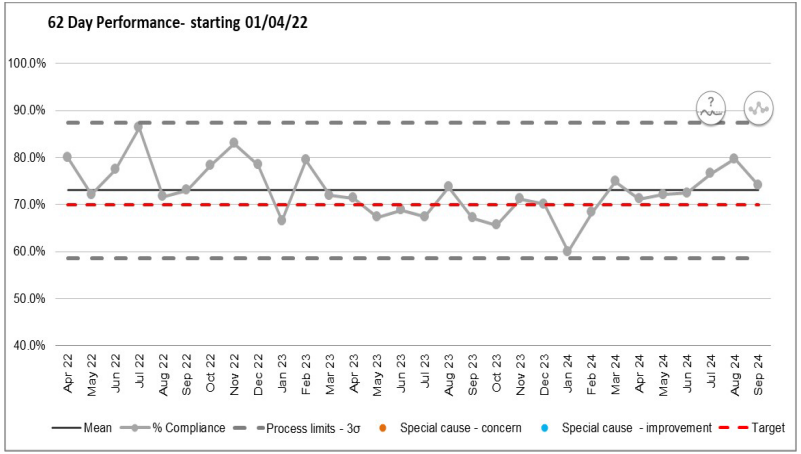


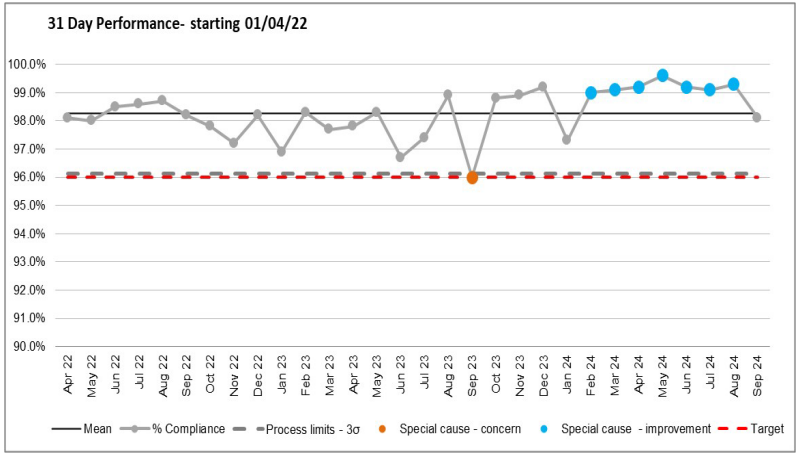


The Inpatient response rate continues to show improvement in recent months. Both the recommended percentage scores for Outpatients and Inpatients remain high with Outpatients maintaining a sustained period of high performance.



Cancer Standards





National Standard	Standard	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
62 Day	70%	65.6%	71.2%	70.1%	60.0%	68.3%	74.9%	71.2%	72.1%	72.4%	76.6%	79.7%	**74.0%**
28 Day FDS	75%	85.0%	66.7%	81.8%	52.9%	60.0%	55.0%	81.3%	75.0%	100.0%	91.7%	86.4%	**90.0%**
24 Day Internal	85%	68.3%	69.6%	73.2%	63.7%	71.7%	76.4%	71.5%	72.2%	74.6%	78.1%	78.4%	**70.7%**
31 Days	96%	98.8%	98.9%	99.2%	97.3%	99.0%	99.1%	99.2%	99.6%	99.2%	99.1%	99.3%	**98.1%**
18 Weeks - Incomplete	92%	97.7%	97.2%	97.2%	97.3%	98.0%	98.0%	98.4%	98.7%	98.1%	98.0%	97.9%	**98.1%**

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

Cancer Standards – Health Inequalities Analysis

62 Day Treatments between 01/04/2023 – 31/08/2024 analysed by gender, age and ethnicity.

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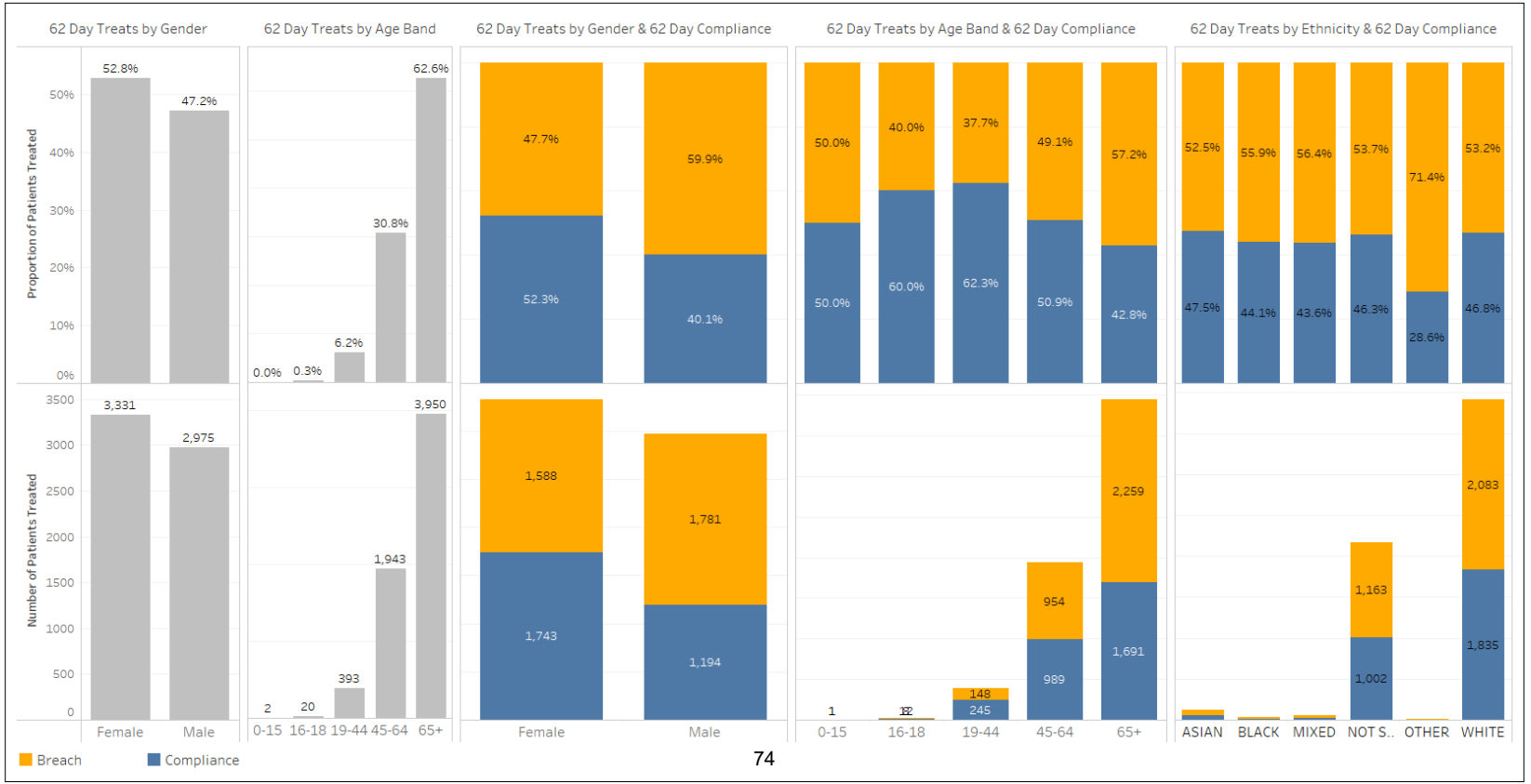

