The Christie
NHS Foundation Trust

Board of Directors meeting
Thursday 27th March 2025 at 12.45 pm

Trust meeting room

Agenda

Patient story / clinical presentation: Engaging staff to improve patient pathways, Network Services – David Thomson, Clinical Oncology Consultant and Trish Murray Head and Neck CNS

30 mins

	Public items	Decision		Lead	Page	Timing
07/25	**Standard business**					
a	Apologies			Chair		
b	Declarations of interest			Chair		
c	Minutes of previous meeting – 30th January 2025	Approve	*	Chair	2	5 mins
d	Action plan rolling programme, action log & matters arising	Review	*	CEO	7	
08/25	**Performance & finance**					
a	Trust report	Review	*	Execs	11	15 mins
b	Planning update 2025/26	Review	*	EDoF	19	10 mins
09/25	**Strategy**					
a	Trust strategy update	Review	*	DoS	30	15 mins
10/25	**Culture**					
a	Shaping our culture; insights from the staff survey 2024	Note	*	DoW	35	20 mins
11/25	**Governance (regulatory / statutory compliance)**					
a	Reports from committees • Workforce Assurance Committee – January 2025 • Quality Assurance Committee – January 2025 • Audit Committee – February 2025	Review	*	Committee chair	47	10 mins
b	Board assurance framework 2024/25	Review	*	CEO	63	10 mins
c	Annual reporting cycle	Approve	*	CEO	75	5 mins
d	FPPT compliance report	Approve	*	Chair	79	
12/25	**Any other business**					
13/25	**Papers for information**					
a	Integrated performance, quality & finance report month 11		*			

Date and time of the next meeting
Thursday 24th April 2025 at 12:45pm

D/CEO	Deputy / Chief Executive Officer
EDoF	Executive Director of Finance
DoS	Director of Strategy
DoW	Director of Workforce

*	paper attached
v	verbal
p	presentation

The Christie
NHS Foundation Trust

Public meeting of the Board of Directors
Thursday 30th January 2025 at 12.45 pm
Christie at Salford Meeting Room

Present: Chair: Edward Astle (EA), Chairman

Roger Spencer (RS), Chief Executive Officer
Tarun Kapur (TK), Non-Executive Director
Alveena Malik (AM), Non-Executive Director
Grenville Page (GP), Non-Executive Director
Sarah Corcoran (SC), Non-Executive Director
Dr Diana Tait (DT), Non-Executive Director
Roy Dudley-Southern (RDS), Non-Executive Director
Alveena Malik (AM), Non-executive Director
Prof Chris Harrison (CJH), Deputy CEO
Vicky Sharples (VS), Executive Chief Nurse
Claire McPeake (CM), Interim 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

Minutes: Jo D'Arcy, Assistant Company Secretary

In attendance: Kathy Kylilis (KK), SRS Specialist Radiographer
Lucy Roberts (LR), SRS Specialist Radiographer

Clinical presentation: Stereotactic Radiosurgery, Kathy Kylilis and Lucy Roberts, SRS Specialist Radiographers, The Christie at Salford.

LR and KK introduced themselves and gave a background to the SRS service. SRS is a highly precise treatment approach that delivers high doses of accurately targeted radiation, in only a single/small number of treatments, alternative option to surgery as less invasive. The treatment can be used to accurately target tumours within the brain.

SRS needs extreme accuracy and robustness when delivering treatment which relies on advanced radiation technologies including 3D imaging and localisation techniques (E.g. CT MRI), advanced image guided radiation therapy (IGRT) and robust systems to accurately immobilise and position patients for treatment.

SRS is rapidly evolving and increasing in patient number. In 2016, NHS England put SRS services out to tender so that a limited number of hospitals across the country with expert teams could deliver this specialised service. SRS service provision – Christie at Salford covers the whole of the GM population.

National service divided into four tiers, which have their own specific pathway. As part of being a specialist service commissioned by NHSE there are targets and criteria that need to be met in regard to MDT and treatment times.

Brain metastases, vestibular schwannoma, meningiomas and pituitary are all treated at Christie at Salford.

Technical developments: machine upgrade during 2023 – changes to delivery treatment times resulting in being able to treat more patients. There are factors that limit the full potential of the equipment – MRI and CT slots, planning and clinician time and radiological review and MDT.

Planning/delivery development: new couch to deliver treatment more accurately, can treat multiple areas within the brain in one single treatment plan, have treated up to 15 individual areas in the brain in a single course.

KK presented on how the service has developed over time since 2011/12 showing growth in numbers and the increasing demand on the service.

Other developments within the service: overview provided on BGM audit undertaken in 2023 which led to improvements to the pathway and ePROMs introduced in 2024, a questionnaire in CWP, this is a good development. Working to develop the referral/waitlist in CWP and MDT referral improvements.

Limits to the service outlined: service increased from 4 patients per week to 6 to meet demand in 2024, limited by the MRI availability at Salford. 6 plans in a less than 2-week period is demanding on the planning team, numbers referred are exceeding the numbers available to treat resulting in the waiting list. Current SLA is under review and hoping this will reflect the increase in numbers. Waitlist and NHSE targets not currently met; only 30% of patients meet the MDT referral to SRS clinic specified timescale of 1week.

Future of the service presented including flexibility in clinics dependant on weekly referrals from MDT, payment by patient set up in the SLA, MRI availability and flexibility to meet patient referral demands.

SRS radiographers education: overview provided covering digital clinical placements, collaboration in cancer conference – neuro-oncology, attendance at annual BRSS conference and expanding the role with having radiographers involved with prescribing.

Feedback from patient experience of SRS shared.

TT asked on the insight from the longitudinal data from ePROMs. KK confirmed the data was used to assess against the NHSE target to check at 6 months post treatment. Required to check before sending an ePROM out to see if the patient is suitable, patients on end-of-life pathway would not be suitable. Questions are specifically related to side effects of SRS.

NB referred to a patient who presented 6 years ago and has been subject to SRS treatment a number of times and how the process works for his treatment plan and that he would not be here if it was not for the SRS service.

DT asked on the roles in the team. LR confirmed she loves the patient side of the role. KK agreed and would prefer for it to be more patient facing.

FB commented that the communication from the SRS team back to the parent team is fantastic.

EA thanked LR and KK for their presentation.

Item		Action
01/25	**Standard business**	
a	**Apologies**	
	Jeanette Livings, Director of Communications and Louise Westcott, Company Secretary	
b	**Declarations of Interest**	
	None noted.	
c	**Minutes of the previous meeting – 28th November 2024**	

	The minutes were accepted as a correct record.	
d	**Action plan rolling programme, action log & matters arising**	
	All items from the rolling programme are complete or noted on the agenda.	
02/25	**Performance & Finance**	
a	**Trust Report**	
	• RS noted the activities in the ICB system are very challenged, Trust report shows trajectory for us to achieve all performance metrics and a slightly better financial position than planned for. • Positive service developments and achievements in research and education fields noted. • Planning process slightly delayed but concluded on today and due to be published in line with the government's mandate to the NHS. • Management of elective activity going forward summarised; paper also provided in pack for information – talks to areas where we need to focus on as part of planning. • Chair recruitment commenced as per the required process. • GP asked on the significance on number of patients consented into studies being red; confirmed as a timing issue, FB noted this being the first time that a monthly threshold has been set, although red it is just below the threshold and also accounts for Christmas and New Year period being included, can fluctuate from month to month. Year to date is more meaningful. • EA noted the research patient experience % amber rating; FB confirmed this is being reviewed monthly and is dependent on a patients outcome on the trial, difficult to analyse as reliant on patient's experience and is a relatively low number associated with the metric. • SC asked on CDiff number and if within threshold; VS confirmed this is under the trajectory. • EA asked on undergraduate placement activity figure; RGF confirmed a quieter month as students go home over the Christmas and New Year period. • EA asked NB on the rise in incidents over 4 years; NB clarified that this is a reflective change in the reporting structure for incidents. VS added the way incidents are reported and captured is very different from this April so will take time to be able to see comparable data.	
b	**Value improvement programme**	
	• CMcP confirmed the paper provides an update for month 9 and a focus on what we want to achieve based on a structured approach and capturing teams ideas, this is quality driven. • £21.4m target schemes planned with £20.4m identified. • GP asked in terms of the recurrent schemes which are the ones which are not delivering. CMcP confirmed a couple of important schemes are moving to next year, each division can have up to 30 schemes and these can change over the year. For recurrent VIP we are not in the same position as other Trusts as we are in a position of growth. • SC reference to admin and clerical and asked if we are talking to the facilities management and portering teams. CMcP confirmed this month has focused on admin and clerical, will be talking to all areas, good cultural pieces of work	

	generated. • EA asked on VIP for next year; CMcP teams have done a great amount of work, will look to deliver earlier next year. 16 or 17 schemes ready to deliver from 1st April 2025.	
03/25	**Strategy**	
a	**Benchmarking in the NHS**	
	• CJH presented on the use of benchmarking in the NHS confirming the intention is to come back to future meetings with specific examples as to where it is being used. • Issue is around who are the appropriate comparable organisations to benchmark against, not always the obvious ones. Often other specialist trusts relevant not just cancer. • RS added on specific data benchmark for GM noted in the paper where available. • FB asked if relevant to do any benchmarking with other international organisations. CJH noted OECI as one, there are limitations but also some insights which can add value, in the past have also worked with Northern American institutes but not proved that beneficial. • AM welcomed the paper; asked on data quality how far this is a challenge and which areas particularly. CJH noted that data quality is an issue in general for the NHS. Definitions is a key point, within the UK, other cancer trusts have differences to us. • DT asked on how much value national audits bring. CJH and NB gave examples of lung cancer and prostate audits, which have been drivers for some beneficial changes and improvements. They are resource intensive but are used nationally. • CMcP added on CWT standards, set up so that every organisation is collecting the same data to work to the same standards. • AM noted patient demographic data as an area of concern and the need to have confidence on accuracy of data. • EA noted if the scorecard is progressed and compared to benchmark data it could become a useful tool from a strategic level.	
04/25	**Governance (regulatory / statutory compliance)**	
a	**Board assurance framework 2024/25**	

	• Changes to the BAF identified on the cover paper summarised.
	• Inputs to the BAF from the assurance committees have been reflected in this version and MIAA audit outcomes.
	• Changes in risk scores over time are illustrated in the summary page.
	• The Q3 risk score has been added to the BAF to show progress of scoring over the year so far.
	• Risk scores have been checked against the latest risk assessments and the following changes are noted;
	  ○ Risk 2 Learning from Patient Safety Incidents, risk score reduced (15 to 12).
	  ○ Risk 5 Impact of system capital allocation, risk score reduced (16 to 12).
	  ○ Risk 14 Legal & statutory compliance, risk score reduced (16 to 12).
	• GP noted it was good to see the supply chain risk added following the discussion	

	at Audit Committee and asked what work is done either by the Trust or ICB around the sustainability of key suppliers. SP confirmed due diligence is done on suppliers, regular suppliers go onto frameworks but it is not fail proof. Majority of things the Trust purchases are from a framework. • EA noted Baxters as a key supplier and asked if outside the NHS framework, do we review regularly. TT confirmed regular reviews take place on rebalancing of drug use and looking at alternative suppliers. • EA asked on the highest rated risk; GP confirmed it relates to the legal and statutory compliance and Audit Committee need to understand how to undertake the deep dive to seek assurance – there is work to do. SP added it will be a blended approach from a number of other committees. Will do a mapping process to address. Risk score noted as 12 but summary states 16; needs amending to 12. **Action** • Operational risks noted and management of review clarified. RS added reviews are seen through the assurance committees. • VS added about to launch risk management policy, also looking at risk appetite for the Board and new operational tools will be in place. • To review following Board Time Out session in February. **Action** **Noted**	**LW** **All**
b	**Reports from Committees**	
	Workforce Assurance Committee – November 2024	
	• TK summarised the report noting that the vacancy pipeline is good, and the committee had a focussed discussion on PDRs. **Noted**	
c	**Quality Assurance Committee – November 2024**	
	• SC summarised the report which reflects the start of change for the committee and evidence of learning. Seeing improvements coming through particularly in relation to training compliance. More assurance will come through in future reports. • Reformat of report welcomed with encouragement to make even more of the Assure/Advice/Alert framework. **Noted**	
05/25	**Any other business**	
	• Request from Chair and NED pre-meet to ensure that papers are kept as short as possible. • RDS noted that the 46.9% on pg 65 of the paper provided for information does not appear to be visually demonstrated correctly.	
	Date and time of the next meeting	
	Thursday 27th March 2025 at 12:45pm	
	Papers for information only	
	Integrated performance, quality & finance report Elective Care Reform Plan Benchmarking – productivity pack	

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Agenda item 07/25d

Meeting of the Board of Directors - March 2025
Action plan rolling programme after January 2025 meeting

C Culture P Performance S Strategy G Governance

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
March 2025		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	For information
	Annual reporting cycle	G	Annual reporting cycle	Executive directors	Approve	11/25b
		P	Trust Strategy Update	DoS	Review	09/25a
		C	Culture update	DCEO/DoW	Approve	10/25a
		G	Annual BAF review	CEO	Review	11/25a
		C	Staff survey initial results	DoW	Note	10/25a
	Annual reporting cycle	G	FPPT Compliance report	Chair	Approve annual compliance	11/25d
April 2025		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	For information
		G	Register of matters approved by the board	CEO	Note April 2023 to March 2024	
	Provider licence	G	Self certification declarations	CEO	To approve the declarations	
	Annual reporting cycle	S	Annual Corporate Objectives review / BAF 2023/24	CEO	Review 2023/24 progress	
		S	Strategy update	DoS	Full year review	
		G	Modern Slavery Act statement	CEO	Approve	
		G	Standing Financial Instructions (SFI's)	DoF	Approve	
		G	Board effectiveness review	Chairman	Undertake survey	
		C	Freedom to speak up Guardian report	FTSUG	6 monthly update	
	Annual reporting cycle	P	Risk Management strategy 2024-25 annual review	ECN	Annual Review	
May 2025 - no meeting	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	By email
Planning & Development Day						
		S	Planning			

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
June 2025		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	For info section
	Annual reporting cycle	G	Annual reports from audit, quality and workforce assurance committees	Committee chairs	Assurance	Joint Audit/Quality
	Annual reporting cycle	G	Annual compliance with the CQC requirements	ECN	Declaration / approval	
		P/S	Education Strategy Update	DoE	Review	
		G	Board effectiveness review	Chair	Report	
		P	Value Improvement Programme	COO	Review	
	Annual reporting cycle	G	Annual report, financial statements and quality accounts (incl Annual governance statement / Statement on code of governance)	EDoF	Approve	
July 2025 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
Planning & Development Day		S	Service Review day with senior leadership teams			
August 2025 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
September 2025		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	For information
		C/P	Health inequalities self -assessment	DCEO	Review	
		P	Value Improvement Programme	COO	Review	
		P	Quality Strategy update	ECN	Review	
Development session		S	Strategy / planning			
October 2025		C	Patient story	CEO	To hear a patient story	Board presentation
		P	Integrated performance & quality report and finance report	COO	Monthly report	For information
		P	EPRR Compliance statement	COO	Approve	
		C	Freedom to speak up guardian	FTSUG	Annual report	
Planning & Development Day		S	Planning with Divisional leadership teams			
		S	Strategy deep dive			
November 2025		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	For information
		S	Strategy update	DoS	Six month review	
		S	Inclusive Culture strategy	DoW	Approve	
		P	Digital Strategy update	DCEO / CIO	Annual Review	
	Annual reporting cycle	P	Interim review of annual objectives	CEO	Review progress	
		S	Annual Sustainabiltiy Report - Boards responsibility for Carbon Net Zero	DCEO	Note approval by Audit Committee	For information
December 2025 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
Planning & Development / Council of Governors Day		S	Board planning / Risk Training			
		S	Council / Board - strategy update			
January 2026		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance report	COO	Monthly report	For information
		P	Value Improvement Programme	COO	Review	
February 2026 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
	Annual reporting cycle	G	Letter of representation & independence	Chair		
	Annual reporting cycle	G	Register of directors interests / FPPT annual declaration	Chair	Circulate	By email

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
	Annual reporting cycle	G	Declaration of independence (non-executive directors only)	Chair		
Planning & Development Day		S	Planning			
		S	Strategy deep dive			

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Agenda item: 07/25d

Action log following the Board of Directors meetings held on

Thursday 30th January 2025

No.	Agenda	Action	By who	Progress	Board review
1	37/24b	Summarised version of Inclusive Culture Strategy to be produced for all staff	EL	In development	April 2025
2	04/25a	Risk score for BAF risk 14 to be updated as score of 12 on snapshot table view to match detailed summary	LW	Completed	March 2025
3	04/25a	Board to review BAF following Board development session in February	All	March meeting	March 2025

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Meeting of the Board of Directors
Thursday 27th March 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 ➢ Corporate Objectives	Achievement of corporate plan and objectives
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	CEO Chief Executive Officer MCRC Manchester Cancer Research Centre NHSE NHS England CQC Care Quality Commission GM Greater Manchester ICB Integrated Care Board ICS Integrated Care System VIP Value Improvement Programme CDEL Capital Departmental Expenditure Limit

The Christie
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Trust Report
March 2025 (February data)

Board Scorecard

Corporate objective	Indicators	Tolerances			Current month	Year to date
All	CQC rating	N/A			Good	Good
All	SOF Rating	N/A			2	2
Quality of Care & Performance						
1,6	Proportion of incidents that are low/no harm (%)	90%+			98.1%	N/A
1,6	31 day compliance (%)	96%			98.4%	N/A
1,6	Patients meeting the faster cancer diagnosis standard (%)	75%			77.8%	N/A
1,6	MRSA bacteraemia infection (attributable) (N)	TBC			1	3
1,6	Clostridium difficile infection (attributable) (N)	TBC			4	47
Finance and Use of Resources						
6	Financial sustainability / liquidity (days)	>21	21 to 14	<14	- 9	- 9
6	Overall financial position (% variance to control total)	0% below plan	0 - 10% below plan	>10% below plan	(536.7%)	0.0%
6	Recurrent VIP performance (% achieved)				75%	75%
6	Current cash balance (£'000)				£134,415	£134,415
6	Exchequer capital spend to date (variance to plan %)	within 10%	10 to 20%	>30%	18.3%	14.8%
6	Average length of time debt is outstanding	<15	>16 - 20	>20	11	11
6	Public Sector Payment Policy - trade creditors paid within 30 days (number and volume)	>95%	95 - 85%	<85%	98%	98%
People and Culture						
7	PDRs completed (%)				88.5%	N/A
7	Mandatory training (%)	>80%		<79%	93.9%	N/A
7	Voluntary turnover in first 2 years (%)	<31%		>32%	12.71%	N/A
Research						
4	New trails open per month (N)	>10	9-10	<8	7	153
4	No. patients consented into studies (N)	>250	200-249	<199	246	2623
4	Christie Sponsored research: new studies opening (N)	>2	1	0	1	16
4	Research patient experience - % strongly agree they would participate in research again	90%	75-89%	<75%	4 (67%)	61 (81%)
Education						
3	Undergraduate placement activity	>165	135-165	<135	175	1579
3	CPD activity (internal & external)	>440	340-440	<340	514	7628
System						
1,6	62 days (%)	>70%		<69.9%	75.2%	N/A
1,6	Priority patients not admitted (deferred)	0		>1	0	0
Digital						
4	Customer Satisfaction score of "Good"	>95%	85-94%	<85%	98.6%	97.3%

Executive Summary

- We are rated Good overall by the CQC.
- We are in segment 2 of the System Oversight Framework.
- Patient quality indicators for February show no significant adverse variances and no issues for escalation. We remain high reporting and low harm.
- Performance in February for the 62-day consolidated cancer standard was 72.1% which is above the operating plan standard of 70%.
- Four operational risks are scored at 15 or above on the risk register.
- The forecast position for Month 12 is a surplus of £15m.
- Key financial performance indicators in month 11 show one adverse variance which is the level of recurrent VIP identified being £10.5m identified so far against a £14m annual target.
- Workforce indicators for February show a decrease in sickness absence rates from the previous month.
- PDR performance and mandatory training performance is over the required thresholds.
- Capital schemes are progressing to plan across the Trust.

Quality of Care

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

Pressure ulcers and falls were in line with internally set trajectory in February. There were 10 complaints in February. The number of contacts with the Patient Advice and Liaison Service (PALS) service in February was 35 which is lower than in previous months.

Nurse staffing numbers met the levels to ensure appropriate levels of safety and care with indicative staffing to maintain a 1:8 nurse to patient ratio which is nationally recommended.

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

1. Not identifying and delivering 2025/26 recurrent VIP programme impacting on financial sustainability and ability to treat patients (16)
2. Operational & patient safety and experience risk in relation to recruitment of medical workforce for Christie haematology at Leighton (16)
3. There is a risk of a patient inadvertently receiving an unintended blood component or product (15)
4. There is a risk to the safe and effective delivery of the Trust's Aseptic service (15)

Operational Performance

The 62-day standard is a barometer of how well the system is performing with cancer pathways. Compliance at the end of February against the 2 key cancer standards was;

- The 62-day consolidated standard was 72.1% against a threshold of 70%.
- We achieved 77.8% against the 75% threshold for the Faster Diagnosis Standard which measures initial referral to diagnosis.

The majority of Christie referred patients are monitored via the 31-day standard (decision to treat to treatment start).

- We have continued to achieve the 31-day standard for treatment to start within 31 days of the decision to treat at 98.4% against a target of 96%.

During February there were no operations cancelled on the day for non-clinical reasons.

Financial Performance

Revenue: Financial performance is ahead of plan by (£4.9m) as illustrated in the table below. The Trust is reporting a (£11.4m) surplus against a (£6.5m) planned surplus position. The better than plan position is primarily due to :-

- Pay underspends arising from vacancies
- Over-achievement of clinical income to-date.

Month 11 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(424,744)	(389,345)	(406,413)	(17,067)
Other Income	(77,916)	(71,376)	(72,898)	(1,522)
Pay	235,252	215,544	210,935	(4,609)
Non Pay (incl drugs)	241,824	221,673	240,700	19,026
Operating (Surplus) / Deficit	**(25,584)**	**(23,504)**	**(27,676)**	**(4,173)**
Finance expenses/ income	30,932	28,348	27,637	(711)
(Surplus) / Deficit	**5,349**	**4,845**	**(39)**	**(4,884)**
Exclude impairments/ charitably funded capital donations	(12,355)	(11,319)	(11,322)	(3)
Adjusted financial performance (Surplus) / Deficit	**(7,006)**	**(6,474)**	**(11,361)**	**(4,887)**

Forecast outturn

The financial performance ahead of plan has been described to the Board throughout the financial year; this is mainly due to underspends on pay and over achievement of bank interest. In addition, the Trust's joint ventures have delivered a profit for the 2024 financial year £2m over the planned value.

GM providers were notified that any performance in excess of the 2024/25 plan would allow access to equivalent additional CDEL in 2025/26. The Trust has reviewed all opportunities to maximise the 2024/25 surplus and is now forecasting an outturn of £15m surplus, £8m over the planned surplus of £7m.

Capital

The capital plan for 2024-25 has been agreed at £17.4m. The Trust has spent £12.1m to M11, which is 85% year to date against the capital plan, primarily on:

- TIF ward refurbishment
- Ongoing digital projects
- Small replacement assets

Value Improvement Programme

The annual VIP target of £21.4m is split into a £14m recurrent target and a £7.4m non-recurrent target. The level of recurrent VIP identified to date is £10.5m giving a recurrent shortfall of £3.5m. The level of non-recurrent VIP identified to date is £10.9m, over plan by (£3.5m). Year to date, £19.6m has been delivered against a target of £19.6m.

KPIs

Variances from the planned financial performance against key measures include the level of recurrent VIP delivered to date. As shown in the table, there are no other significant variances:

Measure of Financial Performance	Red / Amber / Green rating
Revenue: Trust Control Total compared to plan	£4.9m ahead of plan
Capital: Capital expenditure against plan	£2.1m **under** plan
VIP identified (recurrent) against target of £14m	£10.5m identified
Debtor days compared to 15-day target	11 days
Cash balance	£134.4m
Better Payment Practice Code (95% target)	98%

Workforce

Our workforce performance indicators show mandatory training compliance and personal development plan rates are both above (better than) thresholds at 93.9% and 88.5% respectively. Sickness absence rates decreased in February to 4.46% (threshold of 4.25%). The overall turnover for the Trust has reduced from last month to 8.9%. These issues and the associated plans for improvement have been considered by the Workforce Assurance Committee.

Inclusive Culture Strategy

Our new inclusive culture strategy (2025-2030) is a major change in how we develop culture and the approach we take to ensure inclusivity and equity for colleagues and patients. The strategy strongly builds on the foundations laid out in The Christie people and culture plan (2023-2026), and puts equality, diversity, and inclusion principles at the centre of our cultural journey. It has been developed with input from our staff side colleagues and driven by our Trust Board. More detail can be found here.

Research

The number of new studies opened in February declined due to staff vacancies. Recruitment is underway to restore capacity. To date, 16 Christie-sponsored research studies have opened, supported by the newly established Christie Sponsored Research front door. The R&I team received high praise in the recent OECI assessment, highlighting the strength of our Research activities. The Pharmacy relocation to the Paterson Building is scheduled for early April, with preparatory moves completing by the end of March. This will see 105 pharmacists relocated to Level 2. As part of the reconfiguration, space for Clinical Fellows will double, enhancing research and collaboration.

Our Robotic Process Automation (RPA) project remains on track, streamlining Aged Debt processes to sustain lower debt levels more efficiently. Idea to Impact: Paterson Project Awards (up to £100k) launched in March 2025. This competitive funding initiative will support innovative ideas, with awards granted in June. The call will run twice annually for Christie researchers.

Education

The launch of the Christie Institute for Cancer Education represents an important new chapter in Education excellence at the Christie, springboarding from the strong foundations and achievements of the School of Oncology. The launch is accompanied by an internal focus on education opportunities for all Christie staff across induction, focusing on role specific training, continuing professional development and career coaching. We continue to grow our patient engagement in education, particularly through our Experts by Experience panel which complements our health inequalities education activity.

Higher Education Institute (HEI) Project update

Following Phase 2 project approvals, excellent progress has been in made in business modelling for operating models/fee structures. Active pre-procurement engagement/concept and market testing continues with HEIs, cognisant of our business intelligence focus on volatility in some areas of the UK HE sector.

We received incredibly strong feedback on the quality of Education at the Christie after the recent OECI accreditation visit, reflecting a whole organisation commitment to education, training and development. Discussions with the OECI to progress further capacity building are underway. In support of this, we have expanded our international education team expertise, working across Education and R&I to support this important area of work. This supports The Christie becoming a recognised sponsoring organisation through the General Medical Council, directly supporting our growing international observer and fellow programmes.

Strategic and Service Developments

Pathology JV Re-procurement

The Trust received the final tender on 5th March 2025. The Trust is reviewing the response and if appropriate will proceed with our SFI compliant approval process, with the timetable of a final contract be awarded in May 2025.

Ward 12

Work continues the refurbishment of Ward 12. As this project moves closer to completion, attention will move to the refurbishment of Ward 11.

ASIC project

The ASICS project team is due to conclude a key design stage (RIBA Stage 3) later this month including a full review of the project cost plan. The team will continue to focus on detailed design development, supporting decant activity, commencement of supply chain engagement and the development of a target cost.

Inpatient pharmacy
The new inpatient pharmacy robot & the associated refurbishment of Dept 36 is complete two weeks ahead of programme. The pharmacy team are now relocating from the temporary pharmacy.

Linac replacement programme
The programme continues with Linac 3 installation works completed & Linac 11 equipment delivered and being installed in the newly refurbished area, planned to be operational in June.

Future Christie Project

Increasing emphasis on the pace and productivity potential in high impact changes within the Future Christie Programme. Clear medium-term payback on programmes activity. Recruitment initiated for Future Christie leadership team.

Royal Marsden first workshop scheduled for the 4th of April areas of collaboration in service delivery particularly focussed on those areas of common challenge and innovation. The opportunity includes the potential to influence the market in novel technologies, lower the cost of entry, de risk the change and collectively influence on National Cancer strategic planning.

