The Christie
NHS Foundation Trust

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

Agenda

Patient story / clinical presentation: Acute Oncology Service - Sabrina Scott, AACU ward manager, Jess Goulding, Advanced Clinical Practitioner and Sophia McGough, Hotline manager and a patient
30 mins

	Public items	Decision		Lead	Page	Timing
24/24	**Standard business**					
a	Apologies			Chair		
b	Declarations of interest			Chair		
c	Minutes of previous meeting – 27th June 2024	Approve	*	Chair	2	5 mins
d	Action plan rolling programme, action log & matters arising	Review	*	CEO	8	
25/24	**Performance & finance**					
a	Trust report	Review	*	Execs	11	15 mins
b	Value Improvement Programme	Review	*	COO	30	10 mins
26/24	**Culture**					
a	Health Inequalities self-assessment	Review	*	DCEO	34	10 mins
b	Cultural Audit	Review	*		45	5 mins
27/24	**Strategy**					
a	Trust Planning 2025/26	Review	*	DoS	51	10 mins
28/24	**Governance (regulatory / statutory compliance)**					
a	Board assurance framework	Review	*	CEO	55	5 mins
b	Reports from Committees - Workforce Assurance Committee June 2024 - Quality Assurance Committee June 2024 - Audit Committee July 2024	Review	*	Committee chair	62	10 mins
c	Governance Review action plan update	Review	*	DCEO	78	5 mins
d	GM ICB System	Review	*/p	DoS	88	15 mins
29/24	**Any other business**					

Papers for information only

Integrated performance, quality & finance report Month 5	*	
Quality Strategy Update	*	

Date and time of the next meeting
Thursday 31st October 2024 at 12:45pm

D/CEO	Deputy / Chief Executive Officer	COO	Chief Operating Officer	*	paper attached
ECN	Executive Chief Nurse	DoS	Director of Strategy	v	verbal
DoF	Director of Finance			p	presentation

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Public meeting of the Board of Directors
Thursday 27th June 2024 at 12.45 pm
Seminar Room 4/5, Education Centre

Present:	Chair:	Edward Astle (EA), Chairman Roger Spencer (RS), Chief Executive Officer Tarun Kapur (TK), Non-Executive Director Robert Ainsworth (RA), Non-Executive Director Alveena Malik (AM), Non-Executive Director Grenville Page (GP), Non-Executive Director Prof Kieran Walshe (KW), Non-Executive Director Dr Diana Tait (DT), Non-Executive Director Prof Chris Harrison (CJH), Deputy CEO Vicky Sharples (VS), Executive Chief Nurse Sally Parkinson (SP), Executive Director of Finance 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 Geraldine Vesey (GV), Communications officer Dr Kantappa Gajanan, Staff Governor

Clinical presentation: Lung Cancer Services at The Christie - Kathryn Banfill, Clinical Oncology Consultant, Rachael Wooder, Lead Dosimetrist Radiotherapy and Doug Fovargue, patient

KB introduced the service and explained that lung cancers are increasing in prevalence & treatment options are increasing and are complex. Radiotherapy, immunotherapy and chemotherapy is all utilised and people are living longer.

Radiotherapy for lung cancer was described for lung patients including stereotactic ablative body radiotherapy that requires fewer higher doses. There is a move to treatment closer to home for patients for radiotherapy & systemic anti-cancer treatment (SACT).

The Macclesfield site was described and the services offered. Medical students from the University at Crewe come for a rotation at Macclesfield. Trials have also opened at Macclesfield – REFINE & FOXTROT. SACT is also delivered at home.

KB asked her patient, Doug Fovargue (DF) some questions about his treatment. DF was diagnosed in Spring 2019 following feeling unwell. He was referred to Macclesfield and given a CT scan that confirmed he had lung cancer. He was then referred to The Christie and biopsied. Immunotherapy & chemotherapy were prescribed in July 2019. He described the video consultations during Covid as being very effective and working well. Doug experienced the care at Macclesfield before & after the new centre opened. He shared that he thought the new facility is absolutely fantastic, really superb.

Doug described that he had a number of side effects but then became quite poorly, contacted the Hotline and was asked to come in. He had colitis that meant treatment stopped. The cancer was stable from that point. He experienced some hormone issues due to the immunotherapy.

DF was followed up after stopping immunotherapy, had regular scans and it was found that there was some recurrence in the adrenal gland – surgery followed and this was successful. Had this at Wythenshawe, was keyhole and was in for 2 nights. Recent scans have been done and DF will

have the next appointment on a video call as the preferred way to speak to KB. He felt the ability to do appointments in this way was excellent.

Was given written information on treatment, risks & side effects that was very useful.

TT asked about Doug's expectations once referred. He thought he'd have to come to the main site but could have care & treatment nearer to home.

RA asked if there was anything that could have been done better. Doug responded that there is a lot of anxiety around waiting for scan results – the shorter this can be the better as it's very hard. It is normally 2 to 3 weeks and that's very difficult. There's a balance of wanting the correct result and waiting. Appreciative of the complexity.

There are some current issues around availability of scans from Macclesfield in GM.

EA asked about the admin around appointments and if that worked smoothly. Doug confirmed that he chased an expected appointment that he never got a letter about, but this was from East Cheshire not The Christie.

Noted that it would be better to receive an email and liked the MFT patient app.

RW introduced herself and noted that the targeted lung checks have impacted the service by picking up lung cancer at a much earlier stage which opens up more options for treatment including SABRE – this has impacted the requirement for the service.

Have launched One Stop Lung Cancer clinic – for surgery, chemotherapy and radiotherapy – reviewed by an MDT team to assess best options for treatment where it is not clear. Patients see all the specialists in one session and can ask questions of everyone.

Impact of the one stop clinic was outlined around time to treatment, uptake of prehab, radical radiotherapy uptake and frailty interventions. All positive impacts and feedback has been very positive from the patients. Challenges include cross-site working and information overload on the day.

Improving radiotherapy – advanced radiographers are being upskilled to help planning. Saves clinician time. Advanced practitioners have improved patient delays.

AI is being used to contour scans – this is only as good as the people using it, it doesn't take into account variation. There is a risk of automation bias and staff have to be trained to use this, examples were shown of where it can go wrong. Manual editing must be used.

KB outlined the work of the radiotherapy research group in refining the use of AI in heart avoidance. We continue to use anonymised patient data to advance this. There's interest commercially to use our research.

In summary there are more patients, earlier interventions and increasingly complex treatment. Using AI is progressing and advancing.

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

Item		Action
18/24	**Standard business**	
a	**Apologies**	
	Sarah Corcoran (SC), Non-Executive Director, and Dr Neil Bayman (NB), Executive Medical Director	
b	**Declarations of Interest**	
	None noted.	
c	**Minutes of the previous meeting – 25th April 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.	
19/24	**Performance & Finance**	
a	**Trust Report**	
	• RS noted that there is a typo in the exec summary that will be corrected around finance information. • Dashboard presented and there is work to develop this further. • Key patient quality indicators for May 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 2. • Value improvement programme was highlighted as was the new CQC single assessment framework. • Overall very good performance at month 2.	
b	**Value Improvement Programme**	
	• Now called value improvement not cost improvement – drive for efficiency and quality. • Plan for 2024/25 presented – 5% target. • Plans to deliver outlined alongside the methods to do this. • Clinical example included to demonstrate efficiency and saving. Teams are improving pathways which benefits patients and drives savings. • Question on previous problem in achieving recurrent savings, this must be the focus. Long term strategic view required, not just in year. • Trying to create a continuous sustainable model that keeps delivering. The programme is underpinned by a quality impact process. We have additional resource to help deliver this. • Worked example really helps to bring this to life. Engagement section is ambitious and good to understand this is a long-term approach. • Consideration as to whether this needs to be a separate risk from the overall financial risk. Confirmed that this will continue to be scrutinised by Board. • Question on where the greatest inefficiencies are. Response that the pathways need focus as do variable pay. • Description of how this work fits into business as usual in a holistic approach. • Clinical / finance joint working is key – are defined programmes of work as well as continuous programmes. • Deep dives into budgets continue. • Salary costs and headcount are not the focus here. • There are inevitable inbuilt inefficiencies with some aspects of care closer to home so this must be closely controlled. • Board gave full support to the approach.	

c	**GM ICB presentation on undertakings**	

	• GM ICB have requested that the Board understand the issues in the system and the formal undertakings that are in place. This is a deterioration from SOF 3 and a significant problem for the system.
	• Engagement with stakeholders is part of the requirement of the undertakings (regulatory activity).
	• RS drew the Boards attention to the requirement in the undertakings to produce an improvement plan. Areas of focus in the plan include all areas;
	  ◦ Leadership & capability
	  ◦ Performance & assurance
	  ◦ Financial sustainability
	  ◦ Quality
	• Governance arrangements / mechanisms are also outlined.
	• Level of confidence in the process discussed. Aware that this is not easily delivered.
	• Discussion on structural changes in GM and whether there will be additional pressure on The Christie.
	• No clear concerns described.	

20/24	**Culture**	
a	**Cultural development plan**	
	• This provides an interim update on progress that includes communication with staff and identification of specific actions / products that are being produced. • The engagement process is on going and targets different areas of the Trust. • There will be further research / survey activity to probe sub-cultures in the Trust. • This will form the substance of the People & Culture Plan and come through the WAC but will also be discussed at Board. • Big wins include very good medical staff engagement as well as light being shone on specific areas where work is being done. • We have a much better understanding of the issues in the organisation and where effort needs to be made. • The organisation has a much better ownership of improving culture, not just that this is about a central function delivering. • Board acknowledged that this is an issue across the NHS and there are national organisations supporting change in specific groups. • We need to be very clear that we will implement our policies. • PSIRF is about just culture and learning – SACT treatment team brought in a review around vulnerability around getting things wrong that demonstrated the openness and importance of being able to ask for support to improve care. • Time to be arranged for Board on culture in future development programme. • Further thinking taking place on how we know if we have been successful – need to continue to get expert advice to support this.	

21/24	**Strategy**	
a	**Green Plan**	
	• Board noted that they have previously seen the draft Green Plan and inputted into the final version. • This is the formal approval of the final Green Plan following extensive review. • Governors have also been part of the process. Issues around skills and resource were acknowledged. • Approved.	
22/24	**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. • The Board noted the addition of an additional risk relating to patient confidence. • Responsible committee for Finance Risk will be changed to the Board and Culture risk is jointly reviewed by the Board and WAC.	
b	**Annual Report & Accounts 2023/24**	
	• The Board noted that they have followed the normal process through the committees to get to the formal approval of the AR&A. • The Joint Audit & Quality Assurance committee was held yesterday, the external auditors confirmed a clean audit with minor recommendations. • Positive messages from GT around the process of the audit. Approved.	
c	**Reports from Committees**	
	Audit Committee April 2024	
	• Minutes from April verbally reported at the last meeting. This focused on preparation for the year end and closure of the accounts. • The success of this was reflected in the joint meeting that took place yesterday.	
d	**Annual update regarding CQC requirements**	
	• New approach to regulation outlined by the CQC. • Evidence required comes under a number of quality standards. • Recent inspection of the IR(M)ER standard was very successful. • Staff engagement and preparation is on going to ensure that we can evidence the care we provide. • We need to be aware that we need to provide evidence against the standards and we are preparing staff to do this effectively. • External scrutiny will be sought to assess how we are preparing to help us do	

	what we need to do. • Training for the Board is being worked up as part of Board Development. This will include external expertise on the revised approach. • Peer led assessment & best practice and learning from this and evidencing that we do this is key. • Board will look at evidence at QAC and WAC on continuing progress.	
e	**Board effectiveness review outcome report 2023/24**	
	• The report was noted and actions will be updated following discussion. • It was noted that performance is shared with Board through their papers and the comment on 'more performance' relates more to the discussion in the meetings.	
f	**Board skill mix**	
	• EA updated Board on the continuing discussions on what is needed in further NED appointments. • SC has been appointed. • The discussion has continued, and reflections have been made on the loss of expertise and experience of the NHS and the health system in general. • There is an opportunity to do something about this following the most recent recruitment process.	
23/24	**Any other business**	
	• No further items raised.	
	Date and time of the next meeting	
	Thursday 26th September 2024 at 12:45pm	
	Papers for information only	
	Integrated performance, quality & finance report Board allocation framework	

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Agenda item 24/24d

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

C Culture P Performance S Strategy G Governance

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
September 2024		C	Patient story	CEO	To hear a patient story	Clinical presentation
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	For information
		C/P	Health inequalities self -assessment	DCEO	Review	26/24a
		P	Value Improvement Programme	COO	Review	25/24b
		P	Quality Strategy update	ECN	Review	For information
		G	Governance Review action plan	Review	CEO	28/24c
		G	GM ICB undertakings	GMICB	Presentation	28/24d
Development session		C	Inclusive Culture Board development session			18.09.2024
October 2024		C	Patient story	CEO	To hear a patient story	
		P	Integrated performance & quality report and finance report	COO	Monthly report	
		S	EDI Strategy	DoW	For approval	
		G	Standing Financial Instructions (SFI's)	DoF	Approve	
		P	Education Strategy update	DoE	Review	For information
		C	Freedom to speak up guardian	FTSUG	Annual report	
Planning & Development Day		S	Planning with Divisional leadership teams			
		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	
		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	

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
February 2025 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
	Annual reporting cycle	G	Letter of representation & independence	Chair	Circulate	By email
	Annual reporting cycle	G	Register of directors interests / FPPT annual declaration	Chair		
	Annual reporting cycle	G	Declaration of independence (non-executive directors only)	Chair		
Planning & Development Day		S	Planning			
		S	Strategy deep dive			
March 2025		C	Patient story	CEO	To hear a patient story	
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	
	Annual reporting cycle	G	Annual reporting cycle	Executive directors	Approve	
		P	Research & Innovation Strategy Update	DoR	Annual review	
		C	Culture Audit review	DCEO/DoW	Approve	
		G	Annual BAF review / risk deep dive	CEO	Review	
		C	Staff survey initial results	DoW	Note	
		P	Health inequalities performance review	DCEO	Review	
	Annual reporting cycle	G	FPPT Compliance report	Chair	Approve annual compliance	
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	Board effectiveness review	Chairman	Undertake survey	
		C	Freedom to speak up Guardian report	FTSUG	6 monthly update	
	Annual reporting cycle	P	Risk Management strategy 2023-24 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	
		P/S	Quality Strategy annual update	ECN	Review	
		G	Board effectiveness review	Chair	Report	
		P	Value Improvement Programme	COO	Review	
	Annual reporting cycle	G	Annual report, financial statements and quality accounts (incl Annual governance statement / Statement on code of governance)	EDoF	Approve	
July 2024 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
Planning & Development Day		S	Service Review day with senior leadership teams			
August 2024 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email

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Agenda item: 24/24d

Action log following the Board of Directors meetings held on

Thursday 27th June 2024

No.	Agenda	Action	By who	Progress	Board review
		No actions noted			

The Christie
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Meeting of the Board of Directors
September 2024

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

The Christie
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Trust Report
September 2024

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%+			97.1%	N/A
1,6	31 day compliance (%)	96%			99.2%	N/A
1,6	Patients meeting the faster cancer diagnosis standard (%)	75%			86.4%	N/A
1,6	MRSA bacteraemia infection (attributable) (N)	TBC			0	2
1,6	Clostridium difficile infection (attributable) (N)	TBC			5	19
Finance and Use of Resources						
6	Financial sustainability / liquidity (days)	>21	21 to 14	<14	99	99
6	Overall financial position (% variance to control total)	0% below plan	0 - 10% below plan	>10% below plan	(6.7%)	(15.6%)
6	Recurrent VIP performance (% achieved)				62%	62%
6	Current cash balance (£'000)				£130,728	£130,728
6	Exchequer capital spend to date (variance to plan %)	within 10%	10 to 20%	>30%	92%	15%
6	Average length of time debt is outstanding	<15	>16 - 20	>20	8	8
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 (%)				87.9%	86.9%
7	Mandatory training (%)	>80%		<79%	93.8%	93.5%
Research						
4	New trails open per month (N)	>10	9-10	<8	10	68
4	No. patients consented into studies (N)	>250	200-249	<199	165	1132
4	Christie Sponsored research: new studies opening (N)	>2	1	0	1	7
4	Research patient experience - % strongly agree they would participate in research again	90%	75-89%	<75%	75%	75%
Education						
3	To be confirmed				TBC	TBC
System						
1,6	62 days (%)	>70%		<69.9%	77.8%	N/A
1,6	Priority patients not admitted (deferred)	0		>1	0	0
Digital						
4	Customer Satisfaction score of "Good"	>95%	85-94%	<85%	97.8%	97.7%

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 August show no significant adverse variances or issues for escalation. We remain a high reporting, low harm organisation.
- Performance in August for the 62-day consolidated cancer standard was 77.8% 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 August (Month 5) is a (£3.5m) surplus against a planned (£2.9m) surplus. This is a favourable variance of (£0.6m) to plan.
- Key financial performance indicators in month 5 show one variance which is the level of recurrent VIP identified being £10.5m identified so far against a £14m annual target.
- Workforce indicators for August show a slight decrease in sickness absence rates.
- PDR performance has improved from July's position. Mandatory training has improved from July's position and remains well above the set standard.
- We have updated the project arrangements following approval of actions from the cultural audit engagement process and communications have been shared with staff.
- Christie Education projects and events continue to support our aims and objectives.
- Capital schemes are progressing to plan across the Trust.
- On 12th September, Lord Darzi of Denham published the findings of his investigation of NHS performance in England

Quality of Care

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

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

There were 10 complaints in August which is lower than the monthly average. The number of contacts with the Patient Advice and Liaison Service (PALS) service in August was 44 which is slightly higher 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 of Radiology being unable to provide an appropriate turnaround time for reporting of images due to insufficient resource (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 June against the 2 key cancer standards was;

- The 62-day consolidated standard was 77.8% against a threshold of 70%.
- We achieved 86.4% 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 99.2% against a target of 96%.

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

In August we received confirmation from the Head of Cancer Datasets at NHS England that the Trust has reached or exceeded 80% stage completeness in the Cancer Outcomes and Services Dataset (COSD) submissions for the whole of 2023. A letter from the National Clinical Director for Cancer and the Chair of the COSD Governance Board is appended to this report (appendix 1).

Financial Performance

Revenue: Financial performance is ahead of plan by £0.6m as illustrated in the table below. The Trust has a £3.5m surplus against a £2.9m planned surplus position. The better than plan position is primarily due to:-

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

Month 5 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(423,369)	(176,387)	(178,340)	(1,954)
Other Income	(75,466)	(31,403)	(30,851)	551
Pay	231,889	96,568	90,943	(5,625)
Non Pay (incl drugs)	241,363	100,562	104,921	4,360
Operating (Surplus) / Deficit	**(25,584)**	**(10,660)**	**(13,327)**	**(2,668)**
Finance expenses/ income	30,932	12,888	14,852	1,964
(Surplus) / Deficit	**5,349**	**2,229**	**1,525**	**(704)**
Exclude impairments/ charitably funded capital donations	(12,355)	(5,148)	(5,016)	132
Adjusted financial performance (Surplus) / Deficit	**(7,006)**	**(2,919)**	**(3,491)**	**(572)**

The pay underspend of £5.6m is illustrated in the graph below :-

- This is reduced by £1.9m as this relates to hosted services, including GM Cancer, R&I and Charity-funded posts, which has an equivalent reduction in income.
- The remaining variance of £3.7m is due to vacancies predominantly in clinical posts.

Capital: The capital plan for 2024-25 has been agreed at £17.4m. The Trust has spent £4.3m to month 5, 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, £8.9m has been delivered against a target of £8.9m.

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	£0.6m ahead of plan
Capital: Capital expenditure against plan	£0.6m **under** plan
VIP identified (recurrent) against target of £14m	£10.5m identified
Debtor days compared to 15-day target	9 days
Cash balance	£128.3m
Better Payment Practice Code (95% target)	98%

Workforce

Our workforce performance indicators show mandatory training compliance and personal development plan rates are both above (better than) thresholds at 93.8% and 87.9% respectively. Sickness absence rates decreased slightly in August to 4.41% (threshold of 3.4%). The overall turnover for the Trust has reduced from last month to 12.11%. These issues and the associated plans for improvement have been considered by the Workforce Assurance Committee.

A new wellbeing support guide has been developed to help raise visibility of all wellbeing offers at the Trust. This is in response to feedback of 'patchy' levels of awareness during the independent cultural audit meaning that some colleagues may not be accessing support that they need. This is due for sign off at Workforce Committee in Sept 2024, after which it will be available digitally and in printed form, distributed at key events and placed in high traffic spaces such as staff rooms and the Engagement Stall.

A leadership and management competency framework has been developed and is now in the engagement phase with key stakeholders. It outlines the knowledge, skill and behaviour expectations for people managers and will apply to leaders at all levels. It articulates the transition points between different stages of leadership, where support is often most needed to ensure success. The framework illustrates good management and leadership practice to aid development. It will be discussed at Workforce Committee in September, visually designed during October, and launched by November 2024. This links to Theme 5 of the Trust People & Culture Plan (under 'leadership transitions framework').

A new one-day skills session has been designed and launched using NHS Elect. Aimed at those with people management responsibilities, the 'leading curious conversations: adopting a coaching approach' session develops more flexible conversational skillsets. Take the next step in your leadership journey and make a lasting impact on your team and your patients.

Research

Our Researchers have been sharing the impact of their research at the European Society for Medical Oncology in Barcelona and World Conference on Lung Cancer, San Diego. September is Blood Cancer Awareness Month. Research and Innovation, we will be in the Main Outpatient Department Reception on 26th and 27th September to showcase the research we undertake in Blood Cancers. Staff and the general public are welcome to attend.

To celebrate the halfway mark through the CRUK Manchester Centre, a Celebration Event on 7th October will enable attendees to learn more about latest innovations from our five research themes: Cancer Early Detection, Digital Cancer, Experimental Cancer Medicine, Integrative Pathology, and Radiotherapy BioAdaption.

Three Clinicians are among 15 outstanding individuals announced by Manchester Academic Health Science Network Honorary Clinical Chairs for 2024. They are:

- Jon Bell, Consultant Interventional Radiologist
- Mike Dennis, Consultant Haematologist
- Cynthia Eccles, Head of Radiotherapy Research and Development

Martin McCabe, Professor of Paediatric & Young Oncology was promoted to Chair.

We held a Research Divisional Town Hall on 4th September, with 158 attendees. This focussed on engagement with the draft People and Culture Plan and gave opportunities for feedback on the draft.

The Manchester Cancer Centre BioBank has had an audit by Mersey Internal Audit Agency and was given an assurance opinion as substantial. The audit observed there is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.

Education

As the academic year begins, Christie Education looks forward to welcoming a broad range of health professions learners across a breadth of disciplines from our partner institutions. Approximately 2250 students undertook placement activity with us during the 2023-24 year, across face to face and digital clinical placements at the Christie and Christie@ sites. This

new year consolidates our new partnerships with the Universities of Buckingham and Edgehill.

International academic activity includes the growth of our integrated partnership with Peter Mac in Australia, with excellent progress in joint exchange fellowships for Nursing, Medical and Allied Health professional colleagues that support service and career development. Both institutions are exploring jointly delivered, co-created education with a strong focus on patient engagement.

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.

In parallel with this, a 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.

Work continues on the formation of a 20-bedroom ward in the former Trust Administration and Digital floors. All works with the exception of some minor snags have been completed and works have commenced on equipping the ward for use. In parallel, proposals are being developed to undertake a minor refurbishment to the remaining wards in this financial year.

External View of Lift and Stair Core

Public Access Gardens

Reception and Circulation

Typical En-suite

Typical Single Bedroom

Clean Utility Room

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) has been drafted and will be presented to the Board in September. Design and decant works have been paused pending approval of the OBC.

The replacement of the CT SIM2 is complete and the replacement of the Superficial Treatment unit remains ongoing. Proposals to replace the remaining pharmacy robot are being developed as well as the first phase of the multi-year linac replacement programme.

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

Greater Manchester System

An update of GM escalations is included on the September Board of Directors agenda.

Louise Shepherd has been appointed as our NHSE Regional Director for the Northwest and starts on 3rd November. Louise is the current Chief Executive of Alder Hey Children's Hospital NHS FT and the chair of NHS England's Children and Young People's Transformation Programme Board. Louise brings a wealth of experience and expertise.

Regulation and Governance

On 12th September, Lord Darzi of Denham published the findings of his investigation of NHS performance in England. The review was commissioned by Wes Streeting, Secretary of State for Health and Social Care, on 11 July 2024.

The investigation draws on evidence from a wide range of stakeholders, along with insights from an expert reference group comprising over 75 organisations contributing to the health service today.

The report focuses on 'diagnosing' the problems facing the NHS, and provides an assessment of access to care, quality of care, and the overall performance of the health system.

While specific policy recommendations are outside of the scope of the investigation, Lord Darzi sets out the major themes to be explored in the upcoming ten-year plan for the NHS, led by the Department of Health and Social Care. These include re-engaging staff and empowering patients, shifting care closer to home, driving productivity, investing in technology, and contributing to economic prosperity.

NHS Providers briefing on The Darzi Review is appended at Appendix 2.

National Disease Registration Service (NDRS), NHS England
The Leeds Government Hub, 7 - 8 Wellington Place, Leeds, LS1 4AP
0300 303 5678
www.ndrs.nhs.uk | ndrsenquiries@nhs.net

THE CHRISTIE NHS FOUNDATION TRUST
550 WILMSLOW ROAD
WITHINGTON
MANCHESTER
M20 4BX

Date August 2024

CONGRATULATIONS: Cancer Staging Data Completeness

FAO: Chief Executive Roger Spencer

Early stage at diagnosis is one of the most important factors affecting cancer outcomes, and promoting earlier stage at diagnosis is one of the key aims of the NHS Long Term Plan. Measuring and monitoring national staging data is crucial to understand variation and deliver evidence-based decisions. To support this aim, NHS England is aiming for NHS Trusts to report cancer stage for all stageable cancers at diagnosis.

We are pleased to inform you that your trust has reached or exceeded 80% stage completeness in the Cancer Outcomes and Services Dataset (COSD) submissions for the whole of 2023. As you are aware we have been monitoring this work and your provider has made a significant achievement and is directly attributable to the hard work of clinical and administrative staff in your cancer teams. We would like to express our sincere thanks for this work.

This staging data enables national cancer registration and the associated analyses of cancer care pathways at regional, national, and international levels. We are now able to use this data to further support cancer programmes for early-stage diagnosis.

Thank you for supporting this work.

Kind regards,

Professor Peter Johnson
National Clinical Director for Cancer
NHS England and NHS Improvement

Mr Andy Nordin
Chair, COSD Governance Board
Consultant Gynaecologist / Subspecialist Gynae Oncologist
East Kent Gynaecological Oncology Centre

cc:

- Marie Lockwood, marie.lockwood1@nhs.net, Cancer Performance Manager
- Catherine Ohara, catherine.ohara1@nhs.net, Head of Analytics
- Fabio Gomes, fabio.gomes2@nhs.net, Lead Cancer Clinician

- Paul Stacey, Data Liaison Manager, National Disease Registration Service
- Sarah Stevens, sarah.stevens1@nhs.net , Associate Director, National Disease Registration Service
- David Maloney, david.maloney@dhsc.gov.uk, Department for Health and Social Care
- Michelle Rigozzi, mrigozzi@no10.gov.uk, No10 Delivery Unit (Health)
- Sam Hinks, samantha.hinks@nhs.net, NHS England Cancer Program team

The Darzi Review: Independent investigation of the NHS in England

On 12 September 2024, the Rt Hon. Professor the Lord Darzi of Denham published the findings of his investigation of the NHS in England. The investigation was commissioned by Wes Streeting, Secretary of State for Health and Social Care, on 11 July 2024.

This briefing highlights the key points from the document and includes NHS Providers' view.

Introduction

As set out in the terms of reference, Lord Darzi's investigation focuses on 'diagnosing' the problems facing the NHS, and provides an assessment of access to care, quality of care, and the overall performance of the health system. Given this remit, the health of the nation and social care system are only explored in so far as they impact on the NHS.

The report details the current performance of the NHS, and builds a picture of a system where long waits are the norm, quality of care is mixed, productivity is low, and too great a share of the budget is spent in the acute sector.

The key drivers of these challenges around performance are described as: funding austerity and capital starvation; the impact of the Covid-19 pandemic and its aftermath; lack of patient voice and staff engagement; and management structures and systems. The 2012 Health and Care Act is also noted as a costly and distracting process.

Lord Darzi views the structural reforms brought in by the 2022 Health and Care Act as a positive step but calls for greater clarity around the roles and responsibilities of integrated care boards (ICBs). Likewise, NHS managers are viewed as essential to tackling some of the challenges outlined in the document, with a call for greater investment to ensure there are 'more and better leaders.'

While specific policy recommendations are also outside of the scope of the investigation, Lord Darzi sets out the major themes to be explored in the upcoming ten-year plan for the NHS, led by the Department of Health and Social Care (DHSC). These include to:

- Re-engage staffing and re-empower patients.
- Lock in the shift of care closer to home by hardwiring financial flows.
- Simplify and innovate care delivery for a neighbourhood NHS.
- Drive productivity in hospitals.
- Tilt towards technology.
- Contribute to the nation's prosperity.
- Reform to make the structure deliver.

Key findings: performance of the NHS

Health of the nation

An ageing population is the most significant driver of increased demand for healthcare. For example, the majority of people aged 65-74 will have at least one long-term condition and 40% will have two or more. However, many of the social determinants of health - such as income, housing, education – are also moving in the wrong direction. Pressures in social care, and cuts to funding for the public health grant, are also crucial context for the health of the nation and the performance of the NHS.

Access to NHS services

The NHS's constitutional standards, which sit at the heart of the social contract between the NHS and the public, are not being met. Performance on access to care has been declining, for example:

- Nearly 10% of all patients are now waiting for 12 hours or more at A&E.
- The 62-day target for referral to first treatment for cancer has not been met since 2015.
- As of June 2024, more than 1 million people were waiting for community services, including 500,000 people waiting over a year, 80% of whom were children and young people.
- As of April 2024, about 1 million people were waiting for mental health services.
- Autism and ADHD are areas of particular concern, with long waits for assessment and treatment despite increased activity. For instance, since 2019 the number of adults and children waiting at least 13 weeks for an autism assessment has increased by 65% and 77% a year respectively.

Quality of care in the NHS

There is a mixed picture on quality of care. For the most part, people receive high quality care from the NHS. There have been improvements in patient safety in recent years, with more error-free care in hospitals and a reduction in the number of suicides in inpatient mental health facilities. New

innovations, like virtual wards, are also contributing to reductions in attendances and admissions to hospital, as well as reduced length of stay in hospital.

However, clinical negligence claims are at record levels, and significant areas of concern remain. For instance:

- Maternal deaths have been increasing since the Covid-19 pandemic. Complexity in care needs has been increasing, but numbers of midwives has fallen, and the recommendations from a series of inquiries have not been universally adopted.
- Children and young people's physical and mental health has been deteriorating over recent years, and there are challenges in young people being able to access acute, mental health and community services.
- Mortality rates for people with serious mental illnesses has been increasing, and there is a lack of suitable accommodation for inpatients.
- There is scope to reduce avoidable deaths from cancer, cardiovascular disease and suicide.

Health protection, promotion and inequalities

Health protection

Infectious diseases, including Covid-19, remain a major challenge for all health systems. Despite important progress in the UK, there is further to go to tackle the threat of anti-microbial resistance.

Health promotion

More needs to be done to tackle obesity and regulate the food industry. Childhood obesity rates for 10-11 year olds have risen, and the prevalence of diabetes across the whole population has increased from 5.1% in 2008 to 7.5% in 2022. Cuts to the public health grant have contributed to this and have been deeper in more deprived areas. A focus on public health is key to reducing premature mortality and time spent in ill-health, as well as on reducing pressures on the NHS and strengthening the economy.

Health inequalities

People living in poverty are getting sicker and accessing services later. People who live in the most deprived areas of England are twice as likely to wait more than a year for non-urgent treatment. This leads to more acute illness and poorer outcomes. There are also concerning disparities in access to care and outcomes for homeless people, those with learning disabilities and carers.

Where and how the money is spent

During the pandemic productivity in the NHS declined far more significantly than the economy as a whole or the wider public sector. It remains below 2019 levels.

Underinvestment in care delivered in the community is contributing to high demand on hospitals. Although successive governments have promised to shift care away from hospitals and into the community, expenditure and staffing numbers have grown faster in the acute sector than elsewhere, while the number of health visitors fell by 20% between 2019 and 2023. This is reinforced by performance standards focused on hospitals, not primary, community or mental health services. Likewise, single-year budgets reinforce the status quo.

Although ICBs have duties around improving population health, roles and responsibilities remain unclear, hindering progress on population health management.

Health and prosperity

At the start of 2024, 2.8 million people were economically inactive due to long-term sickness, and more than half of the current waiting list for inpatient treatment are working age adults. Being in work is good for wellbeing, having more people in work grows the economy, and creates more tax receipts to fund public services. Improving access to care is a crucial contribution the NHS can make to national prosperity.

Key findings: drivers of performance

Funding, investment and technology

Spending growth sat at around '1% per year in real terms' during the 2010s, much lower than the long-term average of 3.4%. In 2018 the government committed to increasing spending by 3.4% annually for five years. However, actual increases fell at just under 3% for 2019-2024, and this did not include capital spending, medical training, nor any increase in public health expenditure.

In terms of per capita spending, the UK spends about $5,600 per person on health, similar to the EU15 average but below countries where English is predominantly spoken and the Nordic countries.

Capital investment peaked in 2009, declining sharply after this date This led to deteriorating infrastructure, outdated technology, and a significant maintenance backlog. During the 2010s, a substantial capital gap opened between the UK and other countries. A shortfall of £37 billion in capital investment has further exacerbated these issues.

The report outlines key figures demonstrating the strain on capital investment, including:

- The backlog maintenance bill now stands at more than £11.6 billion.
- £4.3 billion was taken from capital budgets between 2014-15 and 2018-19 to cover in-year revenue deficits.
- 20% of the primary care estate predates the founding of the health service in 1948.

The impact of the Covid-19 pandemic

The NHS entered the Covid-19 pandemic after a decade of austerity and underinvestment, which left it with fewer resources and lower resilience compared to other high-income health systems. The pandemic strained health systems globally, but the NHS was particularly impacted, with higher excess mortality rates and significant drops in routine care. Overall, hospital discharges in the UK decreased by 18% between 2019 and 2020, the largest drop among comparable countries.

