The Christie
NHS Foundation Trust

Board of Directors meeting

Thursday 26th October 2023 at 12.45 pm

Education Centre, Seminar Room 4/5

DRAFT Agenda

Clinical presentation: Dr James Price, H&N Oncologist & Erica Murphy, patient – Head & Neck pathway, patient's perspective & use of ePROMs 30 mins

				Page	Timing
Public items					
31/23	**Standard business**				
a	Apologies		Chair		
b	Declarations of interest		Chair		
c	Minutes of previous meeting – 28th September 2023	*	Chair	2	5 mins
d	Action plan rolling programme, action log & matters arising	*	CEO	9	
32/23	**Board assurance**				
a	Board assurance framework 2023/24	*	CEO	12	
b	Quality Assurance Committee summary report to Board – September 2023	*	Committee chair	18	25 mins
c	Review of annual objectives 2023/24	*	CEO	23	
d	Summary of feedback from Board Members	*	Chair	33	
33/23	**Key Reports**				
a	Trust report	*	CEO	35	15 mins
b	Freedom to Speak Up annual report	*	FTSUG	46	15 mins
34/23	**Any other business**		Chair		

Date and time of the next meeting
Thursday 30th November 2023 at 12:45pm

Papers for information only

Integrated performance, quality & finance report	*		64	

CEO	Chief Executive Officer	*	paper attached
FTSUG	Freedom to Speak Up Guardian	v	verbal
		p	presentation

Public meeting of the Board of Directors
Thursday 28th September 2023 at 12.45 pm
Paterson Seminar Room 2-020

Present: Chair: Chris Outram (CO), Chairman
Roger Spencer (RS), Chief Executive Officer
Dr Jane Maher (JM), Non-Executive Director
Robert Ainsworth (RA), Non-Executive Director
Alveena Malik (AM), Non-Executive Director
Tarun Kapur (TK), 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

Minutes: Louise Westcott (LW), Company Secretary

In attendance: Jo D'Arcy, Assistant Company Secretary
Jeanette Livings, Director of Comms & Marketing
Linda Seddon, Public Governor
Darren Buckley, Siemens Healthineers
Rupert Brereton, Pfizer

Clinical presentation: Dr Maria Serra (MS), Consultant Clinical Oncologist, Janine McDermott (JMD) Brachytherapy Nurse and Paul McManus (PM), patient – Past, Present & Future of Brachytherapy at the Christie and the patient pathway

MS introduced the service at The Christie and outlined what brachytherapy is. Brachy is invasive and done in theatre. It is used for prostate and gynae in the main but some skin treatment also. The dose is targeted, and surrounding structures get a low dose. This allows a higher dose of radiotherapy to the tumour; it's bespoke to each patient.

The first prostate brachy was used in 1911 but has been used as standard of care since the 1980's. Christie were pioneers in brachytherapy and the catchment is wider than GM.

The team were outlined, and the service is delivered through a team approach, physicists, radiographers, anaesthesia are all involved.

The ambitions of the service were outlined as a desire for excellence in brachytherapy. The facilities are very good here, there's a high brachytherapy endorsement by the clinical teams although some weaknesses were outlined including succession planning. There are opportunities for extension of the service to penile cancers and for relapse of prostate patients as well as expansion to a wider geographical area. Threats include the slow learning curve as its very complex as well as the future funding and competition from other forms of radiotherapy.

MS outlined the way brachytherapy links to the Trust strategy including use of data, addressing health inequalities as this is a centralised service, research trials that are in place and connections to the Radiotherapy Research team and possibilities with real world research. Teaching is also central to the service and a fellowship is in development.

MS noted that there is competition between the treatment modalities as there are multiple options available for prostate patients.

JM asked if there's been consideration of head & neck or virtual training to spread our expertise internationally. MS agreed there are opportunities for virtual training. In terms of head & neck, there are opportunities but other advances in radiotherapy have taken over as a better option.

The patient pathway was shown on a video clip that showed the outline of the department including the theatres and treatment rooms and the recovery area.

RA asked if everyone who wants brachytherapy gets it. MS said that all that want it here can get it, this isn't the case nationally. We do get second opinion referrals from all over the country.

AM congratulated the team on the service and asked if they are ahead of the rest in Europe and what do the service need. MS noted that staff and stakeholder engagement in future funding is what's needed and that the service is leading.

JMD told her story of developing as a brachytherapy specialist through her apprenticeship course, this is a 3-year course to become a clinical technologist. She was previously an administrator in the team. MS noted that we promote our staff to develop, and JMD is an excellent example.

One of MS's patients, PM introduced himself, he's 55, doesn't smoke has a healthy lifestyle and does everything to keep himself healthy. In 2020 he had a minor stroke and then had an operation to correct a hole in his heart. Through this a PSA test was done and he was diagnosed with prostate cancer. The diagnosis was a huge shock. He was aware of brachytherapy as well as other options. He came to the Christie in August 2022 and met Dr Serra. He outlined that Dr Serra made him so at ease and had a fantastic way of making him feel safe. He decided to have the treatment and he truly felt that he was getting the best treatment in the world. He's still here and healthy. He went through 2 treatments, the empathy and caring nature of those that toughed his and his wife's lives was wonderful and he felt incredibly grateful. There was severe tiredness for a few weeks after the treatment, but this was short lived and was the only major side effect. He returned to work within 3 weeks and hasn't looked back. The side effects have been minimal, and he feels very privileged to have had his treatment at The Christie.

PM also noted that he had a colleague who was treated for prostate cancer who was not in this area and wasn't given the option of having brachytherapy but instead had surgery. He is suffering from some very difficult side effects of his surgery, unlike his own experience.

LS noted that her husband had brachytherapy 12 years ago and is now 76 and well.

CH asked how typical MS's pathway to treatment is where it is an incidental finding from another procedure. MS noted that there are those who have symptoms and are referred and those who had an incidental finding. The diagnosis is variable, and both are common.

NB asked about the shared decision-making process and how patients are supported to make a choice. MS outlined the innovative shared clinics with clinical oncologists and surgeons available for patients to speak to and how they work together with the patient to make decisions on the best treatment option. It is very patient focused. PM agreed that the process to decide was made easy by the team.

KW asked if there are NICE guidelines for brachytherapy. MS noted that there are but outlined that there isn't the skill set to deliver the treatment which is why it's not available everywhere.

The importance of longitudinal research on quality of life and survivorship was noted.

AM noted that JMD is inspiring and brilliant, the development opportunities for staff are fantastic.

CO thanked everyone for coming and speaking to Board and the huge importance of hearing from staff and patients. Thanks to everyone for their participation.

Item		Action
26/23	**Standard business**	
a	**Apologies**	
	Grenville Page (GP), Non-Executive Director	
b	**Declarations of Interest**	
	None noted.	
c	**Minutes of the previous meeting – 29th June 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.	
27/23	**Board Assurance**	
a	**Board assurance framework 2023/24**	
	RS noted the BAF 2023/24. There are some updates on the risks and additional columns have been added to show actions and timescales in line with recommendations from MIAA. It was noted the score of the cyber risk has reduced. The score for the impact of industrial action has increased. The link to the assurance levels given by the committees was also noted. RS noted that attached to the BAF is a summary of how we are transacting the safety approach of NHSE in the organisation and points to the relevant assurance committees for each aspect. Noted.	
b	**Audit Committee summary report to Board – June & July 2023**	
	SP noted the SFI's were reviewed and these are later on the agenda for approval. The High assurance on the financial risk was noted. No other comments or items for escalation.	
c	**Quality Assurance Committee summary report to Board – June 2023**	
	KW noted the issues for assurance – patient safety, incident reporting and PSIRF. Infection control and learning from deaths report was also noted. All received high assurance. There were no items for escalation.	
d	**Workforce Assurance Committee summary report to Board – July 2023**	
	TK noted that the workforce risks are being reviewed and have medium assurance as the outcomes from actions haven't progressed fully. Monitoring of agency staff gained high assurance. CH noted that WDES is positive compared to the last submission.	
e	**Fit & Proper Person Test (FPPT) Framework and updated Policy**	
	CO noted that a new NHSE FPPT framework has been issued in August 2023 and brings in new requirements. The paper outlines the new requirements. CO noted that;	

	• FPP testing must now be recorded in the electronic staff record (ESR) and new fields have been added. • There's a requirement to use Board Member References for all *new* board members and board members *who leave.* This is a standard across all organisations and includes additional information e.g., relating to training & development (last 6 years) • ICB's and some ALB's are now covered by the requirements. • There are additional responsibilities for Chairs as well as the SID / company secretary and CEO amongst others, and a requirement to sign off compliance and report this through Board. • New templates and checklists have been issued for consistent recording. • It outlines specific requirements on appointment / at annual review and as & when FPPT information becomes available. • An annual submission of compliance must be sent to the NHSE Regional Director. The paper also gives a progress update on the actions relating to the F&PP identified in the CQC action plan. The actions have all been completed but the new framework means that further work is required to comply with the new requirements. The paper also includes the updated Fit & Proper Persons Policy that outlines the Trusts responsibilities and processes around CQC Regulation 5: Fit & Proper Persons and reflects the additional requirements of the 2023 NHSE Framework. MIAA have shared a Checklist that is attached as an appendix, and this has been used in the updating of the policy and progress is outlined. Outstanding actions relate to requirements that must be complete by March 2024. The Board; • Noted the introduction of the NHSE FPPT Framework August 2023 and the additional requirements. • Noted the completion of the actions from the CQC action plan 2022 relating to Regulation 5 Fit and Proper Persons requirements and that a full report will come to the October Board for sign off. • Approved the updated Fit & Proper Persons Test Policy and noted the requirement to review the policy in line with the review date. • Noted the progress against the MIAA checklist and plans for further reports on compliance to committees of the Board. CH noted that this is something that we need to understand including the requirement to submit to the regional director and the collection of additional personal data in ESR. LW noted that the policy contains a Privacy Notice and a copy was circulated to each director for review. LW noted that these need to be signed to show acceptance of the updated personal data requirements and returned. There was discussion around the use of data, implications for FOI's, subjective nature of the assessments and what is recorded in the BMR.	**All**
28/23	**Key Reports**	
a	**Trust report & Integrated performance, quality & finance report**	
	RS noted the updated presentation of the report to cover issues in a comprehensive way that includes as an appendix the IPFQR.	

	RS highlighted the results of the patient surveys that will be discussed in the next item. These are very positive and show sustained very high performance of services and care for our patients. Our financial position is better than plan. Success for individual staff was noted, including MAHSC professor appointments and leading research work being undertaken here. Results in the doctors in training questionnaire are very good and are used as a comparator with other organisations. There's an improvement and these are the best results in 5 years. It was noted that we are looking again at the presence of RAAC in our buildings. There are no concerns, but we are assessing this again in line with requirements. The ICB have notified us of a review of our SOF rating as a result of the CQC inspection. We will be notified of this soon. The SOF rating of the ICB has deteriorated and intervention has been put in place. We are participating in this, but it's noted that we are better than our plan. RS noted 2 policy changes, the first is the consolidation & changes to cancer waiting times from 9 to 3 measures. The measures are 31 and 62 days and the faster diagnosis standard (FDS) that looks at suspected cancer diagnosis – 95% of these patients will not end up having cancer or become our patients. The changes may result in a slight improvement for us in performance. The second is the introduction of the NHS enforcement guidance – this is about the consequences for under performance and actions that can be taken by NHSE. Penalties can be imposed as long as the situation is made clear to providers by NHSE. This includes a financial penalty. In terms of industrial action, the challenges are significant, and the escalating situation has been very well managed. We have cancelled 24 day cases, 17 elective inpatient treatments and 14 new appointments as well as 669 follow up appointments since this started. Extra sessions have been put in place to catch up on this delayed activity. There are ever increasing pressures from this action. The next action is next week. RF noted that the improvement in the feedback from trainees comes from collaboration with different departments and bringing trainee voices into this. F2 doctors have been a focus with active supervision and listening to feedback. There's a coaching & mentoring approach. NB noted RF's involvement as well as Dr Ganesh Radhakrishna and Dr Vanessa Clay whose hard work has made a significant change for the juniors. CO noted the impact on the performance of the issues raised around strike action in terms of cancellations and targets. It was noted that around 22 consultants took strike action out of approximately 200.	
b	**Care Quality Commission (CQC) action plan update**	
	JY presented the paper that outlines the action plan and shows progress against the 7 must do's. There's been excellent motivation to get this right and progress the required actions. The report will be submitted to the CQC following final sign off by the Board in October. We continue to meet with CQC colleagues as part of usual catch ups as well as with commissioners and no issues have been raised through these meetings. The IR(ME)R action plan was also discussed. The actions have been completed with evidence and this is going through process for final sign off. This is closed	

	from a CQC perspective. JY noted that we are also progressing work around the should dos from the 2022 inspection report including the cultural audit and a review of our assurance processes. No concerns were escalated to Board. Report and progress noted.	
c	**CQC Adult Inpatient survey results**	
	JY noted the overall we scored 9/10. The lowest score was still in the highest quartile, and this was around opportunities to feedback. We continue to work to improve in this area. The results are excellent and show us as a positive outlier.	
d	**National Cancer Patient Experience Survey**	
	We scored 9.1/10 overall which is above the expected range. Waiting times in outpatients and time to have treatment done were the lower scores. There have been some great changes in ORTC in terms of waiting that we hope will impact on the next lot of results. There was also a lower score around the pre-treatment pathway and we're working with GM Cancer on this. JY noted that the new Patient Experience Plan has been developed and received high assurance at the Quality Assurance Committee in September. We anticipate this making further improvements. AM asked how we disseminate these fantastic results. JY noted that we use social media and it's extensively spoken about internally and on the intranet. It's also shared with NHSE and the ICB. RS noted that these results reflect what patients think and we have seen high performance in these surveys which is fantastic. The trend is very valuable and we continue to look to improve as well as communicating our success.	
e	**Leadership & culture update**	
	EL updated the Board on a paper that addresses 2 publications from NHSE. The first outlines the priorities around culture and leadership. This also addresses the response to the Lucy Letby trial, this publication outlined the importance of Good Governance in relation to speaking up arrangements and reminded Trusts of their responsibilities under the FPP framework. We have assessed our Freedom to Speak Up arrangements against the guidance issued by NHSE. We have responded and provided detail for each recommendation and we are developing our processes further by the implementation of training for managers and undertaking some further analysis into the barriers particularly related to diversity. We are also looking at implementing an anonymous reporting tool to help encourage speaking up. The paper also describes the work to ensure that patient safety incidents are triangulated with employee relations issues. We are developing our existing scrutiny panel to improve the governance and better integrate employee relations and patient safety incident procedures. This will include extending the remit of the panel and representation, oversight of outcomes of hearings and all recommendations to ensure actions are followed through and feedback is given to everyone involved. The most important thing is ensuring that every patient safety issue has a Datix number that is followed throughout the management of the employee relations case and we have a full audit trail of every step of the process . EL referred the board to the Trust People and Culture plan that is reviewed through the Workforce Assurance Committee. This plan sets the groundwork for the culture work we have commenced and are developing which started with the	

	creation of a clear set of values and behaviours. This will link to the Globis cultural review that is currently taking place. The NHS Long Term Workforce Plan was published in June and we are currently reviewing this plan to ensure our people plan addresses the national priorities this will include a review of our annual planning process which will be discussed at the board development day in October. The final part of the communication references a number of national reviews which highlight the importance of leadership and culture. We have summarised our response to these in the report. A separate report has been provided for the board in relation to the FPP. The board were asked to note our response to the national publications. JM asked about metrics to show progress. EL noted that we need to focus on feedback and how we capture this and show learning and shared understanding of what's going on.	
f	**Integrated Care System mandated support**	
	SP outlined the paper that shows the very challenging financial problem in GM. NHSE have acted and have put a turnaround team into GM to work alongside PWC. We attended a meeting with the turnaround team last week. CO noted that the team were mostly very supportive of us. They challenged us to take responsibility for the planned deficit ourselves. RS noted that they were straight forward with us and showed a degree of confidence in our position in the system. RS noted that the other parts of the system are extremely challenged. SP noted that we have received a letter from the CEO of the ICB confirming vacancy controls on all trusts. We will reply with a letter that explains that we are ahead of plan and have had our comprehensive controls recognised and that to continue to deliver our plan we will need to increase headcount. RS noted that we will look at a review of our balance sheet with the team next week.	
29/23	**Approvals**	
a	**Revised Standing Financial Instructions (SFIs)**	
	SP noted that the SFI's have been reviewed and updated to reflect updated admin / portfolios / legislation etc. These have been commented upon by the Audit Committee and the Board are asked to approve them. Approved.	
b	**Trust proposal of nomination of FT Trustee to Christie Charity Board**	
	RS noted that the arrangements for the Charity have been updated from 1st April 2023. This is the agreed process for the nomination of the successor to CO from 1st October. Edward Astle was agreed as the new FT Trustee. Approved. Details to be passed to The Christie Charity	**LW**
30/23	**Any other business**	
	No items raised.	
	Date and time of the next meeting	
	Thursday 26th October 2023 at 12:45pm	

The Christie NHS Foundation Trust

Agenda item 31/23d

Meeting of the Board of Directors - October 2023

Action plan rolling programme after September 2023 meeting

Month	From Agenda No	Issue	Responsible Director	Action	To Agenda no
October 2023	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
November 2023	Annual reporting cycle	Integrated performance & quality report and finance report	COO	Monthly report	
		Greater Manchester Cancer update	GM Cancer lead	Report	
		CQC Action Plan	ECN	Approve for submission	
		6 monthly review of strategy	DoS	Report	
	CQC 'should do'	Globis Culture Audit report	CEO	Report	
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	
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-23	Annual reporting cycle	Integrated performance & quality report and finance report	COO	Monthly report	28/23b
		Standing Financial Instructions (SFI's)	DoF	Approve	29/23a

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Agenda item: 31/23d

Action log following the Board of Directors meetings held on

Thursday 28th September 2023

No.	Agenda	Action	By who	Progress	Board review
1	27/23e	All Board members to review, sign & return a copy of the Privacy Notice relating to the Fit & Proper Person Test	All	Copies received, chasing outstanding forms	To be included in the compliance report to Workforce Assurance Committee and the March 2024 Board of Directors
2	29/23b	Details of the newly approved FT charity trustee to be communicated to The Christie Charity	LW	Complete	N/A

The Christie
NHS Foundation Trust

Agenda Item 32/23a

Thursday 26th October 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

The Christie
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Agenda Item 32/23a

Board of Directors meeting

Thursday 26th October 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;

- Target risk scores updated for each risk.
- Where a risk has been assessed by an assurance committee the level of assurance has been added.
- Additional columns have been added to the BAF in line with recommendations from MIAA to show 'actions to address gaps' and 'timeline for completion'.
- The risk score at the end of Quarter 2 has been added for each risk.
- Risk 6.5: Reputational damage, service disruption and financial loss due to cyber-attack has been rescored as a 12 (3/4) in line with the risk assessment done by the Digital team. This is a reduction from the previous score of 15 (3/5).
- Risk 8.4: Reduced ability to provide services and support to patients due to national / global influences (supplies / fuel costs / strikes etc). This risk has been split into 2 elements to highlight the impact of ongoing strike action and the increased risk this presents to the Trust. The industrial action element of this risk is scored as a 20 (5/4).

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 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
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Agenda Item 32/23b

Meeting of the Board of Directors
Thursday 26th October 2023

Subject / Title	Quality Assurance Committee report – September 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 Quality Assurance Committee at their September meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions
Background papers	Quality Assurance Committee papers 21st September 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.	

The Christie
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Agenda item 32/23b

Meeting of the Board of Directors
Thursday 26th October 2023

Quality Assurance Committee report – September 2023

1 Introduction

The Quality Assurance Committee took place on 21st September 2023. The following summary gives the Board information on the items that were considered, and any actions required by the Board.