Cancer Standards – Health Inequalities Analysis

62 Day Treatments between 01/04/2023 – 30/09/2024 analysed by gender, age and ethnicity.

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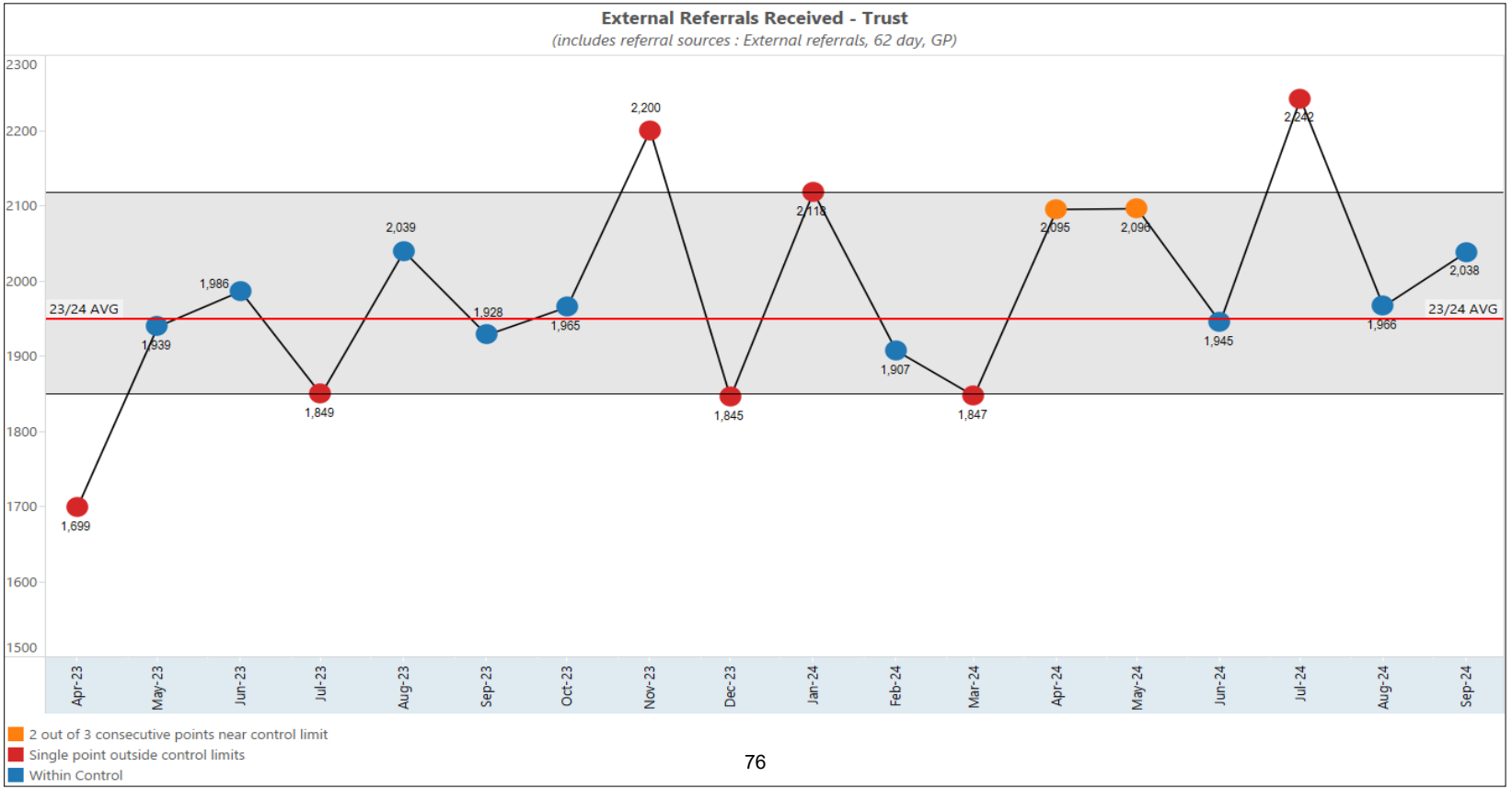
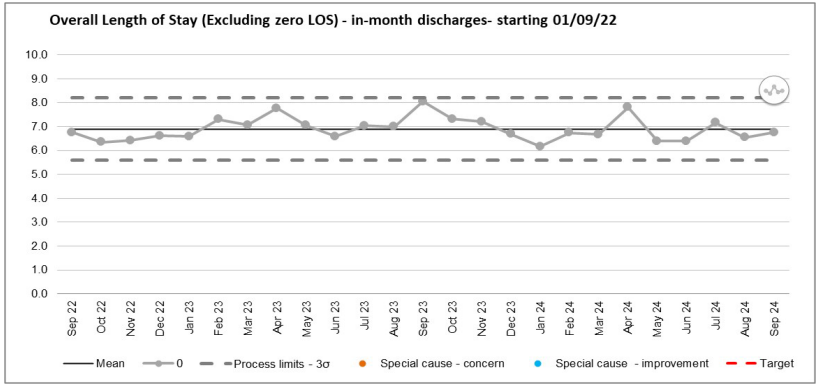
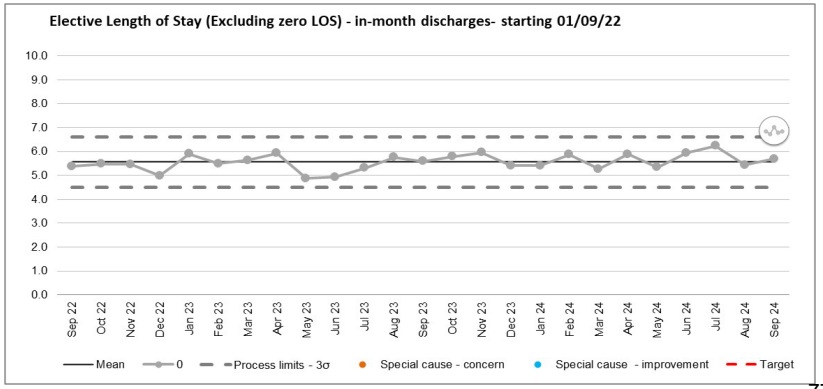
Referrals Analysis

