Board of Directors Public meeting
Thursday 26th March 2026 at 2.00pm
Trust meeting room

Agenda

Patient story / clinical presentation: Senior Adult Oncology, Dr Fabio Gomes Medical Oncology Consultant and a patient

30 mins

Public items		Decision		Lead	Page	Timing
06/26	**Standard business**					
a	Apologies	Note		Chair		
b	Declarations of interest	Note		Chair		
c	Minutes of previous meeting – 29 January 2026	Approve	*	Chair	2	5 mins
d	Action plan rolling programme, action log & matters arising	Review	*	CEO	9	
07/26	**Performance & finance**					
a	Trust report	Review	*	Execs	12	5 mins
b	Integrated performance quality & finance report	Review	*	COO	18	5 mins
c	Value Improvement Programme update	Review	*	COO	61	5 mins
d	Staff survey 2025	Review	*	DoW	72	10 mins
e	Neighbourhood Oncology	Review	*/p	EMD	82	10 mins
08/26	**Planning**					
a	Future Christie update	Review	*	DFC	87	5 mins
b	Strategy Update	Review	*	DoS	93	5 mins
09/26	**Governance (regulatory / statutory compliance)**					
a	Reports from committees (December / January 2025/6 meetings) • Workforce Assurance Committee • Quality Assurance Committee • Audit Committee • Senior Management Committee	Review	*	Committee chair	98 102 106 110	15 mins
b	Board assurance framework	Review	*	CEO	113	5 mins
c	Annual reporting cycle 2026-27	Approve	*	CEO	123	2 mins
d	Code of Conduct for Directors and Employees	Approve	*	CEO	127	5 mins
e	Fit & Proper Persons Test Policy	Approve	*	CEO	152	
f	Fit & Proper Persons Test Compliance report	Approve	*	Chair	164	5 mins
10/26	**Any other business**					
	For information 5 Year Integrated Delivery Plan	Note	*			
	Reflections on the meeting					
	Date and time of the next meeting Thursday 30th April 2026 at 2:00pm					

D/CEO	Deputy / Chief Executive Officer
EMD	Executive Medical Director
DFC	Director of Future Christie
COO	Chief Operating Officer
DoW	Director of Workforce
DoS	Director of Strategy

*	paper attached
v	verbal
p	presentation

Public meeting of the Board of Directors
Thursday 29th January 2026 at 2.00 pm
Trust Meeting Room

Present: Chair: Prof Joe Rafferty (JR), Chair
Roger Spencer (RS), Chief Executive Officer
Alveena Malik (AM), Non-Executive Director
Grenville Page (GP), Non-Executive Director
Amanda Oates (AO), Non-Executive Director
Dr Marisa Logan-Ward (MLW), Non-Executive Director
Sarah Corcoran (SC), Non-Executive Director
Prof Chris Harrison (CJH), Executive Director / Deputy CEO
Claire McPeake (CM), Chief Operating Officer
Vicky Sharples (VS), Chief Nurse and Executive Director of Quality
Sally Parkinson (SP), Executive Director of Finance
Dr Neil Bayman (NB), Executive Medical Director
Eve Lightfoot (EL), Director of Workforce
Tom Thornber, Director of Future Christie
Prof Adrian Bloor (AB), interim Director of Future Christie
Prof Fiona Blackhall (FB), Director of Research
Prof Rikki Goddard-Fuller (RGF), Director of Education
Jeanette Livings (JL), Deputy Director of Communications

Minutes: Louise Westcott (LW), Company Secretary

In attendance: Jo D'Arcy (JD), Assistant Company Secretary
Madelaine Warbuton (MW), Audit One – well-led review observation

Clinical presentation: A patient story - Clinical Research Facility trials – Dr Fiona Thistlethwaite, Director CRF / Deanne a CRF patient

FT introduced herself as a medical oncologist who leads ACMT advanced therapy team and is also the medical director of the CRF. FT introduced Dianna, a CRF patient.

Deanne introduced herself and described being diagnosed with cancer in her 40's. A single parent to a (now) 6-year-old, an occupational therapist and lecturer who also supports disabled parents. Diagnosis is triple negative breast cancer in 2022. Mastectomy & lymph node clearance, surgery, radiotherapy and chemotherapy. No evidence of cancer in November 2023. Then 7 months later a recurrence. August 2025 disease progression and offered the option of a clinical trial.

Multiple lines of treatment had not held off the cancer so knowing the NHS and the reputation of the Trust decided to look at clinical trials as what is available hadn't worked. Felt like a chance worth taking and to take some control. Also motivated by having a daughter who one day may also have cancer and that this may help.

Pathway for the trial was very specific – the consent process was very detailed and complex. Deanna had loads of questions and all of these were dealt with and the team were extremely helpful in responding and providing reassurance where possible.

Lots of imaging and tests were required, a pause phase was extremely difficult to manage where she was not on any treatment. Screening process was a success then the day of the first treatment got a call to say don't come as treatment couldn't be given. She came anyway and had port fitted. The reason for the delay was due to an issue with the aseptic department that meant the drug couldn't be made up. Delays mean reconsent, additional screening etc all of which may mean the treatment isn't given.

There was some flexibility and another week in which treatment could be given. Other options were discussed including referral to The Royal Marsden, the impact would have been to start again with screening – repeating everything.

On 9th October was on the way to London for consent and had a call to say that treatment could go ahead if could arrive in next 2 hours. Arrived and could see that treatment needed to be given straight away. FT explained that a small number of drugs could be processed – there was a 4-hour window, a way was found to deliver to protocol. As the first patient on this trial there were additional risks, and this was outside working hours that demanded support beyond the working day. The whole team worked together under extremely difficult and tight time constraints to give the treatment.

Deanna was discharged after midnight, which was manageable but would be difficult for a lot of people.

The trial is going well, and response so far has been remarkable. Feels any delay would have been very difficult and may not have been able to proceed. There have been difficult side effects.

Skilled team, fine toothcomb approach, involved in every decision and team have made it as good as it could be.

Need an established support network, living with uncertainty is very difficult – looking after mental health is key. Taking part in something bigger than yourself matters.

TT asked about managing uncertainty, managing expectations of others and mental health. Deanna explained that other people's expectations are very difficult, lots of support network are clinical and comfortable with talking about life and death which really helps.

Talking about things helps with mental health. Being proactive with no control was extremely important to managing. Also has professional help particularly around her daughter.

NB thanked Deanna for her presentation. Living a distance away from the hospital, how was she connected to the hospital when at home. When on standard treatment she pushed, and it was driven by her in contacting regularly. When asked about a trial it felt collaborative, and it developed trust. Knowing the hotline was available was great, also used to live and work near here so knew the area. Out of hours it was more difficult, need the same support.

Asked if weekend appointments would help. Deanna agreed that it would help in getting support networks to come to appointments as friends work during the week.

GP asked about connection to community / GP and if any gaps. Deanne explained that she has explained her condition to her local walk in and they have helped her well. Disappointment sits with not being diagnosed earlier.

Referral to Christie was requested by Deanna when being seen in Sheffield and this was initiated by Deanna.

The incredible complexity of the requirements by the trials team were described in detail that explains what is needed to deliver these complex trials by a whole team with aseptics as a key component in making up the trial drugs.

Protocols are so detailed and require constant connection with the trial sponsor and principal investigator for the trial.

Thanks for the candid explanation of treatment and the complexities of delivering these complex and new trials.

The linkages to the aseptics developments in GM were made, driven by developments in drug therapies that require aseptic production. Many have short expiries and therefore we need this on site. The GM project prioritises a single integrated service for GM, JW is leading this. This will develop resilience and be a hub and spoke model to deliver bespoke requirements such as ours.

Looking at working with commercial partners. This will provide resilience in terms of workforce, give operational resilience and provide financial and commercial opportunities. Scoping phase is completing leading to a business case. The system approach aims to provide resilience going forward. The business case development will come back to Board in due course.

Rate of change and interdependencies was demonstrated by the presentation. The reliance on aseptics is very striking in terms of delivery of our ambitions for research and ability to achieve this.

FB described the additional considerations that are considered when addressing patients complicated circumstances in terms of background, support etc.

AO asked what we do to thank patients and teams who come to Board. We send thanks to the clinician and ask this to be passed to the patient. We have many other activities in the Trust where patients engage with us, and this is structured and supported by staff in many ways.

We've had great feedback from patients who come to Board who feel like it benefits them as well as us.

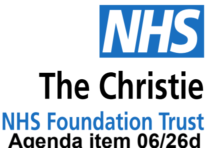
Item		Action
01/26	**Standard business**	
a	**Apologies**	
	Roy Dudley-Southern (RDS), Non-Executive Director, Dr Diana Tait (DT), Non-Executive Director, John Wareing (JW), Director of Strategy	
b	**Declarations of Interest**	
	No declarations made relating to the items on the agenda	
c	**Minutes of the previous meeting – 27th November 2025**	
	The minutes were accepted as a correct record.	
d	**Action plan rolling programme, action log & matters arising**	
	All items from the rolling programme are complete or noted on the agenda.	
02/26	**Performance & Finance**	
a	**Trust Report**	
	• There are no adverse variances against objectives at month 9 and we are on plan for performance and finance requirements. • We are a positive outlier regionally and nationally both financially and in respect to the national standards. • Since production of the report, we have had further confirmation of the difficult financial position in GM that is about £28m worse than the deficit control total. There are also leadership challenges in the ICB with an interim CEO and the imminent retirement of the ICB Chair in June. • ICB are going through a reduction of around 600 staff. • We continue to offer help and support in the system through system leadership e.g. aseptics project. • Planning process is ongoing, and deadlines are coming up for final submission. Board have reviewed the final draft of the 5 year Integrated Delivery Plan and approved it for submission by the February deadline. Report noted	

b	**Integrated performance quality & finance report**	
	• CM outlined the report that aligns to the NHS Oversight Framework. • The executive summary notes the exceptions and what we are doing. • The report shows a high reporting, low harm culture. • We are delivering a surplus plan, and our capital spend is slightly over plan which is intentional. • Cancer pathway performance exceeds the standards alongside growth in demand. We are delivering the faster diagnostic standard. • MR times have dipped, looking at realignment of capacity to address this. • 7 learning responses triggered – PSIRF responses are underway. • VTE compliance achieved, working on sustainability. • Set up times for research trails are a focus, a new system is in place to manage this and associated access in radiology and pathology being addressed. • Risk management is progressing and being well managed. • Non-recurrent VIP over delivery makes up for a shortfall in recurrent, overall VIP has been achieved. • Questions invited. • A question was asked around the management and progress with the anaesthetics 'extreme' risk – response that the risk outlined has been reviewed this week and score reduced following implementation of mitigations.	
c	**Value Improvement Programme update**	
	• Paper shows the monthly update. • Delivered for 2025/26 and are now working on 2026/27 - £8.9m of total identified, we will be at 100% identified in the coming weeks. • We produced a submission in December and are working to a rolling programme of VIP rather than in year. • GP asked when we think we will move to more VIP being recurrent. CM responded that as we rely on service improvement and productivity this won't be realistic. • SP noted that we have put 50% recurrent / 50% non-recurrent in our plan. The reduction in bank interest as we deploy cash on the capital plan will impact our non-recurrent VIP. We are planning based on this reduction. • Challenge on the £16.5m gap to target for 2026/27– the ambition to agree this in a short time frame, is assessed as being realistic. • CM noted that the team feel it is realistic. We are the only organisation who have delivered this year's VIP and developed detailed plans for delivery next year. • GP noted the need to identify it before 1st April. • CM feels this is realistic and deliverable. The Board noted: • Plans for 2026/27 VIP JR congratulated the team on this performance.	
d	**Review of annual objectives**	
	• The paper details the annual objectives for the year and current progress. We are	

	on schedule to deliver the objectives, and no issues are escalated to Board. • Delivery of these objectives sits alongside the other work outlined to Board. • No questions. • Board reviewed the annual objectives set out and the progress against them.	
03/26	**Planning**	
a	**Future Christie update**	
	• AB presented the Future Christie update which is a transformation platform built around the patient, clinician and whole hospital. • Foundational work on several programmes has been undertaken. • EPR programme is on track, OBC due in February, very good engagement with staff. • JAC programme is linked to the EPR programme. CDO interviews planned and have had lots of interest. • April paper will describe the progress on JAC. • Patient portal is working very well with around 10,000 patients signed up. Further work is ongoing. Integration with the NHS app is required and this work continues although this is identified as a risk. • AVT went live last week in pilot teams, issues are being ironed out and then this is being rolled out more widely. Working with workforce team on the impact on the admin teams of this roll out. • AVT will be enormously beneficial for clinicians and patients. • The NHS FDP that aims to link together patient data is being engaged in for 2 distinct projects – patient stratified follow up (PSFU) and single queue diagnostics (SQD). We are carefully considering impacts on patients and how data is shared safely. • EL noted that impact on workforce of the changes described is being considered and a plan established. • SC challenged around the safety reporting around these plans, learning, how we are getting benefits and what we're doing with risk. Agreed that these processes will report to QAC. • EQIA is being strengthened for each project, surfacing this for assurance purposes is key and will be a focus going forward. • GP asked about the hosting arrangement of the FDB for providers. AB noted that this is cloud based, and one provider must host, which means to act as a coordinator. This has come about as the SQD is for a cancer diagnostic initially. • RS reminded board that we are required by NHSE to use the FDP. There's an ambition to get a primary diagnostic running as a single queue, e.g. CT scanning. This will improve waiting times without the need for further capacity. • Concerns around the sharing of data are important and we have undertaken lots of due diligence of the data protection aspects of using the system - this is about the flow of patients. • Feedback on the patient portal requested – this solution is not perfect but has been popular. It will be overtaken by EPR so we don't want to invest too much in something we know will change. • AM asked if we're happy with the rate of change – we are in the process of doing a lot of the building block work now and we are very aware that EPR will take	

	over once we get on with implementation. We want AVT in place by then to support this. We would like to do things faster but know this is not necessarily the right way to proceed. • NB noted that we recognise the benefits of the work and it's the pace of the benefits not just the change that's important. We need to align the work to be successful. • AO noted caution in pace of change for the workforce. • The key to change is the delivery. • Awareness of what we are trying to do with Future Christie is well embedded and we are getting very good engagement from staff.	
b	**Financial & operational planning**	
	• In the October and November Boards we took Board through our planning and submitted our initial plan to national deadlines in December • The Plan needs to be submitted next week • Awaiting income offer from commissioners • The Board are requested to delegate authority to the Chief Executive and Executive Director of Finance to submit the compliant plan by the due date of 4th February 2026 subject to a confirmation of income aligned with the contract and assumed in the plan. The Board: • noted the progress on the financial plan and matters outstanding • delegated authority to the Chief Executive and Executive Director of Finance to submit a compliant plan pending agreement of income with commissioners	RS/SP
04/26	**Governance (regulatory / statutory compliance)**	
a	**Reports from Committees (November 2025)**	
i	**Workforce Assurance Committee**	
	AO noted that first look at mandatory training compliance shows over 85% compliance which is positive progress.	
ii	**Quality Assurance Committee**	
	No items for escalation Extension to Quality Plan, coming back in February Moderate assurance on discharge planning, coming back in June IP survey results were reviewed and show excellent feedback and comparative performance. VTE compliance report came back and showed good progress and assurance	
iii	**Senior Management Committee**	
	SMC report shows the preparatory work done prior to consideration of items by the Board.	
b	**Board Assurance Framework**	
	• BAF has been updated to show the current position against the strategic risks. • Changes to the risk scores are outlined in the cover paper with explanations. • Q3 risk scores have been added.	

	• The 10-point resident doctor plan has been added to the workforce risk to show activity taking place to comply. Noted that this group are balloting for further action. • In the review of annual objectives and BAF reporting we include the elements of the Board self-assessment of our capability over the year. This allows us to look back at evidence. • GP asked about looking at the BAF over a longer period rather than in year. The current presentation runs over a longer period to show change over time.	
	Reflections of the meeting	
	No members of the public in attendance. Board felt that the private first worked well but we need to be very careful to still ask questions in public. Must maintain the criteria for discussion of issues in public / private. Thought FT did an excellent job in the presentation. Noted that we focus on hearing different patient voices and supporting patients with different ways of engaging with us. This work reports through the QAC. Discussion about how we are looking at new models of care & impact on health inequalities– example of lung health checks, this now shows that targeted screening in deprived areas means these patients are being diagnosed earlier in these areas compared to more affluent areas. We need to ensure people are assured on the work that takes place in committees they don't attend. AO noted that from her experience we present the good and bad in assurance committees and board. Continued consideration of how we know we are equitable and how the Board sees this.	
05/26	**Any other business**	
	• No items raised	
	Date and time of the next meeting	
	Thursday 26th March 2026 at 12:45pm	



Agenda item 06/26d

Meeting of the Board of Directors - 26 March 2026
Action plan rolling programme after January 2026 meeting

C Culture P Performance S Strategy G Governance

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
March 2026		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance & quality and finance report	COO	Monthly report	For information
		S	Future Christie update	DFC	Review	08/26a
		P	Value Improvement Programme	COO	Review	07/26c
	Annual reporting cycle	S	Annual reporting cycle	Executive directors	Approve	09/26c
		C	Staff survey initial results	DoW	Review	07/26d
	Annual reporting cycle	G	FPPT Compliance report	Chair	Approve annual compliance	09/26e
April 2026		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance & quality and finance report	COO	Monthly report	
		G	Register of matters approved by the board	CEO	Approve	
	Provider licence	G	Self certification declarations	CEO	To approve the declarations	
		G	Modern Slavery Act statement (in Trust Report	CEO	Approve	
		P	Trust Strategy Update	DoS	Review	
		C	Freedom to speak up Guardian report	FTSUG	6 monthly update	
	Annual reporting cycle	P	Risk Management strategy 2025-26 annual review	ECN	Annual Review	
May 2026 - no meeting	Annual reporting cycle	P	Integrated performance & quality and finance report	COO	Monthly report	By email
Planning & Development Day	**Planning session**	S	Planning			
June 2026		C	Patient story	CEO	To hear a patient story	
	Annual reporting cycle	P	Integrated performance & qualityand finance report	COO	Monthly report	
	Annual reporting cycle	G	Annual reports from audit, quality and workforce assurance committees	Committee chairs	Assurance	
	Annual reporting cycle	G	Annual compliance with the CQC requirements	ECN	Declaration / approval	
		P	Value Improvement Programme	COO	Review	
		S	Annual objectives / BAF 2026/27		Approve	
	Annual reporting cycle	G	Annual report, financial statements and quality accounts (incl Annual governance statement / Statement on code of governance)	EDoF	Approve	
July 2026 - no meeting		P	Integrated performance & quality and finance report	COO	Monthly report	By email
Planning & Development Day	**Planning session**	S	Service Review day with senior leadership teams			
August 2026 - no meeting		P	Integrated performance & quality and finance report	COO	Monthly report	By email
September 2026		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance & quality and finance report	COO	Monthly report	
		P	Value Improvement Programme	COO	Review	
		S	Future Christie update	DFC	Review	

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

Agenda item: 06/26dii

Action log following the Board of Directors meetings held on

Thursday 29th January 2025

No.	Agenda	Action	By who	Progress	Board review
	Patient story	Progress work with Aseptic Service to minimise patient impact	VS	Plan in place, risk described and mitigated. Reporting through Risk & Quality Governance Committee	Quality Assurance Committee
1	03/26b	Delegated authority to the Chief Executive and Executive Director of Finance to submit a compliant plan pending agreement of income with commissioners	SP/RS	Contract agreed with commissioners and compliant plan submitted	Complete

Agenda item 07/26a

Meeting of the Board of Directors

Thursday 26th March 2026

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

Trust Report

March 2026 (February data)

Introduction

We continue to perform well with no current issues requiring escalation and a projected achievement of annual objectives across all domains.

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

Board Capability

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

Our self-assessment of full compliance against the NHS England provider capability domains was made at our September 2025 Public Board and submitted to NHSE in October 2025.

We received confirmation from NHSE on 6th February 2026 that this assessment has been signed off by the regional team and moderated through a national process resulting in our overall capability rating being assessed as 'Green' for 2025/26.

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

NHSE Board capability domain	Relevant Indicators	Evidence	RAG rating
1. Strategy & Leadership	Oversight Framework segment; national ranking	NOF Segment 1, Q3 ranked 3rd nationally NHS Acute & Specialist Trusts.	
2. Quality of Care	62-day cancer standard; Faster Diagnosis Standard; nurse staffing	62-day and FDS remain above target. Nurse staffing consistently exceeding the minimum target of 80% planned levels	
3. Workforce	Sickness absence; PDR compliance; training compliance	Sickness 4.98% (lowest in GM). PDR compliance (85.9%) and mandatory training compliance (95.5%)	
4. Partnerships & System Role	GM Collaborative contributions; national audits	Leadership in Cancer Alliance. Lead GM aseptic programme. OECI reaccreditation confirms global top-tier status.	
5. Financial Sustainability	Monthly surplus; VIP delivery	Surplus (£6.9m) on plan; value improvement plan target achieved.	
6. Improvement & Innovation	Clinical trial set-up; AI pilots; EPR milestones	Research set-up below 60-days. Digital/AI projects and Future Christie milestones progressing to plan.	

Operational Performance – Month 11 Position

We continue to perform strongly across all domains. We are in Segment 1 of the NHS Oversight Framework, the highest possible rating, and at Q3 are ranked 3rd nationally among acute and specialist providers. Our international standing as one of the top 25 global cancer centres as reported at the September 2025 board meeting. Our overall NHSE provider capability rating is assessed as 'Green' for 2025/26.

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

Strategic Objectives – Month 11 Position

Progress against the 2025/26 annual milestones of each of our six strategic objectives is currently rated Green, with risks actively managed and oversight of risks clearly assigned to committees or the board and tracked through the Board Assurance Framework.

Strategic Objective 1: Safe, Effective and Equitable Care

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

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

There were no significant adverse quality variances in February. Two operational risks currently score above 12 and risks are actively monitored via the Risk & Quality Governance Committee, with mitigation plans in place.

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

We have received JAG accreditation in March 2026. This is the formal recognition awarded by the Joint Advisory Group on Gastrointestinal Endoscopy recognising high quality services that meet rigorous standards for patient safety and care.

Strategic Objective 2: Excellent Financial and Operational Performance

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

- Status: Green
- BAF Risks: 2 ≥15
- Committee Oversight: Board of Directors
- Executive Lead: Executive Director of Finance

At Month 11, the Trust is delivering a financial surplus of £6.9 million, in line with plan. The Value Improvement Plan for 2025/26 has been achieved, and operational performance remains compliant against all major cancer standards, including the 62-day, 31-day and Faster Diagnostic Standard (FDS) metrics.

We have agreed a compliant plan for 2026/27 with our commissioners. Our plan is based on our fixed contract being paid and the variable elements being based on activity as per the contract.

Following approval at the February Board meeting, we submitted our 5-year Integrated Delivery Plan in line with the NHSE Medium Term Planning Framework to the NHSE Regional office by the February deadline. The plan sets out how the Trust will meet national planning

requirements, deliver the NHS 10 Year Health Plan for England and achieve refreshed strategic goals, while sustaining outstanding, equitable and financially sustainable cancer care. Overall, the plan provides assurance that The Christie has a credible, affordable, compliant and well governed approach to meeting rising demand, delivering national standards and sustaining world leading cancer care over the next five years.

Strategic Objective 3: Integrated Clinical, Research and Education Services

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

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

We are working towards the national 60-day benchmark for Research trial set-up times which have improved. Further process improvements are taking place to sustain and further improve this position. We are also actively preparing for the new Good Clinical Practice (GCP) regulations coming into force in April 2026. A Health Tissue Authority Remote Inspection took place within the BioBank team at the end of February 2026.

A proposal to establish a credentialled education suite and achieve Higher Education status was shared at the November 2025 Board of Directors. This represents a strategic opportunity to strengthen our academic partnerships and reinforce our position as a centre of excellence in cancer education. Work to develop new academic programmes and delivery partnerships in support of this proposal is well underway.

Gateway C has been named in the National Cancer Plan demonstrating a continued commitment to prevention and neighbourhood work.

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

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

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

Workforce indicators remain strong. Mandatory training compliance stands at 95.5%, and PDR completion is at 85.9%. Sickness absence is currently at 4.98%, the lowest in Greater Manchester. The Christie continues to be rated in the top category nationally for compassionate and inclusive culture, staff engagement, safe & healthy, morale and flexibility, as confirmed by the NHS Staff Survey 2025. A summary of our 2025 results is presented in the March public Board papers.

We have been notified that will be visited by NHSPRB, the body responsible for making recommendations to government on AfC pay. The aim of the visit is to help NHSPRB members get a sense of what is happening 'on the ground' both with members of its remit group (i.e. staff employed on the Agenda for Change contract), and with those leading and managing NHS services at a local level.

Strategic Objective 5: Transform Services and Reduce Inequalities

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

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

Our Future Christie transformation programme remains on track. The Patient Portal has been successfully rolled out, and an outline business case for a new electronic patient record (EPR) was approved by the Board in February. The capital programme is progressing to plan and remains within budget.

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

Strategic Objective 6: Leadership Within the Wider NHS Cancer System

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

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

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

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

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

National Policy Developments

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

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

- The Government published its National Cancer Plan for England on 4 February 2026, World Cancer Day. The Plan sets out a long-term ambition to stabilise and transform cancer services over the next decade, with a renewed national commitment to improving cancer outcomes by delivering faster diagnosis, quicker treatment, and the support to live well with cancer.

As a specialist cancer centre, The Christie has an important responsibility to play our part in delivering these ambitions for patients across Greater Manchester and beyond.

A core ambition of the National Cancer Plan is shifting more cancer care out of hospital and into local neighbourhoods. Neighbourhood oncology is one of the ways The Christie is moving away from care organised primarily around hospital attendances and shifting to managing cancer as a long-term condition in neighbourhoods, delivering more care closer to home and designing services around people's lives.

We welcome the National Cancer Plan's adoption of 'single-queue diagnostics', an approach pioneered in Greater Manchester using latest digital platforms to identify earliest appointment times across the region for essential diagnostic tests. Single-queue diagnostics has been shown to reduce the time taken to diagnose cancers and start treatment for patients and is currently being rolled out for more tests across Greater Manchester.

The Plan also recognises the importance of cutting-edge precision technologies to improve cancer treatments, including expanding the role of stereotactic radiotherapy (SABR) and robotic surgery, and integrating artificial intelligence (AI) to free up 'time to care'.

We Care
We Discover
We Teach

Innovative

Outstanding

EXECUTIVE SUMMARY

Strategy & Leadership: The Trust demonstrates strong organisational grip, with effective governance and timely risk oversight (94% on-time reviews). This provides a solid platform to reinforce resilience and shape The Christie's national specialist narrative under the new Oversight Framework

Safety: Incident reporting culture is robust, with 98% of incidents resulting in low/no harm and 18% being near misses, which reflects proactive risk identification. IPC MRSA remains above trajectory, while E.coli and Klebsiella trends are improving. Sustained focus on IPC fundamentals and compliance monitoring continues to prevent future spikes and maintain patient safety.

Finance: The Trust remains on plan with a £6.90m M11 surplus against a £6.88m plan, supported by £25.3m VIP delivery and strong liquidity with £130.5m cash and a £109.3m forecast year-end balance. Capital expenditure of £23.5m (≈£0.4m over plan) on ASIC, digital, estates backlog and asset replacement aligns directly with strategic priorities to relieve diagnostic bottlenecks and strengthen IPC, linking financial investment to operational recovery

Access & Performance: 62-day cancer performance continues to fluctuate around the ~75% process mean, with peaks (~85.6%) and lows (~68.9%) showing no sustained system improvement, and non-clinical cancellations rising since Oct-25 — all indicating pathway fragility linked to capacity and flow constraints. In contrast, other cancer pathway standards with a 92% target remain consistently exceeded (≈96% in Feb-26), demonstrating that where processes are stable, performance is reliable and recoverable

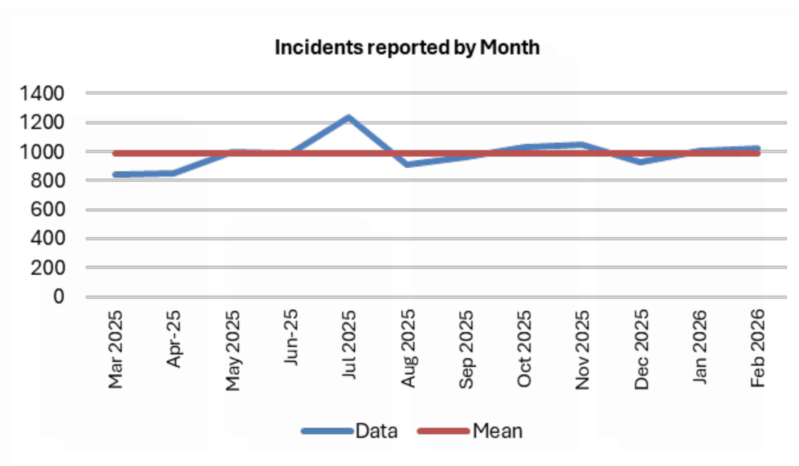
Workforce: Workforce capacity remains stable but continues to rely on temporary staffing, with agency spend at £0.24m in month 11 and £3.01m YTD, and higher bank utilisation at £0.46m in month 11 and £4.84m YTD, reflecting ongoing operational gaps.

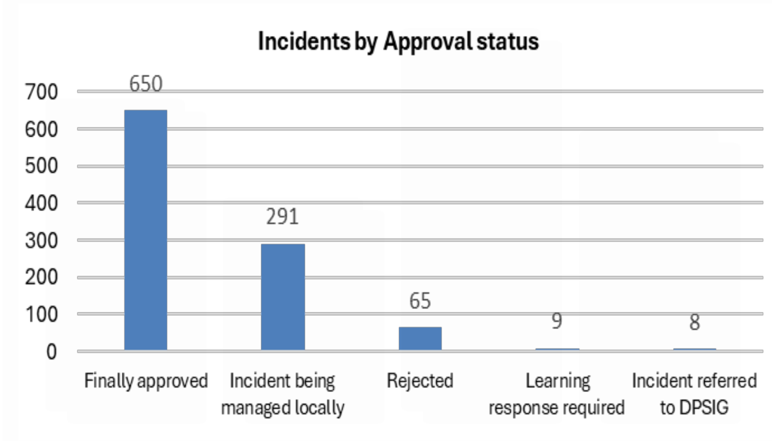
Overall Assessment: The Trust is maintaining financial stability and strong risk governance while addressing operational pressures, as evidenced by controlled temporary staffing costs, a £6.90m M11 surplus on plan, and timely review of all extreme risks amidst rising cancellations and pathway variability. However, sustained performance challenges—including fluctuating 62-day cancer outcomes and diagnostic capacity highlight the need for continued executive oversight

Incident Reporting

A total of 1023 incidents were reported to DCIQ in February 2026.

- At the time of reporting, 64% of incidents have been finally approved. 6% of incidents have been rejected for reasons such as duplication and incidents which involve care provided by an external trust.
- 96% of all incidents reported resulted in low/no harm.
- 18% of incidents were reported to be a 'near miss', evidencing a positive reporting culture.
- Reporting trends in February were within the expected limits.





Integrated Performance Report - Patient Care Metrics Summary

Metric	Month	Measure	Target	Variation	Assurance
Sepsis - screening (presenting as an emergency)	February	95.00%	90.00%		P
Sepsis - timely treatment with IV antibiotics (established inpatients)	February	98.00%	90.00%		?
VTE Assessment Within 14 Hours of Admission	February	95.80%	95.00%	H	F
Falls per 1000 bed days	February	4.3	3.8	H	?
Pressure sores per 1000 bed days	February	0.8	0.5		?
Category 3 pressure ulcers	February	0.0	0.0	L	?
Hospital Cancelled Operations on the day for non clinical reasons	February	13.0	0.0	H	?

VTE Assessment Within 14 Hours of Admission

100%
95%
90%
85%
80%

Target 95%

88.7% 88.6% 87.7% 86.7% 89.4% 90.0% 89.1% 90.8% 91.3% 89.1% 90.2% 92.7% 95.2% 95.8%

Apr 24 May 24 Jun 24 Jul 24 Aug 24 Sept 24 Oct 24 Nov 24 Dec 24 Jan 25 Feb 25 Mar 25 Apr 25 May 25 Jun 25 Jul 25 Aug 25 Sept 25 Oct 25 Nov 25 Dec 25 Jan 26 Feb 26

Icons

Improving H

Failing F

Summary

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

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

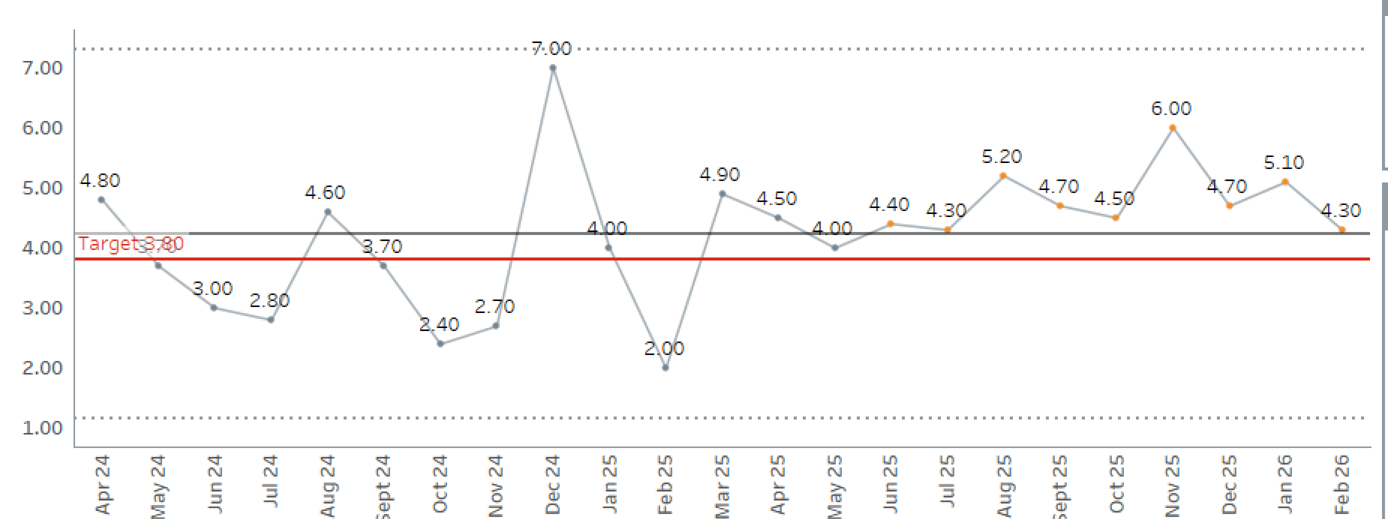
Understanding the performance

VTE assessments within 14 hours have improved steadily across 2024/25 into 2025/26, moving from fluctuating performance in the high-80s/low-90s to consistently achieving and then exceeding the 95% target from November 2025 onward From early 2025 the process stabilized around ~90–92%, followed by a sustained run of month-on-month improvement from Aug–Nov 2025, indicating a genuine process shift rather than random fluctuation. Winter 2025/26 performance has been maintained above target, suggesting recent changes are embedding: The improvement reflects a combination of pathway discipline, clinician awareness, and better prompts/escalation. To protect gains and reduce reversion risk, we will hard-wire reliability into digital prompts, admission checklists, and real-time feedback and focus on weekend coverage and ward-level variation.

Actions (SMART)

Continue with ongoing action plan in order to maintain performance

Falls per 1000 Bed Days



Icons

Concerning

Hit & Miss

Summary

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

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

Understanding the performance

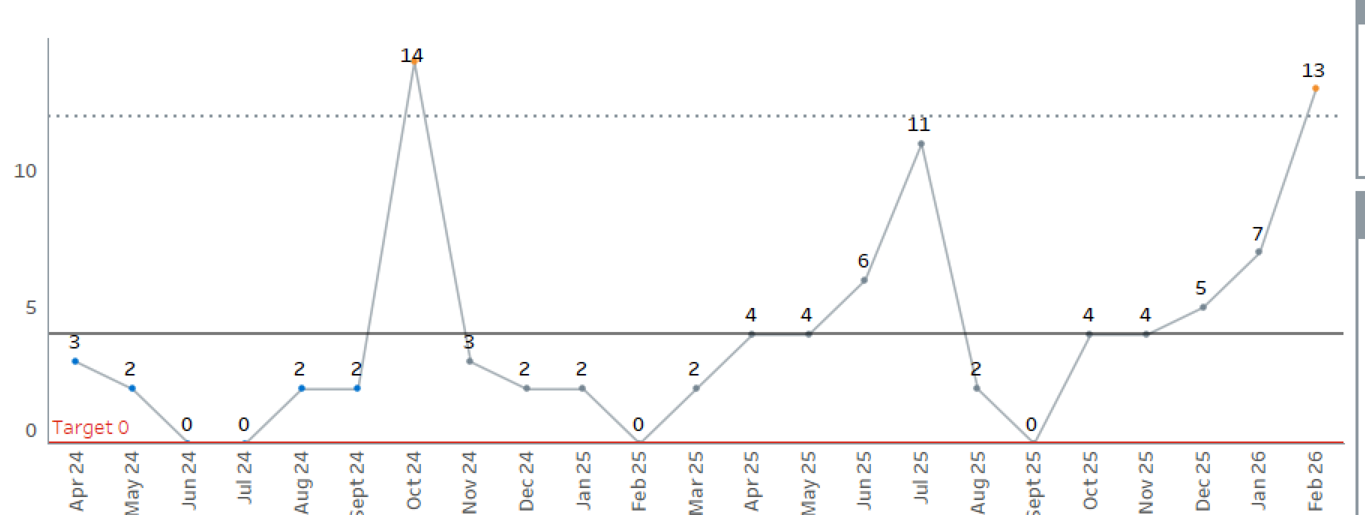
Since June 2025 we have seen increase in falls however, below national average of 6.8 falls per 1000 OBD
Thematic review completed; falls associated with increased complexity of patient cohort, especially inpatients
Modest improvement observed in month

Actions (SMART)

Falls improvement group progressing, chaired by Deputy Chief Nurse, focus on:

Enhanced Therapeutic Observations of Care standards
Use of falls prevention equipment (pressure sensors, low rise beds)
Patient and staff education
Improving assessment process with therapy involvement

Cancelled operations on the day for non-clinical reasons



Icons

Concerning

Hit & Miss

Summary

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

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

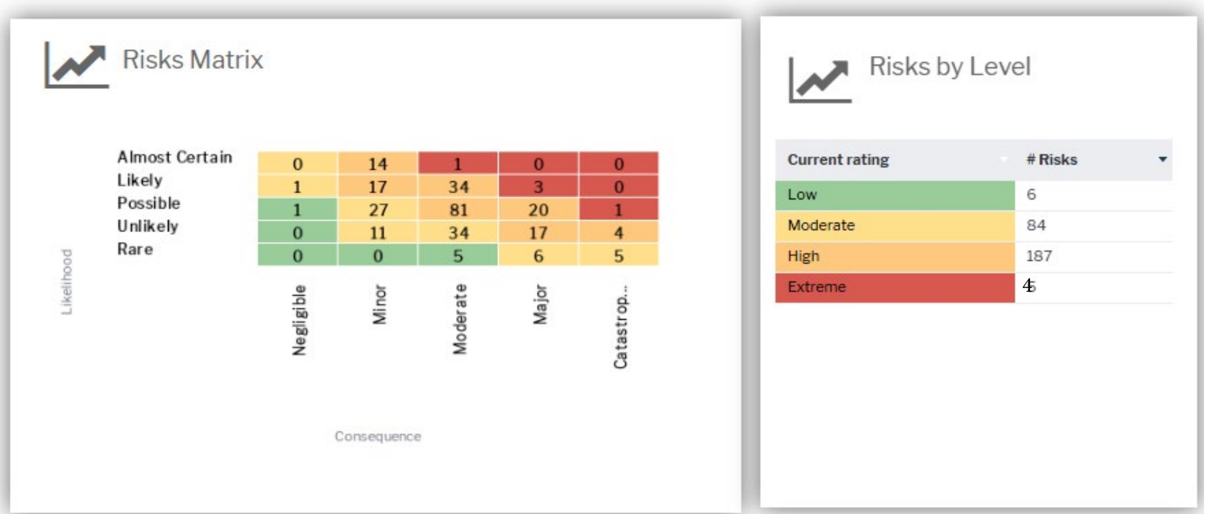
Understanding the performance

Target of 0 is missed every month. For much of the period, cancellations sit around 2–4 per month, showing a low but not zero common-cause baseline. Three spikes stand out all well above the expected range and are part of a learning response. From Oct-25 there's a sustained rise (≈4 → 5 → 7 → 13), signalling a real deterioration in the process rather than random variation. What this means: The pathway is vulnerable to shocks (beds, staffing

Actions (SMART)

Outcome target: Reduce same-day non-clinical cancellations to ≤2 per month by 30 Sep 2026 (stretch ≤1 per month by 31 Dec 2026), sustained for 3 consecutive months, with 100% of patients rebooked within 28 days.
Test of change currently in development with the team to be enacted in April
Weekly oversight of progress with the COO, CNO and MD

Risk Profile



Risks Matrix

Likelihood	Negligible	Minor	Moderate	Major	Catastrop...
Almost Certain	0	14	1	0	0
Likely	1	17	34	3	0
Possible	1	27	81	20	1
Unlikely	0	11	34	17	4
Rare	0	0	5	6	5

Consequence

Risks by Level

Current rating	# Risks
Low	6
Moderate	84
High	187
Extreme	4

- In February 2026 there were 282 open risks recorded in DCIQ
- Of the 282 risks open, 66% (n= 187) were rated as high
- 4 risks were reviewed as being 'extreme' (≥15)
- 95% of all active risks were reviewed within planned timeframes (14 risks were overdue scheduled review)

Trust wide risk register

Risk ID	Risk	Risk register	Type	Subtype	Status	Risk owner	Date opened	Initial rating	Current likelihood	Current consequence	Current rating	Target rating	Movement	Next Review Date
630	Risk that the Aseptic unit will be unable to deliver required capacity during a period of recovery following shutdown due to a recognised inability to maintain required operational & safety standards	Trust wide	Operational Risk	Business Continuity Risk	Active	Joanne McCaughey	26/01/2026	20	4	4	16	4	↔	13/03/2026
617	There is a risk of a patient coming to harm due to unclear and non-standardised operational processes for clinical correspondence	Trust wide	Clinical Risk	Patient Safety / Outcomes Risk	Active	Suzanne MacGregor	19/12/2025	9	4	3	12	6	↔	12/03/2026
548	If the Trust does not deliver the 2026/27 recurrent Value Improvement Programme (VIP) target due to the challenging scale of savings, then there is risk of limited capacity to invest in and improve patient care, leading to reduced ability to achieve	Trust wide	Financial Risk	Financial Management / Waste Reduction Risk	Active	Jo Leece	30/09/2025	12	4	4	16	8	↔	19/03/2026
530	There is a risk that may impact patient safety due to non-compliance with mandatory training	Trust wide	Workforce Risk	Workforce Performance Risk	Active	Mr David Smithson	22/09/2025	12	4	3	12	6	↔	30/06/2026
514	There is a risk that patients may experience harm due to significant delays in the management of patients with colorectal cancers.	Trust wide	Clinical Risk	Patient Safety / Outcomes Risk	Active	Tracey Jones,	05/09/2025	16	3	4	12	8	↔	03/03/2026
496	There is a risks that patients may experience delays to their care and treatment due to limited medical resources within the anaesthetic service	Trust wide	Clinical Risk	Patient Safety / Outcomes Risk	Active	Lauren Oswald,	23/07/2025	9	4	3	12	6	↓	20/03/2026
101	There is a risk to the Trust's ability to demonstrate compliance and adherence to it's regulatory and statutory requirements under PSIRF	Trust wide	External Risk	Strategic Planning Risk	Active	Katerina Pearson	10/03/2025	16	3	3	9	6	↓	13/03/2026
267	Risk of; Ineffective management and application of procedural and clinical documents due to fragmented document control systems.	Trust wide	Operational Risk	Change Risk	Active	Benjamin Vickers	28/02/2019	15	4	3	12	3	↔	09/04/2026

New accepted risks

Risk ID	Risk	Risk register	Type	Subtype	Status	Risk owner	Date opened	Initial rating	Current likelihood	Current consequence	Current rating	Target rating	Movement	Next Review Date
640	(Business continuity risk) Failure of back up isolator resulting in inability to produce trial / critical medications.	Trust wide	Operational Risk	Business Continuity Risk	Active	Jackie Wrench	11/02/2026	15	3	5	15	5	↔	08/04/2026

Closed risks

Risk ID	Risk	Risk Register	Type	Subtype	Status	Risk owner	Date opened	Initial rating	Current likelihood	Current consequence	Current rating	Target rating	Movement	Next Review Date	Date closed
339	There is a risk that a patient may develop a DVT if their VTE assessment is not completed	Trustwide	Clinical Risk	Patient Safety / Outcomes Risk	Closed	Annie Dewberry,	28/03/2025	9	2	3	6	3	↔	08/06/2026	02/03/2026

The Trust wide risks are defined as those that need impact Trust wide or need organisation wide involvement to resolve. Associate Director of Governance hold responsibility for this; agreeing new risk and overseeing controls, reviews and actions.

Movement of extreme risks

Movement of extreme risks

Risk ID	Risk	Risk register	Type	Subtype	Status	Risk owner	Date opened	Initial rating	Current likelihood	Current consequence	Current rating	Target rating	Movement	Next Review Date
640	(Business continuity risk) Failure of back up isolator resulting in inability to produce trial / critical medications.	Trust wide	Operational Risk	Business Continuity Risk	Active	Jackie Wrench	11/02/2026	15	3	5	15	5	↔	08/04/2026
634	Risk that ePro upgrade results in degraded performance/application crashing resulting in typing backlogs, disruption to worklflow of secretarial and clinical staff, and delays to AVT rollout.	Digital Portfolio	Operational Risk	Change Risk	Active	Leon Lau	30/01/2026	9	5	3	15	3	↑	06/03/2026
630	Risk that the Aseptic unit will be unable to deliver required capacity during a period of recovery following shutdown due to a recognised inability to maintain required operational & safety standards	Trust wide	Operational Risk	Business Continuity Risk	Active	Joanne McCaughey	26/01/2026	20	4	4	16	4	↔	13/03/2026
548	If the Trust does not deliver the 2026/27 recurrent Value Improvement Programme (VIP) target due to the challenging scale of savings, then there is risk of limited capacity to invest in and improve patient care, leading to reduced ability to achieve	Trust wide	Financial Risk	Financial Management / Waste Reduction Risk	Active	Jo Leece	30/09/2025	12	4	4	16	8	↔	19/03/2026

- As of the current reporting period, 4 risks have a score of 15 and above.
- In February , all extreme risks were reviewed within the required trust timescales and so were compliant with the trust’s risk review process.
- No risks were downgraded in February 2026.