2 Quality Assurance Committee agenda items

The items listed below were all presented to the Quality Assurance Committee for assurance in September:

Agenda item	Infection Prevention & Control Board assurance framework (IPC BAF)
BAF reference	1.3
Assurance rating given	High

Key points and associated action (where applicable):

- The framework is not compulsory but is intended to help organisations ensure compliance with IPC standards. There are 54 elements to the framework in total; confident that the Trust are currently compliant with 40 of these, 13 are currently partially complaint and there is 1 non-compliant element.
- Staff Side/Health and Safety Union representatives have been invited to IPC Committee since May 2023 and also looking at other representation.

No actions identified.

Agenda item	Lost to Follow Up Update
BAF reference	1.2
Assurance rating given	Medium

Key points and associated action (where applicable):

- Task & Finish Group managing associated actions.
- Waiting lists have been introduced into CareFlow consisting of patients legitimately on hold/awaiting a future appointment with a review date, currently in the testing phase which has flagged an issue so there is a delay with the go live date.
- Working on the clearance of the backlog of open referrals which are already in the system. Significant amount of work on making sure all staff are working to the same process.
- To date, the Task & Finish Group has not been notified of any harm caused to patients as a result of being 'lost to follow up' and this is reviewed regularly through the Task & Finish Group. Assurance provided that actions are being taken and as high priority.

Action:

- Committee agreement to see the next update in January 2024.

Agenda item	Research & Innovation Governance Six Monthly Report
BAF reference	2.1, 2.2, 2.3, 2.4, 5.3
Assurance rating given	High

Key points and associated action (where applicable):

- Research strategy and 1-year deliverables set.
- The outreach programme is gaining pace and progress is being made.
- A number of staff have gained promotions and a number of teams have been nominated for awards.
- The organisational structure progress is going well.
- The Christie are in the first phase of the Cancer vaccine launchpad, which brings some resource. Need to ensure this connects up regionally and nationally. GM Cancer Alliance also involved as a contact point for overseeing.
- The key risk reported previously in relation to capacity to produce investigational medicinal products within aseptic services unit has significantly decreased following completion of the isolator replacement programme and recruitment and training of additional staff.

No actions identified.

Agenda item	Patient Safety Quarterly Report April - June 2023
BAF reference	1.1, 1.3, 1.5
Assurance rating given	High

Key points and associated action (where applicable):

- The number of incidents reported has decreased from the last quarter reported.
- Improvement in how incidents are managed; moderate and above incidents are required to be closed within 60 days and this is now being achieved ensuring patients are receiving feedback quicker.
- The new Patient Safety Incident Group has tightened the links between teams. The incident handling process has also changed, now have assurance that within 48 hours 95% of reported incidents have been looked at and handed out for action.
- In terms of themes for incidents, the highest category relates to administration, but the majority are medication related and are managed well.
- Two serious incidents declared in the quarter, the associated SI Panels have been scheduled.

No actions identified.

Agenda item	PSIRF Six Monthly Compliance Update
BAF reference	1.1
Assurance rating given	High

Key points and associated action (where applicable):

- Learning from Patient Safety Events (LFPSE) is replacing the current National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS), with the intention of providing improved support to services across health and care sectors. This is a big piece of work and is also associated with the replacing of Datix with Datix Cloud to bring better functionality.
- Team have made significant progress in terms of PSIRF implementation.
- National patient safety alerts are managed in a timely manner and monitored weekly via ERG.
- Patient safety culture development is to be embedded into Trust induction and the Trust Freedom to Speak Up Guardian is supporting the work of this.

No actions identified.

Agenda item	Patient Experience Quarterly Report April - June 2023
BAF reference	1.4
Assurance rating given	High
Key points and associated action (where applicable): • The 6-month compliance with complaints and response back to complainants is at 100%. • There is a robust process for reporting into ERG, supported by a RAG table. • There has been a fall in the number of complaints and PALS queries from the last quarter. • Two new staff team members, both have embedded quickly and positively. • The learning from complaints is now being embedded into the learning for improvement bulletins which are published. Complaints process also being added onto Trust induction so new starters are made aware of the process. • Clinical effectiveness - high number of audits completed compared to normal. No actions identified.	
Agenda item	Patient Experience and Engagement Plan
BAF reference	1.4
Assurance rating given	High
Key points and associated action (where applicable): • The plan is aligned to the quality plan and is focussed on maximising how we embed patients into the heart of everything we do and brings opportunities such as looking at how we engage with patient and carers in staff training. • Progress against the aims and objectives set out in plan will be monitored annually by the Quality Assurance Committee with the specific actions and progress of each work stream e monitored through a robust ward to board governance structure. No actions identified.	
Agenda item	Health and Safety Quarterly Report April - June 2023
BAF reference	7.3
Assurance rating given	High
Key points and associated action (where applicable): • Reduction in the number of staff accidents since the last quarter and 1 RIDDOR reportable incident. • Improved links with staff side on health and safety matters. • Currently working on HSE requirements, HSE Preparedness Group in place who are undertaking a gap analysis review of current Trust arrangements. No actions identified.	

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 Quality Assurance Committee in September 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.

The Christie
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Agenda Item 32/23c

Meeting of the Board of Directors
Thursday 26th October 2023

Subject / Title	Annual Objectives 2023/24
Author(s)	Louise Westcott, Company Secretary
Presented by	Chief Executive Officer
Summary / purpose of paper	For the Board of Directors to receive an update on progress on the annual objectives for 2023/24.
Recommendation(s)	The board of directors are asked to; • Note the update on progress
Background papers	Corporate objectives, board assurance framework 2022/23
Risk score	N/A
Link to: ➢ Trust strategy ➢ Corporate objectives	• Trust's strategic direction • Divisional implementation plans • Key stakeholder relationships
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	BAF Board assurance framework ECN Executive Chief nurse EDoF Executive director of finance EMD Executive medical director COO Chief operating officer DoW Director of workforce NHSE NHE England

The Christie
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Agenda item 32/23c

Meeting of the Board of Directors
Thursday 26th October 2023

Annual Objectives 2023/24

1. Introduction

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

2. Background

The annual objectives are summarised in the attached table with reference to a Board Assurance Framework (BAF) risk where relevant and a brief progress update. A full review of progress will be reported at the end of the financial year although it should be noted that for some measures the reporting will take place after the year end. This relates to the Annual Report & Accounts and the Quality Accounts where publication is after year end.

3. Recommendation

The board of directors are asked to;

- Note the update on progress against the annual objectives.

The Christie
NHS Foundation Trust

Executive Objectives 2023/24

1. To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer.						
	BAF	**Annual objective**	**Reporting**	**Timescale**	**Director**	**Progress**
1.1	1.3 1.4 1.5 6.1	Publish all information required under the NHS Code of Governance for Provider Trusts – including relevant oversight framework metrics (See below)	Trust Annual Report & Accounts and other governance documents prepared and reported to board with appropriate audit opinion	30.6.24	CS	External audit sign off of AR&A in October 2023. Require laying before parliament, aim to publish in November for 2022/23 For 2023/24 contained in Audit Committee and Joint Committee programme of work, dates reliant on NHS FT guidance.
1.2	1.3 1.4 1.5	Publish information on our quality of care in 2023/24 in our annual Quality Report and Accounts	Annual Quality Report and Accounts prepared and reported to board with appropriate audit opinion	30.06.24	ECN	Complete for 2022/23 https://www.christie.nhs.uk/about-us/about-the-christie/christie-quality For 2023/24 will be reported through QAC and Board.
1.3	8.3	Publish information on Environmental, Social and Governance (ESG) indicators in our board reports and website and incorporate into annual report	Annual report to board – incorporated into Annual Report	30.06.24	DCEO	To be included in the Annual Report in line with the Annual Reporting Manual 2023/24
1.4	6.1	Publish relevant metrics as set out in the NHS oversight metrics for 2023/24 when published (or 2022/23 metrics if 2023/24 not published by NHSE))	Monthly report to board	Monthly	COO	Monthly reporting in place
1.5	1.2	Publish information on clinical outcomes in line with the 2023/24 milestones in our Clinical Outcomes Strategy	Six monthly report to Quality Assurance Committee	31.3.24	EMD	Quality Assurance Committee rolling programme – January 2024

1. To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer.						
	BAF	**Annual objective**	**Reporting**	**Timescale**	**Director**	**Progress**
1.6	7.1 7.4	Publish progress with EDS 2022 self-assessment action plan	Effective web site page – six monthly report to Workforce Assurance Committee	6 monthly	DoW	Web page in place Our assessment and action plan Reported to Board April 2023 Workforce Assurance Committee rolling programme – March 2024
1.7	1.2 2.1 5.3	Publish self-assessment and action plan for health inequalities based on socio-economic deprivation, ethnicity, and other community characteristics	Effective web site page– six monthly report to Board	6 monthly	DCEO	To be completed
1.8	N/A	Ensure that all board and sub-committee papers contain appropriate impact statements including for health inequalities and EDI	Board and committee papers contain appropriate impact assessment statements	31.08.23	CS	In place where appropriate
1.9	1.6	Publish CQC report and action plan when available and implement agreed actions	Action plan developed, published, submitted to CQC within required timescales and reported to Board Action plan implemented and reported to board	30.11.23	ECN	Monthly updates to Board. 'Must do' actions progressed through assurance committees. Completed action plan to November Board for sign off. Actions identified and in progress around 'Should do's' – reported through Trust Report.
1.10	N/A	Develop our external website to ensure it provides up to date information on our quality of care	Reporting to Audit Committee	31.3.24	DCEO	Audit Committee rolling programme – February 2023

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

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

4. To integrate our clinical, research and educational activities as an internationally recognised and leading comprehensive cancer centre						
	BAF	**Annual objective**	**Reporting**	**Timescale**	**Director**	**Progress**
4.1	4.1	Ensure the website carries accurate, up to date information on our comprehensive cancer centre status	Six monthly reporting to Audit Committee	31.3.24	DCEO	Audit Committee rolling programme – February 2023
4.2	4.1	Prepare for and secure reaccreditation with the OECI as a Comprehensive Cancer Centre	Achievement of reaccreditation	TBC	DCEO	Initial data response being collated
4.3	4.1 4.2	Develop our network of international relationships through the OECI by participating in OECI working groups	Reporting of attendance / involvement in working groups	31.3.24	DCEO	On going participation reported through Trust Report
4.4	4.3	Secure agreement on new governance arrangements for MCRC partnership with University of Manchester and CRUK	Agreement in place and reported to board	31.3.24	DCEO	Ongoing discussions taking place
4.5	4.2	Promote the reputation of The Christie internationally by supporting attendance and scholarly contributions at prestigious international professional and corporate events.	Reporting of attendance at international meetings	31.3.24	DCEO	On going participation reported through Trust Report
4.6	4.2	Continue to develop partnerships in Kenya and Uganda, and others as appropriate	Include in regular international programme reports to board of directors	31.3.24	DCEO	On going participation reported through Trust Report
4.7	4.2	Increase range and uptake of activity made available internationally though the School of Oncology	Six monthly reporting to Workforce Assurance Committee	31.3.24	DE	Ongoing
4.8	1.4	Develop a Patient and Public Involvement & Engagement plan	Annual report to the Quality Assurance Committee	31.3.24	DCEO	Complete – reported in September 2023

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.

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.

We are pleased that we have been recognised by the National Disease Registration Service for the hard work of out outcomes teams in ensuring that our staging data completeness has exceeded 80% stage completeness in the Cancer Outcomes and Services Dataset (COSD) submissions for dates of diagnosis in Quarter 1 (January -March) 2023. This is a significant achievement and is directly attributable to the hard work of clinical and administrative staff in our team. This staging data enables national cancer registration and the associated analyses of cancer care pathways at regional, national, and international levels. The clinical outcomes unit have ensured that the completeness of our data entry has delivered this level of performance.

An enquiry from the HSJ has queried why the Trust reported a higher number of patient deaths to the National Reporting and Learning System (NRLS) in 2021/22 compared to previous years. We have responded explaining that this coincided with a change in criteria for reporting to NRLS which disproportionately increased the likelihood of an event being considered reportable for certain services, including cancer. Following representations about this, in June 2022 the criteria for a notifiable patient safety incident were updated to recognise that “if treatment or care provided went as intended, the incident may not qualify as a notifiable patient safety incident even if harm occurred” which corrected the previous change.

Of the eight deaths recorded for The Christie on the 2021/22 NRLS report during the period when the threshold for reporting was lower, five were due to known complications of an intervention or treatment and care. All deaths were investigated through our usual process.

Health Inequalities
The Greater Manchester Integrated Care Partnership has developed a “Fairer Health for All” framework to address health inequalities. This proposes actions at neighbourhood, locality and system levels on health equity, inclusion and sustainability. The key objectives set out in the framework are to:

- Continue to develop Greater Manchester as a Population Health System, embedding a population health approach, and building population health management capacity and capability.
- Strengthen and scale our approaches to primary and secondary prevention.
- Enhance the role of the Integrated Care Partnership as an anchor system in levering change by shaping the wider, social, economic and commercial determinants of health in Greater Manchester.
- Strengthen the Greater Manchester strategic approach to sustainability through delivery of the Green Plan.

Ratification by the ICB and ICP is anticipated in November 2023. Our plans need to be in line with the agreed GM framework and will be further developed over the coming 6

months. The board may wish to hear directly from the team from the ICP working on this initiative.

Domain 1 of The NHS Equality and Diversity System 2022 (EDS 2022) guides NHS organisations to address health inequalities "with regard to their specific roles and responsibilities". For NHS providers the opportunities for addressing health inequalities are to ensure that

- Patients have the required levels of access to the service
- Individual patients' health needs are met
- When patients use the service, they are free from harm
- Patients report positive experiences of the service.

Our approach to this is set out in our EDS 2022 return to NHSE together with our action plan which is published on the website. Progress is monitored quarterly by the Management Board and reported through its minutes to the Board of Directors.

We are also able to address health inequalities by cooperating with the ICB and ICS in their wider statutory duties such as in the Fairer Health for All framework. We currently do this in a structured way by participation in the GM Anchor Organisations network. Anchor organisations are large organisations with sizeable assets that can be used to support their local community's health and wellbeing and tackle health inequalities, for example, through procurement, training, employment, professional development, and buildings and land use. Further developments of this network will be reported to the board.

Financial Performance

Financial performance is ahead of plan. The Trust is reporting a £2.5m deficit against a £4.0m planned deficit position. This is mainly due to interest received on the Trust's cash balances being above planned levels due to an increase in the Bank of England base rate combined with pay underspends due to vacancies. There have also been additional costs in respect of industrial action plus unbudgeted costs associated with the medical pay award.

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 6 is £0.8m below plan.

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. Whilst divisions are working on the delivery of cost improvement schemes, the level of these assessed as 'delivering' is currently low.

Measure of Financial Performance	Red / Amber / Green rating
Revenue: Trust Control Total compared to plan	£2.5m deficit
Capital: Capital expenditure against plan	£0.8m under plan
CIP achieved (recurrent) against target of £6.4m	£1.9m identified
Debtor days compared to 15-day target	12 days
Cash balance	£126m

GM Recovery

The re-assessment of the GM ICB into 'System Oversight Framework' to level 3 (from level 2) instigated NHS England to commission PwC to undertake a review of Trust and ICB revenue and balance sheet positions to identify the underlying revenue position, forecast scenarios, potential for further balance sheet flexibility and improvements to the financial position.

Following the initial meeting of members of the Trust Board with PwC on 21st September, we received a letter summarising the discussion points and actions on 3rd October 2023. Following clarification of several points and a subsequent email to amend the letter, an

status with the Office for Students. We are now at the stage of convening a formal steering group. We will be updating the board in detail as plans crystallise over the coming months.

Strategic and Service Developments

The Paterson building is now operational and more of the groups from the Trust have started moving into the premises. These include Radiotherapy Related Research, Research and Innovation and Christie Patient Centred Research. Arrangements for the remaining staff continue as does the identifying and closing the old, vacated Estate when the groups have moved.

The Trust is in the process of a re-procurement exercise for its Pathology services. The services are currently provided through a Joint Venture arrangement with Synlab, which is due to conclude in 2024. A formal tender process is planned to commence in late October and will conclude during 2024.

The outpatient pharmacy and new dispensing robot on the Withington site continues to support improvements in the waiting times for outpatient pharmacy.

Works continue on the formation of a 20-bedroom ward in the former Trust Administration and Digital floors. The foundations for the extension to accommodate the new lifts and staircases are complete and work has commenced on forming the new partition walls. The development of the new Art Room design and cost plan remains in progress and works to reform the landscaping around the Tree of Hope has commenced with the new white concrete bench scheduled to arrive late October.

With the announcement to cancel Phase 2 of the HS2 project, the Trust remains in dialogue with their advisors regarding any next steps.

The design and engagement for the proposed Advanced Scanning and Imaging Centre development along Wilmslow Road continues. The design and supporting documentation for the Planning Application are complete and following the most recent meeting of the Christie Neighbourhood Forum no objections or adverse comments were noted. A further route of public engagement has been agreed with the Council and it is anticipated the Planning Application will be submitted early October. The design of the ancillary works to decant existing uses to facilitate the new development continues and the overall cost plan is being updated to include the management of risks to the project.

Our Carbon Energy Fund Scheme which has previously been reported to the Board and Committees is being commissioned and going live in phases through September to November, after over 2 years in development and construction. This is a key project in our sustainability aspirations and puts us a step closer towards achieving the NHS Net Zero targets. The scheme will deliver circa one tonne of carbon emission savings and circa £500k annual in energy cost savings.

Previous assessments and current site analysis indicates that we do not have any issues with Reinforced Aerated Autoclaved Concrete (RAAC) which has been the subject of publicity recently. In respect of our further assessments, we have completed a desktop assessment which remains as a low or very low risk of having RAAC. We have now commenced a validation survey with the summary report anticipated in the next 4 to 6 weeks and will enable us to respond definitively to NHSE most recent correspondence.

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

International

Our international programme covers work on service development, research and education. A recent programme board discussed the following:

- Establishment of a cooperation agreement with the Peter MacCallum Cancer Centre in Melbourne with plans for exchange visits, research collaboration, joint training and development and comparison of clinical outcomes.
- Providing advice as part of the consortium led by Kings College Hospital on agreed or proposed projects to develop cancer care in Nigeria, Dubai, and Saudi Arabia - our role is to advise on a range of specialist oncology areas.
- Proposals to advise the Aghios Savvas (Athens Comprehensive Cancer Centre), Greece on its preparations for OECI accreditation**.**
- Providing advice at national level on cancer care in Uganda and Kenya - for the example, The Christie Global Health Group led by Alison Sanneh is now preparing a joint application to fund 5 mentors and 6 contact sessions from the Tropical Health and Education Fund (THET) 'Global Capacity - Remote International Mentoring Partnership Scheme'.
- Research collaborations for example we are involved in a major NIHR programme in Kenya focussing on early detection of oesophageal cancer.
- Participating in international research networks, for example, Professor Fiona Thistlethwaite the Investigational immunotherapy track chair for ESMO 2024
- Participating in international trade missions where appropriate, for example, Chris Harrison attended a visit to Brazil.
- Preparing for our OECI Comprehensive Cancer Centre reaccreditation programme in 2024/25.
- Participating in international cancer centre network organisations. For example, Fabio Gomes and Fiona Blackhall attended the OECI General Assembly in Paris and Chris Harrison has attended the World Cancer Leaders Conference in Los Angeles to represent The Christie.

Greater Manchester System

Trust Provider Collaborative

The Trust Provider Collaborative (previously the Provider Federation Board) is a meeting of Chief Executives from Mental Health, Ambulance and Trusts in GM. Discussion has been predominately focussed on the current financial and performance position across the system.

Diagnostic Network

In view of the importance of diagnostics to a number of pathways, GM has revised the arrangements for the oversight of the GM Imaging and Pathology Networks to ensure they are better connected to system wide programmes eg elective care, cancer and sustainable services.

Commissioner delegation

As part of the move to Integrated Care Systems (ICS), Specialised Commissioning budgets (except for some regional and national services, e.g., proton beam therapy) will be delegated to Integrated Care Boards (ICBs) from 2024/25 financial year.