NHS England

On 13th March the Prime Minister announced changes to address significant financial challenges to the NHS at a national level. The first of which is the disestablishment of NHS England, with leadership and oversight reverting to the Department of Health and social care. In addition, other significant measure are being required as part of a financial reset. This is in line with the need to ensure that the NHS in England lives within the budget set by the government for 2025/26. NHS England has announced the incoming team who will help lead the organisation's transition into the Department of Health and Social Care.

https://www.england.nhs.uk/2025/03/nhs-england-names-new-executive-team-to-lead-transition/

Further details of these national announcements will be made available over the coming weeks. In the meantime, it is important that all staff at The Christie focus on the delivery of our plans that ensure our patients continue to receive the best care we can provide.

Socio-economic deprivation
In Appendix 1 is a report from Cancer Research UK on health inequalities.

Appendix 1

Health Inequalities: Reflections on The Publication by Cancer research UK on socioeconomic deprivation – Briefing Paper

BRIEFING PAPER SUMMARY	
Title	Health Inequalities: Reflections on The Publication by Cancer research UK on socioeconomic deprivation.
Division	Strategy
Date of Report	March 2025
Authors	Jo Tomlins, Deputy Director of Strategy John Wareing, Director of Strategy
Purpose	The Cancer in the UK 2025: Socioeconomic Deprivation report by Cancer Research UK [Cancer in the UK 2025 - socio economic deprivation] reveals significant disparities in cancer outcomes linked to socioeconomic status. This briefing paper provides a summary of the key findings, in relation to the health inequalities strategy at The Christie.
Key Findings	• **Higher Mortality Rates:** Individuals in the most deprived areas experience cancer death rates nearly 60% higher than those in the least deprived regions, equating to approximately 28,400 additional deaths annually. (Cancer Research UK, 2024a; ONS, 2023; Public Health Scotland, 2024; Northern Ireland Cancer Registry, 2024) • **Lung Cancer Impact:** Lung cancer accounts for nearly half of these excess deaths, with mortality rates almost three times higher in deprived areas. (Cancer Research UK, 2024a; ONS, 2023; Public Health Scotland, 2024; Northern Ireland Cancer Registry, 2024) • Delayed Diagnosis: Individuals in the most deprived areas are over 50% more likely to receive a cancer diagnosis through emergency routes, which often indicates advanced disease stages and poorer prognoses (Abel et al 2015) • Treatment Delays: Approximately one-third of patients from deprived regions experience waiting times exceeding 104 days from referral to treatment initiation, underscoring systemic challenges in timely cancer care delivery (Cancer Research UK, 2024b) • Delayed access to treatment: **Patients with delayed access to treatment living in the most deprived areas had a higher probability of being untreated or dying from the disease**. **(Ling et al (2024)** • **Lower participation in clinical trials:** Patients residing in the most deprived areas of England are 55% less likely to receive novel anti-cancer therapies, such as targeted therapies and immunotherapies, compared to those in the least deprived areas (Norris et al 2023) • **Access to data:** The report utilises deprivation data as its primary means of assessing health inequalities in cancer due to difficulties in accessing patient characteristics data. This limits the ability to fully assess health inequalities in cancer and Cancer Research UK strongly recommend a UK wide approach to accessing data. (Cancer Research UK, 2025). The report emphasises the need for targeted interventions to address these inequities, including taking action to make services more accessible through more effective and community focused service design.
Summary	The report by Cancer Research UK adds to the growing body of evidence in relation to the impact of deprivation on cancer patients. It highlights the importance of focused work in addressing health inequalities at the Christie in

	particular in relation to the impact on delayed diagnosis, treatment delays and delayed access to treatment as well as lower participation in clinical trials in patients who live in deprived areas. While improving patient characteristics, data remains a key area of focus at The Christie, this paper also highlights the rich information that can be derived from deprivation data to inform areas that require focused attention to improve health inequalities.
References	• Abel GA, Shelton J, Johnson S, Elliss-Brookes L, Lyratzopoulos G (2015). Cancer-specific variation in emergency presentation by sex, age and deprivation across 27 common and rarer cancers. Br J Cancer 112: S129–S136. • Cancer Research UK (2025). Cancer in the UK 2025: Socioeconomic deprivation. • Cancer Research UK (2024a). Cancer statistics data hub. • Cancer Research UK (2024b) Which cancer patients experience long waits to treatment, and why? Analysis of patients waiting over 104 days from urgent suspected cancer referral to first cancer treatment in England, for 2017/2018, 2020/2021, 2021/2022 and 2022/2023. • Ling S, Fernandez M-A L, Quaresma M, Belot A, Rachet B (2024). Inequalities in treatment among patients with colon and rectal cancer: a multistate survival model using data from England national cancer registry 2012–2016. Br J Cancer 130: 88–98 • Northern Ireland data were provided by Northern Ireland Cancer Registry on request, July 2024. Similar data available from https://www.qub.ac.uk/research-centres/nicr/CancerInformation/official-statistics/ • Norris RP, Dew R, Greystoke A, Todd A, Sharp L. Socio-economic Inequalities in Novel NSCLC Treatments During the Era of Tumor Biomarker Guided Therapy: A Population-based Cohort Study in a Publicly Funded Healthcare System [published online ahead of print, 2023 May 3]. *J Thorac Oncol*. 2023;S1556-0864(23)00522-1. doi:10.1016/j.jtho.2023.04.018 • Office for National Statistics (2023). Death registrations by cause and IMD, England and Wales, 2001 to 2021 and populations by IMD England and Wales, 2001 to 2020. • Scotland data were provided by Public Health Scotland on request, October 2024. Similar data available from https:// www.gov.scot/publications/long-term-monitoring-health-inequalities-march-2023-report/pages/6/

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Agenda item 08/25b

Meeting of the Board of Directors

Thursday 27th March 2025

Subject / Title	Financial planning update 2025/26
Author(s)	Sally Parkinson, Executive Director of Finance
Presented by	Sally Parkinson, Executive Director of Finance
Summary / purpose of paper	This report updates the Board on the revenue and capital plans for 2025/26
Recommendation(s)	The Board is asked to: • approve the 2025/26 revenue plan noting the level of VIP and associated risk • approve the 2025/26 capital plan • approve the plan to achieve all relevant operational targets • confirm the responses in the board assurance statement
Background Papers	Integrated Performance, Quality and Finance Report Finance Report
Risk Score	See Board Assurance Framework
EDI impact / considerations	Assessed as part of the operational & workforce planning process
Link to: ➢ Trust's Strategic Direction ➢ Corporate Objectives	Achievement of corporate plan and objectives
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	GM Greater Manchester ICB Integrated Care Board CDEL Capital Departmental Expenditure Limit VIP Value Improvement Plan ASIC Advanced Scanning and Imaging Centre

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Agenda item 08/25b

Meeting of the Board of Directors

Financial planning update 2025/26

1. 2025/26 revenue plan

GM has been set a £200m deficit control total by NHSE with the Christie being set a breakeven control total target (before joint venture surplus) as part of this.

The draft assumptions and indicative operational and financial plans were discussed by the Board of Directors in its planning session in January. Given the lack of information available at this point (national planning guidance, commissioning intentions and contract offers), the Board of Directors delegated authority to Chief Executive and Executive Director of Finance to set a breakeven budget (before inclusion of the joint venture surplus forecast to be £7.5m).

An update on progress was provided in the Trust report in February; at this point the Trust's revenue plan was £(8.3)m deficit which increased to £(12.5)m in March on receipt of the initial commissioning contracts.

Following negotiations with the Trust's commissioners (Specialised Commissioning and GM ICB) to ensure that the level of growth in activity could be funded and therefore delivered, additional income of £8.7m was secured.

The level of VIP included in the financial plan has been reviewed and increased to 5.9% (from 5%) of influenceable expenditure. This is an ambitious and challenging efficiency plan but necessary to deliver the levels of productivity and efficient delivery of services required for the Trust to be financially sustainable. This is consistent with other organisation in GM.

The Trust implemented additional reporting to Board on the progress, achievement and risk of VIP schemes in 2024/25 and will continue to do so in 2025/26. VIP plans and delivery form a significant part of the Trust's monthly Service and Operational Reviews which are attended by divisions and the full executive team.

The Trust's plan for a £7.5m surplus (breakeven plus joint venture surplus) was submitted to GM ICB by the deadline of 19th March 2025 to be aggregated with all GM providers and the ICB.

2. 2025/26 capital plan

The Trust has been successful in securing an additional £8m in recognition of its 2024/25 financial performance above plan.

This is in addition to the GM ICB allocation of CDEL resulting in a total 2025/26 CDEL capital plan of £36m.

This allows full delivery of the risk-based replacement programme plus funding for the decant stages of the ASIC programme. Each element of the capital programme will be subject to the usual SFI compliance in terms of business case and contract award governance. The indicative capital plan is summarised below:

	2025/26
Capital Scheme	**£'000**
Capital estates refurbishment programme	**5,603**
Estates backolg programme	**1,754**
Estates facilities development projects	**160**
IT software & systems	**1,056**
IT infrastructure & hardware	**3,870**
IT Product engineering - Electronic Health	**1,410**
IT Portfolio Development	**1,843**
Replacement linac programme	**6,100**
Replacement assets programme	**1,633**
Capital ASIC redevelopment	**10,000**
New lease relating to NC2 PET CT services	**700**
PDC funded linac	**1,850**
	35,979

3. Operational targets

The Trust are planning to meet all relevant operational targets as prescribed in the operational planning guidance.

4. Board assurance of 2025/26 plans

GM ICB have requested that provider boards consider and confirm section B of the document attached in Appendix A to this report. This is to provide assurance from provider boards to the ICB in submitting their plans.

5. Recommendation

The Board are asked to:

- approve the 2025/26 revenue plan noting the level of VIP and associated risk
- approve the 2025/26 capital plan
- approve the plan to achieve all relevant operational targets
- confirm the responses in the board assurance statement

Appendix A

2025/26 priorities and operational planning guidance

Board Assurance and Plan Overview

Version 1.0, 3rd March 2025

Introduction

1. Purpose

The purpose of this document is to set out the requirements for board assurance of operational plans for 2025/26. It includes the statements that Integrated Care Boards (ICBs) must submit as part of the full plan submission process as well as the statements provider boards must sign off and submit to lead ICBs. The document also describes what is expected from the plan overview document which should be submitted as part of the full submission.

2. Guidance on completing the Board Assurance Statements

Integrated Care Boards (ICBs) are asked to respond to the statements at Section A, ensure that the completed document is signed-off by both by ICB Accountable Officer and Chair. Additionally, there is also a series of statements that ICBs should share with their providers, which will assist in assuring ICBs in terms of the process for provider Trusts.

The purpose of the Board Assurance Statements are to provide assurance that all considerations around finance, workforce, activity have been addressed whilst ensuring that the ambitions for 2025/26 can be met and that quality of patient care is prioritised.

The information provided will be used by regional and national teams to inform assurance conversations.

Section A: ICB Assurance

Please double click on the template header and add the name of your Integrated Care Board (ICB).

This section provides ICBs with the opportunity to describe the approach to creating the operational plan and how links with other aspects of planning have been considered.

Section B: Provider Assurance

This section provides providers within a system with the opportunity to describe the approach to creating the operational plan and how links with other aspects of planning have been considered. These should be shared with the Lead ICB to support their assurance process.

Section C: Plan Overview

This section outlines what should be included in the plan overview document which must be signed off by boards and submitted to NHS England as part of the full submission.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted at ICB level, using this template, to the appropriate regional planning mailbox by **11 am on the 27 March 2025**.

Any queries relating to this submission should be directed to regional planning leads:

Location	Contact information
North East and Yorkshire	england.nhs-NEYplanning@nhs.net
North West	england.nhs-NWplanning@nhs.net
East of England	england.eoe-planning@nhs.net
Midlands	england.midlandsplanning@nhs.net
South East	england.planning-south@nhs.net
South West	england.sw-rpdu@nhs.net
London	england.london-co-planning@nhs.net

Integrated Care Board:	Double click on the template header to add details

Section A: ICB Assurance

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the plans for 2025/26 that form the basis of the system's (ICB and partner trusts) submissions to NHS England. This included review of the partner trusts Board Assurance returns.		
The Board has reviewed its quality and finance governance arrangements, and put in place a clinically led process to support prioritisation decisions.		
Prioritisation decisions were reviewed by the Board, including explicit consideration of the principles set out in planning guidance.		
A robust quality and equality impact assessment (QEIA) informed development of the ICB's and wider system's plans and these have been reviewed by the Board.		
The system's plan was developed with appropriate input from and engagement with system partners.		

Integrated Care Board:	Double click on the template header to add details

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Plan content and delivery		
The Board is assured that the system's plans address the key opportunities to meet the national priorities for the NHS in 2025/26. This includes the actions against the national delivery plan 'checklists' and the use of benchmarking to identify unwarranted variation / improvement opportunities.		
The Board is assured that all possible realistic in-year productivity and efficiency opportunities have been considered across the system and are reflected in the plans of each system partner organisation.		
The Board is assured that any key risks to quality linked to the system's plan have been identified and appropriate mitigations are in place.		
The Board is assured of the deliverability of the system's operational, workforce and financial plans. This includes appropriate profiling and triangulation of plan delivery, and mitigations against key delivery challenges and risks.		

ICB CEO/AO name	Date	ICB Chair name	Date

Section B: Provider Assurance

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has systematically reviewed and assured the operational, workforce and financial plans for 2025/26 that form the basis of the organisation's submissions to NHS England.	Yes*	
The Board has reviewed its quality and finance governance arrangements, and put in place a clinically led process to support prioritisation decisions.	Yes*	
Prioritisation decisions were reviewed by the Board, including explicit consideration of the principles set out in planning guidance.	Yes*	
A robust quality and equality impact assessment (QEIA) informed development of the organisation's plan and has been reviewed by the Board.	Yes*	
The organisation's plan was developed with appropriate input from and engagement with system partners.	Yes*	

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Plan content and delivery		
The Board has systematically reviewed and is assured that it has plans in place address the key opportunities to meet the national priorities for the NHS in 2025/26. This includes the actions against the national delivery plan 'checklists' and the use of benchmarking to identify unwarranted variation / improvement opportunities.	Yes*	
The Board is assured that all possible realistic in-year productivity and efficiency opportunities have been considered and are reflected across the organisation's operational, workforce and financial plans.	Yes*	
The Board is assured that any key risks to quality linked to the organisation's plan have been identified and appropriate mitigations are in place.	Yes*	
The Board is assured of the deliverability of the organisation's operational, workforce and financial plans. This includes appropriate profiling and triangulation of plan delivery, and mitigations against key delivery challenges and risks.	Yes*	

*Current status of the plan assurance; this and all other aspects of the plan will be reviewed and reconfirmed by the Board of Directors in their meeting on the 27th March 2025.

Section C: Plan Overview

It is expected that ICBs will get board approval for their plans. The document that is signed off by the board should be submitted as part of the full submission to NHS England. There is no set template for this document, but it is expected that it will cover the following areas:

- A high-level summary of what has been submitted as part of the finance, workforce and performance submission;
- An overview of transformation and major savings opportunities;
- An overview of the system's plans to improve the quality of services including experience and outcomes (this should include an overview of how the system has used data to develop these plans);
- An explanation of the approach to reducing health inequalities, including how this will be monitored throughout the year;
- Key decisions that have been made as part of the planning, including prioritisation and EQIAs that have been completed in relation to these decisions; and
- Risks to delivery of the plan and mitigations.

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Agenda item 09/25a

Meeting of the Board of Directors
Thursday 27th March 2025

Subject / Title	Strategy Update
Author(s)	John Wareing, Director of Strategy
Presented by	John Wareing, Director of Strategy Prof Fiona Blackhall, Director of Research & Innovation
Summary / purpose of paper	This paper provides an update on delivery against the research related activities contained in the Trust Strategy
Recommendation(s)	Members of the Board are requested to note progress against the objectives in the Strategy.
Background papers	Trust Strategy 2023 - 2028
Risk score	N/A
Link to: ➢ Trust strategy ➢ Corporate objectives	Trust Strategy 2023 - 2028
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 09/25a

Meeting of the Board of Directors
Thursday 27th March 2025

Strategy Update

1 Purpose

The purpose of this report is to provide an update to the Board on progress against key research objectives contained within the Strategy.

2 Background

The 2023 – 2028 Trust strategy was developed following a period of extensive consultation and engagement with staff and partners. The Board approved the strategy in March 2023 and work has continued to make progress across a number of the key objectives on which annual updates have previously been provided.

The Strategy is built on four pillars namely, being an organisation that is 'Leading Cancer Care', delivering 'The Christie Experience' of care for our patients and staff, providing access to our specialist services as locally as possible - 'Local & Specialist' and delivering the 'Best Outcomes' for our patients. The Strategy details the range of programmes we are undertaking to deliver against these pillars.

Reducing cancer waits | Tackling cancer inequalities | Improving outcomes

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

This report provides details of progress on the key research related objectives. It should be noted that the Trust retains a specific R&I strategy progress against which is reported separately.

3 Progress

The table below details the range of actions being undertaken against the key research related programmes.

Strategic Pillar	Strategy Objective	Activity
Leading Cancer Care	Realise the potential of the Paterson development – seamless integration of research with clinical care.	• The Paterson plays a key role in bringing a number of activities (eg NIHR, ECMC, BRC) together, hosting staff and researchers - there are over 200 clinical fellows and 300 postgraduate trainees. • The design of the Paterson has been optimised to facilitate structured and informal interactions between teams, supporting a collaborative research culture. Additionally, we have now mapped maximum capacity options, enabling strategic planning for future growth. • Pharmacy will move to the Building in April, alongside a 41% increase in capacity for Surgery and a doubling of space for Clinical Fellows. The consolidation of Pharmacy onto a single level will foster a more unified and efficient working environment. • Organisation of European Cancer Institute (OECI) visit (March 2025) reflected the significance of the Paterson in the translation of research into clinical services.
Leading Cancer Care	Accelerating Research Delivery Through Efficiencies in Innovation – tomorrows treatments to patients faster	• Set-up times have improved, and by Q3 2024/25, the number of new studies opened each month reached previous year's activity levels. 145 new studies have been opened in 2024/25 with 545 open for recruitment. • A new digital front door has been implemented for Christie-Sponsored Research, streamlining sponsorship requests and approvals. The adoption of Monday.com, a project management tool, has significantly improved efficiency in managing research approvals.

Leading Cancer Care	Establish system wide Christie Research Outreach – access to research for every patient across Greater Manchester.	• The Clinical Research Outreach Programme is expanding research accessibility, ensuring inclusivity, and addressing cancer inequalities by conducting studies at satellite sites closer to patients' homes.; this has been supported by investment in leadership capacity to manage Outreach activity.
		• Number of Trials Open at Outreach Sites
		  • Christie @Wigan: 2 open trials (ARIEL, EMBER 4)
		  • Christie @Macclesfield: 2 open trials (PROMOTE, FOxTROT 2)
		• Number of Studies in Set-Up

Strategic Pillar	Strategy Objective	Activity
		• Christie @Wigan: 3 studies in set-up. • Christie @Macclesfield: 5 studies in set-up.
Local & Specialist	Expand the cancer survivorship programme with system leadership for managing late effect, supportive care and research.	• Establishment of a Supportive Care Directorate. • Continued development of ePROMS. • Continued leadership in the BRC research theme, living with and beyond cancer.
Best Outcomes	Develop a Secure Data Environment (SDE) with regional and national capability in collaboration with research partners	• A SDE is a secure data and research analysis platform that allows for analysis and collaboration of data. This is a collaboration between R&I and CODU for the use of real-world data. • Work is ongoing with the Christie digital infra-structure and new servers have already been arranged to house the SDE. • In the interim access the GM SDE can be used by the Christie and data can be uploaded to the GM SDE and be linked to other GM data for analysis within the GM SDE. • Alongside this discussions with the MFT Data Science Unit have been undertaken to explore the potential for collaboration.

4 Future Christie

The development of the Future Christie programme will complement the Trust Strategy and serve to accelerate delivery over next three years of the current strategy and beyond.

5 Recommendation

Members of the Board are requested to note the contents of the report.

Agenda item: 10/25a

Meeting of the Board of Directors

Thursday 27th March 2025

Subject / Title	Shaping our culture; insights from the staff survey 2024
Author(s)	Jane Hanson - Engagement and OD Manager
Presented by	Eve Lightfoot – Director Workforce
Summary / purpose of paper	To provide the Trust Board with: • an overview of cultural interventions implemented during 2024 and how they have been reflected in the NHS Staff Survey results 2024, likely areas of focus for action planning and suggested next steps
Recommendation(s) (assure / alert / advise)	The Trust Board is asked to; • note the contents of the paper
Background papers / source of assurance	Independent Cultural Audit and NHS Staff Survey 2023 Results
Risk score / BAF reference	BAF risk 12
EDI impact / considerations	As noted within report.
Link to: ➢ Trust strategy ➢ Corporate objectives ➢ CQC Quality standard ➢ Regulation	➢ Achievement of Corporate Plan and objectives and The Christie People Plan
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.	N/A

Agenda item: 10/25a

Meeting of the Board of Directors

Thursday 27th March 2025

Shaping our culture; insights from the staff survey 2024

1 Introduction

This paper provides a high-level overview of the interventions that have taken place during the last 12 months and how they have impacted on our staff survey 2024 results. It includes a summary of key themes and how they combine with other ongoing organisational plans.

Several teams worked hard to increase their response rate this year, in particular Estates and Facilities who collaborated with the Engagement and OD Manager on ways to increase survey engagement and provided allocated time for their colleagues to complete the survey. This resulted in a 40% increase for Hard Facilities and a 31% increase for Soft Facilities when compared to 2023. This is an encouraging cultural shift, and their good practice will be shared with other teams for future survey/feedback engagement. Whilst we received an overall response rate of 48% which is the same as in 2023, due to an increase in our overall number of staff, more colleagues completed the survey in 2024.

Notably, despite the continued challenging position of the NHS and especially within Greater Manchester in relation to the financial challenges, degree of industrial action, reports of colleagues feeling stressed and burnt out, we have achieved improved results especially when we consider the impact of these factors.

2 Summary of Highlights

Following the commissioning of the cultural audit and the resulting recommendations along with areas of focus identified following the 2023 staff survey, Figure 1 shows an overview of the actions implemented. These are all factors that have likely contributed to the upward trajectory and increase in all People Promise themes and, in our engagement and morale scores. These increases can be seen in Figure 2 and Figure 3, respectively.

Figure 1 shows an overview of actions implemented following the cultural audit and areas of focus identified from the 2023 annual staff survey

Theme from Cultural Audit	Action implemented
Leadership	• Respectful Resolutions already underway • Joining NHS Elect • Clinical director and new consultant development programmes • Proud2B Ops programme • Recruited new Leadership and Management Trainer
Wellbeing *	• Expressing room to support returning parents • On-site counselling via Health Assured • The Real Lunch Hour (in partnership with our staff side colleagues) • 45 trained Mental Health First Aiders • Art classes to support colleagues with stress/mental health conditions via occupational health referral • The Menopause – Supporting your Team workshops (for those with line management responsibility) • Colleague Health and Wellbeing Support Guide available online and printed copy • Improvements to staff rest areas • NHS Sexual Safety Charter sign up
Staff Communications	• New weekly bulletin • New monthly team brief cascade • New Christie magazine • We are the Christie campaign • Review and refinement of regular communication mechanisms in clinical divisions
Engagement	• Connect and Reflect • New You Made a Difference noticeboard in engagement area • Admin and Clerical engagement events • Development of 8 staff networks
Recruitment	• Fair recruitment process development to further support the reduction of bias and discrimination in our recruitment practice.

* We have seen an increase of 7% in our 2024 NHS Staff Survey score of 65% on Q11a ‘Organisation takes positive action on health and wellbeing’. We scored 58% in 2023 and 61% in 2022 and 2021.

Figure 2 shows our People Promise scores over the last 3 years.

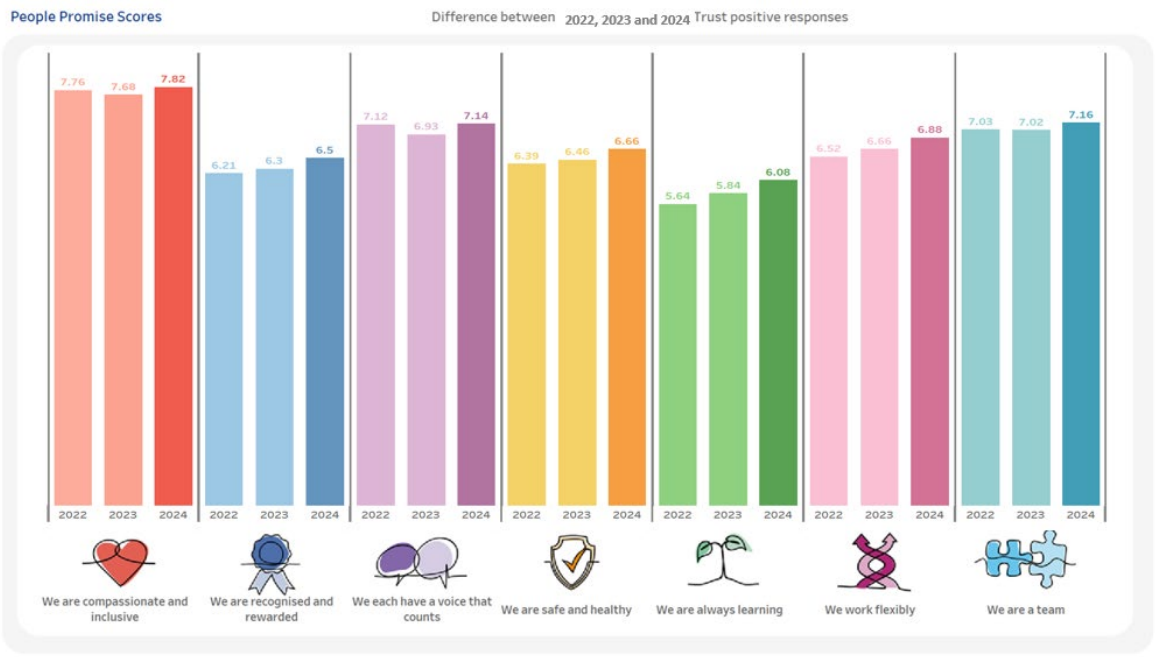
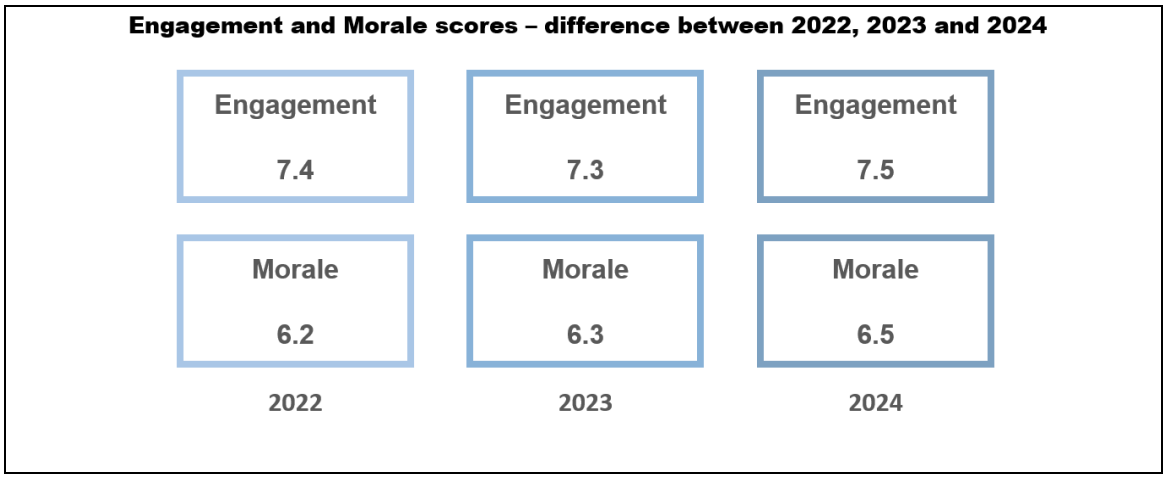


Figure 3 shows our Engagement and Morale scores over the last 3 years.



