The Christie
NHS Foundation Trust

Board of Directors meeting

Thursday 30th November 2023 at 12.45 pm

Meeting Room 103, Ground Floor, Paterson Research Building

Agenda

Clinical presentation: A step into SACT services, Gemma Jones, Modern Matron Chemotherapy Services / Andrew Butler, Public Governor and patient **30 - 40 mins**

					Page	Timing
Public items						
35/23	**Standard business**					
a	Apologies			Chair		
b	Declarations of interest			Chair		
c	Minutes of previous meeting – 26th October 2023	*		Chair	2	5 mins
d	Action plan rolling programme, action log & matters arising	*		CEO	9	
36/23	**Key Reports**					
a	Trust report	*		CEO	12	20 mins
b	CQC Action Plan	*		ECN	23	15 mins
c	The Board's responsibilities for Carbon Net Zero	*		DCEO	78	5 mins
37/23	**Board assurance**					
a	Audit Committee report – October 2023 and Terms of Reference	*		Committee chair	80	5 mins
b	Workforce Assurance Committee report – November 2023	*			91	5 mins
c	Board assurance framework 2023/24	*		CEO	95	5 mins
d	Chairs objectives	*		Chair	101	5 mins
38/23	**Any other business**			Chair		
	Papers for information only					
	Integrated performance, quality & finance report	*				
	Trust Sustainability Annual Report	*				

Date and time of the next meeting
Thursday 25th January 2024 at 12:45pm

CEO	Chief Executive Officer	*	paper attached
COO	Chief Operating Officer	v	verbal
ECN	Executive Chief Nurse	p	presentation

Public meeting of the Board of Directors
Thursday 26th October 2023 at 12.45 pm
Education Centre Seminar Room 4/5

Present: Chair: Edward Astle (EA), Chairman
Roger Spencer (RS), Chief Executive Officer
Robert Ainsworth (RA), Non-Executive Director
Alveena Malik (AM), Non-Executive Director (virtual)
Grenville Page (GP), Non-Executive Director
Prof Kieran Walshe (KW), Non-Executive Director
Prof Chris Harrison (CJH), Deputy CEO
Bernie Delahoyde (BD), Chief Operating Officer
Prof Janelle Yorke (JY), Executive Chief Nurse
Dr Neil Bayman (NB), Executive Medical Director
Sally Parkinson (SP), Interim Executive Director of Finance
Prof Fiona Blackhall (FB), Director of Research
Eve Lightfoot (EL), Director of Workforce
John Wareing (JW), Director of Strategy
Prof Richard Fuller (RF), Director of Education (virtual)

Minutes: Louise Westcott (LW), Company Secretary

In attendance: Jo D'Arcy, Assistant Company Secretary
Theresa Plaiter (TP), Deputy Chief Nurse
Jeanette Livings, Director of Comms & Marketing
Sue Mahjoob (SM), Freedom to Speak Up Guardian
Philip Ormesher, member of the public

EA noted what a privilege it is to have been appointed as the Chair of the Trust, and noted that is meeting as many people as possible as part of his induction.

Clinical presentation: Dr James Price (JP), Head & Neck Oncologist & Erica Murphy, patient – Head & Neck pathway, patient's perspective & use of ePROMs

JP introduced himself as a clinical oncologist and a researcher. He introduced Erica Murphy as one of his patients.

JP outlined who the Head & Neck (H&N) team are, the pathways and the use of electronic patient reported outcome measures (ePROMs).

There are many H&N cancers that impact multiple areas in the head & neck. The team are seeing different types of cancers. There is an increase in cancers caused by the HPV virus. This will hopefully diminish as the impact of the HPV vaccine takes effect. The treatment is intensive. Patients need a combination of therapy, chemotherapy, radiotherapy and surgery. The vast majority of these cancers are curable but patients are pushed hard with treatment.

The deprivation in the catchment is strongly linked to smoking & alcohol use. The team are the largest provider of radiotherapy and treat more than any other provider, survival is comparatively very good. Prof Thompson leads on research, JP outlined the success in trial recruitment and reporting of what we are doing through publications.

The team are very large, and the multidisciplinary team were outlined including medical oncologists, speech & language therapists, specialist nurses & dietitians etc.

The pathway is complex & convoluted. Patients present with symptoms, and multiple tests are needed to diagnose. A discussion is then needed through an MDT. First appointment takes about 2 hours and there are multiple professionals involved. It is information overload. Patients need a

mask fitting in the mould room, and this is very distressing for them. There are chemotherapy appointments, multiple visits, and complex discussions.

JP asked Erica how she felt about the appointments where the treatment was explained. She noted that she had discussions prior to coming to the Christie so already had a certain amount of understanding. The symptoms were getting worse prior to the appointment and quite a lot had been explained. When the diagnosis came, they also had to do a biopsy of the back of her throat. She described feeling at ease but also having information overload, but this eventually gets absorbed and as treatment progresses this gets easier, and you understand what's happening and why you are given the information. It's a balance of information because you don't know what's normal and although you've been told it's hard to take in until you've experienced it.

EM described going deaf in one ear and knows she was told this may happen, but you don't take it in until it happens.

There are often about 30 treatments of radiotherapy that completely takes over the patient's life. They come every day and there is also a radiotherapy clinic to see how this is going. There's then a follow up after 6 months. EM has been given the 'all clear' and been referred back to the surgeon for follow up. JP asked if she feels the discharge following the scan results felt OK. EM noted that she can still contact the team with any questions, there is someone on the end of the phone. She felt able to call the team when needed.

JP described the roll out of electronic patient reported outcome measures (ePROMs). We're the only hospital doing this in the country. This allows feedback from the patient on how they are feeling, symptoms and the severity of what's happening while they are a patient. The ePROMs works through a link that patients can access on an app. The patient scores themselves against the pre-programmed questions. There are then various responses from the team based on the responses.

JP described the feeling of being 'cut adrift' following the end of their treatment. Lots of patients get involved in research and small projects. EM was involved in an ePROMs around radiotherapy. JP showed screenshots of the feedback and noted where red flags come up and what happens but also noted that this allows for much better discussions when the patient comes into the clinic.

JP talked about smoking and the prevalence in GM. Between 15-20% of people smoke, almost double the rest of the country. The impact of smoking can mean patients are not able to have treatment because of other impacts on health of smoking such as lung & heart damage. It is stressed that stopping smoking at any point is extremely beneficial. Patients still have a much better chance of living if they stop smoking after diagnosis. JP described the smoking cessation service at the Trust. We offer a bespoke service and Charlotte Finchett will see all patients that smoke. Charlotte is extremely busy and extremely good at her role. This service needs expansion.

JP outlined the good and not so good – world leading, MDT, leaders in research, excellent outcomes, embracing tech. Not so good – capacity, demand rising, MDT mergers – risk and opportunity to maintain standards. Lack of resilience particularly with Clinical Nurse Specialists (CNS) & dieticians as well as health advisers.

FB noted the alignment of clinical research and service and asked how this works in the team. JP noted that the research is done through normal clinics, there is a research nurse team who support but the clinic infrastructure needs to improve. Time is the limiting factor.

KW noted the number of fractions given and the late effects and management of survivors. JP noted that Head & Neck cancers respond well to radiotherapy. There's a move in many specialities to giving higher doses on fewer occasions but this doesn't work for head & neck. Large doses per fraction can cause big problems with late effects. The smaller doses over more fractions is better. In terms of late effects patients are followed up by ENT services in their local hospitals. ePROMs

follow up doesn't take place after discharge. This is being considered. If someone if reporting problems we must have a way of ensuring this is being responded to.

RA thanked JP for the presentation. He asked that although tobacco use is a huge issue, what about vaping. JP responded that the clinicians here do not like vapes and nicotine replacement therapy is far the better option. The evidence isn't mature yet but there are more & more issues coming through around the dangers of vaping. This is also currently unregulated.

EA thanked JP for the presentation.

Item		Action
31/23	**Standard business**	
a	**Apologies**	
	Tarun Kapur (TK), Non-Executive Director	
b	**Declarations of Interest**	
	None noted.	
c	**Minutes of the previous meeting – 28th September 2023**	
	The minutes were accepted as a correct record.	
d	**Action plan rolling programme, action log & matters arising**	
	All items from the rolling programme are noted on the agenda. There are some outstanding signed privacy notices that will be followed up.	JD
32/23	**Board Assurance**	
a	**Board assurance framework 2023/24**	
	RS noted the BAF 2023/24. He outlined the updated target risk scores and where assurance committee assessment has been made it has been added. Comments from internal auditors have been taken account of in the addition of columns and end of Q2 risk scores have been added. Comments invited. EA commented on the ICB financial risk and industrial action being our highest risks and the external factors impacting these. BD noted that these risks impact other risks such as achievement of performance targets – late referrals etc. GP noted that often Board will solely focus on the red risks, and they must also look at the lower risks to ensure these are also being addressed.	
b	**Quality Assurance Committee summary report to Board – September 2023**	
	KW noted the report. He noted that the committee covered other things as well as those that come through for assurance. In relation to the Lost to Follow up risk this is coming back in January for further review. No escalations were identified and no questions raised.	
c	**Review of Annual Objectives 2023/24**	
	RS presented the progress against the objectives for this year. This shows the current position and notes which committee they are reviewed at. Each objective connects to the risks on the BAF. Progress is being monitored for each element. RS reminded the Board that risks to delivery are managed through normal	

	processes in the organisation. EA asked where there is concern that we won't achieve our objectives. RS noted that the cumulative impact of the industrial action will impact many things, for example, the ability of digitisation of order comms (operating of it / clinical leadership), and the achievement of recurrent CIP. This is being monitored and assessed on an ongoing basis. We are delivering well in challenging circumstances e.g., our clinical trials delivery is bucking the trend nationally. GP noted that the 6 monthly update on carbon zero came to the last Audit Committee and this is impacted by national factors and funding. The Board will see this and may need to make decisions on what we do. GP asked if we are clear on our role as an Anchor institution. RS noted that we have been participating in activities. JW noted there's a GM approach to this that includes employment and sustainability. We are playing our part in this work in GM. In terms of social value, we include this in procurement and have also focused on apprenticeships. This will be sensitive to the organisation. RS noted that our recurrent CIP programme has relied on the carbon energy scheme delivery. SP noted that we got a grant of £9m that has been very helpful.	
d	**Summary of feedback from Board Members**	
	EA noted the summary of the meetings he has had with Board members. He noted that the Board will continue to improve and learn. There are always tweaks to the way the Board manages its business. EA noted that the level of detail of Board papers and the scope for more challenge were raised. We'll look at the agenda and timings to try and support improvement. There is scope for shorter papers and summaries. This will be fed into the work from the Good Governance Institute. The GGI report is due in December and will report early next year. CH noted that there will be an observation of the Board meeting by GGI in November.	
33/23	**Key Reports**	
a	**Trust report**	
	EA asked RS to speak about the report. RS noted the following items; There are no significant variances in general operational activity in terms of quality & performance, we continue to not deliver on the 62 day cancer standard. We continue to work to improve this. Following the changes to the standards nationally we note that we would achieve the consolidated standard in September. Financial performance is better than plan in month 6 linked to the GM system that is in financial recovery. The rest of the system is in a deteriorating position. Actions required by the turnaround team in GM are noted in the report including grip & control on spending, forecast of year end position based on the improved position at month 6 and work on where income due on activity delivered could come from. There is also focus on efficiency plans recurrently. RS noted that we are fully participating in what's required by the system. EA asked if there were any questions on this issue. RA asked about the shortfall in capital and if this is impacting on what we do. SP responded that we can't	

	exceed on capital spend but we can move certain things into next year so that we can still do what we need to. This is a £2m reduction. RS noted the summary information on the planning process for the coming financial year. There is interest in bringing forward planning in the system and we are moving ahead with this. RS updated on the CQC activities. We are on plan to deliver on the must do's and are progressing on should do's. The plan will be reported in full next month. Discussions have taken place with specialised commissioners. JY noted that they will monitor progress. They have received the action plan and supporting documentation. We expect approval from them in the next couple of weeks. Once we get confirmation from them, we'll send this to the CQC who are also aware of our progress. The actions around the should do's, was also shown to the specialised commissioners. The final report will come to Board in November having been through our assurance processes. RS noted that discussions are ongoing with NHSE and the ICB around our segmentation rating which was being reviewed following our CQC report. We've had confirmation that we have been moved from segment 1 to segment 2 pending the outcome of the CQC activities that are monitored through the existing process. This is the mechanism for NHSE to monitor our progress. The activities to move back to segment 1 will be reported to Board. GP asked about the re-evaluation to segment 1 and how confident we are of the evidence to support this. RS responded that the assessment of segmentation was transferred to the ICB from NHSE. The recommendation of the assessment will be communicated by the ICB to NHSE. We are looking at the specific exit criteria that relate to the CQC action plan. There's a meeting with the ICB to go through this. The action plan contains all the evidence including the oversight through an assurance committee. AM noted that we are on the right track and want some assurance on how this becomes part & parcel of how we work and is not a paper exercise. We need to see the embedding of this in the organisation going forward. RS agreed that this is very important. JY noted that the motivation of all staff groups to get this right and sustainable is very good. A lot of what's been put in place is around day to day monitoring and ensuring this is used by managers to ensure compliance. Each must do is associated with a regulation and we are making sure these are reported through assurance committees so they are visible and monitored. RS reported on the delay with getting the auditors opinion in getting sign off of the Annual Report & Accounts. This has now been completed, laid before parliament, and published. We can now have an Annual Members Meeting. GP asked about the wording in the external auditor's report. SP noted that they have to refer to a significant control weakness, this is only linked to the one transaction of a gift to the charity. EA noted that the Royal Marsden were criticised for something similar. NB reminded the Board that we are still in a period of industrial action with our doctors. There are no further actions announced but this will continue and further ballots to strike have been issued by the BMA. The impact here is around the planning and the time this needs. Chemotherapy and radiotherapy are not impacted. Some elective surgical and outpatient activity is impacted and the cumulative impact is an issue. CH noted the section on health inequalities, and this was touched on in the clinical presentation. Work is going on in the ICS and there is a national framework that's been published. We will come back to this. The ICB team are	

	available to come and speak to us. This will be planned for a future date.	LW
b	**Freedom to Speak Up annual report**	
	SM introduced herself and noted that there's an expectation that the FTSU Guardian comes to speak to Board. The role is around support to staff and supporting in a culture of speaking up across the Trust. SM outlined activity raised to her over the last 3 years and where the majority of the issues raised sit – attitudes and behaviours was the biggest. Policies and processes was second and 4 concerns were around a potential to compromise patient safety. These have all been escalated and followed up appropriately and each were happy with the response and feedback. There was 1 anonymous concern and 15 face to face. Most people chose to meet face to face. October is Speak Up month. The national theme is Breaking Barriers. There is a lot of work going on to address this and promote a better culture of speaking up through identifying issues and having conversations about them. Posters and visibility through engagement hub are in place. Management training has been updated around this. Examples of speaking up and what happened as a result have been used to break down the issue around futility. The different ways in which staff can speak up are also highlighted. SM highlighted the roll out of Respectful Resolutions and trying to help with interactions between people that may result in a speaking up issue. SM outlined some things that are in progress including the closer link to the Patient Safety team, additional questions have been added to the staff survey, anonymous reporting for inappropriate behaviours, highlighting that detriment will not be tolerated. This is all about listening to staff, and EDI. There are certain sections of our staff that find it difficult to speak up. Champions are from diverse backgrounds. SM stressed the importance of investing in speaking up as it improves awareness that could impact care, opportunity to learn & improve. SM noted that the Board self-assessment will be completed in December. There is also training for the Board. Speak-up, listen-up and follow-up. SM stressed that the example set by leaders really matters and encouraged Board to continue to do this. FB asked about how to evidence listening and acting whilst maintaining confidentiality. SM agreed that this is very difficult, but confidence & trust is so important. Communication is key and the feedback is monitored through the team formally and reported. There is feedback through the service, and this can be communicated. EL noted that there's some planned activity around triangulating the issues that are raised through different routes to ensure that there is feedback in the right way, and this will be supported by the assurance processes. GP asked about feedback and SM noted that she has a check in process with those who have raised issues to make sure that some way down the line they are happy that their issue has been addressed. AM noted that SM is doing a fantastic job and there's a gear change in terms of visibility whilst respecting confidentiality. RF added that the importance here is about encouraging visibility around the positives of FTSU - around better listening, better/safer patient and colleague care - why it matters, why we value it as an organisation with a culture of	

	improvement.	
34/23	**Any other business**	
a	EA noted that it is JY's last Board meeting. He noted JY's huge contribution to the organisation both from an operational nursing leadership perspective and through her focus on research and pioneering of the pathway for nursing at The Christie. EA noted the importance of ePROMs, and her role on the Board. The Board wished JY well. JY noted the support of the Board in her academic work and RS's vision in taking her on. It's been a delight.	
	Date and time of the next meeting	
b	Thursday 30th November 2023 at 12:45pm	
	Papers for information only	
	Integrated performance, quality & finance report	

The Christie
NHS Foundation Trust
Agenda item 35/23d

Meeting of the Board of Directors - November 2023

Action plan rolling programme after October 2023 meeting

Month	From Agenda No	Issue	Responsible Director	Action	To Agenda no
November 2023	Annual reporting cycle	Integrated performance & quality report and finance report	COO	Monthly report	For information
		CQC Action Plan	ECN	Approve for submission	36/23b
		Boards responsibility for Carbon Net Zero	DCEO	Report	36/23c
December 2023 - no meeting		Integrated performance & quality report and finance report	COO	Monthly report	By email
January 2024	Annual reporting cycle	Integrated performance report	COO	Monthly report	
		Charity update and approval of FT Trustees	CEO	Approve	
	CQC 'should do'	Globis Culture Audit report	CEO	Report	
		6 monthly review of strategy	DoS	Report	
February 2024 - no meeting		Integrated performance & quality report and finance report	COO	Monthly report	By email
	Annual reporting cycle	Letter of representation & independence	Chair	Circulate	By email
	Annual reporting cycle	Register of directors interests / FPPT annual declaration	Chair		
	Annual reporting cycle	Declaration of independence (non-executive directors only)	Chair		
March 2024	Annual reporting cycle	Corporate planning (corporate objectives / BAF 2023/24)	Executive directors	Approve next year's BAF	
	Annual reporting cycle	Integrated performance & quality report and finance report	COO	Monthly report	
		5 year strategy 2023-29 - year 1 review	DCEO		
		Digital Update	EMD/Dep CEO	Update	
		Workforce update	DoW	Quarterly review	
		Annual reporting cycle	Chair	Approve	
	Annual reporting cycle	FPPT Complaince report	Chair	Approve annual compliance	
April 2024	Annual reporting cycle	Integrated performance & quality report and finance report	COO	Monthly report	
		Register of matters approved by the board	CEO	April 2022 to March 2023	
	Annual reporting cycle	Annual Corporate Objectives	CEO	Review 2022/23 progress	
	Annual reporting cycle	Risk Management strategy 2021-24	CN&EDoQ	Annual Review	
		Modern Slavery Act update	CEO	Approve	
		Board effectiveness review	Chairman	Undertake survey	
		Freedom to speak up Guardian report	FTSUG	Quarterly update	

Month	From Agenda No	Issue	Responsible Director	Action	To Agenda no
May 2024	Annual reporting cycle	Integrated performance & quality report and finance report	COO	Monthly report	
	Provider licence	Self certification declarations	EDoF&BD	To approve the declarations	
		Responsible Officer report	EMD	Medical Appraisal & Revalidation Annual report	
	Annual reporting cycle	Annual compliance with the CQC requirements	ECN	Declaration / approval	
	Annual reporting cycle	Risk Management strategy 2021-24 annual review	CN&EDoQ	Annual Review	
June 2024	Annual reporting cycle	Integrated performance & quality report and finance report	COO	Monthly report	
	Annual reporting cycle	Annual reports from audit, quality and workforce assurance committees	Committee chairs	Assurance	
	Annual reporting cycle	Annual compliance with the CQC requirements	ECN	Declaration / approval	
	Annual reporting cycle	Annual report, financial statements and quality accounts (incl Annual governance statement / Statement on code of governance)	EDoF&BD	Approve	
July 2024 - no meeting		Integrated performance & quality report and finance report	COO	Monthly report	By email
August 2024 - no meeting		Integrated performance & quality report and finance report	COO	Monthly report	By email
Sep-24	Annual reporting cycle	Integrated performance & quality report and finance report	COO	Monthly report	28/23b
		Standing Financial Instructions (SFI's)	DoF	Approve	29/23a
October 2024	Annual reporting cycle	6 monthly review of annual objectives	DCEO	Interim review & update	32/23c
	BAF Risk	Christie role in addressing healthcare inequalities	DCEO	Report	33/23a
		Integrated performance & quality report and finance report	COO	Monthly report	for information
		Freedom to speak up guardian	FTSUG	Annual report	33/23b

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Agenda item: 35/23d

Action log following the Board of Directors meetings held on

Thursday 26th October 2023

No.	Agenda	Action	By who	Progress	Board review
1	31/23d	Outstanding privacy notices to be chased and signed / collected	LW/JD	Chased up	N/A
2	33/23a	Add health inequalities to a future Board session agenda	RS/LW	Health inequalities to be discussed at the Board Time Out 8th December	Friday 8th December 2023

The Christie
NHS Foundation Trust

Agenda item 36/23a

Meeting of the Board of Directors
Thursday 30th November 2023

Subject / Title	Trust report
Author(s)	Executive Directors
Presented by	Roger Spencer, Chief Executive
Summary / purpose of paper	This report brings together the key issues for the Board of Directors in relation to our performance, strategy, workforce, the Greater Manchester system landscape, the regulatory landscape and other pertinent matters within the scope of the board's responsibilities.
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
NHS Foundation Trust

Trust Report

30th November 2023

Executive Summary

- Key quality indicators for October show no significant adverse variances or issues for escalation.
- Our operational performance indicators in October shows no significant adverse variances other than our compliance against some of the national Cancer Waiting Times standards.
- Performance in October for the new 62-day consolidated cancer standard was 65% which is consistent with the trajectory to meet the standard by March 2024.
- Industrial Action by medical staff has been managed using our business continuity plans and led to some rescheduling. No patient safety incidents due to the impact of the industrial action were reported.
- Cumulative financial performance at the end of October (month 7) is a £2.9m deficit against a planned £4.7m deficit. This is a positive variance of £1.9m to plan, an improvement on the month 6 position of a £1.5m positive variance to plan.
- Key financial performance indicators in month 7 show no adverse variances other than the level of recurrent efficiency achieved for which £1.9m of a year-end target of £6.4m has been identified.
- Our annual planning process for 2024/25 commenced with an away day for 50 senior leaders discussing workforce, efficiency and infrastructure plans. This process continues now at Service and Operational Reviews with Divisions focussing on planned activity levels for 2024/25.
- Workforce indicators for October show a further increase in sickness absence rates with plans to address this being scrutinised by the Workforce Assurance Committee
- The annual staff vaccination programme commenced on Monday 25th September 2023
- The Staff Survey 2023 is underway and the Trust have been working with staff to provide time for them to complete the survey.
- Our Cultural Audit has completed the data collection phase and will report in late November.
- We remain rated as overall Good by the CQC and we have completed our CQC Action Plan by the end of October, a full report is in the November public Board papers.
- We have been placed in System Oversight Framework (SOF) Segment 2 by NHSE.
- The review of our assurance committees with a particular focus on assurance about the CQC fundamental care standards is nearing completion.

Quality of Care

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

There were 12 formal complaints in October which is in line with the monthly average. The number of contacts with the Patient Advice and Liaison Service (PALS) service in October was 37, slightly lower than the previous month.

Nurse staffing numbers met the levels to ensure appropriate levels of safety and care with indicative staffing to maintain a 1:8 nurse to patient ratio which is nationally recommended. The Biannual Safe Staffing report has been approved through the Workforce Assurance Committee on 14th November 2023.

The actions to address the 'must do' recommendations of the 2022 CQC inspection reports are completed, and a full report is contained in the November Board papers.

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

1. Risk of not achieving the financial plan including the cost improvement programme (16).
2. Risk of delayed cancer referral and treatments due to not meeting 24 / 62-day targets (15).
3. Risk of patients being lost to follow up (15).
4. Risk that patients may experience harm due to significant delays in the management of patients with penile cancer (16).
5. Risk that the IPU Endoscopy could lose JAG accreditation by not being able to maintain the standards for environment (15).

Operational Performance

Our operational performance indicators show no significant adverse variances other than our compliance against some of the national Cancer Waiting Times standards. Compliance at the end of October against the 62-day consolidated standard was 65%. We have continued to achieve the 31-day standard for treatment to start within 31 days of the decision to treat. During October there were 12 operations cancelled on the day for non-clinical reasons all were rebooked within 28 days.

From October, there are three key standards that we are measured against;

1. Faster Diagnosis Standard – referral to diagnosis threshold 75%
2. 62-day referral to treatment standard, (merging all 62-day standards) threshold 70%
3. One headline 31-day decision to treat to treatment standard threshold 96%.

The divisional management teams have refreshed their improvements plans to ensure that we begin to see sustainable improvement in terms of delivery against the cancer waiting times targets. Key areas of focus are outpatient waits for first appointments and radiotherapy capacity. To improve the outpatient waits we are implementing in one disease group direct outpatient booking from multi-disciplinary team meeting (MDT), and we have merged the trackers / MDT co-ordinator's role. In radiotherapy 4 hours of additional capacity have opened this month.

Industrial action by junior doctors and consultants has taken place on 2nd to 5th October (consultants and junior doctors). The divisional teams had to focus their workload to ensure that business continuity plans were robust to ensure no impact on patient safety. Our aim has been to maintain services where possible, with the key priority to maintain the safety of patients requiring urgent admission and current in patients. To ensure safe medical cover we have had to reduce some elective activity. No patient safety incidents were reported as a consequence of industrial action.

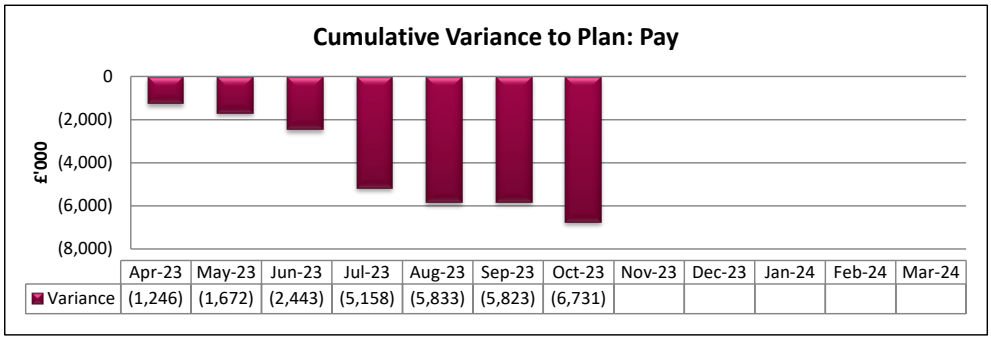
The cumulative effect of several days of industrial action is leading to increased waiting, due to elective cancellations of outpatient appointments and some elective surgical cases as well as a general reduction in capacity over the periods of industrial action. This has not had an impact on radiotherapy or chemotherapy treatments. We continue to advise patients that they should attend for their appointments as normal unless they have been contacted in advance with a rescheduled appointment. We are extremely grateful to all those Christie staff who have helped to maintain patient safety in this period.

Winter plans are now in place to ensure that we can continue to admit all patients requiring non-admission to the trust. The patient flow team and continuing to improve flow through the inpatient beds to reduce delays to admission from OP areas and to improve our LOS which has increased slightly in month. Within our winter plan we will be keeping ward 2 a 5 day elective ward open over the weekend.

The trust submitted the **E**mergency **P**reparedness, **R**esilience and **R**esponse (EPRR) self-assessment in early October where we scored ourselves as being 70% compliant. The output of this original self-assessment was presented to the audit committee on 19th October 2023. The regional assessment of our submission highlighted some areas that required further information, which we have now completed and resubmitted our self-assessment which still scores the trust as 70% compliant. An action plan has been developed to improve the gaps identified in this assessment.

Financial Performance

Revenue: Financial performance is ahead of plan as illustrated in the table below. The Trust is reporting a £2.8m deficit against a £4.7m planned deficit position. This is mainly due to pay underspends due to vacancies and interest received on the Trust's cash balances being above planned levels. The cumulative pay underspend of £6.7m is illustrated in the graph below (note £3.2m relates to income backed services, including GM Cancer, R&I and The Christie Charity)



This underspend has been offset to some degree by additional costs in respect of industrial action plus unbudgeted costs associated with the medical pay award resulting in the financial position and variance illustrated below:

Month 7 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(374,010)	(218,232)	(227,785)	(9,552)
Other Income	(68,838)	(40,094)	(40,282)	(187)
Pay	212,163	123,662	116,930	(6,731)
Non Pay (incl drugs)	218,637	127,637	140,449	12,812
Operating (Surplus) / Deficit	**(12,048)**	**(7,028)**	**(10,688)**	**(3,660)**
Finance expenses/ income	28,723	16,755	18,457	1,702
(Surplus) / Deficit	**16,675**	**9,727**	**7,770**	**(1,957)**
Exclude impairments/ charitably funded capital donations	(8,637)	(5,038)	(4,941)	97
Adjusted financial performance (Surplus) / Deficit	**8,038**	**4,689**	**2,828**	**(1,861)**

Capital: GM providers collectively agreed to reduce annual capital spend against original plans by a proportionate amount as the original GM ICS plan was oversubscribed. The impact of this is a £2m reduction to the original Trust capital plan. The Trust's cumulative capital expenditure at month 7 is £1.9m below the original plan but in line with the revised plan.

Cost improvement: The level of recurrent CIP delivered to date is under plan at £1.9m compared to a target of £6.4m. Whilst divisions are working on the delivery of cost improvement schemes, this has been significantly impacted by the management of industrial action. The annual CIP target of £12.5m is forecast to be delivered but predominantly through non-recurrent measures; this will create associated pressures for 2024/25.

KPIs: As shown in the table there are no significant variances from the planned financial performance against key measures other than the level of recurrent CIP delivered to date:

Measure of Financial Performance	Red / Amber / Green rating
Revenue: Trust Control Total compared to plan	£2.8m deficit
Capital: Capital expenditure against plan	£1.9m under plan
CIP achieved (recurrent) against target of £6.4m	£1.9m identified
Debtor days compared to 15-day target	11 days
Cash balance Better Payment Practice Code (95% target)	£145m 97%

GM Recovery: The GM system continues to be supported by the PwC turnaround team and the Trust is fully engaged in this process. This work included optimising the 2023/24 year-end position, identifying any flexibilities in balance sheet position and assessing the underlying run rate. As part of this work, the GM ICB have assessed and submitted a revised year end forecast.

Reforecast: As previously report to Board, the Trust has reviewed the risks and opportunities in delivery of the Trust's operational plan combined with the financial and operation performance to date to inform a revised year end forecast from £(5.7)m to £(3.4)m.

Following announcement of funding for industrial action, GM ICB received £46.1m and allocated £1.2m to the Trust. This has revised the year end forecast to the range illustrated below:

	Reforecast	
	Best case	Likely case
Plan	-8.0	-8.0
M6 variance to plan	1.5	1.5
Balance sheet release	0.8	0.8
GM ICB income	2.3	0.0
Sub-total	**-3.4**	**-5.7**
Industrial action funding	1.2	1.2
TOTAL	**-2.2**	**-4.5**

Workforce

Our workforce performance indicators show mandatory training compliance and personal development plan rates are both above (better than) thresholds at 90.7% and 84.5% respectively. Sickness absence rates have increased again in October to 4.89% (threshold of 3.4%). The overall all year turnover is 14.10%. These issues and the associated plans for improvement have been considered by the Workforce Assurance Committee.

The annual staff vaccination programme commenced on Monday 25th September 2023. Both covid and influenza vaccines are available for all staff with the opportunity to

receive both vaccines at one appointment. There is also the opportunity to receive each vaccine independently for those who wish to do so. We aim to complete covid vaccination by mid-December with influenza vaccines available into the new year. Current compliance for all staff w/c 20th November stands at: Flu: 44.4% and Covid: 33.2%. This is comparable with reporting for other NHS trusts across the Northwest Region, however we remain the top performing Trust in Greater Manchester for compliance.

The government has agreed to hold talks with consultants' leaders and Junior Doctors in a bid to avert more strikes over pay. The BMA's Consultants Committee has said it will pause any announcement of further strike dates until November to allow time to try to resolve the ongoing industrial action. The BMA's SAS committee said a formal ballot for industrial action would be held if no progress was made by 6 November.

The Trust marked International Stress Awareness Week which ran between 30th October – 3rd November, by putting on a Wellbeing Programme. Staff were invited to take part in several activities including Silence Sessions, Lunchtime Pause and Refresh Sessions, Yoga, MBTI® Assessment Profile and Stress Management and Bite Size Group Sessions - Looking after your Mental Health & Wellbeing.

On the 11th November staff remembered the service and sacrifice of the Armed Forces Community, and paid tribute to the contribution of those who serve and have served, and their families. Andrew Bradley, Chaplaincy Coordinator led a 2-minute silence in the Oak Road reception area on the main site at 11:00am on Friday, 10th November 2023. Roman Catholic mass and a Church of England communion services also took place in the Chapel. A remembrance display including a Remembrance Tree was displayed at the Staff Engagement Stall during Remembrance week, where staff, patients, relatives, and visitors could leave notes of reflection and remembrance.

The Christie Charity has approved the establishment of The Joanne Fitzpatrick Education and Professional Development Grant Awards, in memory of our colleague and Director of Finance Joanne Fitzpatrick.

The grant awards are in support of the professional development of non-clinically qualified staff, to further their Christie career and contribute to service development and improvements for patients. The award supports a range of UK based development opportunities and is particularly encouraging applications from Band 2 and 3 colleagues.

The first tranche of grants have been awarded, with staff from HR, finance and the Charity successful. Grant awards will be considered every quarter.

Globis Mediation have completed their work on a wide-ranging audit of our organisational culture to better understand some of the CQC feedback and comments from staff, triangulating these with other sources of information such as the NHS Staff Survey. The results of the audit are planned to be made available in late November 2023.

The NHS Staff Survey 2023 is open. The survey collects staff views about a wide range of aspects of working at The Christie. The results are used to benchmark us against other organisations, improve local working conditions, and ultimately to improve patient care. Staff have received personalised invitations to complete the survey via email or paper copy (if requested). A range of prize draws, and voucher offers have been made to encourage participation.

Nursing times Awards – October 2023. The Surgical Theatres and Surgical Nursing Team won the Theatre and Surgical Nursing Award, for dignifying surgery for a person with dementia and skin cancer. The judges said that they were an "example of exemplary nurse intuition and compassion in clinical practice", and a "reminder of fundamentals of care".

Two other teams were also shortlisted, the Lymphoma Team and the Complementary Therapy Team.

Research

A joint Christie – GM Cancer Alliance symposium ' Breaking Barriers' held on October 30th was attended by ~ 80 multidisciplinary staff. Presentations encompassed a deep dive into data for patients with protected characteristics, research considerations spanning children and teenage young adults to elderly patients; adults with complex co-morbid medical conditions and/or frailty. A spotlight on digital technology trials highlighted the role of patients in co-creating research. The next goal is to develop a diversity action plan for inclusive research to begin to redress protocols, imbalances and biases that lead to some patient populations being under-represented in research.

The Manchester Cancer Research Centre (MCRC) www.mcrc.manchester.ac.uk, Director Prof Rob Bristow, The Christie Chief Academic Clinician, is a collaborative partnership founded in 2006 by The Christie NHS Foundation Trust, Cancer Research UK and The University of Manchester. The International Advisory Board including Karen Knudsen, CEO American Cancer Society, Patricia LoRusso, Professor of Medicine, Yale Cancer Center and President elect American Association of Cancer Research, David Jaffray Chief Technology and Digital Officer, MD Anderson Cancer Center, US and Sheila Singh, Professor of Surgery and Biochemistry, McMaster Children's Hospital, Canada visited on the 1st and 2nd November. Research presentations highlighted an education programme currently supporting 58 clinical fellows in training as next generation clinical research leaders; the capabilities of the newly established CRUK national biomarker centre located in the Paterson Building; emerging programmes enabled by multidisciplinary teams of scientists and clinicians in brain tumours, vaccines for cancer prevention, prostate cancer, peritoneal and colorectal cancers. Visits to the Clinical Research Facility at The Christie and to The CRUK Biomarker at The Paterson also demonstrated the breadth of bench to bedside research taking place.

