

**Board of Directors meeting
Thursday 23rd October 2025 at 12.45 pm
Trust meeting room**

Agenda

Patient story / clinical presentation: Improving outcomes by learning from every patient (RAPID-RT)
– Dr David Wolfe, Consultant Clinical Oncologist and Kevin Dillon, patient

30 mins

Public items	Decision		Lead	Page	Timing
31/25 Standard business					
a Apologies			Chair		
b Declarations of interest			Chair		
c Minutes of previous meeting – 25 th September 2025	Approve	*	Chair	2	5 mins
d Action plan rolling programme, action log & matters arising	Review	*	CEO	9	
32/25 Performance & finance					
a Trust report	Review	*	Execs	12	
b Integrated performance quality & finance report	Review	*	COO	18	15 mins
c Value Improvement Programme update	Review	*	COO	56	
33/25 Planning					
a Regulatory preparedness update	Review	*	ECN	63	
b Planning update	Review	*	DoS	66	15 mins
c Future Christie update	Review	*	DFC	73	
34/25 People & culture					
a FTSUG Update	Review	*	FTSUG	77	10 mins
35/25 Governance (regulatory / statutory compliance)					
a Reports from committees (Sept 2025 meetings)					
• Quality Assurance Committee		*		91	
• Workforce Assurance Committee	Review	*	Committee chair	98	15 mins
• Audit Committee		v			
• Senior Management Committee		*		103	
b Board assurance framework	Review	*	CEO	106	
c EPRR Compliance statement	Approve	*	COO	116	5 mins
36/25 Any other business					

Reflections on the meeting

Date and time of the next meeting

Thursday 27th November 2025 at 12:45pm

D/CEO Deputy / Chief Executive Officer
ECN Executive Chief Nurse
DFC Director of Future Christie
COO Chief Operating Officer
FTSUG Freedom to Speak Up Guardian
DoS Director of Strategy

* paper attached
v verbal
p presentation



**Public meeting of the Board of Directors
Thursday 25th September 2025 at 12.45 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
Roy Dudley-Southern (RDS), Non-Executive Director
Dr Diana Tait (DT), Non-Executive Director
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
Sally Parkinson (SP), Executive Director of Finance
Dr Neil Bayman (NB), Executive Medical Director
Eve Lightfoot (EL), Director of Workforce
John Wareing (JW), Director of Strategy
Tom Thornber (TT), Director of Future Christie
Prof Fiona Blackhall (FB), Director of Research
Prof Rikki Goddard-Fuller (RGF), Director of Education
Narinda Saini (NS), Deputy Chief Nurse

Minutes: Louise Westcott (LW), Company Secretary

In attendance: Jo D'Arcy (JD), Assistant Company Secretary
Geraldine Vesey (GV), Deputy Director of Communications
Lee Showman, Public Governor

Clinical presentation: 'A 360-degree view of The Christie's National Peritoneal Tumour Centre' – Prof Omer Aziz, Colorectal Surgeon & Rebecca Halstead, Clinical Nurse Specialist and Toby Ward, patient.

OA introduced himself and the highly specialised service. The service deals with peritoneal tumours and covers a range of treatments but specifically for patients that have cancer spread around the lining of the abdomen. The surgery also involves the use of hot chemotherapy washes in the abdomen. These are primarily appendix and colorectal cancers.

The team was described – specialist medical and clinical oncologists, specialist nurses, radiologists, dieticians etc as well as the surgeons.

More & more patients are being referred, this is down to education and earlier detection. There are 2 specialist centres, us and Basingstoke.

RH noted that the team have seen a huge increase in patients since the service started and they are heavily involved with each patient. There is a big focus on survivorship as well as the treatment phase. A Clinical psychologist and dietician have been added to the team. A buddy system has been put in place for patient-to-patient support. The team do a patient day each year with speakers from across the team and from patients. There have been patients that didn't want the surgery and have gone on to have it following the patient day.

There is a focus on increasing awareness amongst health professionals. An appendix module has been created to encourage early referral and knowledge. ePROMs service has been developed for the service – enables patients to let the team know about issues as they come up. This has been presented internationally.

RH introduced Toby.



Toby came 9 years ago (now 42 years old) – he described having had open surgery on a ruptured appendix at Wythenshawe, the surgeon had been trained by The Christie and referred him to the team.

Toby explained that he was a school teacher and keen cricketer but had experienced pain and discomfort that got much worse. He went into Wythenshawe Emergency Department and had surgery. He was then referred with a low grade appendiceal neoplasm. Life changed overnight. Referral to the Christie happened after that. Prof O'Dwyer recommended an exploratory operation where the worst-case scenario was confirmed. Chances of survival were low. Toby described how difficult this time was. The team described things that could be tried. Systemic chemotherapy was advised and following this, Toby became eligible for specialist HIPEC surgery. In this time, he kept teaching and cricket coaching to maintain purpose and keep active. The chemotherapy had worked very well, the aim was to prolong life but not necessarily cure. He described the support from so many people that has enabled him to get through the treatment. He had been married for 2 years at this point and it was very difficult for his wife, Jackie.

There was a year of very intense treatment and following the surgery there was some cancer left behind – this turned out to have been defeated by the chemotherapy and he was effectively cancer free. There were another 12 rounds of chemotherapy following the surgery.

Toby described the fact that he was picked up by a surgeon initially that had been trained, that the team treat each patient as a friend and care is personalised. The lack of control is extreme and the team try to give you back some autonomy.

Toby is now a full-time cricket coach and hasn't gone back to teaching. He now has a child and tried hard not to think about recurrence, counselling has helped a lot. The patient day is hugely impactful and gives community for the patients involved. He described having a chronic disease.

JR thanked the team for the presentation and congratulated Toby on a fantastic description of his experience.

TT asked whether there is support we can offer in a different way across the year to provide support in between the patient day to prevent isolation. Toby described the forum's that exist that helped him and his wife. He is also local so could be here regularly. RH described the charity that supports patients, 'Pseudomyxoma Survivor'. The patient days are virtual and recorded that can be shared.

OA described how ePROMs has also helped to draw out patient themes such as menopause.

DT asked about the extra pressures caused by being a super-specialist service, particularly around feedback and accommodation. The team described that they use StayCity accommodation alongside the Proton Service. The Trust have provided amazing support to allow the service to exist and flourish.

GP asked what is next for the service, QA noted the genetic sequencing – there may be a biomarker for appendix cancer that means early detection through a blood test. There are difficult conversations around what can be funded.

RDS asked about those cannot be treated through surgery. RH noted that we have specialist radiological treatment, we give some patients chemotherapy, and that the team are always here for patients if they want to come back to us.

The Board were invited to attend the patient day next Friday.

JR thanked the team for coming to present with particular thanks to Toby for taking the time to tell his story.



Item		Action
26/25	Standard business	
a	Apologies	
	Vicky Sharples (VS), Executive Chief Nurse, Amanda Oates, Non-Executive Director, Tarun Kapur (TK), Non-Executive Director, Jeanette Livings (JL), Director of Communications	
b	Declarations of Interest	
	SC noted her declaration as an employee of NCA. CH noted his NED role at the NCA. There are no items on the agenda where this creates a conflict.	
c	Minutes of the previous meeting – 26th June 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. The Board activities over the next 6 months were noted.	
27/25	Performance & Finance	
a	Trust Report	
	<ul style="list-style-type: none"> • The new Performance Assessment Framework has been introduced; our Q1 assessment is presented, we are ranked 3/134 and in segment 1. • All indicators are achieved. • Quality indicators are all stable and no issues to escalate. • Financial position is outlined at month 5 as on plan. • Excellent assessments of quality by CQC inpatient survey, latest staff survey and OEI reaccreditation noted. • Regulatory developments noted. • The Board reviewed the Provider Collaborative priorities and noted the commitments made to each of the priorities. • GP asked about the detail of the oversight framework – particularly infection rates and the risks relating to penile and unintended blood products – rise in risk scores. • RS noted that the IPQFR will detail more on this. • Ranking relative levels are very good against all aspects of the assessment. • Report noted 	
b	Integrated performance quality & finance report	
	<ul style="list-style-type: none"> • The report has been redesigned to align with the NHSE Insightful Board and the new NHS assessment framework ensuring consistency with national oversight and supporting informed triangulated Board discussion • Each director will provide narrative outlining risks and opportunities and their implications rather than a separate list of indicators to provide a consistent and meaningful view of performance trends and organisational learning. • Future iterations of the report will include Research & Education ensuring a comprehensive view of Trust wide performance. • IPC – national oversight framework looks at MRSA (2 in last 12 months), CDiff 	CM



	<p>and eColi.</p> <ul style="list-style-type: none"> • Following the last MRSA infection that we reported there was a comprehensive action plan implemented and reviewed by NHSE. • eColi rose during the heatwave in June – learning has been captured and corrective measures introduced. • Monthly IPC walkarounds are in place and an increased focus on ANTT training. We are learning from others. An IPC summit has also been arranged to raise awareness • Risks relating to penile and colorectal delays – time to surgery. Penile cancer is complex and requires multiple surgical episodes. This risk has come down in month through increases in theatre and appointing a new surgeon. • Colorectal risk relates to complex patients and how we are prioritising them. We have now addressed the actions and the risk has been reduced. • Query on medical agency cost rise relates to Leighton haematology activity that was expected, this will reduce following permanent appointments • JR noted that these are extremely good results and reflect excellent overall controls. • Query over national measurement of IPC based on bed days – absolute numbers are also described. 	
c	Financial Planning	
	<ul style="list-style-type: none"> • Assurance letter to GM ICB about our plan has been submitted with best & worse case scenarios. • Financial planning is outlined – previous results outlined (over 5 years) • Benchmarking also noted – GIRFT and Model Hospitals. • Capital expenditure over last 5 years shown including period of restricted spending. • 3-year planning cycle – there was discussion on how exposed we are. There is some uncertainty around commissioning intentions as well as how we are going to be paid. The expenditure plan is clear. <p>The Board noted:</p> <ul style="list-style-type: none"> • The assurance letter provided to GM ICB • 2025/26 year-end forecast scenarios • financial planning requirements 	
c	Value Improvement Programme update	
	<ul style="list-style-type: none"> • Target is £25.3m (5.6% of total expenditure) plus £6m (corporate saving) – delivery phased over 12 months. • Month 5 we are on plan – we have identified the full total with £11.2m recurrently identified. • It was noted that this kind of performance is not standard across GM. • We are working on 2026/27 with improved opportunity packs for divisions using the Model Health System and GIRFT data. • Integrating VIP with operational planning as well as breakthrough projects e.g. Future Christie plans. • Board asked to sign off the planned approach for 2026/27. 	



	<p>Agreed.</p> <ul style="list-style-type: none"> • MLW asked about how this is landing in the organisation. • CM noted that we have engaged at all levels to identify schemes. • Staff understand that we are focused on making the most of our resources. • Recurrent pressures will grow as we cannot rely on cutting ‘heads & beds’. It will get tougher. • It was stressed that we need back-office functions and admin people to support the clinical services. • The Christie School are working with bands 2-4 to support their development and support delivery of further efficiency. • There is a focus on digitisation for patient benefit. • JR noted that there has been significant foresight in getting to this point. • We will continue with a longer-term planning approach • Board agreed to the approach presented. 	
28/25	Planning	
a	OECI accreditation report	
	<ul style="list-style-type: none"> • We have been reaccredited as a comprehensive cancer centre by OECI • A significant amount of work went into this process across the Trust • Assessment is done by people who understand cancer and covers clinical service, research and education • Report outlines an action plan that is being progressed • The next assessment will be in 5 years time <p>Report noted</p> <ul style="list-style-type: none"> • What opportunities does this accreditation bring – connections that are made with other organisations to collaborate with research and education. • We are exposed to contacts from a wider geography than ‘Europe’ through this accreditation. • The method of assessment is peer review undertaken by cancer experts and this gives a very rich set of information that we can use to further improve. 	
b	Future Christie update	
	<ul style="list-style-type: none"> • Organisational change is key • Short-, medium- and long-term goals outlined • Patient portal went live 10 days ago to provide access to outpatient letters and appointments. Good initial sign up. • This is a first step but is limited by integration with other systems through our existing EPR – radiotherapy, SACT and radiology are not integrated • AI planning in radiotherapy is expanding • Looking at an ambient AI solution to release clinical and administrative time • Stressed that the approach to EPR and data are interdependent • Engagement across the Trust has been good but needs more and we need to engage staff and patients further – there is more to be done • We will engage in national systems such as the Federated Data Platform and NHS App. 	



	<ul style="list-style-type: none"> • Comment made about the Patient portal – very good, feels substantial. What about patients who don't want to use an App. Using link to nominated carer helps. We are moving to digital first but must understand who is not engaging and provide information appropriately. Letters continue in the short term • Will be an element of resistance to digital transformation – looking at patient first and staff first approach. • Cultural aspects are a focus • Must be aware of change to roles being a very daunting challenge for staff – we are finding that people understand that there is no choice but to progress • Portal complies with national cyber requirements – MFA is in place. 	
29/25	Governance (regulatory / statutory compliance)	
a	Reports from Committees (September 2025)	
i	Workforce Assurance Committee	
	<p>EL noted the report</p> <p>An escalation came from the last meeting (September) relating to a small number of teams who were below threshold with mandatory training and work has been done to address this. It will come back to the next meeting.</p>	
ii	Quality Assurance Committee	
	<p>No alerts, 2 medium assurances on 'lost to follow up' and medication safety – waiting for audit results.</p> <p>IPC – high assurance relating to the IPC BAF and the correct information.</p>	
iii	Audit committee	
	<p>GP noted a lot of focus on year-end process, and annual reporting. Strong assurance on that position / process.</p> <p>External auditors were very satisfied with the year-end process and reporting.</p> <p>Deep dive on cyber – medium assurance based on action we are taking but the risk remains high.</p> <p>New offense to prevent fraud has come in and there is training taking place on this and the assurance required for Boards. Data quality is an area that needs to be considered. MIAA will make an assessment and report back to the committee.</p>	
b	Board Assurance Framework	
	<ul style="list-style-type: none"> • Updates and amendments outlined in the paper including changes to risk scores and additions of detail in controls, gaps and assurances. • Change to the OECl risk – this can be removed following reaccreditation. • No further changes proposed • Timeline for reduction in the risk around PSIRF – want more evidence in learning but this should be reduced in the coming months. 	
c	Board capability self-assessment	
	<ul style="list-style-type: none"> • RS outlined the new requirement to complete a Board Capability self-assessment associated with the new performance assessment framework. • We are relying on evidence that has been presented over previous assurance and Board meetings that we can confirm we are capable across the 6 areas. • This will form part of the normal process going forward through the assurance 	



	committees and the reporting cycle. <ul style="list-style-type: none"> • It is noted that we are not being asked to confirm that there are no issues but rather that we are confident that the information already received over time allows us to confirm against each area. • Other evidence will also be shared including the annual governance statement, compliance with the provider licence, annual reporting etc. • Board approved the position for submission to NHSE by the deadline of 22nd October. 	LW
d	Board assessment statement on Winter Planning	
	<ul style="list-style-type: none"> • The Board is asked to approve the sign-off of the Board Assurance Statement (BAS) for submission to NHS England by 30 September 2025. • This has been produced as part of a wider system process of assessment • Very low risk over the winter period compared to other Trusts. • QAC have reviewed this assessment and are happy to recommend sign off by Board. • Board approved sign off of the assurance statement for submission to NHSE by the deadline. 	
30/25	Any other business	
	<ul style="list-style-type: none"> • No items noted 	
	Date and time of the next meeting	
	Thursday 23 rd October 2025 at 12:45pm	



Meeting of the Board of Directors - 23rd October 2025
Action plan rolling programme after September 2025 meeting

C Culture P Performance S Strategy G Governance

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
October 2025		C	Patient story	CEO	To hear a patient story	Board presentation
		P	Integrated performance & quality and finance report	COO	Monthly report	32/25b
		P	Value Improvement Programme	COO	Review	32/25c
		S	Future Christie update	DFC	Review	33/25c
		P	EPRR Compliance statement	COO	Approve	35/25c
		G	Regulatory preparedness update	ECN	Review	33/25a
		C	Freedom to speak up guardian	FTSUG	Annual report	34/25a
		Planning & Development Day	S	Board Planning & Development	Chair	Board development programme - externally facilitated
November 2025		C	Patient story	CEO	To hear a patient story	Board presentation
	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	DoE	Approve	
		S	Annual Sustainability Report - Boards responsibility for Carbon Net Zero	DCEO	Note approval by Audit Committee	For information
December 2025 - 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 2026		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 2026 - 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

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
	Annual reporting cycle	G	Annual reporting cycle	Executive directors	Approve	
		S	Future Christie update	DFC	Review	
		P	Value Improvement Programme	COO	Review	
		C	Staff survey initial results	DoW	Note	
	Annual reporting cycle	G	FPPT Compliance report	Chair	Approve annual compliance	
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	Note April 2023 to March 2024	
	Provider licence	G	Self certification declarations	CEO	To approve the declarations	
	Annual reporting cycle	S	Annual Corporate Objectives review / BAF	CEO	Review progress	
		G	Modern Slavery Act statement (in Trust Report)	CEO	Approve	
		P	Trust Strategy Update	DoS	Review	
	Annual reporting cycle	P	Risk Management strategy 2024-25 annual review	ECN	Annual Review	
May 2026 - no meeting Planning & Development Day	Annual reporting cycle	P	Integrated performance & quality and finance report	COO	Monthly report	By email
		S	Planning			
June 2026		C	Patient story	CEO	To hear a patient story	
	Annual reporting cycle	P	Integrated performance & quality and 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	
	Annual reporting cycle	S	Annual objectives / BAF 2026/27		Approve	
	G	Annual report, financial statements and quality accounts (incl Annual governance statement / Statement on code of governance)	EDoF	Approve		
July 2026 - no meeting Planning & Development Day		P	Integrated performance & quality and finance report	COO	Monthly report	By email
		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	



**Action log following the Board of Directors meetings held on
 Thursday 25th September 2025**

No.	Agenda	Action	By who	Progress	Board review
1	27/25b	Include Research & Innovation and Education performance in the Integrated Performance Quality & Finance Report	COO	Indicators and feed of data to be agreed	January 2026
2	29/25c	Submit Board capability self-assessment by 22 nd October deadline following Board approval	Comp Sec	Complete	To note



Meeting of the Board of Directors
Thursday 23rd October 2025

Subject / Title	Trust report
Author(s)	Executive Directors
Presented by	Roger Spencer, Chief Executive
Summary / purpose of paper	This report brings together the key issues for the Board of Directors in relation to our performance, strategy, workforce, the Greater Manchester system landscape, the regulatory landscape and other pertinent matters within the scope of the board's responsibilities.
Recommendation(s)	The board is asked to note the contents of the paper.
Background Papers	Integrated Performance, Quality and Finance Report Finance Report
Risk Score	See Board Assurance Framework
EDI impact / considerations	
Link to: ➤ Trust's Strategic Direction ➤ Strategic Objectives	<ol style="list-style-type: none"> 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 provide leadership within the wider NHS cancer system
Acronyms or abbreviations contained in the report	<p>NHSE NHS England FDS Faster Diagnosis Standard PDR personal development review GM Greater Manchester OECI Organisation of European Cancer Institutes VIP Value Improvement Programme EPR electronic patient record AI Artificial Intelligence NIHR National Institute for Health & Care Research</p>



Trust Report

Thursday 23rd October 2025 (September data)

Introduction

The Christie remains a high-performing organisation, strategically well positioned, with no current issues requiring escalation and a projected achievement of annual objectives across all strategic 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 all 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 detail 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 provides assurance of the board's leadership capacity, governance maturity, and preparedness to meet national performance expectations.

Our self-assessment of full compliance against the [NHS England provider capability](#) domains was approved at the September Public Board. The table below summarises the position with all domains rated Green, with no escalation required. A declaration of full compliance has accordingly been made to NHSE.

NHSE Board capability domain	Relevant Indicators	Evidence	RAG rating
1. Strategy & Leadership	Oversight Framework segment; national ranking	NOF Segment 1, 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 at/above safe 1:8 ratio.	
3. Workforce	Sickness absence; PDR compliance; training compliance	Sickness 4.9% (lowest in GM). PDR compliance (87.2%) and mandatory training compliance (94.7%)	
4. Partnerships & System Role	GM Collaborative contributions; national audits	Leadership in Cancer Alliance. Lead GM aseptic programme. OECl reaccreditation confirms global top-tier status.	
5. Financial Sustainability	Monthly surplus; VIP delivery	Surplus (£3.8m) 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 6 Position

The Trust's national ranking and Segment 1 status confirm our continued excellence and provide strong external assurance of our leadership and capability.

The Christie continues to perform strongly across all domains. We remain in Segment 1 of the NHS Oversight Framework, the highest possible rating, and are currently ranked third nationally among acute and specialist providers. This position reinforces our international standing as one of the top 25 global cancer centres as reported at the September board meeting.

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

Strategic Objectives – Month 6 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 September. The recently published CQC Inpatient Survey and National Cancer Patient Survey both confirm that The Christie remains among the best performing providers nationally. Four operational risks currently score 15 or above and are actively monitored via the Risk & Quality Governance Committee, with mitigation plans in place.

A temporary suspension of production in the Aseptic Unit occurred for five days during early October. The business continuity plan was activated immediately, and an aseptic action plan was implemented to ensure patient safety and service continuity. This incident has been reviewed and does not require escalation.

Our learning culture continues to mature. The Patient Safety Incident Response Framework (PSIRF) has now been implemented across the organisation, and the latest version of the Learning Bulletin has been shared widely to support reflective practice and continuous improvement.

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: 1 ≥15
- Committee Oversight: Senior Management Committee
- Executive Lead: Executive Director of Finance

At Month 6, the Trust is delivering a financial surplus of £3.8 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.

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

Research trial set-up times are currently below the national 60-day benchmark but have improved with further process improvements taking place to sustain and further improve this position. We have secured a capital bid from NIHR to expand our Clinical Research Facility to a seven-day service, which will significantly enhance capacity and access.

A proposal to establish Higher Education status is being developed and a progress report will be brought to the November 2025 Board of Directors meeting for discussion. This represents a strategic opportunity to strengthen our academic partnerships and reinforce our position as a centre of excellence in cancer education.

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 94.7%, and PDR completion is at 87.2%. Sickness absence is currently at 4.9%, the lowest in Greater Manchester. The Christie continues to be rated in the top category nationally for compassionate and inclusive culture, staff engagement, morale and flexibility, as confirmed by the NHS Staff Survey 2024.

Staff engagement activity in September was extensive and well-attended. Highlights include the Strategic Leaders Forum, which brought together over 120 colleagues from across the Trust to discuss risk, planning, operations and inclusive culture strategy. Other events included the Annual Members Meeting, Grand Round on the Future Christie Programme, and multiple staff forums and engagement sessions led by the Executive Team.

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 development of a business case for a new electronic patient record (EPR) is underway. 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, reinforcing our strategic influence.

- Status: Green
- Key Updates: OECl reaccréditation; GM Collaborative leadership; network expansion
- BAF Risks: 1 ≥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 Stockport, Macclesfield and Crewe, further consolidating our system leadership.

We have successfully achieved reaccréditation from the Organisation of European Cancer Institutes (OECl), reaffirming our position among the top 25 global cancer centres.

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		Senior Management Committee
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

- [NHS England » NHS Oversight Framework 2025/26](#), in which The Christie is confirmed in Segment 1
- [NHS England » Planning framework for the NHS in England](#) (September 2025), which sets out requirements for the five-year integrated plan (2026/27–2030/31)
- [NHS England » Assessing provider capability: guidance for NHS trust boards](#), which underpins our Board self-assessment.

Recommendation

To note that The Christie remains a high-performing organisation that is strategically well positioned and has declared full compliance with the NHSE Board capability domains.





Strategy and Leadership

The Trust remains well-aligned with national priorities under the NHS Oversight Framework 2025/26, showing strong domain-level performance and readiness for public benchmarking via Model Hospital. The integration of Leighton Haematology services temporarily affected key metrics, but responsive interventions (extra clinics, locum cover) demonstrate adaptive leadership. The 62-day cancer treatment improvement initiative (Nov 2025–Mar 2026) reflects a proactive approach to sustained performance improvement.