Safe Staffing

		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	15289	12625	4889	5.5
	Total monthly ACTUAL	14677	12385		
	Average Fill Rate %	96.0%	98.1%		
Care Staff	Total monthly PLANNED	8744	6284	4889	2.8
	Total monthly ACTUAL	7641	6089		
	Average Fill Rate %	87.4%	96.9%		
ALL Staff	Total monthly PLANNED	24033	18909	4889	8.3
	Total monthly ACTUAL	22325	18474		
	Average Fill Rate %	92.9%	97.7%		

Registered Nurses	DAY			NIGHT			Cumulative count over the month of patients at 23:59 each day	CHPPD (Care Hours Per Patient Per Day)
	Hours Planned	Hours Actual	% Fill Rate	Hours Planned	Hours Actual	% Fill Rate		
Critical Care Unit	2154	2103	97.6%	2093	2048	97.8%	188	22.1
Palatine Ward	2819	2757	97.8%	2248	2185	97.2%	836	5.9
Ward 10	1918	1615	84.2%	1597	1480	92.7%	731	4.2
Ward 11	1662	1645	99.0%	1299	1317	101.4%	550	5.4
Ward 12	1641	1660	101.2%	1329	1341	100.9%	778	3.9
Ward 4	1701	1729	101.6%	1380	1391	100.8%	726	4.3
Ward 2	1379	1325	96.1%	966	948	98.1%	540	4.2
Acute Assessment Unit	2015	1843	91.5%	1713	1675	97.8%	540	6.5
TOTAL	15289	14677	96.0%	12625	12385	98.1%	4889	5.5

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

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	0	0	100.0%	0	0	100.0%	188	0.0
Palatine Ward	937	893	95.3%	868	870	100.2%	836	2.1
Ward 10	1397	1237	88.5%	805	793	98.5%	731	2.8
Ward 11	1448	1153	79.6%	862	828	96.1%	550	3.6
Ward 12	1466	1260	85.9%	1052	1008	95.8%	778	2.9
Ward 4	1680	1516	90.2%	1327	1292	97.4%	726	3.9
Ward 2	765	712	93.1%	634	598	94.3%	540	2.4
Acute Assessment Unit	1051	870	82.8%	736	700	95.1%	540	2.9
TOTAL	8744	7641	87.4%	6284	6089	96.9%	4889	2.8

**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.*

Integrated Performance Report - Friends & Family Test & Patient Experience

Metric	Month	Measure	24/25 Avg	Variation	Assurance
Inpatient Response Rate	February	39.70%	34.00%		
Inpatient Recommended Score	February	95.40%	97.00%		
Outpatient Recommended Score	February	95.70%	96.00%		
Number of new complaints	February	22	13		
Number of PALS	February	61	37		

Healthcare Associated Infections

HCAIs against thresholds 2025-26 – HOHA & COHA only

Indicator	Threshold	Position	Year so far (as at month 11)	Threshold adjusted to month 11	Difference
C.*Difficile*	≤ 52	Below trajectory	34	52	-18
E.coli BSI	≤ 43	Above trajectory	59	43	+16
Klebsiella spp. BSI	≤ 24	Above trajectory	31	24	+7
P.Aeruginosa BSI	≤ 8	Below trajectory	9	8	+1

HCAIs being monitored

Indicator	Target	Position	Year so far (as at month 11)	Threshold adjusted to month 12
MRSA BSI	Zero tolerance	Above trajectory	2	-
MSSA BSI	No target	No target	23	-

The cases of E.coli and Klebsiella remain above the threshold levels. There is currently a review of this being undertaken by the Infection Prevention and Control team in partnership with microbiology and pharmacy colleagues. Due to NOF performance showing deterioration a report was submitted to December SMC. The Trust held a well-attended IPC summit in October with NHSE representation. The summit focused on the thresholds and on the importance of the fundamentals of IPC practice for clinical staff. The plan is to hold a further event in the summer of 2026.

Cancer Standards – Health Inequalities Analysis

62 Day Treatments between 01/04/2023 – 28/02/2026 analysed by gender, age and ethnicity.

62 Day Treats by Gender

	Female	Male
Proportion of Patients Treated	52.0%	48.0%
Number of Patients Treated	7,095	6,539

62 Day Treats by Age Band

	0-15	16-18	19-44	45-64	65+
Proportion of Patients Treated	0.0%	0.3%	6.1%	29.6%	64.0%
Number of Patients Treated	4	40	828	4,035	8,735

62 Day Treats by Gender & 62 Day Compliance

	Female	Male
Breach %	44.4%	56.3%
Compliance %	55.6%	43.7%
Breach	3,150	3,681
Compliance	3,945	2,858

62 Day Treats by Age Band & 62 Day Compliance

	0-15	16-18	19-44	45-64	65+
Breach %	25.0%	40.0%	35.3%	47.3%	52.9%
Compliance %	75.0%	60.0%	64.7%	52.7%	47.1%
Breach	3 / 1 (overprinted)	26 (overprinted)	292	1,907	4,619
Compliance			536	2,128	4,116

62 Day Treats by Ethnicity & 62 Day Compliance

	ASIAN	BLACK	MIXED	NOT SET	OTHER	WHITE
Breach %	51.9%	59.1%	44.7%	49.4%	55.1%	50.3%
Compliance %	48.1%	40.9%	55.3%	50.6%	44.9%	49.7%
Breach				1,921		4,574
Compliance				1,971		4,523

Breach | Compliance

Cancer Standards – Health Inequalities Analysis

62 Day Treatments between 01/04/2023 – 28/02/2026 analysed by gender, age and ethnicity.

62 Day Treats by Gender & 62 Day Compliance

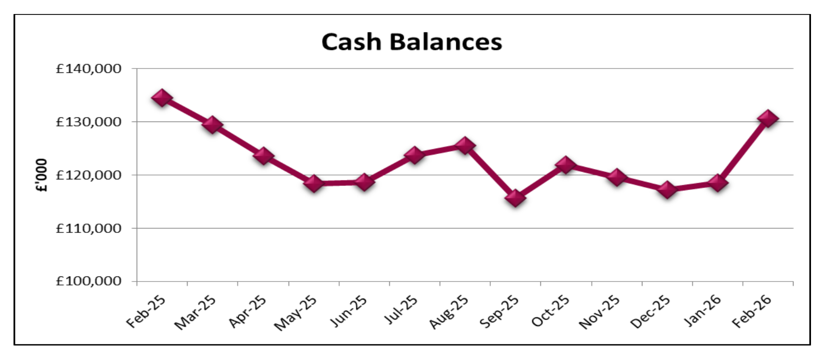
62 Day Treats by Age & 62 Day Compliance

62 Day Treats by Ethnicity & 62 Day Compliance

Finance (Executive Summary)

This report outlines the M11 consolidated financial performance of The Christie NHS Foundation Trust and its wholly owned subsidiary The Christie Pharmacy Ltd.

Month 11 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(470,558)	(431,326)	(434,810)	(3,484)
Other Income	(81,316)	(74,551)	(77,352)	(2,801)
Pay	267,346	244,785	240,133	(4,652)
Non Pay (incl drugs)	258,572	237,269	247,245	9,976
Operating (Surplus) / Deficit	**(25,957)**	**(23,823)**	**(24,784)**	**(961)**
Finance expenses/ income	22,739	20,873	21,933	1,060
(Surplus) / Deficit	**(3,218)**	**(2,950)**	**(2,851)**	**99**
Exclude impairments/ charitably funded capital donations	(4,282)	(3,925)	(4,047)	(121)
Adjusted financial performance (Surplus) / Deficit	**(7,500)**	**(6,875)**	**(6,898)**	**(23)**



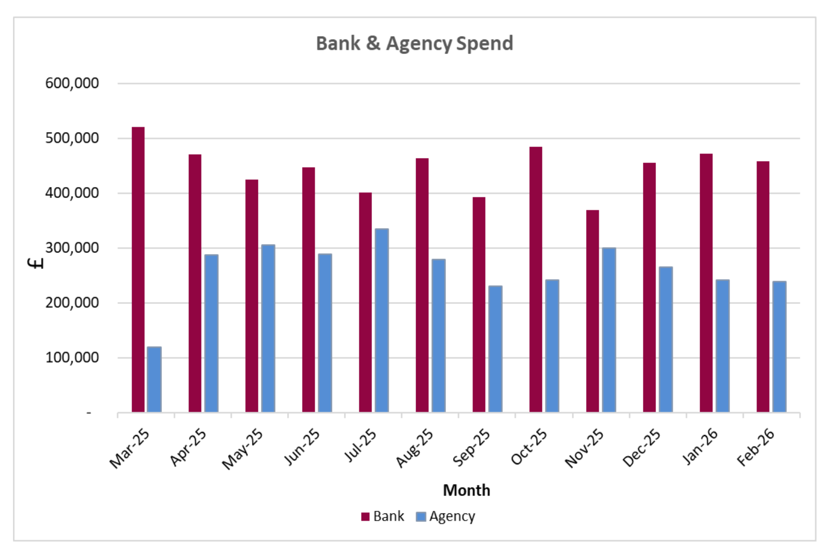
I&E

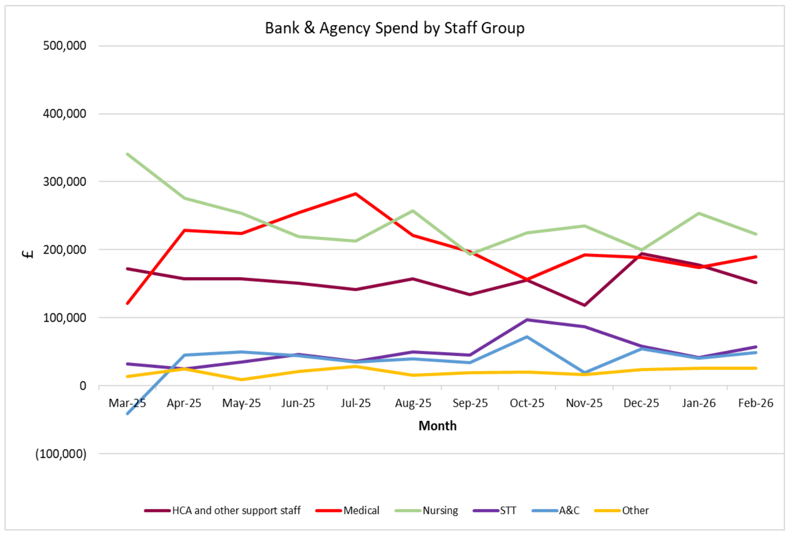
- The Trust is reporting a surplus at the end of month 11 of (£6.90m) against a YTD plan of (£6.88m), which gives a YTD positive variance of (£0.02m).
- Identified in-year VIP is £25.3m against a target of £25.3m. The VIP shortfall against the recurrent VIP target is £1.3m (RAG rated shortfall £1.3m), where £11.4m has been identified against a target of £12.6m (90% of recurrent target identified). Non-recurrent identified VIP is £13.9m against a target of £12.6m, overachieving by (£1.3m).

Balance sheet / liquidity

- The cash balance as of 28th February 2026 is £130.5m, with a forecast yearend balance of £109.3m.
- Capital spend for 2025-26 was £23.5m, this was £0.4m above the revised plan submitted to NHSE.
- Targets have been achieved against payment of creditors paid within the 30-day Better Payment Practice Code target.

Finance (Expenditure)





Agency spend in month 11 is £0.24m, £3.01m YTD, in line with month 10. The spend is predominantly on medical agency.

Alongside this, bank spend in month 11 is £0.46m and £4.84m YTD, a decrease of £0.01m from month 10.

Finance (Expenditure)

Run Rate

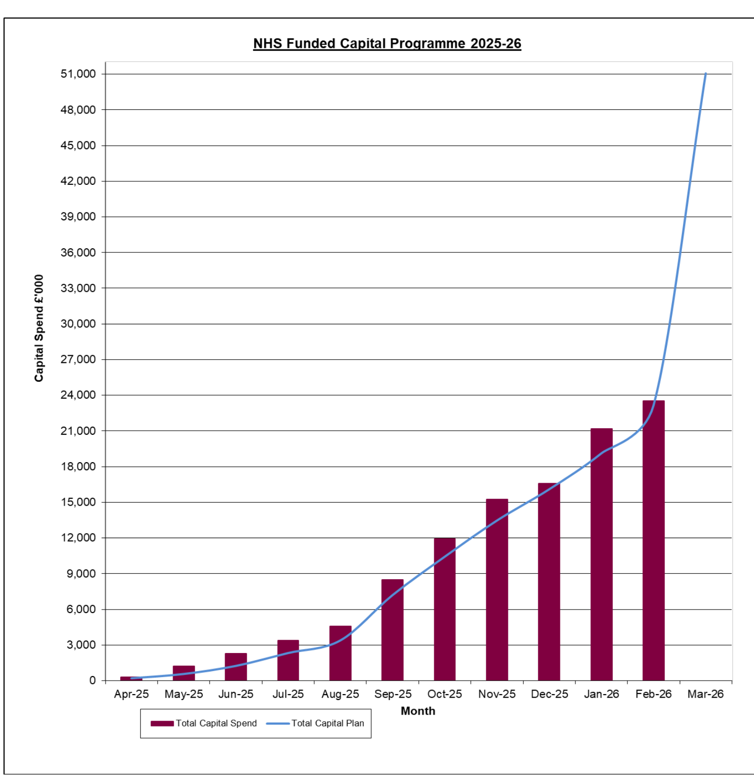
£'000: 0, 2,000, 4,000, 6,000, 8,000, 10,000, 12,000, 14,000, 16,000, 18,000

Month: Mar-25, Apr-25, May-25, Jun-25, Jul-25, Aug-25, Sep-25, Oct-25, Nov-25, Dec-25, Jan-26, Feb-26

- Non Pay - Drugs
- Non Pay - Other
- Pay - Agency
- Pay - Clinical
- Pay - Non Clinical
- Pay - Other

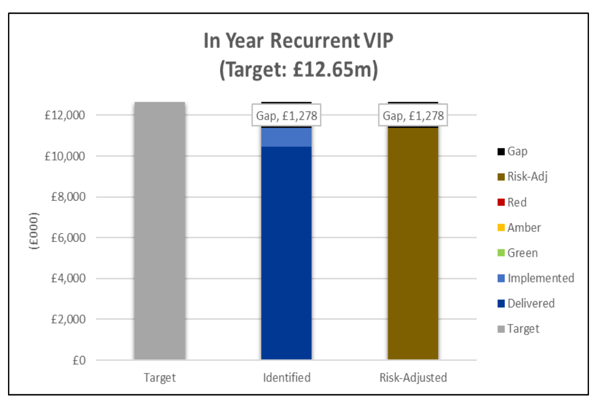
- Drugs spend in month 11 is £11.6m, a decrease of £2.7m from month 10 driven by a decrease in cost and volume drug expenditure.
- Non-Pay – Other spend in month 11 is £10.8m, an increase of £0.9m from month 10 driven by increased spend on establishment & R&I.
- Key elements of 'Non-Pay Other' spend consist of clinical supplies and services, premises and infrastructure costs and R&I costs.
- Pay – Agency spend in month 11 is £0.2m, in line with month 10.
- Pay – Clinical spend in month 11 is £14.6m, in line with month 10.
- Pay – Other spend in month 11 is £2.1m, a decrease of £0.6m from month 10 driven by a reduction in the annual leave provision.

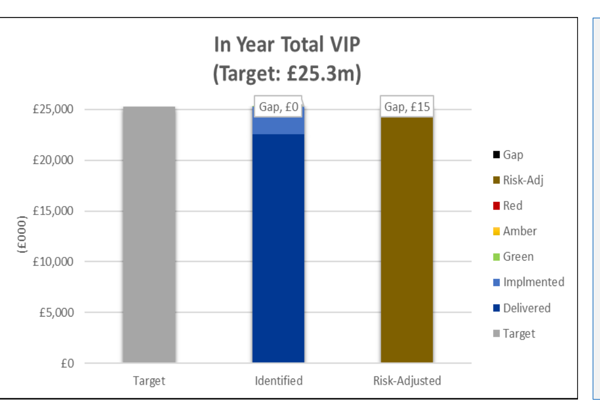
Finance (Capital)



The Trust has incurred £23.5m up to month 11 on capital schemes overspending by £0.4m against the 2025-26 plan. Capital expenditure is primarily on the ASIC scheme, the estates backlog programme, digital projects and a significant operational asset replacement programme across all divisions.

Finance (CIP)





Total In year CIP

- Total identified VIP schemes reported are £25.3m (£13.9m non recurrent / £11.4m recurrent).
- Risk adjusted identified schemes value £25.3m, leaving £0.0m unidentified.

Recurrent

- Schemes totalling £11.4m have been identified recurrently against a recurrent target of £12.6m
- This leaves £1.3m of the recurrent target unidentified, RAG rated unidentified £1.3m.

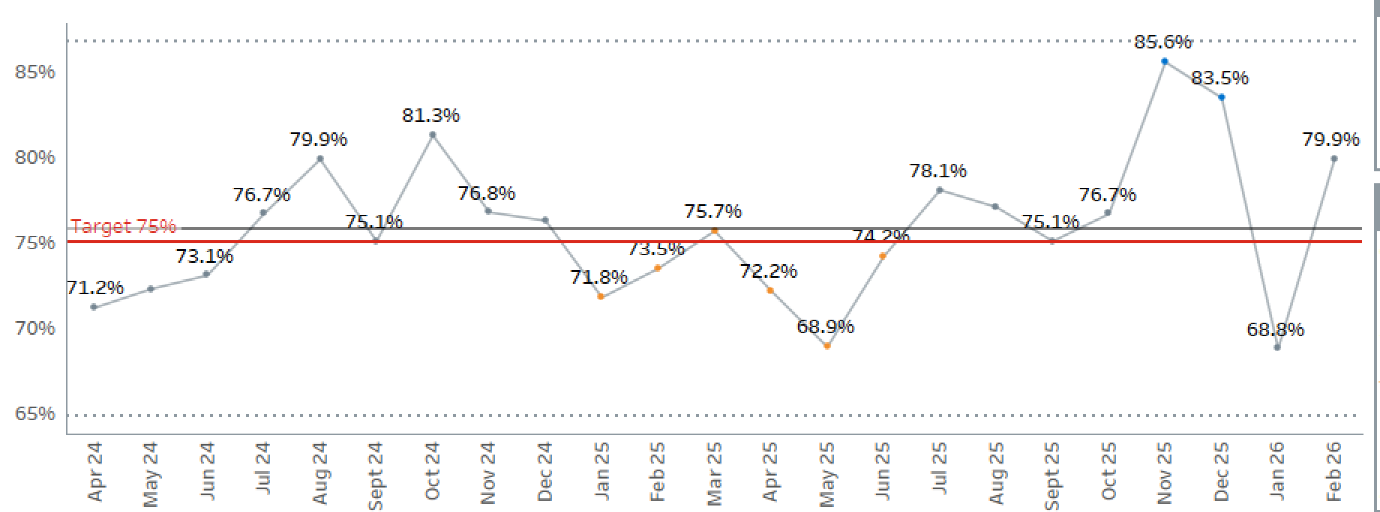
Delivering	Green	Amber	Red	Unidentified
100%	75%	50%	25%	0%

	Annual					Year To Date		
	Target £0	Identifed £0	Unidentified £0	Risk-Adjusted Identified £0	Risk-Adjusted Unidentified £0	Target £0	Delivered £0	Variance £0
Total VIP	25,298	25,298	0	25,275	23	20,998	20,998	0
Recurrent VIP	12,649	11,371	1,278	11,371	1,278	10,541	9,447	1,094
Non-Recurrent VIP	12,649	13,927	(1,278)	13,903	(1,254)	10,457	11,551	(1,094)

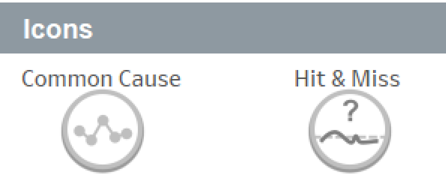
Integrated Performance Report - Cancer Standards Summary

Metric	Month	Measure	Target	Variation	Assurance
18 weeks	February	95.90%	92.00%		P
24 day (Internal Target)	February	80.50%	85.00%		F
28 Day FDS	February	90.60%	80.00%		?
31 day	February	98.90%	96.00%		P
62 Day	February	79.90%	75.00%		?
Waiting >52 Weeks	February	0.00%	0.00%	L	F

Percentage of patients treated for cancer within 62 days of referral



Icons



Summary

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

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

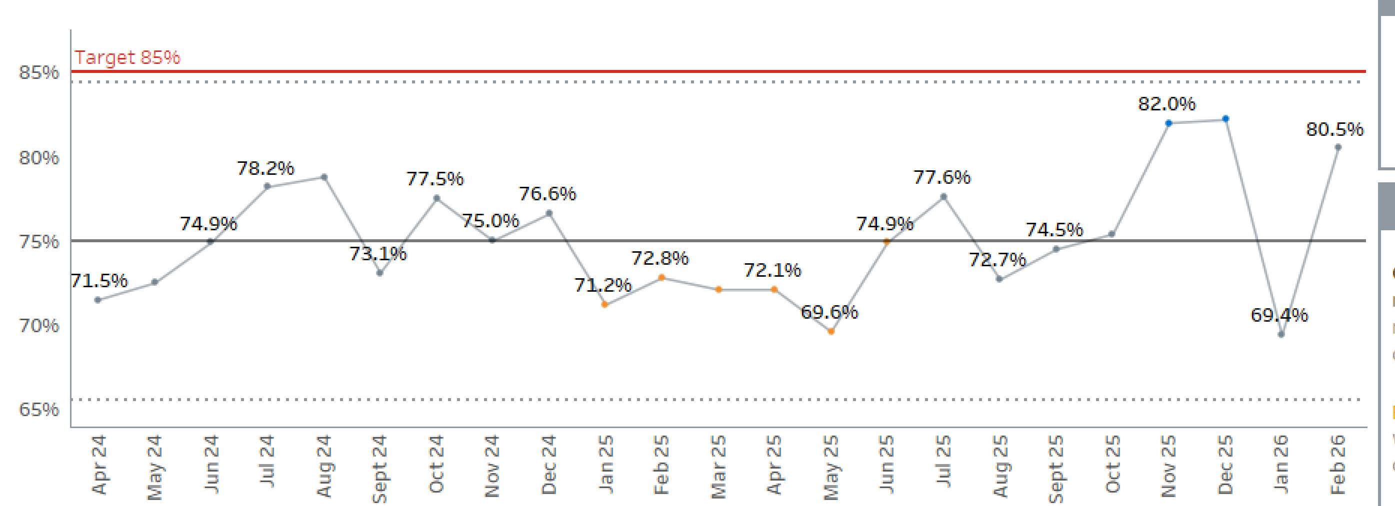
Understanding the performance

Overall: Performance oscillates around the 75% target with common-cause variation. There is no sustained shift indicating a changed system. Recent months: A high in late-2025 (~85.6%), a low in Jan-26 (~68.9%), and a recovery in Feb-26 (~79.9%).Risk for March: With the target close to the process mean, March outcomes depend heavily on month-end breach management (days 49–62) and pathway constraints (diagnostics, pathology, theatre/chemo capacity, and complex multi-specialty pathways).

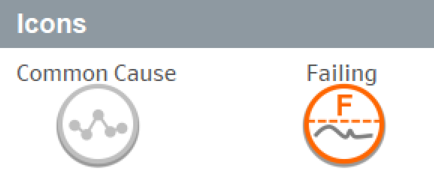
Actions (SMART)

Daily breach control (Day-49+): Maintain a live “days-to-breach” PTL with named owners and next steps booked—aim for ≥90% of Day-49+ patients to have a confirmed appointment/treatment date within 7 days.

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



Icons



Summary

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

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

Understanding the performance

Consistently below the 85% target: Results mostly sit in the 70–82% range with no months reaching 85%; the target is marked “Failing” against common-cause variation, meaning the current system is not capable of reliably achieving the target. Volatility without a sustained shift: Peaks around 82.0% (Nov-25) are followed by a sharp dip to ~69.4% (Jan-26) and a rebound to ~80.5% (Feb-26)—typical of natural variation rather than a stable improvement. Recent position is improved but insufficient: Feb-26 ~80.5% is above many prior months but still below the 85% target, so without a process change the metric will continue to be hit-and-miss.

Actions (SMART)

Daily post-IPT breach control (Day-14+): Run a daily PTL for patients ≥Day 14 post-IPT with named owners, next step, and booked treatment date. Target: ≥95% of Day-14+ patients to have a confirmed treatment date within 5 calendar days of identification. Owner: Tumour-group managers; Start: immediately

Percentage of patients treated within 18 weeks

100%
95%
90%
Target 92%

97.1% 97.1% 97.1% 97.4% 96.6% 98.1% 96.8% 94.6% 94.3% 94.3% 95.8% 97.2% 97.1% 95.9%

Apr 24, May 24, Jun 24, Jul 24, Aug 24, Sept 24, Oct 24, Nov 24, Dec 24, Jan 25, Feb 25, Mar 25, Apr 25, May 25, Jun 25, Jul 25, Aug 25, Sept 25, Oct 25, Nov 25, Dec 25, Jan 26, Feb 26

Icons

Common Cause

Passing

Summary

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

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

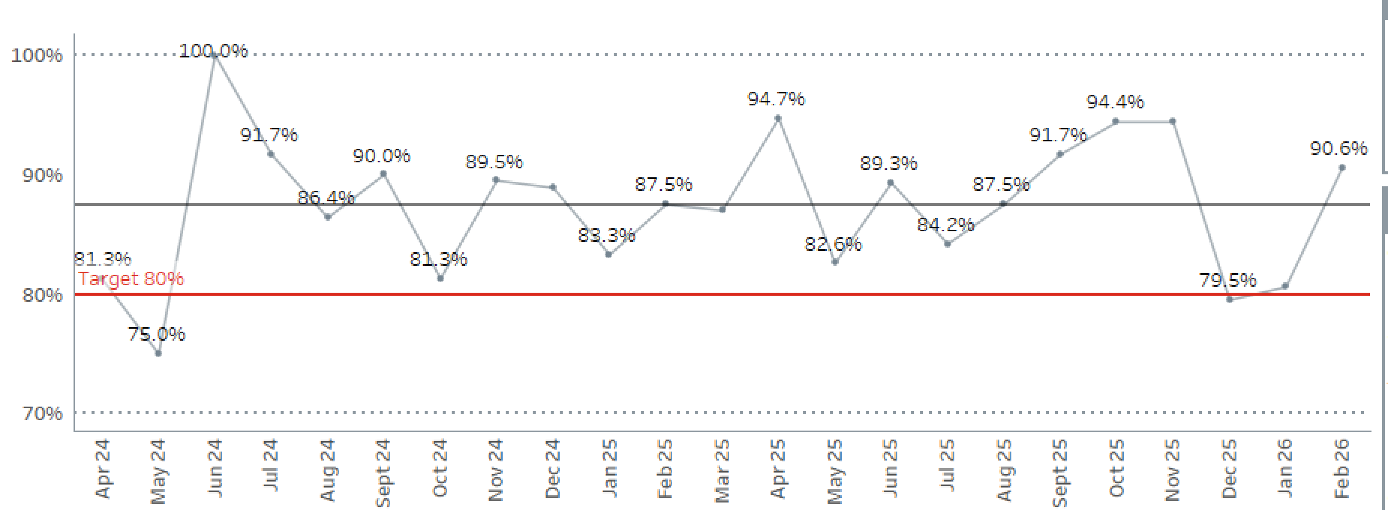
Understanding the performance

Target consistently exceeded: Every month is above the 92% target, with performance generally in the 95–98% range; peak around ~98.1% (Jan-25) and latest at ~95.9% (Feb-26).Stable ("Common Cause") and "Passing": The SPC icon indicates a stable system with natural variation and a target that is comfortably achievable on current process capability.Mid-2025 softening then recovery: A temporary dip to ~93.9–94.6% (May–Jul-25) recovered to ~97.2–97.1% (Oct–Dec-25), with recent months a little lower but still well above target.

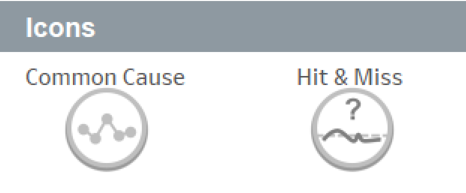
Actions (SMART)

Protect the tail (16–18 weeks): Run a daily PTL for patients at ≥16 weeks, with named owners and booked treatment dates. Targets: ≥95% of 16+ week patients to have a confirmed treatment date within 7 calendar days of identification;

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



Icons



Summary

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

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

Understanding the performance

Generally above target with occasional dips: Most months are ≥80%, with highs up to 100% (May-24) and frequent results in the 90%+ range; there is an isolated low of ~79.5% (Oct-25) below target. The SPC icons indicate normal system variation with the target close to the process mean—so the metric can be met or missed depending on month-to-month pressures unless the pathway is tightened. Recent recovery: After the Oct-25 dip, performance has rebounded to ~90.6% (Feb-26), which is comfortably above target, though not yet a proven sustained shift.

Actions (SMART)

Daily 4-week clock control (Day-21+): Run a daily PTL for patients at ≥Day 21 to diagnosis with named owners, next step, and booked slot. Targets: ≥95% of Day-21+ patients have their next diagnostic/clinic appointment booked within 72 hours; zero >28-day breaches excluding documented patient choice/clinical reasons.

Integrated Performance Report - External Referrals Received Summary

Metric	Month	Measure	24/25 Avg	Variation	Assurance
External Referrals Received - ALL Specialties	February	2,187	2,067	H	?
External Referrals Received -Clinical Oncology	February	940	978		?
External Referrals Received -Haematology	February	246	141	H	?
External Referrals Received -Medical Oncology	February	576	549	H	?
External Referrals Received -Surgical Specialties	February	377	365		?

Integrated Performance Report - Inpatient Length of Stay Averages

Metric	Month	Measure	Target	Variation	Assurance
Inpatient LOS - All Patients (excluding zero LOS)	February	7.5	7.0		?
Inpatient LOS - Elective Patients (excluding zero LOS)	February	5.4	6.0		?
Inpatient LOS - Non-Elective Patients (excluding zero LOS)	February	8.8	7.7		?
Inpatient LOS - Transfer Patients (excluding zero LOS)	February	16.5	17.0		?

Integrated Performance Report - Diagnostic 6 Week Waiting Times Summary

Metric	Month	Measure	Target	Variation	Assurance
Magnetic Resonance Imaging	February	88.90%	99.00%	L	?
Computed Tomography	February	99.85%	99.00%		?
Non-obstetric Ultrasound	February	100.00%	99.00%		P
Dexa Scan	February	100.00%	99.00%		?
Cardiology - Echocardiography	February	99.40%	99.00%	H	?
Flexi Sigmoidoscopy	February	100.00%	99.00%		P
Cystoscopy	February	100.00%	99.00%		?
Barium Enema	February	100.00%	99.00%		P
Colonoscopy	February	100.00%	99.00%		?
Gastroscopy	February	100.00%	99.00%		P
DM01 Return - All Scans	February	96.20%	99.00%	L	?

*Lastest month figures are taken from the National Waiting List Weekly Return. Historical data trends are based on monthly DM01 figures. Latest data is refreshed with DM01 data once submitted.

All Scans - DM01 6 Week Waiting Time Compliance

100%
98%
96%
94%
92%
90%

99.2% Target 99% 99.4% 98.1% 98.9% 99.1% 99.1% 99.4% 99.1% 99.1% 98.5% 99.5% 98.4% 97.4% 96.2%

Apr 24 May 24 Jun 24 Jul 24 Aug 24 Sept 24 Oct 24 Nov 24 Dec 24 Jan 25 Feb 25 Mar 25 Apr 25 May 25 Jun 25 Jul 25 Aug 25 Sept 25 Oct 25 Nov 25 Dec 25 Jan 26 Feb 26

Icons

Concerning Hit & Miss

Summary

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

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

Understanding the performance

Previously on target, now deteriorating: Through most of 2024–mid-2025, MRI 6-week compliance sat around 99–100% (several months ≥99.7%), comfortably meeting the 99% target. Sustained downturn since late-2025: Results fall from ~99.7% to 96.3% (Nov-25), then 91.4% (Jan-26) and ****88.9% (Feb-26)**—a clear special-cause decline (icon: Concerning) and well below target. Implication: The scale and persistence of the drop indicate a system constraint (e.g., capacity loss or demand spike)

Actions (SMART)

Daily breach control & prioritisation (Day-35+): Run a daily PTL for all patients at ≥5 weeks with named owners, next step, and booked scan date.

MRI 6 Week Waiting Time Compliance

Icons

Concerning

Hit & Miss

Summary

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

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

Understanding the performance

Strong through 2024–mid-2025, now deteriorating: Compliance was typically ~99–100% (at/above the 99% target) across most of 2024–mid-2025.Sustained decline since late-2025 (Concerning): Results fall below target with a clear downward run around 97.4% (Jan-26) and ~96.2% (Feb-26) indicating a special-cause shift rather than normal fluctuation relating specifically to MR scanning

Actions (SMART)

Daily breach control (Day-35+ across all modalities): Maintain a daily PTL of patients at ≥5 weeks with named owners and booked scan dates.

Integrated Performance Report - Summary

Area Selection

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

Division
The Christie

Directorate
All Directorates

Summary Table

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

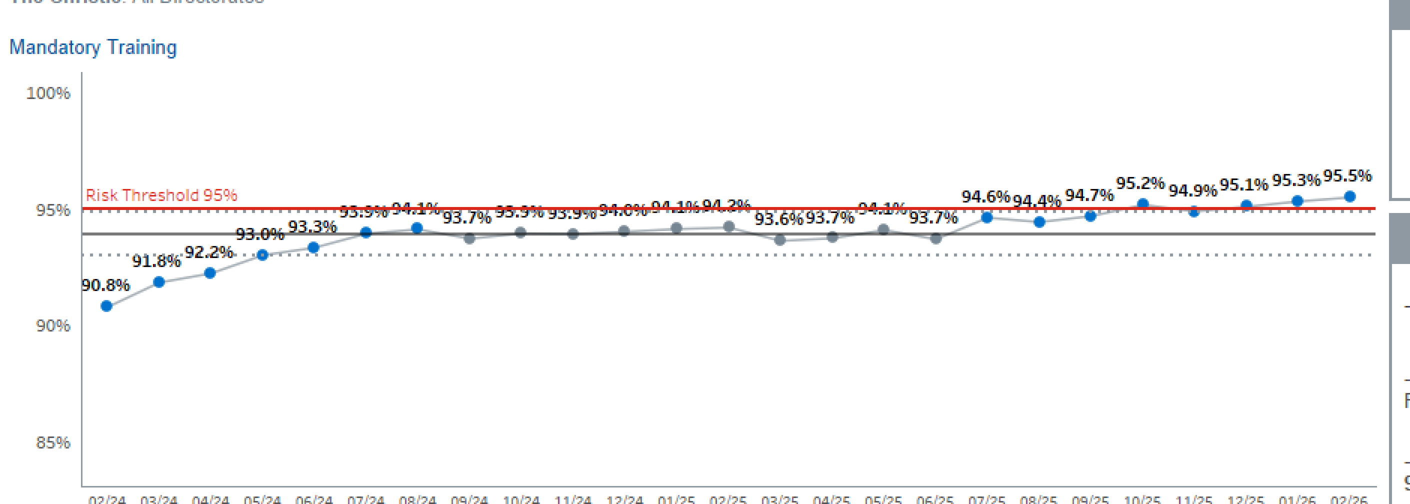
Metric - the KPI metric
Measure - the value of the **Metric** as of the end of the **Month**
Target - the Trust defined minimum or maximum limit for each **Metric**
Mean - the average of the **Measures** over the past 12 months

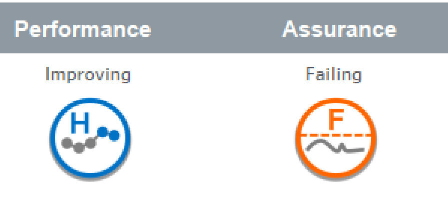
Metric	Month	Measure	Risk Threshold / Target	Mean	Performance	Assurance
Appraisal	February 2026	**85.93%**	90.00%	87.68%	L	F
Mandatory Training	February 2026	**95.47%**	95.00%	93.91%	H	F
Absence	February 2026	**4.98%**	4.10%	4.78%	H	?
All Turnover	February 2026	**11.40%**	11.00%	11.75%	L	?
Voluntary Turnover	February 2026	**8.89%**	9.00%	9.50%	L	?
Vacancy Rate	February 2026	**6.01%**	5.00%	8.18%	L	F

Our People - Mandatory Training and Appraisal Compliance

The Christie: All Directorates

Mandatory Training





Summary

- There are **2,855** outstanding modules.

- The Face to Face training compliance % for February is **88.1%**

- The online training compliance % for February is **96.2%**

Appraisal

95%
90%
85%
80%
Target 90%
86.6% 85.8% 85.8% 86.9% 86.2% 88.2% 87.0% 88.6% 88.8% 88.8% 89.0% 88.5% 89.9% 89.7% 89.2% 88.0% 88.5% 87.7% 87.6% 87.2% 87.3% 87.2% 87.2% 86.3% 85.9%
02/24 03/24 04/24 05/24 06/24 07/24 08/24 09/24 10/24 11/24 12/24 01/25 02/25 03/25 04/25 05/25 06/25 07/25 08/25 09/25 10/25 11/25 12/25 01/26 02/26

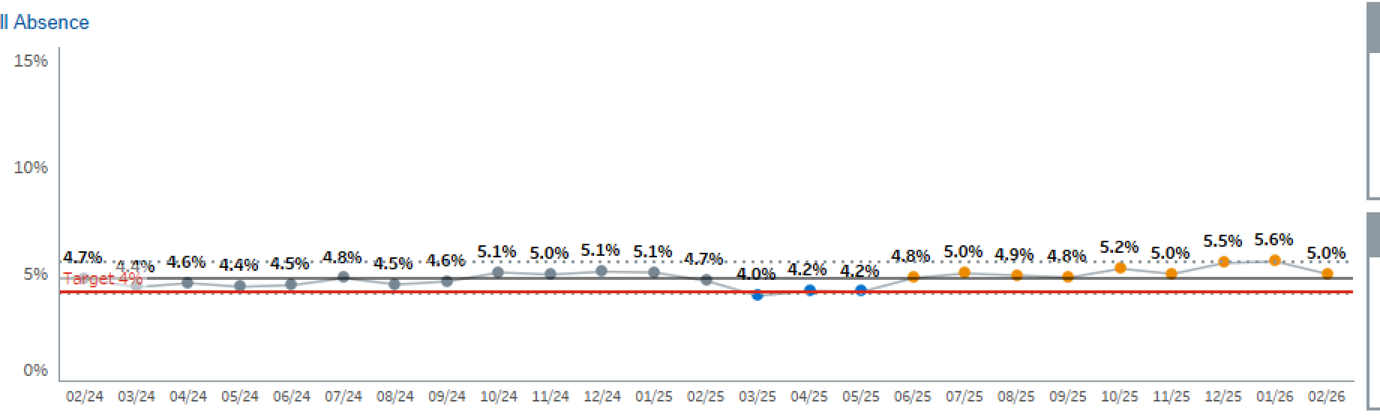
Performance	Assurance
Concerning	Failing

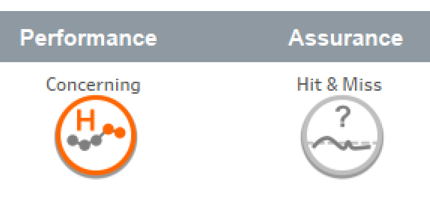
Summary

- There are **502** outstanding appraisals.

Our People - Sickness Absence

All Absence





Summary

- The rolling yearly sickness absence % is **4.9%** as of February.

- There were **169** absences still open at the end of February.

Nursing and Midwifery

15%
10%
5%
0%
Target 4%
5.2% 5.2% 5.3% 5.8% 5.9% 6.1% 5.1% 5.6% 6.2% 5.6% 6.2% 5.6% 5.0% 5.2% 5.0% 4.3% 4.7% 5.0% 5.8% 5.9% 6.2% 5.8% 6.4% 6.7% 5.2%
02/24 03/24 04/24 05/24 06/24 07/24 08/24 09/24 10/24 11/24 12/24 01/25 02/25 03/25 04/25 05/25 06/25 07/25 08/25 09/25 10/25 11/25 12/25 01/26 02/26

Performance	Assurance
Common Cause	Failing

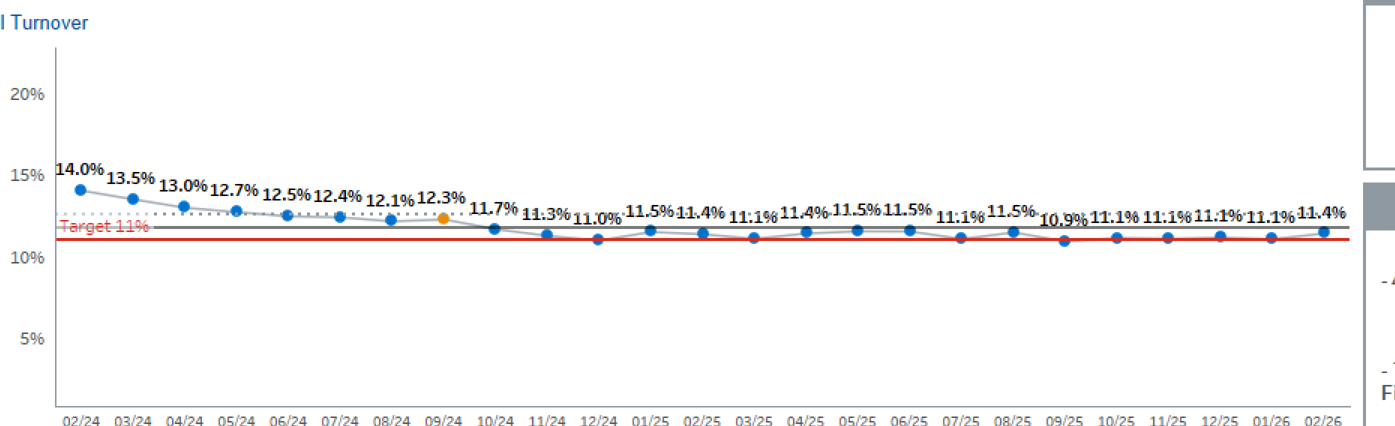
Medical and Dental

10%
5%
0%
Target 4%
1.6% 2.0% 2.1% 1.6% 1.8% 2.4% 1.8% 2.2% 3.0% 2.7% 1.9% 1.6% 2.1% 2.1% 1.9% 1.3% 2.1% 1.9% 2.2% 2.0% 1.7% 2.4% 2.6% 2.7% 2.0%
02/24 03/24 04/24 05/24 06/24 07/24 08/24 09/24 10/24 11/24 12/24 01/25 02/25 03/25 04/25 05/25 06/25 07/25 08/25 09/25 10/25 11/25 12/25 01/26 02/26

Performance	Assurance
Common Cause	Passing

Our People - Turnover

All Turnover



Performance	Assurance
Improving	Hit & Miss

Summary

- 43 colleague(s) left the Trust in February.

- The top non-voluntary leaving reason was **End of Fixed Term Contract**.

Voluntary Turnover

20%
15%
10%
5%

11.4% 11.6% 11.2% 10.8% 10.4% 10.5% 10.3% 10.2% 9.6% 9.0% 8.7% 9.1% 9.0% 8.6% 8.9% 9.1% 9.2% 8.7% 8.8% 8.4% 8.7% 8.7% 8.8% 8.7% 8.9%

Target 9%

02/24 03/24 04/24 05/24 06/24 07/24 08/24 09/24 10/24 11/24 12/24 01/25 02/25 03/25 04/25 05/25 06/25 07/25 08/25 09/25 10/25 11/25 12/25 01/26 02/26

Performance	Assurance
Improving	Hit & Miss

Summary

- The top voluntary leaving reason was **Voluntary Resignation - Promotion**.

Our People - Senior Management Representation

Senior Management (Band 8A - VSM) BAME %

NHSE WRES 2024 16.38%

15%
10%
5%
0%

6.98%
6.71%
7.25%
7.39%
7.36%
7.74%
8.50%
7.79%
7.80%
7.91%
8.27%
8.38%

Mar 25
Apr 25
May 25
Jun 25
Jul 25
Aug 25
Sept 25
Oct 25
Nov 25
Dec 25
Jan 26
Feb 26

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

NHSE WDES 2024 5.40%

6%
5%
4%
3%
2%
1%
0%

5.50%
5.45%
5.59%
5.54%
5.52%
5.50%
5.26%
5.33%
5.54%
5.68%
5.65%
5.59%

Mar 25
Apr 25
May 25
Jun 25
Jul 25
Aug 25
Sept 25
Oct 25
Nov 25
Dec 25
Jan 26
Feb 26

Our People - Staff Survey

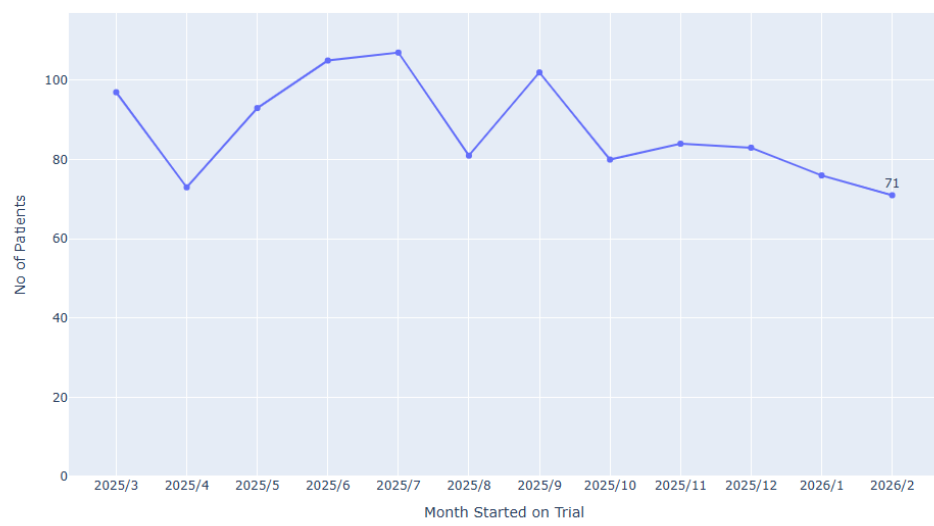
Staff Engagement Score

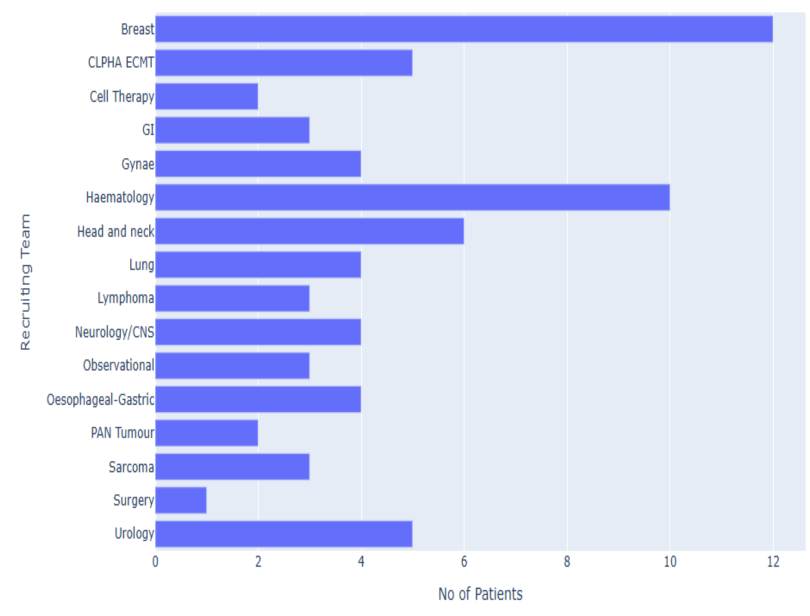
	2021	2022	2023	2024	2025
The Christie	72.3%	74.0%	73.5%	75.0%	74.0%
Advocacy sub-score	82.7%	79.5%	77.9%	80.7%	81.0%
Involvement sub-score	69.7%	72.7%	72.2%	73.0%	72.0%
Motivation sub-score	64.7%	69.9%	70.4%	71.3%	70.0%

Morale Score

	2021	2022	2023	2024	2025
The Christie	54.1%	61.5%	62.7%	65.4%	65.0%
Stressors sub-score	60.4%	66.8%	66.7%	68.1%	68.0%
Thinking about leaving sub-score	54.0%	62.0%	64.6%	67.1%	66.0%
Work pressure sub-score	48.0%	55.6%	56.8%	61.1%	61.0%

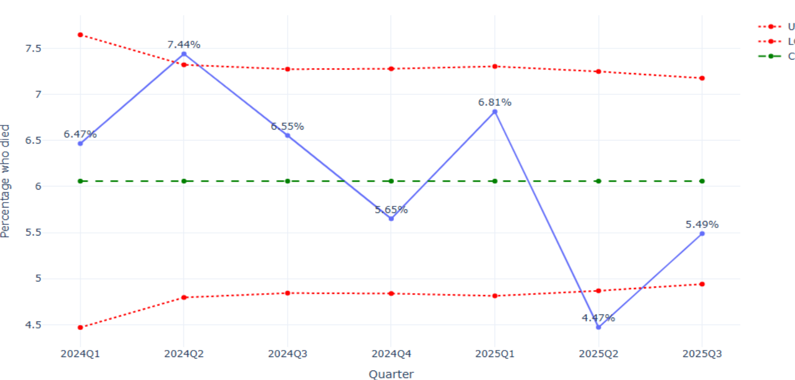
Clinical Trial Entries

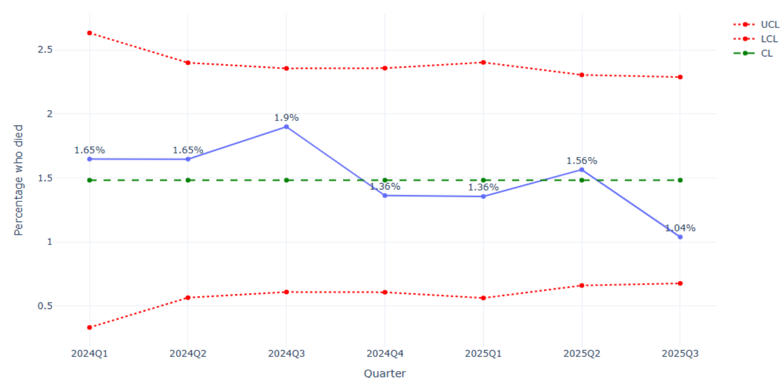


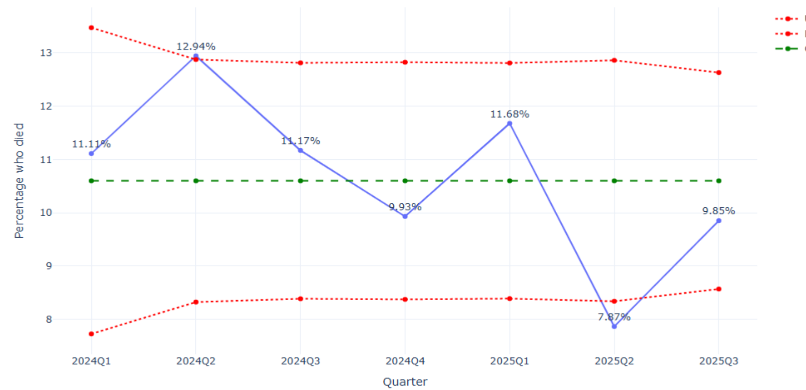


Breast continue to recruit the highest number of patients.