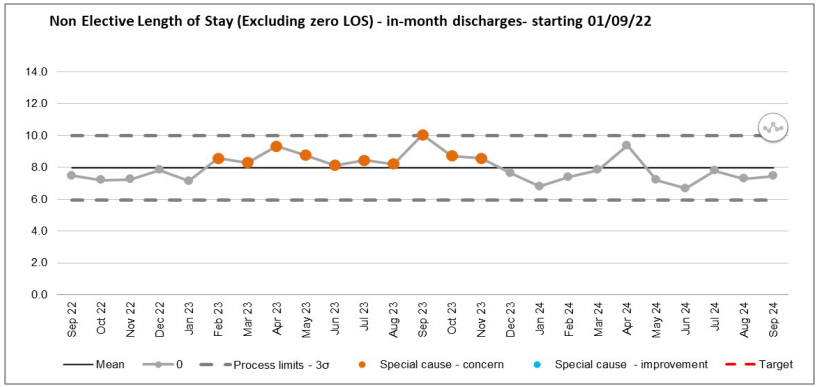


Length of Stay



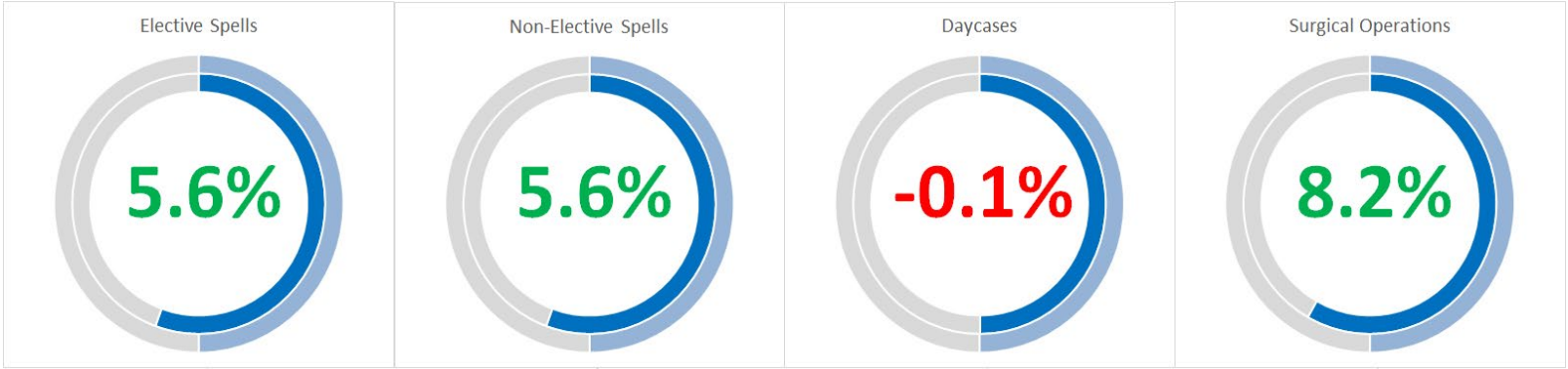
Overall length of stay, elective and non-elective spells continue to be well within control limits.





Activity – YTD Progress

Trust level activity - progress against YTD plan



YTD ACTIVITY ACHIEVED
YTD PLANNED ACTIVITY
**subject to validation*

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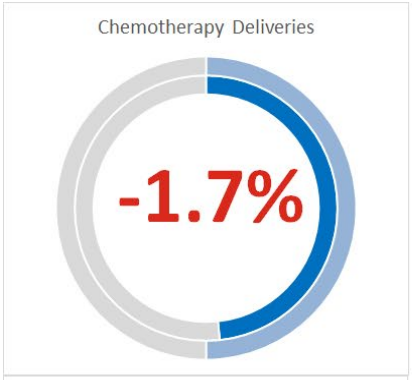
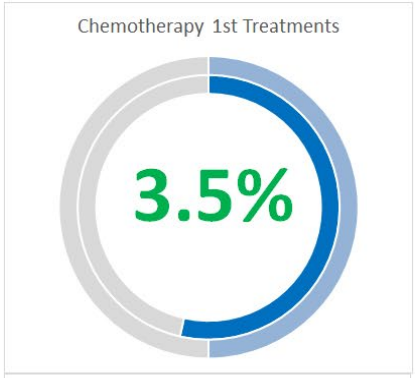
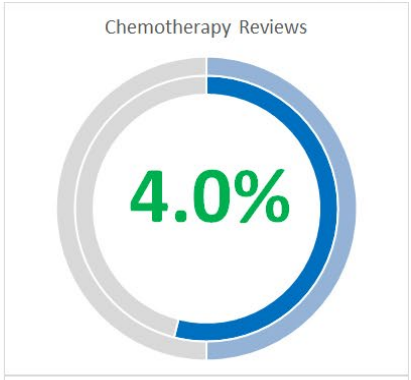
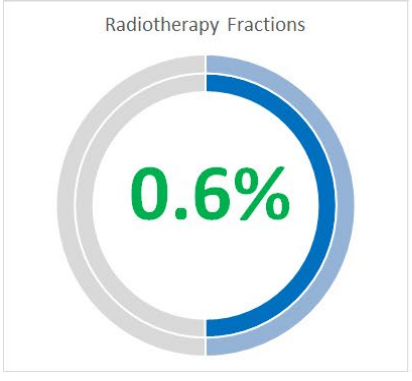
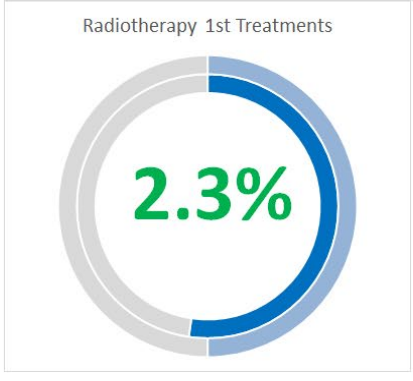
Activity – YTD Progress