Key points include:

- Low resources and squeezed capacity: The NHS had higher bed occupancy rates and fewer doctors, nurses, and beds than comparable health systems.
- Severe impact on routine care: The NHS delayed or cancelled more routine care than other systems, with significant drops in procedures like hip and knee replacements. For example, hip replacements in the UK fell by 46% compared to an OECD average of 13%,
- Increased mortality: The UK had higher excess mortality rates compared to other countries. The health of the population had also deteriorated in the years leading up to the pandemic – making it less resilient to infectious disease since it was less healthy going into the pandemic.
- Reduced healthcare access: Reductions in interactions with primary care due to lockdowns meant fewer physical and mental health problems could be identified, hindering early detection and management of health conditions.
- Mental health: The pandemic significantly increased the need for mental health services.

The NHS's current state is heavily influenced by these factors, with ongoing challenges in recovering from the pandemic's impact.

Patient voice and staff engagement

The voices of patients and the public are not sufficiently heard

Patient satisfaction with the NHS has declined, complaints have increased, and patients feel less empowered to make choices about their care. There is potential for greater patient involvement in designing services.

A recurring issue in care failings is that patients' concerns are not being heard or addressed. Consequently, the NHS is paying nearly £3 billion in compensation for care failures, which is about 1.7% of its total budget.

Disabled people, those with long-term conditions, and women are disproportionately affected by poor communication. Making data more publicly available and involving local communities in decision-making could also help the NHS become more responsive and accountable.

Many staff experience feelings of powerlessness and detachment

Many NHS staff describe feeling disempowered and overwhelmed. Around 60% would recommend their organisation as a place to work, and 65% as a place to receive care.

Staff feel that NHS organisations lack a sense of common purpose. Chronic underinvestment in processes and infrastructure leads to challenges, adding to staff frustration.

There has been a reduction in discretionary effort, with fewer staff working beyond their contracted hours. Sickness absence rates have also increased since the pandemic. The most common reason cited for sickness absence was anxiety, stress or depression or other psychiatric illnesses.

Psychological impact of the pandemic and its aftermath

The pandemic has deeply affected the psychological wellbeing of NHS staff. NHS Practitioner Health, which treats health and social care professionals with mental health and addiction issues, saw a surge in registrations during the pandemic. The pandemic continues to affect the NHS, having a major impact on industrial relations including strikes. Staff felt undervalued despite being praised during the pandemic, especially regarding pay settlements.

Cultural challenges in the NHS and leadership

Cultural challenges within the NHS, such as concealing problems and retaliating against whistleblowers, persist. Effective leadership is essential in tackling these issues, and will require further investment in NHS leaders. The 2022 report by General Sir Gordon Messenger and Dame Linda Pollard highlighted issues around the training and development of leadership and management and recommended improvements, which NHS England has started to implement.

NHS structures and systems, including the role of ICBs

The Health and Social Care Act of 2012 had a 'disastrous' impact on NHS management, leaving long-lasting effects.

The 2022 Act introduced integrated care systems, creating a more coherent management structure with headquarters, seven regions, and 42 ICBs. However, there are still different understandings of roles and responsibilities between ICBs, including how far they are responsible for the performance management of providers. More consistency and standardisation in the organisation and functions of ICBs is needed. There is also a need to revitalise the framework of national standards, financial incentives and earned autonomy to reflect the shift from competition to collaboration.

Frequent reorganisations within the NHS are expensive and disruptive, hindering efforts to enhance care quality and efficiency, as is the growth in the number of organisations that exert some degree of regulatory or policy influence on providers. Senior leaders spend considerable time on internal management instead of focusing on local NHS issues.

The performance of the NHS is shaped by its internal systems, processes, resources, and structures. Key themes include:

- Planning blight:
  - The Health and Social Care Act 2012 divided functions between a number of organisations, leading to delays and complications in planning.
- Data and performance management:
  - The NHS has focused data collection on acute hospitals, with limited data on mental health and community services. This lack of data limits understanding and management of these sectors.
  - The Hewitt Review recommended a focus on fewer key priorities to improve accountability and performance.
  - The performance management framework needs to change, at pace, to clarify the role of the ICB with regards to provider trusts.
- Incentives for performance:
  - There is a tension between protecting funding for specific services and devolving decision-making. NHS England plans to devolve specialised commissioning budgets to ICBs.
  - There has also been a shift in payments away from activity-based mechanisms, although they remain in place for elective care. This can impact on clinical productivity.
  - Trusts are no longer able to advance to foundation trust status, driving frustration among organisations that funding is available to invest, which they do not have the freedom to spend.
- Regulation and quality of care:
  - The interim findings of the review of the Care Quality Commission (CQC) by Penny Dash has found significant internal failings and a deterioration in the ability of the CQC to support quality improvement.
  - The CQC has also been criticised for emphasising inputs over outcomes, contributing to an increase in the numbers of hospital clinicians.

- Competition and quasi-markets:
  - The 2022 Act removed the competitive tendering requirement, but the result is an incoherent service delivery pattern. Despite moving away from market-based approaches, the NHS has not fully adopted the planned alternative.

NHS Providers view

Lord Darzi's investigation explores the significant challenges facing the NHS, the reasons for this, and the impact this is having on patients and service users. We welcome the investigation's timely and perceptive diagnosis of the problems facing the NHS, and its assessment that, although in a critical position, it is fundamentally not broken.

The report lays bare the breadth of issues facing the NHS today and the areas where improvements are needed for patients and for staff. From population health, to waiting times, quality of care, the patient voice, to investment and technology, it is clear that the sector will need to work closely in partnership with the new government to find solutions.

Lord Darzi is right that structural reform is not the answer to the problems facing the NHS. There is great potential within existing structures, but the investigation is also right in highlighting the need for clarity regarding the role of ICBs. We welcome Lord Darzi's call for the responsibilities of ICBs to be clarified 'at pace'. This resonates with many of the challenges trust leaders identify around system working.

We believe that for system working to deliver on its four core aims to improve population health and healthcare, tackle inequalities, enhance productivity and value for money, and support broader social and economic development, there needs to be an equal partnership between ICBs and trusts. There must also be a shared long-term focus on population health and inequalities. For this to work, ICBs should not be asked to performance manage trusts and should not be given a quasi-regulatory role which does not have statutory underpinning.

Related to this, Lord Darzi's review also gives an accurate assessment of the challenging regulatory environment facing trusts, and the issues described around the CQC's role echo concerns raised by trust leaders. Independent regulation and oversight are vital mechanisms to ensure transparency and accountability, but as the investigation suggests, there is an opportunity to both streamline and improve this (as being explored by Dr Penny Dash's review).

We welcome the investigation's emphasis on the importance of the NHS workforce in addressing the pressures Lord Darzi outlines. The investigation rightly highlights the essential role of NHS managers, and the need for greater investment to develop 'more and better leaders', rather than reduce numbers.

Likewise, we welcome the investigation's focus on the need for capital spending, to not only improve estates for the benefit of staff and patients, but also to boost productivity and improve capacity. Again, this reflects what trust leaders have been telling us about the central role of capital funding in creating a sustainable NHS for the future.

The investigation also makes important and powerful points on the need to shift care into the community, and the need for financial flows to follow these ambitions to ensure they become a reality.

It is helpful to see Lord Darzi highlight the challenges facing children and young people in accessing NHS services, and in the resilience of the child health workforce. As outlined in our recent Forgotten Generation report, the health and wellbeing of children and young people must be a cross-government priority.

Finally, we agree that many of the solutions to the problems identified can be found in parts of the NHS today. NHS Providers will continue to work with key national stakeholders, including DHSC, to share examples of good practice that can support the development of the reform agenda described by Lord Darzi.

NHS Providers press statement

Darzi diagnosis shows 'next generation' NHS needs capital injection

A government-commissioned assessment of the NHS in England by Lord Darzi says a desperate shortage of capital affects performance and productivity - and means the NHS isn't contributing to the nation's prosperity in the way it could be.

Sir Julian Hartley, chief executive, NHS Providers, said:

"Times are tough for NHS trusts tackling unprecedented financial and operational challenges.

"Long waiting times for patients, particularly in community and mental health services, are a symptom of years of underinvestment, stop-start funding in the NHS and major workforce challenges.

"Lord Darzi's report acknowledges what trust leaders have long called for - if we want to improve patient care and boost productivity, we need significantly more capital investment in the NHS alongside wider reforms including a shift to providing more care closer to home.

"Old, crumbling buildings, facilities, and equipment well past their sell-by date hamper care for patients. Much of the NHS estate is in a bad way. We need modern, safe places where staff can give patients first-class care in hospitals, mental health, community and ambulance services, and tackle the £11bn-plus bill for essential repairs waiting to be done. We can't afford to let this problem get worse.

"Trust leaders and their teams, working flat out to cut waiting lists and see patients as quickly as possible, need long-term investment to ease pressure, meet demand and step up productivity - all of which can help to raise the quality of care for patients.

"A healthy NHS is vital for the nation's health and wellbeing.

"With the government's 10-year plan for the NHS on the horizon, it's right that we shift our focus now to creating a truly 'next generation' health service. Focusing on the creation of a 'digital' NHS, prevention and public health and ensuring patients are cared for in the right setting are steps in the right direction. These must go hand in hand with sustainable funding and investment, an end to chronic workforce shortages and more support to meet growing demand.

"Trust leaders are ready and willing to do what they can to get the NHS back on track, ready to work with the government to get to grips with the challenges facing the NHS and social care for the benefit of patients and staff."

Busier than ever NHS 'down but not out'

Responding to a speech by the Prime Minister in response to the publication of Lord Darzi's review of the NHS and the monthly performance statistics by NHS England, the chief executive of NHS Providers, Sir Julian Hartley said:

"The NHS is down but not out.

"The sheer scale of the challenge facing trust leaders and their teams as they strive to get the health service back on track is plain for all to see.

"The NHS has had its busiest ever summer and is fast heading into what is expected to be another challenging winter with record levels of demand on A&E departments, patients still waiting far too long for care and persistent pressure on community, mental health and ambulance services.

"Due to hard work by frontline NHS staff, we are seeing much-needed progress with faster ambulance response times, fewer long waits for treatment and record numbers of patients receiving diagnostic tests, cancer referrals and treatments.

"But as the Prime Minister said today, we can't go on like this. To build an NHS fit for the future, the NHS needs to work differently and go further and faster to improve care for patients.

"With the 10-year plan for the NHS on the horizon, trust leaders are ready and willing to work with the government to get to grips with the challenges facing the health and social care system.

"Lord Darzi's prescription for reforming the health service – by creating a digital NHS, focusing on prevention and public health, and ensuring patients are cared for closer to home- is a big step in the right direction. This must go hand in hand with sustainable funding and investment, an end to chronic workforce shortages and more capital investment to boost productivity and meet growing demand.

NHS
The Christie
NHS Foundation Trust

Agenda item 25/24b

Meeting of the Board of Directors
26th September 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 5 position. • A summary of progress against actions from the paper previously presented to senior management committee in July • Overview of what focus on engagement and ownership has taken place to ensure financial sustainability for the future.
Recommendation(s)	The committee is asked to note: • The content of the report and • The associated actions identified to improve delivery.
Background papers	NA
Risk score	Risk 3629
Link to: ➢ Trust strategy ➢ Corporate objectives	Executive objective: 1 -To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer. 6 - To maintain excellent operational, quality and financial performance Board Assurance Framework: Risk 1, Risk 6, Risk 7, Risk 9, Risk 10
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	Value Improvement Programme: VIP Quality Impact Assessment: QIA Equality Impact Assessment: EIA Investment and Capital Planning Committee: ICPC Transformation, Performance and Improvement Group: TPIG

Agenda item 25/24b

Board of Directors
Thursday 27th September 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 to delivery of the strategy is ensuring that we have financial sustainability to support and drive innovation and improvement, whilst ensuring we continue to invest in our capital and services. In line with the rest of GM, the Christie must deliver a challenging cost improvement target. In response to this challenge, a high-level framework has been developed in line with the Trust ambitions, with a focus on delivering value for money through transformation.

A paper was presented in June describing the Trust financial position and progress in delivering cost improvements, which is described as the Value Improvement Programme (VIP). There was a recognition that the Trust needed to inject capacity and pace into the VIP plans to ensure delivery financial forecast, for this reason, several improvement interventions were described and are being supported.

Alongside an internal review of the governance and framework for VIPs, Greater Manchester (GM) has commissioned PWC to conduct a financial review across the whole of GM. been This paper describes the current position of VIP at month 5, and describes the outcomes and actions being taken as a result of recommendations.

2.0 Month 5 Financial Overview: VIP

In 24/25 as at M5, the Trust's year to date (YTD) surplus is £3.5m, £0.6m ahead of plan. The Trust is forecasting a planned surplus of £7m assuming the delivery of a £21.4m VIP target.

As at M5, the Trust has made good progress and £19.6m of this has been identified which is in line with the plan and target. The gap still to be identified is £1.8m with a number of pipeline schemes in development.

Summary	Performance as at M5
Full year forecast outturn **£7.0m surplus**	**M5 YTD Position** £Xm surplus £Xm favourable to plan
24/25 VIP Plan £21.4m	**M5 VIP Identified (YTD)** £19.6m
Target VIP M5 **£8.2m**	**Delivered VIP M5** £8.2m

3.0 Governance and assurance

The newly established Transformation and Performance Improvement Group (TPIG) is chaired by the Chief Operating Officer as VIP SRO. The VIP Workstreams now report to this Group with a highlight report which describes the transformation objectives, progress against key milestones and any risks to escalate. The VIP tracker which is used to manage and translate all ideas into delivery is being updated real time and progress formally reviewed weekly.

As previously presented, only a small number of schemes identified on the tracker had a plan and Quality Impact Assessment (QIA) in place with low assurance on delivery. In order to improve this position, the TPIG commissioned a VIP review to assess the completion and standards of Project Initiation Documents (PIDs) for VIP schemes. This was to assess confidence in delivery by determining if plans possess the attributes such as a robust project scope, financial phasing, Key Performance Indicators (KPIs), whether risks to delivery with corresponding mitigations were present and whether we have quality impact assessments. The outcomes of the review and actions are summarised below.

4.0 Outcomes from the review

Outcomes from the review recognised good practice with improved governance and oversight, and improved engagement and ownership including:

- There is an embedded financial improvement programme supported by finance business partners
- The Trust now has agreed a timeline for activities throughout the year to identify and effectively deliver their VIP target and identify next years target.
- The activities for ideas generation and development of VIP include:
- Idea Generation Workshops / pipeline development meetings.
- Share and Learn process for case studies, examples of best practice.
- Model Hospital - review and work with the national team to see what transferable learning there is for finance, and the latest best practice efficiency checklists.
- Best practice Checklists – Nursing and medical
- Developing capacity and capability - Value maker programme.
- Lessons learnt from previous year (what went well etc)
- Further scoping and development of planned schemes at a Specialty Level.
- There is a developing Value Maker programme where the aim is to developing capacity and capabilities by delivering financial training, enabling the Trust to work together more effectively and ultimately to improve patient outcomes.
- There is also clinical and financial collaboration to identify barriers to change, generate ideas and celebrate success. Success will also shared through quarterly newsletters.

The review concluded that the Trust had opportunity to improve in the following areas:

- The VIP standard operating procedures has recently been updated, with a new

template, approval, monitoring and post scheme evaluation. Although progress has been made, Divisions are still working through completing these to provide assurance that VIP schemes will be delivered.

- That Quality Impact Assessments must be completed for all schemes to provide assurance that there is no detriment to quality.
- That there is still opportunity to increase engagement and understanding of VIP which will be supported with the launch of the new staff ideas process, and a share and learn approach.
- There is an opportunity to improve reporting and value assurance processes to ensure robust sign off processes for staffing, this includes establishing a a vacancy panel to ensure skill mix reviews have been conducted and that recruitment is progressing with no delays to minimise use of agency.
- There is further opportunity to ensure adherence to policies to demonstrate good financial governance this includes, attendance and roster management, sign off for ad hoc shifts, ensuring adherence to pay rates.

A financial improvement plan has been initiated to ensure that these areas can be improved and this will be overseen by the TPIG meeting.

5.0 Next Steps

The following areas of focus will be prioritised over the next month:

- Value Assurance checks will continue through weekly finance meetings to ensure completion of PID's and QIA's and overseen by the Chief Operating Officer.
- Opportunity packs will be developed for each service to support them where to look for improvement – this would include benchmarking using national best practice such as Model hospital Getting It Right First Time (GIRFT)
- Proud to be Ops and One finance are supporting the Trust to building leadership and organisational capacity and capability for financial skills as part of the Finance and Clinical Education (FACE) programme.
- A further focus on staff engagement and workshops to understand VIP will consist of a series of events, sessions with staff and the launch of the 'Do you have an Idea' process.
- Benefits realisation – A review of all business cases invested in the last 18 months to affirm that the benefits listed in the business case have been realised. This includes links to the Sustainable Development Management Plan (SDMP).
- Completion of a deep dive of areas of continued or high overtime, or additional shift usage to understand the driver and financial opportunity of moving to the Bank to ensure there is a clear process for the review and approval of overtime before it is incurred.

The Christie
NHS Foundation Trust

Board of Directors
Thursday 26th September 2024

Agenda item 26/24a

Title	Health Inequalities
Author (s)	Jo Tomlins Deputy Director of Strategy John Wareing, Director of Strategy Professor Chris Harrison, Deputy CEO
Purpose of Paper	This paper reports on the progress in addressing health inequalities at The Christie and sets out key actions we will be taking to further our work on health inequalities.

Executive Summary	• The Trust's recently developed health inequalities dashboard suggests that 35% of The Christie patients live in the most deprived areas of Greater Manchester and are therefore at risk of significant health inequalities and worse cancer outcomes.
	• Reducing health inequalities has been a key strategic priority for the Trust with 'Christie @' sites developed to deliver treatments closer to home and enable treatments to be more accessible. This strategic commitment has continued as demonstrated by the four pillars of our current strategy each having reducing health inequalities embedded.
	• There has been recent guidance by NHS Providers to help Trusts to meet the obligations to reduce health inequalities. The Trust has completed the NHS Providers self-assessment tool to measure where the organisation is against these recommendations and highlight areas for development.
	• Results of the self-assessment shows that the Trust has a firm basis on which to address health inequalities including the following key areas of work:
	  • In house development of comprehensive EHIA tool
	  • Social Value Work including community engagement to develop and design services, local recruitment partnerships, 10-20% social value weighting in all contacts, environmental sustainability programme.
	  • Working across the GM system as key contributors in population health and GM Anchors committees.
	• A development plan for reducing health inequalities which focuses on three key areas:
	  • Further development of the Christie health inequalities dashboard including data analysis and embedding into operational planning.
	  • Embedding use of EHIA as core business.
	  • Building public health capacity.

Action/Decision Required	The Board is asked to: 1. Note the activity the Trust is already undertaking in connection with health inequalities and the processes in place. 2. Note the proposed set of actions in response to the NHS Provider Self Assessment Tool.
Related NHS Strategies and Policy	Reducing health inequalities: A guide for NHS trust board members March 2024 United against health inequalities: Moving in the right direction May 2024 Being an anchor institution: Partnership approaches to improving population health February 2023 What makes us healthy, Lovell & Bibby 2018 as updated by Louise Marshall, July 2024

Board of Directors
Thursday 26th September 2024

Purpose

The purpose of this report is to provide members of the Board with an update on our activities in relation to health inequalities. The paper also details the outcome of our response to the NHS Providers Self-Assessment Tool.

Background

Research shows that the main drivers of health inequalities are social determinants ie where people live, access to employment and start in life (Bibby, 2018). There is also increasing evidence that the health inequalities divide can be further exacerbated by the way health services are designed, delivered, funded and the quality of care they receive (NHS Providers, 2024).

NHS Providers (2024) recommend that services can address health inequalities by:

- Ensuring fair access, experience, and outcomes across different groups in the population.
- Acting as an anchor institution to support work on the wider determinants of health (NHS Providers, 2023a).

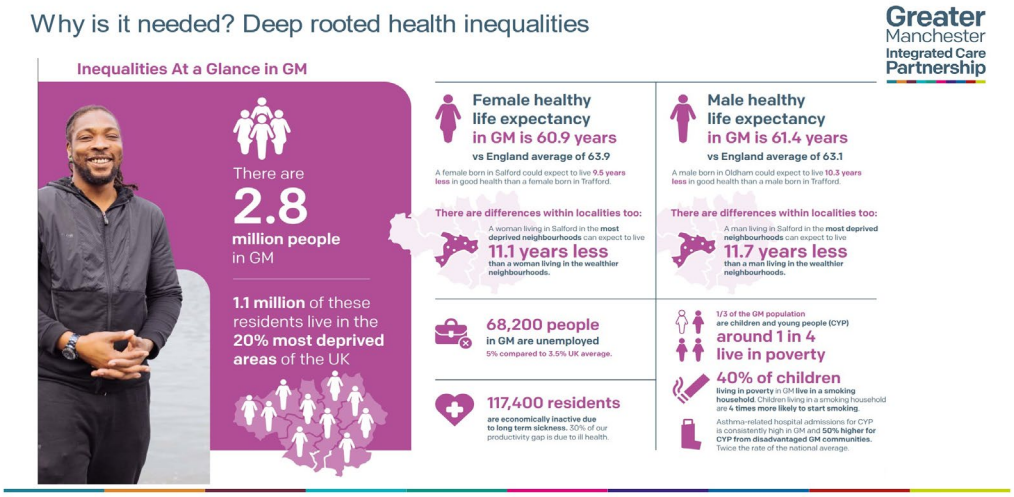
Anchor Institutions are considered to be large, often public sector organisations, whose long-term sustainability is tied to the wellbeing of the populations they serve (NHS Providers, 2023a). It is recognised that such institutions can have a positive impact on health inequalities for local communities through:

- Supporting access to quality work.
- Using their purchasing power for social benefit.
- Using buildings and spaces to support communities.
- Reducing their environmental impact.
- Working closely with communities and local partners.

It is important to recognise that the Trust's Inclusive Culture strategy which brings together equality, diversity, and inclusion (EDI) into a broader programme, is an important contributor to our approach to health inequalities. Through the creation of an inclusive environment we can also support a reduction in health inequalities.

The Christie Demographic

The Trust serves a wide population with many of our services being provided on a regional and national basis. This makes an assessment of our population challenging, however the core of our services are provided to the population of Greater Manchester which has 1.1 million people living in some of the most deprived areas of the UK. This will have a significant impact on their health outcomes including cancer. The slide below from GM Integrated Care Partnership (ICP) demonstrates the significant challenge facing the population.



Our current progress in addressing health inequalities

As demonstrated by the development of chemotherapy at home, locality based systemic antic cancer therapy services and radiotherapy satellites, reducing health inequalities has been central to the Trust strategy for several years. Appendix 1 details a number of activities the Trust has and is taking to support reducing health inequalities and how these map against our Strategy.

More recently we have undertaken work, through our Clinical Outcomes Data Unit to further understand those that use our services; this has resulted in the development of a Health Inequalities Dashboard (see Our patient profile 2023/24). Key outputs from this work includes:

- On Deprivation - 35% of our current patients live in the most deprived areas of GM.
- On Ethnicity - 5% of our current patients classify themselves as one of the non-white ethnic minorities.
- On Disabilities/co-morbidities - 6% of our current patients have disclosed one or more disabilities; note that not all patients chose to disclose if they had any disabilities.
- On Sexuality - Less than 1% of our current patients are recorded as being lesbian, gay or bisexual (LGBTQ); note that not all patients chose to disclose their sexuality.

It is important to note that data capture of health inequalities is challenging as a significant number of patients have not disclosed some or all their protected characteristic.

Building on this initial work, Further actions to improve out data collection and analysis include:

- Improving data capture through a new data capture form to be used at all new and follow up appointments with a QR code to enable electronic completion.
- Support wider GM activity to enable Trusts to be able to view GP data on patient protected characteristics.
- Undertake specific projects focussed on:
  - Patients on a 62 day pathway
  - Systemic Anti-Cancer Therapy (SACT) patients

  to better understand health inequalities within these specific groups.

- Develop disease specific dashboards; three new dashboards to be developed by April 2025.
- Continue clinical engagement to further develop our approach to data analysis.

NHS Providers Health Inequalities Self-Assessment Tool

To support NHS Trusts obligations to address health inequalities, NHS Providers produced guidance for Boards, see Reducing Health Inequalities: A guide for NHS Trust Board members (March 2024). This guidance recommended that all Boards consider:

- Appointing an Executive Lead for Health Inequalities on the Trust Board.
- Developing Organisational plan or strategy on health inequalities for the Trust.
- Building Public Health capability in the Trust.
- Carrying out data analysis to underpin understanding of the health inequalities within the community.

The table below responds to this guidance:

Objective	Response
Appoint an Executive Lead for Health Inequalities.	• Deputy Chief Executive is the nominated lead for Health Inequalities.
Develop Organisational plan or strategy on health inequalities for the Trust.	• Reducing Health Inequalities is embedded in four pillars of the Trust strategy. • Undertake NHS Providers Self Assessment.
Build Public Health capability in the Trust.	• Working with Clinical Outcomes Data Unit, GM Public Health and Fairer Health for All programme to explore opportunities to build in house capability, as necessary, alongside working with system partners.
Carry out data analysis to underpin understanding of the health inequalities within the community.	• Data analysis completed, further project planned.

Acknowledging that the Trust has and continues to take action to address inequalities, the NHS Providers self assessment tool has been completed. This additional step is intended to provide assurance that the Trust is doing as much as possible in meeting its obligations to address health inequalities.

Completed with a number of internal stakeholders, the Self Assessment generates progress scores and produces a specific set of objectives based on the information provided. These objectives have been used to define a development plan. There are four main themes which are comprised of a number or questions within each theme. Depending on the score a 'maturity' level rating is assigned to each of the themes; this ranges from not started, emerging, developing, maturing and thriving.

The table below provides a high level summary of the results. This demonstrates that the Trust has made significant progress committing to work to reduce health inequalities.

Theme	Maturity Level
Building public health capacity & capability	Thriving
Data, insight, evidence and evaluation	Maturing
Strategic leadership & accountability	Thriving
Systems partnerships	Thriving

The result of the self-assessment tool generated a set of actions to further develop and embed our approach to tackling health inequalities; see table overleaf. It is proposed that further updates to the Board are made in line with the agreed Board rolling programme.

Development Plan

No.	Responsible	Objective	Actions	Timeframe
Building public health capacity & capability				
1.1	Trust Board Secretary	Ensure All NEDs to seek opportunities for personal development on health inequalities.	Provide opportunities to access training and development sessions as necessary eg NHS Providers Development offer.	Ongoing
1.2	Directors	Ensure staff at all levels of the organisation are aware of the vision and strategy for tackling health inequalities and understand their roles in delivering these.	Dissemination Inclusive Culture and EDI strategy.	Throughout 2024/25
1.3	Directors	Ensure that board members, senior leaders and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities.	Use of EHIA's in business cases, value improvement programme.	Ongoing
1.4	Directors	Ensure there are systems in place to support frontline work on health inequalities, such as consolidating learning and sharing of best practice across the organisation and establishing learning networks or communities of interest for health inequalities.	Embed culture of health inequalities through Inclusive Culture strategy. EHIA processes.	Throughout 2024/25
1.5	Directors	Develop opportunities and systems to encourage and enable staff to develop public health expertise across a range of roles.	Explore opportunities with GM Population Health Team.	Q3/Q4 2024/25
1.6	Directors	Consider training and development opportunities on inclusion health and trauma informed practice, with priority for staff interested in becoming inclusion health specialists. Training should be refreshed, as relevant.	Review training opportunities with Christie Education.	Q4 2024/25

No.	Responsible	Objective	Actions	Timeframe
1.7	Directors	Build in-house capacity and capability for health inequalities research work.	Review current activity with R&I.	Q3 2024/25
Data Insight, Evidence and Evaluation				
2.1	Directors	Include equality and health inequalities related impacts and risks in Board and Committee papers (including minutes), alongside actions for how they will be mitigated and managed.	Use of EHIA in relevant papers.	As required
2.2	Directors	Ensure a Trust wide focus on inclusive recovery and operational improvement through an equity lens.	Further develop inequalities dashboard to include operational, safety and experience matrix.	2025/26
2.3	Directors	Establish a culture of data reporting among staff on health inequalities outcomes, and on the impact of health inequality initiatives. Consider staff training to enable staff to feel confident in asking questions around ethnicity.	Development of Health Inequalities dashboard (CODU) and programme of work.	Ongoing
2.4	Data, digital and information teams	Consider how digital technology, such as electronic patient record systems, could be used to support health inequalities decision making.	Review how current data can be used to enhance Health Inequalities dashboards (CODU).	Ongoing
2.5	Data, digital and information team	Collect qualitative data through engagement with population groups to incorporate patient's views into health inequalities work (such as those from deprived areas, underrepresented ethnic minority groups, those with protected characteristics and/or inclusion health groups).	Further development of Health Inequalities dashboards.	2025/26

No.	Responsible	Objective	Actions	Timeframe
2.6	R&I	Work with research partners and in partnership with other NHS organisations to ensure participation in relevant research related to health inequalities, to develop an evidence-base on the effectiveness of provider led interventions to tackle inequalities.	Capture and collate health inequalities research activity across the organisation.	Q4 2024/25
2.7	Directors	Consider active case finding approaches to reduce health inequalities, such as hypertension case finding and early cancer diagnosis.	Consider, with the Cancer Alliance, how this is being addressed across GM.	Q4 2024/25
2.8	R&I	Engage with groups that may not be traditionally involved in research or quality improvement, such as those from deprived areas, underrepresented ethnic minority groups, those with protected characteristics and/or inclusion health groups.	Report on activity annually.	In line with Board Programme
Strategic leadership & accountability				
3.1	Directors	Ensure integrated working with HR and equality, diversity and inclusion (EDI) leads to achieve strategic alignment for workforce EDI and tackling inequality.	Development of Inclusive Culture Strategy.	2024/25
3.2	Directors	Embed an equity lens across all organisational priorities, strategic documents and annual planning processes.	Undertake EHIA as required.	Ongoing
3.3	Finance	Work with commissioners and external organisations to identify funding opportunities for health inequalities initiatives.	Review opportunities as they arise.	As required

No.	Responsible	Objective	Actions	Timeframe
Systems Partnerships				
4.1	Director	Work collaboratively with senior leaders and health inequality leads in the ICS, other provider organisations/provider collaboratives and primary care networks (PCNs) to share learning and ensure scalability of health inequalities strategic work across systems.	Continue to participate in GM population health activity and groups.	Ongoing
4.2	Directors	Work collaboratively with board members leading on the organisation's anchor institutions work, to ensure alignment with the health inequalities agenda.	Ensure senior participation from the organisation at GM anchors meetings.	Ongoing
4.3	Directors	Work with system partners to ensure the Trust has pathways to engage with communities and local voluntary, community and social enterprise (VCSE) sector organisations.	Adherence to associated Inclusive Culture and EDI workstreams.	Ongoing
4.4	Directors	Enable services to embed co-production principles to inform work on health inequalities. Co-production could include with staff, public and patient reference groups, engagement events, or similar mechanisms.	Maintain community engagement through neighbourhood forum and patient engagement forums.	Ongoing

Recommendations

The Board is asked to:

1. Note the activity the Trust is already undertaking in connection with health inequalities and the processes in place.

2. Note the proposed set of actions in response to the NHS Provider Self Assessment Tool.

Appendix 1: Mapping progress in reducing health inequalities against The Christie Strategy

One of the key underpinning themes of the Trust strategy is tackling inequalities and we have previously mapped a number of our 5 year objectives to demonstrate how the strategy contributes to addressing health inequalities.

Reducing cancer waits **Tackling cancer inequalities** **Improving outcomes**

Leading cancer care	The Christie experience	Local & specialist care	Best outcomes
Realise the potential of the Paterson development - seamless integration of research with clinical care	Improve in-patient experience and efficiencies through emerging / next generation ward environments	Lead a single Christie non-surgical oncology service with equitable care for all patients across GM	Drive improvements in quality, safety and patient experience through real-time data for 'data-enhanced clinicians'
Grow pipeline of Christie leaders with regional, national and international influence	Establish system-wide Christie Research Outreach - access to research for every patient across Greater Manchester	Collaborate with system partners to improve access to cancer diagnosis and treatment targeting areas of greatest need	Accelerate improving outcomes through launching a Clinical Outcomes & Data Unit (CODU)
Accelerate research delivery through efficiencies and innovation - tomorrow's treatments to patients faster	Personalise the Christie out-patient experience embedding digital healthcare tools	Expand cancer survivorship programme with system leadership for managing late effects, supportive care and research	Develop a secured-data environment with regional/national capability in collaboration with research partners
Create sustainable opportunities for our staff to work within international partnerships to tackle cancer inequalities locally and globally	Embed cancer partnerships beyond GM by building on the success of national service networks and hosting Operational Deliver Networks	Establish a Christie Advanced Cancer Scanning Centre for state-of-the-art diagnostics and increasing system capacity	Work in partnership with the GM Cancer Alliance to establish and report cancer equality metrics and KPIs
Amplify accessible and inclusive cancer care education and training for Christie staff, external colleagues and patients	Grow active patient and public engagement opportunities across cancer education priorities	Work with partner organisations to integrate a sustainable next-generation cancer pathology service in cytogenetics, histopathology and blood sciences	Improve outcomes for older patients with cancer through the Christie Senior Adult Oncology service

The Christie
NHS Foundation Trust

Agenda item 26/24b

Public Meeting of the Board of Directors

Thursday 27th September 2024

Subject / Title	Cultural Audit
Author(s)	Prof Chris Harrison, Deputy Chief Executive
Presented by	Executive Directors
Summary / purpose of paper	To highlight the work undertaken to respond to the cultural audit and to confirm that this process will now be continued through a new Inclusive Culture Strategy.
Recommendation(s)	To note
Background papers	The Christie NHSFT Cultural Audit
Risk score	Risk in relation to Objective 7 Likelihood of affecting objective 2 Impact on objective 3 Overall risk 6
EDI Impact / considerations	Ensuring a consistent experience for all staff regardless of protected characteristics
Link to: ➢ Trust strategy ➢ Corporate objectives	Relevant to Objective 7: People – To be an excellent place to work and attract the best staff
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	NHSFT – NHS Foundation Trust ED – Executive Director (Prof C Harrison) GM – Greater Manchester EHIA – Equality Health Impact assessment BAME – Black and Minority Ethnic OD – Organisational Development

Board of Directors
Thursday 27th September 2024

Cultural Audit

1 Background

The cultural audit was commissioned to explore comments about organisational culture in the 2023 CQC reports and help us improve. It was undertaken by Globis Limited, an organisation nationally recognised for its expertise in organisational culture diagnosis. The board has received updates as the work has progressed and has received and accepted a paper describing its specific responsibilities.