Unwanted behaviour of a sexual nature in the workplace

We have seen a small increase of 0.07% for Q17a in the last 12 months how many times have you been the target of unwanted behaviour of a sexual nature in the workplace from patients/services users, their relatives and other member so the public. This is also higher than the benchmark average. There was also a small increase of 0.22% for Q17b when asked in the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace from staff/colleagues. This was the same as the benchmark average as shown in Appendix 1.

To show our commitment in eradicating this type of behaviour and to act when concerns are raised, the Trust have signed up to the NHS Sexual Safety Charter, we've also made meaningful progress by creating a specific, Trust-wide sexual safety policy, delivered focused 'Surviving in Scrubs' training, and revamped our induction programme to raise awareness about the policy and our commitments. As this work is in its infancy, having started in September 2024, we will likely see improvements in next year's survey.

Speaking up – raising concerns

Following the launch of the Freedom to Speak Up Plan last year, and the implementation of actions it is encouraging to see improvements reflected in the increase in our results for all questions on speaking up and raising concerns as shown in Appendix 2. These are also all higher than the benchmark average. Last year we scored lower than the benchmark average in all the same questions. Some of the deliverables achieved are:

- Raising awareness of FTSUG and the speaking up and listening message at team meetings, via HIVE and team brief and in person attendance at staff induction as part of the Values & Behaviours session
- Development of posters and daily programme of items to support October's Freedom to Speak Up
- FTSUG presentation at the EDI champions meeting to provide knowledge and understanding of FTSU and how to support it
- Feedback on Datix a mandatory requirement so all staff can review the outcomes of an incident they report and are able to challenge outcomes
- Embedding of Respectful Resolutions which includes a tool to aid speaking up
- Schwartz rounds focused on speaking up

Appendix 3 provides a summary of our most improved and most declined scores when compared to 2023. A deeper dive is currently underway as early indications reflect areas of concern in some teams we already know exist and are covered by programmes of work such as Respectful Resolution, mediation etc.

Appendix 4 shows the comparison of our position nationally, alongside other Greater Manchester Trusts and Oncology Centres. We scored the highest in 4 of the themes; we are safe and healthy, we are always learning, staff engagement and morale. We only scored .1 below the highest in nearly all the other themes apart from one, we work flexibly, but we had the 2nd highest score. This is an encouraging improvement when compared to last year where we were the highest in one theme, staff engagement.

Free text comments high level summary

The following themes were identified from the free text comments provided at the end of the survey when asked for 'any other comments.' These comments provide valuable insight into the experiences of colleagues across the organisation and are being addressed by existing programmes of work, such as recruitment and retention mechanisms, reward and recognition and management development programmes and the introduction of leadership communities of practice.

There were positive reflections on the following:

- Excellent development and educational opportunities with financial and study

leave support frequently available
- Colleagues feel supported by both line manager and colleagues in their team
- Colleagues are proud to work here and enjoy working here
- Colleagues feel valued and cared for

Areas of improvement: (notably some areas for improvement such as pay, have no opportunity for improvement action).

- Lack of recognition and reward particularly regarding pay equity and appreciation for long-serving colleagues
- Workload and stress with reports of burnout, increased patient acuity and staffing shortages
- Leadership and management with some colleagues feeling unsupported or unheard buy senior leaders
- Bullying, discrimination, and workplace culture with reports of intimidation and favouritism in training and career progression
- Flexible working with colleagues calling for better work-life balance and predictable shift patterns

3 Areas of focus/priorities for the coming year

- Continued focus on Respectful Resolutions and Build on BUILD
- Trust-wide colleague listening events (in addition to connect and reflect)
- Speaking Up particularly in respect of reporting experiences of physical violence (Appendix 2)
- Link the new education brochure and new leadership and management competency framework together to further highlight and develop training for leaders and managers
- New manager induction
- Introduction of Leadership Communities of Practice
- Promotion of new PDR materials

4 Conclusion

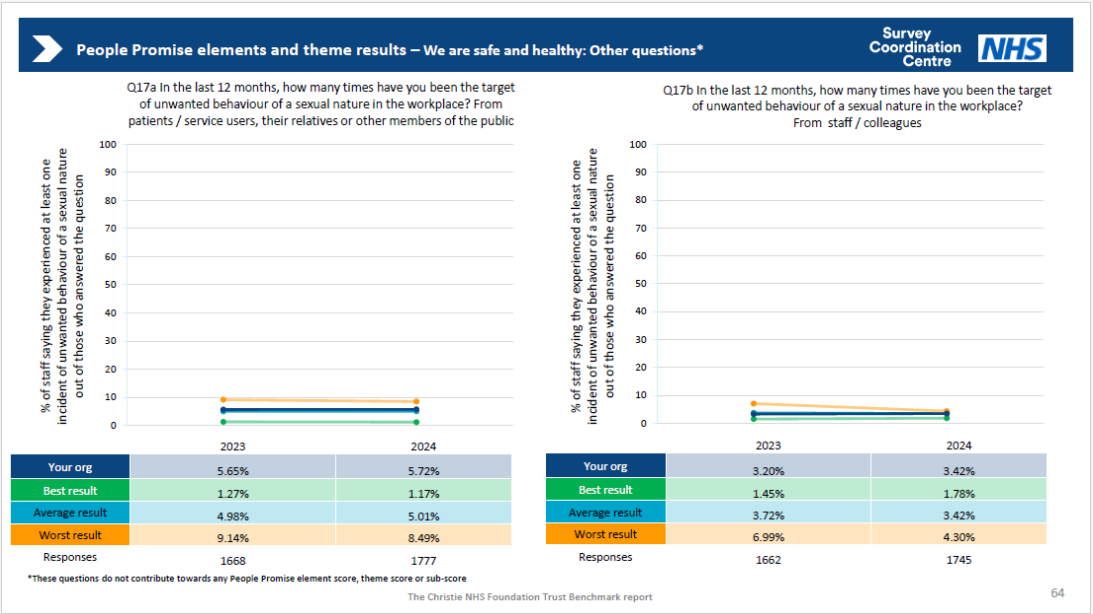
The Trust's culture journey continues to grow, and it is acknowledged that 2024 continued to be a challenging year with significant operational pressures, financial challenges, industrial action, staffing issues and cost of living rises. Whilst we have used the staff survey as a significant measure to help improve the working lives of our colleagues, it is a snapshot in time and is only one mechanism for feedback we obtain. We gather feedback in many other ways throughout the year via patient surveys, Equality Delivery System stakeholder events, healthy workplace steering group and a variety of colleague engagement and listening events.

5 Next Steps – utilising the staff survey to improve organisational culture

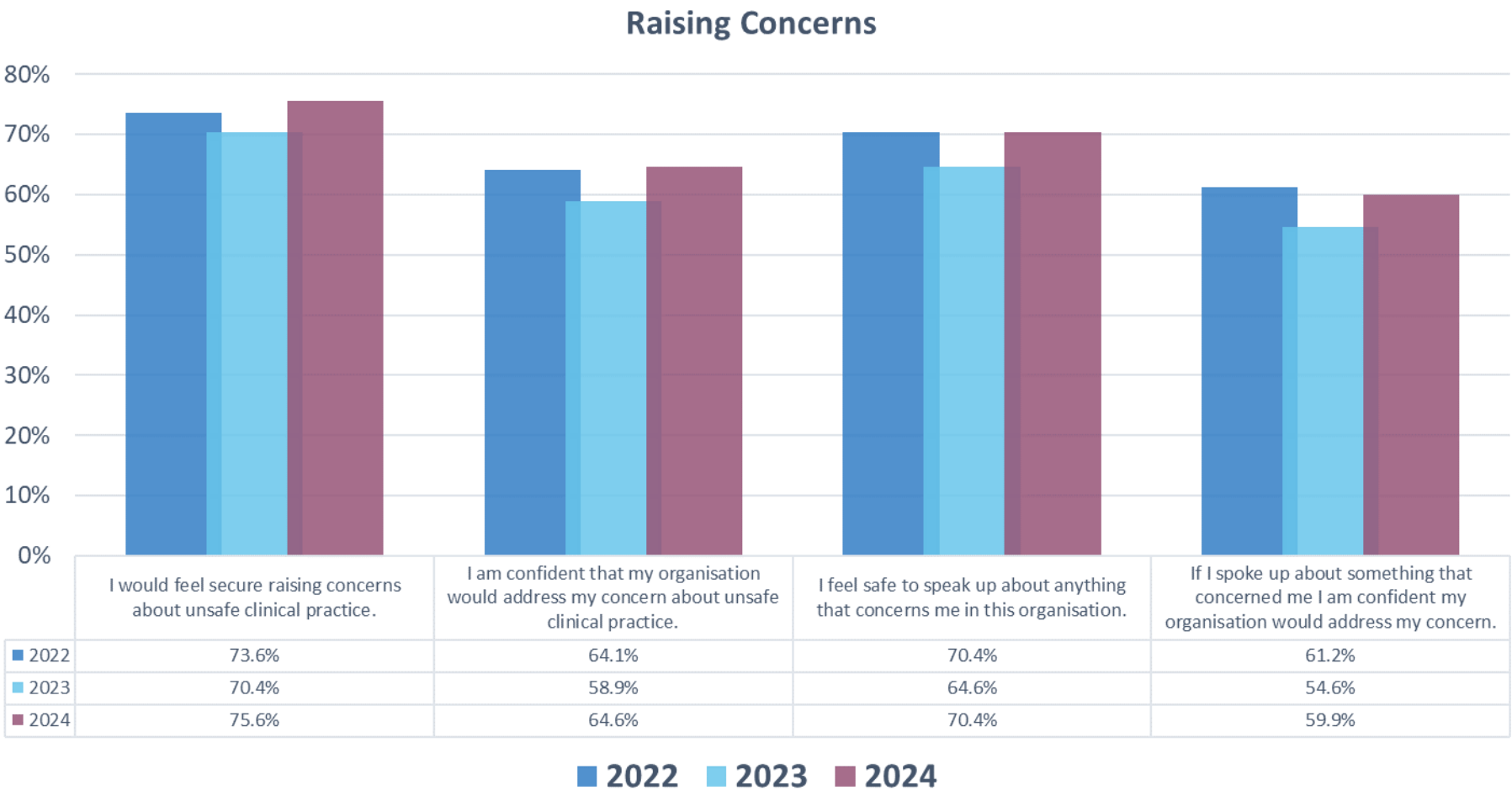
Divisional leads are already in receipt of their divisional results, this is much earlier than in previous years as we had access to our results earlier. This will enable divisions to consider their results and start implementing their actions in a more timely and meaningful way. A more in-depth review of our results will be provided to Workforce Committee in June 2025.

The Trust Board are asked to note the staff survey results update and actively engage in divisional action planning.

Appendix 1 shows our scores are higher when compared to 2023 and higher or the same as the benchmark average when asked about unwanted behaviour of a sexual nature in the workplace



Appendix 2 shows all 2024 scores for raising concerns have improved when compared to our 2023 scores



	I would feel secure raising concerns about unsafe clinical practice.	I am confident that my organisation would address my concern about unsafe clinical practice.	I feel safe to speak up about anything that concerns me in this organisation.	If I spoke up about something that concerned me I am confident my organisation would address my concern.
2022	73.6%	64.1%	70.4%	61.2%
2023	70.4%	58.9%	64.6%	54.6%
2024	75.6%	64.6%	70.4%	59.9%

Appendix 3 shows our most improved/declined scores compared with our own 2023 survey results

Most improved scores	Org 2024	Org 2023
q3i. Enough staff at organisation to do my job properly	47%	38%
q25c. Would recommend organisation as place to work	78%	71%
q5a. Have realistic time pressures	35%	28%
q11a. Organisation takes positive action on health and well-being	65%	58%
q3h. Have adequate materials, supplies and equipment to do my work	70%	64%

Most declined scores	Org 2024	Org 2023
q13d. Last experience of physical violence reported	62%	74%
q7d. Team members understand each other's roles	73%	75%
q7e. Enjoy working with colleagues in team	83%	85%
q3b. Feel trusted to do my job	90%	91%
q16b. Not experienced discrimination from manager/team leader or other colleagues	93%	94%

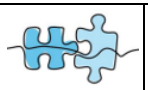
When looking at the most improved scores there has been a significant improvement of 9% when asked Q3i 'enough staff at this organisation to do my job properly'. There has also been a significant improvement of 7% for most of the others but of note:

- Q25c 'would recommend the organisation as a place to work'. Cultural work such Respectful Resolution, establishment of EDI staff groups and quarterly Connect and Reflect events could be a contributing factor to this improvement.
- Q11a 'organisation takes positive action on health and wellbeing'. We launched the colleague health and wellbeing support guide, delivered monthly The Menopause – Supporting your Teams workshops and worked collaboratively with colleagues to review the health and wellbeing offer.

When looking at the most declined scores on the right, Q13d 'last experience of physical violence reported' saw the greatest decline of 12%. It is recommended that extra focus is given to supporting this as an area of concern. The other questions saw a decline in 1 or 2% when compared to 2023.

Appendix 4

Results comparison of our position nationally alongside other Greater Manchester Trusts 2024

	 We are compassionate and inclusive	 We are recognised and rewarded	 We each have a voice that counts	 We are safe and healthy	 We are always learning	 We work flexibly	 We are a team	 Staff Engagement	 Morale
The Christie	**7.8**	6.5	**7.1**	**6.7**	**6.1**	6.9	7.2	**7.5**	**6.5**
RANKING (out of 10)	= 1	= 2	= 1	= 1	= 1	= 2	= 2	= 1	= 1
Bolton NHS FT	7.4	6.1	6.8	6.2	5.7	6.3	7.0	6.9	6.0
East Cheshire NHS Trust	7.4	6.0	6.8	6.1	5.6	6.3	6.8	6.9	5.9
Manchester Uni FT	7.2	5.9	6.7	6.2	5.6	6.0	6.8	6.8	5.9
Northern Care Alliance	7.2	5.8	6.6	6.0	5.5	6.4	6.7	6.7	5.8
Stockport NHS FT	7.3	6.1	6.8	6.1	5.7	6.4	6.9	6.9	6.0
Tameside & Glossop	7.2	6.0	6.6	6.1	5.5	6.2	6.8	6.8	5.9
Wrightington, Wigan & Leigh	7.2	5.9	6.7	6.2	5.3	6.2	6.6	6.8	6.1
GMMH	7.3	6.3	6.8	6.2	5.6	6.7	7.0	6.8	6.0
Pennine Care	7.7	**6.6**	**7.1**	6.5	**6.1**	**7.2**	**7.3**	7.3	6.4

Those in bold highlight the highest score for each People Promise theme

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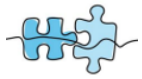
Results comparison of our position nationally alongside other Acute Specialist Trusts 2024

	 We are compassionate and inclusive	 We are recognised and rewarded	 We each have a voice that counts	 We are safe and healthy	 We are always learning	 We work flexibly	 We are a team	 **Staff Engagement**	 **Morale**
The Christie	7.8	6.5	7.1	6.7	6.1	**6.9**	7.2	7.5	6.5
RANKING (out of 13)	= 3	= 3	= 3	= 2	= 2	= 1	= 3	= 2	= 2
The Royal Marsden	7.6	6.2	7.0	6.4	6.0	6.3	6.9	7.4	6.3
Clatterbridge	7.9	6.6	7.2	6.7	6.1	6.7	7.3	7.4	6.4
Great Ormond Street	7.5	6.0	6.8	6.3	5.8	6.3	6.8	7.2	6.1
Liverpool Heart and Chest	**8.0**	**6.7**	**7.5**	**7.0**	**6.4**	**6.9**	**7.4**	**7.7**	**6.8**
Liverpool Women's	7.3	5.9	6.7	6.2	5.5	6.1	6.6	6.9	5.9
Moorfields Eye Hospital	7.3	5.9	6.7	6.4	5.7	6.1	6.7	7.2	6.1
Queen Victoria Hospital	7.7	6.3	7.0	6.5	5.9	6.6	7.0	7.4	6.2
Royal National Orthopaedic Hospital	7.5	6.1	7.0	6.5	6.0	6.7	7.0	7.3	6.3
Royal Papworth Hospital	7.4	6.1	6.8	6.3	5.6	6.8	6.8	7.2	6.1
The Robert Jones and Agnes Hunt Orthopaedic Hospital	7.7	6.1	6.8	6.5	5.7	6.6	7.0	7.3	6.3
The Royal Orthopaedic Hospital	7.4	6.1	6.8	6.6	5.7	6.7	6.8	7.1	6.3
The Walton Centre	7.5	6.2	7.0	6.5	5.7	6.4	6.9	7.3	6.3

Those in bold highlight the highest score for each People Promise theme

Results comparison of our position nationally alongside other Acute Specialist Trusts 2024 for Q25c - I would recommend my organisation as a place to work

Organisation	2023	2024	Change 2023-2024
Liverpool Heart and Chest	83%	83%	-0.1
The Christie	71%	79%	7.6
Royal National Orthopaedic Hospital	72%	76%	3.9
The Royal Marsden	71%	75%	4.5
Great Ormond Street	71%	73%	3.0
The Robert Jones and Agnes Hunt Orthopaedic Hospital	76%	74%	-2.0
The Clatterbridge	71%	73%	2.7
Queen Victoria Hospital	75%	73%	-2.9
The Royal Orthopaedic Hospital	73%	72%	-1.2
Royal Papworth Hospital	69%	71%	1.6
The Walton Centre	72%	70%	-2.3
Moorfields Eye Hospital	64%	67%	2.9
Liverpool Women's	62%	63%	0.6

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Agenda Item 11/25a(i)

Meeting of the Board of Directors
Thursday 27th March 2025

Subject / Title	Workforce Assurance Committee report – January 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 January meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions
Background papers	Workforce Assurance Committee papers – January 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 ➢ Corporate objectives ➢ CQC Quality standard ➢ Regulation	• Trust's strategic direction • Divisional implementation plans • Our Strategy • Key stakeholder relationships
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	

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Agenda item 11/25a(i)

Meeting of the Board of Directors
Thursday 27th March 2025

Workforce Assurance Committee report – January 2025

1 Introduction

The Workforce Assurance Committee took place on 23rd January 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 January 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:

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

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

3 Recommendation

The Board are asked to note the summary report from the Workforce Assurance Committee in January 2025.

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Appendix 1

Agenda item	BAF ref	CQC regulation reference	Assurance rating given	Key points and associated actions (where applicable)
02/25a	3, 12	18	High	**Workforce dashboard and risk review**
Assure				• Sickness rate – 5.3% for December, this is below the rate where we were last year so a positive. • PDRs – up to 87.46% compliance for December • Mandatory training – 93.95% compliance for December. Moving some training back to the day of induction has shown to be a benefit. • Staff turnover – reducing in a positive way, keeping at around 8-9%. • Establishment against paid FTE gap – FTE gap at 364 vacancies; 216 of these have a start date confirmed. • Workforce risk summary presented, risk in terms of workforce supply remains at a 9 and regularly reviewed at Workforce Committee.
Alert				• No alert points to report.
Advise				• No advise points to report.
02/25b	3	N/A	Medium	**Exit interview focused review**
Assure				• Robust process checklist for employees and managers to complete. • Current performance post launching presented, will start to gather data on the back of this. From the 20+ responses received so far; the average rating is 3.85 out of 5.
Alert				• Positive and negative comments received shared. Need to assess if negative comments are producing any trends within specific areas.
Advise				• Exit interviews renamed to 'Your Next Chapter.' Shared at Workforce Committee and divisional meetings, well received. • Your Next Chapter options and changes presented covering both leaving the Trust and moving roles internally. • Process changes – all leavers receive an email within a week of termination being processed and reminder email. All internal moves receive within a month of move being processed. • Reporting changes – monthly dashboard to be created via Christie Data Insights and circulated to relevant managers and support services.

Actions				• Update on Your Next Chapter progress to be presented to the committee in January 2026.
03/25a	3, 12	18, 19	High	**The Christie people and culture plan update**
Assure				• Fair and inclusive recruitment – reviewing policy. • Consultant and clinical development programmes – both programmes started and good feedback received, already requests for more so amber reflects the work required to plan and move forward.
Alert				• Dashboard work remains ongoing due to capacity.
Advise				• Management training – new Leadership & Management Trainer recruited, looking to incorporate into existing induction from April 2025.
03/25b	N/A	N/A	Medium	**Wellbeing programme**
Assure				• Staff survey results shows an improvement in health and wellbeing. • Introduced opportunity for staff to receive counselling onsite. • Real lunch hour implemented to ensure colleagues get proper breaks. • Health and wellbeing support guide produced and promoted on the back of the cultural audit – available on Hive and in paper-based format, extending the reach to ensure this is accessible to all staff. New starters are also directed to where it can be found during induction.
Alert				• No alert points to report.
Advise				• Mental health first aiders in place, these are staff volunteers – were oversubscribed on the uptake for being a mental health first aider. • Workshops delivered to managers on menopause.
03/25c	12	N/A	Medium	**Improving the working lives of Doctors in Training**
Assure				• Resident doctor oversight group – working to a shared programme of improvements based on prior negative feedback. Excellent attendance including resident doctor representation each month. Resident doctor representative; positive feedback on improvements made since Feb 2024, negative feedback and solutions identified to address. Encouraging feedback being received and seeing increased job satisfaction. • Log of all training activities being maintained. • Rota team – new expanded team in place. Daily presence at morning handover which allows for immediate resolve of issues and queries.
Alert				• Awaiting official feedback from the Deanery but had a positive meeting.

Advise				• Doctors mess – environmental upgrade taking place and resident doctors involved in decision making. • Changeover and rotational planning – work done on handover and shadowing opportunities. Enhancing web pages and moving to e-rostering.
03/25e	3	18	Medium	**Update report from Christie Workforce Education**
Assure				• Work experience – number of work experience placements increased and available for young people from local communities, with a particular focus on unaccompanied asylum seekers and care leavers. Log of all training activities being maintained. • Learning needs analysis (LNA) - has been a significant achievement. It helps to better understand the educational needs of our medical workforce, particularly in areas such as specialist cancer care. • Sector based work academy programme – partnership with Trafford College. Provides participants with guaranteed job interviews, interview coaching, and free professional attire. Since its launch, the program has filled six full-time positions in healthcare support roles. The plan is to increase learner capacity and continue to offer tailored learning opportunities for individuals seeking careers in healthcare. • Apprenticeships – starts have increased and ahead of target, there is dedicated resource within the team to manage this. • Supervisor training – following feedback on how supervision was happening, training has been implemented in this area. Seen a 50% increase in the rate of written feedback provided by supervisors, and plan to continue expanding this training to ensure that all learners receive meaningful and constructive guidance.
Alert				• No alert points to report.
Advise				• Relaunched observership programme •
Actions				• KPI measures and performance monitoring through the use of RAG ratings to be implemented for future Education update reports.
04/25c	N/A	N/A	Medium	**Sexual Safety Charter**
Assure				• Working towards framework (provided by NHSE) compliance and progress update provided. • Sexual Safety Policy has been developed and launched. • Specific reporting system within Datix has been developed • A series of training classes and seminars delivered in collaboration with Surviving in Scrubs
Alert				• No alert points to report.

Advise	• Aim is to complete all actions by the end of March 2025.
Actions	• Progress update to be presented to the committee in June 2025.

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Agenda Item 11/25a(ii)

Meeting of the Board of Directors
Thursday 27th March 2025

Subject / Title	Quality Assurance Committee report – January 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 January meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions.
Background papers	Quality Assurance Committee papers – January 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 ➢ Corporate objectives	• Trust's strategic direction • Divisional implementation plans • Our Strategy • Key stakeholder relationships
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	

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Agenda item 11/25a(ii)

Meeting of the Board of Directors
Thursday 27th March 2025

Quality Assurance Committee report – January 2025

1 Introduction

The Quality Assurance Committee took place on 23rd January. 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 January 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:

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

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

3 Recommendation

The Board are asked to note the summary report from the Quality Assurance Committee in January 2025.

Appendix 1

Agenda item	BAF ref	CQC regulation reference	Assurance rating given	Key points and associated actions (where applicable)
02/25a	1, 6	N/A	High	**Research & Innovation divisional report**
Assure				• Updated governance structure implemented. Risk management processes being adopted. Reviewing directorate risk registers, new quality assurance group will review risks.
Alert				• RPeak interface continues to provide challenges with national uploading of recruitment data. Working with Digital Services to move to a different system, Edge, to prevent future issues. Will be some impact on workforce.
Advise				• Key operational challenge is the time taken to set up clinical trials. Reviewing dashboards and performing deep dives into delays to understand the reasoning, will report back through next report to the committee. • New post recruited to within the aseptic services team to provide increased support for the review of new and amended clinical trials, joined in October 2024 and working well in the team. • MIAA internal audit review of Biobank partnership governance arrangements and assurance processes – received substantial assurance, actions agreed and planned for completion by March 2025. • RedCAp implemented. Data within the system is secure and functionality for researchers to deploy data edit, validation and consistency checks improving the quality of the data. • Christie Research bid was approved by The Christie Charity Board of Trustees in Q3 2024 to provide £30 Million over 5 years.
Actions				• For future reports, where referring to research activity and where numbers are quoted, context to be included to see how this compares.
02/25b	N/A	N/A	Medium	**Lost to follow up update**
Assure				• Financial approval was given for resource during 2024/25 to support the review and closure of the historic open referrals.

Alert				• Although progress has been made towards removal (auto closure) of these referrals, a number of delays associated with the supplier (System C) have resulted in this not yet being complete. This work is scheduled to take place in Quarter 4 of 2024/25 and will remove c15,000 open referrals from CareFlow. • 2 patients have been found to come to harm, these cases were subject to a full review through the Trust incident review process. • Further risk identified – backlog of patients on the waiting list who have not been outcomed, backlog clearance will complete at the end of this quarter.
Advise				• PTL process needs to be refined, this is a manual process open to human factor error.
Actions				• Progress update to come to the committee in June 2025.
02/25c	2	N/A	Medium-high	**PSIRF progress update (Deep Dive) and thematic review**
Assure				• Commissioned external training from Morgan Human Factors, cohort of 64 staff enrolled onto Human Factors Training. Executive colleagues completing next week. • 86% compliance with level 1 of Patient Safety Syllabus – mandated training for all staff and 68% compliance with level 2 Patient Safety Syllabus – essential to role. • Completed 35 learning responses since go live of PSIRF; 6 Patient Safety Incident Investigations with 2 being completed, tracking how many are triggered each month. • Department recently conducted a thematic review of medication administration incidents involving omission of concomitant medications leading to themes, areas for improvement and learning being identified. Shared learning between SACT services and Pharmacy promoting open and honest communication.
Alert				• No alerts to report.
Advise				• Recruitment of patient safety partners; circa 20 applications to take forward as part of recruitment process.
Actions				• Review of safety priorities update to come to the committee through the PSIRF progress report in June 2025.
02/25d	N/A	12	High	**Learning from deaths update**
Assure				• All in-patient deaths looked at by the medical examiners, triggering SCR where required.

Alert				• Trust's mortality surveillance has identified an increase in mortality figures since April 2024, analysis to date has identified no patterns or concerns with regards to place of death, days of admission, days of death, hours of death, disease groups or cause of death. • No concerns have been identified from the SCRs or from the Medical Examiners who have scrutinised every death. There were no serious incident investigations/patient safety incident investigations initiated from any of the inpatient deaths.
Advise				• The new mortality module on the Datix cloud-based system (DCIQ) went live successfully in March 2024.
02/25e	N/A	N/A	Low	**Quality spot check MIAA audit report - medication safety and medication administration**
Assure				• Policies and procedures rated as green.
Alert				• Medicines safety rated as red and medication administration rated as amber resulting in overall limited assurance rating. • High risks relate to medication storage and delivery of drugs. Some immediate actions have been taken to address. Other actions are in progress and around taking ownership and informing staff of what is expected.
Advise				• Staff are signing up to pledges which outline key role responsibilities. • Mini code being introduced for senior staff to take ownership of.
Actions				• Progress update to come to September committee meeting. • Audit outcome to be alerted to Board of Directors.