In preparation, all ICBs are subject to national assessment and moderation process (in Autumn 2023) to assess the system's readiness to take on the delegated specialised commissioning function. This creates several 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.

Health Innovation Manchester has published its Annual Impact Report for 2022-2023, showcasing the innovation activity that has taken place across Greater Manchester's health and care system over the last year. The report features a spotlight on Health Innovation

Manchester's key pillars: Digital Transformation, Innovation Development and Deployment, Research and Academia, and Industry Partners.

Regulation and Governance

The actions to address recommendations of the 2022 CQC inspection reports remain on trajectory to be completed by the deadline. We are addressing both the must do and should do recommendations. The must do actions are scheduled for implementation by the end of October 2023 and the full action plan progress report will be scrutinised by the relevant assurance committees before being reported to the board for final approval in November.

As previously reported the CQC rating of good triggered a review by the ICB and NHSE of our segmentation within the NHS Oversight Framework. The formal outcome of the review is awaited.

The Good Governance Institute work to review of our assurance processes with a particular focus on reporting has started. As previously reported the work includes document reviews, board and committee observations, 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 are in the process of supplying 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

A new National Improvement Board, chaired by David Fillingham, has been established to oversee NHS IMPACT (Improving Patient Care Together) a national initiative to support all NHS organisations and systems to have the skills and techniques to deliver continuous improvement. We are undertaking a self-assessment as suggested by NHS IMPACT. This will help us to identify where we can development our approach to service improvement. As reported to and acknowledged by The CQC we use a multi-channel approach, adapting the improvement techniques used to the circumstances.

b. NGO- Fear and Futility : What does the staff survey tell us about speaking up in the NHS

The NGO brought together the questions in the staff survey relating to Freedom to Speak Up. Key findings included the reduction in raising concerns relating to clinical practice and the growing feeling that speaking up in the NHS is futile, nothing changes as a result. The True for Us review is underway.

c. Progress with Freedom to Speak Up guidance and reflection and planning tool for Board

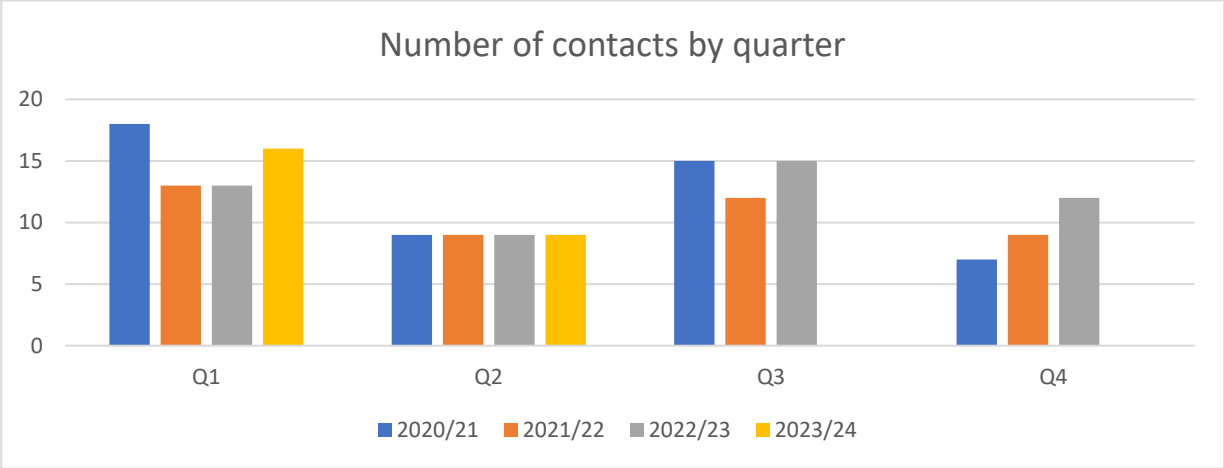
By 31 January 2024, all Trust boards will be expected to evidence in their Board papers:

- An updated FTSU policy that reflects the new national template
- Results of the trust's assessment of its FTSU arrangements against the revised guidance.
- Assurance that it's on track with its FTSU improvement plan.

The FTSU policy has been updated to reflect new national template and ratified. The guidance and planning tool have been reviewed by the Executive and Non-executive leads for FTSU and presented to the Workforce Assurance Committee in May 2023 with agreement to be presented to the Board in November.

6. Contacts

6.1 Number of contacts by quarter



6.2 Type of contact

The table below describes the activity from 1st April 2023 to 30th September 2023. Descriptions of concerns are recorded as described by the staff member and concerns can have more than one issue.

Quarter	Number of contacts	Issue category	Description	Action
2023/24 Q1	16	Attitudes and behaviour (x13)	Colleague behaviour (x4)	Staff member raising formally via HR

Quarter	Number of contacts	Issue category	Description	Action
				Staff member had conversation with manager (x3)
			Manager behaviour (x2)	Staff member raising formally via HR Staff member did not want to proceed
			Bullying culture (x2)	Staff member did not proceed Concern raised with manager and also personal support sought
			Trust communications do not reflect that senior management are supportive of staff speaking up (x1)	Staff member did not need further action
			Lack of communication about proposed plan for department (x4)	Response from senior leadership addressing concern given. Additional senior leadership visibility.
		Policies, procedures and processes (x3)	Conduct of PDR (x1)	PDR process reviewed by HR
			Conduct of Job Offer (x1)	Discussion with manager and HR
			Conduct of probation conversation (x1)	Staff member decided to leave the role and did not want to proceed
		Quality and safety (x4)	Potential changes within department could lead to potential for patient safety (x4)	Response from senior leadership addressing concern
		Service change (x4)	Service future plan not in place (x4)	Response from senior leadership addressing concern
2023/24 Q2	9	Attitudes and behaviour (x9)	Attitude of manager (x7)	Decided not to proceed Raised with senior manager resulting in change in line manager Moved team so deciding whether to proceed formally

Quarter	Number of contacts	Issue category	Description	Action
				Discussed with more senior manager and situation resolved One anonymous and two at beginning of raising concern (joint concern)
			Behaviour of manager (x2)	Preferential treatment given to one team member (joint concern)
		Policies and processes (x2)	Process for use of funds not followed (x2)	At start of raising concern process
		Quality and safety (x2)	Negativity of attitude within department results in a reduced quality of service (x1)	Person shared with senior manager their observations and proposed solutions including improved communications
			Teams not working together effectively to find solutions (x1)	Manager in discussion with manager of teams involved to improve effectiveness and work together to find solutions to issues

6.3 The Christie – Q1 & Q2 2023/20234 concerns

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

Category	Q3 & Q4 2022/2023	Q1 & Q2 2023/2024
Patient safety/quality	3% (1)	11% (4)
Worker safety/quality	9% (3)	5% (2)
Attitudes and behaviours	40% (14)	60% (22)
Policies, procedures and processes	29% (10)	14% (5)
Denominator – number of issues	35	37

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

Role	Q3 & Q4 2022/2023	Q1&Q2 2023/2024
Senior leader	7% (2)	4% (1)
Manager	44% (12)	36% (9)
Worker	37% (10)	56% (14)
Anonymous	11% (3)	4% (1)
Denominator – number of cases	27	25

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

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

6.4 Summary

In summary, over the last six months, 60% of concerns (as a percentage of number of issues) have had an element relating to attitudes and behaviours. This compares with 40% for the previous six months. 14% related to policies, procedures and processes (29% previously).

4 staff members together raised their concern relating to a change within the management of a department they felt could lead to patient safety being compromised. Senior managers discussed the concern and provided a response. In addition, they increased senior leader visibility within the department to provide support and opportunity to share any arising concerns directly.

There was 1 concern raised anonymously which was passed to the relevant manager.

7. FTSU plan

The Freedom to Speak Up plan describes the aims and action to promote, develop and support the culture, values and behaviour that will meet the ambition that “we are comfortable to speak up.” The related action plan has been updated and is included as Appendix 3.

Over the six months the main deliverables achieved were:

- Ratification of the updated Freedom to Speak Up policy, which reflects the national policy
- Development of posters to highlight examples of speaking up concerns and outcomes to counteract the Futility barrier to speaking up
- Launch of Respectful Resolutions toolkit to support positive attitudes and behaviours which includes a tool to aid speaking up
- Inclusion of reference to speaking up and listening in management training
- Activity to support Freedom to Speak Up month, with the focus on breaking the barriers to speaking up

In progress:

- Working with the Patient Safety Specialist to understand reluctance to speak up about clinical concerns. This has included adding questions to the national staff survey 2023 to ask:
    - What would make staff more likely to speak up
    - If they have spoken up previously, how satisfied were they with their experience
    - If they raised an incident, did it involve a patient
    - How satisfied were they with how the incident was managed
    - If they received feedback from the incident handler and their satisfaction with the incident feedback

  Staff have the opportunity to comment on the reason for their answers.
- Development of anonymous reporting for inappropriate behaviours
- Consideration on how message that detriment will not be tolerated can be further highlighted

8. National Freedom to Speak Up month

October is National Freedom to Speak month and the focus for organisations is Breaking Barriers. We will be supporting FTSU month by displaying a number of posters and having a presence at the Engagement Hub.

9. Freedom to Speak Up Training

The National Guardian's Office, in association with Health Education England launched Freedom to Speak Up e-learning training divided into three modules, Speak Up for all staff, Listen Up for managers at all levels and Follow Up for Senior leaders. The Speak Up module is part of the Trust mandatory training programme and 90.34% of staff are compliant.

The leadership training modules reference FTSU and the FTSU training.

10. Effectiveness

Feedback from staff contacts

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

12 contacts replied in Q1 and Q2 2023/2024.

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

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

11 said they understood very well what would happen once they raised a concern, one contact said they understood quite well.

8 said they were communicated with very well, 4 quite well.

4 said they were informed of learning that happened as a result, 7 said there was no learning and 1 said no.

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

Comments made:

- It was a good and positive experience.
- My concerns were raised against a manager whom I have no direct dealings with on a day to day basis. I have had minimal contact with them since the incident, so any disadvantageous or demeaning treatment has not occurred.
- Positive experience. Would do the same again if ever in the same situation.
- On this occasion the result was very positive. The concern I had was highlighted to top manager level and has been dealt with very positively.
- Sue was very approachable and made me feel at ease.
- I felt supported if I needed to take my concern further to a formal complaint. Fortunately issues were ironed out between myself and my manager. But I have recommended the service to a colleague who has been struggling with a similar issue.
- Raised concern and then asked to report to FTSU guardian, HR and then had to go through Trade Union. Distressing, tiring and very repetitive. We need to do better as an organisation with handling feedback where things haven't gone well rather than what felt like a defensive

approach by managers. I felt the managers needed to improve their communication about next steps as it was not clear I was walking into a mediation meeting and that I had choices.

- That they were taken seriously by Sue and she gave a number of us a platform to voice our concerns collectively. At no point did we worry it could come back on us as we felt assured it was all strictly confidential. I really appreciated the way she supported us.
- I felt heard and listened too, but I don't feel I saw any changes be implemented reflecting on my concerns.

Suggestions for improvement of the FTSU service:-

- I know colleagues who are concerned of consequences if they speak up. Maybe something could be done to show that speaking up can only improve situations and prevent it in the future.
- I think in my case it was all very positive and I felt very supported.
- Include management in meetings if the person wanted them to be.
- Significant events that staff report are real learning opportunities that should be recognised, appreciated - just as much as positive feedback. The experience of speaking up was very upsetting and takes real courage. I appreciate the concern by the FTSU guardian who I regard as a trusted colleague who I have known for decades.
- It would be useful to update on an action plan based on the concerns raised.

Equality monitoring information

Contacts were asked to provide information on their personal characteristics. Further work is required to make the collection of this information more robust, in parallel with the Trust's overall focus on monitoring activity by protected characteristics. There are sections of our workforce who are not speaking up. Although our FTSU champions provide some diversity, this could be expanded. EDI champions will be provided training and information on Freedom to Speak Up so they can signpost.

Age	Do you have a disability	Sex	Ethnicity	Detail other ethnic group	Religion	Sexual Orientation Please tick the box that best describes
35- 44	No	Female	White : British		No religion	Heterosexual
55 - 64	No	Female	White : British		No religion	Heterosexual
55 - 64	No	Female	White : British		Christian	Heterosexual
45 - 54	No	Female	White : British		No religion	Heterosexual
45 - 54	Yes	Female				
55 - 64	No	Female				
35- 44	No	Female	White : British		Christian	Heterosexual

Age	Do you have a disability	Sex	Ethnicity	Detail other ethnic group	Religion	Sexual Orientation Please tick the box that best describes
35- 44	No	Female	White : British		Christian	Heterosexual
35- 44	No	Female	Mixed : Other		No religion	Heterosexual
45 - 54	No	Female	White : Irish		Christian	Heterosexual
25 - 34	No	Male	White : British		No religion	Heterosexual
25 - 34	No	Female	White : British		Christian	Heterosexual

11. Review of Guardian Hours

Following good practice, a review was carried out on the time allocation for the freedom to Speak Up Guardian. The current 22.5 hours is considered sufficient but will be reviewed on an annual basis or earlier should circumstances change which would require additional time. (Appendix 4)

12. Conclusion

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

Appendix 1 – FTSU information in response to NHSE letter following Lucy Letby verdict

Assessment of FTSU Arrangements at the Christie

NHSE Guidance	Current Assurance	Planned Activity
All Trusts are expected to adopt updated national Freedom to Speak Up policy by January 2024	• The Christie Freedom to Speak Up (FTSU) policy was updated to reflect the national policy and ratified in May 2023.	
All staff have easy access to information on how to speak up	• Information on how to speak up is on the staff internet (HIVE) • Posters with the Freedom to Speak Up Guardian's (FTSUG) contact information are visible in staff areas. • FTSUG attends induction in person so that all staff are aware of role in providing support and advice. • Electronic booklet is available on HIVE • The FTSU policy, which contains information on how to speak up, has been publicised via Team Brief. • HIVE banners have been used to promote Freedom to Speak Up month, FTSU champions, examples of concerns raised, and action taken posters. • Physical presence during FTSU month on staff engagement stall. • Permanent FTSUG poster present on staff engagement stall.	
Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.	• The national Speaking Up Support Scheme was publicised in June 2023 Team brief ahead of the deadline of the application process. • FTSUG and HR colleagues are aware they can refer or can signpost people that meet the criteria to the scheme for 2024. • Scheme will continue to be promoted via Team Brief and HIVE.	• Further session with full HR team to promote the national speaking up support scheme
Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who	• The Ethnic Diversity Staff Network were supported to produce a video of their experiences for the purpose of learning. These have been publicised during October Freedom to Speak Up month and February via team brief.	• Questions have been added to the 2023 staff survey to identify what would help staff feel more able to speak up. • To undertake a mapping exercise of the staff

NHSE Guidance	Current Assurance	Planned Activity
are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up	• Speak Up training is mandatory and the FTSUG attended the Speak Up training face to face sessions for Facilities staff. • FTSU champions have been recruited, some with protected characteristics to increase diversity in who staff can speak up to.	groups and the barriers that stop them speaking up with consultation as to how these barriers could be overcome.
Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place	• Communication methods include: ➢ Team brief ➢ Information on the staff internet recent activity included a supportive message from the Chief Nurse & Director of Quality and the Medical Director ➢ FTSUG attendance at induction ➢ FTSUG attendance at team meetings ➢ Senior leader videos on their experiences of speaking up ➢ Posters showcasing examples of concerns raised and action taken ➢ Focus in induction on Values and Behaviours, which includes the importance of speaking up ➢ Roll out of Respectful Resolutions package which includes tool to help speak up ➢ Virtual and in person Schwartz rounds on Speaking up	• Management training in development, which will support managers to develop psychologically safe teams

Appendix 2 – True for Us review of the NGO FTSUG survey

National Guardian's Office Freedom to Speak Up Guardian Freedom to Speak Up Guardian Survey Report 2023

1. Introduction

In January and February 2023, the National Guardian's Office (NGO) distributed a survey to 950 FTSU Guardians on the NGO's directory. The response rate was 39%, with 368 completed surveys. Among Freedom to Speak Up Guardians (FTSUGs) 45% provide support to NHS Trusts, the majority of FTSUGs support other types of organisations, such as independent healthcare providers and primary medical services.

Key findings

- 78% said speaking up was taken seriously in their organisations but this figure is down by six percentage points compared to results in 2020.
- 84% said their organisation was taking action to tackle barriers to speaking up, a nine percent increase compared to previous survey results
- 66% identified the concern that nothing will be done as a barrier to workers in their organisation speaking up, an 8% increase and puts futility on par with a fear of detriment as the main barrier to speaking up
- A fall from 72% to 65% in guardians feeling that they were meeting the needs of the workforce
- For FTSUGs to fulfill their role effectively support from leaders is essential; time, resources, emotional support, training

Following the feedback, NGO has identified a number of recommendations, both for Trusts, FTSUGs and for the NGO.

2. Recommendations and Christie position

Below outlines how The Christie position against the recommendations.

	Recommendations	The Christie position
1	Leaders to mandate Speak Up training for all workers, prioritising those responsible for responding to colleagues' concerns	Speak Up training for all workers is mandated. Listen Up for supervisors and managers, and Follow up for senior leaders is referred to in a number of other training packages
2	Identify and initiate a plan to address barriers to speaking up particularly the perception of futility and fear of retaliation	Posters and HIVE banner link with examples where people have spoken up and action taken including thanks from managers. National Speak Up month has a focus on breaking barriers and posters and presence on engagement stall promotes this. **Action :** identify barriers and develop plan to address
3	Evaluation of resources including 1. Lack of budget 2. Administrative support 3. Communications and publicity 4. Lack of private space 5. IT and technological support 6. Travel expenses 7. Absence cover	1. A budget is available to cover promotional expenses 2. Ringfenced FTSUG hours are sufficient to enable administrative tasks to be completed.

	Recommendations	The Christie position
		3. The Communications, Marketing and Engagement team have supported the FTSUG with any requests 4. Private space is available both in Kinnaird house (away from main hospital site) and on the main hospital site 5. IT and technological support is available 6. Travel expenses are paid 7. SOP available to outline what takes place during absences.
4	Wellbeing and support – attending regional and national meetings	FTSUG attends regional and national meetings
5	Those responsible for responding to workers speaking up must receive effective training to listen with curiosity, empathy and be conscious of barriers to speaking up and their impact on marginalised groups	A multi-faceted approach is being considered so that the message gets continually reinforced, and the different elements are at various stages. The proposed management skills training will contain essential practical skills and workable recommendations taken to HR board. Coaching skills will include a focus on listening with curiosity and empathy. Respectful Resolution approach and Kindness into Action e-learning has a focus on listening and ways of communicating with kindness and empathy to generate more psychologically safe teams. A new approach to inclusion training is being considered which would include discussions on difference and marginalised groups.
6	Workers should have a variety of routes available to them to voice their concerns	FTSUG at induction highlights the routes to speak up to, information is within the FTSU policy. “Examples” posters highlight different ways to speak up
7	Ensure a fair and open recruitment process for FTSUG	SOP developed to highlight process and resources available to ensure a fair and open recruitment process
8	FTSUGs undergoing Foundation and Refresher training	FTSUG is up to date with FTSU refresher training (completed Aug 23)

Conclusion

The review of Christie practice indicates that it meets the recommendations from the National Guardians Office report. There is work in progress to identify and address barriers to speaking up and developing a multifaceted approach to reinforce messages related to speaking up including training.