The audit involved reviewing relevant documents, interviewing 107 individual staff members, conducting 16 staff focus groups, visiting sites, and conducting a questionnaire survey of all staff. One thousand one hundred seventy-one individual staff members contributed.

The audit also considered the feedback from an initial engagement exercise following the publication of the CQC report, which included information from staff across the organisation, including open sessions for clinical staff. Following this, some immediate actions were taken, for example, improvements in our safe, sustainable waste arrangements, the facilities management service area configuration, canopy arrangements over some areas, changes in the switchboard, etc.

2 Findings

The audit found that Christie staff are incredibly passionate about the specialist nature of their work. They strive to provide exceptional patient care and support, enhance the trust's reputation, and encourage the improvement of working practices.

The audit also identified frustration about workload, communication, variable leadership styles, some working practices, behaviour toward colleagues, inconsistent teamwork, and resources. These issues affected people's feelings about their roles, well-being, and stress. No evidence of systematic discrimination or bullying was found. These findings are consistent with insights from the staff survey and other data, showing notable differences between parts of the organisation.

The report and recommendations were published in full on the Trust website. Throughout January and February 2024, staff discussed the report and provided feedback, allowing initial thoughts about the priority actions to be developed and tested.

3 Response

This stage involved focused formal sessions (e.g., chief nurse forum, admin & clerical forum, staff forum, etc.), discussion as an item on agendas of committees and forums, cascade and discussion via divisional meetings, and drop-in/informal sessions with advisory group members and executives.

The focus was on listening and dialogue balanced with moving forward and action, gathering insights on the priorities, central issues, work underway, quick wins, actions to accelerate, potential blockers and support required. Written feedback was received from all these forums and analysed to identify critical themes for action.

As reported to the board in March 2024, six key themes emerged from the engagement with staff. As work on these themes has progressed, they have evolved and been grouped into four core action areas, shown below, with summaries of the actions taken under each heading. Appendix 1 shows how the audit recommendations, themes and actions connect, demonstrating that although the process has evolved, the changes are linked to the original audit.

4 Conclusions and Next Steps

The literature confirms there is no quick fix to address the current challenges of culture and staff well-being across the NHS. In the wake of the global pandemic, long-standing pressures on the public sector and recent industrial action by clinical staff, systematic and sustained attention to culture and workforce wellbeing is required, nationally and locally.

The CQC inspection, undertaken in the later stages of the pandemic, the cultural audit, and our subsequent engagement process identified some specific issues that we could address at The Christie alongside ongoing programmes of organisational development, including those set out in The Christie People & Culture Plan.

Information from the staff survey, supplemented by possible additional research, will target future improvements. The work in response to the cultural audit will inform the new Inclusive Culture Strategy.

We will undertake a follow-up reaudit of culture at The Christie in 2025.

Recommendations

To note:

1. The new Inclusive Culture Strategy will draw on the outcomes and response to the cultural audit
2. Progress will be monitored through the results of the NHS staff survey, local data collection and research, and a follow-up reaudit in 2025.

Appendix 1 – Cultural Audit Recommendations

The table shows the recommendations of the cultural audit undertaken by Globis, together with the action theme and action group under which each was addressed. This is presented to provide board assurance that the recommendations were addressed, albeit presented differently in line with the engagement and discussion with staff.

No	Recommendation	Plan Theme	Action Group
1	Establish a mechanism for staff to gain a greater understanding of job descriptions, different roles, departmental structures and decision-making processes and ensure that communication channels are clear.	2	1, 3, 4
2	Provide safe spaces and access to emotional support for all staff.	5	2, 4
3	Support managers throughout the Trust to perform their role to the highest standard.	1, 2, 4	1, 4
4	Review procedures that relate to PDRs and access to training and development opportunities.	1, 4	1, 2
5	Review the Freedom to Speak Up process and the options and support available to staff who raise concerns and those dealing with the process.	3	1, 3, 4
6	Implement activities to encourage all colleagues to reflect upon their behaviour and improve the level of kindness, civility and respect in the workplace.	1, 4	1, 2
7	Equip all staff with the skills to better manage difficult conversations and deal with challenging behaviour.	1, 4	1, 3
8	Exit interviews to be carried out for all leavers and the data analysed.	1, 4	2, 4
9	Produce transparent and consistent recruitment and selection criteria for every role and development opportunity to reduce perceptions of ‘cronyism’ or favouritism.	1, 4	1, 2
10	Continue and enhance activities that promote equal treatment of staff regardless of race, religion or any other characteristic.	1, 4	1, 2, 3
11	All leaders should communicate and behave in a way that makes it clear bullying/racist behaviour in the workplace in unacceptable. A transparent and robust grievance process should be well documented and easily accessible.	1, 4, 6	1, 2, 3
12	Create more opportunities for staff to shadow, mentor, learn from and meet with those from other teams and in other roles, to improve understanding, share best practice and encourage.	2	1, 3,
13	Senior managers to acknowledge the importance of listening and learning to make improvements and display behaviour that reassures staff of their commitment to improvement.	7	1,
14	Review and prioritise ‘quick fixes’ in terms of equipment, repairs and space to work/conduct meetings/meet as a team etc.	Undertaken separately	
15	Issue clear policies on remote working.	5	1, 2
16	Comprehensive policy development across the whole organisation, rather than decisions being made at managers discretion. Policies should be tailored to the specific needs of The Christie and regularly updated as needed.	Being dealt with by policy approval committee	1, 2, 3, 4

Appendix 2 – Engagement Themes and Actions Taken

Themes from engagement:

1. To ensure that all senior leaders (including clinical leaders) in the organisation have specific training and are provided with support for those activities known from research to promote a healthy organisational culture.
2. To ensure that all staff know the accountability, decision-making and communication mechanisms and the expectations, responsibilities, and accountabilities of senior clinical and operational leaders within the organisation.
3. Ensure that our speaking-up policies are designed to enable the raising of clinical concerns.
4. Ensure all staff know the range of staff well-being and support services available and how to access them.
5. Ensure the board of directors demonstrates clear leadership in developing an inclusive culture based on our agreed values (Make a Difference, Act with Kindness, Connect with People) and behaviours in which we all support each other to provide the best possible care.
6. Ensure that we continue the conversation with and between our staff.

Examples of actions taken (as communicated to staff by CEO)

1. Leadership, development and training

- We have started targeted support programmes in areas across the Trust to help leaders address issues they face, including coaching, mentoring, and team development.
- We have focused our 'Respectful Resolution' training and culture conversations across the Trust, particularly in departments identified as having the greatest need.
- A clinical director leadership program, new consultant peer coaching programme, coaching conversation skills training, management essentials programme, and leadership community activity programme start in late 2024
- We have developed an education brochure for leaders detailing how to access training on management and leadership competencies known to improve team culture. This will be followed by a more structured training and support programme for leaders. We are also launching the 'Proud2beOps@The Christie' programme with the operational workforce in the autumn as part of the nationally recognised Proud2beOps network to help improve operational leadership, professional development, and safe, high-quality care delivery.
- We will make the GMC-led civility and respect programme available to the medical workforce.
- We are an early adopter of the national NHS uniform, which will be in effect in early 2025. This will ensure greater clarity for staff and patients about who is who
- We have joined NHS Elect, a national membership organisation that provides courses, training, support, and development delivered by experienced staff.
- We are implementing an electronic document management system to move non-clinical Trust policies from HIVE to Sharepoint. This means these can be accessed remotely without being on the internal network. Clinical documents will be on Q-Pulse.

2. Staff health and wellbeing

- We are compiling a digital and printed document where all health and well-being offers available to colleagues will be located in one easy-to-access place.
- We are continuing to work to produce a workforce policy handbook

- We have formed an additional area for staff rest and well-being in the former outpatient department's former waiting area by the Wilmslow Road entrance. We are continuing to look for further temporary arrangements in due course, as well as including the spaces in future Trust developments
- We have signed the "NHS Sexual Safety Charter", which commits The Christie to 10 principles to improve safety at work and have a zero-tolerance approach to unwanted, harmful or sexualised behaviours. More information about this can be found here.
- Mersey Internal Audit Agency (MIAA) will audit our recruitment activity to ensure that Trust policies and procedures for advertising, shortlisting, and selection are followed. This is in response to feedback from some colleagues who felt that the availability of roles was not always transparent and that, in the past, roles have been offered without a robust and open advertisement and recruitment procedure taking place.

3. Staff Communications

- We have focussed on improving internal communications within the Trust
- The four main clinical divisions have reviewed their communication arrangements within teams to ensure that staff meet their line managers regularly
- We have simplified our management decision-making and committee structures and introduced a system whereby divisional leaders formally raise divisional issues and risks at the Senior Management Committee
- We have initiated a 'We Are The Christie' campaign. You will start to see this across all our communications, where staff across all areas share their pride in working for The Christie and demonstrate how their role contributes to our broader Trust strategy
- There is now a weekly bulletin for all staff, which will also be distributed by text message (SMS) for those staff who would like this
- The bi-monthly Trust magazine is being redesigned with a refreshed version starting with the autumn edition. It will share the great work our teams do
- The monthly written team brief is now cascaded to senior divisional and departmental leaders and directors to ensure it is cascaded to all colleagues and displayed for those who do not have easy access to email.

4. Staff Engagement

- We have introduced quarterly 'Connect and Reflect' sessions for new starters with approximately six months of employment, the first of which was in July.
- We are developing a staff handbook that will include helpful information, including senior leadership's 'who's who', a description of committees, and the decision-making processes.
- The staff handbook and the health and wellbeing offer will be available on a staff app, which will put all this information into one place and allow staff to access it on personal devices if they wish
- We are strengthening our 'You Made a Difference' award with a display board showcasing winning teams/colleagues planned for our staff engagement area.
- There are frequent drop-ins at the engagement stall where colleagues can share ideas, a staff suggestion box (physical and online), and quarterly themed engagement events led by a range of Trust leaders for colleagues to attend and share feedback.
- We continue to promote the importance of completing the annual staff survey because it is valuable for making improvements and tracking improvements in our culture.

The Christie NHS Foundation Trust

Agenda item 27/24a

Board of Directors

Thursday 26th September 2024

Subject / Title	Trust Planning 2025/26
Author(s)	John Wareing, Director of Strategy
Presented by	John Wareing, Director of Strategy
Summary / purpose of paper	This paper provides the Board with a summary of the activities carried out as part of the Trust planning cycle during July
Recommendation(s) (assure / alert / advise)	The Board is requested to note the contents of the report and support the activities proposed for the next planning session
Background papers / source of assurance	• Data • Soft intelligence • Benchmarking • External assessments • Risks and mitigation • Trajectory and changes over time
Risk score / BAF reference	N/A
EDI impact/considerations	N/A
Link to: ➢ Trust strategy ➢ Corporate objectives ➢ CQC Quality standard ➢ Regulation	Trust Strategy & objectives
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	GM Greater Manchester AAA alert, advise, assure

Agenda item 27/24a

Meeting of the Board of Directors
26 September 2024

Planning Workshop – Summary & Next Steps

1. Background

As part of the annual planning cycle the Trust undertakes three workshops throughout the year (July, October, February). The sessions bring together senior leaders from across the organisation with Executive and Non Executive Directors to discuss key system and organisational challenges. Whilst the individual workshops may have different emphasis from year to year they form the backbone of the Trust's structured approach to annual planning.

2. Introduction

The first of the 2025/26 planning sessions took place on 5 July and brought together 45 delegates from across the Trust to focus on 'sustainability' in the context of the wider NHS and Greater Manchester challenges. Sessions were held in a marketplace format with our clinical divisions (Clinical Support & Specialist Surgery, Networked Services, Research & Innovation), Digital and Education, leading discussions with attendees.

The format of the sessions used the 'AAA' framework, with colleagues talking through those issues that required the organisation to be 'Alerted', 'Advised' 'Assured'. This approach was deliberately designed to provide focus for discussion within the sessions.

The afternoon session focussed on key themes and actions to be developed through the annual planning discussions. These included:

- Digital Alignment
- Developing new workforce roles
- Working across boundaries
- Retaining a patient focus

These themes will be further refined and brought into our more detailed planning activities through the rest of the year.

Feedback from those attending the session was positive with high ratings for format, content and venue. There was particular emphasis in the free text feedback on having the opportunity to spend time connecting with others and having the opportunity to think, plan and discuss common issues.

Building on this initial session the October meeting will focus on our strategic approach to service delivery and Value Improvement Programme for the forthcoming year. Consistent with our approach, this will bring together a multi-disciplinary group of key leaders with Executive and Non Executive Directors

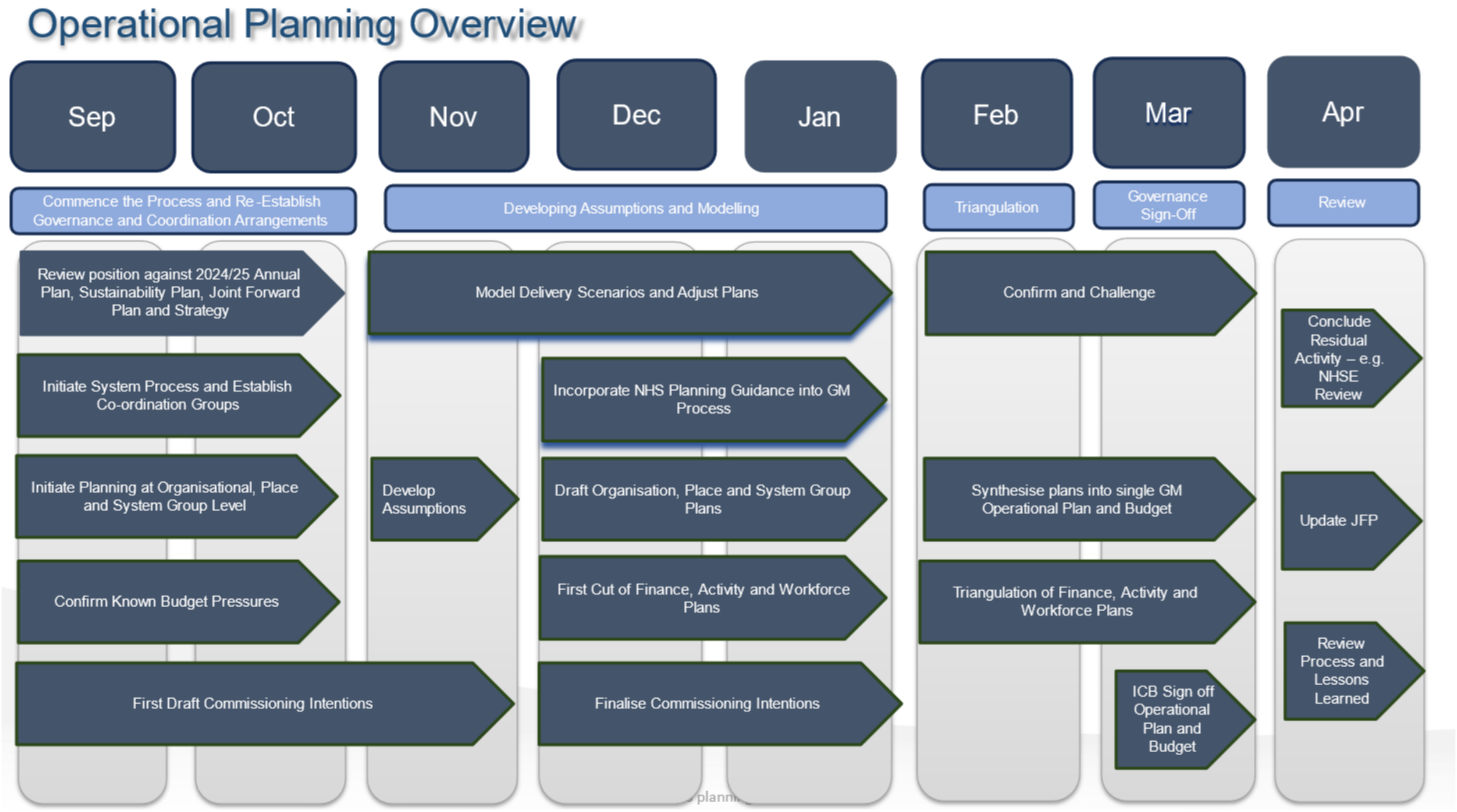
Between October and February, wider NHS planning activity is expected to accelerate with NHS planning guidance published in December and GM based discussions taking places (see appendix 1 for outline GM planning timetable). During this time we will refine our activity and financial plans in particular such that for the February session we anticipate having a draft Trust operational plan available for discussion. This is subject to the provision of external information and confirmation of relevant national and local priorities and assumptions.

4. Recommendation

The Board of Directors is asked to:

- Note that Operational Planning for 2025/26 has commenced.
- Note that the next planning engagement session will take place on 4 October and be focussed on our Value Improvement Programme.
- Note that, subject to wider NHS planning timelines, a draft Trust operational plan is expected in February 2025.

Appendix 1: Outline GM Planning Framework



The Christie
NHS Foundation Trust

Agenda Item 28/24a

Meeting of the Board of Directors

Thursday 26th September 2024

Subject / Title	Board Assurance Framework 2024/25
Author(s)	Louise Westcott, Company Secretary
Presented by	Louise Westcott, Company Secretary
Summary / purpose of paper	This paper provides the Board with the Board Assurance Framework 2024/25. 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.
Recommendation(s) (assure / **alert** / advise)	The Board 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				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				8	16
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	15				5	15
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				1	15
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				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				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				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				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				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				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				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				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				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				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				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	High
		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			0			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			0			0			0	1	1	1

RISK 3	Recruitment and retention of skilled staff	Date Risk Opened	Current Risk Score
Description	**If we are unable to maintain current levels of skilled staff there is a risk that they will not have the time or expertise required for excellent care and communication leading to a reduction in the standards of patient safety and experience.**	Apr-24 Date of Last Review 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			0			0			0	2	2	4

RISK 4	Changes in quality regulation	Date Risk Opened	Current Risk Score
Description	**If the CQC or other regulatory body changes their approach to regulation there is a risk that we will not be able to demonstrate compliance leading to us being assessed as not meeting the fundamental care standards.**	Apr-24 Date of Last Review 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

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
	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**			**0**			**0**			**0**	4	1	**4**

RISK 5	Impact of the system capital allocation framework	Date Risk Opened	Current Risk Score
Description	**If the capital planning and allocation system does not enable full use of our charitable and commercial reserves there is a risk that we may not be able to fund our capital and asset replacement programmes leading to delays, cancellations or reprioritising of planned projects and equipment not being replaced when needed.**	Apr-24 Date of Last Review 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

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
	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**			**0**			**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** 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
	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**			**0**			**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	**15**
Associated Corporate Objectives	To promote equality, diversity & sustainability through our system leadership for cancer care To maintain excellent operational, quality and financial performance.	Executive Lead Responsible Committee Assurance Level Risk Appetite	Chief Operating Officer **Quality Assurance Committee** Cautious

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	Executive led monthly divisional performance review meetings. Integrated performance & quality report to Management Board and Board of Directors monthly. Weekl;y performance reporting via trust operational group. Escalation internally & across GM of delays impacting waiting time targets. Monitoring cancer waiting time standards through GM Cancer & IPR.	Impact of ongoing Industrial Action leading to delays in referrals	Level 1 – Data and management reports • repors to Senior Management Committee and Board□ Level 2 – Management team and committee scrutiny • 6 monthly review by QAC Level 3 – External assurances • MIAA review of 62 days / Cancer Alliance	None identified	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	5	3	15			0			0			0	5	1	5

RISK 8	Extreme weather events	Date Risk Opened	Current Risk Score
Description	**If there is an extreme weather event (heat wave, freeze, floods etc) due to climate change there is a risk of business disruption (increased staff absence, increased patient non-attendance and equipment malfunction) leading to delayed or cancelled care.**	Apr-24 Date of Last Review 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			0			0			0	4	1	4

RISK 9	Industrial action	Date Risk Opened	Current Risk Score
Description	**If there is ongoing industrial action, there is a risk of business disruption leading to delayed or cancelled care**	Apr-24 Date of Last Review 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			0			0			0	5	1	5

RISK 10	Financial balance	Date Risk Opened	Current Risk Score
Description	**If we do not achieve the planned activity levels and our target efficiency savings there is a risk that we won't achieve financial balance leading to us having to repay the difference to our agreed plan in the following year**	Apr-24 Date of Last Review 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	
		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			0			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	
		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 undertaking Data Protection Toolkit assessment (DPST)	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			0			0			0	2	2	4

RISK 12	Ineffective response to cultural audit	Date Risk Opened	Current Risk Score
Description	**If our response to the cultural audit is insufficient there is a risk that a negative culture will persist in some specific parts of our organisation leading to an increase in the number of staff reporting a poor experience.**	Apr-24 Date of Last Review 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			0			0			0	1	2	2

RISK 13	Insufficient data on patient protected characteristics	Date Risk Opened	Current Risk Score
Description	**If we are unable to capture data on the protected characteristics of our patients there is a risk we will be unable to assess any inequalities in access, experience or outcomes leading to lack of focus in addressing health inequalities**	Apr-24 Date of Last Review 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**			**0**			**0**			**0**	2	2	**4**

RISK 14	Legal and statutory compliance	Date Risk Opened	Current Risk Score
Description	**If we do not maintain an awareness of and respond to changing statutory and legal requirements there is a risk that we will fail to comply leading to being sanctioned for being in regulatory or statutory breach.**	Apr-24 Date of Last Review 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	
		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	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**			**0**			**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**										1	2	**2**

The Christie
NHS Foundation Trust

Agenda Item 28/24b(i)

Meeting of the Board of Directors
Thursday 26th September 2024

Subject / Title	Workforce Assurance Committee report – June 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 June meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions
Background papers	Workforce Assurance Committee papers – June 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 28/24b(ii)

Meeting of the Board of Directors
Thursday 26th September 2024

Workforce Assurance Committee report – June 2024

1 Introduction

The Workforce Assurance Committee took place on 13th June 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 June 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 June 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				
09/24a	3, 12	18	High	**Workforce dashboard** • Overview of major KPIs provided; reviewed monthly at Workforce Committee. • Sickness trend; April slightly higher than previous month. We are the lowest in GM region but still higher than would like. Benchmarking to be done to see if target of 3.2% is still appropriate. Breakdown provided in report, April sickness cost around £200k. • PDRs going in the wrong direction; monitored and managed by managers. Detailed further as part of 10/24c below. • Staff turnover month by month is coming down. • Establishment vs pipeline – finished year in healthy position at 8%. Now at 10.5% due to establishment growth. Vacancy data provided, in a good position. • Workforce risk remains at a score of 9; impact is being managed but need to maintain the efforts.
09/24b	3	N/A	Medium	**Education six monthly report** • Good engagement coming through, staff feel much more able to contribute. Staff can see where their work impacts on patient care. • EDI and wellbeing focussed officer role - successful piece of work, which will continue. • Good working relationship with Workforce team around the cultural audit and some legacy issues around training. • **Action:** Level of granularity (as it becomes clearer as to what measures can be assessed) to be provided as part of Education six-monthly report when confirming compliance progress with the Education strategy.

10/24a	3	18, 19	High	**The Christie people and culture plan update** • Activity underway in terms of management training to try and define further, working with the Education team and progressing through the cultural audit work. • Managers are receptive to management training but not currently seeing the impact in terms of skills and knowledge. Going to take a while to move forward. • % of staff experiencing discrimination is rated as red; focus moving forward is working on getting people to speak up, progressing with looking at anonymous reporting, lots of work to be done. Cases are reviewed anonymously and this is being embedded through appropriate representation on review panels.
10/24b	N/A	12	High	**Values and behaviours dashboard** • 89% of staff confirmed they are aware of the Trust values through staff survey results. • Interactive dashboard can be drilled down to show the full breakdown of how each divisional area has answered the survey questions providing an extra layer of analysis. • Shows highlights on most improved, most reduced scores and can compare to previous year, directorate and against Christie overall. • The dashboard will be the main method of how culture will be represented going forward. • Engagement will be through the work of the Workforce Committee and having divisions present to the committee for sharing best practice.
11/24b	N/A	18	High	**Responsible officer report - annual medical appraisal and revalidation** • 326 doctors in our organisation, 299 were due appraisals, numbers reported representative at end of March 2024. 288 had completed appraisal. Been difficult this year due to periods of industrial action. • Now have 62 trained appraisers. • For those submitted for revalidation, 58 recommendations were made, 1 was deferred as required to complete patient satisfaction section.
11/24c	3	18	High	**Guardian of working hours report** • Consistently low number of exceptions reported; all resolved. One adjustment to a work schedule based on 1 escalation.

11/24g	N/A	14	High	**Employee Relation (ER) patient safety case review** • Each ER case commenced between 01 December 2023 and 31 May 2024 has been reviewed; 18 cases raised, 4 cases have involved patient safety concerns as set out in report. • All 4 cases were approved for investigation as per process. 3 of the 4 are live cases with the other case reported back through PALS. • Robust systems and processes exist to ensure that patient safety incidents are investigated in a timely and effective way and staff who raise concerns are supported and receive feedback.
Alert				
10/24c	12	N/A	Medium	**Staff survey results** • Response rate higher than last year and representative of national response rate. Reasonably favourable picture compared to last year. Compassionate and inclusive came out favourably which is representative of the work which has been done in this area. • There is a declining trend on raising concerns over the last 4 years of data. Actions already taken and those in progress in terms of speaking up summarised and discussed. • Compared to national data and other specialist acute trusts, overall we came out lower than other specialist trusts but higher than national average. • PDR/appraisals – noted slight improvement but still low compliance rate. Responses on why colleagues feel PDR does not make a difference presented were based on leadership, relationships, mindset and process. Seen as quantity over quality in some areas when having to perform PDRs and leading to not much value. Manager skill and process is key. Areas of focus for PDR described from the paper; activities to focus on are how to make the process slicker and have managers who are trust leaders to have meaningful conversations with staff. • EDI trends deep dive done on staff survey; more work required as don't have the richness of the data. Figures either demonstrate a problem or is representative of a small number of responses. Actions on EDI trends outlined. • Discussion around outcomes not yet being there despite actions in place to address. Senior divisional management have been invited to future meetings to present on culture work in their areas. • Constraint noted as taking time out to train managers. • **Action:** Response numbers for EDI trend data to be provided.
Advise				
No items to report.				

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Agenda Item 28/24b(ii)

Meeting of the Board of Directors
Thursday 26th September 2024

Subject / Title	Quality Assurance Committee report – June 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 June meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions
Background papers	Quality Assurance Committee papers – June 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.	

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Agenda Item 28/24b(ii)

Meeting of the Board of Directors
Thursday 26th September 2024

Quality Assurance Committee report – June 2024

1 Introduction

The Quality Assurance Committee took place on 13th June 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 June 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 June 2024.

Appendix 1

Agenda item	BAF ref	CQC regulation reference	Assurance rating given	Key points and associated actions (where applicable)
Assure				
18/24b	2	12, 20	High	**Patient Safety Quarterly Report January- March 2024** • General decline in moderate incidents, this is due to higher reporting in near misses. • Serious incident framework – the number of calendar days for turning around is being maintained. • Education piece done around Duty of Candour, SOPs now in place to follow and final letter gets approval before issued.
18/24c	2	N/A	High	**PSIRF six monthly update** • SOPs going through ratification and will be part of governance processes from July 2024. Appetite for PSIRF across the Trust, staff want to get it right. • Learning From Patient Safety Events (LFPSE) –staff frustration with the new requirement, is a longer process to complete. • Funding secured for patient safety partners, developing business case and role description, will be members of the public. • Patient Safety Syllabus Level 1 and 2 available for all staff on Christie Learning Zone, hoping to get to above 90% compliance by July (level 1 currently at 56% and level 2 29%).
18/24d	1	9, 10, 12, 16	High	**Patient Experience & Clinical Effectiveness Quarterly Report January- March 2024** • Work done to bring down open complaints at a divisional level and less complaints coming in. • PALS response timeframe at 100%. • No new PHSO cases and no further update as yet on previous cases reported.

18/24e	1		High	**Infection Control Annual Report** • New lead nurse recruited and now have a more structured team in place and investment into admin roles. • Work has continued on reviewing policies which were out of date due to covid and new guidance released. • Mandatory reporting detailed in report, above trajectory (set by NHSE) for C. Diff and E. coli – similar trend to what is being seen nationally. • Outbreaks; covid one earlier this year different to those previously experienced, managed well. Debrief done based on the outcome of a survey to see where any improvements could be made. C. Diff on Ward 4 – a lot of learning identified from this. • Sepsis; one breach of the target in-year, thematic review undertaken following this. • Largely compliant with the IPC BAF, identified actions completed.
18/24f	N/A	N/A	High	**Learning from deaths** • Backlog of case reviews cleared and all cases since then also maintained. No cases required to be shared with the CQC. • 3 patients received poor care, no patients received very poor care. Compared to previous years, avoidability remains the same, poor score up by 1 case. No deaths referred to LeDeR. • One child death referred to us by the Consultant in-charge and though this was not an inpatient death, there was a review conducted to help the regional Child death mortality review process.

18/24g	1, 6	N/A	High	**Research and Innovation six monthly report** • Reference to the cultural audit report and assured the committee the division have been doing listening events which will lead to a response through the divisional meeting. • Working to improve the way in which Good Clinical Practice (GCP) training is managed and reported, working with the trust level task and finish group on this. Compliance at end of May was 78%. • Developed new governance structure; Terms of Reference and other governance documents to be implemented which will help deliver the strategy. • Working towards OECI accreditation, recently achieved Christie gold CODE status. • In terms of process improvement, set up times for trials are not where they want to be, working towards 60 days and at the start of the journey to bring down. Reference to the O'Shaughnessy recommendations, big focus to work on this area. • Quality improvement plan in place for invoicing and aged debt reduction. • Audit plan not delivered due to capacity to recruit, 1 out of 3 audits completed. Risk of deferral was considered, and audits will feature in the forward plan for 2024/25 which was approved at the May R&I Quality Committee. • 3 escalations from research sponsors in the last 6 months. Full investigations found nothing contributed to the site and related to the instructions provided by the sponsor. • 3 incidents met the criteria to report as a serious breach as could potentially harm patient or affect trial data: all correctly reported and subject to ERG process.
19/24d	N/A	14	High	**Nutrition and hydration compliance report** • Trust Nutrition Steering Committee has a number of subgroups that report to the committee; the committee ensures compliance with the CQC regulation. • Annual work plan ensures achieving compliance with the regulation and guidance. • Nutrition policy in place in accordance with national guidance and audited, reported as part of annual report.

Alert				
18/24a	6	N/A	Medium	**Cancer waiting times** • Ability to deliver standards remains at a risk of 15 on risk register; won't be dropped until appropriate to do so. • Change to faster diagnosis standard (FDS) performance target - to deliver 77% by March 2025. • Important part of FDS pathway is lessons learned as only a small number of patients breach the pathway. On track to deliver in June but doesn't take a lot to fail the standard, tracking of patients takes a considerable amount of work. • Number of patients referred has increased including those referred after 38 days so in our gift to treat within 24 days to avoid a breach. Trying to understand if there is a specific pathway or region where patients are likely to be referred from that may be the cause of a breach. • Assessments of patients breaching 24-day pathway done with analysis provided. Capacity to treatment highlighted; down to 16% now. Not seeing improvement in time to first outpatient appointment. Range of actions put in place. Governance structure for reporting to also be made more formal. Improvement group to also meet monthly and report into Senior Management Committee. • Targets not currently being met but actions are in place and often reliant on other organisations. 62-day target has been achieved for the last 2 months, but only by 2%-3% so not deemed appropriate enough to reduce risk at this point, would like to see slightly higher compliance for a couple more months. Noted that industrial action also has an impact and have the next period coming up. • **Action:** Further update report on cancer waiting times to be presented to the committee in November 2024.
Advise				
No items to report.				

The Christie
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Agenda Item 28/24b(iii)

Meeting of the Board of Directors
Thursday 26th September 2024

Subject / Title	Audit Committee report – June and July 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 Audit Committee at their June and July meetings and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions
Background papers	Audit Committee papers – June and July 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.	

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Agenda Item 28/24b(iii)

Meeting of the Board of Directors
Thursday 26th September 2024

Audit Committee report – June and July 2024

1 Introduction

The Audit Committee took place on 26th June and July 2024. The meetings were quorate. The following summary gives the Board information on the items that were considered by the committee at their meetings under the headings of Assure / Alert / Advise.

2 Audit Committee agenda items

The items listed in Appendix 1 of the report were all presented to the Audit Committee in June and July 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 Audit Committee in June and July 2024.

Appendix 1

June meeting

Agenda item	BAF ref	CQC regulation reference	Assurance rating given	Key points and associated actions (where applicable)
Assure				
21/24b	11	N/A	High	**Digital outage update** • 3 debriefs took place post the outage; a hot debrief, a questionnaire based on the outcome and a full debrief meeting. Action plan developed from the meeting. • EPRR meeting held monthly will monitor progress and report to Risk & Quality Governance Committee. **No actions.**
Alert				
No items to report.				
Advise				
21/24	10, 14	N/A	High	**Executive Director of Finance report** • No ex-gratia payments for 2023/24 relating to redundancy pay. • Losses and special payments; 77 cases of aged debt written off, not significant in total. • Annual plan set at £7m surplus for the Trust. Reporting regularly to Board. • Included in the revenue plan is cost and productivity improvements (VIP) of £21.5m, this equates to 5.4% based on the GM ICB's definition of 'influenceable expenditure'. • Capital plan presents a significant risk, same position across GM. **No actions.**

July meeting

Agenda item	BAF ref	CQC regulation reference	Assurance rating given	Key points and associated actions (where applicable)
Assure				
27/24b	11	N/A	Medium	**Deep Dive – Digital Services** • DSPT mandated assessment submitted as compliant. • A dedicated task force has been set up to review and determine the long term view of the Trust's EPR. **Action:** • Consider the inclusion of hard indicators such as audit outcomes and external validations for future Digital reports to the committee.
Alert				
27/24b	11	N/A	Medium	**Deep Dive – Digital Services** • Main risk is the cyber risk. A change to the BAF cyber risk description was recommended to also incorporate the supplier chain risk. Risk will continue to be monitored and managed.
Advise				
27/24a	10, 14	N/A	High	**Executive Director of Finance report** • Staff survey results give assurance that team are working effectively and flexibly. 4th in the whole country. • Procurement KPIs reviewed by the Finance team and felt there is more meaningful information that could be provided to the committee. **Action:** • Finance team will review and prepare a new data set to include in future reporting.
27/24b	11	N/A	Medium	**Deep Dive – Digital Services** • NHS mandated cyber assessment changing. Looking more at policy implementation rather than just having a policy. Will be subject to audit by MIAA as well as self-assessment. • ICS level cyber strategy underway. Maturity assessment exercise completed with Trust involvement. Assessment done through work with a consultancy firm. Reasonable compliance position for the Trust. • Undertaking service desk institute (SDI) accreditation. SDI maturity assessment also being completed as part of this. Will bring service delivery assurance.