The Christie
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Agenda Item 11/25a(iii)

Meeting of the Board of Directors
Thursday 27th March 2025

Subject / Title	Audit Committee report – February 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 Audit Committee at their February meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions.
Background papers	Audit Committee papers – February 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 ➢ Corporate objectives	• Trust's strategic direction • Divisional implementation plans • Our Strategy • Key stakeholder relationships
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	

The Christie
NHS Foundation Trust

Agenda Item 11/25a(iii)

Meeting of the Board of Directors
Thursday 27th March 2025

Audit Committee report – February 2025

1 Introduction

The Audit Committee took place on 20th February. 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 Audit Committee agenda items

The items listed in Appendix 1 of the report were all presented to the Audit Committee in February 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:

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

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

3 Recommendation

The Board are asked to note the summary report from the Audit Committee in February 2025.

The Christie NHS Foundation Trust

Appendix 1

Agenda item	BAF ref	CQC regulation reference	Assurance rating given	Key points and associated actions (where applicable)
02/25a	11	N/A	Medium	**Deep Dive – BAF risk number 11 Digital/Cyber/DSPT update**
Assure				• Lots of layers of protection security wise. • Healthy position in terms of ability to react and work closely with the Trust's business continuity lead. • Suppliers and vulnerabilities - procurement standards are in place and additional protections required. Hold third party suppliers to account with regards to required standards and use supplier frameworks. • Penetration testing is undertaken, outcomes reported with any gaps. No present concerns. • Business case for replacing Mosaiq approved.
Alert				• Cyber risk inevitable, scored at 12.
Advise				• Need to keep up with the landscape of cyber threats.
Actions				• Consideration to be given to need for additional internal audit review in 2025/26 plan. • Development of dashboard noted, to be presented as part of the next report to the committee in six months' time.
02/25b	10, 14	N/A	High	**The Christie Pharmacy Limited Report**
Assure				• 2024 was the best year for the pharmacy company since inception in relation to prescription turnaround times with no complaints and only a small number of incidents, no moderate or major incidents. • Old robot has now been decommissioned so the related cyber risk now closed. • SFIs have been reviewed and going to February Pharmacy Board for approval. • Inpatient dispensary refurbishment going well – on target to re-open by end March/early April.
Alert				• Stock loss noted as below target (0.1% cumulative). Pertinent questions have been asked and will be discussed at the February Pharmacy Board with escalation where required. • Cyber risk added in relation to iQemo system, share the risk with the Trust.

Advise				• Risk of severe and sustained service disruption due to pharmacy robot malfunction is being maintained while Pharmacy in a temporary decant area but will also become no longer relevant. • Financial performance slightly off plan and update to be presented to February Pharmacy Board, no concerns and still on target. • Some operational changes being made to the Pharmacy's meeting structures; as a result of this Pharmacy Board meetings will then be reduced with a more focused agenda.
02/25c	10, 14	N/A	High	**Executive Director of Finance report**
Assure				• Trust completed and submitted the Month 9 return on 21st January 2025. • Internal audit recommendations will be tracked, monitored and reported through the Risk and Quality Governance Committee then presented to Audit Committee for assurance. • Key Financial Transactional Processing internal audit review received substantial assurance
Alert				• Delegated authority to be requested from the Board of Directors for the signing of the Audited Annual Report and Accounts, to take place at the Joint Assurance Committee, where all Board Members are present (to also be added to the scheme of delegation as part of the review to enable the process for future years).
Advise				• In midst of planning for 2025/26, £8.5m deficit currently – confidence that will get to a breakeven position.
Actions				• Board of Directors to be alerted to the request for delegated authority for the signing of the Audited Annual Report and Accounts to take place at the Joint Assurance Committee, where all Board Members are present. • Scheme of delegation to be updated to enable the signing of the Audited Annual Report and Accounts to take place at the Joint Assurance Committee for future years.

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

Alert	• Internal audit progress report - 3 completed audit reviews received limited assurance; Critical App (Careflow), Divisional Recruitment (reported to Workforce Assurance Committee) and Quality Spot Checks (reported to Quality Assurance Committee). The critical App review was discussed with access controls identified as an issue to work on and strengthen through third parties. BCP and testing also needed. Maintenance of data also a recommendation. Timescales and audit recommendations agreed with management were reasonable given the limited assurance, the challenge will be the management of the third parties. Other completed audit reviews; Key Financial Transactional Processing (Substantial Assurance) and Data Quality (Moderate Assurance),
Assure	• Board Assurance Framework - updates noted. Discussion on BAF risk on legal and statutory compliance – to be presented as an overview to future committee meeting as deep dive. EPRR risk to be reviewed and presented to Audit Committee as part of next deep dive review. • Anti-fraud progress report - NHS Counter Fraud Authority recent Strategic Intelligence Assessment (2024) noted. Counter fraud activities: summarised communications issued. Exercise on learning related to people remote working and line management controls recently undertaken, created a document aimed at line managers on things to look out for including secondary working and working whilst sick. 2 policies reviewed and updated. 6 new referrals since the last Audit Committee; 3 closed, 2 upgraded to investigations and 1 remains open. • External audit progress report - changes within the audit team for this year as part of rotational requirements noted. Work is well underway and Trust colleagues have attended a workshop ran by GT. Changes for this year's audit were outlined; due to the Trust's I&E, considered a major audit and an external expert valuer is to be brought in to work on the valuation and provide the required level of scrutiny. Planning work in progress, VFM work also underway. Timetable engaged, aiming to complete mid-June ahead of deadline at end of June. Informing the audit risk assessment 2024/25 noted.
Advise	• Draft internal audit plan 2025/26 - Board of Directors to be advised that the internal audit plan was endorsed within the current resource available, wider discussion to be undertaken with a view to assurance mapping and deciding if additional audit resource required. • Draft anti-fraud audit plan 2025/26 – plan endorsed. Board briefing on new failure to prevent fraud legislation and requirements for Board members to be considered for incorporation into anti-fraud audit plan, to include considering as part of a Board planning day if deemed the most appropriate route.

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Agenda Item 11/25b

Meeting of the Board of Directors

Thursday 27th March 2025

Subject / Title	Board Assurance Framework 2024/25
Author(s)	Louise Westcott, Company Secretary
Presented by	Roger Spencer, CEO
Summary / purpose of paper	This paper provides the Board with the Board Assurance Framework 2024/25. The risks outlined impact on achievement of the corporate objectives and the relevant objectives are indicated for each risk. The paper includes a snapshot of the risks ordered by current risk score and a report with the detail relating to each risk. The risks are reviewed alongside the risks on the Trust risk register and the top operational risks are also listed.

Updates to note in month	• 2024/25 MIAA Audit outcomes / assurance level added where relevant.
	• Changes to lead executive for risks as follows:
	  ○ Risk 8 now falls under Director of Strategy
	  ○ Risk 11 now falls under Executive Medical Director
	  ○ Risk 12 now falls under Director of Workforce
	• Additional fields have been added to the snapshot page to demonstrate trends in risk scores, risk appetite & target date for each risk.
	• Risk scores have been checked and the following changes are noted;
	  ○ **Risk 2** has reduced from 12 (3x4) to 9 (3x3) due to progress made with PSIRF implementation, completion of PSIRF training & improved timeframe for incident management. MIAA audit of PSIRF processes confirms substantial assurance.
	  ○ **Risk 3** has been updated to include confirmation of the agreement to recruit to the onboarding post on a permanent basis.
	  ○ The financial risks - **Risk 5 & Risk 10** have been assessed and scores reduced to reflect the year-end financial position (both capital (12 to 4) & revenue (12 to 5))
	• Updates to control and assurance as appropriate.
	• Operational risks scoring 15 & above are detailed in the report.
	• Updates made in line with recommendations from MIAA's assurance framework review 2024/25 – assessment of target scores based on risk appetite / update to gaps in controls & assurance.

Recommendations (assure / **alert** / advise)	The Board of Directors are asked to; • note the Board Assurance Framework (BAF) 2024/25 and updates made. • consider if there are any further risks that need to be added to the BAF. • reflect the review of the risks in the BAF for the next meeting. • Note the operational risks scoring 15 and above
Background papers	Board assurance framework 2023/24. Corporate objectives 2024/25, operational plan and revenue and capital plan 2024/25. MIAA Assurance Framework review 2024/25.
Risk score	N/A
Link to: ➢ Trust strategy ➢ Corporate objectives	• Trust's strategic direction • Divisional implementation plans • Our Strategy • Key stakeholder relationships
Acronyms or abbreviations in the attached paper	BAF Board assurance framework MDT multi-disciplinary team NICE National Institute for Health & Care Excellence PSIRF Patient Safety Incident Response Framework IP(QF)R Integrated Performance Quality & Finance Report GM Greater Manchester

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Agenda Item 11/25b

Meeting of the Board of Directors

Thursday 27th March 2025

Board Assurance Framework 2024/25

The Board held a development day on 7th February 2025. The morning session was focused on Risk and was delivered by a subject expert from NHS Providers. The summary below outlines some of the points for improvement that came from the session and what we have done in response.

Point for improvement		Action	Progress
1	Review definitions of strategic and operational risks to ensure - They are risks not issues - They are as specific as possible	Review of BAF risks undertaken by Company Secretary and MIAA in their annual review	Complete
2	Review detailed risk register pages to ensure correct distinction between controls and assurance (highlighting whether 1st, 2nd or 3rd line) and to align these against specific risk components	Initial review undertaken and amendments made to controls / assurance	Complete
3	Continue to bring BAF and top operational risks to each Board, with appropriate time allocated	BAF & operational risks on agenda for each meeting	Complete
4	Ensure BAF covers top strategic risks, whether in-year or longer term (i.e. not just impacting annual objectives)	BAF restructured to show longer term view of risks and move away from annual review	Complete
5	Tweak BAF and operational risk summaries to add risk appetite, 'residual' risk, and target mitigation date	Overview page amended to include additional fields	Complete
6	Board to review overall BAF risks, and risk appetite and allocation (some to Board, most to committees) annually, preceded by annual horizon scan.	Added to rolling programme for May 2025	Complete
7	In gaining assurance, spend more time seeking evidence of first line ownership and effective mitigation of top risks e.g. through deep dives, while also gaining assurance about risk processes	Deep dives for each BAF risk on rolling programmes of Assurance Committees. Risk Management Strategy presented for approval to Board & reviewed annually	Complete
8	Each committee to report on its risk oversight activities annually to Audit as part of enhanced annual report.	Contained in the committee annual reports for the joint assurance committee	Complete
9	Ensure continued triangulation of risk across Board and Committees, through Board review at each meeting, informal Chairs meetings, and potentially through the refreshed IFQPR	Continued focus on reporting back from assurance committees to Board to ensure communication to whole Board	Complete

MIAA Assurance Framework Review 2024/25

MIAA issued their final Assurance Framework review 2024/25 in March. Below is the summary of the recommendations and management responses all of which have been actioned and are complete.

No	Issue	Recommendation	Management Response
1.	Target risk scores for certain risks do not align with the risk tolerance for the particular risk appetite.	The Trust should review the target risk scores in line with the stated risk appetite as there are some risks where the target risk score does not correlate with the risk appetite.	All target risk scores reviewed and amended where appropriate.
2.	Whilst actions have been formally referenced to address gaps, the section for gaps in the BAF is referenced as 'none identified' for all BAF risks.	Actions correlate to gaps identified.	BAF updated to reflect gaps in controls and assurance – March 2025
3.	The WAC has not received any deep dive assurance in year on allocated BAF risks. Furthermore, discussion in the QSC and WAC could provide for more scrutiny and challenge.	The WAC should schedule within its cycle of business a deep dive on its allocated BAF risks. In addition, the minutes of both the QAC and WAC should evidence further scrutiny and challenge of BAF updates received.	WAC cycle of business incorporates deep dives (risk 3 – March 2025 / risk 12 – every meeting plus additional all Board session with NHSP 18/09/2024 and Board sign off of Inclusive Culture plan Nov 2024). Minutes of specific agenda items cover discussion of risks e.g. people & culture plan item at each WAC meeting. Patient safety report at each QAC meeting.
4.	The Committee Triple A reports are received after the BAF review on the Board agenda.	On the Board Agenda it would be beneficial to have the Committee Triple A reports before the BAF so the Board is sighted on the committee risk discussions and recommendations to Board.	Board agenda updated from March 2025
5.	Our review of Triple A reports received since Sept 2024 found they are not covering all aspects of committee business, and some were not fully complete. It is key that these reports also provide assurance to Board that BAF risks are being scrutinised and any changes for Board approval are highlighted.	Triple A reports should be fully completed and provide assurance to Board that BAF risks are being scrutinised and any changes for Board approval are highlighted.	Triple A reports updated to include all items discussed on each assurance committee agenda. BAF risk discussions are incorporated into Triple A reports.

Summary

Number of current open 15+ risks in the Trust	4
Number of new 15+ risks since last month	1
Number of risks reduced in score since last month	0

Current 15+ Risks

Risk Title	Date risk went 15+	Datix ID	Risk Owner	Initial Risk Score	Target Risk Score	Current Risk Score	Update from last month	Lead Division	Update received
Not Identifying and Delivering 25/26 Recurrent VIP programme impacting on financial sustainability and ability to treat patients	30/10/2024	3776	CM	16	16	**16**	⇨	Finance	Yes
Operational and patient safety and experience risk in relation to recruitment of medical and admin workforce for Christie haematology at Leighton	03/06/2024	3697	VB	16	8	**16**	⇨	NWS	Yes
There is a risk of a patient inadvertently receiving an unintended blood component or product	25/01/2025	3508	SJ	10	5	**15**	⇨	NWS	Yes
There is a risk to the safe and effective delivery of the Trust's Aseptic service	17/02/2025	3819	AM	10	5	**15**	New risk	NWS	Yes

Recommendation

The Board of Directors are asked to;

- Note the Board Assurance Framework (BAF) 2024/25 and updates made relating to risk scores, controls, assurances & gaps as well as outcomes from the Board Time Out and from MIAA's assessment as detailed in the paper.
- Consider if there are any further risks that need to be added to the BAF.
- Reflect the review of the risks in the BAF for the next meeting.
- Note the operational risks scoring 15 and above.

BOARD ASSURANCE FRAMEWORK 2024/25 OVERVIEW OF RISKS

RISK No.	Risk Title	Risk Description	Responsible Committee	Risk Appetite	Inherant Risk Score	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	Q1 25/26	Q2 25/26	Target Risk Score	Current Risk Score	Target date
RISK 14	**Legal and statutory compliance**	If we do not maintain an awareness of and respond to changing statutory and legal requirements there is a risk that we will fail to comply leading to being sanctioned for being in regulatory or statutory breach.	Audit Committee	Averse	20	16	16	12				4	12	**Review Q1 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	16	12	12				8	12	**Reviewed Q3 24/25**
RISK 11	**Cyber attack**	If we or our suppliers are subjected to a cyber-attack there is a risk of loss of data and operational disruption leading to patient care being delayed or cancelled	Audit Committee	Averse	25	12	12	12				4	12	**Reviewed Q4 24/25**
RISK 4	**Changes in quality regulation**	If the CQC or other regulatory body changes their approach to regulation there is a risk that we will not be able to demonstrate compliance leading to us being assessed as not meeting the fundamental care standards.	Board of Directors	Averse	15	12	12	12				4	12	**Review Q1 25/26**
RISK 16	**Supply chain**	If we can't maintain supply of essential products for the treatment and care of our patients there is a risk that their treatment and care will be adversly impacted or delayed	Audit Committee	Averse	16	N/A	N/A	12				4	12	**Review Q1 25/26**
RISK 2	**Learning from patient safety incidents**	If we are unable to fully implement the new Patient Safety Incident Response Framework (PSIRF) there is a risk that we will miss opportunities to learn lessons and improve patient safety leading to preventable patient harm.	Quality Assurance Committee	Averse	15	6	15	12				4	9	**Reviewed Q4 24/25**
RISK 3	**Recruitment and retention of skilled staff**	If we are unable to maintain current levels of skilled staff there is a risk that they will not have the time or expertise required for excellent care and communication leading to a reduction in the standards of patient safety and experience.	Workforce Assurance Committee	Averse	20	9	9	9				4	9	**Reviewed Q4 24/25**
RISK 6	**Insufficient contractual support for networked cancer care provision**	If the GM system does not continue to support local provision of cancer care with contractual and funding flow changes there is a risk that we are unable to devolve more systemic therapy, clinical trials and radiotherapy treatments to local communities leading to persistence or increases in inequalities in provision to economically deprived and ethnically diverse communities.	Quality Assurance Committee	Cautious	12	9	9	9				6	9	**Review Q1 25/26**
RISK 8	**Extreme weather events**	If there is an extreme weather event (heat wave, freeze, floods etc) due to climate change there is a risk of business disruption (increased staff absence, increased patient non-attendance and equipment malfunction) leading to delayed or cancelled care.	Audit Committee	Averse	16	8	8	8				4	8	**Reviewed Q3 24/25**
RISK 12	**Ineffective response to cultural audit**	If our response to the cultural audit is insufficient there is a risk that a negative culture will persist in some specific parts of our organisation leading to an increase in the number of staff reporting a poor experience.	Workforce Assurance Committee	Averse	16	8	8	8				4	8	**Review Q3 & Q4 24/25**
RISK 13	**Insufficient data on patient protected characteristics**	If we are unable to capture data on the protected characteristics of our patients there is a risk we will be unable to assess any inequalities in access, experience or outcomes leading to lack of focus in addressing health inequalities	Quality Assurance Committee	Cautious	10	8	8	8				4	8	**Within tolerance**
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	9	9	6				4	6	**Within tolerance**
RISK 15	**Patient confidence in services**	There is a risk that adverse events will attract media coverage resulting in a decrease in public confidence in our services	Board of Directors	Averse	12	9	9	6				4	6	**Reviewed Q4 24/25**
RISK 10	**Financial balance**	If we do not achieve the planned activity levels and our target efficiency savings there is a risk that we won't achieve financial balance leading to us having to repay the difference to our agreed plan in the following year	Board of Directors	Averse	25	20	12	12				5	5	**Reviewed Q4 24/25**
RISK 5	**Impact of the system capital allocation framework**	If the capital planning and allocation system does not enable full use of our charitable and commercial reserves there is a risk that we may not be able to fund our capital and asset replacement programmes leading to delays, cancellations or reprioritising of planned projects and equipment not being replaced when needed.	Board of Directors	Eager	25	16	16	12				4	4	**Reviewed Q4 24/25 / Within tolerance**

RISK 1	New technologies and increased standards of care	Date Risk Opened	Current Risk Score
Description	**If there are changes to NICE guidance or other advances in practice that we have not anticipated (diagnostic, therapeutic, care) there is a risk that there will be a delay in their introduction leading to a delay in patients obtaining the benefits of new treatments.**	Apr-24 Date of Last Review Mar-25	6
Associated Corporate Objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer	Executive Lead	Exec Medical Director
		Responsible Committee	**Quality Assurance Committee**
		Assurance Level	Medium
		Risk Appetite	Cautious

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	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.□ Level 2 – Management team and committee scrutiny • Review NICE guidelines compliance through QAC and monthly IPQFR□ Level 3 – External assurances • NICE□	None identified	Forward views of upcoming NICE guidelines assessed	Within tolerance

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

RISK 2	Learning from patient safety incidents	Date Risk Opened	Current Risk Score
Description	**If we are unable to fully implement the new Patient Safety Incident Response Framework (PSIRF) there is a risk that we will miss opportunities to learn lessons and improve patient safety leading to preventable patient harm.**	Apr-24 Date of Last Review Mar-25	9
Associated Corporate Objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer	Executive Lead	Exec Chief Nurse
		Responsible Committee	**Quality Assurance Committee**
		Assurance Level	Medium
		Risk Appetite	Averse

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
	The Trust has invested in external training for the patient safety strategy with 2 cohorts in November and January respectively covering all components of the patient safety strategy. The patient safety team are hosting training for incident handlers to ensure management of incidents across teams is standardised. Improvement workstreams have been established to implement recommendations following the publication of learning responses. Review through Patient Safety & Experience Committee and Risk & Quality Governance. Introduction of new DATIX system	New ways of working require new skills across the organisation and resource at a team level to manage incidents.	Level 1 – Data and management reports • PSIRF reports to Patient Safety Committee / Risk & Quality Governance / Senior Management Committee • ERG□ Level 2 – Management team and committee scrutiny • Review compliance through patient safety reports to QAC□ Level 3 – External assurances • MIAA review • Updates presented to ICB	None identified	Full roll out of new Datix - incident module Training programme across the Trust Progression with PSIRF implementation, completion of PSIRF training and improved timeframe for incident management. Draft report for MIAA audit of PSIRF processes confirms substantial assurance.	Reviewed Q4 24/25

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	3	5	15	2	3	6	3	5	15	3	4	12			0			0

RISK 3	Recruitment and retention of skilled staff	Date Risk Opened	Current Risk Score
Description	**If we are unable to maintain current levels of skilled staff there is a risk that they will not have the time or expertise required for excellent care and communication leading to a reduction in the standards of patient safety and experience.**	Apr-24 Date of Last Review Mar-25	9
Associated Corporate Objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey. To be an international leader in professional and public cancer education. To maintain excellent operational, quality and financial performance.	Executive Lead	Workforce Director
		Responsible Committee	**Workforce Assurance Committee**
		Assurance Level	High
		Risk Appetite	Averse

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
	Recruitment & retention Trust-wide group reporting to Workforce Committee. Partnership with external provider to deliver our domestic recruitment offer, advertising and brand – social media Staffing levels maintained through coordinated utilisation of bank and agency International Recruitment Programme Christie People and Culture Plan 2023-26 Quarterly oversight of Trust wide vacancies and recruitment activity presented to the workforce committee Divisional oversight of recruitment activity and vacancies discussed at the monthly service review meetings Turnover analysis and exit interview data presented and discussed six monthly at the workforce committee Robust sickness absence management and health and wellbeing offer Agreement to recruit to the onboarding post on a permanent basis established	National staff shortages impacting recruitment	Level 1 – Data and management reports • Divisional oversight of recruitment through Service & Operatonal Review meetings □ Level 2 – Management team and committee scrutiny • Review compliance through WAC People & Culture plan updates□ • F&PP Compliance report to WAC / Board □ Level 3 – External assurances • National staff survey□ • MIAA audit - Role Specific Training July 24 - limited assurance / Divisional Recruitment Nov 24 - limited assurance	Actions outlined by MIAA in Nov 24 Divisional Recruitment audit	Recruitment of onboarding coordinator - agreement to recruit to the onboarding post on a permanent basis now established	Reviewed Q4 24/25

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	5	20	3	3	9	3	3	9	3	3	9			0			0

RISK 4	Changes in quality regulation	Date Risk Opened	Current Risk Score
Description	**If the CQC or other regulatory body changes their approach to regulation there is a risk that we will not be able to demonstrate compliance leading to us being assessed as not meeting the fundamental care standards.**	Apr-24 Date of Last Review Mar-25	**12**
Associated Corporate Objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey. To be an international leader in professional and public cancer education. To maintain excellent operational, quality and financial performance.	Executive Lead Responsible Committee Assurance Level Risk Appetite	Exec Chief Nurse **Board of Directors** Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
Actions	Self assessments underway against 2022 must do actions and well-led quality indicators. Attendance at CQC briefings / NHS Providers briefings	Lack of national understanding of the detail of the new inspection regime	Level 1 – Data and management reports • Self assessment against 2022 Must Do's□ • Self assessment against Well Led quality indicators Level 2 – Management team and committee scrutiny • QAC /WAC review of CQC regulations - all on rolling programmes□ • Board level training on new CQC assessment framework Feb 24 Level 3 – External assurances • GGI review□ • Globis Culture Audit • CQC Inspection Reports (IR(M)ER)	Full review of well-led quality indicators to indentify gaps	Plan in development for full review of well led	Review Q1 25/26

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

RISK 5	Impact of the system capital allocation framework	Date Risk Opened	Current Risk Score
Description	**If the capital planning and allocation system does not enable full use of our charitable and commercial reserves there is a risk that we may not be able to fund our capital and asset replacement programmes leading to delays, cancellations or reprioritising of planned projects and equipment not being replaced when needed.**	Apr-24 Date of Last Review Mar-25	**4**
Associated Corporate Objectives	To promote equality, diversity & sustainability through our system leadership for cancer care	Executive Lead Responsible Committee Assurance Level Risk Appetite	Exec Director of Finance **Board of Directors** Eager

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
Actions	Alternative proposals put forward by GM ICB indicate allocation options linked to existing or nationally calculated depreciation. Participation at local and national level (NHSE / GM ICB) to influence allocation. Development of mitigating financial strategies. Identification & implementation of new models of working. All high capital risks included and delivered in capital plan 24/25	National / local funding rules / arrangements. Cap on CDEL	Level 1 – Data and management reports • Monthly finance reports□ Level 2 – Management team and committee scrutiny • summary of progress with capital plan/strategy implementation at Board / Planning Days□ • Regular reporting to Senior Management Committee & Board of Directors□ Level 3 – External assurances • ICB allocation	None identified	Capital bids collated including level of priority, impact on patient care and activity should the bid not be approved. Manage capital priorities within existing ICB allocation and support the ICB to deliver a compliant capital plan. New models being	Reviewed Q4 24/25 / Within tolerance

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	5	**25**	4	4	**16**	4	4	**16**	4	3	**12**			**0**			**0**

RISK 6	Insufficient contractual support for networked cancer care provision	Date Risk Opened	Current Risk Score
Description	**If the GM system does not continue to support local provision of cancer care with contractual and funding flow changes there is a risk that we are unable to devolve more systemic therapy, clinical trials and radiotherapy treatments to local communities leading to persistence or increases in inequalities in provision to economically deprived and ethnically diverse communities.**	Apr-24 Date of Last Review Mar-25	**9**
Associated Corporate Objectives	To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey. To promote equality, diversity & sustainability through our system leadership for cancer care	Executive Lead Responsible Committee Assurance Level Risk Appetite	Chief Operating Officer **Quality Assurance Committee** Medium Cautious

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
Actions	Participating in GM ICS meetings. Work with GM Cancer Alliance and pathway leads across the system. Exec attendance at system meetings. Working with GM / Cheshire Trusts to develop pathways	GM ICB / Specialised Commissioning decisions on funding	Level 1 – Data and management reports • GM Cancer Board□ Level 2 – Management team and committee scrutiny • Reports to Senior Management Committee & Board of Directors□ Level 3 – External assurances • MIAA review□	GM ICB confirmations of commissioning intentions 25/26	Highlighting financial / operational / risks at provider oversight meetings	Review Q1 25/26

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	3	**12**	3	3	**9**	3	3	**9**	3	3	**9**			**0**			**0**

RISK 7	Ineffective Greater Manchester system-wide cancer pathways	Date Risk Opened	Current Risk Score
Description	**If diagnostic, MDT and referral processes at local hospitals across the GM system are not efficient there is a risk that we receive patients on 62-day pathways late leading to them not being treated within 62 days.**	Apr-24 Date of Last Review Mar-25	**12**
Associated Corporate Objectives	To promote equality, diversity & sustainability through our system leadership for cancer care To maintain excellent operational, quality and financial performance.	Executive Lead Responsible Committee Assurance Level Risk Appetite	Chief Operating Officer **Quality Assurance Committee** Cautious

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
Actions	Executive led monthly divisional performance review meetings. Integrated performance & quality report to Management Board and Board of Directors monthly. Weekl;y performance reporting via trust operational group. Escalation internally & across GM of delays impacting waiting time targets. Monitoring cancer waiting time standards through GM Cancer & IPR.	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	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	5	**25**	4	4	**16**	4	3	**12**	3	4	**12**			**0**			**0**

RISK 8	Extreme weather events	Date Risk Opened	Current Risk Score
Description	**If there is an extreme weather event (heat wave, freeze, floods etc) due to climate change there is a risk of business disruption (increased staff absence, increased patient non-attendance and equipment malfunction) leading to delayed or cancelled care.**	Apr-24 Date of Last Review Mar-25	**8**
Associated Corporate Objectives	To maintain excellent operational, quality and financial performance.	Executive Lead Responsible Committee Assurance Level Risk Appetite	Director of Strategy **Audit Committee** Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
Actions	What we have in place to prevent the risk materialising (reduce likelihood): Sustainable Development Management Plan (SDMP) - with aims to reduce system wide emissions within direct NHS control (NHS Carbon Footprint) by 80% by 2028-2032 What we have in place to reduce the impact of the risk if it materialises (reduce impact): Business Continuity Plan (BCP) - sections on extreme weather conditions	In development - Climate Change Adaptation Plan (CCAP) - adapt normal business processes to changed environment	Level 1 – Data and management reports • SDMP compliance • BCP compliance and effectiveness Level 2 – Management team and committee scrutiny • Quarterly Net Zero and Climate Adaptation Committee (NZACAC) advises Executive Director • Annual SDMP report to MB and BoD (Assurance Scrutiny by Quality Assurance Committee) • Statutory disclosures in Trust Annual Report Level 3 – External assurances • Internal audit of compliance with NHS requirements • NHSE review of plans and progress	None identified	•Developing methodology to assess carbon footprint in collaboration with other Trusts •Developing a CC •Annual Report - Check what audit scrutiny this receives	Reviewed Q3 24/25