Quality of Care

Patient safety remains robust: one notifiable incident in September, duty of candour complete. Positive safety culture evidenced by high reporting rates: 83% no-harm and 16% near-miss incidents. Six PSII/SWARM learning responses initiated, embedding a continuous learning culture. Infection control: C. Difficile and P. Aeruginosa below trajectory; E. Coli and Klebsiella above, requiring targeted surveillance. Patient feedback continues to validate high-quality, compassionate care. Three operational risks scoring over 15 in September.

Workforce

Safe staffing sustained (1:7 average nurse–patient ratio, occasionally 1:8) with no correlation to incident trends. Staff absence: 4.9% (above target) due to short-term sickness. Turnover falling, and mandatory training compliance high (94.68%). PDR completion above target, supporting staff development and engagement.

Financial Sustainability

£3.8m surplus at month 6, aligned with plan. Capital spend £8.5m (slightly above plan) focused on ASIC, estates, digital, and asset replacement. Value Improvement Programme (VIP): £25.3m identified; £0.9m recurrent gap actively managed. Agency/bank costs stable or decreasing, reflecting strong workforce cost control.

Service Improvement

Cancer performance remains strong: 62-day: 75.3% (above stretch target) 31-day: 98% Faster diagnosis: 90% (target 80%) RTT 18-1week: 94.5%; 52-week waiters resolved with treatment scheduled. Referral growth from service expansion prompts ongoing capacity and pathway optimisation.

Overall Assessment

The Trust demonstrates robust leadership, financial stability, and high-quality care delivery, with clear evidence of strategic alignment and continuous improvement. Key focus areas ahead include infection control performance, short-term sickness management, and sustaining cancer pathway gains through capacity planning.

Report Flags

VTE - assessment compliance is stable but below target, requiring improved workflows, staff engagement, and EPR optimisation to reach 95%

24 Day Performance – 85% of breaches (average 80 pts per month) late referrals from secondary care improvement plan in place being monitored through operational improvement group

52 Week performance - In September, we reported that 0.04% (1 patient) of patients were waiting over 52 weeks for treatment, against a target of 0%. Patient now dated

Vacancy Rate - The vacancy rate for September 2025 was 6.67%, exceeding the target threshold of 5.00%.



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 initial data below shows the Trust's rankings based on the first cut of data (the Access to services module is not currently being populated for specialist cancer Trusts). 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

1.51

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

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

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

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?](#)

Focussed performance areas ?

Access to services	(Blank)	?
Finance and productivity	2 - Above average	?
Effectiveness and experience of care	1 - High performing	?
Patient safety	1 - High performing	?
People and workforce	1 - High performing	?

Average score by trust rank placement

[View full league table](#)

Segment ● 1 ● 2 ● 3 ● 4 Selected trust ●

Average score

Trust rank

1 out of 134 (highest ranked) 20 40 60 80 100 120 134 out of 134 (lowest ranked)



Oversight Framework 25/26

Segment

1 - High performing

Finance and productivity domain segment

2 - Above average

[Return to overview](#)

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric score	Rank	Average value	Standard
Finance and productivity	Finance	Combined finance	Q1 2025/26		score	1.00			
Finance and productivity	Finance	Planned surplus/deficit	2025/26	1.39	percent	1.00	5 out of 134	-1.62	0
Finance and productivity	Finance	Variance year-to-date to financial plan	Month 3 2025	-0.37	percent	2.00	98 out of 134	0.00	
Finance and productivity	Productivity	Implied productivity level	To M12 2024/25 vs 2023/24	1.64	percent	2.92	86 out of 134	2.91	

Segment

1 - High performing

Effectiveness and experience domain segment

1 - High performing

[Return to overview](#)

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric score	Rank	Average value	Standard
Effectiveness and experience	Effective flow and discharge	Average number of days from discharge ready date to actual discharge date (including zero days)	Jun-25	0.30	days	1.34	15 out of 126	0.70	
Effectiveness and experience	Patient experience	CQC inpatient survey satisfaction rate	2023		score	1.00			



Segment

1 - High performing

Patient safety domain segment

1 - High performing

[Return to overview](#)

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric score	Rank	Average value	Standard value
Patient safety	Patient safety	NHS Staff survey - raising concerns sub-score	2024	6.93	out of 10	1.11	6 out of 134	6.42	
Patient safety	Patient safety	Number of MRSA infections	Jul 24 - Jun 25	3.00	count	2.63	55 out of 134	3.00	0
Patient safety	Patient safety	Rate of C-Difficile infections	Jul 24 - Jun 25	1.04	rate	2.11	26 out of 134	1.22	1
Patient safety	Patient safety	Rate of E-Coli infections	Jul 24 - Jun 25	1.05	rate	2.22	34 out of 134	1.16	1

Segment

1 - High performing

People and workforce domain segment

1 - High performing

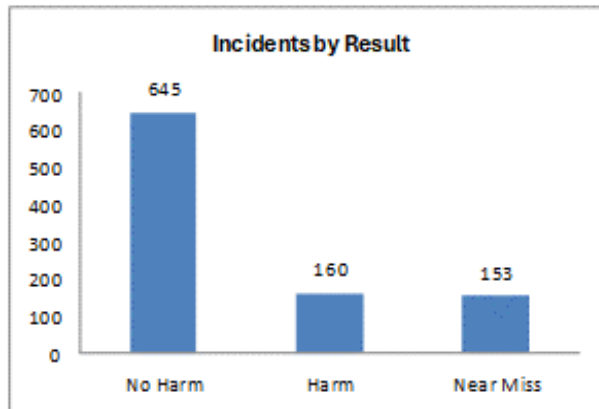
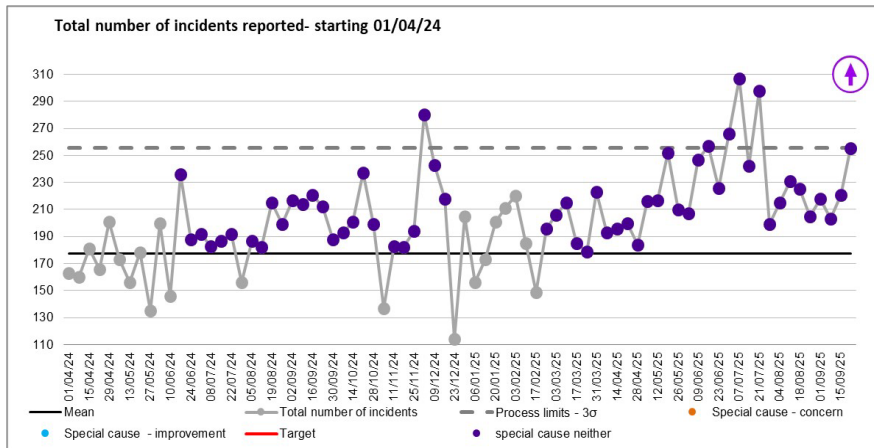
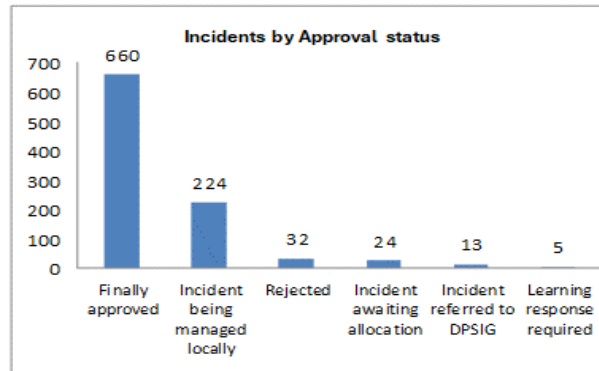
[Return to overview](#)

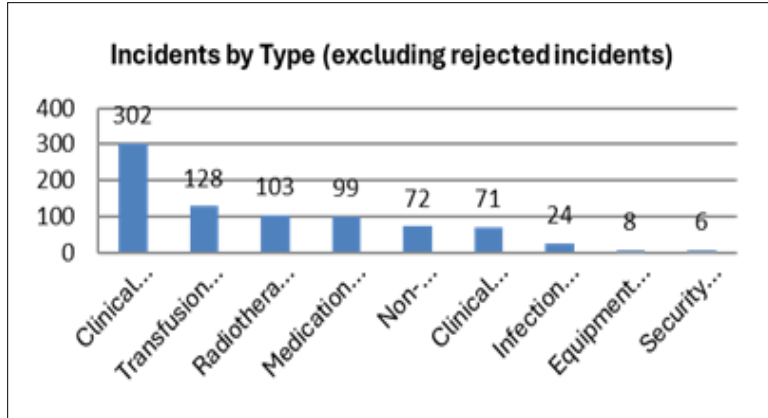
Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric score	Rank	Average value	Standard value
People and workforce	Retention and culture	NHS staff survey engagement theme sub-score	2024	7.52	out of 10	1.02	2 out of 134	6.88	
People and workforce	Retention and culture	Sickness absence rate	Q4 2024-25	4.38	percent	1.38	22 out of 134	5.21	



A total of 958 incidents were reported to DCIQ in September 2025.

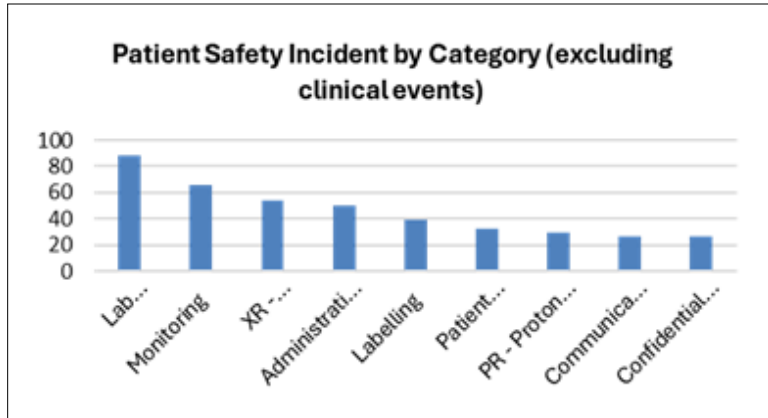
- At the time of reporting, 69% of incidents have been finally approved. 3% of incidents have been rejected for reasons such as duplication and incidents which involve care provided by an external trust.
- 83% of incidents reported resulted in no harm
- 16% of incidents were reported to be a 'near miss', evidencing a positive reporting culture
- Reporting trends in September were within the expected limits, with a decrease in incidents reported from last month





In September 2025, 88% of all incidents reported (841/958) were classed as 'Incidents affecting a patient' and therefore reported to LFPSE (Learning from Patient Safety Events).

The chart shows that of these (excluding rejected), 71 (8%) were clinical events, this category includes cardiac arrests, known complications and events recorded for monitoring purposes.



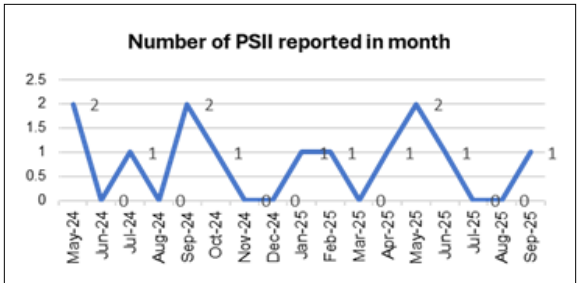
The remaining 742 incidents were categorised in the DCIQ system, and the chart shows the top 10 categories identified.

Lab investigation - high volume of reports noted due to challenges encountered with meeting sampling labelling requirements for the order comms system.

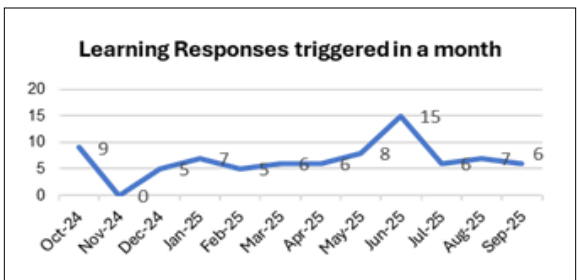
Monitoring – near miss/no harm incidents relating to omitted vital signs during the blood transfusion administration process. Individual clinical areas are reviewing these incidents to devise an action plan to improve practice.



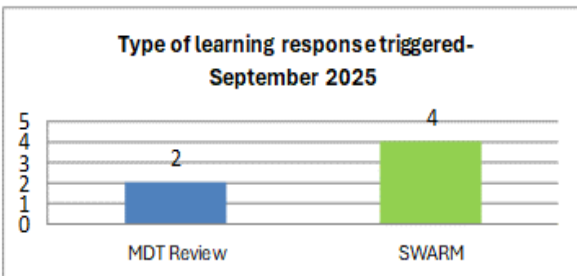
Incidents identified that require a Learning Response



- Patient Safety Incident Investigations (PSII) are triggered when there is a significant opportunity for learning and improvement. PSIIs are extensive investigations which result in specific outcomes recommended by trained investigator.
- 1 PSII was reported in September 2025:
- I16517 – HIV status of patient disclosed to patient's family after HIV status included on transfer form



- Learning responses are triggered when an opportunity for new learning is identified.
- Potential learning responses are discussed and agreed at the PSIRF delivery group which is held weekly and attended by the patient safety team and divisional governance teams.
- 6 Learning responses were triggered locally and via the divisional PSIGs in September 2025.



- 2 MDT reviews and 4 SWARMs were triggered in September 2025.

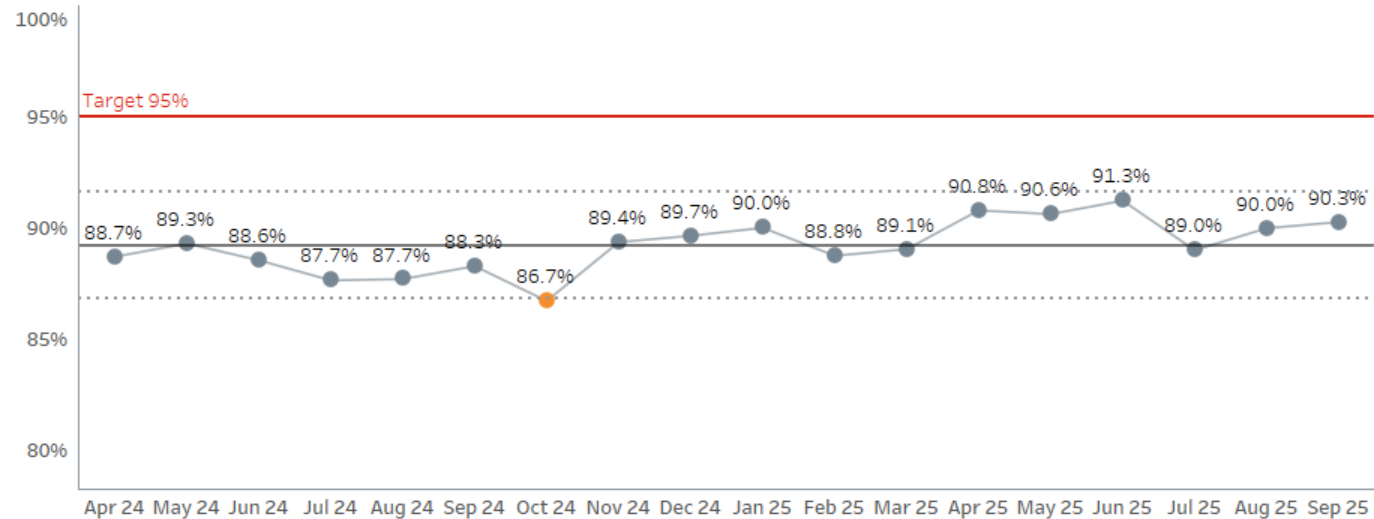


Integrated Performance Report - Patient Care Metrics Summary

Metric	Month	Measure	Target	Variation	Assurance
Sepsis - screening (presenting as an emergency)	September	98.80%	90.00%		
Sepsis - timely treatment with IV antibiotics (established inpatients)	September	98.75%	90.00%		
VTE Assessment Within 14 Hours of Admission	September	90.29%	95.00%		
Falls per 1000 bed days	September	5	4		
Pressure sores per 1000 bed days	September	0	1		
Category 3 pressure ulcers	September	0	0		
Hospital Cancelled Operations on the day for non clinical reasons	September	0	0		



VTE Assessment Within 14 Hours of Admission



Icons

Common Cause

Failing

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 target: No month achieved or exceeded the target level. Variation analysis: Data indicates common cause variation — the process is stable but currently incapable of achieving the required standard. Current VTE assessment compliance demonstrates a stable but suboptimal process. Focused interventions centered on workflow efficiency, staff engagement, and EPR optimisation—will be critical to achieving sustainable improvement and meeting the 95% compliance target

Actions (SMART)

- Examine workflow bottlenecks, staffing levels, and electronic documentation delays within the admission process.
- Progress to be monitored and reported through monthly governance meetings.
- Implement mandatory VTE assessment prompts within the EPR system to ensure timely completion.
- Deliver targeted training for clinical teams focused on prompt and accurate VTE documentation.



Risks with a current risk score of 15 and above:

Risk ID	Risk	Risk Register	Type	Subtype	Risk owner	Date opened	Initial rating	Current likelihood	Current consequence	Current rating	Target rating	Movement from initial rating	Next Review Date
236	Risk of microbiological contamination or delivery of service in ASU due to facility limitations	Pharmacy	Operational Risk	Business Continuity Risk	Dawn Gillibrand	21/03/2025	9	3	5	15		↑	30/10/2025
453	There is a risk to patient safety and experience due to issues relating to how results appear from blood tests sent externally to Manchester Foundation Trust (MFT).	Haematology Teenage and Young Adults	Clinical Risk	Patient Safety / Outcomes Risk	Ruth Elizabeth Clout	14/05/2025	15	5	3	15		↔	26/09/2025
514	There is a risk that patients may experience harm due to significant delays in the management of patients with colorectal cancers.	Trustwide	Clinical Risk	Patient Safety / Outcomes Risk	Tracey Jones	05/09/2025	16	4	4	16		↔	29/10/2025

Risks downgraded from extreme in September :

Risk ID	Risk	Risk Register	Type	Subtype	Risk owner	Date opened	Initial rating	Current likelihood	Current consequence	Current rating	Target rating	Movement from initial rating	Next Review Date
357	There is a risk of a patient inadvertently receiving an unintended blood component or product	Trustwide	Clinical Risk	Patient Safety / Outcomes Risk	Sharon Jackson	16/06/2023	10	2	5	10	5	↓	30/10/2025
389	Not Identifying and Delivering 25/26 recurrent VIP programme impacting on financial sustainability and ability to treat patients	Trustwide	Financial Risk	Financial Management / Waste Reduction Risk	Claire Mcpeake	30/10/2024	16	3	3	9	16	↓	30/11/2025

Extreme risks closed in September :

Risk ID	Risk	Risk Register	Type	Subtype	Risk owner	Date opened	Initial rating	Current likelihood	Current consequence	Current rating	Movement from initial rating	Next Review Date	Date closed
135	There is a risk that patients may experience harm due to significant delays in the management of patients with colorectal and penile cancers.	Trustwide	Clinical Risk	Patient Safety / Outcomes Risk	Tracey Jones	22/07/2025	12	4	4	16	↑	05/09/2025	05/09/2025

- As of the current reporting period, 3 risks have a score of 15 and above.
- 1 new risk was reported in September with a risk score of 16 (ID 514)
- 1 risk was upgraded in September to extreme, with a risk score of 15 (ID 236)
- 2 risks were downgraded from extreme in September (ID : 357, 389)
- 1 extreme risk was closed in September (ID : 135)
- In September 2/3 risks were reviewed within the required trust timescales and so were compliant with the trust's risk review process.



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	16358	13619	5080	5.5
	Total monthly ACTUAL	15461	12723		
	Average Fill Rate %	94.5%	93.4%		
Care Staff	Total monthly PLANNED	9666	6660	5080	2.9
	Total monthly ACTUAL	8657	6223		
	Average Fill Rate %	89.6%	93.4%		
ALL Staff	Total monthly PLANNED	26024	20279	5080	8.5
	Total monthly ACTUAL	24118	18946		
	Average Fill Rate %	92.7%	93.4%		

Registered Nurses	DAY			NIGHT			Cumulative count over the month of patients at 23.59 each day	CHPPD (Care Hours Per Patient Per Day)
	Hours Planned	Hours Actual	% Fill Rate	Hours Planned	Hours Actual	% Fill Rate		
Critical Care Unit	2099	1833	87.3%	2059	1715	83.3%	142	25.0
Palatine Ward	2980	2826	94.8%	2483	2303	92.8%	911	5.6
Ward 10	2133	1924	90.2%	1715	1570	91.5%	747	4.7
Ward 11	1928	1909	99.0%	1514	1503	99.3%	773	4.4
Ward 12	1760	1904	108.2%	1454	1459	100.3%	686	4.9
Ward 4	1913	1818	95.0%	1543	1491	96.6%	804	4.1
Ward 2	1398	1290	92.3%	1046	1001	95.7%	464	4.9
Acute Assessment Unit	2147	1957	91.2%	1805	1681	93.1%	553	6.6
TOTAL	16358	15461	94.5%	13619	12723	93.4%	5080	5.5

Registered Nursing Associates	DAY			NIGHT		
	Hours Planned	Hours Actual		Hours Planned	Hours Actual	
Critical Care Unit						
Palatine Ward						
Ward 10		23				
Ward 11						
Ward 12		12				
Ward 4						
Ward 2						
Acute Assessment Unit						

Care Staff	DAY			NIGHT			Cumulative count over the month of patients at 23.59 each day	CHPPD (Care Hours Per Patient Per Day)
	Hours Planned	Hours Actual	% Fill Rate	Hours Planned	Hours Actual	% Fill Rate		
Critical Care Unit	0	0	100.0%	0	0	100.0%	142	0.0
Palatine Ward	1205	1055	87.6%	986	873	88.5%	911	2.1
Ward 10	1625	1387	85.4%	816	738	90.4%	747	2.8
Ward 11	1536	1380	89.8%	990	930	93.9%	773	3.0
Ward 12	1796	1590	88.5%	1155	1284	111.2%	686	4.2
Ward 4	1683	1480	87.9%	1433	1281	89.4%	804	3.4
Ward 2	765	719	94.0%	565	471	83.4%	464	2.6
Acute Assessment Unit	1056	1046	99.1%	715	646	90.3%	553	3.1
TOTAL	9666	8657	89.6%	6660	6223	93.4%	5080	2.9

*Nursing Associate hours are displayed separately 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.

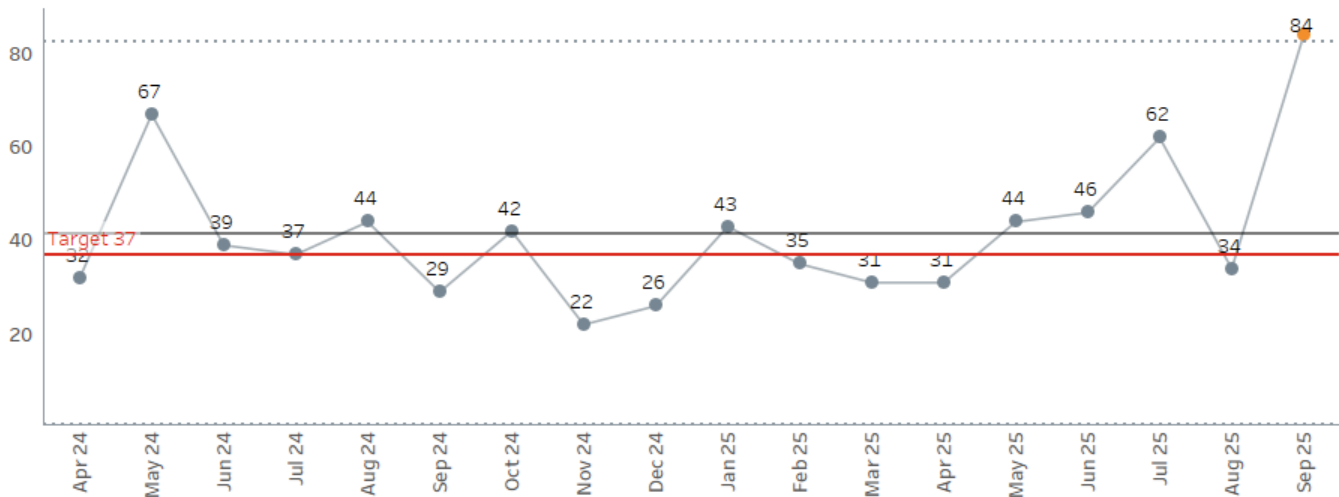


Integrated Performance Report - Friends & Family Test & Patient Experience

Metric	Month	Measure	24/25 Avg	Variation	Assurance
Inpatient Response Rate	September	33.30%	34.00%		
Inpatient Recommended Score	September	95.50%	97.00%		
Outpatient Recommended Score	September	96.10%	96.00%		
Number of new complaints	September	17	13		
Number of PALS	September	84	37		



Integrated Performance Report - PALS



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

Although informal PALS concerns has increased, formal complaints are consistent. The aim to have higher PALS and low formal complaints.