The Biomedical Research Centre funded a Living With and Beyond Cancer research theme showcase held in November in the Christie Education Centre was well attended and included presentations on reducing cardiac complications of treatment and bone health. Professor Janelle Yorke will be succeeded by Dr Claire Higham as lead of The Christie Patient Centred Research Group.

A strategy for ensuring a training pipeline of international research leaders focussing on early career clinical fellowships (medical, nursing and allied health professionals) is in development for presentation to The Christie Charity Funding Committee in December 2023.

Research delivery and performance continues to focus on the themes of the 2023 Lord O'Shaughnessy review with the National Contract Value Review now implemented and representation at GM Clinical Research Network Task and Finish Groups for faster study set up and reduced research bureaucracy.

Education

Excellent progress is being made with Year 1 strategic objectives with timelines on track or ahead of schedule. A number of new, key appointments strengthen our Education activity, drawing skills from charity, industry and public/private Higher Education backgrounds.

As part of our registered Higher Education provider status plans, a new education Executive Oversight Group, chaired by the Deputy Chief Executive has been convened, providing enhanced governance to our Education Structures. The new structure provides corporate leadership and oversight for Christie Education strategy, governance of our provider status programme of change and scrutiny of new, and existing partnerships. This provides an additional layer of interface with Research & Innovation and Christie International, supporting the Christie's overarching objectives.

Lucy Buckley received the National Award for Radiographer of the Year, 2023 (UK) from the Society and College of Radiographers. Lucy has driven the ACP and Consultant agenda for

Therapeutic Radiographers. She is inclusive and supporting at every level from pre-registration learners (and their dissertations) through to supporting global health. We applaud Lucy's exceptional dedication and role modelling for our current and future workforce.

International

Christie International hosted a visit on 15th November by Dr Gloria Rowlands, The Chief Nurse and member of the newly appointed Executive Team for the African Medical Centre of Excellence (AMCE) in Abuja, Nigeria. During her visit, Gloria had a tour of the SACT and Radiotherapy departments as well participating in a round table discussion with Christie International's core project team.

Following on from the visits by Andy Dimech (Chief Nurse) and Professor Michael Jefford from the Peter Mac Cancer Centre in Melbourne, Australia, earlier in the year, The Christie hosted Associate Professor Vikas Wadhwa on 21st November. During his visit to The Christie, Professor Vikas participated in a round table discussion hosted by the Interim Chief Nurse, Theresa Plaiter, as well as meeting colleagues from SACT services and Acute Oncology.

The Christie is currently working to formalise a partnership agreement with the Peter Mac Cancer Centre covering the 3 themes of Education, Research and Clinical Service.

Digital

The Electronic Prescribing and Medicines Administration (ePMA) project will introduce electronic prescribing of non-chemotherapy medications for inpatients and outpatients which, in turn, will release the associated safety, quality and efficiency improvements while releasing time for our clinical teams. This will include full integration with our Systemic Therapy prescribing solution and CWP and includes the introduction of a new allergies module that will allow significant patient benefit as allergies will be collated in one place instead of within multiple disparate systems. Go live is planned for inpatients in early 2024.

Phase 3 of the ePROMs project aims to develop the solution to ensure the visualisation of the data meets the needs of the clinical and operational teams using it. In addition, development of a solution called Responsive will allow patients to initiate contact with a healthcare professional when required using ePROMs. This will enhance the effectiveness of consultations and reduce the number of appointments required. However, the key benefit will be that it will offer a solution that supports the early identification of deteriorating patient conditions. The project is progressing well with fantastic engagement with operational and clinical colleagues.

This Greater Manchester & Cheshire Care Records project enables the transfer of Christie clinical data to both the Greater Manchester and Cheshire Shared Care Records. This enhances patient care management through improved access to Christie data for other organisations, while also providing single sign on access for The Christie clinical teams to the data supplied by other health and social care organisations held in those systems, thus facilitating joined-up care for patients across the region. Access to the GM Care Record is live with Cheshire Care Records to follow.

The Christie digital teams are working alongside our operational teams on the consolidation of oncology outpatient capacity. The aim is to consolidate all oncology outpatient appointments under The Christie. Clinics will still be delivered locally, but the booking, co-ordination, management of activity and recording would be via The Christie. This will maximise utilisation, allow activity to be flexed to meet demand, allocate extra waiting list initiative sessions to meet waiting time needs, even out waiting times, and reduce variation.

Service transition is location by location with activity at Bolton and Tameside already underway. Meetings to consider clinics at MRI and North Manchester will start in November.

Strategic and Service Developments

The Paterson building is now operational with most of the Trust's groups either having moved in or in the process of moving in. With maximising space utilisation being of key importance, the level of occupancy will be reviewed over the coming months with further groups moving in if possible and areas reallocated if appropriate. Arrangements to close the old vacated Estate space when the groups move is ongoing and some of the areas may be re-allocated.

The Trust formally launched the re-procurement of the pathology joint venture with the publication of the supplier questionnaire in October. As reported earlier the procurement is being undertaken through a competitive dialogue process, which whilst taking longer than a traditional procurement allows for greater flexibility such that the Trust can deliver the greatest value under overall procurement. The deadline for the supplier questionnaire response is 27th November and following evaluation we expect to launch the first stage dialogue on 11th December 2024.

Work continues on the formation of a 20-bedroom ward in the former Trust Administration and Digital floors. Internally, the partition walls are advanced, and work has commenced on the mechanical and electrical services. Externally, the lift cores, which are manufactured off-site, is about to commence. A number of risks were identified in respect of the delivery of the project and these continue to be managed. A key risk has been the need to replace the external cladding to the building due to the existing materials and this is likely to cause a delay to completion.

The agreement of the works for the new Art Room is nearing completion and is expected to commence after Christmas. The works to reform the landscaping around the Tree of Hope has commenced and will complete this month.

The design and engagement for the proposed Advanced Scanning and Imaging Centre development along Wilmslow Road continues. The planning application was submitted and is due for a decision in January 2024. In the meantime, the development of the designs and staff engagement continues. The development of the complicated decant and site clearance scheme is also continuing with the most significant decant being the joint venture Pathology service.

Although capital funding is increasingly limited, the Trust continues to explore relatively small projects to maximise the use of the funds available and should additional funding be available later in the year.

Our Carbon Energy Fund Scheme is a key project in our sustainability aspirations and puts us a step closer towards achieving the NHS Net Zero targets. Most of the works are complete with the systems undergoing final connection to the Trust infrastructure and testing and commissioning. The scheme will deliver circa one tonne of carbon emission savings and circa £500k annual in energy cost savings.

The validation survey phase of the review of the presence of Reinforced Aerated Autoclaved Concrete (RAAC) has been completed with the report being finalised. This has confirmed the previous view that there is no known RAAC on the site.

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

Greater Manchester System

The Trust Provider Collaborative (previously the Provider Federation Board) is a meeting of Chief Executives from Mental Health, Ambulance and Trusts in GM. Recent meetings have focused on the provider contribution to the medium-term plan, with a particular emphasis on the contribution to meeting national targets,

Specialised Commissioning Delegation
As highlighted in previous reports, there is a national policy to delegate responsibility for a commissioning several specialised services to ICBs from 2024/5.

In line with all other ICBs GM has submitted a 'pre delegation assessment framework' document setting out how this responsibility would be managed. A national decision on delegation is expected in early December. As highlighted in earlier reports, this process is likely to create a number of additional financial risks resulting from increased pressure from the delegated budgets, changes to the resource allocation formula which are likely to disadvantage Greater Manchester and the significant level of the budget changes.

As most of The Christie's services are funded from these budgets, we continue to work with other GM providers with specialist services and NW Specialised Commissioning colleagues to contribute to the process and ensure risks are understood, minimalised and mitigated as far as possible.

Regulation and Governance

The actions to address recommendations of the 2022 CQC inspection reports are on trajectory to be completed by the deadline. We are addressing both the must do and should do recommendations. The must do actions were implemented by the end of October 2023 and the full action plan progress report is presented to the board for final approval at the November public meeting. The 'should do' recommendations provide us with valuable feedback on areas where we can develop and improve. We will continue to monitor these actions through designated action plan meetings and report progress through Management Board and assurance committees through to Board of Directors to ensure continuous longer term progress monitoring linked to our overall strategic aims.

Our CQC rating of 'good' triggered a review by the ICB and NHS England of our segmentation within the NHS Oversight Framework. We have been notified that we have been placed in Segment 2 pending the completion of CQC actions and improvements.

The Good Governance Institute work to review of our assurance processes with a particular focus on reporting is nearing completion. As previously reported the work includes document reviews, board and committee observations, and interviews with board members and senior leaders. The output will be a summary baseline report which captures the findings and makes recommendations for development and development of an implementation plan.

Our accreditation as a European Comprehensive Cancer Centre expires in 2024/5 and we continue to supply the data required in the initial phase of the reaccreditation process. We are working closely with the OECI Accreditation Team and will report further to the board when we know the timescale for peer review visits and assessment.

National Policy Initiatives
All NHS organisations and systems are being supported to embed an approach to improvement aligned with NHS IMPACT (Improving Patient Care Together). The NHS IMPACT self-assessment is designed to support Trusts to understand where they are in their improvement journey. It will support you to identify strengths and opportunities for development when applying an organisation-wide approach to improvement. It provides a framework to build a development strategy.

The self-assessment is designed to stimulate a discussion and debate about how we could embed the five components of NHS IMPACT.

- Building a shared purpose and vision
- Investing in people and culture
- Developing leadership behaviours
- Building improvement capability and capacity

- Embedding into management systems and processes

A full list of the questions and a glossary of terms is available on the NHS IMPACT website.

The Provider Selection Regime (PSR) will be a new set of rules for the procurement of health care services by relevant authorities, which have been co-developed with colleagues across the NHS and local government by NHS England and the Department of Health and Social Care (DHSC). The DHSC introduced the PSR regulations into Parliament on 19 October 2023. Subject to parliamentary scrutiny and approval, DHSC intends for the PSR regulations to come into force on 1 January 2024

NHS
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Agenda item 36/23b

Meeting of the Board of Directors
Thursday 30th November 2023

Subject / Title	Care Quality Commission action plans
Author(s)	Chief Nurse & Executive Director of Quality Trust CQC Project Lead Company Secretary
Presented by	Chief Nurse & Executive Director of Quality (interim)
Summary / purpose of paper	To inform the Board of Directors of: 1. the CQC 'must do' action plan completion. 2. the progress and ongoing monitoring of the CQC 'should take' recommendations.
Recommendation(s)	The Board are asked to: 1. Approve the CQC 'must do' action plan as complete. 2. Note the progress and ongoing monitoring of the 'should take' recommendations.
Background papers	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Care Quality Commission (Registration) Regulations 2009
Risk score	BAF risk 1.6: Lack of preparedness for a CQC inspection leading to a poor performance. Risk score 8 (2/4)
Link to: ➢ Trust strategy ➢ 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
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	CQC - Care Quality Commission IPQFR - Integrated Performance, Quality and Finance report EDI -

The Christie
NHS Foundation Trust

Agenda item 36/23b

Meeting of the Board of Directors
Thursday 30th November 2023

Completed CQC (medical core service & well led) action plan

1. Background

The Trust, as part of its registration with the CQC, is required to demonstrate standards set under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009. The Trust has established an approach to demonstrate on-going compliance through internal and external audit reports, the IPQFR, operational governance committees and, board assurance committees that report to the Board of Directors.

2. Introduction

CQC inspections of the Trust's medical core service and well led inspections were undertaken 11-12 October 2022 and 15-17 November 2022 respectively. On 12th May 2023, the Trust was rated overall as 'Good' by the Care Quality Commission.

2.1 'Must do' actions

The final published report identified 7 'must do' actions to meet regulatory requirements.

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

A comprehensive action plan was submitted to the CQC on the 5th June 2023 that outlined how the 'must do' actions would be met. Progress and completion of the actions has been monitored through designated weekly action plan meetings and reported through the Trusts governance and assurance structure for each action. Each action was assigned to a specific assurance committee, dependent on the action, and the detail around the progress and evidence to show completion was assessed.

The action plan and supporting evidence has now been completed and reviewed by the Specialised Commissioning team in line with the stipulated process. Following the Trust's regular Specialised Commissioning quality assurance meeting on 24th October 2023, they

have reported to the Greater Manchester System Quality Group on 16th November that they have received the required assurance that the actions have been completed.

2.2 'Should take' recommendation

The report also made 4 'should take' recommendations:

- The trust should continue to make improvements in culture across the organisation, support staff when raising concerns and act on them in a timely way.
- The trust should continue to develop and promote fundamental strategies such as the equality, diversity and inclusion strategy and take appropriate actions to improve staff engagement, especially those with particular equality characteristics.
- The trust should consider monitoring delayed discharges or transfers of care in regard to patient experience.
- The trust should ensure there is an effective process to provide information in an accessible format for service users with information or communication needs.

The progress of these recommendations does not need to be reported in the same way as the must-do actions, however, they provide us with valuable feedback on areas where we can develop and improve. We will continue to monitor these actions through designated action plan meetings and report progress through Management Board and assurance committees through to Board of Directors to ensure continuous longer term progress monitoring linked to our overall strategic aims. There is much to learn, and the Trust have taken some significant steps to continue to improve against the CQC's 'should take' actions.

In relation to the recommendation around the Trust culture and the development of strategies on EDI, and staff engagement, we have commissioned Globis Mediation Limited to undertake a wide-ranging audit of our organisational culture. The purpose is to better understand some of the CQC feedback and comments from staff, triangulating these with other sources of information such as the NHS Staff Survey. The full background and terms of reference of the cultural audit have been published on our website.

The draft report will be shared with the Trust by the end of November and will be reported to the public Board in January 2024. The data collection phase of the work comprised Globis speaking with 20 focus groups, circa 110 semi-structured interviews with 1 or more people, a survey of all staff with 1,073 responses (30.48%), and a desktop review of relevant reports and data. Site visits for observations also took place.

Whilst the audit work and report writing are the responsibility of Globis a small advisory group has been supporting the work with advice on content, documentation availability and the logistics of surveys. The membership includes the Executive Director/DCEO (Coordinator), all 4 staff governors, Staff Side, a Workforce team representative, and the Company Secretary.

Our work to progress our EDI plan continues and has been reported through the Workforce Assurance Committee in November 2023. The plan sets out the Trust EDI aims and objectives and is based on the national NHS and statutory requirements. The plan incorporates our actions in response to the WRES and WDES requirements. The plan has been published on the Trust website.

In relation to the monitoring of delayed discharges, a new process has been put in place to always ensure visibility of this information and actions in relation to the data are monitored through the Trust huddle and the Trust Operational Group (TOG).

Work is ongoing to continue to improve the Trusts compliance with the accessible information standard and a plan is in place to address gaps in information capture. This is monitored monthly via the Executive Directors meeting and a further work plan is under development.

3. Action Plan

Appendix A shows the 'must do' action plan as complete. The embedded evidence is not included in this report to limit the size but is available for review if required via the Quality & Standards Directorate.

Appendix B shows the progress of the 'should take' recommendations to date mapped against the content of the final CQC report.

4. Recommendation

The Board of Directors are asked to:

- Approve the CQC 'must do' action plan as complete.
- Note the progress and ongoing monitoring of the 'should take' recommendations.

CQC Improvement Plan

Improvement Plan:	Core Services inspected:	Date report published:	Improvement Plan Lead:
Improvement plan following Care Quality Commission 2022 inspection	Medical service (October 2022) Well led (November 2022)	12 May 2023	Janelle Yorke – Chief Nurse & Executive Director of Quality
Date Improvement plan agreed:	**Improvement Plan completion date:**	**Date approved as complete:**	**Approving committee:**
05 June 2023	31 October 2023	TBC	Board of Directors

Regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Surgical procedures
- Treatment of disease, disorder or injury

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Action the trust 'must' take

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

Regulation 5: Fit and Proper Persons: directors

Objective	Accountable Lead	Action required (reference to detail)	Responsible Improvement Lead	Target Completion date (TC) Completion date (C)	Progress and outcomes - include review date (R)	Evidence of implementation (embed evidence)
Ensure there is an effective process to manage the administration of the fit and proper persons checks in line with Regulation 5: Fit and proper persons: directors	Chair	Implement a standalone Fit & Proper Persons Policy addressing gaps in assurance.	Company secretary	28 July 2023 (TC) 29 June 2023 (C)	22 June 2023 (R): In progress – policy review and updates complete. Scheduled for approval by accountable committee 29/06/23. 29 June 2023 (R): Policy approved at Board of Directors 29/06/23. 31/08//23 (R): CQC action regarding Fit and Proper Persons completed prior to the publication of the NHS England Fit and Proper Persons Test Framework for board members, August 2023. Any required updates to trust policy and	Fit and Proper Persons Policy PDF Fit Proper Persons Policy 2023 June FINA Minutes of approval PDF Draft Board minutes 29.06.23.pdf

					processes are going through process and will be evidenced in the September 2023 Public Board papers / minutes where the updated policy is approved, and a further MIAA Checklist outlined for assurance. 28 September 2023 (R): Policy updated & approved by Board of Directors, 28/09/23.	
	Chair	Update checklist in line with the Fit & Proper Persons Policy.	Company secretary	28 July 2023 (TC) 25 April 2023 (C)	25 April 2023 (R) Checklists updated, completed and added to existing files. 31 August 2023 (R): CQC action regarding Fit and Proper Persons completed prior to the publication of the NHS England Fit	Board of Directors new appointment checklist PDF Board of Directors' new appointment che Board of Directors Annual Governance Checklist

					and Proper Persons Test Framework for board members, August 2023. Any required updates to trust policy and processes are going through process and will be reported to Board / relevant committees.	Board of Directors' - Annual Governance C
	Chair	Include in the annual programme of the Audit* Committee and Board of Directors. *Updated after completion. Future monitoring via annual programme of the Workforce Assurance Committee	Company secretary	28 July 2023 (TC) 25 April 2023 (C)	25 April 2023 (R): MIAA 2022/23 Checklist – Fit and Proper Persons Requirements (FPPR) and MIAA checklist presented at Audit Committee 25/04/23. 31 August 2023 (R): FPPR Compliance will now be reported through Workforce Assurance Committee and to Board of Director annually and added to the Annual Internal Audit Plan.	FPPR checklist and Audit Committee minutes 12-23c MIAA FPP cover paper.pdf 12-23ci MIAA 22-23 Checklist_Fit and Prop 18-23c Audit Committee minutes - Audit Committee rolling programme

						23-23d(i) Audit committee - rolling pr FPP paper presented at Workforce Committee Oct'23. The same paper is tabled for Workforce Assurance Committee Nov'23. -23 FPP CQC progress report Oct 2

Regulation 12: Safe care and treatment

Objective	Accountable Lead	Action required (reference to detail)	Responsible Improvement Lead	Target Completion date (TC) Completion date (C)	Progress and outcomes - include review date (R)	Evidence of implementation (embed evidence)
Ensure that serious incidents and mortality reviews are investigated in a timely manner and learning is shared across the	Medical Director	Allocation of all incident lead investigators and mortality reviewers for cases reported in the previous 7-days to be confirmed at	Associate Medical Director for Quality & Patient Safety	29 September 2023 (TC) 13 July 2023 (C)	29 June 2023 (R): In progress 13 July 2023 (R): Allocation of incident lead investigators and mortality	ERG report 10.07.23 - 16.07.23 ERG report.pptx

organisation as required in line with Regulation 12: Safe care and treatment		weekly Executive Review Group and monitored through Risk & Quality Governance Committee.			reviewers included in weekly ERG report	Q2 Patient Safety Report for R&QGC Q2 Patient Safety Report- Final.pdf Septembers ERG reports demonstrate ongoing evidence of completion of the action and monitoring. 26. 25.09.23 - 01.10.23 ERG report.p 25. 18.09.23 - 24.09.23 ERG report.p 24. 11.09.23 - 17.09.23 ERG report.p 23. 04.09.23 - 10.09.23 ERG report.p
	Medical Director	Implement a traffic light system to identify and escalate	Associate Medical Director for Quality & Patient Safety	29 September 2023 (TC) 06 July 2023 (C)	22 June 2023 (R): In progress	Weekly ERG report

		cases at risk of not meeting timeliness requirements.			06 July 2023 (R): Complete	26.06.23 - 02.07.23 ERG report.pptx
	Medical Director	Enhance surveillance through the Executive Review Group to ensure compliance with guidance.	Associate Medical Director for Quality & Patient Safety	29 September 2023 (TC) 22 June 2023 (C)	22 June 2023 (R): Enhanced surveillance through ERG presented in weekly report	Weekly ERG report 05.06.23 -11.06.23 ERG report.pptx
	Medical Director	Implementation of the new Datix Mortality software to support timely reviews.	Associate Medical Director for Quality & Patient Safety	29 September 2023 (TC) 14 September 2023 (C)	22 June 2023 (R): In progress 13 July 2023 (R): Further testing scheduled for w/c 17/7/23 17 August 2023 (R): Mortality module on track for implementation by the end of September 2023 07 September 2023 (R): Further testing scheduled for w/c 11/09/23.	Screen shots of final User Access Testing (UAT) Screenshots of Datix mortality modı Datix SCR training resource presentation DATIX SCR how to Final.pptx

					14 September 2023 (R): Implementation process for the Datix mortality module complete. 'Go live' planned for October '23 to coincide with the start of Q3. 28 September 2023 (R): All trust actions completed. 'Go live' when external supplier assurance complete.	
	Medical Director	Increase frequency of Learning for Improvement Bulletin from every 2 months to every month	Associate Medical Director for Quality & Patient Safety	29 September 2023 (TC) 22 June 2023 (C)	22 June 2023 (R): Monthly bulletins commenced May 2023	May 2023 Learning for Improvement Bulletin Learning Improvement Bulletin June 2023 Learning for Improvement Bulletin Learning_Improvement_Bulletin_june final.p

						July 2023 Learning for Improvement Bulletin Learning Improvement Bulleti August 2023 Learning for Improvement Bulletin Learning Improvement Bulletin September 2023 Learning for Improvement Bulletin Learning Improvement Bulleti
Ensure that patient risk assessments are consistently completed and reviewed in a timely	Executive Chief Nurse & Director of Quality	Align internal policies to national guidelines for falls, nutrition, pressure ulcers and VTE.	Associate Chief Nurse for Quality & Patient Safety	29 September 2023 (TC) 06 July 2023 (C)	15 June 2023 (R): In progress – Pressure ulcers, nutrition & VTE all in alignment.	Nursing risk assessment requirements

manner for all patients in line with Regulation 12: Safe care and treatment					22 June 2023(R): Slips, trips and falls policy and Moving & Handling Policy updates in process.	Nursing risk assessment requirem Prevention and Management of Pressure Ulcers policy Prevention & Management of Press Nutrition policy Nutrition Policy V05 FINAL.pdf Slips, trips and falls policy Slips trips and falls policy V07.1.pdf Moving and Handling policy

						Moving and handling policy.pdf VTE compliance continues to be monitored as per usual process (IPQFR)
	Executive Chief Nurse & Director of Quality	Update ward coordinator checklist to reflect daily monitoring of risk assessments.	Associate Chief Nurse for Quality & Patient Safety	29 September 2023 (TC) 27 July 2023 (C)	15 June 2023 (R): In progress – Initial drafts of checklists under review. 13 July 2023 (R): Under review 27 July 2023 (R): Complete	Inpatient Ward Coordinator checklist Coordinator Daily Checklist Inpatient wa
	Executive Chief Nurse & Director of Quality	Introduce an alert for patient risk assessments within our electronic patient records.	Associate Chief Nurse for Quality & Patient Safety	29 September 2023 (TC) 29 June 2023(C)	15 June 2023 (R): In progress 29 June 2023 (R): Implementation of patient risk assessment alerts in electronic patients' records (CWP) completed.	Screen shot of CWP risk assessment alert CWP risk assessment alert.ppt

	Executive Chief Nurse & Director of Quality	Implement ward level view of live risk assessment compliance.	Associate Chief Nurse for Quality & Patient Safety	29 September 2023 (TC) 29 June 2023 (C)	15 June 2023 (R): In progress – dashboard in development. 29 June 2023 (R): Complete.	Screenshot of dashboard Nursing Risk Assessments Dashboa Screenshot of Dashboard.pdf
	Executive Chief Nurse & Director of Quality	Include nursing risk assessment requirements in the local induction.	Associate Chief Nurse for Quality & Patient Safety	29 September 2023 (TC) 10 August 2023 (C)	15 June 2023 (R): In progress 10 August 2023 (R): Complete	New starter checklist – staff nurses New Starter Checklist- Staff Nurs
	Executive Chief Nurse & Director of Quality	Continue to measure compliance through bedside handover quality improvement project.	Associate Chief Nurse for Quality & Patient Safety	29 September 2023 (TC) 27 July 2023 (C)	15 June 2023 (R): In progress with Quality Lead Nurse 20 July 2023 (R): Bedside handover QI project being presented at Friday FoCUS 21/07/23 27 July 2023 (R): Beside handover QI project presentation	Bedside handover QI project presentation (Friday FoCUS 21/07/23): Bedside Handover for Friday Focus 21 July 2 14 FF Minutes 21.07.23.pdf

					delivered to Friday FoCUS 21/07/23	
Ensure the proper and safe management of medicines, to include the completion of antimicrobial documentation for safe prescribing in line with trust policies in line with Regulation 12: Safe care and treatment	Chief Operating Officer	Update of prescriber induction and other training to document clinical indication and duration of all antimicrobials.	Director of Pharmacy	29 September 2023 (TC) 07 September 2023 (C)	06 July 2023 (R): In progress; specific antimicrobial stewardship action plan. Regular meetings and progress monitoring scheduled. Education & awareness discussed at Safe Medicines Practice committee (May'23), Medical Oncology Consultants meeting (June '23) and Clinical Oncology Consultants meeting (July 23) 20 July 2023 (R): Prescriber education including trust expectation and national targets included in prescriber induction delivered by Antimicrobial	Safe medicines practice committee minutes 24/05/23 SMPC Minutes May 2023 - Final.pdf Medical Oncology Consultants meeting minutes June '23 Minutes 30062023 Medical Oncology.p Clinical Oncology Consultants meeting July '23 Minutes 07072023LL1 Clincial Antimicrobial Stewardship presentation for junior doctors induction

					pharmacist and Consultant Microbiologist. Medical and nursing teams also involved in this process. Education talk delivered 17/7/23 to all pharmacists involved compliance audits that included: responsibilities and expectations from the monthly audit. 27 July 2023 (R): Further education talks distributed to Non-Medical Prescribers (NMPs) Junior doctor induction presentation being delivered 1st week of August. This has also been recorded so the junior doctors have education material that can be referred back to	Christie AMS induction CQC update Antimicrobial stewardship audits pharmacy education talk 17/07/23 Antimicrobial Stewardship Audits pl Antimicrobial stewardship prescribing education presentation for Non-Medical Prescribers (NMPs) Ab prescription prompt v1 - NMPs.pp Email communications to NMP CPD Forum Presentations from the NMP CPD Forum.l

					throughout the year, outside of full inductions times. 10 August 2023 (R): Antimicrobial documentation to be tabled at next Acute and Supportive Cancer Services Directorate meeting. 31 August 2023 (R): Acute and Supportive Cancer Services Directorate meeting scheduled for 04/09/23. 14 September 2023 (R): The updated induction materials will continue to be delivered to junior doctors, and this aspect of prescribing continues to be flagged by the microbiologists and	Acute and Supportive Cancer Services Directorate meeting minutes September '23 Acute and Supportive Cancer S Antimicrobial prescribing improvement plan AMS CQC Action plan 28.9.23.pdf

					pharmacists on the wards. 28 September 2023 (R): Additional opportunities highlighted as learning at Friday FoCUS 15/09/23 and a request for inclusion of antimicrobial stewardship be included in the next Medicines study day.	
	Chief Operating Officer	Monitor compliance through ward pharmacists undertaking surveillance of completeness of inpatient antimicrobial prescriptions.	Director of Pharmacy	29 September 2023 (TC) 28 September 2023 (C)	06 July 2023 (R): In progress – Antimicrobial prescribing improvement plan and meetings developed. Next meeting 07/07/23. 10 August 2023 (R): Monthly monitoring of compliance against trust policy.	July 2023 AMS compliance monitoring report PDF AMS Report July 2023.pdf August 2023 AMS compliance monitoring report PDF AMS Report August 2023.pdf

					07 September 2023 (R): Monthly monitoring of compliance against trust policy. 14 September 2023 (R): Compliance continues to be monitored in line with the trusts antimicrobial policy. In line with trust policies, monitoring continues. Electronic prescribing and medicines administration (EPMA) will mandate indication and review date of all prescriptions. Roll out of EPMA is scheduled to commence in Q4 (2023/24). 21 September 2023 (R):	Combined AMS report June – September 2023 AMS JUNETOSEPTEMBER Combined AMS report September 2022-2023 AMS REPORT September 22-23.pd Antimicrobial prescribing improvement plan AMS CQC Action plan 28.9.23.pdf Risk assessment AMS documentation RA 22.9.23 with Datix

					Our current process is the subject of a risk assessment within our risk management system. 28 September 2023 (R): In line with trust policies, compliance and incidents will continue to be monitored, investigated and reported through Nosocomial Infection Performance (NIPR) and escalated to Infection Prevention & Control Committee (IPCC) when required. Action complete.	All C difficile cases are subject to an RCA; there is no evidence of underlying patient harms or healthcare associated infections due to these aspects of documentation from the RCAs of C difficile cases.

Regulation 16: Receiving and acting on complaints

Objective	Accountable Lead	Action required (reference to detail)	Responsible Improvement Lead	Target Completion date (TC) Completion date (C)	Progress and outcomes - include review date (R)	Evidence of implementation (embed evidence)
Ensure there is an effective process to manage complaints, in particular, ensuring the timeliness of responses in line with Regulation 16: Receiving and acting on complaints	Executive Chief Nurse & Director of Quality	Report as required by the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.	Associate Chief Nurse for Quality & Patient Experience	29 September 2023 (TC) 15 June 2023 (C)	15 June 2023 (R): Complete - Reporting 3 day and 6 month compliance to weekly ERG. This will continue to be reported to Quality Assurance Committee in the quarterly patient experience report. 21 September 2023 (R): Q1 Patient experience report papered at Quality Assurance Committee, 21/09/23.	Weekly ERG report 05.06.23 -11.06.23 ERG report.pptx Q1 Patient Experience Report for Quality Assurance Committee (September 2023) – page 5 Q1 Patient Experience Effectivne
	Executive Chief Nurse & Director of Quality	Implement a traffic light system to identify and escalate cases at risk of not meeting timeliness requirements.	Associate Chief Nurse for Quality & Patient Experience	29 September 2023 (TC) 27 July 2023 (C)	15 June 2023 (R): In progress – traffic light process in place. Policy under review. 20 July 2023 (R):	Weekly ERG report 05.06.23 -11.06.23 ERG report.pptx Complaints and concerns policy

					Policy updates approved. Awaiting ratification. 27 July 2023 (R): Policy ratified and published on HIVE 25/07/23.	Complaints and Concerns Policy - July
	Executive Chief Nurse & Director of Quality	Enhance surveillance through Executive Review Group to ensure compliance with national guidelines.	Associate Chief Nurse for Quality & Patient Experience	29 September 2023 (TC) 15 June 2023 (C)	15 June 2023 (R): Complete	Weekly ERG report 05.06.23 -11.06.23 ERG report.pptx
	Executive Chief Nurse & Director of Quality	Immediate learning to be identified through Executive Review Group and shared with divisional governance leads and through Friday Focus.	Associate Chief Nurse for Quality & Patient Experience	29 September 2023 (TC) 14 September 2023 (C)	15 June 2023 (R): In progress 10 August 2023 (R): Immediate learning identified in ERG weekly report and Friday Focus minutes	ERG weekly report 27/07/23 16. 17.07.23 - 23.07.23.pptx ERG weekly report 16/08/23 19. 07.08.23 - 13.08.23.pptx Friday Focus minutes 23/06/23

						12 FF Minutes 23.06.23.pdf Friday Focus minutes 27/07/23 14 FF Minutes 21.07.23.pdf Friday Focus minutes 03/08/23 15 FF Minutes 03.08.23.pdf August 2023 Learning for Improvement Bulletin Learning Improvement Bulletin September 2023 Learning from Improvement bulletin

						Learning Improvement Bulleti

Regulation 17: Good governance

Objective	Accountable Lead	Action required (reference to detail)	Responsible Improvement Lead	Target Completion date (TC) Completion date (C)	Progress and outcomes- include review date (R)	Evidence of implementation (embed evidence)
Ensure that policies are reviewed and ratified in a more timely manner in line with Regulation 17: Good governance	Chief Operating Officer	Review all trust policies against expiry dates.	Associate Chief Nurse for Quality & Patient Safety	29 September 2023 (TC) 13 July 2023 (C)	15 June 2023 (R): In progress. 06 July 2023 (R): Task & finish group commenced 04/07/23. 13 July 2023 (R): Review complete. 21 September 2023 (R): Initial review complete 13/07/23. These reviews have continued and reported to the task and finish group as limitations of HIVE	Letter to accountable committees 16/06/23 Letter to AC's 20230616.pdf

					and the manual process of review have been identified. These will continue to be addressed through the Task and Finish group and a risk entry updated on the risk register outlining further actions and mitigations in the absence of an electronic document management system.	
	Chief Operating Officer	Review Trust Procedural Documents policy and policy template.	Associate Chief Nurse for Quality & Patient Safety	29 September 2023 (TC) 18 May 2023 (C)	15 June 2023 (R): Procedural documents policy and policy template reviewed, updated and approved by Management Board 18/05/23 and published on HIVE 02/06/23. 28 September 2023: Further review with amendments of the procedural	Minutes from management board 18/05/23 PDF 25-23a Management Board Minutes May A Procedural documents policy and policy template approved by management board 21/09/23.

					documents policy and policy template due to the development of the SOP for the management of procedural documents. Approved by Management Board 21/09/23 and published 26/09/23.	Procedural Documents Policy v2 Policy Template V1.7 FINAL.pdf
	Chief Operating Officer	Develop and implement a Document Management Standard Operating Procedure.	Associate Chief Nurse for Quality & Patient Safety	29 September 2023 (TC) 26 September 2023 (C)	06 July 2023 (R): Task & finish group commenced 04/07/23. 27 July 2023 (R): In development 10 August 2023 (R): Development and consultation progressing. 14 September 2023 (R): Scheduled for Management board approval 21/09/23.	SOP for the management of procedural documents SOP for the management of pro

					21 September 2023 (R): SOP for the management of procedural documents approved by Management Board. 28 September 2023 (R): SOP ratified and published on HIVE 26/09/23.	