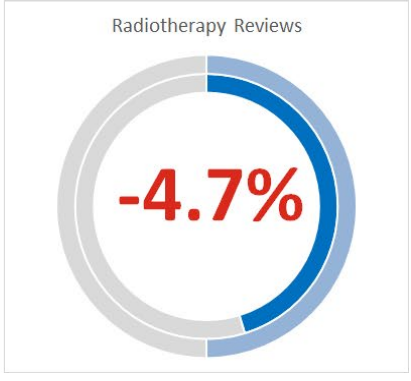








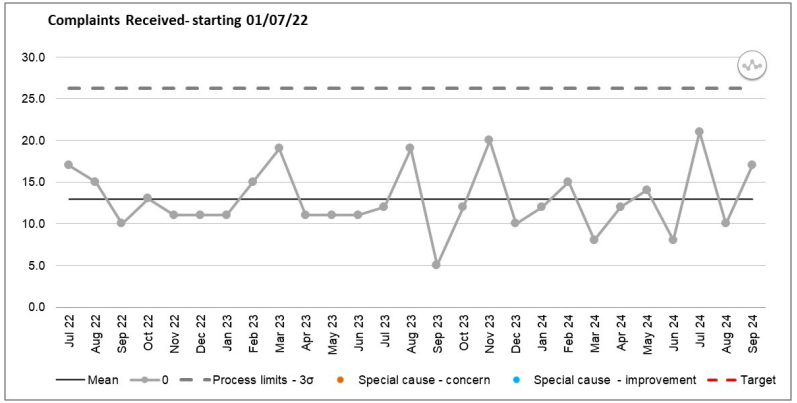


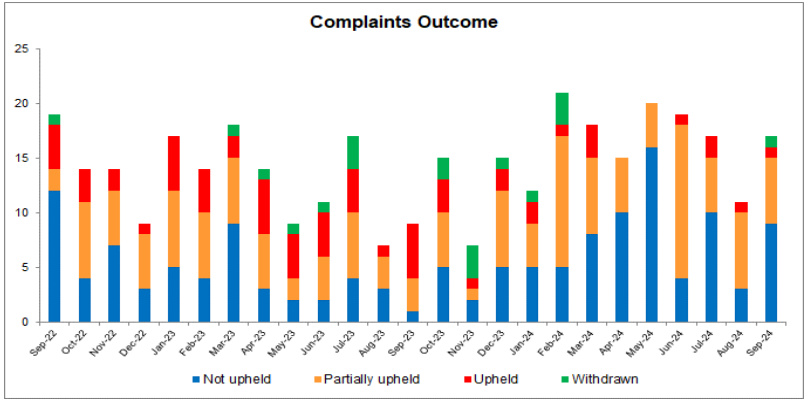


SACT 1st Treatments, 1st Fractions & Surgical Operations do not form part of the 24/25 activity plan and are used as supplementary guides to productivity. The figures are monitored against the previous year's month for comparison.

YTD ACTIVITY ACHIEVED
YTD PLANNED ACTIVITY
subject to validation

Complaints





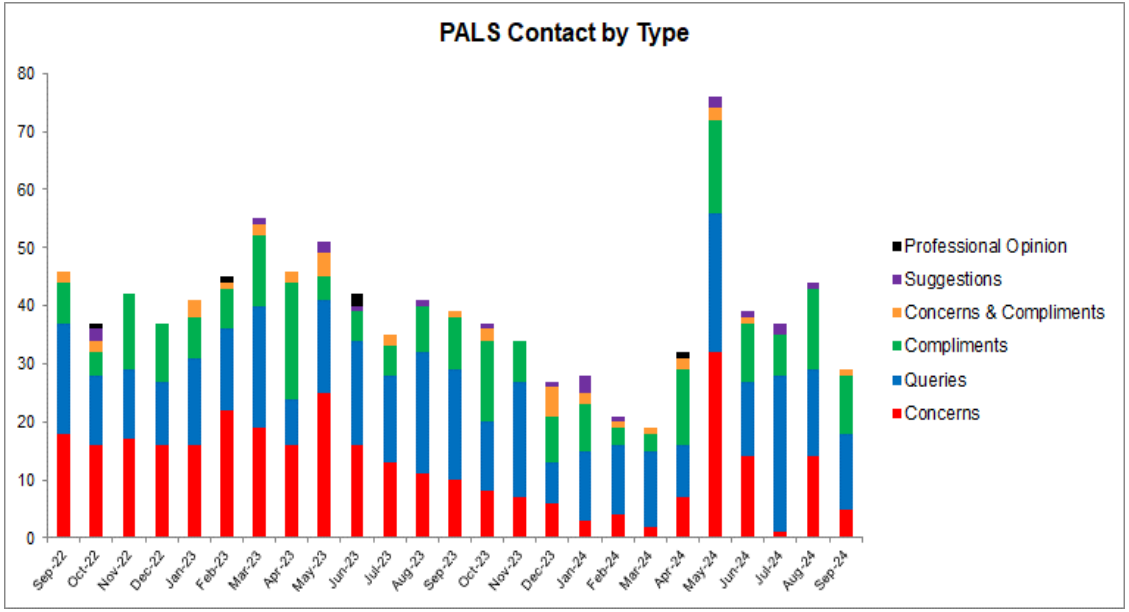
17 new complaints received in September 2024

17 complaints were closed in September 2024

Ombudsman Cases
Complainants have the right to refer their case to the Parliamentary and Health Service Ombudsman (PHSO) if they are not satisfied it has been resolved by the Trust.

0 cases were referred to the PHSO in September 2024. 3 active cases in total with the PHSO.

PALS



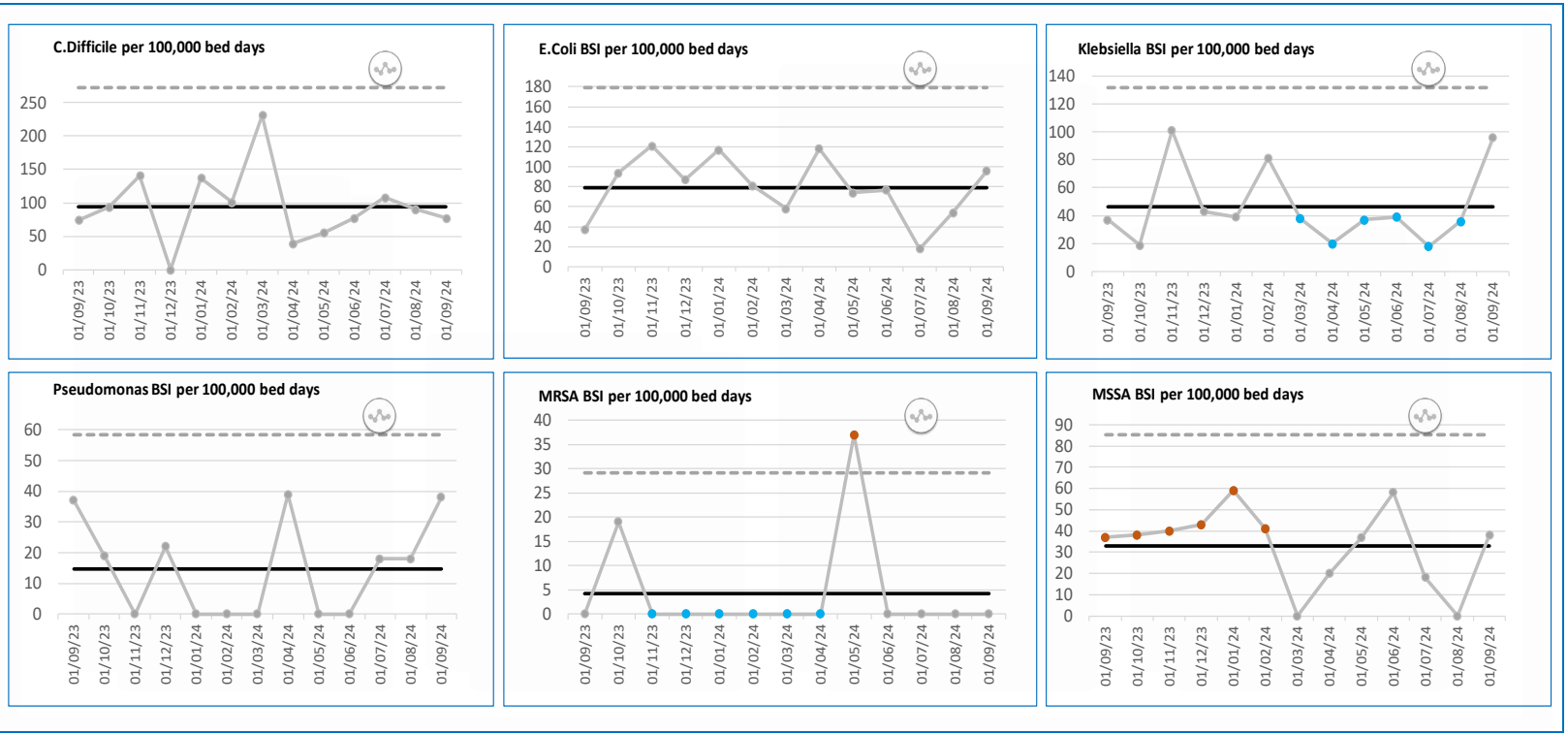
29 PALS contacts have been received in September 2024.