Appendix 3 – Freedom to Speak Up plan deliverables for 2023/2024

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

Use of staff survey results to highlight areas or staff groupings that require additional focus	Initial analysis complete Awaiting results from Globis culture survey to identify areas that require additional focus	May 2023 7e. Staff survey - FTSU 2022.docx
Work with the Patient Safety Specialist and the Risk team to highlight FTSU messages within the implementation of the NHS Patient Safety Strategy and support improvement in the confidence of staff raising clinical concerns	Implementation of Patient Safety Strategy ongoing. FTSU captured within the domain of staff engagement within Patient Safety Incident Response Framework	January 2024
Identify indicators of a healthy speaking up culture	Link with HR metrics and culture work undertaken by the Organisational Development team. HR reporting to develop a tool to report on culture metrics FTSU results to be considered alongside Trust organisational development work on psychological safety in teams Leadership guide produced which highlights the leadership training offers and leadership expectations to support psychological safety	December 2023 Leadership Prog Overview September 2023 v.01 (canva.com)
Promote Respectful Resolutions package which provides tools and training to address bullying and harassment and includes a tool to aid speaking up	Planning in progress for launch	March 2024
Support		
Enhance and promote support arrangements for staff and managers involved in raising a concern	Respectful Resolution package purchased and gaps in support to be identified once package is in place. As part of the breaking barriers focus, consideration is being given to identifying	March 2024

	support that would be of benefit to staff with protected characteristics	
Enhance communication about zero tolerance approach to detriment	Highlighted in updated FTSU policy	January 2024
Understand views on detriment and measure effectiveness of support	Additional questions to be added to staff survey	March 2024
Learning		
Continue with listening exercise with the staff network groups	Ethnic diversity video complete and promoted Offer extended to staff networks. Neither networks proceeded. Conversation about how networks will operate going forward and how the Trust gets views and engagement is ongoing.	March 2024 Action closed waiting conclusion of wider Trust discussion
Contribute to a FTSU/ patient safety culture exercise to ascertain views on culture and suggestions to improve confidence to raise a patient safety concern	Questions asked within 2023/2024 staff survey. Globis independent culture review underway	March 2024
Identify further triangulation of information and use to identify areas for improvement	Wider Trust discussion taking place on triangulation of information	January 2024
Share good practice more widely by developing a series of posters that highlight examples of speaking up and outcomes	Posters on display and advertised via HIVE on corridors	July 2023 FTSU_Make_a_difference_A4_V5.pdf FTSU_Make_a_difference_HIVE banner.p

Appendix 4 – Review of FTSUG hours

Review of Freedom to Speak Up role time requirements

1. Introduction

To meet the needs of workers, Freedom to Speak Up guardians need protected time which is ring-fenced for their Freedom to Speak Up Guardian duties. Therefore, it is important that the time allocation to carry out this role is reviewed on a regular basis with consideration given to any events that may impact on the time required.

2. The Freedom to Speak Up Guardian role

The Freedom to Speak Up Guardian (FTSUG) role involves:

A reactive element. Responding to workers who want to speak up and managing each case, including the initial conversation, by accurately recording, following up and feeding back.

Proactive element. Specifically:

- Looking at barriers to speaking up and working in partnership to help reduce them
- Communicating the role and making sure there is appropriate training on speaking up
- Supporting and challenging senior leaders including through producing regular reports for the senior team or board

National requirements. Fulfilling the expectations of the National Guardian's Office, including:

- Providing information and regular data returns such as the details of the cases they handle
- Reading and carrying out gap analyses based on case review or speaking up review reports
- Playing an active part in guardian networks, including attending regional and national meetings, training and other events.
- Making sure their knowledge and skills are current, including taking part in National Guardian's Office Training, keeping abreast of and implementing national guidance and taking part in other activities such as webinars and conferences

Other elements including self development, taking part in supervision or mentoring where needed, and supporting their own emotional and psychological well-being.

3. National comparison

The National Guardian's Office conducted a survey with Freedom to Speak Up Guardians. They asked about allocated time. Caution is needed when using comparison information as the organisations vary in size and their geographical footprint.

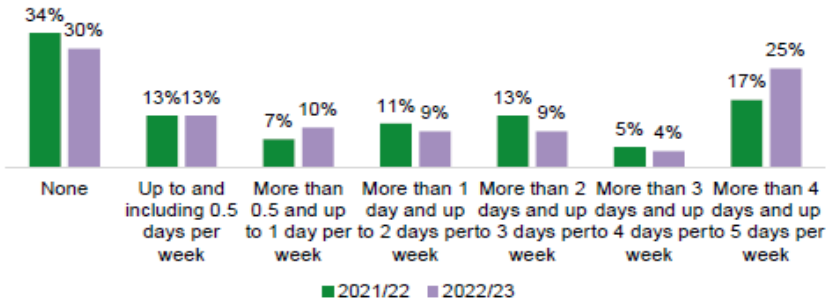


Figure 30: How much ring-fenced time is given to carry out the Freedom to Speak Up role?

4. Review of time allocation

In considering the appropriate time allocation the following questions were asked.

Are there any significant events imminent within the Trust, for example changes to Trust structure, amalgamation of services?	Yes	Current external media interest and focus in relation to a number of individuals speaking out publicly
Are there any significant events that have occurred in the wider NHS or nationally that could result in additional activity or promotional work?	Yes, Lucy Letby case	Unable to say if there will be national requirements implemented that require significant additional work
Are there any findings in any external assessments relating to Speaking Up?	Yes	CQC report. Small increase in cases but flexibility within role enabled FTSUG to respond and support workers
Does the FTSUG consider they have the time available to undertake all aspects of the role?	Yes	
Does the FTSUG consider they have sufficient flexibility with other role requirements to meet the needs of the workforce?	Yes	

5. Conclusion

Following a review jointly undertaken by the FTSUG and the Director of Workforce it is proposed that the allocated time should remain at 3 days per week. This will be reviewed annually unless there is a requirement to bring forward should there be some significant additional work required.

The Christie NHS Foundation Trust

EXECUTIVE SUMMARY

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

Safety

- No serious incidents were reported in September. There were 2 incidents reported in month with the classification of moderate, 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 15.
- Safer staffing numbers have met the required acuity levels to ensure appropriate levels of safety and care for our patients. Indicative staffing, in line with nursing establishments, is set to maintain a 1:7 nurse to patient ratio. On occasion this has been extended to 1:8 which is in line with recommended national staffing ratios. While we have seen an increase in patient safety incidents, following thematic review, these were not related to nurse staffing ratios.
- There were 4 cases of C-Difficile, 2 cases of E-Coli, 2 cases of Klebsiella, 2 cases of Pseudomonas and 2 cases of MSSA in September that were deemed attributable to the Trust. No lapses in care have been identified.
- There was 1 nosocomial Covid-19 infection outbreak affecting 8 patients and 3 staff members in September.

Performance

- Performance against the 62-day standard has deteriorated from August and the standard has not been met with a performance of 68.9%, subject to validation. The 62 day unvalidated upgrade performance has also not met the standard with a performance of 78.4%, subject to validation. The internal 24-day target is below standard and is at 70.9%. All 62- and 24-day breaches are reviewed to ensure any delays are understood and plans can be implemented to mitigate any future delays. All 31-day targets and 18-week RTT standards have been achieved in September subject to validation. Performance against the CWT thresholds is constantly monitored, and action plans are in place to improve performance going forward.
- The two patients waiting over 52 weeks at the end of September are both patients referred to us after long waits in secondary care. One patient had an extremely complex diagnosis pathway whilst the other patient has a pathway that includes several postponements and delays due to patient choice.
- Referral numbers in September decreased from a high point in August but are higher than September 2022. Overall YTD referral levels remain higher than 22/23 levels.

HR

- Staff absence levels increased slightly from August to a position of 4.58% against a target of 3.4%.
- PDR performance and mandatory training performance have deteriorated from August's positions, however both measures remain well above the set standard.

Finance

- At month 6 the Trust is reporting a month end deficit of £2,530k compared to an expected £4,019k, giving a variance against plan of £1,489k. 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 £8,228k on capital schemes to month 6, 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. This is a small underspend against the plan submitted to NHSE.
- 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

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Safe

Indicator	Threshold / Standard 23/24	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	YTD
Serious Incident Reported	-	0	0	0	2	0	0	2
Never Events	0	0	0	0	0	0	0	0
Radiation Incidents Reported (IRMER Reportable)	0	2	1	0	0	0	0	3
Radiation Incidents Reported (IRMER Reportable - Grade 2 or above)	0	0	0	0	0	0	0	0
Number of Pressure Ulcers (Post admission - Grade 2 or above) - Rate per 1000 occupied bed days	0.4 (22/23 Avg)	0.2	0.4	0.2	0.2	0.8	0.6	-
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	-
VTE Assessments Completed	95.0%	98.0%	98.2%	98.8%	97.8%	98.6%	98.8%	-
Sepsis - timely treatment with IV antibiotics (established inpatients)	90.0%	96.9%	95.1%	90.2%	92.2%	90.1%	97.7%	-
Sepsis - screening (presenting as an emergency)	90.0%	95.0%	95.3%	98.7%	96.1%	96.0%	97.1%	-
Number of Corporate Risks Grade 15 or Above	-	4	4	4	4	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%	-

Responsive

Indicator	Threshold / Standard 23/24	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	YTD
62 Day Compliance	85.0%	71.30%	67.30%	70.30%	67.60%	74.70%	68.90%	-
62 Day Compliance - Upgrades	85.0%	67.10%	74.00%	87.90%	74.40%	75.50%	78.40%	-
62 Day Compliance - Screening	90.0%	75.00%	63.60%	100.00%	58.30%	33.30%	57.10%	-
24 Day Compliance	85.0%	73.80%	74.60%	76.60%	68.90%	75.30%	70.90%	-
31 Day Compliance	96.0%	97.80%	97.80%	96.70%	97.30%	99.20%	96.80%	-
31 Day Compliance - Subsequent Drug Therapy	98.0%	100.00%	100.00%	100.00%	100.00%	99.10%	99.10%	-
31 Day Compliance - Subsequent Radiotherapy	94.0%	99.20%	99.20%	100.00%	99.80%	99.80%	98.30%	-
31 Day Compliance - Subsequent Surgery	94.0%	98.80%	100.00%	98.60%	98.80%	100.00%	95.10%	-
18 Weeks Compliance - Incomplete Pathways	92.0%	96.50%	96.91%	97.50%	97.80%	98.00%	98.20%	-
Patients waiting >52 Weeks	0	1	1	1	1	2	2	8
Patients waiting >104 days at end of month (All 62 Day Targets)	-	34	42	44	46	40	52	-
Length Of Stay (Elective & Non-Elective Inpatients)	-	7.77	7.1	6.59	7.02	6.99	8.04	-
Hospital Cancelled Operations on the day for non clinical reasons	0	2	4	2	5	9	0	22
Hospital Cancelled Operations on the day for non clinical reasons - NOT rebooked within 28 days	0	0	1	1	1	0	0	3
Complaints Received	14 (22/23 Avg)	11	11	11	12	19	5	69
PALS Contacts	44 (22/23 Avg)	46	51	42	35	42	42	258
Inquests	-	2	5	2	2	1	2	14
Coroner Request	-	11	12	4	3	4	3	37

SUMMARY DASHBOARD

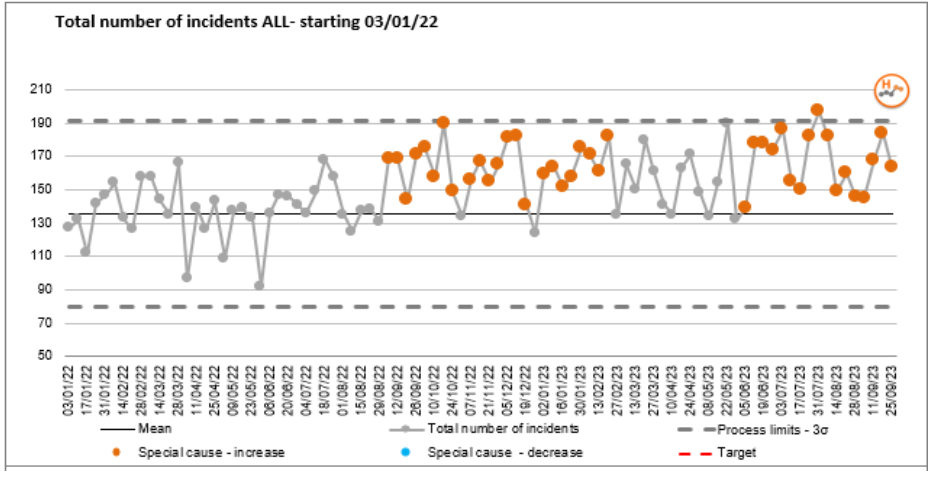
The Christie NHS Foundation Trust

Effective

Indicator	Threshold / Standard 23/24	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	YTD
MRSA	0	1	0	0	1	0	0	2
C-Difficile - All Attributable Cases (Pre & Post 48 Hours)	51	2	3	4	4	3	4	20
C-Difficile - Attributable Cases Due To Lapse In Care	0	0	0	0	0	0	0	0
MSSA Bacteraemia - Attributable	25	1	1	1	2	4	2	11
E-Coli - Attributable	58	5	4	7	6	8	2	32
Klebsiella Species - Attributable	17	4	2	0	1	2	2	11
Pseudomonas Aeuriginosa - Attributable	10	1	0	2	1	1	2	7
COVID infections - Hospital Aquired	0	2	1	0	0	7	8	18
Palliative Radiotherapy 30 Day Suvival Rate	-	92.2%	91.7%	92.1%	87.4%	92.0%	-	-
Final Chemotherapy 30 Day Survival Rate	-	99.0%	99.3%	99.5%	99.4%	99.4%	-	-
Surgery 30 Day Survival Rate	-	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%	-
Staff Mandatory Training	>80%** <80%	89.4%	92.1%	92.9%	91.9%	92.2%	91.2%	-
Staff PDRs	-	84.7%	84.5%	85.6%	85.9%	86.5%	85.2%	-

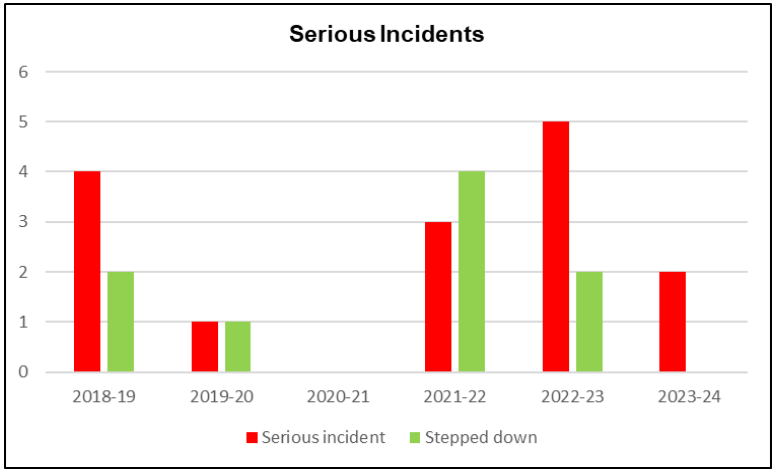
***Compliance if <80% & risk assessment in place**

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 September 2023.

Incidents identified that require a Learning Response

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September 2023 – RCA identified through PSIG/ERG

Reference	Description	Reported Harm Level
W80535	Patient reviewed by TVN, found to have DTI and unstageable to sacrum and buttocks	Minor – for RCA to identify action plan and learning as uncommon occurrence
W79352	Patient discharged home without one of their supportive medications for pain - Etoricoxib 60mg OD. Patient subsequently was admitted to local hospice for pain management/symptom control	Moderate
W79717	Chest drain inserted for drainage of a pleural effusion. Stopped draining after 1 day. Not removed till day 5. Patient developed chest Sepsis.	Moderate

Learning - Patient Safety Incidents

The Christie NHS Foundation Trust

Agreed learning and revised severity outcome following executive reviews September 2023

Ref	Description	Root cause	Learning	Outcome
W74695	Incident reported following call from patient reporting 3-week history of watery diarrhoea containing blood and mucus occurring 10 times per day	The lack of detailed documentation concerning the initial report of diarrhoea from the patient. This led to a concern that the patient had received inappropriate advice regarding the subsequent management of the problem.	• Pain Management Team will ensure that this element of their consultation is included in future documentation • Liaise with team leader to discuss the CSW practice and seek assurance that the CSW acts within appropriate boundaries • SACT Team Leads (Head of Service; Lead Nurse and Clinical Lead to consider if changes are required to documentation and patient education materials • Lack of staff awareness around long-term side effects of immunotherapy	No Harm
W76592	A patient during an inpatient admission, had numerous chest drains. It was highlighted one of the chest drains inserted had been insitu for 7 days with inadequate drainage.	This incident was caused by insufficient information being communicated from the medical team to radiology and within the medical and radiology team. There was not sufficient communication between the teams to allow appropriate care to be planned and prioritised in a timely manner to prevent the deterioration of the patient	• To gather data on inpatient procedures to start a discussion on regular radiology review of in patients who have undergone procedures. • Blue care plan to be updated with trouble shooting information • Devise an escalation and troubleshooting flow chart and disseminate to junior doctors and display in all inpatient areas.	Minor

Learning - Patient Safety Incidents

NHS
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Agreed learning and revised severity outcome following executive reviews September 2023

Ref	Description	Root cause	Learning	Outcome
W77767	Whilst an inpatient a patient was commenced on dexamethasone. (a corticoid steroid) On discharge the discharge letter stated for the patient to continue steroids with no plan of review or when the medication should be stopped.	Medicines Practice Operational Policy guidelines about prescribing to take home medicines was not followed when the patient was discharged from The Christie.	• Junior Doctor education lead to look at incorporating incident as a case study on induction and to share learning with NMP forum • To review the discharge policy • Supportive care staff to liaise directly with GP.	Major
W78772	A patient presented in clinic with Metastatic Spinal Cord Compression (MSCC) symptoms, but were not admitted for an urgent MR scan as per the MSCC pathway and instead were booked an outpatient MR scan.	This was a missed opportunity to involve the MSCC Co-ordinator, who would likely have advised that the patient was admitted for an urgent MR scan as per the MSCC pathway.	• Improved programme of education extending to Clinical and Research Fellows and to be accommodate the junior doctors rotations	No Harm
W78879	A patient required emergency surgery to remove her breast implant following radiotherapy treatment.	Implant-associated infection and radiotherapy induced skin necrosis.	• Amend patient letter to ensure it is clear to patients they may directly request a clinic appointment via the clinical oncology secretary • Learning identified from missed opportunities for escalation to breast surgery team for review. Dissemination to wider breast team who provide radiotherapy in both team meetings and via email.	Moderate

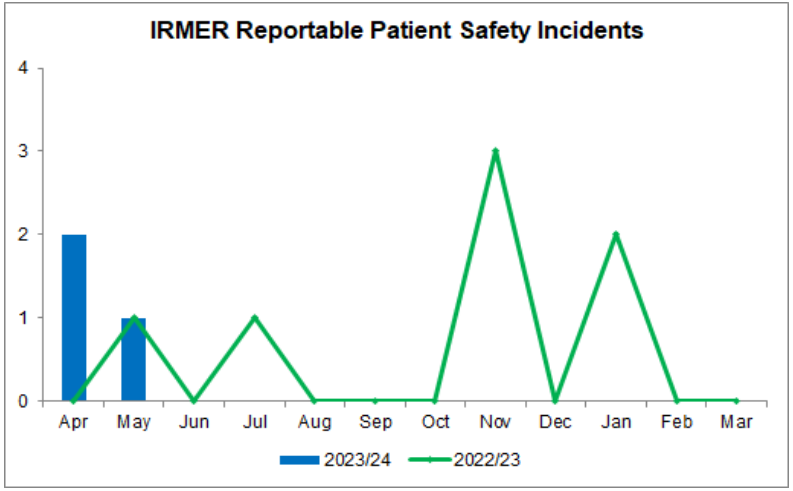
Learning - Patient Safety Incidents

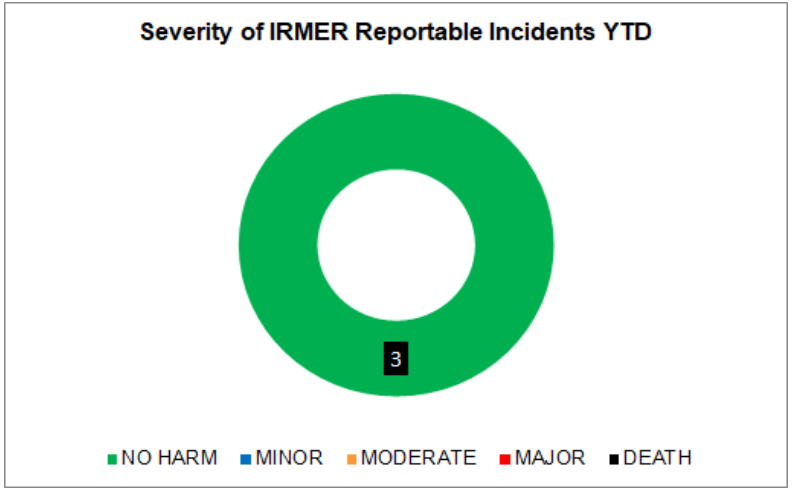
NHS
The Christie
NHS Foundation Trust

Agreed learning and revised severity outcome following executive reviews September 2023

Ref	Description	Root cause	Learning	Outcome
W78299	Patient not given prescribed G-CSF after chemotherapy. Subsequently developed neutropenic sepsis and was admitted to local Hospital	There was insufficient time between prescribing and the patient's appointment for the filgrastim to be dispensed and transported to local hospital for the patient's appointment, particularly as it was over a Bank Holiday weekend. Misunderstanding between 2 members of staff about who was arranging provision of GCSF	• Feedback to consultants and trainees regarding the guidelines for prescribing • Discuss whether prescribing for every treatment cycle at cycle 1 is an option and whether this would prevent a similar incident occurring or whether its introduction would add additional risk. • Alertive team to be contacted for audit trail from the day of staff member requesting that prescription is completed • Mechanism at local hospital to ensure that chemotherapy and supportive medication is available on the treatment day • Screening process in Pharmacy	Minor
W79105	Blood results of abnormal biochemistry not actioned. Patient subsequently admitted when seen in outpatient clinic for emergency management of AKI and electrolyte imbalance	Failure to follow AKI policy/acute oncology handbook 'management of hypokalaemia'	• Implementation of 'Bloods and Review' policy on area including responsibilities for checking results and parameters for actioning / process of escalation for actioning of abnormal results and documenting decision making. • Awareness of PGD triggers and need for documentation of reasons if PGD considered but not undertaken. • Team review of guidelines/re-education re. AKI/hypokalaemia guidelines.	Moderate
W79284	A patient had a central venous access device inserted for chemotherapy treatment. When the patient attended two months later for removal of line it was noted that the dressing had not been changed since the insertion.	Patient attended blood room and Chemotherapy Unit on several occasions, due process not followed by staff as line site was not checked or changed appropriately. Numerous opportunities missed by staff to avoid this situation	• Sharing of Incident for learning with all staff • Sharing of Incident for learning with all staff in morning huddle etc • Clinical Skills contacted to provide Blood Room staff with CWP training for CVADs	Minor

Radiation Incidents





There were no IRMER reportable patient safety incident in September.