Actions (SMART)

PALS team presence in Oak road entrance 5 days a week, improving accessibility, which has seen increase in informal concerns. This is positive as this supports informal timely resolution of concerns.



Positive feedback received.....

“I would personally wish to express my sincere thanks to you for going the extra mile on my behalf. I would be grateful if you could relay my thanks to the team for providing such an exemplary service. This is the third time I have called upon the services and expertise of the Christie and its teams and on each occasion, I have been overwhelmed by the quality of the care given.”

“To all the Radiotherapy Team. A big thank you to you all. Such kindness and care during my treatment.”

“Me and my family would like to thank you for your kindness and dedication. I'm grateful for your patience and uplifting energy every single day. Thank you for all your support. God bless you all. A massive thank you to you all.”

“Thank you doesn't really express what I feel for the compassionate professionalism and care shown to me during appointments and treatment. When I arrived anxious and concerned as soon as I see your smiling faces, I know I was in safe hands. You do an amazing job day in day out. I feel so fortunate to have been cared for by such an impressive team”.



HCAIs against thresholds 2025-26 – HOHA & COHA only

Indicator	Threshold	Position	Year so far (as at month 6)	Threshold adjusted to month 6	Difference
<i>C.Difficile</i>	≤ 52	Below trajectory	24	26	- 2
E.coli BSI	≤ 43	Below trajectory	33	22	+ 11
Klebsiella spp. BSI	≤ 24	Below trajectory	18	9	+ 9
<i>P.Aeruginosa</i> BSI	≤ 8	Below trajectory	2	4	-2

HCAIs being monitored

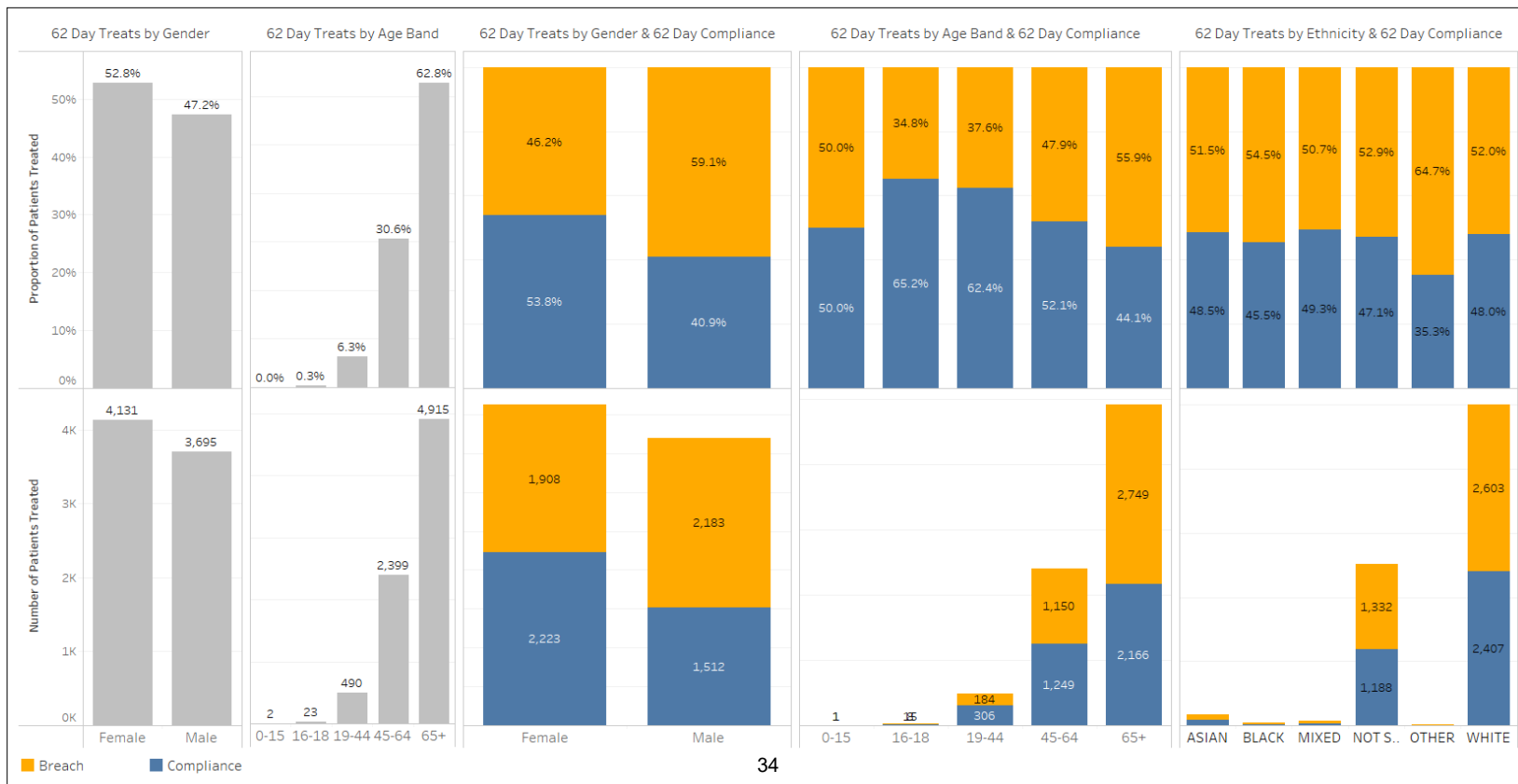
Indicator	Target	Position	Year so far (as at month 6)	Threshold adjusted to month 6
MRSA BSI	Zero tolerance	Above trajectory	1	-
MSSA BSI	No target	No target	13	-

A thematic analysis of E.coli and Klebsiella cases and actions to address has been conducted and areas for improvement included in the Trust IPC improvement action plan, which is overseen in the IPCC committee and reports into Risk and quality governance.



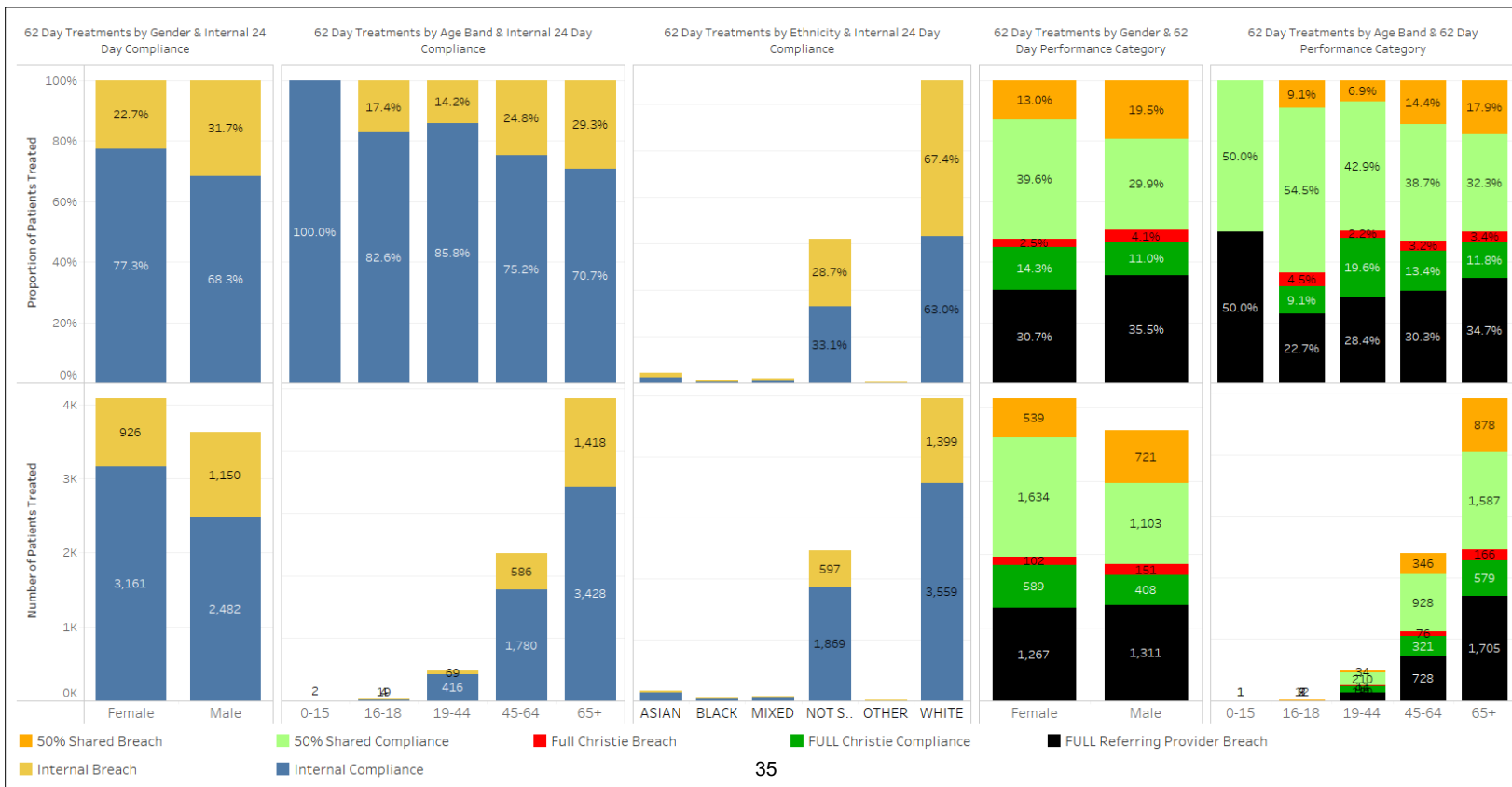
Cancer Standards – Health Inequalities Analysis

62 Day Treatments between 01/04/2023 – 30/09/2025 analysed by gender, age and ethnicity.



Cancer Standards – Health Inequalities Analysis

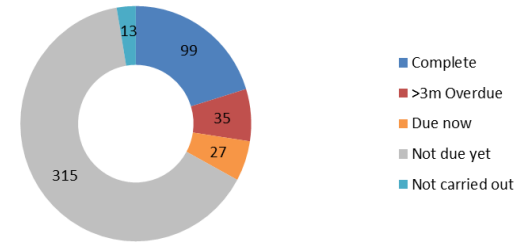
62 Day Treatments between 01/04/2023 – 30/09/2025 analysed by gender, age and ethnicity.



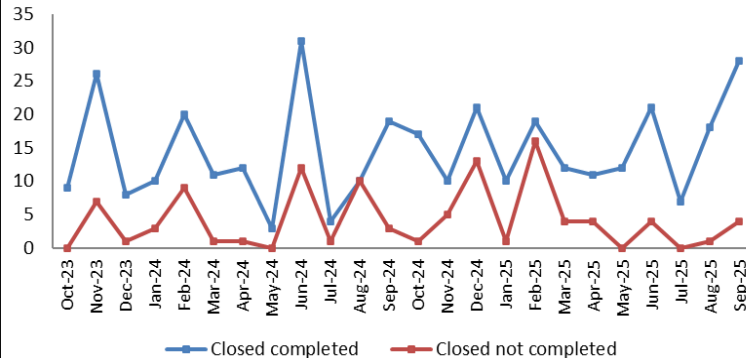
QICA programme – Quality Improvement and Clinical Audit Including service evaluations and patient surveys. Figures include all agreed Trust priority projects. Projects with ‘Individual interest’ priority are not included here.

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

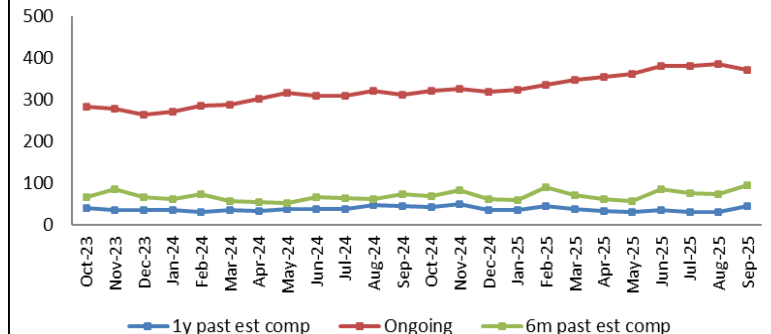
Summary status of projects (September 2025)



No. closed projects by month
(Quality improvement, Clinical audit and service evaluation)

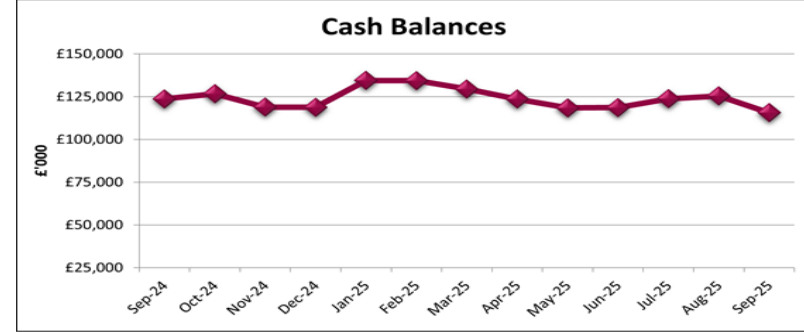


No. open projects by month
(Quality improvement, Clinical audit and service evaluation)



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

Month 06 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(470,392)	(235,082)	(234,769)	313
Other Income	(81,823)	(40,604)	(40,820)	(217)
Pay	266,890	132,008	129,815	(2,193)
Non Pay (incl drugs)	259,020	130,524	132,038	1,514
Operating (Surplus) / Deficit	(26,307)	(13,153)	(13,736)	(583)
Finance expenses/ income	23,089	11,544	12,188	644
(Surplus) / Deficit	(3,218)	(1,609)	(1,547)	62
Exclude impairments/ charitably funded capital donations	(4,282)	(2,141)	(2,207)	(66)
Adjusted financial performance (Surplus) / Deficit	(7,500)	(3,750)	(3,754)	(4)



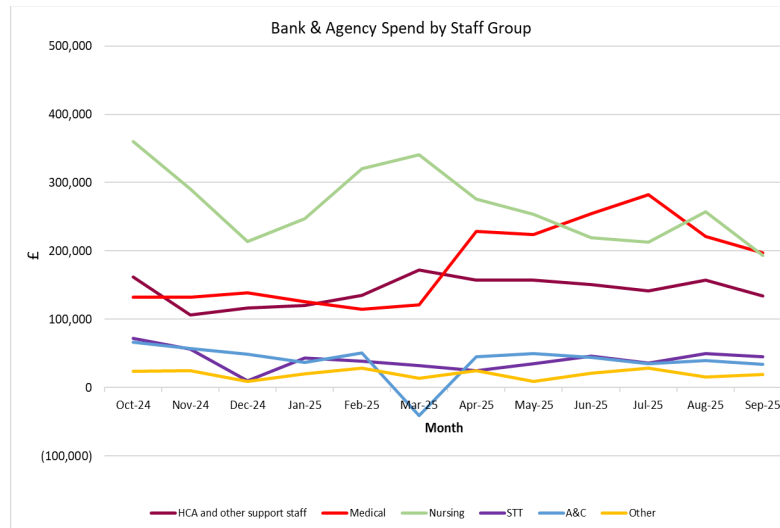
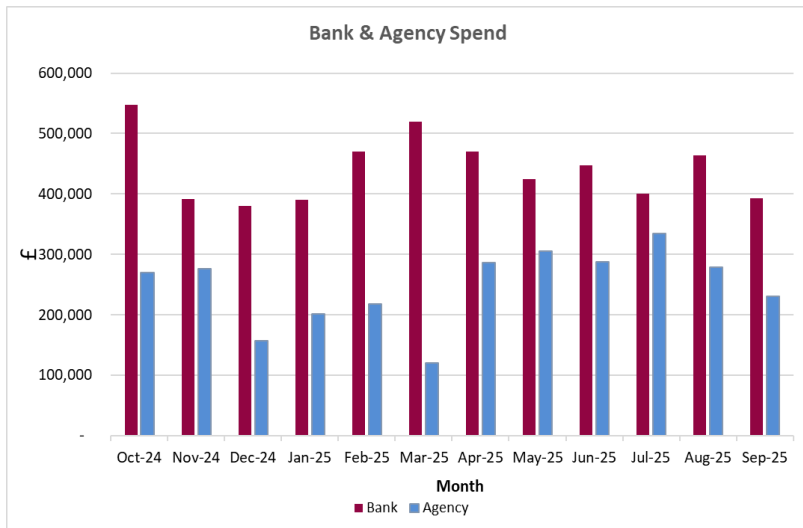
I&E

- The Trust is reporting a surplus at the end of month 6 of £3.8m in line with the YTD plan.
- Identified in-year VIP is £25.3m against a target of £25.3m. The VIP shortfall against the recurrent VIP target is £0.4m (Rag rated shortfall £0.6m), where £12.2m has been identified against a target of £12.6m (95% of recurrent target identified). Non-recurrent identified VIP is £13.1m against a target of £12.6m, overachieving by (£0.4m).

Balance sheet / liquidity

- The cash balance is £115.6m.
- Capital spend for 2025-26 was £8.5m, this was £1.3m 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.

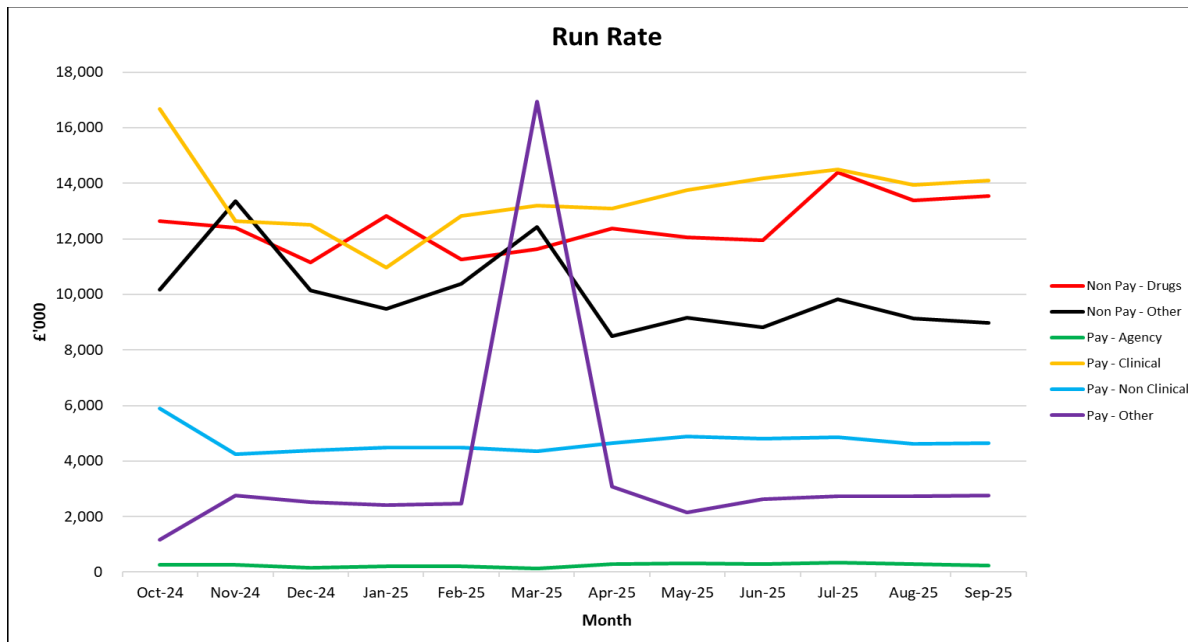




Agency spend in month 06 is £0.2m, £1.7m YTD, a decrease of £0.1m from month 05. The spend is predominantly on medical agency.

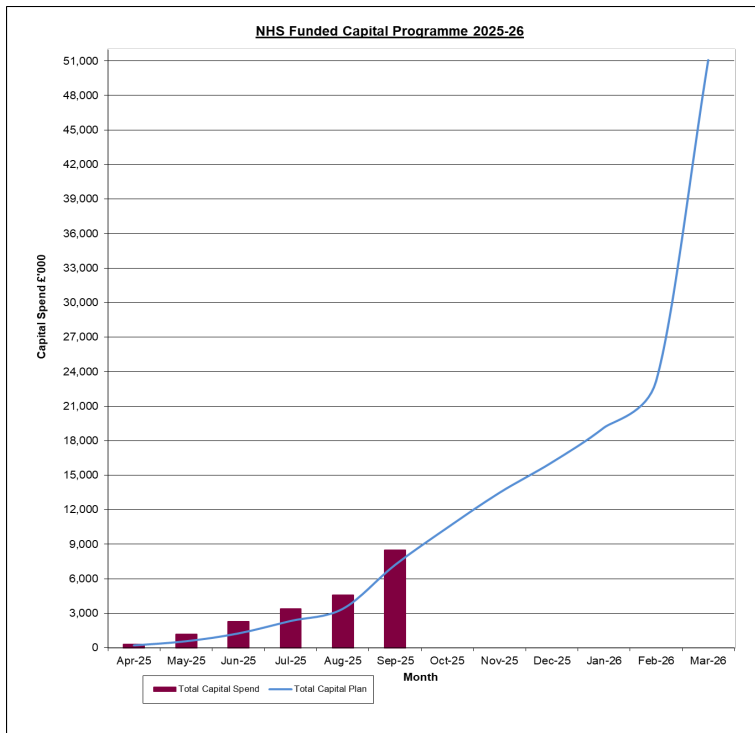
Alongside this, bank spend in month 06 is £0.4m and £2.6m YTD, a decrease of £0.1m from month 05.





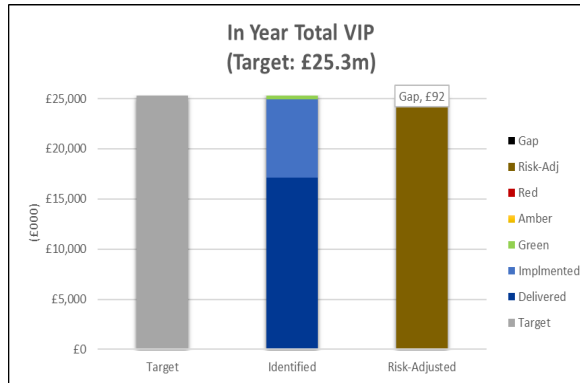
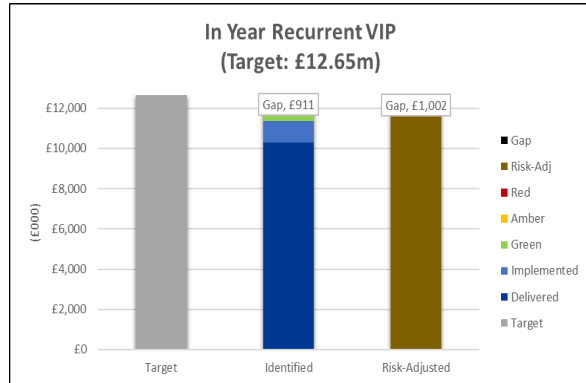
- Drugs spend in month 06 is £13.6m, an increase from month 05 of £0.2m linked to fluctuations in pass through drug spend.
- Non-Pay – Other spend in month 06 is £9.0m, a decrease of £0.1m from month 05 driven by decreased spend on premises & clinical supplies and services.
- Key elements of ‘Non-Pay Other’ spend consist of clinical supplies and services, premises and infrastructure costs and R&I costs.
- Pay – Agency spend in month 06 is £0.2m, consistent with month 05.
- Pay – Clinical spend in month 06 is £14.1m, an increase from month 05 of £0.2m driven by consultants.





The Trust has incurred £8.5m up to month 06 on capital schemes overspending by £1.3m 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.





Total In year CIP

- Total identified VIP schemes reported are £25.3m (£11.7m non recurrent / £13.6m recurrent).
- Risk adjusted identified schemes value £25.2m, leaving £0.1m unidentified.