30-Day SACT Mortality







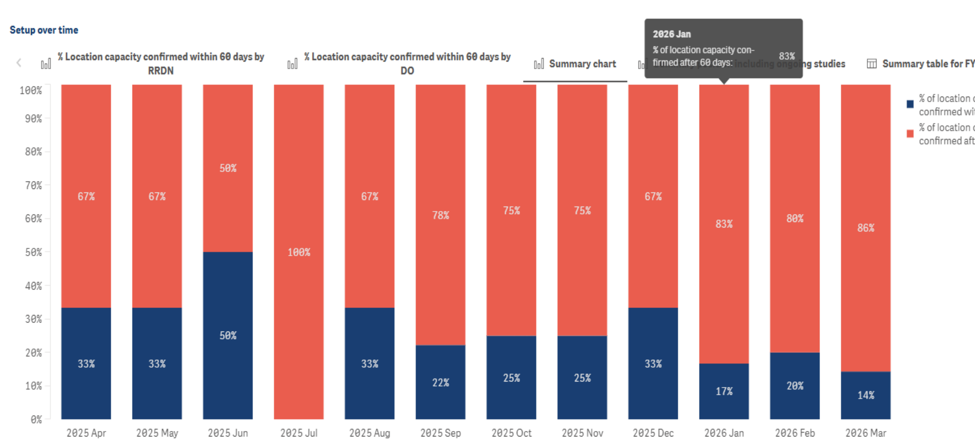
The control line shows the 30-day mortality rate over the entirety of time frame shown (Last administrations up to 30/09/2025 (end of Q3)).

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

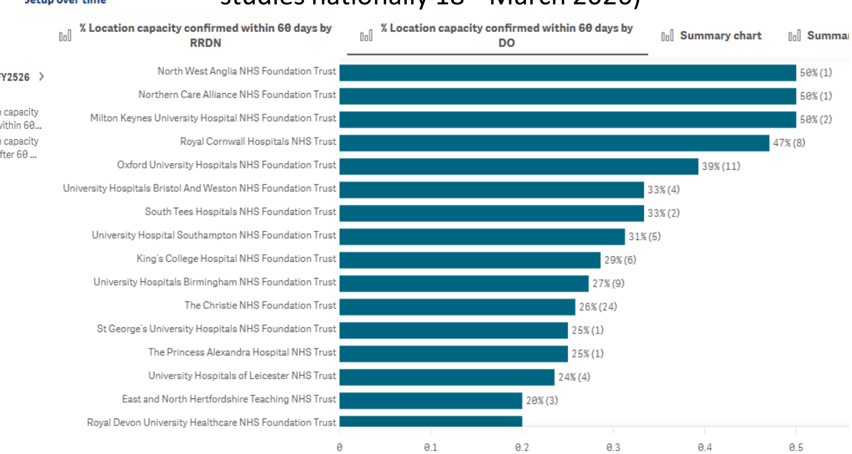
Current rates of 30-day post SACT mortality are within the normal range expected and are consistent with those published by NDRS* for The Christie and for national average rates.

Research and Innovation

% studies opening within 60 days (commercial)



Current Monthly set up performance for Commercial Cancer studies nationally 18th March 2026)



Understanding Performance

- Performance variable and below 90% target – inconsistency is the core issue. YTD in 25/26: 2 Global First, 1 EU First, 4 UK Firsts for site activation.
- Lack of defined, standardised timelines and ownership across pathway
- Increasing complexity of portfolio (24% Phase I studies)
- Support department impacting delivery, including pathology backlog.

Actions to address performance

- Leadership reset with direct oversight and accountability for delivery.
- EDGE rollout (June).
- Process mapping completed and staged gateway approach defined with expected sprints for rapid improvement.
- Benchmarking at study level to identify and close performance gaps.
- Pathology performance review underway.
- Anticipated achievement by early Q4.

Oversight Framework 25/26

The new NHS Oversight Framework 2025/26 describes a consistent and transparent approach to assessing ICBs and NHS trusts and foundation trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement. The data below relates to Q2 (Access to services module data has been excluded for specialist cancer Trusts whilst the national team work on a different way of displaying this data). Metrics have been grouped into domains and will be scored individually and across each domain, with Trust's being segmented into an overall score for comparison against other Trusts. The information is to be publicised on the Model Hospital platform.

Select a trust

The Christie NHS Foundation Trust (RBV)

View the glossary page

Average score

1.59

Higher by 0.08 from previous quarter

Trusts are scored on up to 30 measures of performance (metrics).

Scores range from 1.00 (high performing) to 4.00 (low performing).

How has average score been calculated?

Trust in financial deficit?

No

No change from previous quarter

If an organisation is reporting a financial deficit or in receipt of deficit support, that organisation's segment can be no greater than 3.

How is financial deficit applied?

Segment

1 - High performing

Previous quarter's segment: 1

Each trust is assigned to a segment ranging from 1 – 4 based on average metric score and taking into consideration the financial deficit override.

Some of the more challenged trusts may be referred to the Recovery Support Programme and therefore allocated to a fifth segment.

How has segment been calculated?

Trust rank

7 out of 134

Previous quarter's rank: 3 out of 134

Each trust receives a rank based first on their segment and then their average score within that segment. Ranks range from 1 (the segment one trust with the lowest average score) to 134 (the segment four trust with the highest average score).

How has rank been calculated?

Performance domains

Domain	Rating
Access to services	(Blank)
Finance and productivity	3 - Below average
Effectiveness and experience	1 - High performing
Patient safety	1 - High performing
People and workforce	1 - High performing

Average score by trust rank placement

View full league table

Copyright © NHS England, 2025

Oversight Framework 25/26

Quarter	Segment	Finance and productivity domain segment
Q2 2025/26	1 - High performing	3 - Below average

Return to overview

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
Finance and productivity	Finance	Planned surplus/deficit	2025/26	1.39	%	0.00 →	1.00	5 out of 134	-1.54	0
Finance and productivity	Finance	Variance year-to-date to financial plan	Month 6 2025	0.00	%	0.37 ↑	1.00	46 out of 134	0.00	
Finance and productivity	Finance	Combined finance	Q2 2025/26		score		1.00			
Finance and productivity	Productivity	Implied productivity level	Q1 2025/26 vs Q1 2024/25	-0.84	%	-2.48 ↓	3.39	107 out of 134	1.77	

Quarter	Segment	Effectiveness and experience domain segment
Q2 2025/26	1 - High performing	1 - High performing

Return to overview

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
Effectiveness and experience	Effective flow and discharge	Average number of days from discharge ready date to actual discharge date (including zero days)	Sep-25	0.03	days	-0.27 ↑	1.24	11 out of 125	0.78	
Effectiveness and experience	Patient experience	CQC inpatient survey satisfaction rate	2024		score		1.00			

Oversight Framework 25/26

Quarter	Segment	Patient safety domain segment
Q2 2025/26	1 - High performing	1 - High performing

Return to overview

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
Patient safety	Patient safety	Number of MRSA bacteraemia cases	Oct 24 - Sep 25	2.00	count	-1.00 ↑	2.33	39 out of 134	3.00	0
Patient safety	Patient safety	Proportion of E. coli bacteraemia	Oct 24 - Sep 25	1.28	rate	0.23 ↓	3.39	100 out of 134	1.18	1
Patient safety	Patient safety	NHS Staff survey - raising concerns sub-score	2024	6.93	out of 10	0.00 →	1.11	6 out of 134	6.42	
Patient safety	Patient safety	Proportion of C. difficile infections	Oct 24 - Sep 25	0.98	rate	-0.06 ↑	1.00	1 out of 134	1.18	1

Quarter	Segment	People and workforce domain segment
Q2 2025/26	1 - High performing	1 - High performing

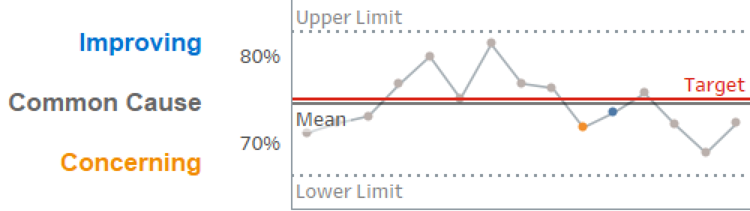
Return to overview

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
People and workforce	Retention and culture	Sickness absence rate	Q1 2025/26	4.24	%	-0.14 ↑	1.68	41 out of 134	4.72	
People and workforce	Retention and culture	NHS staff survey engagement theme sub-score	2024	7.52	out of 10	0.00 →	1.02	2 out of 134	6.88	

Integrated Performance, Quality & Finance Report - New Reporting Guidance

SPC Charts

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



SPC Rules

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

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

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

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

a single data point is outside the control limits

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

Interpreting Performance Icons

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

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

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

Interpreting Assurance Icons

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

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

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

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

Agenda item 07/26c

Board of Directors

Thursday 26th March 2026

Subject / Title	Value Improvement Programme (VIP) 2026/27 – Assurance and Delivery Plan Update
Author(s)	Jo Leece – Associate Director Value Improvement Programme
Presented by	Claire McPeake – Chief Operating Officer
Summary / purpose of paper (alert / advise / assure)	This paper provides an update on identification of Value Improvement Programme (VIP) schemes for 2026/27; assurance on oversight, governance and organisational grip to deliver the financial and operational components of the plan; and the Trust's response to NHS England planning feedback, including strengthened assurance around cost improvement delivery and associated risk management.
Recommendation(s)	Note progress to date, including delivery of £25.298m VIP in 2025/26 and the developing 2026/27 pipeline. Endorse the governance and assurance arrangements (including use of the national Grip & Control checklist) and ongoing weekly tracking of delivery. Agree the planned approach to clinically led service reviews informing the VIP pipeline and to continue Quality Impact Assessments (QIA) and Equality Impact Assessments (EqIA) for all schemes. Confirm alignment with the Five-Year Integrated Delivery Plan and 2026/27 operational and financial plans.
Background papers / source of assurance	Model Health System (MHS) metrics; internal costing and activity analyses; divisional performance review data VIP weekly tracking and finance reports Soft intelligence: Clinically led service review outputs and stakeholder feedback Benchmarking: Getting It Right First Time (GIRFT) opportunities; national productivity benchmarks External assessments: NHS England planning review feedback; national Grip & Control checklist self-assessment status Risks and mitigation: Delivery risk to cost improvement targets mitigated through strengthened financial governance, weekly oversight, and QIA/EIA

	Grip & Control framework actions tracked to completion (15 actions remaining at the time of writing) Trajectory and changes over time: 2025/26 VIP delivered £25.298m against target; 2026/27 pipeline under development with staged validation and approval gates
Risk score / BAF reference	Board Assurance Framework: Risk 1, Risk 6, Risk 7, Risk 9, Risk 10
EDI impact/considerations	Quality/Equality Impact Assessments will be completed for all schemes prior to implementation, with ongoing monitoring via divisional governance. No adverse impacts identified to date where assessments are complete
Link to: ➢ Trust strategy ➢ Corporate objectives ➢ CQC Quality standard ➢ Regulation	Executive objective: To deliver safe, effective & equitable care To deliver excellent financial and operational performance Links to: Trust strategy – The Christie Strategy 2023–2028 Corporate objectives – Five-Year Integrated Delivery Plan CQC Quality standards – safe, effective, responsive, well-led Regulation – NHS England planning and financial governance requirements (Grip & Control)
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.	VIP – Value Improvement Programme MHS – Model Health System GIRFT – Getting It Right First Time NHSE – NHS England BAF – Board Assurance Framework QIA – Quality Impact Assessment EIA – Equality Impact Assessment OPIG – Operational Performance Improvement Group

Agenda item 07/26c

Board of Directors

Thursday 26th March 2026

Value Improvement Programme

1.0 Background

The Trust's Five-Year Integrated Delivery Plan sets out how we will deliver our organisational ambitions over the next five years, building on The Christie Strategy 2023–2028 and our vision to be a leader in both specialist and local cancer care. It provides the framework through which we will continue to improve outcomes and experience, strengthen pathway reliability, support our workforce, enhance productivity, and ensure long-term financial sustainability.

Our five year goals:

Deliver outstanding clinical excellence and outcomes:
We will continue to be providers of safe, equitable care, sustaining top-decile survival, safety and experience across all tumour groups. We will embed the practices and culture that underpin CQC 'Outstanding'.

Achieve operational excellence and financial sustainability:
We will continuously improve safety, flow, quality and value while maintaining financial sustainability and segment one oversight status. Delivering national operational planning standards.

Integrate clinical research and education:
We will lead in cancer research, supporting the shift from sickness to prevention and increasing patient participation in clinical studies.

Be an excellent place to work:
We will develop our people and culture to be in the top 10% of NHS staff survey results.

Transform services to improve access and outcomes:
We will continue to develop our digital maturity with our Future Christie transformation programme to release time to care, improve access and improve experiences. We will develop new integrated models of care, such as neighbourhood oncology, to better respond to patient needs.

Lead the wider NHS cancer system and partnerships:
We will work with system partners to address shared challenges and use new organisational approaches, such as Advanced Foundation Trust status and as an Integrated Healthcare Organisation, to support improved patient outcomes, better system performance and the shift of treatment to prevention and hospital to community.

These goals are underpinned by our values and our core purpose to care, to discover and to teach.

Following the submission of a compliant operational plan in February 2026, as part of our Quality Management System, we have adopted a structured strategy-deployment approach. This approach clarifies the relationship between long-term goals and annual delivery requirements through a set of Annual Objectives, Improvement Priorities and supporting measures. (Appendix 1)

Aligned and central to delivering our objectives, is our Value Improvement Programme (VIP). VIP is an established programme with a structured approach to identifying, developing, and delivering improvement initiatives that safely removes waste to achieve cost improvement targets while enhancing productivity, quality and value for patients. Progress and assurance have been reported to the Trust Board monthly during 2025/26, where we successfully delivered our target of £25m.

This paper provides an update on identification of VIP schemes for 2026/27 to provide assurance that the Trust has the required oversight, governance and organisational grip to deliver the financial and operational components of the plan underpinning each of our objectives. This paper also responds to feedback received through the NHS England planning review process by setting out the board's approach to strengthening assurance around cost improvement delivery and management of the associated risks.

2.0 Performance

Following the successful delivery of the Trust's 2025/26 financial position, work commenced following a structured milestone plan to identify the 2026/27 targets in line with national trajectories and local planning assumptions. The Value Improvement Programme (VIP) supports delivery of these targets through a defined pipeline of initiatives at various stages of development, each progressing through structured financial validation, quality assessment and executive approval before implementation.

2025/26 VIP: £25,298,000 has been delivered in line with the target.

2025/26 Value Improvement Delivery			
Target	Identified: Recurent	Identified: Non-Recurent	Unidentified: Gap to Target
£25,298,000	£11,371,487	£13,926,512	£0

2026/27 VIP Efficiency plan submission:

Efficiency Plan Status	Pay Plan 31/03/2027 Year Ending £'000	Non Pay Plan 31/03/2027 Year Ending £'000	Income Plan 31/03/2027 Year Ending £'000	Plan 31/03/2027 Year Ending £'000
Fully Developed	7,054	4,758	3,000	**14,812**
Plans in Progress	3,101	1,553	10	**4,664**
Opportunity	2,035	0	827	**2,862**
Unidentified	946	1,894	120	**2,960**
Total Efficiencies	**13,137**	**8,204**	**3,957**	**25,298**
i	OK	OK	OK	

The programme pipeline continues to evolve as the clinically led service reviews conclude, generating additional productivity opportunities that are being assessed and prioritised to support the achievement of the 2026/27 target. The Trust has submitted a compliant financial plan and report progress weekly to NHSE with every scheme risk rated in line with national risk rating.

4.0 Delivery approach

The Trust has a robust and integrated Value Improvement Programme aligned with the organisation's Five-Year Integrated Delivery Plan and annual objectives. VIP governance provides clear oversight of cost improvement delivery, ensuring all schemes are subject to financial validation, Quality and Equality Impact Assessments and strengthened financial governance through the implementation of the national Grip & Control checklist.

Opportunity packs have been developed using established benchmarking methodologies including Getting It Right First Time (GIRFT), the Model Health System (MHS), costing and internal analysis to identify improvement opportunities. These insights have providing a structured foundation for reviewing how we perform and where we can improve productivity.

The national Grip & Control frameworks have been reviewed. Of the 156 checks assessed, the substantial majority are now complete, with 15 actions remaining in progress. These checks collectively strengthen financial discipline, workforce controls, cost governance and benefits realisation. Earlier papers submitted to the Board and the Audit Committee set out the Trust's position against the framework; this report reaffirms that progress and confirms that the remaining actions continue to be monitored through the Value Improvement Board reporting progress into the Operational Performance Improvement Group which is the established governance channel. This provides assurance that the Trust is operating within expected financial governance parameters and has best practice controls in place required for the delivery of its cost improvement plans.

The clinically led service reviews continue to identify opportunities across major services, integrating clinical, operational and financial perspectives. These reviews have highlighted opportunities to strengthen pathway efficiency, optimise clinical time, reduce unwarranted variation and improve resource utilisation. Outputs from the reviews feed directly into the VIP pipeline, underpinning the development of recurrent, sustainable schemes. This clinically grounded approach ensures that VIP schemes are evidence-based, operationally realistic and aligned with service needs.

Oversight of delivery continues through weekly tracking of VIP performance for the development of schemes for 2026/27. This ensures progress against improvement initiatives is transparently monitored, with emerging risks identified early and addressed promptly. Routine reporting through divisional performance reviews, and the Operational Performance Improvement Group (OPIG) provides a stable and reliable mechanism for ongoing assurance and risk management.

3.0 Governance

The governance arrangements supporting the Value Improvement Programme (VIP) are well established, fully embedded and consistent with those previously presented to the Board. Executive leadership is provided by the Chief Operating Officer as Senior Responsible Officer, directed by the Assistant Director for Value Improvement. Divisions hold clear accountability

for delivery, supported by Divisional Medical and Nursing Directors to ensure clinical alignment, safe implementation and strong senior clinical ownership of all schemes.

VIP reporting is incorporated into the Trust's routine performance management cycle, including divisional performance reviews, and the monthly Operational Performance Improvement Group (OPG) and finance report. This approach reflects the model used in previous Board cycles, where VIP updates have been presented alongside operational and financial performance to provide a consolidated and transparent view of delivery. A VIP Board brings together finance, operations, workforce and quality colleagues to maintain programme discipline, track delivery progress, escalate risks and ensure benefits realisation. The stability of this governance structure provides continuity, predictability and reliable Board oversight.

Quality and patient safety remain central to delivery. All schemes undergo a structured Quality Impact Assessment, with further review where clinical or operational risks are identified. Clinical leadership ensures that quality is protected, and post-implementation reviews assess the impact of schemes once embedded. This provides continued assurance that improvements are delivered safely, responsibly and in a way that maintains the highest standards of care.

The governance model is fully aligned to the Trust's Board Assurance Framework (BAF), with VIP contributing directly to the mitigation of key financial, operational and workforce risks. This ensures the Board receives a connected view of organisational risk and performance, supported by routine triangulation across workforce, quality, operational and financial indicators.

The Board has previously received detailed papers on the VIP structure, governance arrangements and the Trust's findings against the national Grip & Control checklist, and this paper builds on that history. Additional assurance arises from independent scrutiny through internal reviews where findings have been incorporated into programme development together with continued executive and divisional ownership and a clear assessment of organisational capacity and capability to deliver the programme.

Taken together, these elements provide a high level of assurance to both the Board and NHS England that the Trust has the organisational grip, governance, capability and confidence required to deliver its 2026/27 financial and operational targets.

5.0 Summary

The Board can be assured that the Trust has a mature and well-governed Value Improvement Programme, aligned with our five-year delivery plan and supported by strengthened financial controls, clinically led service reviews and established reporting arrangements. The programme reflects national best practice, incorporates benchmarking through GIRFT and the Model Health System, and is underpinned by the Grip & Control checklist. With a clear pipeline, strong divisional ownership and ongoing monthly oversight through OPIG and the Board, the Trust has the organisational grip and capability required to deliver the 2026/27 financial and operational targets while maintaining the highest standards of care.

Appendix 1: Annual Objectives and improvement priorities

Annual objective 1:
Embed reliable end-to-end cancer pathway standards to deliver national access targets, reduce unwarranted variation and achieve 2% productivity improvement

Improvement Priorities	Success Measures
1. **Re-design Outpatient and follow up models to reduce variation, releasing capacity** (Advice & guidance, EPROMS, PIFU, PSFU. AVT, triage and clinics) 2. **Theatre and Inpatient flow reliability.** (Theatre utilisation, cancellation reduction, criteria to admit/reside, proactive discharge planning) 3. **Re-design two priority tumour pathways end to end** (improved flow, outcomes) 4. **Accelerate digital models to improve access and efficiency**: (NHS App, FDP, virtual devices)	• Faster Diagnosis Standard 80% • 62 day 85% • 31 day 96% • 18 weeks • 2% productivity • 0 Cancelled operations for none clinical reasons • Reduced % of beds with patients with long stays, or who don't meeting the criteria to reside • 1% waiting >6 weeks for diagnostic • Advice and Guidance and PIFU
Key messages:	**5 year goals**
This objective embeds disciplined pathway standards so access targets, flow and productivity are delivered reliably and consistently across the organisation. Governance oversight signals: MHS Benchmarking, Peer reviews. NOF	✓ Deliver outstanding clinical excellence and outcomes ✓ Achieve operational excellence and financial sustainability ✓ Transform services to improve access and outcomes

Annual objective 2:
Align workforce capacity, capability and job planning to demand to ensure safe, responsive care for patients seven days a week.

Improvement Priorities	Success Measures
1. **Consultant job planning and programmed activity alignment to demand** (job planning diagnostic, refreshed policy, agreed approach for activity based job planning) 2. **Strengthen seven-day clinical resilience and high-risk cover** (7 day working) 3. **Workforce capacity modelling to ensure resource match demand.** Skill mix, role redesign **(**Areas with high ECAPs, hard to recruit)	• Reduction in weekend related delays to treatment • 95% job plan compliance • 30% reduction in temporary staffing (agency, locum) • Improved performance in agreed pathway access linked to workforce alignment (to be agreed locally)
Key messages:	**5 year goals**
This objective ensures that our workforce model is aligned to demand, supporting safe, timely and sustainable care every day	✓ Deliver outstanding clinical excellence and outcomes ✓ Achieve operational excellence and financial sustainability ✓ Transform services to improve access and outcomes ✓ Be an excellent place to work

Annual objective 3: Expand neighbourhood models of care, delivering a measurable shift of appropriate activity into neighbourhood settings, strengthening multidisciplinary teams and reducing variation in access and outcomes across communities.

Improvement Priorities	Success Measures
1. **Implement a phased expansion of an agreed neighbourhood oncology model** by expanding community-delivered pathways, supporting multidisciplinary teams, and improving access and outcomes closer to home. 2. **Strengthen Workforce Capability for Community-Based Care**. Build a flexible, skilled workforce by expanding multidisciplinary training, enabling cross-boundary working, and developing leadership for neighbourhood-led improvement. 3. **Embed research** opportunities across neighbourhood pathways to increase participation, accelerate innovation adoption, and reduce inequities in access to research	• % of activity delivered in out of hospital settings • Participation in research • Patient reported experience
Key messages:	**5 year goals**
This objective operationalises the NHS 'Left shift' by moving appropriate cancer care closer to home without compromising specialist oversight, improving access, reducing variation, and strengthening system integration.	✓ Deliver outstanding clinical excellence and outcomes ✓ Transform services to improve access and outcomes ✓ Integrate research and innovation into routine care ✓ Lead the wider NHS cancer system and partnerships

Annual objective 4: Deliver the Quality Strategy, advancing safety learning (PSIRF), consistent evidence-based standards and patient partnerships to improve outcomes and experience.

Improvement Priorities	Success Measures
1. **Strengthen safety culture and system learning** (PSIRF maturity, thematic learning, improvement collaborative) 2. **Deliver consistent evidence based standards and reduce unwarranted variation** (QI capability aligned to NHS Impact, NICE, GIRFT, outcome monitoring by pathway) 3. **Embed structured patient and user partnership in engagement** (patient feedback, co-design, equitable access)	Achieve the measures and standards in the delivery plan aligned to 2026-2028 Quality Strategy; to be published April 2026.
Key messages:	**5 year goals**
This objective advances the practices and culture that underpin CQC 'outstanding', ensuring safety learning, reliable standards and patient partnerships translate into measurable improvements.	✓ Deliver outstanding clinical excellence and outcomes ✓ Achieve operational excellence and financial sustainability ✓ Transform services to improve access and outcomes ✓ Be an excellent place to work

Annual objective 5: To strengthen our culture and workforce sustainability by improving staff experience, wellbeing, leadership capability, and inclusion—ensuring we remain a place where people are proud to work, feel safe and supported, and are empowered to deliver outstanding care.	
Improvement Priorities	**Success Measures**
1. **Improve staff experience and engagement.** Higher staff engagement and more people recommending The Christie as a great place to work. 2. **Strengthen wellbeing and reduce sickness**. Lower overall sickness absence, especially stress-related absence, and improved wellbeing and flexible working scores. [3. **Strengthen leadership, learning and development.** Higher PDR completion, strong mandatory training compliance, and increased access to apprenticeships and CPD. 4. **Advance inclusion and fairness.** Reduced bullying, harassment and discrimination, fairer recruitment outcomes, and greater diversity in senior roles. 5. **Build a sustainable, future-ready workforce.** Reduced turnover and vacancies, higher stability, and more effective use of rostering and workforce resources.	• The success measures for this objective are set out in The Christie People & Culture Plan 2026–2030, which provides the Trust's agreed KPIs across engagement, wellbeing, leadership, inclusion and workforce sustainability.
Key messages:	**5 year goals**
Our focus is to deliver the ambitions set out in The Christie People & Culture Plan 2026–2030, strengthening a positive and inclusive culture, improving wellbeing and compassionate leadership, and building a digitally enabled, sustainable workforce that reflects and supports the communities we serve.	✓ Embed a consistently positive, compassionate and inclusive culture across all teams. ✓ Significantly improve wellbeing and reduce avoidable sickness rates. ✓ Strengthen leadership capability and ensure clear, accessible development pathways. ✓ Build a digitally enabled, diverse and sustainable workforce for the future.

Annual objective 6: Strengthen system leadership by collaborating on major cancer pathway improvements, and using emerging organisational flexibilities (e.g. Advanced Foundation Trust and Integrated Healthcare Organisation models) to improve system performance.

Improvement Priorities	Success Measures
1. **Lead system wide service optimisation:** Development of single Aseptic model and associated business case to improve system capacity and resilience. 2. **Secure Advanced Foundation Trust designation** to enable greater autonomy, collaboration and system leadership 3. **Establish Joint Analytics Centre for Cancer:** supporting pathway performance, and population insight 4. **Expand specialist partnership models:** Christie@Leighton, and other place based developments	• Full aseptic business case submitted and approved • AFT submission completed and accepted by NHSE with all assessment criteria met • Reduction in patient travel time, increased % of care delivered closer to home • Increased % of care closer to home
Key messages:	**5 year goals**
This objective strengthens system performance and resilience by working with partners to optimise cancer pathways, using shared data insights to improve outcomes and access	✓ Deliver outstanding clinical excellence and outcomes ✓ Transform services to improve access and outcomes ✓ Lead the wider NHS cancer system and partnerships

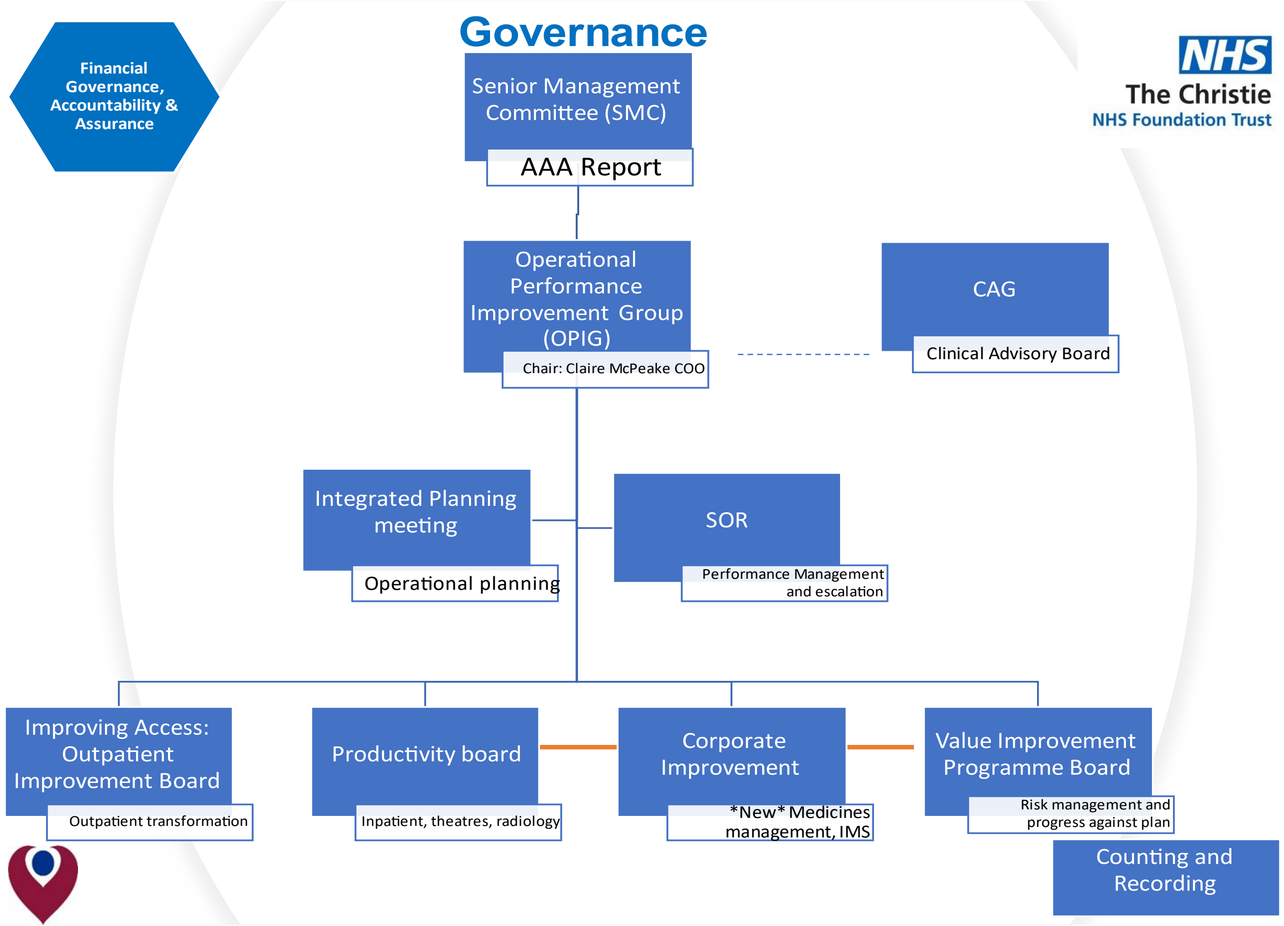
Appendix 2: VIP approach

Value Improvement Programme (VIP)

Ideas generation		Development		In Delivery	
Stage 1 Ideas Generation **Staff engagement**	Stage 1 Idea Generation **Corporate opportunity assess**	Stage 2 Scoping & Development **Divisional Level**	Stage 2 Scoping & Development **Speciality Level**	Stage 3 Delivery & Tracking **Div & Speciality level**	Stage 4 Control & Escalation **Div & Speciality level**
Share & Learn HIVE Engagement /ideas Sharing	Benchmarking opportunity assessment	Building capacity and capability	QIA Process Continuous improvement transformation	VIP tracker & Reporting Financial Governance, accountable assurance	Benefits Benefits tracking and realisation
Ideas generation and alignment	Benchmarking and opportunity assessment	Capacity and capability	Initiation	Weekly tracking of schemes	Divisional performance, continuous improvement

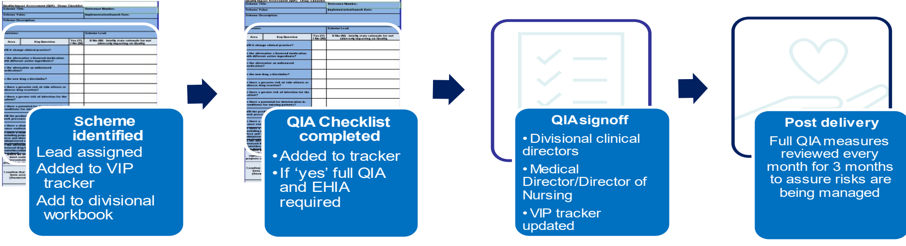
• Idea Generation Workshops / pipeline development meetings
• Share and Learn process for examples of best practice.
• 'Grow your idea' Ensure staff understand how to submit ideas
• Clinical Directors: reducing variation ideas
• HIVE pages linked
• Communication and engagement plan
• Strategy review – links with QI
• Corporate alignment – operational planning framework, NHS 10 year plan, strategy
• Engagement sessions
• Board away day – planning
• Full review of alignment to operational plan with governance structure and ToR updated
	• **Opportunity packs**
	• **Model Health System (MHS)** review areas of opportunity
	• Getting it Right First Time(**GIRFT**) **governance and best practice opportunities**
	• Costing and PLICs
	• Demand & Capacity
	• Best practice checklists; whats new?
	• Health populations needs assessment, strategic/Commissioning intentions to be reviewed
	• Developing capacity and capability - **Value maker programme**
	• Lessons learnt from previous year (what went well etc)
	• Operational plan: ensure plan updated and governance in place
	• Refreshed QIA/EIA governance based on learning
		• Sessions on oversight and planning framework Model health system training
		• Division ensures activity planning, targets and budget setting is completed
		• Creation of the VIP Tracker – monitored weekly
		• Value maker programme
		• Establishment reviews for all wards completed
		• Plans and governance for divisionally led projects eg PSFU, theatres
		• Staff signed up to training – operational excellence/MHS/Oversight framework sessions
		• QIA pop up sessions
			• Specialties ensure plans are developed against ideas in ICIP workbooks
			• Further scoping and development of Planned Schemes at a Speciality Level
			• Each scheme to have a Quality Impact Assessment completed
			• Service review process commences: Support understanding of key strategic challenges and opportunities and based on these, agree options and ensure there is a plan for addressing them
			• Continuous improvement and transformation
			• Improvement boards reporting to OPIG monthly via highlight report for performance improvement
				• Weekly report of the Divisional Level position to execs
				• Weekly Review of Speciality level plans/workbooks
				• Monthly performance meetings attended by:
				  • Matron
				  • Clinical lead
				  • Business manager
				• Operational Plan – actions and risk management
				• VIP deep dive assurance checks
					• Specialties who are rated RED for risks score high, meet weekly with the Exec team as part of escalation process
					• Monthly Divisional review performance support and escalation via SOR
					• Monthly VIP monitoring to assess progress – highlight report to execs
					• Risk reviews
					• Monthly VIP board paper
					
					"I DRIVE VALUE FOR PATIENTS AND TAX PAYERS"

Appendix 3



Quality Impact Assessment (QIA)

- ✓ Provides assurance that savings are not being made at detriment to quality, by risk assessing potential impact of any change
- ✓ A QIA checklist can be completed for every scheme, only a full QIA/EHIA is required if triggering a 'yes' on the checklist
- ✓ A specific QIA checklist has been developed for medicine management
- ✓ QIA checklists must be signed off by Divisional Medical and Nursing Directors
- ✓ QIA dashboard will be submitted to the Chief Nurse and Medical Director monthly
- ✓ A post implementation review is to consider whether the scheme is delivering as intended, benefits are being realised and risks are being managed



Agenda item 07/26d

Meeting of the Board of Directors

Thursday 26th March 2026

Subject / Title	Shaping our culture; insights from the staff survey 2025
Author(s)	Jane Hanson – Colleague Experience and Engagement Manager
Presented by	Eve Lightfoot – Director Workforce
Summary / purpose of paper	The paper provides a summary of cultural and wellbeing initiatives delivered in 2025 and their impact on the 2025 NHS Staff Survey results. Results have remained largely stable or improved despite ongoing operational pressures. Key actions from last year including expanded wellbeing support, strengthened communications, and increased engagement opportunities we have seen impact through maintaining strong People Promise outcomes, alongside improved experiences relating to unwanted sexual behaviour from colleagues and increased use of the Freedom to Speak Up service. The paper sets out next year's priorities including enhanced staff networks, further listening events, strengthened speaking-up culture and new wellbeing services.
Recommendation(s)	The Board of Directors is asked to; • note the contents of the paper and support divisional action planning
Background papers	NHS Staff Survey 2025 Results
Risk score	BAF Risk 2 and 12
EDI Impact	The paper demonstrates **clear positive EDI intentions**, with multiple initiatives aimed at strengthening inclusion, psychological safety, cultural awareness, and equitable access to wellbeing and career opportunities. However, the report also **surfaces ongoing risks** around fairness, cultural competence, representation, and inclusion—especially regarding protected characteristics. These risks will need continued focus to ensure equity is not only aspired to but operationalised. Overall impact: **Moderately positive**, with **identified gaps requiring targeted action**.
Link to: ➢ Trust strategy ➢ Strategic objectives	Achievement of Corporate Plan and objectives and The Christie People Plan and Inclusive Culture Strategy
Acronyms or abbreviations where they appear in the attached paper.	EDI Equality, diversity, Inclusion PDR personal development review Q&A question & answer n number

Agenda item: 07/26d

Meeting of the Board of Directors

Thursday 26 March 2026

Shaping our culture; insights from the staff survey 2025

1 Introduction

This paper provides an insight into staff survey 2025 themes and an overview of interventions during the last 12 months which have contributed to these.

The 2025 Trust response rate was 47%, 1% lower than in 2024, however more colleagues completed the survey than previous due to workforce growth.

2 Summary of Highlights

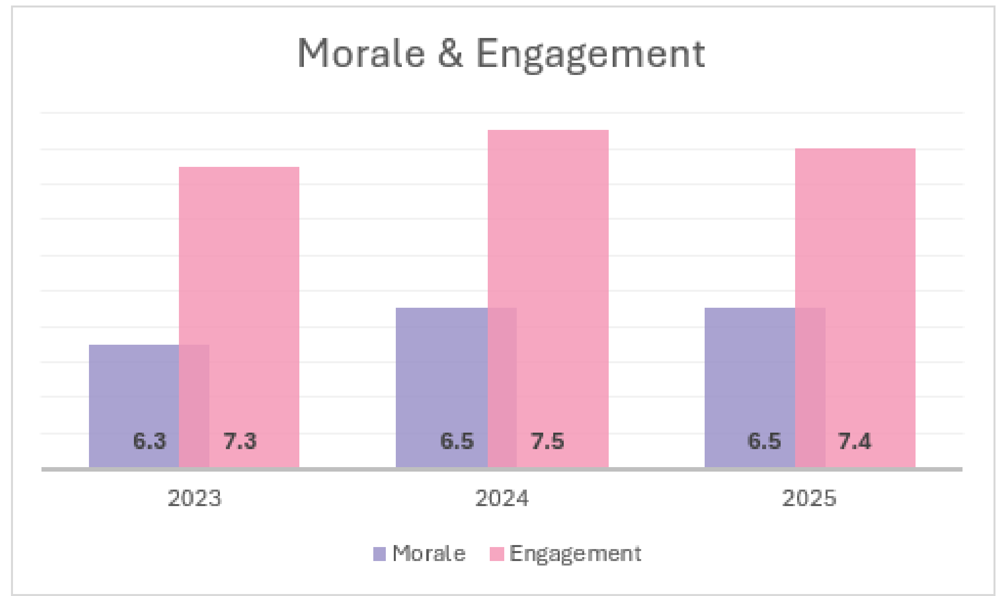
Figure 1 shows an overview of the actions implemented since the 2024 annual staff survey. The impact of these actions have contributed to both the increases and the consistency of our scores in the majority of the People Promise themes. Appendix 1 shows our People Promise scores over the last 3 years.

Figure 2 shows our Engagement and Morale scores over the last 3 years.

Figure 1 shows an overview of actions implemented since the 2024 annual staff survey

Theme from Staff Survey	Action implemented
Wellbeing	• Launch of Inclusive Culture Strategy • Lotus Room (expressing room) created to support returning parents • Hand and back massage • Acquisition of Vivup (new Employee Assistance Programme) • Lifestyle benefits platform launched via Vivup • Reasonable adjustments project implemented
Staff Communications	• Continued with staff magazine, new monthly Trust briefing and weekly bulletin launched • Held regular executive led Grand Rounds
Engagement	• Exec led quarterly Trust-wide engagement/Q&A events • Developed Admin & Clerical forum in partnership with staff side • EDI staff network events • Developed the strategic leadership forum • Continued and enhanced quarterly connect and reflect sessions

Figure 2 shows our Engagement and Morale scores over the last 3 years



Despite ongoing NHS pressures, particularly in Greater Manchester, including financial constraints, industrial action, and workforce stress, we've achieved good results given the challenging context.

Unwanted behaviour of a sexual nature in the workplace

Following the launch of the NHS Sexual Safety Charter there has been a significant focus in the Trust to ensure we are meeting the commitments of the charter and ensuring these are sustainable. We have developed and launched a Sexual Safety policy, raised awareness of our commitments during the corporate induction programme, promoted sexual safety e-learning and delivered Surviving in Scrubs training.

This has resulted in an increase in our response for staff coming forward when they have been the target of unwanted behaviour of a sexual nature in the workplace from patients/services users, their relatives and other member of the public' (5.83% in 2025; higher than 5.23% benchmark average)

We have also seen a decrease in staff stating that in the last 12 months they have been the target of unwanted behaviour of a sexual nature in the workplace from staff/colleagues' (2.67% in 2025; lower than 3.27% benchmark average).

Appendix 2.1 shows the most improved and declined scores for 2025. We have reviewed the data in relation to our most declined scores around appraisal and have found that due to the reporting rules where only "yes definitely" responses are counted, as opposed to all of the other questions which include all positive responses "yes to some extent" is a likely factor that has skewed the data. We have escalated this to the National Team.

Appendix 2.2 shows the impact that this has had on our data.
Following focused work in 2025 a new PDR/appraisal process was introduced late summer and it is hoped that this will have an impact on 2026 results once fully embedded.

Free text comments high level summary
An initial analysis of the free text comments has identified the following:

There were positive reflections on the following:

- supportive and compassionate line managers
- availability of flexible working arrangements
- positive experiences of professional development
- pride in working for the organisation, its purpose and its impact on patients.

Areas of development and focus:

- high workload, staffing shortages and burnout indicators
- not feeling listened to by senior leaders and inconsistency in communication from senior teams
- lack of cultural understanding around religious observance or protected characteristics.
- limited progression pathways with some favouritism in career progression

These comments highlight workforce pressure points that could impact retention, morale and perceptions of organisational culture. Key risks include workload-related stress, inconsistent communication, and concerns around fairness and inclusion.

In response to these themes, we will be undertaking the following actions:

- strengthen organisational listening activities and develop clearer escalation pathways.
- strengthen support for EDI staff network leads
- develop and publish an annual calendar highlighting health and wellbeing initiatives alongside key cultural events to provide more notice for colleagues to attend key events
- working with the networks to identify barriers to accessing EDI events like lunch and learns
- develop a 'supporting colleagues through difficult times' guide
- develop cultural awareness and education sessions to improve knowledge and decision-making for colleagues and managers

Survey response rate demographics
Appendix 3 shows our response rates were broadly consistent across most demographic groups, with strongest participation from staff aged 31–40 and those from White ethnic backgrounds. Representation from Mixed/multiple ethnic groups was slightly lower. Engagement among staff declaring a disability was marginally higher than those not declaring a disability.