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

RISK 10	Financial balance	Date Risk Opened	Current Risk Score
Description	**If we do not achieve the planned activity levels and our target efficiency savings there is a risk that we won't achieve financial balance leading to us having to repay the difference to our agreed plan in the following year**	Apr-24 Date of Last Review Mar-25	5
Associated Corporate Objectives	To maintain excellent operational, quality and financial performance.	Executive Lead Responsible Committee Assurance Level Risk Appetite	Exec Director of Finance **Board of Directors** High Averse

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
	Activity plans agreed with Divisions and progress monitored weekly at TOG and monthly at Senior Management Committee. Variable income performance tracked as part of month end financial position and reviewed in the clinical Divisions monthly financial meetings. Development of mitigating strategies including efficiency and transformational programmes. Identification and consideration of new models of working to deliver and finance the Trust's strategic plan. Trusts VIP programme reviewed by MIAA and all recommendations implemented including developing a VIP SOP, improved governance of VIP schemes and escalating VIP reporting and responsibility to ICPC. VIP delivery at a divisional level monitored via the Trusts Service Operational Review framework October planning session with senior leaders focused on VIP delivery for 24/25 & 25/26. Board has recieved monthly financial report showing performance	Commissioning intentions. Funding growth	Level 1 – Data and management reports • Monthly Divisional scrutiny of financial position□ • Trust Operation Group (TOG) review weekly□ Level 2 – Management team and committee scrutiny • Reports to Senior Management Committee, Audit Committee and Board of Directors□ Level 3 – External assurances • MIAA review of financial systems □ • External audit of Annual Accounts□ • MIAA review of VIP programme	None identified	VIP Programme recommendations implemented	Reviewed Q4 24/25

Scoring	Inherent Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	5	25	5	4	20	3	4	12	3	4	12			0			0

RISK 11	Cyber attack	Date Risk Opened	Current Risk Score
Description	**If we or our suppliers are subjected to a cyber-attack there is a risk of loss of data and operational disruption leading to patient care being delayed or cancelled**	Apr-24 Date of Last Review Mar-25	12
Associated Corporate Objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey. To be an international leader in professional and public cancer education.	Executive Lead Responsible Committee Assurance Level Risk Appetite	Executive Medical Director **Audit Committee** Medium Averse

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
	Data Security and Protection Toolkit submissions with audits undertaken. Digital board reporting. Board level Senior Information Risk Owner in place. Reviews of risk registers, alerts, reports, actions and observations MIAA audit - Data Protection Toolkit (DPST) Q4 23/24	The Trust does not currently have cyber security insurance.	Level 1 – Data and management reports • Regular updates from NHS Digital - Vulnerability Monitoring Service□ Level 2 – Management team and committee scrutiny • Reports to Senior Management Comittee and Audit Committee□ Level 3 – External assurances • Cyber Essentials + accreditation July 2023□ • MIAA Data Protection Toolkit assessment (DPST) - Substantial assurance July 2024	None identified	Review of alerts MFA fully rolled out Explore security insurance options	Reviewed Q4 24/25

Scoring	Inherent Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	5	25	3	4	12	3	4	12	3	4	12			0			0

RISK 12	Ineffective response to cultural audit	Date Risk Opened	Current Risk Score
Description	**If our response to the cultural audit is insufficient there is a risk that a negative culture will persist in some specific parts of our organisation leading to an increase in the number of staff reporting a poor experience.**	Apr-24 Date of Last Review Mar-25	8
Associated Corporate Objectives	To be an excellent place to work and attract the best staff	Executive Lead Responsible Committee Assurance Level Risk Appetite	Director of Workforce **Workforce Assurance Committee** Medium Averse

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
	Plan developed through extensive engagement with staff following production of Globis Culture Audit and approved by Board. Board responsibilities outlined. Work commenced to implement agreed actions and continue to communicate with staff. Advisory Group in place and meetings arranged. Regular reporting to Board. Inclusive Culture work taking forward actions and approach for the Trust.	None identified	Level 1 – Data and management reports • Culture oversight group□ • Divisional action plans from staff survey□ Level 2 – Management team and committee scrutiny • Reporting to Workforce Committee, Workforce Assurance Committee and Board of Directors • Board development session on Inclusive Culture facilitated by NHS Providers expert Sept 2024 • Board approved Inclusive Culture Plan Nov 2024□ Level 3 – External assurances • Globis culture audit□ • Annual CQC Staff Survey 2023 / 2024	None identified	Implemenetation of agreed action plan Cost additional resource requirments Advisory Group meetings to take place and review progress / report	Review Q3 & Q4 24/25

Scoring	Inherent Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	4	16	2	4	8	2	4	8	2	4	8			0			0

RISK 13	Insufficient data on patient protected characteristics	Date Risk Opened	Current Risk Score
Description	**If we are unable to capture data on the protected characteristics of our patients there is a risk we will be unable to assess any inequalities in access, experience or outcomes leading to lack of focus in addressing health inequalities**	Apr-24 Date of Last Review Mar-25	**8**
Associated Corporate Objectives	To be an excellent place to work and attract the best staff	Executive Lead	Exec Medical Director
		Responsible Committee	**Quality Assurance Committee**
		Assurance Level	
		Risk Appetite	Cautious

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
	Collation of existing data into a report for publication on the website. Areas of poor data quality identified and group established to identify actions to improve.	Lack of data from national spine	Level 1 – Data and management reports • published data□ • review by Exec Team monthly□ Level 2 – Management team and committee scrutiny • Integrated Performance report to Senior Management Committee and Board of Directors□ Level 3 – External assurances • Submissions to NHSE • MIAA - Data Quality audit Oct 24 - moderate assurance	Outcomes from planned improvements not yet demonstrated in performance	Reports to be tailored to ensure they accurately reflect our services / patient group	Within tolerance

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	2	**10**	4	2	**8**	4	2	**8**	4	2	**8**			**0**			**0**

RISK 14	Legal and statutory compliance	Date Risk Opened	Current Risk Score
Description	**If we do not maintain an awareness of and respond to changing statutory and legal requirements there is a risk that we will fail to comply leading to being sanctioned for being in regulatory or statutory breach.**	Apr-24 Date of Last Review Mar-25	**12**
Associated Corporate Objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey. To be an international leader in professional and public cancer education. To integrate our clinical, research and educational activities as an internationally recognised and leading comprehensive cancer centre To maintain excellent operational, quality and financial performance.	Executive Lead	Chief Executive Officer
		Responsible Committee	**Audit Committee**
		Assurance Level	High
		Risk Appetite	Averse

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
	Engagement in national updates and regulatory briefings. Designated leads for statutory requirements across the Trust reporting into committee structure. Policies and procedures in place e.g. conflicts of interest, SFI's, Document ratification processes. Membership of NHS Providers to recieve most up to date advice and guidance. Exec Team engagement in national briefings. Close working with regulators, GM ICS / ICB and NHSE. Leads identified internally for each statutatory requirement e.g. health & safety / IRMER / CQC etc	None identified	Level 1 – Data and management reports • Regular reports to Executive Team□ • Monthly IPQFR□ Level 2 – Management team and committee scrutiny • Board self-assessments April 2024□ • Board reporting on regulatory changes□ • Work of the 3 assurance committees Level 3 – External assurances • CQC Inspection Reports (IR(M)ER)□ • SOF Rating 2 • MIAA role specific training audit (CQC Reg 19) - Limited assurance Oct 24□ • MIAA data quality audit Oct 24 - moderate assurance	None identified	Take MIAA checklists / advisory notes to appropriate assurance committees Agreed exit criteria from SOF 2 to SOF 1 agreed and being monitored for compliance to specified timeframes.	Review Q1 25/26

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	4	**20**	4	4	**16**	4	4	**16**	3	4	**12**			**0**			**0**

RISK 15	Patient confidence in services	Date Risk Opened	Current Risk Score
Description	**There is a risk that adverse events will attract media coverage resulting in a decrease in public confidence in our services**	May-24 Date of Last Review Mar-25	**6**
Associated Corporate Objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey. To be an international leader in professional and public cancer education. To integrate our clinical, research and educational activities as an internationally recognised and leading comprehensive cancer centre To be an excellent place to work and attract the best staff	Executive Lead	Chief Executive Officer
		Responsible Committee	**Board of Directors**
		Assurance Level	
		Risk Appetite	Averse

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
	Policies and procedures e.g. management of claims External legal advice where necessary Outcomes of legal cases 2024/25	None identified	Level 1 – Data and management reports • Regular reports to Executive Team□ • Monitoring & reporting of clinical / HR events□ Level 2 – Management team and committee scrutiny • Quality Asurance Committee review of clinical cases • Workforce Assurance Committee review of HR cases Level 3 – External assurances • MIAA audits commissioned to review specific issues where appropriate	None identified	Proactive review and response by the senior responsible person of activities that could result in negative publicity	Reviewed Q4 24/25

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	3	**12**	3	3	**9**	3	3	**9**	3	2	**6**			**0**			**0**

RISK 16	Supply chain	Date Risk Opened	Current Risk Score
Description	**If we can't maintain supply of essential products for the treatment and care of our patients there is a risk that their treatment and care will be adversly impacted or delayed**	Nov-24 Date of Last Review Mar-25	**12**
Associated Corporate Objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer To maintain excellent operational, quality and financial performance.	Executive Lead Responsible Committee Assurance Level Risk Appetite	Chief Operating Officer Audit Committee Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
Actions	Pharmacy - TCP procurement team work closely with regional & national drug procurement teams. Mutual aid MOU in place in NW. Management with clinicians to avoid imapct on care Medical Physics - close relationship with national supply chains and management of demand based on availability of radioactive materials. BCP in place for Radiopharmacy to maintain supplies and regular discussions with supplier of FDG for the PETCT scanner. Procurement - policies & processes in place for management of supplies incl escalations & triggers / communication.	National / international shortages / supply issues	Level 1 – Data and management reports • Regular reports to relevant committee • Monitoring & review by management team Level 2 – Management team and committee scrutiny • Reports to The Christie Pharmacy Company Board and Audit Committee, via Trust Drug & Therapeutics Committee • Esclations from Risk & Quality Governance to Senior Management Committee Level 3 – External assurances • MIAA audits commissioned to review specific issues where appropriate	None identified	Review of alerts	Review Q1 25/26

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	4	**16**			**N/A**			**N/A**	4	3	**12**			**0**			**0**

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Agenda item 11/25c

Meeting of the Board of Directors
Thursday 27th March 2025

Subject / Title	Annual board reporting cycle 2025/26
Author(s)	Louise Westcott, Company Secretary
Presented by	Chief Executive Officer
Summary / purpose of paper	To summarise the Board of Director's month by month strategic and regulatory requirements / priorities for 2024/25
Recommendation(s)	To approve the annual board reporting cycle 2025/26
Background papers	Annual board reporting cycle 2024/25
Risk score	N/A
EDI impact / considerations	N/A
Link to: ➢ Trust strategy ➢ Corporate objectives ➢ CQC Quality standard ➢ Regulation	All corporate objectives NHSEI Code of Governance
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	CoG – council of governors CQC - Care Quality Commission FPPT – fit and proper persons test SO – standing orders SFI – standing financial instructions

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Agenda item 11/25c

Meeting of the Board of Directors

Thursday 27th March 2025

Annual board reporting cycle 2025/26

1. Introduction

The annual board reporting cycle 2025/26 is based on the Intelligent Board format which has been used as the basis for the board reporting cycle since The Christie NHS Foundation Trust was authorised in April 2007.

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

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

2. Recommendation

The board is asked to approve the annual board reporting cycle 2025/26.

The Christie NHS Foundation Trust

Annual board reporting cycle 2025/26

Apr 2025 – Sep 2025

Item	April 2025	May 2025	June 2025	July 2025	Aug 2025	Sept 2025
***Integrated performance report – quality accounts (patient experience, clinical effectiveness and patient safety), strategy, finance, efficiency, workforce, access and targets, research and development and additional reports**	✓	By email	✓	By email	By email	✓
Strategic planning:						
5-year strategy				Planning Day		
Corporate plan and objectives (annual review 2023/24)	✓					
Board Assurance Framework	✓		✓			✓
Finance & investment	✓		✓	By email		✓
Financial plans – revenue and capital	✓ **(subject to receipt of guidance)**					
Regulatory requirements:						
Annual compliance - CQC regulations & key lines of enquiry	Declaration					
Annual reports from audit & governance committees	Draft		Approve			
Annual Governance Statement	Draft		Approve			
Annual report, financial statements and quality accounts	Draft		Approve			
Statement on code of governance	Draft		Approve			
Letter of representation & independence						
FPPT compliance report						
Board development / time out days		Exec development session Set July agenda		Service reviews / Update on 5-year strategy		
Other Items	Registers of approvals Register of sealings Approve SOs and SFIs (after approval by audit) Modern slavery statement		Review Board effectiveness			Approve changes to SFI's

The Christie NHS Foundation Trust

Annual board reporting cycle: Oct 2025 – Mar 2026

Item	October 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	March 2026
***Integrated performance report – quality accounts (patient experience, clinical effectiveness and patient safety), strategy, finance, efficiency, workforce, access and targets, research and development and additional reports**	✓	✓	By email	✓	By email	✓
Strategic and annual items:						
5-year strategy		✓				Reported in corporate objectives
Corporate plan and objectives 2025/26		Interim review				Approve next year's
Board Assurance Framework	✓	✓		✓		Approve next year's
Finance & investment	✓	✓		✓		✓
Financial plans – revenue and capital					Review this year plans Draft plans- revenue & capital (Board time out)	First draft for next year
Regulatory requirements:						
Annual compliance- CQC regulations & key lines of enquiry						
Annual reports from audit & governance committees						
Annual Governance Statement						
Annual report, financial statements and quality accounts						
Statement on code of governance						
Letter of representation & independence / Register of Interests					Directors to sign	
FPPT compliance report					Circulate papers	✓
Board development / time out days	Set joint board / CoG agenda		Approve annual plan		Review revenue & capital plans	
Other Items						Review annual reporting cycle

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Agenda item 11/25d

Meeting of the Board of Directors
Thursday 27th March 2025

Subject / Title	Fit & Proper Person Test Annual Compliance Report 2024/25
Author(s)	Jo D'Arcy, Assistant Company Secretary
Presented by	Louise Westcott, Company Secretary
Summary / purpose of paper	This paper provides an annual update in relation to compliance with the requirements of the NHS England Fit and Proper Persons Test Framework 2023.
Recommendation(s) (**assure** / alert / advise)	It is recommended that: • the Chair signs off that the relevant directors are fit and proper for 2024/25 by the end of March 2025 and that this is recorded in ESR; and • the Annual NHS FPPT submission reporting template is completed and returned to NHSE to reflect compliance.
Background papers / source of assurance	The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 5: Fit and Proper Persons Requirement NHS England Fit and Proper Person Test Framework for board members
Risk score / BAF reference	8 (2/4)
EDI impact / considerations	N/A
Link to: ➢ Trust strategy ➢ Corporate objectives ➢ CQC Quality standard ➢ Regulation	➢ Trust Strategy ➢ Corporate objective 7 – To be an excellent place to work and attract the best staff ➢ NHS England Fit and Proper Persons Test Framework 2023 ➢ CQC Regulation 5
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	FPPT – Fit and Proper Persons Test BMR – Board Member Reference ESR – Electronic Staff Record MIAA – Mersey Internal Audit Agency NHSE – NHS England ICB – Integrated Care Board ALB – Arm's Length Bodies

Meeting of the Board of Directors
Thursday 20th March 2025

Fit & Proper Person Test Annual Compliance Report 2024/25

1. Introduction

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

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

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

2. Fit and Proper Persons Test Framework

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

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

The FPPT Framework brings together:

- the FPPT assessment at recruitment, annual review and at any time that new information relevant to FPPT becomes available
- learning and development offers and a standard set of competencies with minimum levels expected for board members
- appraisal process for board members
- specific reference requirements for board members (the Board Member Reference - BMR)

3. Changes to the Board of Directors during 2024/25

During 2024/25, two non-executive directors have left the Board of Directors and two new non-executive directors have joined the Board of Directors. A new Chief Nurse and Executive Director of Quality has also been appointed. The FFPT requirements have been followed for all posts.

4. Compliance statement

Since the introduction of the F&PPT Framework in August 2023 and our approved F&PPT Policy that aligns to the framework, we have been working to this policy in any subsequent recruitment to the Board of Directors as follows:

- Checklists covering all FPPT framework elements (for both new and existing directors) have been maintained for all relevant files to enable each file to be updated in line with the FPPT requirements. The Company Secretaries Office and the Recruitment and Workforce Information teams work closely to ensure that each requirement is complete for all relevant directors in line with the policy. Hard copy files are in place and maintained in line with the checklists and information shared between the teams to ensure ESR is updated correctly.

- Annual self attestation and board governance forms have been completed and signed by each board member.

- DBS checks (every 3 years) are in date for all board members.

- Annual social media checks have been undertaken for all board members by a specialist external company on our behalf with no issues identified.

- the Leadership Competency Framework has been incorporated into annual appraisals for board members.

The teams are satisfied that the appropriate checks have been undertaken and recorded. No concerns around the fit and proper test requirements have arisen from the checks undertaken for any of the board members.

The checks conclude that all board members have been appropriately tested and that they are all fit and proper. The dashboard at appendix 1 shows the fields that have been checked for each director in ESR and the status against each field.

5. Recommendation

Based on the work undertaken and the evidence contained in both the hard copy files and ESR as demonstrated by the dashboard at appendix 1, it is recommended that:

- the Chair signs off that the relevant directors are fit and proper for 2024/25 by the end of March 2025 and that this is recorded in ESR; and

- the Annual NHS FPPT submission reporting template is completed and returned to NHSE to reflect compliance.

Appendix 1 – ESR fit & proper persons dashboard

Last Name	First Name	Job role	Employment History	Date of Qualifications Check	References Check Date	Annual Performance Appraisal Complete	Open/Upheld Disciplinary Case	Open/Upheld Grievance Case	Social Media Date Checked	Not Disqualified as a Charitable Trustee	Not Disqualified from Directors Register	No Employment Tribunal Judgements Found	DBS Requirements	Date of Medical Clearance	Not Found on Insolvency Register	Date Prof Reg Check	Self Attestation
Astle	Edward	Chairman	17/10/2023	N/A	15/06/2023	15/05/2024			18/01/2024	20/09/2023	15/08/2024	15/08/2024	Checked	21/08/2023	20/09/2023	N/A	03/07/2023
Bayman	Neil	Executive Medical Director	06/12/2023	09/09/2021	24/02/2009	20/03/2024			12/01/2024	20/09/2023	15/08/2024	15/08/2024	Checked	18/02/2009	20/09/2023	01/10/2021	04/04/2023
Blackhall	Fiona	Director of Research	06/03/2024	01/06/2021	06/03/2024	29/04/2024			12/01/2024	20/09/2023	15/08/2024	15/08/2024	Checked	13/01/2025	20/09/2023	01/10/2023	10/05/2023
Corcoran	Sarah	Non-Executive Director	01/06/2024	N/A	20/05/2024	Not yet due - planned			22/03/2024	22/03/2024	15/08/2024	15/08/2024	Checked	26/04/2024	22/03/2024	N/A	03/07/2024
Dudley-Southern	Roy	Non-Executive Director	01/09/2024	N/A	29/08/2024	Not yet due - planned			20/03/2024	20/03/2024	15/08/2024	15/08/2024	Checked	28/08/2024	20/03/2024	N/A	17/07/2024
Goddard-Fuller	Rikki	Director of Education	06/12/2023	01/10/2021	01/09/2021	28/08/2024			19/01/2024	20/09/2023	15/08/2024	15/08/2024	Checked	10/09/2021	20/09/2023	01/10/2021	20/04/2023
Harrison	Christopher	Deputy CEO and Executive Director	06/03/2024	14/03/2016	15/03/2016	19/02/2025			18/01/2024	20/09/2023	15/08/2024	15/08/2024	Checked	04/02/2016	20/09/2023	10/03/2016	03/04/2023
Kapur	Tarun	Non-Executive Director	16/10/2023	N/A	28/04/2016	09/05/2024			02/02/2024	20/09/2023	15/08/2024	15/08/2024	Checked	16/06/2016	20/09/2023	N/A	21/04/2023
Lightfoot	Eve	Director of Workforce	06/12/2023	01/09/2008	09/09/2008	18/02/2025			15/01/2024	20/09/2023	15/08/2024	15/08/2024	Checked	01/09/2008	20/09/2023	N/A	03/04/2023
Malik	Alveena	Non-Executive Director	17/10/2023	N/A	03/08/2021	14/05/2024			14/03/2024	20/09/2023	15/08/2024	15/08/2024	Checked	23/09/2021	20/09/2023	N/A	10/05/2023
Mcpeake	Claire	Chief Operating Officer	14/12/2010	19/10/2010	14/12/2010	19/02/2025			12/02/2024	22/01/2024	15/08/2024	15/08/2024	Checked	01/11/2010	22/01/2024	19/10/2010	24/01/2024
Page	Grenville	Non-Executive Director	17/10/2023	N/A	03/08/2021	18/04/2024			24/01/2024	20/09/2023	15/08/2024	15/08/2024	Checked	24/08/2021	20/09/2023	N/A	05/04/2023
Parkinson	Sally	Executive Director of Finance & Business Development	02/12/2019	12/07/2023	02/12/2019	03/02/2025			18/01/2024	20/09/2023	15/08/2024	15/08/2024	Checked	25/11/2019	20/09/2023	N/A	03/04/2023
Sharples	Victoria	Chief Nurse and Executive Director of Quality	20/01/2022	23/02/2024	20/01/2022	Not yet due - planned			18/03/2024	18/03/2024	15/08/2024	15/08/2024	Checked	27/02/2024	18/03/2024	14/02/2024	12/03/2024
Spencer	Roger	Chief Executive Officer	06/12/2023	24/03/2015	06/12/2023	29/05/2024			12/01/2024	20/09/2023	15/08/2024	15/08/2024	Checked	09/11/2011	20/09/2023	09/07/2008	03/04/2023
Tait	Diana	Non-Executive Director	06/03/2024	19/12/2023	22/01/2024	22/05/2024			16/01/2024	22/11/2023	15/08/2024	15/08/2024	Checked	12/12/2023	22/11/2023	N/A	29/02/2024
Thornber	Thomas	Director of Strategy	06/12/2023	18/06/2009	23/06/2009	03/02/2025			12/08/2024	05/10/2023	15/08/2024	15/08/2024	Checked	30/06/2009	05/10/2023	N/A	18/07/2024
Wareing	John	Director of Strategy	15/03/2023	20/12/2022	15/03/2023	22/11/2024			01/03/2024	20/09/2023	15/08/2024	15/08/2024	Checked	22/09/2022	20/09/2023	N/A	03/04/2023

The Christie NHS Foundation Trust

EXECUTIVE SUMMARY

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

Safety

- 4 incidents in February were identified as meeting the criteria of a notifiable safety incident and so required statutory duty of candour.
- There are 4 Trust level risks scored at 15+. Details of these can be found on slide 8.
- Safer staffing numbers have met the required acuity levels to ensure appropriate levels of safety and care for our patients. Indicative staffing, in line with nursing establishments, is set to maintain a 1:7 nurse to patient ratio. On occasion this has been extended to 1:8 which is in line with recommended national staffing ratios. While we have seen an increase in patient safety incidents, following thematic review, these were not related to nurse staffing ratios.
- There was one case of MRSA, 4 cases of C-Difficile, 3 cases of E-Coli, 1 case of Klebsiella and 1 case of MSSA reported in February that were deemed attributable to the Trust. No lapses in care were identified.

Performance

- In February the combined 62-day performance subject to validation was at 72.1% which is above the standard of 70%. The combined 31-day performance was 98.4% which is above the standard of 96%. The internal 24-day performance was below our internal standard at 71.5%. All 62 and 24-day breaches are reviewed to ensure any delays are understood and plans can be implemented to mitigate any future delays. The Trust's RTT 18-week performance is well above standard at 98.1%. The Trust achieved the 75% faster diagnosis standard in February with a compliance score of 77.8%.
- There were no patients waiting over 52 weeks at the end of February.
- Referral numbers in February reduced from a high point in January but remained on average for the financial year. Referrals cumulatively remain well above the 23/24 average.

HR

- Staff absence decreased from January to a position of 4.46% against a target of 3.4%.
- PDR performance improved from January's position. Mandatory training remained at the same level and remains well above the set standard.

Finance

- The Trust is reporting a surplus at the end of M11 of (£11.4m) against a M11 YTD plan of (£6.5m), which gives a month 11 variance of (£4.9m) better than plan.
- Capital performance to month 11 was (£2.1m) below the revised plan submitted to NHSE&I in June 24. The Trust has spent 85% year to date of the capital plan.
- Capital spend to month 11 was (£2.1m) below the revised plan submitted to NHSE&I in June 24. This is lower than the plan position due to timing in the anticipated completion of the first linear accelerator.
- The Trust has incurred £12.1m on capital schemes to month 11, primarily on the TIF ward refurbishment as well as ongoing digital projects and small replacement assets. The Trust has spent 85% year to date of the capital plan.