Recurrent

- Schemes totalling £11.7m have been identified recurrently against a recurrent target of £12.6m,
- This leaves £0.9m of the recurrent target unidentified, RAG rated unidentified £1.0m.



	Annual			Risk-Adjusted		Year To Date		
	Target (£000)	Identified (£000)	Unidentified (£000)	Risk-Adjusted Identified (£000)	Risk-Adjusted Unidentified (£000)	Target (£000)	Delivered (£000)	Variance (£000)
Total VIP	25,298	25,298	0	25,206	92	12,431	12,431	0
Recurrent VIP	12,649	11,738	911	11,647	1,002	6,325	5,611	714
Non-Recurrent VIP	12,649	13,560	-911	13,560	-911	6,107	6,820	-714

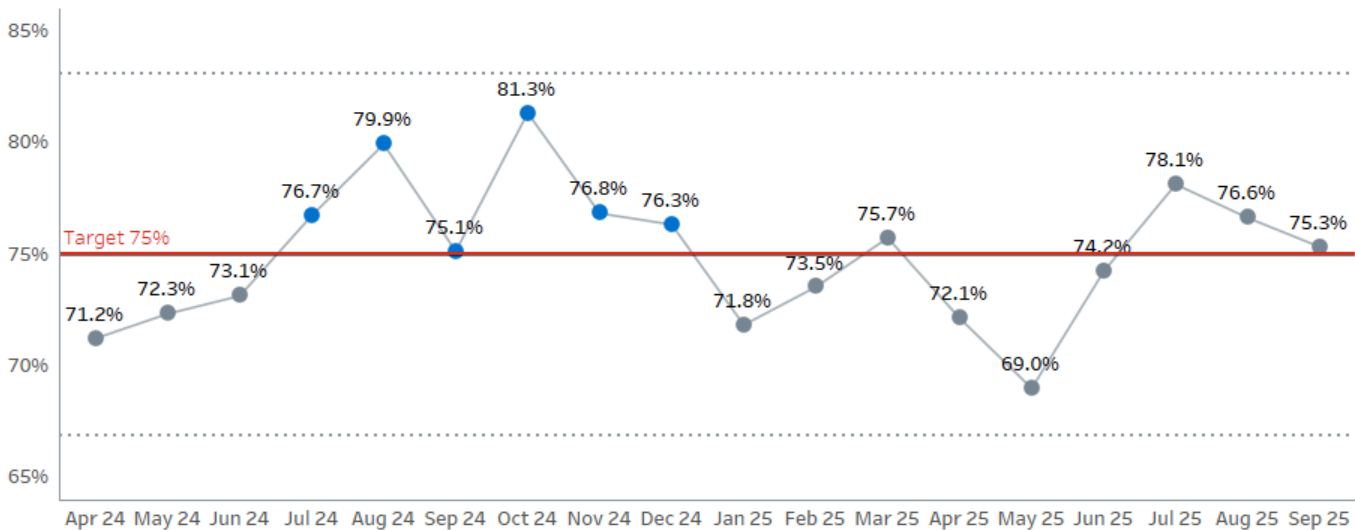


Integrated Performance Report - Cancer Standards Summary

Metric	Month	Measure	Target	Variation	Assurance
18 weeks	September	94.50%	92.00%		
24 day (Internal Target)	September	73.40%	85.00%		
28 Day FDS	September	90.00%	80.00%		
31 day	September	98.00%	96.00%		
62 Day	September	75.30%	75.00%		
Waiting >52 Weeks	September	0.04%	0.00%		



Percentage of patients treated for cancer within 62 days of referral



Icons

Common Cause

Hit & Miss

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

The system shows natural variation with no significant process changes.

Performance is inconsistent, with periods of both exceeding and falling short of the target.

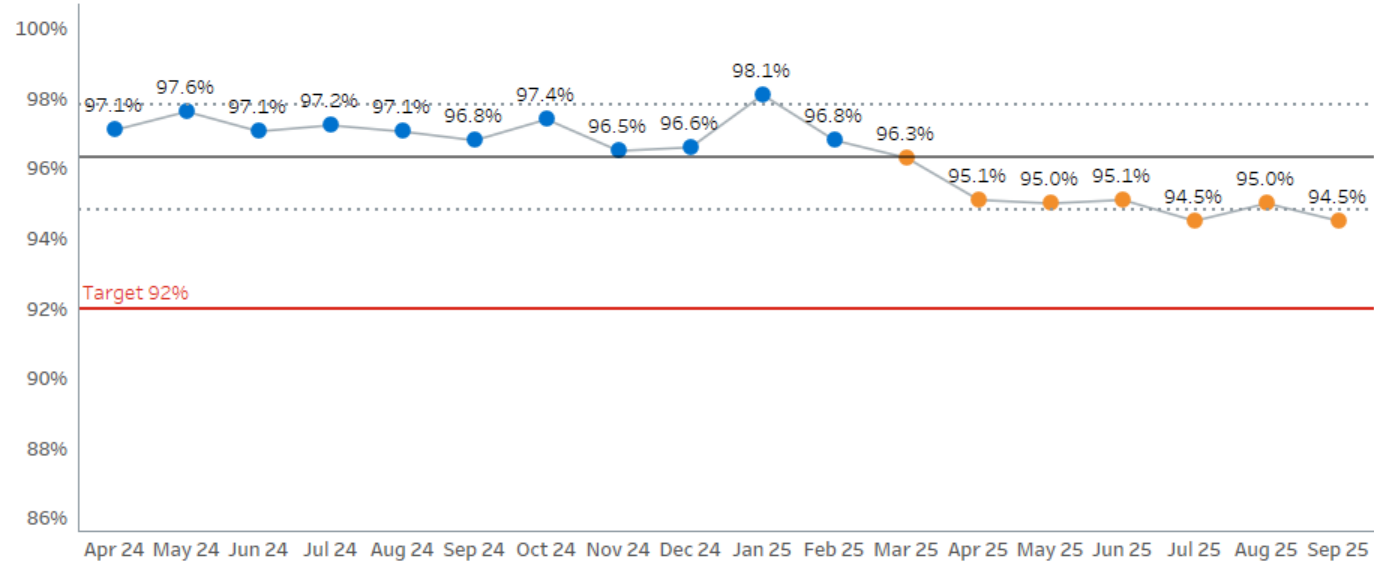
The recent upward trend suggests that interventions or seasonal factors may be positively influencing outcomes.

Actions (SMART)

- Launch a targeted initiative to improve referral-to-treatment workflows, focusing on bottlenecks identified during low-performance months.
- Increase the monthly percentage of patients treated within 62 days to $\geq 78\%$ for at least 4 consecutive months.
- Provide refresher training for MDT coordinators and pathway managers, and introduce weekly performance huddles to monitor progress.
- Align actions with the Trust's strategic goals for cancer care and patient outcomes, ensuring timely access to treatment. Implement changes by November 2025, with a review in March 2026 to assess sustainability and impact.



Percentage of patients treated within 18 weeks



Icons

Concerning

Passing

Summary

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

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

The strong performance until January demonstrated effective operational processes and resource allocation.

The decline from April is attributed to the transfer of Leighton Haematology services











Actions (SMART)

Deployed targeted resources (e.g., additional clinics, locum staff, streamlined triage)

Corrective actions by end of October 2025. Progress monitored monthly through to December, with mid-point review in November.

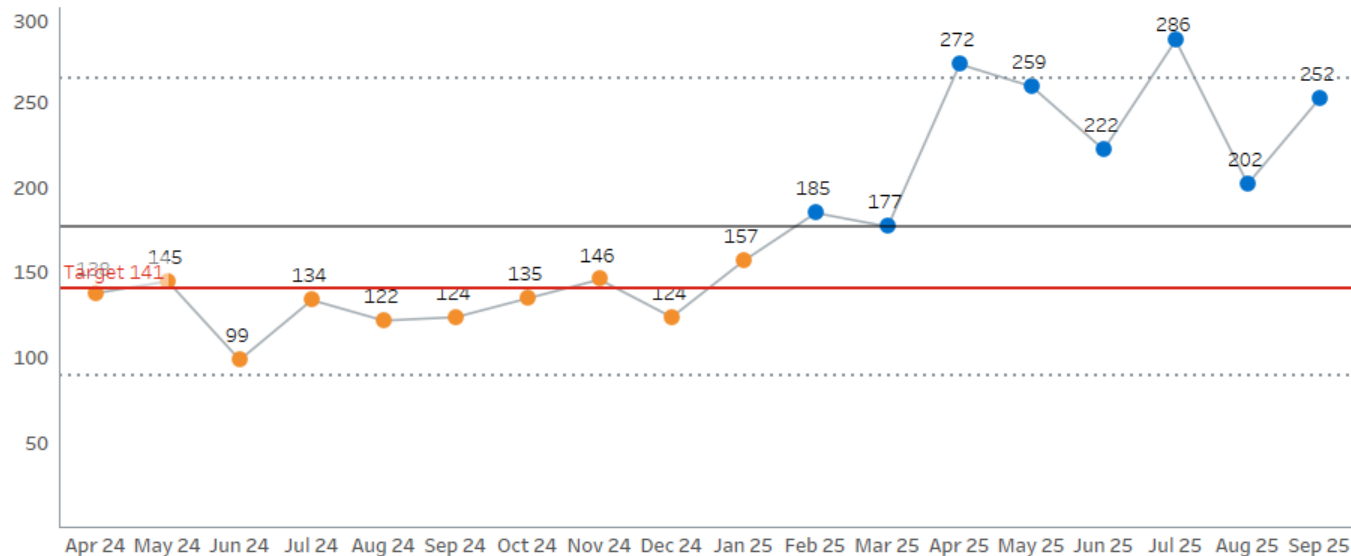


Integrated Performance Report - External Referrals Received Summary

Metric	Month	Measure	24/25 Avg	Variation	Assurance
External Referrals Received - ALL Specialties	September	2,322	2,067		
External Referrals Received -Clinical Oncology	September	1,015	978		
External Referrals Received -Haematology	September	252	141		
External Referrals Received -Medical Oncology	September	645	549		
External Referrals Received -Surgical Specialties	September	384	365		



External Referrals Received - Haematology



Icons

Improving



Hit & Miss



Summary

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.

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

Understanding the performance

The current change in performance against the 24/25 average is due to the Mid Cheshire hospital Haematology service takeover in April. Additional Two Week Wait patients as well as non-cancer Haematology referrals are being accepted and therefore there has been a step change in the baseline number. By the end of 25/26 a new consistent average will be seen and the performance and assurance icons will reflect that.

























Integrated Performance Report - Inpatient Length of Stay Averages

Metric	Month	Measure	Target	Variation	Assurance
Inpatient LOS - All Patients (excluding zero LOS)	September	6.6	7.0		
Inpatient LOS - Elective Patients (excluding zero LOS)	September	5.6	5.8		
Inpatient LOS - Non-Elective Patients (excluding zero LOS)	September	7.2	7.9		
Inpatient LOS - Transfer Patients (excluding zero LOS)	September	22.5	17.1		



Integrated Performance Report - Diagnostic 6 Week Waiting Times Summary

Metric	Month	Measure	Target	Variation	Assurance
Magnetic Resonance Imaging	September	98.80%	99.00%		
Computed Tomography	September	99.40%	99.00%		
Non-obstetric Ultrasound	September	100.00%	99.00%		
Dexa Scan	September	100.00%	99.00%		
Cardiology - Echocardiography	September	100.00%	99.00%		
Flexi Sigmoidoscopy	September	100.00%	99.00%		
Cystoscopy	September	100.00%	99.00%		
Barium Enema	September	100.00%	99.00%		
Colonoscopy	September	100.00%	99.00%		
Gastroscopy	September	100.00%	99.00%		
DM01 Return - All Scans	September	99.30%	99.00%		



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.

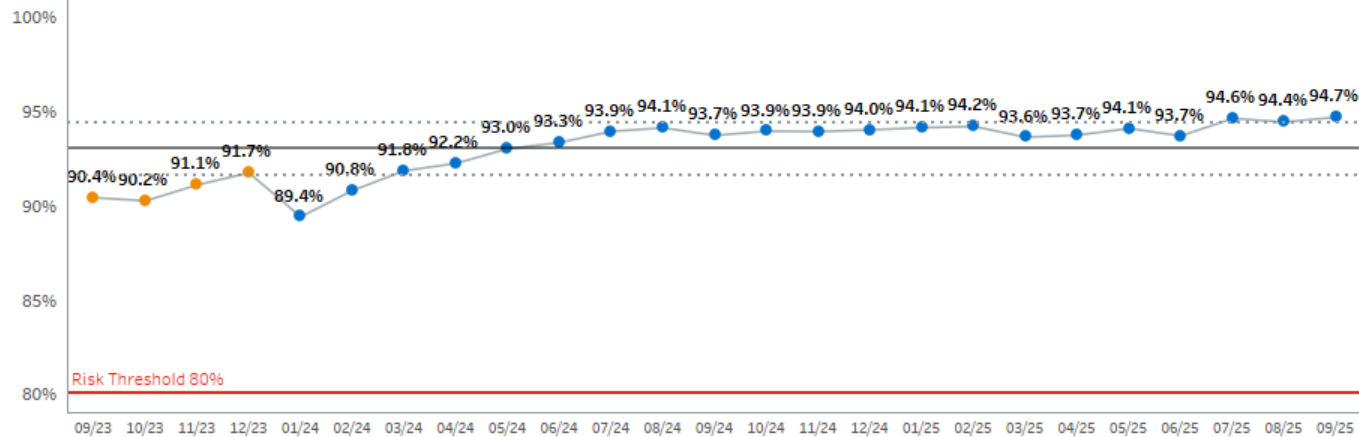
- Metric** - the KPI metric
- Measure** - the value of the **Metric** as of the end of the **Month**
- Target** - the Trust defined minimum or maximum limit for each **Metric**
- Mean** - the average of the **Measures** over the past 12 months

Metric	Month	Measure	Risk Threshold / Target	Mean	Performance	Assurance
Appraisal	September 2025	87.15%	80.00%	87.37%		
Mandatory Training	September 2025	94.68%	80.00%	92.99%		
Absence	September 2025	4.90%	4.25%	4.69%		
All Turnover	September 2025	10.86%	Null	12.47%		
Voluntary Turnover	September 2025	8.51%	Null	10.21%		
Vacancy Rate	September 2025	6.67%	5.00%	9.29%		

Our People - Mandatory Training and Appraisal Compliance

The Christie: All Directorates

Mandatory Training



Performance

Improving



Assurance

Passing



Summary

- There are 3,304 outstanding modules.
- The Face to Face training compliance % for September is 85.9%
- The online training compliance % for September is 95.6%

Performance

Common Cause



Assurance

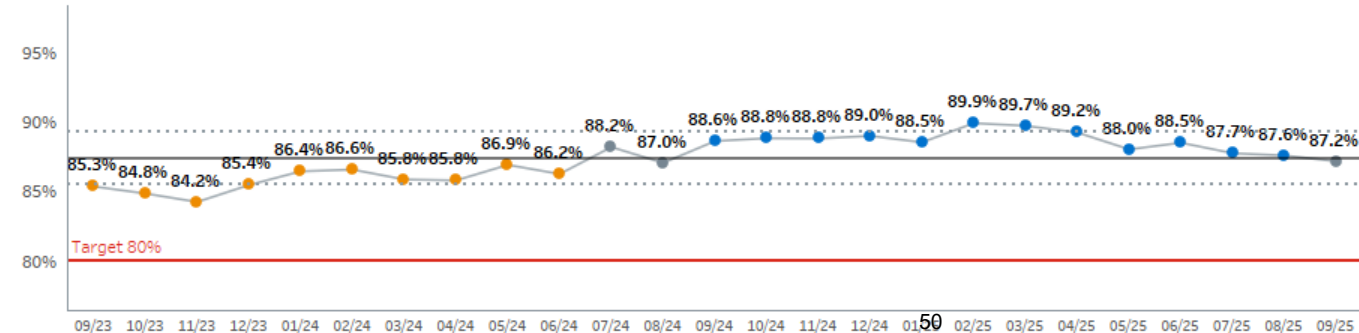
Passing



Summary

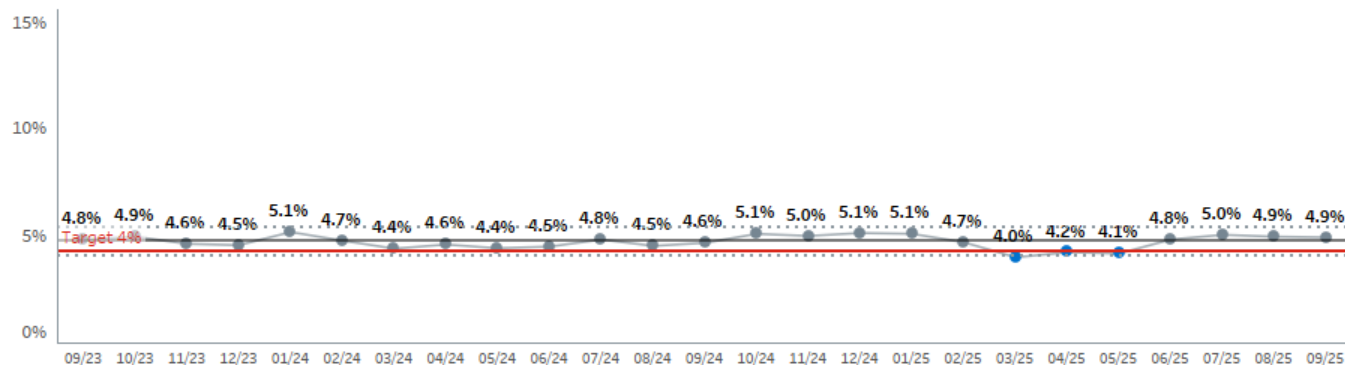
- There are 446 outstanding appraisals.

Appraisal



Our People - Sickness Absence

All Absence



Performance	Assurance
Common Cause 	Hit & Miss

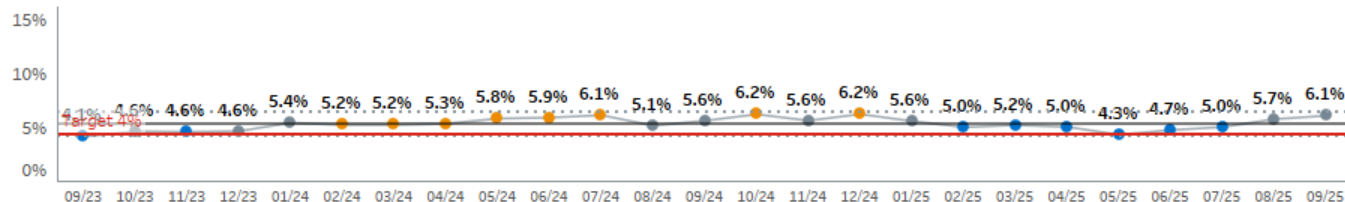
Summary

- The rolling yearly sickness absence % is **4.7%** as of September.
- There were **191** absences still open at the end of September.

Performance	Assurance
Common Cause 	Hit & Miss

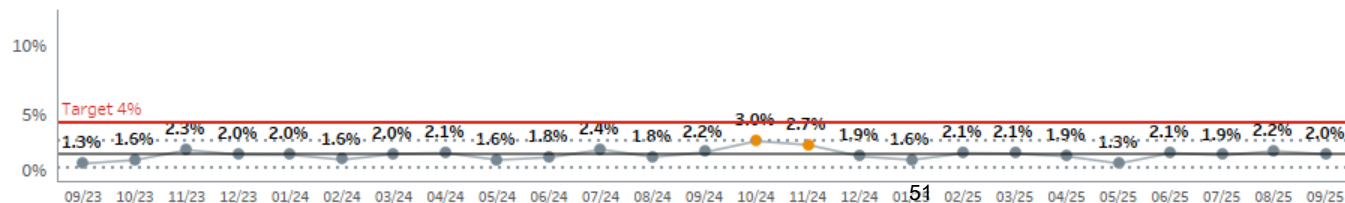
Performance	Assurance
Common Cause 	Passing

Nursing and Midwifery



Performance	Assurance
Common Cause 	Passing

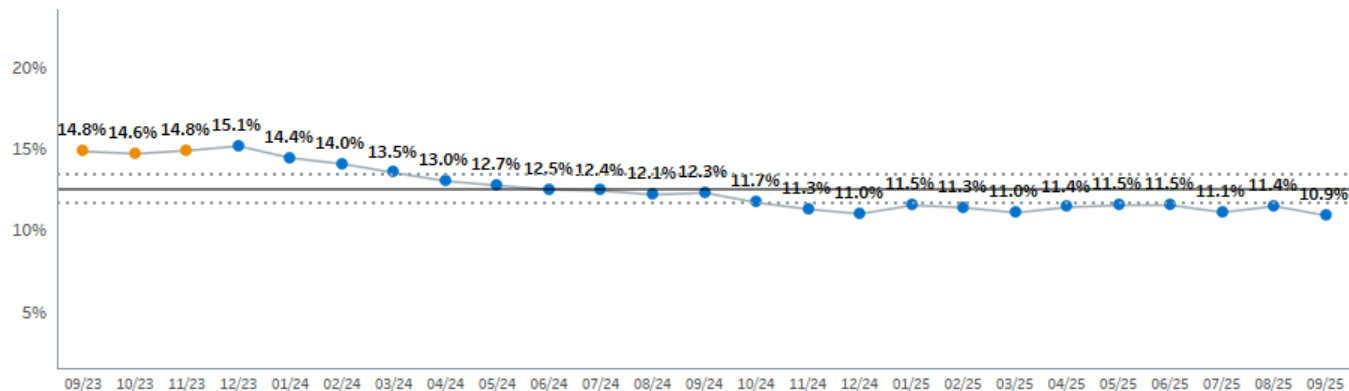
Medical and Dental



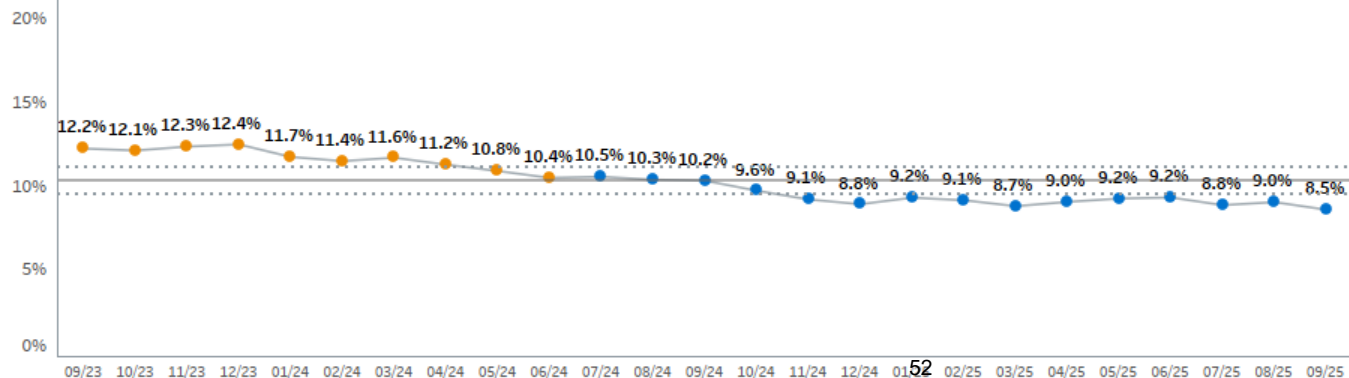
Our People - Turnover

The Christie: All Directorates

All Turnover



Voluntary Turnover



Performance

Improving



Assurance

No Target



Summary

- 43 colleague(s) left the Trust in September.
- The top non-voluntary leaving reason was **End of Fixed Term Contract**.
- The 12m rolling Turnover % for September for staff with less than 1 year service was **1.68%**

Performance

Improving



Assurance

No Target

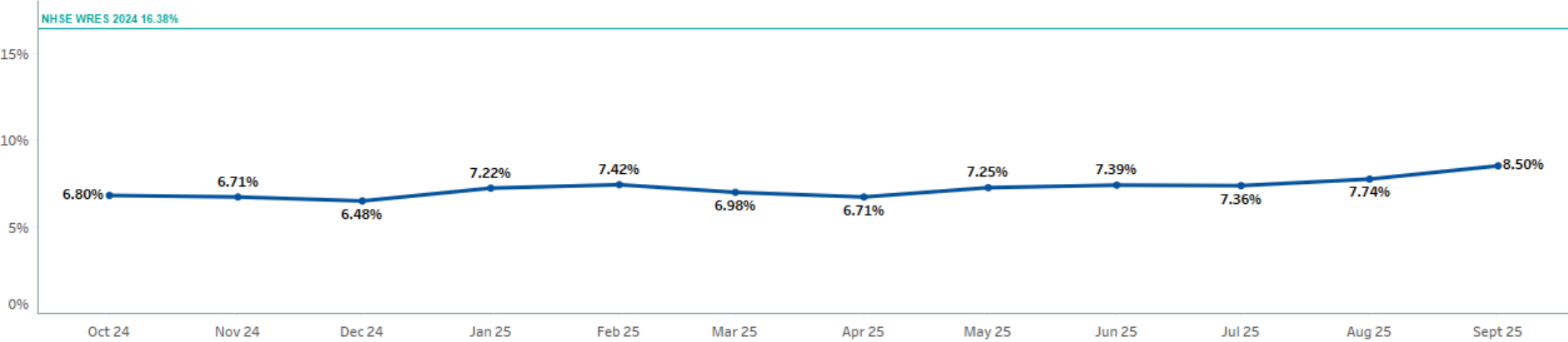


Summary

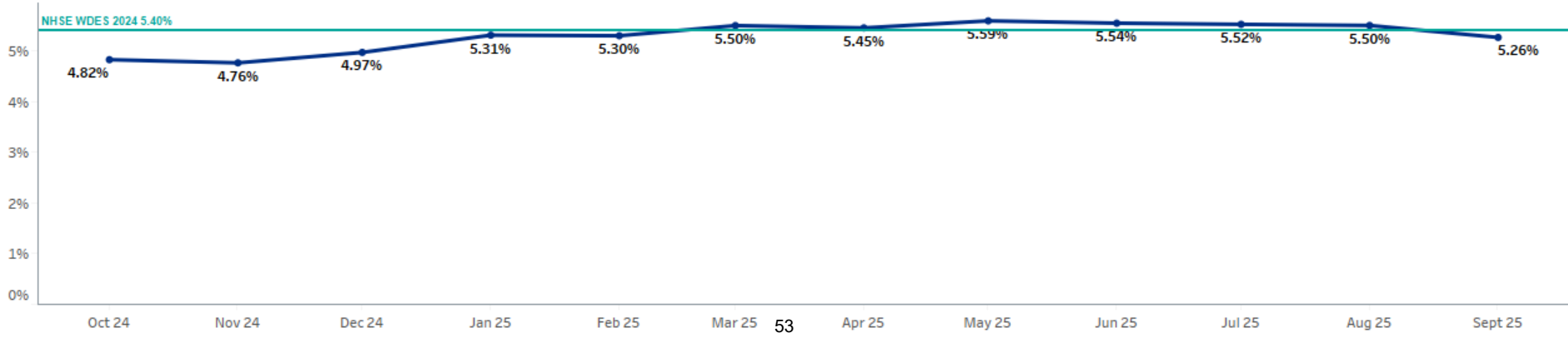
- The top voluntary leaving reason was **Voluntary Resignation** - To undertake further education or training.