We will provide a more detailed report including our response to the findings at the June Workforce Assurance Committee.

Appendix 4 shows the comparison of our position nationally, alongside other Greater Manchester Trusts and Oncology Centres. The Trust has scored the highest across all People Promise themes apart from 'we are a team' where we scored the average result.

3 Areas of focus/priorities for the coming year

- Review format and content for quarterly Trust-wide listening and Q&A events
- Review and develop mechanisms to increase awareness of cultural difference
- Enhance existing wellbeing package for staff to include introduction of podiatry service, work towards Henpicked Menopause Accreditation
- Develop and implement Menopause action plan

4 Conclusion

While the staff survey continues to provide an important indicator to inform improvements to employees' working lives it is only one of several feedback mechanisms. The Trust continues to listen and learn through a broad range of in time engagement channels, including connect & reflect events, Equality Delivery System stakeholder events, the Healthy Workplace Steering Group, and regular Executive led Trust-wide colleague engagement and listening activities.

We are pleased to report that the Trust has scored above the benchmark average across all People Promise themes. This reflects the strength of our culture, leadership, and commitment to supporting our colleagues. While we recognise there are areas requiring focus and improvement, these results provide assurance that we are performing well relative to our peers and are building a positive and supportive working environment.

5 Next Steps

Central areas of focus will form part of our People and Culture plan implementation. Divisional leads have received their results to enable them to action plan on areas of focus. Progress against their actions will be monitored through the workforce committee. A more in-depth review of our results including staff group and demographic data will be presented to the June Workforce Assurance Committee.

The Trust Board are asked to note the staff survey results and note a further in-depth analysis will be provided to the June Workforce Assurance Committee.

Appendix 1 shows our People Promise scores over the last 3 years

	2023	2024	2025
Promise 1: We are compassionate and inclusive	76.8%	78.2%	79.0%
Promise 2: We are recognised and rewarded	63.0%	65.0%	65.0%
Promise 3: We each have a voice that counts	69.3%	71.4%	71.0%
Promise 4: We are safe and healthy	64.6%	66.6%	67.0%
Promise 5: We are always learning	58.4%	60.8%	59.0%
Promise 6: We work flexibly	66.6%	68.8%	68.0%
Promise 7: We are a team	70.2%	71.6%	71.0%
Theme: Morale	62.7%	65.4%	65.0%
Theme: Staff Engagement	73.5%	75.0%	74.0%

Appendix 2.1 shows our most improved/declined scores compared with our own 2024 survey

Most improved scores	Org 2025	Org 2024
q13d. Last experience of physical violence reported	75%	62%
q11e. Not felt pressure from manager to come to work when not feeling well enough	85%	81%
q14d. Last experience of harassment/bullying/abuse reported	55%	51%
q31b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	83%	81%
q19a. Staff involved in an error/near miss/incident treated fairly	69%	67%

Most declined scores	Org 2025	Org 2024
q23b. Appraisal helped me improve how I do my job	22%	27%
q23d. Appraisal left me feeling organisation values my work	35%	40%
q8b. Colleagues are understanding and kind to one another	74%	78%
q23c. Appraisal helped me agree clear objectives for my work	35%	39%
q8d. Colleagues show appreciation to one another	71%	75%

p.5 | The Christie NHS Foundation Trust | NHS Staff Survey 2025

Tables are based on absolute % differences, not statistical significance

Appendix 2.2 reflects a positive position on appraisal-related questions, showing improvement compared with 2024 with the combined scores but shows a decline in the scores where ‘yes definitely’ was selected.

Staff survey question	'yes definitely' 2024	Combined score of 'yes, definitely' and 'yes to some extent' 2024	'yes definitely' 2025	Combined score of 'yes, definitely' and 'yes to some extent' 2025
Q23b: 'my appraisal helped me to improve how I do my job'	27%	74.50%	22%	75.90%
Q23c: 'my appraisal helped me to agree clear objectives for my work'	39%	84%	35%	85%
Q23d: 'my appraisal left me feeling that my work is valued by my organisation'	40%	80.80%	35%	82%

Appendix 3 shows our response rates were broadly consistent across most demographic groups

Demographic	Response rate highest	Sample size	% response	Response rate lowest	Sample size	% response
Age	31-40 (n=521)	1236	42.2%	16-20 (n=12)	12	100%
Ethnicity	White (n=1554)	3135	49.6%	Mixed/multiple ethnic groups (n=53)	109	48.6%
Gender	Female (n=1315)	3085	42.6%	Prefer not to say (n=85)	n/a	n/a
Disability	No (n=1687)	3657	46.1%	Yes (n=167)	326	51.2%

Appendix 4 shows the comparison of our position nationally, alongside other Greater Manchester Trusts and Oncology Centres

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
The Christie	**7.9**	**6.5**	**7.1**	**6.6**	**6.0**	**6.8**	7.1	**7.4**	**6.5**
The Royal Marsden	7.7	6.3	7.0	6.5	**6.0**	6.4	7.0	**7.4**	6.4
Clatterbridge	**7.9**	6.4	**7.1**	6.5	**6.0**	6.5	**7.3**	7.2	6.2
Bolton NHS FT	7.3	**5.9**	**6.6**	**5.9**	**5.3**	6.2	6.8	**6.5**	**5.6**
East Cheshire NHS Trust	7.4	6.1	6.7	6.0	5.7	6.5	**6.7**	6.8	5.8
Manchester Uni FT	7.3	**5.9**	**6.6**	6.2	5.6	6.2	**6.7**	6.7	5.9
Northern Care Alliance	**7.2**	**5.9**	**6.6**	6.1	5.5	6.4	**6.7**	6.6	5.8
Stockport NHS FT	7.5	6.1	6.8	6.2	5.7	6.3	6.9	6.9	6.0
Tameside & Glossop	**7.2**	**5.9**	**6.6**	6.0	5.5	**6.1**	**6.7**	6.7	5.8
Wrightington, Wigan & Leigh	7.3	**5.9**	6.7	6.3	**5.3**	6.3	6.8	6.7	6.0
GMMH	7.3	6.2	**6.6**	6.2	5.6	6.8	7.0	6.7	5.9
Pennine Care	7.6	6.4	6.8	6.2	5.6	6.9	**7.3**	6.9	6.1

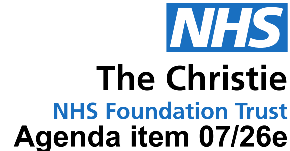
Those in bold highlight the highest and lowest scores for each People Promise them

Agenda Item 07/26e

Meeting of the Board of Directors

Thursday 26th March 2026

Subject / Title	Neighbourhood Oncology
Author(s)	Dr Neil Bayman, Executive Medical Director
Presented by	Dr Neil Bayman, Executive Medical Director
Summary / purpose of paper	This paper provides the Board with a full update on the Neighbourhood Oncology programme, including strategic context, delivery pillars, clinical rationale and programme milestones.
Recommendation(s)	The Board is asked to note the expansion and strategic importance of the Neighbourhood Oncology programme and endorse continued progression across Greater Manchester.
Background papers	Strategic objectives, Board assurance framework
Risk score	N/A
EDI Impact	Neighbourhood oncology is expected to deliver **net positive EDI impact**, improving service accessibility, reducing cancer inequality gaps, and supporting a more inclusive patient and workforce experience. Risks are manageable with planned mitigations, and ongoing engagement with communities will be essential to maximise impact.
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.	GM Greater Manchester SACT systemic anti-cancer treatment MDT multi-disciplinary team EPR electronic patient record ePROMs electronic patient reported outcome measures



Agenda item 07/26e

Meeting of the Board of Directors
Thursday 26th March 2026

Neighbourhood Oncology

1. Purpose

This paper provides the Board with a full update on the Neighbourhood Oncology programme, including strategic context, delivery pillars, clinical rationale and programme milestones.

2. External Policy Drivers

Following the Darzi report (2024) and *Fit for the Future: 10 Year Health Plan for England (2025)*, the NHS is entering a new phase of reform. Rising demand, increasing clinical complexity and constrained resources mean that existing hospital-centric delivery models are no longer sustainable.

Cancer services are at the forefront of this challenge:

- Cancer incidence continues to rise by ~5% annually
- Treatments are more complex, longer in duration, and increasingly personalised
- More patients are living longer with cancer as a long-term condition
- Inequalities in access, experience and outcomes are widening

The National Cancer Plan (2026) reinforces this urgency and sets clear ambitions:

- Earlier diagnosis and improved survival
- Faster and more personalised treatment pathways
- Reduction in inequalities
- A fundamental shift of cancer care into neighbourhood settings
- Digital-first, proactive models of care

Neighbourhood Oncology is a primary delivery mechanism for realising these ambitions within Greater Manchester and for The Christie as a national leader.

3. Case for Change

By 2040, an estimated 6 million people will be living with cancer in the UK. This represents a structural shift in demand that cannot be absorbed by existing models of care which are episodic, hospital-based and reactive to complications once they have occurred. The current approach relies on emergency hospital attendances and hospital admission in an already overstretched Urgent and Emergency Care system, creates inequalities in access between communities and too often fails to support cancer as a long-term condition.

Neighbourhood Oncology redesigns the cancer pathway to address these challenges fundamentally, moving from a reactive, hospital-centred model to a proactive, digitally enabled, neighbourhood-based system of care.

4. Engagement

We have undertaken extensive engagement with clinical experts across the organisation, GM system partners including GM Cancer Alliance and neighbourhood teams, commissioners, governors and the Board in the development of our neighbourhood oncology proposition.

5. Neighbourhood Oncology

Neighbourhood Oncology represents a transformation in how cancer care is delivered across Greater Manchester. It makes home and neighbourhood care the default, delivered by community-based teams with The Christie as a system anchor organisation. Pathways are redesigned to be proactive rather than reactive, taking a risk stratified approach to care based on continuous connection to patients utilising new digital tools, with early intervention to prevent complications escalating to require hospital admission, and treating cancer as a managed long-term condition.

While building on 15 years of experience delivering cancer care "closer to home", this programme provides a step-change to a system-wide standard model, moving from opt-in to default pathways at home/neighbourhood pathways under and a single Christie-based set of clinical protocols and guidelines.

Neighbourhood Oncology is a primary delivery mechanism for the three strategic shifts in cancer care: hospital to community, analogue to digital, and treatment to prevention.

For patients, Neighbourhood Oncology will deliver:

- Care closer to home as standard, reducing travel, disruption and cost
- Faster access to specialist advice, including same-day decision-making
- Earlier identification of complications, preventing deterioration
- Reduced need for hospital attendance and admission
- More personalised, continuous care, supported by digital monitoring
- Improved experience and quality of life during treatment
- More equitable access, with services focussed around deprived and underserved populations

Recognising cancer as a chronic condition, neighbourhood oncology positions cancer care to fit around patient's lives, rather than requiring their lives to fit around care.

6. Delivery model

Neighbourhood oncology is delivered through three integrated pillars:

i. SACT delivered in neighbourhoods and at home

Local or home-based SACT will become the default model for eligible patients, enabled by digital identification and referral (opt-out model), standardised eligibility and governance based on drug regimen, expansion of SACT neighbourhood hubs and reconfiguration of Christie@Home.

Currently 1300 patients receive treatment at home with 8500 treatments delivered annually. Modelling of our current patient population and available drug regimens has shown this could increase three- or four-fold, with potentially more than 5000 patients receiving SACT@Home each year.

ii. Ambulatory Acute Oncology

A Christie-anchored ambulatory acute-oncology model will replace reactive urgent and emergency driven care for patients requiring acute care due to complications of their cancer diagnosis or treatment. Daily specialist decision-making through the pan-GM acute oncology MDT will support same-day assessment and treatment locally where appropriate based on the developing national clinical guidelines for acute oncology conditions that can be managed outside of hospital. Patients will be continuously connected to The Christie using established and developing digital tools (ePROMS, physiological surveillance devices) to enable early intervention prior to acute oncology crises. Under the current care model, approximately 15% of patients require an emergency admission to hospital with 30-days of a cancer treatment. Neighbourhood oncology will reserve hospital admission only for those who need it, sparing specialist hospital capacity to manage the more complex conditions often associated with newer anti-cancer treatments and technologies.

This builds directly on the GM Acute Oncology Transformation Programme which is already demonstrating improved access to senior decision-making and reduced variation for acute oncology conditions.

iii. Supportive Oncology integrated with neighbourhood services

Supportive oncology becomes core infrastructure to support the 6 million people predicted to be living with and beyond cancer in the UK by 2040. Supportive oncology delivers secondary and tertiary prevention for patients after a cancer diagnosis, incorporating symptom control, pre- and rehabilitation, psychological and social support. Services are seamlessly integrated with primary care and community services, and partner with the Voluntary, Community and Social Enterprise (VCSE) sector, within people's neighbourhoods closer to their homes. Facilitated through personalised care plans accessible digitally via the NHS App,

Neighbourhood Oncology manages cancer as a long-term condition, aligned with NHS Cancer Plan.

7. Five-year deliverables

Over the plan period, neighbourhood oncology will deliver:

- Neighbourhood and home-based care as the default model for cancer treatment in GM
- A fully integrated ambulatory acute oncology system, significantly reducing emergency admissions
- Digitally enabled, proactive cancer pathways, including ePROM-driven surveillance
- Reduction in inequalities, with measurable improvement in access and outcomes by deprivation
- Release of specialist centre capacity, enabling Christie to focus on complex, research and tertiary care
- A scalable workforce model, including advanced practice roles and new competencies
- Expansion of Christie's physical footprint through strategic neighbourhood hubs (e.g. Leighton)
- A single, standardised GM cancer care model, reducing unwarranted variation

Neighbourhood Oncology positions The Christie and Greater Manchester as a national exemplar for neighbourhood-based cancer care delivery.

8. 12 Month Next Steps

Over the next 12 months, the programme will prioritise transition from design to scaled delivery:

i. Scale SACT@Home and Neighbourhood Delivery

- Implement opt-out digital referral pathways via EPR
- Expand Christie@Home workforce, fleet and hub model
- Add new drugs/regimens to homecare portfolio

ii. Deliver Ambulatory Acute Oncology at Scale

- Fully embed pan-GM daily virtual acute oncology MDT
- Launch standardised ambulatory pathways ("Big 5" conditions)
- Develop acute oncology at home pathways

iii. Digital Enablement

- Roll out ePROMs across major tumour groups
- Integrate pathways into NHS App and Christie portal
- Develop real-time monitoring and escalation systems

iv. Workforce Transformation

- Expand advanced clinical practitioner roles
- Deliver acute oncology passport training across GM
- Align job planning to neighbourhood delivery model

v. Equity and Population Health

- Target rollout in high deprivation neighbourhoods first
- Implement routine reporting by deprivation and geography

vi. System and Financial Enablers

- Pilot new payment mechanisms aligned to pathway-based care

9. Recommendation

The Board is asked to note the expansion and strategic importance of the Neighbourhood Oncology programme and endorse continued progression across Greater Manchester.

Agenda item 08/26a

Meeting of the Board of Directors

Thursday 26th March 2026

Subject / Title	Future Christie Update
Author(s)	Adrian Bloor, Medical Director of Future Christie
Presented by	Adrian Bloor, Medical Director of Future Christie
Summary / purpose of paper	To update the Board on progress delivered to date within the Future Christie Programme, including: • Deployment of Ambient Voice Technology (AVT) • Advancement of the Electronic Patient Record (EPR) procurement • Implementation of the Joint Analytics for Cancer (JAC) initiative – the foundation of the intelligent hospital vision. • Planned developments
Recommendation(s)	The Board is asked to: 1. Note the ongoing progress made across key Future Christie workstreams. 2. Note the progress made with EPR business case 3. Acknowledge the ongoing challenges and the mitigating actions in place.
Background Papers	Trust Strategy 2023-2028 NHS 10 year plan Future Christie Overview
Risk Score	See Board Assurance Framework Risk 13 and Risk 15
EDI impact / considerations	The Future Christie Programme is expected to have a **positive Equality, Diversity and Inclusion (EDI) impact**, particularly through digital improvements that support more consistent, equitable and data-driven patient care. Initiatives such as the Electronic Patient Record, Joint Analytics for Cancer, and Ambient Voice Technology have the potential to reduce unwarranted variation in clinical processes and improve access to services, aligning directly with the Trust's strategic aim to deliver safe, effective and equitable care and reduce health inequalities. There are **potential EDI risks**, including digital exclusion, varied digital confidence among staff, and the need for accessible training and change-management support. These will require ongoing monitoring to ensure all staff and patient groups benefit equitably from the programme's implementation.
Link to:	1. To deliver safe, effective & equitable care 2. To deliver excellent financial and operational performance 3. To provide integrated clinical, research and education services

➢ Trust's Strategic Direction ➢ Strategic Objectives	4. To be an excellent place to work and attract the best staff 5. To transform our services to improve access and reduce health inequalities 6. To provider leadership within the wider NHS cancer system
Acronyms or abbreviations used in the paper	EPR Electronic patient record JAC Joint analytics for Cancer AI Artificial Intelligence AVT Ambient Voice Technology SQD Single Queue Diagnostics PSFU Patient Stratified Follow up FDP Federated Data Platform

Agenda item 08/26a

Meeting of the Board of Directors

Thursday 26th March 2026

Future Christie Update

1.0 Joint Analytics for Cancer

Appointment of Chief Data Officer

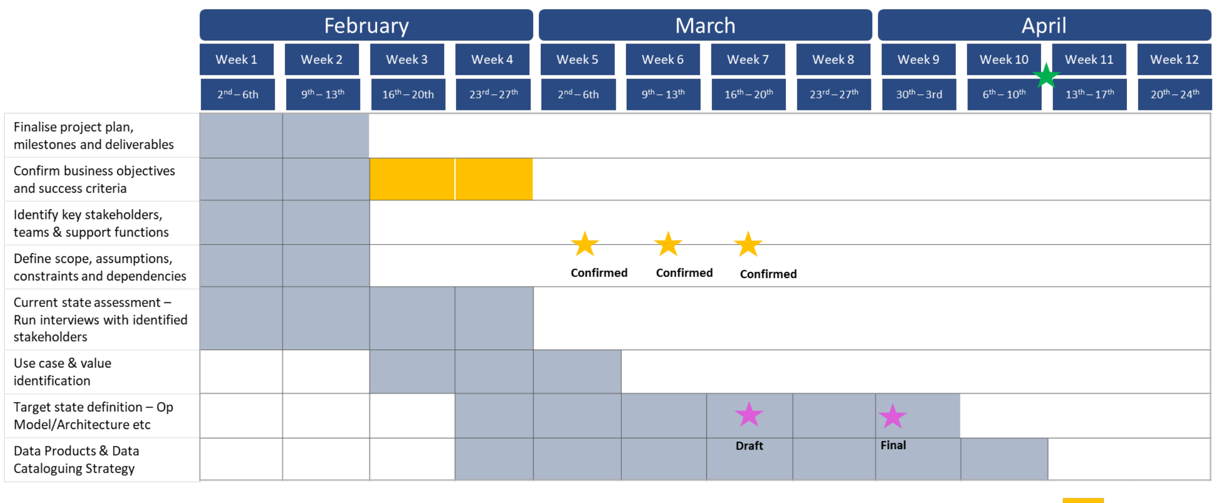
Wes Baker was appointed as Chief Data Officer at the end of January 2026 following a highly competitive recruitment process and will be starting in post mid-June 2026. His appointment will significantly strengthen the Future Christie leadership team, accelerate progress with the JAC program and facilitate preparation for the implementation of the new electronic patient record.

Foundations for JAC

Following the phase 1 business case approval in October 2025, a strategic collaboration with Accenture was commissioned to modernise the hospital's data infrastructure through the JAC initiative. The primary objective is to transition toward an intelligent hospital model by establishing a robust data strategy and platform assessment that supports advanced research, AI, and personalized patient care.

Over a twelve-week period which commenced in February 2026, the project team are undertaking 3 streams of work; a Data Platform Assessment, Initial Data Strategy Development, and a Data Quality Assessment. This will ensure readiness for a future Electronic Patient Record (EPR) and provide foundational assistance for the incoming Chief Data Officer to drive innovation and optimise clinical decision-making.

The program is progressing steadily, with extensive stakeholder engagement underway across clinical, research, and corporate functions and by the end of Q1 2026 aims to deliver a clear recommendation for a target data platform and data strategy.



2.0 Electronic Patient Record

The project team has completed the Outline Business Case presented to the Senior Management Committee and Board in February 2026. Three options were considered (Core EPR; Enterprise EPR; Enterprise EPR through GM Partnership) against a do-nothing base case and evaluated against programme risk, value for money, alignment to Trust objectives and critical success factors.

Option	CSF Fit	Summary Rationale
1. Do Nothing Continue with the modernisation of CWP at current page with no additional investment.	1.40	• Included to aid comparison of options against 'base case' scenario. • Does not enable the Trust to meet its service strategy. • Low cost initially. Current technical debt will accrue, resulting in increasing risks and costs over 10 years.
3. Core EPR Deployment of a core EPR application and integration capabilities to create modular solution landscape.	1.93	• Focuses on current model. Does not support operational and network service objectives. • Requires greater emphasis on transformation and Trust-led organisational change. • Replaces individual components of clinical technology but does not address risks associated with disparate application and dataflows.
4. Enterprise EPR Comprehensive EPR procured and configured by the Trust. Integrate with remaining specialist applications. The Trust may explore opportunities to integrate with local or specialist partners to better support patient flows.	2.18	• Structured EPR workflows enable future model of care, related processes and broader integration with NHSE partners as designed by the Trust. • Opportunity for interoperability with regional or specialist partners, whereby the Trust can also benefit from experiences, lessons and resources where partnerships are formed. • Enhanced functionality and consolidation allows patients to better engage with their care along pathways, either though the EPR, NHS app or other integrated solutions. • High costs associated with EPR software, process design, operational change, and training. • Greater delivery risk than modular approach, including archiving and migration of data.
5. Enterprise EPR through Partnership Adopt an enterprise EPR with a local partner to support patient flows.	2.65	• Supports the treatment of common patients along shared pathways and the management of integrated pathways through service networks. • Allows Trust to use experience, lessons and resources from partner(s) to manage delivery risks, deliver safe deployment and leverage benefits.

Using a weighting scoring matrix against key metrics including cost, affordability, strategic fit and deliverability, the OBC identifies that an enterprise-level EPR through partnership with a GM provider us the optimal solution for our organisation. The OBC includes a detailed benefits assessment built into the revenue model.

Following OBC approval, the project team will be undertaking further work leading to a Full Business Case expected in Q3 2026. Key steps include:

- **Finalisation of the commercial case and route to procurement**. Consultation with legal advisors, procurement team and NHS England is ongoing to identify the optimal route which is compliant with relevant legislation and regulatory requirements (eg from NHSE, DHSC and Cabinet Office)

- **Financial Case.** Further work is ongoing to develop the financial model and identify additional efficiencies. The final capital and revenue position will be described in the full business case.

- **Operational review.** A detailed review of the operational and governance arrangements of a partnership alongside other due diligence will be undertaken and approved following confirmation of the partner and approval of the route to procurement.

3.0 Ambient Voice Technology (AVT)

AVT has completed technical validation and commenced a phased roll out in Surgery and Haematology on 19th January 2026. The AVT solution is based on an upgraded version of existing digital dictation product (Epro). Functional issues, affecting a minority of users, relating to the upgrade rather than AVT were identified shortly after deployment which has slowed deployment. It is anticipated that the AVT roll out will be able to continue following a technical fix and further testing.

The AVT expansion programme is now fully with programme governance, clinical and operational workstreams, and supplier engagement in place to drive a coordinated rollout of advanced voice technology across priority use-cases. The programme is focused on improving clinical efficiency, documentation quality and patient experience by extending AVT beyond the current outpatient test of change into areas such as MDTs, board rounds, virtual clinics, hotline workflows and emerging automations. Early scoping work is underway with suppliers including Microsoft Dragon, UiPath and Cisco, alongside clinical teams who are shaping templates, prompts and operational workflows.

4.0 Strategic Alignment and Benefits

The Future Christie Programme directly supports the Trust Strategy and Corporate Objectives, particularly in improving patient experience, operational excellence, and research capability. It aligns with the NHS Long-Term Plan through digital enablement, data-driven care, and partnership-based innovation.

4.0 Challenges and Mitigations

EPR Programme Risks:

- Finalisation of the commercial case and identification of the route to procurement will be the principal drivers to the project timeline. Indicative timescale for a framework procurement exercise is 12-14 months.

- Implementation of an EPR will consume considerable resource from across the organisation. A project delivery plan is being developed in collaboration with operational teams and funding for additional resource is built into the business case. This risk will be mitgated by a partnership solution.

AVT Programme Risks:

- The principal risk to AVT is the dependency on new technology which has limited maturity. This is mitigated by strengthening supplier governance, requesting clear delivery roadmaps, and planning contingencies.
- There is a risk that staff may not adopt new workflows or may experience change fatigue. Mitigated by structured change management, early engagement, and targeted training to support adoption.

5.0 Next Steps

- Continue progress with AVT deployment.
- Complete JAC discovery work with further update in April 2026
- Complete the Commercial Case for the EPR following engagement with NHSE, Cabinet Office and legal team. Move to Full Business Case for delivery in Q3 2026

Agenda Item 08/26b

Meeting of the Board of Directors

Thursday 26th March 2026

Subject / Title	Strategy update
Author(s)	Louise Westcott, Company Secretary
Presented by	John Wareing, Director of Strategy
Summary / purpose of paper	This paper outlines progress against the Strategy and an update on the national policy context that is informing our future direction.
Recommendation(s)	The board of directors are asked to note the update on the current strategy and national policy context that will inform the next iteration of the Trust Strategy.
Background papers	The Trust Strategy 2023-28 NHS 10 Year Plan National Cancer Plan
Risk score	See BAF
EDI Impact	Achievement of the strategic objectives is expected to advance equity, improve access, or reduce disparities for one or more protected or disadvantaged groups.
Link to: ➢ Trust strategy ➢ Strategic 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.	KPI key performance indicator PET-CT positron emission tomography EPR electronic patient record TIL tumour-infiltrating lymphocyte AFT Advanced Foundation Trust JAC Joint analytics for cancer IHO Integrated Healthcare Organisation

Agenda item 08/26b

Meeting of the Board of Directors
Thursday 26th March 2026

1. Introduction

This paper outlines progress against the current Strategy 2023-28 and outlines the national policy developments that will impact this and inform the development of the next iteration of the Trust strategy.

2. Background

The Christie's mission is described in three parts – To Care, To Discover, To Teach. The goal of the organisation is to improve outcomes for patients and be a leader in delivery of cancer treatments.

We look at how we can achieve this through four areas:

Leading cancer care – doing things to be at the forefront on cancer care such as the development of the Paterson, our 2030 Research & Innovation strategy, our international work – supporting service delivery through education and partnerships.

Christie experience – consistently improving how patients are looked after. Providing the best possible experience wherever Christie services are delivered. Underpinned by our staff and our culture.

Local & specialist care – relates to our network model of care which has been our approach over the past 20 years. Our focus is how can we get the right care as close to people as possible.

Best outcomes – providing the most up to date and effective treatment and care to ensure that patients achieve the best possible outcomes, comparable with the best in the world.

The below diagram articulates our vision, strategic approach and Trust values.

Our Vision

we care, we discover, we teach

Our Strategic Framework

- **Leading Cancer Care**
- **The Christie Experience**
- **Local & Specialist Care**
- **Best Outcomes**

Our Strategic Objectives

To deliver safe, effective & equitable care
To deliver excellent financial and operational performance
To provide integrated clinical, research and education services
To be an excellent place to work and attract the best staff
To transform our services to improve access & reduce health inequalities
To provider leadership within the wider NHS cancer system

Our Values & Behaviours

Making a difference
Acting with kindness
Connecting with people

3. Strategic objectives

Our current Strategy 2023-28 describes a number of areas of focus. The table below outlines the key 20 priorities and how they relate to the aims of reducing cancer waits, tackling health inequalities and improving outcomes.

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

Reducing cancer waits | Tackling cancer inequalities | Improving outcomes

In order to further our strategic ambition we have built on these areas in the last 3 years to progress other advances such as the expansion of the Haematology Network, the Diagnostics Network, progressing with the use of the Federated Data Platform, establishing Total Body PET, expansion of services in Mid Cheshire, new state of the art ward environments, the GM aseptics project, and the National Biomarker Centre.

Further developments include a new EPR, the launch and developments of the Joint Analytics for Cancer project, progressing with establishing Neighbourhood Oncology and new treatments such as TIL.

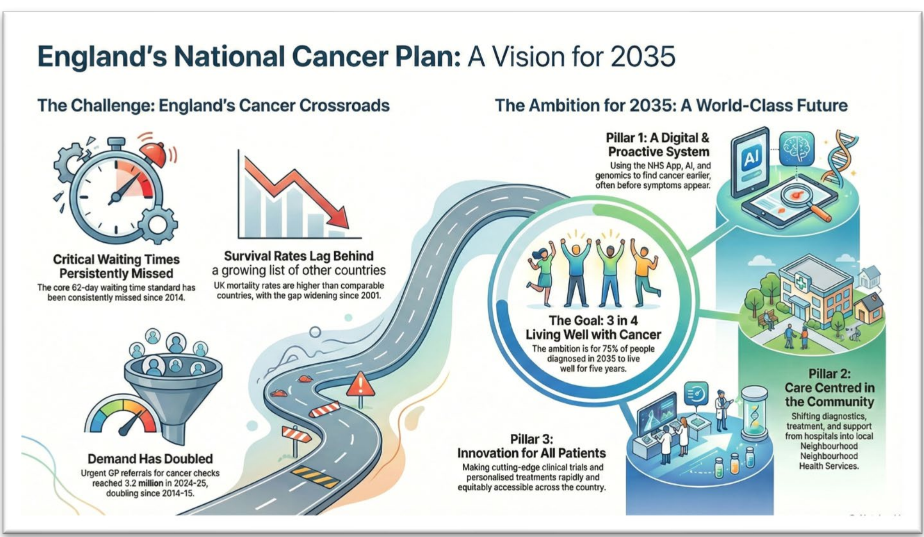
No strategy can stand still, and we need to be cognisant of the external environment and how changes affect our approach. The NHS context changes and adapts with national policy changes such as the NHS 10-year Plan and the National Cancer Plan and we want to keep pace with technological changes, apps, better digital as well as advances in methods of delivering treatment. This includes the move to more oral treatments for cancer, greater emphasis on ambulatory care and reduced fractions for radiotherapy treatment, all of which means we must change the way we deliver our services. This sits alongside the continuing rise in demand for care.

Our strategies and plans therefore need to adapt, often to new language, but also to new priorities and objectives. We are nearly 2/3 of the way through our existing 5-year strategy and now need to take stock of developments in the recent period and understand whether this fundamentally alters our focus or serves to sharpen it.

4. National policy developments

The changing external environment in recent times includes a new government, bringing a new health secretary with a new mandate for change. The initial approach was the Darzi report that assessed the current state of the NHS and provided ideas about how to improve.

The national response to this report was the NHS 10-year Plan. We have since outlined our response to the Medium-Term Planning Framework which has a focus on constitutional standards, financial 'reset' and reform. In February 2026 the National Cancer Plan was published.



The plan outlines the themes we have been focused on through our strategy and recognises the growth in demand for cancer services across the board.

In terms of the impact of the new plan on our strategy, we remain focussed on cancer care, on treating people, developing new treatments to deliver constantly improving outcomes for patients alongside educating our staff and patients. We have already evolved our thinking, Neighbourhood Oncology being a current example, but also recognising that to meet some of the digital aspirations we need to do more than is in our current strategy, for example in the development of a new EPR.

Our current strategic framework aligns to the direction outlined in both the 10-year plan and the national cancer plan. The diagram below illustrates how the 3 shifts identified in the 10-year plan relate to some of the projects outlined through our current strategy.

5. Advanced Foundation Trust programme

The NHS 10-year plan set out plans to improve the delivery of health services through a new organisational constructs. The Plan specifically refers to two new changes, Advanced Foundation Trusts (AFT) and Integrated Healthcare Organisations (IHO).

Advanced Foundation Trust status is awarded to high performing NHS Foundation Trusts and Trusts. It is designed to reward such organisations with greater freedom to act, greater control e.g. over financial matters and lighter touch regulatory oversight; the status is initially expected to remain for 5 years. The policy intent is to 'reinvigorate the original Foundation Trust model' in which a rules-based approach to regulation was in place and organisations were 'rewarded' with greater autonomy.

As a currently high performing Trust (NHS Oversight Framework 1 Q1 and Q2), green rated Provider Capability Assessment, and CQC Good rating, applying to become an Advanced Foundation Trust is a logical step for the organisation to take.

6. Developing a specialist cancer IHO

Becoming an AFT is a requirement before holding an IHO contract. The aim of developing an Integrated Healthcare Organisation (IHO) is to improve outcomes for the people served. For cancer patients in Greater Manchester, this approach would help us:

- **Detect cancer earlier**, for example by rolling out targeted Lung Screening faster than the national 10-year cancer plan.
- **Diagnose patients more quickly**, through wider use of straight-to-test pathways in primary care, reducing delays and anxiety.
- **Bring care closer to home**, by expanding Neighbourhood Oncology, supporting people to access specialist input where they live.
- Over time, reduce health inequalities by focusing on the specific needs of our local population.

An IHO is a way for the NHS to organise care such that a provider takes responsibility for improving the health of a defined population. In this model:

- The ICB acts as the strategic commissioner, setting overall goals.
- The Advanced Foundation Trust (AFT) holds the contract and is accountable for improving outcomes, coordinating care, and managing resources.

These wider opportunities will undoubtedly inform the development of the next iteration of the Trust Strategy.

7. Recommendation

The board of directors are asked to note the update on the current strategy and national policy context that will inform the next iteration of the Trust Strategy.

Agenda Item 09/26a(i)

Meeting of the Board of Directors
Thursday 26 March 2026

Subject / Title	Workforce Assurance Committee report – January 2026
Author(s)	Jo D'Arcy, Assistant Company Secretary Amanda Oates, Committee Chair
Presented by	Amanda Oates, Committee Chair
Summary / purpose of paper (alert / advise / assure)	This paper provides the Board with a AAA summary of the items considered by the Workforce Assurance Committee at their November meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions required.
Background papers / sources of assurance	Workforce Assurance Committee papers – 22 January 2026
EDI impact / considerations	While no direct EDI impacts were identified, the committee noted several areas with positive and emerging EDI relevance. The Christie @ Oldham service demonstrated exemplary inclusive community engagement and strong staff wellbeing and development practices, and the Committee commended the organisation's ongoing work to stand against racism and antisemitism. Potential EDI considerations were also noted in relation to equitable access to learning and development opportunities, particularly given apprenticeship levy changes, and in the need to monitor PDR and training compliance to ensure consistency across all staff groups. These themes do not require escalation but represent opportunities to strengthen future workforce assurance through enhanced EDI-sensitive workforce analysis.
Link to: ➢ Board Assurance Framework ➢ Trust strategy ➢ Corporate objectives ➢ CQC Quality standard ➢ Regulation	• Board Assurance Framework – Risks 3, 4 and 12 • Corporate objective 4 - to be an excellent place to work and attract the best staff • CQC Regulations – 9, 10, 12 and 18
Risk score	N/A
Acronyms or abbreviations that appear in the attached paper.	EDI – Equality, Diversity & Inclusion MIAA – Mersey Internal Audit Agency

Agenda Item 09/26a(i)

Meeting of the Board of Directors
Thursday 26 March 2026

Workforce Assurance Committee summary report – January 2026

1 Introduction

The committee took place on 22 January 2026. Quoracy met with 3 of 4 members present, including the Chair. All decisions are valid.

2 AAA summary from committee meeting

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

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

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

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

3 Recommendation

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

Appendix 1

Staff Story - Christie @ Oldham, presentation from Julie Davies, Operational Manager Therapeutic Radiographer

The committee received a comprehensive overview of the well established Christie @ Oldham satellite, which delivers strong clinical services, robust governance links to The Christie, and exemplary community engagement. Communication and staff involvement are well embedded through regular Trust/NCA updates, structured meetings, and appointed champions. Staff engagement, recognition and wellbeing are notable strengths.
The site runs a successful medical student training programme, generating ring fenced educational income that is reinvested directly into staff development, supporting a strong learning culture and good retention. All support staff have completed the Care Certificate.
Community engagement is extensive and longstanding, involving diverse local groups, voluntary initiatives, wellbeing events, and culturally inclusive outreach. The site provides a wide range of patient workshops and supportive services.
Committee members praised the enthusiasm and impact of the work. Sustainability was discussed in light of the current manager's retirement in July; she is embedding processes within the team, though some community work currently relies on her own time.

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

Advise:	Assurance rating (if applicable)
Education six monthly report - KPIs remain in a positive position, with progress continuing on the Care Certificate to achieve required compliance (escalation processes and policies are now in place, with renewed engagement planned through the Chief Nurses' Forum and manager involvement). The committee noted upcoming changes to the apprenticeship levy, including the end of Level 7 funding in December 2025 and the shift of Advanced Practitioner training to NHSE applications, alongside a reduced levy expiry period of 12 months, increasing the risk of lost funds. Both items will be brought back as part of the next six-monthly education report, and overall progress and outstanding actions will be reassessed at the next committee update.	To be agreed at point of next report.
PDR compliance (as part of workforce dashboard) - below target at 87.2%, areas where challenges noted. PDR focused review will come to the June committee meeting and will be looking for support on how to address. Challenge across the NHS noted.	N/A
Role specific training - verbal update to the committee confirmed that the data upload was achieved by the December 2025 deadline. In terms of compliance, this is sitting at around 86%. A further detailed update will come to the committee in March.	N/A

Assure:	BAF reference	CQC reference	Assurance rating
Director of Workforce report – committee members welcomed the report noting the narrative gives a good overview of the work of the team. Report will remain in place.	3, 4, & 12	N/A	N/A
Workforce dashboard – bank and medical metrics measures in a good position, vacancy gap reducing due to active recruitment, mandatory training improving month on month, staff turnover remains at constant level, price cap compliance achieved for the last few months.	3, 4, & 12	18	High

Standing against racism and antisemitism - committee commended the work done to date based on the regional and national call for action from NHSE and noted the importance to continue to utilise the national guidance.	N/A	N/A	High

Risks discussed (including any new risks identified):

- Apprenticeship levy and increased risk to loss of funds discussed.

The following agenda items were also discussed during the meeting:

- Approval of previous minutes and a review of actions
- National job profiles for nursing
- Tackling sexual misconduct in the NHS
- Organisational digital competency strategy
- Board assurance framework (BAF) 2025/26
- Resident doctors oversight group quarterly report
- Committee effectiveness review - notification of requirement
- Internal audit recommendation tracker

Agenda Item 09/26a(ii)

Meeting of the Board of Directors

Thursday 26 March 2026

Subject / Title	Quality Assurance Committee report – January 2026
Author(s)	Jo D'Arcy, Assistant Company Secretary Sarah Corcoran, Committee Chair
Presented by	Sarah Corcoran, Committee Chair
Summary / purpose of paper (alert / advise / assure)	This paper provides the Board with a AAA summary of the items considered by the Quality Assurance Committee at their January meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions required.
Background papers / sources of assurance	Quality Assurance Committee papers – 23 January 2026
EDI impact / considerations	A small number of indirect considerations relating to: • the development of clinical outcomes reporting, • staff experience within accreditation programmes, and • potential equity implications arising from operational pressures linked to demand and capacity. These areas do not require escalation but represent opportunities to strengthen future assurance by incorporating routine EDI-sensitive analysis where appropriate.
Link to: ➢ Board Assurance Framework ➢ Trust strategy ➢ Corporate objectives ➢ CQC Quality standard ➢ Regulation	• Board Assurance Framework – Risks 1, 2, 4 and 7 • Corporate objective 1 - To deliver safe, effective & equitable care • Corporate objective 3 - To provide integrated clinical, research and education services • Corporate objective 5 - To transform our services to improve access and reduce health inequalities • Corporate objective 6 - To provider leadership within the wider NHS cancer system • CQC Regulations – 9, 10, 12, 16 and 20
Risk score	N/A
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	EDI – Equality, Diversity & Inclusion MIAA – Mersey Internal Audit Agency PDR – Performance Development Review

Agenda Item 09/26a(ii)

Meeting of the Board of Directors
Thursday 26 March 2026

Quality Assurance Committee summary report – January 2026

1 Introduction

The committee took place on 23 January 2026. Quoracy met with 2 of 4 members present, including the Chair. All decisions are valid.

2 AAA summary from committee meeting

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

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

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

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

3 Recommendation

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

Appendix 1

Alert	Assurance rating (if applicable)	Action (to be taken)	By Whom	Target Date
Committee informed that report retracted due to an external re-inspection took place on 16 January and the action plan has now been superseded, awaiting the final report.	N/A	Further update will come to the next committee meeting in March.	Director of Pharmacy	March committee meeting

Advise:	Assurance rating (if applicable)
Clinical outcomes annual series bite size report (Melanoma) - committee welcomed the report and agreed a medium level of assurance, recognising the current gaps and the risks associated with producing routine outcome reports. This reflects the committee's present understanding of outcomes and acknowledges that the Trust is the first to undertake this work. Further development is required to define the committee's future reporting requirements, which will be incorporated into the Terms of Reference in due course.	Medium

Assure:	BAF reference	CQC reference	Assurance rating
CODE accreditation/Quality Mark – During 2025, eight inpatient areas achieved Gold accreditation, one achieved Green with reassessment planned for early 2026, and all Quality Mark areas were rated Gold. The programme is underpinned by QI methodology. The introduction of the mini-CODE enables departmental self-assessment, with insights to be included in next year's report. Positive staff feedback on CODE received during the NED visit to Ward 12.	N/A	10, 12	High
Medication safety and medication administration - assurance that progress is continuing. January re-audit identified a small number of outstanding storage issues, which are being addressed through a working group. The committee agreed a medium level of assurance and requested a further update in November.	N/A	N/A	Medium
Learning from deaths – From Q1 and Q2 reviews, majority of deaths assessed as not avoidable, two cases identified as having slight avoidability, and one PSII-related case validated at avoidability level 3 and progressing to inquest; no care scores of 4 or below had been recorded previously. No LeDeR deaths reported. Key advise and assurance points summarised from the report.	N/A	N/A	Strong
VTE assurance - compliance now exceeds the 95% standard. A recent audit identified no harm and noted improvements. The committee supported targeted improvement actions, including reinforcing medical accountability, introducing exception reporting for patients nearing the 14-hour threshold, and refining system-generated compliance flags to reduce false non-compliance. A further update will be brought back in November to confirm implementation and demonstrate the resulting impact.	N/A	N/A	High

Risks discussed (including any new risks identified):

- BAF risk 1 – risk score increased to 12; relates to operational risk of new treatments and trying to accommodate the demand and capacity to deliver, maintaining the risk at present and overseen at Risk & Quality Governance Committee.
- BAF risk 2 – PSIRF progressing and evidence shows this, risk scored at 9 and moving in the right direction. Maturity assessment also in process of review.

The following agenda items were also discussed during the meeting:

- Approval of previous minutes and a review of actions
- PSIRF Lead Investigator experience
- Quality improvement methodology
- Health and safety annual report
- Board assurance framework (BAF) 2025/26
- Internal audit progress report and audit recommendation tracker
- Quality assurance committee effectiveness review - notification

Agenda Item 09/26a(iii)

Meeting of the Board of Directors

Thursday 26 March 2026

Subject / Title	Audit Committee report – February 2026
Author(s)	Jo D'Arcy, Assistant Company Secretary Grenville Page, Committee Chair
Presented by	Grenville Page, Committee Chair
Summary / purpose of paper (alert / advise / assure)	This paper provides the Board with a AAA summary of the items considered by the Audit Committee at their February meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions required.
Background papers / sources of assurance	Audit Committee papers – 19 February 2026
EDI impact / considerations	No direct EDI impact identified; however, several enabling considerations were noted relating to equitable training access, the development of EIA-linked audit work, and ensuring inclusivity within digital, cyber and AI policy activity.
Link to: ➢ Board Assurance Framework ➢ Trust strategy ➢ NHS Oversight Framework ➢ Corporate objectives ➢ CQC Quality standard ➢ Regulation	• Board Assurance Framework – Risks 4,5, 6, 8, 10 and 14 • Corporate objective 1 - To deliver safe, effective & equitable care • NHS Oversight Framework: Finance and Productivity domains • CQC Regulations – 15 and 17
Risk score	N/A
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	EDI – Equality, Diversity & Inclusion MIAA – Mersey Internal Audit Agency PDR – Performance Development Review

Agenda Item 09/26a(iii)

Meeting of the Board of Directors

Thursday 26 March 2026

Audit Committee summary report – February 2026

1 Introduction

The committee took place on 19 February 2026. Quoracy met with 2 of 4 members present, including the Chair. All decisions are valid.

2 AAA summary from committee meeting

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

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

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

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

3 Recommendation

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

Appendix 1

Alert	Assurance rating (if applicable)	Action (to be taken)	By Whom	Target Date
Medical Devices Training – internal audit report received limited assurance. Report to be discussed in detail at Workforce Assurance Committee in March.	N/A	Update requested on progress of actions for April Audit Committee.	Director of Education	April Audit Committee

Advise:	Assurance rating (if applicable)
NHSE National Grip & Control Checklist – red/amber areas: Two red areas; (1) Trust has taken the decision to not do a non-clinical recruitment freeze as this would result in clinicians doing non-clinical work. (2) Estates survey – undergoing review. Amber area themes outlined; controls in place but are being strengthened to ensure they are efficient and effective. Detailed follow up paper due to committee in July.	N/A
Internal audit plan 2026/27 - Two additional reviews added to plan; learning from deaths and waiting list; endorsed by the committee. Scope for EIA/PMO/transformation audit work to be discussed and agreed between MIAA and Executive team; confirmation of inclusion in plan to come to April Audit Committee.	N/A

Assure:	BAF reference	CQC reference	Assurance rating
Digital/Cyber: significant progress on DSPT noted; 2023/24 submission outcome was 'standards exceeded', framework then changed to a cyber based assessment framework for 2024/25, resulting in an assessment of 'approaching standards', which was reported to Audit Committee in July 2025. Improvement plan developed and submitted to NHSE. Actions completed pending MIAA audit review during late February and the outcome will be reported to Audit Committee in July 2026. Risk score reduced from 12 to 9 and expect to close the risk pending the outcome of the audit review. AI policy is a key focus for 2026. Strong risk-based approach to cyber security noted.	4, 8	N/A	Medium
High assurance gained from operational controls noted in the Pharmacy update report.	4	N/A	High
3 internal audit reviews reported with substantial assurance: procurement, key financial systems and health & safety.	N/A	N/A	N/A
Internal audit plan approved in principle and anti-fraud plan approved.	N/A	N/A	N/A
Excellent progress noted on closure of audit management actions from internal audit follow up review.	N/A	N/A	N/A
Preparatory work for Annual Report & Accounts and external audit confirmed as on plan.	N/A	N/A	N/A

Risks discussed (including any new risks identified):

- Cyber security risks a focus of discussion during digital update; strong risk-based approach adopted. Data Security & Protection Toolkit compliance - risk score reduced from 12 to 9.
- Space constraints in Pharmacy; ongoing risks relating to bulk storage, cold storage and over labelling space requirements on the risk register and will go to the Trust's Space Utilisation Group at the appropriate time.
- Detailed conversations during the meeting noted on both BAF risks assigned to the committee.
- Supply chain risk has been added to the rolling programme for update to a future committee.