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

Healthcare Associated Infections

The Christie NHS Foundation Trust

HCAIs per 100,000 bed days – rolling 12 months



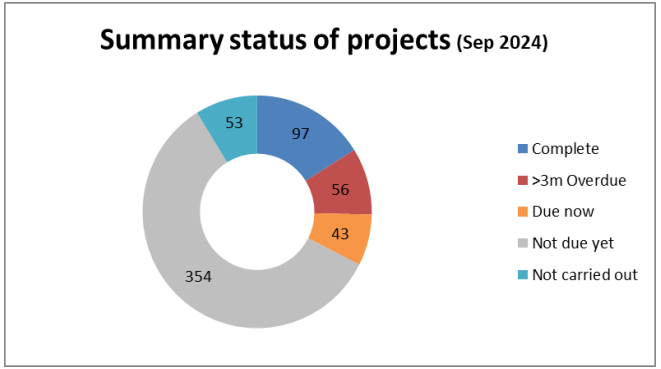
All cases reviewed through IPC team and reported through NIPR.

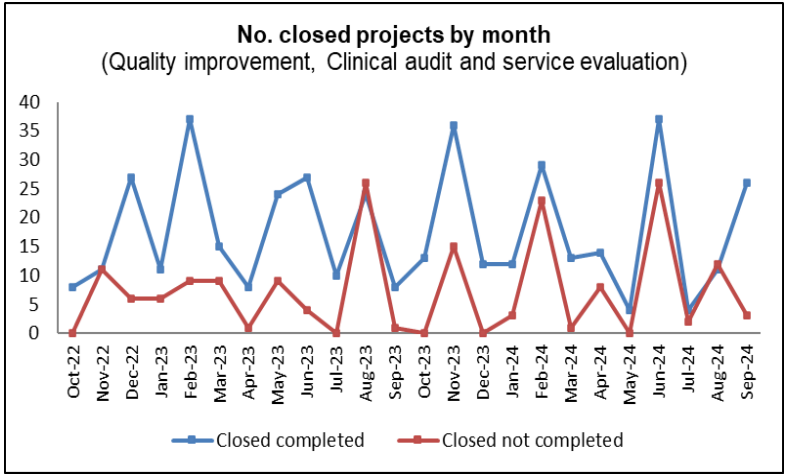
Quality Improvement & Clinical Audit

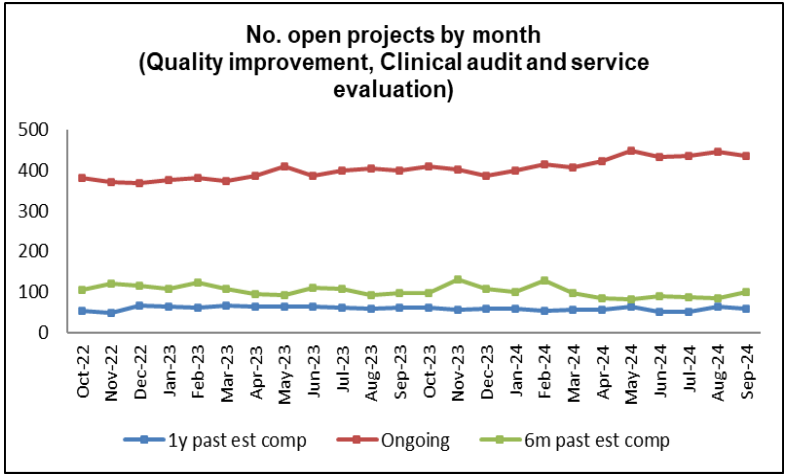
The Christie NHS Foundation Trust

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

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







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HR Metrics Sickness

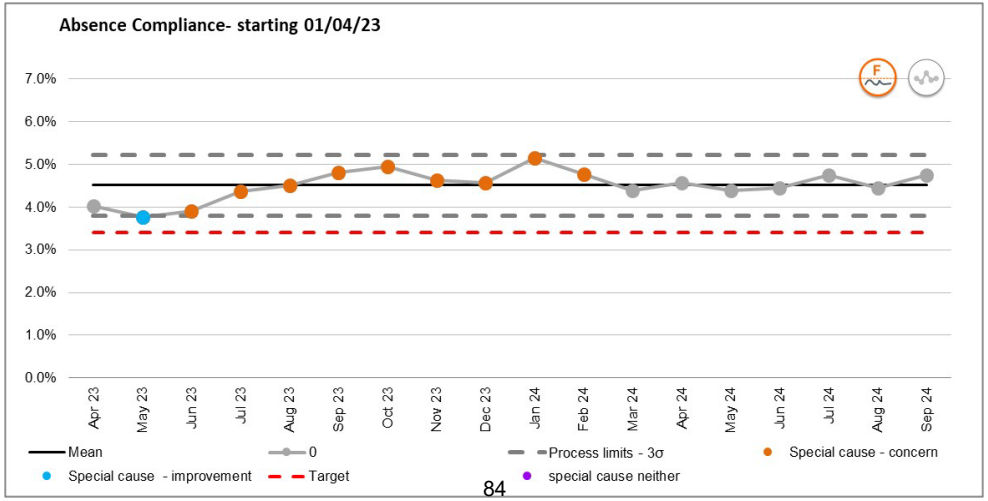
The Christie NHS Foundation Trust

Performance | Absence

Monthly Sickness %	Yearly Sickness %	Absences Ended	Long Term	Short Term
4.74%	4.66%	474	45	429

Trust Overview

Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
4.95%	4.63%	4.56%	5.16%	4.77%	4.39%	4.56%	4.39%	4.45%	4.75%	4.44%	4.74%