Harm Free Care

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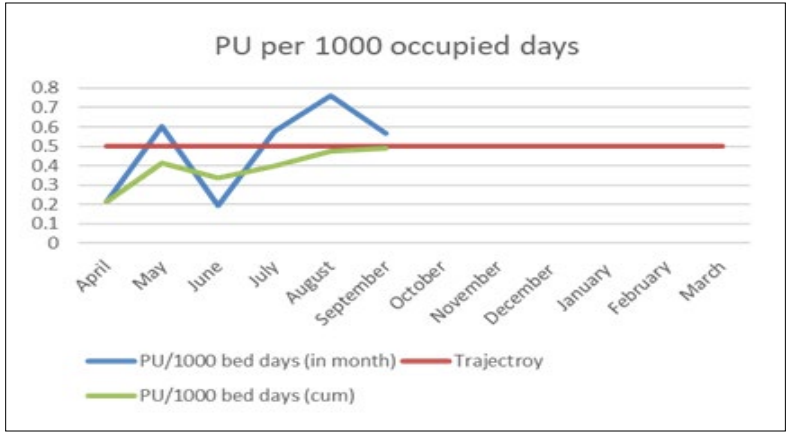
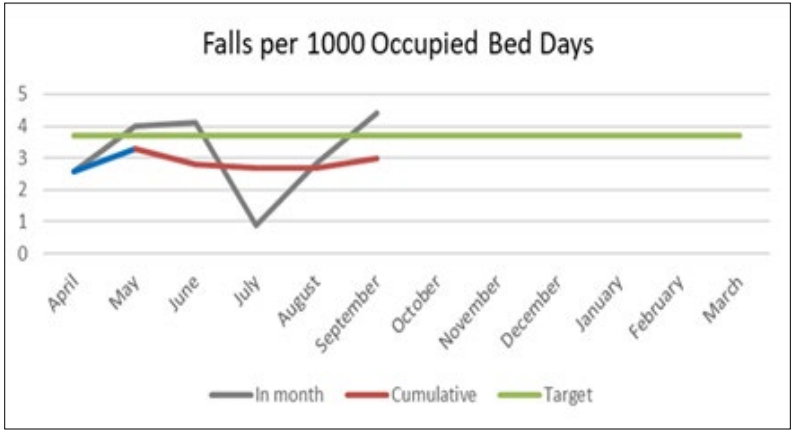
Pressure ulcers per 1000 occupied bed days



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

Falls per 1000 occupied bed days



4.4 falls per 1000 occupied bed days in month
Rolling average is 3.0 which is well below Trust average of 3.8, and national average of 6.6
No moderate or above harm falls in month.

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 September

Description	Score	Controls
Financial Risk 2023-24 (ID 3378)	16	M6 outturn is a deficit of £2.5m against a deficit plan of £4m, a performance ahead of the deficit plan. Recurrent CIP of £1.8m has been identified against the target of £6.4m which remains a significant challenge.
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 two consultants recruited on 28/06/2023. Additional Penile Theatre lists on Fridays. To commence on Friday 28/07/2023. 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.

Safe Staffing

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		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	17075	13027	5259	5.2
	Total monthly ACTUAL	14981	12432		
	Average Fill Rate %	87.7%	95.4%		
Care Staff	Total monthly PLANNED	10298	6985	5259	2.7
	Total monthly ACTUAL	7957	6106		
	Average Fill Rate %	77.3%	87.4%		
ALL Staff	Total monthly PLANNED	27373	20012	5259	7.9
	Total monthly ACTUAL	23021	18586		
	Average Fill Rate %	84.1%	92.9%		

Registered Nurses	DAY			NIGHT			Cumulative count over the month of patients at 23:59 each day	CHPPD (Care Hours Per Patient Per Day)
	Hours Planned	Hours Actual	% Fill Rate	Hours Planned	Hours Actual	% Fill Rate		
Critical Care Unit	2671	1862	69.7%	1814	1649	90.9%	163	21.5
Palatine Ward	3210	2645	82.4%	2593	2150	82.9%	869	5.5
Ward 10	2514	2039	81.1%	1619	1602	99.0%	789	4.6
Ward 11	1827	1768	96.8%	1524	1536	100.8%	851	3.9
Ward 12	1830	1824	99.7%	1530	1561	102.0%	840	4.0
Ward 4	1859	1780	95.8%	1392	1350	97.0%	776	4.0
Ward 2	982	988	100.7%	560	823	147.1%	410	4.4
Acute Assessment Unit	2183	2076	95.1%	1997	1761	88.2%	561	6.8
TOTAL	17075	14981	87.7%	13027	12432	95.4%	5259	5.2

Registered Nursing Associates	DAY			NIGHT		
	Hours Planned	Hours Actual		Hours Planned	Hours Actual	
Palatine Ward					35	
Ward 11					41	
Ward 12		12			13	
Ward 4		83				
Ward 2					14	

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	1200	859	71.5%	813	595	100.0%	163	8.9
Palatine Ward	1330	1171	88.0%	1400	1090	77.9%	869	2.6
Ward 10	2004	1364	68.0%	1028	864	84.1%	789	2.8
Ward 11	1624	1255	77.3%	1138	1147	100.8%	851	2.8
Ward 12	1395	1155	82.7%	998	1003	100.5%	840	2.6
Ward 4	1566	1438	91.8%	1333	1073	80.5%	776	3.2
Ward 2	508	499	98.3%	276	335	121.2%	410	2.0
Acute Assessment Unit	672	219	32.6%	0	0	100.0%	561	0.4
TOTAL	10298	7957	77.3%	6985	6106	87.4%	5259	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…..

"Outstanding service. I recently received treatment for stage 1 womb cancer, from start to finish the care I received was first class, from the reception to the surgery and beyond. 6 weeks later I received the excellent news that I am now cancer free and it's all down to the brilliant surgeon and his caring staff."

"Thanks from patients' family following relatives sad death, for such brilliant care and support during end of patients life"

"Compliments to Mr Winter-Roach and his team and the amazing care and treatment offered."

"Patient been under gynae medical oncology team for five years, team are wonderful. Recently been assigned a nurse who has gone the extra mile and made a difference, kind, caring and very professional and helped patient through a very dark time."

Patient wanted to say that when he was on CCU all staff were great with him, but one nurse in particular was really good with him, and he would like me to let the team and nurse know.

Friends & Family Test

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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%
YTD Total	1387	127	24	10	12	4	5178	1564	30.20%	96.80%

	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%
YTD Total	8063	967	248	107	72	101	9558	94.48%

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)	15	2	1	0	0	0	88	18	20.5%
10 Ward-Surg Onc Unit (Dept 4)	32	3	0	0	1	0	139	36	25.9%
11 Ward (Dept 4)	1	0	0	0	0	0	65	1	1.5%
12 Ward (Dept 4)	4	3	0	1	0	0	84	8	9.5%
The BMR Unit (Dept 16)	15	0	0	0	0	0	46	15	32.6%
Endocrine Ward (Dept 63)	9	1	0	0	0	0	22	10	45.5%
Haematology Day Unit (Dept 26)	42	5	4	1	0	1	135	53	39.3%
Integrated Procedure Unit (Dept 2)	87	9	3	0	3	0	222	102	45.9%
Palatine Ward (Dept 27)	2	1	0	0	0	0	70	3	4.3%
CTU Inpatient Ward (Dept 1)	1	1	0	0	0	0	23	2	8.7%
Total	208	25	8	2	4	1	894	248	27.7%

Cancer Standards

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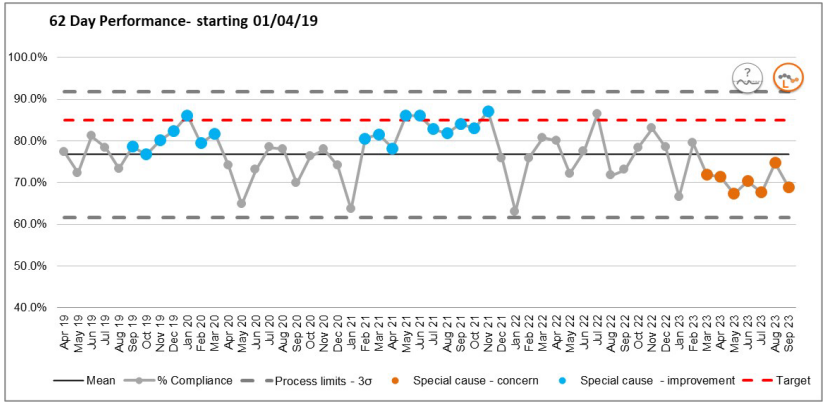
62 Day / 31 Day / 18 Weeks



			62 Days			
			62 Classic		Upgrades	
			Pts	Acc Num	Pts	Acc Num
62 Compliance	**(CaRP Rec)**	**Total Timeframe**	211	83.5	141	67
FULL Christie Compliance	> 38 Days	<= 62 Days	37	37	21	21
FULL Christie Breach	<= 38 Days	> 62 Days	5	5	3	3
50% Shared Breach	> 38 Days	> 62 Days, Treat > 24 Days	42.0	21.0	23.0	11.5
50% Shared Compliance	<= 38 Days	<= 62 Days	41.0	20.5	63.0	31.5
FULL Referring Provider Breach	> 38 Days	> 62 Days, Treat <= 24 Days	86	86	31	31
TOTAL Compliances			78.0	57.5	84.0	52.5
TOTAL Breaches			47.0	26.0	26.0	14.5
% Compliance				68.9%		78.4%

National Standard	Standard	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
62 Day	85%	73.00%	78.30%	83.00%	78.40%	66.50%	79.40%	71.90%	71.30%	67.30%	70.30%	67.60%	74.70%	68.90%
62 Day Upgrades	85%	86.50%	84.40%	83.00%	82.00%	78.00%	79.10%	77.80%	67.10%	74.00%	87.90%	74.40%	75.50%	78.40%
62 Day Screening	90%	50.00%	88.90%	50.00%	83.30%	77.80%	100.00%	100.00%	75.00%	63.60%	100.00%	58.30%	33.30%	57.10%
24 Day Internal	85%	82.40%	87.60%	84.10%	82.30%	72.40%	86.50%	77.00%	73.80%	74.60%	76.60%	68.90%	75.30%	70.90%
31 Days	96%	98.20%	97.80%	97.20%	98.20%	96.90%	98.30%	97.70%	97.80%	97.80%	96.70%	97.30%	99.20%	96.80%
31 Day Subsequent Drug	98%	99.60%	100.00%	99.70%	99.20%	99.20%	100.00%	99.60%	100.00%	100.00%	100.00%	100.00%	99.10%	99.10%
31 Day Subsequent XRT	94%	99.60%	99.20%	99.50%	99.60%	99.00%	99.50%	99.30%	99.20%	99.20%	100.00%	99.80%	99.80%	98.30%
31 Day Subsequent Surgery	94%	99.10%	99.10%	99.10%	100.00%	99.00%	100.00%	98.40%	98.80%	100.00%	98.60%	98.80%	100.00%	95.10%
18 Weeks - Incomplete Pathways	92%	97.60%	98.10%	98.40%	96.70%	97.10%	96.70%	96.50%	96.50%	96.91%	97.50%	97.80%	98.00%	98.20%

		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
2 Week Wait (Standard = 93%)	Compliances	8	16	22	8	10	18
	Breaches	0	0	0	1	0	1
	%	100%	100%	100%	89%	100%	95%
28 Day Faster Diagnosis (standard 75%)	Compliances	2	5	11	7	5	7
	Breaches	2	7	10	10	5	6
	%	50%	42%	52%	41%	50%	54%

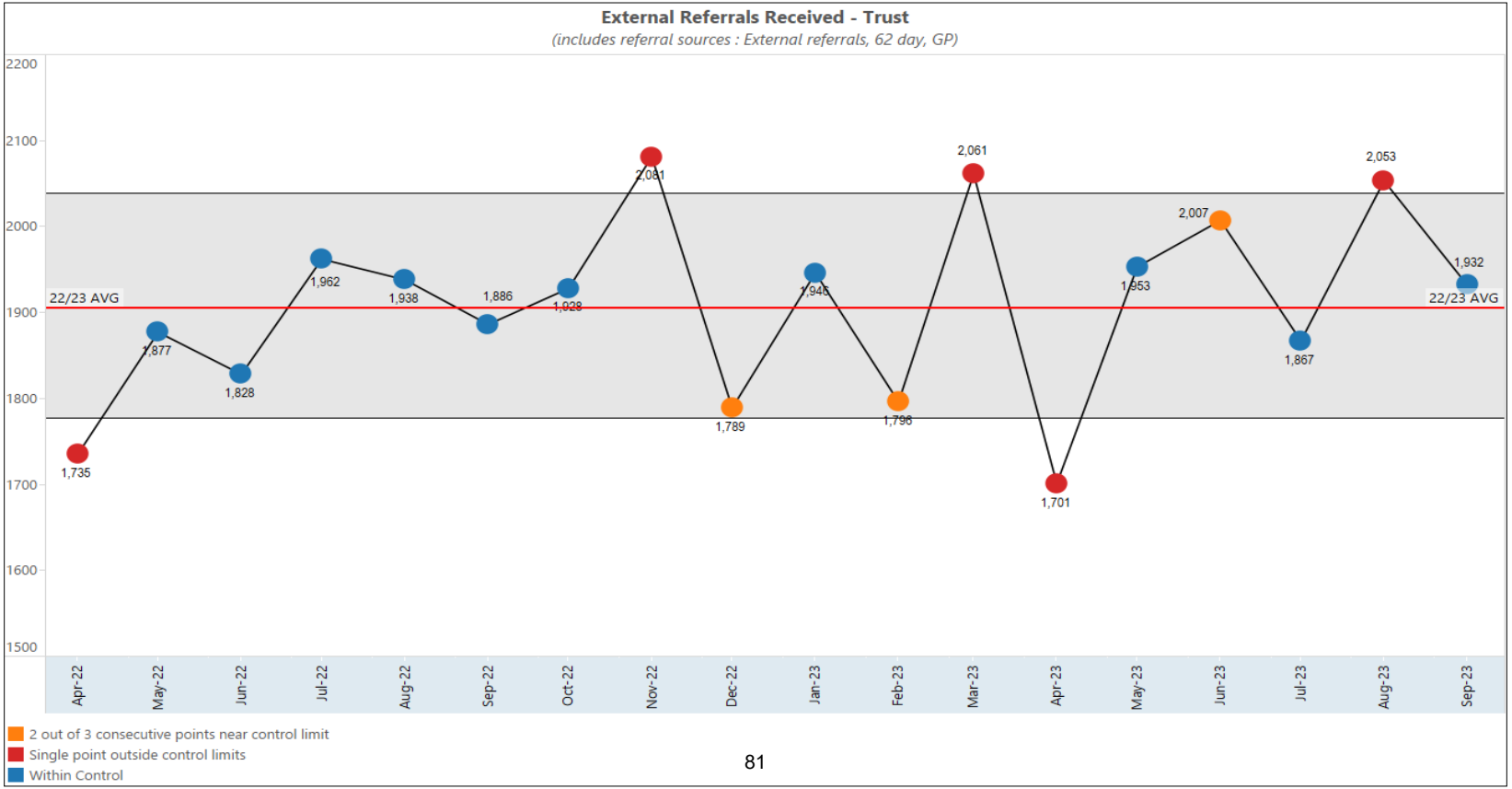
*Patients are reported in the month the compliance/breach occurs.

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

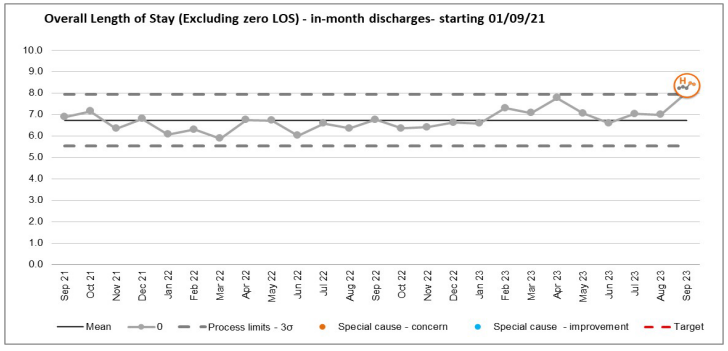
There has been a recent trend of underperformance against the 62 day standards. Improvement plans are in place and improvements are expected to be seen by Q3.

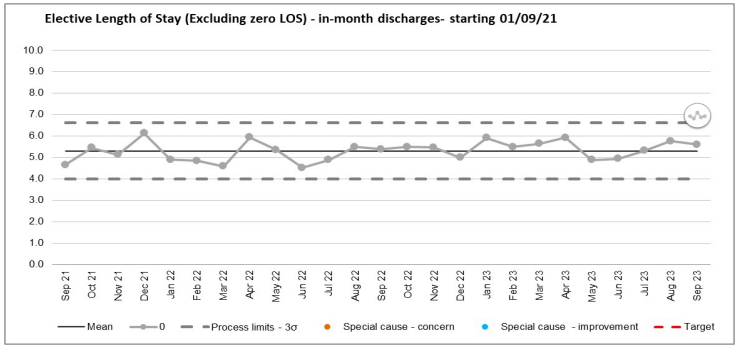
All target positions are subject to validation and are correct as of the time of reporting.