The following agenda items were also discussed during the meeting:

- Approval of previous minutes and a review of actions
- Executive Director of Finance report
- NHS Oversight Framework (NOF) assurance
- Self-assessment of committee effectiveness - notification
- Internal audit progress report
- Internal audit service external quality assessment approach
- Anti-fraud progress report
- External audit plan 2025/26
- NED feedback from department visit to Radiology

Agenda Item 09/26a

Meeting of the Board of Directors
Thursday 26th March 2026

Subject / Title	Senior Management Committee report – February 2026
Author(s)	Louise Westcott, Company Secretary
Presented by	Committee Chair
Summary / purpose of paper	This paper provides the Board with a summary of the items considered by the Senior Management Committee at their February meeting in a triple A format.
Recommendation(s)	To note the report and any actions.
Background papers	Senior Management Committee papers – February 2026
Risk score	Board Assurance Framework (BAF) references noted within the report.
EDI impact / considerations	Ensure governance arrangements provide assurance and appropriate oversight of EDI requirements for the organisation.
Link to: ➢ Trust strategy ➢ Strategic objectives	• Trust's strategic direction • Divisional implementation plans • Our Strategy • Key stakeholder relationships
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	CAG Clinical Advisory Group CQC Care Quality Commission WRES workforce race equality standard WDES workforce disability equality standard EPR electronic patient record PET positron emission tomography BAF Board Assurance Framework EPRR emergency preparedness, resilience & response

Agenda Item 09/26a

Meeting of the Board of Directors
Thursday 26th March 2026

Senior Management Committee Report – February 2026

Items considered were:

- Approval of previous minutes and action log
- Integrated Performance, Quality & Finance Report (IPQFR)
- Escalation from SORs
- Key risk summary and CQC preparedness update
- Clinical Advisory Group update
- Future Christie Programme
- Financial planning update
- Strategy update
- EDS 2026/27 update and recommendation
- Options appraisal for electronic document management systems
- Business cases – EPR OBC; Total Body PET CT Scanner contract award
- Divisional and Subcommittee AAA Reports

ALERT

Cancer Pathway Performance

January performance failed to meet the 62-day standard (target 75%). February shows improvement. Pathways are at or near their capability ceiling, and a step-change will be required to meet 2026/27 standards.
Fundamentals emphasised for focus:

- 7-day booking into clinic
- Daily PTL review
- Strengthened cross-cover arrangements

Digital System Risks

A review of risks relating to digital systems is underway due to increasing performance concerns, including digital dictation issues requiring system upgrade.

Operational Escalations from SORs

Recent escalations included:

- Surgical cancellations and critical care flow issues
- Critical care peer review findings
- Oversight of agency spend and ECAP process
- Early preparatory work for 2026/27 financial recovery and VIP programme

ADVISE

Cancer Pathway Improvement Plan

With performance now plateauing near capability limits, SMC emphasises the need for more assertive operational management and strengthened oversight structures.

Digital Infrastructure

A Trust-wide digital risk review is required at pace to support the EPR programme and mitigate interruptions to operational services.

Document Management
SMC recommends transitioning to a single internal document management system to reduce risk, deliver consistency and support future EPR integration. (Option 2 approved; business case to follow.)

Workforce & Clinical Governance

- Mandatory training remains high overall, but pockets require strengthened governance.
- Anaesthetic workforce pressures being mitigated through recruitment and temporary cover; continued monitoring required.

ASSURE
Strong Governance and Safety Performance

- 94% of risks reviewed on time
- 97% of incidents result in low/no harm
- Pressure ulcer rates remain below trajectory
- Infection control performance stable

Financial Position Remains Strong M10

- £6.29m surplus year-to-date
- £130m cash position
- Low agency spend
- Planned efficiencies of £21m identified towards £25m target; EPR benefits already exceeding early expectations.

Aseptic Services
Risk reduced from 20 to 16; mitigation actions include exploring external contingency options and recommissioning work.

Future Christie Programme

- Recruitment of Chief Data Officer
- External engagement (Accenture) supporting new data platform
- Preparations for EPR integration underway

Pathology & Private Care Partnerships
Improved joint working, preparation for new pathology building, and growth opportunities for private care noted.

APPROVALS
EPR Outline Business Case (OBC) – *Approved by SMC for Board consideration*
Preferred option: Enterprise-level EPR in partnership with GM provider. Procurement route under legal and NHSE review. £24m identified efficiencies (vs £16m target).

Total Body PET CT Scanner Contract Award – *Approved to progress to Board*
Procurement complete; costs within approved capital and revenue business case. Estates work is now the key constraint.

Agenda Item 09/26b

Board of Directors meeting
Thursday 26th March 2026

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

Agenda Item 09/26b

Board of Directors meeting
Thursday 26th March 2026

Board Assurance Framework

1 Introduction

The board assurance framework (BAF) is presented to each Board and assurance committee meeting. The risks identified in the framework relate to achievement of the strategic objectives.

2 Background

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

3 MIAA annual assurance framework review

The annual review was undertaken by MIAA in Q3 and reported in February 2026. The summary opinion is outlined below.

Opinion

Structure	The organisation's AF is structured to meet the NHS requirements of assurance best practice model.
Processes	Processes in place to update the AF are in place led by the Company Secretary.
Objectives	The organisation's objectives were subject to review and update.
Risk Appetite	The organisation considers risk appetite regularly and the risk appetite is used to inform the management of the AF.
Engagement	The AF is visibly used by the organisation
Quality & Alignment	The AF reflects the risks discussed by the Board and its sub committees

There were 4 actions outlined, and responses have been agreed. The first relates to risk appetite and this will be considered alongside the Well-led Review output once received. The other actions cover more detail on actions and timescales, evidence of committee review of BAF risks and strengthening Triple A reports to Board.

4 Updates to risks

All risks in the framework have been reviewed to reflect the current position. Controls, gaps and assurances have been updated. MIAA audit outcomes added as assurance to the applicable risks – financial systems / procurement / health & safety / DPST.

In line with recommendations from the annual MIAA assurance framework review where applicable a timeframe for completion or review of the identified actions has been added.

The following updates have been made to risks -

Risk 1 – New technologies & increased standards of care, risk score reduced from 12 to 6 to reflect implementation of care model to ensure compliance with guidance, systems are in place to assess, manage and implement guidance

Risk 2 – If we do not follow the Patient Safety Incident Response Framework (PSIRF) there is a risk that we will miss opportunities to learn lessons and improve patient safety leading to preventable patient harm – timeframes for implementation of actions added.

Risk 6 – If the changes in the NHSE financial framework do not maintain the level of income needed to support the planned growth in activity there is a risk that we will not be able to provide optimum care – risk score reduced from 16 (4/4) to 8 (2/4) reflecting the signed contract and likelihood of achieving control total.

Risk 10 – If we do not achieve the operational plan and our planned efficiency savings there is a risk that we won't achieve financial balance on NHS activity. Gaps in control added to reflect cost increases as a result of conflicts in the Middle East.

Risk 12 – If we do not maintain levels of staff engagement there is a risk that turnover and sickness absence will increase leading to workforce shortages, poor staff experience and a deterioration in the quality of patient care. Assurance added to reflect Staff Survey 2025 results and actions updated with timeframes.

Risk 13 – If we do not develop transformational capacity & capability, there is a risk that we will not transform services to improve access and reduce health inequalities. Actions updated with timeframes.

Risk 14 – If there are disruptions to the supply of essential products and services for the treatment and care of our patients, there is a risk of service disruption leading to delayed or cancelled care. Full review of risk undertaken of all aspects of the risk in the context of escalated conflict in the Middle East. Risk score increased from 9 (3/3) to 12 (4/3) to reflect overall increase in likelihood of supply being impacted. Review also reflected anticipated cost increases that will impact 2026/27 VIP.

5 Recommendation

The Board are asked;

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

BOARD ASSURANCE FRAMEWORK - OVERVIEW OF RISKS

RISK No.	Risk Title	Risk Description	Responsible Committee	Risk Appetite	Inherant Risk Score	Q4 24/25	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	Target Risk Score	Current Risk Score	Review /Target date
RISK 10	**Financial balance**	If we do not achieve the operational plan and our planned efficiency savings there is a risk that we won't achieve financial balance on NHS activity.	Board of Directors	Averse	25		5	5	15		5	15	**Achieved VIP 25/26** **Current risk relates to VIP 26/27**
RISK 15	**Technological advancements**	If we do not keep pace with technological advancements, there is a risk that we will not provide the best possible experience to our patients and carers	Board of Directors	Cautious	20		12	12	12		4	12	**Reviewed Q4 25/26**
RISK 7	**Ineffective Greater Manchester system-wide cancer pathways**	If diagnostic, MDT and referral processes at local hospitals across the GM system are not efficient there is a risk that we receive patients on 62-day pathways late leading to them not being treated within 62 days.	Quality Assurance Committee	Cautious	25		12	12	12		8	12	**Reviewed Q3 25/26**
RISK 4	**Compliance with regulatory standards**	If we do not continuously review our compliance with the regulatory standards and take corrective action where needed there is a risk that we will fall below required fundamental standards and quality of care will be reduced.	Board of Directors	Averse	15		12	12	12		4	12	**Q1 26/27**
RISK 13	**Transformational capacity & capability**	If we do not develop transformational capacity & capability, there is a risk that we will not transform services to improve access and reduce health inequalities	Board of Directors	Cautious	20		12	12	12		8	12	**Reviewed Q4 25/26**
RISK 14	**Supply chain**	If there are disruptions to the supply of essential products and services for the treatment and care of our patients, there is a risk of service disruption leading to delayed or cancelled care.	Audit Committee	Averse	12	9	9	9	9		3	12	**Reviewed Q4 25/26**
RISK 8	**Emergency event**	If there is a serious emergency event (pandemic/cyber-attack/extreme weather event etc) there is a risk of business disruption (increased staff absence, increased patient non-attendance and equipment malfunction) leading to delayed or cancelled care.	Audit Committee	Averse	20	12	10	10	10		5	10	**Review Q3 25/26**
RISK 2	**Learning from patient safety incidents**	If we do not follow the Patient Safety Incident Response Framework (PSIRF) there is a risk that we will miss opportunities to learn lessons and improve patient safety leading to preventable patient harm	Quality Assurance Committee	Averse	15		12	12	9		4	9	**Q4 26/27**
RISK 3	**Recruitment and retention of skilled staff**	If we are unable to maintain current levels of skilled staff there is a risk that they will not have the time or expertise required for excellent care and communication leading to a reduction in the standards of patient safety and experience.	Workforce Assurance Committee	Averse	20		9	9	9		6	9	**Reviewed Q4 25/26**
RISK 6	**NHSE Financial Framework and support for growth**	If the changes in the NHSE financial framework do not maintain the level of income needed to support the planned growth in activity there is a risk that we will not be able to provide optimum care	Board of Directors	Cautious	16		16	16	16		4	8	**Reviewed Q2 25/26**
RISK 12	**Staff engagement**	If we do not maintain levels of staff engagement there is a risk that turnover and sickness absence will increase leading to workforce shortages, poor staff experience and a deterioration in the quality of patient care.	Workforce Assurance Committee	Averse	16		8	8	8		4	8	**Review June 26**
RISK 9	**Integrated research, education & service**	If our research, education and clinical services do not operate as an integrated whole there is a risk that we will not secure the benefits of high-quality research and education on patient care and that this will lead to less-than-optimal quality of care.	Board of Directors	Averse	12	8	8	8	8		4	8	**Reviewed Q4 25/26**
RISK 1	**New technologies and increased standards of care**	If there are changes to NICE guidance or other advances in practice that we have not anticipated (diagnostic, therapeutic, care) there is a risk that there will be a delay in their introduction leading to a delay in patients obtaining the benefits of new treatments.	Quality Assurance Committee	Cautious	20	6	6	6	12		4	6	**Review Q4 25/26**
RISK 5	**Capital funding**	If we don't receive adequate CDEL there is a risk that we won't deliver the planned improvements resulting in delays in providing the best possible environment & equipment to provide care	Board of Directors	Eager	15		5	5	5		5	5	**Reviewed Q3 25/26 / Within tolerance**

RISK 1	New technologies and increased standards of care	Date Risk Opened	Current Risk Score
Description	**If there are changes to NICE guidance or other advances in practice that we have not anticipated (diagnostic, therapeutic, care) there is a risk that there will be a delay in their introduction leading to a delay in patients obtaining the benefits of new treatments.**	Apr-24	6
		Date of Last Review	
		Mar-26	
Associated Strategic Objectives	To deliver safe, effective & equitable care	Executive Lead	Exec Medical Director
		Responsible Committee	**Quality Assurance Committee**
		Assurance Level	Medium
		Risk Appetite	Cautious

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date
Actions	Annual planning process with divisions. The trust has a risk-based process with divisional support to assess applicability and implement relevant guidance. Guidance that is not resolved or on the risk register is monitored and escalated if there are issues Model for delivery of upcoming NICE guidance established and in place	Uncertainty around what / when. External factors. Issue with breast cancer treatment - scale of impact	Level 1 – Data and management reports • Review of NICE guidelines through risk-based process with divisional support • risk register in place.□ Level 2 – Management team and committee scrutiny • Review NICE guidelines compliance through QAC and monthly IPQFR□ Level 3 – External assurances • NICE□	None identified	None identified	Review Q4 25/26

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	4	20	2	3	6	2	3	6	4	3	12			0	2	2	4

RISK 2	Learning from patient safety incidents	Date Risk Opened	Current Risk Score
Description	**If we do not follow the Patient Safety Incident Response Framework (PSIRF) there is a risk that we will miss opportunities to learn lessons and improve patient safety leading to preventable patient harm**	Jun-25	9
		Date of Last	
		Mar-26	
Associated Strategic Objectives	To deliver safe, effective & equitable care	Executive Lead	Exec Chief Nurse
		Responsible Committee	**Quality Assurance Committee**
		Assurance Level	Medium
		Risk Appetite	Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	The Trust has undertaken external training for the patient safety strategy covering all components of the patient safety strategy. The patient safety team have/ will continue to host training for incident handlers to ensure management of incidents across teams is standardised. Improvement workstreams have been established to implement recommendations following the publication of learning responses. Review through Patient Safety & Experience Committee and Risk & Quality Governance. Introduction of new DATIX system	New ways of working require new skills across the organisation and resource at a team level to manage incidents.	Level 1 – Data and management reports • PSIRF reports to Patient Safety Committee / Risk & Quality Governance / Senior Management Committee • ERG□ Level 2 – Management team and committee scrutiny • Review compliance through patient safety reports to QAC□ Level 3 – External assurances • MIAA review of PSIRF processes confirms substantial assurance • Updates presented to ICB • MIAA Health & Saftey - substantial assurance	Embed quality improvement methodology across the Trust	Embed agreed Quality Improvement methodology across the Trust by Q4 26/27	Q4 26/27

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	3	5	15	3	4	12	3	4	12	3	3	9			0	2	2	4

RISK 3	Recruitment and retention of skilled staff	Date Risk Opened	Current Risk Score
Description	**If we are unable to maintain current levels of skilled staff there is a risk that they will not have the time or expertise required for excellent care and communication leading to a reduction in the standards of patient safety and experience.**	Apr-24 Date of Last Mar-26	**9**
Associated Strategic Objectives	To deliver safe, effective & equitable care To deliver excellent financial and operational performance To be an excellent place to work and attract the best staff	Executive Lead	Workforce Director
		Responsible Committee	**Workforce Assurance Committee**
		Assurance Level	High
		Risk Appetite	Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	Staffing levels maintained through coordinated and risk based utilisation of bank and agency Christie People and Culture Plan 2023-26 Quarterly oversight of Trust wide vacancies and recruitment activity presented to the workforce committee & WAC Divisional oversight of recruitment activity and vacancies discussed at the monthly service review meetings Turnover analysis and 'next chapter' data presented and discussed six monthly at the workforce committee Robust sickness absence management and health and wellbeing offer Connect & reflect sessions in place for new starters within first 3 months of employment Weekly executive led vacancy management panel in place Recruitment of onboarding coordinator Nursing workforce lead appointed Completion and reporting to WAC of progress against the 10 point plan to improve resident doctors lives.	National staff shortages impacting recruitment.	Level 1 – Data and management reports • Divisional oversight of recruitment through Service & Operatonal Review meetings Level 2 – Management team and committee scrutiny • Review compliance through WAC People & Culture plan updates and update on compliance with CQC regulation • F&PP Compliance report to WAC / Board • Safe staffing 6 monthly reviews to external standard Level 3 – External assurances • National staff survey • CQC Inpatient survey • OECI accreditation • MIAA Bank & Admin audit - Moderate assurance	None identified	None identified	Reviewed Q4 25/26

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	5	**20**	3	3	**9**	3	3	**9**	3	3	**9**			**0**	2	3	**6**

RISK 4	Compliance with regulatory standards	Date Risk Opened	Current Risk Score
Description	**If we do not continuously review our compliance with the regulatory standards and take corrective action where needed there is a risk that we will fall below required fundamental standards and quality of care will be reduced.**	Jun-25 Date of Last Mar-26	**12**
Associated Strategic Objectives	To deliver safe, effective & equitable care To deliver excellent financial and operational performance To be an excellent place to work and attract the best staff	Executive Lead	Exec Chief Nurse
		Responsible Committee	**Board of Directors**
		Assurance Level	Medium
		Risk Appetite	Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	Self assessments underway against 2022 must do actions and well-led quality indicators. Attendance at CQC briefings / NHS Providers briefings Engagement in national updates and regulatory briefings. Designated leads for statutory requirements across the Trust reporting into committee structure. Policies and procedures in place e.g. conflicts of interest, SFI's, Document ratification processes. Membership of NHS Providers to recieve most up to date advice and guidence. Exec Team engagement in national briefings. Close working with regulators, GM ICS / ICB and NHSE. Attendance at system level and national meetings. Leads identified internally for each statutatory requirement e.g. health & safety / IRMER / CQC etc Excellence in action programme underway.	External political factors	Level 1 – Data and management reports • Self assessment against 2022 Must Do's • Self assessment against Well Led / Safety quality indicators Level 2 – Management team and committee scrutiny • QAC /WAC review of CQC regulations - all on rolling programmes • Board level training on new CQC assessment framework Feb 24 • Board reporting on regulatory changes • Work of the 3 assurance committees • Board capbility self-assessment Level 3 – External assurances • CQC Inspection Reports (IR(M)ER) • NOF Rating 1 (Q1 rated 3/134 acute & specialist trusts) • MIAA role specific training audit (CQC Reg 19) - Limited assurance Oct 24 • MIAA data quality audit Oct 24 - moderate assurance • OECI accreditation • MIAA Medical devices Training - limited assurance • MIAA Key Financial systems - substantial assurance • MIAA Health & Safety - substantial assurance	External well-led review (underway, will report Q1 26/27)	Plan in development for full review of all domains (1 per quarter) Actions relating to role specific training data reporting and compliance - reporting to WAC March 26	Q1 26/27

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	3	**15**	4	3	**12**	4	3	**12**	4	3	**12**			**0**	4	1	**4**

RISK 5	Capital funding	Date Risk Opened	Current Risk Score
Description	**If we don't receive adequate CDEL there is a risk that we won't deliver the planned improvements resulting in delays in providing the best possible environment & equipment to provide care**	Jun-25	5
		Date of Last	
		Mar-26	
Associated Strategic Objectives	To deliver excellent financial and operational performance	Executive Lead	Exec Director of Finance
		Responsible	**Board of Directors**
		Assurance Level	High
		Risk Appetite	Eager

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	Financial planning includes utilisation of 'capital freedoms' (CDEL) to increase the CDEL allocation to deliver our plan. Capital planning is part of our planning process and based on risk assessment within divisions. NHSE rules for 26/27 allow greater freedom with CDEL / capital spend	National / local funding rules / arrangements.	Level 1 – Data and management reports • Monthly finance reports Level 2 – Management team and committee scrutiny • summary of progress with capital plan/strategy implementation at Board / Planning Days • Regular reporting to Senior Management Committee & Board of Directors Level 3 – External assurances • ICB allocation - maximum capital freedoms	None identified	None identified	Reviewed Q3 25/26 / Within tolerance

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	3	5	15	1	5	5	1	5	5	1	5	5			0	1	5	5

RISK 6	NHSE Financial Framework and support for growth	Date Risk Opened	Current Risk Score
Description	**If the changes in the NHSE financial framework do not maintain the level of income needed to support the planned growth in activity there is a risk that we will not be able to provide optimum care**	Jun-25	8
		Date of Last	
		Mar-26	
Associated Strategic Objectives	To deliver excellent financial and operational performance	Executive Lead	Exec Director of Finance
		Responsible	**Board of Directors**
		Assurance Level	High
		Risk Appetite	Cautious

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	Senior team attendance at national and regional meetings to keep updated on policy changes and influence discussions on cancer. Monthly service & operational reviews to ensure efficient delivery of service. Board member attendance at national events to influence policy. 2026/27 contract signed	External political factors	Level 1 – Data and management reports • SOR's • Divisional Boards reports Level 2 – Management team and committee scrutiny • SMC reporting Level 3 – External assurances • External Audit VfM assessment • Signed contract for 26/27 in line with activity • MIAA Key Financial systems - substantial assurance	None identified	Continued attendance at regional & national events and on going discussions with ICB to understand funding	Reviewed Q2 25/26

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	4	16	4	4	16	4	4	16	4	4	16			0	1	4	4

RISK 7	Ineffective Greater Manchester system-wide cancer pathways	Date Risk Opened	Current Risk Score
Description	**If diagnostic, MDT and referral processes at local hospitals across the GM system are not efficient there is a risk that we receive patients on 62-day pathways late leading to them not being treated within 62 days.**	Apr-24	12
		Date of Last	
		Mar-26	
Associated Strategic Objectives	To deliver safe, effective & equitable care To deliver excellent financial and operational performance	Executive Lead	Chief Operating Officer
		Responsible	**Quality Assurance**
		Assurance Level	Medium
		Risk Appetite	Cautious

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	Executive led monthly divisional performance review meetings. Integrated performance & quality report to Management Board and Board of Directors monthly. Weekly performance reporting via trust operational group. Escalation internally & across GM of delays impacting waiting time targets. Monitoring cancer waiting time standards through GM Cancer & IPQFR.	NHS pressures leading to delays in referrals from other Trusts	Level 1 – Data and management reports • 62 / 31 / 24 day reports to Senior Management Committee and Board • Service & Operational Review feedback Level 2 – Management team and committee scrutiny • 6 monthly review by QAC Level 3 – External assurances • MIAA review of 62 days / Cancer Alliance	Evidence of progress in underperforming parts of the pathway	Pathway improvement workstream in GM Cancer - reporting on progress 6 monthly to QAC	Reviewed Q3 25/26

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	5	25	4	3	12	4	3	12	4	3	12			0	4	2	8

RISK 8	**Emergency event**	Date Risk Opened	Current Risk Score
		Apr-24	
Description	**If there is a serious emergency event (pandemic/cyber-attack/extreme weather event etc) there is a risk of business disruption (increased staff absence, increased patient non-attendance and equipment malfunction) leading to delayed or cancelled care.**	Date of Last	**10**
		Mar-26	
Associated Strategic Objectives	To maintain excellent operational, quality and financial performance.	Executive Lead	Chief Operating Officer
		Responsible	**Audit Committee**
		Assurance Level	Medium
		Risk Appetite	Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	No ability to reduce likelihood as an organisation, however we do have an Annual Assurance process that is externally reviewed to develop our Statement of Compliance Adaptations to existing buildings / equipment to manage temperature rises. GM approach. Business Continuity Plans (BCP) - regularly tested and reviewed Extreme weather plan approved & published on intranet Data Security and Protection Toolkit submissions with audits undertaken. Digital board reporting. Board level Senior Information Risk Owner in place. Reviews of risk registers, alerts, reports, actions and observations MIAA audit - Data Protection Toolkit (DPST) 2024/25 approaching standards (new assessment) - improvement plan submitted to NHSE, actions completed (pendng MIAA audit review) - report to July Audit Committee.	The Trust does not currently have cyber security insurance.	Level 1 – Data and management reports • SDMP compliance • BCP compliance and effectiveness • Approved Extreme weather plan • Regular updates from NHS Digital - Vulnerability Monitoring Service Level 2 – Management team and committee scrutiny • Emergency Planning & Resilience Committee - reporting of regular testing of BCP's • Quarterly Net Zero and Climate Adaptation Committee (NZACAC) advises Executive Director • Annual SDMP report to MB and BoD (Assurance Scrutiny by Quality Assurance Committee) • Statutory disclosures in Trust Annual Report • Reports to Senior Management Comittee and Audit Committee • Annual Assurance Report and Statement of Compliance- substantial compliance Level 3 – External assurances • Internal audit of compliance with NHS requirements • NHSE review of plans and progress - agreement of current compliance (as in self-assessment) • MIAA Data Protection Toolkit assessment (DPST) - Substantial assurance July 2024 / approaching standards for 2024/5 (new assessment)	Not at 100% compliance for self-assessment / external assessment	Developing methodology to assess carbon footprint in collaboration with other Trusts Developing a CC Adaptation plan in development for future developments	Review Q3 25/26

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	4	**20**	5	2	**10**	5	2	**10**	5	2	**10**			**0**	5	1	**5**

RISK 9	**Integrated research, education & service**	Date Risk Opened	Current Risk Score
		Jun-25	
Description	**If our research, education and clinical services do not operate as an integrated whole there is a risk that we will not secure the benefits of high-quality research and education on patient care and that this will lead to less-than-optimal quality of care.**	Date of Last	**8**
		Mar-26	
Associated Strategic Objectives	To provide integrated clinical, research and education services	Executive Lead	Chief Executive Officer
		Responsible	**Board of Directors**
		Assurance Level	High
		Risk Appetite	Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	Research / Education / CODU plans all approved and being monitored through divisional boards and SMC OECI accreditation achieved and reported to Board Business case for expansion of CRF approved at January 2026 Board.		Level 1 – Data and management reports • Divisional Board reports Level 2 – Management team and committee scrutiny • Regular reports on progress to Board and assurance committees Level 3 – External assurances • OECI accreditation	None identified	None identified		Reviewed Q4 25/26

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	3	4	**12**	2	4	**8**	2	4	**8**	2	4	**8**			**0**	1	4	**4**

RISK 10	**Financial balance**	Date Risk Opened	Current Risk Score
Description	**If we do not achieve the operational plan and our planned efficiency savings there is a risk that we won't achieve financial balance on NHS activity.**	Apr-24	15
		Date of Last	
		Mar-26	
Associated Strategic Objectives	To maintain excellent operational, quality and financial performance.	Executive Lead	Exec Director of Finance
		Responsible	**Board of Directors**
		Assurance Level	High
		Risk Appetite	Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	Activity plans agreed with Divisions and progress monitored weekly at TOG and monthly at Senior Management Committee. Variable income performance tracked as part of month end financial position and reviewed in the clinical Divisions monthly financial meetings. Development of mitigating strategies including efficiency and transformational programmes. Identification and consideration of new models of working to deliver and finance the Trust's strategic plan. Agreed governance of VIP schemes and escalating VIP reporting and responsibility to SMC. VIP delivery at a divisional level monitored via the Trusts Service Operational Review framework Board has recieved monthly financial report showing performance 2025/26 VIP achieved from month 6 - focus on 2026/27 Prices locked in for gas / electricity prior to escalations in Middle East resulting in control of price for 80% of power requirement.	Commissioning intentions. Funding growth. Impact of cost increases (power/medicines etc) as a result of global factors (war in Middle East)	Level 1 – Data and management reports • Monthly Divisional scrutiny of financial position • Trust Operation Group (TOG) review weekly Level 2 – Management team and committee scrutiny • Reports to Senior Management Committee, Audit Committee and Board of Directors Level 3 – External assurances • MIAA review of financial systems • External audit of Annual Accounts • MIAA review of VIP programme • MIAA Key Financial systems - substantial assurance	None identified	Complete Quality Impact Assessments for all identified schemes as they arise	Achieved VIP 25/26 Current risk relates to VIP 26/27

	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
Scoring	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	5	25	1	5	5	1	5	5	3	5	15			0	1	5	5

RISK 12	**Staff engagement**	Date Risk Opened	Current Risk Score
Description	**If we do not maintain levels of staff engagement there is a risk that turnover and sickness absence will increase leading to workforce shortages, poor staff experience and a deterioration in the quality of patient care.**	Jun-25	8
		Date of Last	
		Mar-26	
Associated Strategic Objectives	To be an excellent place to work and attract the best staff	Executive Lead	Director of Workforce
		Responsible	**Workforce Assurance**
		Assurance Level	Medium
		Risk Appetite	Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	Inclusive Culture Strategy developed through extensive engagement with staff and approved by Board. Board responsibilities outlined. Service & Operational reviews include 'people & culture' focus for all divisions. Progress reports to WAC. Divisions report staff engagement activity / priorities to Workforce Committee on rolling programme Workforce Assurance committee recieve regular presentations from divisions on cultural activities. Strategic Leaders Forum - scheduled across the year Divisional plans in place for events and meetings across the year	None identified	Level 1 – Data and management reports • Divisional action plans from staff survey • Service & operational reviews Level 2 – Management team and committee scrutiny • Reporting to Workforce Committee, Workforce Assurance Committee and Board of Directors • Board development session on Inclusive Culture facilitated by NHS Providers expert Sept 2024 • Board approved Inclusive Culture Plan Nov 2024 Level 3 – External assurances • Annual CQC Staff Survey 2024 / 2025	None identified	Implementation of next phase of People & Culture Plan - reporting to WAC June 2026	Review June 26

	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
Scoring	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	4	16	2	4	8	2	4	8	2	4	8			0	2	2	4

RISK 13	Transformational capacity & capability	Date Risk Opened	Current Risk Score
Description	**If we do not develop transformational capacity & capability, there is a risk that we will not transform services to improve access and reduce health inequalities**	Jun-25	12
		Date of Last	
		Mar-26	
Associated Strategic Objectives	To transform our services to improve access and reduce health inequalities	Executive Lead	Dir of Future Christie
		Responsible Committee	**Board of Directors**
		Assurance Level	Medium
		Risk Appetite	Cautious

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	Future Christie Director and Medical Director in place. Director of Transformation appointed. Service Planning day with senior leadership team. Communication plan with wider organisation commenced. Alignment of Digital & Transformation under Future Christie. Year 1 objectives on track for delivery - patient portal / expanded AI / EPR outline case / staff engagement	None identified	Level 1 – Data and management reports • Exec review weekly Level 2 – Management team and committee scrutiny • Monthly to SMC and Board • Board approved EPR OBC Level 3 – External assurances • Deloitte engaged in options appraial for new EPR • MIAA Key Financial systems - substantial assurance	External assessment of capability and readiness to be developed	Year 1 objectives on track for delivery - patient portal / expanded AI / EPR outline case / staff engagement	Reviewed Q4 25/26

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	4	20	3	4	12	3	4	12	3	4	12			0	2	4	8

RISK 14	Supply chain	Date Risk Opened	Current Risk Score
Description	**If there are disruptions to the supply of essential products and services for the treatment and care of our patients, there is a risk of service disruption leading to delayed or cancelled care.**	Nov-24	12
		Date of Last	
		Mar-26	
Associated Strategic Objectives	To deliver safe, effective & equitable care To deliver excellent financial and operational performance	Executive Lead	Chief Operating Officer
		Responsible Committee	**Audit Committee**
		Assurance Level	Medium
		Risk Appetite	Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	Pharmacy - TCP procurement team work closely with regional & national drug procurement teams. Mutual aid MOU in place in NW. Management with clinicians to avoid imapct on care Medical Physics - close relationship with national supply chains and management of demand based on availability of radioactive materials. BCP in place for Radiopharmacy to maintain supplies and regular discussions with supplier of FDG for the PETCT scanner. Procurement - policies & processes in place for management of supplies incl escalations & triggers / communication.	National / international shortages / supply issues	Level 1 – Data and management reports • Regular reports to relevant committee • Monitoring & review by management team Level 2 – Management team and committee scrutiny • Reports to The Christie Pharmacy Company Board and Audit Committee, via Trust Drug & Therapeutics Committee • Esclations from Risk & Quality Governance to Senior Management Committee Level 3 – External assurances • MIAA audits commissioned to review specific issues where appropriate	None identified	Continuous review of alerts March 2026 - Comprehensive review undertaken of all aspects of supply chain risk in the context of escalated conflict in the Middle East	Reviewed Q4 25/26

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	3	4	12	3	3	9	3	3	9	3	3	9			0	3	1	3

RISK 15	Technological advancements	Date Risk	Current Risk Score
Description	**If we do not keep pace with technological advancements, there is a risk that we will not provide the best possible experience to our patients and carers**	Jun-25	12
		Date of Last	
		Mar-26	
Associated Strategic Objectives	To transform our services to improve access and reduce health inequalities	Executive Lead	Dir of Future Christie
		Responsible Committee	**Board of Directors**
		Assurance Level	Medium
		Risk Appetite	Cautious

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	Future Christie team leading service change ambitions incorporating technological advances with partners. Engaging with other health providers around effective systems on the market. Development of strategic outline case for new EPR Year 1 objectives on track for delivery - patient portal / expanded AI / EPR outline case / staff engagement	Recognition of fast moving market	Level 1 – Data and management reports • reports to Board of Directors Level 2 – Management team and committee scrutiny • Execs, SMC and Board reports Level 3 – External assurances • Deliotte engaged in options appraial for new EPR • OECI accreditation	Development of full business cases	EPR business case to Board July 2026. Seeking expertise internally & externally around best option - 'expert customer'	Reviewed Q4 25/26

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	4	20	3	4	12	3	4	12	3	4	12			0	1	4	4

Agenda item 09/26c

Meeting of the Board of Directors
Thursday 26th March 2026

Subject / Title	Annual board reporting cycle 2026/27
Author(s)	Louise Westcott, Company Secretary
Presented by	Chief Executive Officer
Summary / purpose of paper	To summarise the Board of Director's month by month strategic and regulatory requirements / priorities for 2025/26
Recommendation(s)	To approve the annual board reporting cycle 2026/27
Background papers	Annual board reporting cycle 2025/26
Risk score	N/A
EDI impact / considerations	Governance, reporting and assurance cycles may support EDI oversight elsewhere
Link to: ➢ Trust strategy ➢ Corporate objectives ➢ CQC Quality standard ➢ Regulation	All corporate objectives NHSEI Code of Governance
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.	CoG – council of governors CQC - Care Quality Commission FPPT – fit and proper persons test SO – standing orders SFI – standing financial instructions

Agenda item 09/26c

Meeting of the Board of Directors

Thursday 26th March 2026

Annual board reporting cycle 2026/27

1. Introduction

The annual board reporting cycle 2026/27 is based on the Intelligent Board format which has been used as the basis for the board reporting cycle since The Christie NHS Foundation Trust was authorised in April 2007.

The reporting cycle presents a framework for our board governance requirements and is updated annually to reflect any changes made to reporting deadlines.

It outlines key strategic and regulatory requirements by month and is not an exhaustive list of the matters to be assessed by Board.

2. Recommendation

The board is asked to approve the annual board reporting cycle 2026/27.

Annual board reporting cycle 2026/27

Apr 2026 – Sep 2026

Item	April 2026	May 2026	June 2026	July 2026	Aug 2026	Sept 2026
***Integrated performance report – quality accounts (patient experience, clinical effectiveness and patient safety), strategy, finance, efficiency, workforce, access and targets, research and development and additional reports**	✓	By email	✓	By email	By email	✓
Strategic planning:						
5-year strategy				Planning Day		
Corporate plan and objectives 2025/26	Brought forward to Jan 25					
Board Assurance Framework	✓		✓			✓
Finance & investment	✓	By email	✓	By email		✓
Financial plans – revenue and capital	✓ **(subject to receipt of guidance)**					
Regulatory requirements:						
Annual compliance - CQC regulations & key lines of enquiry	Declaration					
Annual reports from audit & governance committees	Draft		Approve			
Annual Governance Statement	Draft		Approve			
Annual report, financial statements and quality accounts	Draft		Approve			
Statement on code of governance	Draft		Approve			
Letter of representation & independence						
FPPT compliance report						
Board development / time out days		Exec development session Set July agenda		Service reviews / Update on 5-year strategy		? additional development day
Other Items	Registers of approvals Register of sealings Approve SOs and SFIs (after approval by audit) Modern slavery statement		Review Board effectiveness			Approve changes to SFI's

Annual board reporting cycle: Oct 2026 – Mar 2027

Item	October 2026	Nov 2026	Dec 2026	Jan 2027	Feb 2027	March 2027
*Integrated performance report – quality accounts (patient experience, clinical effectiveness and patient safety), strategy, finance, efficiency, workforce, access and targets, research and development and additional reports	✓	✓	By email	✓	By email	✓
Strategic and annual items:						
5-year strategy		✓				Reported in corporate objectives
Corporate plan and objectives		Interim review				Approve next year's
Board Assurance Framework	✓	✓		✓		Approve next year's
Finance & investment	✓	✓		✓		✓
Financial plans – revenue and capital					Review this year plans Draft plans- revenue & capital (Board time out)	First draft for next year
Regulatory requirements:						
Annual compliance- CQC regulations & key lines of enquiry						
Annual reports from audit & governance committees						
Annual Governance Statement						
Annual report, financial statements and quality accounts						
Statement on code of governance						
Letter of representation & independence / Register of Interests					Directors to sign	
FPPT compliance report					Circulate papers	✓
Board development / time out days	Set joint board / CoG agenda		Approve annual plan / Joint meeting with CoG		Review revenue & capital plans Board Development	
Other Items						Review annual reporting cycle

Agenda Item 09/26d/e

Board of Directors meeting

Thursday 26th March 2026

Subject / Title	Code of Conduct for directors & employees (Management of Conflicts of Interest) Fit & Proper Person's Test Policy
Author(s)	Louise Westcott, Company Secretary
Presented by	Louise Westcott, Company Secretary
Summary / purpose of paper	The Board is the responsible committee of both the Code of Conduct for directors and employees (Management of Conflicts of Interest) and the Fit & Proper Persons Policy. Updates have been made to the policies to reflect the updated Trust template and reference to the new Failure to Prevent Fraud requirements. Further information has also been added to the Code of Conduct around consultancy & advisory payments.
Recommendation(s)	The Board are asked; • To note the changes and updates made to the policies • Approve the updated policies for ratification and publication.
Background papers	NHS England » Managing conflicts of interest in the NHS NHS England » NHS England fit and proper person test framework for board members
Risk score	BAF risk 3 / 4 / 12
Link to: ➢ Trust strategy ➢ Strategic objectives	• Trust's strategic direction • Divisional implementation plans • Our Strategy • Key stakeholder relationships
Acronyms or abbreviations where they appear in the attached paper.	FPPT fit and proper person test

CODE OF CONDUCT FOR DIRECTORS AND EMPLOYEES (Management of Conflicts of Interest)

Document reference:	M2	Version:	V11.1
Document owner:	Chief Executive Officer	Document author:	Company Secretary
Accountable committee:	Senior Management Committee	Date approved:	20 April 2023
Ratified by:	Document Ratification Committee	Date ratified:	14 November 2024
Date issued:	14 November 2024	Review date:	20 April 2028
Target audience:	All Trust employees and non-executive directors	Equality impact assessment:	July 2017

Key points

- Adhering to this policy will help to ensure that we use NHS money wisely, providing best value for taxpayers and accountability to our patients for the decisions we take.
- This gives a code of conduct for all staff and non-executives of the organisation and guidance around conflicts of interest
- This policy gives guidance on duties of staff and non-executives in relation to national legislation
- The policy gives specific guidance on acceptance of gifts and hospitality, appropriate use of the register of interests, donations, commercial sponsorship, outside employment, shareholdings, patents, loyalty interests, private practice and inspection visits.

CONTENTS

CODE OF CONDUCT FOR DIRECTORS AND EMPLOYEES 11
CONTENTS 12
1. ASSOCIATED DOCUMENTS 13
2. INTRODUCTION 13
2.1 Statement of intent 13
2.2 Purpose 13
2.3 Scope 15
3. DEFINITIONS 16
4. DUTIES 16
4.1 Chief executive 16
4.2 Senior managers 16
4.3 The Company Secretary 17
4.4 Committees in level of hierarchy 17
5. DECISION MAKING STAFF 17
6. IDENTIFICATION, DECLARATION AND REVIEW OF INTERESTS 18
6.1 Identification & declaration of interests (including gifts and hospitality) 18
6.2 Proactive review of interests 18
7. RECORDS AND PUBLICATION 18
7.1 Maintenance 18
7.2 Publication 18
8. WIDER TRANSPARENCY INITIATIVES 19
9. MANAGEMENT OF INTERESTS – GENERAL 19
10. MANAGEMENT OF INTERESTS – COMMON SITUATIONS 19
10.1 Gifts 19
10.2 Hospitality 20
10.3 Outside Employment 21
10.4 Consultancy & Advisory Payments 21
10.5 Shareholdings and other ownership issues 22
10.6 Patents 22
10.7 Loyalty interests 23
10.8 Donations 23
10.9 Commercial Sponsorship 24
10.9.1 General Sponsorship 24
10.9.2 Sponsored events 24
10.9.3 Sponsored research 25
10.9.4 Sponsored posts 26
10.10 Clinical private practice 26
11. MANAGEMENT OF INTERESTS – ADVICE IN SPECIFIC CONTEXTS 27
11.1 Managing Conflicts of Interest at Meetings 27
11.2 Strategic decision-making groups 28
11.3 Procurement 28
12. DEALING WITH BREACHES 29
12.1 Identifying and reporting breaches 29
12.2 Taking action in response to breaches 29
12.3 Learning and transparency concerning breaches 30
13. LOST PROPERTY 30
14. CONSULTATION PROCESS 30
15. DISSEMINATION, IMPLEMENTATION & TRAINING 30
15.1 Dissemination 30
15.2 Implementation 31
15.3 Training/Awareness 31
16. PROCESS FOR MONITORING EFFECTIVE IMPLEMENTATION 31
17. REFERENCES 31
18. VERSION CONTROL SHEET 33
Appendix 1 34

1. ASSOCIATED DOCUMENTS

Scheme of reservation and delegation of powers
Standing Financial Instructions
Disciplinary Policy
Raising Concerns at Work Policy
Secondary employment policy
Anti-fraud, bribery & corruption policy & response plan

2. INTRODUCTION

2.1 Statement of intent

The Christie NHS Foundation Trust is a public organisation responsible for the care of public funds. Whilst the Trust recognises that staff have a strong commitment to the care of patients and a high sense of propriety in the way that they conduct both their public and private affairs, it is necessary to have a formal Code of Conduct as a guide to all members of the Trust. In line with the Code of Conduct for NHS Managers (Department of Health – October 2002), the Prevention of Corruption Acts of 1909 and 1916 and the Bribery Act 2010, the Trust has produced a "Code of Conduct for Directors and Employees".

2.2 Purpose

As a Foundation Trust, The Christie has greater freedom to manage its affairs. However, this freedom also carries with it responsibilities and certain risks. It is important, therefore, to:-

(i) Remember that the Trust is still responsible for the care and use of public funds.

(ii) Avoid placing the Trust in situations where the conduct of individual members of staff or the Trust as a whole could appear to be compromised.

The Trust recognises that staff have a strong sense of commitment to the care of patients and most have a very high sense of propriety in the way that they conduct both their public and private affairs. Increasingly, however, staff are exposed to contact with outside organisations and individuals where it is normal to give and receive both gifts and hospitality. It is not the Trust's intention to create an environment where staff must refuse all such offers but there is a need for caution. The Code of Conduct is intended to help everyone in the Trust with some of the difficult decisions with which they may be faced, without being over prescriptive. This guidance is intended to supplement the Trust's Standing Orders (SO) and Standing Financial Instructions (SFI).

The Trust and the people who work with and for us, collaborate closely with other organisations, delivering high quality care for our patients. These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely. But there is a risk that conflicts of interest may arise.

Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly, are both key principles in the NHS Constitution. We are committed to maximising our resources for the benefit of the whole community. As an organisation and as individuals, we have a duty to ensure that all our dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that we are using our finite resources in the best interests of patients.

In line with the guidance outlined above, the Trust has produced a "Code of Conduct for Directors and Employees", the main points of which are listed below. Your manager will have access to a copy of the full Code, please bear the following points in mind and, if in any doubt, consult either your manager or the Code. The code applies to all employees of the Trust and Non-Executive

Directors.

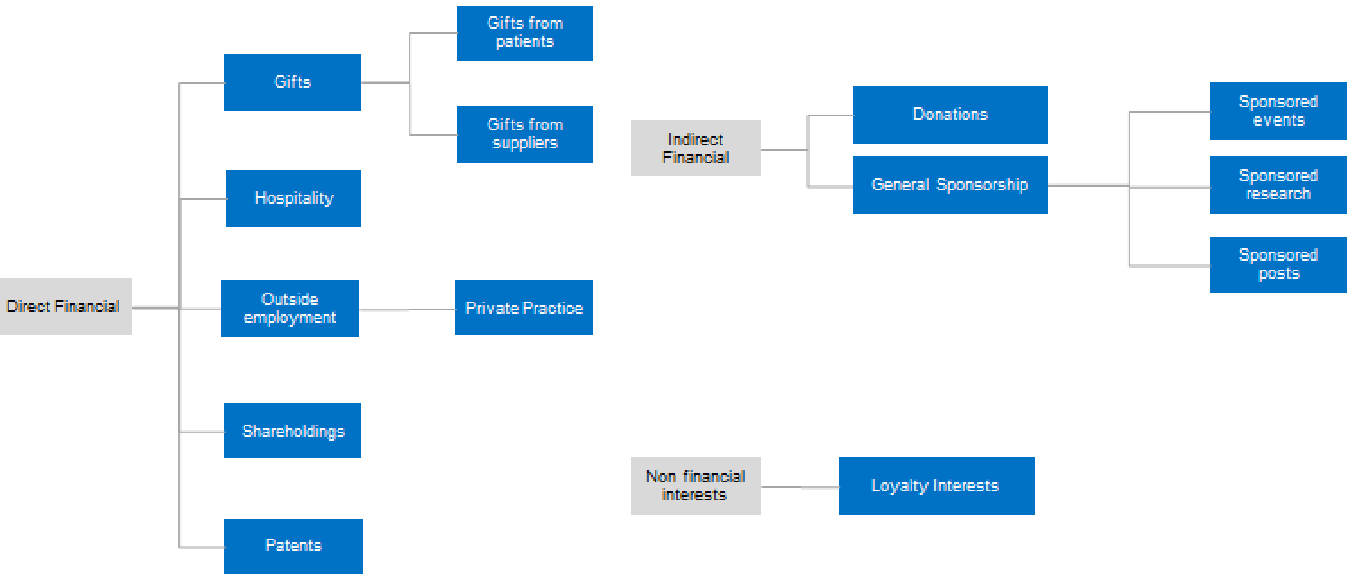
- Make sure that you are not in a position to risk conflict between your official and private position.
- You should act impartially in all your work.
- You must fulfil your contractual obligations to the Trust before embarking on any extra work, paid or otherwise. If you do take on extra work, you must obtain permission from your manager.
- You must not abuse your position to obtain preferential rates for private dealings with firms with which you have official dealings.
- Declare and record financial or personal interest (e.g. company shares, research grant) in any organisation with which you have to deal, and be prepared to withdraw from those dealings if required, thereby ensuring that your professional judgement is not influenced by such considerations; you should not work in a post which may involve a conflict of interest.
- Refuse gifts, benefits, hospitality, or sponsorship of any kind which might reasonably be seen to compromise your personal judgement or integrity and seek to obtain preferential consideration. All such gifts should be returned, and hospitality refused.
- Declare and register gifts, benefits, hospitality or sponsorship of any kind, (provided that they are worth at least £25), whether refused or accepted. In addition, gifts should be declared if several small gifts worth a total of over £100 are received from the same or closely related source in a 12 month period.
- Report any offers of sponsorship that could possibly breach the Code of Conduct to the Board through your appropriate Manager / Executive Director.
- Do not misuse your official position or information acquired in the course of your official duties to further your private interests or those of others.
- You must not make use of, or make known publicly, confidential information that you have gained during the course of your work.
- Beware of bias generated through sponsorship where this might impinge on professional judgement and impartiality.
- Be aware of what would constitute an act of bribery or corruption and of the Trust's commitment to zero tolerance with regard thereto.
- If your duties involve tendering or contracting you must not give unfair advantage to one competitor over another. You must also be careful that your action, or inaction, does not create an impression that you might give such an advantage.
- Ensure professional registration (if applicable) and/or status are not used in the promotion of commercial products or services.
- Neither agree to practice under any conditions which compromise professional independence or judgement, nor impose such conditions on other professionals.