29/24a	N/A	N/A	N/A	The committee approved an addition to the internal audit plan to reflect a review identified as required in relation to fair and equitable recruitment.

The Christie
NHS Foundation Trust

Agenda item 28/24c

Meeting of the Board of Directors
Thursday 27th September 2024

Subject / Title	GGI assurance review action plan review
Author(s)	Louise Westcott, Company Secretary
Presented by	Professor Chris Harrison, Deputy Chief Executive Officer
Summary / purpose of paper	This paper updates the Board on progress against the action plan developed following the GGI Governance Review (Jan 2024).
Recommendation(s)	Board are asked to; • Note progress and completion of the actions as detailed in the action plan. • Note that further work is incorporated into the business plan going forward.
Background Papers	Good Governance Improvement – The Christie NHS FT, Enhancing Board Assurance January 2024 10/24a GGI assurance review action plan
Risk Score	See Board Assurance Framework
EDI impact / considerations	Ensure governance arrangements provide assurance and appropriate oversight of EDI requirements for the organisation
Link to: ➢ Trust's Strategic Direction ➢ Corporate Objectives	Achievement of corporate plan and objectives
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	GGI Good Governance Improvement CQC Care Quality Commission

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Agenda item 28/24c

Board of Directors Meeting
Thursday 27th September 2024

GGI assurance review action plan review

1 Purpose

This paper provides the Board with an update on the action plan agreed at the March 2024 Board of Directors meeting in response to the GGI Governance Review published in January 2024.

2 Background

Several actions were outlined relating to the recommendations from the 'Good Governance Improvement – The Christie NHS FT, Enhancing Board Assurance January 2024' report. In addition, further actions were outlined relating to improvements that were also agreed by the Board.

3 Update to actions

Appendix 1 details progress against the outlined actions. Most of the actions are complete at the end of Q2. There are some actions that will be addressed over the coming months / years due to the nature of the action and the associated timescales. These will continue to be monitored by the responsible lead and incorporated into normal business. No risks have been identified in the completion of any of the actions.

4 Recommendation

Board are asked to;

- Note progress and completion of the actions as detailed in the action plan.
- Note that further work is incorporated into the business plan going forward.

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Appendix 1 - GGI Recommendations and action plan 2024

The table shows the GGI recommendations and how they are to be addressed. We have monitored the GGI recommendations through the agreed set of actions set out in this paper (the plan) as reported to the committee chairs and executive sponsors meetings and to the board.

No.	Recommendations	Accept Y/N	Action	Responsible	Progress
1.	The board should complete a skills audit to identify what experience and professional backgrounds should be sought when recruiting non- executives.	Y	Already in place – reviewed at December 2023 Board Planning Day	Company Secretary	Audit to be completed by new Board members as they join and reviewed every 2 years (due December 2025)
2.	The board may also wish to consider establishing associate non- executive director roles as a means of broadening the skill mix.	Y	Join NHSE NExT Director scheme	Chair / Company Secretary	Joined scheme and are looking at candidates that are coming through. Aim to have in place by end 2024/25.
3.	The trust should start to plan the induction of non-executive directors in advance of the recruitment process for these vacancies.	Y	Induction reviewed 2023 & detail updated	Company Secretary	Induction is planned in advance and course dates / induction calls arranged ahead of start date. Complete
4.	In view of the pending changes in membership of the board, the future board development programme should cover not just high-profile topics affecting the NHS, but also soft skills required for governance, such as working together as a board and asking the right questions.	Y	Board Development programme 2024/25 to include soft skills once new appointments in post	Chair / Chief Executive	Soft skills element of the programme to be planned for early 2025.
5.	The board should consider whether it would like to receive a separate, regular report from the director of strategy, covering strategic developments at the trust and in the integrated care system.	Y	Update included in Trust Report and through Strategy updates six monthly	Director of Strategy	Complete and in rolling programme for Board.
6.	The trust should systematically, through a formal 360-degree exercise, elicit feedback from stakeholders and partners.	Y	Similar exercise undertaken as part of current strategy. More structured approach will be incorporated into plans for future strategy development	Director of Strategy	Timing of future stakeholder feedback to align with current strategy implementation.
7.	The board should consider whether to establish a subcommittee with responsibility for finance.	N	Part 2 of the Board of Directors will fulfill this requirement	Company Secretary / Director of Finance	In place for Part 2 of Board of Directors

No.	Recommendations	Accept Y/N	Action	Responsible	Progress
8.	The trust should undertake a mapping and evaluation exercise of the management groups in the organisation and update all terms of reference to a standard template including reporting groups.	Y	Review & update of ToR of committees - including reference to regulations / performance / policies for review & provide assurance	DCEO / Company Secretary	Updated terms of reference to be reviewed by each committee. Complete
9.	The trust should rename management groups to clarify their role and purpose.	Y	Renaming to be included in reviews of ToR	Committee chairs / Company Secretary	Included in review of terms of reference. Use of terms 'board' & 'committee' clarified through this process. Complete
10.	The board should introduce chair's reports from each committee, to summarise the committees' business for the board's benefit in 3A format (assure, alert, advise).	Y	Reports in form of more structured minutes agreed from January 2024	Committee chairs / Company Secretary	Reports from assurance committees in triple A format in place. Summary style minutes included in papers. Complete
11.	The board should review the style in which minutes are taken, and move towards a more high-level, summary style of minute taking.	Y	New minute style to be introduced from January 2024 meetings	Assistant / Company Secretary	
12.	The audit committee should review its remit in line with the NHS Audit Committee Handbook.	Y	Reviewed annually – new handbook released April 2024	Director of Finance	Reviewed annually – paper to June 2024 Audit Committee with identified actions / amendments made to ToR. Complete
13.	The agendas of the board, its committees and management groups should include time at the end to reflect on the meeting.	Y	Added to the committee agendas or managed through NED pre-meet for Board	Company Secretary	Considered for each committee / Board. Complete
14.	The trust should review the board's programme of business to ensure an appropriate balance towards strategic items.	Y	Board agenda restructured	Chair/ Company Secretary	Complete – in place from March 2024 meeting
15.	Meeting chairs should be reminded that it is good practice to complete each agenda item with a brief summary.	Y	Committee chairs	Company Secretary	Added into Board guidelines. Complete
16.	The trust should take a 'zero-based' approach to its performance indicators. In other words, it should start with a blank canvas every four or five years and work out what it needs to measure based on	Y	Review of the Integrated Performance report and the summary dashboard to be undertaken. Metrics to be	Company Secretary/ DCEO	This approach will be taken for the setting of the next 5 year strategy. New draft dashboard from April 2024. Review of the IPQFR to ensure consistent approach in

No.	Recommendations	Accept Y/N	Action	Responsible	Progress
	national standards and regulations, commissioners' contractual requirements, and its own strategic and operational objectives. A good time to commence this work is when a new strategy has been adopted.		developed for board dashboard as a result.		line with NHSE Making Data Count principles. Aim to provide new draft by end of Q4 2024/25.
17.	The board assurance framework should be used more systematically to identify any gaps in assurance against standards and objectives.	Y	BAF to be updated	Company Secretary/ DCEO	New format 2024/25 BAF in place for Board and Assurance Committees. Complete
18.	The trust should regularly seek assurance on the quality of data included in management information reported to the board or committees. This is a service performed by internal audit in many organisations.	Y	In place through internal audit and other mechanisms	Director of Finance	In the internal audit programme for 2024/25.
19.	The trust should ensure that it has fully prepared itself for any future CQC announced inspections, for example by briefing the workforce at all levels, and completing (and keeping up to date) a full and candid self-assessment against the regulator's quality standards.	Y	Work programme including priority areas to be identified.	Chief Nurse	Work programme outlined. Testing taking place into compliance with 2022 inspection report Must Do's.
20.	Papers reported to the board or its committees should be cross- referenced to the CQC quality standards, and any other regulations that may be relevant, on their covering sheets.	Y	Cover sheets to include reference to CQC quality standards.	Company Secretary	Cover sheets updated to include reference to quality standards. Agendas / rolling programmes updated with reference to CQC guidelines.
21.	The trust should seek outside assurance on any action plans arising from critical regulatory inspections, for example by asking internal audit to review the evidence showing whether actions have been completed.	Y	This is normal practice and will be undertaken for future action plans	Executive Directors	In place CQC action plan assessed by specialised commissioning quality committee. MIAA assessment of assurance framework annually.
22.	The trust should consider establishing its own small in-house compliance and assurance team, which would gather and maintain evidence of compliance with regulatory standards (not limited	N	Quality & Standards team in place with reporting via relevant assurance committee	Chief Nurse	Quality & Standards team in place

No.	Recommendations	Accept Y/N	Action	Responsible	Progress
	to the CQC's quality standards), horizon scan for legislative and regulatory developments, co-ordinate planning for reviews by external bodies, and monitor development / implementation of action plans				
23.	The trust should consider expanding the use of statistical process control techniques to identify variations of concern, where appropriate.	Y	Review of the IPQFR to include expansion of use of SPC charts	Chief Operating Officer	Expansion of SPC charts used in the Integrated Performance Finance and Quality report as part of review to be complete by end of Q4 2024/25
24.	The board and committees should discuss whether they find it useful to allocate assurance levels to each paper, or if a different approach would be better.	Y	Agreed to allocate assurance only to governance issues allocated to the committee	Committee Chairs / Company Secretary	In place for governance issues allocated to each committee and picked up in minutes / BAF. Reviewed by committee chairs and remains in place.
25.	The trust should consider procuring a document management system for policies and guidelines.	Y	The Trust has a long-standing document management system	COO/CIO	Roll out of SharePoint for non-clinical documents underway. To be complete by end 2024/25.
26.	The trust should redesign its board assurance framework to make it a more engaging and user-friendly document.	Y	New version to be implemented in 2024/25 – initial draft of 1 risk per page. Looking to use a Tableau dashboard	Company Secretary/ DCEO	2024/25 BAF updated in line with recommendation and in place. Complete.
27.	The BAF should include graphics such as 'heat maps' showing the risk profile in visual form and how this has changed over time.	Y	Appropriate format being developed	Company Secretary/ DCEO	To be incorporated into BAF 2024/25. Complete
28.	Committees need only be presented with those risks in the BAF for which they are the lead committee.	Y	In place from January 2024 meetings	Committee Chairs/ Company Secretary	Complete
29.	The trust should review GGI's report in conjunction with the report of the cultural review carried out by Globis, consider any themes common to the two, and ensure a consistent approach.	Y	Themes to be identified and actions determined as a result.	DCEO	Analysis undertaken alongside Globis report and reported to Board in March 2024. Complete

No.	Recommendations	Accept Y/N	Action	Responsible	Progress
30.	The board should consider how it can best gain ongoing assurance that the trust has the right culture, by thinking about the different sources of data and intelligence (HR statistics, local and national staff surveys, FTSU concerns, employee relations issues, etc.), and how these are analysed and reported.	Y	Reporting on culture through the WAC and other reports in restructured agendas	Company Secretary / DCEO and HRD	Reviewed reporting for committees and new agendas in place. Complete.
31.	The trust should ensure that staff networks have sufficient resources at their disposal to be effective.	N/A	Outside ToR of review	N/A	N/A
32.	Governors should be encouraged to observe meetings of board subcommittees (on the understanding that they are there as observers and not as participants in committee business).	Y	Offer to be made to governors for 1 or 2 to observe per meeting	Company Secretary	Discussed at February Council of Governors and managed through Company Secretaries office. Offer sent to governors. In place.
33.	The trust secretary and a sub-group of governors should work together to identify any unmet training needs for the council of governors.	Y	Already in place	Company Secretary	Induction refreshed and delivered annually to new & existing governors. Training offered throughout the year with NHS Providers programme 'GovernWell' plus locally delivered to suit need. Complete.
34.	The trust should consider how governors could be enabled to communicate with the foundation trust membership, for example email bulletins, a social media group, etc.	Y	Being taken forward by Membership & Community Engagement Committee of CoG	Membership Team	Membership & Community Engagement Committee taking action forward alongside Membership team.
35.	The trust should enable more frequent contact between governors and non-executives, in order that the governors can better hold NEDs to account.	Y	NED committee chairs to present their report to full CoG – minutes to be added to agenda. NEDs attend governor committees. Governors invited to Assurance Committees	NED committee chairs / Company Secretary	NED reporting to full Council of Governors February 2024 onwards. Invite sent to Governors to attend Assurance Committees. Complete

Other Actions outside of GGI Review

No.	Recommendations	Action	Responsible	Progress
36.	Responsibility for overall strategy and supporting strategies (Quality, finance, digital, workforce, EDI, sustainability, research, education, etc.) to remain with the board with committees seeking assurance on delivery.	Rolling programmes updated	Company secretary & Executive Leads	All rolling programmes updated. Complete
37.	Board / committee agendas to be re-organised into sections on strategy / performance / culture / governance following Board agreement of allocation of responsibility for scrutiny	Agendas to be restructured following agreement of allocation by Board	Company Secretary	Agendas restructured. Delegation of specific items approved by Board and reflected in ToR. Complete
38.	Adopt the nomenclature of “board” for the board of directors only and “committee” for those groups reporting directly to the board of directors only: • Statutory committees e.g. remuneration committee. • Assurance committees i.e. audit, workforce, quality committees. • Operational committee i.e. senior management committee. Refer to other forums as “team” or “group” as appropriate and update the terms of reference accordingly.	Update committee ToR’s to reflect change in name and communicate change across the Trust	Executive Directors	ToR’s updated and committee names changed. Complete.
39.	Increase the diversity and skills of the board by actively seeking and welcoming applications from those with all protected characteristics and who are representative of the communities we serve.	Include requirement in brief to external recruitment partners. Use best practice advice on language / presentation of recruitment materials. Ensure recruitment panels (including governors) are appropriately trained in EDI.	Chair	Nominations Committee members trained in EDI. Included in recent recruitment briefs to external search partners. Looking to appoint someone on the NHSE NExT Director Scheme by end Q4 2024/25. Successful NED recruitment taken place.

No.	Recommendations	Action	Responsible	Progress
40.	Maintain the current schedule of board meetings, committee meetings development sessions and other meetings but keep under review with a view to reducing the frequency (subject to on-going discussion and agreement with board committee chairs).	Review rolling programmes. Proposed to remove Board meeting in May, schedule WAC & QAC on the same day (increasing WAC meetings from 4 to 5 per annum)	Company Secretary and Chief Executive Officer	WAC & QAC meetings rescheduled to take place on the same day. May Board meeting replaced with Planning Day.
41.	Deep dives on progress in key strategy areas to be maintained as part of away day and development programme	To add to Board Planning / Development Plan for 2024/25	Company Secretary	Added to forward plan for Board Planning / Development sessions.
42.	Review the composition and make up of each committee to ensure that each has the appropriate balance of skills and experience, including the chair role.	Assessment to be carried out once 2 new NEDs in place – end Q3 2024/25	Company Secretary / Exec Leads	Assessment undertaken following successful appointment of 2 new NEDs. Committee composition updated. Complete.
43.	Review support for committee chairs to promote best practice in chairing including providing summaries, reflecting on meeting effectiveness, assurance reporting and balance of agenda items – to include GGI observations on meeting conduct.	Training offered to committee chairs through NHS Providers	Company Secretary	Training offer communicated with NEDs and completed where required.
44.	Current arrangements for remuneration committee will continue but with explicit additional responsibility for board succession planning incorporated in the Terms of Reference	Add to Terms of Reference	Company Secretary	Added to Terms of Reference and included in 2024 agenda / papers.
45.	Revise the terms of reference and membership of the current management board to include changing its name to senior management committee to emphasise its role as a board committee with delegated authority to be the main operational management decision making forum of the Trust	Update Terms of Reference Communicate change to key stakeholders	Deputy Chief Executive Officer	Revised Terms of Reference approved March / September 2024. Key stakeholders informed of decision and rationale.

No.	Recommendations	Action	Responsible	Progress
46.	Confirm and simplify the terms of reference and reporting lines of those groups reporting into the senior management committee (currently management board).	Review of groups / committees reporting to Senior Management Committee	Deputy Chief Executive	To be completed by end Q2 2024/25. Complete
47.	Reconfirm the allocation of the responsibility to each committee from the Board	To be included in terms of reference of each committee	Company Secretary	Discussion with committee chairs / exec leads in April 2024. Complete.
48.	The Board will receive a comprehensive revised dashboard as part of the public papers	Dashboard being developed for April 2024	DCEO / COO	To be presented from April 2024. Revised dashboard in place, further work underway to reflect updated IPQFR and use of SPC charts.

The Christie NHS Foundation Trust

Agenda item 28/24d

Meeting of the Board of Directors
26 September 2024

Subject / Title	GM Sustainability Plan
Author(s)	John Wareing, Director of Strategy
Presented by	John Wareing, Director of Strategy
Summary / purpose of paper	This paper provides an update to the Board on the Greater Manchester Sustainability plan.
Recommendation(s)	Members of the Board are requested to note the contents of the Greater Manchester Sustainability Plan.
Background papers	None
EDI impact/considerations	N/A
Risk score	N/A
Link to: ➢ Trust strategy ➢ Corporate objectives	N/A
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	GM Greater Manchester ICB Integrated Care Board

Agenda item 28/24d

Meeting of the Board of Directors
26 September 2024

1. Background

As part of the response to the NHS England Undertakings and the current financial, quality and performance challenges in Greater Manchester, the Integrated Care Board (ICB) is required to develop a Sustainability Plan (appendix 1).

The plan is designed to show how the system both returns to financial balance through addressing the underlying deficit and secures a sustainable future through addressing future demand growth and implementing new models of care year on year.

The Plan is separated in to 5 'pillars', including:

- Cost Improvement
- System Productivity and Performance
- Reducing Prevalence
- Proactive Care
- Optimising Care

Each of the pillars details a set of planned activities that will contribute to addressing the performance and financial challenge.

Key assumptions underpinning the Plan are:

- Delivery of the planned cost improvement programmes
- Savings being delivered through the optimising care pillar
- Implementation of a model of care that will reduce prevalence and enable proactive care.

2 Recommendations

The Board is asked to note the contents of the GM ICB Sustainability Plan.

For information, appendix 2 Letter re: Devolution Trailblazer Deal

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Greater Manchester

GM Sustainability Plan

10 September 2024

For ICB Board 18.9.24

Part of Greater Manchester Integrated Care Partnership

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Contents

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1. Introduction and context

This plan

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- Greater Manchester (GM) Integrated Care System (ICS) provides healthcare for 3m people living in 10 places. As a system, GM has sought to improve population health through working with partners whilst at the same time improving the NHS financial position and health service performance.
- A population-based approach to developing this Sustainability Plan has set out the current and future pattern of demand and associated costs attributable to Non-Demographic Growth (NDG), quantified the opportunities to improve population health, set out the immediate priorities to inform phasing and sequencing of these opportunities over time and considered the financial and performance position of the 9 NHS providers.
- This shows how a deficit this year may be compounded by approximately £600m of additional demand but can be addressed over time through a combination of population health measures, system collaboration and provider efficiencies. This will required a mixture of targeted, evidenced-based improvement with additional innovation in key areas of priority
- The plan is based on the recognition that system sustainability rests on addressing the challenges we face across finance, performance and quality and population health - and the relationship between these
- This is a ‘plan of plans’ since it comprises plans from across the GM system, categorised under 5 ‘pillars’ of sustainability.

Overview – What the Plan Shows

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We need to show ***how*** the system:

- ***Both*** returns to financial balance through addressing the underlying deficit
- ***And*** secures a sustainable future through addressing future demand growth and implementing new models of care year on year

This plan shows that:

- The projected remaining deficit, after Cost Improvement Plan delivery, could be eliminated over three years through
  - Consistent and complete implementation of existing Cost Improvement Plans (CIPs)
  - Complete implementation of system wide plans already developed across GM along with assumptions about those not yet detailed
  - Assumptions on reconfiguration of parts of the system which have not yet been planned in detail
  - Assumptions on reducing the number and scope of procedures of limited clinical value (PLCV), although this is not yet detailed
- With additional investment, the impact of Non-Demographic Growth (NDG) could be mitigated through
  - Assumptions about the impact of reducing prevalence and enabling proactive care on the health of the population

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Our vision and the outcomes we are seeking

“We want Greater Manchester to be a place where everyone can live a good life, growing up, getting on and growing old in a greener, fairer more prosperous city region”

Everyone has a fair opportunity to live a good life	Everyone has improved health and wellbeing	Everyone experiences high quality care and support where and when they need it	Health and care services are integrated and sustainable

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Our missions

Strengthen our communities

We will help people, families and communities feel more confident in managing their own health

Recover core health and care services

We will continue to improve access to high quality services and reduce long waits

Help people get into, and stay in, good work

We will expand and support access to good work, employment and employee wellbeing

Help people to stay well and detect illness earlier

We will work together to prevent illness and reduce risk and inequalities

Support our workforce and carers at home

We will ensure we have a sustainable, supported workforce including those caring at home

Achieve financial stability

We will manage public money well to achieve our objectives

Our strategy and our plans

NHS Greater Manchester

- Our Five-Year ICP Strategy (March 2023) sets out how we will work together to improve the health of our city-region's people. It is supported by our Five-Year Joint Forward Plan. We have described our plans for this financial year (2024-25) in our Operational Plan.

- The relationship between these plans is illustrated on the next slide. This includes the importance of the Sustainability Plan in addressing the undertakings issued by NHS England

- This Sustainability Plan is needed because the challenges we face now are more complex and acute than we have ever experienced in Greater Manchester. These challenges cover finance, performance, quality and population health. We have a significant underlying financial deficit; we are not consistently meeting core NHS delivery standards; and the health of our population is getting worse

- Innovation is a priority for us as described in the five year joint forward plan, and the recent HInM strategic plan describes how innovation will contribute to the agenda.

- We know that we need to change what we do and how we do it. We must do this to deliver on our responsibility to improve the health of our population – and to do this within the resources available to us

- We know that this will take longer than a single year, so this plan covers three years initially

NHS GM Plan Alignment

NHS Greater Manchester

The plans are connected and build on each other to ensure the delivery of the overarching 5-year strategy and national NHS objectives

24/25 Operational Plan

- Actions to deliver the performance workforce and financial commitments in the GM planning response to NHSE
- Additional actions to improve population health through prevention and early intervention

Sustainability Plan

A framework including:

- Priorities to achieve financial sustainability and effective use of resources across the GM NHS system , focusing on the next 3 years
- Delivered through GM, provider, locality and programme delivery plans.

Joint Forward Plan

The 5-year plan to deliver the ICP strategy through our missions:

- Strengthen our communities
- Help people stay well and detect illness earlier
- Help people get into and stay in good work
- Recover core NHS and care services
- Support our workforce and our carers
- Achieve financial sustainability

ICP Strategy

Sets out how we will work together over a 5-year period to achieve a GM where

- Everyone has the opportunity to live a good life
- Everyone has improved health and wellbeing
- Everyone experiences high quality care where and when they need it
- Health and care services are integrated and sustainable

NHS GM Single Improvement Plan

NHS GM response to the grounds for undertakings and improvement actions .

The plan is focused on ensuring the ICB is structured and has the right approaches and governance in place to enable it to deliver on the agreed priorities of the above plans.

How the pillars of sustainability contribute to our missions

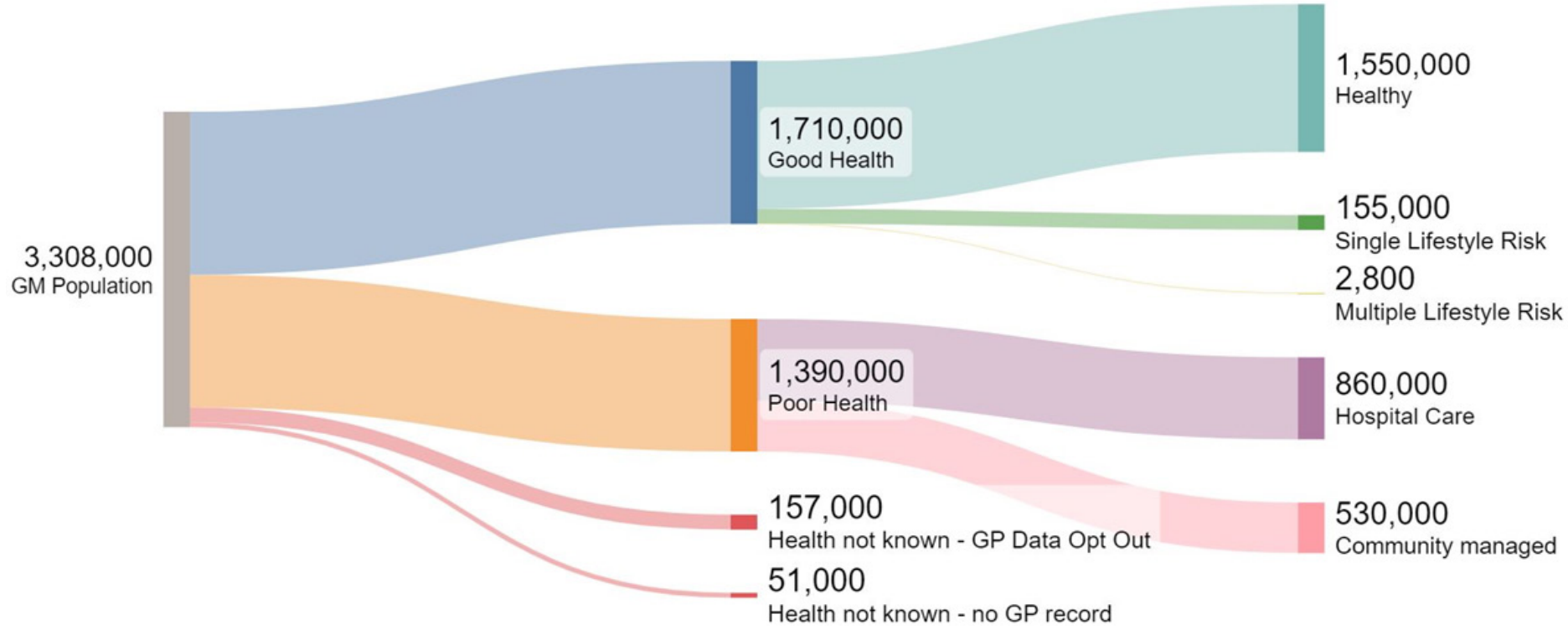
NHS Greater Manchester

- The ‘pillars’ of sustainability cover the full range of our missions – from enabling people to live good lives – through to ensuring financial sustainability
- **Cost improvement** in both providers and the ICB and **system productivity** will enable the effective recovery of core NHS services and support our workforce, thus enabling financial sustainability
- **Reducing prevalence** – acting on the wider determinants of health – will be enabled through Strengthen communities resilience and helping people to stay well and detecting illness earlier, as well as enabling people to get into and stay in good work
- **Proactive care** will also help people to stay well and detecting illness earlier, as well as enabling people to get into and stay in good work, and contributing to recovering NHS services and thus enabling financial sustainability
- **Optimising care** will enable the system to move towards the model of health described in our strategy and missions. It will also enable people to stay well and detect illness earlier, the effective recovery of core NHS services and support for our workforce, thus enabling financial sustainability

The Health of our Population

NHS Greater Manchester

- The strain our system is under reflects the poor health of much of our population. The newly available longitudinal record data which includes both primary and secondary care data shows that around half of the GM population presently have some formally identified poor health
- This is the primary driver of demand and cost in the system – and we know that the position will deteriorate further if we do not change our models of care and support



The Greater Manchester Model for Health

NHS Greater Manchester

- In the ICP Strategy we set out our Model for Health (see next slide). The model aims to ensure that as many people as possible are supported to maintain good health at home and in their communities –reducing demand on crisis-based and specialist care. We will explore new service models and strengthen the need for services to be flexible and offer a good range of options.

- We know that we must do more, and rapidly, to make sure this model is delivered consistently across our conurbation. This needs to focus on:
    - Consistent, at scale, delivery of an integrated neighbourhood model – including same day GP access where clinically appropriate and a community services delivered to a core GM standard
    - The systematic use of Population Health Management approaches to identify at risk cohorts and intervene earlier, delivered through more resilient primary care connecting to community and intermediate tier services
    - Accelerated progress of our mental health model, particularly crisis and community developments including Living Well, in-patient transformation, and access to psychological therapies
    - Continued focus on early cancer diagnosis
    - Much greater support for people to take more control over their own health - including digital offers
    - Standardisation of care pathways with consistent offer across GM and reduced variation
    - Significantly expanded use of new care models – including more care delivered outside hospital

The Greater Manchester Model for Health

NHS
Greater Manchester

2. The pillars of sustainability and the financial bridge

The pillars of sustainability

NHS Greater Manchester

Cost improvement	System Productivity and Performance	Reducing prevalence	Proactive care	Optimising care
Cost Improvement Plans (CIPs) leading to financial sustainability through Financial Sustainability Plans (FSPs)	Multi-provider/system activities to improve the use of our resources and our performance	Maintaining the population in good health - avoiding future costs through prevention and building up individuals capabilities and positive assets	Catching ill health early, managing risk factors, and delivering evidence based, cost effective interventions to reduce the level of harm	Transforming the model of care through system actions

These pillars are of course interdependent and cannot exist in isolation.

- For example, collective actions on provider productivity may enhance performance and optimise care as well as contribute to individual provider CIPs.
- Similarly, progress in proactive care delivery may also impact on other financial drivers, such as prescribing costs.

These interdependencies need to be understood as we make key decisions in implementing this plan.

Estimating non-demographic growth impacts

NHS Greater Manchester

- To understand the health needs of the population we have used the Analytics and Data Science Platform (ADSP) to access linked patient-level data on the GM population and developed a segmentation of the population. We have updated the methodology produced by Carnall Farrar in the SFF in Jan 2024, to use data that now includes primary care.
- In this analysis, we have observed what actually happened to the population's health between 2018 and 2024 and then used our understanding of this change to project forward to what the health of the population, and the resultant demand for services and their associated cost, might look like in 2030

We have identified the following population segments (each person can only be in one of these)

- Good health – no/one lifestyle risk
- Maternity
- Single long-term condition (LTC)
- Multiple LTCs
- Mental health illness
- Homelessness and substance misuse
- Cancer
- Frailty
- Palliative Care

- Our estimates show that the population will tend to move from better health and less costly segments to more complex and costly segments

The consequence of these changes in terms of patient numbers is substantial:

- the number of people in the Mental health illness segment being about 5 times larger in 2030 than it currently is
- The number of people in the Frailty segment (the most costly) being 3 times larger than it currently is

The cost of non-demographic growth

NHS Greater Manchester

- In the Strategic Financial Framework (presented to Board in January 2024) the estimated non-demographic growth costs stood at £539m. This was calculated by taking provider estimates of future activity demands and taking out what could be attributed to demographic growth
- Using this new population deterioration methodology, we estimate additional costs of non-demographic growth to be around £600m. This figure has been further validated by the Health Economics Unit who have been undertaking similar work in London
- The best way to reduce the cost impact of non-demographic growth, and an objective for our 'Investment Strategy', is to support people to stay in, or move into, a healthier segment.
    - For example, the projected additional costs from people moving from the 'good health' segment to the mental health illness' segment is around £85m so our interventions should be aimed at keeping people mentally well and in the good health segment.
- Similarly, the projected costs for the 120k people who move from multiple long-term conditions segment into the frailty segment is £222m.
    - Although there may be some benefits from reducing the high costs of healthcare to those in the frailty segment through service redesign and other model of care adjustments, the most sustainable and cost-effective solution is to stop people moving into the frailty segment at all – this could be through transformed models of care or targeted upstream investments such as in the Ageing Well programme

Leading action on non-demographic growth

NHS Greater Manchester

- The actions to address the projected non-demographic growth must be place-led.
- This will require an understanding of local projections by population segment, age and deprivation. It will set a clear challenge and trajectory for localities to be measured against and to demonstrate their ability to maintain or improve the health of their population.
- The action required will need to have considered blend of improvement and innovation, underpinned by demanding targets and rigorous method.
- Locality level performance against a comprehensive and appropriate set of preventative measures will be developed with localities each locality. For example:

  - The effectiveness of primary care, especially performance against care processes for CVD, diabetes etc alongside health checks for SMI, LD etc
  - The effectiveness of social care – e.g. proportion of people still at home 91 days after discharge from hospital into reablement/ rehabilitation services, the proportion of service users reporting control over their daily life etc.
  - A&E attendance, admission and readmission by population
  - Falls prevention,
  - Reductions in violence-, alcohol- or drug-related admissions,
  - The proportion of the adult population economically active
  - Decent Homes standards and supported housing provision
  - Medicines optimisation,
  - School readiness,
  - Obesity reduction
  - Active Lives survey results

Developing the Financial Bridge: the key activities

NHS Greater Manchester

Identifying the size of the financial and population health challenge:

Identifying and modelling how we will address the challenge

Dealing with the current financial deficit

- Confirming the position on the underlying deficit
- Including other projected further movements in the model (e.g. convergence and Cost Uplift Factors)
- Analysing the FSPs from all parts of the system
- The impact of key system programmes
- Modelling the impact of plans to change the model of care (for example, Health and Care Review) to optimise care

Addressing population need: priority activity

- Modelling non-demographic growth to predict future demand
- Priority activity already planned to address population need: reducing prevalence and enabling proactive care

Investment strategy

- Additional population health interventions funded through additional investment

The financial bridge – what it shows

NHS Greater Manchester

The bridge shows three ‘blocks’ with associated pillars.

Dealing with the current financial deficit

Shows how the underlying deficit can be substantively closed in three years, with detailed plans in place for year 1 and the inclusion of assumptions about developing plans for years 2 and 3

- Cost improvement
- System Productivity and Performance
- Optimising care

Addressing NDG 2024/5-2026/7 inc. investment (2025/6 onwards)

Shows how Non-Demographic Growth can be partially mitigated in three years through planned population health interventions where funding is already agreed and the partial impact of additional investment (in years 2 and 3) of £50m per year.

Impacts from population health interventions take time to demonstrate a full effect and so an impact of 1/3rd of the full impact from additional investment has been assumed in years 2 and 3.