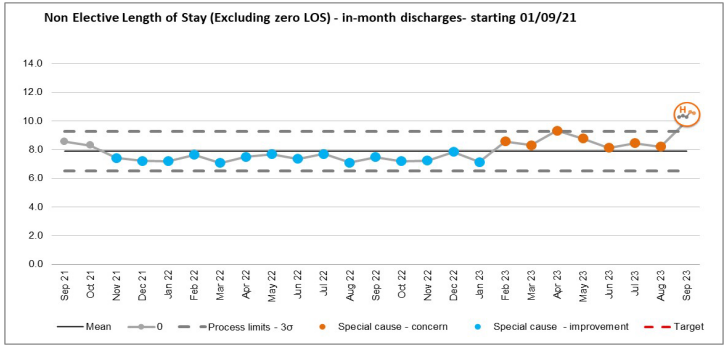
Referrals Analysis

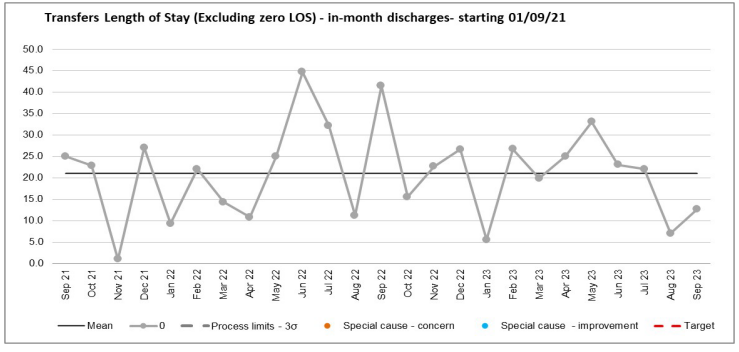


Length of Stay









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

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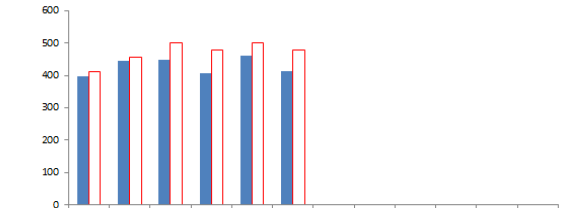
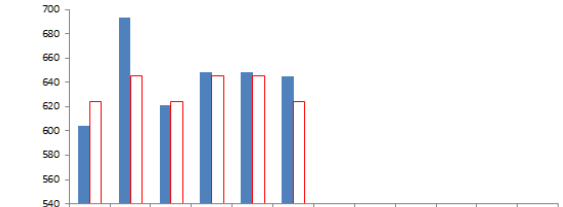
Elective Spells



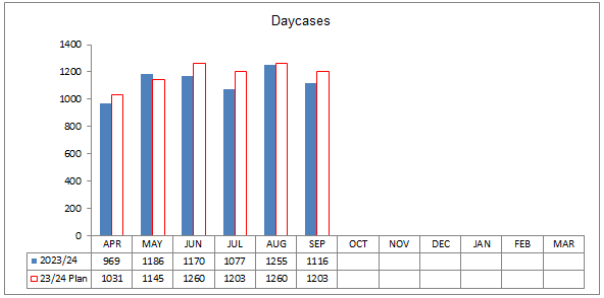
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	398	446	447	408	461	414						
23/24 Plan	410	456	502	479	502	479						

Non-Elective Spells



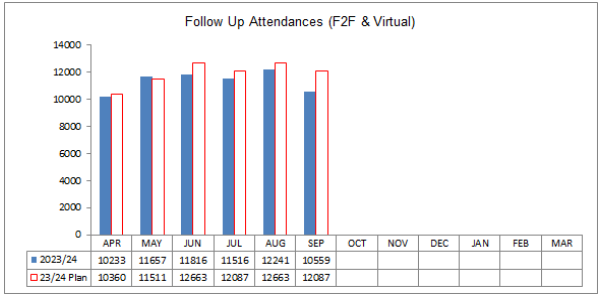
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	604	693	621	648	648	645						
23/24 Plan	624	645	624	645	645	624						

Daycases



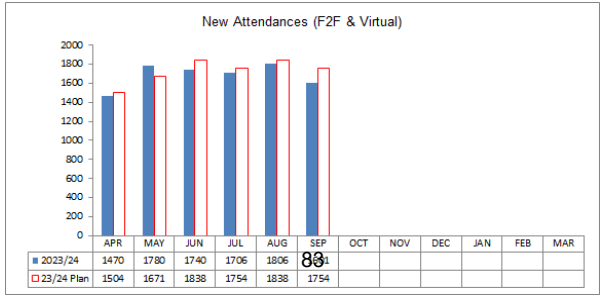
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	969	1186	1170	1077	1255	1116						
23/24 Plan	1031	1145	1260	1203	1260	1203						

Follow Up Attendances (F2F & Virtual)



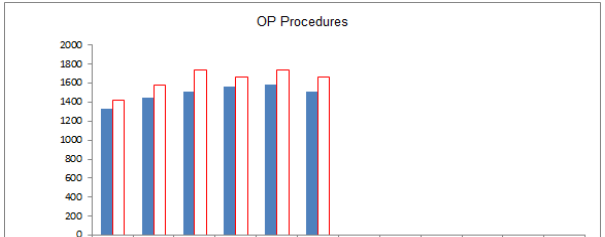
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	10233	11657	11816	11516	12241	10559						
23/24 Plan	10360	11511	12663	12087	12663	12087						

New Attendances (F2F & Virtual)



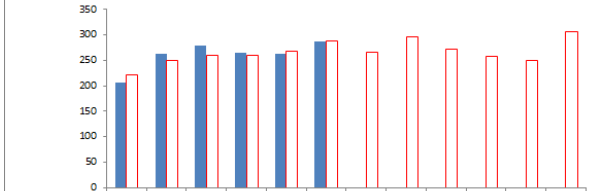
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	1470	1780	1740	1706	1806	1831						
23/24 Plan	1504	1671	1838	1754	1838	1754						

OP Procedures



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	1335	1444	1507	1567	1589	1506						
23/24 Plan	1423	1581	1739	1660	1739	1660						

Surgical Operations Against 22/23 Activity (Excluding Scopes & Brachytherapy)



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

Activity

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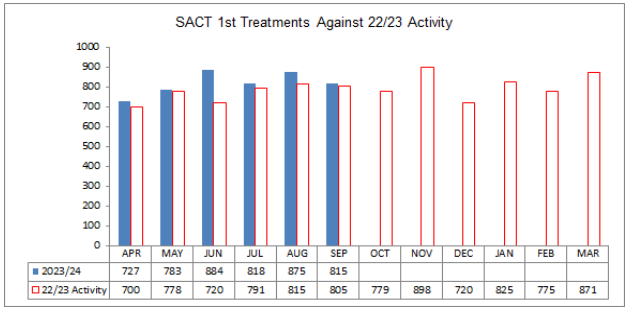
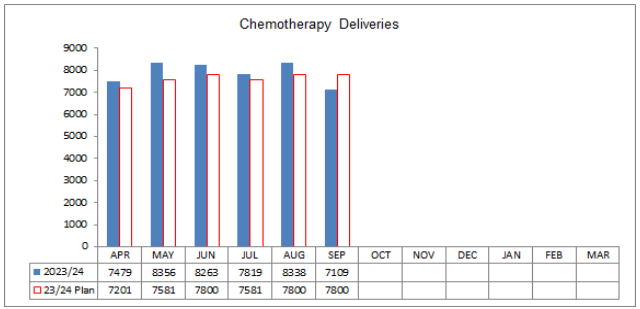
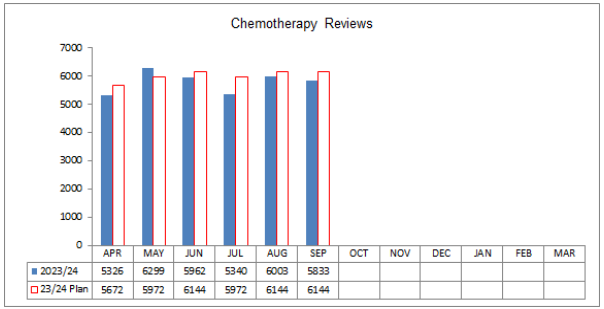


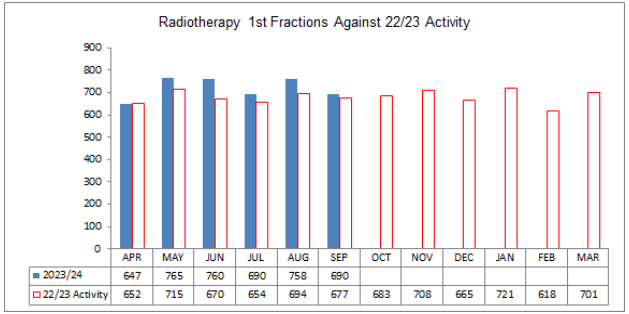
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	727	783	884	818	875	815						
22/23 Activity	700	778	720	791	815	805	779	898	720	825	775	871



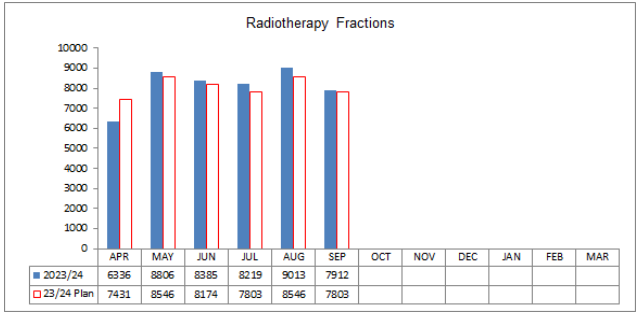
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	7479	8356	8263	7819	8338	7109						
23/24 Plan	7201	7581	7800	7581	7800	7800						



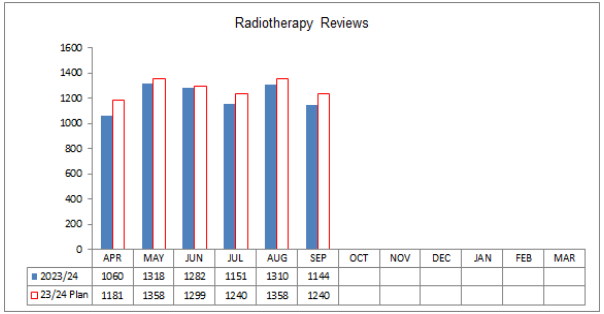
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	5326	6299	5962	5340	6003	5833						
23/24 Plan	5672	5972	6144	5972	6144	6144						



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



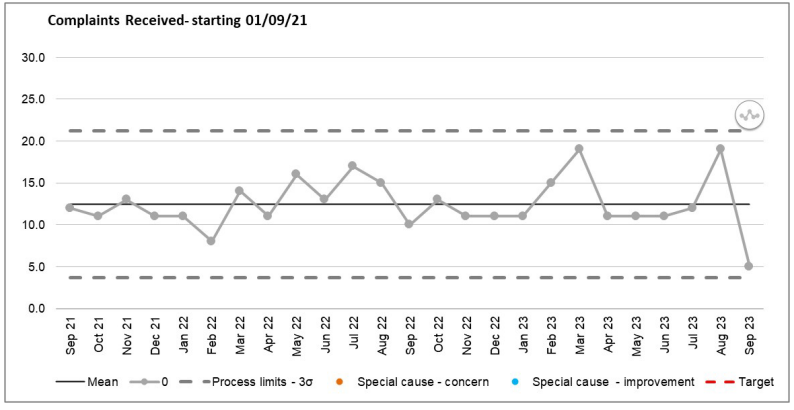
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	6336	8806	8385	8219	9013	7912						
23/24 Plan	7431	8546	8174	7803	8546	7803						

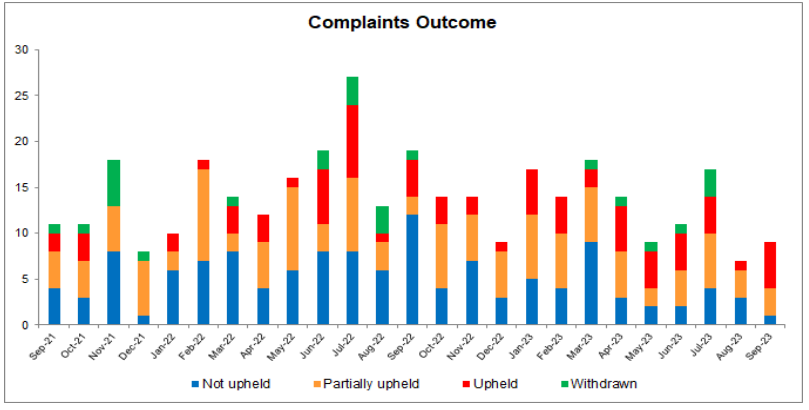


	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	1060	1318	1282	1151	1310	1144						
23/24 Plan	1181	1358	1299	1240	1358	1240						

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

Complaints



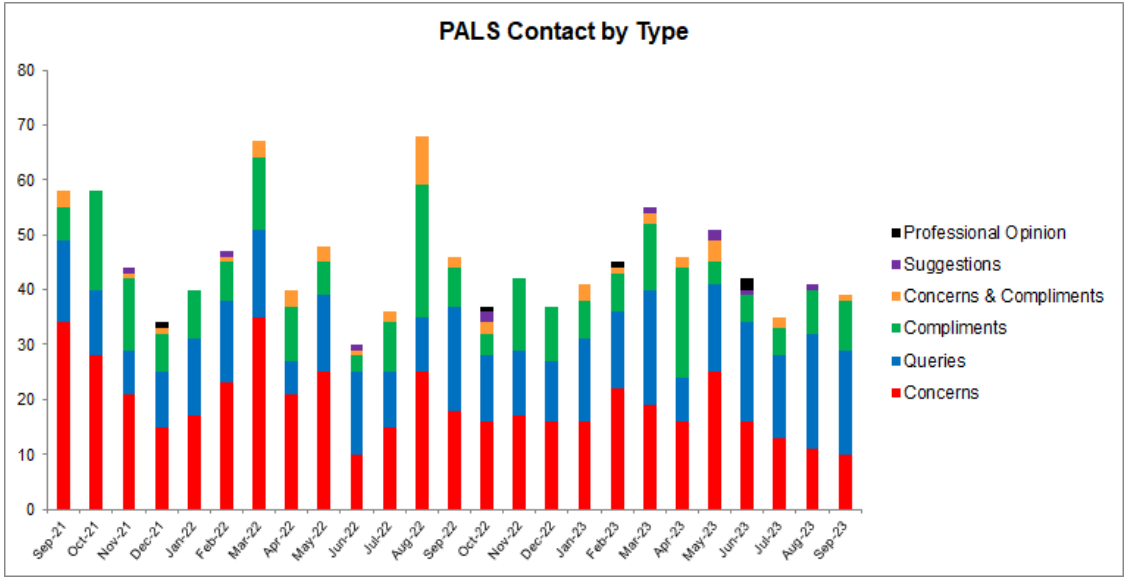


5 new complaints received in September 2023

9 complaints were closed in September 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. 1 case was referred to the PHSO in September 2023. 6 cases in total with the PHSO.

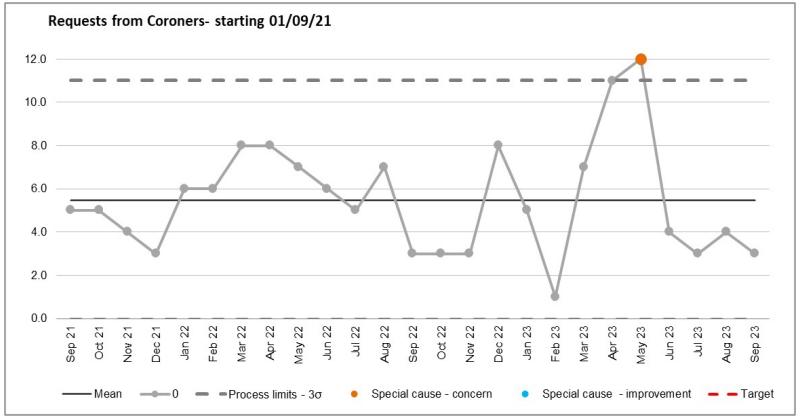
PALS

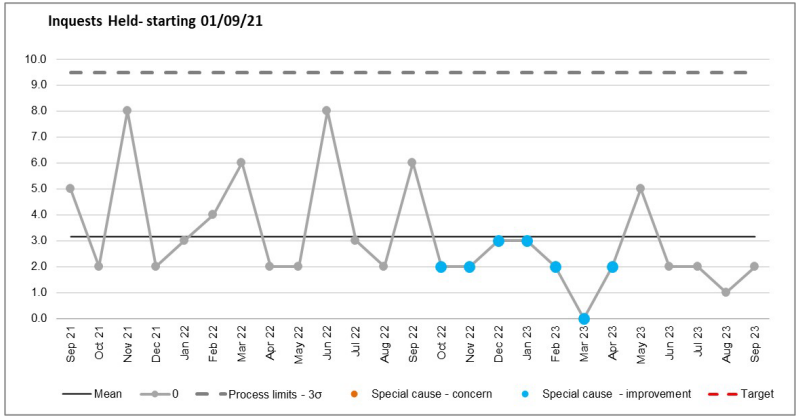


39 PALS contacts have been received in September 2023.

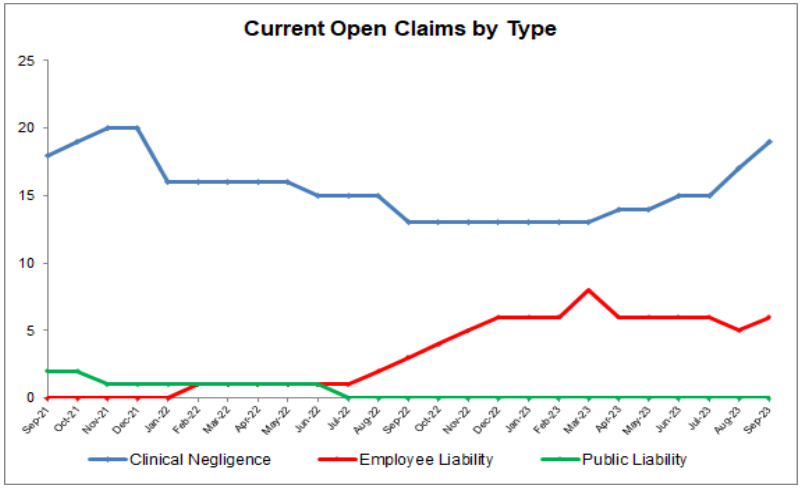
11 of those raised concerns about their experience at The Christie but did not wish to take them down the formal complaints route. The other reasons for contacting PALS are captured in the graph.

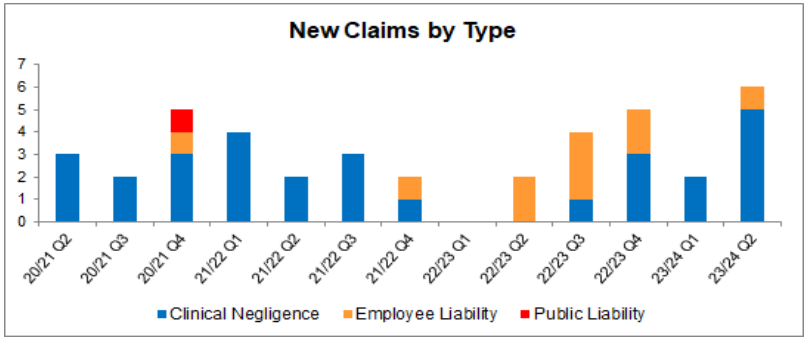
Inquests


Requests from Coroners- starting 01/09/21
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Sep 21
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
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


Inquests Held- starting 01/09/21
10.0
9.0
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Sep 21
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
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

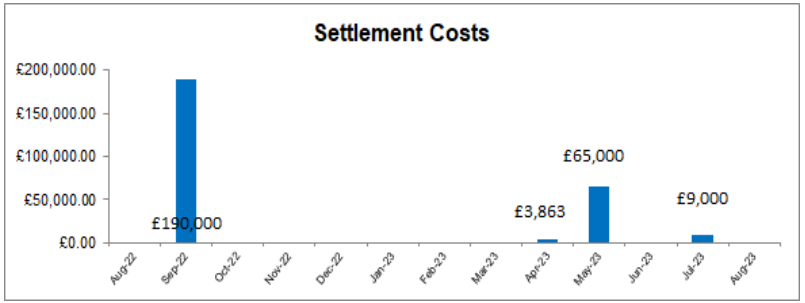
Claims





3 new claims received in September 2023
(2 'Clinical negligence & 1 'Employee Liability)

0 claims settled in September 2023.