This policy will help our staff manage conflicts of interest risks effectively. It:

- Introduces consistent principles and rules
- Provides simple advice about what to do in common situations.
- Supports good judgement about how to approach and manage interests

As a member of staff you should…	As an organisation we will…
• Familiarise yourself with this policy and follow it. Refer to the guidance for the rationale behind this policy Managing conflicts of interest in the NHS guidance for staff & organisations • Use your common sense and judgement to consider whether the interests you have could affect the way taxpayers' money is spent • Regularly consider what interests you have and declare these as they arise. If in doubt, declare. • **NOT** misuse your position to further your own interests or those close to you • **NOT** be influenced, or give the impression that you have been influenced by outside interests • **NOT** allow outside interests you have to inappropriately affect the decisions you make when using taxpayers' money	• Ensure that this policy and supporting processes are clear and help staff understand what they need to do. • Identify a team or individual with responsibility for: ➢ Keeping this policy under review to ensure they are in line with the guidance. ➢ Providing advice, training and support for staff on how interests should be managed. ➢ Maintaining register(s) of interests. ➢ Auditing this policy and its associated processes and procedures at least once every three years. • **NOT** avoid managing conflicts of interest. • **NOT** interpret this policy in a way which stifles collaboration and innovation with our partners

The following provides some basic subcategories to assist staff with understanding whether a type of interest risks becoming a conflict.



2.3 Scope

The code applies to all employees of the Trust and Non-Executive Directors. This includes;

- All salaried employees
- All prospective employees – who are part-way through recruitment
- Contractors and sub-contractors
- Agency and bank staff; and
- Committee, sub-committee and advisory group members (who may not be directly employed or engaged by the organisation)
- Previous employees who become a supplier of the Trust

3. DEFINITIONS

Term	Meaning
Actual conflict of interest	There is a material conflict between one or more interests
Breach	An act of breaking, or failing to observe, a law, agreement or Code of Conduct e.g. failing to disclose a relevant interest
Bribery	Giving someone a financial or other advantage to encourage them to perform their functions or activities improperly or reward them for having done so, for example, payment to manipulate a procurement process
Chief Executive	The person who has delegated responsibility from the Board of Directors for the management of governance arrangements within the Trust, and is ultimately responsible for ensuring that the Trust meets its obligations with regards to the safe and effective delivery of services. This is delegated to responsible individuals within the Trust
Conflict of interest	A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold
Financial interests	Where an individual may get direct financial benefit[1] from the consequences of a decision they are involved in making
Indirect interests	Where an individual has a close association[2] with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making
Non-financial personal interests	Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career
Non-financial professional interests	Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career
Pecuniary	Relating to money
Potential conflict of interest	There is the possibility of a material conflict between one or more interests in the future
Trust	The Christie NHS Foundation Trust

4. DUTIES

4.1 Chief executive

It is a duty of the chief executive to ensure that existing directors and officers, employees and all new appointees are notified of, and understand, their responsibilities in relation to this policy.

4.2 Senior managers

Managers must:-

(i) Ensure that all staff are aware of this guidance.

(ii) Ensure that staff involved in tendering or contracting do not give unfair advantage to one competitor over another or give the impression, by their action or inaction, that they

are giving such an advantage.

(iii) Where staff report possible conflicts of interest, this information must be recorded on The Christie NHS Foundation Trust (mydeclarations.co.uk).

(iv) Ensure that staff are aware that they should report offers of a gift, hospitality and sponsorship. Record such offers in formal records (which will be the subject of review), i.e. The Christie NHS Foundation Trust (mydeclarations.co.uk) .

(v) Where sponsorship is offered by an organisation which may at some time be competing to supply goods or services to the Trust, care should be taken to ensure that the Trust does not appear to be compromised by acceptance of such sponsorship.

(vi) Ensure that staff are aware that they are required to report all outside employment and that they could breach their contract of employment by working for another employer without approval.

(vii) Assess possible conflicts of interest when staff wish to carry out work outside the Trust.

(viii) Take appropriate disciplinary action against employees who fail to declare an interest or are found to have abused their official position.

All members of the board and employees, severally and collectively, are responsible (in line with the Standing Financial Instructions) for:

a) the security of the property of the trust;
b) avoiding loss;
c) exercising economy and efficiency in the use of resources; and
d) conforming to the requirements of the Constitution, SFIs, financial procedures and other financial procedures which the director of finance may issue, that have been agreed by the board and the reservation of powers and detailed scheme of delegation

4.3 The Company Secretary

The Company Secretary is responsible for reviewing the policy and making appropriate updates in line with the review period agreed. The Company Secretary will monitor declarations and check completeness of declarations through the Declare system. The Company Secretary will contact decision making staff from whom declarations or a nil return has not been received by way of an electronic alert. Quarterly cross checks will be undertaken by the Company Secretary against the gifts & hospitality declarations and the list of companies tendering for work.

4.4 Committees in level of hierarchy

The Board of Directors should note the recommendations of the Audit Committee in relation to declarations.

The Audit Committee is responsible for receiving the gifts and hospitality register for noting on a quarterly basis.

Senior Management Committee is the committee responsible for reviewing and approving the policy in line with the agreed approval timeframe.

5. DECISION MAKING STAFF

All staff are asked to make declarations of interest and declare gifts & hospitality; however, some staff are more likely than others to have a decision-making influence on the use of taxpayers' money, because of the requirements of their role. For the purposes of this guidance these people are referred to as 'decision making staff'. These staff are more likely to be at risk of being conflicted & must be particularly aware of the policy.

Decision making staff in this organisation are:

- Executive and non-executive directors
- Members of advisory groups which contribute to direct or delegated decision making on the commissioning or provision of taxpayer funded services
- Those banded at Agenda for Change band 8a and above

- Consultants and other senior medical staff
- Administrative & clinical staff who have the power to enter into contracts on behalf of their organisation
- Administrative & clinical staff involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment, and formulary decisions
- All finance and procurement team staff regardless of banding
- Clinical nurse specialists

6. IDENTIFICATION, DECLARATION AND REVIEW OF INTERESTS

6.1 Identification & declaration of interests (including gifts and hospitality)

All staff should identify and declare material interests at the earliest opportunity (and in any event within 28 days). If staff are in any doubt as to whether an interest is material then they should declare it, so that it can be considered. Declarations should be made:

- On appointment with the organisation.
- When staff move to a new role, or their responsibilities change significantly.
- At the beginning of a new project/piece of work.
- As soon as circumstances change and new interests arise (for instance, in a meeting when interests staff hold are relevant to the matters in discussion).

The system for declarations is a live system. The forms can be accessed via the following link The Christie NHS Foundation Trust (mydeclarations.co.uk) and employees with any such interests should, once reported to their manager, complete the online form. The Company Secretary will monitor the registers and will contact those individuals from whom a form has not been received by way of a reminder email.

The Company Secretary will review the appropriateness of declarations made in liaison with Executive Directors concerned (e.g. the Medical Director in the case of a Consultant's register of interest in a private practice).

This policy provides advice on the type of interests that should be declared and how they should be declared. Further advice is available through the company secretary's office.

After expiry, an interest will remain on register(s) for a minimum of 6 months and a private record of historic interests will be retained for a minimum of 6 years.

6.2 Proactive review of interests

As part of the electronic register a prompt will be sent by email on an annual basis to everyone with an existing declaration (whether it is a declaration or a nil return) to ask them to review their entries and make any necessary updates.

7. RECORDS AND PUBLICATION

7.1 Maintenance

The organisation will maintain a register of all declarations.

7.2 Publication

The Declare system of declarations is live and can be accessed to view through the Trust website The Christie Publication Scheme under Lists & Registers.

If decision making staff have substantial grounds for believing that publication of their interests should not take place then they should contact the Company Secretary's office to explain why. In exceptional circumstances, for instance where publication of information might put a member of

staff at risk of harm, information may be withheld or redacted on public registers. However, this would be the exception and information will not be withheld or redacted merely because of a personal preference.

8. WIDER TRANSPARENCY INITIATIVES

The Christie NHS Foundation Trust fully supports wider transparency initiatives in healthcare, and we encourage staff to engage actively with these.

Relevant staff are strongly encouraged to give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative. These "transfers of value" include payments relating to:

- Speaking at and chairing meetings
- Training services
- Advisory board meetings
- Fees and expenses paid to healthcare professionals
- Sponsorship of attendance at meetings, which includes registration fees and the costs of accommodation and travel, both inside and outside the UK
- Donations, grants and benefits in kind provided to healthcare organisations

Further information about the scheme can be found on the ABPI website:
http://www.abpi.org.uk/our-work/disclosure/about/Pages/default.aspx

9. MANAGEMENT OF INTERESTS – GENERAL

If an interest is declared but there is no risk of a conflict arising, then no action is warranted. However, if a material interest is declared then the general management actions that could be applied include:

- restricting staff involvement in associated discussions and excluding them from decision making
- removing staff from the whole decision-making process
- removing staff responsibility for an entire area of work
- removing staff from their role altogether if they are unable to operate effectively in it because the conflict is so significant

Each case will be different and context-specific, and we will always clarify the circumstances and issues with the individuals involved. Staff should maintain a written audit trail of information considered and actions taken.

Staff who declare material interests should make their line manager or the person(s) they are working to aware of their existence.

10. MANAGEMENT OF INTERESTS – COMMON SITUATIONS

This section sets out the principles and rules to be adopted by staff in common situations, and what information should be declared.

10.1 Gifts

- Staff should not accept gifts that may affect, or be seen to affect, their professional judgement.
- All declarations should be made on the electronic register The Christie NHS Foundation Trust (mydeclarations.co.uk)

Gifts from suppliers or contractors:

- Gifts from suppliers or contractors doing business (or likely to do business) with the organisation should be declined, whatever their value. These offers need to be declared as offered but rejected as they may indicate a pattern of behaviour in respect of a supplier or contractor.

- Low cost branded promotional aids such as pens or post-it notes may, however, be accepted where they are under the value of £6 in total and need not be declared.

Gifts from other sources (e.g. patients, families, service users):

- Gifts of cash and vouchers to individuals should always be declined. The acceptance of monetary gifts is not acceptable in any circumstances.
- Staff should not ask for any gifts.
- Gifts valued at over £50 should be treated with caution and only be accepted on behalf of the Trust not in a personal capacity. These should be declared by staff.
- Donations in cash of any value should be deposited immediately with the Hospital Cashier or with The Christie Charity for payment to the appropriate Charitable Fund. Anyone expressing an interest in making such a payment should be advised to make the cheque payable to The Christie NHS Foundation Trust Charitable Fund. Under no circumstances should cheques be made payable to individuals, wards or departments.
- Modest gifts accepted under a value of £50 do not need to be declared (e.g. chocolates / bottle of wine).
- A common-sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).
- Multiple gifts from the same source over a 12-month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50.

What should be declared:

- Staff name and their role with the organisation.
- A description of the nature and value of the gift, including its source.
- Date of receipt
- Any other relevant information (e.g., circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).
- Whether the gift was accepted / declined.

10.2 Hospitality

- Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement.
- Hospitality must only be accepted when there is a legitimate business reason, and it is proportionate to the nature and purpose of the event.
- Caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. This can be accepted, and must be declared, if modest and reasonable. Senior approval must be obtained. These offers need to be declared as offered but rejected as they may indicate a pattern of behaviour in respect of a supplier or contractor.
- When staff are attending events, either as a speaker or an expert, and receiving speakers' fees or honorarium for speaking / attending, these must be declared.
- All declarations should be made on the electronic register The Christie NHS Foundation Trust (mydeclarations.co.uk)

Meals and refreshments:

- Under a value of £25 - may be accepted and need not be declared.
- Of a value between £25 and £75[4] - may be accepted and must be declared.
- Over a value of £75 - should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept.
- A common-sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or a reasonable estimate).

Travel and accommodation:

- Modest offers to pay some or all the travel and accommodation costs related to attendance at events may be accepted and must be declared.

- Offers which go beyond modest or are of a type that the organisation itself might not usually offer, need approval by senior staff, should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on the organisation's register The Christie NHS Foundation Trust (mydeclarations.co.uk) as to why it was permissible to accept travel and accommodation of this type. A non-exhaustive list of examples includes:
    - offers of business class or first-class travel and accommodation (including domestic travel)
    - offers of foreign travel and accommodation.

What should be declared

- Staff name and their role with the organisation.
- The nature and value of the hospitality including the circumstances.
- Date of receipt.
- Who the hospitality is from (organisation / company)
- Whether the hospitality was for an individual or team. Make it explicit whether the money has been taken as a personal payment or paid into a Trust account for other use. Detail on the use may also be included.
- Any other relevant information (e.g., action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).
- Whether the hospitality was accepted / declined.

10.3 Outside Employment

- Outside employment includes, but is not limited to, paid & unpaid work, consultancy and voluntary work. The Trust policy on secondary employment can be found here; Secondary employment policy
- Trust employees should not engage in outside employment which might adversely affect their ability to perform their normal employment obligations or which conflict, or may be seen to conflict, with their obligations to the Trust.
- Staff should declare any existing outside employment on appointment and any new outside employment when it arises. There is a requirement to do this as part of the personal development review (PDR) process.
- Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks.
- Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from the organisation to engage in outside employment.
- Trust employees must not undertake other paid employment during periods of paid sickness from the Trust.
- Also, except where specific conditions of service allow, private work or lectures to outside organisations should not be undertaken within time contracted to the Trust.
- Any such interests must be declared to the Company secretary on a Register of Interest Form The Christie NHS Foundation Trust (mydeclarations.co.uk).

The organisation may also have legitimate reasons within employment law for knowing about outside employment of staff, even when this does not give rise to risk of a conflict.

What should be declared?

- Staff name and their role with the organisation.
- The nature of the outside employment (e.g. who it is with, a description of duties, time commitment).
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

10.4 Consultancy & Advisory Payments

- All consultancy activity must be declared, irrespective of whether it is undertaken in NHS time or in personal time.
- Where relevant, staff must comply with the ABPI Disclosure UK transparency requirements.

- Staff undertaking consultancy in their own time may not use NHS resources in the delivery of their service.
- Consultants should comply with the requirements in the Consultants Code of Conduct for Private Practice
- Consultancy or advisory work undertaken **during NHS contracted hours** or included within an individual's **agreed job plan** must have all associated fees paid **directly to the Trust**. No payment may be made to the individual.
- When consultancy work is performed during approved annual leave, it is deemed wholly personal. Fees may be paid directly to the individual.
- Consultancy work may be undertaken in personal time if:
    - It is wholly outside NHS working hours
    - No NHS resources or facilities are used
    - It does not conflict with NHS duties
- Personal donations of consultancy income must be voluntary, irrevocable, and not be made with the expectation of later gaining access to said income for personal or departmental benefit.
- Individuals may waive consultancy fees in favour of a charity donation, resulting in a donation being made directly from the external organisation to a charity, noting that donations received through this route must not be made with the expectation of later gaining access to said income for personal or departmental benefit.

10.5 Shareholdings and other ownership issues

- Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the organisation.

Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

- There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

What should be declared?

- Staff name and their role with the organisation.
- Nature of the shareholdings/other ownership interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

10.6 Patents

- Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the organisation.
- Staff should seek prior permission from the organisation before entering into any agreement with bodies regarding product development, research, work on pathways etc, where this impacts on the organisation's own time, or uses its equipment, resources or intellectual property.
- Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

What should be declared

- Staff name and their role with the organisation.
- A description of the patent.
- Relevant dates.
- Other relevant information (e.g., action taken to mitigate against a conflict, details of any

approvals given to depart from the terms of this policy)

10.7 Loyalty interests

Loyalty interests should be declared by staff involved in decision making where they:

- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.
- Sit on advisory groups or other paid or unpaid decision-making forums that can influence how an organisation spends taxpayers' money.
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.
- Are aware that their organisation does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

What should be declared

- Staff name and their role with the organisation.
- Nature of the loyalty interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

10.8 Donations

The NHS has benefitted substantially from donations and the Trust would not wish to discourage donations that improve the service that it provides to its patients. However, there are risksassociated with the acceptance of donations from unsuitable sources or of inappropriate items of equipment. The difficulties in accepting inappropriate donations can take a number of forms and these include:-

(i) The creation of a sense of obligation on the part of either the giver or the recipient.

(ii) The commitment to purchase, servicing, spare parts, refills, etc., from a single source. This may also contravene European Economic Community legislation.

(iii) The appearance of partiality towards the giver, which the acceptance of a gift might imply to a firm's competitors.

(iv) The acceptance of equipment can carry with it revenue costs such as staffing, consumables, accommodation, etc. Where an offer of equipment is received, this should be referred to the Director of Finance and Business Development.

Donations made by suppliers or bodies seeking to do business with the organisation should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.

Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the organisation or is being pursued on behalf of the organisation's own registered charity or other charitable body and is not for their own personal gain.

Staff must obtain permission from the organisation if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the organisation's own.

Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued.

Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

Donations in cash should be deposited immediately with the Hospital Cashier or to The Christie Charity for payment to the appropriate Charitable Fund. Anyone expressing an interest in making such a payment should be advised to make the cheque payable to The Christie NHS Foundation Trust Charitable Fund. Under no circumstances should cheques be made payable to individuals, wards or departments.

What should be declared

- The organisation will maintain records in line with the above principles and rules and relevant obligations under charity law.

10.9 Commercial Sponsorship

10.9.1 General Sponsorship

For this policy, sponsorship is defined as sponsorship offered to individuals and organisations by external parties who may prospectively seek to contract with that individual and organisation in relation to the commissioning or provision of NHS services.

Sponsorship can take different forms. Collaborative partnerships with industry can have several benefits and a transparent approach across the Trust is essential. NHS bodies are accountable for achieving the best possible healthcare within the resources available. However, consideration should be given to the implications of any proposed partnership, its costs and benefits, and an awareness of bias generated through financial contributions from industry, where this might impinge on professional judgement and impartiality. High ethical standards must be adhered to at all times.

Purchasing decisions including those concerning pharmaceuticals and appliances should always be taken based on best clinical practice and value for money. The impact on other parts of the health care system should also be considered. Clinician’s judgement should always be based upon clinical evidence that the product is the best for their patient. Professional registration and/or status should not be used in the promotion of commercial products or services.
It is important to realise that commercial sponsorship is a business arrangement. It is not endorsing a particular product or company but is acknowledging that a particular organisation has provided support.

The Trust would not wish to decline appropriate offers of commercial sponsorship. However, when considering whether offers are appropriate the following conditions should be met:-

(i) The purpose for which the commercial sponsorship is obtained should relate to the activities of, and be of benefit to, the Trust.
(ii) Sponsorship should not be intended to benefit individuals.
(iii) Where sponsorship is given for a course, seminar or conference, a reasonable limitation has been placed on time allocated for recreational purposes.
(iv) Approval should be sought from the Head of Department before sponsorship is accepted.

No information should be supplied to a company for their commercial gain unless there is a clear benefit to the NHS. As a general rule, information which is not in the public domain should not normally be supplied.

The commercial sponsor of an event, post or research etc. should always be clearly identified in the interest of transparency.

The senior individual responsible for arranging the commercial sponsorship is responsible for declaring it.

10.9.2 Sponsored events

- Sponsorship of events by appropriate external bodies will only be approved if a reasonable

person would conclude that the event will result in clear benefit the organisations and the NHS.
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.
- No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.
- At the organisation's discretion, sponsors or their representatives may attend or take part in the event, but they should not have a dominant influence over the content or the main purpose of the event.
- The involvement of a sponsor in an event should always be clearly identified.
- Staff within the organisation involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.
- Staff arranging sponsored events must declare this to the organisation.

What should be declared

- The organisation will maintain records regarding sponsored events in line with the above principles and rules.

10.9.3 Sponsored research

All staff undertaking research must comply with this process.

- Funding sources for research purposes must be transparent.
- Any proposed research must go through the relevant health research authority or other approvals process.
- There must be a written protocol and written contract between staff, the organisation, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services.
- The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service.
- Staff should declare involvement with sponsored research to the organisation.

Where collaborative partnerships involve a pharmaceutical company then the proposed arrangements must comply fully with the Medicines (Advertising) Regulations 1994s (regulation 21 'Inducements and Hospitality' attached at Appendix 1). Any person who contravenes regulation 21(1) is guilty of an offence, and liable, on summary conviction to a fine not exceeding £5000, and on conviction on indictment to a fine or to imprisonment for a term not exceeding two years, or both. Anyone contravening regulation 21(5) is also guilty of an offence and liable on summary conviction to a fine not exceeding £5000.

The Trust undertakes numerous research projects, many of which require commercial sponsorship or commercial support. The Research Division oversees all of these studies, ensuring that they comply with the regulatory requirements for research in the UK and that the funding arrangements comply with the DH Research & Development guidance and are costed accordingly. The Research Division are responsible for checking and authorising all contracts relating to these studies and for maintaining a database of this activity whether commercially sponsored or supported.

Research projects cannot be started until Trust approval has been issued by the Research Division to ensure that all projects meet these standards. All income associated with this work is managed by the Research section of the finance department and reported through the Research Division so that ongoing financial probity is maintained.

What should be declared

- The organisation will retain written records of sponsorship of research, in line with the above principles and rules.
- Staff should declare:
  - their name and their role with the organisation.

- Nature of their involvement in the sponsored research.
- relevant dates.
- Other relevant information (e.g., what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

10.9.4 Sponsored posts

- External sponsorship of a post requires prior approval from the organisation.
- Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and withdraw if appropriate.
- Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise.
- Sponsored post holders must not promote or favour the sponsor's products, and information about alternative products and suppliers should be provided.
- Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

What should be declared

- The organisation will retain written records of sponsorship of posts, in line with the above principles and rules.
- Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this policy.

10.10 Clinical private practice

Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises[5] including:

- Where they practice (name of private facility).
- What they practice (specialty, major procedures).
- When they practice (identified sessions/time commitment).

Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- Seek prior approval of their organisation before taking up private practice.
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.[6]
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf

Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf.

What should be declared

- Staff name and their role with the organisation.
- A description of the nature of the private practice (e.g. what, where and when staff practice, sessional activity, etc).
- Relevant dates.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11. MANAGEMENT OF INTERESTS – ADVICE IN SPECIFIC CONTEXTS

11.1 Managing Conflicts of Interest at Meetings

The chair of a meeting of the Trust's Board or any of its committees or groups has ultimate responsibility for deciding whether there is a conflict of interest and for taking the appropriate course of action to manage the conflict of interest.

If the chair of a meeting has a conflict of interest, the deputy chair is responsible for deciding the appropriate course of action to manage the conflict of interest. If the deputy chair is also conflicted, then the remaining non-conflicted voting members of the meeting should agree between themselves how to manage the conflict(s).

In making such decisions, the chair (or deputy chair or remaining non-conflicted members as above) may wish to consult with the Company Secretary or another member of the Board.

The chair, with support of the Trust's Company Secretary, should proactively consider ahead of meetings what conflicts are likely to arise and how they should be managed, including taking steps to ensure that supporting papers for agenda items of private sessions/meetings are not sent to conflicted individuals in advance of the meeting where relevant.

The chair should ask at the beginning of each meeting if anyone has any conflicts of interest to declare in relation to the business to be transacted at the meeting. Each member of the group should declare any interests which are relevant to the business of the meeting whether or not those interests have previously been declared. Any new interests which are declared at a meeting must be included on the Trust's relevant register of interests to ensure it is up to date.

It is the responsibility of each individual member of the meeting to declare any relevant interests which they may have. However, should the chair or any other member of the meeting be aware of facts or circumstances which may give rise to a conflict of interests, but which have not been declared then they should bring this to the attention of the chair who will decide whether there is a conflict of interest and the appropriate course of action to take in order to manage the conflict of interest.

When a member of the meeting (including the chair or deputy chair) has a conflict of interest in relation to one or more items of business to be transacted at the meeting, the chair (or deputy chair or remaining non-conflicted members where relevant) must decide how to manage the conflict. The appropriate course of action will depend on the circumstances, but could include one or more of the following:

- Where the chair has a conflict of interest, deciding that the deputy chair (or another non-conflicted member of the meeting if the deputy chair is also conflicted) should chair all or part of the meeting;

- Requiring the individual who has a conflict of interest (including the chair or deputy chair if necessary) not to attend the meeting;

- Ensuring that the individual concerned does not receive the supporting papers or minutes of the meeting which relate to the matter(s) which give rise to the conflict;

- Requiring the individual to leave the discussion when the relevant matter(s) are being discussed and when any decisions are being taken in relation to those matter(s). In private meetings, this could include requiring the individual to leave the room and in public meetings to either leave the room or join the public section of the room;

- Allowing the individual to participate in some or all of the discussion when the relevant matter(s) are being discussed but requiring them to leave the meeting when any decisions are being taken in relation to those matter(s). This may be appropriate where, for example, the conflicted individual has important relevant knowledge and experience of the matter(s) under

discussion, which it would be of benefit for the meeting to hear, but this will depend on the nature and extent of the interest which has been declared;

- Noting the interest and ensuring that all attendees are aware of the nature and extent of the interest but allowing the individual to remain and participate in both the discussion and in any decisions. This is only likely to be the appropriate course of action where it is decided that the interest which has been declared is either immaterial or not relevant to the matter(s) under discussion

11.2 Strategic decision-making groups

In common with other NHS bodies the Trust uses a variety of different groups to make key strategic decisions about things such as:

- Entering into (or renewing) large scale contracts.
- Awarding grants
- Making procurement decisions
- Selection of medicines, equipment, and devices

The interests of those who are involved in these groups should be well known so that they can be managed effectively. For this organisation these groups are: Senior Management Committee and The Board of Directors.

These groups should adopt the following principles:

- Chairs should consider any known interests of members in advance and begin each meeting by asking for declaration of relevant material interests.
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.
- Any new interests identified should be added to the organisation's register(s).
- The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that may prejudice their judgement.

If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

- Requiring the member to not attend the meeting.
- Excluding the member from receiving meeting papers relating to their interest.
- Excluding the member from all or part of the relevant discussion and decision.
- Noting the nature and extent of the interest but judging it appropriate to allow the member to remain and participate.
- Removing the member from the group or process altogether.

The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. Good judgement is required to ensure proportionate management of risk.

11.3 Procurement

Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour - which is against the interest of patients and the public.

Those involved in procurement exercises for and on behalf of the organisation should keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process.

The Procurement Conflict of Interest declaration should be completed for all tender processes. This is done through the Trust procurement team.

12. DEALING WITH BREACHES

There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as 'breaches'.

12.1 Identifying and reporting breaches

It is the duty of every Trust employee, Board member, Governor and committee member to speak up about genuine concerns in relation to the administration of this policy on conflicts of interest management, and to report these concerns. These individuals should not ignore their suspicions or investigate themselves, but rather report it to the Company Secretary.

Alternatively concerns can be raised in accordance with the Trust's Raising Concerns at Work Policy or the relevant employer organisation (where the breach is being reported by an employee or worker of another organisation). Further information can also be found in the Anti-fraud, bribery & corruption policy & response plan.

Employees, Board members, governors and committee members should report suspected or known breaches of this policy by contacting the Company Secretary. Reports or concerns can be raised in complete confidence. Anyone who wishes to report a suspected or known breach of the policy, who is not an employee or worker of the Trust, should also ensure that they comply with their own organisation's Raising concerns / whistleblowing policy, since most such policies should provide protection against detriment or dismissal.

Staff who fail to disclose any relevant interests or who otherwise breach an organisation's rules and policies relating to the management of conflicts of interest are subject to investigation and, where appropriate, to disciplinary action.

Breaches of the conflicts of interest element of this policy will be investigated and reported in line with the Trust's Raising Concerns Policy and Disciplinary Policy.

In some instances, breaches of the policy may also equate to criminal offences and the Trust's Anti-Fraud Specialist and other relevant authorities may be notified

The organisation will investigate each reported breach according to its own specific facts and merits and give relevant parties the opportunity to explain and clarify any relevant circumstances.

Following investigation the organisation will:

- Decide if there has been or is potential for a breach and if so what the severity of the breach is.
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum.
- Consider who else inside and outside the organisation should be made aware
- Take appropriate action as set out in the next section.

12.2 Taking action in response to breaches

Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of the organisation and could involve organisational leads for staff support (e.g. Human Resources), fraud, bribery and Corruption (e.g. Anti-Fraud Specialists), members of the senior management committee or executive teams and organisational auditors.

Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures.
- Consideration as to whether HR/employment law/contractual action should be taken against staff or others.

- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Counter Fraud Authority (NHS CFA), the Police, statutory health bodies (such as NHS England, NHS Improvement or the CQC), and/or health professional regulatory bodies.

Inappropriate or ineffective management of interests can have serious implications for the organisation and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the organisation can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes:

- Employment law action against staff, which might include
  - Informal action (such as reprimand or signposting to training and/or guidance).
  - Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal).
- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be.
- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach.
- Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation and the Economic Crime and Corporate Transparency Act 2023 (ECCTA 2023) includes a new corporate fraud offence of 'failure to prevent fraud'.

12.3 Learning and transparency concerning breaches

Reports on breaches, the impact of these, and action taken will be considered by the Board of Directors through the quarterly legal & regulatory report.

To ensure that lessons are learnt and management of interests can continually improve, anonymised information on breaches, the impact of these, and action taken will be prepared as appropriate, or made available for inspection by the public upon request.

13. LOST PROPERTY

Any items of lost property found on the hospital site should be handed in to the security team. The security team will record the details of the lost property including date found, where found and a description of the item. Items must be stored safely, with anything of value placed in the safe in the Finance department and non-valuable items being disposed of after a 3 month period.

If any valuable items of lost property remain unclaimed for over 12 months, they will be disposed of or donated.

14. CONSULTATION PROCESS

Consultation has been undertaken with Executive Directors, General Managers, Finance Department, Workforce Department and Internal Audit. The policy has been approved by the Senior Management Committee and ratified by the Document Ratification Committee.

15. DISSEMINATION, IMPLEMENTATION & TRAINING

15.1 Dissemination

This document has been disseminated by posting the ratified document on the intranet. New

starters' to the trust are made aware of the policy and all staff banded 8a and above receive an email on a quarterly basis reminding them of their duties in relation to the policy.

15.2 Implementation

The Policy will be implemented upon ratification by the Document Ratification Committee.

15.3 Training/Awareness

Divisional Management Teams are responsible for raising awareness of this policy amongst their staff. Trust induction and the essential training programme includes reference to the policy.

16. PROCESS FOR MONITORING EFFECTIVE IMPLEMENTATION

The Company Secretary will monitor the Register of Interests and Gifts and Hospitality register.

The Research & Development Manager holds the database of Commercial Sponsorship relating to Research and Development.

The Chief Executive Officer will have overarching responsibility for monitoring effectiveness of the Policy.

Internal Audit will monitor the effectiveness of the Policy as part of the annual audit cycle.

The Payroll Provider will undertake audits on the effectiveness of the Policy.

The Company Secretary and Human Resources Department will monitor the number of forms that are received from staff that are incomplete and follow these up to ensure completeness.

The Audit Committee will review the gifts and hospitality register on a quarterly basis and report, where necessary, their findings to the Board of Directors.

The Board of Directors should note the recommendations of the Audit Committee in relation to the gifts & hospitality register.

Standard to be monitored	**Process for monitoring** e.g. audit, ongoing evaluation etc	**Frequency** e.g. annually 3 yearly	**Person responsible for:** undertaking monitoring & developing action plans	**Committee accountable for:** review of results, monitoring action plan & implementation	**Frequency of monitoring** e.g. monthly, quarterly
Gifts and hospitality register	Audit and evaluation	Annually	Company secretary / responsible executive director	Review, monitoring and reporting to executive lead	Annually
Register of interests	Review	Annually	Company secretary	Board of Directors	Annually
Code of conduct	Audit	3 yearly	Internal Audit	Audit Committee	Annually
Code of conduct	Audit	3 yearly	Payroll provider	Senior Management Committee	3 yearly
Completion of register of interests forms	Electronic audit	Annually	Company secretary / HR	Board of Directors	Annually

17. REFERENCES

The Christie NHS Foundation Trust Standing Orders (SO) & Standing Financial Instructions (SFI)
Managing Conflicts of Interest in the NHS - Guidance for staff and organisations NHS England Managing conflicts of interest

Prevention of Corruption Acts 1909 and 1916
HSG (93)5 - Standards of Business Conduct for NHS Staff
Commercial Sponsorship - Ethical Standards for the NHS (Department of Health November 2000).
The Data Protection Act 1998.
The Medicines (Advertising) Regulations 1994.
Code of Conduct for NHS Managers (Department of Health – October 2002)
The Bribery Act 2010 http://www.legislation.gov.uk/ukpga/2010/23/contents
The Money Laundering Regulations 2007
CQC Regulation 5: Fit & Proper Persons CQC Regulation-5-fit-and-proper-persons-directors
Consultants Code of Conduct for Private Practice

18. VERSION CONTROL SHEET

Version	Date	Author	Status	Comment
01	01/12	Louise Westcott, Company Secretary	Closed	
01.1	12/12	Louise Westcott Company secretary	Closed	New register of interest form added
02	12/14	Louise Westcott Company secretary	Closed	Updated as a result of internal audit recommendations
03	07/15	Louise Westcott Company secretary	Closed	Removal of register of interest form from appendix. Inclusion of link to electronic register of interest.
04	12/16	Louise Westcott Company Secretary	Closed	Review of policy and appropriate updates made to links and appendices
05	06/17	Louise Westcott Company Secretary	Closed	Policy updated to reflect new guidance from NHS England
06	08/18	Louise Westcott Company Secretary	Closed	Updates links to registers following introduction of new Trust intranet
07	02/20	Louise Westcott Company Secretary	Closed	Updated following review and recommendations from Cath Greenwood, Anti-Fraud Specialist, MIAA
08	04/21	Louise Westcott Company Secretary	Closed	Update to section on declaration of gifts & hospitality (10.2) to clarify what should be declared
09	07/22	Louise Westcott Company Secretary	Closed	Update section 5 to include all finance & procurement team staff as decision makers and 14.1 dissemination to reflect quarterly reminders to staff
10	04/23	Louise Westcott Company Secretary	Review approved at Management Board April 2023 Closed	Updated throughout to reflect new Civica Declare system for making declarations – replacing forms held on the intranet. New link added. Update to decision making staff Update to responsibilities section to reflect change to Civica Declare system Update to reflect values & behaviours (replace Christie commitment)
11	02/24	Louise Westcott Company Secretary	Final	Section on lost property added
11.01	01/26	Paul Kay, Anti-Fraud Specialist	Draft	Section 12.2 – minor amend to include failing to prevent fraud offence
11.01	03/26	Louise Westcott	Final	Updates to committee names / bringing format in line with Trust policy template (removal of EIA / Good Corporate Citizen / Values & Behaviours) / addition of section 10.4 Consultancy & advisory payments

Appendix 1

Extract from the Medicines (Advertising) Regulations 1994

Inducement and hospitality

21 (1) Subject to paragraphs (2) and (4), where relevant medicinal products are being promoted to persons qualified to prescribe or supply relevant medicinal products, no person shall supply, offer or promise to such persons any gift, pecuniary advantage or benefit in kind, unless it is inexpensive and relevant to the practice of medicine or pharmacy.

(2) The provisions of paragraph (1) shall not prevent any person offering hospitality (including the payment of travelling or accommodation expenses) at events for purely professional or scientific purposes to persons qualified to prescribe or supply relevant medicinal products, provided that:-

a) such hospitality is at a reasonable level

b) it is subordinate to the main scientific objective of the meeting

c) it is offered only to health professionals.

(3) Subject to paragraph (4), no person shall offer hospitality (including the payment of travelling or accommodation expenses) at a meeting or event held for the promotion of relevant medicinal products unless:-

a) such hospitality is reasonable in level

b) it is subordinate to the main purpose of the meeting or event

c) the person to whom it is offered is a health professional.

(4) Nothing in this regulation shall affect measures or trade practices relating to prices, margins or discounts which were in existence on 1st January 1993.

(5) No person qualified to prescribe or supply relevant medicinal products shall solicit or accept any gift, pecuniary advantage, benefit in kind, hospitality or sponsorship prohibited by this regulation.

FIT & PROPER PERSONS POLICY

Document reference:	HR69	Version:	V1.3
Document owner:	Company Secretary	Document author:	Company Secretary
Accountable committee:	Board of Directors	Date approved:	21st February 2023
Ratified by:	Document Ratification Committee	Date ratified:	21st April 2023
Date issued:	25th April 2023	Review date:	24th February 2027
Target audience:	Board directors, board members and equivalents, including associate directors and any other individuals who are members of the board, irrespective of their voting rights or if in interim positions.	Equality impact assessment:	5th April 2023

Key points

- To outline the requirements & processes in place to ensure those who have director level responsibility for the quality and safety of care, and for meeting the fundamental standards, comply with the Fit & Proper Persons regulation and are therefore fit and proper to carry out their role.

CONTENTS

Contents

1. ASSOCIATED DOCUMENTS 3
2. INTRODUCTION 3
   2.1 Statement of intent 3
   2.2 Purpose 3
   2.3 Scope 4
3. DEFINITIONS 4
4. DUTIES 4
   4.1 Trust Chair 4
   4.2 Senior Managers and individuals as applicable 5
   4.2.1 Chief Executive 5
   4.2.2 Director of Workforce 5
   4.2.3 Company Secretary 5
   4.3 Committees in level of hierarchy 6
   4.3.1 Board of Directors 6
   4.3.2 Workforce Assurance Committee 6
5. FIT & PROPER PERSONS REGULATION 6
   5.1 Good Character 6
   5.2 Unfit 7
   5.3 Requirement for standard / enhanced DBS check 7
6. PROCEDURE 7
   6.1 New Appointments 7
   6.2 Care Quality Commission (CQC) 8
7. CONSULTATION PROCESS 9
8. DISSEMINATION, IMPLEMENTATION & TRAINING 9
   8.1 Dissemination 9
   8.2 Implementation 9
   8.3 Training/Awareness 9
9. PROCESS FOR MONITORING EFFECTIVE IMPLEMENTATION 9
10. REFERENCES (IF APPLICABLE) 9
11. VERSION CONTROL SHEET 10
12. APPENDICES 11
   Appendix 1: 11
   Appendix 2: 12
   Fit and Proper Person Declaration 12

1. ASSOCIATED DOCUMENTS

- Recruitment and selection policy and procedure
- Disciplinary Policy
- Code of Conduct (Management of Conflicts of Interest)

2. INTRODUCTION

2.1 Statement of intent

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 5 recommends that a statutory Fit and Proper Person's Requirement (FPPR) be imposed on health service bodies. This policy outlines the application of this test for new appointments and existing post holders. In addition, where the Trust engages an interim at a senior level equivalent to the posts in Section 2.6, the same process and FPPR test will apply if they are employed or registered as an external worker.

2.2 Purpose

The purpose of this policy is to ensure the Trust complies with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 5: Fit and Proper Persons Requirement.

The regulations have been integrated into the Care Quality Commission's (CQC's) registration requirements and falls within the remit of their regulatory inspection approach.

2.3 Scope

This policy and procedure apply to all board appointments i.e., executive and non-executive directors and those other directors who are recognised as part of the Trust board. This includes permanent, interim and associate positions whether employed or registered as an external worker.

The following posts are subject to the arrangements outlined in this policy:

a) the Chair of the Trust;
b) Non-Executive Directors appointed to the Board of Directors (including Associate Non-Executive Directors);
c) the Chief Executive of the Trust,
d) Executive Directors who can vote at the Board of Directors,
e) non-voting Directors who attend the Board of Directors.

3. DEFINITIONS

Term	Meaning
Chief Executive	The person who has delegated responsibility from the Board of Directors for the management of governance arrangements within the Trust and is ultimately responsible for ensuring that the Trust meets its obligations with regards to the safe and effective delivery of services. This is delegated to responsible Indivi"uals'within the Trust.
Trust Chair	Chairs the Board of Directors and Council of Governors. The chair has an ambassadorial role, as well as encompassing leadership, strategy, independent oversight and assurance.
Executive Director	Very senior manager, employee and member of the Board of Directors. Have legal responsibilities to The Christie as a Director. The Board of Directors is collectively responsible for promoting the success of The Christie and supervising The Christie's affairs.
Non-Executive Director	Member of the Board of Directors. Have the same general legal responsibilities to The Christie as any other Director. The Board of Directors is collectively responsible for promoting the success of The Christie and supervising The Christie's affairs.
Trust	The Christie NHS Foundation Trust
Fit & Proper Person	As defined by Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (see section 5 for full details)
Regulated activity	The regulated activities of an NHS organisation are detailed in the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. Each organisation have their regulated activities described in their CQC registration.

4. DUTIES

4.1 Trust Chair

The Trust Chair will confirm to the CQC that the fitness of all new Executive and Non-Executive Directors, Non-Board Directors including Associate and Deputy Directors has been assessed in line with the Fit and Proper requirements under the Health and Social Care Act 2008 (Regulated Activities) Regulations and that they are satisfied that they are fit and proper individuals for that role.

The Trust Chair will be assured by the Company Secretary that all Non-Executive Directors meet the definition of the Fit and Proper Persons requirements under the Health and Social Care Act 2008 (Regulated Activities) Regulations and act as necessary and proportionate to ensure that the position in question is held by an individual who meets such requirement. Where the individual is a health care professional, social worker or other professional and during their tenure they become 'unfit' the Chair will be responsible for ensuring that the regulator is notified.

4.2 Senior Managers and individuals as applicable

4.2.1 Chief Executive

The Chief Executive will be assured by the Director of Workforce that all Executive and Non-Board Directors including Associate and Deputy Directors meet the definition of the Fit and Proper Persons requirement under the Health and Social Care Act 2008 (Regulated Activities) Regulations and act as necessary and proportionate to ensure that the position in question is held by an individual who meets such requirement.

Where the individual is a health care professional, social worker or other professional and during their tenure they become 'unfit' the Chief Executive will be responsible for ensuring that the regulator is notified.

4.2.2 Director of Workforce

The Director of Workforce will be responsible for ensuring that all recruitment and selection processes to Executive and Non-Board Directors including Associate and Deputy Directors positions and subsequent recruitment checks comply with the Fit and Proper Persons requirements under the Health and Social Care Act 2008 (Regulated Activities) Regulations.

The Director of Workforce will be responsible for ensuring that all Executive and Non-Board Directors including Associate and Deputy Directors complete a Fit and Proper Persons self-declaration at commencement of employment and annually thereafter.

The Director of Workforce will advise on the process where an Executive or Non-Board Directors including Associate and Deputy Directors is deemed unfit- this will ordinarily result in the Disciplinary Policy being applied.

4.2.3 Company Secretary

The Company Secretary will be responsible for ensuring that all recruitment and selection processes to Non- Executive Director positions and subsequent recruitment processes comply with the Fit and Proper Persons requirements under the Health and Social Care Act 2008 (Regulated Activities) Regulations.

The Company Secretary will ensure that annual declarations are completed and stored appropriately.

The Company Secretary will hold evidence relating to the fit & proper persons regulation on all relevant individuals and ensure that this is available for inspection by the CQC when required.

4.2.4 Board Director & Non-Board Directors including Associate & Deputy Directors

All Board and Non-Board Directors including Associate and Deputy Directors positions will complete a Fit and Proper Persons self- declaration at appointment and annually thereafter.

All Board Directors and Non-Board Directors including Associate and Deputy Directors are required to declare to their line manager and to the Director of Workforce (for Executives/Non-Board Directors including Associate and Deputy Directors) and Company Secretary (for Non-Executives) should they, prior to the commencement of their appointment or during the course of their employment/ tenure, become 'unfit'.

4.3 Committees in level of hierarchy

4.3.1 Board of Directors
Board of Directors are responsible for approval of the policy in line with the review date.

4.3.2 Workforce Assurance Committee
The Committee are responsible for receiving assurance on compliance with this policy annually.

5. FIT & PROPER PERSONS REGULATION
Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (referred to as the 2014 Regulations) places a duty on NHS providers not to appoint a person, or allow a person to continue to be, an Executive Director or equivalent or a Non-Executive Director under given circumstances. This means Executive/Non-Executives should not be appointed/continue to hold office unless they:

a) are of good character
b) hold the required qualifications and have the competence, skills and experience required for the relevant office for which they are employed
c) are, by reason of their physical and mental health, after any reasonable adjustments if required, capable of properly performing their work
d) can supply relevant information as required by schedule 3 of the act, i.e. documentation to support the FPPR
e) have not been responsible for or privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying out regulated activity (or providing a service elsewhere which if provided in England would be a regulated activity).

5.1 Good Character
When assessing a person being 'of good character' NHS providers are required to take account of Schedule 4 of the 2014 Regulations, namely:

a) whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence, and
b) whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

The CQC's definition of good character is not the objective test of having no criminal convictions but instead rests upon a judgement as to whether the person's character is such that they can be relied upon to do the right thing under all circumstances.

The CQC names the following as features 'normally associated' with good character that should be taken into account when applying FPPR to an individual, in addition to those specified in part 2 of schedule 4:

- Honesty
- Trustworthiness
- Integrity
- Openness
- Ability to comply with the law
- A person in whom the public can have confidence in prior employment history, including reason for leaving
- If the individual has been subject to any investigations or proceedings by a professional or regulation body
- Any breaches of the The Seven Principles of Public Life (Nolan Principles)
- Any breaches of the duties imposed on directors under the Companies Act
- The extent to which the director has been open and honest with the Trust

- Any other information which may be relevant, such as disciplinary action taken by an employer.

An individual subject, has a continuing obligation to inform the Trust of any investigation into their conduct by the police, professional body or similar, " including Fraud Act 2006, Bribery Act 2010 and the new corporate offence of 'failure to prevent fraud' contained within The Economic Crime and Corporate Transparency Act 2023 (ECCTA 2023)"

5.2 Unfit

Under Schedule 4 part 1 of the regulations, Executive/Non-Executive Directors are deemed 'unfit' and prevented from holding the office and for whom there is no discretion if:

a) the person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged
b) the person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland
c) the person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40)
d) the person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it
e) the person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006 (legislation.gov.uk)
f) the person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

5.3 Requirement for standard / enhanced DBS check

In January 2018 the CQC issued revised guidance for providers and CQC inspectors in respect of Regulation 5 of the 2014 Regulations. Specifically, the CQC made a minor change to its guidance to make it explicit that they expect providers to undertake an "enhanced Disclosure and Barring Service (DBS) check for directors to check that they are not on the children's and / or safeguarding barred list where they meet the eligibility criteria". However, Executive/Non-Executive Directors are only eligible for such an enhanced DBS check if the role that they take falls within the definition of a "regulated activity" as defined by the Safeguarding Vulnerable Groups Act 2006.