Regulation 18: Staffing

Objective	Accountable Lead	Action required (reference to detail)	Responsible Improvement Lead	Target Completion date (TC) Completion date (C)	Progress and outcomes- include review date (R)	Evidence of implementation (embed evidence)
Ensure staff complete mandatory training, including safeguarding in accordance with the relevant schedule and receive relevant training, supervision and appraisal to perform their duties	Director of Workforce	Allocate dedicated time for all new starters to attend induction and complete mandatory training before commencing duties.	Deputy Director of Workforce	31 October 2023 (TC) 19 October 2023 (C)	15 June 2023 (R): In the process of establishing the project leadership and team. 22 June 2023 (R): Project brief established, objectives	Project brief: Induction - Project Brief FINAL.pdf Induction and mandatory training project presentation July '23:

competently in line with Regulation 18: Staffing					confirmed, stakeholders engaged. Project lead to be appointed. 20 July 2023 (R): Project lead now in post. 17 August 2023 (R): Note to TOG on allocation of time for mandatory training. 31 August 2023 (R): Mandatory & Essential Training Policy being updated. 05 October 2023 (R): Induction Policy and Mandatory & Essential Training Policy approved by Staff Forum and LNC; awaiting ratification and publication.	Induction Mandatory Training Project (1) - (Trust wide Operations Group (TOG) 16/08/23 Notes and Actions TOG 20230816.pdf Mandatory & Essential Training Policy Mandatory Essential Training Policy V14 FII Corporate and Local Induction Policy Corporate Local Induction Policy v13 -

					19 October 2023 (R): Both the Mandatory & Essential Training Policy and the Corporate & Local Induction Policy have been ratified and published to HIVE 19/10/23.	
	Director of Workforce	Allocate dedicated time for all staff to refresh mandatory training.	Deputy Director of Workforce	31 October 2023 (TC) 19 October 2023 (C)	15 June 2023 (R): DoW to work with COO, MD, CN to assess options. 22 June 2023 (R) Scoping in progress 17 August (R): Note to TOG on allocation of time for mandatory training. 31 August 2023 (R): Mandatory & Essential Training Policy being updated. 05 October 2023 (R):	Trust wide Operations Group (TOG) 16/08/23 PDF Notes and Actions TOG 20230816.pdf Mandatory & Essential Training Policy PDF Mandatory Essential Training Policy V14 FII

					Mandatory & Essential Training Policies approved by Staff Forum and LNC; awaiting ratification and publication. 19 October 2023 (R): Mandatory & Essential Training Policy ratified and published to HIVE 19/10/23.	
	Director of Workforce	Align our mandatory training including safeguarding training to the Core Skills Training Framework.	Deputy Director of Workforce	31 October 2023 (TC) 15 June 2023 (C)	15 June 2023 (R): Completed.	Communications of aligned mandatory training on trust intranet: PDF Mandatory and Essential Training at T
	Director of Workforce	Review and update our Mandatory Training Policy.	Deputy Director of Workforce	31 October 2023 (TC) 19 October 2023 (C)	15 June 2023 (R): Review and update of mandatory training policy complete. Approved at Staff Forum (April '23). Awaiting review by Local Negotiating Committee (LNC)	Staff forum minutes: PDF Staff Forum Minutes April 2023 - FINAL.pd Local Negotiating Committee minutes:

					scheduled for 3/7/23. 27 July 2023 (R): Further revision to Mandatory & Essential Training Policy to include dedicated time - in progress. 31 August 2023 (R): Updates to Mandatory & Essential Training Policy in progress. 07 September 2023 (R): Updated Mandatory & Essential Training policy papered for Staff Forum (October '23), LNC (September '23) and DRC (October '23). 05 October 2023 (R): Mandatory & Essential Training Policy approved by	LNC Minutes 03.07.2023.pdf Mandatory & essential training policy Mandatory Essential Training Policy V14 FII

					Staff Forum and LNC; awaiting DRC ratification and publication. 19 October 2023 (R): Policy ratified and published to HIVE 19/10/23.	
	Director of Workforce	Communicate our mandatory training requirements to all staff.	Deputy Director of Workforce	31 October 2023 (TC) 15 June 2023 (C)	15 June 2023 (R): Completed. 22 June 2023 (R): Repeat of global emails.	Communications of mandatory training requirements on trust intranet: Mandatory and Essential Training at T Communications via global team briefing: Team briefing Monday 05 June 202
	Director of Workforce	Implement a mandatory training dashboard to improve visibility and monitoring of	Deputy Director of Workforce	31 October 2023 (TC) 15 June 2023 (C)	15 June 2023 (R): Completed	Dashboard Screenshot ET Dashboard - Screenshot.pptx

		compliance with the mandatory training policy.				Trust Operational Group (TOG) Monitoring Report TOG-23-06-13.pptx TOG-23-07-04.pptx
	Director of Workforce	Review our PDR policy, training, tools and processes to improve accessibility.	Deputy Director of Workforce	31 October 2023 (TC) 06 July 2023 (C)	15 June 2023 (R): Policy reviewed and amended; approved by Staff Forum 13/06/23. Awaiting DRC. 06 July 2023 (R): Ratified and published on HIVE 04 July 2023.	PDR Policy Personal Development Policy J
	Director of Workforce	Implement a PDR dashboard to improve visibility and monitoring of compliance with the PDR policy.	Deputy Director of Workforce	31 October 2023 (TC) 06 July 2023 (C)	15 June 2023 (R): In progress 22 June 2023 (R): Complete – out to divisions for consultation	Dashboard Screenshot of mandatory training and PDR compliance Mandatory Training Compliance and PDR

					06 July 2023 (R): Complete	PDR Dashboard.pptx
	Director of Workforce	Pilot Talent Tool as an alternative approach to PDR.	Deputy Director of Workforce	31 October 2023 (TC) 15 June 2023 (C)	15 June 2023 (R): Pilot completed in Education. 22 June 2023 (R): Pilot in progress within digital & workforce. Further evaluation after 3 pilots.	Talent tool evaluation - Education Talent Tool Impact Report January 2023.pdf
	Director of Workforce	Align supervision requirements to professional standards for Agenda for Change trainee ACP roles* *action amended to reflect findings reported in final CQC report	Head of Workforce Education	31 October 2023 (TC) 05 October 2023 (C)	15 June 2023 (R): In progress. 22 June 2023 (R): Benchmarking underway against professional standards. 29 June 2023 (R): Weekly monitoring of supervision and escalation process. Supervisor training to commence Sept '23	Advanced Practice Education Lead Job Description, Person Spec and Advert Advanced Practice Education Lead.pdf Advanced Practice Education Lead - Job Evidence of benchmarking Supervision 22623 Trainee ACP.ppt

					07 September 2023 (R): Two supervisor training sessions commissioned: 06/09/23 (delivered) and 13/10/23. No trainee ACP supervision escalations reported since post holder commencing in post. 14 September 2023 (R): Supervision update presented at the Postgraduate Clinical Education Group meeting 14/09/23. 21 September 2023 (R): Paper regarding supervision and escalation for trainee advanced clinical practitioners (ACPs) to be presented to the	Supervision and escalation process update 28/06/23. Supervision update 28623.ppt Supervision update presentation and minutes of the Postgraduate Clinical Education Group meeting 14/09/23 Supervision update 11092023.ppt PCG minutes 14.9.23 V3.pdf Supervision report and minutes of Education Executive Group 27/09/23

					Education Executive Group w/c 25/9/23.	EEG Supervision report September 202 EEG - Minutes - Sept 23.pdf

CQC Improvement Plan – Action the trust 'should' take to improve.

Evidence to demonstrate the progress made by the trust in response to the 'should take' recommendations following the Care Quality Commission's medical core service and well led inspection 2022.

The trust should continue to make improvements in culture across the organisation, support staff when raising concerns and act on them in a timely way		
BAF reference: 7.1		
Report	**Activity**	**Evidence**
The trust's draft 'people and culture plan' indicated limited aspirations related to bullying and harassment over its planned 3 years duration. Within the theme of 'treating our people fairly' the measure to know when this was achieved was set out as; • the percentage of staff experiencing harassment, bullying or abuse from managers and staff; between 9.5% and 16.2% was the baseline, with an aim to reduce this to 5% or 8% by year 3. • the percentage of staff experiencing discrimination from a manager or colleague had a baseline of 5.4% with a 3-year target of 3%. We asked senior leaders why these targets were not set at zero tolerance to bullying, harassment or discrimination. We were told that it "had to be started somewhere". We were concerned this sent a message that bullying, harassment or discrimination was acceptable. Senior leaders afterwards told us they were considering rethinking the targets.	We launched our **Christie People & Culture Plan 2023-2026** in January 2023. The Plan identifies six themes for action. Central to it is culture change and organisational development	Christie People Plan 2023-2026 Christie People Plan 2023-2026.pdf

The mean (average) gender pay gap had increased from 17.2% in 2020 to 17.5% in 2021, after previous years when the gap had decreased. The median gender pay gap had increased from 4.8% in 2020 to 5.5% in 2021. The trust gender pay gap report (March 2022) stated an action would be produced by the equality, diversity and inclusion board.		
Not all NEDS or executives spoke specifically about the trust values.	**Values & Behaviours** – We have refreshed and relaunched a set of values and behaviours in January 2023 which articulate what our culture 'looks and feels like' when we are operating at our best. They were co-created with 260 colleagues, and in partnership with our Staff Side colleagues. Work continues to embed our values and behaviours in everything we do and have a clear plan how we will embed throughout the employee lifecycle. Workforce Committee continues to receive stories about how our divisions are embracing and embedding them in their day to day activities. In May 2023 we launched our new induction. Our values and behaviours are now a central focus for staff in their first days of employment.	Values & Behaviours Framework The Christie Values Behaviours Framewor Values & Behaviours action plan 2e. WFC VB Paper July.August 2023.pd Values & Behaviours Stories Values & Behaviours WFC Up
We had variable feedback about the visibility of senior leaders We were told by a range of staff that there was a lack of visibility of some senior and executive leaders. The relationship with staff side (trade	**Culture Review** – Following the CQC inspection, Globis Mediation are supporting the Trust to undertake a wide-ranging audit of our organisational culture to better understand some of the CQC feedback and comments from staff, triangulating these with other sources of	Culture Audit Terms of Reference 2023-06-30 Advisory Group.pdf

unions) required development; there had been very limited engagement from the CEO for around 18 months. Staff side described an 'us versus them' situation and said they didn't feel recognised or listened to by executives. The terms of reference for the staff side committee were being reviewed. Union representatives told us most of their engagement was with the director of workforce, and there wasn't a lot of visibility from other executive leaders. Very senior executives were heavily invested in the promotion and protection of the trust's reputation. This impacted negatively on some staff and was clearly evidenced from feedback by some staff, staff interviews and focus groups we conducted. However, before, during and after our inspection we received information of concern from staff about the workplace culture at the trust. We also received other mixed feedback; some staff told us culture had recently improved in their workplace, and others told us there was a supportive culture. During our inspection we heard repeatedly from staff that there was a perceived need to protect the reputation of the organisation which impacted negatively on some staff. This was clearly indicated from feedback by some staff during and after focus groups we conducted.	information such as the NHS Staff Survey. The data collection phase of the work is now almost complete and has comprised 20 focus groups, circa 110 semi-structured interviews, a survey of all staff with 1,073 responses (30.48%), and a desktop review of relevant reports and data. Site visits for observations are being arranged. The results of the audit are planned for publication in November 2023	Engagement post CQC inspection – in progress

However, only 59% of nursing staff and 85% of medical staff had completed this *[FTSU]* training. The compliance rate for allied health professionals was 100%.		
	This next iteration of **The Christie Strategy 2023-2028** has been informed through extensive consultation with our staff, patients and public and now has our values and behaviours at its centre.	The Christie Strategy 2023-2028 Our Future Overview | Information About Our Strategy (christie.nhs.uk)
	Leadership – Recognising the links between leadership and organisational culture, leadership is a key focus of our People & Culture Plan. We continue to provide our Leadership Development Programme to aid ability for leaders to build psychologically safe and effective teams. The Programme covers how our leaders can set and influence culture. Our 'Leadership Canva' has been developed to aid leadership development and to support managers in role modelling our values and behaviours. We have introduced Action Learning Sets to support Consultant leadership development. We have strengthened how we assess the quality of leadership and leadership behaviours in candidates applying for roles at the Christie. We have introduced The Real World Leader tool which is a leadership behaviour assessment tool used to recruit and/or develop leaders operating at Head of Service level and above.	Christie Leadership Programme 2022-2023 Leadership Program Leadership Canva available on HIVE Leadership Prog Overview September 2023 v.01 (canva.com) Consultant ALS Leadership Programme AL_Principles and Practice_Intro session Real World Leader Evaluation Trail of Real World Leader Tool_Sept 202

The trust had launched a 'Respect Campaign' prior to the review which aimed to reduce the occurrence of bullying and harassment. However only around 150 people had signed up to the campaign in the first 10 months	**Respectful Resolutions** – Activity is progressing to bring in the Respectful Resolution framework; our new approach to improving culture and putting kindness at the heart of how we communicate with each other. A project team is up and running with representatives from Staff Side, FTSU, HR, OD and EDI teams. Three alignment workshops have taken place with key stakeholders, including Staff Side, Exec colleagues and departmental representatives, to get early feedback. All documents have now been tailored to The Christie and the eLearning is being updated. The associated eLearning product Kindness into Action has been streamlined and is in final review stages prior to being launched on Christie Learning Zone. Launch is planned late November.	Respectful Resolution – Project Outline A Kind Life_culture solution Dec 22.pptx
	Delve Talent Tool – Several Divisions have been piloting the Delve Talent Tool an alternative to our appraisal/ PDR process designed to foster more person-focused conversations and supporting staff on any issues	Delve Talent Tool Outline How_to_have_a_talent_coversation.pdf The_Delve_Talent_Tool.pdf
There had been previous concerns about culture and freedom to speak up processes at the trust. The trust's audit committee commissioned a review into freedom to speak up processes. The report, dated January 2021, drew attention to deficiencies into the trust policy and processes. An investigation was also commissioned by NHS England/Improvement about the same concerns. This report was published in December 2021.	**Raising Concerns** - The Christie Freedom to Speak Up (FTSU) policy was updated to reflect the national policy and ratified in May 2023. June 2023's team brief promotes NHS England's Speaking Up Support Scheme We have developed our Freedom to Speak Up Plan 2023/4 which describes our aims and actions to promote, develop and support the culture, values and behaviour to support staff to be comfortable to	Freedom to Speak Up - Raising Concerns Policy Freedom to Speak Up Policy February 20 June 2023 Team Brief Team briefing Monday 05 June 2023

Some staff who had raised concerns told us they lacked confidence in the FTSU process as they were asked to attend face to face meetings which would not protect their anonymity. Staff expressed concern about current facilities in pharmacy, especially in areas used for clinical trials and the aseptic unit. Outcomes were not always shared with staff who had reported the incident. The audit data related to all incidents (from minor harm to serious harm) for April 2021 to March 2022 showed that only 55% of incidents had learning shared with the reporter.	speak up. Updates on our plans are monitored at Management & Trust Board. The FTSU report 01/04/23 – 30/09/23 for Board of Directors provides updates on the plan and recent FTSU activities. The report also outlines additional questions to the national staff survey 2023/24 (see section 7 of the report) to understand speaking up about clinical concerns and satisfaction with the incident feedback. Feedback from those who raise a concern continues to be evaluated and effectiveness reported in the bi-annual FTSU report to Board of Directors (see Section 10 of the report).	FTSU Plan 2023/24 1e. FTSU plan 2023.pdf FTSU Report 1st April 2023 - 30th September 2023 for Board of Directors 16. FTSU 2022-2023 six month report (BoD
Most executive directors had been internal appointments. This could indicate effective succession planning and investment in existing employees. Although, an overreliance on internal hiring could lead to a stagnant culture, reduced talent pool and less diversity	**Succession planning** We agree it's important to get the right balance between realising the potential we have invested in and bringing in external expertise and thought. Our current Chief Nurse and Executive Director of Quality, our Director of Strategy, our previous Chief Operating Officer and our Director of Education are good examples of where we have seen the benefit of external appointments. We take a holistic approach to succession planning utilising a broad range of leadership and development programmes and support offers.	
However, we looked at board papers for the previous six months and only positive feedback was quoted in the patient experience section.	**Putting patients first –** The IPQFR is under review to capture all aspects and proportionality of patient experience feedback which will be shared with the board.	

There was no additional section for any negative feedback to be shared with the board.		
	Other examples of a positive culture -	2023/24 Better Payment Practice Code (BPPC) performance. CHRISTIE_BPPC performance M04 202

The trust should continue to develop and promote fundamental strategies such as the equality, diversity and inclusion strategy and take appropriate actions to improve staff engagement, especially those with particular equality characteristics		
BAF reference: 6.6, 7.1, 7.3, 7.4		
Report	**Activity**	**Evidence**
Not all board members we spoke with understood the priorities and issues the trust faced. Some of these *[trust strategies]* were waiting final ratification and would not be published until 2023. These included; • the clinical outcomes strategy, • the workforce strategy (people and culture plan), • the digital strategy. The trust had an equality, diversity and inclusion (EDI) plan (2019-2023) with an underpinning one year delivery plan of objectives (June 2022- June 2023). There was no patient experience strategy. There was minimal progress made in implementing the objectives in the EDI Plan due to COVID-19	**Develop and promote fundamental strategies –** The Clinical Outcomes, Workforce, Digital, Patient Experience and R&I strategies have been approved to enable the Trust strategy 2023-2028 Clinical Outcomes Strategy approved by Management Board February 2023. Workforce (People and Culture Plan) approved by Workforce Assurance Committee November 2022 and reports to Management Board in the Workforce reports. Digital Strategy approved by Management Board March 2023. Research & Innovation Strategy approved by Management Board February 2023.	Management Board paper for the Trust Strategy 10-23a Christie Strategy Refresh_Man Our Future Overview | Information About Our Strategy (christie.nhs.uk) Management Board paper for the Clinical Outcomes Strategy (includes strategy) 10-23aiii Clinical Data Outcomes Strategy_M Workforce (People and Culture Plan) and plan.

from 2019 and 2022 which resulted in EDI taking less of a priority across all trust activities. There had also been a change in EDI Managers during that time which had halted momentum in driving the EDI agenda across the organisation". Following our inspection, the trust provided a copy of the EDI delivery plan. It showed actions with expired timescales and no updates on progress or outcomes recorded. It was not clear if the actions had been completed or not.	Patient Experience Plan approved by Quality Assurance Committee September 2023 which is reported to Board. Our EDI plan builds upon the work that we have embedded during 2022/23 to address inequalities for our staff and patients.	 Christie People Plan 2023-2026.pdf Management Board paper for the Digital Strategy. and Strategy  18-23f Digital Strategy MB March 2( Digital_Strategy_Final_ v1.pdf Management Board paper for the Research & Innovation Strategy (includes strategy)  10-23aii RI Strategy_Final_Trust M Quality Assurance Committee paper for the Patient Experience Plan  19-23d Patient Exp Paper and Plan 2023- EDI plan 2023/2024  EDI Delivery Plan July 2023 - October 2024
	International Recruitment – We have recruited 26 international nurses. The programme was designed	IR Evaluation Report to Workforce Committee

	with the specific aim of bringing diversity into the Christie	INR evaluation.pptx
	Equality and Health Inequality Analysis (EHIA) Process & Training – We have overhauled and relaunched our processes to ensure we are fulfilling our responsibilities for undertaking EHIAs for our polices, strategies, business cases and projects.	EHIA Relaunch HIVE Communication April/May 2023 and screen shots of EHIA toolkit HIVE - Equality and Health Inequality Anal Equality & Health Inequality Analysis To HIVE - Equality and Health Inequalities Analysis (EHIA) (xchristie.nhs.uk) (Accessed 12 October 2023) June 2023 Team Brief Communicating launch of EHIA Team briefing Monday 05 June 2023
During the inspection we spoke with senior leaders about health inequalities and how they could use data and information to help improve outcomes for patients. Leaders told us it was a challenge which needed further work. They said they needed to improve the completeness of data and to not repeatedly ask patients the same questions. For example, the recording of patients' ethnicity was less than 50%. Monthly monitoring of this was now being reported to the executive team. They also told us the new digital strategy and new clinical outcome strategy would link this work on	**Equality Delivery System (EDS) 2022** – We have robust plans in place in order to deliver the requirements of the Equality Delivery System. The ICB Diversity Lead has recognised the Christie approach as exemplar best practice and has asked our EDI manager to present our approach to regional EDI Leads.	EDS 2022 Plan and ICB feedback EDS 2022 Action Plan 2023-24-July-Septemb EDS 2022 .msg

inequalities and build technology to support the data. There would be a clinical outcome objective to improve how data on inequalities is recorded. Both strategies were due to be approved and published in March and April 2023. The trust had collected and analysed equality monitoring information annually for their patients. However, the latest published report was dated March 2020 and gaps in some data had impacted on the quality of data collected. For example, there was no ethnicity data for 26% of patients, no religion or belief data for 33.3% of patients and no sexual orientation data for 83% of patients		
Deterioration in several indicators and most significantly in relation to bullying, harassment and discrimination by managers and other staff and opportunities to develop career aspirations. Staff survey results showed that 21.8% of staff from ethnic minority groups reported harassment, bullying or abuse from staff in the last 12 months (actual national 28.8%), compared to 19% of White staff (actual national 23.2%). These rates were high for both groups of staff but better than the England average. White staff were 3 times more likely to be appointed after being shortlisted for a job, and 12.8% of staff from ethnic minority groups reported discrimination at work compared to 4.1% of White staff. There were 68.4% of White staff in senior roles (band 8a and above) compared to 9% of staff	**WRES/WDES Plans** – We are about to submit our WRES/WDES action plans for 2023. These plans build on the robust plans from 2022. Our 2022 WRES plans received the highest rating and very positive feedback from the National WRES Team. Further work in progress	2023 WRES/ WDES Plans presented to Management Board WRES-WDES Action Plans 23-24 Managem WRES Feedback from NHSE July 2023 FW WRES RESUBMISSION .msg

from ethnic minority groups. The trust acknowledged progress was needed on all 9 WRES indicators and an action plan had been developed. The WDES consists of 10 indicators of workforce disability equality, including the profile of the workforce and data from the national staff survey indicators. It highlights differences between the experience and treatment of disabled staff and non-disabled staff and provides a way to take necessary remedial action on the causes of disability disparities or differential treatment of disabled staff. There was mixed performance against the WDES indicators. There was deterioration or lack of progression in other areas, for example, the relative likelihood of disabled staff entering the formal capability process was 8 times higher compared to non-disabled staff. This was a significant increase from around 3 and a half times in the previous year. The trust acknowledged further progress was needed so that disabled staff had equality in all aspects of their working lives. An action plan had been developed and was due to be approved in November 2022.		
Equality diversity and inclusion (EDI) had not previously been successfully promoted and delivered within the organisation and the wider community. Staff, including those with particular	**EDI Organisational Structures** have been implemented to support the mainstreaming of EDI across the Trust. Divisions have appointed EDI Coordinators and Champions and have developed	EDI – Divisional Infrastructure

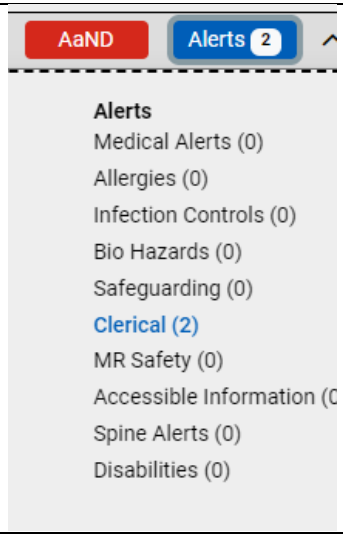
equality characteristics had not always felt they were treated equitably. There had been a lack of delivery on EDI issues at the trust. lack of EDI training resources and lack of EDI champions. We were told the networks had not been effective, but work was being done to make them better. Staff with particular equality characteristics had not always had their views and experiences considered, but this had improved recently.	EDI actions plans. Divisions are reporting their progress at our EDI Programme Board.	EDI DIVISIONAL IMPLEMENTATION PL
	Celebrating Diversity – We continue to celebrate diversity in line with our calendar of diversity events. For example - In October 2023 we celebrated Black History Month (BHM)	EDI calendar EDI Comms and marketing plan Jun-D HIVE Comms – BHM HIVE - Black History Month 2023.pdf HIVE - Black History Month 2023 (xchristie.nhs.uk) (Accessed 12 October 2023)
	Christie Colleague Awards – In 2023 we have relaunched our Christie Colleague Awards. Categories have been aligned to the new trust values and behaviours and an award will be made for contribution to EDI. Shortlisted colleagues and/or teams, along with the colleague who made the nomination, will be invited to a celebratory	HIVE – The Christie Colleague Awards 2023 Launch Communication HIVE - The Christie Colleague Awards 202

	event in the Auditorium on Wednesday 18th October 2023 where the winners will be announced.	HIVE - The Christie Colleague Awards 2023 (xchristie.nhs.uk) (Accessed 12 October 2023)
	Veteran Aware Accreditation – The Trust was awarded Veterans Aware accreditation in April 2023.	Veteran Aware Accreditation Letter  01 - Veteran Aware Accreditation Award 2
	Staff Engagement – The Christie's staff engagement score from the Staff Survey 2022 of 7.6 was better than our benchmark group median (7.2) and significantly above the average for all Trusts (6.8). To support further improvement, results and feedback has been analysed and all Divisions have discussed their results, completed action plans and shared progress at our Workforce Committee.	Staff Survey Action Taken – Management Board Paper and Slides  Staff Survey Management Board S  NHS Staff Survey update_Management
	Doctors in Training Survey - The 2023 National Training Survey of doctors in training posts has shown sustained improvement in overall experiences of doctors in training at The Christie	GMC NTS Results 2023  NTS Results.pptx
	Menopause - The Trust has a Menstruation to Menopause Policy and have made a Menopause Workplace Pledge. The Trust also runs a regular Menopause Café which provides support and promoting helpful resources.	Menstruation to Menopause Policy (awaiting ratification and publication) HIVE – World Menopause Day resources HIVE - World Menopause Day Seminars (xchristie.nhs.uk) (Published 07 August 2023)

The trust should consider monitoring delayed discharges or transfers of care in regard to patient experience		
BAF reference: 6.1		
Report	**Activity**	**Evidence**
The trust did not measure specific reasons for patients remaining in hospital when they were ready to be transferred or discharged. This meant the trust would not know which areas to target for improvement.	Since June 2023, this has been reported weekly to TOG outlining the barriers to discharge and any updates. Introduction & implementation of an In-patient discharge status list status in CWP went live 23/07/23 and displays: • Estimated discharge date for all IPs • Projected discharge pathway • Identified reason to reside. The In-patient discharge list is reviewed at daily MDT board rounds and helps to identify early potential barriers to discharge.	Example TOG report (redacted – 18/10/23)  TOG - Patients on site without criteria to Reason to Reside presentation presented to Friday FoCUS 15/09/23  Reason To Reside presentation.pptx

The trust should ensure there is an effective process to provide information in an accessible format for service users with information or communication needs.		
BAF reference: 5.1, 6.3		
Report	**Activity**	**Evidence**
The trust was not fully compliant yet, despite AIS coming into legislation in 2016.	**HIVE update** - The Accessible Information Standard (AIS) home page on HIVE was updated 21/04/23 (accessed 21/09/23)	Content on HIVE home page  Accessible Information Standar
	AIS Policy & SOP - The accessible communication policy has been reviewed and updated and a new accessible communications	Accessible communications policy and SOP

	SOP developed. Both were published 31/03/23 following committee approval and ratification. The annual audits outlined in the AIS policy are on Patient Experience Committees work programme for discussion in November.	Accessible Communications Po Accessible Communications SO
	AIS sub-group meetings - Monthly Accessible Information Standard sub-group meetings were relaunch July 2023. These have since moved to bi-monthly with the next meeting scheduled for 07/11/23 and will report to Patient Experience Committee. The group are currently developing an action plan as to how key areas are addressed for the Trust; a draft action plan is scheduled to be presented at Novembers AIS sub-group meeting.	
	Patient registration - The Trust introduced an updated patient registration form in July 2023 that will help with identification of patients that have accessible communication needs. Accessible communication needs are identified as an alert on CWP. A baseline audit is underway looking at registration data and how well communication needs are identified. The audit findings are scheduled to be presented at Novembers AIS sub-group meeting.	Patient registration form Patient Registration Form - New Design.p Screenshot of Accessible Communication alert in patients' electronic records (CWP).

		
	Cardmedic - The Trust has become the first specialist cancer trust to deploy CardMedic; a healthcare communication app used to bridge communication gaps, such as language barriers or cognitive impairments, between clinicians and patients to reduce health inequalities.	The Christie becomes first specialist cancer trust to deploy CardMedic (digitalhealth.net) (Accessed 05 October 2023)

The Christie
NHS Foundation Trust

Agenda item 36/23c

Meeting of the Board of Directors
Thursday 30th November 2023

Subject / Title	The Board's responsibilities for Carbon Net Zero
Author(s)	Will Blair - Sustainability Manager
Presented by	Professor Chris Harrison - Deputy Chief Executive Officer Alex Beedle - Head of Facilities Will Blair - Sustainability Manager
Summary / purpose of paper	In accordance with the NHS Standard Contract Service Conditions 23/24, the Trust must provide an annual summary of progress on delivery of Sustainable Development Management Plan. The report has been approved by the Net Zero and Climate Adaptation Committee and Audit Committee.
Recommendation(s)	To note
Background papers	Sustainable Development Management Plan (2021-2024)
Risk score	9 (BAF Risk 8.4)
Link to: ➢ Trust strategy ➢ Corporate objectives	1. To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer 6. To maintain excellent operational, quality and financial performance 7. To be an excellent place to work and attract the best staff 8. To play our part in the local health care economy and community
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.	IPPC - Intergovernmental Panel on Climate Change SDMP - Sustainable Development Management Plan CQC – Care Quality Commission

The Christie
NHS Foundation Trust

Agenda item 36/23c

Meeting of the Board of Directors
Thursday 30th November 2023

The Board's responsibilities for Carbon Net Zero

1 Introduction

This report brings the Trust's Sustainable Development Management Plan Annual Report to the attention of the board of directors and is to note.

2 Background

We are required (NHS Standard Contract Service Conditions 2023/24) to publish an annual report on progress with our Sustainable Development Management Plan (SDMP). The board approved an updated SDMP in June 2021. This included work on the ambitions set by "Delivering a Net Zero NHS".

The SDMP covers:

- Ten modules - Corporate Approach, Asset Management & Utilities, Travel and Logistics, Adaptation, Capital Projects, Green Space & Biodiversity, Sustainable Care Models, Our People, Sustainable use of Resources, Carbon / GHGs

- Four cross-cutting themes - Governance & Policy, Core Responsibilities, Procurement and Supply Chain, and Working with Staff, Patients & Communities.

Sustainability and achievement of Net Zero are integrated into the strategic objectives of the organisation. Progress has been made but as described in the report we aspire to place more emphasis on these strategic objectives in coming years. To this end we have strengthened the internal governance and reporting mechanisms with the introduction of a Net Zero and Climate Adaptation Committee (chaired by the DCEO) with oversight from the Management Board.

The annual report has been approved by the Net Zero and Climate Adaptation Committee (Chaired by the DCEO) and Management Board and for assurance purposes has been scrutinised by the Audit Committee at their meeting in October 2023. The report is included with the items for information.

3 Recommendation

The Board are asked to note the paper.

The Christie
NHS Foundation Trust

Agenda Item 36/23a

Meeting of the Board of Directors
Thursday 30th November 2023

Subject / Title	Audit Committee report – October 2023
Author(s)	Company Secretary's Office
Presented by	Committee Chair
Summary / purpose of paper	This paper provides the board with a summary of the assurance items considered by the Audit Committee at their October meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions
Background papers	Audit Committee papers 19th October 2023
Risk score	BAF references noted within report
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.	DoF Director of Finance CIO Chief Information Officer

The Christie
NHS Foundation Trust

Agenda item 36/23a

Meeting of the Board of Directors
Thursday 30th November 2023

Audit Committee report – October 2023

1 Introduction

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

2 Audit Committee agenda items

The items listed below were all presented to the Audit Committee for assurance:

Agenda item	BAF ref.	Assurance rating suggested	Comments and associated action (where applicable)
Executive Director of Finance report	6.2	High	• An exercise has been undertaken across GM on the level of insurances in place. The Christie's appears high, but this is due to areas such as the Nursery, Research and Pharmacy. • Update provided on the GM ICB System Oversight Framework (SOF) rating downgraded to a 3 and the PwC commissioned review of all GM providers. • Progress has been made towards the implementation of the new fit and proper persons test framework, compliance reporting and assurance will go through the Workforce Assurance Committee. • The recent awards and recognition for the Finance and Business Development Team were highlighted, Committee commended the team on their achievements. No actions noted.
The Christie Pharmacy Company (TCP) report	6.4	Medium	• No recent HMRC inspections in relation to VAT claims but currently have a review ongoing with VAT advisers to see if any further savings that could be made. • A GPhC (General Pharmaceutical Council) inspection confirmed satisfaction and the new licence was issued prior to the department opening. • Investment in the facility has achieved exactly what it set out to do, currently working to 84% of target for turnaround time on prescriptions. • An internal audit programme update will go to the next TCP Board. • Final accounts for the financial year ending 2022/23 were approved by the external auditors and signed off by TCP Board. • Opening the new outpatient dispensary allowed a number of key risk scores to be reduced, with only two risks scoring more than 10 remaining on the register. • Financial performance shows a £144K surplus at M5

Agenda item	BAF ref.	Assurance rating suggested	Comments and associated action (where applicable)
			2023/24, £38K better than plan, with a healthy cash balance and the £1.2m loan from the Trust on target to be fully repaid by May 2025.
Data Security and Protection Toolkit (DSPT) update	6.3, 6.5	Medium	• July's self-assessment achieved substantial assurance and an overall assurance level of moderate assurance. • There is no improvement plan with NHS Digital required for this year and the externally reported status of 'Standards Met' has been reported since 2019. • Plans progressing for all standards of 2023/24 DSPT submission – annual submission remaining end June 2024. • Areas of growth summarised with key challenge noted as getting new team members up to speed on DSPT requirements. **Action:** For Committee to consider whether an annual update on the DSPT remains a requirement given the compliance status and that a DSPT update is now routinely included within the six monthly digital report to Audit Committee.
Sustainability annual report	8.3	Medium	• Report is a mandatory requirement and required to be approved by Board before being published. • A lot of work has taken place around energy within clinical practice and the link to sustainability. There have been some good successes. Some areas have slipped and these have been reviewed; these related to the period of the pandemic and having to catch up. Currently in the process of reviewing the actions alongside developing new ones. No actions noted.
EPRR annual report	8.4/8.5	Medium	• 3 training sessions delivered in Q1 involving 10 members of the exec on call rota, and 22 other senior managers. • Cyber tabletop exercise and incident response testing to a cyber incident have both been facilitated by immersive labs. Digital team have also participated in a GM cyber tabletop exercise. • The Trust has used BCP's in relation to several episodes of Industrial action over the last 10 months. • 6 EPRR risks – including 1 new risk relating to no EPRR management lead at present. Recruited to the post and just waiting on the start date. • All EPRR risks have been reviewed and updated. Highest risk is in relation to industrial action. • An action plan is in place to support compliance standards with the self-assessment, some are currently compliant and some are partially compliant. No actions noted.

A summary of the governance items discussed at the meeting is provided below:

Declarations of Interest Q2 Update – Report provided a summary on compliance which has seen a drop due to the monthly download of staff data now including staff on honorary contracts. Pushing compliance and communications are in place to promote the system and declaration requirement. One of the entries on the Q2 declarations extract relates to the gift of a Wagamama's voucher which is outside of Trust policy. Currently waiting on clarification, it is noted as pending so not yet approved. An action was taken to follow up on this to ensure appropriate action taken and for further messaging and reinforcement to also be made as opportunities arise.

Internal audit progress report – Two reviews were confirmed as finalised with a further five in progress. A discussion was held in relation to a request by management to make a change to the audit plan and to consider replacing a review with a review of bank administration staff following an identified issue. Following the discussion, an action was taken for the identified issue to be looked at internally through Executives.

Anti-fraud progress report - The NHS CFA are due to start inspections again. The vigilance of the finance team was noted in dealing with a recent payment requested but not sent as identified as fraudulent. A review of NFI creditor matches identified a saving of £6,320.41 for the Trust where invoices had been duplicated. There was no indication of any fraud. The Christie are one of only two Trusts across the NW to complete.

External audit progress report and Auditors annual report - Approval remains outstanding from HM Treasury and NHSE but have relooked at the situation within GT to try to progress and can now move to issuing the audit opinion to enable the Trust to progress with issuing its annual report and accounts. There is still a need to ensure the approval is received but will report on this accordingly as a significant weakness, which is consistent with what has been reported elsewhere for another Trust. This will be reported in the Auditor's Annual Report as part of the financial statement and VFM section. The Auditor's Annual Report covers the annual review of the arrangements in place. No significant weaknesses identified; some minor improvements recommended. A positive report which reflects the hard work of the Trust. An action was taken for Grant Thornton to confirm the triggers for the amber rating on the performance assessment.

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

3 Recommendation

The Board are asked to note the reports received for assurance by the Audit Committee in October.