SUMMARY DASHBOARD

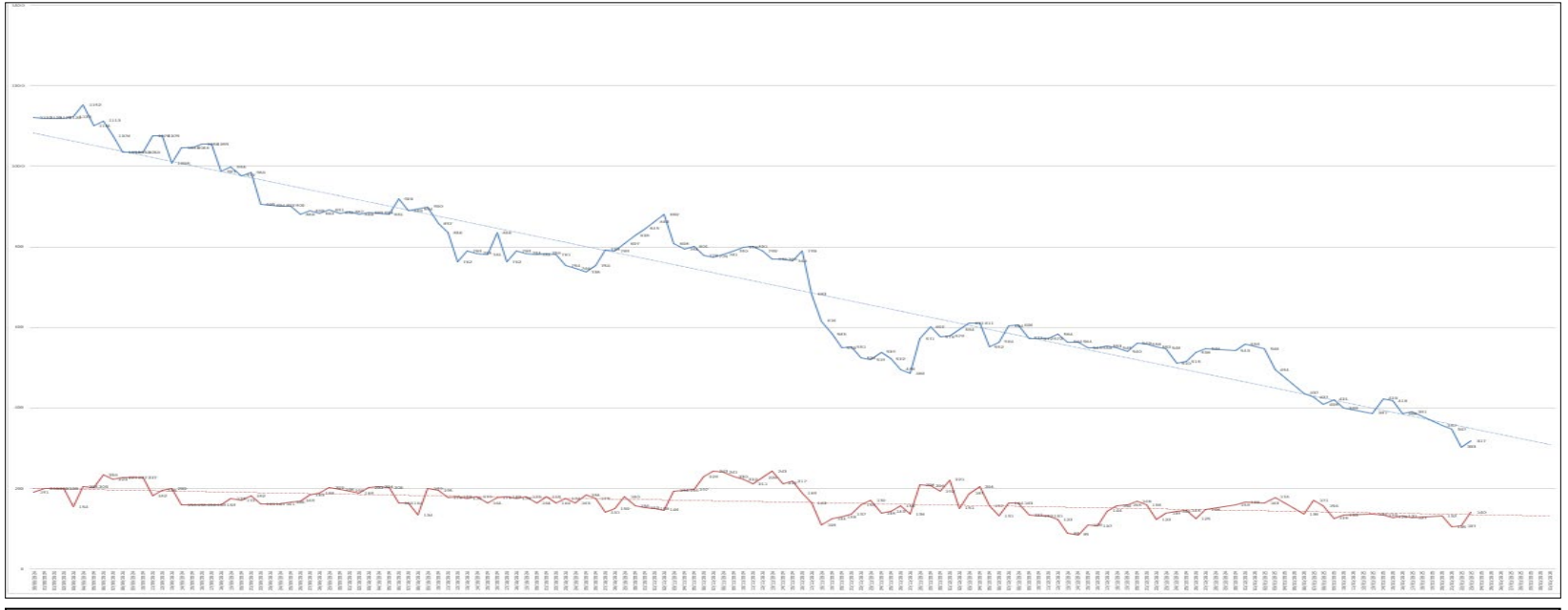
NHS
The Christie
NHS Foundation Trust

Indicator	Threshold / Standard 24/25	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	YTD
Patient Safety Incident Investigations	-	1	2	1	0	0	3	1	0	2	1	4	15
Never Events	0	0	0	0	0	0	1	0	0	0	0	0	1
Radiation Incidents Reported (IRMER Reportable)	0	1	3	1	3	1	2	2	3	1	3	2	22
Radiation Incidents Reported (IRMER Reportable - Grade 2 or above)	0	0	0	0	0	0	0	0	0	0	0	0	0
Sepsis - timely treatment with IV antibiotics (established inpatients)	90%	90.0%	87.0%	96.4%	94.4%	92.4%	91.4%	93.0%	94.2%	95.8%	93.8%	95.2%	-
Sepsis - screening (presenting as an emergency)	90%	94.9%	100.0%	100.0%	97.5%	96.9%	98.1%	97.4%	97.4%	99.2%	99.2%	98.2%	-
Number of Trust-Wide Risks Grade 15 or Above	-	6	6	9	13	8	8	8	6	4	3	4	-
28 Day Faster Diagnosis Standard	75%	81.3%	75.0%	100.0%	91.7%	86.4%	90.0%	81.3%	89.5%	88.9%	83.3%	77.8%	-
62 Day Compliance	70%	71.2%	72.3%	73.1%	76.7%	79.9%	75.1%	81.3%	76.8%	75.8%	71.2%	72.1%	-
24 Day Compliance	85%	71.5%	72.5%	74.9%	78.2%	78.8%	73.1%	77.5%	75.0%	76.6%	71.1%	71.5%	-
31 Day Compliance	96%	99.2%	99.6%	99.3%	99.2%	99.3%	98.8%	98.6%	98.0%	99.1%	98.8%	98.4%	-
18 Weeks Compliance - Incomplete Pathways	92%	97.1%	97.6%	97.1%	97.2%	97.1%	96.8%	95.9%	97.4%	97.6%	97.4%	98.1%	-
Patients waiting >52 Weeks	0	0	0	0	0	0	0	0	0	0	0	0	0
Patients waiting >62 days at end of month (62 Day Classic)	80	129	119	100	95	93	101	108	105	101	112	110	-
Patients waiting >104 days at end of month (All 62 Day Targets)	-	47	51	42	49	49	42	43	50	57	61	61	-
Length Of Stay (Elective & Non-Elective Inpatients)	-	7.81	6.39	6.39	7.16	6.54	6.76	7.29	6.65	7.12	6.9	6.36	-
Patients Discharged Beyond Ready for Discharge Date	-	14	2	7	18	13	6	14	13	6	10	7	110
Patients Discharged Beyond Ready for Discharge Date - Total Bed Days Lost (days counted in the month of discharge)	-	213	15	90	296	97	33	108	91	133	183	32	1291
Patients Discharged Beyond Ready for Discharge Date - Average Bed Days Lost (days counted in the month of discharge)	-	15.2	7.5	12.9	16.4	7.5	5.5	7.7	7.0	22.2	18.3	4.6	-
Hospital Cancelled Operations on the day for non clinical reasons	0	3	2	0	0	2	2	14	3	2	2	0	30
Hospital Cancelled Operations on the day for non clinical reasons - NOT rebooked within 28 days	0	0	0	0	0	0	0	1	0	0	0	0	0
Complaints Received	12 (23/24 Avg)	12	14	8	21	10	17	15	12	14	15	10	148
PALS Contacts	35 (23/24 Avg)	32	67	39	37	44	29	42	22	26	43	35	416
MRSA	0	0	2	0	0	0	0	0	0	0	0	1	3
C-Difficile - All Attributable Cases (Pre & Post 48 Hours)	<52	2	3	4	6	5	4	7	3	3	6	4	47
C-Difficile - Attributable Cases Due To Lapse In Care	0	0	0	0	0	0	0	0	0	0	0	0	0
MSSA Bacteraemia - Attributable	No Target	1	2	3	1	0	2	1	2	3	1	1	17
E-Coli - Attributable	<57	6	4	4	1	4	5	5	4	2	2	3	40
Klebsiella Species - Attributable	<25	1	2	2	1	2	5	2	3	1	4	1	24
Pseudomonas Aeuriginosa - Attributable	<8	2	0	0	1	1	2	2	1	1	0	2	12
Staff Sickness	3.4%	4.57%	4.39%	4.47%	4.80%	4.48%	4.61%	5.03%	4.93%	5.08%	4.96%	4.46%	-
Staff Mandatory Training	>80%** <80%	92.7%	92.7%	93.2%	93.7%	93.8%	93.7%	93.7%	93.6%	94.0%	93.9%	93.9%	-
Staff PDRs	-	84.6%	85.7%	85.3%	86.6%	88.0%	87.2%	87.1%	87.3%	87.5%	87.2%	88.5%	-

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

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

Incident Management



At the time of reporting, 43% of incidents were managed locally within 10 calendar days. The trust target for in time locally managed incidents is to above 80% by the end of Q4.

Divisions continue to hold divisional patient safety improvement groups (DPSIG) meetings on a weekly basis which provide oversight on a divisional level of all incidents, emerging themes and potential risks to patient safety. The DPSIG process is supported by the patient safety team via the PSIRF delivery group.

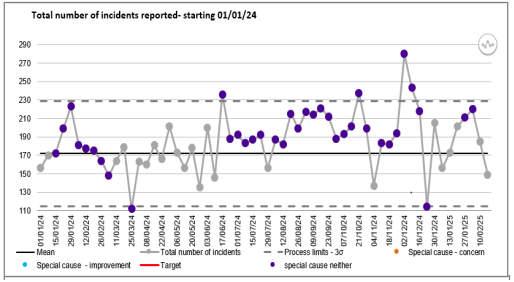
Dashboards have been developed for each division to show live incident management progress that can be utilised to highlight areas that require further support/ education.

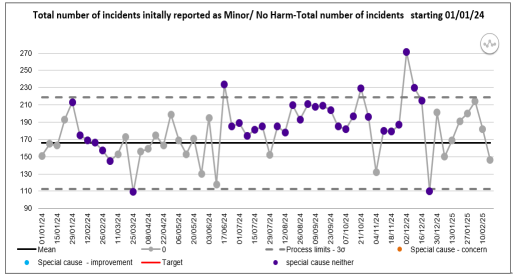
Incident Reporting

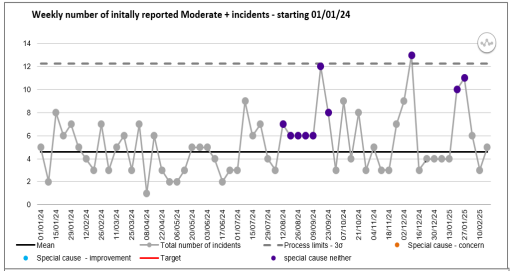
A total of 627 incidents were reported to DCIQ in February 2025.

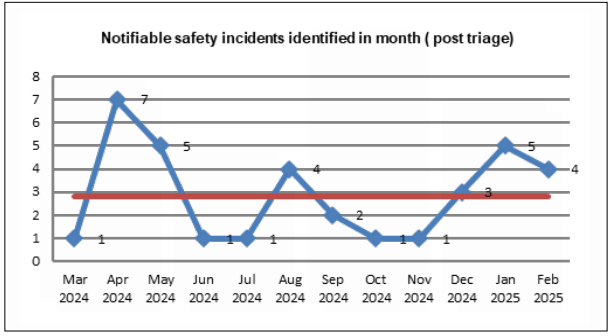
- 82.5% of incidents reported (517/627) were classed as 'Incidents affecting a patient' and therefore reported to LFPSE (Learning from Patient Safety Events).
- 4 incidents in February were identified as meeting the criteria of a notifiable safety incident and so required statutory duty of candour.

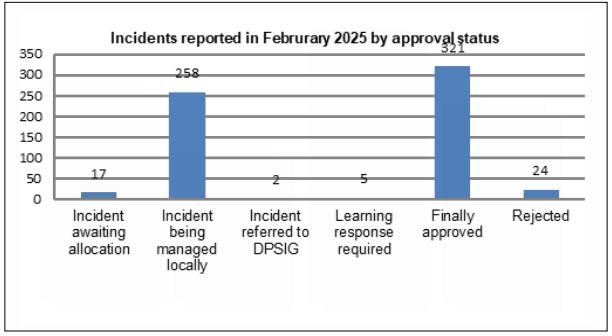
At the time of reporting, 52% of incidents have been finally approved. 4% of incidents have been rejected for reasons such as duplication and incidents which involve care provided by an external trust. Reporting trends in February were in line with trust expected limits.



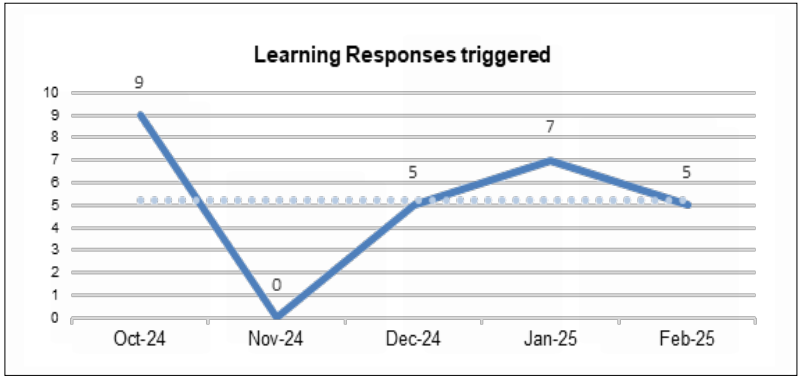






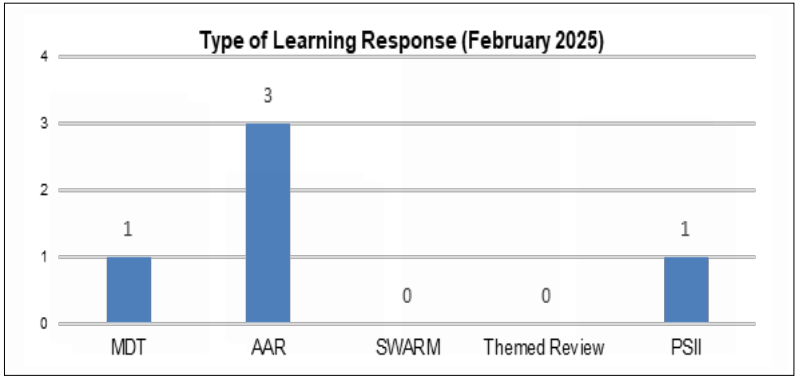


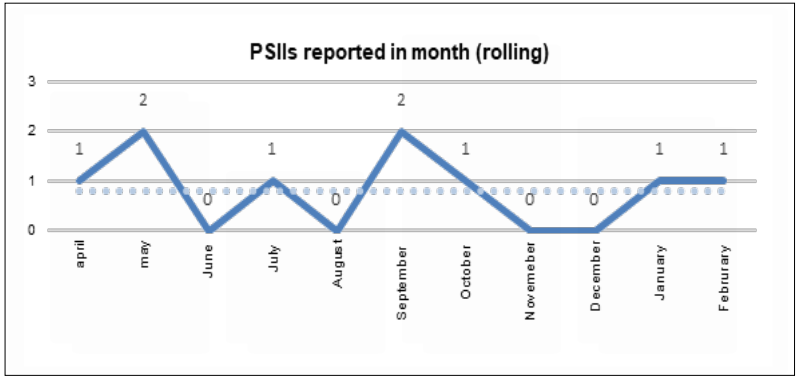
Incidents identified that require a Learning Response



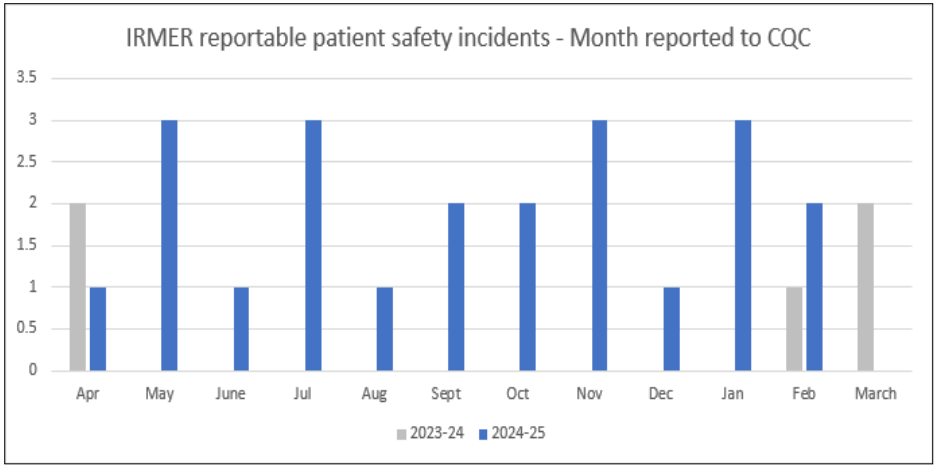
- Learning responses are triggered when an opportunity for new learning is identified. Learning responses are not triggered based on harm and do not stipulate whether statutory duty of candour is commenced
- 5 learning responses were triggered both locally and via the divisional PSIGs in February 2025.

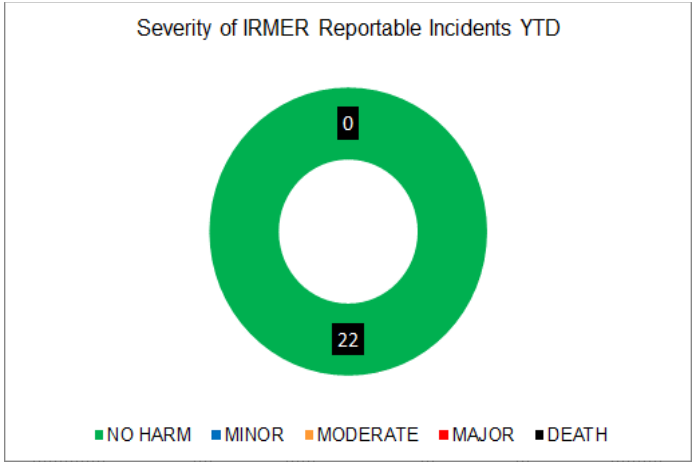
- Patient Safety Incident Investigations (PSII) are triggered when there is a significant opportunity for learning and improvement. PSIIs are extensive investigations which result in specific outcomes recommended by trained investigator.
- 1 PSII was reported in February 2025:
  - **9664** – Care of the dying patient





Radiation Incidents





There were two IRMER reportable incident reported in February 2025:
9227– no harm
9486– no harm

Operational Risks

NHS
The Christie
NHS Foundation Trust

There are 4 Trust-wide 15+ risks in February

Description	Score	Controls
Not Identifying and Delivering 25/26 Recurrent VIP programme impacting on financial sustainability and ability to treat patients	**16**	Complete best practice checklist for outpatients, theatres and inpatients to seek opportunities and demonstrate efficiency
Operational and patient safety and experience risk in relation to recruitment of medical and admin workforce for Christie haematology at Leighton.	**16**	Finalise written plan for on the ground admin support at Leighton hospital for booking of appointments, outcoming and adding of referrals and transfer of appointment on to Christie system). Plan to cover period until substantive staff recruited and trained.
There is a risk of a patient inadvertently receiving an unintended blood component or product	**15**	Draft business case to propose the purchase of an electronic tracking system that prevents the incorrect blood from being released from the fridge, requires barcode scanning at every stage of the process (Issuing in the lab, collection, receiving and bedside administration) and finally scans the blood against the patient's identity band at the bedside.
There is a risk to the safe and effective delivery of the Trust's Aseptic service	**15** **New Risk**	Due to the audit being reported as high risk, monthly meetings will be held to ensure progress against the action plan. This is currently being managed as L1, lowest, with the aim to exit this after 3 months. First meeting held on 25/02/2025.

Safe Staffing

NHS
The Christie
NHS Foundation Trust

		DAY	NIGHT	Cumulative count over the month of patients at 23:59 each day	CHPPD (Care Hours Per Patient Per Day)
		Hours	Hours		
Registered Nurses	Total monthly PLANNED	15005	11691	4538	5.7
	Total monthly ACTUAL	14375	11582		
	Average Fill Rate %	95.8%	99.1%		
Care Staff	Total monthly PLANNED	9456	5983	4538	3.1
	Total monthly ACTUAL	8222	5882		
	Average Fill Rate %	87.0%	98.3%		
ALL Staff	Total monthly PLANNED	24461	17674	4538	8.8
	Total monthly ACTUAL	22597	17464		
	Average Fill Rate %	92.4%	98.8%		

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	1984	1825	92.0%	1840	1552	84.3%	124	27.2
Palatine Ward	2943	2540	86.3%	2291	2052	89.6%	830	5.5
Ward 10	2052	1700	82.8%	1417	1382	97.5%	692	4.5
Ward 11	1685	1824	108.2%	1395	1426	102.2%	760	4.3
Ward 12	1698	1895	111.6%	1349	1465	108.6%	549	6.1
Ward 4	1641	1623	98.9%	1266	1267	100.1%	703	4.1
Ward 2	945	1110	117.5%	510	858	168.2%	416	4.7
Acute Assessment Unit	2057	1858	90.3%	1623	1580	97.4%	464	7.4
TOTAL	15005	14375	95.8%	11691	11582	99.1%	4538	5.7

Registered Nursing Associates	DAY			NIGHT		
	Hours Planned	Hours Actual		Hours Planned	Hours Actual	
Critical Care Unit						
Palatine Ward						
Ward 10						
Ward 11		16				
Ward 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	310	260	83.9%	0	0	100.0%	124	2.1
Palatine Ward	1224	1078	88.1%	1019	966	94.8%	830	2.5
Ward 10	1673	1179	70.5%	791	742	93.8%	692	2.8
Ward 11	1434	1295	90.3%	970	1077	111.0%	760	3.1
Ward 12	1635	1576	96.4%	1092	1023	93.7%	549	4.7
Ward 4	1628	1417	87.0%	1184	1171	98.9%	703	3.7
Ward 2	534	543	101.7%	276	363	131.5%	416	2.2
Acute Assessment Unit	1018	874	85.9%	651	540	82.9%	464	3.0
TOTAL	9456	8222	87.0%	5991	5882	98.3%	4538	3.1

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

Patient Experience

NHS
The Christie
NHS Foundation Trust

Positive feedback received…..

"I would like to thank you for your extraordinary efforts, expertise, time and patience in answering our questions. Last week I received the amazing news that I was declared NED. You have not only put me back on my feet but also brought hope to me and my family. I would also like to thank your brilliant team for their exceptional care, professionalism and commitment. I can't thank you all enough for everything you have done for me."

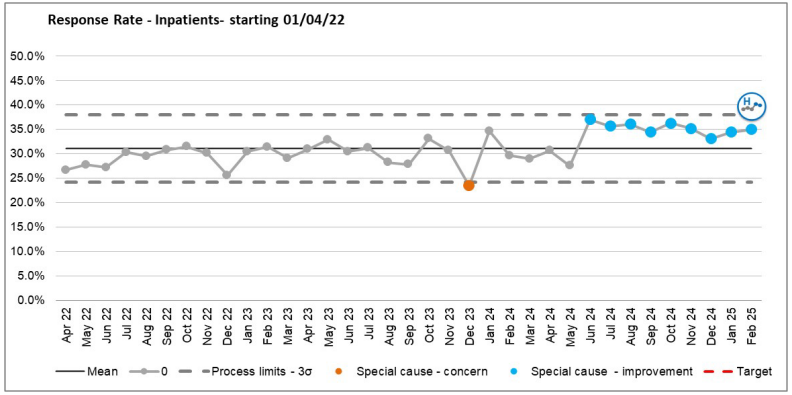
"Patient relative thanking The Christie for the care provide to patient and in particular care from ward 14, where the patient felt safe, the care and compassion provided was beyond brilliant and the family could not have asked for more (the patient died peacefully on ward 14). The family have taken a lot of positives from their experience at the Christie and hold it even in higher esteem, it is a special place and that is largely due to the special people who looked at the patient so well."

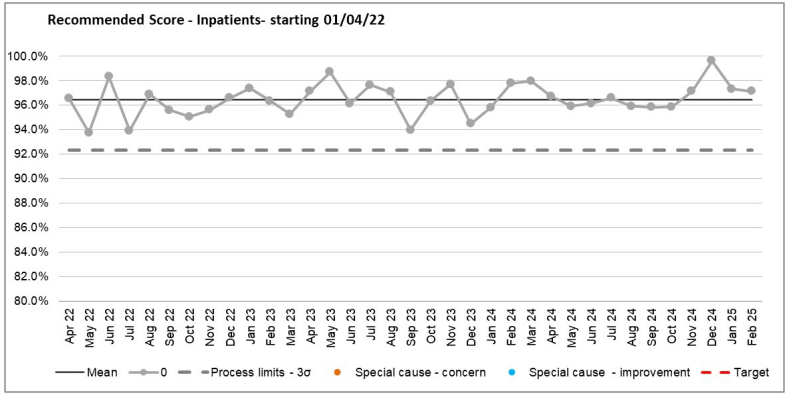
"I would like to express my gratitude to Mr Ramani, who treated my husband for prostrate cancer last year. He has been amazing from our first meeting, he was very professional and informative. He was very kind and fully listened to us and explained everything in detail and checked our understanding. I can't emphasis enough, how we felt we were in safe hands. We will be forever grateful to his surgical skills and the care we received."

Friends & Family Test

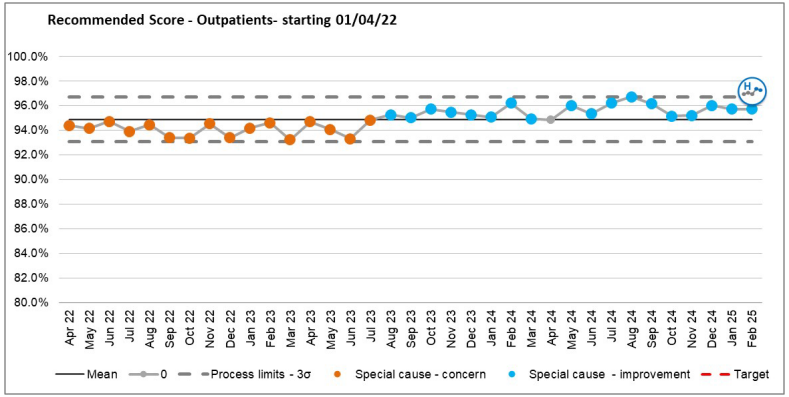
The Christie NHS Foundation Trust

Monthly Summary



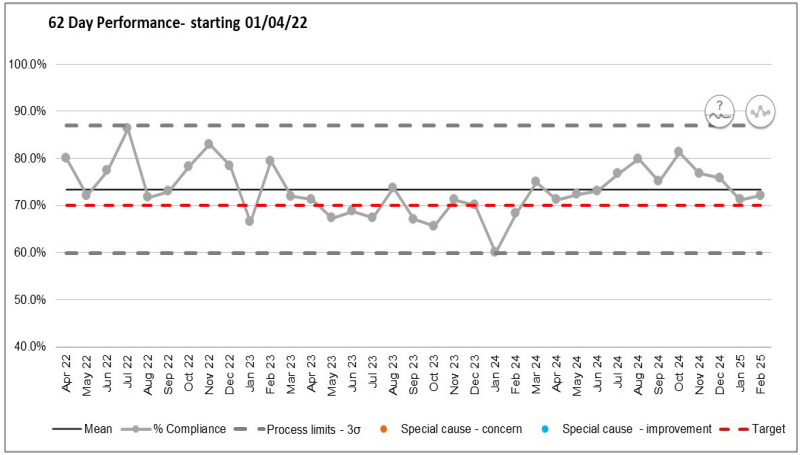


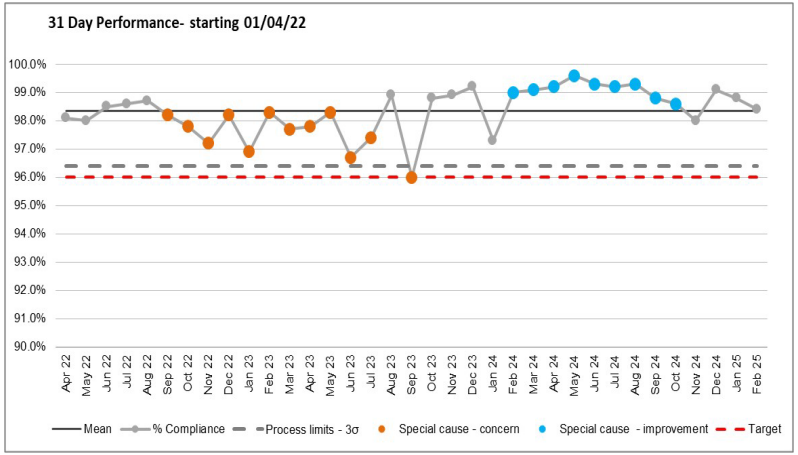
The Inpatient response rate continues to show improvement in recent months. Both the recommended percentage scores for Outpatients and Inpatients remain high with Outpatients maintaining a sustained period of high performance.