Only those Board members who are required to undertake regulated activities will be required to have an Enhanced DBS check. Where a role does not undertake regulated activity, a standard DBS check will be required. However, all Board members will be required to make a declaration annually that they meet the FPPR.

6. PROCEDURE

6.1 New Appointments

Where a post is subject to FPPR, candidates will be notified as part of the Trust's recruitment process. It is important when making appointments that consideration is given to the values of the organisation and the extent to which the candidate fits with these values. It is therefore expected that the interview process will incorporate values-based questions.

Where an interim is sourced by an agency the recruitment agency will be made aware of the FPPR process and must confirm that they have undertaken the necessary checks.

Executive search companies will also be required to confirm compliance with the FPPR and provide relevant evidence for inspection by the Trust. This should include a web search of the individual including Google, social media and news searches.

The Trust's comprehensive pre-employment checking processes are determined by the NHS

employment standards and include the following:

1. Proof of identity / address
2. Evidence of the right to work in the UK
3. Disclosure and Barring Service (DBS) check as relevant to the role
4. Occupational Health Clearance as relevant to the role
5. Evidence of a values-based interview process
6. Proof of qualifications/professional registration applicable to role
7. A check of employment history. Specifically, this includes validating a minimum of three years continuous employment including details of any gaps in service.
8. Two references one of which must be the most recent employer. References must question whether the candidate has "been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or providing a service elsewhere which, if provided in England, would be a regulated activity"

In addition, the following registers will be checked:

a) Disqualified directors
b) Bankruptcy and insolvency

The Chair will be responsible for ensuring compliance supported by the Workforce Team. A sign off form will be completed at appointment and will be retained on the post holder's personal file for the purposes of audit (Appendix 1).

The FPPR requires new employees to complete a Fit and Proper Person's Declaration form (Appendix 2) on appointment and then annually. This form will be included with the application pack and form part of the application process for the position.

Where specific qualifications are deemed by the Trust as necessary for a role, the Trust will make this clear and will only appoint those individuals that meet the required specification; including any requirements to be registered with a professional body.

Where the Trust considers that an individual can be appointed to a role based on their qualification, skills and experience but there is an expectation that they will be required to develop specific competencies to undertake the role within a specified timescale, any such discussions or recommendations will be recorded in minutes of the Nominations Committee for Non-Executive Director appointments or for other Board appointments where confirmation of appointment is discussed.

If the candidate has a disability, wherever possible, reasonable adjustments will be made to enable the individual to carry out the role that they have been appointed to. Any discussion or decision as to whether a candidate is appointable on grounds of health will be recorded in the minutes of relevant Nominations Committee.

The Council of Governors is responsible for the appointment and removal of the Chair and the Non-Executive Directors, drawing on the recommendations of the Council of Governors Nominations Committee. In respect of Executive Directors, this responsibility will be discharged by the Board of Directors.

6.2 Care Quality Commission (CQC)

The CQC will cross-check notifications about new Directors against other information that they hold or have access to, to decide whether the Trust should look further into the individual's fitness. The CQC will also have regard to any other information that they hold or obtain about Directors, in line with current legislation on when convictions, bankruptcies or similar matters are to be considered 'spent'.

Where a director is associated with serious misconduct or responsibility for failure in a previous role, the CQC will have regard to the seriousness of the failure, how it was managed, and the individual's role within that. There is no time limit for considering such misconduct or responsibility.

Where any concerns about an existing Director come to the attention of the CQC, they may also ask the Trust to provide the same assurances.

Should the CQC use their enforcement powers to ensure that all Board Directors are fit and proper for their role, they will do this by imposing conditions on the Trust's registration to ensure that the Trust takes the appropriate action to remove the Board Director.

7. CONSULTATION PROCESS

Consultation has been undertaken with staff side representatives and the Director of Workforce as well as MIAA as internal auditors. A check is undertaken against the content of this policy against a checklist developed by MIAA and this is assessed through the Audit Committee. Comparison has also been done with other Trust Fit & Proper Person Policies. The policy has been approved by Staff Forum and ratified by the Document Ratification Committee.

8. DISSEMINATION, IMPLEMENTATION & TRAINING

8.1 Dissemination

This document has been disseminated by posting the ratified document on the intranet and shared with the Workforce Team for inclusion in their raft of policies.

8.2 Implementation

The Policy will be implemented upon ratification by the Document Ratification Committee.

8.3 Training/Awareness

The policy will be owned and updated by the Company Secretary and Director of Workforce and used in all Board level and very senior manager recruitment. The responsible committee is the Staff Forum.

9. PROCESS FOR MONITORING EFFECTIVE IMPLEMENTATION

Compliance with the policy will be monitored through annual audit by the Company Secretary's office and reported through the Audit Committee against MIAA's checklist. Evidence is maintained in personnel files for inspection by the CQC.

10. REFERENCES (IF APPLICABLE)

- Health and Care Act 2022 (legislation.gov.uk)
- Care Act 2014 (legislation.gov.uk)
- Companies Act 2006 (legislation.gov.uk)
- Companies Act 2006 (legislation.gov.uk)
- Employment standards and regulation | NHS Employers
- Safeguarding Vulnerable Groups Act 2006 (legislation.gov.uk)
- Standards of conduct, performance and ethics | (hcpc-uk.org)
- Principles in practice – Committee on Standards in Public Life (blog.gov.uk)
- CQC regulation-5-fit-proper-persons-directors

11. VERSION CONTROL SHEET

Version	Date	Author	Status	Comment
1.0	December 2022	Louise Westcott Company Secretary	Closed	Feedback from parent committee and document ratification committee (DRC) reflected in final version
1.1	November 2024	DRC Team	Closed	Amend accountable committee to Board of Directors, from Staff Forum.
1.2	December 2024	Louise Westcott	Final	Amend accountable committee from Staff Forum to Board of Directors, and oversight committee from Audit Committee to Workforce Assurance Committee.
1.3	January 2026	Pay Kay, Anti-Fraud Specialist (AFS)	Draft	Minor amend to section 5.1 to include information on failure to prevent fraud
1.3	March 2026	Louise Westcott	Final	Updates to remove sections not in Trust policy template (EIA / Good Corporate Citizen / The Christie Commitment)

12. APPENDICES

Appendix 1:

Board of Directors' recruitment
Chairman sign off form

Recruiter (delete as appropriate)	Nominations committee	NED led interview panel

SUCCESSFUL CANDIDATE

Name of Candidate:			
Job Title:			
Line Manager:			
Start Date			
Salary:		Hours:	
Permanent / Fixed Term:		Fixed Term End Date:	
Appropriate additional approvals received (non-executives only)		Date:	
All pre-employment checks complete (see attached checklist)			

Name:			
Title:	Chair		
Signature:		Date:	

Appendix 2:

Fit and Proper Person Declaration

In line with the requirement for Directors of an NHS Foundation Trust to be a fit and proper person, I hereby declare

Declaration	Confirmed
I am of good character by virtue of the following:	
• I have not been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence	
• I have not been erased, removed or struck-off a register of professionals maintained by a regulator of health or social care.	
• I have not been sentenced to imprisonment for three months or more within the last five years	
• I am not an undischarged bankrupt	
• I am not the subject of a bankruptcy order or an interim bankruptcy order	
• I do not have an undischarged arrangement with creditors	
• I am not included on any barring list preventing them from working with children or vulnerable adults	
I have the qualifications, skills and experience necessary for the position I hold on the Board	
I am capable of undertaking the relevant position, after any reasonable adjustments under the Equality Act 2010	
I have not been responsible for any misconduct or mismanagement in the course of any employment with a CQC registered provider	
I am not prohibited from holding the relevant position under any other law. e.g. under the Companies Act or the Charities Act.	

Signed	
Name	
Position	
Date	

Agenda item 09/26f

Meeting of the Board of Directors

Thursday 26th March 2026

Subject / Title	Fit & Proper Person Test Annual Compliance Report 2025/26
Author(s)	Louise Westcott, Company Secretary
Presented by	Louise Westcott, Company Secretary
Summary / purpose of paper	This paper provides an annual update in relation to compliance with the requirements of the NHS England Fit and Proper Persons Test Framework 2023.
Recommendation(s) (**assure** / alert / advise)	It is recommended that: • the Chair signs off that the relevant directors are fit and proper for 2025/26 by the end of March 2026 and that this is recorded in ESR; and • the Annual NHS FPPT submission reporting template is completed and returned to NHSE to reflect compliance.
Background papers / source of assurance	The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 5: Fit and Proper Persons Requirement NHS England Fit and Proper Person Test Framework for board members
Risk score / BAF reference	8 (2/4)
EDI impact / considerations	All Board members / regular attendees at Board are assessed in the same way and against the same set of standards in line with the framework. Protected characteristics do not impact the way these standards are applied.
Link to: ➢ Trust strategy ➢ Corporate objectives ➢ CQC Quality standard ➢ Regulation	➢ Trust Strategy ➢ Corporate objective 7 – To be an excellent place to work and attract the best staff ➢ NHS England Fit and Proper Persons Test Framework 2023 ➢ CQC Regulation 5
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.	FPPT – Fit and Proper Persons Test BMR – Board Member Reference ESR – Electronic Staff Record MIAA – Mersey Internal Audit Agency NHSE – NHS England ICB – Integrated Care Board ALB – Arm's Length Bodies

Agenda item 09/26f

Meeting of the Board of Directors

Thursday 26th March 2026

Fit & Proper Person Test Annual Compliance Report 2025/26

1. Introduction

NHS England (NHSE) published a Fit and Proper Persons Test (FPPT) Framework (the Framework) on 2nd August 2023 alongside guidance for chairs and relevant staff on implementation. A directory of board level learning and development opportunities was published at the same time. NHSE set out elements of the framework to be used from 30th September 2023 with full implementation by 31st March 2024. The Trust complied with this requirement and continues to monitor and comply on an ongoing basis.

The Framework introduced new and more comprehensive requirements around board appointments and annual review and supports transparency. This included the introduction of a new standardised board member reference (BMR) which should be created whenever a board member leaves an NHS organisation, regardless of whether they are moving immediately to another NHS role and should be sought by employing NHS organisations when making a job offer.

New requirements were also introduced to require data fields to be populated within the Electronic Staff Record (ESR) related to FPPT checks and references. This provides a standard way to record and report compliance internally. Retrospective population of data was not required. Hard copy files are still required.

2. Fit and Proper Persons Test Framework

The Fit and Proper Persons Test Framework and assessment includes all **current** elements relating to CQC Regulation 5: fit and proper persons: directors along with the following additional elements relating to recommendations made by Tom Kark KC in his review of the Fit and Proper Person Test, all of which were incorporated into the review of the Trust's Fit and Proper Persons Policy approved in September 2023:

- The NHS Leadership Competency Framework (LCF) – used as part of board member appraisals
- FPPT fields in NHS Electronic Staff Record (ESR) to record testing
- A Board Member Reference (BMR)
- Extending the scope to include Integrated Care Boards (ICB) and some Arm's Length Bodies (ALB) – *not applicable to us*
- Clear statement of accountability of chairs in implementing the Framework in their organisations

The FPPT Framework brings together:

- the FPPT assessment at recruitment, annual review and at any time that new information relevant to FPPT becomes available
- learning and development offers and a standard set of competencies with minimum levels expected for board members
- appraisal process for board members

- specific reference requirements for board members (the Board Member Reference - BMR)

3. Changes to the Board of Directors during 2025/26

During 2025/26, 2 non-executive directors have left the Board of Directors (including the Chair) and two new non-executive directors have joined the Board of Directors. A new Chair has been appointed. An interim director has also joined the Board. The FFPT requirements have been followed for all posts.

4. Compliance statement

Since the introduction of the F&PPT Framework in August 2023 and our approved F&PPT Policy that aligns to the framework, we have been working to this policy in any subsequent recruitment to the Board of Directors as follows:

- Checklists covering all FPPT framework elements (for both new and existing directors) have been maintained for all relevant files to enable each file to be updated in line with the FPPT requirements. The Company Secretaries Office and the Recruitment and Workforce Information teams work closely to ensure that each requirement is complete for all relevant directors in line with the policy. Hard copy files are in place and maintained in line with the checklists and information shared between the teams to ensure ESR is updated correctly.
- Annual self-attestation and board governance forms have been completed and signed by each board member.
- DBS checks (every 3 years) are in date for all board members.
- Annual social media checks have been undertaken for all board members by a specialist external company on our behalf with no issues identified.
- the Leadership Competency Framework has been incorporated into annual appraisals for board members.

The teams are satisfied that the appropriate checks have been undertaken and recorded. No concerns around the fit and proper test requirements have arisen from the checks undertaken for any of the board members.

The checks conclude that all board members have been appropriately tested and that they are all fit and proper. The dashboard at appendix 1 shows the fields that have been checked for each director in ESR and the status against each field.

5. Recommendation

Based on the work undertaken and the evidence contained in both the hard copy files and ESR as demonstrated by the dashboard at appendix 1, it is recommended that:

- the Chair signs off that the relevant directors are fit and proper for 2025/26 by the end of March 2026 and that this is recorded in ESR; and
- the Annual NHS FPPT submission reporting template is completed and returned to NHSE to reflect compliance.

Appendix 1 – ESR fit & proper persons dashboard

Last Name	First Name	Title	Job Role	Employment History	Date of Qualifications Check	References Check Date	Annual Performance Appraisal Complete	Open/Upheld Disciplinary Case	Open/Upheld Grievance Case	Social Media Date Checked	Not Disqualified as a Charitable Trustee	Not Disqualified from Directors Register	No Employment Tribunal Judgements Found	DBS Requirements	Date of Medical Clearance	Not Found on Insolvency Register	Date Prof Reg Check	Self Attestation	Tests Complete/Chair Sign-off
Mcpeake	Claire	Mrs.	Chief Operating Officer	14/12/2010	19/10/2010	14/12/2010	planned			14/01/2026	01/08/2025	01/08/2025	01/08/2025	Checked	01/11/2010	01/08/2025	19/10/2010	27/03/2025	27/03/2025
Spencer	Roger	Mr.	Chief Executive	06/12/2023	24/03/2015	06/12/2023	planned			13/01/2026	01/08/2025	01/08/2025	01/08/2025	Checked	09/11/2011	01/08/2025	09/07/2008	27/03/2025	27/03/2025
Lightfoot	Eve	Miss	Chief People Officer	06/12/2023	01/09/2008	09/09/2008	26/02/2026			13/01/2026	31/07/2025	31/07/2025	31/07/2025	Checked	01/09/2008	31/07/2025	N/A	27/03/2025	27/03/2025
Bayman	Neil	Dr	Medical Director	06/12/2023	09/09/2021	24/02/2009	planned			12/01/2026	01/08/2025	01/08/2025	01/08/2025	Checked	18/02/2009	01/08/2025	01/10/2021	27/03/2025	27/03/2025
Thornber	Thomas	Mr.	Chief Strategy Officer	06/12/2023	18/06/2009	23/06/2009	18/01/2026			24/02/2026	01/08/2025	01/08/2025	01/08/2025	Checked	30/06/2009	01/08/2025	N/A	27/03/2025	27/03/2025
Blackhall	Fiona	Dr	Medical Director	06/03/2024	01/06/2021	06/03/2024	planned			16/01/2026	01/08/2025	01/08/2025	01/08/2025	Checked	13/01/2025	01/08/2025	01/10/2023	27/03/2025	27/03/2025
Logan-Ward	Marisa	Dr	Non-Executive Director	01/09/2025	N/A	07/07/2025	planned			12/01/2026	31/07/2025	31/07/2025	31/07/2025	Checked	08/07/2025	31/07/2025	N/A	04/07/2025	09/04/2025
Parkinson	Sally	Ms.	Finance Director	02/12/2019	12/07/2023	02/12/2019	planned			14/01/2026	01/08/2025	01/08/2025	01/08/2025	Checked	25/11/2019	01/08/2025	N/A	27/03/2025	27/03/2025
Harrison	Christopher	Professor	Medical Director	06/03/2024	14/03/2016	15/03/2016	planned			09/03/2026	01/08/2025	01/08/2025	01/08/2025	Checked	04/02/2016	01/08/2025	10/03/2016	27/03/2025	27/03/2025
Page	Grenville	Mr.	Non-Executive Director	17/10/2023	N/A	03/08/2021	planned			13/01/2026	31/07/2025	31/07/2025	31/07/2025	Checked	24/08/2021	31/07/2025	N/A	27/03/2025	27/03/2025
Malik	Alveena	Mrs.	Non-Executive Director	17/10/2023	N/A	03/08/2021	planned			27/02/2026	31/07/2025	31/07/2025	31/07/2025	Checked	23/09/2021	31/07/2025	N/A	27/03/2025	27/03/2025
Goddard-Fuller	Rikki	Professor	Medical Director	06/12/2023	01/10/2021	01/09/2021	planned			13/01/2026	01/08/2025	01/08/2025	01/08/2025	Checked	10/09/2021	01/08/2025	01/10/2021	27/03/2025	27/03/2025
Sharples	Victoria	Mrs.	Director of Nursing	20/01/2022	23/02/2024	20/01/2022	planned			12/01/2026	01/08/2025	01/08/2025	01/08/2025	Checked	27/02/2024	01/08/2025	14/02/2024	27/03/2025	27/03/2025
Wareing	John	Mr.	Chief Strategy Officer	15/03/2023	20/12/2022	15/03/2023	planned			03/02/2026	01/08/2025	01/08/2025	01/08/2025	Checked	22/09/2022	01/08/2025	N/A	27/03/2025	27/03/2025
Tait	Diana	Dr	Non-Executive Director	06/03/2024	19/12/2023	22/01/2024	planned			14/01/2026	31/07/2025	31/07/2025	31/07/2025	Checked	12/12/2023	31/07/2025	N/A	27/03/2025	27/03/2025
Corcoran	Sarah	Ms.	Non-Executive Director	01/06/2024	N/A	20/05/2024	planned			30/01/2026	31/07/2025	31/07/2025	31/07/2025	Checked	26/04/2024	31/07/2025	N/A	27/03/2025	27/03/2025
Dudley-Southern	Roy	Mr.	Non-Executive Director	01/09/2024	N/A	29/08/2024	planned			in progress	31/07/2025	31/07/2025	31/07/2025	Checked	28/08/2024	31/07/2025	N/A	27/03/2025	27/03/2025
Rafferty	Joseph	Professor	Chair	03/12/2025	N/A	09/04/2025	planned			22/01/2026	31/07/2025	31/07/2025	31/07/2025	Checked	01/09/2025	31/07/2025	N/A	23/04/2025	04/09/2025
Oates	Amanda	Mrs.	Non-Executive Director	27/08/2025	N/A	15/07/2025	planned			22/01/2026	31/07/2025	31/07/2025	31/07/2025	Checked	27/08/2025	31/07/2025	N/A	04/07/2025	09/04/2025
Bloor	Adrian	Dr	Medical Director	05/01/2026	05/01/2026	05/01/2026	planned			23/10/2025	14/10/2025	14/10/2025	14/10/2025	Checked	05/01/2026	14/10/2025	05/01/2026	14/10/2025	14/10/2025

*Self-attestation forms and chair sign off for 2025/26 will be finalised by 31/03/2026; dates for ESR will be updated to reflect this.

The Christie Five-Year Integrated Delivery Plan 2026-2031

Contents

1.0	**Executive summary**	**3**
2.0	**Strategic context**	**4**
2.1	Introduction	4
2.2	National context	4
2.3	Our five-year delivery plan	5
2.4	The Christie's five-year strategic goals	6
3.0	**Delivery**	**8**
3.1	Delivery approach	8
4.0	**Delivery areas**	**9**
4.1	Quality and safety	9
4.2	Operational performance	11
4.3	Focus on: Neighbourhood oncology transformation programme	13
4.4	Focus on: Future Christie transformation programme	14
5.0	**Workforce**	**16**
5.1	Strategic vision	16
5.3	Productivity and planning assumptions	16
5.4	Delivering our people and culture plan	16-17
6.0	**Finance**	**18**
7.0	**Productivity and transformation**	**20**
7.1	Partnership working and delivering the left shift	20-21
8.0	**Enablers**	**21**
8.1	Key enablers for the plan, how they will be resourced, and dependencies	21
8.4	Digital infrastructure and data	21
8.5	Financial sustainability and investment	22
8.6	Estates and infrastructure	22
8.7	System partnerships and integrated working	22
8.8.	Research, innovation and clinical trials	22
8.9	Emergency preparedness, resilience and response (EPRR)	22
8.10	Tackling inequalities and improving access	22
8.11	Sustainability and greener care	22
8.12	The Christie Institute for Cancer Education	22
9.0	**Risks and mitigations**	**23**
9.1	Risk model	23
9.2	High-level risk analysis	23
10.	**Monitoring and reporting**	**26**
11.	**Supplementary information**	**27**
11.1	Service user engagement plan	27
11.2	Equality impact assessments	28
11.3	Health population needs	28

1.0 Executive Summary

The Christie NHS Foundation Trust's five-year integrated delivery plan 2026–2031 sets out how the Trust will meet national planning requirements, deliver the NHS 10 Year Health Plan for England and achieve refreshed strategic goals, while sustaining outstanding, equitable and financially sustainable cancer care.

The plan responds to rising demand, increasing complexity and widening inequalities within a constrained workforce and financial environment. It is built on population health analysis, demand and capacity modelling and clinically led service reviews to ensure priorities are evidence based and deliverable. National cancer and diagnostic standards are fully embedded, with compliant trajectories, risks and mitigations agreed.

The five-year delivery plan describes the strategic and operational approach through which productivity, demand management and capacity optimisation will be achieved. Detailed activity trajectories, workforce modelling and phasing are set out in the activity and workforce submissions, overseen by the Trust board. Delivery aligns to the NHS 10 Year Health Plan's three strategic shifts: prevention, care closer to home and digital transformation. Major enablers include the neighbourhood oncology programme and the Future Christie transformation programme. The plan is underpinned by the Trust's quality management system aligned to NHS IMPACT, with the value improvement programme (VIP) driving productivity and sustainability while safeguarding quality and equity.

Goals are translated into a coherent programme across performance, workforce, finance, transformation and partnerships. Workforce modernisation supports new models of care, and financial plans are affordable, supported by credible productivity gains and targeted capital investment.

Clear governance arrangements including the board assurance framework, assurance committees and integrated performance reporting, provide oversight, with risks identified, mitigated and managed.

Overall, the plan provides assurance that The Christie has a credible, affordable, compliant and well governed approach to meeting rising demand, delivering national standards and sustaining world leading cancer care over the next five years.

2.0 Strategic context

2.1 Introduction

As an organisation we are renowned world experts in cancer care, research and education. We remain committed to staying at the forefront of innovation in cancer treatment and are driven by our vision to be a leader in both local and specialist cancer care and ensure that every patient receives the best experience and outcomes.

As one of Europe's leading cancer centres, we look after over 60,000 patients annually. Based in Manchester, we serve a population of 3.2 million across Greater Manchester and Cheshire, with approximately a quarter of our patients referred from other regions of the UK as part of our national specialist services.

With more than 4,100 staff, with turnover of over £540m, the Trust is the largest radiotherapy provider in the NHS and operates the largest systemic anti-cancer therapy (SACT) service in the UK, delivering treatment across multiple sites and at home. We are also a leading tertiary surgical centre, a pioneer in robotic surgery and experimental cancer medicine, and a major international research and education partner.

2.2 National context

Following the Darzi report (2024) and Fit for the Future: 10 Year Health Plan for England (2025), the NHS is entering a new phase of reform. Rising demand, increasing clinical complexity and constrained resources mean that the way services are delivered must continue to evolve. The 5% growth in cancer incidence, increased treatment complexity and survivorship continue, placing sustained pressure on specialist services. Coupled with greater awareness of cancer symptoms mean that more people than ever have been referred to their GP for urgent checks – with double the number of referrals in 2024-25 compared to 2014-15. Population health data from highlights widening inequalities in outcomes, later presentation in deprived cohorts, and increasing multi-morbidity all of which shape demand for Christie services.

The 10 Year Health Plan and the Medium-Term Planning Framework 2025/26 – 2028/29 set out a clear direction for this change, built around three strategic shifts:

- from treatment to prevention
- from hospital to community
- from analogue to digital.

Aligned with this, the National Cancer Plan for England, published on 4 February 2026, sets clear priorities for earlier diagnosis, faster treatment, improved survival and more personalised, community-based care. Digital tools such as the NHS App, the Federated Data Platform and AI will be central to delivering this transformation.

A major focus of the National Cancer Plan is shifting more care into local neighbourhoods. The Christie's neighbourhood oncology model builds on existing services, including Christie at Oldham, Salford and Macclesfield, multi-site SACT delivery and The Christie at Home, to make home and community-based care the default when clinically appropriate to support patient care.

The National Cancer Plan also reinforces system-wide improvements in diagnosis, such as single-queue diagnostics pioneered in Greater Manchester, and continued development of precision technologies including SABR and robotic surgery.

Overall, the National Cancer Plan strengthens the direction of The Christie's five-year delivery plan: earlier diagnosis, personalised support, consistent high-quality care and better outcomes for patients.

2.3 Our five-year delivery plan

Taking into account the national picture, the plan has been shaped by analysis of population needs, working with ICBs, place-based partners, local authorities and the voluntary sector to understand demand. The Trust has used shared population health intelligence which includes specialist cancer demand forecasts, access and outcomes variation, and system-level inequalities insight, to shape service priorities, target unwarranted variation, to ensure our plan is responsive to the needs of the communities we serve.

The plan describes how The Christie NHS Foundation Trust will deliver national, system and organisational priorities over the period 2026–2031, while sustaining high-quality, safe and equitable cancer care.

Our plan is aligned to:

- the NHS 10 Year Health Plan, including the three strategic shifts
- the operational planning guidance
- the Medium-Term Planning Framework
- Greater Manchester system priorities
- The National Cancer Plan for England

The plan is grounded in evidence and has been informed by population health needs assessment, demand and capacity modelling, and alignment between the Trust's clinical strategy, operational delivery and investment decisions. It has been developed with strong clinical leadership and active Board oversight, and provides assurance that delivery assumptions are credible, and risks are understood and actively managed.

National operational standards including cancer access and diagnostic standards are treated as non-discretionary and have been fully incorporated into activity, workforce and financial plans.

In shaping this plan, we have also taken account of emerging national policy direction. (National Cancer Plan), setting out long-term ambitions for cancer prevention, earlier diagnosis, treatment innovation and workforce sustainability. Our planning assumptions, service priorities and investment decisions have been designed to ensure readiness and full compliance.

2.4 The Christie's five-year strategic goals

Our current Christie strategy (2023-2028) has two years to run and sets out how we will continue to deliver our vision. We expect to review and develop our strategy during the next 12 months to ensure it remains, fit for purpose and consistent with the emerging NHS landscape.

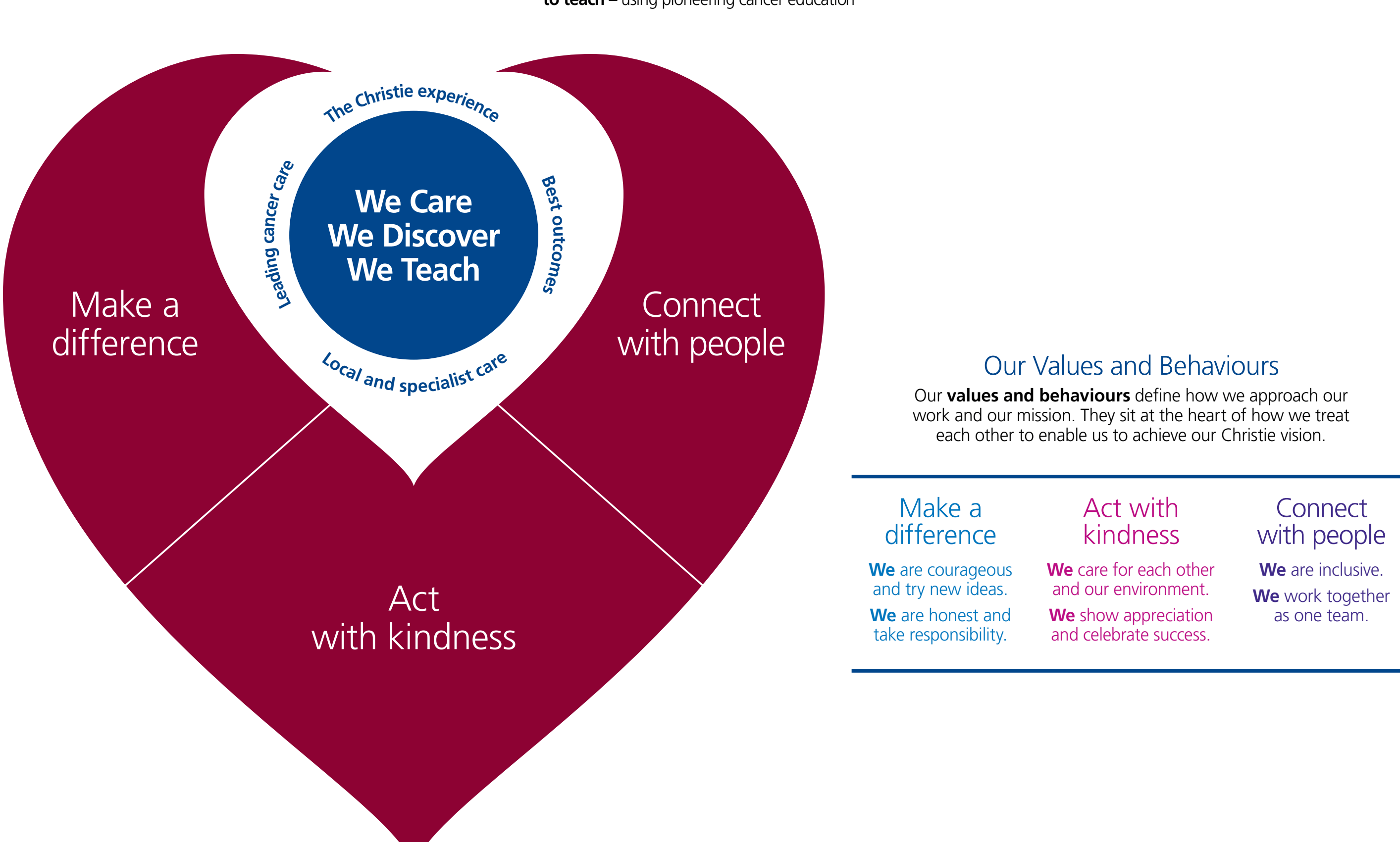
Our vision is to be a leader in both local and specialist cancer care and ensure that every patient receives the best experience and outcomes.

Our vision:

To be a leader in both local and specialist cancer care and ensure that every patient receives the best experience and outcomes.

Our core purpose is:

to care – with compassion for our patients and staff
to discover – through world leading cancer research
to teach – using pioneering cancer education



In working towards the vision, we have developed four underpinning pillars:

- Leading cancer care
- The Christie experience
- Local and specialist
- Best outcomes

These areas guide our strategic approach to delivering and developing our services. Our networked approach to service delivery in systemic anti-cancer treatment (SACT) and radiotherapy are clear examples of how we make this approach a reality. We deliver SACT in 12 locations across Greater Manchester and Cheshire as well as in peoples homes. Our radiotherapy services are provided in four locations with plans in during the lifetime of this plan to extend to a fifth. These not only already reflect the themes in the 10 Year Plan but also demonstrate real leadership and commitment to providing specialist care and the best possible outcomes as close to people's homes as possible. Our aim is to improves patient experience and save precious time during often difficult and challenging circumstances.

We have taken the opportunity as part of the five-year planning process to refresh our five-year goals, and to ensure our strategic plan translates these goals into a coherent delivery programme across quality, operational performance, workforce, transformation, productivity and partnerships, underpinned by robust governance and risk management.

Our five year goals:

Deliver outstanding clinical excellence and outcomes:
We will continue to be providers of safe, equitable care, sustaining top-decile survival, safety and experience across all tumour groups. We will embed the practices and culture that underpin CQC 'Outstanding'.

Achieve operational excellence and financial sustainability:
We will continuously improve safety, flow, quality and value while maintaining financial sustainability and segment one oversight status. Delivering national operational planning standards.

Integrate clinical research and education:
We will lead in cancer research, supporting the shift from sickness to prevention and increasing patient participation in clinical studies.

Be an excellent place to work:
We will develop our people and culture to be in the top 10% of NHS staff survey results.

Transform services to improve access and outcomes:
We will continue to develop our digital maturity with our Future Christie transformation programme to release time to care, improve access and improve experiences. We will develop new integrated models of care, such as neighbourhood oncology, to better respond to patient needs.

Lead the wider NHS cancer system and partnerships:
We will work with system partners to address shared challenges and use new organisational approaches, such as Advanced Foundation Trust status and as an Integrated Healthcare Organisation, to support improved patient outcomes, better system performance and the shift of treatment to prevention and hospital to community.

These goals are underpinned by our values and our core purpose to care, to discover and to teach.

3.0 Delivery

3.1 Delivery approach

Our plan sets out how The Christie will deliver national and local priorities through a clinically led, evidence based and system focused approach. This approach is grounded in:

- clinically led service redesign
- evidence based practice (NICE, GIRFT and national cancer guidance)
- partnership working across neighbourhood, place and system
- integrated planning across activity, workforce, finance and quality

Transformation is informed by population health insight, robust demand and capacity modelling and a deep understanding of what matters most to patients and their families. We recognise that for many patients, reducing time spent away from home is a major contributor to wellbeing, continuity and quality of life. Our approach will support more care in local settings, minimising unnecessary travel and keeping people closer to home wherever safe and appropriate.

The Christie is committed to contributing to national ambitions for earlier diagnosis, improved outcomes and strengthened survivorship. We will expand our survivorship programme, providing system leadership in late effects services, supportive care and research so that more people live well through and after treatment.

Our approach provides a clear line of sight between clinical strategy, operational delivery and investment decisions. The Trust has consistently performed strongly against national standards and maintained a segment one position. However, the rising incidence of cancer and increasing treatment complexity require us to ensure our operational delivery plan includes how we redesign pathways, improve productivity and apply best practice consistently to meet future demand safely and effectively.

To support this, our newly launched quality management system (QMS) aligned to NHS Impact provides the governance, infrastructure and common approach to improvement to ensure a robust approach for planning, problem solving, standardisation, measurement and daily operational grip. It ensures improvement is systematic, variation is reduced and change is sustained by building on the improvement capability of our leaders and teams is central to this approach, empowering them to identify, test and own improvements.

We work closely with commissioners, Greater Manchester partners and neighbourhood services to deliver integrated pathways that support admission avoidance, shift care closer to home, reduce time away from home for patients, and reduce unwarranted variation. This includes our neighbourhood oncology model, our collaborative work with the national pilots in Rochdale and Stockport to improve cancer uptake and outcomes, and our expanding 'Christie at' network, including plans for a neighbourhood oncology centre in Leighton.

Reducing inequalities in outcomes and experience remains a priority. We will continue to use data to identify variation, tailor support for underserved groups and ensure digital solutions and pathway redesign are inclusive and equitable. Workforce modernisation underpins delivery, including strengthened multidisciplinary teams, expanded advanced practice, digital skills development and support for leaders to drive operational excellence. Through our academic networks we will continue to attract world leading experts in experimental cancer therapeutics, radiotherapy and tumour specific research.

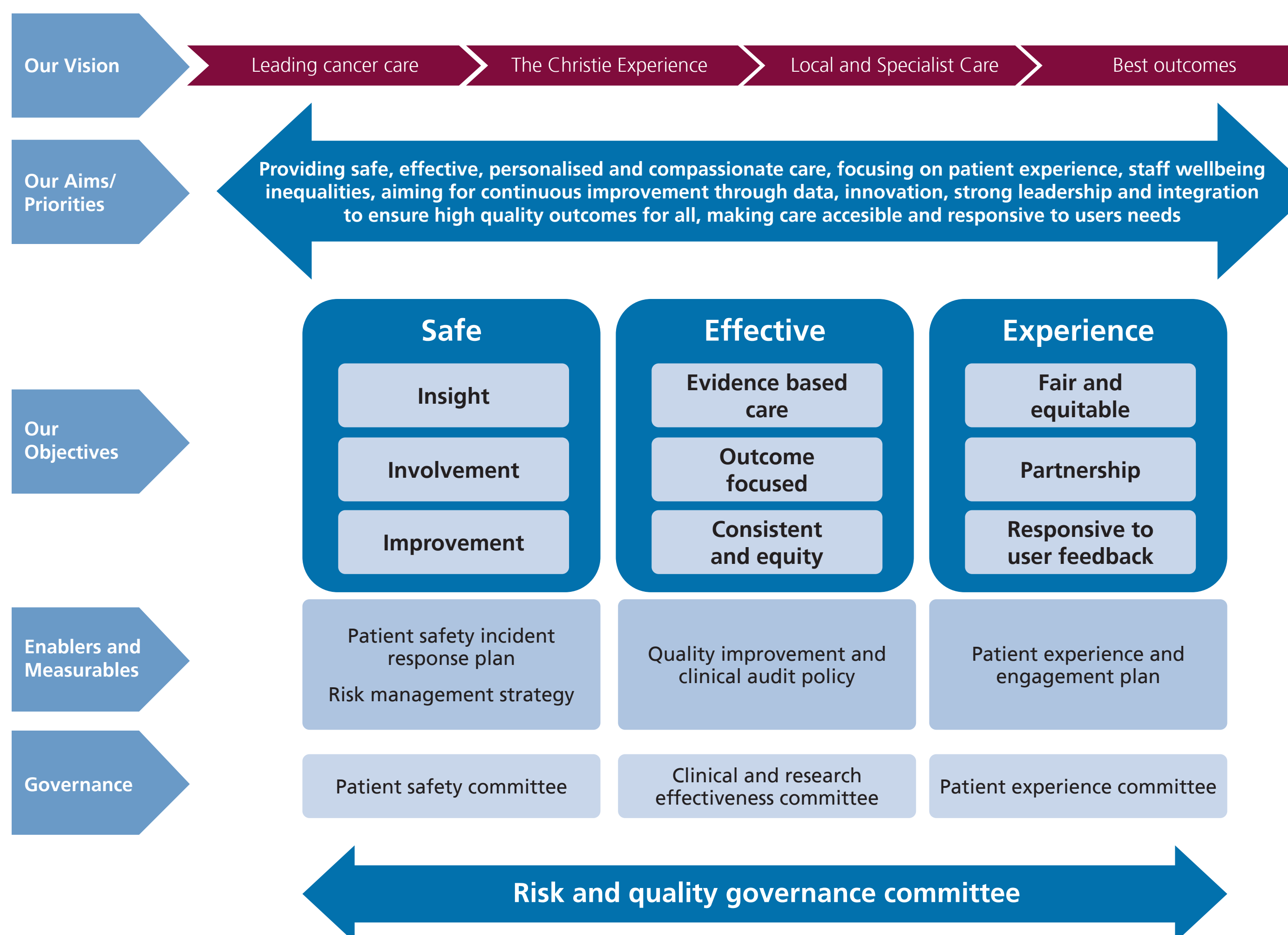
Delivery is triangulated across quality, access, productivity, workforce, digital enablement and finance. Sustainability is embedded across delivery, including reduced waste, optimised energy use, and pathway design that minimises travel and time away from home. Research and innovation remain core to our identity and are described as one of our enablers, with continued expansion of clinical trial access and the rapid adoption of proven innovations.

4.0 Delivery areas

The Trust is accountable for meeting national operational standards over the next three to five years, including cancer access, diagnostics, elective recovery and productivity. Delivering these standards reliably is essential to maintaining our segment one position in the NHS Oversight Framework and reflects our commitment to timely access, reduced waits and excellent patient experience. Our delivery areas are quality and safety, operational performance, workforce and finance. Baseline performance, trajectories and delivery milestones have been submitted as part of the national planning process, with monthly monitoring through the operational performance improvement group.

4.1 Quality and safety

The Trust's quality strategy underpins all delivery activity and is structured around three domains, with supporting improvement goals and plans. Delivery of the quality strategy is overseen through the risk and quality governance committee, with reporting of success measures, escalation through the board assurance framework, and formal post implementation review of all changes.



We will:

Safe

- build a proactive, just and learning safety culture
- embed PSIRF, human factors and system learning
- use data and early warning indicators to anticipate and prevent harm
- engage patients, families and staff as partners in safety

Effective

- deliver evidence-based, outcome focused and equitable care
- ensure consistent application of NICE, GIRFT and national standards
- reduce unwarranted variation
- strengthen clinical governance and quality improvement capability

Experience

- deliver kind, compassionate and person-centred care
- co-design improvements with patients and carers
- actively seek and act on real-time feedback
- champion equity of experience across all communities

Success measures

Safe

- meet planned standards of PSIRF maturity matrix; a framework to assess how well we are embedding compassionate, system-based learning from patient safety incidents across domains of engagement, investigation and improvement
- achieve objectives set out in our three-year risk management strategy

Effective

- identify and implement all appropriate clinical guidelines and standards within the required timeframes
- clinical outcomes and audits are monitored, reported and acted upon
- clinical outcomes are reported by protected characteristic groups to address unwarranted variation

Experience

- embed consistent monthly feedback mechanisms to inform and shape service improvements and developments
- maintain compliance to complaint KPIs
- maintain or improve national patient experience survey (NPCES and NIPS) and PLACE scores.

4.2 Operational performance

Our operational model is built on operational excellence, strong leadership and empowered teams. We will continue to strengthen operational capability through leadership development, skills programmes and active participation in Proud2bOps, ensuring our operational managers have the competencies required to lead complex services effectively.

We take a whole system approach to demand and flow, working with partners across Greater Manchester to improve referral quality, reduce variation and streamline care. Sustained pathway growth will be managed through proactive demand management, redesign and approaches that reduce unnecessary activity and reduce time patients spend away from home, including expanded ambulatory models and community based treatment where appropriate.

How we do this

Our value improvement programme supports safe, effective and financially sustainable delivery. Underpinned by our quality Management system (QMS), it ensures:

- **Quality planning** through strategy deployment
- **Quality assurance** through visibility of reliability, standards and variation
- **Quality improvement** through structured, measurable change

Our operational performance priorities are to:

- achieve cancer access and waiting time standards
- improve flow and utilisation across complex pathways, including theatres
- redesign pathways to support ambulatory and networked models
- strengthen operational grip through data and digital tools
- reduce inequalities in access, experience and outcomes
- deliver ongoing productivity improvements and modernised care models to achieve productivity improvement of 2% year on year

Our operational improvement plan supports us to deliver these priorities and includes the following programmes of improvement:

Outpatients, follow up and MDT productivity

We will expand Advice and Guidance in haematology and embed **PIFU and PSFU** as the standard where appropriate supported by innovative approaches such as ePROMs to support remote monitoring and earlier intervention, reducing routine appointments and reducing unnecessary time away from home.

Clinic flow will be improved via learning from the **Further Faster methodology**, standardised templates and greater use of virtual consultations. Multi-Disciplinary Teams (MDT) will be strengthened through triage, protocolled decisions and the roll out of **ambient voice technology (AVT)** into outpatients, inpatient and MDT settings.

Theatre utilisation and elective productivity

We will continue to benchmark against best practice and enhance theatre efficiency through strengthened planning, start time discipline, reduced risk of cancellations and improved coordination between surgical, anaesthetic and peri operative teams. This will increase throughput and improve overall productivity.

Flow, discharge and bed productivity

We will continue to develop our hotline, and ambulatory care provision to avoid risk of hospital admission unless clinically appropriate. We will apply consistent use of **criteria to admit** and **criteria to reside, early discharge planning** and strengthened multidisciplinary coordination will reduce length of stay and avoidable bed days. Working with partners, we will minimise delays in transfer of care and ensure patients spend as little time in hospital as clinically necessary another key factor in **reducing time away from home**.

Strengthening system-wide pathway reliability

We will strengthen the reliability of upstream pathways by working proactively with referring providers to identify and address delays before patients enter specialist care. This includes establishing improved structured feedback loops where recurrent issues are identified and using shared breach prevention dashboards to highlight patients who may be at risk of delay. We will standardise referral completeness criteria so that patients arrive with the information needed to progress without interruption. This collective approach will improve overall system performance and reduce avoidable delays within the 62 day standard. We will adopt the Federated Data Platform to support single queue diagnostics and develop follow up management of patients.

Optimising complex pathways

Once patients reach The Christie, our focus is on ensuring the smoothest and fastest possible progression to treatment. We will undertake

systematic skill mix reviews to strengthen senior clinical availability, expand AHP and nurse led assessment models where appropriate, and increase the contribution of advanced practice to routine or predictable pathway steps. GIRFT recommendations will continue to guide our efforts to reduce treatment variation and enhance scheduling efficiency. We will also review the coordination and sequencing of radiotherapy, SACT and surgical oncology through more reliable booking, enhanced planning processes and better use of predictive demand and capacity tools.

Enhancing seven day resilience
Where clinically appropriate and operationally beneficial, we will expand seven day services to ensure continuity of care and reduce weekend related delays. This will include targeted expansion in areas such as radiotherapy planning, SACT initiation, specialist imaging and theatre access. Enhancing resilience across the full week will help maintain momentum in complex pathways and support timely progression even during periods of high demand or late referral.

Accelerating decision to treat and first treatment intervals
We will accelerate the intervals between referral, decision to treat and first treatment by continuing to develop one stop specialist models, allowing multiple assessments and decisions to take place within a single visit. MDT efficiency will be strengthened through improved triage, streamlined preparation and increased use of digital workflows. Booking processes will become more reliable and responsive, supported by dedicated pathway coordination and real time oversight. Daily review of all patients on 62 day pathways will enable swift escalation, ensuring that any emerging delays are addressed promptly.

Digital insight and real time management
Digital tools will play a central role in improving pathway reliability and operational grip. We will introduce live breach prediction alerts that highlight potential delays early, enabling proactive intervention. Standardised dashboards will give tumour groups a consistent view of referral readiness, MDT timings, treatment scheduling and capacity utilisation. Strengthening data quality and coding processes will ensure more accurate reporting, better forecasting and earlier identification of risks to performance.

Governance and system accountability
Governance arrangements will be strengthened through close collaboration with Greater Manchester Cancer Alliance, ensuring shared visibility of upstream delays, coordinated improvement activity and a consistent system wide approach to managing risk. A tertiary referral policy will set out clear expectations for timelines, minimum information requirements and escalation processes. These measures will support transparent trajectory monitoring, maintain accountability across organisations and ensure that performance is managed proactively and effectively.

Success measures
In line with our five-year goals, we are aiming for outstanding, timely and equitable cancer care with outcomes among the best internationally. We have submitted a compliant plan, against all national expectations and targets, have assessed the risks, and have robust plan, governance structure and monitoring of progress against targets to achieve:

Success Measures
- Faster Diagnosis Standard: **80%**
- 31 day decision to treat: **96%**
- 62 day referral to treatment: **85%**
- diagnostics: **1%** waiting over six weeks
- sustained RTT improvement
- minimum 2% annual productivity improvement
- reduced unwarranted variation
- reduced avoidable bed days
- improved equity of access and experience
- expanded use of **NHS App** for patient communication and remote care.