- Reducing prevalence
- Proactive care

Investment 2027/8-2028/9

Shows how the remaining NDG ‘gap’ will be mitigated in the following two years (2027-2029) by further full impact from continued investment at the same level

The financial bridge

NHS Greater Manchester

The pillars of sustainability and their contribution

NHS Greater Manchester

From the analysis to develop the bridge, we identified five aspects of sustainability which we need to pursue: the 'pillars' of sustainability. Each of these contributes through finance and/or performance impacts. Details are in the following slides

Cost improvement	System Productivity and Performance	Reducing prevalence	Proactive care	Optimising care
Cost Improvement Plans (CIPs) leading to financial sustainability through Financial Sustainability Plans (FSPs)	**Multi-provider/system activities to improve the use of our resources and our performance**	**Maintaining the population in good health and avoiding future costs through prevention**	**Catching ill health early, managing risk factors, and delivering evidence based, cost effective interventions to reduce the level of harm**	**Transforming the model of care through system actions**
Combined contribution to overall plan leaves an underlying deficit after three years (~£160m) Financial savings through FSPs/CIPS: **£1046m**	Contribution to overall plan through achievement of performance objectives and improved productivity No financial savings	Contribution to addressing non-demographic growth (NDG) of £360m over 3 years ~£40m confirmed ~£67m from additional investment (to be detailed)	Contribution to addressing non-demographic growth (NDG) of £360m over 3 years ~£120m confirmed ~£33m from additional investment (to be detailed)	Contribution to overall plan of £148m (over three years) 40% of this contribution through confirmed plans, with the remainder still to be detailed
		Contribution to addressing non-demographic growth (NDG) of £240m in years 4&5 £300m (reducing prevalence), £200m (proactive care) from additional investment (to be detailed)		

Cost Improvement - Overview

Cost Improvement Programmes (CIPs) are a key driver of bridging the underlying gap, both for providers and the ICB.

- The focus of respective CIPs needs to be clear to ensure we avoid double counting elsewhere across the sustainability plan.
- ICB CIPs covers some system costs e.g. Contract Reconciliation. These are currently included here as cost improvement.
- We show here the key programmes included in CIP plans for the ICB and across the providers

Principles used in developing this plan

- Trust/provider improvement plans were checked to include only those things that are within their scope
- Assumptions within provider plans were checked against assumptions about allocations from the ICB and any associated growth
- GM-wide programmes will have financial implications for individual providers and these impacts were calculated/reported centrally to avoid double-counting

Cost improvements – Trusts and ICB

NHS Greater Manchester

- As part of individual Trust Financial Sustainability Plans, there are ambitious levels of Cost Improvement Programmes (CIP) set out over the next 3 years to support working to run rate balance. Work is planned at different levels
    1. At individual organisational level. A thematic framework for this is under development, to be completed by the end of September.
    2. At locality/ sector level
    3. At GM level – Trust Provider Collaborative (TPC) led commitments and schemes (listed under the System Productivity and Performance pillar in this plan)

Organisation (Trust)	Locality/ sector	ICB	
Key themes in Trust CIPs • Income • Corporate services transformation • Digital transformation • Estates and Premises transformation • Medicines efficiencies • Procurement • Service re-design • Pay	Examples include: • Four Localities Partnership • Mental Health Trust collaboration • Joint working Bolton FT & WWLFT	A wide range of programmes, including: • Continuing Health Care • Medicines Optimisation • Mental Health OAPs • Autism and LD • Better Care Fund • Community Services • Estates • Independent Sector	• Legal Services • Locality Individual Schemes • Non-Healthcare Contract Consolidation (NHCC)s • Optimal Organisational Structure • Translation and Interpretation • Virtual Wards • Workforce External Drivers

System Productivity and performance improvement

NHS Greater Manchester

- The national definition of NHS productivity is how well the NHS turns a volume of inputs into a volume of outputs. In the context of the GM Sustainability Plan it is about how we optimise and maximise the use of our assets and resources in order to produce the best outcomes for our population, which address the system's deficits in performance, population health and finance.
- It is closely associated with our aims for sustained performance improvement and collaborative schemes are in place/ planned, aimed to improve system productivity and performance. These will be integral to delivering financial plans, alongside returning to consistent delivery of all NHS core standards.
- The schemes will enable delivery of the individual Trust and ICB commitments in terms of CIPs and FSPs, as well as working to improve performance and quality – exploiting our opportunities as a system to work at scale, and to learn and adopt best practice.
- Whilst these programmes may not generate financial savings, they are a vital part of enabling and securing a sustainable system, improving the experience of patients in the system, and supporting the dedication and skills of our colleagues delivering and supporting care.
- Trusts will continue to work together across GM in terms of productivity, facilitated through the relevant system group, and building on various benchmarking exercises with regular updates available for consideration and action through GM governance

System Productivity and Performance – the programmes

NHS Greater Manchester

Programme	Contribution to system sustainability
Programmes to drive performance improvement and quality of care through optimising models of care and implementing targeted new ones	
Elective care	• Reduced waiting times for patients • Reduce variation in access
Cancer	• Reduced waiting times and managing growth in demand. • Reduce variation in access and provide service resilience. • Cost avoidance – reduced LoS related to anticipated growth in demand, waiting list initiatives, in/outsourcing. • Reduced variation.
Diagnostics	• Wait list reduction • Reduction in outsourcing • Reduced turnaround times for patients
Mental Health	• Savings from reduced OAPs can be reinvested in Mental Health services
Urgent and Emergency Care (UEC)	• Improved patient flow. • Achievement of 95% of patients seen within 4hrs in A&E by March 2027 • Sustain Cat 2 ambulance response times at or above national target
Transform corporate services through innovation and enhanced collaboration, to make them more efficient, resilient and cost-effective	
Scaling People Services Programme	• Enabler of realising CIPs; standardisation of systems/processes and automation will enable efficiencies
Corporate services	• Enabler of realising CIPs; improved workforce resilience
Other programmes	
Workforce	• Sickness absence - potential savings contribution to CIPs • Turnover - cost prevention • Reduced temporary staffing and improved capacity
Digital	• Requires significant capital investment • Will then deliver both financial efficiencies and productivity gains

Reducing prevalence

NHS Greater Manchester

The opportunity to reduce the growth in prevalence is based on primary prevention

Primary prevention involves taking action to reduce the incidence of disease and health problems within the population. The purpose is to prevent disease or illness from ever occurring.

Primary prevention of poor health includes actions to :

- Supporting people to live healthier lives by improving the conditions in which they are born, work, live, grow, and age (including education, employment, income, social support, community safety, air and water quality, and housing).
- Supporting people to tackle behavioural risk factors (such as smoking alcohol, substance misuse, poor diet and inactivity)
- Prevent infectious disease (such as with immunisation)
- These can be delivered at a whole population level (universal measures) or targeting those at highest risk

Benefits

- This will reduce the number of individuals that move between segments, particularly those that may drift out of the good health segment without intervention
- Reducing the volume of individuals that become ill will allow for resource to be spent on those most in need and produce a saving to the system

Reducing prevalence – programmes and impact

NHS Greater Manchester

Programme	Investment already agreed 3 years (£m)	Savings 3 years (£m)
HIV	12.6	52.3
Making Smoking History		
Physical Activity		
Work and health		
Home Improvement		

In addition to the impact from investment already agreed, further impact could be gained from additional investment for the faster and wider implementation of programmes already underway

	Additional investment to be agreed 3 years (£m)	Additional savings 3 years (£m)
Other Population Health	50	117

Overall Impact ~£40m (savings – investment)

Impact from additional investment in three years: £67m (savings – investment)

ROI from additional investment assumed to be 1/3rd of full impact because of the early stage of the programmes

Proactive care

NHS Greater Manchester

There are two streams of work in this pillar:

- The secondary prevention elements of the GM multi-year prevention plan
- A focus on reducing variation in the provision of services across GM

Secondary and tertiary prevention are key to providing more consistent, person centred and proactive care

- Secondary prevention focuses on early detection of a problem to support effective early treatment such as prescribing statins to reduce cholesterol and activities such as screening and health checks in non-symptomatic patients

Tertiary prevention is about supporting people to live well by optimising the treatment and management of chronic conditions to minimise further harm

Benefits

Providing care more efficiently will be driven by improvement in population health management and also reduce the financial costs to the system if people are seen/supported by the most appropriate teams

Proactive care: programmes and impact

NHS Greater Manchester

Programme	Investment already agreed 3 years (£m)	Savings 3 years (£m)
Alcohol Care Teams	30	150
CVD		
Diabetes		
Social Prescribing		
Tobacco Treatment Teams		

In addition to the impact from investment already agreed, further impact could be gained from additional investment for the faster and wider implementation of programmes already underway

	Additional investment to be agreed 3 years (£m)	Additional savings 3 years (£m)
Other Population Health	50	83

Overall Impact ~£120m (savings – investment)

Impact from additional investment in three years: £33m (savings – investment)

ROI from additional investment assumed to be 1/3rd of full impact because of the early stage of the programmes

Optimising care

NHS Greater Manchester

- This pillar focuses on transforming the model of care through system actions.
- This will be driven through reviews of our health and care system and strategic commissioning,
- Commissioning (supported by robust contracts) of outcome-focused and evidence-based services and interventions will ensure we commission the right service at the right time by the right team in the most cost effective, efficient way.
- Further potential reconfiguration through the Health and Care review, as well as options such as hot and cold sites will require new models to be implemented.
- This will include commissioning new care models/services with a prevention focus (with outcome-based specifications) from other sectors – including primary and/or community care where acute based services are currently a less efficient/resilient option. This is in line with the GM Model for Health and will need to be supported by an investment strategy

Optimising care: programmes and impact

NHS Greater Manchester

Programmes already identified	Savings 3 years (£m)
Pathology	59.6
Dermatology	
Neurorehabilitation	
Commissioning more effective processes – vasectomies	
Adult ADHD	
Referral Thresholds	
PLCV - TES and spinal injections	

	Additional savings 3 years (£m)
Programmes with financial savings not yet confirmed	88.9

Impact from programmes already detailed ~£60m
Impact from additional savings to be confirmed: ~£89m

Total savings: ~£149m

The development and delivery of the plan

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- Delivering this plan and moving to a sustainable health and care system will require us to be explicit about investment (revenue and capital). Investment in prevention, early diagnosis, primary and community care and mental health is inherent in this plan. Transparent identification and reporting against that investment will be established.
- Where plans for future years are less well developed, assumptions have been made (and described)
- Discussions with local authority Treasurers are underway to support the connection to financial health at a place level as part of local integrated planning and delivery
- The governance and monitoring of the plans has yet to be determined in detail but is indicated in this plan and will be confirmed swiftly (see next slide).

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Governance Summary

- The governance and accountability for the elements in this plan can be summarised as follows:

Pillar	Governance and oversight through
Cost Improvement	Trust Boards, ICB Provider Oversight Meetings, ICB Board and Finance Committee
System Productivity	System Boards, TPC (currently under review)
Reducing Prevalence	Locality Boards, Population Health Committee
Proactive Care	Locality Boards, Population Health Committee
Optimising Care	Commissioning Oversight Group (COG), relevant System Boards, TPC (currently under review)

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3. How we will enable sustainability

Investment strategy

- Each year NHS GM receives growth funding as part of its national allocation from NHSE. Some of this is contractually allocated to various parts of the system, including providers. However, the remainder could be used (as is its intention) to fund growth in parts of the system determined by the strategy of NHS GM
- In 2024/5 the remainder was **~£61m**. This varies year on year depending on changes to national contractual arrangements.
- To date NHS GM has not spent this funding on growth but has netted it off in their accounts against other costs – usually against convergence costs which are of a similar amount
- If the convergence costs can be covered by savings elsewhere in the system, this growth funding could be used for its original purpose. For the purposes of this analysis, we have assumed **£50m** a year might be available to fund growth (from year 2 – 2025/6).
- This proposal requires consideration by the GM system but must target allocative efficiency for the achievement of outcomes for the population.

The Role of Capital

Capital is an important enabler to the delivery of the Sustainability Plan

The Capital Resource and Allocation Group has been tasked with developing a long-term plan for deployment of system capital. This work is focusing on:

- Clearly defining the parameters of what is meant by a sustainable capital plan.
- The investment strategy if we must live within current capital constraints.
- What the system could achieve if it had increases capital to deploy into several key areas (Estates, Digital, Equipment). Particularly linking this to known areas i.e. the £3.4bn of national capital to support productivity.

This work is ongoing and focused on three phases, including a Y1 plan for no increases in capital income, with options for Y2-5 being developed to support strategic requirements

Continued grip and control

The strengthened NHS GM oversight arrangements will be pivotal in tracking delivery of the programmes set out in the Sustainability Plan. These include:

- Provider Oversight Meetings (POMS): building on and succeeding the PWC led finance and performance recovery meetings. The scope is broader to include finance, quality, performance and workforce
- Locality Assurance Meetings (LAMS): focus on delivery of delegated functions. These follow a consistent approach to the POMS
- System Group Meetings: focus on delivery of transformation programmes
- Performance Improvement Assurance Group (PIAG): focus on tracking actions and impact of the refreshed Performance Improvement Plans (PIPs)

Addressing the undertakings

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The Sustainability Plan supports our system response to the four pillars in the Improvement Plan developed in response to the undertakings issued by NHS England:

- Leadership and governance
- Financial sustainability
  - Develop three-year plan to address underlying deficit position
  - Clarify system commissioning intentions and implement
- Performance and assurance
- Quality

Our Workforce

NHS Greater Manchester

- This plan has a strong relationship to our People and Culture strategy. As illustrated below, our ability to deliver this plan rests on supporting our workforce and developing collaborative cultures as well as the appropriate controls to ensure that the size and composition of our workforce matches the financial resources available.

Assumptions on which the plan is based

NHS Greater Manchester

The following assumptions are the basis of the Sustainability Plan:

a) Trust and ICB **cost improvement** will be delivered in full as planned, along with the achievement of all performance objectives.
b) Other financial savings will be achieved through **optimising care** through service review/commissioning, and consideration (specifically) of reducing Procedures of Limited Clinical Value (PLCV)
c) We will move to a model of care that supports people to maintain good health (**reducing prevalence** and **proactive care**) through changing how we allocate our financial resources

NHS Greater Manchester

ANDY BURNHAM
MAYOR OF GREATER MANCHESTER

Wes Streeting MP
Secretary of State for Health and Social Care
Department of Health and Social Care
39 Victoria Street
London
SW1H 0EU

16th August 2024

Ref: AB/SRL

Dear Secretary of State

Congratulations on your appointment as Secretary of State for Health and Social Care.

Greater Manchester has a long history of working in partnership with Government to improve the lives of our residents. The health and care system has always been central to this, and Greater Manchester was the first city region to secure a devolution deal for health and care.

As one of only two ICSs in the country that are coterminous with a Mayoral Combined Authority (MCA) we believe this represents a significant opportunity. The partnership between an ICS and an MCA working at city-region level gives us the capability to act at scale both on delivering safe, effective and timely NHS services and on the things that make us healthy - including jobs, skills, planning, housing, transport and air pollution. This has been enhanced by our Devolution Trailblazer Deal – including the Integrated Settlement – which is the only trailblazer deal to incorporate health and care. In addition, NHS GM and GMCA are now co-located in the same building, further enhancing integration.

We share your Government's view that the NHS and care are vital contributors to the priority of kickstarting economic growth. To deliver on this agenda, we believe there is significant potential for the Government and Greater Manchester to work together to develop the partnership between the ICS and GMCA further across four key areas. These were agreed through a session of Greater Manchester's Reform Board, including all public service partners, and led by the Mayor of Greater Manchester and the Chair of the Integrated Care Board.

A Prevention First Approach

We know that to secure the sustainability of the health and care system in Greater Manchester we must move to a 'prevention first' approach. Our analysis shows that if we do not act on prevention now, the health of our population will continue to deteriorate creating additional costs of £600m in the next five years.

We want to go further on our neighbourhood model – and GM offers the opportunity to test at scale national reforms in primary and social care – as part of our Live Well model. For example, GM could integrate our community Live Well offer with primary care to reduce the significant demand and pressure on GPs arising from non-medical issues.

A high-quality social care system that enables people to live the life they want as independently as possible is integral to our neighbourhood model. We have the right infrastructure to test reformed models of social care at a city region level. Greater Manchester

is ready to step forward to test and implement a new minimum wage for care workers. The investment could immediately benefit recruitment and retention in the sector, increasing the quality, capacity and sustainability of the market. With nearly 85,000 roles in adult social care across Greater Manchester, this investment would also drive economic growth and build community wealth.

Spend on children's services is the one of the most significant financial and operational risks facing councils in Greater Manchester. We have embraced the family hub agenda with hubs now operational in all ten districts. We would welcome the opportunity to work with both DfE and DHSC on what a next phase might look like including what is needed to get the best possible health offer in the family hubs.

To underpin our approach to prevention, we want to partner with Government to expand the current Single Settlement to enable locally driven public service reform that provides greater flexibility and innovation in how our systems of support deliver prevention – including our multiple disadvantage programme. This would enable sustainable funding approaches and facilitate more community-led approaches to prevention.

Skills, Work and Health

Our Integrated Care Strategy makes a clear commitment for the health sector to play its role in supporting people into good quality work in our city region. We share your Government's commitment to break down the barriers that prevent people experiencing health problems from accessing good work.

GM is ready to work with Government to build on our successful track record of delivering the Working Well approach – and to do this at a much greater scale and to be a test site for further innovation. We want to work with Government to extend the devolution of JCP and DWP employment support to GM as part of our Single Settlement, aligned to our current Adult Skills funding and the Live Well model. Devolution will allow us to provide flexible work, health and skills support to more people for the same funding by integrating services via a place-based model.

This integrated model will include:

- Our support for targeting an increase in the employment rate from 75% to 80%. This equates to 150,000 GM residents moving into work – our employment rate is 71.9% so GM has more ground to cover.
- Through a new model of outreach and engagement we will reach more people that traditionally wouldn't access support through JCP.
- Devolved employment support would allow us to shape a joined-up work, health and skills offer and enable Jobcentres to be more responsive to local needs. In GM this would see the creation of a 'Live Well' service – a new way of providing social support, stability, and security with community-based early intervention, triage and signposting to help people back to work.

The health and care sector is the biggest employer in the city region. We know that we have an obligation to set the standard as a good employer. We have been working with health and care employers to ensure they are members of the Greater Manchester Good Employment Charter which includes payment of the real living wage, sickness pay on first day of absence, limits on zero hours contracts (employee led only) and evidence that employees' voices are heard. Health and care employers are exploring how to increase our apprenticeship and T-Level capacity and contributing to achieving parity between technical and academic education through the Greater Manchester Baccalaureat.

Advancing Health Innovation

Greater Manchester has a vital role to play in making the UK a life sciences and medical technology powerhouse. We have one of the largest and most successful life science clusters in the UK allied to an integrated health innovation system – led by Health Innovation Manchester. This is underpinned, by the unique digital asset of the Greater Manchester Health and Care Record based on GM's Secure Data Environment Platform GM now has the permissions, agreements and governance in place to be able to access this data for direct care, generating population health insights, and for secondary uses and research – in partnership with academia and industry on a global scale.

There are four strategic areas where we can go further through partnership with Government:

- Health Innovation in Places - there is opportunity to develop next generation health innovation and wellness approaches for local people, using modern facilities underpinned by digital and multi-channel approaches, with embedded commercial property for life sciences, health care and wellness innovation, and housing
- Life Sciences Eco System Development – GM has undertaken a robust analysis of its health innovation and life sciences ecosystem, identifying a significant cluster with high recent growth. We will drive growth through local and inward investment to advance GM's position as a globally important life sciences cluster. This will include a focus on biologics manufacturing, a major global growth market.
- Academic Accelerator – Last year we secured investment from Innovate UK to an advanced diagnostics accelerator programme, which is delivering benefits for patients through specific projects and maturity of the academic-industry interface. This short-term funding is due to complete in March 2025, but we believe there are major opportunities to improve outcomes for local people and drive economic growth by furthering this approach within GM, under a devolved innovation settlement.
- Accelerated Life Sciences Market Access - GM has the ingredients to become a global life sciences superpower, with a focus on accelerated regulation, effective clinical trials, a learning market for pharma/medtech and accelerated access for citizens to novel innovations at scale.

Health Capital Investment and Regeneration

We believe there is significant opportunity from unlocking the potential of NHS capital investment and new models of care as part of wider regeneration and place development. This can support your Government's priorities.

We understand the challenges surrounding the New Hospital Programme and will work with you to support the review. However, we would like to take the opportunity to emphasise the centrality of the redevelopment of North Manchester General Hospital to the health and prosperity of people in and around North Manchester and the north of Greater Manchester. Should the redevelopment be further delayed or not proceed, then the achievement of these population outcomes would be put at risk and there will be a material impact on the sustainability of health and care services in the conurbation.

In North Manchester, our communities experience some of the highest socio-economic disadvantage and poorest health and life outcomes in the country, with healthy life expectancy below 60 years for both men and women – nine fewer years than the England average. Compounding this challenge, NMGH, currently operates from dilapidated and in part Victorian estate of which 70% is in urgent need of rebuilding. The hospital estate experiences failures on a month-by-month basis which exacerbates the already incredibly challenging NHS delivery environment – including notably a ceiling collapse leading to the closure of theatres for a six-week period last year.

The estates maintenance 'backlog' at NMGH now stands at £146m and, in reality, this means that it would cost between £200m to £300m to simply bring the existing estate to a fit for purpose condition within current guidance and regulations. With the Trust currently expending in excess of £10m per annum just to keep the building operational, the current situation is untenable.

The redevelopment of NMGH will also act as a catalyst for the wider growth and regeneration of North Manchester, together with the Victoria North programme - supporting housing development, increasing economic activity and productivity – directly speaking to the Government's central mission.

More broadly, we are progressing an approach to health capital investment linked to new models of health delivery but also in context of local growth priorities. There is huge potential to align capital investment across sectors to underpin local growth objectives. In addition to NMGH plans are in progress for a Wythenshawe Health Campus; a new hospital model in Stockport aligned to a £1bn regeneration of the town centre; and a major new health campus in Farnworth, Bolton. These developments will embed health investment as part of wider regeneration across GM. However, access to national NHS capital pipelines remains problematic with a disjointed and opaque capital application system. We would want to work with Government to find new ways for ICSs to access capital on a consistent basis and deploy it to boost productivity.

The capital programmes set out above can play a vital role in delivering in both Greater Manchester's and your Government's commitment to boost house building – through providing suitable sites for housing development. Greater Manchester has formalised the relationship between health, the housing sector and GMCA through our Tripartite Agreement. This means we are ideally placed to test innovative approaches that connect housing, health and care to reduce demand on services and boost growth. This includes upscaling delivery of Supported Housing and working with Government to implement the Warm Homes Plan – in conjunction with other Retrofit Programmes and Decent Homes.

We also believe there is potential to work with Government to enhance and accelerate the work already underway in Greater Manchester to reform the childrens social care market through access to additional capital funding. This would enable local authorities, health partners and the voluntary sector to work together to increase sufficiency and quality of provision to improve outcomes for our children and young people looked after.

We would be keen to meet with you to discuss the opportunity to work together highlighted in this letter. We would also be happy to put together a programme of visits for you across Greater Manchester so you can see firsthand how the partnership between the ICS and GMCA offers a unique opportunity to improve health at city-region scale as a core component of driving economic growth.

We look forward to hearing from you.

NHS
Greater Manchester

ANDY BURNHAM
MAYOR OF
GREATER
MANCHESTER

ANDY BURNHAM
MAYOR OF GREATER MANCHESTER

SIR RICHARD LEESE
CHAIR, NHS GREATER MANCHESTER INTEGRATED CARE

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 no patient safety incident investigations triggered in August. There were 2 incidents in total reported in August which require a learning response, both of which were reported with the classification of moderate harm. Details of each incident can be found on slide 6. All the incidents are still progressing through to full root cause analysis. No never events were reported in month.
- There are 8 Trust level risks scored at 15+. Details of these can be found on slides 10&11.
- 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 5 cases of C-Difficile, 3 cases of E-Coli, 2 case of Klebsiella and 1 case of Pseudomonas reported in August that were deemed attributable to the Trust. No lapses in care were identified.

Performance

- In August the new combined 62-day performance subject to validation was at 77.8% which is above the new standard of 70%. The new combined 31-day performance was 99.2% which is above the new standard of 96%. The internal 24-day performance continues to improve but is below standard at 77.3%. All 62 and 24-day breaches are reviewed to ensure any delays are understood and plans can be implemented to mitigate any future delays. Improvement plans are in place and performance is expected to improve before the end of the financial year. The Trust's RTT 18-week performance is well above standard at 98%. The Trust achieved the 75% faster diagnosis standard in August with a compliance score of 86.4%.
- There were no patients waiting over 52 weeks at the end of August.
- Referral numbers in August reduced from a high in July but remain above the 23/24 average.

HR

- Staff absence decreased from July to a position of 4.41% against a target of 3.4%.
- PDR performance improved from July's position. Mandatory training has also improved from July's position and remains well above the set standard.

Finance

- The Trust is reporting a surplus at the end of M5 of (£3.5m) against a M5 YTD plan of (£2.9m), which gives a month 5 variance of (£0.6m) better than plan.
- Capital performance to month 5 was (£0.6m) below the revised plan submitted to NHSE&I in June 24.
- Performance to month 5 was £0.6m 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 £4.3m on capital schemes to month 5, primarily on the TIF ward refurbishment as well as ongoing digital projects and small replacement assets

SUMMARY DASHBOARD

NHS
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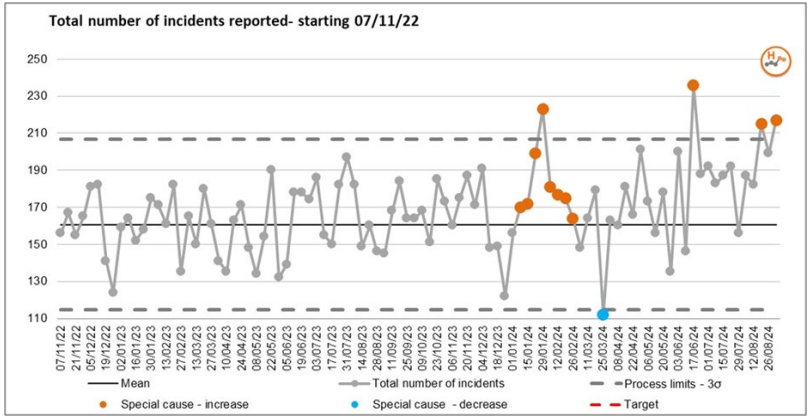
Indicator	Threshold / Standard 24/25	Apr-24	May-24	Jun-24	Jul-24	Aug-24	YTD
Patient Safety Incident Investigations	-	1	2	1	0	0	4
Never Events	0	0	0	0	0	0	0
Radiation Incidents Reported (IRMER Reportable)	0	1	3	1	3	0	8
Radiation Incidents Reported (IRMER Reportable - Grade 2 or above)	0	0	0	0	0	0	0
Number 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	0.3
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	3.8
Sepsis - timely treatment with IV antibiotics (established inpatients)	90%	90.0%	87.0%	96.4%	94.4%	92.4%	-
Sepsis - screening (presenting as an emergency)	90%	94.9%	100.0%	100.0%	97.5%	96.9%	-
Number of Trust-Wide Risks Grade 15 or Above	-	6	6	9	13	8	-
28 Day Faster Diagnosis Standard	75%	81.3%	75.0%	100.0%	91.7%	86.4%	-
62 Day Compliance	70%	71.2%	72.1%	72.4%	76.6%	77.8%	-
24 Day Compliance	85%	71.5%	72.2%	74.6%	78.1%	77.3%	-
31 Day Compliance	96%	99.2%	99.6%	99.2%	99.1%	99.2%	-
18 Weeks Compliance - Incomplete Pathways	92%	98.4%	98.7%	98.1%	98.0%	98.0%	-
Patients waiting >52 Weeks	0	0	0	0	0	0	0
Patients waiting >62 days at end of month (62 Day Classic)	80	129	119	100	95	93	-
Patients waiting >104 days at end of month (All 62 Day Targets)	-	47	51	42	49	49	-
Length Of Stay (Elective & Non-Elective Inpatients)	-	7.81	6.39	6.39	7.16	6.54	-
Patients Discharged Beyond Ready for Discharge Date	-	13	2	6	17	16	54
Patients Discharged Beyond Ready for Discharge Date - Total Bed Days Lost (days counted in the month of discharge)	-	116	15	84	289	207	711
Patients Discharged Beyond Ready for Discharge Date - Average Bed Days Lost (days counted in the month of discharge)	-	8.9	7.5	14	17	12.9	-
Hospital Cancelled Operations on the day for non clinical reasons	0	3	2	0	0	2	7
Hospital Cancelled Operations on the day for non clinical reasons - NOT rebooked within 28 days	0	0	0	0	0	0	0
Complaints Received	12 (23/24 Avg)	12	14	8	21	10	65
PALS Contacts	35 (23/24 Avg)	32	67	39	37	44	219
MRSA	0	0	2	0	0	0	2
C-Difficile - All Attributable Cases (Pre & Post 48 Hours)	<36	2	2	4	6	5	19
C-Difficile - Attributable Cases Due To Lapse In Care	0	0	0	0	0	0	0
MSSA Bacteraemia - Attributable	No Target	1	2	3	1	0	7
E-Coli - Attributable	<29	6	4	4	1	3	18
Klebsiella Species - Attributable	<14	1	2	2	1	2	8
Pseudomonas Aeuriginosa - Attributable	<10	2	0	0	1	1	4
Staff Sickness	3.4%	4.56%	4.39%	4.45%	4.75%	4.41%	-
Staff Mandatory Training	>80%** / <80%	92.7%	92.7%	93.2%	93.7%	93.8%	-
Staff PDRs	-	84.6%	85.7%	85.3%	86.6%	88.0%	-

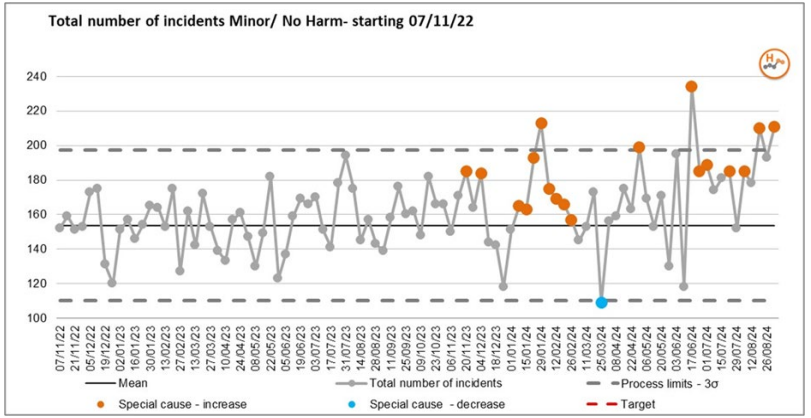
***Compliance if <80% & risk assessment in place*

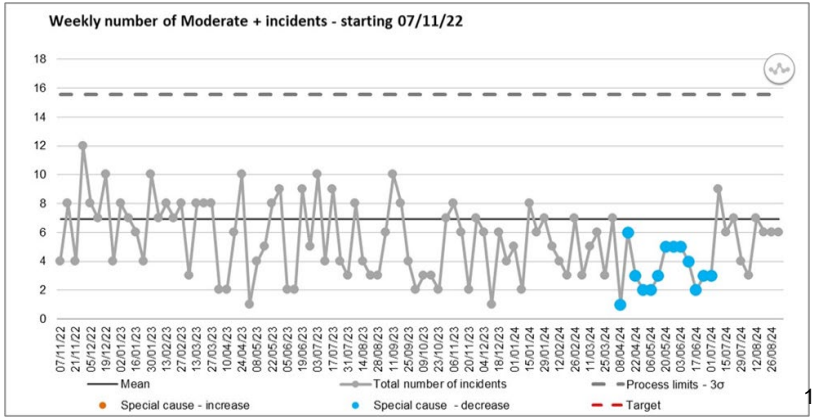
*****Measures currently monitored externally in the Oversight Framework reporting process.*

Incident Reporting

The Christie NHS Foundation Trust

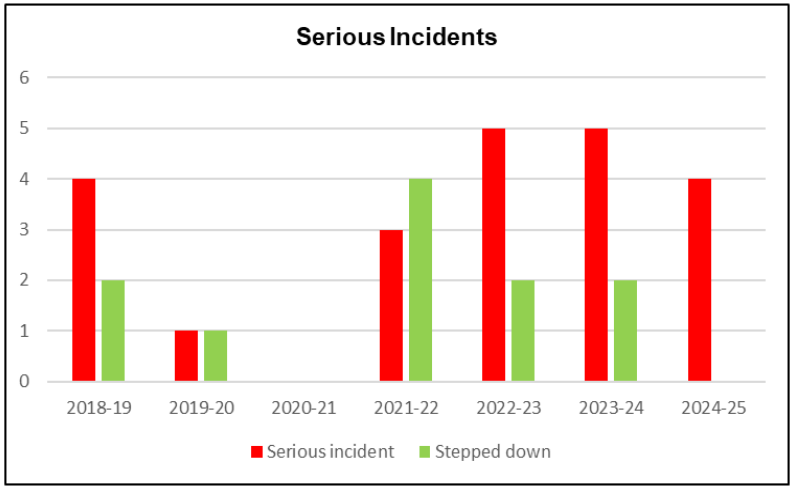






Special cause decrease can be noted for reported weekly moderate incidents (post triage) , this reflects the change in incident grading in the new Datix system from March 2024 .'Near miss' incidents can now be submitted (graded as no harm) which previously were submitted as moderate in severity.

Serious Incidents and Never Events



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

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

Patient Safety Incident Investigations (PSII's) triggered
There were no PSII's identified in August 2024

Note: the Trust transitioned from the Serious Incident Framework to the Patient Safety Incident Framework in April 2024.