Assurance level descriptions:

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

Audit Committee Terms of Reference	
1. Constitution	The Board of Directors' has established a Committee, known as the Audit Committee, reporting to the Board in accordance with standing order 6 for the practice and procedure of the Board of Directors (annex 8 of the constitution). The Committee shall have Terms of Reference and powers and be subject to such conditions, such as reporting back to the Board, as the Board shall decide and shall act in accordance with any legislation and regulation or direction issued by the regulator. The Committee shall be a Non-Executive Committee of the Board comprised of independent Non-Executive Directors and has no executive powers, other than those specifically delegated in these terms of reference.
2. Terms of Reference	**a. Purpose / duties / role** The role of the Committee is to provide assurance to the Board along with the Quality Assurance Committee and Workforce Assurance Committee that The Christie is properly governed and well led across the full range of activities, including investment, and to provide internal and external assurance by reviewing the establishment and maintenance of effective systems of governance, risk management and internal control.
3. Membership	The Committee membership shall be comprised of: Non-Executive Directors and should include at least three independent Non-Executive Directors. The Chair of The Christie shall not be a member. The Board should satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience. (NHS Code of Governance D.2.2.1). The Chair of the Committee shall be one of the Non-Executive Directors selected by the Board. In their absence their place needs to be taken by another Non-Executive Director. **a. Quorum** The quorum shall be any two Non-Executive members of the Committee. **b. Attendance at meetings** The following individuals shall normally be in attendance: • Executive Director of Finance and Business Development (EDoF&BD). • Chief Nurse & Executive Director of Quality (CN&EDoQ). • Committee secretary (minutes). • Appointed representatives of the EDoF&BD, normally the Financial Services Manager and / or Deputy Director of Finance. • Representative(s) of the external audit service provider. • Representative(s) of internal audit service provider. • Representative(s) of counter fraud service provider. The Chair of the Board, Chief Executive and other Directors may be invited to attend, particularly when the Committee is discussing areas of

	risk or operation that are the responsibility of that Director. The Chief Executive should be invited to attend at least annually, to discuss the process of assurance that supports the annual governance statement. **c. Attendance by others** As required by the Committee. **d. Notice of meetings** Meetings of the Audit Committee shall be called at the request of the Committee Chair. Notice of each meeting, including an agenda and supporting papers shall be forwarded to each member of the Audit Committee not less than five working days before the date of the meeting.
4. Responsibilities/ accountability and reporting arrangements	The Committee has a shared responsibility with the Quality Assurance Committee and Workforce Assurance Committee, to provide assurances to the Board of Directors that The Christie is properly governed and well led across the full range of their activities. In broad terms, the Audit Committee has responsibility for providing overarching assurance on governance, risk management and control and for all matters relating to corporate, financial and investment governance and risk management along with digital and carbon reduction whilst the Quality Assurance Committee is responsible for clinical and research governance and risk management and the Workforce Assurance Committee is responsible for leadership and development of The Christie workforce and ensuring progress against our People Plan. Where any Committee is concerned that identified risks have a material impact on the remit of the other, they will refer the details to it. **Governance, risk management and internal control** The Committee will provide internal assurance by reviewing the establishment and maintenance of effective systems of governance, risk management and internal control, particularly in relation to the corporate, financial and investment activities that support the achievement of the objectives of The Christie. In particular, the Committee will review the adequacy and effectiveness of: • All risk and control related disclosure statements (in particular the board assurance framework, annual governance statement, Regulation 17 of the Care Quality Commission essential standards), together with any accompanying head of internal audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the board of directors. • The underlying assurance processes that indicate the degree of achievement of the corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements. • The policies for ensuring compliance with regulatory, legal and code of conduct requirements, as they relate to corporate, financial and investment issues. This includes an annual audit review of the Data Security and Protection Toolkit.

	• The policy on data quality particularly as it relates to the data which forms the basis of self-assessments or disclosures to NHS Improvement. • Review the policies and procedures for all work related to fraud, bribery and corruption as set out within NHS Standards Contract and as required by NHS Counter Fraud Authority Standards for Providers. This will include receipt of the Anti-Fraud Work Plan with progress reports provided on a recurring basis, plus the Anti-Fraud Annual Report, to ensure that the committee is satisfied with action taken throughout the year and that significant losses have been properly investigated and reported to the internal and external auditors and relevant external bodies including NHS Counter Fraud Authority. • Review arrangements by which staff of The Christie may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. In carrying out this function, the Committee will primarily utilise the work of internal audit, external audit, and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from Directors and Managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. The tracking and monitoring of the completion of audit recommendations will take place through the review of the audit recommendation tracker report presented to the Committee. Through its annual rolling programme of work, the Committee will request and review reports and positive assurances from Directors and Managers on the overall arrangements for governance, risk management and internal control. Reporting will be received on the following areas in line with the Committee annual rolling programme: • Digital– six monthly. • Emergency Preparedness, Resilience and Response (EPRR) – annually. • Sustainability – annually. The Committee may also request specific reports from individual functions within the organisation, as they may be appropriate to the overall arrangements. In addition, the Committee will review the work of other Committees within The Christie, whose work can provide relevant assurance to the Committee's own scope of work. This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it. **Raising concerns** The Committee shall review the effectiveness of arrangements in place for allowing staff to raise (in confidence) concerns about possible

	improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently. **Wholly Owned Subsidiaries** The Committee will have oversight of the Trust's wholly owned subsidiaries (WOS). This will include review of governance and effectiveness arrangements for the entity. Twice yearly reports will be received by the Committee from the WOS. The joint ventures within the Trust are independent bodies so are not included within the ToR of the Audit Committee. **Internal Audit** The Committee will secure independent assurance by ensuring that there is an effective internal audit function, which meets mandatory NHS internal audit standards and provides appropriate independent assurances to this Committee, the Quality Assurance Committee, the Workforce Assurance Committee, the Chief Executive and the Board. This will be achieved by: • Leading the procurement process and consideration of any questions regarding the appointment of the internal audit service or revisions to/termination of the internal audit service contract. • Ensuring that adequate internal audit capacity is identified and purchased, and that the function has appropriate standing within The Christie. • Reviewing and approving the internal audit strategy, operational plan and more detailed programme of work, ensuring that these are consistent with the audit and governance needs of The Christie, as identified in the assurance framework. • Discussion and agreement with internal audit, of the nature and scope of the audit plan in coordination with the other assurance Committees. • Consideration of the major findings of internal audit reports, and management's response, ensuring co-ordination between internal and external audit in order to optimise audit resources and between the Audit, Quality and Workforce Assurance Committees. • Provision of all final internal audit reports to the Audit Committee Chair and audit review summaries along with confirmation of assurance ratings assigned to completed reviews provided through internal audit progress reports to each Committee meeting. • Leading an annual review of the performance and effectiveness of the internal audit service. **External Audit** The Committee will review the work and findings of the external auditor and consider the implications and management's responses to their work. This will be achieved by: • Consideration of the appointment, effectiveness and performance of the external auditor, as far as any applicable rules permit. • Consideration of the independence and objectivity of the external auditor. • Consideration of the provision and cost of the external audit service.

	• Discussion with the external auditors of their local evaluation of audit risks and assessment of The Christie, and the associated impact on the audit fee. • Review of all external audit reports, including agreement of the annual audit letter before submission to the board, and any work carried out outside the annual audit plan, together with the appropriateness of management responses. The Committee will make recommendations to the Council of Governors, in relation to the appointment and removal of the external auditor in line with the Trust Constitution. For the avoidance of doubt the Council of Governors has no responsibility in relation to the external audit of The Christie Pharmacy Company. The Committee will develop and implement a policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm. **Reporting to the Board** The proceedings of each meeting of the Audit Committee shall be reported to the next meeting of the Board of Directors. The Chair shall draw to the attention of the Board of Directors any issues that require disclosure to the Board or require executive action. The Committee will report annually to the Board of Directors on its work in support of the statement on internal control, specifically commenting on the fitness for purpose of the assurance framework, and the completeness and the effectiveness of risk management in the organisation, together with the adequacy and effectiveness of The Christie's arrangements for economy and efficiency. **Reporting to/working with the Council of Governors and members** The Committee will report to the Council of Governors, identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken. The Committee will ensure that appropriate arrangements are made when appointing or re-appointing the external auditor to involve Governors in the process and present a recommendation to the Council of Governors. The Committee will ensure that the annual report and financial statements, the report of the auditor and forward planning information for the next financial year are presented to the Council of Governors at appropriate times in the annual reporting cycle. The Committee will ensure that the annual report and financial statements, the report of the auditor and forward planning information for the next financial year are presented to the members at the Annual Members' Meeting. **Annual report and financial statements**

	The joint Committee meeting (consisting of the Audit Committee, Quality Assurance Committee and Workforce Assurance Committee) shall review the annual report and financial statements for The Christie before submission to the Board of Directors, focusing particularly on: • The wording in the statement on internal control and other disclosures relevant to the Terms of Reference of the Committee. • Changes in, and compliance with, accounting policies and practices. • Unadjusted mis-statements in the financial statements. • Major judgmental areas. • Significant adjustments resulting from the audit. The Committee shall employ appropriate measures such as internal audit reports to ensure that: • The systems for financial reporting to the board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the Board of Directors, and • They monitor the integrity of the financial statements and any formal announcements relating to the financial performance, reviewing significant financial reporting judgements contained in them. The Committee must review and update these Terms of Reference not less than annually recommending any changes to the Board of Directors and publish them on the Christie website. The Committee must evaluate its own membership and performance on a regular basis.
5. Frequency	The Audit Committee shall meet at least four times per year. The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention. At least once a year the Committee shall meet privately with the external audit, internal audit and counter fraud service providers and the senior representatives of these organisations may request a meeting if they consider that one is necessary.
6. Authority	The Committee is authorised by the Board of Directors to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee, and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board of Directors to obtain reasonable external legal or other independent professional advice and to secure the attendance of outsiders with relevant experience or expertise, if it considers this to be necessary. The Committee is authorised by the Board of Directors to incur expenditure up to £5,000 in line with the Scheme of Reservation and Delegation of Powers.
7. Relationship with other committees	This Committee and the other assurance Committees have a shared responsibility to provide assurances to the Board of Directors. As such, all Committees need to work collaboratively, to ensure that all aspects of governance are covered and that the Board receives comprehensive assurances on The Trust's business and activities. Joint meetings can be

	arranged to review assurances supporting the annual governance statement and to agree the specific responsibilities relating to each element of the Assurance Framework.
8. Dissemination of information	Information is disseminated via the Board of Directors' and Council of Governors.
9. Review	The Audit Committee Terms of Reference are to be reviewed annually.
10. Administration	The Committee shall be supported administratively by the Committee Secretary, who will agree the agenda with the Chair, produce all necessary papers, attend meetings to take minutes, keep a record of matters arising and issues to be carried forward and generally provide support to the Chair and members of the Committee. Minutes of all meetings of the Committee shall be taken and kept by the Committee Secretary or an appropriate alternative.
Date issued	**May 2006**
Date Approved	April 2007, February 2008, July 2008, February 2009, November 2009, October 2011, January 2012, January 2013, January 2014, April 2015, April 2016, April 2017, April 2018, April 2019, July 2020 (delayed due to Covid-19), February 2021, February 2022, July 2022, July-October 2023
Review Date	October 2024

The Christie
NHS Foundation Trust

Agenda Item 37/23b

Meeting of the Board of Directors
Thursday 30th November 2023

Subject / Title	Workforce Assurance Committee Report – November 2023
Author(s)	Company Secretary Office
Presented by	Committee Chair
Summary / purpose of paper	This paper provides the board with a summary of the assurance items considered by the Workforce Assurance Committee at their November meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions
Background papers	Workforce Assurance Committee papers 14th November 2023
Risk score	BAF references noted within the report
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.	EDG Ethnic Diversity Group BAF Board Assurance Framework WRES Workforce Race Equality Standard WDES Workforce Disability Equality Standard FTSU Freedom to Speak Up

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Agenda Item 37/23b

Meeting of the Board of Directors

Thursday 30th November 2023

Workforce Assurance Committee report – November 2023

1 Introduction

The Workforce Assurance Committee took place on 14th November 2023. The following summary gives the Board information on the items that were considered, and any actions required by the Board.

2 Workforce Assurance Committee agenda items

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

Agenda item	**Workforce Dashboard**
BAF reference	**7.1**
Assurance rating given	**High**

Key points and associated action (where applicable):

A detailed overview of the Workforce Dashboard was presented, this was the first review of the dashboard for the Committee. The dashboard links to the BAF and has aims for delivery. The update presented to the Committee evidenced where an impact is starting to be made. The dashboard contained workforce data metrics for all divisional areas and the following areas were expanded on (based on looking at last year's staff survey (current year's survey is underway)):

- Engaging our people
- Trust morale average score
- Division morale average score
- Looking after our people
- Sickness rate and analysis
- Developing our people
- Treating our people fairly and with respect
- Leading our people
- Our people of the future
- Trust establishment against paid FTE
- Bank and agency

Through discussion, the Committee were assured that the dashboard demonstrated progress whilst recognising where improvements can be made and the actions in place to achieve.

Agenda item	**The Christie People Plan**
BAF reference	**7.1, 7.2, 7.4**
Assurance rating given	**High**

Key points and associated action (where applicable):

The people plan links to the Workforce Dashboard, the plan is designed to improve the dashboard against achieving set objectives. The people plan also maps to national priorities. The Committee were assured on the plan in place and raised the assurance rating from medium to high.

Agenda item	**WRES and WDES Update Report**
BAF reference	**7.4**
Assurance rating given	**Medium**
Key points and associated action (where applicable): New action plans have been developed and these were provided to the Committee. The plans have been submitted to NHSE. Through the action plans there are a number of accountable owners and the actions have been developed with these staff members, resulting in collaborative work.	
Agenda item	**EDI plan update**
BAF reference	**7.4**
Assurance rating given	**Medium**
Key points and associated action (where applicable): The plan is an extension to the Trust's existing document, sets out the Trust EDI aims and objectives and is also based on all of the national NHS and statutory requirements. The plan has been published on the Trust website. The EDI annual report was also summarised.	
Agenda item	**Compliance with CQC Safe Staffing Six Monthly Report**
BAF reference	**7.1 and 7.2**
Assurance rating given	**High**
Key points and associated action (where applicable): The bi-annual review for the monitoring period (January to June 2023) was summarised. The report provided assurance on bed occupancy, incidents, patient experience and HR metrics. There was an acknowledgement of the challenging time due to industrial action when the report was produced, all ward managers provided assurance of safe levels being maintained during this time. The inpatient wards continue to report a steady staffing ratio of 1:7 during the day and 1:7/8 during the night, the Trust ratio is better than other Trusts. Establishments are safe and effective to deliver care.	
Agenda item	**CQC Improvement Plan – Mandatory training and supervision (Regulation 18)**
BAF reference	**7.1**
Assurance rating given	**High**
Key points and associated action (where applicable): The summary of the paper set out the background, the action plan submitted to the CQC and provided assurance that all actions have been completed in line with the deadlines set.	
Agenda item	**CQC Action Plan – Fit & Proper persons (Directors) (Regulation 5)**
BAF reference	**1.6 and 7.3**
Assurance rating given	**High**
Key points and associated action (where applicable): The paper related to a 'must do' action from the CQC report in relation to Regulation 5. The three identified actions have all been completed and evidence to support this was provided in the paper. Since the actions were outlined, there is also now a new framework and guidance for the Fit and Proper Persons Test which has been published by NHSE, the Trust is also compliant with this framework.	

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

3 Recommendation

The Board are asked to note the reports received for assurance by the Workforce Assurance Committee in November 2023.

Assurance level descriptions:

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

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Agenda Item 37/23c

Thursday 30th November 2023

Board Assurance Framework 2023/24

Subject / Title	Board Assurance Framework 2023/24
Author(s)	Louise Westcott, Company Secretary
Presented by	Louise Westcott, Company Secretary
Summary / purpose of paper	This paper provides the Board with the closing position of the Board Assurance Framework 2023/24 that summarises the risks to achievement of the corporate objectives. The cover paper gives detail of the updates.
Recommendation(s)	To note the Board Assurance Framework (BAF) 2023/24
Background papers	Board assurance framework 2022/23. Corporate objectives 2023/24, operational plan and revenue and capital plan 2022/23.
Risk score	N/A
Link to: ➢ Trust strategy ➢ Corporate objectives	• Trust's strategic direction • Divisional implementation plans • Our Strategy • Key stakeholder relationships
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	BAF Board assurance framework ECN Executive chief nurse EDoF Executive director of finance EMD Executive medical director COO Chief operating officer DoW Director of workforce DCEO Deputy chief executive officer

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Agenda Item 37/23c

Board of Directors meeting

Thursday 30th November 2023

Board Assurance Framework 2023/24

1 Introduction

The board assurance framework (BAF) 2022/23 was presented to the Board of Directors and Quality Assurance Committee in June and the Audit Committee in July.

2 Updates to risks

The risks in the 2023/24 framework have been reviewed to reflect the annual objectives against each of the 8 agreed corporate objectives. The executive directors and the company secretary have reviewed the risks and updated the BAF with the latest position. In addition, the following has been updated this month;

- Where a risk has been assessed by an assurance committee the level of assurance has been added.

3 Suggested updates

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

4 Recommendation

The Board are asked to note the Board Assurance Framework (BAF) 2023/24 that reflects the risks to achievement of the corporate objectives and note assurance levels assigned by the Assurance Committees following review of the risks, as detailed in the committee reports to Board.

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

Number	Principal Risks	Exec Lead	Likelihood	Impact	Key Control established	Key Gaps in Controls	Current Risk Score	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Risk appetite (Averse / Cautious / Eager)	Responsible committee	Assurance level achieved (High / Medium / Low)	Opening Position	Position at end of Q1	Position at end of Q2	Position at end of Q3	Position at end of Q4	Target risk score	Target date for completion
1.1	Not meeting national requirements of Patient Safety Incident Response Framework (PSIRF)	ECN	2	4	Associate Chief Nurse for Quality and Patient Safety and Associate Medical Director for Patient Safety leading training and implementation programme. Progress monitored through Risk & Governance Committee and Quality Assurance Committee. Updates presented to ICB	None identified	**8**	Monitoring of reporting requirements through reports / asurance committee rolling programmes	None identified	Team progressing implementation of PSIRF. Detail & dates in September Board paper	September Board paper	Averse	Quality	High	**8**	8	8			**2**	Year end
1.2	Lack of data to fully understand equity of access to services & its impact on outcomes	COO	4	3	Project established to address data quality gap with clinical leadership. Go live date of July 2023 for identified projects. Impact to be assessed in September 2023.	Incomplete data set	**12**	Local audit of compliance reported to Executive Team. MIAA audit re GM cancer Q3	None identified	Regular review and reporting to executive team. System changes identified	July implementaion of actions. Review in November 23	Cautious	Quality	Mediu m	**12**	12	12			**4**	Year end
1.3	Risk to patients and reputational risk to trust of exceeding healthcare associated infection (HCAI) standards	ECN	2	3	Patients with known or suspected HCAI are isolated. Medicines management policy contains prescribing guidelines to minimise risk of predisposition to C-Diff & other HCAI's. RCA undertaken for each known case. Review of harm undertaken. Induction training & bespoke training if issues identified. Close working with NHS England at NIPR meetings. Clinical advisory group in place. Following national guidance. IPC BAF in place	None identified.	**6**	Levels reported through performance report to Management Board and Board of Directors and quarterly to NHS Improvement. MIAA audit planned Q2	None identified	Actions relating to IPC BAF identified with target dates - full report to Sept QAC	Monthly assessment of progress	Averse	Quality	High	**6**	6	6			**6**	Year end
1.4	Failure to learn from patient feedback (patient satisfaction survey / external patient surveys / complaints / PALS)	ECN	2	2	Monthly patient satisfaction survey undertaken and reported through performance report. Negative comments fed back to specific area and plans developed by ward leaders to address issues. Action plans developed and monitored from national surveys. Complaints and PALs procedures in place. Action plans monitored through the Patient Experience Committee	None identified	**4**	Management Board and Board of Directors monthly Integrated performance and quality report. National survey results presented to Board of Directors. MIAA audit complaints Q1 / risk management Q4. CQC Inpatient survey results. National Cancer Patient Experience Survey results	None identified	Team progressing implementation of PSIRF	September Board paper	Averse	Quality	High	**4**	4	4			**2**	Year end
1.5	Risk of exceeding the thresholds for harm free care indicators (falls, pressure ulcers, venous thromboembolism)	ECN	2	4	All falls with low harm come through Friday-Focus and moderate/above through ERG. Falls prevention group operational. Training required for all nursing/HCA staff. All hospital acquired pressure ulcers reviewed through Friday-Focus. Monitoring of VTE assessment compliance through Thrombosis Committee. Continuous assessment of progress against thresholds. At 6 monthly position will further assess likely year end position and risk score.	Risk assessments for falls and skin assessment not always completed in a timely manner	**8**	QI project evaluating introduction of bedside handover to improve compliance with risk assessments. Risk assessment compliance added to CWP and monitored daily. Regular reports to Quality Assurance committee. MIAA audit risk management Q4	None identified	Continuous monitoring through monthly reports. Escalations in place where appropriate. No current concerns.	Monthly assessment of progress	Averse	Quality	High	**8**	8	8			**2**	Year end
1.6	Lack of preparedness for a CQC inspection leading to a poor performance	ECN	2	4	Assessment against standards ongoing. Timetable of mock inspections being arranged. Looking at Trust wide requirements. Assessment of assurance process to ensure all regualtions assessed.	Full understanding of CQCs new approach to inspection	**8**	Good rating 2023. MIAA audit - risk management Q4	None identified	Engagement in CQC's regulation updates	Regular engagement meetings in diary	Averse	Quality		**8**	8	8			**4**	Year end

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

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

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

	Principal Risks	Exec Lead	Likelihood	Impact	Key Control established	Key Gaps in Controls	Current Risk Score	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Risk appetite (Averse / Cautious / Eager)	Responsible committee	Assurance level achieved (High / Medium / Low)	Opening Position	Position at end of Q1	Position at end of Q2	Position at end of Q3	Position at end of Q4	Target risk score	Target date for completion
3.1	Risk to delivery of the Christie Education strategy due to reduction in demand	DoE	3	3	Review the deliverables and prioritise in line with financial investment available. Maximise the potential of external income. Refresh the Christie Education focus on integration of objectives with clinical and research divisions. Work with finance to review funding options, develop business cases for high priority initiatives and look at alternative funding sources. Christie Education board reports to Management Board. 6 monthly assessment of progress.	Continuing inability to deliver all strategic objectives due to difficulty in accessing curent investment funds to deliver new initiatives.	**9**	Reporting to Workforce Assurance Committee and Board	None identified	Divisional Board being restructured. Reporting to Management Board and DCEO	Divisional Board to manage timelines of actions	Cautious	Workforce		**9**	9	9			**3**	Year end
3.2	External factors / pipeline of high quality clinical and teaching staff	DoE	3	3	Monitoring of workforce numbers / turnover. Active recruitment and investment in Christie pipeline.	External factors / pipeline of high quality oncologists	**9**	Reporting to Workforce Assurance Committee and Board	None identified	Active recruitment practices / investment	Divisional Board to manage timelines of actions	Cautious	Workforce		**9**	9	9			**3**	Year end
3.3	Lack of progress with organisational governance arrangements for Christie Education	DoE	3	3	Project group in place. Plans established and resourse identified. Project progress reported to Board of Directors.	External factors	**9**	Reporting to Workforce Assurance Committee and Board	None identified	Project group identified actions and timelines, reported through Education Board.	Divisional Board to manage timelines of actions	Cautious	Workforce		**9**	9	9			**3**	Year end

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

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

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

	Principal Risks	Exec Lead	Likelihood	Impact	Key Control established	Key Gaps in Controls	Current Risk Score	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Risk appetite (Averse / Cautious / Eager)	Responsible committee	Assurance level achieved (High / Medium / Low)	Opening Position	Position at end of Q1	Position at end of Q2	Position at end of Q3	Position at end of Q4	Target risk score	Target date for completion
5.1	Inability to fully implement the 2023/24 Greater Manchester Cancer operating model	CEO	3	4	CEO chairs Manchester Cancer Board. Director of Strategy attendance at key meetings. Christie Strategy 2023-28 approved	None identified	**12**	Reports to Management Board and Board of Directors	None identified	GM Cancer Board monitoring progress and sharing & reviewing progress through regular meetings	Annual objectives assessed at 6 and 12 months	Averse	Board		**12**	12	12			9	Year end
5.2	Failure to implement 2023/24 objectives of the SACT strategy	COO	3	4	Strategy on track but constrained by other trusts. Expansion on Withington site. 6 monthly assessment of progress.	None identified	**12**	Regular reports to Management Board and Board of Directors. Six monthly assurance reports to Quality Assurance Committee.	None identified	SACT team report to Board on progress June 2023. On going assessments of demand and response in place	SACT Board manages action progress and reports through QAC	Averse	Quality		**12**	12	12			**3**	Year end
5.3	Inequity of access for patients to Christie trials due to delays in implementing governance arrangements for Christie led & hosted trials at the networked centres	DoR/COO	3	4	Research & Innovation Strategy approved. Approval for the trust to further expand the management of local oncology and chemotherapy services across GM. Focus on improved digital access e.g. appointments / ePROMs and Shared Decision Making. Chemotherapy services in locations across GM & Cheshire - strategy on track but constrained by other trusts.	Workforce and engagement from other trusts.	**12**	Regular reports to Quality Assurance Committee and Board of Directors	None identified	Working with other Trusts to understand issues and actions. Monitored through R&I / SACT boards	SACT Board manages action progress and reports through QAC	Averse	Quality	High	**12**	12	12			**9**	Year end

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

	Principal Risks	Exec Lead	Likelihood	Impact	Key Control established	Key Gaps in Controls	Current Risk Score	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Risk appetite (Averse / Cautious / Eager)	Responsible committee	Assurance level achieved (High / Medium / Low)	Opening Position	Position at end of Q1	Position at end of Q2	Position at end of Q3	Position at end of Q4	Target risk score	Target date for completion
6.1	Key performance targets not achieved	COO	3	4	Executive led monthly divisional performance review meetings. Integrated performance & quality report to Management Board and Board of Directors monthly. Weekl;y performance reporting via trust operational group. Escalation internally & across GM of delays impacting waiting time targets. Monitoring cancer waiting time standards through GM Cancer & IPR.	Impact of ongoing Industrial Action	**12**	Executive Team monitor activity weekly. Integrated performance report to Management Board, Quality Assurance Committee and Board of Directors.	None identified	Weekly monitoring through Executive Team, actions discussed and escalated as appropriate	Monthly review of annual targets	Cautious	Quality	Mediu m	**12**	12	12			**4**	Year end
6.2	Change in financial regime resulting in inability to deliver the Trust's strategic plan.	EDoF	4	4	Participating at national level and ICS (Greater Manchester) level to influence the new financial framework and its implementation. Development of mitigating strategies including efficiency and transformational programmes. Identification and consideration of new models of working to deliver and finance the Trust's strategic plan.	Changes in national funding arrangements and delegation of commissioning functions.	**16**	To continue to report through Managment Board and Board of Directors via financial reports and updates. Executive Team monitor activity weekly. MIAA audit - CIP Q2 / financial systems Q3 / Critical Apps Q3	None identified	External advice sought on new models of working. Close working with national & regional team	Monthly assessment of progress towards annual plan	Cautious	Audit	High	**16**	16	16			**4**	Year end
6.3	Digital programme unable to support delivery of operational objectives	COO	3	4	CWP (clinical web portal) on stable platform. Review of digital programme and to align ditial strategy with Service strategies. Key projects moving forward e.g.Order comms. EPMA, ePROMs, clinical outcomes.	Internal capability & expertise to support system going forward.	**12**	Reports to Management Board & Board of Directors. MIAA audit - Data Protection Toolkit (DPST) Q4	None identified	Progress and objectives set/reviewed by Quarterly Digital board. Esaclations through Management Board.	Monthly assessment of progress towards annual plan	Cautious	Audit	Mediu m	**12**	12	12			**4**	Year end
6.4	Not delivering the objectives of our commercial partnerships resulting in negative financial / patient experience or reputational impact	EDoF	3	3	Partnership Boards in place. Review of contract arrangemnts for CPP. TCP - Internal and external auditors in place. MIAA governance audit gave significant assurance. KPI's reported via partnerhip board structure.	None identified	**9**	Close contact with partners & management of joint incidents. Regular reports to Board and Audit Committee	None identified	Issues outlined and escalated through Boards	Regular assessment of progress towards annual plan	Averse	Audit / Board	High	**9**	9	9			**3**	Year end
6.5	Reputational damage, service disruption and financial loss due to cyber-attack.	COO	3	4	Risk committee regular reporting on cyber security alerts established. Digital Programme progression of key cyber security improvement projects continues. Digital Board reporting. NHS Digital linked monitoring tools being deployed. Internal scanning tools deployed. External summary reports provided. Regular testing and reporting of security vulnerabilities. Staff training mandatory. Cyber incident response support established via NHS Digital. Cyber essential assessment underway.	The Trust does not currently have cyber security insurance.	**12**	Data Security and Protection Toolkit submissions with audits undertaken. Digital board reporting. Board level Senior Information Risk Owner in place.MIAA audit - Data Protection Toolkit (DPST) Q4	None identified	Actions identified through MIAA DSPT review. Progress monitored on target dates through divisional meetings.	Monthly review of identified actions	Averse	Audit	Mediu m	**15**	15	12			**12**	Year end
6.6	Not implementing the in year objectives of the Trust strategy and its underpinning plans (Quality / Patient Experience / Risk Management / Operational)	DCEO	3	4	Strategy / plans approved and reported through assurance committees. 6 monthly assessment reported to Board.	None identified	**12**	Published Trust Strategy	None identified	Objectives monitored through appropriate divisional board	Annual objectives assessed at 6 and 12 months	Averse	Board		**12**	12	12			**4**	Year end

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

	Principal Risks	Exec Lead	Likelihood	Impact	Key Control established	Key Gaps in Controls	Current Risk Score	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Risk appetite (Averse / Cautious / Eager)	Responsible committee	Assurance level achieved (High / Medium / Low)	Opening Position	Position at end of Q1	Position at end of Q2	Position at end of Q3	Position at end of Q4	Target risk score	Target date for completion
7.1	Failure to achieve the year 1 milestones of the People and Culture Plan 2023/26	DoW	3	4	Plan approved and actions underway against each element of the plan	None identified	**12**	Workforce Assurance Committee reports. MIAA audit EDS 22 Q4.	None identified	Target dates for all elements of the plan identified	Monthly review of identified actions	Averse	Workforce	Medium	**12**	12	12			**4**	Year end
7.2	Risk of negative impact on delivery of services and staff engagement levels due to Trustwide staffing gaps in some occupations and ability to recruit and retain	DoW	4	3	Recruitment & Retention Trust wide group in operation reporting to the workforce committee. Commenced programme of work with an external organisation to develop our recruitment offer, advertising and brand. Commenced a programme of recruiting international nurses over a 6 month period. Quarterly oversight of Trust wide vacancies and recruitment activity presented to the workforce committee. Divisional oversight of recruitment activity and vacancies discussed at the monthly service review meetings. Turnover analysis and exit interview data presented and discussed six monthly at the workforce committee.	National staff shortages impacting recruitment	**12**	National staff survey 2021 results. Reports to Management Board . Agency spend. Workforce Committee Oversight. MIAA audit - sickness absence Q1	None identified	Recrutiment and retention workplan in place - monitored through Workforce Assurance Committee	Regular assessment of progress towards annual plan	Averse	Workforce	High	**12**	12	12			**6**	Year end
7.3	Management of Board succession and appointment of new Chair / NEDs	DoW/CS	3	3	External search agency appointed to undertake Chair recruitment process. Plan outlined for future requirements to replace NEDs as they come to end of term. New Chair successfully appointed to start October 2023. Process for recruitment of 2 NEDs commenced July 2023.	None identified	**9**	Nominations Committee decisions reported to Council of Governors. Adherence to Fit & Proper Persons regulation - report to Audit Committee. Use of external search partner.	None identified	NED recruitment underway and plans outlined for further recruitment with timelines. Skill mix assessment updated and plan in place for Board discussion once new Chair in post.	Year end review of succession plan to determine future NED requirements	Averse	Audit	Medium	**9**	9	9			**9**	Year end
7.4	Race/Disability discrimination impacting staff experience and therefore patient care	DoW	3	3	Staff networks established, Board development sessions planned across the year focussing on discrimination. EDI programme board monitors delivery of the EDI plan, monitoring of risks and WRES/WDES action plans. EDS2022 progress against plans monitored at the Management Board. Workforce Assurance Committee oversight of progress.	None identified	**9**	Reports to Workforce Committee, Management Board and Workforce Assurance committee. Staff story at each Workforce Assurance Committee. MIAA audit EDS 22 Q4.	None identified	WRES / EDS2022 action plans identify actions & timelines	Regular assessment of progress towards annual plan	Averse	Workforce	Medium	**9**	9	9			**6**	Year end

Corporate objective 8 - To work with others in promoting a sustainable environment and eliminating health inequalities																						
	Principal Risks	Exec Lead	Likelihood	Impact	Key Control established	Key Gaps in Controls	Current Risk Score	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Risk appetite (Averse / Cautious / Eager)	Responsible committee	Assurance level achieved (High / Medium / Low)	Opening Position	Position at end of Q1	Position at end of Q2	Position at end of Q3	Position at end of Q4	Target risk score	Target date for completion
8.1	Impact on our ability to obtain planning approval for future capital developments.	EDoF	2	3	Close working with Manchester City Council (MCC) planning and development issues as well as implementation of the Trust's green travel plan. Strategic planning framework approved which includes current and future requirements for travel to site. Regular communication with residents through the Neighbourhood Forum and newsletters and with local councillors. Agreement by MCC of strategic development plan and delivery of the Trust's 5 year Capital Plan delivery	None identified	**6**	Monitored through Management Board & Board of Directors. Capital programme shared with MCC and Board of Directors.	None identified	MCC aware of current and future plans and timelines. Planning team engaged in discussions alongside Neighbourhood Forum	Dates in line with capital plan	Cautious	Board		**6**	6	6			**3**	Year end
8.2	Not able to progress our role as an Anchor Institution	DoS	2	3	Engagement in relevant GM meetings	None identified	**6**	Monitored through Trust report to Board of Directors.	None identified	Continued attendance at relevant GM meetings	6 monthly review of progress	Cautious	Board		**6**	6	6			**3**	Year end
8.3	Failure to progress towards achievement of the NHS net zero Carbon targets through failure to achieve the annual milestones for The Christie set out in the Sustainable Development Management Plan (SDMT)	DCEO	4	2	Progress against SDMT plan regularly reported to Sustainability Committee and to Management Board as part of Integrated Performance Report. Progress against objectives overseen and reviewed by DCEO as Trust Net Zero lead. Board training on net zero Carbon arranged for November 2022	None identified	**8**	Progress against SDMT plan regularly reported to Board of Directors as part of Integrated Performance Report. Annual Report to Board of Directors. Oversight by Audit Committee	None identified	Actions outlined in SDMT with annual objectives	Annual milestones monitored monthly	Cautious	Audit	Mediu m	**8**	8	8			**4**	Year end
8.4	Reduced ability to provide services and support to patients due to national / global influences (supplies / fuel costs / industrial action)	COO	5	4	Industrial Action - close working with unions. Business continuity plans in place. Planning meetings in place around strike acton and incident management approach used. Management of demand. Risk assessments undertaken.	Impact of ongoing Industrial Action	**20**	Reports to Management Board and Board of Directors	Impact of ongoing Industrial Action	Detailed planning of patient demand and catch up. Staff cover planned. Liaision with unions and national team.	On going dependent on mandate to take action	Averse	Board		**9**	9	20			**10**	Year end
		DCEO	3	3	Group in place to review supply chain.	Global position. Lack of control for supply chain e.g. radioisotopes	**9**	Reports to Audit Committee	None identified	Escalations in place for supply issues through procurement team.	As appropriate dependent on issue	Cautious	Audit		**9**	9	9			**3**	Year end
8.5	Failure to adapt to climate change & other environmental factors e.g., floods / extreme temps / new pathogen	DCEO	3	3	Business continuity planning process in place. Plans tested and reviewed.	Uncertainty around what / when	**9**	Sustainable Development Plan in place and reported to Audit Committee	None identified	EPRR lead out to advert	Appointment to be made by end November 2023	Cautious	Audit	Medium	**9**	9	9			**3**	Year end

The Christie
NHS Foundation Trust

Agenda Item 37/23d

Board of Directors
Thursday 30th November 2023

Subject / Title	**Chair Objectives 2023/24**
Author(s)	Edward Astle, Chair
Presented by	Edward Astle, Chair
Summary / purpose of paper	This paper outlines the objectives for the Chair, Edward Astle for 2023/24.
Recommendation(s)	The Board are asked to note the Chairs objectives for 2023/24.
Background papers	N/A
Risk score	Reference to BAF Risk 7.4 Management of Board succession and appointment of new Chair / NEDs, risk score 9 (3/3)
Link to: ➢ Trust strategy ➢ Corporate objectives	• Trust's strategic direction • 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.	EDI equality, diversity, inclusion ICB Integrated Care Board NED non-executive director GGI Good Governance Institute CEO Chief Executive Office

The Christie
NHS Foundation Trust

Agenda Item 37/23d

Board of Directors meeting
Thursday 30th November 2023

Chair Objectives 2023/24

1. Gain sufficient understanding in first 3 months of
   - hospital operations/patient pathways
   - hospital and NHS finances
   - key Christie strategies and 2023/4 objectives (Workforce, EDI, research, education etc)
   - compliance and assurance processes

2. Ensure the appropriate balance in the Board's agenda between strategy, performance, governance and culture in order to oversee / support / challenge delivery of all key milestones in the current year, always ensuring that the patient interest comes first.