Our People - Senior Management Representation

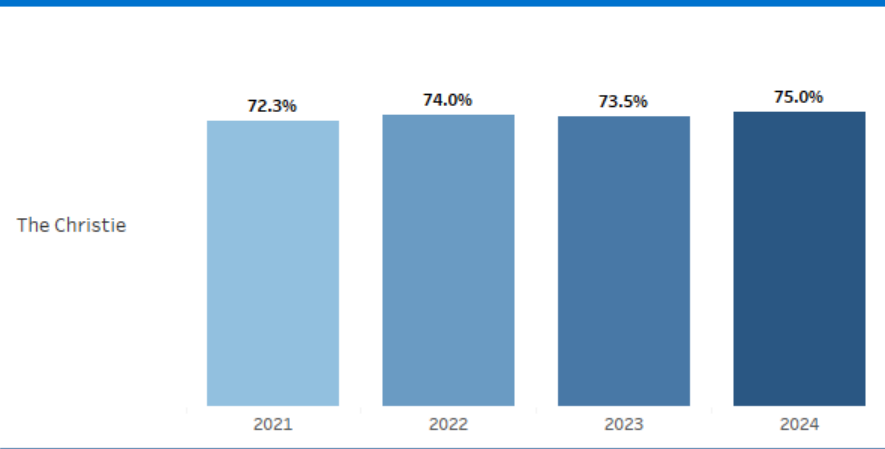
Senior Management (Band 8A - VSM) BAME %



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

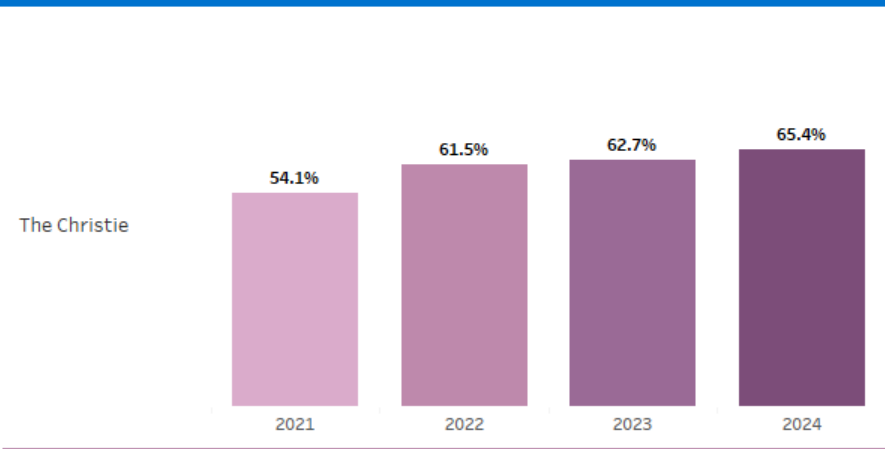


Staff Engagement Score



	2021	2022	2023	2024
Advocacy sub-score	82.7%	79.5%	77.9%	80.7%
Involvement sub-score	69.7%	72.7%	72.2%	73.0%
Motivation sub-score	64.7%	69.9%	70.4%	71.3%

Morale Score

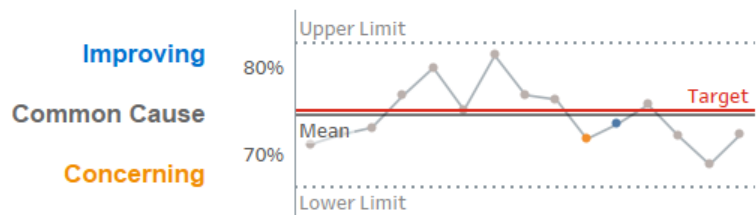


	2021	2022	2023	2024
Stressors (HSE index) sub-score	60.4%	66.8%	66.7%	68.1%
Thinking about leaving sub-score	54.0%	62.0%	64.6%	67.1%
Work pressure sub-score	48.0%	55.6%	56.8%	61.1%

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.

55

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.

Meeting of the Board of Directors
Thursday 23rd October 2025

Subject / Title	Value Improvement Programme (VIP) 2025/26
Author(s)	Jo Bolger Leece, Assistant Director for Value Improvement
Presented by	Claire McPeake Chief Operating Officer
Summary / purpose of paper	<p>This report provides:</p> <ul style="list-style-type: none"> • An update on the Month 6 position of the Value Improvement Programme, confirming that the Trust has delivered its target for 2025/26. • An overview of progress in developing the 2026/27 VIP plan, including the integration of NHS IMPACT principles and specialty-led improvement reviews. • Assurance that programme delivery is supported by robust governance, clinical engagement, and alignment with national and local strategic priorities. • A summary of next steps to sustain improvement momentum and ensure readiness for ICB and Board assurance reviews. <p>Executive Summary</p> <p>The Value Improvement Programme (VIP) 2025/26 has delivered its annual financial improvement target of £25.3 million. This performance demonstrates strong governance, clinical leadership, and alignment with <i>The Christie Strategy 2023–2028</i> as well as the NHS Operational Planning Framework. The Trust continues to balance productivity and quality improvement, ensuring efficiency gains translate into tangible patient and service benefits.</p> <p>Preparations for the 2026/27 VIP are well underway, with an enhanced focus on recurrent financial sustainability, clinical-led specialty reviews, and embedding data-driven improvement across operational and clinical services. Governance oversight remains robust through the Operational Performance Improvement Group (OPIG), with clear escalation routes to senior management and the Board. While risks remain (notably workforce capacity and demand growth), the strengthened infrastructure and culture of improvement position the Trust well for continued delivery and regulatory assurance.</p>
Recommendation(s)	<p>The Board is asked to:</p> <ol style="list-style-type: none"> 1. Note the Month 6 position, confirming full identification of the £25.3m VIP target for 2025/26. 2. Support continued focus on recurrent efficiency delivery, ensuring sustainability beyond 2025/26.



	<p>3. Endorse the approach to the 2026/27 VIP, including the clinically led specialty review programme and strengthened integration with operational and workforce planning.</p> <p>4. Acknowledge ongoing risks (workforce, demand, and financial sustainability) and endorse continued mitigation through PMO oversight and benchmarking (GIRFT, Model Health System).</p> <p>5. Receive further updates on specialty review outputs and 2026/27 planning progress at the December Board.</p>
Background papers	NA
Risk score	<p>Risk 3629 – Score 12</p> <p>Board Assurance Framework: Risk 1, Risk 6, Risk 7, Risk 9, Risk 10</p>
<p>Link to:</p> <ul style="list-style-type: none"> ➤ Trust strategy ➤ Strategic objectives 	<p>Executive objective:</p> <ol style="list-style-type: none"> 1. To deliver safe, effective & equitable care 2. To deliver excellent financial and operational performance
Acronyms or abbreviations used in the paper	<p>Value Improvement Programme: VIP</p> <p>Quality Impact Assessment: QIA</p> <p>Equality Impact Assessment: EIA</p> <p>NHS England: NHSE</p> <p>Getting it Right First Time (GIRFT)</p> <p>Model Health System (MHS)</p> <p>Clinical Advisory Group (CAG)</p>



Board of Directors
Thursday 23rd October 2025

Value Improvement Programme (VIP)

1.0 Background and Introduction

The Trust has successfully achieved its Value Improvement Programme (VIP) 2025/26 financial target, demonstrating assurance to the Board and system partners that The Christie continues to deliver sustainable value in alignment with national expectations and local strategic priorities.

This achievement represents a significant milestone in operational and financial performance, directly supporting *The Christie Strategy 2023–2028* and its mission to care, discover, and teach through the four themes of our vision: leading cancer care, the Christie experience, local and specialist care, and best outcomes. In line with the 2025/26 NHS Operational Planning Framework, which requires providers to contribute to a system-wide financial reset through enhanced productivity, reduced waste, and maintained financial balance, the VIP remains central to delivering these objectives.

As The Christie’s framework for operational and financial improvement, the VIP translates national performance targets into a delivery plan that drives improved outcomes, productivity, and efficiency — going beyond cost reduction to support sustainable, high-quality care. This Month 6 update builds on the September report, setting out next steps for the 2026/27 programme and providing assurance that delivery continues to be underpinned by robust governance, strong clinical leadership, active staff engagement, and a clear line of sight to patient benefit.

2.0 Financial Overview: VIP month 6

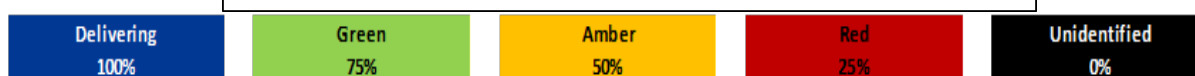
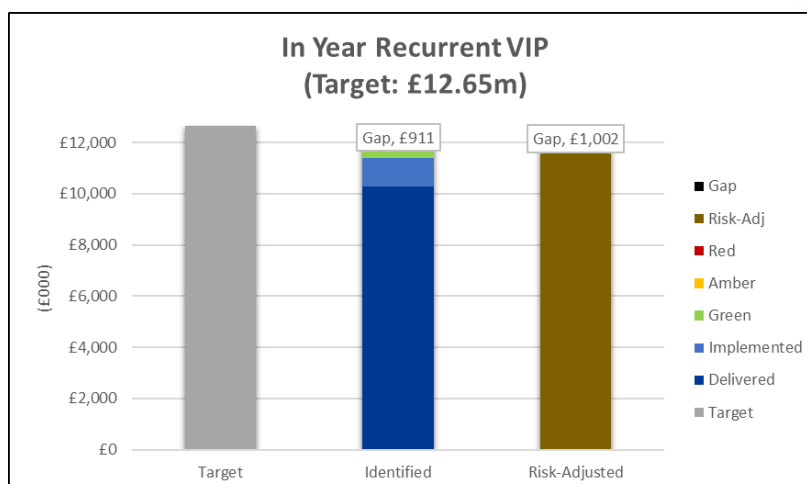
The Trust has achieved its full Value Improvement Programme (VIP) target of £25.3 million for 2025/26.

- Breakdown: £11.7 million of recurrent schemes and £13.6 million of non-recurrent schemes have been identified, meaning the total target has been fully met.
- Recurrent delivery: Against a recurrent target of £12.6 million, £11.7 million has been identified, leaving a shortfall of £0.9 million. This is offset by additional non-recurrent savings achieved this year.
- Implementation status: £0.4 million of schemes are fully developed but still awaiting implementation by Divisions.
- Future planning: Any remaining recurrent shortfall at year end will be carried forward into the 2026/27 planning cycle.

Work is already underway to integrate financial, workforce, and operational planning for the 2026/27 VIP Programme, ensuring continued alignment with strategic priorities and sustainable improvement delivery.

	Annual			Risk-Adjusted		Year To Date		
	Target (£000)	Identified (£000)	Unidentified (£000)	Identified (£000)	Unidentified (£000)	Target (£000)	Delivered (£000)	Variance (£000)
Total VIP	25,298	25,298	0	25,206	92	12,431	12,431	0
Recurrent VIP	12,649	11,738	911	11,647	1,002	6,325	5,611	714
Non-Recurrent VIP	12,649	13,560	-911	13,560	-911	6,107	6,820	-714





3.0 2026/27 Value Improvement Programme (VIP)

Planning for the 2026/27 VIP is underway, building on the success of 2025/26. The focus will be on delivering sustainable, recurrent efficiencies while maintaining high-quality, patient-centred care. The programme continues to follow NHS IMPACT principles, promoting data-driven and clinically led improvement.

Key areas of progress:

- Scheme identification: Divisions are reviewing improvement ideas, aiming to confirm all 2026/27 schemes by December 2025.
- Delivery planning: Detailed implementation plans, milestones, and performance measures will be completed by March 2026.
- Governance: Updated divisional templates and refreshed training on Quality and Equality Impact Assessments will ensure changes remain safe and fair.
- Engagement: The HIVE system, finance training, and operational excellence programmes are being expanded to support staff involvement.
- Specialty reviews: Clinically led reviews will begin in Quarter 3, using GIRFT and Model Health System data to identify opportunities, reduce variation, and drive improvement.
- Productivity and efficiency: Focus on reducing duplication, improving workforce planning, and cutting reliance on temporary staffing.
- Procurement, digital, and estates: Ongoing work to optimise resource use, improve flow, and support sustainable service delivery.
- Culture and capability: NHS IMPACT training and coaching will help embed continuous improvement into everyday practice.

Improvement work is now more data-driven, using benchmarking and national standards to target the greatest areas of opportunity. From November Board onwards, progress updates on delivery will be reported.



A major next step is the launch of the Clinically Led Specialty Review Programme, an eight-week structured process that combines benchmarking (via Model Health System, GIRFT, and clinical networks) with quality and operational insights. These reviews will:

- Inform 2026/27 operational and financial planning,
- Guide investment priorities, and
- Strengthen assurance reporting through Divisional Boards and OPIG.

The programme will be launched at an engagement event led by the Medical Director and Chief Operating Officer, highlighting how specialty reviews will help maintain world-class, value-based care and embed improvement into everyday clinical practice.

4.0 Governance and risks

The Value Improvement Programme reports to the Operational Performance Improvement Group (OPIG), chaired by the Chief Operating Officer, which also oversees the Improving Access: Outpatient Improvement Group and the Improving Productivity: Reducing Time Away from Home programme. This alignment ensures that improvement, performance, and transformation activity are coordinated through a single governance route, with consistent reporting, risk management, and escalation to Senior Management Committee and Board.

Each scheme is tested against four standards of robustness: ownership, quality assurance, financial validation, and deliverability. The Value Improvement Programme is delivering steady progress and maturing into a consistent method for operational and financial improvement. It is grounded in clinical leadership, supported by strong governance, and informed by national benchmarking. While challenges remain, particularly around workforce and growth in demand, the strengthened governance, culture of improvement, and alignment to national frameworks provide confidence that The Christie's approach to value improvement is sustainable, credible, and resilient under scrutiny.

The overall risk score for programme delivery remains high (12), reflecting the scale of efficiency required and ongoing demand growth. Mitigations include strengthened PMO oversight, phased pipeline development, and improved visibility through GIRFT and MHS dashboards.

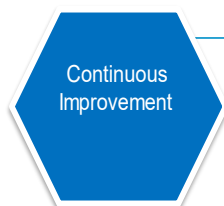
5.0 Next Steps

- Finalise identification of all 2026/27 schemes by December 2025.
- Develop full delivery plans by March 2026 with confirmed milestones and executive sponsorship.
- Launch specialty reviews in Quarter 3 with findings reported to the Board in December.
- Prepare for ICB assurance review of VIP governance and delivery as part of the operational planning framework.



Appendix:

Improvement approach



Approach to improvement

Improvement Approach	What it is	Examples in Practice	How it aligns to Quality Management
Daily Management	<ul style="list-style-type: none"> •Getting the basics right every day/knowing how we are doing •Focused on reliability, safety, standard work, and simple problem -solving at the front line. •Builds confidence that the system is stable. 	Daily safety huddles, handover checklists, visual management boards, roster management, job planning. Managing Performance.	Quality Control & Assurance – ensuring stability and reliability in line with management systems and processes
Continuous Improvement	Small, team-led cycles of testing and learning, supported by QI coaching	PDSA cycles, QI coaching sessions, tests of change eg new clinic flows or inpatient improvements. Patient experience.	Quality Improvement - building improvement capability and capacity, ensuring improvement is part of routine delivery
Breakthrough Improvement	<ul style="list-style-type: none"> •Tackling a big, complex issue with a structured, focused approach. •Requires cross-organisational effort, data - driven redesign, leadership 	Reducing time away from home initiatives, redesigning pathways, new ways of working (GIRFT)	Quality Planning & Strategic Focus - shared purpose and vision and leadership behaviours
Projects	Structured, time-specific initiatives to deliver agreed priorities	Digital, RPA, service reconfiguration, estates.	Embedding improvement into management systems and processes using standardised approach



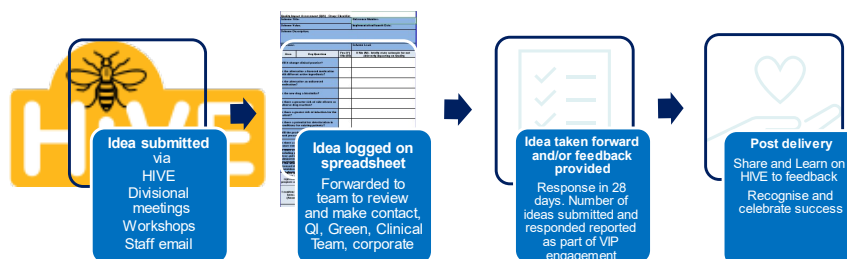
Ideas process



Do you have an idea?



- Central place on HIVE where staff can submit all ideas for improvement
- Ideas will be logged and forwarded to the most appropriate team to manage
- Staff member will be involved in taking idea forward and feedback will be provided to ensure outcomes



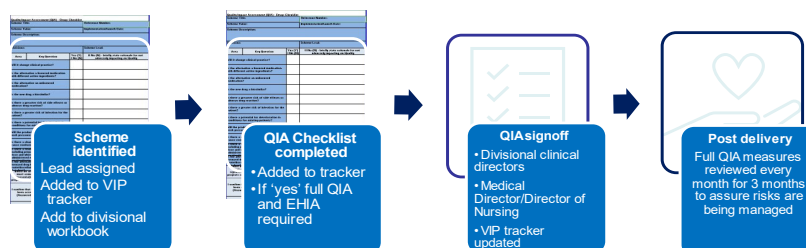
QIA process



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 33/25a

Meeting of the Board of Directors

Thursday 23rd October 2025

Subject / Title	Regulatory preparedness update
Author(s)	Chief Nurse and Executive Director of Quality Compliance Lead
Presented by	Chief Nurse and Executive Director of Quality
Summary / purpose of paper	This paper provides a summary update on Trust wide regulatory preparation
Recommendation(s) (assure / alert / advise)	Note the continued progress of the Trust's regulatory preparedness for the Well-Led domain and the ongoing delivery of the Excellence in Action programme. Acknowledge the engagement of staff across clinical and non-clinical areas in evidence mapping, peer mock inspections, and review activities.
Background papers / source of assurance	<ul style="list-style-type: none"> • Data • Soft intelligence • Benchmarking • External assessments • Risks and mitigation • Trajectory and changes over time
Risk score / BAF reference	BAF Risks 4
Link to: ➤ Trust strategy ➤ Corporate objectives ➤ CQC Quality standard ➤ Regulation	Trust strategy CQC regulations (all key questions and quality statements)
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.	A&C – Admin and clerical AHP – Allied health professional CAG – Clinical advisory group CQC Care Quality Commission



Meeting of the Board of Directors

Thursday 23rd October 2025

Regulatory preparedness

1 Overview

The Trust continues to make strong progress in its regulatory preparedness programme, ensuring full alignment with the Care Quality Commission (CQC) Single Assessment Framework. Since focused preparation began in early 2025, a structured approach has been embedded across the organisation to evidence compliance, strengthen governance, and promote a culture of continuous improvement.

2 Progress to Date

• **Evidence Matrix and Mapping:**

A comprehensive evidence matrix has been developed to map Trust activities and assurance materials against the CQC quality statements and six evidence categories. This ensures a clear and accessible repository of evidence demonstrating compliance and best practice.

• **Collaborative Preparation:**

The compliance team has worked closely with divisions, the Executive Chief Nurse, and external legal advisors to review and validate the evidence base. Dedicated review days have confirmed the robustness of documentation, governance structures, and quality systems supporting ongoing regulatory readiness.

• **Excellence in Action Programme:**

Launched in April 2025, this Trust-wide initiative embeds regulatory readiness into daily practice. The programme engages staff through quarterly cycles focused on each of the CQC key questions—Safe, Caring, Responsive, Effective, and Well-Led—linking everyday activity to regulatory expectations.

- Regular communication through briefings, intranet resources, and divisional meetings promotes understanding of the assessment framework.
- Engagement has been extensive across clinical, corporate, and support services, with strong participation in programme activities.
- Excellence in Action is now a standing item at key forums, ensuring visibility, shared learning, and sustained focus on quality improvement and compliance.

3 Assurance Activities

• **Evidence Validation:**

Comprehensive evidence reviews have been completed for the Well-Led and Safe domains, confirming effective governance, leadership, and safety systems.



- **Mock Inspections and Interviews:**
Peer-led mock inspections and Board-level interviews have taken place to test readiness, validate assurance processes, and familiarise teams with CQC methodology. These activities demonstrate a mature approach to regulatory engagement and continuous improvement.
- **External Support:**
Legal expert input continues to provide independent validation and assurance on the quality and completeness of evidence and preparations.

4 Next Steps (2025/26)

The Trust will maintain momentum through continued delivery of the Excellence in Action programme:

- Completion of evidence mapping for the Effective, Caring, and Responsive domains.
- Ongoing Board and divisional engagement through review days, staff handbooks, and communication campaigns.
- Continued peer review and mock inspection programme to sustain confidence and readiness across all services.
- Development of a Board briefing pack to consolidate learning and evidence from the mock activities.

5 Conclusion

The Trust's structured approach to regulatory preparedness provides clear assurance that systems, evidence, and engagement are in place to demonstrate compliance with the CQC Single Assessment Framework. The Excellence in Action programme is embedded across the organisation, fostering a culture of quality, safety, and improvement. Ongoing activity throughout 2025/26 will ensure sustained readiness, enhanced confidence, and continuous alignment with regulatory expectations.