Incidents identified that require a Learning Response

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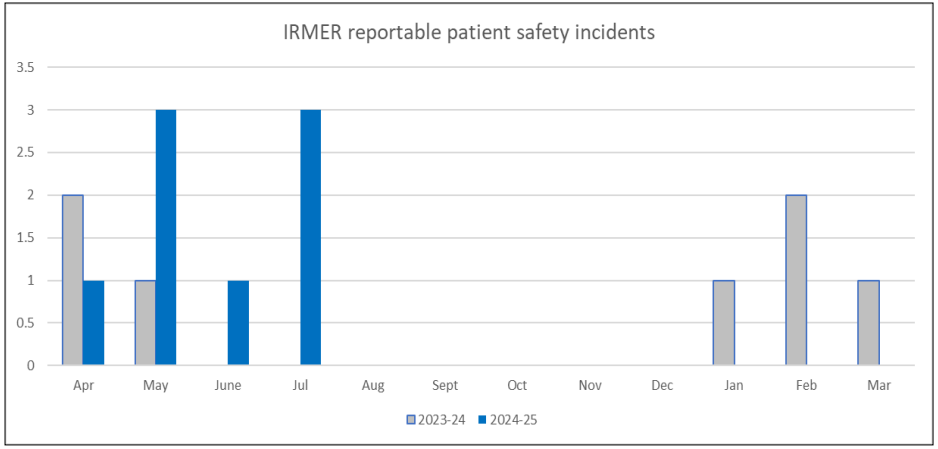
August 2024 – RCA/learning response to be presented to ERG		
Reference	**Description**	**Reported Harm Level**
2121	Patient was reviewed in clinic in May 2024 and admitted directly to hospital due to significant pain issues. Urgent CT arranged which revealed significant progressive nodal disease. On review, the disease had been present but not reported on imaging in April and January 2024.	Moderate Harm
4021	Audit of inpatient medication charts identified incidences of transcribing of prescriptions/ medication given without completed prescription	Moderate Harm

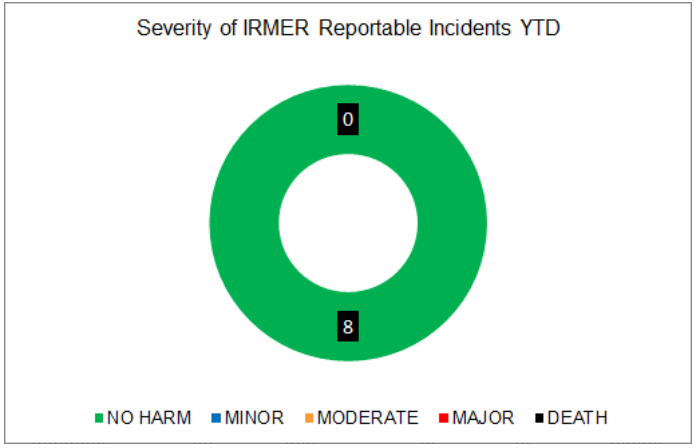
Learning – Patient Safety Incidents

The Christie NHS Foundation Trust

Agreed learning and revised severity outcome following executive reviews August 2024			
Ref	**Description**	**Learning**	**Outcome**
1433	A patient was 1:1 nursed due to being confused and a falls risk. Fall resulting in hip fracture occurred when mobilising with assistance.	• Review moving, handling and risk assessments to ascertain if a prompt for number of staff required to assist with equipment is required. • Explore education and training for enhanced observation.	Moderate Harm
1059	Patient admitted for surgery, staff noticed impaired cognition and low mood. Review by dementia nurse specialist identified sertraline had not been prescribed whilst an in-patient.	• Pharmacy determined patient was prescribed sertraline medication in the community but relied on patient information, this was not followed up by any team. Not known if they were aware of capacity concerns • The patient lives out with the Manchester area so pre op were unable to use GM Care records. • History of depression not added to past medical history when completing surgical listing card	Moderate Harm

Radiation Incidents





There were no IrMER reportable incidents reported in August 2024:

Harm Free Care

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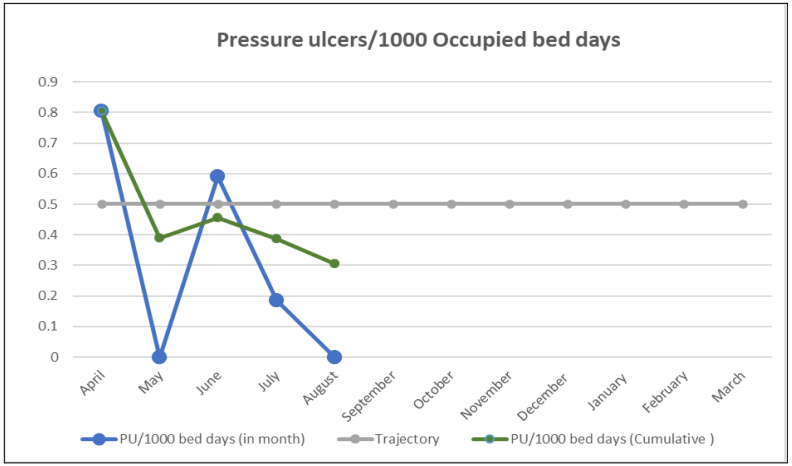
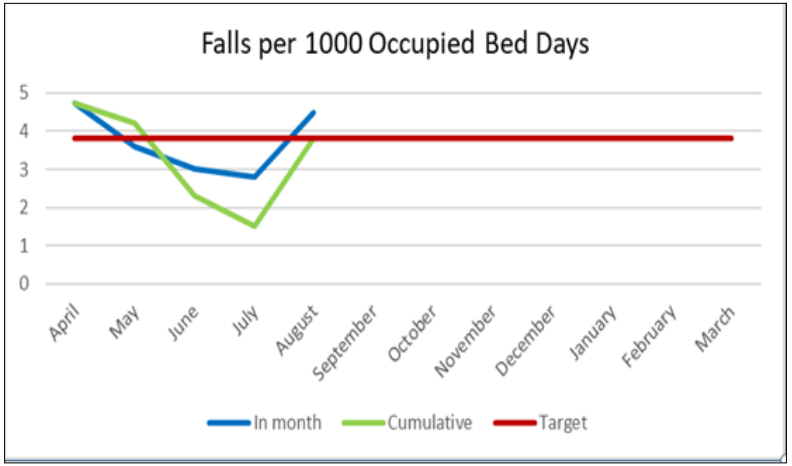
Pressure ulcers per 1000 occupied bed days



The ambition for 2024/25 is to maintain previous good performance of no less than 0.5/1000bed occupied bed days a month. Currently below this at 0.3/1000 occupied bed days.

No pressure ulcers were identified in August

Falls per 1000 occupied bed days



25 IP Falls in August (above target mean of 20).

4.5 fall per 1000 OBD, above target mean of 3.8.

4 low harm falls, 0 moderate

84% no harm falls

Fallsafe essential training for role specific—please encourage all your teams to complete

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

Corporate Risks

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There are 8 Trust-wide 15+ risks in August

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 had not accepted this proposal.
There is a risk that patients management plans may be impacted due to delayed radiology reporting. (Risk ID 3380)	16	Ongoing weekly review of ECAP uptake following change in rate on 01/07
Risk of delayed patient treatment due to extended TAT in histopathology results (Risk ID 3688)	16	• A daily update of cut up status is sent out • A weekly divisional escalation meeting is held • Specialist GI escalation group has been created meeting fortnightly • Discussion with JV partnership in respect of external expert overview in Histopathology
Financial and Operational Risk to The Christie in relation to Transfer of Mid-Cheshire Foundation Trust Clinical Haem in 2025 (Risk ID 3697)	16	• Work with existing provider (UHNM) to explore opportunities for staff to transfer. • Work with provider on service improvements prior to service transfer to improve working environment. • Maximise opportunity to recruit as part of Christie branded service. • Review workforce model and potential to increase ACP/Clinical Fellow grade posts and increase nurse led activity. • The Christie Medical Workforce Team to link directly with recruitment agencies and advertise widely in national publications to target and attract suitable candidates. • A full financial model will be worked up prior to transition and agreed via The Christie Management Board. • Opportunities for efficiencies will be explored at each stage of the transition.

Corporate Risks

NHS
The Christie
NHS Foundation Trust

There are 8 Trust-wide 15+ risks in August		
Description	**Score**	**Controls**
Risk to Treatment Delivery due to Workforce Recruitment & Retention (Risk ID 2959)	15	Coaching training for managers and mediation for selected staff to reduce conflict and internal disputes – started June 24
Breach of 28- day Faster Diagnosis Standard (FDS) for patients with a possible haematology malignancy (Risk ID 3669)	15	Daily monitoring of PTL – live tracking of potential breaches, and regular meetings with clinicians.
Delivery of 24/25 Recurrent VIP Plan (Risk ID 3742)	16	New risk
Evacuation system (Risk ID 3797)	16	New risk

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	16401	12979	5381	5.1
	Total monthly ACTUAL	14936	12392		
	Average Fill Rate %	91.1%	95.5%		
Care Staff	Total monthly PLANNED	10031	6439	5381	2.5
	Total monthly ACTUAL	7687	5946		
	Average Fill Rate %	76.6%	92.3%		
ALL Staff	Total monthly PLANNED	26432	19418	5381	7.6
	Total monthly ACTUAL	22635	18338		
	Average Fill Rate %	85.6%	94.4%		

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	2126	1873	88.1%	2009	1606	79.9%	149	23.3
Palatine Ward	3171	2913	91.9%	2484	2293	92.3%	901	5.8
Ward 10	2262	1790	79.1%	1495	1439	96.3%	805	4.0
Ward 11	1838	1741	94.7%	1524	1432	94.0%	843	3.8
Ward 12	1914	1765	92.2%	1609	1523	94.7%	831	4.0
Ward 4	1831	1790	97.8%	1442	1441	99.9%	825	3.9
Ward 2	1036	1008	97.3%	582	794	136.4%	446	4.0
Acute Assessment Unit	2223	2056	92.5%	1834	1864	101.6%	581	6.7
TOTAL	16401	14936	91.1%	12979	12392	95.5%	5381	5.1

Registered Nursing Associates	DAY			NIGHT		
	Hours Planned	Hours Actual		Hours Planned	Hours Actual	
Critical Care Unit						
Palatine Ward						
Ward 10						
Ward 11		8				
Ward 12		41				
Ward 4						
Ward 2		18				
Acute Assessment Unit		12				

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	547	235	43.0%	41	98	100.0%	149	2.2
Palatine Ward	1134	830	73.2%	826	778	94.2%	901	1.8
Ward 10	1812	1259	69.5%	1049	953	90.8%	805	2.7
Ward 11	1798	1225	68.1%	1012	948	93.7%	843	2.6
Ward 12	1313	1276	97.2%	1005	980	97.5%	831	2.7
Ward 4	1676	1449	86.5%	1460	1243	85.1%	825	3.3
Ward 2	495	454	91.7%	299	303	101.3%	446	1.7
Acute Assessment Unit	1256	959	76.4%	747	643	86.1%	581	2.8
TOTAL	10031	7687	76.6%	6439	5946	92.3%	5381	2.5

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

The Christie NHS Foundation Trust

Positive feedback received…..

"I cannot thank everyone enough for everything you have done for me from how quickly you responded to making be comfortable to preparing for surgery etc, The care, compassion and treatment plan which had potentially saved by life. I appreciate you all and will be forever grateful. Thank you so much. ."

"We just wanted to say a big thank you to you all. Most of the MDT we did not meet, but you were all working hard behind the scenes to provide the best possible care. Thank you for being very caring and reassuring. You are all highly skilled healthcare professionals, but we know it's not just a job for you, you genuinely care. You are all doing a great job, well done."

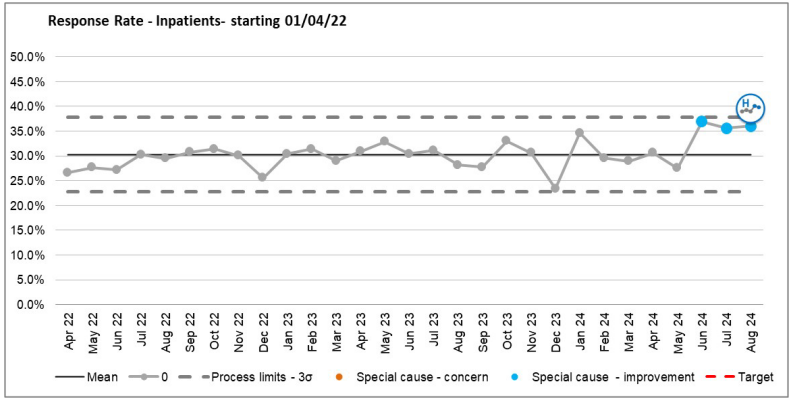
"To Miss Faulkner, Jenny, all the pre-op staff, the surgical team and the staff on Ward 10. Thank you for everything you have all done for me and taking such good care of me. You are all amazing.."

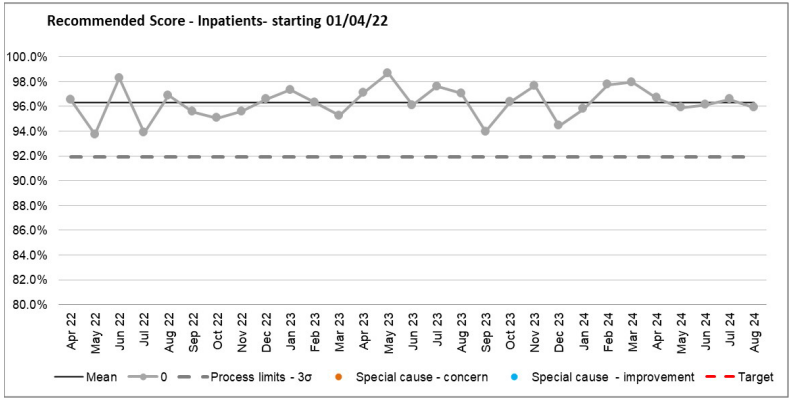
"I have recently had occasion to visit the Christie and have been a regular weekly attendant of the IPU whilst accompanying my dear friend. I am a retired Health Visitor of almost thirty years' experience and was a staff nurse / midwife for a decade on the wards prior to this.
The care given from all the staff starting with the car park attendants, the reception of the staff, going the extra mile even finding my lost cardigan one week is a beacon and flagship for the goodness of the NHS. I have never given praise lightly and I was just blown away by the care and dedication and compassion to their respective roles.
Please convey my gratitude to everyone and continue to be a shining example of how care should be."

Friends & Family Test

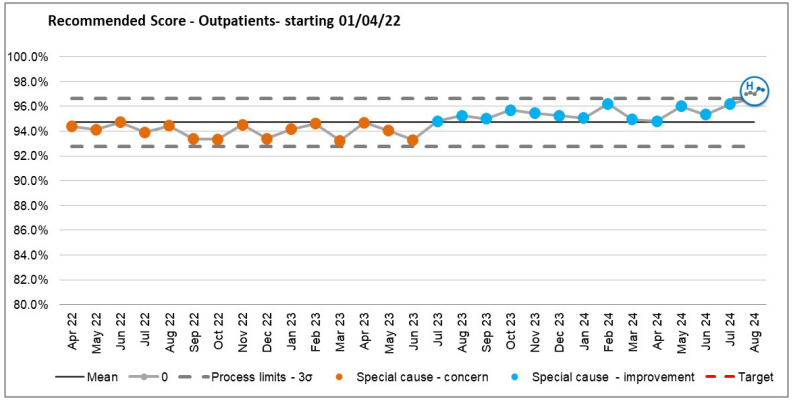
The Christie NHS Foundation Trust

Monthly Summary

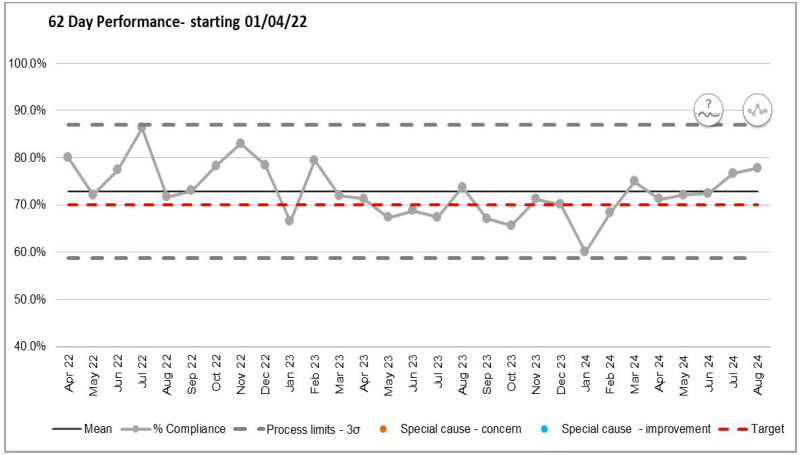


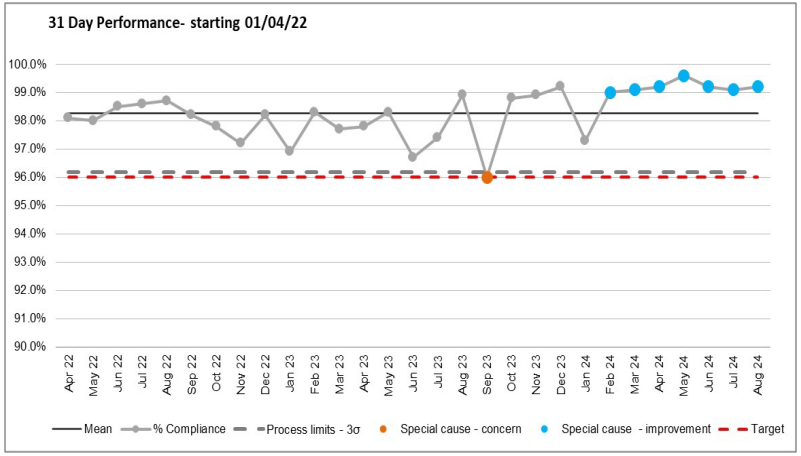


The Inpatient response rate continues to show improvement in recent months. Both the recommended percentage scores for Outpatients and Inpatients remain high with Outpatients maintaining a sustained period of high performance.



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
62 Day	70%	65.6%	71.2%	70.1%	60.0%	68.3%	74.9%	71.2%	72.1%	72.4%	76.6%	**77.8%**
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%**
24 Day Internal	85%	68.3%	69.6%	73.2%	63.7%	71.7%	76.4%	71.5%	72.2%	74.6%	78.1%	**77.3%**
31 Days	96%	98.8%	98.9%	99.2%	97.3%	99.0%	99.1%	99.2%	99.6%	99.2%	99.1%	**99.2%**
18 Weeks - Incomplete	92%	97.7%	97.2%	97.2%	97.3%	98.0%	98.0%	98.4%	98.7%	98.1%	98.0%	**98.0%**

As of October 2023, all 62-day standards are merged in to one 62-day standard and all 31-day standard types are merged in to one combined 31-day standard. The Targets have been 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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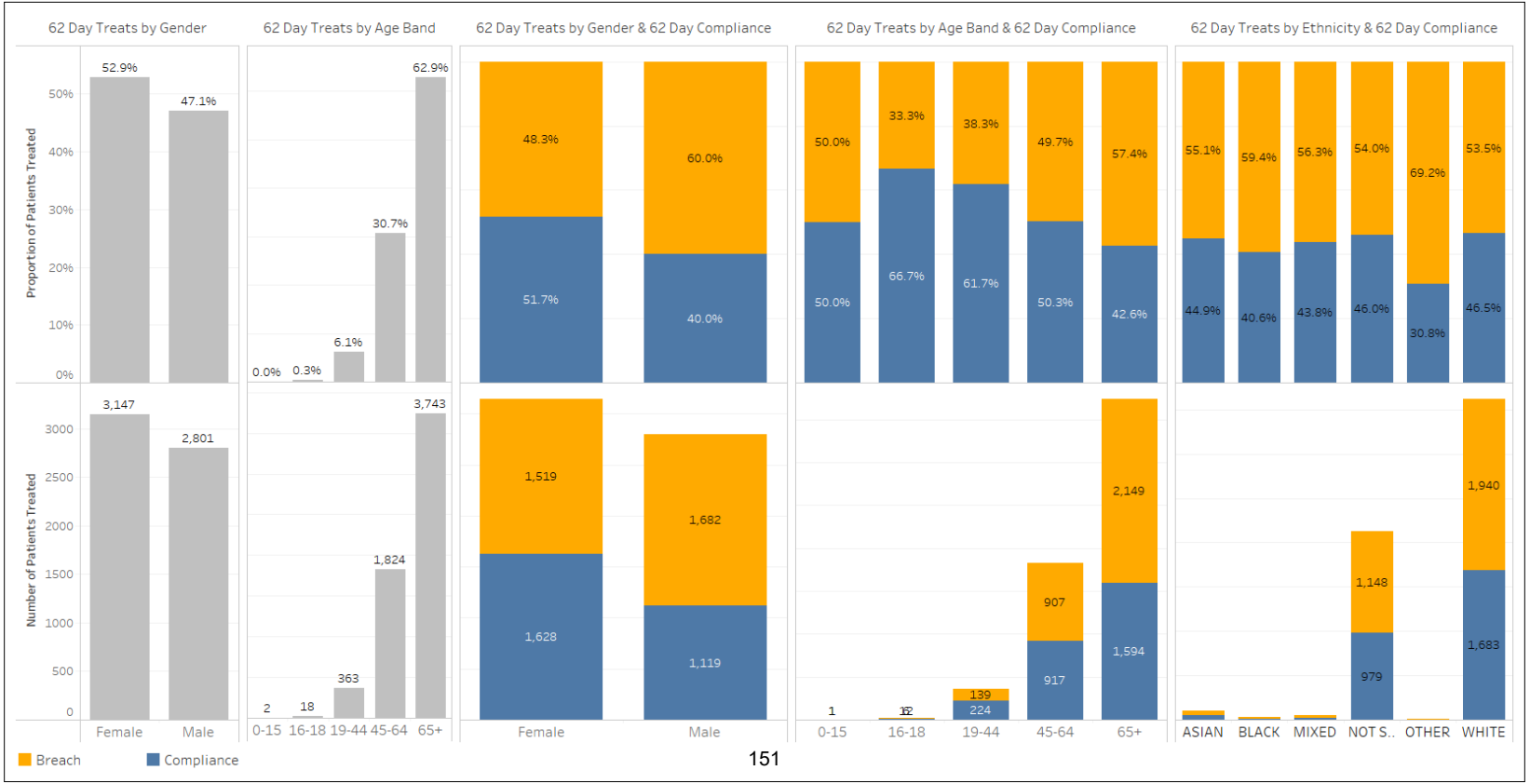

Cancer Standards – Health Inequalities Analysis

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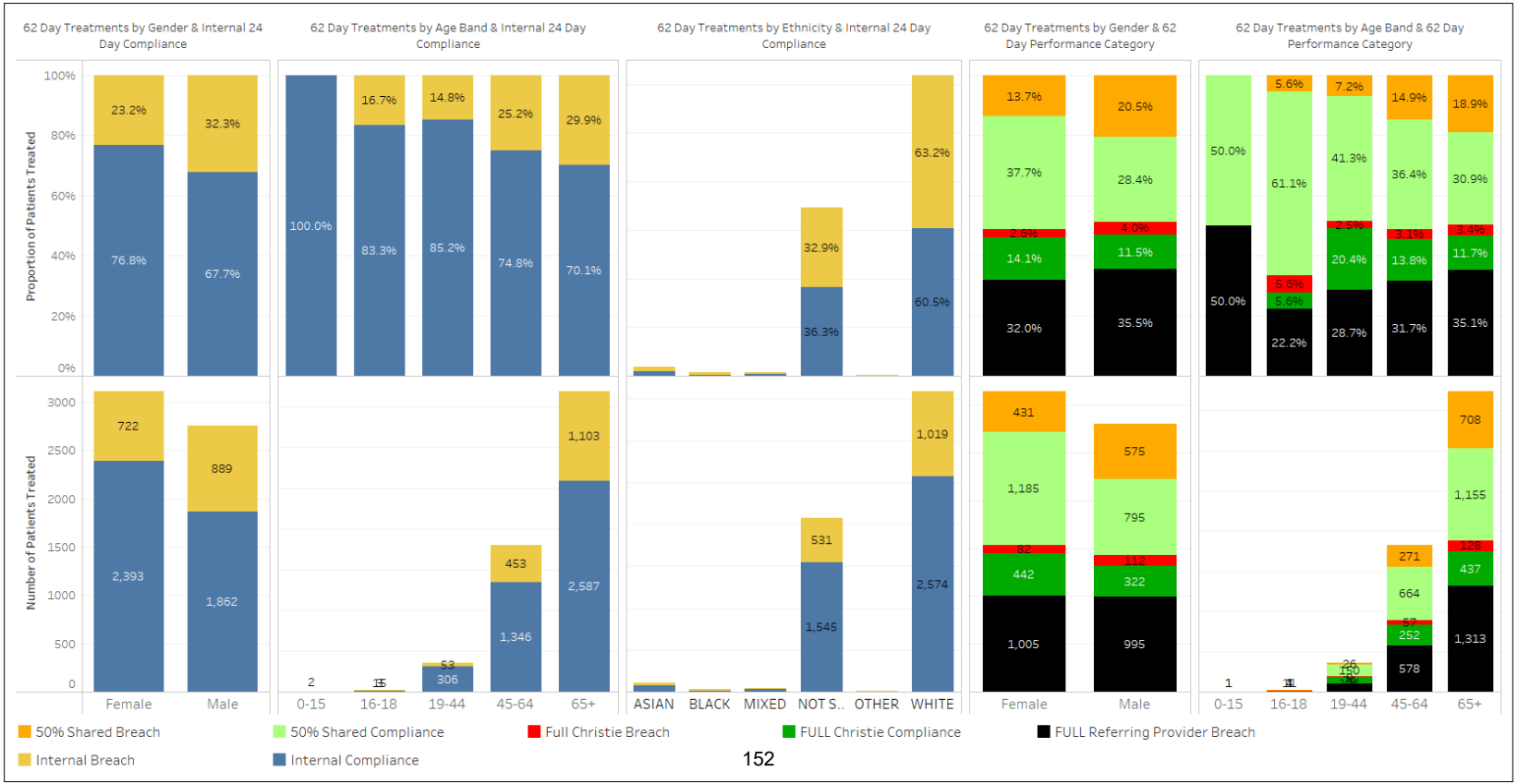

Referrals Analysis

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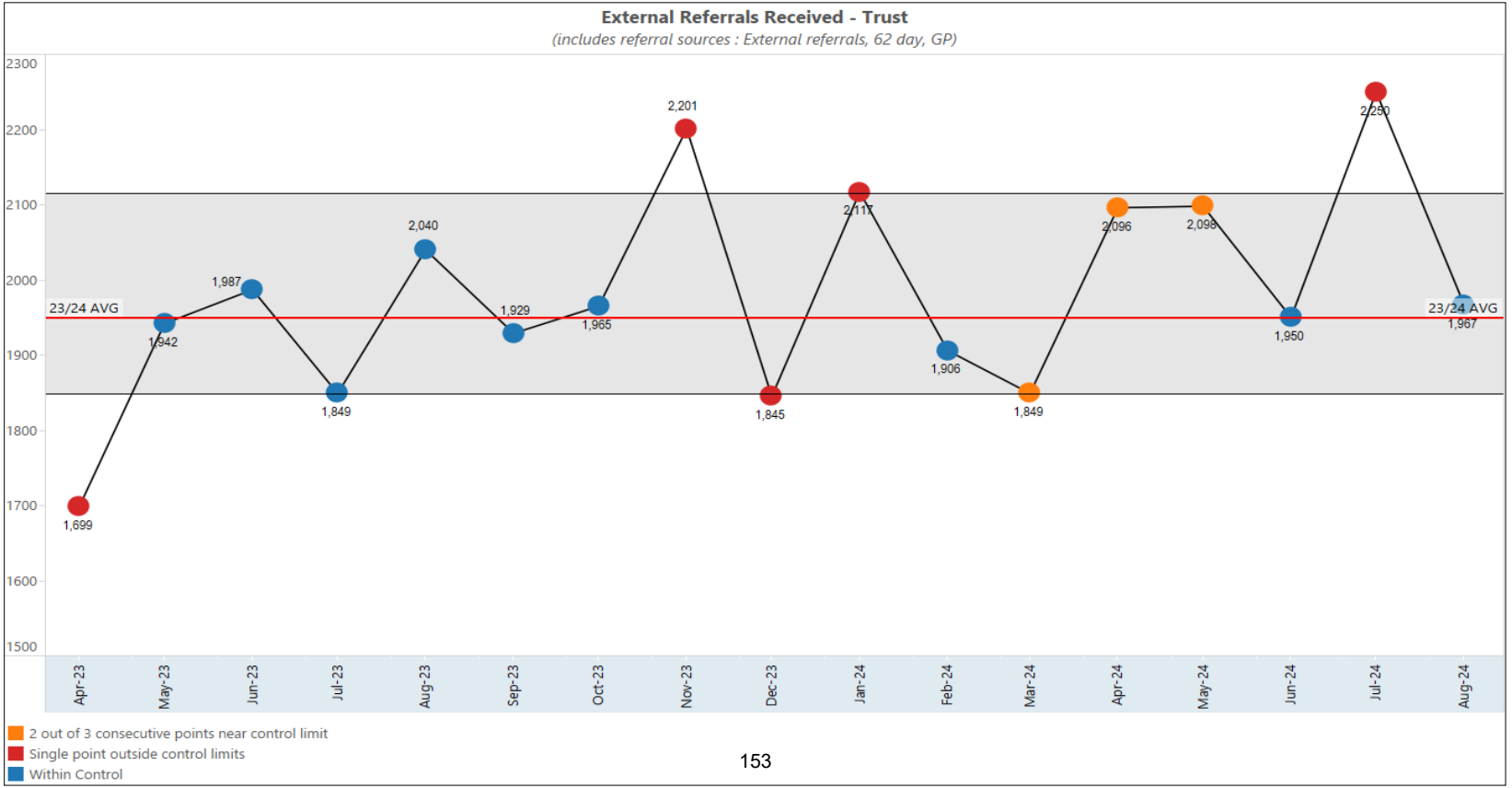

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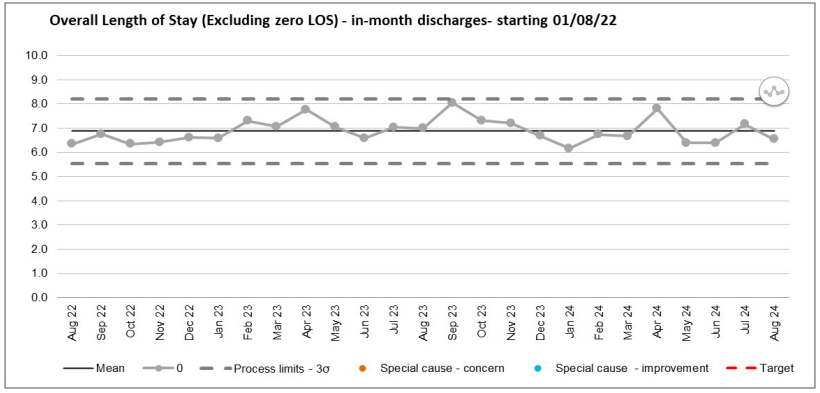
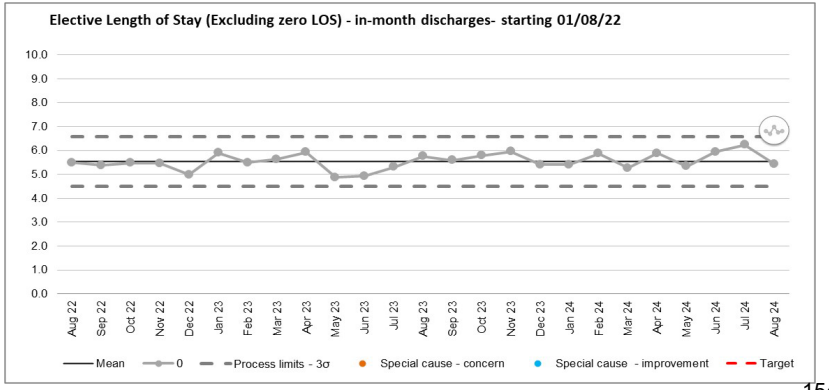
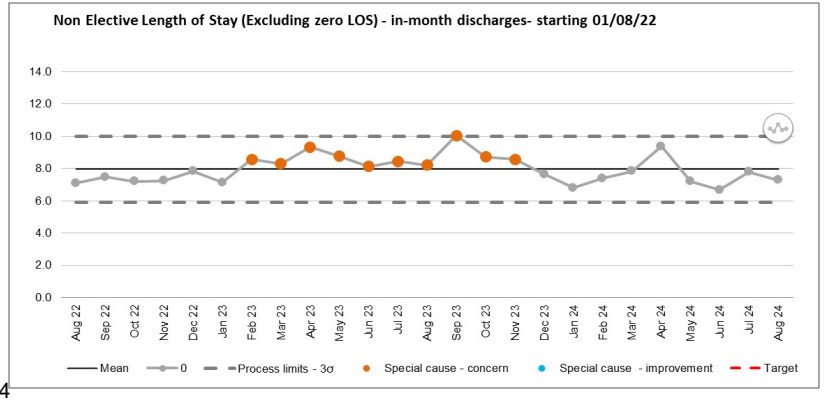
Length of Stay



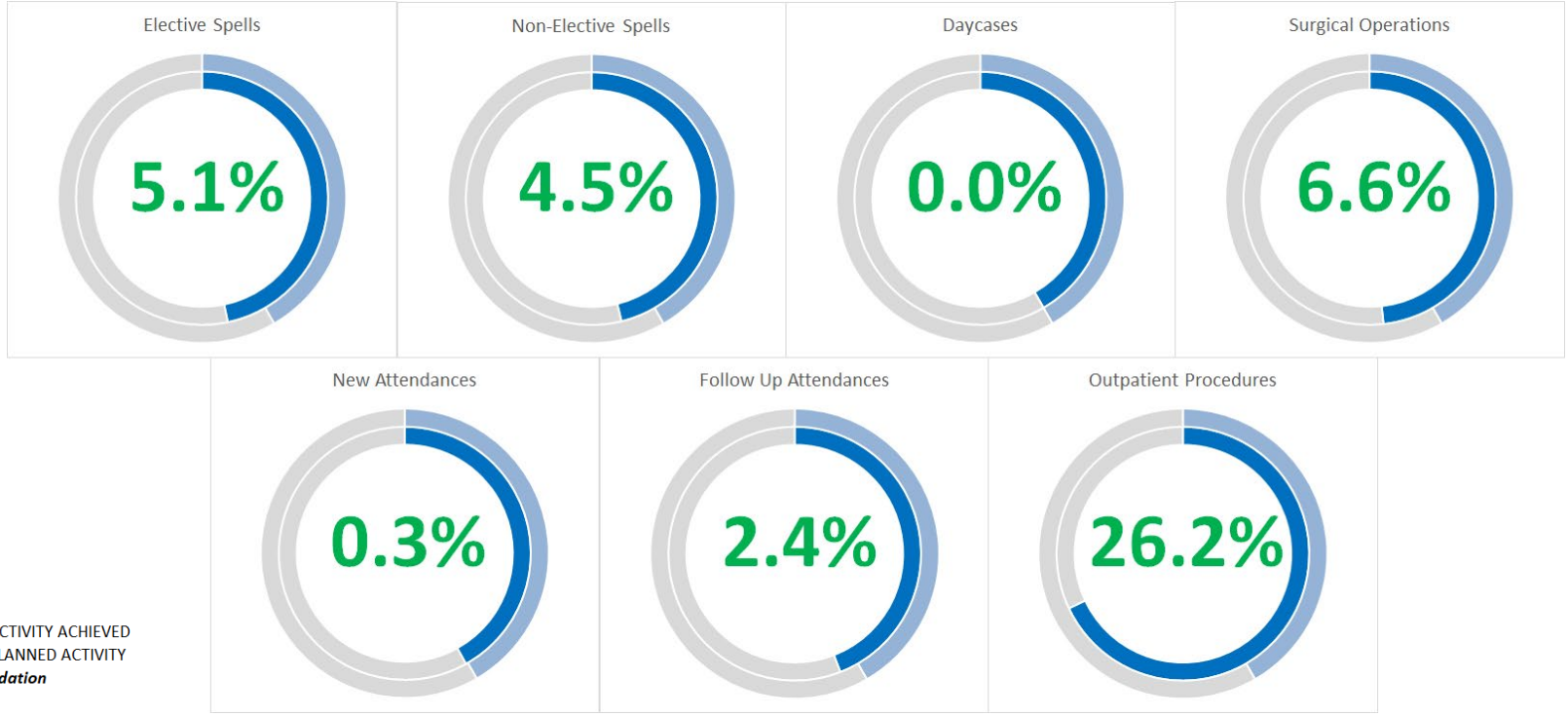
Overall length of stay, elective and non-elective spells continue to be well within control limits.