3. Ensure through the Board that the Christie is aligned with ICB priorities, exploring further collaboration opportunities across the region and leaning into the ICB's current financial situation without impacting on our core mission and 23/24 patient care targets.

4. Support the drive to develop a more inclusive culture across the organisation through;
   - my own behaviours; ensuring an open and supportive environment around the board table; and contributing my experience from elsewhere
   - seeking to increase the Board's diversity in terms of skills, background and protected characteristics in upcoming NED appointments and through longer term succession planning
   - ensuring Board oversight (directly and through Workforce Committee) of EDI, speak up and other relevant strategies, as reinforced by Globis (and any other) recommendations agreed by the Board.

5. Working with committee chairs, improve Board and wider governance and compliance processes in line with Board member feedback and GGI recommendations

6. Represent the board internally and externally and;
   - ensure visibility to a wide cross section of staff both informally and through attendance at key staff events
   - build relationships with key external stakeholders and represent The Christie at relevant external events.

7. Build a strong critical friend relationship with CEO, ensuring appropriate balance of challenge and support.

8. Explore ways to increase Council member engagement both in and beyond Council meetings.

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

- No serious incidents were reported in October. There were 2 incidents reported in month with the classification of moderate and one with the classification of minor, details of which can be found on slide 7. All the incidents are still progressing through to full root cause analysis. No never events were reported in month.
- There are 5 Trust level risks scored at 15+. Details of these can be found on slide 12.
- Safer staffing numbers have met the required acuity levels to ensure appropriate levels of safety and care for our patients. Indicative staffing, in line with nursing establishments, is set to maintain a 1:7 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, 5 cases of E-Coli, 1 case of Klebsiella, 1 case of Pseudomonas, 2 cases of MSSA and 1 case of MRSA bacteraemia in October that were deemed attributable to the Trust. No lapses in care have been identified.
- There were no nosocomial Covid-19 infection outbreaks affecting patients or staff members in October.

Performance

- In October the new combined 62-day performance subject to validation was at 65% which is below the new standard of 70%. The new combined 31-day performance was 97.3% which is above the new standard of 96%. The internal 24-day performance is also below standard and is at 67.6%. 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 be above the standard in November. The Trust's RTT 18-week performance is well above standard at 97.9% and the Trust has also achieved the 75% faster diagnosis standard with a compliance score of 90%. Performance against the CWT thresholds are constantly monitored, and action plans are in place to improve performance going forward.
- The one patient waiting over 52 weeks at the end of October has a pathway that includes several postponements and non-attendance delays due to patient choice. This patient has now been stepped off the pathway and referred back to their GP due to a lack of reasonable engagement with the service.
- Referral numbers in October increased from September and were also higher than October 2022. Overall YTD referral levels continue to remain higher than 22/23 levels.

HR

- Staff absence levels increased slightly from September to a position of 4.89% against a target of 3.4%.
- PDR performance and mandatory training performance have deteriorated from September's positions. Mandatory training performance remains well above the set standard.

Finance

- At month 7 the Trust is reporting a cumulative deficit of £2.8m compared to a forecast deficit of £4.7m, a variance against plan of £1.9m. The main reason for an improved position relates to interest received above plan and continued underspends on pay whilst growth vacancies are recruited to.
- The Trust has incurred £10.6m on capital schemes to month 7, primarily on the backlog maintenance programme, the linac and CT scanner replacements, Digital Services Electronic Health Records projects, final works on the Paterson scheme and the TIF ward.
- All Providers within GM have agreed to reduce annual capital spend against original plans by a proportionate amount as the original GM ICS plan was oversubscribed. The impact of this is a £2m reduction to original forecast planned capital spend for the Christie.

SUMMARY DASHBOARD

NHS
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Indicator	Threshold / Standard 23/24	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23		Oct-23	YTD
Serious Incident Reported	-	0	0	0	2	0	0		0	2
Never Events	0	0	0	0	0	0	0		0	0
Radiation Incidents Reported (IRMER Reportable)	0	2	1	0	0	0	0		0	3
Radiation Incidents Reported (IRMER Reportable - Grade 2 or above)	0	0	0	0	0	0	0		0	0
Number of Pressure Ulcers (Post admission - Grade 2 or above) - Rate per 1000 occupied bed days	0.4 (22/23 Avg)	0.2	0.4	0.2	0.2	0.8	0.6		0.2	-
Inpatient Falls Resulting in Harm (Grade 2 or above) - Rate per 1000 occupied bed days	3.6 (22/23 Avg)	2.6	4	4	2.7	2.9	4.4		5	-
VTE Assessments Completed	95.0%	98.0%	98.2%	98.8%	97.8%	98.6%	98.7%		98.3%	-
Sepsis - timely treatment with IV antibiotics (established inpatients)	90.0%	96.9%	95.1%	90.2%	92.2%	90.1%	97.7%		93.0%	-
Sepsis - screening (presenting as an emergency)	90.0%	95.0%	95.3%	98.7%	96.1%	96.0%	97.1%		95.1%	-
Number of Corporate Risks Grade 15 or Above	-	4	4	4	4	5	5		5	-
Safe Staffing (% of planned hours vs actual hours across all inpatient areas)	-	82.7%	87.4%	85.7%	86.5%	84.1%	87.8%		87.1%	-
28 Day Faster Diagnosis Standard	75.0%	50.00%	42.00%	53.00%	44.00%	50.00%	54.00%	75%	90.00%	-
62 Day Compliance	85.0%	71.30%	67.30%	70.30%	67.40%	73.70%	66.50%			-
62 Day Compliance - Upgrades	85.0%	67.10%	74.00%	87.90%	74.40%	75.50%	79.10%	70%	65.00%	-
62 Day Compliance - Screening	90.0%	75.00%	63.60%	100.00%	58.30%	33.30%	66.70%			-
24 Day Compliance	85.0%	73.80%	74.60%	76.60%	69.00%	75.50%	70.20%	85%	67.63%	-
31 Day Compliance	96.0%	97.80%	97.80%	96.70%	97.40%	98.90%	96.30%			-
31 Day Compliance - Subsequent Drug Therapy	98.0%	100.00%	100.00%	100.00%	100.00%	98.90%	99.20%	96%	97.30%	-
31 Day Compliance - Subsequent Radiotherapy	94.0%	99.20%	99.20%	100.00%	99.80%	98.80%	98.60%			-
31 Day Compliance - Subsequent Surgery	94.0%	98.80%	100.00%	98.60%	100.00%	98.90%	96.90%			-
18 Weeks Compliance - Incomplete Pathways	92.0%	96.50%	96.91%	97.50%	97.80%	98.00%	98.30%	92%	97.91%	-
Patients waiting >52 Weeks	0	1	1	1	1	2	2		1	9
Patients waiting >62 days at end of month (62 Day Classic)	80	89	84	102	109	105	114		114	-
Patients waiting >104 days at end of month (All 62 Day Targets)	-	34	42	44	46	40	52		64	-
Length Of Stay (Elective & Non-Elective Inpatients)	-	7.77	7.1	6.59	7.02	6.99	8.04		7.30	-
Patients Discharged Beyond Ready for Discharge Date	-	*Reporting commenced last week of Aug*				1	18		8	27
Patients Discharged Beyond Ready for Discharge Date - Total Bed Days Lost (days counted in the month of discharge)	-					9	172		63	244
Patients Discharged Beyond Ready for Discharge Date - Average Bed Days Lost (days counted in the month of discharge)	-					9	9.6		7.9	9.0
Hospital Cancelled Operations on the day for non clinical reasons	0	2	4	2	5	9	0		12	34
Hospital Cancelled Operations on the day for non clinical reasons - NOT rebooked within 28 days	0	0	1	1	1	0	0		0	3
Complaints Received	14 (22/23 Avg)	11	11	11	12	19	5		12	81
PALS Contacts	44 (22/23 Avg)	46	51	42	35	42	42		37	295
Inquests	-	2	5	2	2	1	2		0	14
Coroner Request	-	11	12	4	3	4	3		3	40

SUMMARY DASHBOARD

NHS
The Christie
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Indicator	Threshold / Standard 23/24	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	YTD
MRSA	0	1	0	0	1	0	0	1	3
C-Difficile - All Attributable Cases (Pre & Post 48 Hours)	51	2	3	4	4	3	4	5	25
C-Difficile - Attributable Cases Due To Lapse In Care	0	0	0	0	0	0	0	0	0
MSSA Bacteraemia - Attributable	25	1	1	1	2	4	2	2	13
E-Coli - Attributable	58	5	4	7	6	8	2	5	37
Klebsiella Species - Attributable	17	4	2	0	1	2	2	1	12
Pseudomonas Aeuriginosa - Attributable	10	1	0	2	1	1	2	1	8
COVID infections - Hospital Aquired	0	2	1	0	0	7	8	0	18
Palliative Radiotherapy 30 Day Suvival Rate	-	92.0%	91.5%	91.8%	87.1%	91.5%	93.5%	-	-
Final Chemotherapy 30 Day Survival Rate	-	98.9%	99.3%	99.5%	99.4%	99.4%	99.3%	-	-
Surgery 30 Day Survival Rate	-	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	-	-
Staff Sickness	3.4%	4.09%	4.03%	3.87%	4.29%	4.35%	4.58%	4.89%	-
Staff Mandatory Training	>80%** <80%	89.4%	92.1%	92.9%	91.9%	92.2%	91.2%	90.7%	-
Staff PDRs	-	84.7%	84.5%	85.6%	85.9%	86.5%	85.2%	84.5%	-

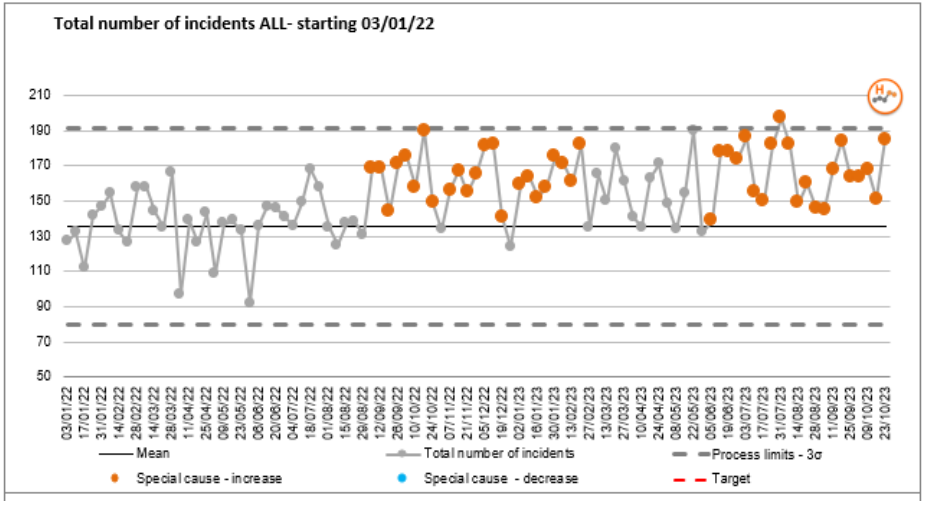
Compliance if <80% & risk assessment in place

****Data unavailable for the whole month due to being out of sync with SUS reporting. Data will be backdated and refreshed each month.***

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

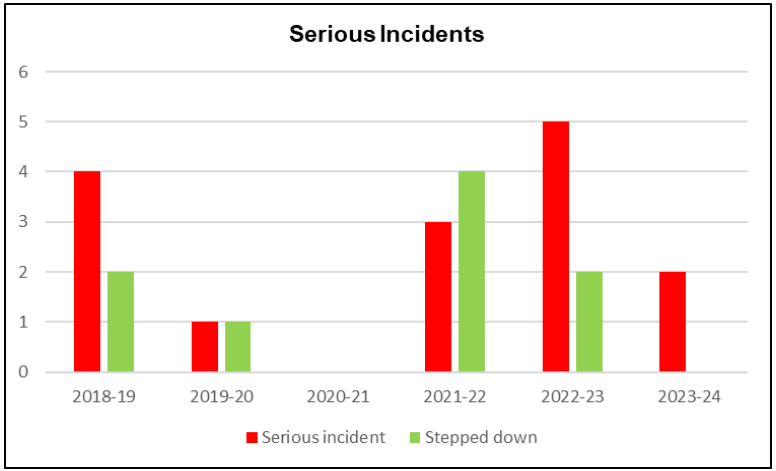
Due to the differences in reporting periods and the specification and measurement of the metrics involved, from next month the indicators highlighted in the above dashboard will also be presented alongside other indicators in a separate scorecard.

Incident Reporting



The Trust experienced a reduction in incident reporting throughout the period July 2020 to July 2022 due to the COVID-19 Pandemic, it is felt that the last 6 month increases in incident reporting are recovery to pre pandemic levels of incident reporting as well as proportionate to activity increasing.

Serious Incidents and Never Events



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

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

Serious incidents
There were no serious incidents identified in October 2023.

Incidents identified that require a Learning Response

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October 2023 – RCA identified through PSIG/ERG

Reference	Description	Reported Harm Level
W80756	Patient identified as being lost to follow up following last cycle of chemotherapy in 2019 (identified through lost to follow up work)	Moderate
W81016	Patient uncontactable to receive results of urine sample after presenting 4 days prior with symptoms of a urine infection. Team escalated to safeguarding as GP surgery did not wish to do welfare check. Safeguarding practitioner attended patient home but was not able to locate patient. The patient was admitted to local Emergency Department after a fall at home.	Moderate
W80813	Patient incorrectly administered IV actrapid instead of prescribed vancomycin resulting in hypoglycaemia	Minor

Learning - Patient Safety Incidents

The Christie NHS Foundation Trust

Agreed learning and revised severity outcome following executive reviews October 2023

Ref	Description	Root cause	Learning	Outcome
W77270	Patient commenced concurrent radiotherapy alongside Chemotherapy. Actinomycin chemotherapy should be omitted from any chemotherapy cycles delivered during radiotherapy. Actinomycin was not crossed off the prescription and so was administered. This resulted in early emergence of radiotherapy toxicity but did not impact ongoing treatment.	Actinomycin was not omitted from the chemo cycles delivered concomitant to radiotherapy, actinomycin was not crossed off the prescription as required	• Question to be added on the radiotherapy booking form to check whether the patient is on actinomycin and whether it had been stopped. • Incident to be discussed at Team Board round. • Restriction of Actinomycin to be prescribed by named individuals	Moderate
W78087	Concern raised that Meta Pixel technology may have been processing identifiable data of individuals visiting the trust website.	Trusting in the Subject Matter Expert without additional knowledge locally of risks around cookies application resulted in the Meta Pixel being places across the Trust website, and not specifically to the campaign page(s) as intended.	• Lack of knowledge by Trust staff on risks of installing Cookies to the trust website • The Trust website hosting platform is shared by the Christie and the Charity • Methodology required to remove redundant cookies/meta pixels/widgets implemented for specific short-term purposes. • Review potential to reset the need for a visitor to the trust website to reset their preferences of cookie usage – for example every 12 months	No Harm

Learning - Patient Safety Incidents

NHS
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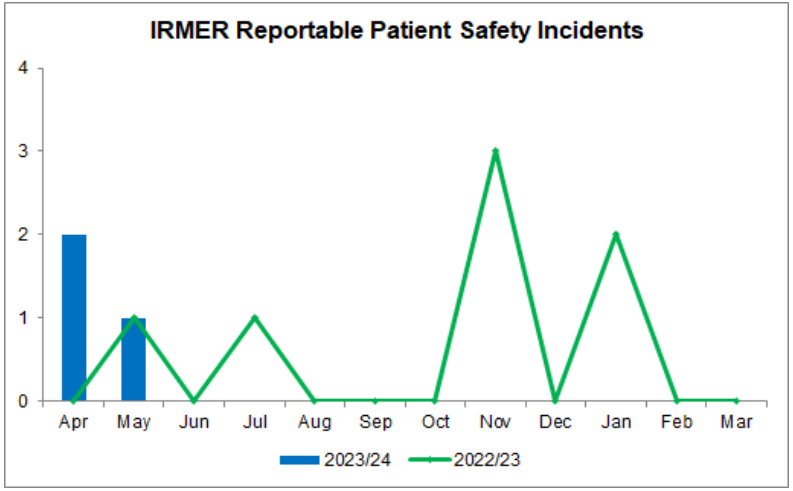
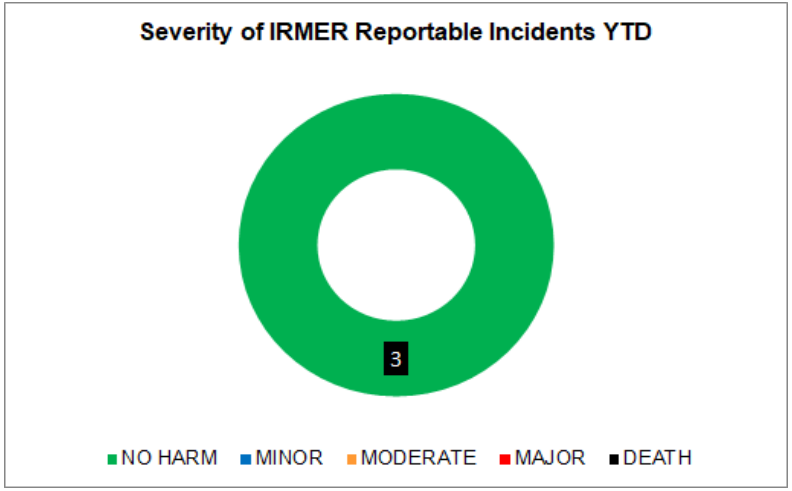
NHS Foundation Trust

Agreed learning and revised severity outcome following executive reviews October 2023

Ref	Description	Root cause	Learning	Outcome
W75835	Several issues identified by Trust staff occurring across the iQemo-Baxter chemotherapy e-ordering interface for the Trusts electronic prescribing system for SACT.	Review by iQemo team of the messages via the Interface Engine (IE) between the iQemo system (Trust side) and the Baxter Merlin system revealed a number that had not received a response from The Christie Baxter Interface channel. Report of affected prescriptions provided to the pharmacy EP team	• Improved logging and alerting for the Baxter interface Integration Engine to alert should a failure to create an HL7 message file be encountered. • Baxter interface testing between iQemo and Baxter merlin system as part of Azure migration testing. • System migration to new hosting infrastructure (Azure) • Testing of Azure development on 'test' system, full UAT & RBT test. Review and sign off for the testing programme. Project team to agree upgrade date for trust system.	Moderate
W79846	Post surgery patient developed acute delirium. During episodes of hyper delirium that patient became agitated and became aggressive to staff.	Staff attempted to de-escalate and assist patient but unfortunately 2 members of staff sustained injuries.	• Case to be shared in discussed in the learning bulletin. • Clinical team to share learning from investigation • To share investigation with health and safety committee and patient safety committee to review existing policies, procedures and training	Moderate injury to staff

Radiation Incidents





There were no IRMER reportable patient safety incident in October.

Harm Free Care

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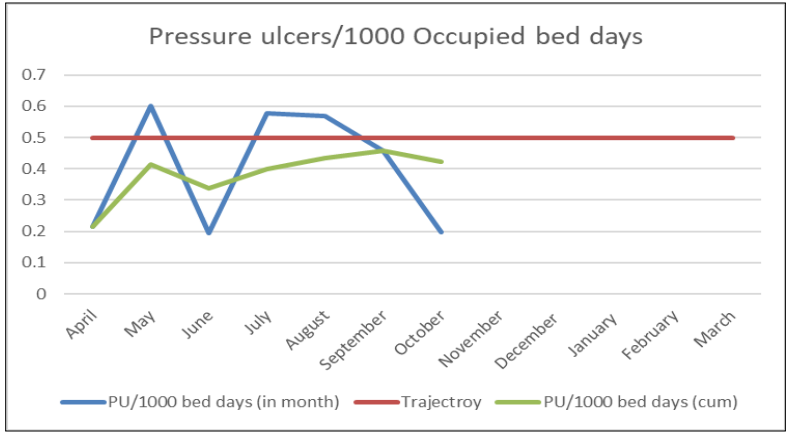
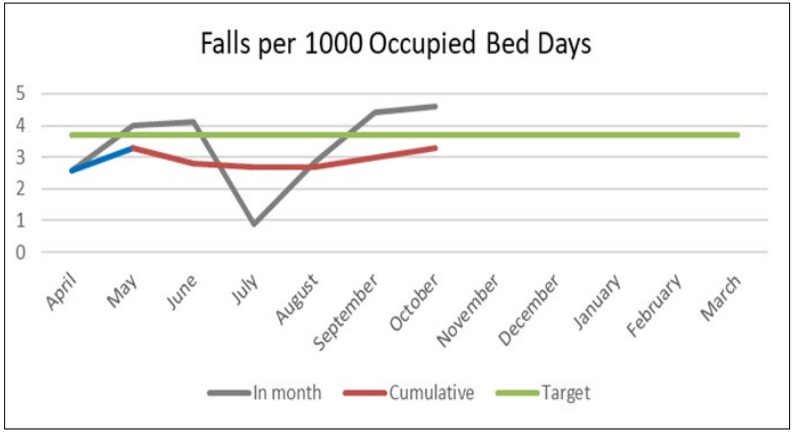
Pressure ulcers per 1000 occupied bed days



0.19 pressure ulcers per 1000 occupied bed days in month.
Rolling average remains less than internal ambition of 0.5 or less AT 0.42.
No category 3 or above pressure ulcers in month

Falls per 1000 occupied bed days



4.6 falls per 1000 occupied bed days in month
Rolling average is 3.3 which is below Trust ambition of 3.7, and national average of 6.6
No moderate or above harm falls in October.

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

Corporate Risks

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There are 5 Trust-wide 15+ risks in October

Description	Score	Controls
Financial Risk 2023-24 (ID 3378)	16	M2 outturn is a deficit of £0.9m against a deficit plan of £1.3m so ahead of plan but still a financial deficit. Recurrent CIP of £0.7m has been identified against an annual target of £6.4m which will remain a challenging target. Capital plans still to be finalised.
Post clinic appointments processes are contributing to a risk to patients being lost to follow up (ID 3299)	15	Work continues on action plan, working with MIAA to assess actions and assurance. Work continues on developing the wait list and all teams are working through the Open referrals.
Risk to delayed cancer referral and treatments due to not meeting 24 / 62 day target (ID 2407)	15	Action plan in place. Service leads and heads of service working on capacity and pathways
There is a risk that patients may experience harm due to significant delays in the management of patients with penile cancer (ID 3319)	16	Awaiting confirmation on start dates for new Consultants. Additional Penile Theatre lists on Fridays. Clinics overbooked to accommodate patients. Bi Weekly Extended Thursday Theatre session for Penile work
There is a risk that the IPU Endoscopy could lose JAG accreditation by not being able to maintain the standards for environment (ID 3534)	15	JAG standard states that Endoscopy patients' privacy and dignity be maintained throughout the endoscopy patient pathway on IPU. Patient pathways adapted to maintain this, and staff escort all patients transferred through clinical areas.

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	17870	13349	5163	5.5
	Total monthly ACTUAL	15872	12275		
	Average Fill Rate %	88.8%	92.0%		
Care Staff	Total monthly PLANNED	10702	6161	5163	2.7
	Total monthly ACTUAL	8247	5496		
	Average Fill Rate %	77.1%	89.2%		
ALL Staff	Total monthly PLANNED	28572	19510	5163	8.1
	Total monthly ACTUAL	24119	17772		
	Average Fill Rate %	84.4%	91.1%		

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	2243	1977	88.2%	2092	1813	86.7%	142	26.7
Palatine Ward	3469	3118	89.9%	2683	2182	81.3%	909	5.8
Ward 10	2492	2142	86.0%	1625	1575	96.9%	745	5.0
Ward 11	1869	1786	95.5%	1555	1509	97.1%	867	3.8
Ward 12	1835	1869	101.8%	1575	1584	100.6%	847	4.1
Ward 4	2110	1908	90.4%	1484	1466	98.8%	852	4.0
Ward 2	1022	812	79.5%	518	507	97.9%	250	5.3
Acute Assessment Unit	2830	2260	79.9%	1819	1639	90.1%	551	7.1
TOTAL	17870	15872	88.8%	13349	12275	92.0%	5163	5.5

Registered Nursing Associates	DAY			NIGHT		
	Hours Planned	Hours Actual		Hours Planned	Hours Actual	
Critical Care Unit						
Palatine Ward		7		58	58	
Ward 10						
Ward 11					24	
Ward 12		31			7	
Ward 4		49			35	
Ward 2						
Acute Assessment Unit						

Care Staff	DAY			NIGHT			Cumulative count over the month of patients at 23:59 each day	CHPPD (Care Hours Per Patient Per Day)
	Hours Planned	Hours Actual	% Fill Rate	Hours Planned	Hours Actual	% Fill Rate		
Critical Care Unit	538	382	70.9%	0	23	100.0%	142	2.8
Palatine Ward	1387	1069	77.1%	1139	1004	88.1%	909	2.3
Ward 10	2044	1218	59.6%	756	566	74.8%	745	2.4
Ward 11	1713	1232	71.9%	998	974	97.5%	867	2.5
Ward 12	1722	1472	85.5%	1125	1099	97.7%	847	3.0
Ward 4	1490	1542	103.5%	1127	1121	99.4%	852	3.1
Ward 2	521	433	83.0%	276	235	85.1%	250	2.7
Acute Assessment Unit	1288	900	69.9%	740.5	476	100.0%	551	2.5
TOTAL	10702	8247	77.1%	6161	5496	89.2%	5163	2.7

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

Patient Experience

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Positive feedback received…..

"To all the staff at Ward 10. There really are no words to describe your care love and attention to Len. We as a family have been touched by your kindness, love and support to us too. You go above and beyond what is required. Our family will always be grateful to every single one of you. You are simply the best."

"Many thanks for the attention and first class care I had while under your care at The Christie , everyone on your team were fantastic."

"My mum came in to look at wigs today and Emily helped her find something she was happy with. She was so helpful and kind, really putting my Mum at ease. I just wanted to pass this on as it made such a difference to my Mum during what is quite a difficult period of time for her. She's been quite self-conscious of her hair loss and I can tell just how much more confident she feels now she can go out looking and feeling 'normal' again. Thank you!"

"To all my lovely nurses, NCA's, physios and dieticians, thank you all so much for the wonderful care you have all shown to me over the past week, you are all amazing. This operation is probably the biggest thing I have faced in my life so far and your absolute dedication to your work under pressure has seen me through. I feel so privileged to have received this standard of care. Wish you all the very best for the future."

Friends & Family Test

The Christie NHS Foundation Trust

Monthly Summary

	INPATIENT & DAYCASE RESPONSES						Total Number of people eligible to respond	Total Responses	Response Rate	% Recommended
	1 - Very Good	2 - Good	3 - Neither Good nor Poor	4 - Poor	5 - Very Poor	6 - Don't Know				
Apr-23	207	27	4	0	2	1	780	241	30.9%	97.10%
May-23	280	20	1	2	0	1	926	304	32.8%	98.68%
Jun-23	247	24	6	2	3	0	927	282	30.4%	96.10%
Jul-23	223	23	2	1	2	1	810	252	31.1%	97.62%
Aug-23	222	8	3	3	1	0	841	237	28.2%	97.05%
Sep-23	208	25	8	2	4	1	894	248	27.7%	93.95%
Oct-23	237	26	4	4	2	0	827	273	33.0%	96.34%
YTD Total	1624	153	28	14	14	4	6005	1837	30.59%	96.73%

	OUTPATIENT RESPONSES						Total responses	% Recommended
	1 - Very Good	2 - Good	3 - Neither Good nor Poor	4 - Poor	5 - Very Poor	6 - Don't Know		
Apr-23	1348	165	38	19	10	18	1598	94.68%
May-23	1336	166	52	18	13	12	1597	94.05%
Jun-23	1458	181	54	23	21	20	1757	93.28%
Jul-23	1310	148	35	16	13	16	1538	94.80%
Aug-23	1215	167	29	14	10	16	1451	95.24%
Sep-23	1396	140	40	17	5	19	1617	94.99%
Oct-23	1606	170	47	17	7	9	1856	95.69%
YTD Total	9669	1137	295	124	79	110	11414	94.67%

Ward name	INPATIENT & DAYCASE RESPONSES - BY WARD						Total Number of people eligible to respond	Total responses for each ward	Response rate for each ward
	1 - Very Good	2 - Good	3 - Neither Good nor Poor	4 - Poor	5 - Very Poor	6 - Don't Know			
04 Ward (Dept 52)	13	4	0	0	0	0	78	17	21.8%
10 Ward-Surg Onc Unit (Dept 4)	36	7	0	2	0	0	142	45	31.7%
11 Ward (Dept 4)	3	0	1	0	0	0	53	4	7.5%
12 Ward (Dept 4)	8	1	0	0	1	0	79	10	12.7%
The BMR Unit (Dept 16)	10	0	0	0	0	0	34	10	29.4%
Endocrine Ward (Dept 63)	10	1	0	0	0	0	28	11	39.3%
Haematology Day Unit (Dept 26)	38	4	1	0	0	0	106	43	40.6%
Integrated Procedure Unit (Dept 2)	109	9	2	2	1	0	224	123	54.9%
Palatine Ward (Dept 27)	8	0	0	0	0	0	62	8	12.9%
CTU Inpatient Ward (Dept 1)	2	0	0	0	0	0	21	2	9.5%
Total	237	26	4	4	2	0	827	273	33.0%

Cancer Standards

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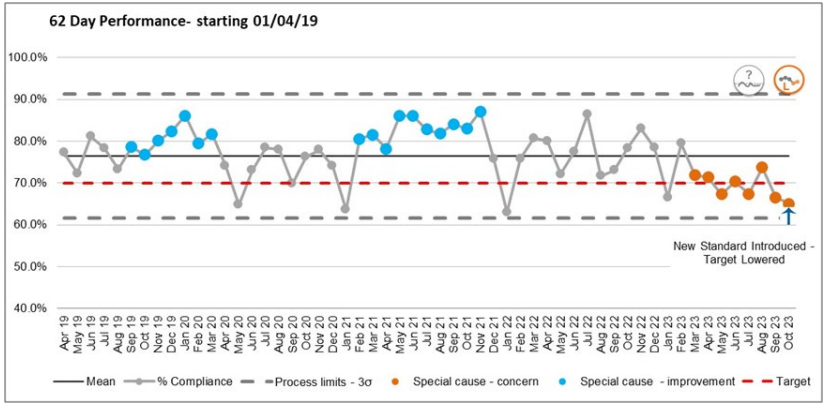
NHS Foundation Trust

62 Day / 31 Day / 18 Weeks



National Standard	Standard	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	New Standard	Oct-23
62 Day	85%	71.30%	67.30%	70.30%	67.40%	73.70%	66.50%	70%	65.00%
62 Day Upgrades	85%	67.10%	74.00%	87.90%	74.40%	75.50%	79.10%		
62 Day Screening	90%	75.00%	63.60%	100.00%	58.30%	33.30%	66.70%		
24 Day Internal	85%	73.80%	74.60%	76.60%	69.00%	75.50%	70.20%	85%	67.63%
31 Days	96%	97.80%	97.80%	96.70%	97.40%	98.90%	96.30%	96%	97.30%
31 Day Subsequent Drug	98%	100.00%	100.00%	100.00%	100.00%	98.90%	99.20%		
31 Day Subsequent XRT	94%	99.20%	99.20%	100.00%	99.80%	98.80%	98.60%		
31 Day Subsequent Surgery	94%	98.80%	100.00%	98.60%	100.00%	98.90%	96.90%		
18 Weeks - Incomplete Pathways	92%	96.50%	96.91%	97.50%	97.80%	98.00%	98.30%	92%	97.91%

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

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		Oct
50% Shared Breach		77
50% Shared Compliance		101
Full Christie Breach		13
FULL Christie Compliance		45
FULL Referring Provider Breach		113
Grand Total		349
62 Combined		65.0%
24 Day Compliance		67.63%
31 Day	Breach	17
	Compliance	341
31 day - Subsequents	Breach	17
	Compliance	894
31 day - Combined	Breach	34
	Compliance	1,235
31 day - Combined		97.3%

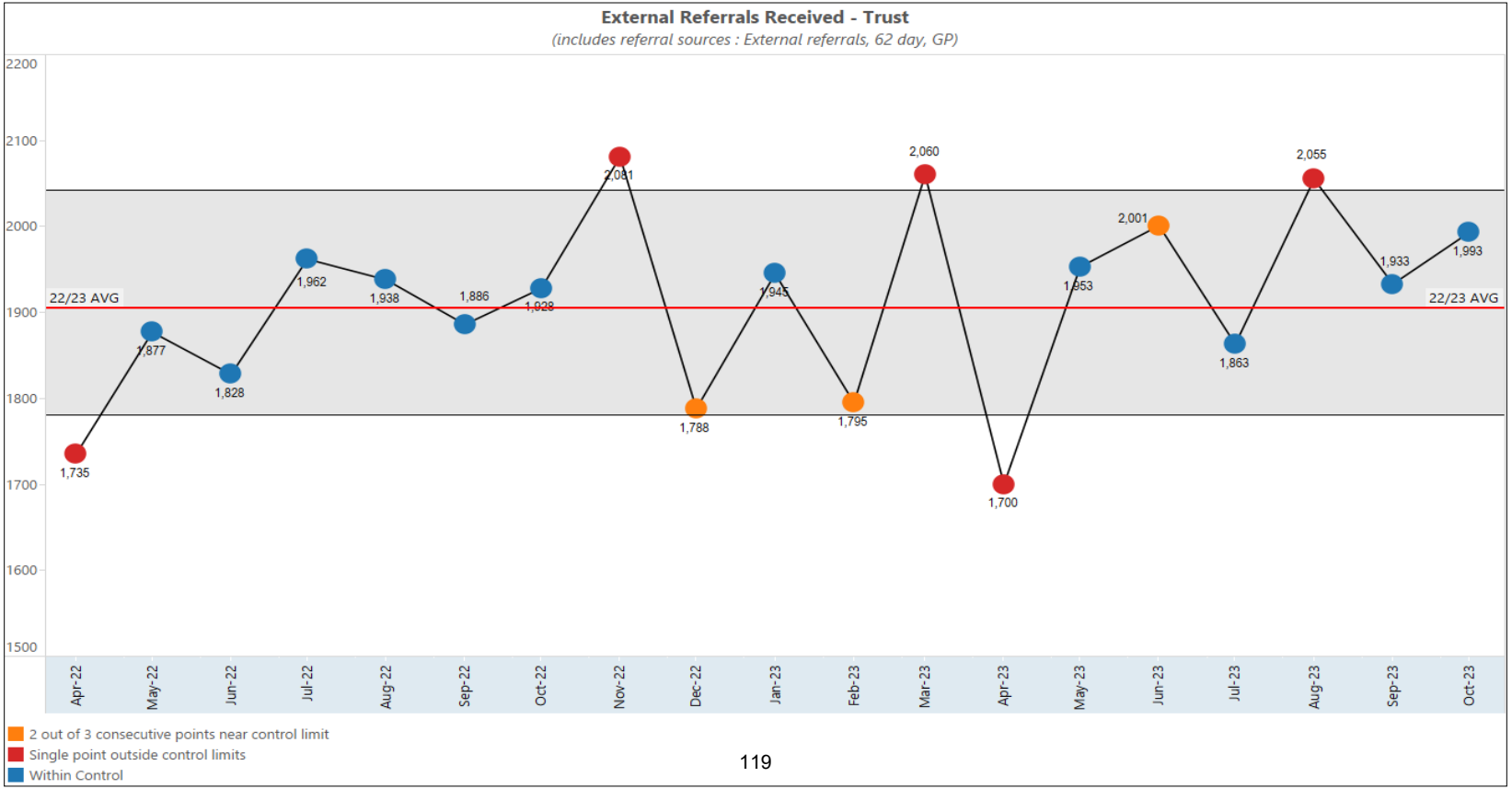
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
28 Day Faster Diagnosis (standard 75%)	Compliances	2	5	10	8	5	7	18
	Breaches	2	7	9	10	5	6	2
	%	50%	42%	53%	44%	50%	54%	90%

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

****Patients with no date are measured up to the date of reporting***

Referrals Analysis

The Christie NHS Foundation Trust



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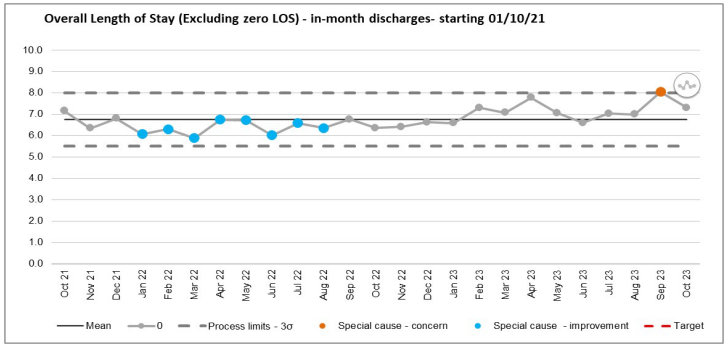
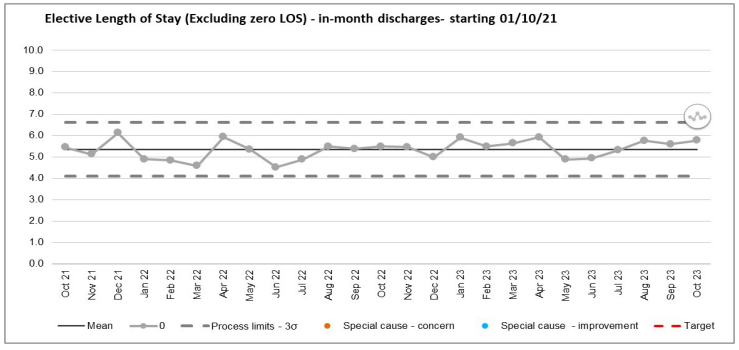
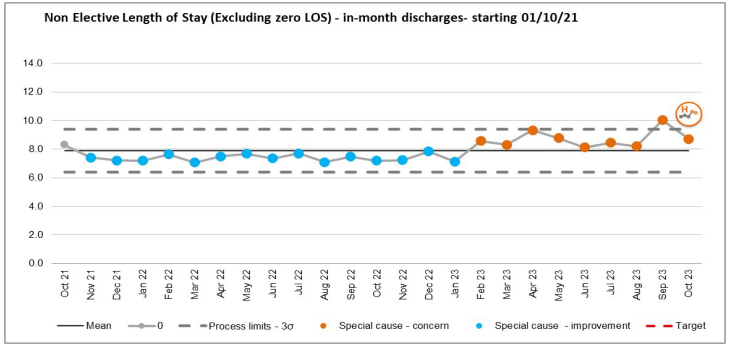
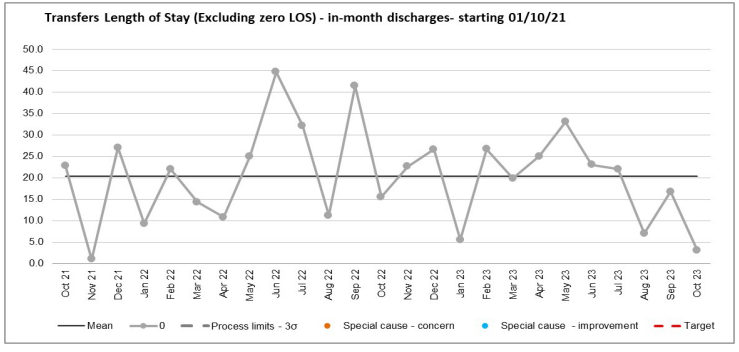
Length of Stay



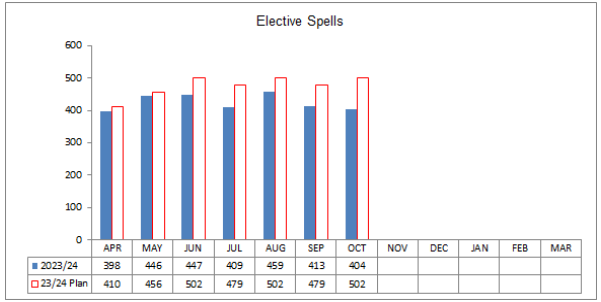




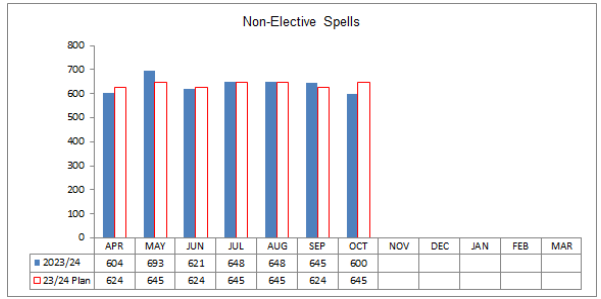


Elective, transfer patients and overall length of stay continues to be well within control limits – note special cause variation increase in non-elective LoS impacting on flow.