Cancer Standards

The Christie NHS Foundation Trust





National Standard	Standard	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
62 Day	70%	68.3%	74.9%	71.2%	72.3%	73.1%	76.7%	79.9%	75.1%	81.3%	76.8%	75.8%	71.2%	**72.1%**
28 Day FDS	75%	60.0%	55.0%	81.3%	75.0%	100.0%	91.7%	86.4%	90.0%	81.3%	89.5%	88.9%	83.3%	**77.8%**
24 Day Internal	85%	71.7%	76.4%	71.5%	72.5%	74.9%	78.2%	78.8%	73.1%	77.5%	75.0%	76.6%	71.1%	**71.5%**
31 Days	96%	99.0%	99.1%	99.2%	99.6%	99.3%	99.2%	99.3%	98.8%	98.6%	98.0%	99.1%	98.8%	**98.4%**
18 Weeks - Incomplete	92%	98.0%	98.0%	97.1%	97.6%	97.1%	97.2%	97.1%	96.8%	99.6%	97.4%	97.6%	97.4%	**98.1%**

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

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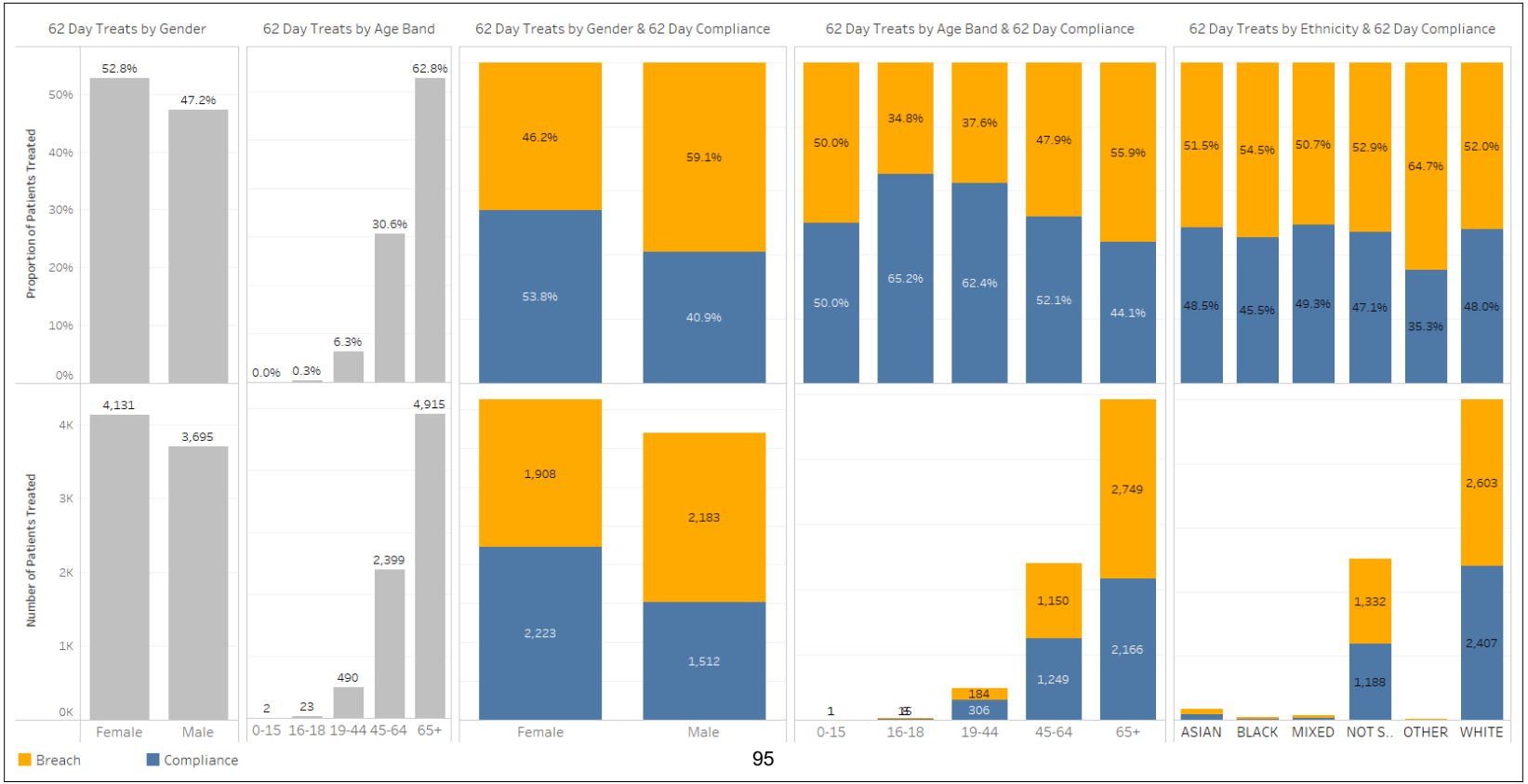
Cancer Standards – Health Inequalities Analysis

62 Day Treatments between 01/04/2023 – 28/02/2025 analysed by gender, age and ethnicity.

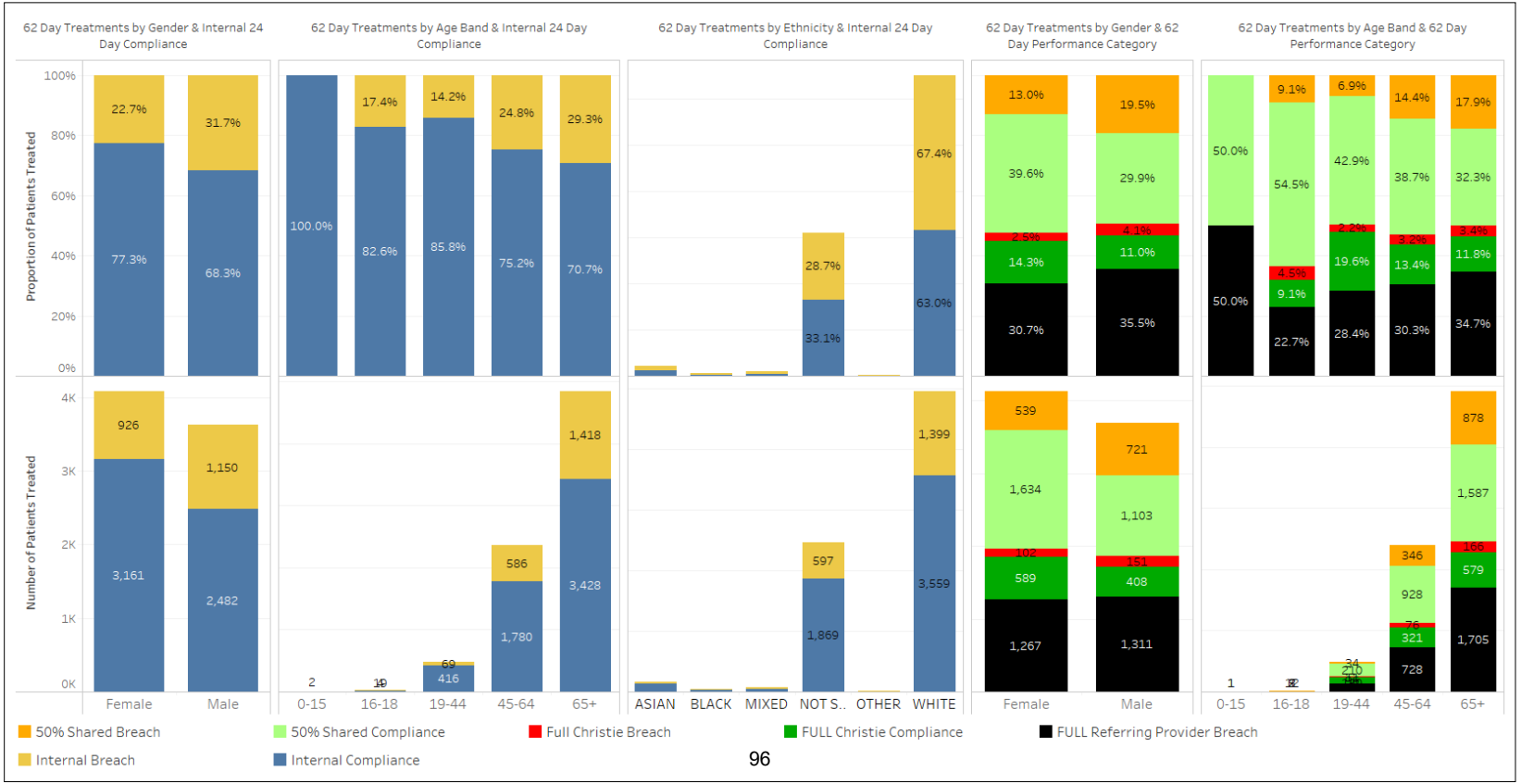
NHS
The Christie
NHS Foundation Trust



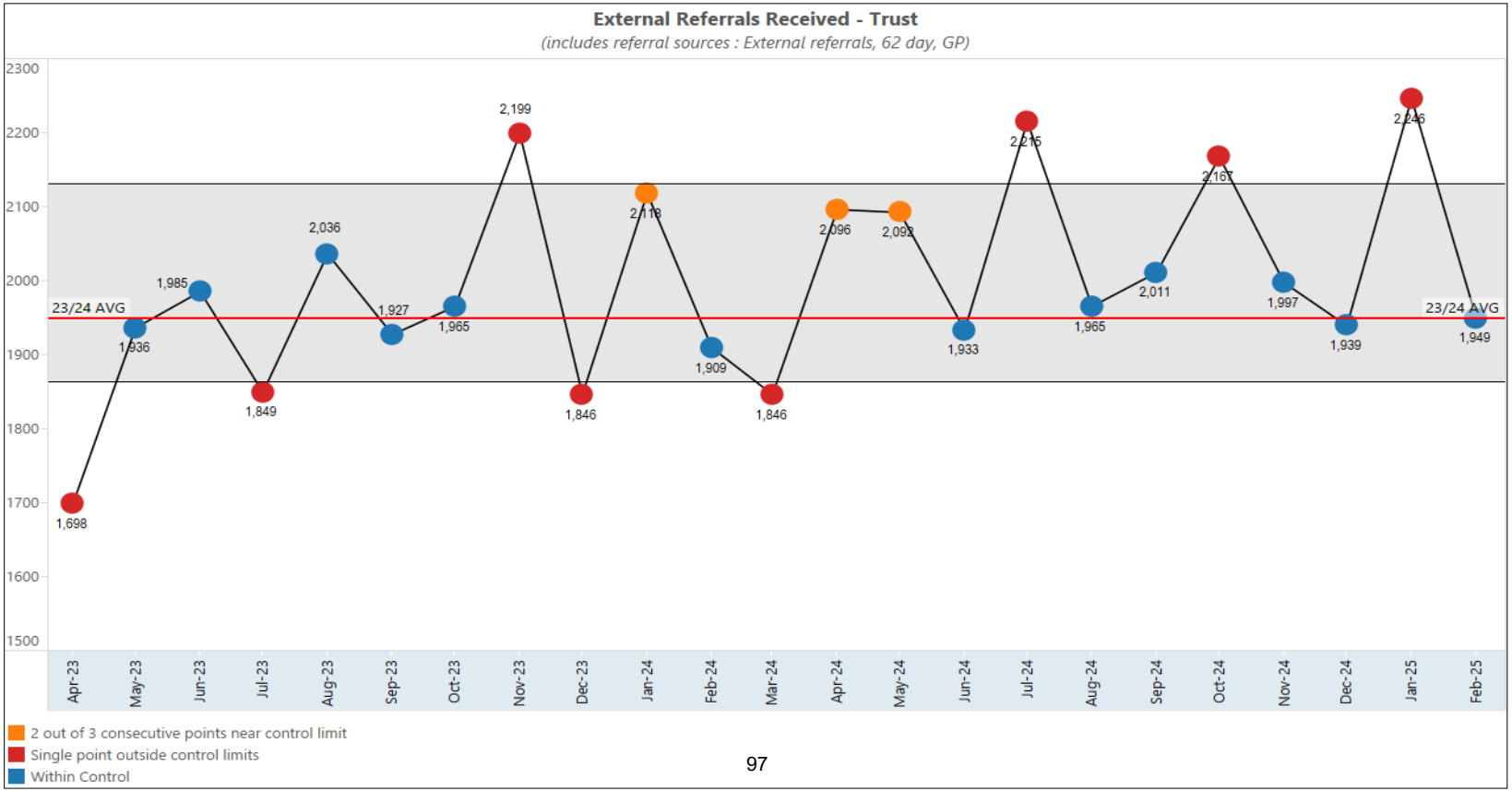
Cancer Standards – Health Inequalities Analysis

62 Day Treatments between 01/04/2023 – 28/02/2025 analysed by gender, age and ethnicity.

The Christie NHS Foundation Trust

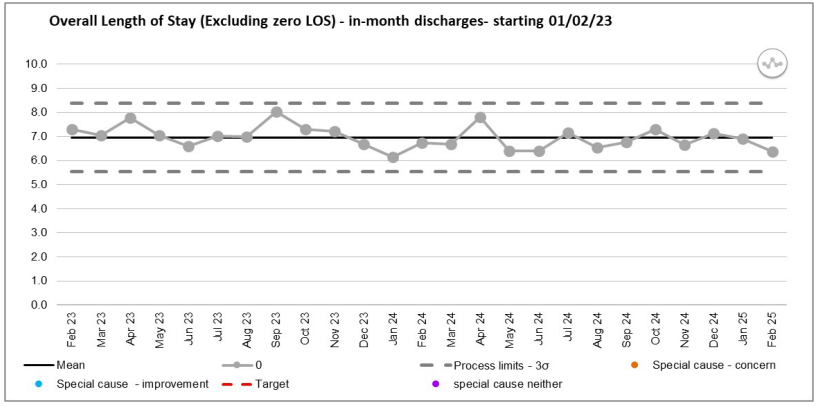


Referrals Analysis

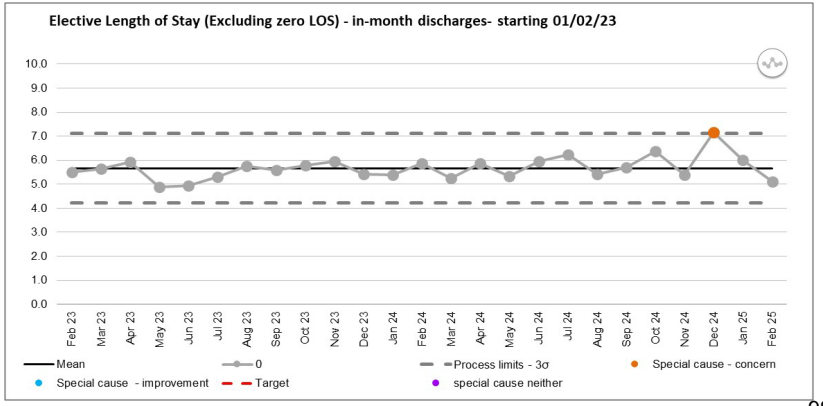


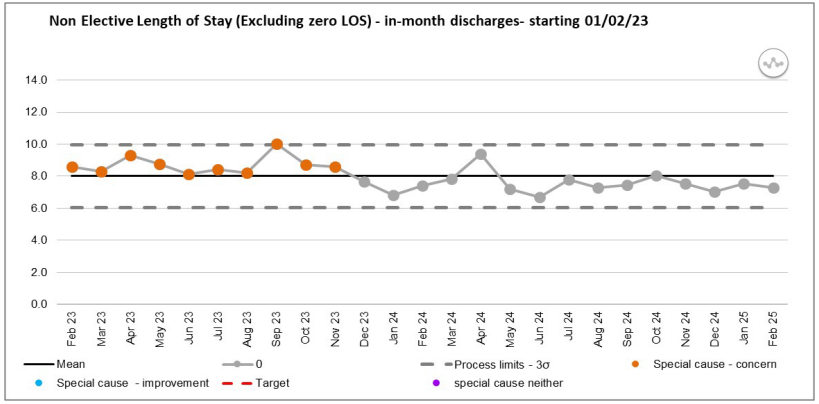
97

Length of Stay



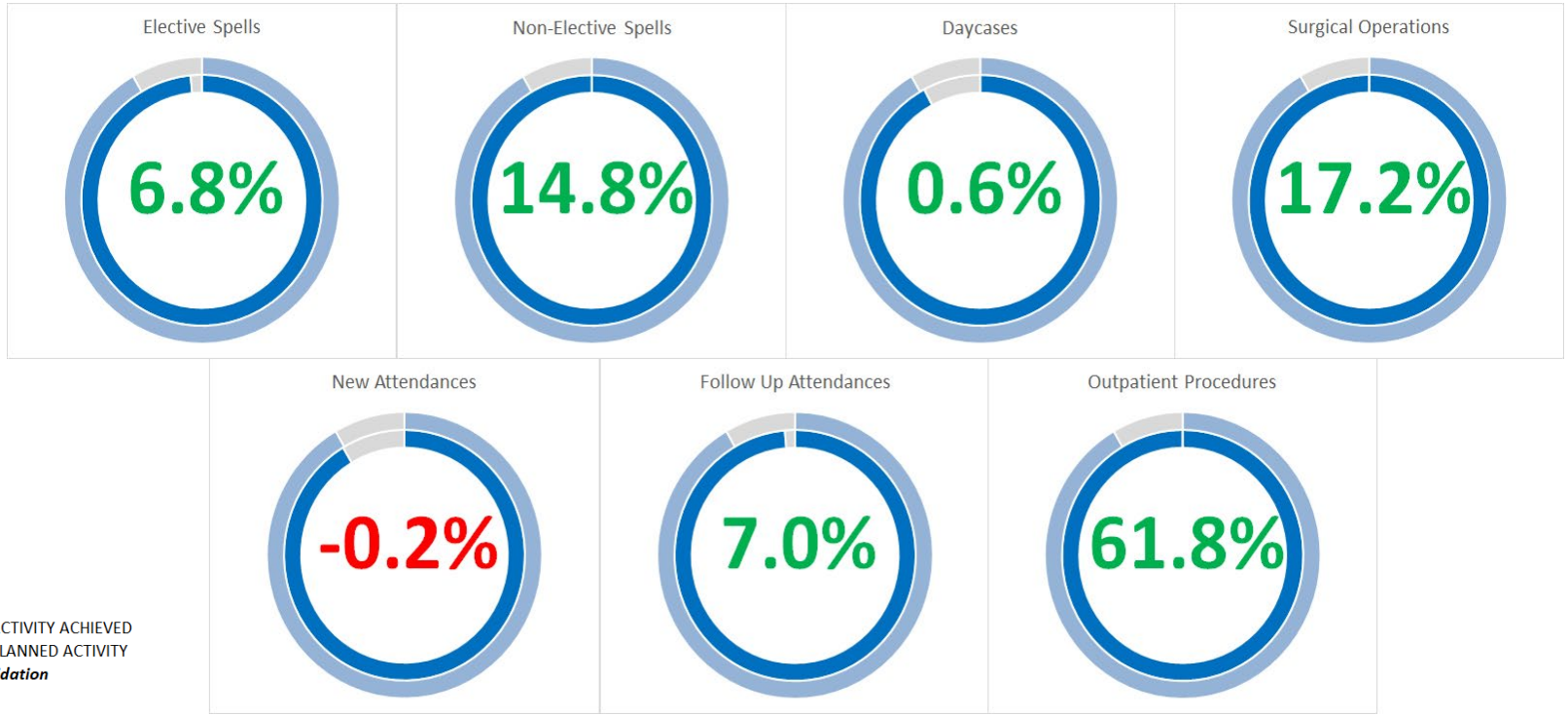
Overall length of stay, elective and non-elective spells continue to be well within control limits.





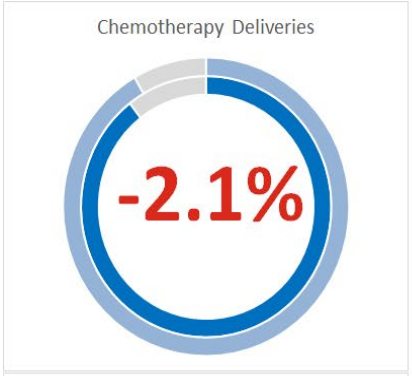
Activity – YTD Progress

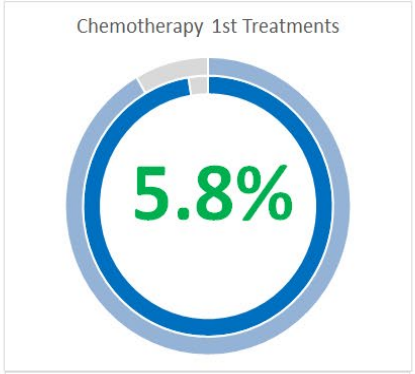
Trust level activity - progress against YTD plan

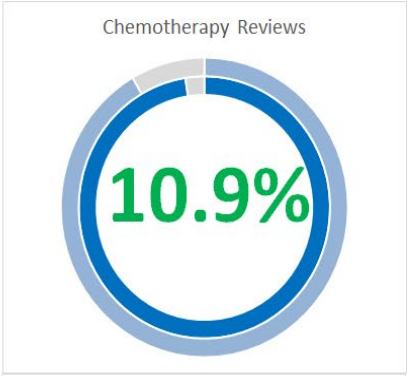


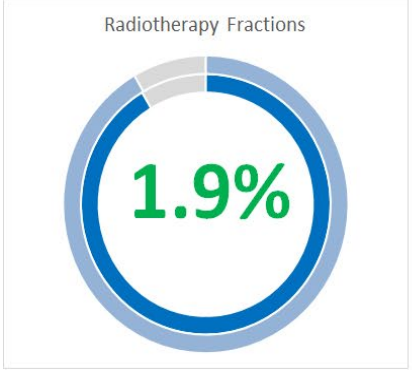
Activity – YTD Progress

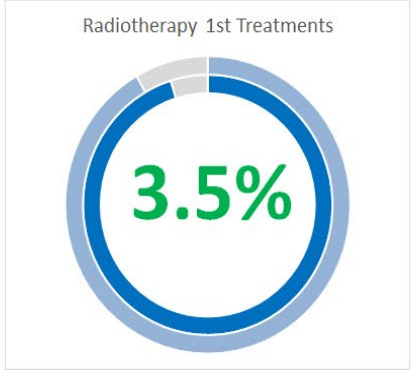
The Christie NHS Foundation Trust

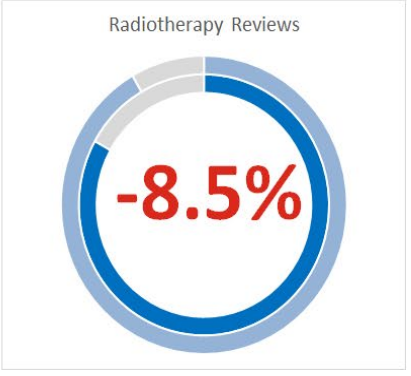












SACT 1st Treatments, 1st Fractions & Surgical Operations do not form part of the 24/25 activity plan and are used as supplementary guides to productivity. The figures are monitored against the previous year's month for comparison.

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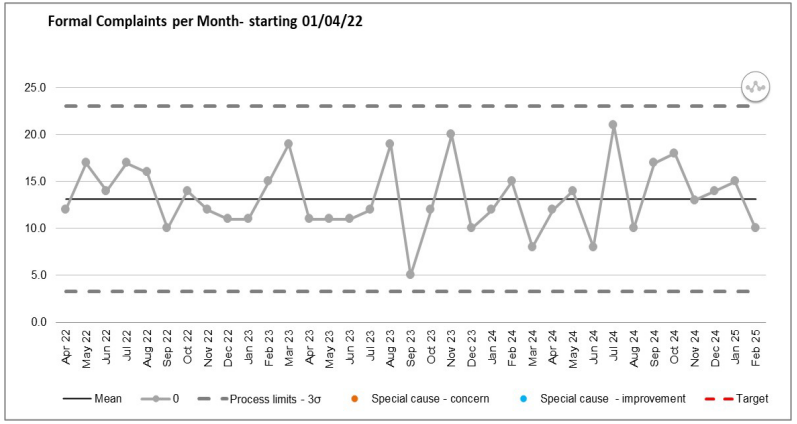
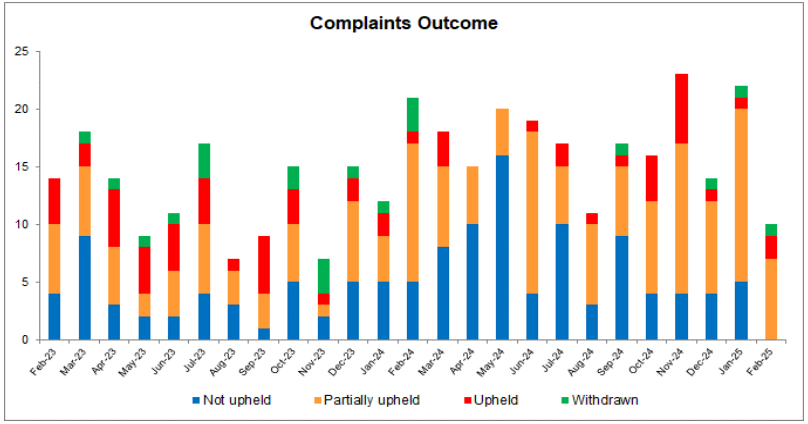
YTD ACTIVITY ACHIEVED
YTD PLANNED ACTIVITY

subject to validation

Complaints





10 new complaints received in February 2025

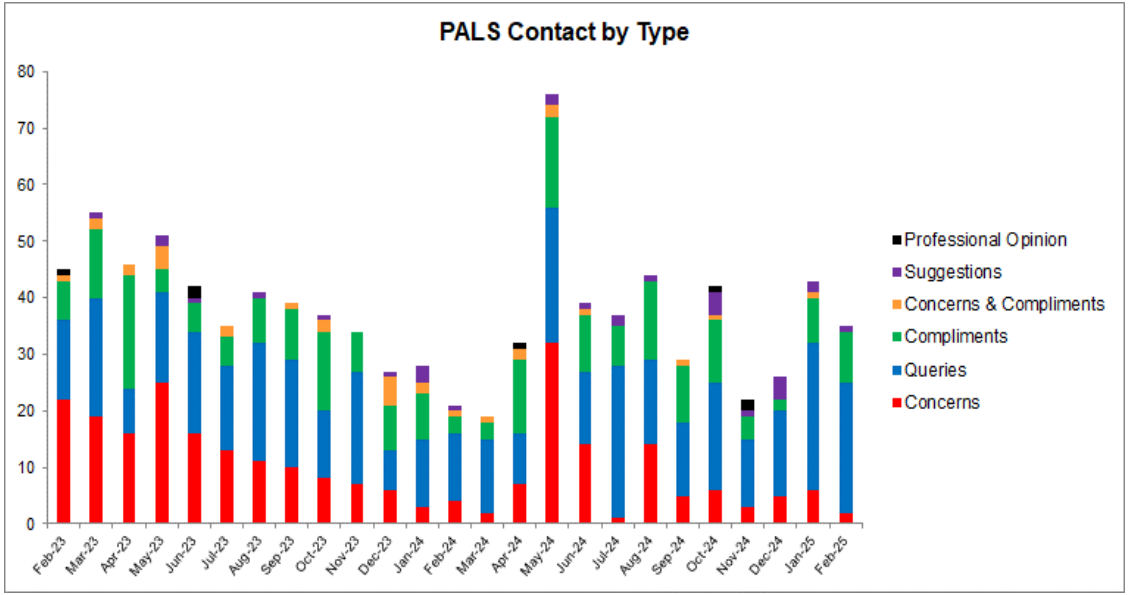
10 complaints were closed in February 2025

Ombudsman Cases

Complainants have the right to refer their case to the Parliamentary and Health Service Ombudsman (PHSO) if they are not satisfied it has been resolved by the Trust.

0 cases were referred to the PHSO in February 2025. 3 active cases in total with the PHSO.

PALS



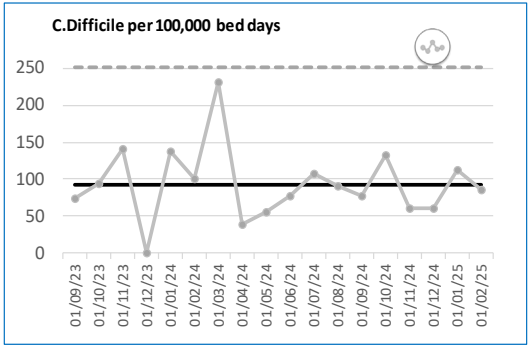
35 new PALS contacts have been received in February 2025.

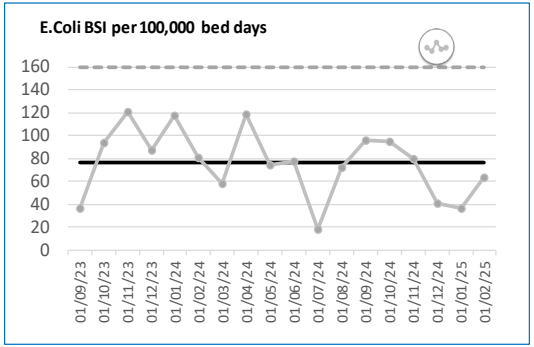
2 of those raised concerns about their experience at The Christie but did not wish to proceed with a formal complaint. The other reasons for contacting PALS are captured in the graph.

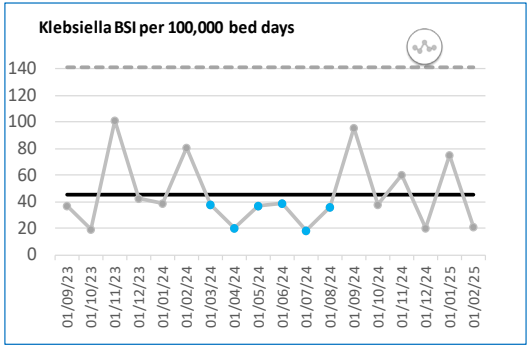
Healthcare Associated Infections

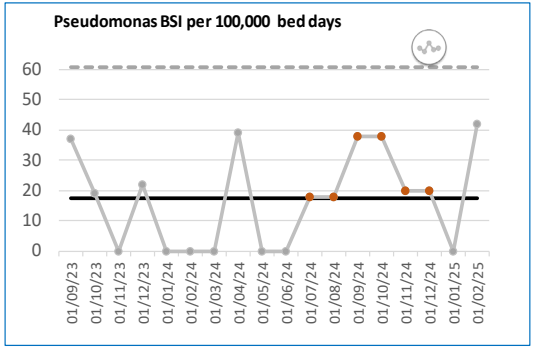
The Christie NHS Foundation Trust

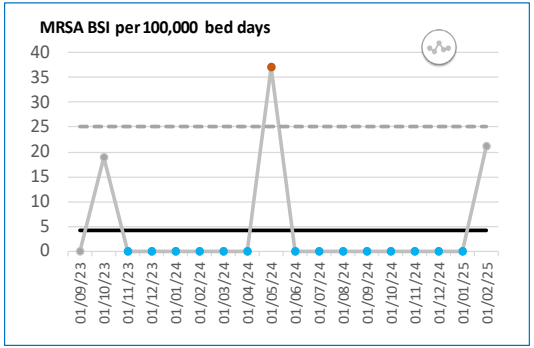
HCAIs per 100,000 bed days – rolling 12 months

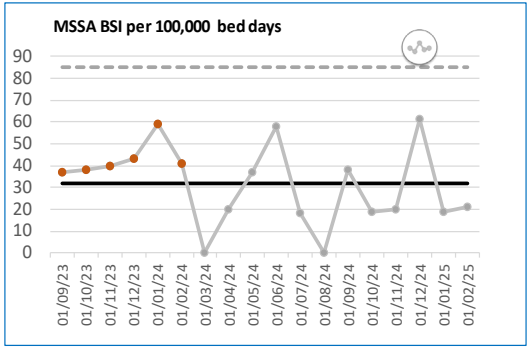












All cases reviewed through IPC team and reported through NIPR.