4.3 Focus on: Neighbourhood oncology transformation programme

Neighbourhood oncology is a transformation programme that delivers the hospital-to-community shift for cancer services at scale across Greater Manchester. It redesigns cancer pathways so that treatment, monitoring and support are delivered closer to home as the default where clinically appropriate. Neighbourhood oncology is a single system-wide service, where The Christie retains accountability for specialist standards, clinical governance, prescribing, pathway design and escalation.

The programme responds directly to rising cancer incidence, increasing treatment complexity, workforce constraints and persistent inequalities. It moves beyond incremental outreach to a system-wide model that manages cancer as a long-term condition, supported by proactive surveillance, early intervention and digital-first pathways reducing A&E and hospital admissions for complications of cancer and cancer treatments across Greater Manchester. Neighbourhood oncology is a core delivery mechanism for the NHS 10-Year Health Plan and the three strategic shifts: hospital to community, analogue to digital, and treatment to prevention.

Delivery model

Neighbourhood oncology is delivered through three integrated pillars:

SACT delivered in neighbourhoods and at home

Local or home-based SACT will become the default for eligible patients, supported by digital-first referral, standardised eligibility criteria and opt-out pathways. Delivery is consolidated into neighbourhood SACT hubs with medical cover, monitoring and local Christie at Home infrastructure, improving access, equity and productivity while releasing specialist centre capacity.

Ambulatory acute oncology

A Christie-anchored ambulatory acute oncology network will be established, underpinned by a pan-Greater Manchester daily virtual acute oncology MDT, standardised pathways and defined escalation thresholds. Acute cancer presentations are managed through specialist-led triage, proactive monitoring and early intervention, with hospital admission reserved for patients who clinically require it.

Supportive oncology integrated with neighbourhood services

Supportive oncology is embedded as core infrastructure, integrating symptom control, psychological support, rehabilitation and comorbidity management with primary care, community services and voluntary, community and social enterprise (VCSE) partners. Cancer is managed as a long-term condition through personalised care plans and coordinated neighbourhood delivery.

Five-year deliverables

Over the plan period, neighbourhood oncology will deliver:

- neighbourhood and home-based SACT as the default model for eligible patients
- a system-wide ambulatory acute oncology model reducing avoidable A&E attendances and admissions
- integrated supportive oncology pathways delivered through neighbourhood services.
- digital-first pathways using the Electronic Patient Record (EPR), NHS App and Christie portal, including ePROMs-driven surveillance and early intervention.
- single Greater Manchester standards for access, governance and outcomes, with routine reporting by deprivation and neighbourhood to address unwarranted variation.
- workforce models aligned to neighbourhood delivery, including expanded advanced practice roles and Christie-led education and competency frameworks.

Contribution to operational performance and sustainability

Neighbourhood oncology improves access, experience and equity while supporting delivery of cancer access standards and productivity requirements. By shifting appropriate activity out of hospital settings, it reduces avoidable admissions, improves flow, releases specialist capacity for complex care and supports more sustainable use of workforce and estates across Greater Manchester. The programme is complementary to Future Christie, which provides the digital and data enablers required to deliver neighbourhood models at scale.

4.4 Focus on: Future Christie programme

Our Future Christie transformation programme aims to modernise cancer care digitally, clinically, and culturally. It will support the delivery of the digital and data capabilities required to meet the ambitions of the NHS 10 Year Plan, the National Cancer Plan, the Medium Term Operational Planning Framework and The Christie's five-year goals. Future Christie will ensure that new technology platforms, digital tools and data infrastructure can be translated into real productivity gains, better patient experience and more efficient clinical workflows

At the core of Future Christie are three, mutually reinforcing programmes.

Electronic Patient Record (EPR): The Christie's legacy EPR no longer meets clinical or operational needs leading to fragmented workflows, manual workarounds and poor integrations compounded by increasing technical debt. As demand outpaces capacity and more care shifts to community and home settings, we must connect seamlessly with primary care and system partners. Converging on a single, standardised enterprise EPR is essential to deliver safe, equitable, cross organisational care.

Key Deliverables

- **electronic patient record:** Replacement EPR delivered to the organisation by the end of 2028 and optimised by the end of 2031.
- **workforce capability uplift:** Targeted digital upskilling and super user support to accelerate safe adoption and maximise realised benefits will be integral to the EPR program and essential to meet broader ambitions.

Joint Analytics for Cancer (JAC). JAC will be the digital intelligence core of the Future Christie and is being developed in parallel with the EPR replacement. JAC aims to integrate data into a single, governed platform linking clinical and non-clinical data assets. JAC will unify Christie's clinical, imaging, genomic and patient-reported data into a single, high-quality analytics layer that enables safer, more personalised care. It will also enable operational intelligence, optimal financial performance and predictive modelling. Data from JAC will feed the NHS Federated Data Platform supporting pathway optimisation and can be provided into secure research environments for collaborative studies and research projects.

Key Deliverables

- **Self-service analytics:** JAC dashboards and 'data as a service' available to clinical and corporate teams, powered by structured data captured at source.
- **Research enablement:** JAC supported cohort discovery and trial matching embedded in routine care, shortening research cycle times.
- **System level flow improvement:** Utilisation of FDP to demonstrably reduce pathway delays.

Adoption of technology and Artificial Intelligence. Artificial intelligence (AI) will be a key driver for change and will be integrated where it demonstrably improves safety, patient experience and productivity. Trust wide deployment of Ambient Voice Technology (AVT) will capture consultations, MDTs and generate clinician verified drafts of notes and letters, reducing administrative workload, accelerating correspondence and improving the accuracy and timeliness of information for patients.

Precision AI will strengthen clinical capacity through automated radiotherapy contouring, shortening planning times, and imaging triage tools that help prioritise radiologist time for reporting. Agentic AI will support automation of routine pre and post clinic tasks, improving workflow efficiency.

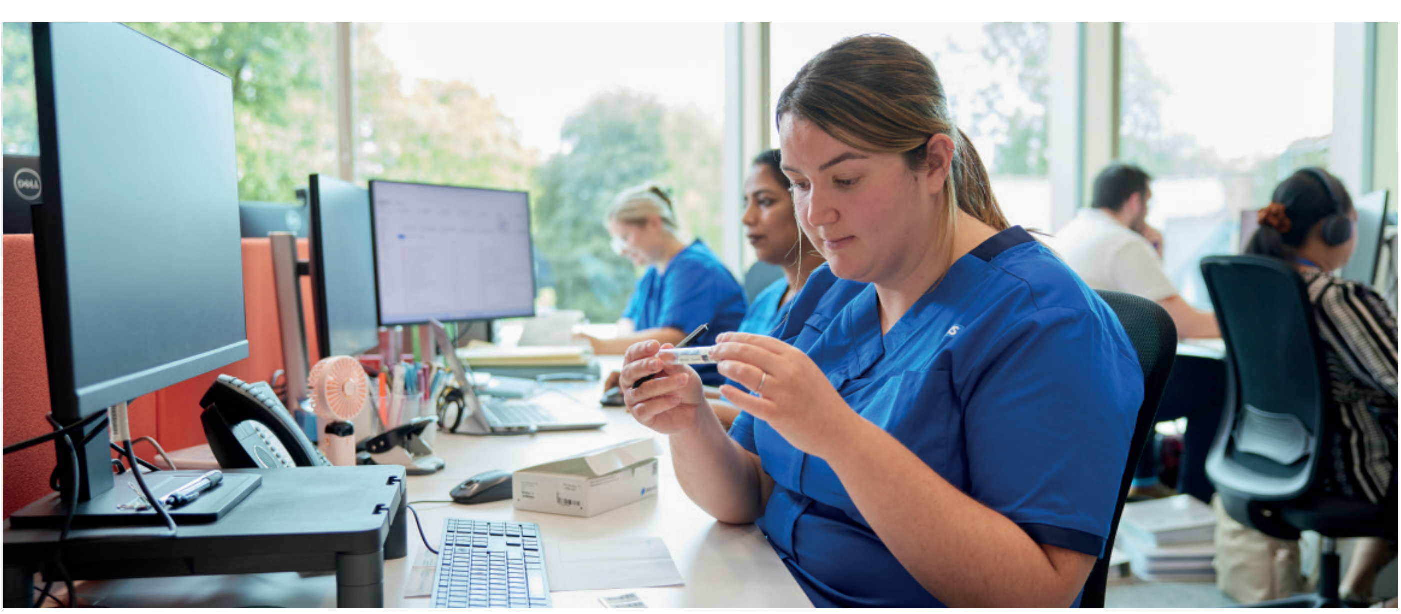
Near real time analysis of patient reported outcomes and remote monitoring data will enable more tailored follow up and earlier intervention, reducing unnecessary appointments and supporting personalised care.

Collectively, these technologies will reduce variation, release clinical time to care and deliver measurable improvements in throughput, efficiency and outcomes.

Key Deliverables

- **Ambient documentation at scale:** AVT rolled out across clinics and multidisciplinary team meetings with measurable reductions in documentation time and letter turnaround. Further rollout to additional areas including the hotline and inpatient wards.
- **Decision support in priority pathways:** AI deployed widely in radiotherapy contouring and imaging triage with established safety and effectiveness metrics. Exploratory development in other areas.
- **Agentic AI for administrative tasks:** Use of agentic AI to chain routine tasks (pre-clinic preparation, in-clinic retrieval of pathways/guidelines, post-clinic actions), releasing clinical time to care.
- **Near real-time patient monitoring:** Analyse PROMs and remote-monitoring data to trigger earlier intervention and personalise follow-up, reducing avoidable attendances and optimising clinic capacity.
- **NHS App:** In line with the planning guidance, we will continue to integrate our Patient Portal with the NHS App as the primary digital front door for patients to support access to appointments, communications and information. This will reduce reliance on paper-based processes, improve patient experience, and releasing staff capacity to improve productivity.

Digital delivery will be implemented alongside inclusive alternatives to ensure equitable access for all our patients.



5.0 Workforce

5.1 Strategic vision

Our workforce vision for the next five years is to build a skilled, inclusive and digitally enabled workforce that supports delivery of our strategy and the requirements of the 10 Year Plan. The Christie people and culture plan (2026–2030) and inclusive culture strategy (2025–2030) will embed purposeful leadership, connectivity and belonging across all staff groups, while ensuring that workforce planning reflects sustainable workloads, staff wellbeing and long term service transformation.

5.2 Workforce trajectory and delivery

The Trust's workforce plan projects growth in substantive WTE from 4,090 in 2025/26 to 4,567 by 2028/29, with total workforce (including bank and agency) reaching 4,711 WTE. Growth is concentrated in clinical roles, registered nurses, AHPs and scientific/technical staff, to support new models of care and the three strategic shifts in the 10 Year Health Plan (10YHP).

- **Hospital to community shift:** role redesign and skill mix changes to support neighbourhood oncology and increased delivery of care closer to home.
- **Analogue to digital shift:** investment in digital, data and technology, alongside digital literacy training, enabling e rostering, automation and virtual care.
- Sickness to prevention shift: expansion of AHP and psychological professions to deliver prehabilitation, lifestyle interventions and survivorship support.

Workforce growth is modelled alongside activity projections, seasonal variation and current workforce behaviours (recruitment performance, retention trends, agency availability). Activity driven staffing ratios, safe staffing and acuity tools, and wellbeing indicators (sickness trends, stress related absence, overtime and flexible working demand) are embedded into future profiling to ensure workloads remain safe and sustainable.

Alongside growth, the Trust will reduce agency WTE from 27.7 to 19.3 by 2028/29, deliver a 30% reduction in agency spend in 2026/27 and move towards zero agency use by 2029/30. This will be supported by strengthened recruitment pipelines, improved retention, flexible deployment models and seasonal workforce profiling. Sickness absence will continue on a trajectory to achieve the lowest national average of 4.1% through targeted wellbeing interventions, restorative culture initiatives and enhanced absence management support.

5.3 Productivity and planning assumptions

The workforce plan is triangulated with finance and activity plans, using demand and capacity modelling and aligned to the Medium Term Planning Framework principles of credibility, deliverability and affordability. Key assumptions include:

- productivity gains through team based job planning, capped theatre utilisation (95%) and digital enablement
- consultant job planning compliance at 95% by 2027/28, progressing to multi professional job planning by 2028/29
- an integrated planning cycle replacing annual cycles, ensuring continuous alignment with the 10-Year Health Plan, system commissioning intentions and long term workforce requirements
- agency and bank controls, sickness reduction targets and implementation of the 10 Point Plan to improve doctors' working lives.

Seasonality is explicitly modelled through multi year trend analysis of demand, absence, turnover and temporary staffing usage, ensuring baseline and peak season staffing requirements are accurately reflected in future plans.

Absence related interventions, including enhanced occupational health, wellbeing initiatives and improved line manager capability will be assessed for their impact on attendance, workforce resilience and the achievability of wider organisational ambitions.

5.4 Delivering our people and culture plan

Delivery of the workforce strategy is underpinned by the five themes of the People and Culture Plan, ensuring alignment with the 10 Year Plan and long term workforce needs:

1. **Engaging our people:** listening events, improved induction and recognition initiatives to strengthen pride, voice and organisational connection
2. **Keeping our people safe and well:** flexible rostering pilots, mental health support, physiotherapy access and wellbeing campaigns, supported by real time monitoring of wellbeing indicators
3. **Developing and leading our people:** embedding the management and leadership framework into recruitment and appraisal, expanding digital capability training, apprenticeships and inclusive education, and implementing the reformed statutory/mandatory training framework

4. **Embedding a positive and inclusive culture:** anti racism actions, WRES monitoring, mentoring and co designed diversity events to strengthen belonging and equity
5. **Our people of the future:** workforce planning aligned to Future Christie, streamlined HR systems, outreach programmes and adoption of digital and AI enabled roles.

Strategic workforce planning principles, including long term demand and capacity modelling, productivity assumptions and system wide workforce forecasts will be embedded. Governance will be strengthened through regular workforce committee oversight, ensuring alignment with the 10 Year Health Plan for England is maintained throughout the year and that service transformation, digital investment and pathway redesign are fully reflected in future workforce demand.

6.0 Finance

Background

The Trust operates within a group structure including a wholly owned subsidiary and two joint ventures. The Trust is also supported by The Christie Charity which contributes significantly to specific revenue and capital programmes. As an independent organisation, the charity is not consolidated within the group structure.

Financial rigour of decision making

The Trust operates under a scheme of delegation and standing financial instructions that are reviewed and approved on a periodic basis by the Trust's audit committee.

Any investment required in services is described in a business case which is considered by the leadership division requesting the funding. Following review and examination by division, if approved, this then passes onto the Trust's governance structure depending on value.

Where there is a change in service provision or other change that requires commissioner input, Greater Manchester Integrated Care Board or Specialised Commissioning are involved. A key element of change in services is driven by new NICE approved drugs and treatments that are required to be implemented within three months of decision.

There is a committee structure below the Trust board that has delegated approval limits including:

- investment and capital planning committee (chaired by the director of finance)
- senior management committee (chaired by the chief executive)
- Trust board.

Overview of financial plans

Revenue plans

The Trust is funded to break even from NSH England exchequer funding. The profit from the Trust's joint ventures brings the overall group financial position to a surplus, currently £7.5m control total for 2025/26 and 2026/27.

As a specialist tertiary centre, the Trust receives referrals from secondary care providers, both from Greater Manchester and other locations. The pathways for treatment of our patients are standardised and prescribed, hence there are no opportunities for demand management within the Trust's activity.

Due to successes in both screening programmes and development of new drugs and treatments, we are receiving higher referrals and treating around 8% more patients each year across the main treatment modalities of SACT, radiotherapy and surgery.

We work closely with commissioners to deliver this care in the most effective and efficient way possible, this relies on the use of technology and streamlined referrals to the Trust. Due to this substantial and constant increase in the number of patients we treat, we are transforming services to respond to this demand, a key focus of our Future Christie programme. This allows us to deliver this level of increase at a lower level of resource than the circa 8% demand increase through productivity gains.

We intend to continue this response to increase in demand and work with our commissioners to ensure we are adequately funded to deliver the level of required activity whilst continuing to make essential productivity gains.

.

Capital plans

Adequate access to capital (CDEL) is an essential component to the productivity gains outlined in our revenue plan. We need to be able to treat more patients for the same level of resource and the only way to achieve this is by utilising new and emerging technologies and treatments.

As a result of our surplus position combined with constraints in the ability to spend cash balances on capital programmes under previous NHS England regimes, the Trust has had to build up a cash balances as a result of being allocated CDEL levels that are lower than depreciation.

As the Trust is in segment one of the National Oversight Framework it can access capital freedoms that allow us to utilise additional capital equivalent to the in-year surplus. This can be rolled forward two years which has assisted in both delivering and managing the capital strategy over financial years. The Trust's long term capital plan includes ambitious new technologies combined with pathway re-design to maximise efficiency, quality of care and the three shifts required in the NHS Long Term Plan. It is essential to the Trust's strategic plan that the capital can be deployed to deliver this.

Maintenance of long-term financial stability

The Trust has several in-flight programmes that are key components of the maintenance of the long-term financial sustainability of the organisation. These include:

- construction of an advanced scanning and imaging centre combined with transformation of how these services are delivered
- Christie Charity funded pathology facility to drive efficiencies in the delivery of this service
- new electronic patient record system that will transform the efficiency of services
- moving to the next phase of The Christie Private Care with maximisation of revenue and subsequent profit from this joint venture
- Management and delivery of a new aseptic facility for Greater Manchester which will enable a substantial increase in the level of research trials that The Christie can deliver with associated benefits to patients and income to the Trust.

The five-year plan is affordable within current funding assumptions and includes mitigations for financial risk through productivity, transformation and system working. The Trust does not require any Deficit Support Funding.

7.0 Productivity and transformation

The Trust already demonstrates strong productivity performance, reflecting its specialist focus and long-standing emphasis on efficient, high value care. National corporate services benchmarking indicates a limited indicative opportunity of circa £0.5m which led to a review against best practice and improvements made, suggesting that corporate functions are already operating close to lower-quartile benchmarks. Operationally, the Trust's DNA rates are among the lowest nationally, supporting efficient use of clinical capacity and effective patient communication.

Notwithstanding this position, the Trust will continue to pursue further productivity improvement in line with demonstrating 2% productivity gain and has developed internal opportunity packs using Model Health System, costing and local intelligence to support and focus on reducing unwarranted variation, tackling failure demand, optimising pathways and making effective use of technology to deliver sustained gains over the planning period.

Delivery of the targets set out in this plan will be set within our quality management system and achieved through a combination of quality improvement, daily management, project management and when appropriate time limited transformation support for complex, cross cutting change. The Trust will continue to build staff capability in improvement methods to ensure our plan is delivered consistently across all services. Over the next five years, improvement and transformation efforts will focus on delivering Trust wide goals, as referred to in this plan, and in terms of productivity specifically include:

- pathway redesign to manage rising demand, strengthen early senior decision making, and expand best practice follow up (e.g. PIFU, PSFU)
- productivity improvement across outpatient, diagnostic, surgical and inpatient pathways through digital enablement, standardisation and improved flow
- strengthening MDT and outpatient effectiveness through standardised triage, protocol driven decision making and ambient voice technology
- reducing avoidable hospital stays by ensuring patients can be supported in their own home, and for planned admissions, improved discharge planning, proactive criteria to reside management and enhanced multidisciplinary coordination to reduce time away from home
- embedding prevention, early intervention and personalised care to improve outcomes and reduce future demand
- reducing inequalities through inclusive pathway design, targeted improvements and better use of data.
- modernising the workforce by expanding advanced practice, improving digital skills and reducing administrative burden
- accelerating research and innovation adoption to ensure patients benefit rapidly from new evidence and technologies
- improving sustainability by reducing waste, unnecessary travel and supporting lower carbon models of care
- delivering the next phase of our shift to digital maturity, enabling smarter, technology supported care to improve and impact on the 2% productivity gain
- supporting our corporate services to realise improvements based on national benchmarking and best practice.

These priorities are forecast to improve value and productivity by reducing unnecessary activity, improving flow, increasing clinical time for value adding care and ensuring capacity is used efficiently.

7.1 Partnership working and delivering the left shift

The Christie works closely with neighbourhood, place and system partners across Greater Manchester to deliver integrated cancer pathways and major transformation programmes. Redesign is coordinated across partners to ensure consistency, alignment with system priorities and improved patient experience.

Key areas of joint working include earlier diagnosis, improved pathway flow, shared care arrangements, community based diagnostics and the expansion of Advice and Guidance.

Over the next five years, enabling the left shift moving appropriate care from hospital to community settings will be delivered through:

- expanding community based and ambulatory models to reduce reliance on hospital care
- earlier intervention and admission avoidance, supported by the cancer hotline, specialist advice and remote monitoring (e.g. ePROMs)
- shared pathways with primary and community services, including risk stratified follow up and community delivered elements of treatment and surveillance

- strengthening system wide diagnostics, such as single queue diagnostics and networked imaging, to improve access and reduce variation
- Using the Federated Data Platform to support population health management, pathway redesign and shared decision making
- co-ordinated workforce planning to ensure skills are deployed in the right settings.
- Improving equitable access through collaboration with local authorities, VCSE organisations and community groups.

Through these partnerships, the Trust will support care closer to home, reduce acute pressures, improve patient experience and create more sustainable, community focused cancer services.

8.0 Enablers

8.1 Key enablers for the plan, how they will be resourced, and dependencies
Delivery of this five-year plan is underpinned by a set of key enablers that provide the foundations for sustainable improvement, productivity gains and high-quality cancer care. These enablers have been developed with clear consideration of dependencies, resource requirements and alignment across clinical, operational, workforce, digital and financial plans.

8.2 Quality management system (QMS) and NHS Impact
As described, our QMS, aligned to NHS Impact, is a core enabler for improvement. It provides a consistent approach to problem-solving, standardisation, measurement and daily operational grip. Investment in leadership development, improvement capability and coaching will ensure teams are equipped to drive and sustain change. The QMS is fully aligned with operational planning, workforce development and digital transformation to ensure improvement is embedded across all services. There is a quality improvement (QI) team in place and also access to operational excellence and QI training is employed to develop our leaders capacity and capability. Where there are large organisational cross cutting workstreams, project leads are deployed using the skills we have in the organisation, this will be crucial in the developments of Future Christie.

8.3 Workforce capability, capacity and modernisation
A skilled, flexible and resilient workforce is essential to delivering the plan. Key enablers include strengthened multidisciplinary working, expansion of advanced practice roles, targeted recruitment and retention initiatives, and investment in digital and quality improvement skills. Workforce plans are aligned with activity, finance and digital strategies to ensure the right skills are available in the right settings. Dependencies include national workforce supply, training capacity and system-wide workforce planning.

8.4 Digital infrastructure and data
Digital transformation delivered through Future Christie is a critical enabler of productivity, pathway redesign and improved patient experience.
The new EPR, NHS App integration, Federated Data Platform, automation and ambient voice technology will support more efficient workflows, reduce administrative burden and improve clinical decision-making. These technology changes are essential to enable efficient and productive delivery of the increase in activity we are forecasting.

These programmes are resourced through capital investment, digital workforce expansion and national funding streams. Dependencies include interoperability with system partners, national digital standards and timely delivery of core platforms.

8.5 Financial sustainability and investment
As described in the finance section, delivery of the plan requires targeted investment in digital, workforce, estates and service redesign. Financial plans are aligned to transformation priorities, with a focus on delivering productivity improvements, reducing unwarranted variation and shifting activity to more cost-effective settings. Dependencies include national funding allocations, capital availability and system-wide financial planning. Our value improvement programme supports how we deliver cost improvements, we continue to develop a culture of improving quality and as a consequence ensure we are using our resources to directly contribute to those services and features which deliver the best outcomes, and what patients and their families value and find important.

8.6. Estates and infrastructure
Safe, modern and flexible clinical environments are essential to support pathway redesign, ambulatory care models and improved flow. Estates plans include optimising existing capacity, supporting community-based models and ensuring facilities meet infection prevention and control standards. Dependencies include capital availability, planning approvals and alignment with digital infrastructure upgrades.

8.7 System partnerships and integrated working
Delivery of the plan relies on strong collaboration with neighbourhood, place and system partners. Shared pathways, community-based models, single queue diagnostics, mutual aid and joint workforce planning are key enablers of the 'left shift' and improved productivity. Dependencies include partner capacity, shared digital infrastructure and alignment of priorities across the Greater Manchester system.

8.8. Research, innovation and clinical trials
The Christie is home to the largest single site early phase clinical trials unit in the UK and is recognised internationally for excellence in research and innovation. Our leadership is further strengthened through our partnership in the Manchester Cancer Research Centre (MCRC) and collaboration with Health Innovation Manchester.

Over the next five years, The Christie will enhance its role as a system anchor for cancer research, embedding clinical research as a routine element of care and improving equitable access for patients across the Greater Manchester Integrated Care System. In alignment with The Christie research and innovation strategy, we will focus on earlier patient identification, increasing participation, and deepening collaboration with system partners to support research delivery beyond the specialist centre where appropriate. This approach will drive improved outcomes, accelerate the adoption of innovation into clinical pathways, and build greater research resilience and capacity across the system.

A key enabler of this ambition will be the implementation of Florence and EDGE as our core research delivery platforms, providing end to end digital oversight of study set up, governance, and performance. These systems will support standardisation, real time reporting, and enhanced assurance, enabling The Christie to consistently achieve a 150 day study set up target for both commercial and non-commercial trials. Over the planning period, this will reduce unwarranted variation, improve productivity, and strengthen system-wide visibility of research activity, supporting the ICB's objectives around efficiency, partnership working, and the wider life sciences agenda.

8.9 Emergency preparedness, resilience and response (EPRR)
We maintain strong EPRR arrangements to ensure continuity of safe cancer care during system pressures or incidents. This includes resilient staffing models, digital continuity plans and strong operational command structures. Dependencies include system-wide coordination, compliance with the core standards and national resilience frameworks.

8.10 Tackling inequalities and improving access
Reducing inequalities is a core enabler of improved outcomes and productivity. The Trust will continue to use data to identify variation, co-designing improvements with patients and communities as partners, and ensure digital and pathway redesign is inclusive. Dependencies include access to population health data, community partnerships and system-wide prevention initiatives.

8.11 Sustainability and greener care
Sustainable models of care such as reduced travel, lower-carbon pathways and efficient use of resources support both productivity and environmental goals. The Christie has made great improvements already in sustainable green agenda, and dependencies include estates upgrades, digital alternatives to face-to-face care and alignment with the Greater Manchester green plan. Our future estates and facilities plans play a central role in delivering our five-year goals and deploying our strategy.

8.12 The Christie Institute for Cancer Education
A core element of delivering the five-year plan at The Christie is education. With our Christie Institute for Cancer Education - the first of its kind in the UK - The Christie educates healthcare professionals not only for our own organisation, but from across the country, enhancing the patient experience and promoting developments in cancer care.

9.0 Risks and mitigations

9.1 Risk model

The Christie uses a well established and integrated risk management model that supports the board in delivering the Trust's strategic objectives and in providing effective oversight of the five-year plan. The model is centred on the **board assurance framework (BAF)**, which sets out the strategic risks to achieving our objectives and is reviewed regularly by the board and its assurance committees. Each strategic objective is allocated to one of the board's assurance committees, enabling focused scrutiny of the risks and the controls in place.

Our **risk management strategy and policy** (2025) provides the framework for how risks are identified, assessed and managed across the organisation. It aims to:

1. embed a culture where all staff are risk aware, empowered to identify risk and accountable for managing it
2. support early identification and mitigation of risk, improving patient and staff safety and enabling timely escalation
3. ensure risks are recorded, reviewed and managed systematically to prevent avoidable adverse events.

Risks are assessed using the ISO 31000:2009 methodology, combining **likelihood** and **impact** to determine risk scores. Levels of likelihood range from "extremely unlikely" to "very likely", while impacts are assessed across financial and non financial domains using the Trust's consequence matrix.

Managers review risks within their services, with high level risks escalated through divisional governance to the **risk and quality governance committee** and **senior management committee**. These groups review the Trust's risk profile and ensure that appropriate mitigation and controls are in place, escalating significant risks to the board via the relevant assurance committee.

The board undertakes an annual review of its **risk appetite**, published in board papers and on the Trust website. The Trust has a **low appetite** for risks that could compromise patient or staff safety, compliance or regulatory standards but accepts higher, managed levels of risk in pursuing innovation, transformation and strategic development. This ensures that the Trust can continue to innovate safely while protecting its core clinical services.

The risk and control framework ensures timely reporting and clear accountability. The BAF acts as a key tool for alerting the board to areas of concern or gaps in control, allowing appropriate resource and oversight to be directed where most needed. Internal Audit reviews the BAF annually and has confirmed that it meets NHS requirements and is used effectively by the board.

9.2 High-level risk analysis

The Christie's risk model ensures systematic identification, assessment and management of risks through our board assurance framework, risk appetite statement and robust governance processes. Regular reporting cycles through the board, assurance committees and senior management committee ensure timely oversight and mitigation. The key risks to delivering our five-year plan include rising service demand, workforce capacity, financial pressures, infrastructure constraints, upstream delays, research delivery risks, inequalities, and potential impacts on quality and safety. These risks are mitigated through pathway redesign, workforce development, system collaboration, digital enablement, the quality management system, and the use of quality impact assessments/equality health impact assessments to safeguard patient care.

The risks below represent a summary of the high-level risks to successful delivery of the five-year plan and mitigating actions which have been built into our QEIA:

Risk Area	Description of Risk	Mitigations/Controls
Rising demand and pathway growth	Continued increase in cancer incidence, greater clinical complexity and higher referral volumes may exceed capacity in key services.	• Pathway redesign (Further Faster); PIFU/PSFU expansion • Enhanced demand-and-capacity modelling • 'Christie at' and neighbourhood oncology expansion to reduce travel/time away from home • Workforce modernisation and advanced practice expansion
Workforce capacity and capability	National workforce shortages, skills gaps and recruitment/retention pressures may limit delivery capability. Staff sickness/turnover	• Workforce strategy, leadership development and Proud2bOps • Improved retention, flexible working and wellbeing support • Expansion of MDT roles and advanced practice • Targeted recruitment through academic partnerships
Financial sustainability and productivity requirements	National financial constraints, inflation and increasing treatment costs may affect delivery of the plan and investment capacity.	• Value Improvement Programme and QMS embedded to drive efficiency • Productivity improvements across theatres, outpatients and inpatient flow • Rigorous business case scrutiny aligned with risk appetite • Prioritised transformation investment • Best practice in line with Thrive and Survive national guidance.
Infrastructure, estates and digital resilience	Estate constraints, digital dependencies or insufficient capacity in critical clinical areas may limit growth or disrupt resilience.	• Targeted estates development aligned to five-year priorities • Strengthened digital infrastructure and real-time performance tools • Robust EPRR and business continuity plans • Leveraging EDGE/Florence for research and operational oversight
Upstream delays from referring providers	Delays in diagnostic pathways or incomplete referrals from acute Trusts may impact 62 day performance and patient experience.	• Shared breach prevention dashboards • Standardised referral completeness criteria • Upstream pathway support using Further Faster methodology • System governance with GM Cancer

Risk Area	Description of Risk	Mitigations/Controls
Research & innovation delivery	Regulatory or operational barriers may impact trial recruitment, research productivity or innovation adoption.	• Implementation of Florence and EDGE to streamline research processes • Closer integration between research and clinical operations • Targeted academic recruitment and partnerships
Inequalities in access and outcomes	Persistent disparities across communities may reduce the impact of improvement initiatives and widen gaps in care.	• Population-health driven intervention design • Neighbourhood oncology outreach and 'Christie at' expansion • Collaboration with VCSE partners and primary care • Targeted improvement for identified groups resulting from analysis of cancer outcomes and experiences (including environment)
Quality and safety risks	Operational pressures may affect safety, patient experience or compliance with standards.	• Strong clinical governance, PSIRF implementation, and learning culture • Daily operational grip through QMS and early warning indicators • Regular monitoring through risk and quality governance committee and divisional governance • All major changes subject to quality/equality impact assessment (QEIA)

10. Monitoring and reporting

Delivery of our five-year integrated delivery plan is supported by a robust and mature governance and accountability framework that ensures the Trust is well led, compliant with statutory and regulatory requirements, and consistently focused on safe, high quality and high performing cancer care. The board is responsible for ensuring compliance with its terms of authorisation, constitution, mandatory guidance, statutory duties and contractual obligations. Through these arrangements, the board provides assurance to patients, the public and stakeholders that their care is in safe hands.

All board members meet the NHS Fit and Proper Person Test (FPPT) framework (August 2023), ensuring strong leadership and integrity. The board reviews its risk appetite annually, and this informs all strategic decision making, business cases, investment choices and quality considerations. This ensures that the governance framework not only provides compliance assurance but also acts as a central mechanism for **delivering the priorities and commitments set out in this five-year plan**.

The board receives independent assurance through internal audit reports, compliance reviews and an annual audit programme. At each public meeting, the board considers the integrated performance, quality and finance report, enabling transparent monitoring of delivery against national standards and strategic objectives. These reporting cycles ensure that progress against our delivery plan is reviewed regularly and that risks are identified and managed promptly.

To support effective oversight, the board delegates assurance functions to three non executive director–led committees: **audit**, **risk and quality governance**, and **workforce assurance**. Each committee works to an annual programme of business aligned to the board assurance framework and provides summary assurance reports back to the board. These committees ensure that governance, risk management and internal control systems are effective across their respective domains and that issues affecting delivery of the integrated delivery plan are escalated appropriately.

The audit committee provides independent scrutiny of governance, internal control and risk management, including financial governance. The risk and quality governance committee ensures the Trust is properly governed and well managed for all aspects of clinical quality, safety and patient experience. The workforce assurance committee provides oversight of workforce governance, capability, leadership and culture – all essential enablers of sustainable delivery.

Escalations, assurance gaps and improvement requirements identified by these committees are reviewed at each board meeting, ensuring clear accountability and transparency.

The remuneration committee, composed of independent non executive directors, oversees the remuneration, performance, induction and development of the chief executive and executive directors, ensuring leadership capability is aligned to the performance demands of the organisation and the delivery of this plan.

Operational leadership and delivery are overseen by the **senior management committee (SMC)**, chaired by the chief executive. SMC meets monthly and reviews financial performance, operational performance, risk, quality and safety. It is responsible for aligning operational delivery with board approved strategy. This ensures that day to day decisions, resource deployment and service changes directly support the commitments set out in the integrated delivery plan.

Safety, experience and research governance are coordinated through the patient safety committee, patient experience committee and clinical research effectiveness committee, which report to the risk and quality governance committee. These structures ensure systematic oversight of risk, adherence to clinical standards and delivery of continuous improvement all essential conditions for delivering our five-year plan's ambitions.

The **board assurance framework (BAF)** sets out the Trust's strategic risks and the mitigations required to deliver our objectives. Ownership by the company secretary ensures independence from operational management. The BAF is reviewed at each committee and board meeting, providing a continuous and structured view of the risks that could impact delivery of this plan. Internal audit confirms annually that the BAF meets NHS requirements and is used effectively by the board.

These governance arrangements, combined with regular reporting cycles, independent assurance, and robust risk management, ensure that progress against the five-year integrated delivery plan is monitored rigorously, that delivery risks are identified early and acted upon, and that accountability for performance is clear at every level of the organisation. Delivery of the plan will also be subject to external scrutiny through NHS England oversight, ICB assurance and statutory reporting.

11. Supplementary information

11.1 Service user engagement plan

The Christie's service user engagement plan is built on a clear and sustained commitment to putting patients at the heart of everything we do. Our approach ensures that patients, carers and the wider population are active partners in shaping services, influencing improvement and helping us design care pathways that reflect what matters most to them. This framework is grounded in three core principles: *listening and learning, collaborating with our patients, and communicating clearly and consistently.*

Listening and learning

We are committed to creating an environment where patients and carers feel fully heard and supported. A strong quality improvement model underpins our listening approach, ensuring that feedback is systematically collected, understood and acted upon. Patients and carers have regular opportunities to share their experience, and we close the loop by reporting back on what we have learned and how their insights have shaped service developments. This ensures that learning directly informs improvements, strengthens safety and enhances the experience of care across all services. Carers and those identified as important to the patient are actively included in this process, ensuring that our understanding of experience extends beyond the individual to those who support them.

Collaborating with our patients

Collaboration with service users is central to delivering personalised, high quality care. Personalised care is embedded throughout the entire pathway, and shared decision making is a fundamental expectation of every clinical interaction. We will continue to support the development of patient safety partners and expand opportunities for patients to take active roles in governance, improvement programmes and service redesign. This collaborative approach ensures that improvements are co produced, grounded in lived experience and aligned with what patients identify as most valuable. Through this, we improve both the quality and the relevance of our services.

Communicating clearly with our patients

Clear, accessible and compassionate communication is essential for building trust and ensuring patients and families feel confident and involved in their care. We will ensure communication is equitable across the organisation, with accessible information tailored to meet the diverse needs of our population. This includes strengthening communication in palliative and supportive care and ensuring that staff have the skills and confidence needed to provide a positive communication experience. Information will be available in inclusive formats, ensuring that no patient or carer is disadvantaged in understanding their care, treatment options or available support.

Engagement across communities and neighbourhoods

Through our 'Christie at' network and neighbourhood oncology programme, we will continue to work with local communities to design and deliver services that reduce unnecessary travel, improve local access and respect the preferences of patients who wish to remain closer to home. Our outreach work with partners, such as the collaboration with Rochdale to understand barriers to engagement and cancer outcomes, reflects our commitment to reducing inequality and strengthening relationships with underserved groups.

Embedding insight into improvement

Real time patient feedback, experience based engagement and patient reported outcome measures (including ePROMs) will continue to guide improvement at every level. Insights are integrated through our quality management system and value improvement programme, ensuring patient experience is a core driver of improvement, not an afterthought. The learning gained through engagement directly informs service redesign, workforce development and pathway transformation.

Supporting staff to deliver excellent experience

Our engagement plan recognises that communication and experience are shaped not only by processes but by the skills, confidence and compassion of staff. We will continue to invest in training, tools and support that enable staff to provide high quality, person centred communication and care. This includes supporting staff to engage more effectively with patients throughout their care pathway and ensuring they have the skills required to deliver consistently positive interactions.

A partnership with purpose

Our approach ensures that patient experience and engagement is not a standalone activity but an essential thread running through all aspects of care delivery, quality improvement, service redesign and governance. By listening to our communities, collaborating with those who use our services, and communicating clearly and compassionately, we ensure that our plans and improvements reflect real needs and support the delivery of safe, personalised and equitable cancer care.

Patient Experience and Engagement

Listening and Learning	Collaborating with our patients	Communicating clearly with our patients
Use of a strong Quality Improvement Model to support listening and learning from patients and carers	Personalised care embedded throughout care pathway	Equitable access across the organisation
Carers and those that are important to patients are fully supported and heard	Shared Decision Making lies at the heart of high quality care	Communication and information will be accessible to all patients and carers
Opportunities for patients to feedback their experiences and sharing the results back to service users	Development of patient safety partner roles	Communication in palliative and supportive care
Learning shapes service improvements and developments	Improve the experience for patients	Ensure staff have the necesary skills to support a positive patient experience

Putting patients at the heart of everything we do

11.2 Equality and equality impact assessments

The NHS operational planning guidance sets a clear expectation that providers must deliver financial sustainability while maintaining high standards of care. At The Christie, this is reflected through our value improvement programme (VIP), which is designed to deliver efficiency and transformation in a way that protects, and where possible enhances, the quality of services we provide.

To ensure that value improvement activity does not compromise patient care, The Christie operates a quality impact assessment (QIA) process aligned to the equality and health impact assessment (EHIA). This ensures that patient safety, clinical effectiveness, patient and staff experience, and equity are systematically considered as part of all VIP schemes.

The QIA/EHIA governance is aligned to national expectations set out by NHS England so that quality impacts for any change programme, or cost improvement programme are identified, mitigated, monitored and reviewed, providing assurance that decisions remain within organisational risk appetite and quality standards. This has been signed off by our risk and quality governance committee.

For the overall five-year delivery plan, a quality and equality and health impact assessment has been completed, aligned to our board assurance framework and risk management strategy. This will be monitored as part of our improvement plan directly reporting and providing assurance to our board that the risk metrics are being managed within tolerated parameters.

11.3 Health population needs

This section summarises the population health needs and demand evidence reviewed and applied in the development of the five-year delivery plan, in line with planning submission and board assurance statement requirements. The assessment informs the Trust's role in delivering the National Cancer Plan for England, including the ambition that 75% of people diagnosed with cancer will be cancer-free or living well five years after diagnosis. In addition to this, capacity and demand is carried out at service level and aligned to delivery plans.

Population context, inequalities and catchment

The Greater Manchester population needs assessment (2025) describes Greater Manchester as the largest Integrated Care Board in England, with a growing, younger, highly urban and increasingly diverse population. Despite a younger age profile overall, the fastest population growth is projected in older age groups, increasing cancer incidence and treatment demand.

Greater Manchester has a higher concentration of deprivation than the England average, which is strongly associated with increased cancer risk, later presentation, higher clinical complexity and poorer outcomes. The assessment is underpinned by the 'fairer health for all' framework, which identifies cancer as a priority condition contributing to inequality and premature mortality.

While Greater Manchester represents the Trust's core population baseline, The Christie is a specialist cancer centre with a wider regional and national catchment, particularly for complex and tertiary services. Wider population needs are therefore used to inform both place-based inequalities within Greater Manchester and planning of specialist services for patients referred from beyond the region.

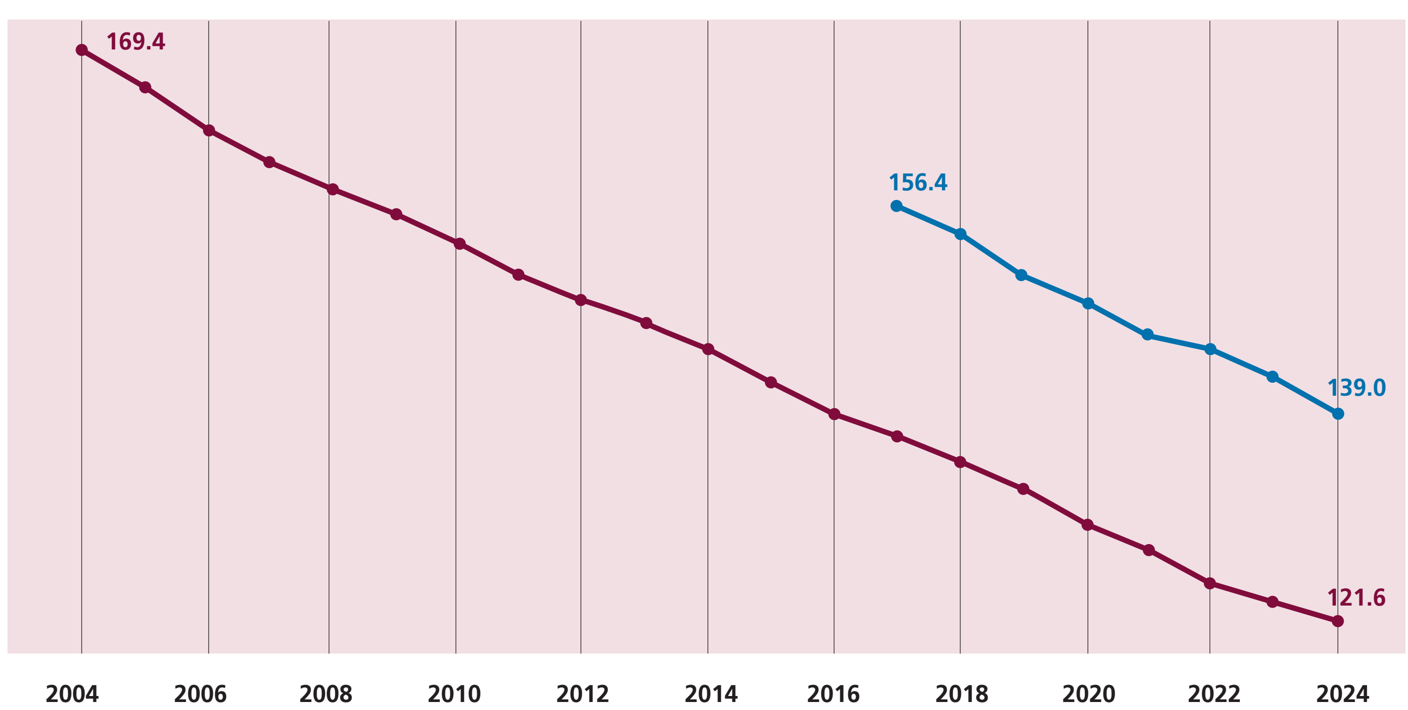
Key population health findings

Cancer outcomes and inequalities

- Under-75 cancer mortality in Greater Manchester reduced from 142.1 per 100,000 (2020) to 139.0 per 100,000 (2023)
- The England average over the same period was 121.6 per 100,000
- Greater Manchester therefore continues to experience higher premature cancer mortality than England, despite improvement.

(Source: Greater Manchester Population Needs Assessment, 2025)

Trend over time for **Greater Manchester** compared to **England** for **Under 75 mortality from cancer**



This reflects the combined impact of deprivation, later diagnosis and higher clinical complexity, rather than the quality of specialist cancer treatment.

Deprivation, late diagnosis and complexity

- Deprivation is associated with lower screening uptake, later stage at diagnosis and higher co-morbidity, increasing treatment intensity and duration
- Later diagnosis drives higher use of systemic anti-cancer therapies, radiotherapy, inpatient care and extended follow-up
- Within our five-year plan, we have reflected how we continue to do to work across our system to support localities.

(Source: Greater Manchester Population Needs Assessment, 2025; Cancer Research UK)

National cancer growth and demand

Authoritative national projections reviewed as part of the assessment show that:

- there are expected to be over 6 million new cancer diagnoses in the UK between 2020 and 2040
- this represents an increase of approximately 14% compared with the previous 15-year period
- growth is driven largely by population ageing and population growth, with relatively modest changes in age-standardised risk over time.

(Source: Cancer Research UK incidence projections; Office for National Statistics population projections)

In Greater Manchester, these demographic drivers are compounded by deprivation and later diagnosis, resulting in higher demand and poorer outcomes relative to the England average.

Tumour-specific demand drivers

Tumour-specific incidence data demonstrates where demand is greatest:

- breast, prostate, lung and bowel cancers account for over 50% of all new cancer diagnoses in the UK
- cancer incidence in adults aged 25–49 increased by approximately 24% between 1995 and 2019
- overall cancer incidence rates increased by approximately 4% over the last decade and are projected to continue rising
- there are now nearly 3.5 million people living with cancer in the UK, compared with around 3.0 million in 2020, increasing demand for survivorship and follow-up care.

(Source: Cancer Research UK; Macmillan Cancer Support prevalence analysis)

Implications for the five-year delivery plan

The Greater Manchester population needs assessment has informed the five-year delivery plan and references are included throughout this plan. In summary by:

- prioritising action to reduce inequalities in cancer outcomes by supporting population analysis to expand the reach of Christie at home
- supporting assumptions for sustained growth in demand driven by demography, deprivation and complexity
- informing long-term capacity, workforce and productivity planning
- supporting modernisation of cancer treatment and medicines infrastructure, including participation in one of four national aseptic medicines hubs planned to be operational by 2027.

The Christie NHS Foundation Trust

Wilmslow Road
Manchester
M20 4BX

christie.nhs.uk