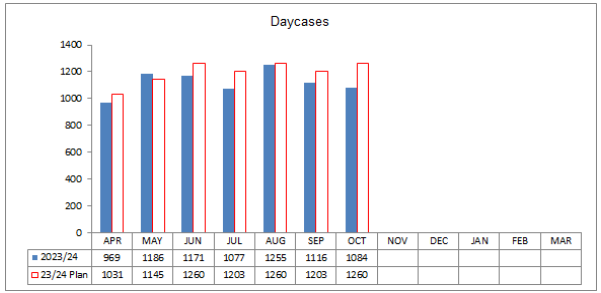
Activity



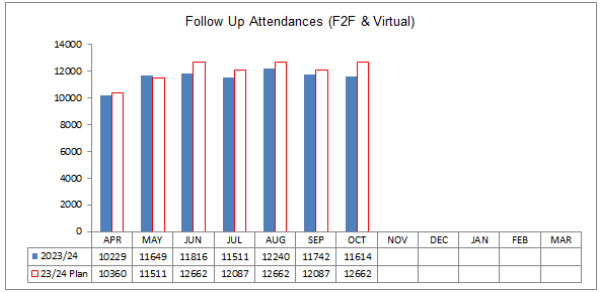
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	398	446	447	409	459	413	404					
23/24 Plan	410	456	502	479	502	479	502					



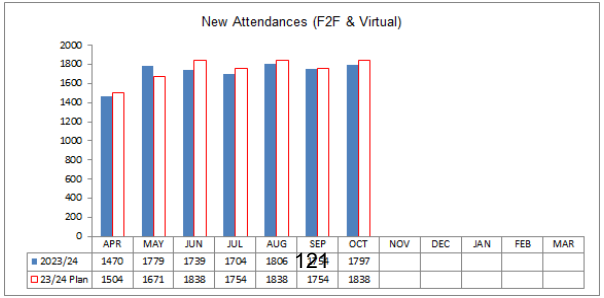
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	604	693	621	648	648	645	600					
23/24 Plan	624	645	624	645	645	624	645					



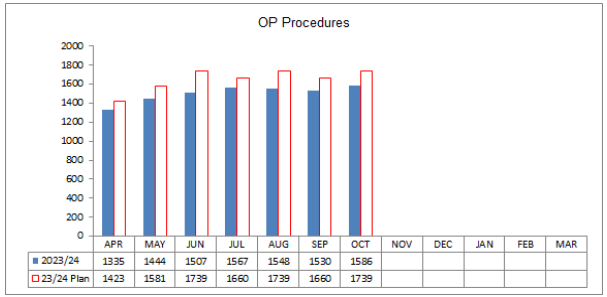
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	969	1186	1171	1077	1255	1116	1084					
23/24 Plan	1031	1145	1260	1203	1260	1203	1260					



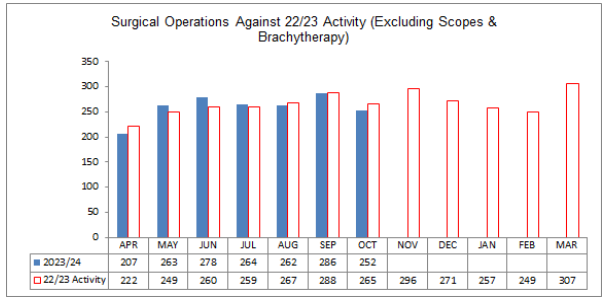
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	10229	11649	11816	11511	12240	11742	11614					
23/24 Plan	10360	11511	12662	12087	12662	12087	12662					



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	1470	1779	1739	1704	1806	1754	1797					
23/24 Plan	1504	1671	1838	1754	1838	1754	1838					

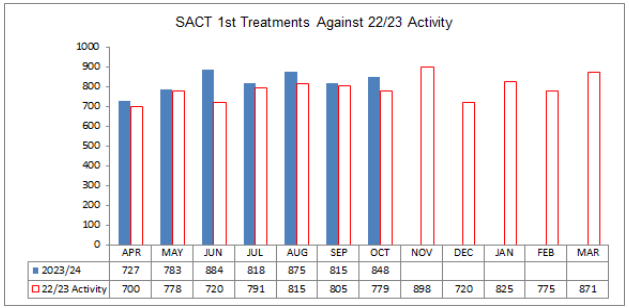


	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	1335	1444	1507	1567	1548	1530	1586					
23/24 Plan	1423	1581	1739	1660	1739	1660	1739					

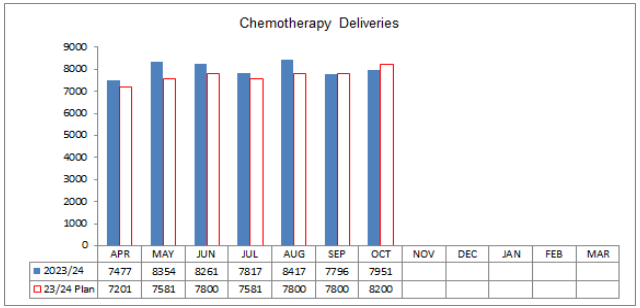


	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	207	263	278	264	262	286	252					
22/23 Activity	222	249	260	259	267	288	265	296	271	257	249	307

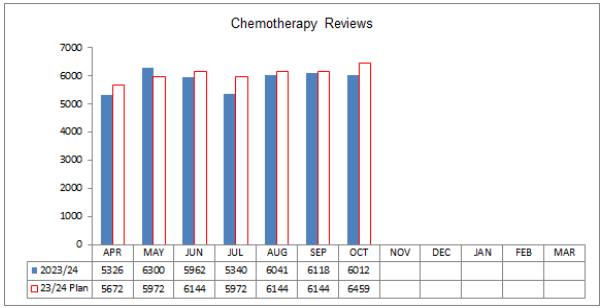
Activity



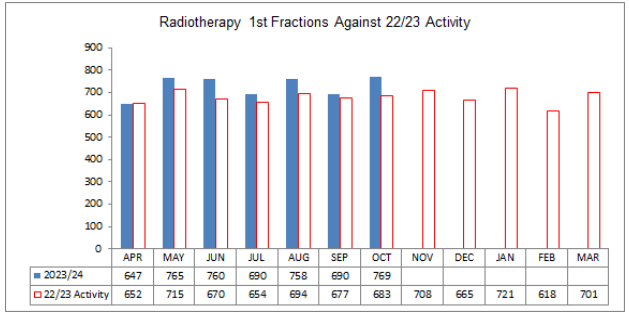
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	727	783	884	818	875	815	848					
22/23 Activity	700	778	720	791	815	805	779	898	720	825	775	871



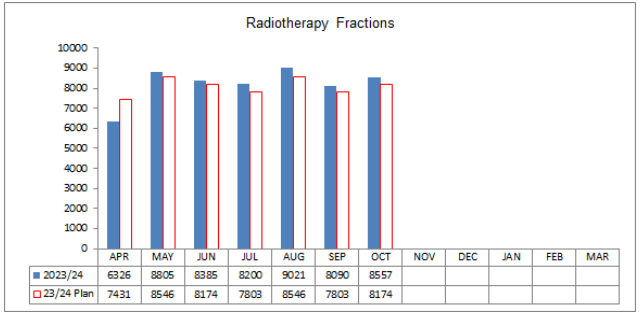
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	7477	8354	8261	7817	8417	7796	7951					
23/24 Plan	7201	7581	7800	7581	7800	7800	8200					



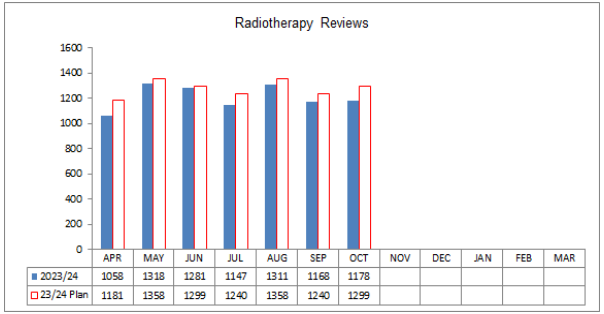
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	5326	6300	5962	5340	6041	6118	6012					
23/24 Plan	5672	5972	6144	5972	6144	6144	6459					



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



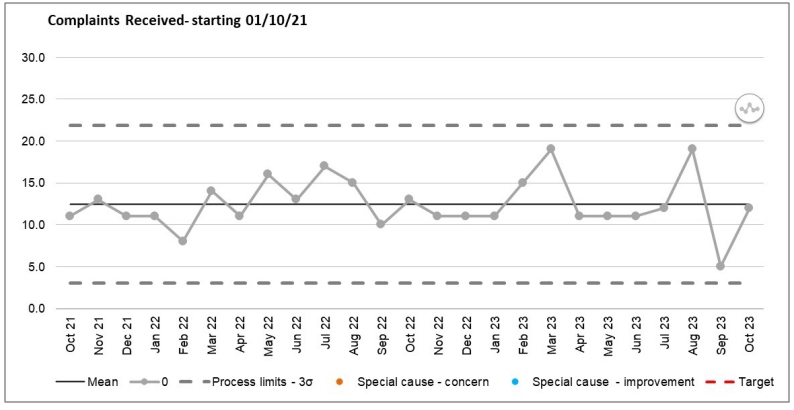
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	6326	8805	8385	8200	9021	8090	8557					
23/24 Plan	7431	8546	8174	7803	8546	7803	8174					

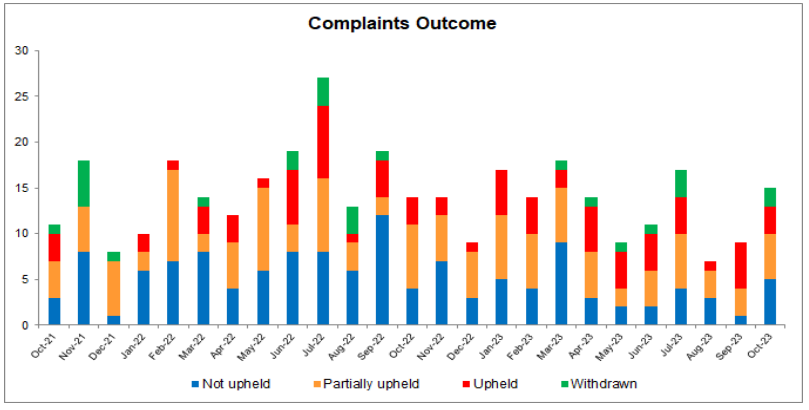


	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	1058	1318	1281	1147	1311	1168	1178					
23/24 Plan	1181	1358	1299	1240	1358	1240	1299					

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

Complaints



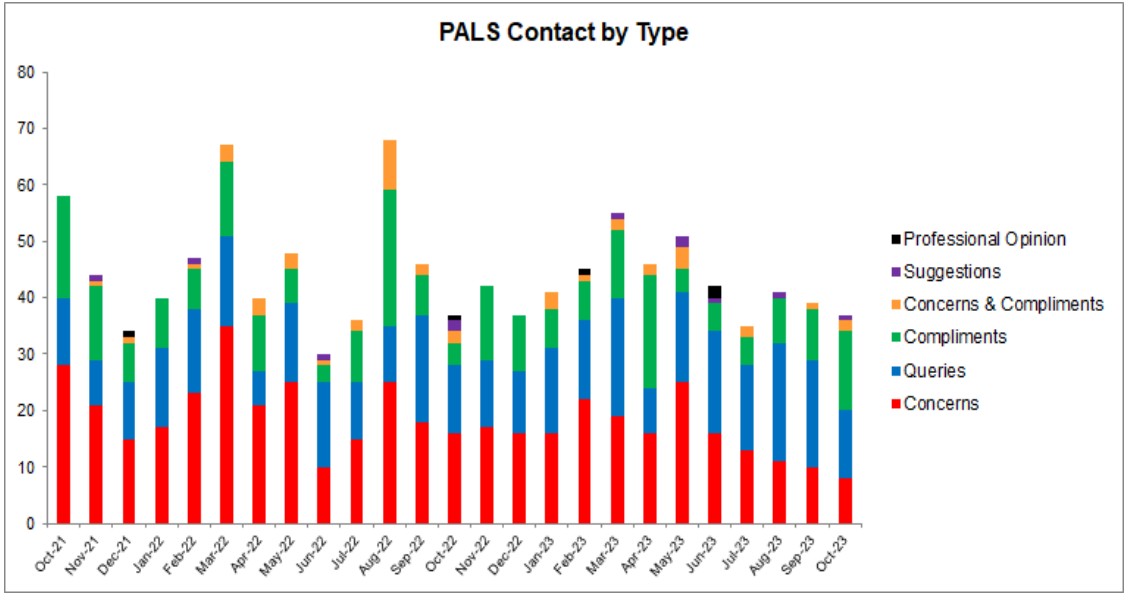


12 new complaints received in October 2023

15 complaints were closed in October 2023

Ombudsman Cases
Complainants have the right to refer their case to the Parliamentary and Health Service Ombudsman (PHSO) if they are not satisfied it has been resolved by the Trust. 0 case was referred to the PHSO in October 2023. 1 case closed. 5 cases in total with the PHSO.

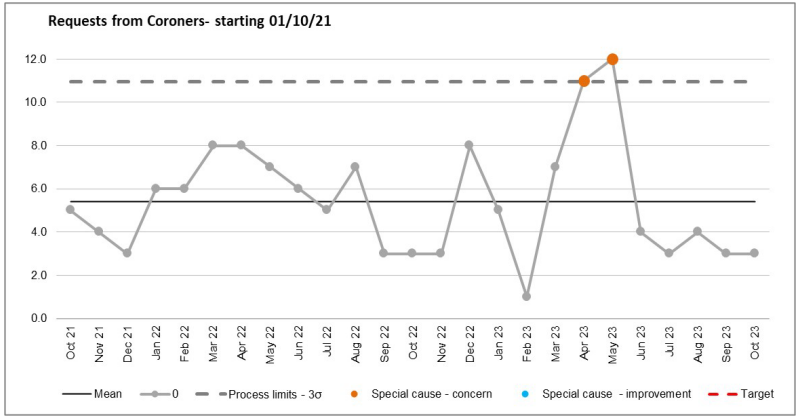
PALS

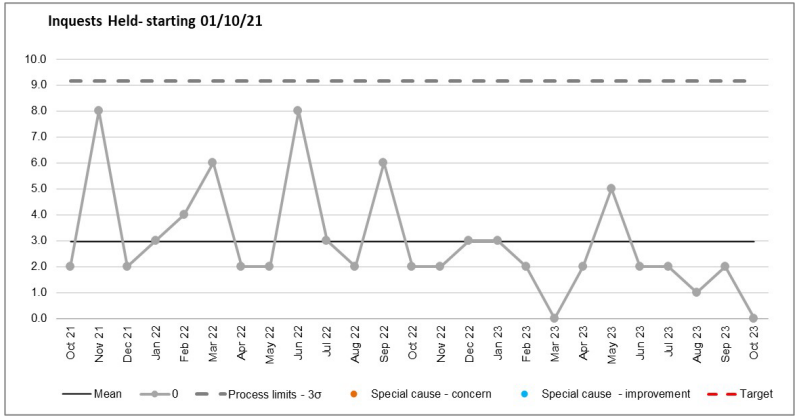


37 PALS contacts have been received in October 2023.

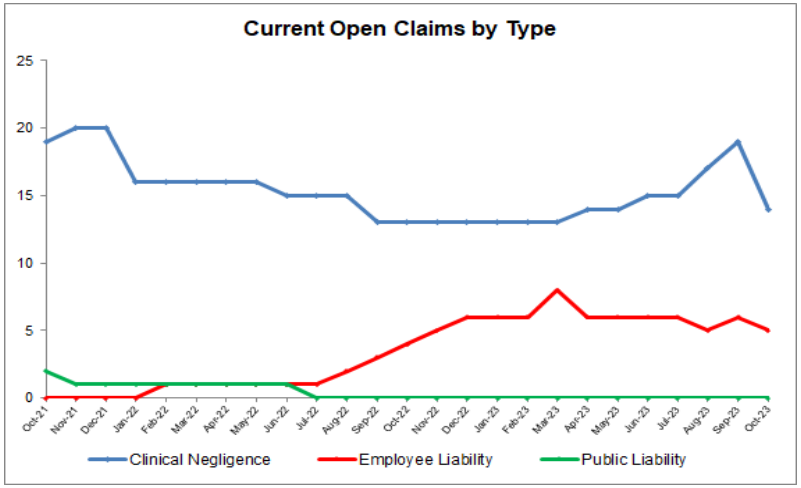
8 of those raised concerns about their experience at The Christie but did not wish to proceed with a formal complaint. The other reasons for contacting PALS are captured in the graph.

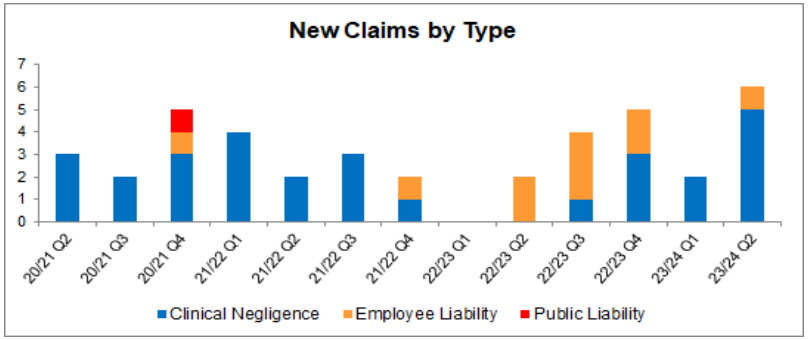
Inquests


Requests from Coroners- starting 01/10/21
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22
Oct 22
Nov 22
Dec 22
Jan 23
Feb 23
Mar 23
Apr 23
May 23
Jun 23
Jul 23
Aug 23
Sep 23
Oct 23
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


Inquests Held- starting 01/10/21
10.0
9.0
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22
Oct 22
Nov 22
Dec 22
Jan 23
Feb 23
Mar 23
Apr 23
May 23
Jun 23
Jul 23
Aug 23
Sep 23
Oct 23
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

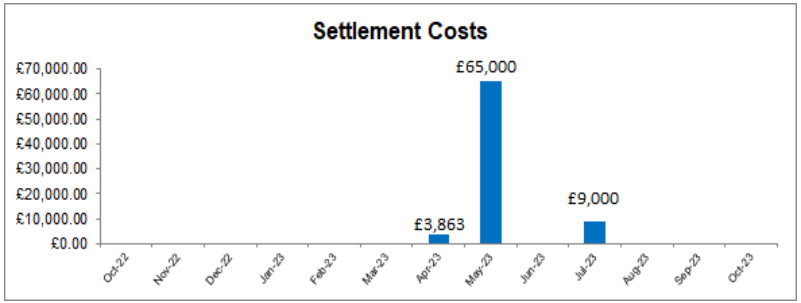
Claims





0 new claims received in October 2023.

6 claims settled in October 2023.
associated costs will be updated in next month's report when finalised



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Healthcare Associated Infections

NHS
The Christie
NHS Foundation Trust

Curent Month	Community Onset - Indeterminate Acquisition (COIA)	Community Onset - Community Acquired (COCA)	Community Onset - Healthcare Acquired (COHA)	Healthcare Onset - Healthcare Acquired (HOHA)	Lapses in Care	Area(s) Occurred
Clostridium Difficile	1	1	2	3	0	(PW x1) (W11 x1) (W10 x1) (W12 x1) (W4 x1)
E.coli Bacteraemia		4	1	4	0	(W10 x2) (W11 x1) (W4 x1) (IPU x1)
Klebsiella spp.		2	1		0	(Procedures x1)
Pseudomonas aeruginosa bacteraemia		2		1	0	(PW x1)
MSSA Bacteraemia		1	1	1	0	(W11 x1) (Procedures x1)
MRSA Bacteraemia				1	0	(PW x1)

YTD	Community Onset - Indeterminate Acquisition (COIA)	Community Onset - Community Acquired (COCA)	Community Onset - Healthcare Acquired (COHA)	Healthcare Onset - Healthcare Acquired (HOHA)	Lapses in Care
Clostridium Difficile	4	8	9	16	0
E.coli Bacteraemia		20	16	21	0
Klebsiella spp.		8	8	4	0
Pseudomonas aeruginosa bacteraemia		4	3	5	0
MSSA Bacteraemia		6	7	6	0
MRSA Bacteraemia			2	1	0

Organism	COVID 19 first positive 3 – 7 days from admission (HO-iHA)	COVID 19 first positive 8 – 14 days from admission (HO-pHA)	COVID 19 first positive 15 or more days from admission (HO-dHA)	TOTAL (YTD)	Lapses in care
COVID-19	5	9	11	25	0

Organism	Number of Cases (YTD)	Lapses in care
CPE colonisation / infection	5	0

There were 5 cases of C-Difficile, 5 cases of E-Coli, 1 case of Klebsiella, 1 case of Pseudomonas, 2 cases of MSSA and 1 case of MRSA bacteraemia in October that were deemed attributable to the Trust. **No lapses in care have been identified.**

Definitions

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

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

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

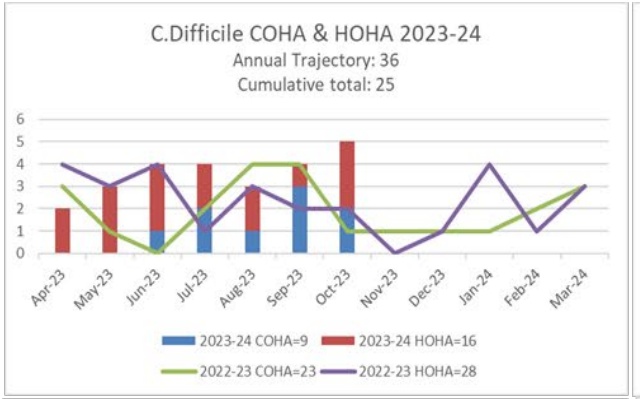
COHA - Symptoms commenced within first two days of admission and inpatient in the past 12 weeks (but not past 4 weeks)

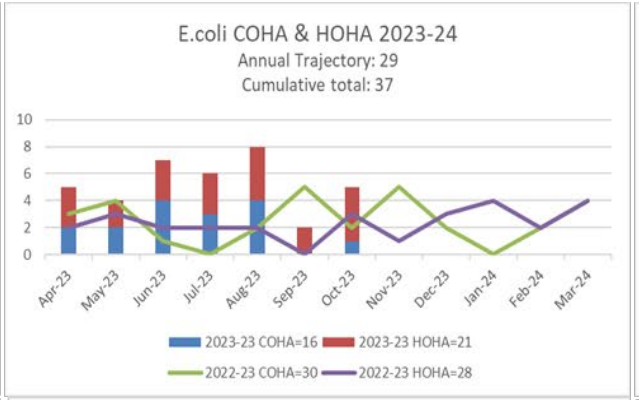
HOHA - Symptoms commenced within first two days of admission (No admission in past 12 weeks)

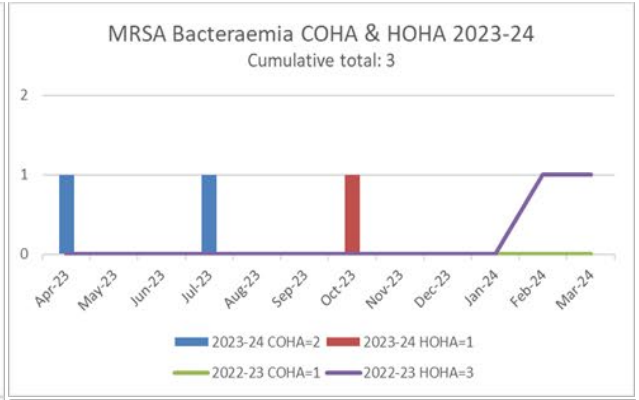
Healthcare Associated Infections

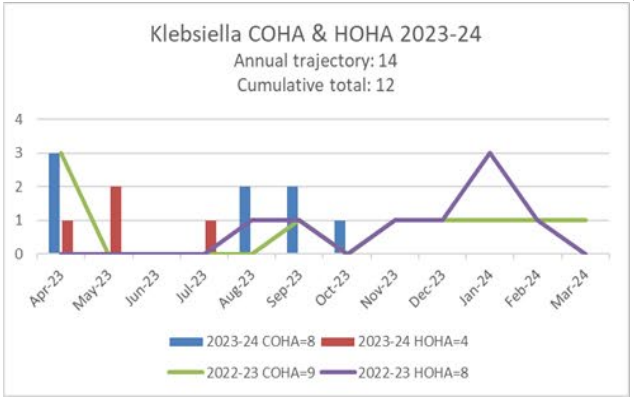
The Christie NHS Foundation Trust

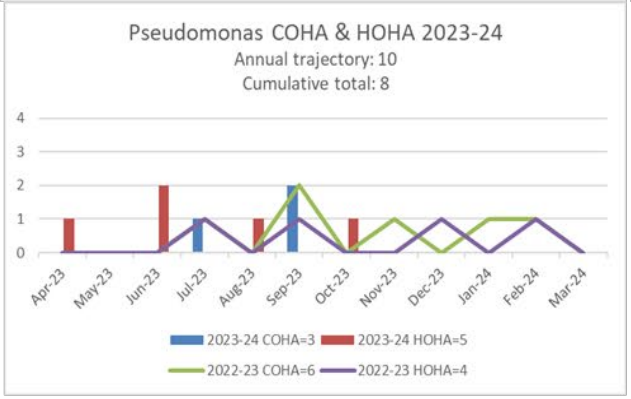
Alert Organisms

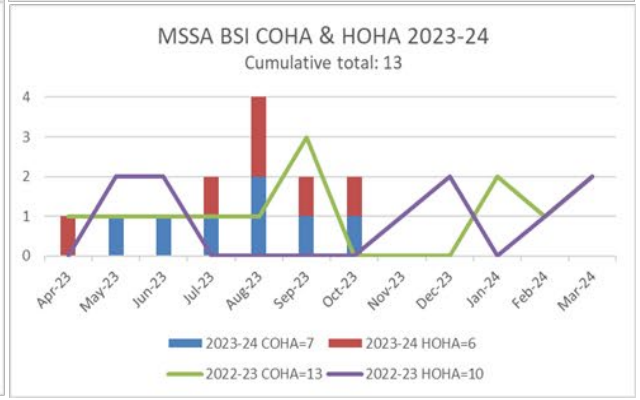








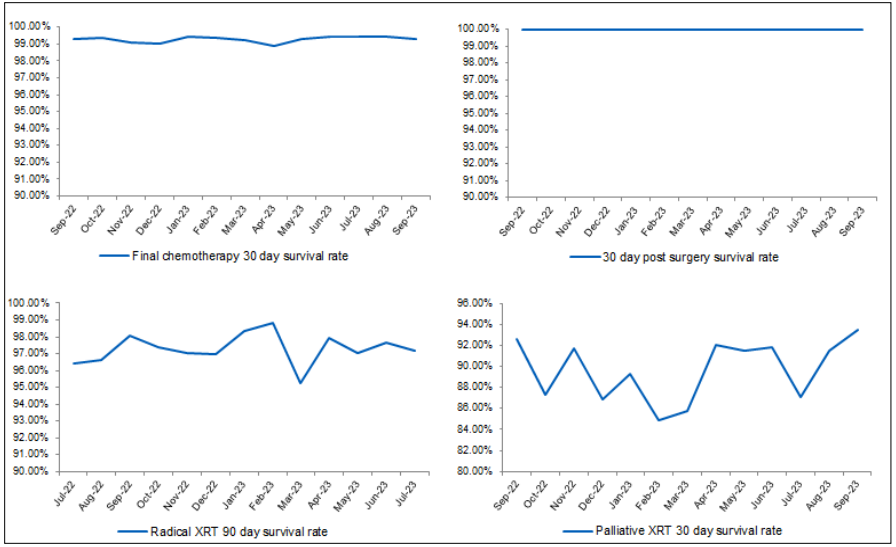




Mortality Indicators & Survival Rates

The Christie NHS Foundation Trust

Survival Rates



Inpatient Deaths – Onsite Deaths

		Oct-23
Number of NHS Christie onsite deaths	Elective/planned admission	6
	Non Elective/emergency admission	19
	TOTAL	**25**
Number of deaths that have triggered Structured Casenote Review (SCR) Note: screening is ongoing so further triggers may be identified	Mortuary screened triggers (including reported to the coroner) - 2	**5**
	Bereaved families raised concern – 2	
	Medical Triggers - 0	
	Nursing Triggers - 4 (inc in family concern)	
	(note there may be more than one trigger)	

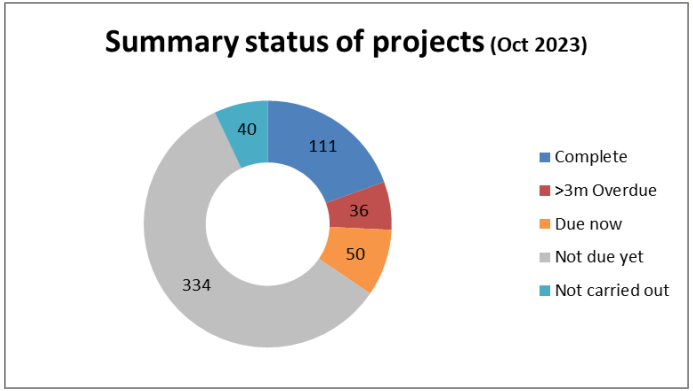
The Christie process for learning from deaths follows the 2017 NHSI guidance. All in-patient deaths are screened and where flagged by one or more triggers an independent structured case note review (SCR) is undertaken. Reviews are discussed by the Mortality Surveillance Group and the findings and actions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