Meeting of the Board of Directors

Thursday 23rd October 2025

Subject / Title	Operational Planning Framework
Author(s)	Jo Leece: Assistant Director for Value Improvement
Presented by	Claire McPeake Chief Operating Officer
Summary / purpose of paper	<p>The purpose of this paper is to:</p> <ul style="list-style-type: none"> • Brief the Board of Directors on the governance, requirements, and approach for implementing the new NHS Operational Planning Framework. • Outline the actions being taken to ensure The Christie's operational plan is clinically led, financially sustainable, and compliant with both national and Greater Manchester planning standards. • Provide assurance that robust governance, oversight, and engagement mechanisms are in place to deliver a credible and timely five-year plan aligned with The Christie's strategic ambitions.
Recommendation(s)	<p>The Committee is asked to:</p> <ol style="list-style-type: none"> 1. Note the requirements of the NHS Operational Planning Framework and the Greater Manchester Planning Handbook. 2. Support the governance arrangements established, including the integrated planning team, weekly planning meetings, and divisional engagement structures. 3. Ensure divisional teams are briefed and engaged to align operational and clinical strategies with system priorities. 4. Support timely submission of the draft plan (December 2025) and final plan (March 2026), ensuring it meets affordability, workforce, and quality standards. 5. Endorse the Clinically Led Specialty Review approach to align service design and improvement with patient-centred outcomes. 6. Acknowledge the associated risks (tight timelines, workforce, and financial pressures) and the mitigations through weekly monitoring and GM ICB engagement. 7. Recognise the link between performance and assurance frameworks, noting that delivery will directly inform oversight and rating within the NHS Performance Framework.
Background papers	<p>NHS England » NHS Oversight Framework 2025/26 NHS England » Planning framework for the NHS in England</p>
Risk score	Board assurance framework Risk 1, Risk 6, Risk 7, Risk 9, Risk 10



<p>Link to:</p> <ul style="list-style-type: none"> ➤ Trust strategy ➤ Corporate objectives 	<ol style="list-style-type: none"> 1. To deliver safe, effective & equitable care 2. To deliver excellent financial and operational performance
<p>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.</p>	<p>Operational Performance Improvement Group (OPIG) Value Improvement Programme: VIP Quality Impact Assessment: QIA Equality Health Impact Assessment: EHIA NHS England: NHSE Getting it Right First Time (GIRFT) Model Health System (MHS) Clinical Advisory Group (CAG)</p>



Meeting of the Board of Directors

Thursday 23rd October 2025

Operational Planning Framework

1.0 Background and Introduction

The purpose of this paper is to set out how The Christie will meet the requirements of the refreshed NHS Operational Planning Framework (2026/27–2030/31) through a robust, clinically led, and strategically aligned planning process. This is a critical step in ensuring that our organisational plans are fully triangulated with the national oversight framework, NHS strategy, and board self-assessment, while also evidencing our contribution to system-wide impact and national priorities.

The refreshed Operational Planning Framework marks a shift from single-year planning to a rolling five-year horizon, strengthening the focus on deliverability, affordability, and integration across activity, workforce, and finance. In response, Greater Manchester has developed a bespoke Planning Handbook to apply these requirements locally, aligning national standards with the GM Strategy 2025–2035 and prioritising prevention, earlier diagnosis, neighbourhood delivery, and financial sustainability.

For The Christie, this new approach complements our 2023–2028 Strategy, which defines how we will continue to deliver our mission—to care, discover, and teach—through the four themes of our vision: leading cancer care, the Christie experience, local and specialist care, and best outcomes. It provides a significant opportunity to demonstrate leadership in cancer care, innovation, and value-based healthcare both within Greater Manchester and nationally.

This paper therefore outlines the governance structure, timetable, and approach being adopted to deliver a compliant, timely, and aligned 3–5-year plan. It should be read alongside the previously presented SMC paper, *“Trust Planning including Performance Assessment Framework and Provider Capability Assessment,”* which provides further detail on the wider five-year planning approach and its links to the NHS Long Term Plan, the Performance Assessment Framework, the Provider Capability Assessment, and the Trust Strategy.

2.0 Strategic Context

National: The 10-Year Health Plan sets a clear direction for prevention, digital transformation and shifting care closer to home. The new framework requires providers to demonstrate credible, triangulated plans that are sustainable and affordable.

The new Operational Planning Framework launched early September, introduces a number of important changes:

- A move from annual to rolling five-year planning: The NHS is moving away from single-year submissions to a continuous, five-year horizon, with an expectation that plans are credible, deliverable and affordable.



- Separate submissions: Providers are now required to submit their own operational plans, aligned to system priorities, rather than contributing solely to a single system-wide return.
- Regional oversight: NHS England regional teams will now be responsible for assuring and accepting plans, strengthening accountability at both provider and system level.
- Two-phase cycle: Planning has commenced earlier, and has been split into two phases, foundational work by September 2025, followed by detailed plan development from October to December 2025. Confirm and challenge and 'stress-testing' will take place early 2026.
- Links to Model Health System (MHS) as means of benchmarking improvement and measuring performance (Performance Oversight Framework)
- Aligns more closely with clinical strategy.

3.0 Phases and Provider Actions

The Operational Planning Framework sets out clear provider actions, structured in two phases. The table below summarises these phases, actions and the Christie's response against each.

Phase 1 – Initial Planning (Sept - Dec 2025)

- Establish governance and leadership for plan development, with Board/executive oversight.
- Produce draft five-year operational plan covering activity, workforce, finance, quality.
- Triangulate activity, workforce and finance in first draft plans.
- Apply national and GM planning assumptions.
- Identify risks to delivery and initial mitigations.
- Submit draft plan to GM ICB for early review.

Phase 2 – Refinement & Confirm/Challenge (Jan - Mar 2026)

- Participate in confirm-and-challenge sessions with GM ICB (Jan/Feb 2026).
- Stress test plans against affordability, workforce supply and performance standards.
- Refine CIP/VIP schemes with full QIA/EIA.
- Address gaps identified in phase 1.
- Ensure commissioning intentions and GM ICP missions are embedded.
- Submit final triangulated plan for ICB and Trust Board approval (March 2026).

GM ICB has applied these requirements to a planning handbook, and re-established the ICB Planning Hub. Roles and responsibilities are clearly defined, and planning requirements more explicit:

- The Greater Manchester ICB will lead system-level planning, coordinate national responses and support providers via the fortnightly planning hub.
- Providers, including The Christie, must develop their own strategic, operational and financial plans that align with clinical strategy, commissioning intentions and system priorities.
- Neighbourhood health plans, led by Health and Wellbeing Boards, will be integrated into the overall framework to ensure local delivery and prevention are at the core.
- A population healthcare needs assessment will be conducted for the system by the ICB and shared with providers.



- Providers must submit a compliant plan on time and then demonstrate how delivery will be achieved.
- We must identify and mitigate risks to delivery, including those relating to workforce, finance and performance.
- We will need to ensure plans reflect outcome focused with evidence based priorities linked to the clinical strategy for The Christie.
- All providers must demonstrate financial sustainability over the medium term.

4.0 Governance and Oversight

The new Operational Planning Framework represents a step change for the NHS. It demands credible, sustainable and system-aligned plans. The Christie is well placed to respond. We have robust governance, engaged divisions, and a clear timetable. Importantly, we bring added value as a specialist cancer centre, driving innovation, research, and outcomes that matter to patients, while supporting GM to achieve its strategic ambitions.

- In support of the timeline and phases, there are a number of actions for providers to take which are being built into a plan for The Christie by the Integrated Planning Team. The Christie has established clear governance to ensure plans are developed in line with national and GM requirements.
- We have re-established a weekly integrated planning meeting to bring together finance, workforce, performance and quality leaders to oversee progress and address issues early. Divisional engagement will ensure that clinical and operational teams shape plans and validate assumptions.
- Fortnightly flash reports are being submitted to the ICB and reviewed by the Executive Team prior to submission, providing assurance on progress and risks.
- Board oversight will need to be through regular updates and final approval of the plan before submission to the GM ICB in March 2026.
- To ensure that our plan is aligned to clinical strategy, a process for clinically led specialty reviews has been designed. (described below)

The planning framework recognises risks including tight timelines, workforce supply constraints, and financial pressures. For The Christie, there is also the challenge of balancing specialist cancer priorities with GM-wide ambitions.

These risks will be mitigated through weekly monitoring, early confirm and challenge participation, engagement with GM planning leads. The fortnightly flash report (appendix 1) provides a summary of activities against planning timescales, risks being managed and escalations for support to the system partners.

This approach provides confidence that our plans will be timely, credible and aligned to both system and Christie strategic priorities.

5.0 Clinically led strategic reviews

To ensure The Christie's clinical strategy remains aligned with the Operational Planning Framework and national priorities, a structured Strategic Specialty Review process has been introduced. This approach provides a consistent, evidence-based method for reviewing each



specialty's performance, opportunities and challenges, and for translating findings into clear improvement and investment plans.

The process builds on the principles of value-based healthcare and the NHS IMPACT model, combining benchmarking, patient-level costing, workforce planning, quality outcomes, and patient experience measures. It ensures that clinical strategy, operational delivery, and financial sustainability are considered together.

Each review follows an eight-week structured timeline which will be led by the Clinical Director, supported by divisional management, finance, workforce, and quality teams.

- Week 1–2: Initial data requests and benchmarking from Model Health System, GIRFT, and clinical networks; definition of review scope and stakeholder roles.
- Weeks 3–4: Service review outputs from modelling; SWOT, horizon scanning for trends which may affect the service, and risk analysis. Based on this, identification of the key strategic challenges and opportunities.
- Weeks 5–6: Divisional management engagement; development of preliminary recommendations and quality impact assessments (QIA).
- Weeks 7–8: Presentation to CAG for support, feedback and consider interdependencies. Development of improvement plans and agreement of delivery approach and Operational Improvement Plan governance.

A slide-pack template has been developed to guide Clinical Directors and their teams through the process. The template standardises information capture, including baseline metrics, benchmarking data, workforce and activity profiles, quality indicators, risks, and proposed improvement actions, ensuring consistency across specialties and ease of review by divisional and corporate teams.

The output of each review will inform:

- The Operational Planning Round and Operational Improvement Plan for 2026/27.
- Prioritisation of investments and transformation initiatives.
- Assurance reporting through divisional boards, OPIG, and CAG.

The approach will be launched at the engagement event which will be led by the Medical Director and the Chief Operating officer. This session will be an interactive session on national priorities and the launch of how we are aligning our clinical strategy to ensure services are designed around what patients value most.

- The NHS 10-Year Plan & Operational Planning Framework – what's changing and what it means for us.
- Our approach to patient-centred service design – launching clinically led specialty service reviews to keep our services world class, sustainable, and focused on what matters to patients.
- Support staff to hear first-hand how clinically-led specialty reviews will ensure our services are designed around what matters most to patients, ask questions, and share ideas

This approach strengthens alignment between clinical strategy, operational planning, and value improvement, supporting the Trust's ambition to deliver high-quality, efficient, and sustainable cancer care.

A timeline with phases has been developed:





6.0 Recommendations for action

The committee is asked to note and action:

- The requirements of the new NHS Operational Planning Framework and the GM Planning Handbook attached.
- Support the governance arrangements in place.
- Engage divisional teams by briefing key messages.
- Support submission of a compliant plan in line with deadlines, including producing improvement trajectories. Performance against which will be measured by scorecard held in GM ICB, and the Model Health System.
- Note that formal performance ratings will impact on the NHS Oversight Framework which is why robust plans are required.
- Support the clinical service review approach.
- Support the delivery of the actions required to ensure a timely and aligned plan, with draft submission in December 2025 and final approval in March 2026.



Meeting of the Board of Directors

Thursday 23rd October 2025

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	<p>To update the Board on progress delivered to date within the Future Christie Programme, outline upcoming priorities for Year 1 delivery, and seek endorsement of programme direction and next-stage actions, including:</p> <ul style="list-style-type: none"> • 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. <p>The Future Christie Programme continues to deliver significant progress toward building a world-leading, intelligent, and data-driven cancer centre. Over the past quarter, the programme has achieved major milestones across digital transformation, patient engagement, and data integration.</p>
Recommendation(s)	<p>The Board is asked to:</p> <ol style="list-style-type: none"> 1. Note the significant progress made across key Future Christie workstreams. 2. Endorse programme priorities for the next quarter, including AVT deployment, EPR business case completion, and JAC Phase 1 implementation. 3. Support the continued integration of data strategy and EPR planning as enablers for an intelligent hospital model. 4. Acknowledge the ongoing cultural and capacity challenges and the mitigating actions in place.
Background Papers	<p>Trust Strategy 2023-2028 NHS 10 year plan Future Christie Overview</p>
Risk Score	See Board Assurance Framework Risk 13 and Risk 15
EDI impact / considerations	

<p>Link to:</p> <ul style="list-style-type: none"> ➤ Trust's Strategic Direction ➤ Strategic Objectives 	<ol style="list-style-type: none"> 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 								
<p>Acronyms or abbreviations used in the paper</p>	<table border="0"> <tr> <td>EPR</td> <td>Electronic patient record</td> </tr> <tr> <td>JAC</td> <td>Joint analytics for Cancer</td> </tr> <tr> <td>AI</td> <td>Artificial Intelligence</td> </tr> <tr> <td>AVT</td> <td>Ambient Voice Technology</td> </tr> </table>	EPR	Electronic patient record	JAC	Joint analytics for Cancer	AI	Artificial Intelligence	AVT	Ambient Voice Technology
EPR	Electronic patient record								
JAC	Joint analytics for Cancer								
AI	Artificial Intelligence								
AVT	Ambient Voice Technology								

Meeting of the Board of Directors
Thursday 23rd October 2025
Future Christie Update

1.0 Introduction

The programme has moved from design into delivery, with progress across all core workstreams:

1. Patient Portal Implementation	Rolled out Trust-wide, with over 2,000 patients now accessing appointment details and clinical correspondence electronically. Integration of patient feedback indicates improved access, transparency, and satisfaction.
2. Ambient Voice Technology (AVT)	Business case approved; deployment to begin November 2025, focusing initially on surgical services. Expected benefits include real-time generation of clinic letters and immediate upload to the Patient Portal — directly improving patient experience and administrative efficiency.
3. Electronic Patient Record (EPR)	Development of the outline business case underway. Procurement expected to commence early 2026, consolidating multiple legacy systems and enabling future integration with JAC.
4. Joint Analytics for Cancer (JAC)	Phase 1 business case completed. JAC will deliver a federated data platform integrating clinical and corporate datasets, enabling personalised care, research, and innovation. Strategic alignment confirmed through external reviews with Deloitte and the University of Cambridge.
5. Engagement and Governance	Appointment of a dedicated Transformation Lead. Establishment of delivery groups and staff engagement forums to ensure inclusive development and cultural alignment.

2.0 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.

3.0 Challenges and Mitigations

Challenge	Mitigation
Capacity for change	Investment in specialist roles (e.g., Chief Data Officer, Transformation Lead) and rationalisation of the digital delivery portfolio to focus on priority projects.
Cultural adaptation	Co-designed implementation plans, supported by staff education and communication strategies.
Procurement complexity	Adoption of an “expert customer” model with soft market engagement and specialist consultation to ensure value and optimal solutions.

4.0 Next Steps and Year 1 Priorities

- Q4 2025 – Q1 2026: Deploy AVT in Surgical Services; expand Patient Portal features; complete EPR Outline Business Case; commence JAC data cleaning and recruitment.
- Q2 2026: Launch EPR procurement; link Patient Portal to NHS App; scale AVT Trust-wide.
- Q3 2026: Complete JAC Phase 2 business case; conduct impact reviews with staff and patients; co-design 2026–27 delivery plan.

Meeting of the Board of Directors

Thursday 23rd October 2025

Subject / Title	Freedom to Speak Up Report - 1st April 2025 to 30th September 2025								
Author(s)	Fiona Jenkinson, Freedom to Speak Up Guardian								
Presented by	Fiona Jenkinson, Freedom to Speak Up Guardian								
Summary / purpose of paper	This report provides a six-monthly update on Freedom to Speak Up (FTSU) activity within The Christie, covering the period from 1st April to 30th September 2025. It outlines key developments in promoting a speaking up culture, including staff engagement, training, and champion recruitment, and presents data on the nature and volume of concerns raised. The paper also reflects on national guidance, staff feedback, and demographic trends which are informing ongoing improvements to the FTSU service.								
Background papers	Previous six-month Freedom to Speak Up report								
Risk score / BAF reference	N/A								
EDI impact/considerations	FTSUG attends EDI network steering group meetings								
Link to: ➤ Trust strategy ➤ Corporate objectives	<ol style="list-style-type: none"> 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 								
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.	<table border="0"> <tr> <td>FTSUG</td> <td>Freedom To Speak Up Guardian</td> </tr> <tr> <td>NGO</td> <td>National Guardian's Office</td> </tr> <tr> <td>EDI</td> <td>Equality, Diversity and Inclusion</td> </tr> <tr> <td>NHSE</td> <td>NHS England</td> </tr> </table>	FTSUG	Freedom To Speak Up Guardian	NGO	National Guardian's Office	EDI	Equality, Diversity and Inclusion	NHSE	NHS England
FTSUG	Freedom To Speak Up Guardian								
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Board of Directors
Thursday 23rd October 2025

Freedom to Speak Up Report 1st April 2024 to 30th September 2025

1. Introduction and Background

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

This report provides a six-monthly update on Freedom to Speak Up (FTSU) activity within The Christie, covering the period from 1st April to 30th September 2025. It outlines key developments in promoting a speaking up culture, including staff engagement, training, and champion recruitment, and presents data on the nature and volume of concerns raised. The paper also reflects on national guidance, staff feedback, and demographic trends which are informing ongoing improvements to the FTSU service.

2. Activity

To be a visible presence and embed the importance of a healthy speak Up culture, The Freedom to Speak Up Guardian (FTSUG) where possible attends meetings and induction in person. Speak Up training is mandatory within the trust; this has recently undergone review at the Mandatory Training Oversight Group and it was felt this training is making an impact and should continue.

The FTSUG is a member of the Equality and Diversity (EDI) steering group, this is important for triangulation and to hear diverse voices from across the trust.

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

The FTSUG has fostered a good working relationship with the comms team who have produced new posters which have been distributed through the trust. The posters have a simplified design and provide details of the new guardian. The weekly bulletin has been utilised to promote the service and recruit champions, as have Newsflash and regular blogs linked to topical events or NGO reports.

Promotion of speaking up is supported by activity during Freedom to Speak Up Week. This year it will be held 13-17th October.

2.1 FTSU Champions

Since coming into post in March the FTSUG has had a drive to recruit more Champions to try and ensure the service has representation within every division, and to develop a team which better reflects the make-up of the workforce. The network has grown from 3 to 13 staff and members range from Band 2 to medical consultants. We now have 3 male champions, an overseas-trained champion and a range of ages and ethnicities. We have champions at our Salford site and aim to recruit from Oldham and Macclesfield before the end of the year



3. Culture

3.1 A post-cultural audit Christie

It has been noted that since the cultural audit there has been an increase in FTSUG contacts, this is in line with a national rise, and it is felt that staff in a post-pandemic NHS are more likely to Speak Up about elements of the culture which are not aligned with our Values and Behaviours.

3.2 Values and Behaviours

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

3.3 Staff survey

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

This information is also available to view on the staff Survey Dashboard

3.4 Patient Safety Incident Response Framework (PSIRF)

The Christie continues to embed PSIRF which sets out the approach to responding to patient safety incidents with an emphasis on the system and culture. PSIRF recognises a culture of strong psychological safety underpins openness and transparency in incident reporting and promotes respectful investigations with meaningful system-based learning. The FTSUG meets regularly with the Patient Safety Matron to triangulate concerns raised.

4. National guidance and reports

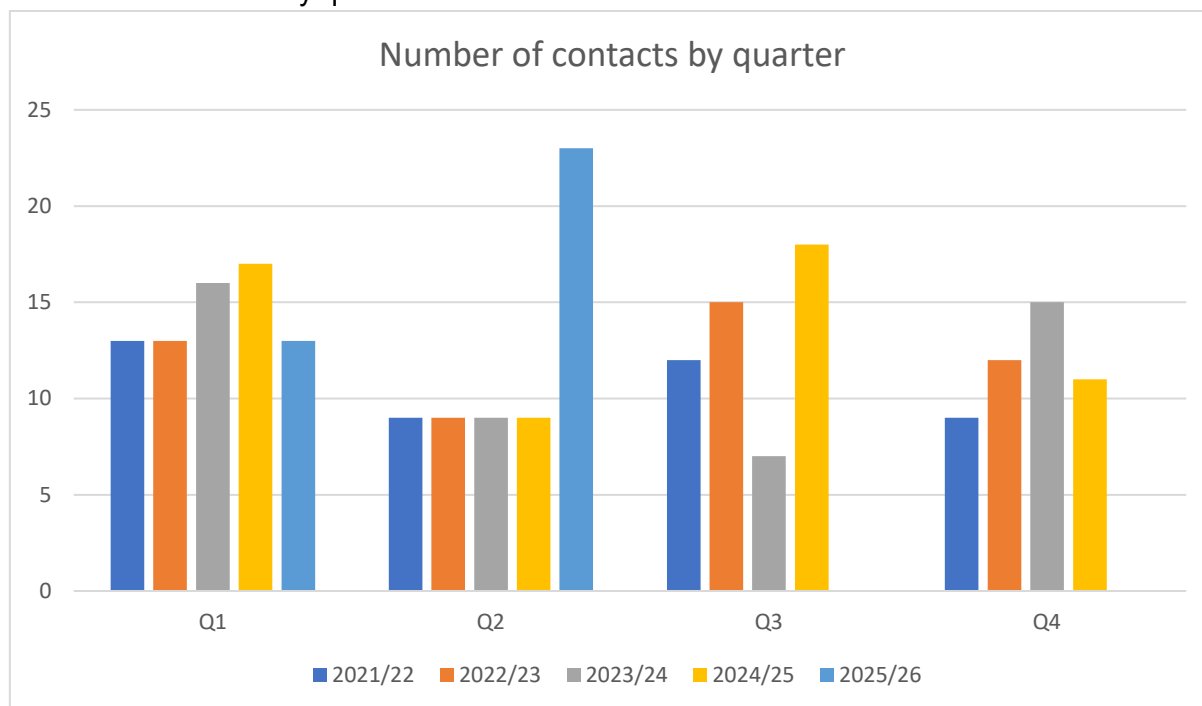
Throughout the last six months the following reports were issued and reviewed.

- *Requirements for recruiting and embedding Freedom to Speak Up guardians – a framework for organisations and leaders* – the guidance was used in the production of the new FTSU Plan and will be used for the service review planned for March
- *Listening and learning: Amplifying the voices of overseas-trained workers, a review of the speaking up experiences of overseas-trained workers in England* - highlights the unique challenges faced by NHS workers trained outside the UK when speaking up. Following its publication we have recruited an overseas trained guardian and recommended the Professional Nurse Advocate team puts forward an overseas-trained staff member for their training module.
- *Freedom to Speak Up Guardian Survey 2025, Thematic Review.* – The review sets out comprehensive recommendations for both local organisations and future national bodies, focusing on enhanced local implementation, improved organisational support, strengthened communications, leadership engagement, and guardian wellbeing. We will undergo a full “true for us” review against the recommendations as part of the service review in March 2026. See Appendix 1 For the FTSUG self-assessment.



5. Contacts

5.1 Number of contacts by quarter



5.2 Type of contact

The table below describes the activity from 1st April 2025 to 30th September 2025; concerns can have more than one issue.