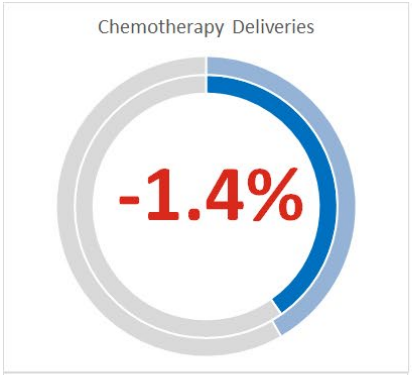


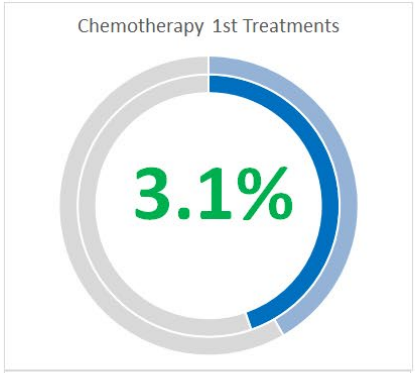
Activity – YTD Progress

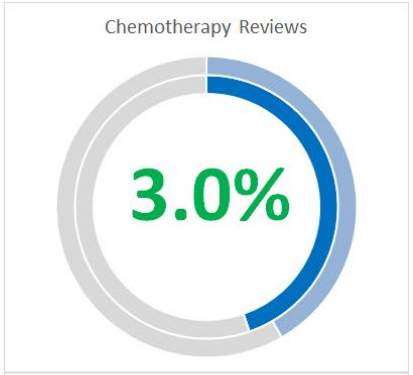
Trust level activity - progress against YTD plan

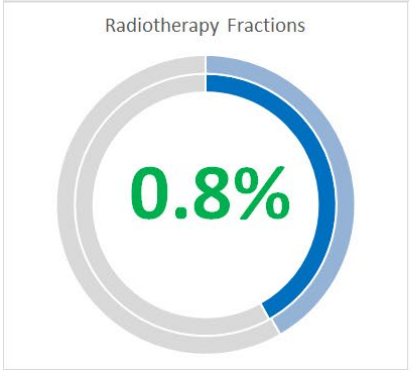


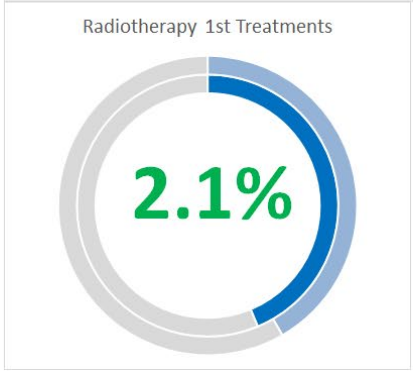
Activity – YTD Progress

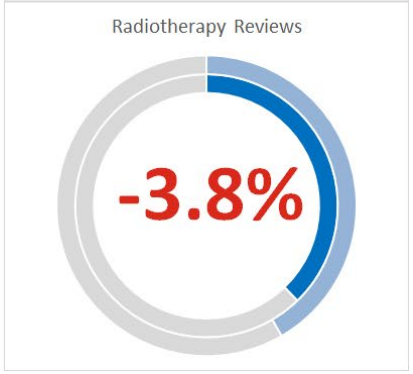








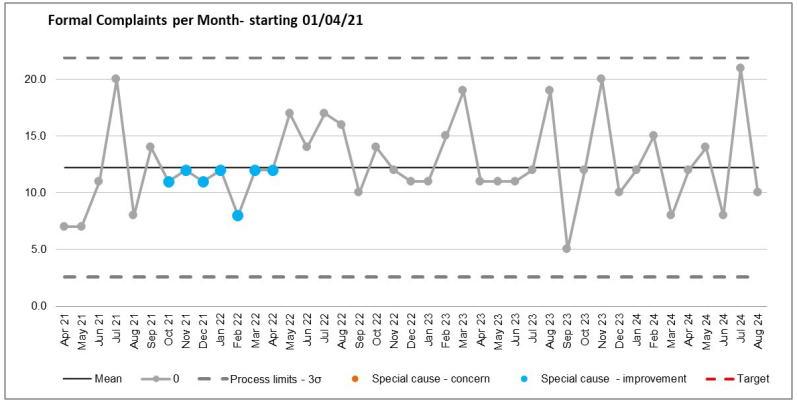


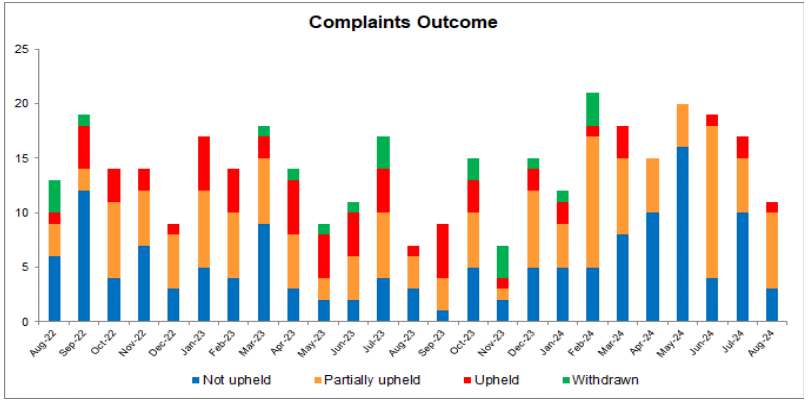


SACT 1st Treatments, 1st Fractions & Surgical Operations do not form part of the 24/25 activity plan and are used as supplementary guides to productivity. The figures are monitored against the previous year's month for comparison.

YTD ACTIVITY ACHIEVED
YTD PLANNED ACTIVITY
subject to validation

Complaints





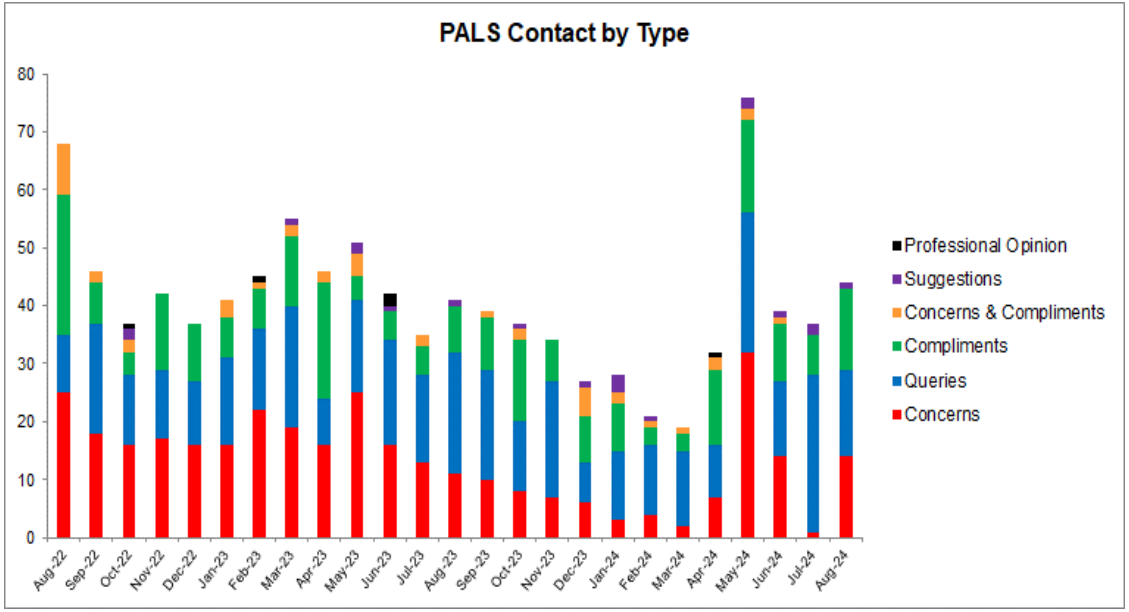
10 new complaints received in August 2024

11 complaints were closed in August 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 August 2024. 2 case's closed – both not upheld. 3 active cases in total with the PHSO.

PALS



44 PALS contacts have been received in August 2024.

14 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

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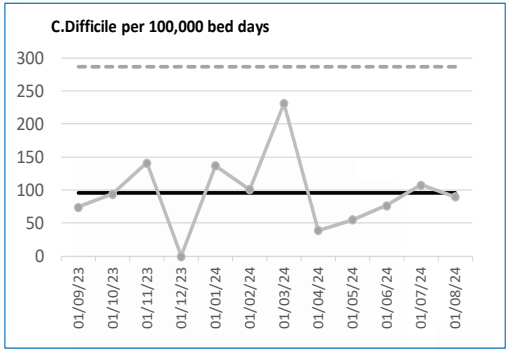
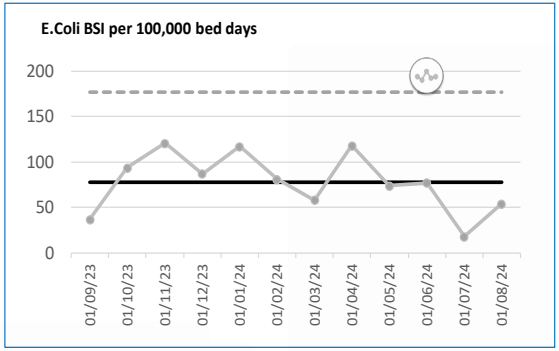
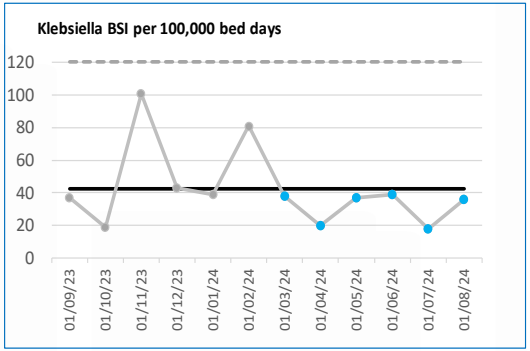
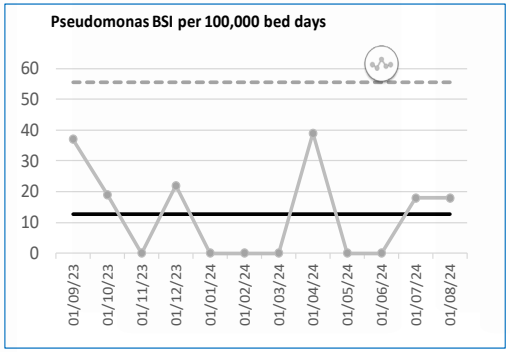
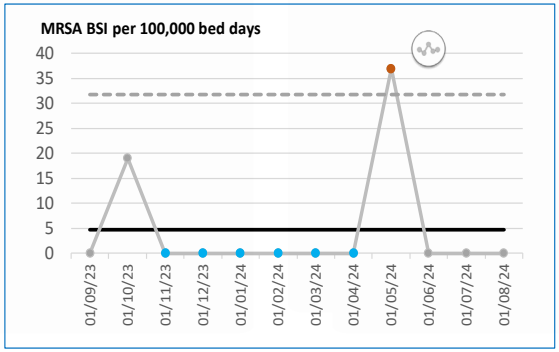
HCAIs per 100,000 bed days – rolling 12 months

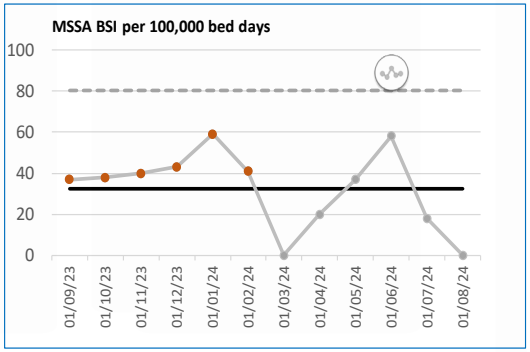












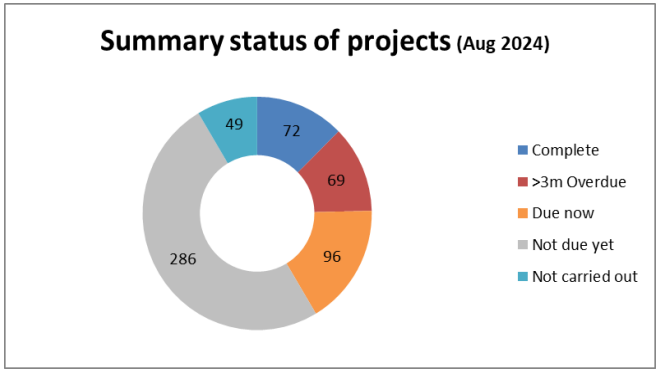
All cases reviewed through IPC team and reported through NIPR.

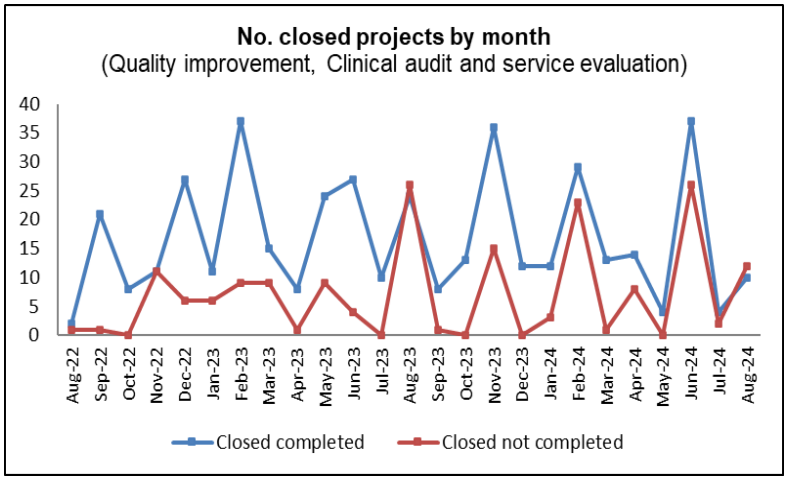
Quality Improvement & Clinical Audit

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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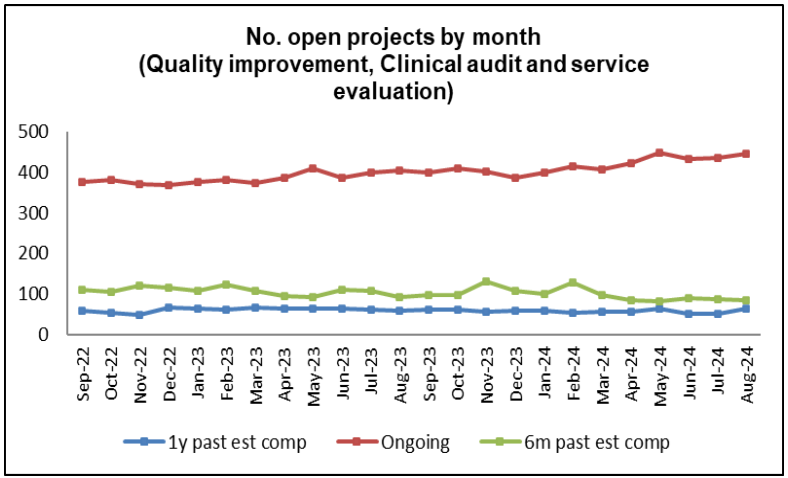


HR Metrics Sickness

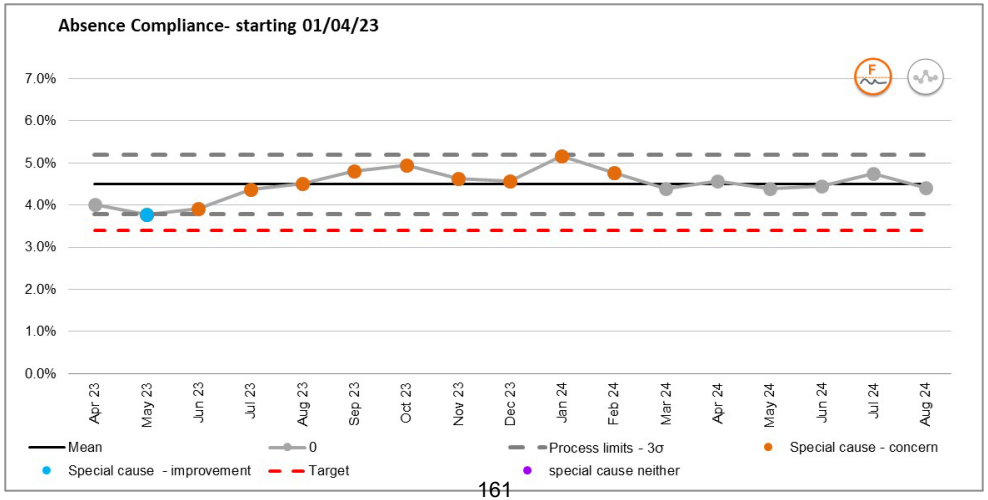
The Christie NHS Foundation Trust

Performance | Absence

Monthly Sickness %	Yearly Sickness %	Absences Ended	Long Term	Short Term
4.41%	4.65%	425	32	393

Trust Overview

Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24
4.81%	4.95%	4.63%	4.56%	5.16%	4.77%	4.39%	4.56%	4.39%	4.45%	4.75%	4.41%



HR Metrics – Mandatory Training

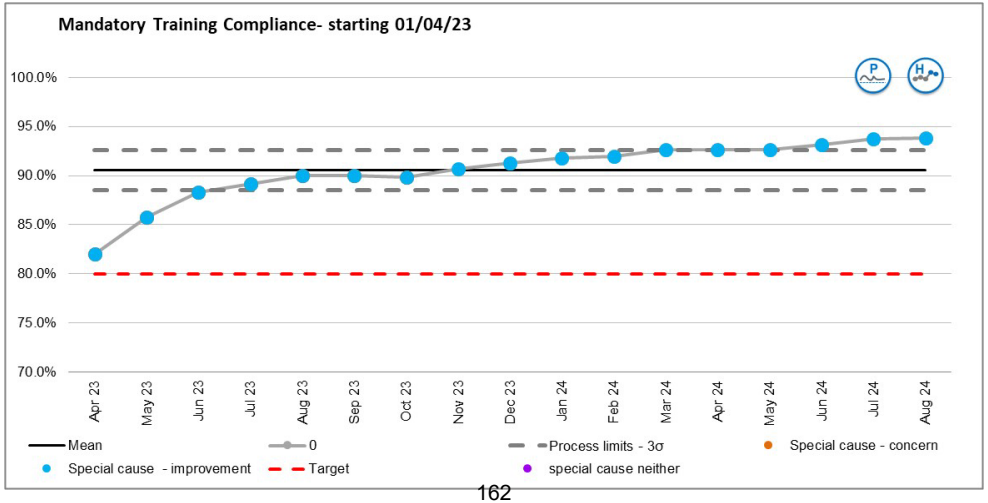
The Christie NHS Foundation Trust

Performance | Mandatory Training

Overall Compliance	Modules Outstanding	F2F Compliance	Online Compliance
93.79%	3,469	83.80%	94.76%

Trust Compliance

Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24
90.02%	89.85%	90.68%	91.30%	91.75%	91.96%	92.60%	92.67%	92.68%	93.19%	93.73%	93.79%



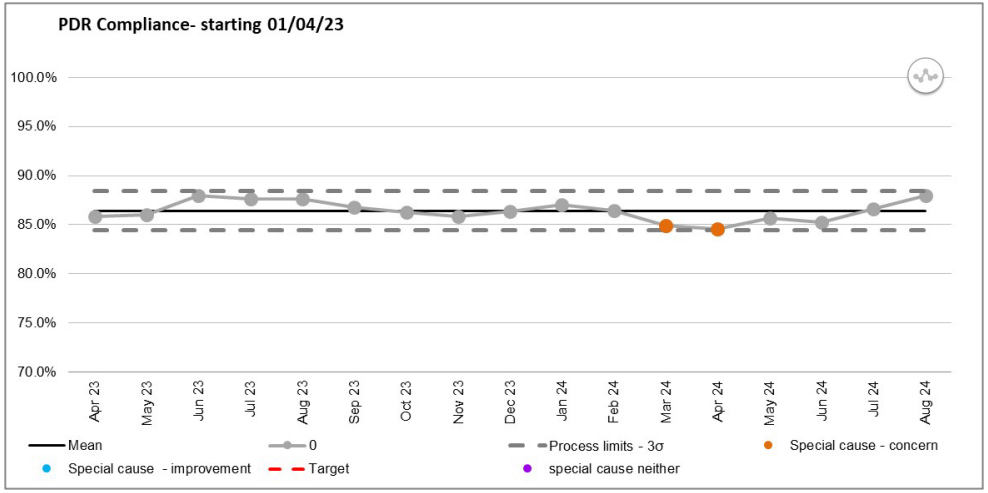
HR Metrics - PDR

The Christie NHS Foundation Trust

Performance | Appraisal

Overall Compliance	Expired Appraisals	Appraisals Due Soon
87.95%	452	544

Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24
86.78%	86.27%	85.84%	86.33%	87.04%	86.45%	84.94%	84.61%	85.68%	85.28%	86.63%	87.95%



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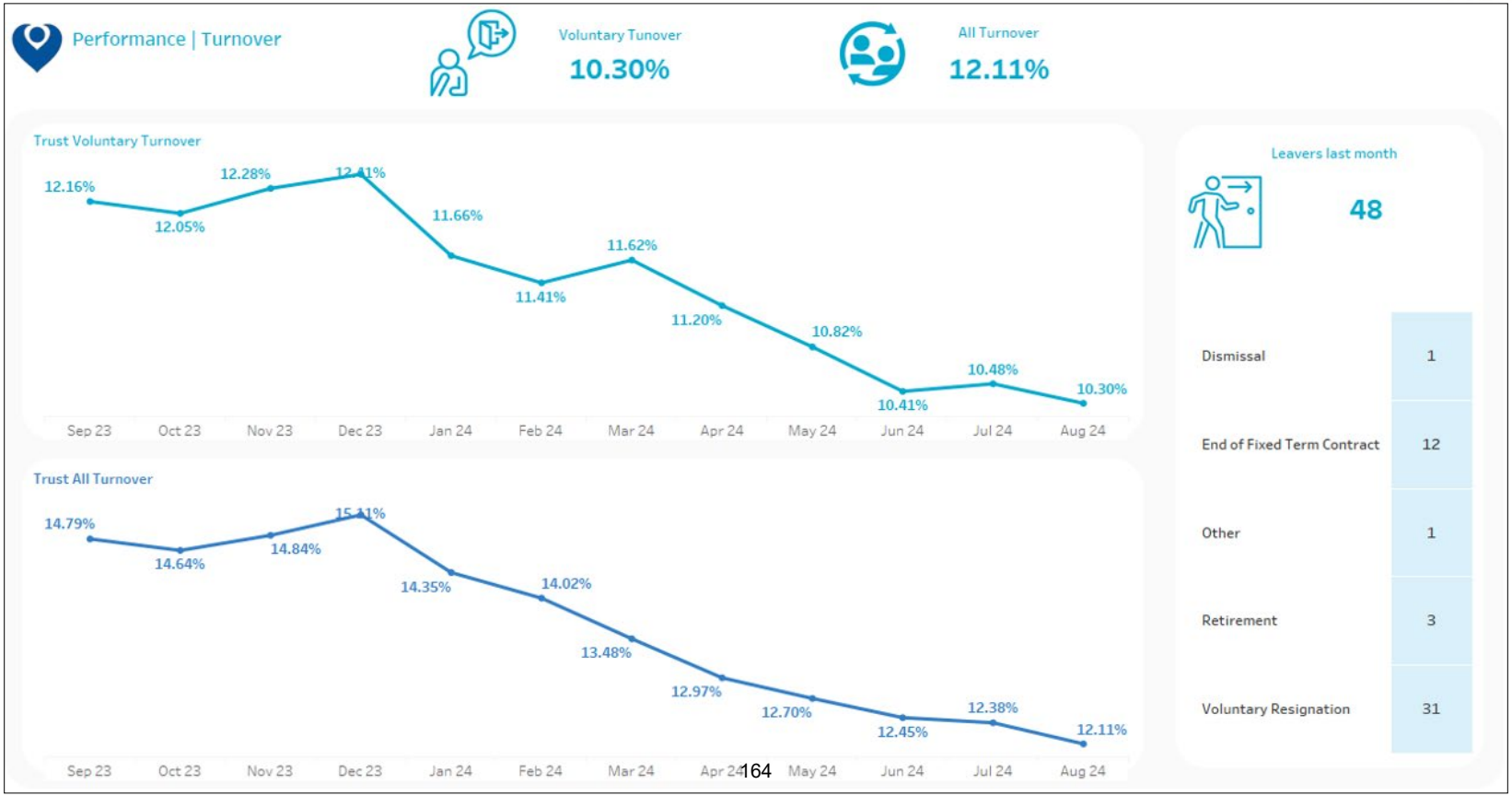
Workforce Metrics - Turnover

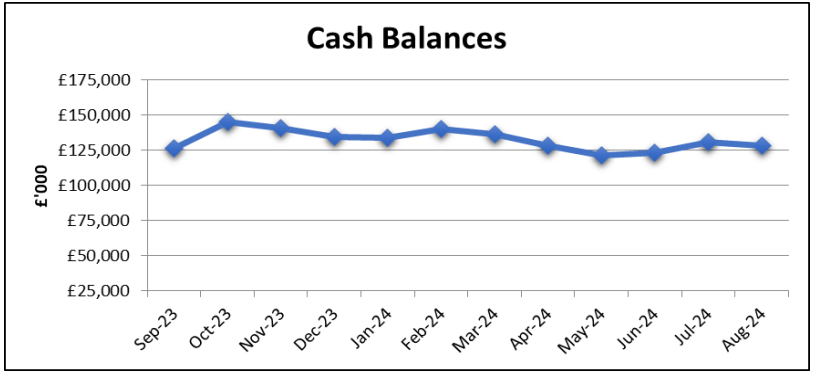
The Christie NHS Foundation Trust



Finance (Executive Summary)

The Christie NHS Foundation Trust

Month 5 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(423,369)	(176,387)	(178,340)	(1,954)
Other Income	(75,466)	(31,403)	(30,851)	551
Pay	231,889	96,568	90,943	(5,625)
Non Pay (incl drugs)	241,363	100,562	104,921	4,360
Operating (Surplus) / Deficit	**(25,584)**	**(10,660)**	**(13,327)**	**(2,668)**
Finance expenses/ income	30,932	12,888	14,852	1,964
(Surplus) / Deficit	**5,349**	**2,229**	**1,525**	**(704)**
Exclude impairments/ charitably funded capital donations	(12,355)	(5,148)	(5,016)	132
Adjusted financial performance (Surplus) / Deficit	**(7,006)**	**(2,919)**	**(3,491)**	**(572)**



This report outlines the M5 consolidated financial performance of The Christie NHS Foundation Trust and its wholly owned subsidiary The Christie Pharmacy Ltd.

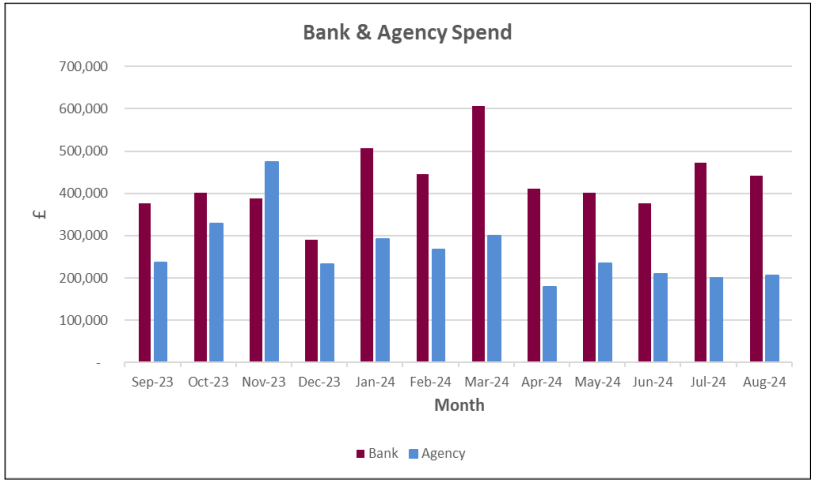
I&E

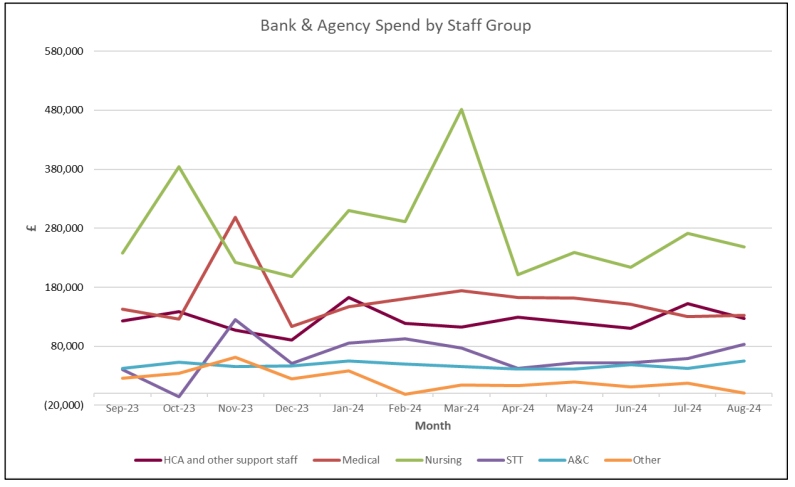
- The Trust is reporting a surplus at the end of M5 of (£3.5m) against a M5 YTD plan of (£2.9m), which gives a month 5 variance of (£0.6m) better than plan.
- Identified in year VIP is £19.6m against a target of £21.4m. The VIP shortfall against the recurrent VIP target is £3.5m, where £10.5m has been 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 £128.3m.
- Capital performance to month 5 was (£0.6m) below the revised plan submitted to NHSE&I in June 24.
- Targets have been achieved against payment of our NHS creditors paid within the 30-day Better Payment Practice Code target.

Finance (Expenditure)

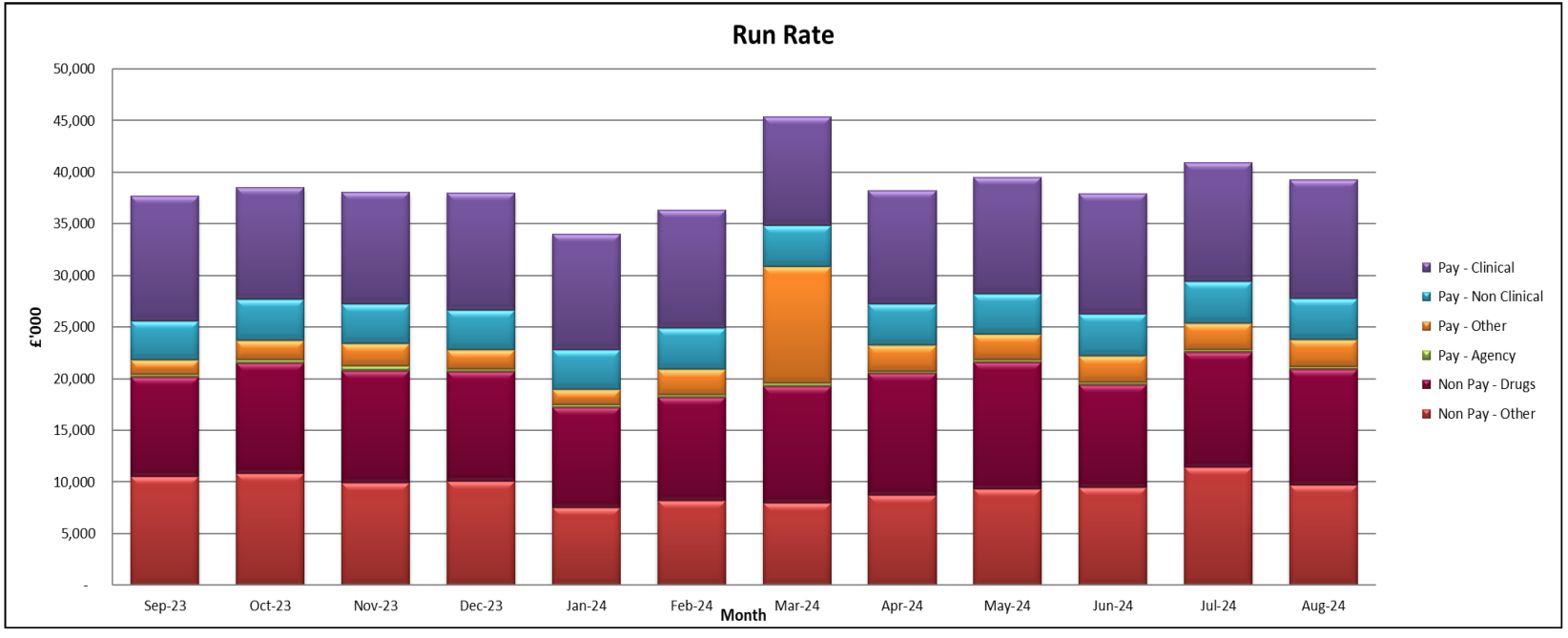




Agency spend in month 5 is £0.2m, £1.0m YTD, the spend is predominantly on medical agency at outreach sites, whilst vacancies are being actively recruited to.