HR Metrics – Mandatory Training

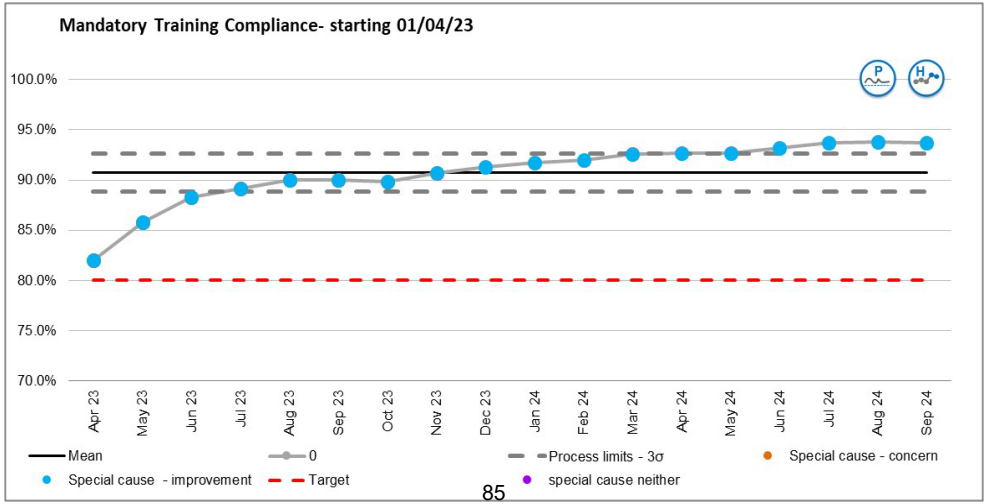
The Christie NHS Foundation Trust

Performance | Mandatory Training

Overall Compliance	Modules Outstanding	F2F Compliance	Online Compliance
93.68%	3,579	82.64%	94.76%

Trust Compliance

Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
89.85%	90.68%	91.30%	91.75%	91.96%	92.60%	92.67%	92.68%	93.19%	93.73%	93.79%	93.68%



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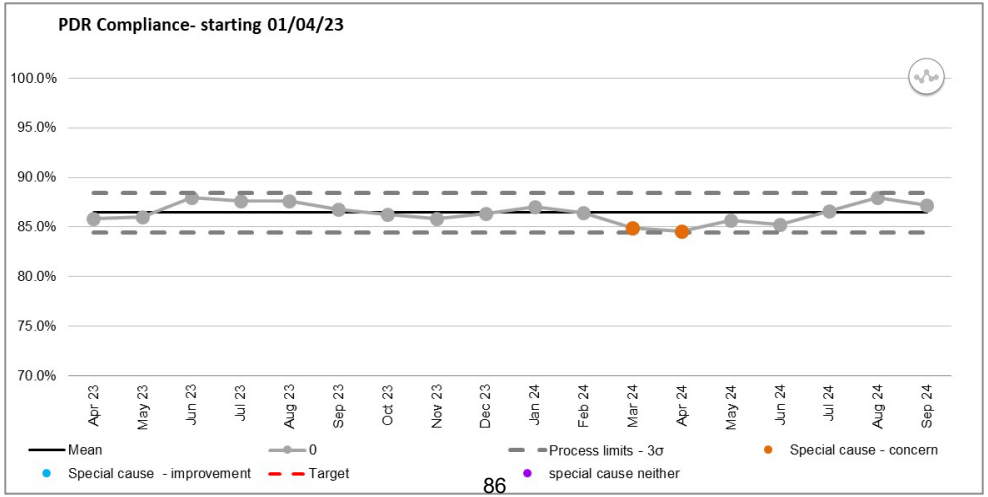
HR Metrics - PDR

The Christie NHS Foundation Trust

Performance | Appraisal

Overall Compliance	Expired Appraisals	Appraisals Due Soon
87.18%	407	576

Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
86.27%	85.84%	86.33%	87.04%	86.45%	84.94%	84.61%	85.68%	85.28%	86.63%	87.95%	87.18%



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Workforce Metrics - Turnover

NHS
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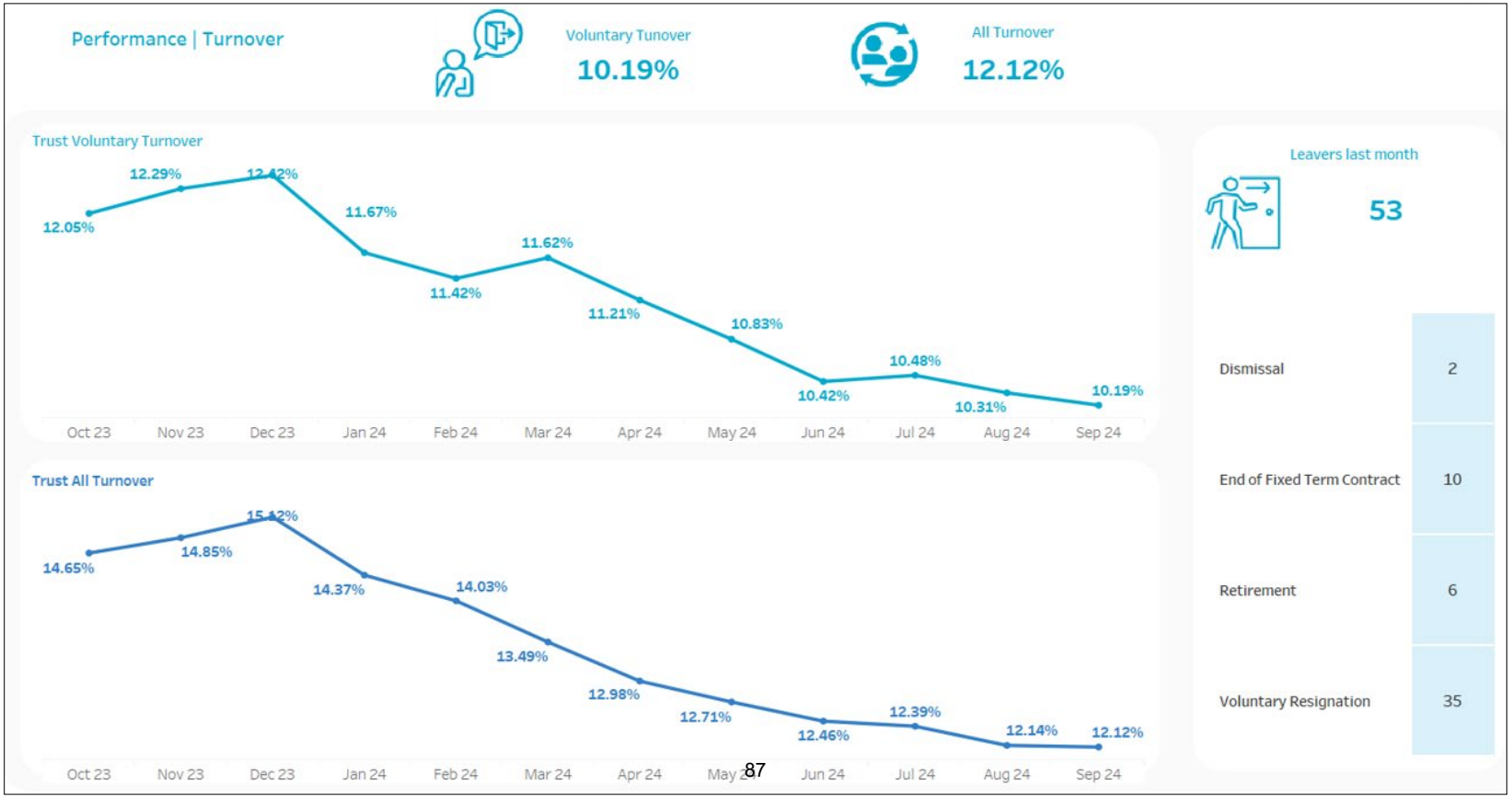
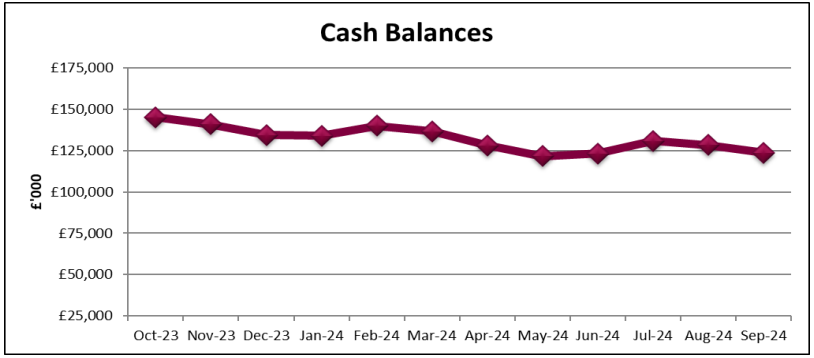
NHS Foundation Trust