Quarter	Number of contacts	Issue category	Description	Action
2025/26 Q1	13	Attitudes & Behaviours X 13	Concerns regarding attitudes and behaviours of line manager X 6	Own action taken x 2 Escalation to Deputy Head of Workforce x 5
		Policies, procedures & processes X 10	Unfair dismissal X 1	Escalation to Chief Nurse & CEO x 2 Escalation to service lead x 1
		Performance capability X 2	Advice to support a colleague with FTSU concerns X 1	No further action taken x 1
		Quality & safety X 2	Concerns regarding the treatment of a colleague X 1	Contact did not respond x 2
		Other X 2		



Quarter	Number of contacts	Issue category	Description	Action
			<p>Concerns regarding the competency and practice of a team X 2</p> <p>Complaint about a HIVE blog comment X 1</p> <p>Wanting information regarding the re-banding process and how this should be communicated X1</p> <p>Poor communication prior to induction which continued after starting in post X 1</p>	
2025/26 Q2	23	<p>Attitudes & behaviours X 19</p> <p>Policies, procedures & processes X 13</p> <p>Sexual safety X 2</p>	<p>Grievance against manager x 1</p> <p>Advice regarding behaviour of line manager x5</p> <p>Support/ conversation regarding reports of racism from 3 separate staff members x1</p> <p>Anonymous report of whether Town Hall meetings in R&I are fit for purpose x 1</p> <p>Carer's passport not acknowledged x 1</p> <p>Sexual WhatsApp messages and concern of potential fraud x 1</p>	<p>Formal Grievance raised x 1</p> <p>Information/signposting x 2</p> <p>Own actions taken x 2</p> <p>Escalation to Deputy Head of Workforce x 8</p> <p>Actions for the team x 1</p> <p>Escalation to service lead x 4</p> <p>Escalation to Line Manager x 2</p> <p>No further action taken x 1</p> <p>Contact did not respond x 1</p>



Quarter	Number of contacts	Issue category	Description	Action
			Report of 2 historic sexual safety concerns x 1 Racist comment from a visitor x 1 Incivility x 2 MOA policy being used wrongly to punish an individual x 1 Poor management communication and implementation of change x 4 Lack of transparency in recruitment x 1 Inappropriate implementation on an Action Plan x 1 Lack of support through induction and probation x 1	

5.3 Summary

In summary, over the last six months, 89% of concerns (as a percentage of number of issues) have had an element relating to attitudes and behaviours.

72% related to policies, procedures and processes and 12% related to service change.

The majority (75%) of attitude/behaviour concerns related to manager behaviour. 5 of the 32 cases concerned behaviour of a colleague(s) whilst 1 person reported an incident of a racist remark from a visitor. Both cases relating to Sexual Safety related to a colleague.

The 4 cases relating to poor management communication and implementation of change we're brought as a collective concern. It is noted that in the last 12 months the trust has implemented training for those who have a role in managing staff. Whilst this is very much an overview, the training includes information on where guidance on good practice (such as the Managing Change section of the HR Encyclopaedia) can be found.

Concerns relating to policies, procedures and processes are varied but highlights how implementation of trust policies must be transparent, robust and fair to maintain confidence.

6. Who is raising the concern

A review of who is raising concerns and how they are raised helps to identify if there are groups of staff who are not speaking up. There would be a benefit in reviewing how staff are encouraged to



raise concerns and what channels they use for those groups where there are low numbers contacting the FTSUG.

6.1 Number of FTSUG contacts by staff group

Staff group	Q1&2 24/25	Q3&4 24/25	Q1&2 25/26	Total for 18 mths
Additional clinical services	2	4	6	12
Additional professional, scientific and technical	1	2	3	6
Administrative and clerical	10	8	2	20
Allied health professionals	8	4	7	19
Estates and ancillary	1	1	3	5
Healthcare scientists	0	0	0	0
Medical and dental	1	2	0	3
Nursing and midwifery	3	5	7	15
Students	0	0	0	0
Other	0	1	0	2
Unknown	2	2	6	9
Total	28	29	36	95

Staff group	Total number (18 months)	% of total no. of contacts	Staff numbers by group 2024	% of total number of staff
Additional clinical services	12	13.2	441	10.6
Additional professional, scientific and technical	6	6.6	163	3.9
Administrative and clerical	20	22	1230	29.7
Allied health professionals	19	20.9	454	11
Estates and ancillary	5	5.5	291	7
Healthcare scientists	0	0	212	5.1
Medical and dental	3	3.3	373	9
Nursing and midwifery	15	16.5	977	23.6
Students	0	0.0	4	0.1
Other	2	2.2		
Unknown	9	9.9		
Total	91		4145	2.2

6.2 Demographics

From April 2024, all contacts have been asked to provide their demographic information at their first meeting with the FTSUG. 20 provided this information during the 6 months covered by this report. This data can be compared with the overall workforce demographics to identify gaps.

Age	16-24	2
	25-34	5
	35-44	8
	45-54	5
	55-64	3
Ethnicity	White British	17
	Mixed other	2
	Pakistani	1



Disability	Yes	3
	No	17
Religion	Christian	5
	Muslim	2
	No religion	7

6.3 Role

Role	Q1&Q2 2024/2025	Q3&Q4 2024/2025	Q1&Q2 2025/2026
Senior leader	0	0	11%
Manager	27%	20.7%	8%
Worker	73%	75.9%	53%
Unknown	0	3.4%	28%
Denominator – number of cases	26	29	36

6.4 Method of speaking up

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

Method	Q1&Q2 2024/2025	Q3&Q4 2024/2025	Q1&Q2 2025/2026
Face to face	13	5	7
MS Teams	12	2	2
Telephone	1	0	3
Form on intranet	0	2	4
Email	0	19	18
Letter	0	1	0

7. FTSU plan

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

The plan for 2025-27 has been developed by triangulating data from several sources, these include, the 2024 Staff Survey, the last 12 months of organisational FTSU data, and NGO (National Guardian’s Office) reports from the last 12 months.

Following a review of the 2024/25 plan a decision was taken to make the FTSU plan a two-yearly plan. Having an annual plan has not provided enough time develop the themes, deliver the points of the plan to their fullest and to measure the impact.

Whilst most actions have a timescale of completion by October 2026, continuing the plan into 2027 gives the opportunity to fully embed, develop and assess the impact of these actions before a new plan is produced.

Embedding the plan includes recognising the ownership of its delivery as the responsibility of us all. The plan will be reviewed six-monthly, and the Divisions within the Trust will be asked to contribute to the ongoing development and updating of the plan.

The plan can be found in Appendix 2

Since its implementation the deliverables achieved were:



- Develop and expand the Champion network, including targeted recruitment of Champions from the areas most dissatisfied (recommendation from the Regional FTSU network meeting March 2025)
- Review feedback from those who raised a concern to share learning, including free-text responses from the staff Survey 2024
- Engage with national issues relating to the development and promotion of Freedom to speak Up, and related NHS/Healthcare culture initiatives (an ongoing objective)

In progress:

- Roundtable triangulation meetings
- Roll out of guide to support managers who receive a concern

8. National Freedom to Speak Up Week

October 13th-17th is National Freedom to Speak month and the focus for organisations is how concerns raised are followed up. Throughout the week there will be an engagement campaign at the Staff Engagement Stand with an aim to spread awareness of the service and launch the expanded Champions Network. This will include the launch of a quarterly FSTU newsletter, the promotion of national webinars, awareness of FTSU as a means to share suggestions for improvement and a FTSU Week Schwartz Round.

9. Freedom to Speak Up Training

The National Guardian's Office, in association with Health Education England launched Freedom to Speak Up e-learning training divided into three modules, Speak Up for all staff, Listen Up for managers at all levels and Follow Up for Senior leaders. The Speak Up module is part of the Trust mandatory training programme and 97% of staff are compliant.

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

10. FTSU service effectiveness

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

8 contacts replied in Q1 and Q2 2025/2026.

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

All said they felt very well supported.

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

All said they were communicated with very well.

4 said they were informed of learning that happened as a result, 3 said there was no learning, 1 said they were not informed.

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

Comments made:



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

- *Still awaiting outcome of the issue but the support made me feel that I could move forward and that it was a good thing to speak up.*
- *Glad I raised the concern, seems to be being treated seriously and sensitively*
- *It was a cathartic experience and helped to realise it was not all in my head. I felt a burden lifted and being able to express my feelings.*
- *Positive. I felt that Fiona took my concern seriously, I was completely confident of her commitment to confidentiality and thought that it was useful to iterate the details of the concern with her.*
- *I'm glad I did so, I was treated respectfully and Fiona made me feel really comfortable with discussing something quite awkward*
- *I was made to feel supported and feel like it has helped me understand my options and feel comfortable raising my concerns if my current situation devolves.*

Suggestions for improvement of the FTSU service: -

- *So far seems to be working as intended*
- *It was great, it needs to be publicised more to reach individuals who are struggling and unable to reach out. I think the FTSU should visit every department at least annually. It's good to present at induction but it needs to be remain visible. I have found the blogs helpful too.*
- *Not at the moment. I have confidence in the Trust's commitment to recognise the importance of feedback through the process, although I did not need it this time. I used the service a few years ago and the previous guardian was unable (not her fault) to tell me whether my concern had even been acknowledged. I know that this should not happen now and would feel confident of receiving feedback.*
- *No, I'm really happy with my experience*
- *Some links don't work on phones other than that the service was great.*

11. Conclusion

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



APPENDIX 1

Recommendations for organisations to implement locally based upon Freedom to Speak Up Guardian Survey 2025 Thematic Review

True For Us Self-Assessment

1. Enhancing local implementation and role capacity	
Ensuring local implementation of the Freedom to Speak Up Guardian role aligns with national policy and the recruitment framework maintaining consistency with national standards.	Yes
Adapt the role locally to reflect the organisation's specific needs, culture, and context, this may include tailoring communication, support, and engagement strategies to enhance accessibility and impact	Yes
Apply the development guide consistently at the local level to support equitable access to training and capability development for Guardians.	Yes
Establish and apply a locally appropriate guardian-to-staff ratio to support manageable caseloads and enable proactive engagement.	Yes
Uphold the core principles of Freedom to Speak Up in all local adaptations, promoting a culture of openness, psychological safety, and continuous Learning.	Yes
Conduct regular local reviews of implementation to ensure continued alignment with best practice and evolving national guidance.	Yes
2. Improve organisational support	
Ring-fence dedicated time for guardians to carry out their duties effectively	Yes
Follow national recommendations by appointing Freedom to Speak Up guardians in standalone roles, to strengthens their independence and visibility, and is strongly encouraged in the latest recruitment framework guidance.	Yes
Use the guardian recruitment framework as the base, develop a local tailored salary banding guidance that reflects organisational size, workforce numbers, and the complexity of the role.	New framework to be used at next review
Ensure guardians have access to confidential meeting spaces, a dedicated budget for training, travel, and promotional activities.	Yes
Ensure speak up processes are inclusive and accessible to all staff, including those from underrepresented groups.	Yes
Train guardians to support diverse staff needs and encourage organisations to identify and address barriers to speaking up.	Yes
Establish mechanisms to use feedback from staff and guardians, and collected data inform improvements and share learning across departments and teams.	Yes
3. Strengthen communications	
Promote consistent, strategic communications support at the organisational level, beyond campaign-based activity to raise awareness and visibility of the Freedom to Speak Up guardians.	Yes
4. Engage leadership	
Provide targeted training for managers and senior leaders on key people-related policies, especially where these intersect with speak up concerns, such as grievance procedures, disciplinary processes, and recruitment practices.	Yes
Mandate Freedom to Speak Up training for all managers and senior managers to reduce barriers to speak up and understand the importance of the guardian function.	Yes – mandatory for all staff



Promote visible leadership support for Freedom to Speak Up guardians. Active endorsement from senior leaders helps build trust and signals a genuine commitment to openness and psychological safety across the organisation.	Yes
5. Support Guardian wellbeing	
Individual organisations should recognise and proactively address the emotional demands of the role.	Yes
Employing organisations should encourage guardians to access wellbeing resources, peer support, and reflective practice opportunities.	Yes
NHS trusts need to pay particular attention to burnout risks, where emotional Strain is often more pronounced.	Yes



APPENDIX 2

Deliverable	Action	Timescale
Ensuring safety, quality, and organisational learning		
In-depth analysis of Staff survey results, to inform Speak Up activity and highlight which areas may require more support to develop their Speak-Up culture	<ul style="list-style-type: none"> Asses if priority action areas from the 2023 Christie Independent Cultural Audit are featuring in Speak up disclosures Divisional presentations to Workforce Committee on focus for action following staff survey results 2024 	November 2025
Continue to embed Speaking Up as an important element in the implementation of the Patient Safety Incident Response Framework (PSIRF). Build awareness of the clear mechanisms for raising, investigating, and escalating clinical concerns to build confidence of staff and ensure Speaking Up is aligned with the culture of PSIRF.	<ul style="list-style-type: none"> Regular triangulation meetings with Patient Safety leads. Make PSIRF part of the conversation when visiting areas in person. Ensure that when Speak Up disclosures have a concern for patient safety DATIX forms have been completed. Liaise with patient safety leads when a need for more education regarding PSIRF is required. Roll out of Anonymous reporting for inappropriate behaviours via the Datix system (planned 01/08/2025) 	Ongoing
Promoting a Speaking Up culture		
Develop and expand the Champion network, including targeted recruitment of Champions from the areas most dissatisfied (recommendation from the Regional FTSU network meeting March 2025)	<ul style="list-style-type: none"> Active recruitment drive at Induction, via comms, using blogs and newsflash Link with EDI champions and Mental Health first aiders Targeted recruitment of medics as Speak-up champions 	March 2026
Target barriers to speaking up, particularly for those with protected characteristics	<ul style="list-style-type: none"> Engage with EDI champions to identify barriers to speaking up, encourage EDI champions and Mental Health first aiders to complete additional Speak Up training Review NGO paper “Listening & Learning: amplifying the voices of overseas-trained workers” and how the learning can be applied at The Christie. Targeted Champion recruitment to reflect our diverse workforce 	March 2026



Supporting workers compassionately		
Campaign relating to FTSU promoting the Just and Learning Culture charter, incorporating 'Civility Saves Lives'	<ul style="list-style-type: none"> • Liaise with comms, use of blogs, HIVE 	October 2026
Initiate discussion around the issues raised in the HPMA paper "When We Do Harm" and the "Avoiding Harm" programme, acknowledging the impact that the application of policies and processes can have on our workforce.	<ul style="list-style-type: none"> • Promote these conversations from Board level downwards • Initiate conversations with HR team • Share paper with leaders throughout the trust 	October 2026
Collaborating with leadership to drive cultural change		
Triangulation of FTSU information, patient safety concerns and employee relations matters	<ul style="list-style-type: none"> • Meet regularly with other leads for staff wellbeing and safety • Present themes and learning to Workforce Committee, Senior Management Committee and The Board 	Ongoing
Review feedback from those who raised a concern to share learning, including free-text responses from the staff Survey 2024	<ul style="list-style-type: none"> • Review feedback, highlight themes and share learning with the Workforce Committee, Senior Management Committee and The Board 	October 2025
Engagement beyond the organisation		
Engage with national issues relating to the development and promotion of Freedom to speak Up, and related NHS/Healthcare culture initiatives	<ul style="list-style-type: none"> • Disseminate papers from the NGO and other affiliated organisations • Develop external Speak-Up networks though the "buddy" system, regional meetings and national networks 	Ongoing



Agenda Item 35/25a

**Meeting of the Board of Directors
 Thursday 23 October 2025**

Subject / Title	Quality Assurance Committee report – September 2025
Author(s)	Assistant Company Secretary Committee Chair
Presented by	Committee Chair
Summary / purpose of paper	This paper provides the Board with a summary of the items considered by the Quality Assurance Committee at their September meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions.
Background papers	Quality Assurance Committee papers – September 2025
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	<ul style="list-style-type: none"> • 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.	

Agenda item 35/25a



**Meeting of the Board of Directors
 Thursday 23 October 2025**

Quality Assurance Committee report –September 2025

1 Introduction

The Quality Assurance Committee took place on 18 September. The meeting was quorate. The following summary gives the Board information on the items that were considered by the committee at their meeting under the headings of Assure / Alert / Advise.

2 Quality Assurance Committee agenda items

The items listed in Appendix 1 of the report were all presented to the Quality Assurance Committee in September 2025. Following discussion, the items are presented to Board for information and action where appropriate.

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

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 Quality Assurance Committee in September 2025.



Appendix 1

Agenda item	BAF ref	CQC regulation reference	Assurance rating given	Key points and associated actions (where applicable)
24/25a	N/A	N/A	Medium	Lost to follow up
Assure				<ul style="list-style-type: none"> Initial backlog of 78,000 referrals, these have all been reviewed.
Alert				<ul style="list-style-type: none"> No alerts to raise.
Advise				<ul style="list-style-type: none"> Emerging risks discussed: (1) backlog of unoutcomed appointments - unoutcomed patient appointments are being monitored and escalated for action. Progress is being made in clearance of historic unoutcomed appointments and introduction of steps to identify missing outcome forms in real time. Email alerts to clinicians with the aim of reducing the number of unoutcomed appointments due to missing outcome forms. (2) Multiple episodes of care - relates to patients who have multiple episodes of care captured under one referral in CareFlow. The outpatient waiting list can only show one review date and one on hold reason per referral and there is a risk that patients may miss or be delayed for appointments for one part of their care. Recent audit looked at cases between September 2024 and March 2025; 4 'lost to follow up' incidents related to the residual risk of outcoming and 1 related to the residual risk of multiple episodes of care. Ultimately, reliant on EPR migration and re-design; need to safety net until the move to new EPR. Strategic business case going to Board in September, if approved, looking at a 2-year implementation process. Next steps – (1) develop robotic system automation as a solution for outcoming, (2) recruit temporary staffing resource to move to real-time outcoming and (3) address the management of multiple episodes of care as part of the new Trust EPR.
Actions				<ul style="list-style-type: none"> Further update and audit outcome in relation to lost to follow up to be presented to the committee in March 2026.



24/25b	2	12, 20	High	Incident management deep dive audit
Assure				<ul style="list-style-type: none"> Incidents presented to ERG between April 2024 - March 2025 were assessed as part of the deep dive audit utilising the Learning Response Review and Improvement Tool by the Health Services Safety Investigations Body (HSSIB). Audit findings: Good practice – a shift under PSIRF to more system-focused investigations which seek to identify learning rather than apportion blame. Reports were assessed as being clear and easy to understand with actions identified.
Alert				<ul style="list-style-type: none"> No alerts to raise.
Advise				<ul style="list-style-type: none"> Results found that 20% of cases demonstrated little evidence of patient engagement, hindering the ability to fully understand and identify learning from incidents. The lowest performing area was related to safety actions created in response to learning responses, with only 7.5% of incidents reviewed demonstrating good evidence that actions are focused on system level improvements. Discussion on how staff are trained and supported in investigating incidents, psychological safety of those involved in incidents and applying a focus to ensuring we are capturing the engagement as well as we can do.
Actions				<ul style="list-style-type: none"> Staff member to attend a future meeting and share their experience of involvement in an incident investigation. Following a review of the learning associated with PSIRF, risk score to be reviewed in November. Quality improvement methodology to be presented to the committee in January.
24/25c	4	12	High	Infection prevention & control board assurance framework (IPC BAF) – AAA executive summary
Assure				<ul style="list-style-type: none"> Currently 14 areas confirmed as partially compliant, detail provided in the paper as to the requirements to be completed.
Alert				<ul style="list-style-type: none"> No alerts to raise.
Advise				<ul style="list-style-type: none"> Full review to be completed by end of October.
Actions				<ul style="list-style-type: none"> No actions noted.



16/25d	1, 2, 4	9, 10, 12, 16, 20	High	Integrated safety, quality and experience quarterly report
Assure				<ul style="list-style-type: none"> • Patient Experience: 96%+ FFT positive scores sustained across Q1; no complaints breached statutory timeframes. • Incident Management: 2827 incidents reported; 86% finally approved; 95% no/low harm rate sustained. • PALS: 121 contacts managed appropriately; responsive improvements documented. • H&S: No claims received related to manual handling; compliance with statutory training maintained.
Alert				<ul style="list-style-type: none"> • Extreme Risks: 8 risks remain ≥ 15, with 6 not yet reduced from initial score. • Duty of Candour: 81% compliance with statutory requirements (initial apology and letter). • Scorecard in place highlighting areas requiring focus at a divisional level to achieve compliance with strategic and operational standards aligned to integrated governance agenda.
Advise				<ul style="list-style-type: none"> • Audit Governance: 14 core and 24 non-core QICA projects overdue >3 months, affecting assurance. • Risk Governance: 75 risks remain overdue for scheduled review; compliance with monthly review remains variable across divisions. • End-of-Life Care: Themes emerged across complaints, incident reviews and PSIRF responses requiring patient safety priority, group is developing scope. • PSIs: 3 new serious investigations triggered under PSIRF, all complete at time of reporting. • Large number of open projects linked to QICA causing resource pressure.
Actions				<ul style="list-style-type: none"> • No actions noted.
24/25e	4	13	High	Safeguarding vulnerable people annual report 2024/25 – updated format
Assure				<ul style="list-style-type: none"> • NICE guidance compliance confirmed; Clinical Research & Effectiveness Committee (subcommittee of Risk & Quality Governance Committee) oversee the requirements and track completion, also reported through to Safeguarding Committee and fed into the safeguarding annual report.
Alert				<ul style="list-style-type: none"> • No alerts to raise.
Advise				<ul style="list-style-type: none"> • Next annual report will focus more on the contractual standards and include more data.
Actions				<ul style="list-style-type: none"> • No actions noted.



24/25f	N/A	N/A	Medium	Medication safety and medication administration progress update
Assure				<ul style="list-style-type: none"> Action plan developed on the back of the MIAA audit has been completed and closed down by MIAA. Summary of actions completed; updates to policy made. Regular task and finish group meetings took place to work through completion of actions. Daily ward checklists now in place. Mini CODE in operation covering ward safety and patient care. Good compliance with medicines safety.
Alert				<ul style="list-style-type: none"> No alerts to raise.
Advise				<ul style="list-style-type: none"> The annual wristband audit was completed in May 2025; 90% compliance. The patients sampled were from across all inpatient areas. The results of the audit have been shared to harness learning and improve compliance. Looking to re-audit ward areas on the elements which were identified as part of the audit.
Actions				<ul style="list-style-type: none"> Following completion of the re-audit in October, a further medication safety and medication administration progress update to come back to the committee in January 2026.
24/25g	N/A	N/A	Strong	Winter planning board assurance statement
Assure				<ul style="list-style-type: none"> Trust formally required to submit a board approved statement to NHSE by the end of September. Plan has been developed collectively through the GM system and stress tested at GM level. Reviewed alongside capacity and demand. Our risk profile is low given that we do not have an A&E. Statement approved for presentation to Board for approval.
Alert				<ul style="list-style-type: none"> No alerts to raise.
Advise				<ul style="list-style-type: none"> Need to review the process for QICA projects; working with the coding team to ensure triage pointing at the right projects.
Actions				<ul style="list-style-type: none"> No actions noted.



The following agenda items were also discussed at the meeting but did not require an assurance level assigning:

Alert	<ul style="list-style-type: none"> No alerts to raise.
Assure	<ul style="list-style-type: none"> Board Assurance Framework:- Risk 1 – referred to as part of safeguarding update provided to the committee and NICE guidance. Risk 2 – links to the PSIRF updates that come through to the meeting. Risk 7 – relates to cancer waiting times, on the rolling programme for November. Action: Quality improvement methodology requirement to be added to the relevant BAF risk with the time frame for closure. MIAA audit recommendation tracker and extension request procedure: noted that regular reports will come from MIAA.
Advise	<ul style="list-style-type: none"> No advise points to raise.



**Meeting of the Board of Directors
 Thursday 23 October 2025**

Subject / Title	Workforce Assurance Committee report – September 2025
Author(s)	Assistant Company Secretary Committee Chair
Presented by	Committee Chair
Summary / purpose of paper	This paper provides the Board with a summary of the items considered by the Workforce Assurance Committee at their September meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions.
Background papers	Workforce Assurance Committee papers – 18 September 2025
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	<ul style="list-style-type: none"> • 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.	



**Meeting of the Board of Directors
 Thursday 23 October 2025**

Workforce Assurance Committee report – September 2025

1 Introduction

The Workforce Assurance Committee took place on 18 September 2025. The meeting was quorate. The following summary gives the Board information on the items that were considered by the committee at their meeting under the headings of Assure / Alert / Advise.

2 Workforce Assurance Committee agenda items

The items listed in Appendix 1 of the report were all presented to the Workforce Assurance Committee in September 2025. Following discussion, the items are presented to Board for information and action where appropriate.

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

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 Workforce Assurance Committee in September 2025.