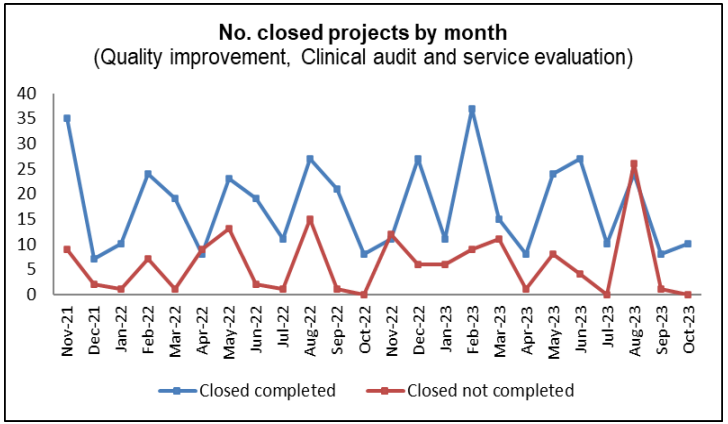
Quality Improvement & Clinical Audit

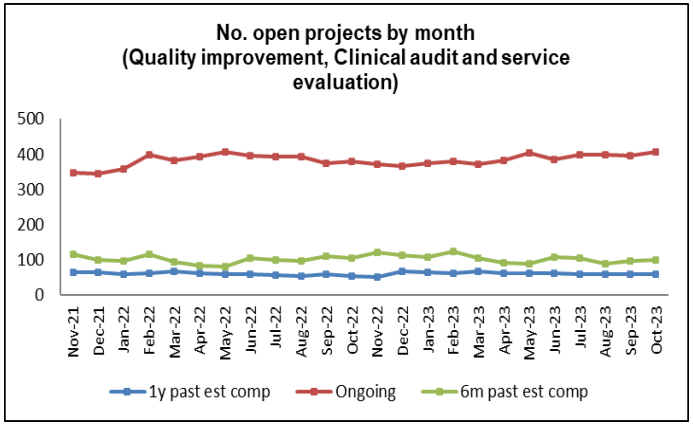
The Christie NHS Foundation Trust

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

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







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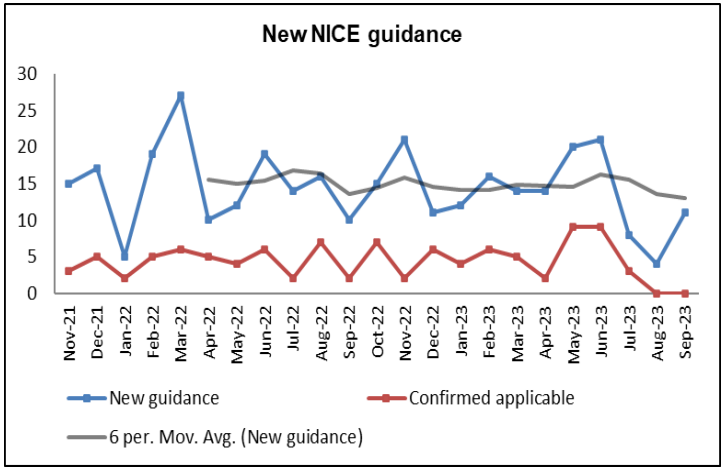
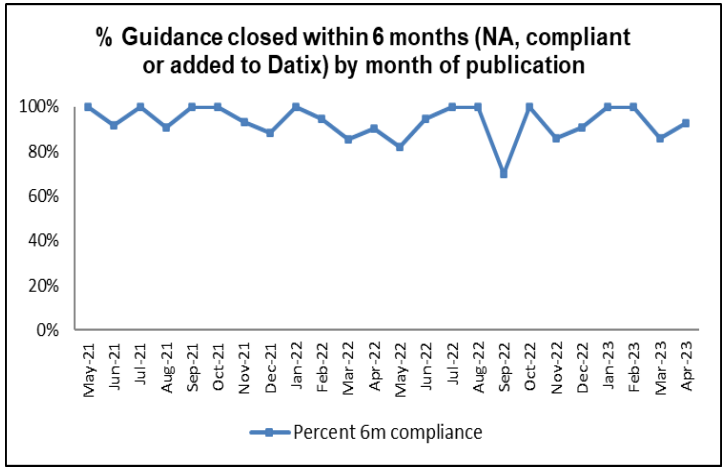
NICE Guidance





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

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

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

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

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

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HR Metrics Sickness

The Christie NHS Foundation Trust

4.89%
Monthly Absence

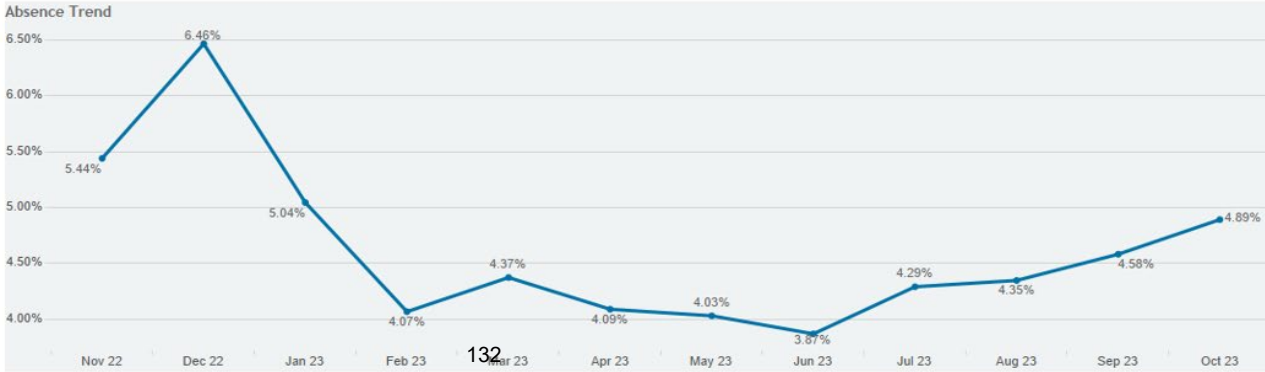
4.62%
Yearly Absence

108
Returned Last Month

72
No. of Employees on Long Term Sick

120
No. of Employees on Short Term Sick

Division	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23
Christie Medical Physics & Engineering	1.70%	3.07%	3.24%	2.45%	2.26%	1.67%	2.32%	3.24%	3.35%	3.65%	3.51%	3.24%
Clinical Networked Services	4.73%	5.43%	4.58%	3.66%	4.27%	3.79%	3.49%	3.92%	4.74%	4.63%	4.46%	5.50%
Clinical Support & Specialist Surgery	6.74%	8.26%	5.59%	4.97%	5.03%	4.94%	5.54%	4.68%	4.72%	4.97%	5.86%	6.22%
Corporate Development	0.65%	3.94%	1.61%	0.00%	0.46%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.80%
Digital Services	4.99%	4.25%	1.80%	1.55%	1.65%	1.83%	2.53%	1.23%	1.27%	3.01%	3.15%	1.39%
Education (School of Oncology)	0.51%	3.72%	4.60%	3.35%	1.42%	1.86%	0.93%	0.43%	0.20%	0.65%	2.04%	2.73%
Estates & Facilities	12.15%	13.09%	11.09%	9.01%	9.83%	8.97%	5.91%	5.81%	7.64%	7.36%	7.34%	6.87%
Finance & Business Development	4.45%	3.91%	2.75%	1.83%	2.43%	1.88%	3.43%	2.50%	2.06%	1.26%	1.75%	2.23%
GM Cancer	0.22%	3.47%	3.78%	1.36%	0.00%	0.35%	0.86%	0.00%	0.73%	0.00%	0.54%	0.06%
Performance	11.12%	6.47%	4.01%	4.32%	7.10%	7.40%	9.78%	8.85%	9.24%	8.46%	2.67%	3.42%
Quality & Standards	6.71%	9.36%	7.96%	6.44%	5.78%	4.25%	5.93%	3.95%	2.43%	6.04%	8.98%	7.06%
Research & Innovation	4.11%	5.27%	4.45%	3.14%	3.74%	3.74%	3.62%	3.32%	3.23%	3.13%	3.17%	3.10%
Strategy	6.00%	8.28%	3.70%	0.00%	0.00%	2.19%	0.00%	0.00%	0.00%	0.45%	0.00%	0.00%
Trust Administration	6.21%	7.07%	6.42%	6.21%	5.85%	6.65%	6.88%	6.21%	6.23%	5.87%	5.83%	5.51%
Workforce	4.48%	3.83%	1.75%	0.93%	1.40%	0.52%	0.35%	1.93%	3.30%	1.62%	2.11%	1.31%



HR Metrics – Mandatory Training

The Christie NHS Foundation Trust

90.67%
Compliance

5,045
Outstanding Modules

78.81%
Face to Face

92.59%
Online

Division	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23
Christie Medical Physics & Engineering	95.48%	95.55%	95.37%	94.95%	95.06%	96.03%	96.20%	95.32%	95.46%	95.99%	95.74%	94.43%
Clinical Networked Services	87.27%	87.11%	87.62%	87.45%	85.86%	87.05%	90.05%	90.84%	90.10%	90.63%	89.21%	89.11%
Clinical Support & Specialist Surgery	83.59%	82.47%	83.39%	81.15%	81.96%	84.99%	88.93%	90.30%	89.00%	88.96%	87.88%	86.59%
Corporate Development	96.94%	95.76%	96.19%	95.58%	95.71%	96.12%	100.00%	100.00%	100.00%	100.00%	100.00%	99.48%
Digital Services	96.24%	95.22%	94.86%	96.21%	98.97%	98.35%	98.55%	98.38%	96.79%	96.46%	94.88%	95.85%
Education (School of Oncology)	95.09%	93.86%	93.91%	94.14%	94.81%	94.11%	96.06%	96.70%	95.27%	94.77%	94.71%	91.82%
Estates & Facilities	92.98%	92.97%	93.65%	93.13%	95.21%	93.98%	94.46%	95.03%	93.81%	94.33%	94.54%	92.15%
Finance & Business Development	98.74%	98.25%	97.14%	97.75%	99.67%	97.93%	99.11%	99.37%	99.44%	99.54%	98.63%	98.47%
GM Cancer	82.20%	81.66%	82.66%	80.54%	86.04%	87.44%	92.97%	95.42%	91.29%	91.32%	92.28%	91.55%
Performance	94.74%	93.91%	95.03%	96.39%	95.06%	95.32%	93.38%	94.12%	98.80%	96.20%	92.28%	93.32%
Quality & Standards	88.80%	89.07%	92.26%	92.17%	92.86%	94.08%	93.04%	94.48%	94.97%	93.76%	90.37%	88.25%
Research & Innovation	93.42%	92.88%	94.20%	93.53%	93.57%	94.32%	96.53%	97.33%	96.68%	96.97%	96.00%	95.38%
Strategy	90.21%	85.57%	95.49%	93.22%	93.85%	94.17%	98.26%	96.80%	93.33%	97.50%	95.69%	93.08%
Trust Administration	95.88%	95.88%	97.99%	98.33%	93.15%	93.56%	96.04%	95.45%	95.57%	94.42%	93.39%	89.64%
Workforce	88.17%	89.12%	88.84%	92.94%	91.61%	92.72%	96.12%	96.30%	91.18%	96.50%	97.31%	97.41%

HR Metrics - PDR

The Christie NHS Foundation Trust

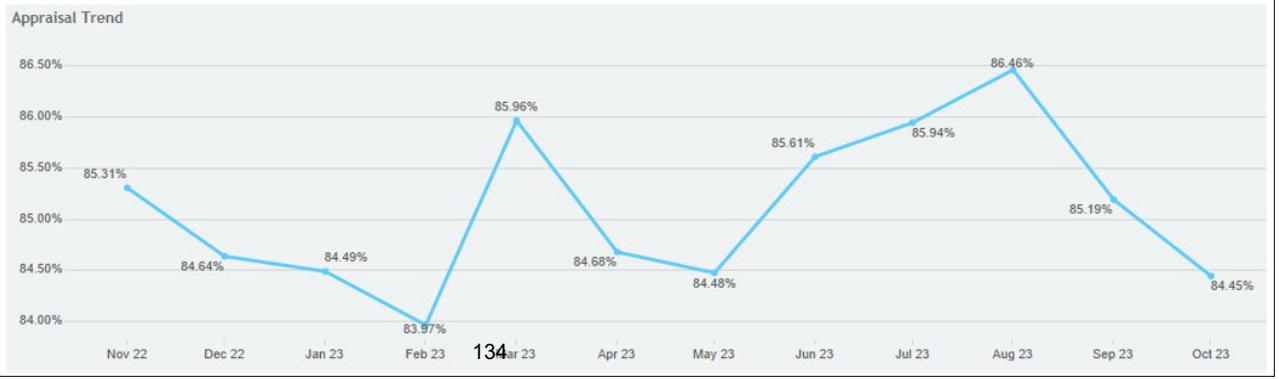
84.45%
Compliance

445
Expired

493
Due Soon (3 Months)

67.21%
Predicted Compliance
(If the Due Soon were to expire)

Division	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23
Christie Medical Physics & Engineering	84.58%	89.58%	88.84%	88.07%	90.00%	90.46%	92.08%	91.97%	93.12%	91.94%	89.88%	86.69%
Clinical Networked Services	86.45%	86.04%	83.43%	81.33%	80.90%	81.26%	86.13%	86.71%	89.15%	89.18%	86.99%	84.96%
Clinical Support & Specialist Surgery	82.72%	83.83%	84.59%	84.94%	87.08%	85.64%	82.19%	83.71%	81.02%	80.43%	81.81%	82.15%
Corporate Development	96.97%	93.94%	88.57%	75.68%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	90.91%	90.91%
Digital Services	87.06%	84.27%	91.11%	89.36%	93.62%	93.75%	89.69%	88.00%	81.00%	83.00%	78.43%	77.45%
Education (School of Oncology)	92.06%	87.30%	92.19%	90.48%	92.31%	94.03%	89.39%	91.18%	92.42%	92.31%	92.65%	88.24%
Estates & Facilities	84.32%	83.05%	83.40%	82.68%	84.28%	80.60%	72.10%	78.21%	81.47%	85.41%	83.82%	86.07%
Finance & Business Development	95.24%	87.30%	90.63%	88.89%	96.67%	89.06%	95.24%	90.63%	92.06%	92.19%	90.63%	93.85%
GM Cancer	63.64%	61.76%	57.14%	53.85%	71.79%	61.90%	65.96%	65.31%	73.47%	80.39%	82.35%	83.02%
Performance	91.30%	91.30%	91.30%	90.91%	91.30%	82.61%	72.73%	68.42%	70.00%	70.00%	72.73%	73.91%
Quality & Standards	75.00%	79.31%	82.76%	76.67%	87.10%	78.79%	82.35%	88.24%	90.91%	94.29%	90.91%	90.91%
Research & Innovation	87.96%	82.01%	82.08%	87.02%	90.71%	88.24%	85.37%	86.56%	86.15%	88.28%	85.32%	84.35%
Strategy	37.50%	30.00%	33.33%	30.00%	30.00%	30.00%	50.00%	60.00%	60.00%	60.00%	66.67%	66.67%
Trust Administration	80.00%	80.00%	66.67%	80.00%	85.71%	92.86%	92.86%	92.86%	92.86%	86.67%	82.35%	82.35%
Workforce	91.67%	87.93%	94.92%	98.28%	94.74%	91.38%	98.28%	95.16%	95.00%	95.08%	89.83%	91.38%



Workforce Metrics - Turnover

The Christie NHS Foundation Trust

45
Leavers

11.99%
Voluntary Yearly Turnover

14.10%
All Yearly Turnover

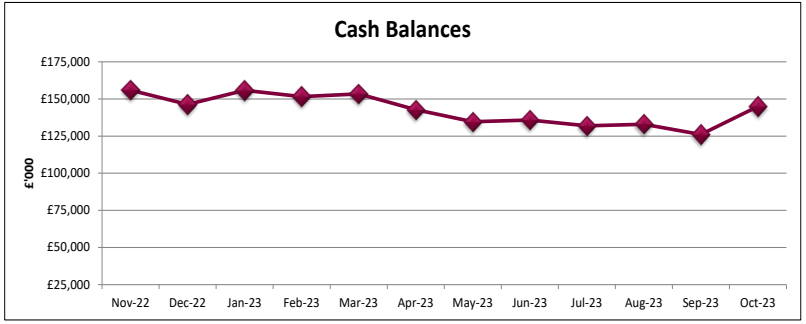
3,660
Headcount

End of Fixed Term Contract	7
Retirement	7
Voluntary Resignation	30
End of Fixed Term Contract - External Rotation	1
Grand Total	45

Finance (Executive Summary)

The Christie NHS Foundation Trust

Month 7 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(374,010)	(218,232)	(227,785)	(9,552)
Other Income	(68,838)	(40,094)	(40,282)	(187)
Pay	212,163	123,662	116,930	(6,731)
Non Pay (incl drugs)	218,637	127,637	140,449	12,812
Operating (Surplus) / Deficit	**(12,048)**	**(7,028)**	**(10,688)**	**(3,660)**
Finance expenses/ income	28,723	16,755	18,457	1,702
(Surplus) / Deficit	**16,675**	**9,727**	**7,770**	**(1,957)**
Exclude impairments/ charitably funded capital donations	(8,637)	(5,038)	(4,941)	97
Adjusted financial performance (Surplus) / Deficit	**8,038**	**4,689**	**2,828**	**(1,861)**



This report outlines the month 6 consolidated financial performance of The Christie NHS Foundation Trust and its wholly owned subsidiary The Christie Pharmacy Ltd.

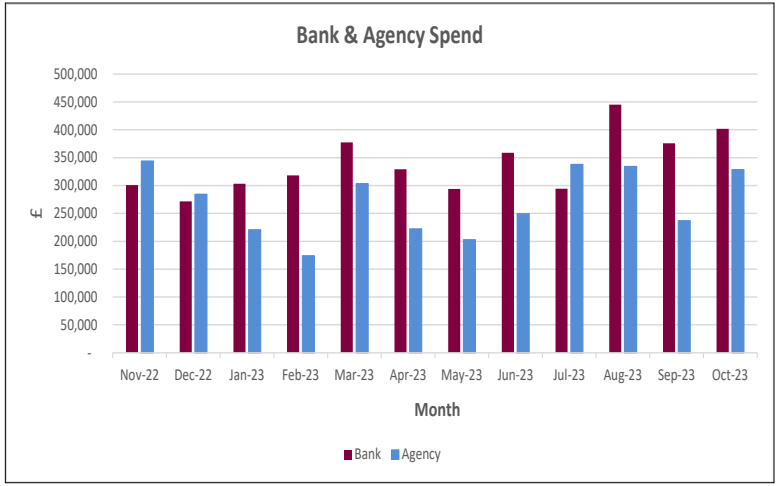
I&E

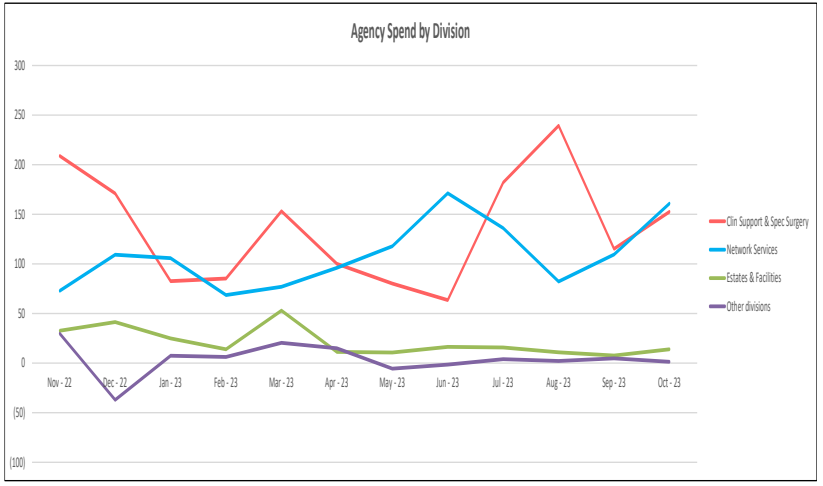
- The Trust is reporting a month end deficit of £2.9m compared to a planned deficit of £4.7m, a variance of £1.9m. The main reason for an improved position relates to interest received above plan and continued underspends on pay whilst growth vacancies are recruited to.
- The month 7 revenue position is £0.4m better than plan.
- 2023-24 CIP – Identified in year CIP is £12.1m (£10.7m non- recurrent / £1.8m recurrent) and is 99% of the in-year target of £12.5m leaving £366k unidentified.

Balance sheet / liquidity

- The cash balance is £145m.
- Capital expenditure is under CDEL original plan by £1.9m but in line with the revised plan.
- Targets have been achieved against payment of our NHS creditors paid within the 30-day Better Payment Practice Code target.

Finance (Expenditure)

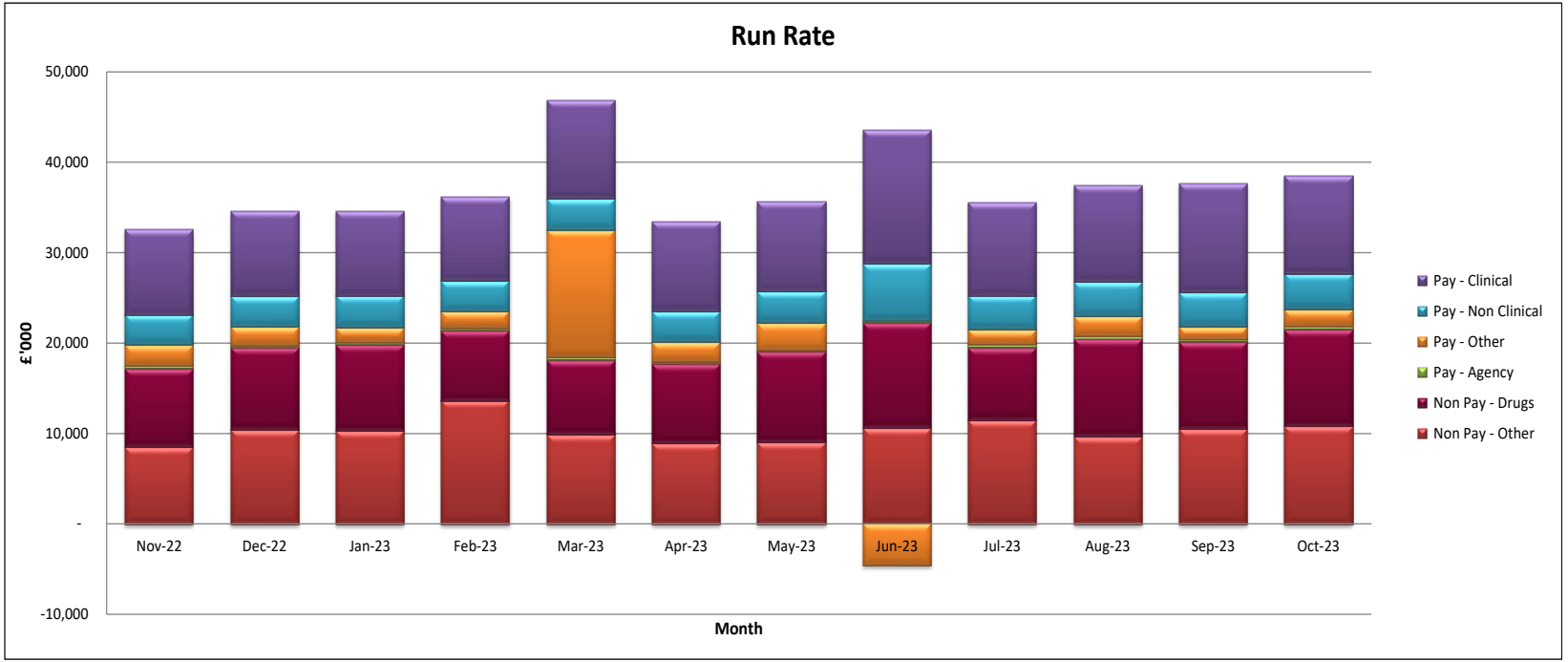




The agency spend is £328k in month 7, an increase of £91k from month 6. This is mainly due to an increase on clinical nursing agency spend.

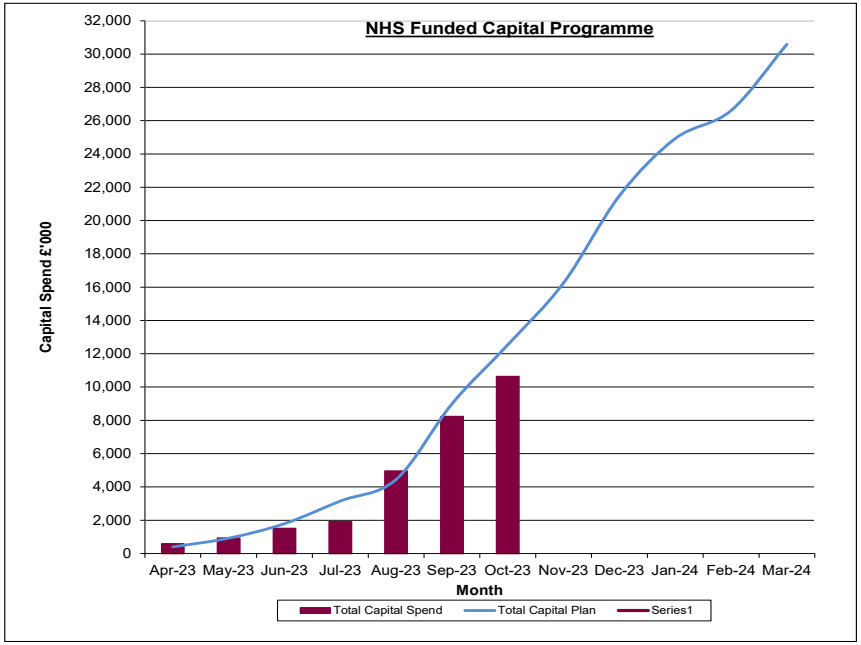
Bank spend has increased by £26k in month compared to M6, largely driven by an increase on clinical nursing.

5.2 - Finance (Expenditure)



- Drugs spend in month 7 is £10,697k, an increase from month 6 of £1,067k.
- Pay – Agency spend in month 7 is £328k, an increase of £91k from month 6.
- Pay – Clinical decreased by £1,253k compared to month 6 mainly relating to pay awards in month 6.
- Key elements of 'Non Pay Other' spend consist of clinical supplies and services, premises and infrastructure costs

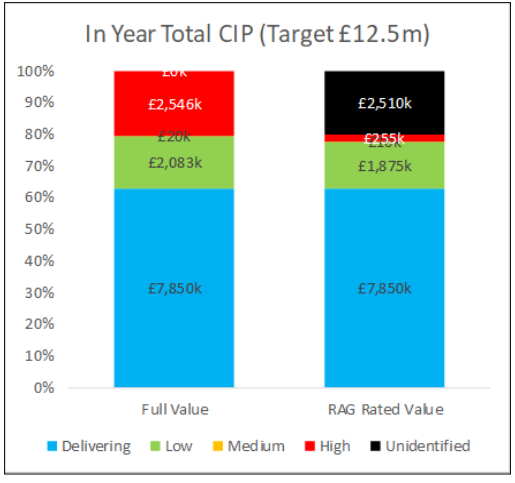
Finance (Capital)

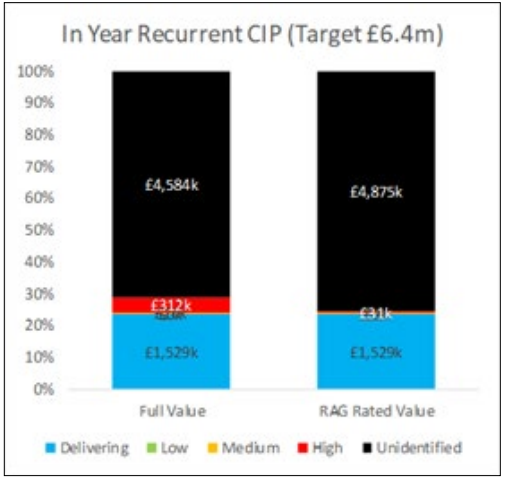


	Original Plan	Revision	Revised plan/ forecast		Year to date- original plan	Year to date - actual	Year to date - variance
	Apr-23 £k	£k	o/s £k		£k	£k	£k
Annual depreciation charge 2023-24	**21,370**	**2,000**	**23,370**		**12,466**	**13,700**	**(1,234)**
GM capital plan control total - Trust own cash	**19,820**	**(2,000)**	**17,820**		**7,536**	**7,986**	**(450)**
PDC capital funded schemes	**10,083**	**0**	**10,083**		**5,000**	**2,615**	**2,385**
Loan and lease funded schemes	**686**	**0**	**686**		**0**	**0**	**0**
Total annual capital programme under CDEL	**30,589**	**(2,000)**	**28,589**		**12,536**	**10,601**	**1,935**
ASIC development	**0**	**0**	**0**		**0**	**0**	**0**
Art room refurbishment	**0**	**424**	**424**		**0**	**33**	**(33)**
Charity funded programme	**0**	**424**	**424**		**0**	**33**	**(33)**
Total Trust Annual Capital Programme	**30,589**	**(1,576)**	**29,013**		**12,536**	**10,634**	**1,902**

Performance for month 7 was an underspend of £1.9m against the original CDEL plan submitted to NHSE but in line with the revised plan.
The Trust has incurred £10.6m on capital schemes to month 7, primarily on the backlog maintenance programme, the linac and CT scanner replacements, Digital Services Electronic Health Records projects, final works on the Paterson scheme and the TIF ward.

Finance (CIP)





Total In year CIP

- Total identified CIP schemes reported are £12.5m (£10.7m non recurrent / £1.9m recurrent).
- Risk adjusted identified schemes value £10m leaving £2.5m unidentified.

Recurrent

- Schemes totalling £1.9m have been identified recurrently against a recurrent target of £6.4m.
- This leaves £4.6m of the recurrent target unidentified, this increases to £4.9m when risk adjusted.

	Annual					Year to Date		
	Target	Identified value	Unidentified Value	Identified RAG Value	Unidentified RAG Value	Target	Delivered	Unidentified
Total CIP	**£12,500k**	**£12,500k**	**£0k**	£9,990k	(£2,510k)	**£7,291k**	**£7,291k**	**(£0k)**
Recurrent CIP	£6,445k	£1,861k	(£4,584k)	£1,570k	(£4,875k)	£3,759k	£969k	(£2,790k)
Non-Recurrent CIP	£6,055k	£10,639k	£4,584k	£8,420k	£2,365k	£3,532k	£6,322k	£2,790k

Annual Sustainability Report 2022/23

1. Introduction and background

1.1 Climate Change

Human-induced climate change is causing dangerous and widespread disruption in nature and affecting the lives of billions of people around the world, despite efforts to reduce the risks. People and ecosystems least able to cope are being hardest hit.

There is a rapidly closing window of opportunity to secure a liveable and sustainable future for all. Without urgent, effective, and equitable mitigation and adaptation actions, climate change increasingly threatens ecosystems, biodiversity, and the livelihoods, health and wellbeing of current and future generations.

The Intergovernmental Panel on Climate Change's (IPCC) final instalment of their Sixth Assessment Report on climate change impacts, adaptation and vulnerability was published on 20 March 2023. The report, which is being described as survival guide for humanity, brings into sharp focus the losses and damages experienced now, and expected to continue into the future, which are hitting the most vulnerable people and ecosystems especially hard. Climate change is a threat to human well-being and planetary health.

The world faces unavoidable multiple climate hazards over the next two decades with global warming of 1.5°C. Scientists believe it is increasingly likely that threshold will be crossed between now and 2026. Even temporarily exceeding this warming level will result in additional severe impacts, some of which will be irreversible. Risks for society will increase, including to infrastructure and low-lying coastal settlements. The cumulative scientific evidence is unequivocal: Climate change is a threat to human well-being and planetary health. Any further delay in concerted anticipatory action on adaptation and mitigation will miss a brief and rapidly closing window of opportunity to secure a liveable and sustainable future for all.

1.2 Climate Change and Health

Climate change, caused by human greenhouse gas emissions, is already harming people's health and driving widespread losses and damages. The health impacts of climate change are happening now and are worsening. They overwhelmingly affect disadvantaged and marginalised communities and exacerbate existing health inequities. As climate change threatens the foundations of good health, with direct and immediate consequences for our patients, the public and the NHS.

Many climate solutions also have benefits for health and wellbeing, and early climate action will bring long-term economic and health gains. The benefits to health far exceed the costs of implementing climate actions.

'The climate crisis is a health emergency, it's that simple. More than 13 million deaths around the world each year are due to avoidable environmental causes.'

Nick Watts, NHS Chief Sustainability Officer
April 2022

1.5 Delivering a Net Zero NHS

On 1 July 2022, the NHS became the first health system to embed net zero into legislation, through the Health and Care Act 2022. The Delivering a Net Zero National Health Service report is now issued as statutory guidance. The report was launched to mobilise NHS staff and set an ambitious, evidence-based route map and date for the NHS to reach net zero.

The statutory targets are to reduce system wide emissions within direct control (NHS Carbon Footprint) to net zero by 2040, and wider indirect emissions including the supply chain (NHS Carbon Footprint Plus) by 2045, with interim 80% reduction targets by 2028-2032 and 2036-39 respectively.

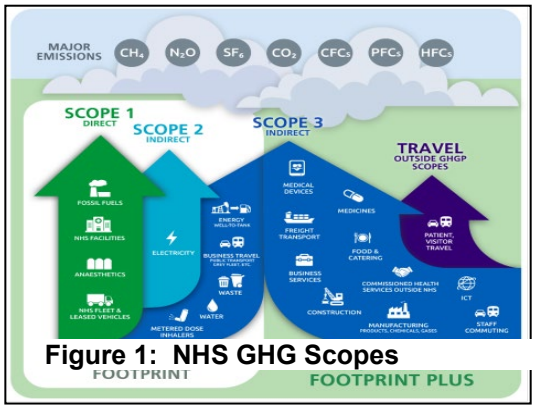
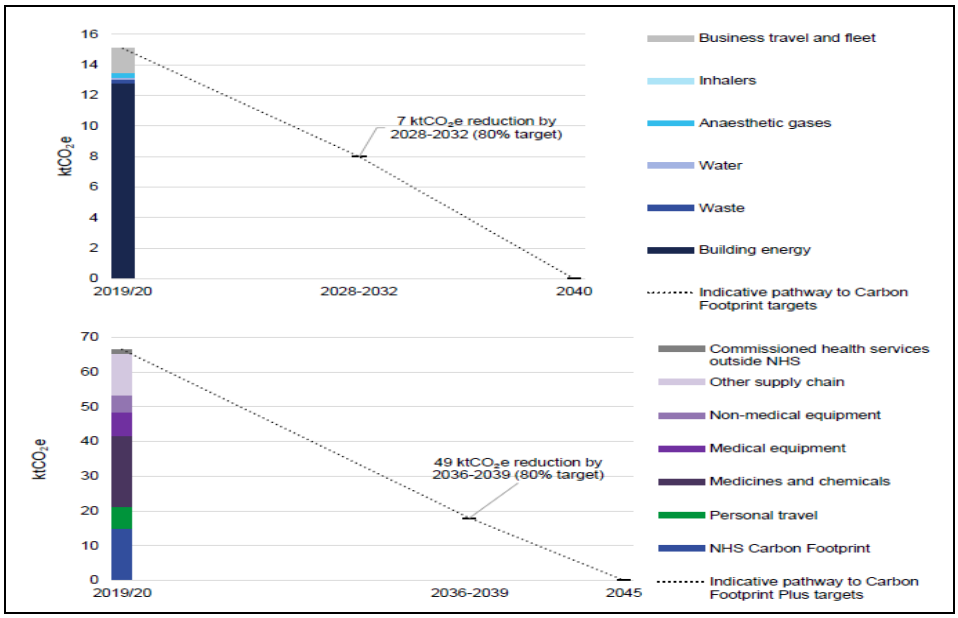


Figure 1: NHS GHG Scopes

Trust Carbon Footprint Plus Baseline

NHS Carbon Footprint	**15,061**	**tCO_2e**
Building energy	*12,810*	tCO_2e
Waste	*261*	tCO_2e
Water	*110*	tCO_2e
Anaesthetic gases	*284*	tCO_2e
Inhalers	*7*	tCO_2e
Business travel and fleet	*1,589*	tCO_2e
Personal travel	**6,174**	**tCO_2e**
Staff commuting	*2,198*	tCO_2e
Patient travel	*2,897*	tCO_2e
Visitor travel	*1,079*	tCO_2e
Medicines, medical equipment and other supply chain	**44,177**	**tCO_2e**
Medicines and chemicals	*20,472*	tCO_2e
Medical equipment	*6,838*	tCO_2e
Non-medical equipment	*4,679*	tCO_2e
Other supply chain	*12,188*	tCO_2e
Commissioned health services outside NHS	**1,065**	**tCO_2e**
NHS Carbon Footprint Plus	**66,477**	**tCO_2e**

Trust Carbon Footprint Plus Net Zero Trajectories



1.6 Staff Feedback

Introduction

The NHS staff survey now includes questions around sustainability. These are added by the Trust as local questions and so results cannot be compared with other Trusts.

Aim

To help support the delivery of SDMP commitments and inform leadership of workforce climate knowledge.

How important do you think it is for the Trust to take action against climate change?

	Organisation Overall	
Option	Count	Percent
Very important	720	55%
Quite important	354	27%
Quite unimportant	77	6%
Very unimportant	85	6%
Don't know	76	6%
Total Responses	1312	100%

At work do you feel it is easy to do things that would support the environment?

	Organisation Overall	
Option	Count	Percent
Strongly agree	106	10%
Agree to some extent	510	46%
Disagree to some extent	307	28%
Strongly disagree	175	16%
Don't know	14	1%
Total Responses	1112	100%

To what extent do you think you would benefit from training to raise your awareness of climate?