Finance (Executive Summary)

The Christie NHS Foundation Trust

Month 6 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(423,369)	(211,670)	(216,406)	(4,736)
Other Income	(75,495)	(37,703)	(35,871)	1,832
Pay	231,872	115,858	109,382	(6,475)
Non Pay (incl drugs)	241,409	120,699	126,874	6,175
Operating (Surplus) / Deficit	**(25,584)**	**(12,816)**	**(16,020)**	**(3,204)**
Finance expenses/ income	30,932	15,463	17,769	2,307
(Surplus) / Deficit	**5,349**	**2,646**	**1,749**	**(897)**
Exclude impairments/ charitably funded capital donations	(12,355)	(6,174)	(6,068)	106
Adjusted financial performance (Surplus) / Deficit	**(7,006)**	**(3,528)**	**(4,319)**	**(791)**



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

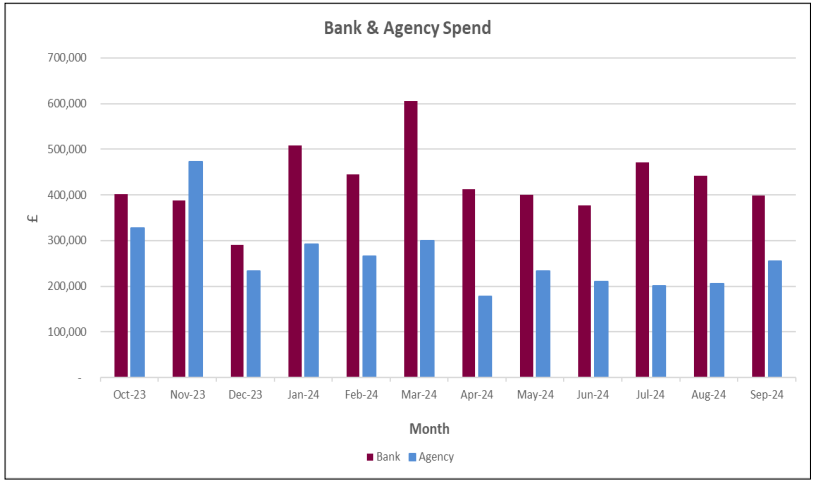
I&E

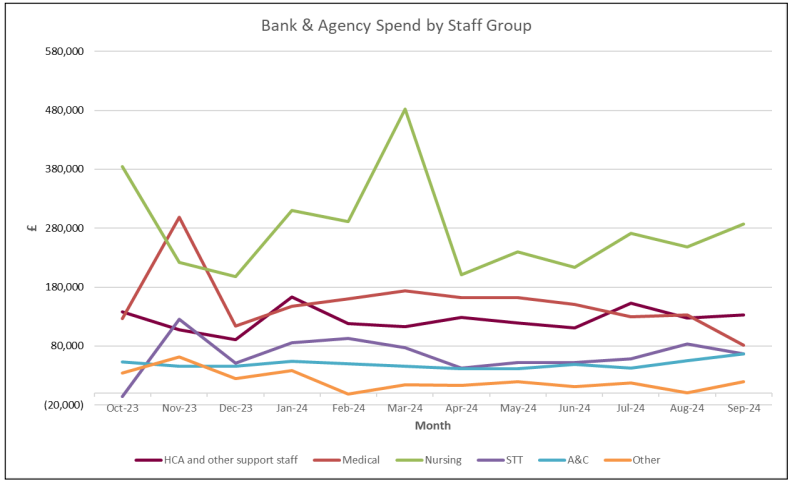
- The Trust is reporting a surplus at the end of M6 of (£4.3m) against a M6 YTD plan of (£3.5m), which gives a month 6 variance of (£0.8m) better than plan.
- Identified in year VIP is £19.6m against a target of £21.4m. The VIP shortfall against the recurrent VIP target is £3.5m, where £10.5m has been identified against a target of £14.0m. Non-recurrent identified VIP is £9.1m against a target of £7.4m, overachieving by (£1.7m).

Balance sheet / liquidity

- The cash balance is £123.7m.
- Capital performance to month 6 was (£0.9m) below the revised plan submitted to NHSE&I in June 24. The Trust has spent 86% year to date of the capital plan.
- Targets have been achieved against payment of creditors paid within the 30-day Better Payment Practice Code target.

Finance (Expenditure)