Appendix 1

Agenda item	BAF ref	CQC regulation reference	Assurance rating given	Key points and associated actions (where applicable)
23/25a	3, 4, 12	18	High	Workforce dashboard and risk review
Assure				<ul style="list-style-type: none"> Dashboard updated to reflect insightful board guidance. Sickness rate – end of August 4.8%, target 4.25%; challenges in a number of divisions, performing well against GM benchmark. PDR compliance – remains constant at 87.6%. Staff turnover – positive trend, 11.3% includes R&I which have a large turnover of short-term contracts. Voluntary turnover sits at 8.9%. Establishment against paid FTE gap – vacancy rate stands at 6.6%. Recruitment activity – assurance provided on closing the gap; forecasted gap 84.21 but healthy pipeline. Employee experience – what staff tell us when they leave the Trust. Majority positive comments, workload and change in roles areas highlighted as main reasons for leaving.
Alert				<ul style="list-style-type: none"> Mandatory training - compliance stands at 94.4%; some challenges in some areas (see 23/25b below).
Advise				<ul style="list-style-type: none"> Workforce supply risk remains at a 9 and regularly reviewed at Workforce Committee.
Actions				<ul style="list-style-type: none"> No actions noted.
23/25b	3	N/A	Low	Mandatory training assurance – focused review
Assure				<ul style="list-style-type: none"> 174 departments from 224 have never fallen below the 80% threshold (78%).
Alert				<ul style="list-style-type: none"> 12 departments have been below the 80% threshold for 6 or more consecutive months. Of these, 5 departments remain non-compliant as of 31 July 2025. Further analysis of the 5 departments confirmed that some areas of non-compliance were in relation to patient facing training. Meetings have taken place within the divisions to agree the requirement for correcting and monitoring as an immediate action. Time and access pressures were provided as the reasoning for non-compliance. Divisions have been asked to complete risk assessments and this is monitored through service and operational reviews, the escalation process needs to be reviewed to tackle the issue and hold to account.
Advise				<ul style="list-style-type: none"> No points noted.
Actions				<ul style="list-style-type: none"> Areas of non-compliance escalated to Board at September Board meeting. Update on mandatory training compliance assurance to come to the November Workforce Assurance Committee.



23/25c	N/A	N/A	High	Sexual safety charter framework assurance update
Assure				<ul style="list-style-type: none"> Letter from NHSE in terms of ongoing commitments to the charter; Trust in a good position. Completion of outstanding actions planned for the end of December.
Alert				<ul style="list-style-type: none"> No points to raise.
Advise				<ul style="list-style-type: none"> Function for looking for unusual activity in electronic patient record required. Policy on chaperoning required.
Actions				<ul style="list-style-type: none"> Update on sexual safety charter framework assurance progress (including timescales for completion) to come to the January Workforce Assurance Committee.
24/25a	3	N/A	Strong	Inclusive culture strategy update and The Christie people and culture plan update
Assure				<ul style="list-style-type: none"> Draft plan for 2026-2030 presented (will replace current plan). Divisional engagement and shared ownership of the plan across the Trust, evidenced through the embedding of good practices and feedback. Plan continues to be aligned to the NHS people promise and Trust strategy. Timescales for plan intentionally aligned with the inclusive culture strategy.
Alert				<ul style="list-style-type: none"> No points to raise.
Advise				<ul style="list-style-type: none"> No points to raise.
Actions				<ul style="list-style-type: none"> No actions noted.

The following agenda items were also discussed at the meeting but did not require an assurance level assigning:

Assure	<ul style="list-style-type: none"> Guardian of safe working hours quarterly report - 17 exceptions reported, a reduction from the previous quarter. Haematology reporting down significantly, work plan being implemented in relation to rota changes, which is a positive. Lead registrar appointed to consultant role to enhance communication with resident doctors. Short time frame to deliver 10-point plan, being overseen by resident doctors working group, outcome will be reported in the next report to the committee. No concerns to raise at present, some challenges but will be addressed.
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<p>Alert</p>	<ul style="list-style-type: none"> • Board Assurance Framework (BAF) - Need to consider as part of the escalation on the mandatory training risk to Board whether the associated risk needs to be reflected in the BAF.
<p>Advise</p>	<ul style="list-style-type: none"> • Role essential training assurance update - report provided an update on progress to strengthen governance and compliance for role specific training. Highlighted the residual risks, gaps, and plans to mitigate risks; a further report will be presented to the November committee meeting Positive progress noted. • Internal audit recommendation tracker update - number of actions relating to recruitment selection policy – policy now approved. Role specific training policy action not yet due.



**Meeting of the Board of Directors
Thursday 23 October 2025**

Subject / Title	Senior Management Committee report – September 2025
Author(s)	Chris Harrison, Deputy Chief Executive
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 September meeting in a triple A format.
Recommendation(s)	To note the report and any actions.
Background papers	Senior Management Committee papers – 18 September 2025
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	<ul style="list-style-type: none"> • 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.	<p>CAG Clinical Advisory Group</p> <p>CQC Care Quality Commission</p> <p>AI Artificial Intelligence</p> <p>EPR electronic patient record</p> <p>PET positron emission tomography</p> <p>CMPE Clinical Medical Physics & Engineering</p> <p>BAF Board Assurance Framework</p>



**Meeting of the Board of Directors
Thursday 23 October 2025**

Senior Management Committee report September 2025

Items Considered were:

- Approval of previous meeting minutes and review of actions
- Mandatory training compliance and associated risks
- Risk register cleansing, training, and calibration
- Inclusive Culture Strategy and People & Culture Plan updates
- Performance Assessment Framework and NHS multi-year planning
- Clinical Advisory Group (CAG) role and engagement
- CQC preparedness and Excellence in Action programme updates
- Future Christie Programme updates, including Patient Portal, Ambient AI, and EPR
- PET project progress and equipment procurement
- Approval of the CMPE building redesign business case
- Governance reports and partnership updates

See also the Trust Report and Integrated Performance Quality & Finance Report

ALERT

Mandatory Training Compliance Risks

Compliance gaps were identified and escalated through operational channels. Targeted interventions have been made to address non-compliance in identified low-compliance workforce groups. Operationally, this is overseen by the Risk Committee, with Board Assurance through the Workforce Committee.

Risk Register Cleansing and Calibration

The operational risk register has been reviewed and updated to remove outdated or inaccurately described operational risks, ensuring that an accurate risk profile, consistent with the BAF risks, is available for the trust. Operational risks and consistency are overseen by the Risk Committee.

CQC Preparedness

Preparatory actions include the rollout of the Excellence in Action programme. Readiness assessments are in progress. The board has a report on its agenda with more details of current preparedness, triangulated evidence, and next steps ahead of any future inspection.



ADVISE

Christie Programmes

Updates received from the International, Private Care, Education, and Digital portfolios were received; no additional escalations are needed

Future Christie Programme (Patient Portal, Ambient AI, EPR)

These initiatives were discussed and are on track. The board will receive further assurance reports.

ASSURE

Clinical Advisory Group Engagement

CAG involvement confirms the clinical voice is embedded in strategic planning. The Terms of Reference and membership are being reviewed to ensure continued effectiveness.

Performance Assessment Framework and Multi-Year Planning

The implications of the Performance Assessment Framework are being closely monitored. The key metrics are being integrated into the performance report.

CMPE Building Redesign Business Case

Approved and is consistent with the estate's strategy. Assurance received that the redesign supports clinical and digital transformation goals.



Board of Directors meeting
Thursday 23rd October 2025

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)	<ul style="list-style-type: none"> • 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.
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	<ul style="list-style-type: none"> • 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



**Board of Directors meeting
Thursday 23rd October 2025**

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.

2 Updates to risks

All risks in the framework have been reviewed to reflect the current position. Controls and assurances have been updated.

The quarter 2 risk score has been added for each risk.

Review dates and assurance levels have been updated for each risk.

3 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.



BOARD ASSURANCE FRAMEWORK - OVERVIEW OF RISKS

RISK No.	Risk Title	Risk Description	Responsible Committee	Risk Appetite	Inherent Risk Score	Q4 24/25	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	Target Risk Score	Current Risk Score	Target date
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			4	16	Reviewed Q2 25/26
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			4	12	Reviewed Q2 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			8	12	Reviewed Q3 24/25
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			4	12	Review Q3 25/26
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			8	12	Reviewed Q2 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		9	9			4	12	Reviewed Q2 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			5	10	Review Q3 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			3	9	Review Q3 25/26
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			6	9	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			4	8	Reviewed Q2 25/26
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			4	8	Reviewed Q2 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			4	6	Within tolerance
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			5	5	Reviewed Q2 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	Reviewed Q3 25/26 / Within tolerance

RISK 1	New technologies and increased standards of care															Date Risk	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		
																Oct-25		
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	
Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date												
	Annual planning process with divisions. The trust has a risk-based process with divisional support to assess applicability and implement relevant guidance. Guidance that is not resolved or on the risk register is monitored and escalated if there are issues	Uncertainty around what / when. External factors	Level 1 – Data and management reports • Review of NICE guidelines through risk-based process with divisional support • risk register in place. <input type="checkbox"/> Level 2 – Management team and committee scrutiny • Review NICE guidelines compliance through QAC and monthly IPQFR <input type="checkbox"/> Level 3 – External assurances • NICE <input type="checkbox"/>	None identified	Forward views of upcoming NICE guidelines assessed	Within tolerance												
Scoring	Inherent 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			0			0	2	2	4

RISK 2	Learning from patient safety incidents															Date Risk	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	12	
																Date of Last Review		
																Oct-25		
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	
Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for												
	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 <input type="checkbox"/> Level 2 – Management team and committee scrutiny • Review compliance through patient safety reports to QAC <input type="checkbox"/> Level 3 – External assurances • MIAA review of PSIRF processes confirms substantial assurance • Updates presented to ICB	None identified	Further focus on improvement - Embed agreed Quality Improvement methodology across the Trust	Reviewed Q2 25/26												
Scoring	Inherent 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	3	9	3	3	9			0			0	2	2	4

RISK 3 Recruitment and retention of skilled staff		Date Risk	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	9															
		Date of Last																
		Oct-25																
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	National staff shortages impacting recruitment	Level 1 – Data and management reports • Divisional oversight of recruitment through Service & Operational 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 • OECl accreditation	Actions outlined by MIAA in Nov 24 Divisional Recruitment audit	None identified	Reviewed Q2 25/26												
Scoring	Inherent 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			0			0	2	3	6

RISK 4 Compliance with regulatory standards		Date Risk	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	12															
		Date of Last																
		Oct-25																
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 receive most up to date advice and guidance. 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 statutory requirement e.g. health & safety / IRMER / CQC etc	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 capability 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 • OECl accreditation	Full review of well led quality indicators to identify gaps	Plan in development for full review of all domains (1 per quarter)	Review Q3 25/26												
Scoring	Inherent 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			0			0	4	1	4

RISK 5	Capital funding												Date Risk			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					
													Oct-25					
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		
Actions	Key Control established			Key Gaps in Controls			Assurance			Gaps in			Actions to address			Target date for		
	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.			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			Capital bids collated including level of risk, impact on patient care and activity should the bid not be approved. Manage capital priorities within existing ICB allocation and support the ICB to deliver a compliant capital plan.			Reviewed Q3 25/26 / Within tolerance		
Scoring	Inherent 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			0			0	1	5	5

RISK 6	NHSE Financial Framework and support for growth												Date Risk			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			16		
													Date of Last					
													Oct-25					
Associated Strategic Objectives	To deliver excellent financial and operational performance												Executive Lead			Exec Director of Finance		
													Responsible			Board of Directors		
													Assurance Level					
													Risk Appetite			Cautious		
Actions	Key Control established			Key Gaps in Controls			Assurance			Gaps in			Actions to address			Target date for		
	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.			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			None identified			Continued attendance at regional & national events and on going discussions with ICB to understand funding			Reviewed Q2 25/26		
Scoring	Inherent 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			0			0	1	4	4

RISK 7	Ineffective Greater Manchester system-wide cancer pathways												Date Risk			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					
													Oct-25					
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		
Actions	Key Control established			Key Gaps in Controls			Assurance			Gaps in			Actions to address			Target date for		
	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 & IPR.			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			Supporting cancer improvement plans in GM Cancer Pathway improvement workstream in GM Cancer			Reviewed Q3 24/25		
Scoring	Inherent 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			0			0	4	2	8

RISK 8	Emergency event										Date Risk			Current Risk Score				
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.										Apr-24			10				
											Date of Last							
											Oct-25							
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				
Actions	Key Control established			Key Gaps in Controls			Assurance			Gaps in			Actions to address			Target date for		
	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 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) Q4 23/24			The Trust does not currently have cyber security insurance.			<ul style="list-style-type: none"> 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 Committee 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 			Not at 100% compliance for self-assessment / external assessment			Developing methodology to assess carbon footprint in collaboration with other Trusts Developing a CC Annual Report - Check what audit scrutiny this receives Review of cyber alerts			Review Q3 25/26		
Scoring	Inherent 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			0			0	5	1	5

RISK 9	Integrated research, education & service										Date Risk			Current Risk Score					
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.										Jun-25			8					
											Date of Last								
											Oct-25								
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					
Actions	Key Control established			Key Gaps in Controls			Assurance			Gaps in assurance			Actions to address gaps			Target date for implementation		Target date for completion	
	Research / Education / CODU plans all approved and being monitored through divisional boards and SMC						<ul style="list-style-type: none"> 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 • OECL accreditation 											Reviewed Q2 25/26	
Scoring	Inherent 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			0			0	1	4	4	

RISK 10	Financial balance										Date Risk			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			5				
											Date of Last							
											Oct-25							
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				
Actions	Key Control established			Key Gaps in Controls			Assurance			Gaps in			Actions to address			Target date for		
	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 received monthly financial report showing performance			Commissioning intentions. Funding growth.			Level 1 – Data and management reports • Monthly Divisional scrutiny of financial position <input type="checkbox"/> • Trust Operation Group (TOG) review weekly <input type="checkbox"/> Level 2 – Management team and committee scrutiny • Reports to Senior Management Committee, Audit Committee and Board of Directors <input type="checkbox"/> Level 3 – External assurances • MIAA review of financial systems <input type="checkbox"/> • External audit of Annual Accounts <input type="checkbox"/> • MIAA review of VIP programme			None identified			Complete Quality Impact Assessments for all identified schemes			Reviewed Q2 25/26		
Scoring	Inherent 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	1	5	5	1	5	5			0			0	1	5	5

RISK 12	Staff engagement										Date Risk			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							
											Oct-25							
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				
Actions	Key Control established			Key Gaps in Controls			Assurance			Gaps in			Actions to address			Target date for		
	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 receive regular presentations from divisions on cultural activities.			None identified			Level 1 – Data and management reports • Divisional action plans from staff survey • Service & operational reviews <input type="checkbox"/> 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 <input type="checkbox"/> Level 3 – External assurances • Annual CQC Staff Survey 2024			None identified			Implementation of next phase of Inclusive Culture Strategy Extension of People & Culture Plan			Reviewed Q2 25/26		
Scoring	Inherent 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	2	4	8	2	4	8			0			0	2	2	4

RISK 13	Transformational capacity & capability										Date Risk			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							
											Oct-25							
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				
Actions	Key Control established			Key Gaps in Controls			Assurance			Gaps in			Actions to address			Target date for		
	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 Level 3 – External assurances • Deloitte engaged in options appraisal for new EPR			External assessment of capability and readiness to be developed			Development of the EPR OBC. Expansion of patient portal adoption and compliance with NHS App standards. Progression of data preparedness for JAC and Intelligent Hospital. Broader evaluation of AI pilots and automation opportunities. Development of external partnerships for delivery of ambitions.			Reviewed Q2 25/26		
Scoring	Inherent 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			0			0	2	4	8

RISK 14	Supply chain										Date Risk			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			9				
											Date of Last							
											Oct-25							
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							
											Risk Appetite			Averse				
Actions	Key Control established			Key Gaps in Controls			Assurance			Gaps in			Actions to address			Target date for		
	Pharmacy - TCP procurement team work closely with regional & national drug procurement teams. Mutual aid MOU in place in NW. Management with clinicians to avoid impact 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 • Escalations from Risk & Quality Governance to Senior Management Committee Level 3 – External assurances • MIAA audits commissioned to review specific issues where appropriate			None identified			Review of alerts			Review Q3 25/26		
Scoring	Inherent 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			0			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 Oct-25							
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							
											Risk Appetite			Cautious				
Actions	Key Control established			Key Gaps in Controls			Assurance			Gaps in			Actions to address			Target date for		
	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			Recognition of fast moving market			<ul style="list-style-type: none"> 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 • Deloitte engaged in options appraisal for new EPR • OECl accreditation 			Development of full business cases			Seeking expertise internally & externally around best option - 'expert customer'			Reviewed Q2 25/26		
Scoring	Inherent 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			0			0	1	4	4

Agenda item: 35/25c

Meeting of the Board of Directors
Thursday 23 October 2025

Subject / Title	Emergency Preparedness, Resilience and Response (EPRR) – Annual Assurance Report and Statement of Compliance
Author(s)	Claire McPeake (Accountable Emergency Officer) Stefano Piscitelli (Head of Emergency Preparedness)
Presented by	Claire McPeake (Accountable Emergency Officer)
Summary / purpose of paper (alert / advise / assure)	The purpose of this paper is to present the Board of Directors with the annual self-assessment of The Christie NHS Foundation Trust against the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) for the period 1 October 2024 – 30 September 2025. The paper seeks approval of the EPRR Statement of Compliance and outlines the Trust's current compliance status, recent improvements, and the action plans in place to achieve full compliance.
Recommendation(s)	To note and approve the contents of this report and the attached Statement of Compliance.
Background papers / source of assurance	<ul style="list-style-type: none"> • Self-assessment data against NHS England EPRR Core Standards • Benchmarking and external assessments • Risk register entries and mitigation plans • Improvement trajectory 2023–2025
Risk score	Board assurance framework Risk 8
Link to: ➤ Trust strategy ➤ Strategic objectives	<ol style="list-style-type: none"> 1. To deliver safe, effective & equitable care 2. To deliver excellent financial and operational performance
Acronyms or abbreviations in the paper.	EPRR Emergency Preparedness, Resilience and Response ePMA electronic patient medication administration



Meeting of the Board of Directors

Thursday 23 October 2025

Emergency Preparedness, Resilience and Response (EPRR) – Annual Assurance Report and Statement of Compliance

1. Background

Emergency Preparedness, Resilience and Response (EPRR) is a statutory requirement for NHS providers. The duty arises from the Civil Contingencies Act 2004, the NHS Act 2006, the Health and Social Care Act 2012, and the Health and Care Act 2022.

The NHS England EPRR Framework and the NHS Standard Contract (Service Condition 30) provide the operational obligations for NHS-funded providers. As a Category 1 responder, The Christie NHS Foundation Trust is required to:

- Assess emergency risks affecting the organisation and wider system.
- Maintain robust emergency and business continuity plans.
- Share information and cooperate with local and national partner agencies.

The NHS England EPRR Core Standards set the minimum benchmark for compliance across the NHS. Each year providers must complete a self-assessment and submit an assurance return to NHS England.

2. Introduction

This paper presents The Christie NHS Foundation Trust’s annual self-assessment against the NHS England EPRR Core Standards for the period 1 October 2024 – 30 September 2025.

The submission consists of three key components:

- A Statement of Compliance, signed by the Accountable Emergency Officer.
- An improvement plan, addressing any partially compliant standards.
- The completed EPRR Core Standards spreadsheet, detailing evidence and RAG ratings.

For 2025/26 there are 59 standards. The national framework defines four levels of organisational compliance:

Full	Substantial	Partial	Non-Compliant
Compliant with all standards	The organisation is 89-99% compliant.	The organisation is 77-88% compliant	The organisation is compliant with 76% or less



This report sets out the Trust's current compliance position, the progress achieved since 2023, and the improvement work that continues to be taken forward.

3. Assurance Position:

This paper provides the Board with assurance on the Trust's compliance position following the 2025/26 self-assessment.

The Trust's overall compliance rating has improved significantly:

- **2023** – 1% (non-compliant)
- **2024** – 61% (non-compliant)
- **2025** – 89% (substantial)

This trajectory demonstrates a step change in the Trust's approach to EPRR and reflects the maturity of governance, training and exercising now in place.

The Board are asked to note the following:

Alert

Three domains remain partially compliant. Importantly, each of these areas is already subject to active improvement plans and mitigation measures, meaning that the overall risk to the Trust is being effectively managed.

- **Warning and informing** – resilience for out-of-hours communications remains limited. However, the Trust has established a pool of trained spokespeople to provide cover, ensuring a reasonable level of resilience while work continues to strengthen the model.
- **Duty to maintain plans (Countermeasures)** – Further development is required in relation to protective and countermeasure planning. While the potential impact for The Christie is assessed as limited, proportionate arrangements are still required. This work is underway and will be overseen by the EPRR Committee to ensure appropriate alignment with national guidance and timely completion.
- **Data Protection Security Toolkit** – full alignment with NHS Digital assurance requirements is not yet complete, but a clear programme of work is underway with the Digital team and remains on track.

In addition, third-party business continuity assurance continues to be a key area of focus. A structured programme of engagement with critical suppliers and the Digital team is already in progress and is providing greater visibility and control over these risks.

Advise

The Trust has delivered a strong programme of training and exercising. Training has been designed to meet the Minimum Occupational Standards for Health Commanders, with compliance across the on-call cohort reaching 80%.

Exercises have tested key risks on the Trust risk register, including cyber security, radiological response and evacuation. The Trust has also participated in multi-agency and national exercises: *Exercise Kaus Australis* (national power outage), *Exercise Semaphore*



(major incident communications cascade), and *Exercise Pegasus* (national Tier 1 pandemic exercise).

No major incidents or critical incidents have been declared in the last 12 months. One business continuity incident was declared following an ePMA outage.

Lessons identified through incidents and exercises have been captured, debriefed, and translated into actions. Completed actions include new training packages, updated policies and infrastructure improvements. Ongoing actions are monitored by the EPRR Committee, demonstrating evidence of an embedded learning cycle.

Assure

The Trust is now assessed as 89% compliant with the NHS England Core Standards for EPRR. This represents substantial compliance and is a significant improvement compared to previous years. The majority of domains are fully compliant, with only three areas of partial compliance, all of which are under active management through improvement plans.

This provides assurance to the Board that the Trust has robust governance, a functioning learning cycle, and a clear trajectory towards full compliance.

Level of Compliance	Standards	Comments
Full compliance	53 standards	A significant improvement compared to the 36 standards that achieved compliance in 2024/2025.
Partial compliance	6 standards	A detailed action plan has been drafted to convert the partial compliance status to full compliance by the year 2026/2027
Non-compliance	Zero	

Actions to address the partially compliant standards are in place and outlined in an action plan. The action plan will be overseen by the Christie EPRR Committee to ensure delivery, with assurance to the trust Risk and Quality Governance Committee and Audit Committee via Committee minutes. Cascade of actions will be undertaken through the Christie EPRR governance structure.

In addition, external oversight, and peer review of provider EPRR self-assessments and associated action plans are provided through the Local Health Resilience Partnership. It should be noted that Greater Manchester’s Integrated Care Board will review the Christie EPRR Core Standard submission during an official visit on the 7th of October 2025.

4. Recommendation

In light of the progress made and the outcome of the 2025/26 EPRR Core Standards assurance process, the Board of Directors is asked to consider and approve the following:

- Note the Trust’s current assurance position, with a compliance rating of 89% against the NHS England EPRR Core Standards, representing substantial compliance.



- Approve the attached Statement of Compliance, which formally records the Trust's position and will be submitted to NHS England as required.
- Endorse the improvement plans that are in place to address the three remaining areas of partial compliance: communications resilience, countermeasures, and data protection assurance.
- Support the continuation of the Trust's structured programme of training, exercising and third-party business continuity assurance, which is critical to maintaining progress and embedding resilience across the organisation.
- Agree to receive a further update at the conclusion of the 2025/26 assurance cycle, ensuring that the Board is kept fully informed of ongoing improvements and risks.



**Greater Manchester Local Health Resilience Partnership
(LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2025-
2026**

STATEMENT OF COMPLIANCE

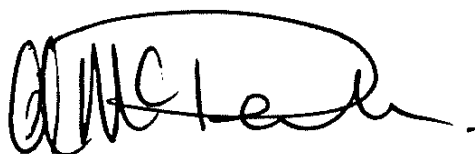
The Christie NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool.

Where areas require further action, The Christie NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has declared an EPRR assurance rating of **Substantial** (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan.




Signed by the organisation's Accountable Emergency Officer

25/09/2025

16/10/2025

23/10/2025

July 2026

Date to be presented to Audit
Committee

Date presented at Public Board

Date published in organisation's
Annual Report