88

Healthcare Associated Infections

The Christie NHS Foundation Trust

Curent Month	Community Onset - Indeterminate Acquisition (COIA)	Community Onset - Community Acquired (COCA)	Community Onset - Healthcare Acquired (COHA)	Healthcare Onset - Healthcare Acquired (HOHA)	Lapses in Care	Area(s) Occurred
Clostridium Difficile	1	2	3	1	0	(W10x1) (W12x2) (AAUx1)
E.coli Bacteraemia		2		2	0	(AAUx1) (PWx1)
Klebsiella spp.		2	2		0	(AAUx1) (AACUx1)
Pseudomonas aeruginosa bacteraemia			2		0	(PWx1) (HTDUx1)
MSSA Bacteraemia			1	1	0	(W11x1) (Proceduresx1)
MRSA Bacteraemia						

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	3	7	7	13	0
E.coli Bacteraemia		16	15	17	0
Klebsiella spp.		6	7	4	0
Pseudomonas aeruginosa bacteraemia		2	3	4	0
MSSA Bacteraemia		5	6	5	0
MRSA Bacteraemia			2		0

Organism	Location	Date OB identified	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)
COVID-19	Ward 4	11/09/2023	5	9	11

Organism	Number of Cases (YTD)	Lapses in care
CPE colonisation / infection	4	0

There were 4 cases of C-Difficile, 2 cases of E-Coli, 2 cases of Klebsiella, 2 cases of Pseudomonas and 2 cases of MSSA in September 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

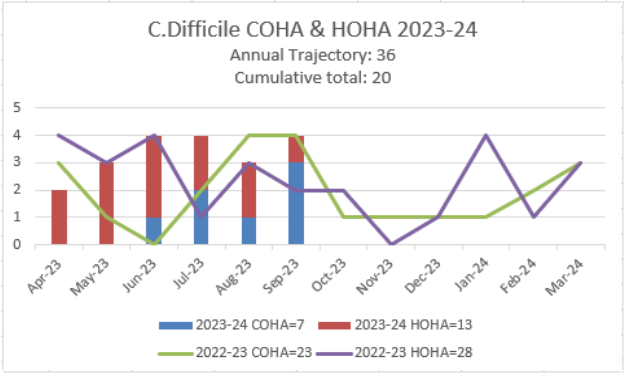
COHA - Symptoms commenced within first two days of admission and inpatient in the past 12 weeks (but not past 4 weeks)

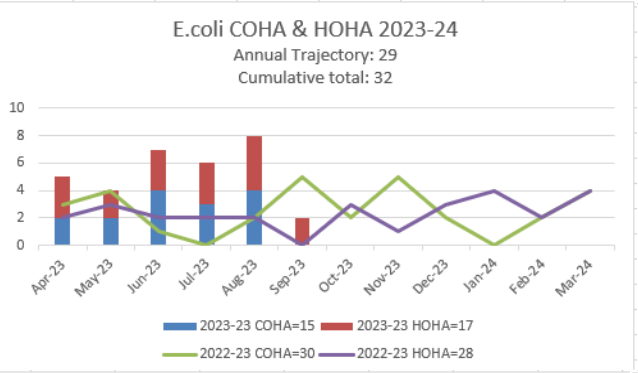
HOHA - Symptoms commenced within first two days of admission (No admission in past 12 weeks)

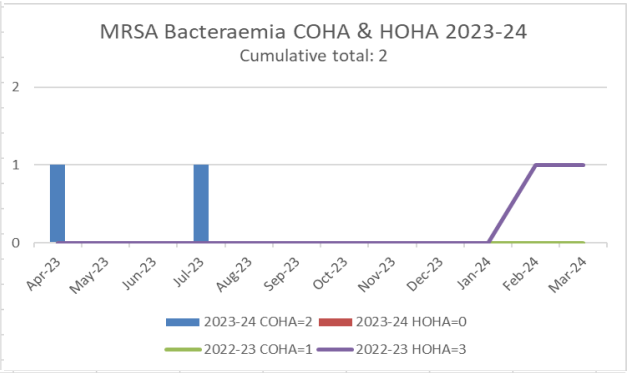
Healthcare Associated Infections

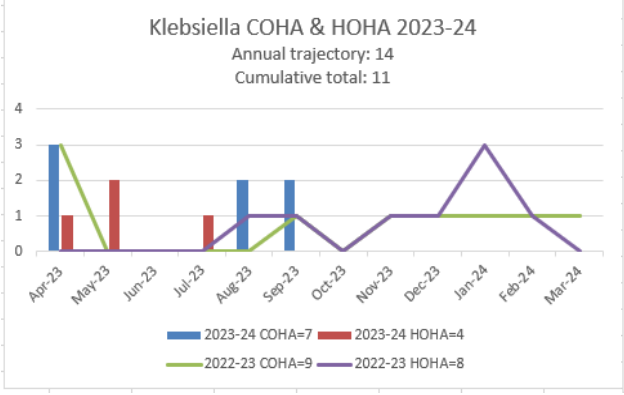
The Christie NHS Foundation Trust

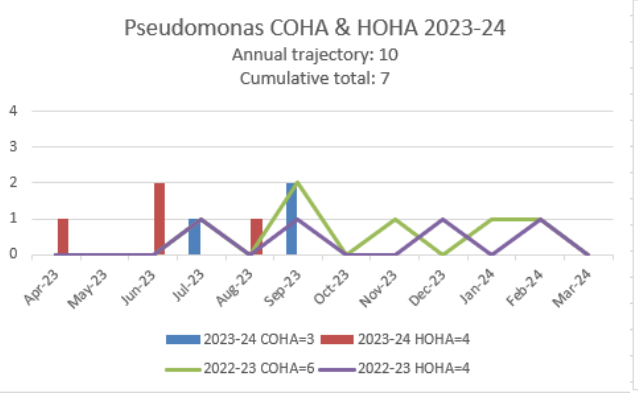
Alert Organisms

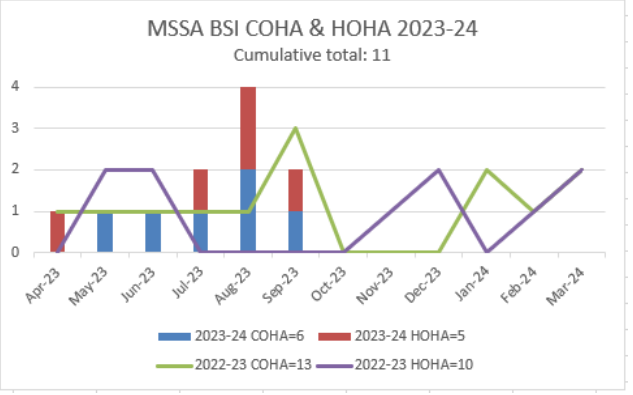








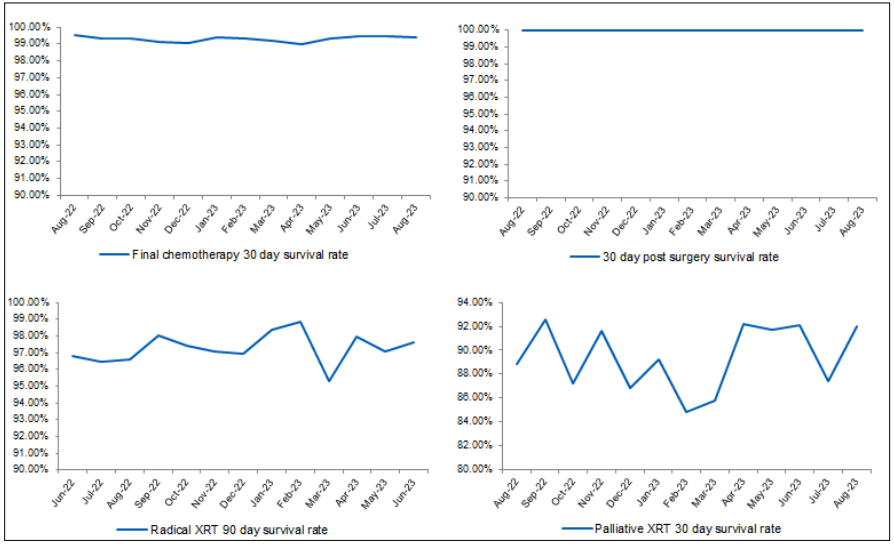




Mortality Indicators & Survival Rates

The Christie NHS Foundation Trust

Survival Rates



Inpatient Deaths – Onsite Deaths

		Sep-23
Number of NHS Christie onsite deaths	Elective/planned admission	11
	Non Elective/emergency admission	21
	TOTAL	**32**
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) - 4	**9**
	Bereaved families raised concern – 0	
	Medical Triggers - 4	
	Nursing Triggers - 4 (inc in family concern)	
	COVID-19 - 0	
	(note there may be more than one trigger)	

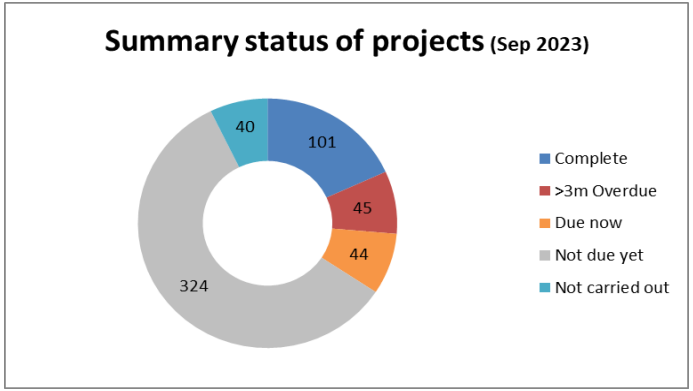
The Christie process for learning from deaths follows the 2017 NHSI guidance. All in-patient deaths are screened and where flagged by one or more triggers an independent structured case note review (SCR) is undertaken. Reviews are discussed by the Mortality Surveillance Group and the findings and actions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

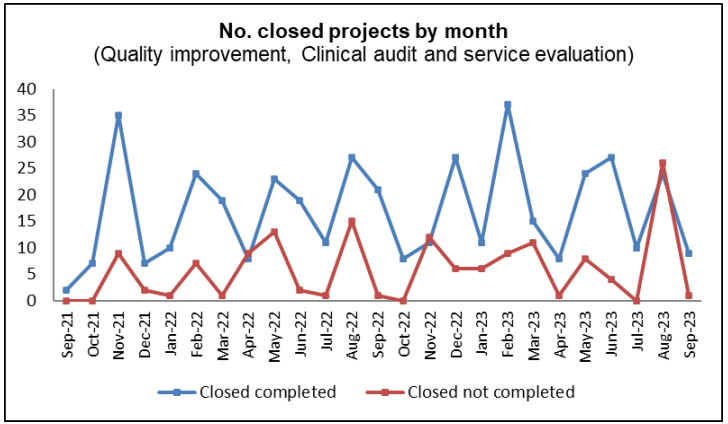
Quality Improvement & Clinical Audit

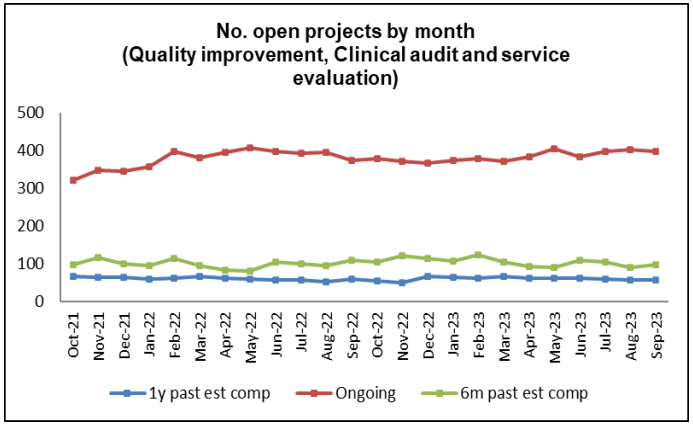
The Christie NHS Foundation Trust

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

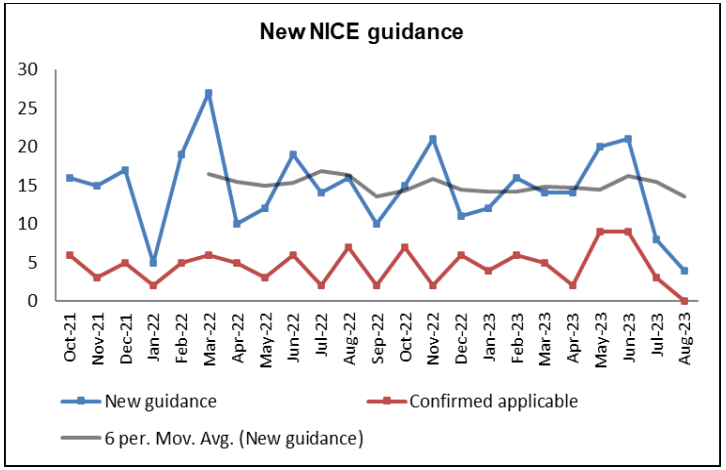
Reminders are sent mid-quarter which lead to increased number of closed projects

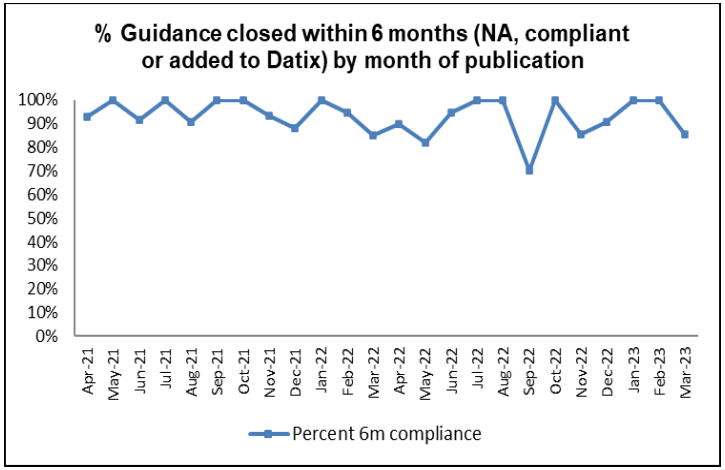






NICE Guidance





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

HR Metrics Sickness

NHS
The Christie
NHS Foundation Trust

4.58%
Monthly Absence

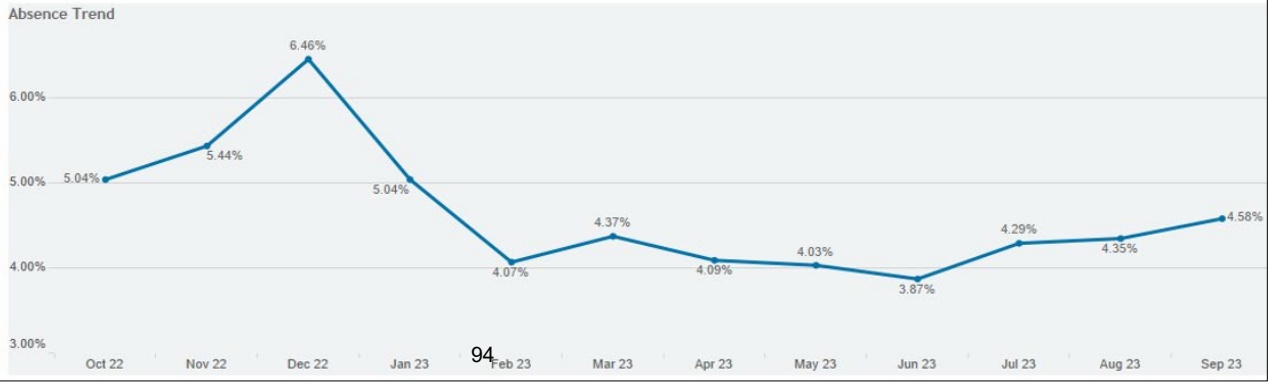
4.64%
Yearly Absence

334
Returned Last Month

90
No. of Employees on Long Term Sick

352
No. of Employees on Short Term Sick

Division	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
Christie Medical Physics & Engineering	2.55%	1.70%	3.07%	3.24%	2.45%	2.26%	1.67%	2.32%	3.24%	3.35%	3.65%	3.51%
Clinical Networked Services	5.32%	4.73%	5.43%	4.58%	3.66%	4.27%	3.79%	3.49%	3.92%	4.74%	4.63%	4.46%
Clinical Support & Specialist Surgery	4.85%	6.74%	8.26%	5.59%	4.97%	5.03%	4.94%	5.54%	4.68%	4.72%	4.97%	5.86%
Corporate Development	4.06%	0.65%	3.94%	1.61%	0.00%	0.46%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Digital Services	4.69%	4.99%	4.25%	1.80%	1.55%	1.65%	1.83%	2.53%	1.23%	1.27%	3.01%	3.15%
Education (School of Oncology)	1.57%	0.51%	3.72%	4.60%	3.35%	1.42%	1.86%	0.93%	0.43%	0.20%	0.65%	2.04%
Estates & Facilities	10.77%	12.15%	13.09%	11.09%	9.01%	9.83%	8.97%	5.91%	5.81%	7.64%	7.36%	7.34%
Finance & Business Development	2.86%	4.45%	3.91%	2.75%	1.83%	2.43%	1.88%	3.43%	2.50%	2.06%	1.26%	1.75%
GM Cancer	1.08%	0.22%	3.47%	3.78%	1.36%	0.00%	0.35%	0.86%	0.00%	0.73%	0.00%	0.54%
Performance	5.17%	11.12%	6.47%	4.01%	4.32%	7.10%	7.40%	9.78%	8.85%	9.24%	8.46%	2.67%
Quality & Standards	6.01%	6.71%	9.36%	7.96%	6.44%	5.78%	4.25%	5.93%	3.95%	2.43%	6.04%	8.98%
Research & Innovation	4.47%	4.11%	5.27%	4.45%	3.14%	3.74%	3.74%	3.62%	3.32%	3.23%	3.13%	3.17%
Strategy	6.00%	6.00%	8.28%	3.70%	0.00%	0.00%	2.19%	0.00%	0.00%	0.00%	0.45%	0.00%
Trust Administration	5.85%	6.21%	7.07%	6.42%	6.21%	5.85%	6.65%	6.88%	6.21%	6.23%	5.87%	5.83%
Workforce	2.82%	4.48%	3.83%	1.75%	0.93%	1.40%	0.52%	0.35%	1.93%	3.30%	1.62%	2.11%