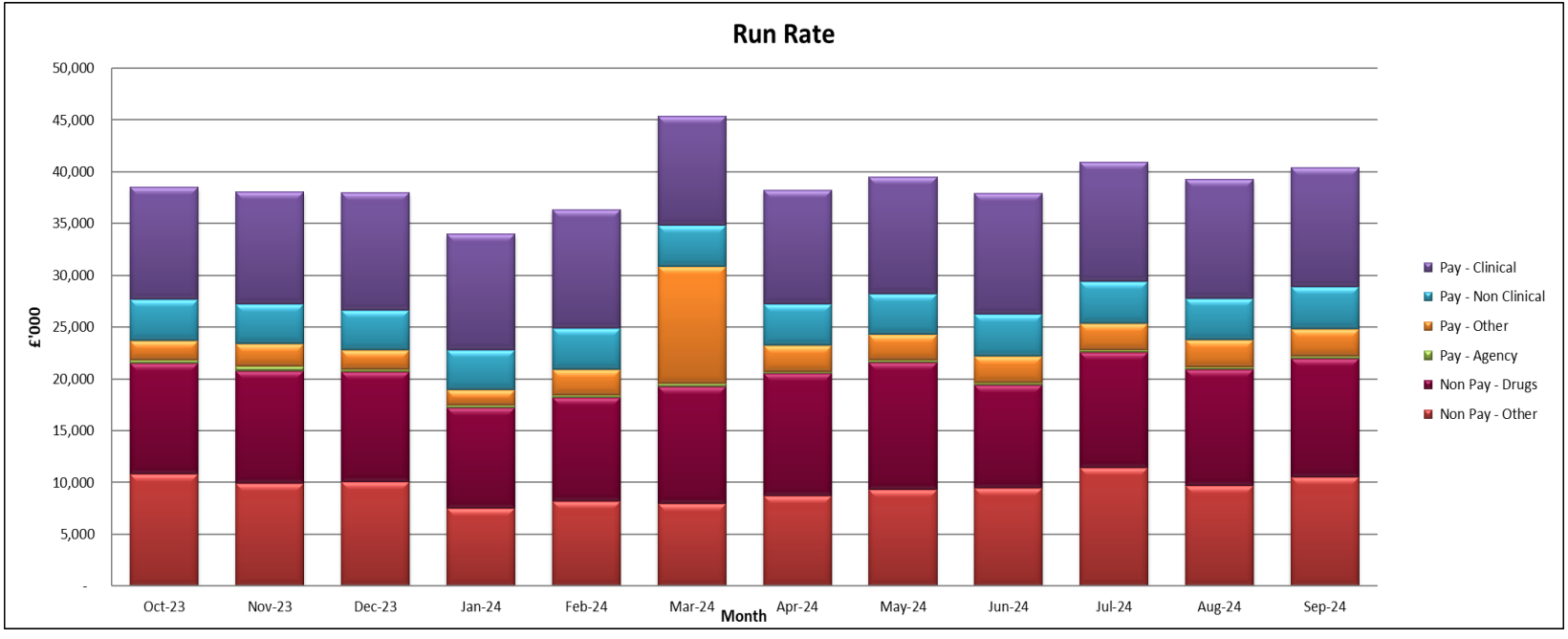




Agency spend in month 6 is £0.3m, £1.3m YTD, the spend is predominantly on nursing agency in-month, whilst vacancies are being actively recruited to.

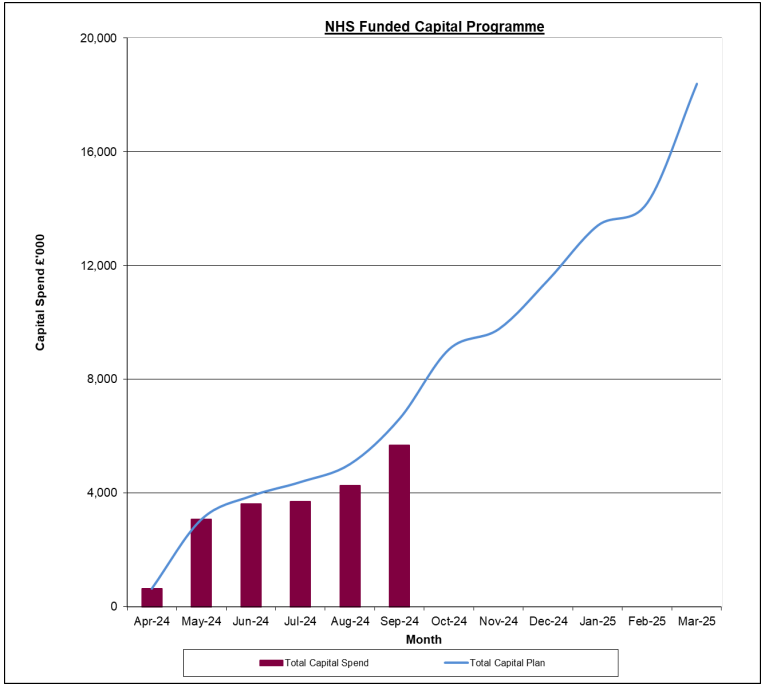
Alongside this, bank usage has remained largely the same in month 6 compared to month 5, giving £0.4m in month 6 and £2.5m YTD.

Finance (Expenditure)



- Drugs spend in month 6 is £11.4m, an increase from month 5 of £0.2m.
- Pay – Clinical spend in month 6 is £11.4m, consistent with Month 5.
- Pay – Other spend in month 6 is £2.6m, a decrease of (£0.1m) from month 5.
- Pay – Agency spend in month 6 is £0.3m, an increase from month 5 of £0.1m
- Key elements of 'Non-Pay Other' spend consist of clinical supplies and services, premises and infrastructure costs and R&I costs.

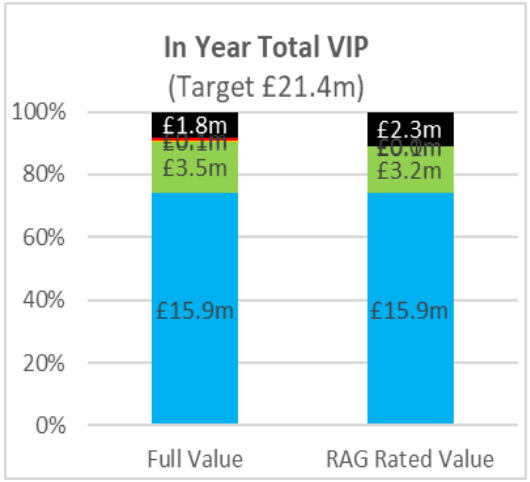
Finance (Capital)

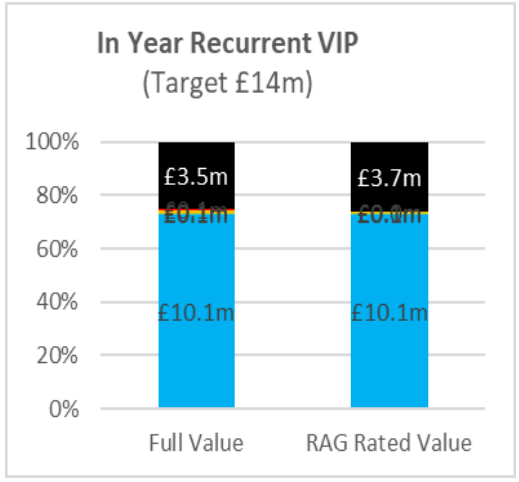


Capital spend to month 6 was £0.9m below the revised plan submitted to NHSE&I in June 24. This is lower than the plan position due to the TIF Ward position.

The Trust has incurred £5.7m on capital schemes to month 6, primarily on the TIF ward refurbishment as well as ongoing digital projects and small replacement assets. The Trust has spent 86% year to date of the capital plan.

Finance (CIP)





Total In year CIP

- Total identified VIP schemes reported are £19.6m (£9.1m non recurrent / £10.5m recurrent).
- Risk adjusted identified schemes value £19.1m, leaving £2.3m unidentified.

Recurrent

- Schemes totalling £10.5m have been identified recurrently against a recurrent target of £14.0m.
- This leaves £3.5m of the recurrent target unidentified.

Risk Rating:	Delivering	Low	Medium	High	Unidentified
RAG Weighting:	100%	90%	50%	10%	

	Annual					Year to Date		
	Target	Identified value	Unidentified Value	Identified RAG Value	Unidentified RAG Value	Target	Delivered	Variance
Total VIP	**£21,396k**	**£19,594k**	**£1,802k**	**£19,073k**	**£2,323k**	**£10,714k**	**£10,714k**	**£0k**
Recurrent VIP	£13,996k	£10,502k	£3,494k	£10,319k	£3,677k	£7,012k	£5,055k	(£1,957k)
Non-Recurrent VIP	£7,400k	£9,092k	(£1,692k)	£8,754k	(£1,354k)	£3,702k	£5,659k	£1,957k