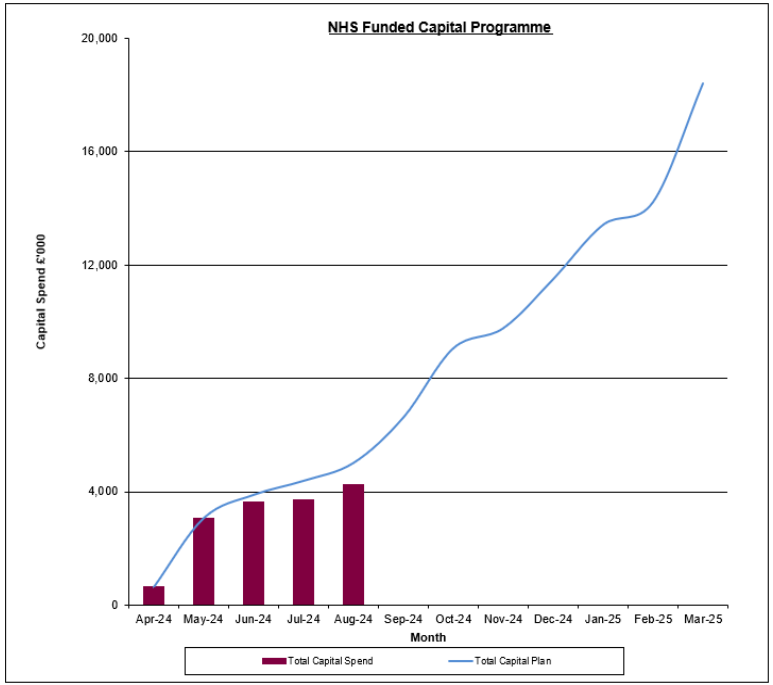
Alongside this, bank usage has decreased by £0.1m in month 5 compared to month 4, giving £0.4m in month 5 and £2.1m YTD.

Finance (Expenditure)



- Drugs spend in month 5 is £11.2m, an increase from month 4 of £0.1m.
- Pay – Clinical spend in month 5 is £11.5m.
- Pay – Other spend in month 5 is £2.7m, an increase of £0.1m from month 4.
- Pay – Agency spend in month 5 is £0.2m, remaining largely the same compared to month 4.
- Key elements of 'Non-Pay Other' spend consist of clinical supplies and services, premises and infrastructure costs and R&I costs.

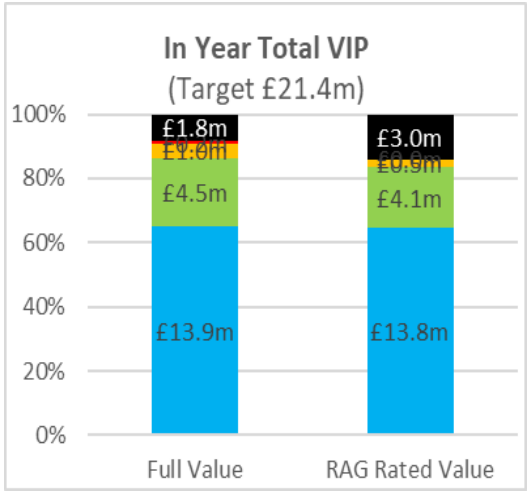
Finance (Capital)

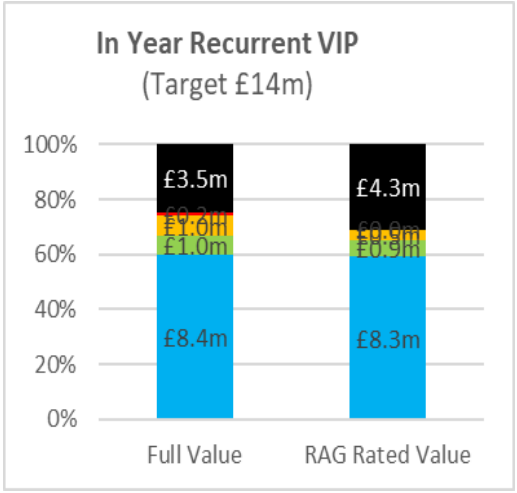


Performance to month 5 was £0.6m below the revised plan submitted to NHSE&I in June 24. This is lower than the plan position due to the TIF Ward position.

The Trust has incurred £4.3m on capital schemes to month 5, primarily on the TIF ward refurbishment as well as ongoing digital projects and small replacement assets.

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 £18.4m, leaving £3.0m 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%	

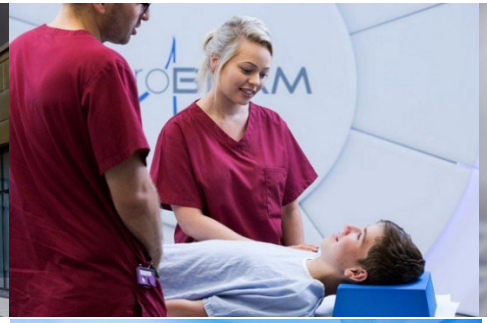
	Annual					Year to Date		
	Target	Identified value	Unidentified Value	Identified RAG Value	Unidentified RAG Value	Target	Delivered	Variance
Total VIP	**£21,396k**	**£19,602k**	**£1,794k**	**£18,393k**	**£3,003k**	**£8,935k**	**£8,935k**	**£0k**
Recurrent VIP	£13,996k	£10,510k	£3,486k	£9,656k	£4,340k	£5,845k	£3,393k	(£2,452k)
Non-Recurrent VIP	£7,400k	£9,092k	(£1,692k)	£8,737k	(£1,337k)	£3,090k	£5,542k	£2,452k

The Christie
NHS Foundation Trust

Meeting of the Board of Directors
Thursday 27th September 2024

Report of	Chief Nurse & Executive Director of Quality
Paper Prepared By	Trust CQC Project Lead
Subject/Title	Quality Plan and implementation plan 2022-2025: annual progress report 2022/23
Background Papers	Quality strategy 2022 – 2025 Quality implementation plan 2022 - 2025
Purpose of Paper	To provide the Board of Directors with an annual update of the progress being made against the Quality Plan 2022-2025 and it's supporting implementation plan. Evidence has been embedded and is available for review if required.
Action/Decision Required	To note
Link to: ➢ NHS Strategies and Policy	
Link to: ➢ Trust's Strategic Direction ➢ Corporate Objectives	➢ Leading cancer care ➢ The Christie experience ➢ Local and specialist care ➢ Best outcomes
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.	CDI – Clostridium difficile CLZ - Christie Learning Zone COHA - Community Onset/Hospital acquired CQC – Care Quality Commission GM – Greater Manchester HCAI - Healthcare Associated Infections HOHA – Hospital Onset/Hospital acquired LFPSE - Learning from patient safety events PSIRF – Patient Safety Incident Response Framework SAF – Single assessment framework

The Christie
NHS Foundation Trust

Quality Strategy Implementation Plan

2022-2025

Listening | Collaborating | Caring | Learning

NHS
The Christie
NHS Foundation Trust

QUALITY

Listening | Collaborating | Caring | Learning

Safe

- Implement the National Patient Safety Strategy
- Improve patient falls prevention and management
- To deliver on the Healthcare Associated Infections (HCAI) trajectories
- To deliver on Pressure Ulcer trajectories
- Develop and maintain CQC preparedness in line with new inspection methodology
- To engage in peer to peer 'mock' inspections to ensure a continuous focus on learning

Quality Improvement & Clinical Effectiveness

- Staff have the necessary skills, support and feel empowered to improve the quality of care or service they deliver
- Staff are recognised for the achievements and contributions they make as a result of QI initiatives
- QICA collaboration around the Clinical Data Strategy

Positive Experience

- To undertake development and ensure delivery of the patient and public experience plans
- Review, reintroduction and expansion of the Christie Quality Mark to all Christie satellite sites
- Development and expansion of the Christie Quality CODE
- Reintroduction of pre-pandemic PLACE (Patient-Led Assessments of the Care Environment) assessment processes
- Develop and deliver an Equality, Diversity & Inclusion (EDI) framework specific to service users
- Achieve best care for all via patient centred care and shared decision making

Putting patients at the heart of everything we do

Annual progress report 2023 - 2024

SAFE					
Focus	Drivers	22/23	Progress	23/24	Progress
Implement the National Patient Safety Strategy	Appoint a designated Patient Safety Specialist and Patient Safety Partners	• Patient Safety Specialist & Head of Risk commenced in post 3/10/22. • Patient safety partners is progress as part of the Patient Safety Incident Response Framework (PSIRF) implementation plan.	In progress	Patient Safety Partner role outline agreed, and budget identified. Work with GM partners to agreed most effective approach to recruitment and deployment. This is overseen within the PSIRF Delivery Group.	In progress.
	Transition to the new Learn from patient safety events (LFPSE) service from NRLS and StEIS	• Datix upgrade programme confirmed and underway which will deliver a system compliant with Learning from patient safety events (LFPSE). • Target completion date September 2023.	Complete		
	Implement patient safety training and education	• Patient Safety & Risk Level 1 & Patient Safety & Risk Level 2; Access to Practice – human factors and safety culture & Access to Practice – systems thinking and risk expertise, are available for staff on Christie Learn Zone (CLZ) and training compliance monitored by the Patient Safety & Risk	Complete		

SAFE					
Focus	Drivers	22/23	Progress	23/24	Progress
		team through CLZ since March 2023. • Face to face incident management training has been undertaken with 36 B6/B7 staff on different study and governance days.			
	Transition from Serious Incident Framework (SIF) to Patient Safety Incident Response Framework (PSIRF) within 12 months of publication	• PSIRF and supporting guidance published 16/8/22. • PSIRF implementation group and implementation plan developed in line with national target date 30th September 2023 and presented to Quality Assurance Committee 2022/23 of which high level assurance given.	Complete	• Complete 01/04/2024 • PSIRF Policy and Plan available on Trust website: psirf-policy-v01.pdf (christie.nhs.uk) christie.nhs.uk/media/xglldvbf/the-christie-patient-safety-incident-response-plan.pdf	Complete
Improve patient falls prevention and management	There will be no more than 3.35 inpatient falls per 1000 occupied bed day	• Our inpatient falls target compares to a national average of around 6.6 per 1000 occupied bed days. • Our overall performance was slightly above this ambitious target, at 3.6 falls per 1000 occupied bed days; an improvement on our previous years performance of 3.8 falls per 1000 occupied bed days.	Complete	• Ambition realigned to 3.8 falls per 1000 for 2023/24 Occupied Bed days in line with patient acuity. This ambition was met. Falls Prevention 2023-24.pdf	Complete

SAFE					
Focus	Drivers	22/23	Progress	23/24	Progress
		• The action plan and reduction in inpatient falls from the previous year is overseen by the falls prevention group. Falls Prevention 2022-23.pdf			
	Introduce improved falls prevention and management awareness training to front line clinical staff	• A falls prevention training package has been identified and reviewed, which will be launched 2023/24.	In progress	• FallSafe training now available on Christie Learning Zone and promoted to key staff. • Assessing potential to add to role specific training.	In progress
	Relaunch our Falls Prevention Group with a new format to monitor the delivery of our ambitious falls action plan	• Falls Prevention Group was relaunched April 2022. This is a multidisciplinary group which is chaired by the Associate Chief Nurse for Quality & Patient Safety. • The actions were developed from national guidance, and also from learning identified through our falls screening tools, and root cause analysis. • We have joined the National Audit of Inpatient Falls, so learning can be shared across the NHS in England.	Complete	• This work remains ongoing. • Falls prevention has been included as a Safety Priority for the Trust as part of our Patient Safety Incident Response Plan.	Complete

<table>
<tr><th colspan="6">SAFE</th></tr>
<tr><th>Focus</th><th>Drivers</th><th>22/23</th><th>Progress</th><th>23/24</th><th>Progress</th></tr>
<tr><td></td><td>Develop the way we learn from Outpatient falls through our new Outpatient Falls Prevention leads</td><td>• Outpatient Falls Lead Nurse commenced April 2022.
• Falls screening tool for outpatient falls introduced.
• Outpatient falls reviewed at Friday Focus to identify learning.</td><td>Complete</td><td>• This work is ongoing and monitored through the OP screening tools for Friday FoCUS and Falls prevention reports.</td><td>N/A</td></tr>
<tr><td>To deliver on the Healthcare Associated Infections (HCAI) trajectories as set by NHS England on a yearly basis</td><td>2022/23 thresholds for Community Onset/Hospital acquired (COHA) and Hospital; Onset/Hospital acquired (HOHA):
• C.difficile (CDI) - 37
• E.coli - 31
• P.aeruginosa - 15 Klebsiella spp – 19
• MRSA bacteraemia – 0</td><td>• The trust ended 2022/23 over trajectory for CDI, E.coli & MRSA bacteraemia.
<table><tr><th></th><th>Target</th><th>Actual</th></tr><tr><td>CDI</td><td>37</td><td>51</td></tr><tr><td>E.coli</td><td>31</td><td>58</td></tr><tr><td>P.aeruginosa</td><td>15</td><td>10</td></tr><tr><td>Klebsiella spp</td><td>19</td><td>17</td></tr><tr><td>MRSA bacteraemia</td><td>0</td><td>2</td></tr></table>
HCAI reportable alert organisms 22-2
• A reduction strategy was implemented in August 2022 as cases of CDI & E.coli had increased and an action plan developed.</td><td>Complete</td><td>N/A</td><td>N/A</td></tr>
</table>

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<tr><th colspan="6">SAFE</th></tr>
<tr><th>Focus</th><th>Drivers</th><th>22/23</th><th>Progress</th><th>23/24</th><th>Progress</th></tr>
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<td></td>
<td>2023/24 thresholds for Community Onset/Hospital acquired (COHA) and Hospital; Onset/Hospital acquired (HOHA):
• C.difficile (CDI) - 36
• E.coli - 29
• P.aeruginosa - 10
• Klebsiella spp – 14
• MRSA bacteraemia – 0</td>
<td>N/A</td>
<td>N/A</td>
<td>• The trust ended 2023/24 over trajectory for CDI, E.coli, Klebsiella & MRSA bacteraemia.

<table>
<tr><th></th><th>Target</th><th>Actual</th></tr>
<tr><td>CDI</td><td>36</td><td>56</td></tr>
<tr><td>E.coli</td><td>29</td><td>60</td></tr>
<tr><td>P.aeruginosa</td><td>10</td><td>9</td></tr>
<tr><td>Klebsiella spp</td><td>14</td><td>27</td></tr>
<tr><td>MRSA bacteraemia</td><td>0</td><td>3</td></tr>
</table>

• A themed review for CDI & E.Coli cases took place.
• A gram-negative bloodstream infection strategy with action plan was developed.
• Exception reports for cases over trajectory were presented to Infection Prevention and Control Committee.

Healthcare Associated Infection</td>
<td>Complete</td>
</tr>
<tr>
<td>To deliver on Pressure Ulcer trajectories</td>
<td>Monitor Pressure ulcer rates per 1000 occupied bed days and use these to set</td>
<td>• Pressure ulcers rates are monitored throughout the year and reported in a monthly report to the</td>
<td>Complete</td>
<td>• Pressure ulcers rates have continued to be monitored throughout 2023-24 and reported in a monthly report</td>
<td>Complete</td>
</tr>
</table>

SAFE					
Focus	Drivers	22/23	Progress	23/24	Progress
	improvement trajectories each year	Infection Prevention & Control Quality Meeting, Friday FoCUS, Quality & Standards directorate meeting and circulated to the divisions via email.		to the Infection Prevention & Control Quality Meeting, Friday FoCUS, Quality & Standards directorate meeting and circulated to the divisions via email.	
	Aim for no more than 0.5 or above Pressure ulcers (PU) at grade 2, deep tissue injury (DTI) or unstageables.	• Achieved within target 0.4 per1000 occupied bed days and 24 Category 2, DTI and unstageable PU in 2022-23 . 3. PU Report March 2023.pdf	Complete	• Achieved within target 0.36 per1000 occupied bed days (22 patients) in 2023-24. PU Report March 2024.pdf	Complete
	We will continue to have zero Grade 3 or 4 pressure ulcers	• No category 3 or 4 pressure ulcers were acquired in 2022-23. 3. PU Report March 2023.pdf	Complete	• No category 3 or 4 pressure ulcers were acquired in 2023-24. PU Report March 2024.pdf	Complete
	Aim for no more than 1.5 moisture lesions per 1000 occupied bed days	• 0.89 moisture-associated skin damage per 1000 occupied bed days in 2022/23.	Complete	• 1.17 moisture-associated skin damage per 1000 occupied bed days in 2023/24. MASD report for 2023 2024.pdf	Complete

SAFE					
Focus	Drivers	22/23	Progress	23/24	Progress
Develop and maintain CQC preparedness in line with new inspection methodology	Engage with CQC updates on the new single assessment inspection methodology	• Webinars, electronic newsletters and regular engagement meetings with the CQC have been maintained throughout 2022/23 attended by the Executive Chief Nurse & Director for Quality and Deputy Chief Nurse, CQC's designated Engagement Manager. • Monitoring of insights reports has not been possible since June 2022 when paused by the CQC to enable migration to a new data platform. The new data platform is yet to be re-launched.	In progress	• The Trust has continued through 2023-24 to engage with all CQC updates in relation to the single assessment framework. This includes webinars, electronic newsletters and any other webinar activities hosted by other providers e.g., NHS providers. • CQC engagement meetings have continued attended routinely by the Chief Nurse & Executive Director for Quality, Deputy Chief Nurse and the Trusts designated CQC inspector/relationship owner. • The Trust has had 2 CQC relationship owners in the 2023-24 period. Other personnel from both the Trust and the CQC may be invited to attend the engagement meetings. • CQC's data platform is no longer available to providers.	Complete
	Once new CQC inspection methodology published develop a	• A phased approached to the publication of inspection methodologies and the single assessment framework commenced in	In progress	• A phased approach to publications continued throughout 2023-24 in relation to the single assessment framework (SAF).	In progress

SAFE					
Focus	Drivers	22/23	Progress	23/24	Progress
	mock inspection programme	summer 2022. This started with key questions and quality statements that will replace KLOEs. Further updates include: ○ Evidence categories (Aug '22) ○ Assessing services (Oct '22) • By late 2023 the CQC will gradually start to carry out assessments in the new way using the single assessment framework, powered by new Integrated Assessment and Inspection teams and supported by new technology.		• The SAF was launched late November 2023, with a phased roll out across the country. From February 2024 any assessments undertaken of registered providers in the North and Midlands region were using the SAF. • The Trust has not undergone any assessments in 2023-24 using the new SAF.	
To engage in peer to peer 'mock' inspections to ensure a continuous focus on learning	Undertake mock inspections in line with mock inspection programme Share learning from mock inspections Develop a programme of peer to peer quality inspections Undertake inspections in line with inspection programme	• CQC Preparedness meetings and mock inspection planning were scheduled to commence 20th October 2022. However, due to the unannounced CQC inspection of our core medical service inspection 11-12 October 2022 followed by a well-led inspection 15-17 November 2022 with focus groups /	In progress	• Following the unannounced CQC inspection (medical core service and well led) in late 2022, the final CQC report was published May 2023. This outlined several 'must take' actions. The report of actions outlined how the Trust would meet, monitor and complete these requirements before 31 October 2023.	In progress

SAFE					
Focus	Drivers	22/23	Progress	23/24	Progress
	Share learning from peer-to-peer inspections	listening events continuing into December 2022 the trust has been responding to the CQC's 'monitor, inspect and rate' approach of this recent inspection. • Learning from above inspections has been shared widely across the Trust. • Plans for mock inspection programme to commence in 2023/24.		• Executive CQC meetings commenced May 2023 and have been scheduled weekly throughout the remainder of 2023-24 to review the progress and processes of the improvements outlined in the report of actions and self-assess against the must take actions beyond the report of actions deadline by way of assurance and preparedness. • Due to the ongoing work associated with the 2022 inspection, action planning and progress monitoring, no mock inspections have been undertaken. However, the trusts internal CODE inspections have continued in line with its inspection calendar • Trust wide learning and engagement following the final CQC report continues to take place via e.g., monthly learning for improvement bulletins and trust wide communications.	

Quality Improvement and Clinical Effectiveness					
Focus	Drivers	22/23	Progress		
Staff have the necessary skills, support and feel empowered to improve the quality of care or service they deliver	Utilise AQuA offer 2022-23 in collaboration with School of Oncology • Application process being designed to ensure there is equitable access to training based on Training Needs Analysis • Ensure QI skills are utilised in improvement activity; progress of QI projects can be reported (short and longer term) • Monitoring and further development of metrics for the QICA programme	• Aqua membership funded by School of Oncology (SoO) from April '22 for 12 months. • Limited uptake: 57 course registrations by 23 staff. • Average number of QIP registrations has tripled. Projects delivering improvements QI score >3 increased. • Online training related to QI refreshed for ease of access	In progress	• Funding for NHS Elect training has been identified for 12 months; start date and further details awaited, but QI training is included • Uptake of SusQI eLearning package on ESR now able to be monitored via Green Plan; this add sustainability to the Model for Improvement • Implementation of NHS IMPACT will support QI; a self-assessment was reviewed by the Board of Directors and an action plan is underway	In progress
	SusQI (sustainability in healthcare QI) tools to be shared and promoted to support action on NHS Net Zero targets	• SusQI resources shared, SusQI and carbon footprinting modules completed in QICA team. • Green Team competition completed with ceremony	Complete		

Quality Improvement and Clinical Effectiveness					
Focus	Drivers	22/23	Progress		
	• Sustainability category in QICA database to track numbers of projects	for 5 projects with financial & carbon savings alongside real impact patients Green Team Competition Summary • 6 projects completed with sustainability theme. QICA projects: QICA programme – Christie Data Insights • There are 14 projects ongoing with sustainability theme in 2023/24.			
Staff are recognised for the achievements and contributions they make as a result of QI initiatives	Annual QI Awards	• Promotion of annual QICA awards on HIVE and internal distribution lists with submission of entry forms by 28/10/22. • Another successful event took place on 2nd December 22. • The winning project 'Improving Inpatient Discharges' with 2 runners up; 'Assessing tolerability and efficacy of modified FOLFIRINOX versus standard FOLFIRINOX for the treatment of patients with advanced pancreatic cancer' and 'A pilot to establish and evaluate an ambulatory	Complete	• QICA Awards took place on 01 December 2023 and event booked for 13 Dec 2024 • Winners listed on QICA HIVE (xchristie.nhs.uk) page	Complete

Quality Improvement and Clinical Effectiveness					
Focus	Drivers	22/23	Progress		
		nasogastric feeding service for head and neck patients undergoing chemo/radiotherapy' • The presentation and awards event can be watched on demand. • Next years annual QICA awards are already scheduled for 1st December 2023.			
	Include new Sustainability category to support action on NHS Net Zero targets • Number of submissions • Shared award-Winning presentations, posters, abstracts • Presentation event held, numbers attended, evaluation • Track Overall numbers of sustainability related projects	• Sustainability included in QICA Awards entry guidance; winning project sustainability related. • 15 entries • 48 staff attended the presentation event in person whilst an additional 33 staff watched online on the day (50 signed up).	Complete		

Quality Improvement and Clinical Effectiveness					
Focus	Drivers	22/23	Progress		
QICA collaboration around the Clinical Data Strategy	QICA team to co-locate with Analytics and other teams to promote collaboration on clinical outcomes	• Planning to co-locate QICA team with Analytics and other teams in progress. • Target move date delayed to July 2023.	In progress	• Co-located since July 2023	Complete
	Develop a 'one stop' process for QICA project approvals in collaboration with Analytics and IG teams	• Regular meetings, process mapping and planning has commenced. • Clinical outcomes and data unit (CODU) triage meetings commenced April 2023.	Complete	• Triage meetings continue with addition of CODU fellows and Costing team from Finance	Complete
NHS delivery and continuous improvement review	Undertake NHS IMPACT self assessment	N/A – new for 2023/24	N/A – new for 2023/24	• A self-assessment was conducted and reviewed by the Board of Directors early in 2024. An action plan is underway. • Appointment of Associate medical director with lead for NHS IMPACT will support progress.	In progress

Positive Experience					
Focus	Drivers	22/23	Progress		
To undertake development and ensure delivery of the patient and	To engage stakeholders	• January 2023 stakeholder engagement held with Christie Members to discuss the planned patient experience actions	In progress	• The draft plan was discussed with stakeholders during July and August 2023, prior to final agreement of the document.	Complete

Positive Experience					
Focus	Drivers	22/23	Progress		
public experience plans		associated with Equality Delivery System (EDS) 2022. • Further stakeholder discussions will be held once draft Patient Experience Plan is written.			
	Develop a patient and public experience plan.	• Associate Chief Nurse for Quality and Patient Experience commenced in post November 2022. • Decision in April 2023 to develop two separate plans, one for 'experience' and separate 'engagement' plan which will sit within the Deputy Director of Communications, Marketing & Engagements remit. • Work is in progress to develop the Patient Experience Plan and is to be presented to Quality Assurance Committee in September 2023 prior to implementation.	In progress	Patient Experience implementation Plan ; Patient Experience Plan 2023-2026 final. • The Patient Experience and Engagement Plan was presented and given assurance by the Quality Assurance Committee (QAC) in September 2023. Progress against the plan in 2023-24: • CODE and Quality Mark updates are contained within the plan. • survey introduced to CODE inspections. • Friends and Family survey provider under review, May 2024, with a process underway to review prospective suppliers. • QR code attached to all complaint responses so that	In progress

Positive Experience					
Focus	Drivers	22/23	Progress		
				complainants can provide feedback on their experience. • Shared decision making update contained within this document. • EHIA and EDS updates contained within this document. • 2 new education facilitators recruited to the Palliative and Supportive Care Team to support education of Trust staff – including ACP.	
Review, reintroduction and expansion of the Christie Quality Mark to all Christie satellite sites	Review standards and process for accreditation to ensure The Quality Mark meets current service delivery and practices.	• Standards and processes for both Chemotherapy and Radiotherapy have been reviewed and updated in collaboration with Service Leads, September 2022.	Complete		
	Develop and plan an inspection programme to include all satellite sites that deliver chemotherapy and radiotherapy treatments.	• Inspection programme developed, concentrating on Christie @ sites. • The inspection programme for 2023/24 will also include SLA sites and outreach centres.	Complete		

Positive Experience					
Focus	Drivers	22/23	Progress		
	Inspect all Christie satellite sites in line with a planned inspection programme	• Christie at Salford inspected on 15th March 2023. • Proton Beam Therapy Centre January 2023	Complete	• Christie at Oldham and Christie at Macclesfield completed in May 2023. • Christie at Stockport completed in December 2023. • All other Christie at sites planned for inspection throughout 2024, as detailed in the timetable:  Quality Mark Areas Timetable & Program	Complete
	Initiate an engagement and re-education programme with all sites to ensure a full understanding of the Quality Mark and the expectation for sites to achieve accreditation.	• Individual engagement sessions delivered by the Lead Nurse for Quality & Standards. • A Quality Mark inspection tool has been developed for both Chemotherapy and Radiotherapy.	Complete	• Engagement sessions ongoing, pre-visits undertaken by Lead Nurse for Quality & Standards. • Outreach Centre pre-visits and inspections will be undertaken in 2025.	Complete
Development and expansion of the Christie Quality CODE; a framework for measuring the	Ensure all patient care areas provide high quality care and treatment	• An annual CODE accreditation programme was developed and undertaken in 2022/23.	Complete	• Ward 12 inspections completed on 30/06/23 and 14/02/24. • Revalidation inspections continuing throughout the year, as per the CODE calendar:	Complete

Positive Experience					
Focus	Drivers	22/23	Progress		
quality of CARE provided to patients by OBSERVATION, clear DOCUMENTATION and patient and staff EXPERIENCE, with areas accredited according to a comprehensive set of standards.		• All areas, except Ward 12 were inspected and accredited.		CODE Maintenance Calender 2022-2024.›	
	To implement stretch targets for ward CODE re-accreditation scheme assessments	• Stretch targets regarding implemented and added to the CODE accreditation tool for all areas for 2022/23. These include: • care of the patient in last days of life • care of the patient with, or at risk of hyperglycaemia	Complete	• CODE standards fully reviewed August – December 2023. CODE tool and manual updated January 2024. • A new CODE standard, care of the deteriorating patient, was initiated to capture the care of the acutely unwell patient.	Complete
	To implement CODE accreditation to ambulatory care services	• CODE accreditation inspection tool currently tailored for ambulatory services updated September 2022. • Clinical Research Facility (CRF) inspection November 2022. • Ongoing discussions with Acute Ambulatory Care Unit (AACU), Integrated Procedures Unit (IPU) and Outpatient Department (OPD) ongoing.	In progress	• CODE accreditation programme agreed for 23/24.	In progress
Reintroduction of pre-pandemic PLACE (Patient-	Re-introduce PLACE assessment processes.	• PLACE assessments are the annual assessment of	Complete	• PLACE assessments on the Christie Withington site (02/10/23) and The	Complete

Positive Experience					
Focus	Drivers	22/23	Progress		
Led Assessments of the Care Environment) assessment processes		environments and how they support the delivery of care. • Assessments in 2020 and 2021 had been prevented by the COVID-19 pandemic. PLACE meetings recommenced in 2022 prior to assessments that were undertaken at the main trust site 26th September 2022, followed by the Christie @ Macclesfield on 28th September 2022. • The assessments were undertaken by teams of healthcare staff and public. Public members (known as patient assessors) account for at least half of the assessing team and recruited from the Christie membership in addition to an independent external assessor from Stockport NHS Trust who participated in the main site assessment. • The results of the PLACE assessments were published		Christie at Macclesfield (05/10/23) have been undertaken in 2023-24. • The assessments looked at areas such as privacy and dignity, food & hydration, cleanliness, accessibility and general condition/maintenance and appearance as well as the extent to which the environment has the ability to support the care of those with dementia and disability. • All inpatient wards, except Oncology Critical Care Unit (OCCU), were assessed along with outpatient areas and oak road treatment centre. All general circulation areas were covered, including Oak Road foyer, lifts, corridors, public toilets, external areas, car parks C and D and the main entrances. The lunch service on two wards, 4 and 10 was also assessed.	

Positive Experience					
Focus	Drivers	22/23	Progress		
		nationally 23rd March 2023 and presented to the Patient Experience Committee on 26th April 2023. • The results describe a 100% Ward Food Score which was the top score in the country and highlighted areas for improvement that include site wide review of wayfinding / signage, information provided in other languages and braille, update to general décor on some ward areas and Disability / Access site survey required. Related action plan to be monitored through Patient Experience Committee.		• The Christie Withington site scored better than national average across all PLACE Domains. The trust continues to perform well, but there are some general areas that need improvement. Actions have been identified for these improvements. PLACE-Report for PEC April 2024 RG.do	
Develop and deliver an Equality, Diversity & Inclusion (EDI) framework specific to service users	Undertake an EDI self-assessment and develop an action plan in relation to our baseline outcome of the assessment	• The EDI Delivery Plan July 2022- June 2023 was approved by EDI Programme Board July 2022, which provided a strategic overview of EDI activities for the Trust. • EDI Divisional Implementation Plan	In progress	edi_annual_report_2023_v2.pdf • We submitted our evidence for EDS 2022 during 2023/24. This was accepted by the national team.	Complete

Positive Experience					
Focus	Drivers	22/23	Progress		
		approved by EDI Programme Board and Trust Operational Group (TOG) in September 2022. This is a one year plan of EDI activities for the Divisional Boards to implement. This was to agree 2/3 SMART actions against the 3 strategic objectives in the EDI Delivery Plan and provide evidence and impact of EDI activities at a local level and ensure accountability of EDI activities across all areas of the Trust. • Actions to align to the Equality Delivery System for the NHS 2022 (EDS2) which will be monitored through Patient Experience Committee with the oversight and approval through EDI Programme Board.		Equality Delivery System March 2024_F • MIAA report provides confidence that our processes are robust around EDI and particularly around EDS. MIAA TCFT Equality Delivery System Revie	
	Implement the Accessible Information Standard (AIS) to develop	• The Accessible Communication policy was reviewed and updated March 2023.	Complete	• A draft action plan to support the embedding of AIS is due to be presented to Patient Experience Committee in May 2024.	In progress

Positive Experience					
Focus	Drivers	22/23	Progress		
	improved patient information	• A new Accessible Communications SOP has been developed and published March 2023. • Both documents are available on the trust intranet; HIVE.		• The Trust launched a new patient registration form in September 2023 to improve patient demographic data collection.	
	Equality of access of the estate	• Assessment of appropriate flooring for wheelchair users • Assessment of signage provision underway	In progress	• Improved signage to inform people of the long slope into department 22 • New signage on toilet doors following PLACE inspections • Wayfaring and signage project initiated for 24/25	In progress
	Smarter undertaking of Equality Impact Assessments (EIAs)	• Revised process transitioning from Equality Impact Assessments (EIAs) to Equality & Health Inequality Analysis (EHIA) to be launched 01/06/23 • Training for accountable committee chairs, vice chairs and documents authors and appropriate staff groups has been undertaken in 2022/23 and will be ongoing.	Complete	• An audit was undertaken in November 2023 to assess the effectiveness of the process, training and the quality of the EHIA's uploaded onto the system. This audit was presented to the EDI programme board in December 2023 and changes have been made on the training as a result of the audit. EHIA Audit Nov 2023_.doc	Complete

Positive Experience					
Focus	Drivers	22/23	Progress		
Achieve best care for all via patient centred care and shared decision making	To be delivered and monitored as a national CQUIN. This will be a 12 month implementation plan to include 4 disease groups. This will be reported on in line with the requirements of the CQUIN	• The Shared Decision making CQUIN has been achieved for 2022/23. • A 75% positive patient response was achieved for Breast, Lung and Colorectal teams.	Complete	• The shared decision making (DSM) CQUIN requirements were met for 2023/24 with an 86% positive response. The CQUIN was expanded to cover 10 disease groups.	Complete
Work to ensure that Advanced Care Planning (ACP) conversations are held with patients and appropriately documented and updated	Facilitate several Mayfly training sessions within the Trust.	N/A	N/A	• New for 2023/24. • Several Mayfly training sessions facilitated during 2023/2024. • Further Mayfly training sessions will be delivered during 2024/25.	Complete
	Recruit end of Life Care Facilitators	N/A	N/A	New for 2023/24. • The Palliative and Supportive Care Team (PSCT) have recruited two new End of Life Care facilitators during 2023/24. These roles have been created to support roll-out of education and support for staff across the Trust, regarding palliative and end of life care.	Complete

Positive Experience					
Focus	Drivers	22/23	Progress		
	Undertake a retrospective audit of documentation on the electronic Clinical Web Portal (CWP) of advance care planning discussions with patients and/or their significant others.	N/A	N/A	• The Palliative and Supportive Care Team (PSCT) conducted an ACP audit. • The audit highlighted evidence of good ACP conversations between professionals and patients but it also highlighted a need to carry out further education to increase the completion of the ACP form and create a greater level of consistency. • As this ambition was only partially achieved in 2023/24 we will continue to work to improve the number and quality of ACP's during 2024/25.	In progress