HR Metrics – Mandatory Training

The Christie NHS Foundation Trust

91.28% Compliance

4,020 Outstanding Modules

83.02% Face to Face

92.93% Online

Division	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
Christie Medical Physics & Engineering	94.94%	95.48%	95.55%	95.37%	94.95%	95.06%	96.03%	96.20%	95.32%	95.46%	95.99%	95.74%
Clinical Networked Services	89.85%	87.27%	87.11%	87.62%	87.45%	85.86%	87.05%	90.05%	90.84%	90.10%	90.63%	89.21%
Clinical Support & Specialist Surgery	85.29%	83.59%	82.47%	83.39%	81.15%	81.96%	84.99%	88.93%	90.30%	89.00%	88.96%	87.88%
Corporate Development	98.17%	96.94%	95.76%	96.19%	95.58%	95.71%	96.12%	100.00%	100.00%	100.00%	100.00%	100.00%
Digital Services	93.50%	96.24%	95.22%	94.86%	96.21%	98.97%	98.35%	98.55%	98.38%	96.79%	96.46%	94.88%
Education (School of Oncology)	96.38%	95.09%	93.86%	93.91%	94.14%	94.81%	94.11%	96.06%	96.70%	95.27%	94.77%	94.71%
Estates & Facilities	92.61%	92.98%	92.97%	93.65%	93.13%	95.21%	93.98%	94.46%	95.03%	93.81%	94.33%	94.54%
Finance & Business Development	98.39%	98.74%	98.25%	97.14%	97.75%	99.67%	97.93%	99.11%	99.37%	99.44%	99.54%	98.63%
GM Cancer	77.89%	82.20%	81.66%	82.66%	80.54%	86.04%	87.44%	92.97%	95.42%	91.29%	91.32%	92.28%
Performance	96.57%	94.74%	93.91%	95.03%	96.39%	95.06%	95.32%	93.38%	94.12%	98.80%	96.20%	92.28%
Quality & Standards	93.27%	88.80%	89.07%	92.26%	92.17%	92.86%	94.08%	93.04%	94.48%	94.97%	93.76%	90.37%
Research & Innovation	94.19%	93.42%	92.88%	94.20%	93.53%	93.57%	94.32%	96.53%	97.33%	96.68%	96.97%	96.00%
Strategy	90.91%	90.21%	85.57%	95.49%	93.22%	93.85%	94.17%	98.26%	96.80%	93.33%	97.50%	95.69%
Trust Administration	98.74%	95.88%	95.88%	97.99%	98.33%	93.15%	93.56%	96.04%	95.45%	95.57%	94.42%	93.39%
Workforce	89.61%	88.17%	89.12%	88.84%	92.94%	91.61%	92.72%	96.12%	96.30%	91.18%	96.50%	97.31%

HR Metrics - PDR

The Christie NHS Foundation Trust

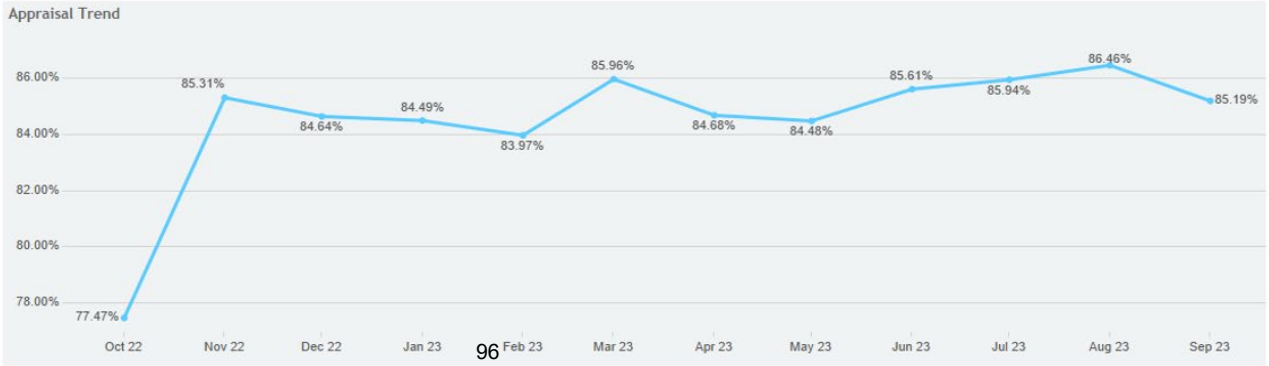
85.19%
Compliance

421
Expired

533
Due Soon (3 Months)

66.44%
Predicted Compliance
(if the Due Soon were to expire)

Division	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
Christie Medical Physics & Engineering	83.75%	84.58%	89.58%	88.84%	88.07%	90.00%	90.46%	92.08%	91.97%	93.12%	91.94%	89.88%
Clinical Networked Services	74.31%	86.45%	86.04%	83.43%	81.33%	80.90%	81.26%	86.13%	86.71%	89.15%	89.18%	86.99%
Clinical Support & Specialist Surgery	72.34%	82.72%	83.83%	84.59%	84.94%	87.08%	85.64%	82.19%	83.71%	81.02%	80.43%	81.81%
Corporate Development	96.97%	96.97%	93.94%	88.57%	75.68%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	90.91%
Digital Services	79.31%	87.06%	84.27%	91.11%	89.36%	93.62%	93.75%	89.69%	88.00%	81.00%	83.00%	78.43%
Education (School of Oncology)	77.78%	92.06%	87.30%	92.19%	90.48%	92.31%	94.03%	89.39%	91.18%	92.42%	92.31%	92.65%
Estates & Facilities	79.24%	84.32%	83.05%	83.40%	82.68%	84.28%	80.60%	72.10%	78.21%	81.47%	85.41%	83.82%
Finance & Business Development	88.89%	95.24%	87.30%	90.63%	88.89%	96.67%	89.06%	95.24%	90.63%	92.06%	92.19%	90.63%
GM Cancer	66.67%	63.64%	61.76%	57.14%	53.85%	71.79%	61.90%	65.96%	65.31%	73.47%	80.39%	82.35%
Performance	86.96%	91.30%	91.30%	91.30%	90.91%	91.30%	82.61%	72.73%	68.42%	70.00%	70.00%	72.73%
Quality & Standards	78.57%	75.00%	79.31%	82.76%	76.67%	87.10%	78.79%	82.35%	88.24%	90.91%	94.29%	90.91%
Research & Innovation	88.21%	87.96%	82.01%	82.08%	87.02%	90.71%	88.24%	85.37%	86.56%	86.15%	88.28%	85.32%
Strategy	37.50%	37.50%	30.00%	33.33%	30.00%	30.00%	30.00%	50.00%	60.00%	60.00%	60.00%	66.67%
Trust Administration	76.47%	80.00%	80.00%	66.67%	80.00%	85.71%	92.86%	92.86%	92.86%	92.86%	86.67%	82.35%
Workforce	93.22%	91.67%	87.93%	94.92%	98.28%	94.74%	91.38%	98.28%	95.16%	95.00%	95.08%	89.83%



Workforce Metrics - Turnover

NHS
The Christie
NHS Foundation Trust

45
Leavers

12.07%
Voluntary Yearly Turnover

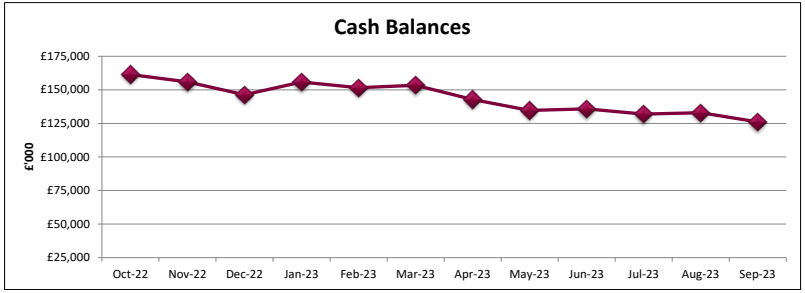
14.14%
All Yearly Turnover

3,610
Headcount

Dismissal	1
End of Fixed Term Contract	4
Retirement	14
Voluntary Resignation	25
Others	1
Grand Total	45

Finance (Executive Summary)

Month 6 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(373,706)	(186,982)	(193,748)	(6,766)
Other Income	(68,735)	(34,316)	(34,309)	7
Pay	211,585	105,759	99,936	(5,823)
Non Pay (incl drugs)	218,807	109,515	118,956	9,441
Operating (Surplus) / Deficit	**(12,048)**	**(6,024)**	**(9,165)**	**(3,141)**
Finance expenses/ income	28,723	14,362	16,012	1,650
(Surplus) / Deficit	**16,675**	**8,338**	**6,847**	**(1,491)**
Exclude impairments/ charitably funded capital donations	(8,637)	(4,319)	(4,316)	2
Adjusted financial performance (Surplus) / Deficit	**8,038**	**4,019**	**2,530**	**(1,489)**



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

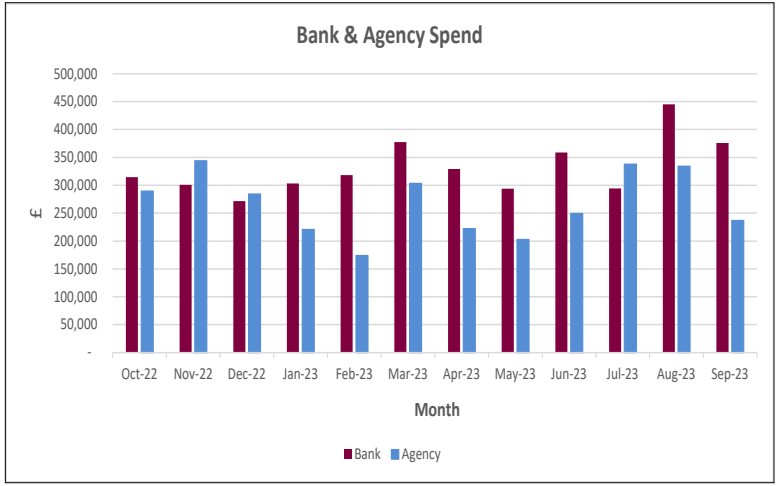
I&E

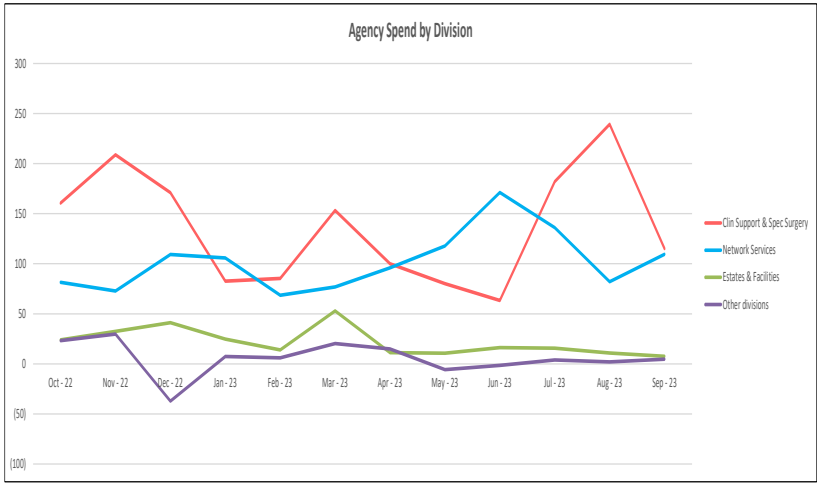
- The Trust is reporting a month end deficit of £2,530k compared to an expected £4,019k, giving a variance against plan of £1,489k. The main reason for an improved position relates to interest received above plan and continued underspends on pay whilst growth vacancies are recruited to.
- The in month position is on plan.
- 2023-24 CIP – Identified in year CIP is £12.3m (£10.5m non- recurrent / £1.8m recurrent) and is 99% of the in year target of £12.5m.

Balance sheet / liquidity

- The cash balance is £126,172k.
- Capital expenditure is under CDEL original plan by £789k.
- Targets have been achieved against payment of our NHS creditors paid within the 30 day Better Payment Practice Code target.

Finance (Expenditure)

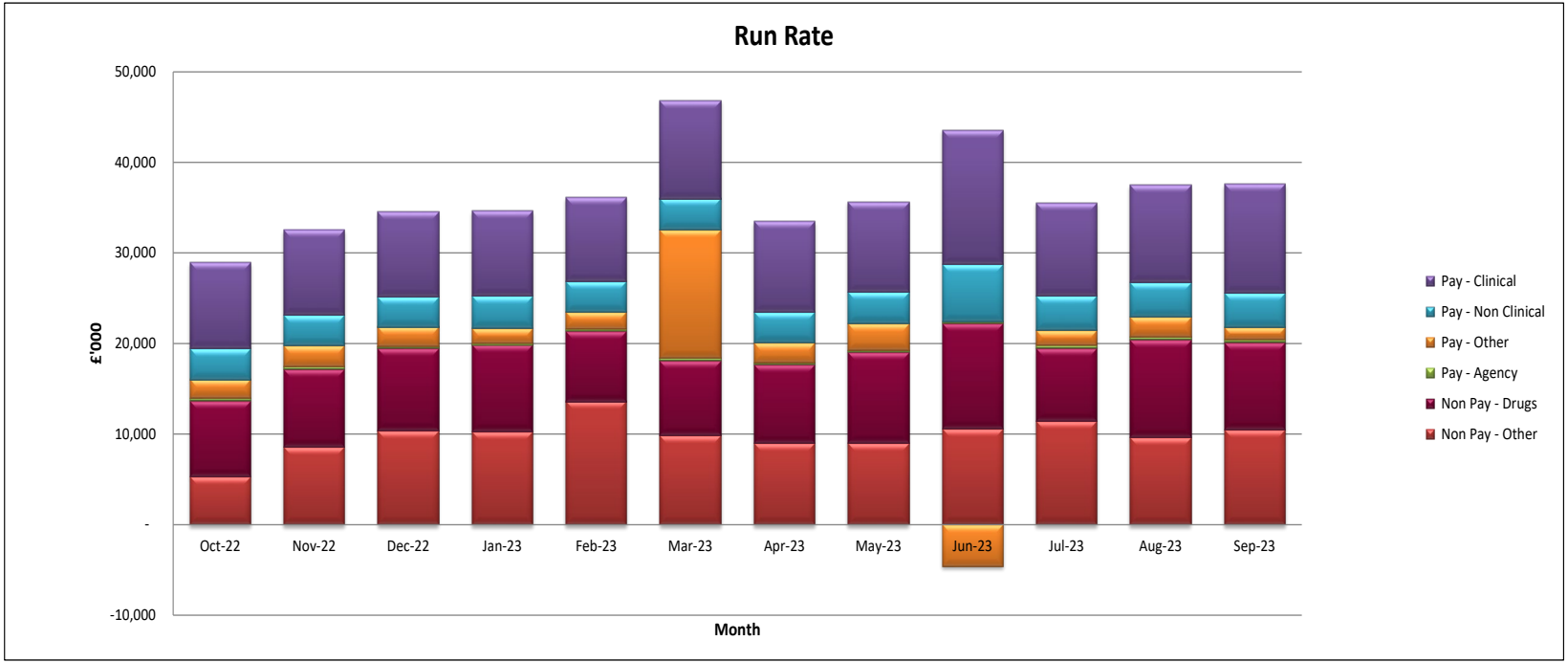




The agency spend is £237k in month 6, a decrease of £97k from month 5. This is mainly due to a decrease on clinical nursing agency spend.

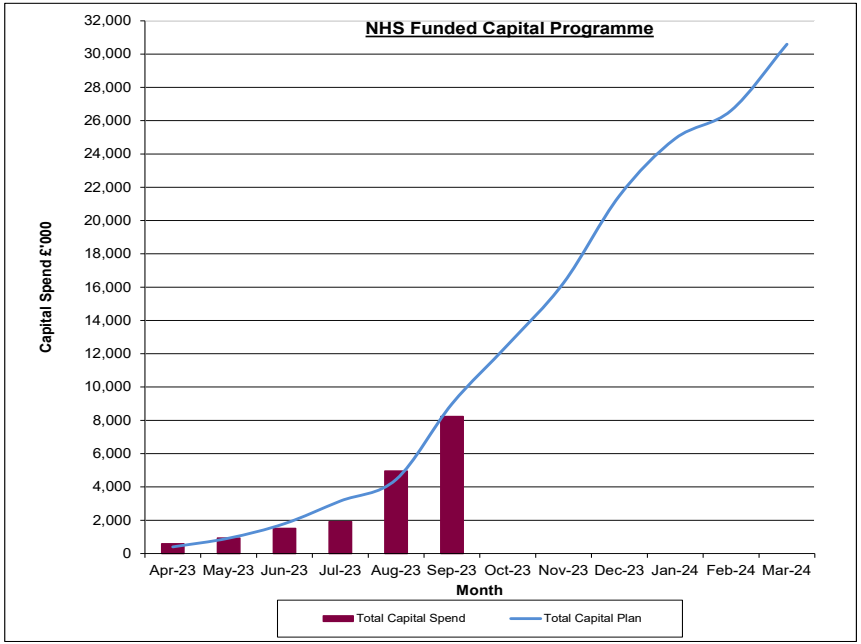
Alongside this, bank usage has decreased by £69k in month compared to M5, largely driven by a decrease on clinical nursing.

5.2 - Finance (Expenditure)



- Drugs spend in month 6 is £9,629k, a decrease from month 5 of £1,116k.
- Pay - Agency spend in month 6 is £237k, a decrease of £97k from month 5.
- Pay – Clinical increased by £1,351k compared to month 5 mainly due to medical pay awards.
- Key elements of 'Non Pay Other' spend consist of clinical supplies and services, premises and infrastructure costs.

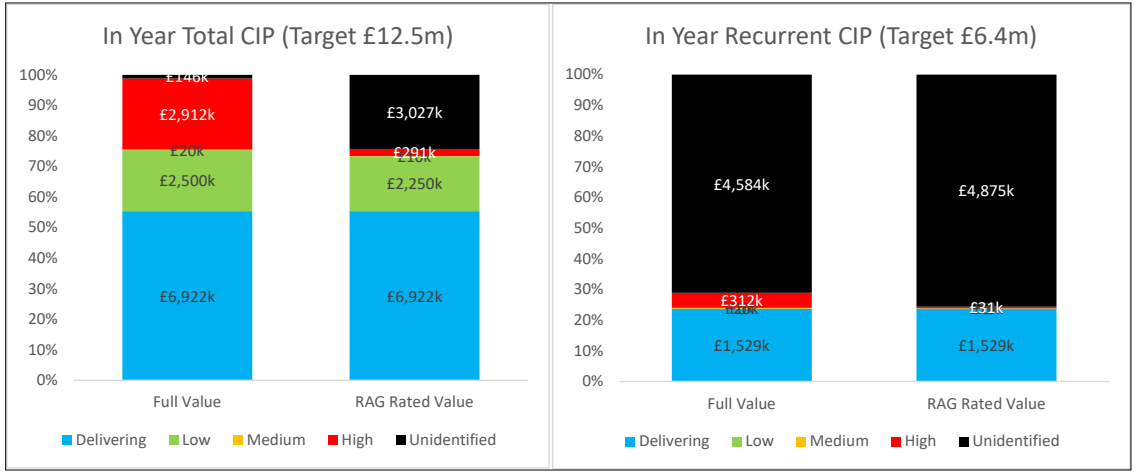
Finance (Capital)



	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		10,685	11,685	(1,000)
GM capital plan control total - Trust own cash	19,820	(2,000)	17,820		5,588	6,918	(1,330)
PDC capital funded schemes	10,083	0	10,083		3,400	1,281	2,119
Loan and lease funded schemes	686	0	686		0	0	0
Total annual capital programme under CDEL	30,589	(2,000)	28,589		8,988	8,199	789
ASIC development	0	0	0		0	0	0
Art room refurbishment	0	424	424		0	29	(29)
Charity funded programme	0	424	424		0	29	(29)
Total Trust Annual Capital Programme	30,589	(1,576)	29,013		8,988	8,228	760

Performance for month 6 was an underspend of £789k against the CDEL plan submitted to NHSE&I
The Trust has incurred £8,228k on capital schemes to month 6, 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.

Finance (CIP)



Total In year CIP

- Total identified CIP schemes reported are £12.3m (£10.5m non recurrent / £1.8m recurrent).
- Risk adjusted identified schemes value £9.5m leaving £3m unidentified.
- This is 99% of the in year target of £12.5m leaving £146k 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**	**£12,354k**	**(£146k)**	£9,473k	(£3,027k)	**£6,250k**	**£6,251k**	**£1k**
Recurrent CIP	£6,445k	£1,861k	(£4,584k)	£1,570k	(£4,875k)	£3,222k	£858k	(£2,365k)
Non-Recurrent CIP	£6,055k	£10,493k	£4,438k	£7,903k	£1,848k	£3,028k	£5,393k	£2,366k