	Organisation Overall	
Option	Count	Percent
Strongly agree	250	22%
Agree to some extent	589	52%
Disagree to some extent	157	14%
Strongly disagree	117	10%
Don't know	17	2%
Total Responses	1130	100%

1.7 Care Quality Commission

The Care Quality Commission (CQC) will be implementing a new regulatory approach this year. Based on a new single assessment framework, the framework includes a quality statement on environmental sustainability. Through the CQC regulatory approach, inspectors may consider how providers have made efforts to become more environmentally sustainable.

The environmental sustainability quality statement, under well-led, will look at any negative impact of providers activities on the environment, how they are acting to reduce it and supporting people to do the same.

In addition to this, climate change adaptation will be assessed in the quality statement 'safe environments' and within 'Governance, management and sustainability'. Within these quality statements steps taken to adapt to the effects of climate change will be looked at e.g., adverse weather plans.

2 The Christie Sustainable Development Management Plan

Introduction

All NHS organisations in performing their obligations under the NHS Standard Contract 23/24 must take all reasonable steps to minimise its adverse impact on the environment and to deliver the commitments set out in Delivering a 'Net Zero' National Health Service. Furthermore, they must maintain and deliver a Sustainable Development Management Plan (SDMP), approved by its Governing Body.

The Trust Board approved a new SDMP in June 2021 to commence work on the ambitions within Delivering a Net Zero NHS.

The plan was developed using the NHS Sustainable Development Assessment Tool (SDAT). The SDAT evolved from the Good Corporate Citizen (GCC) Self-Assessment Tool, which has been widely used by NHS providers and commissioners since 2008. The SDAT covered ten modules with four cross-cutting themes, namely Governance & Policy, Core responsibilities, Procurement and Supply chain, and Working with Staff, Patients & Communities.

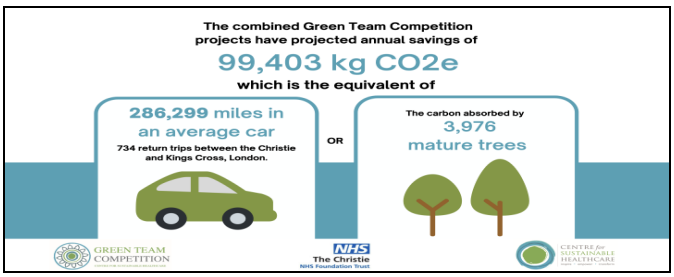
- Corporate Approach
- Asset Management & Utilities
- Travel and Logistics
- Adaptation
- Capital Projects
- Green Space & Biodiversity
- Sustainable Care Models
- Our People
- Sustainable use of Resources
- Carbon / GHGs

An organisation's sustainable journey is usually very unique therefore this approach to the modules allowed users to demonstrate their progress in a way that mirrors an individual organisations journey. However, as part of the wider Greener NHS programme regional deliverables were also developed as part of the Regional Memorandum of Understanding 2022/2023.

2.1 Key Highlights 22/23

Green Team Competition

Through the Green Team Competition, the Trust invited five teams to engage in a 10-week project, where they received mentoring from Centre for Sustainable Healthcare facilitators. The teams were tasked with identifying, developing, running, and measuring the outcomes of sustainable quality improvement projects. The final report identified potential savings of £554,525 and 99,403 kgCO2e if the projects are implemented.



Anaesthetic Gases

Desflurane is known to be significantly more harmful to greenhouse gas than carbon dioxide. The nationally driven target is to reduce the proportion of desflurane used to less than 5% of all the anaesthetic gas we use. To support this, desflurane is no longer made routinely available and therefore must be requested to be put onto an anaesthetic machine. As a result, the use of desflurane is now less than 3% by volume.

Carbon Energy Fund

The Trust have a Framework Partnership with Vital Energi and the Carbon Energy Fund and achieved part Public Sector Decarbonisation Scheme grant funding for a carbon reduction scheme which will be delivered by mid-2023. This scheme is expected to reduce our carbon emissions by 1,000t of CO2. The scope of the scheme is wide ranging and includes a new solar photovoltaic system, battery energy storage system, air source heat pumps, LED Lighting upgrades along with site wide energy saving measure improvements which include a new higher efficiency combined heat and power supply and transfer of steam heating to more efficient low temperature hot water.

North West Greener NHS Innovation Fund

Following an application to the NW Greener NHS Innovation Fund, a project team at The Christie was awarded nearly £10,000 to estimate the carbon footprint of the radiotherapy pathway. Different parts of the radiotherapy pathway including patient travel, linac and imaging power consumption, consultations and other medicines that patients require will be analysed retrospectively. Two time periods, before and during COVID-19 were used to assess the impact of changes in practice during this period. The process helped identify the hotspots of the radiotherapy pathway so that we can focus on reducing the environmental impact of those. The result of the work has been published in Physica Medica (August 2023).

2.2 Corporate Approach

Introduction

Sustainable healthcare is only achievable if the principles of sustainability are embedded across the organisation. It is essential that all staff, governors and stakeholders are held accountable for delivering the goals set in our SDMP. This means ensuring our policies, strategies, procedures and business cases reflect our ambition for sustainable healthcare, and that operationally all activity across the Trust ensures the delivery of our goals.

Aim

To ensure that sustainability is embedded within organisational strategy and processes, and that we deliver, monitor and report on progress supported by a nominated Trust board level net zero carbon lead.

Tracking Progress

Ref	Module title	X-Cutting Theme	Action	Responsible person	Target implementation date	Status
CA1	Corporate Approach	Governance & Policy	Approval of Sustainable Development Management Plan	Director of capital, estates and facilities	Jul-21	Implemented
CA2	Corporate Approach	Governance & Policy	Trust board to adopt sustainability as a corporate objective	Director of capital, estates and facilities	Jul-21	Implemented
CA3	Corporate Approach	Governance & Policy	Trust board publically acknowledges GMHSCP climate emergency as part of the release of the sustainable development management plan	Director of capital, estates and facilities	Jul-21	Implemented
CA4	Corporate Approach	Governance & Policy	Publish sustainable development management plan	Deputy Director of Corporate Affairs and Engagement	Jul-21	Implemented
CA5	Corporate Approach	Governance & Policy	Publish sutainability governance structure, including Trust board net zero carbon lead	Deputy Director of Corporate Affairs and Engagement	Jul-21	Implemented
CA6	Corporate Approach	Governance & Policy	Trust Board supported with sustainability training	Sustainability Manager	Mar-23	Implemented
CA7	Corporate Approach	Governance & Policy	Develop Sustainability Impact Assessment (SIA) for use in all business cases.	Sustainability Manager/Head of Capital/Assistant Director of Finance	Oct-22	Implemented
CA8	Corporate Approach	Governance & Policy	Mandatory Sustainability Impact Assessment (SIA) for all business cases. This will include requirement for discussion of the SIA at the approving committee.	Director of Finance & Business Development	Mar-23	Requires Action
CA9	Corporate Approach	Governance & Policy	Develop key indicator reports for the Trust board against all modules to be submitted on a six monthly basis. Once reports are approved by theTrust board the will be made available to staff on the intranet.	Sustainability Manager/Head of facilities	Oct-22	Implemented
CA10	Corporate Approach	Governance & Policy	Annual report format updated to include updates across all ten modules of the Sustainable Development Assessment Tool. Once report is approved by the Trust board it will be made available to staff on the intranet.	Sustainability Manager/Head of facilities	Mar-23	In Progress
CA12	Corporate Approach	Governance & Policy	Completed interim review of Sustainable Development Management Plan (2021-2024)	Sustainability Manager	Mar-23	Implemented
CA13	Corporate Approach	Governance & Policy	Commence full review of the Sustainable Development Management Plan (2021-2024)	Sustainable Development Committee	Mar-23	In Progress
CA14	Corporate Approach	Governance & Policy	Development for approval of a new Sustainable Development Management Plan based on NHS guidelines.	Sustainability Manager	Mar-24	Requires Action
CA15	Corporate Approach	Core responsibilities	Identify training gaps for Sustainable Development Committee leads	Sustainability Manager	Oct-22	Implemented
CA16	Corporate Approach	Core responsibilities	Implement training requirements for Sustainable Development Committee leads	Head of facilities	Mar-23	Implemented
CA17	Corporate Approach	Procurement and Supply chain	Develop Sustainable procurement policy	Head of procurement	Mar-23	Requires Action

2.3 Our People

Introduction

Every single staff member has a part to play in delivering our strategy, and making sure we educate and engage them is paramount to success. Staff need to understand the impact they have and how even small changes can make a difference to the organisation both in a positive and negative context.

Aim

To support staff to improve sustainability at work and empower them to make sustainable choices.

Tracking Progress

Ref	Module title	X-Cutting Theme	Action	Responsible person	Target implementation date	Status
OP1	Our People	Governance & Policy	Develop a communication and marketing stratergy	Deputy Director of Corporate Affairs and Engagement	Mar-22	Implemented
OP2	Our People	Core responsibilities	Develop a section on Trust intranet dedicted to sustainability	Deputy Director of Corporate Affairs and Engagement	Mar-22	Implemented
OP3	Our People	Core responsibilities	Sustainability awareness included in staff annual survey	Deputy Director of Workforce	Oct-22	Implemented
OP4	Our People	Core responsibilities	Develop sustainability induction package for new starters	Sustainable Development Committee	Mar-23	Implemented
OP5	Our People	Core responsibilities	Develop training and awareness raising programme opportunities to increase knowledge and understanding of sustainability amongst our staff.	Deputy Director of Workforce/Sustainability	Mar-23	Implemented

2.4 Capital Projects
Introduction

The built environment contributes around 40% to the UK's total carbon footprint, so tackling the construction, refurbishment and decommissioning of buildings is a key part of our carbon reduction plans. Our Estate is constantly evolving and expanding to cope with increasing pressures, but we need to ensure that sustainability is considered in all stages of the projects.

Aim

To reduce the environmental impact of building works during design, refurbishment, construction, operation and decommissioning stages.

Tracking Progress

Ref	Module title	X-Cutting Theme	Action	Responsible person	Target implementation date	Status
CP1	Capital Projects	Core responsibilities	Full review of NHS Net Zero requirements on capital developments. This is will include: • Reviewing and understanding the commitments set out in Delivering a 'Net Zero' National Health Service. • Reviewing and understanding the implications of the NHS Operational Planning and Contracting Guidance requirement that all NHS organisations must ensure all new builds and refurbishment projects are delivered to net zero carbon standards. • Engagement with Greater Manchester Health and Social Care Partnership and the wider NHS to define what the NHS Net Zero requirements means for healthcare facilities. • Baselining with other NHS providers. • Exploring funding options available for the Delivering a 'Net Zero' National Health Service commitments • Assessment of capital costs required to deliver Net Zero Carbon	Dircetor of capital	Mar-24	Requires Action
CP3	Capital Projects	Core responsibilities	Sustainable capital projects plan/process in place to; • Ensure any designed scheme advisers need to provide idea of the energy usage • Every scheme needs to justify why it is not sub metered • Challenge long term requirement of all developments in the business case and if flexibly design can be incorporated.	Head of capital	Dec-23	In Progress
CP5	Capital Projects	Core responsibilities	Incorporate sustainability into handover process to communicate and induct staff into the new building or area, on the way it works and designed to support them to make energy efficiency decisions	Head of capital	Mar-23	In Progress

2.5 Asset Management and Utilities

Introduction

Our Estate activities are intensive and constant. Utilities represent a substantial cost and environmental impact to the organisation, so it is essential that we accurately measure and reduce consumption through efficiencies, new technologies, and increased staff awareness.

Aim

To embed energy and water efficient technologies and practices throughout our Estate and services and deliver year-on-year reductions in consumption.

Tracking Progress

Sustainable Development Management Plan

Ref	Module title	X-Cutting Theme	Action	Responsible person	Target implementation date	Status
AM1	Asset Management & Utilities	Governance & Policy	Commence implementation of carbon and energy fund project to bring guaranteed savings and a reduction in carbon footprint	Head of facilities/Energy Manager	Jul-23	In Progress
AM2	Asset Management & Utilities	Core responsibilities	Conduct water use survey to identify options to reduce water usage through best practice efficiency standards and new innovations.	Technical manager for hard facilities/Energy Manager	Mar-23	Requires Action

Building Energy Carbon Footprint

Resource		2018/19	2019/20	2020/21	2021/22	2022/23
Gas	Use (kWh)	44,988,718	46,274,930	36,792,367	27,188,907	32,079,912
	tCO_2e	8,276	8,509	6,739	4,894	5,777
Oil	Use (kWh)	0	0	0	0	3,455
	tCO_2e	0	0	0	0	1
Coal	Use (kWh)	0	0	0	0	0
	tCO_2e	0	0	0	0	0
Electricity	Use (kWh)	10,661,428	10,113,690	12,548,996	20,836,718	20,127,033
	tCO_2e	3,018	2,358	2,637	4,029	4,168
Green Electricity	Use (kWh)	0	29,307	28,106	27,050	26,000
	tCO_2e	0	0	0	0	0
Total Energy CO2e		11,294	10,866	9,376	8,923	9,945

2.6 Carbon and Greenhouse Gases

Introduction

Every activity that is undertaken across our organisation generates a carbon footprint. Monitoring and minimising our emissions is vital if we are to reach the ambitious reduction targets set in the Delivering a Net Zero NHS Report and the GM Environment Plan. The Trust has recorded annual reductions in its carbon footprint but more work needs to be done with staff, contractors, and procurement to agree a metric and support a trend of improvement.

Aim

To measure our carbon emissions, identify hotspots and take targeted action to reduce this year-on-year.

Tracking Progress

Ref	Module title	X-Cutting Theme	Action	Responsible person	Target implementation date	Status
C1	Carbon / GHGs	Governance & Policy	To set a carbon footprint baseline figure for this SDMP	Sustainability manager	Oct-22	Implemented
C2	Carbon / GHGs	Governance & Policy	To set interim targets for carbon reduction to identify how we can meet net-zero commitments.	Sustainable Development Committee	Mar-23	Requires Action
C3	Carbon / GHGs	Governance & Policy	Develop air condition and ventilation management process (See action AM1)	Energy Manager	Sep-23	Requires Action
C4	Carbon / GHGs	Core responsibilities	Public sector decarbonisation scheme project	Energy Manager	Feb-23	In Progress
C5	Carbon / GHGs	Core responsibilities	Through a new sustainable health care committee explore options to reduce use of desflurane and sevoflurane anaesthetic gases.	Sustainable health care committee	Oct-22	Implemented
C6	Carbon / GHGs	Procurement and Supply chain	Transfer electricity purchase into 100% renewable energy tariffs	Energy Manager	Mar-22	Implemented
C7	Carbon / GHGs	Procurement and Supply chain	Purchase Hydrotreated Vegetable Oils as fuel for stand-by generators	Energy Manager	Dec-23	In Progress
C8	Carbon / GHGs	Working with Staff, Patients & Communities	Engagement with GMHSCP and wider NHS to define carbon trajectories for the Estate and explore opportunities for external funding to support further carbon reduction schemes.	Sustainability Manager	Mar-23	In Progress

2.7 Green Space and Biodiversity

Introduction

Sustaining and improving green space helps combat climate change through carbon storage, supports local biodiversity, reduces noise pollution, improves air quality and act as solutions to cooling overheated cities. But the benefits are not just environmental; having access to outdoor space has been proven to improve both mental and physical wellbeing which is hugely important for our patients and also our staff.

Aim

To maximise the quality and benefits from our green spaces and reduce biodiversity loss by protecting and enhancing natural assets.

Tracking Progress

Ref	Module title	X-Cutting Theme	Action	Responsible person	Target implementation date	Status
GS1	Green Space & Biodiversity	Governance & Policy	Develop a biodiversity strategy for approval by Trust board	Technical manager for hard facilities/Head of capital	Mar-23	In Progress
GS3	Green Space & Biodiversity	Core responsibilities	Implementation of Trust board approved Biodiversity Strategy	Technical manager for hard facilities	Mar-24	Requires Action
	Green Space & Biodiversity	Working with Staff, Patients & Communities	Explore possible collaboration options with Greater Manchester Health and Social Care Partnership	Technical manager for hard facilities/Head of capital	Mar-23	Implemented
GS4	Green Space & Biodiversity	Core responsibilities	Complete a tree register for the Withington Site	Technical manager for hard facilities	Mar-23	In Progress

2.8 Sustainable Use of Resources

Introduction

Procurement constitutes the largest proportion of our carbon footprint and how we purchase and use our resources accounts for significant impacts on the environment. We are working to procure more efficiently and sustainably, reduce unnecessary waste, and move away from a throwaway culture.

Aim

To take an innovative approach to driving out waste, delivering year on year reductions in cost and volumes.

Tracking Progress

Ref	Module title	X-Cutting Theme	Action	Responsible person	Target implementation date	Status
SU1	Sustainable use of Resources	Core responsibilities	Review opportunities for reusable personal protective equipment	Lead Nurse Infection Control	Mar-23	In Progress
SU2	Sustainable use of Resources	Core responsibilities	Develop and implementation of a non-clinical plastics plan to remove the use of single use plastics where there is a viable and lower carbon option.	Sustainable Development Committee	Jun-23	In Progress
SU3	Sustainable use of Resources	Core responsibilities	Develop a clinical plastics plan to remove the use of single use plastics where there is a viable and lower carbon option.	Sustainable health care committee/Lead Nurse Infection Control	Mar-23	Requires Action
SU4	Sustainable use of Resources	Procurement and Supply chain	Membership of WARP-IT (a customisable online peer to peer reuse network)	Requisition & Supplies Manager	Mar-22	Implemented
SU5	Sustainable use of Resources	Procurement and Supply chain	No longer purchase single-use plastic cutlery, plates or single-use cups made of expanded polystyrene or oxo-degradable plastics	Head of procurement/Catering Manager/Requisition & Supplies Manager	Mar-22	Implemented
SU6	Sustainable use of Resources	Working with Staff, Patients & Communities	Commence waste management projects in departments to identify avoidable waste	Sustainability manager/Waste minimisation officer	Oct-22	In Progress
SU7	Sustainable use of Resources	Working with Staff, Patients & Communities	Address the over-use of non-sterile gloves through education and training.	Lead Nurse Infection Control	Mar-23	In Progress
SU8	Sustainable use of Resources	Working with Staff, Patients & Communities	Staff have access to initiatives and discount schemes that allow them to procure more sustainable products.	Deputy Director of Workforce	Mar-23	Implemented

2.9 Sustainable Care Models

Introduction

We need to embed sustainability into the heart of clinical pathways; helping to integrate healthcare services so they are more efficient, support patients in receiving care closer to home, and improve the general health and wellbeing of our population to reduce hospital admissions.

Aim

To deliver the best quality of care while being mindful of its social, environmental and financial impact and take a whole systems approach to the way it is delivered.

Tracking Progress

Sustainable Development Management Plan

Ref	Module title	X-Cutting Theme	Action	Responsible person	Target implementation date	Status
SC1	Sustainable Care Models	Governance & Policy	Awareness training for the Trust board net zero carbon lead on the role of sustainable care models	Sustainability manager	Mar-23	In Progress
SC2	Sustainable Care Models	Core responsibilities	Formation of a committee that will bring clinical leads together to help develop sustainable care models. This will include looking at areas such as anaesthetic gases and procurement.	Medical Director/Chief Nurse	Mar-22	Implemented
SC3	Sustainable Care Models	Core responsibilities	Explore training opportunities for clinicians to develop sustainable healthcare skills in the context of the NHS.	Sustainability manager	Mar-22	Implemented
SC4	Sustainable Care Models	Core responsibilities	Implementation of training for clinicians to develop sustainable healthcare skills in the context of the NHS.	Medical Director/Chief Nurse	Mar-23	In Progress
SC5	Sustainable Care Models	Working with Staff, Patients & Communities	Participation in the Centre for Sustainable Healthcare Green Ward competition	Chief Nurse	Mar-22	Implemented

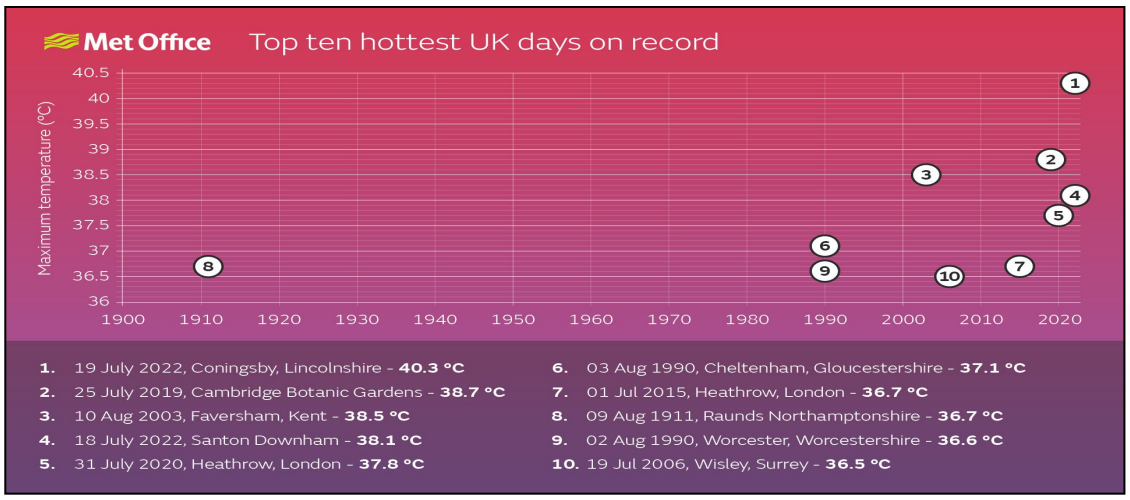
2.10 Climate Change Adaptation

Introduction

We must be resilient against the threats of a changing climate and adapt now. We need to take appropriate action to prevent or minimise the damage of increasing temperatures and extreme

weather events across our estate so that our staff and patients are safe, and that we can continue to deliver our services.

In 2022 particular concern was raised around the increase in frequency and intensity of heatwaves. The UK has slowly been getting warmer. Data collected by the Met Office, shows that the most recent decade (2009-2018) was around 1°C warmer than the pre-industrial period (1850-1900). Nine of the top ten warmest years for the UK since 1884 have occurred since 2002. In contrast, none of the coldest years have been recorded in this century.



A significant moment occurred in 2022 when the UK Health Security Agency (UKHSA) declared a national state of emergency on Monday 18th July with a level 4 heat-health alert which remained in place until Wednesday 20th July. The level 4 alert is the highest warning and the first time it had been issued on a national level. At level 4 illness and death can occur among the fit and healthy. Also, that the impacts could go beyond health and social care with potential effects on transport systems, food, water, energy supplies and businesses.

On 19 July, a record temperature of 40.3 °C was recorded and verified by the Met Office in Coningsby, England, breaking the previous record set in 2019 of 38.7 °C. The same day Greater Manchester temperature reached record high of 37.7°C, with the previous record of 33.9°C from July 25th, 2019. As climate change has driven such unprecedent severe weather events it can be difficult to make the best decisions because the heat was far more intense and widespread than previous comparable heatwaves. The UKHSA estimates that between 17 to 20 July, when temperatures were at their highest, there were 1,012 excess deaths in those aged over 65. These figures demonstrate the possible impact that hot weather can have on the elderly and how quickly such temperatures can lead to adverse health effects vulnerable groups.

The table below is taken form the Trust Heatwave Plan and identifies the vulnerable groups.

Group	Factors
Older age	Especially women over 75 years old, or those living on their own who are socially isolated, or in a care home
Chronic and severe illness	Including heart conditions, diabetes, respiratory or renal insufficiency, Parkinson's disease or severe mental illness. Medications that potentially affect renal function, the body's ability to sweat, thermoregulation or electrolyte balance can make this group more vulnerable to the effects of heat
Inability to adapt behaviour to keep cool	Having Alzheimer's, a disability, being bed bound, too much alcohol, babies and the very young
Environmental factors and overexposures	Living in urban areas and south-facing top-floor flats, being homeless, activities or jobs that are in hot places or outdoors and include high levels of physical exertion

In a moderate heatwave, the above high-risk groups are mainly affected, with our patients – and some staff, possibly – mainly falling into the chronic and severe illness category. However, during an extreme heatwave such as that between 17 to 20 July 2022, normally fit and healthy people can also be affected.

The extreme heat put significant pressure onto the Trust cooling systems. All areas with mechanical ventilation struggled with the air handling units working at full capacity.

Throughout the heatwave the main areas of concern where: -

- Proton Beam Therapy
- Oak Road Patient Treatment Centre
- Radioisotopes
- Magnetic Resonance Imaging (MIR)

As the outside air temperature was so high it restricted how much the cooling coils in cooling systems could bring internal temperatures down. The roof top chillers required manual cooling with hosepipes throughout the heatwave. The building power supply also tripped due to the amount of load being demanded for the colling systems. If the cooling systems had failed it could have led to overheating of equipment on site and impacted service delivery.

Aim

To ensure that our whole organisation is prepared to deal with the effects of climate change, particularly extreme weather events, and continue to invest in adaptation and mitigation measures.

Tracking Progress

Ref	Module title	X-Cutting Theme	Action	Responsible person	Target implementation date	Status
A1	Adaptation	Governance & Policy	A Climate Change Risk Assessment to be added to Trust risk register and reviewed annually.	Health, safety and emergency planning lead/Sustainability Manager	Oct-22	In Progress
A2	Adaptation	Governance & Policy	Develop an Adaptation Plan for approval by Trust board	Health, safety and emergency planning lead/Sustainability Manager	Mar-23	Requires Action

2.11 Travel and Logistics

Introduction

As a Trust with multiple sites and the need to provide some elements of patient transport, the transport of goods and services, as well as staff, patients and visitors has a significant impact on the environment. We need to reduce the impact of these activities by eliminating unnecessary journeys, and promoting sustainable and active travel methods, leading to cost savings and health benefits.

Aim

To encourage sustainable and active travel wherever possible and reduce carbon and air quality impacts of our organisation and supply chain.

Tracking Progress

SDMP

Ref	Module title	X-Cutting Theme	Action	Responsible person	Target implementation date	Status
TL1	Travel and Logistics	Governance & Policy	Complete a green fleet baseline review (19/20)	Deputy Director of Workforce/Sustainability Manager	Oct-22	Implemented
TL2	Travel and Logistics	Governance & Policy	Cut business mileages and Trust fleet air pollutant emissions by 20% by 2023/24.	Director of Finance & Business Development/Deputy Director of Workforce	Mar-24	In Progress
TL3	Travel and Logistics	Governance & Policy	Review Expenses Travel and Subsistence Policy in line commitment to reduce emissions from fleet by 20% by 2023/24.	Deputy Director of Workforce	Oct-22	Implemented
TL4	Travel and Logistics	Governance & Policy	End all domestic flights for business travel, including reimbursement for domestic flights	Director of Finance & Business Development	Mar-22	Implemented
TL5	Travel and Logistics	Core responsibilities	Assessment to ensure staff have access to facilities for video/teleconferencing to support homeworking, reduce business miles between sites and from attending external meetings.	Chief Information Officer	Oct-22	Implemented
TL6	Travel and Logistics	Core responsibilities	Continued implementation of the Green Travel Plan (2014-2030)	Sustainability Manager	Mar-22	Implemented
	Travel and Logistics	Procurement and Supply chain	A strategy in place to ensure that at least 90% of the Trust fleet uses low-emissions engines (including 25% ultra-low emissions) by 2028.	Head of procurement/Sustainability Manager	Mar-23	In Progress
TL7	Travel and Logistics	Procurement and Supply chain	All new Trust leased or purchased vehicles must be zero emission vehicles.	Head of procurement/Requisition & Supplies Manager	Mar-23	Requires Action
TL8	Travel and Logistics	Procurement and Supply chain	Engagement with GMHSCP to develop target for reducing the environmental impact (GHGs and Air pollution) of the logistics associated with the delivery of goods and services to site .	Head of procurement	Mar-24	In Progress

Green Travel Plan

As part of the agreement for Christies strategic planning framework (SPF) the Trust produced a Green Travel Plan to support site development. The GTP aims to support all site employees in a move away from single occupancy vehicles (SOV).

The modal shift is based on the following targets for staff using sustainable travel:

- Medium term (2024) – 52%
- Long term (2030) – 60%

The tables below detail the process for conducting the 2022 survey and the results; -

Table 1: Staff survey statistics

	2013	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**
Nº of staff surveyed	789	1682	1781	3758	3527	3565	3538	3721	3795	3735
Returns	394	650	599	1330	1428	1474	1560	1591	1556	1442
Non returns	395	1032	1118	2339	2099	2091	1978	2130	2239	2293
Response rate	49%	39%	34%	35%	40%	41%	44%	43%	41%	39%

Table 2: Modal Split results

Method of commute	**Baseline** 2013 (%)	2014 (%)	2015 (%)	2016 (%)	2017 (%)	2018 (%)	2019 (%)	2020 (%)	2021 (%)	2022 (%)
N/A - Working from home								13.07	13.07	9.50
Walk	14.00	12.62	14.02	14.51	13.94	14.25	15.00	11.57	13.24	13.66
Bicycle or motorcycle	6.30									
Bicycle		6.15	6.68	8.72	7.28	6.85	6.79	6.91	7.07	7.98
Motorcycle		0.15	0.67	0.08	0.91	0.54	0.38	0.31	0.32	0.21
Bus	6.90	7.23	11.52	9.32	7.42	8.48	9.62	7.42	6.68	7.63
Train	1.00	1.23	1.00	0.75	1.96	1.02	1.03	0.82	0.58	0.83
Metrolink	1.80	0.62	0.83	1.88	2.52	3.60	3.46	1.57	2.06	3.12
Car share/passenger	4.80									
Car share		2.92	5.34	4.36	2.80	3.60	2.12	1.45	1.35	1.66
Lift share *		2.77	3.01	2.18	2.10	2.10	5.83	2.14	2.76	1.94
Park & ride transport		0.00	0.67	1.42	1.12	1.22	1.28	0.31	1.16	
Drive (SOV)	61.90	66.31	56.26	56.77	59.94	58.34	54.49	54.43	51.48	53.47
Unknown	3.40									
Total Sustainable Travel	34.80	33.69	43.74	43.22	40.05	41.66	45.51	45.57	48.29	46.53

*A staff member giving a lift to another colleague who is not a car driver and therefore a car has not been removed from the road. Whilst this is encouraged under the Green Travel Plan this situation will not afford the same benefits as the defined car sharing situation.

A full report on the 23/23 progress on the Green Travel Plan (2014-2030) can be found here.

3. Greener NHS Data Collection 22/23

Introduction

The Greener NHS Team developed a Memorandum of Understanding outlining deliverables and targets for the 2022/23. Wherever possible, Greener NHS are making use of existing sources of data and pre-developed metrics to minimise the burden of collection. However, Greener NHS need to fill the gaps and to improve the quality, completeness, and timeliness of existing data.

Aim

The Greener NHS Data Collection has been created understand progress on the deliverables.

Data from the collection is reported back via the Greener NHS Dashboard and other Greener NHS Support Tools to:

- support benchmarking;
- show progress against deliverables; and
- aid further planning exercises.

The process has helped develop an understanding of the data and metrics needed to underpin the delivery of the NHS' Net Zero ambitions and provide the basis for accountability at The Public Board, The NHS Sustainability Board and Regional level.

Tracking Progress

Greener NHS Deliverables	Greener NHS Data Collections			
	Q1	Q2	Q3	Q4
Q1. Does your organisation purchase 100% of its electricity from renewable sources?	In Place	In Place	In Place	No
Q2. Have you (a) undertaken the piped nitrous oxide waste audit, as illustrated by the nitrous oxide waste reduction toolkit, (b) identified wasted nitrous oxide by comparing clinical use of nitrous oxide and procurement data and (c) acted on the findings?	No	No	In Progress	In Progress
Q3. Does your organisation purchase or lease solely vehicles (under 3.5 tonnes) that are ultra-low emission vehicles (ULEVs) or zero emission vehicles (ZEVs)?	No	No	No	No
Q4. Does your organisation's salary sacrifice scheme for vehicles allow for the purchase of only ULEVs or ZEVs?	No	In Place	In Place	In Place
Q5. What travel-related schemes do you operate across your organisation?	In Place	In Place	In Place	In Place
Q6. Which local transport partners does your organisation work closely with?	In Place	In Place	In Place	In Place
Q7. Please select number of sites to be added to enter. What facilities does your organisation offer for people who arrive by a mode of active travel?	In progress	In progress	In progress	In progress
Q8. At the site where you have the largest food service, how does your organisation measure the total amount of food waste produced?	In Place	In Place	In Place	In Place
Q9. Does your organisation have a digital meal ordering system for patients installed, as recommended by the Independent Review of NHS Hospital Food, to enable more accurate meal planning and reduce food waste?	No	No	No	No
Q10. In your food service, have you identified opportunities to make menu options healthier and lower carbon by increasing the proportion of fruit, vegetables, beans, pulses or other low carbon ingredients/proteins?	In Place	In Place	In Place	In Place
Q11. Have you identified a list of suppliers that will be impacted by the April 2023 Carbon Reduction Plan requirement (PPN 06/21)?	In progress	In progress	In progress	In Place
Q12. How are you managing the inclusion of the minimum of 10% on Net Zero and Social Value in every tender?	In Place	In Place	In Place	In Place
Q13. Do you participate in a walking aids return and reuse scheme?	In Place	In Place	In Place	In Place
Q14. Does your organisation have a nominated lead who is accountable for adaptation planning and management?	No	No	No	No
Q15. Does your organisation have a long-term climate change adaptation plan separate from your business continuity plan?	No	No	No	No

4. Challenges and Risks

4.1 Introduction

There are a number of challenges and risks that the organisation faces in ensuring implementation of the SDMP and the underpinning work programme. The risk assessment of the sustainable development management plan is currently scored at nine. We have identified seven key risks that we must work together with key stakeholders both within and outside of the Trust to overcome in the next year:

4.2 Organisation Vision

Although significant progress has been made in the last year, sustainability is still not fully embedded into the organisational culture as evidenced by no formal consideration for sustainability in business cases. This could be addressed by ensuring that there is a sustainable impact assessment for business cases.

4.3 Workforce and system leadership

Due to the scope of the work involved with responding to the climate crisis it is anticipated that additional staff resources will be needed. Training is also required to ensure that all staff understand the commitments around delivering a net zero service and how climate change will impact the service we provide at this Trust. Particular attention needs focused on raising awareness around the urgency of the climate crisis. Training will help to embed sustainability into operations and governance, create sustainable improvements and change culture. Through education we will be able to support adaptation and also incorporating the 'triple bottom line' into care pathways.

4.4 Finance

Budget constraints and access to financial capital is limited, if the Christie is to reach the NHS net zero targets, we will require significant access to capital. The cost to achieve net zero is not included here as there is no reliable way of doing this at present. In addition, there is no dedicated funding to support the delivery of the SDMP actions.

4.5 Heat Decarbonisation

All NHS trusts and NHS foundation trusts are to have a heat decarbonisation plan, identifying and prioritising the phasing out of existing systems by 31st March 2024.

4.5 Travel & Transport

All NHS organisations in performing their obligations under the NHS Standard Contract 2023/2024 must take action to reduce air pollution from fleet vehicles, transitioning as quickly as reasonably practicable to use exclusively Zero and Ultra-Low Emission Vehicles. Currently there are no restrictions in place at the Trust and no fleet vehicles onsite are compliant with these emission standards.

4.6 Adaptation

Climate change is already happening. There is a clear and immediate need for the reducing our carbon emissions to net zero, and to adapt to the impacts of climate change that can't be avoided.

Building resilience into the system as it protects and promotes the health of populations now and in the future.

To meet our obligations to adapt the premises and the manner in which services are delivered to reduce risks associated with climate change and severe weather a climate change needs adding to the Trust risk register. In addition, an adaptation plan needs developed.

4.7 Carbon Footprint Plus

The Trust currently does not have a process in place to report the carbon footprint plus, carbon budget and trajectories. Current challenges are the volume of data that needs collecting and categorised to produce a footprint.

5. Conclusion

We have seen a significant increase in levels of interest and engagement, as public consciousness grows. The frequency of staff enquiries has grown as they see opportunities in their own work areas. This will only intensify, as people will come to expect large public sector organisations like ours to be leading from the front on sustainability and climate change. This will undoubtedly present challenges, but we will continue to find innovative ways of engaging staff with this agenda.

Embedding sustainability into the core values of our organisation is vital to ensure sustainable healthcare and support the Trust to continue to deliver exceptional care in a time when the climate crisis is escalating. There may be many challenges but there are also opportunities to deliver a service that delivers socially, financially and environmentally.

October 2023