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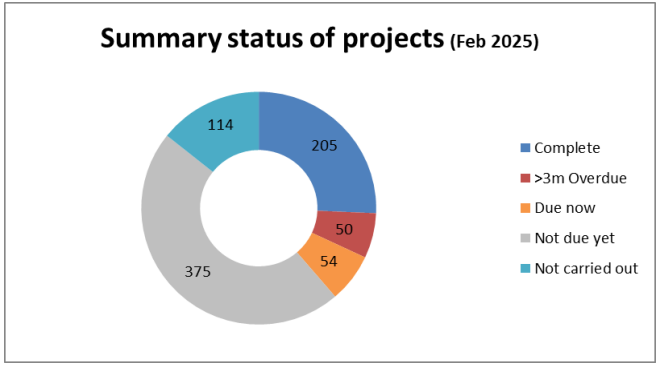
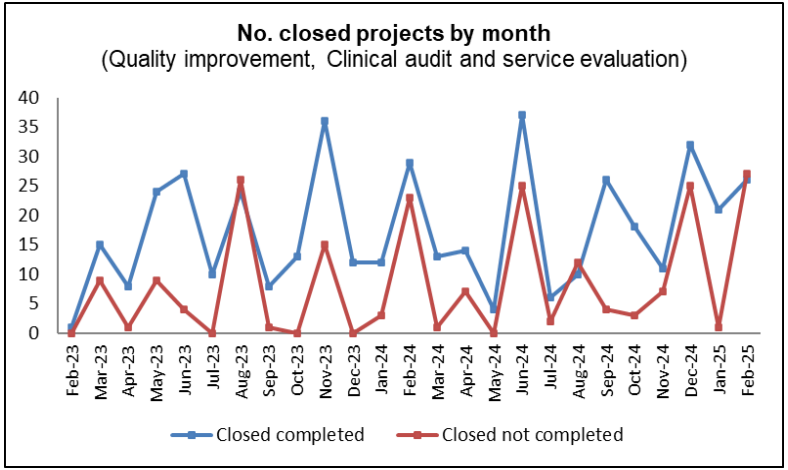
Quality Improvement & Clinical Audit

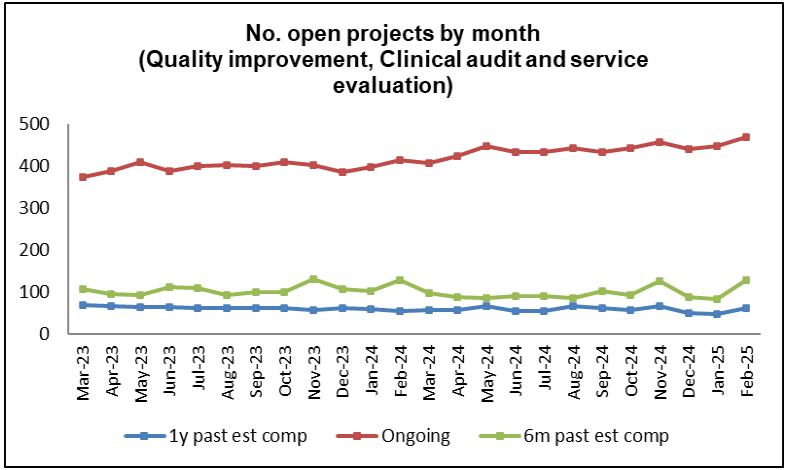
The Christie NHS Foundation Trust

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

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







HR Metrics Sickness

Our sickness absence target has been revised, it is now 4.25% for 2025

Our sickness absence rates have increased post Covid. This mirrors a trend in the NHS and across other sectors nationally. The previous absence target of 3.4% is no longer realistic.

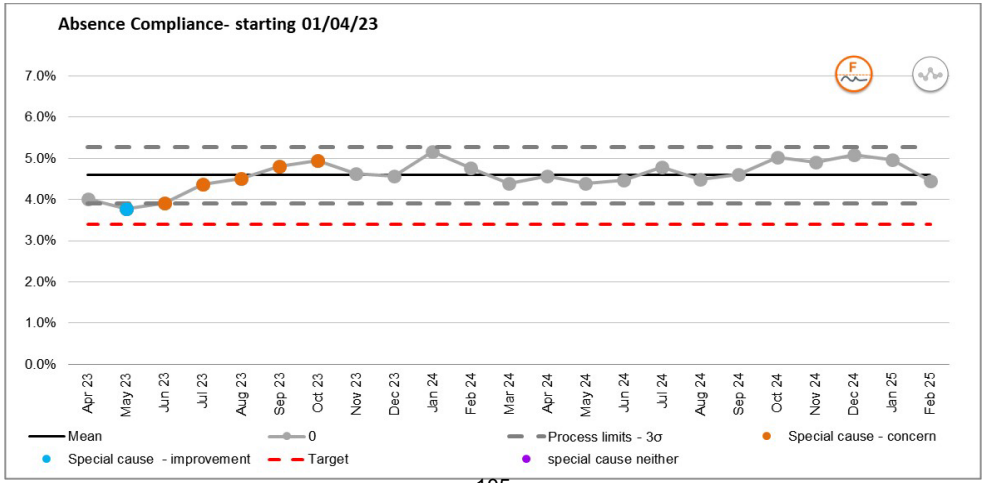
Last updated: 11/03/2025

Performance | Absence

Monthly Sickness %	Yearly Sickness %	Absences Ended	Long Term	Short Term
4.46%	4.68%	523	46	477

Trust Overview

Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25
4.36%	4.54%	4.39%	4.47%	4.80%	4.48%	4.61%	5.03%	4.93%	5.08%	4.96%	4.46%



HR Metrics – Mandatory Training

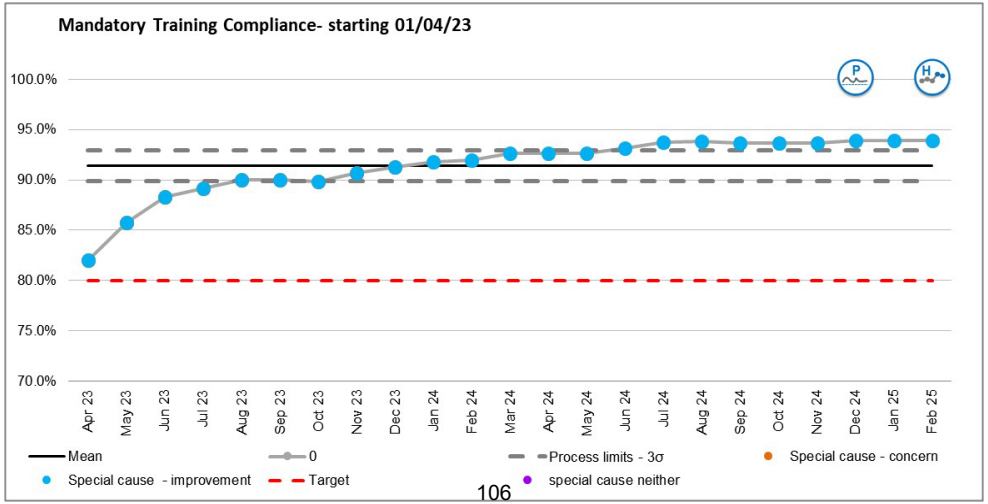
The Christie NHS Foundation Trust

Performance | Mandatory Training

Overall Compliance	Modules Outstanding	F2F Compliance	Online Compliance
93.94%	3,629	84.25%	94.89%

Trust Compliance

Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25
92.60%	92.67%	92.68%	93.19%	93.73%	93.79%	93.68%	93.66%	93.62%	93.95%	93.91%	93.94%



HR Metrics - PDR

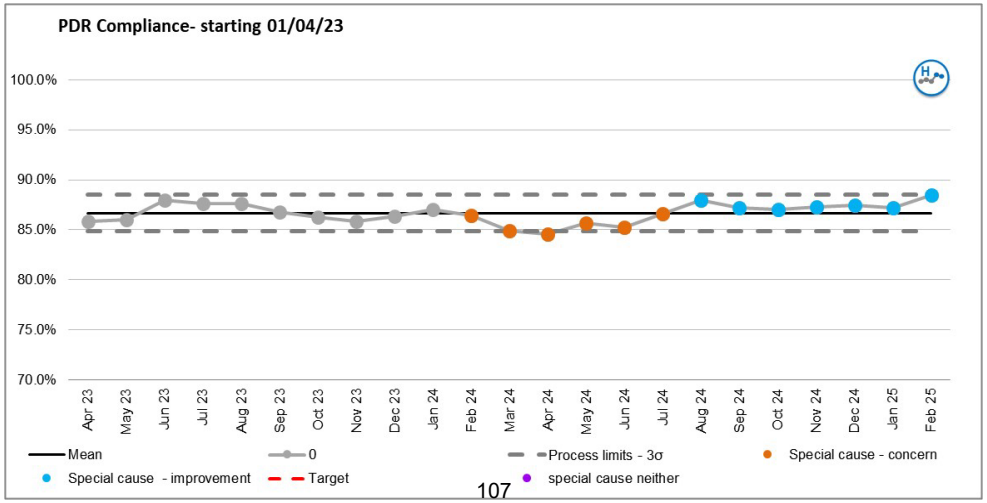
Performance | Appraisal

Overall Compliance
88.49%

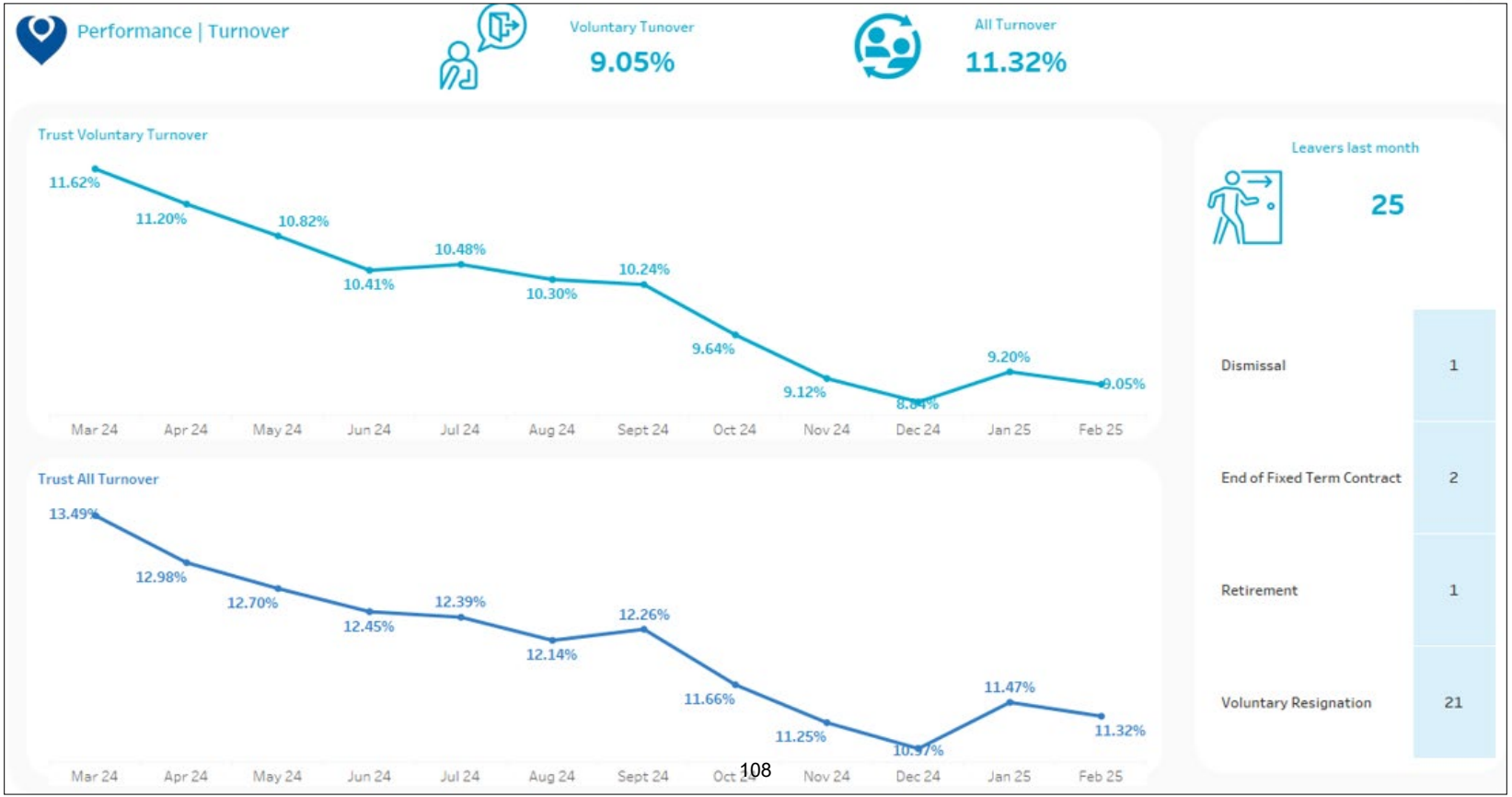
Expired Appraisals
372

Appraisals Due Soon
577

Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25
84.94%	84.61%	85.68%	85.28%	86.63%	87.95%	87.18%	87.05%	87.27%	87.46%	87.22%	88.49%



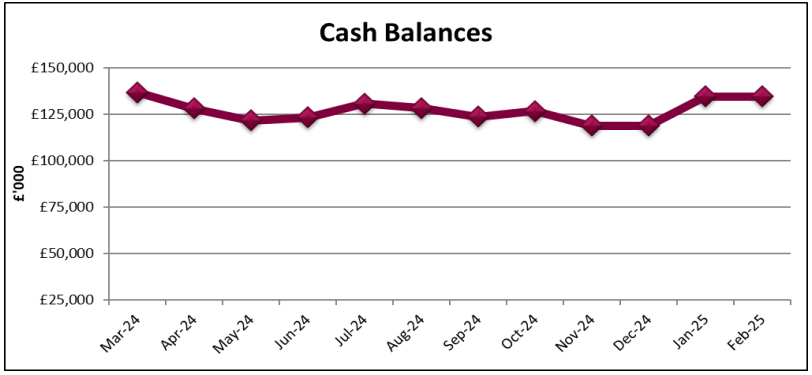
Workforce Metrics - Turnover



Finance (Executive Summary)

The Christie NHS Foundation Trust

Month 11 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(424,744)	(389,345)	(406,413)	(17,067)
Other Income	(77,916)	(71,376)	(72,898)	(1,522)
Pay	235,252	215,544	210,935	(4,609)
Non Pay (incl drugs)	241,824	221,673	240,700	19,026
Operating (Surplus) / Deficit	**(25,584)**	**(23,504)**	**(27,676)**	**(4,173)**
Finance expenses/ income	30,932	28,348	27,637	(711)
(Surplus) / Deficit	**5,349**	**4,845**	**(39)**	**(4,884)**
Exclude impairments/ charitably funded capital donations	(12,355)	(11,319)	(11,322)	(3)
Adjusted financial performance (Surplus) / Deficit	**(7,006)**	**(6,474)**	**(11,361)**	**(4,887)**



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

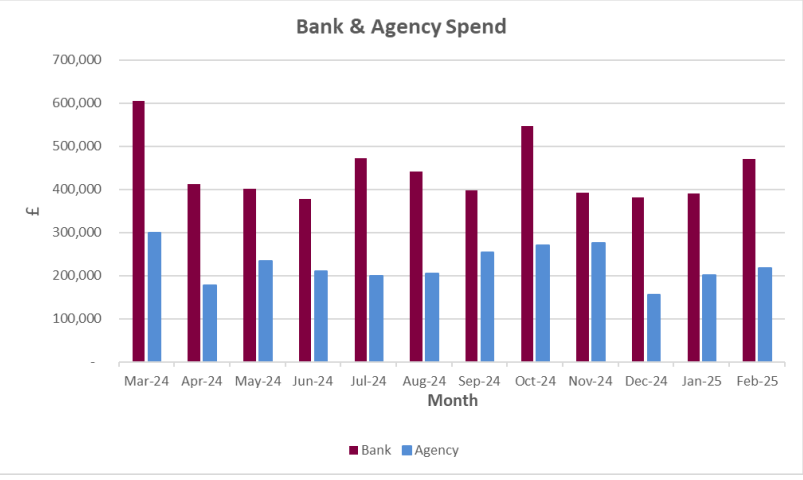
I&E

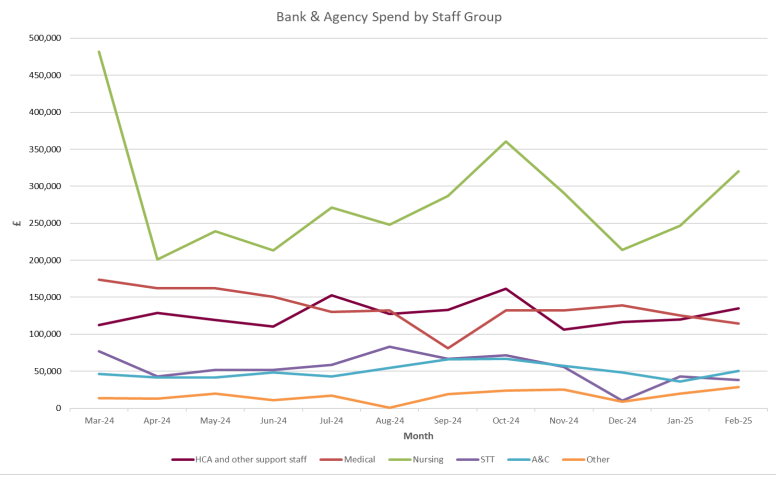
- The Trust is reporting a surplus at the end of M11 of (£11.4m) against a M11 YTD plan of (£6.5m), which gives a month 11 variance of (£4.9m) better than plan.
- In month the Trust reported a surplus position of £3.8m against a plan of £0.6m.
- The Month 12 forecast is a £15m surplus position.
- Identified in year VIP is £21.4m against a target of £21.4m. The VIP shortfall against the recurrent VIP target is £3.5m, where £10.5m has been identified against a target of £14.0m (75% of recurrent target identified). Non-recurrent identified VIP is £10.9m against a target of £7.4m, overachieving by (£3.5m).

Balance sheet / liquidity

- The cash balance is £134.4m.
- Capital performance to month 11 was (£2.1m) below the revised plan submitted to NHSE&I in June 24. The Trust has spent 85% year to date of the capital plan.
- Targets have been achieved against payment of creditors paid within the 30-day Better Payment Practice Code target.

Finance (Expenditure)

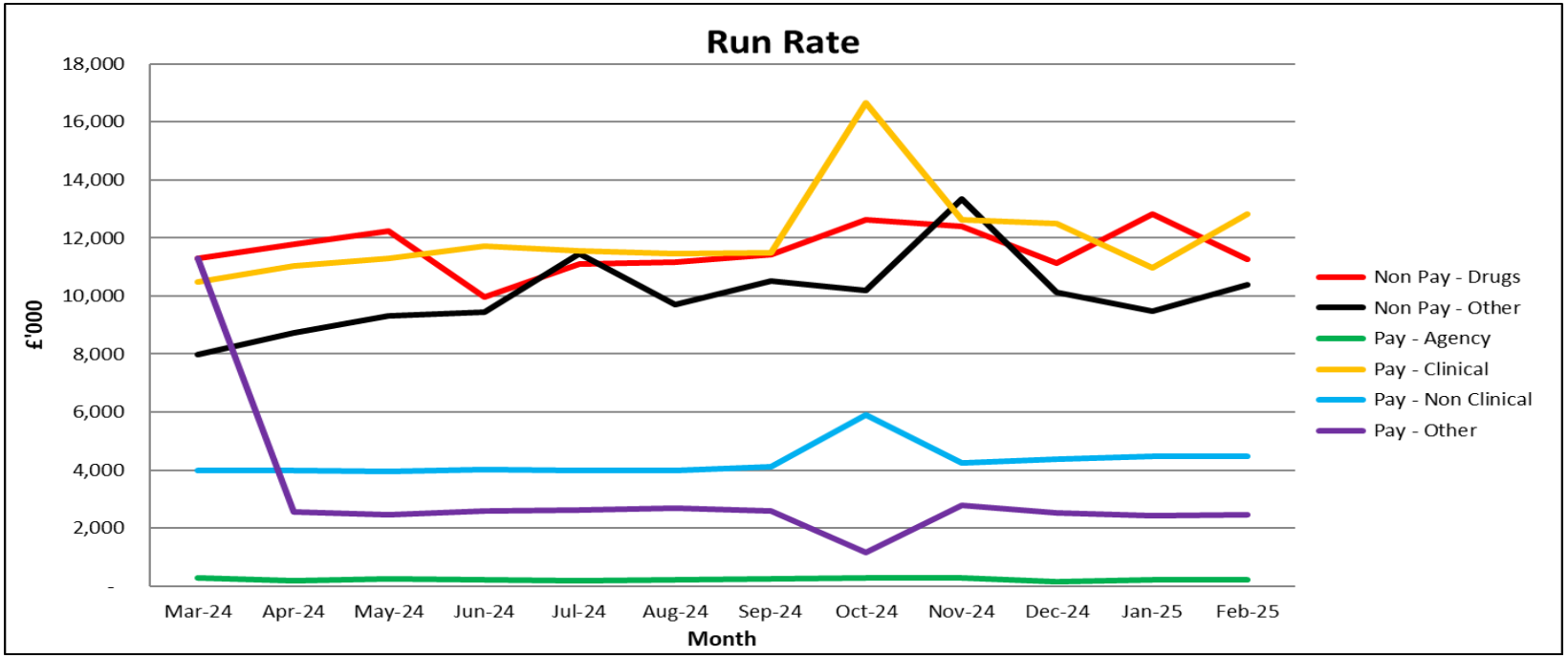




Agency spend in month 11 is £0.2m, £2.4m YTD. The spend is predominantly on medical agency with increases in month on nursing agency compared to month 10.

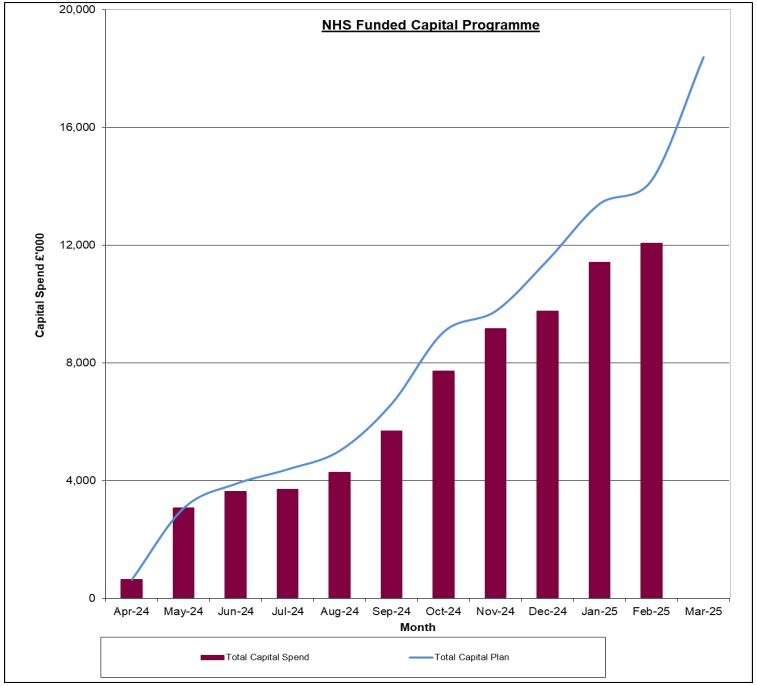
Alongside this, bank spend increased in month 11 by £0.1m compared to month 10, giving £0.5m in month 11 and £4.7m YTD.

Finance (Expenditure)



- Drugs spend in month 11 is £11.3m, a decrease from month 10 of (£1.5m) linked to fluctuations in pass through drug spend.
- Pay – Clinical spend in month 11 is £12.8m, an increase from month 10 of £1.9m due to M10 including year to date pay accrual corrections.
- Pay – Agency spend in month 11 is £0.2m, remaining consistent with month 10.
- Key elements of 'Non-Pay Other' spend consist of clinical supplies and services, premises and infrastructure costs and R&I costs.

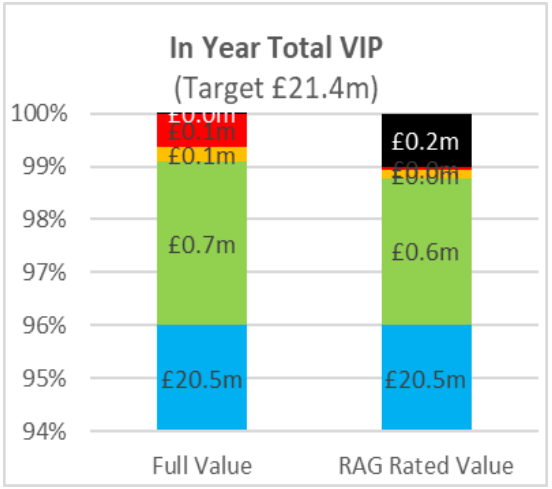
Finance (Capital)

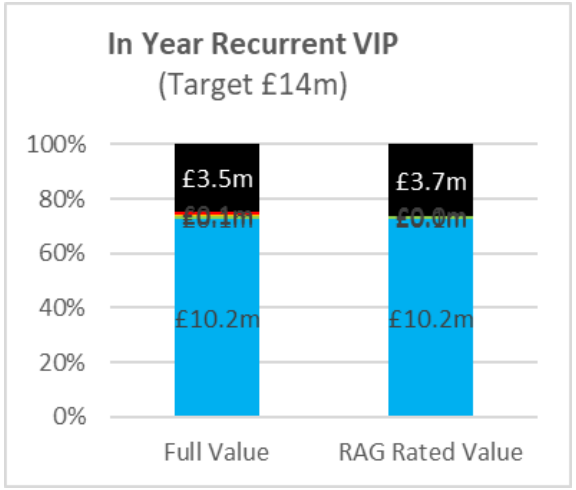


Capital spend to month 11 was (£2.1m) below the revised plan submitted to NHSE&I in June 24. This is lower than the plan position due to timing in the anticipated completion of the first linear accelerator.

The Trust has incurred £12.1m on capital schemes to month 11, primarily on the TIF ward refurbishment as well as ongoing digital projects and small replacement assets. The Trust has spent 85% year to date of the capital plan.

Finance (CIP)





Total In year CIP

- Total identified VIP schemes reported are £21.4m (£10.9m non recurrent / £10.5m recurrent).
- Risk adjusted identified schemes value £21.2m, leaving £0.2m unidentified.

Recurrent

- Schemes totalling £10.5m have been identified recurrently against a recurrent target of £14.0m.
- This leaves £3.5m of the recurrent target unidentified.

Risk Rating:	Delivering	Low	Medium	High	Unidentified
RAG Weighting:	100%	90%	50%	10%	

	Annual					Year to Date		
	Target	Identified value	Unidentified Value	Identified RAG Value	Unidentified RAG Value	Target	Delivered	Variance
Total VIP	**£21,396k**	**£21,396k**	**£0k**	**£21,179k**	**£217k**	**£19,649k**	**£19,649k**	**(£0k)**
Recurrent VIP	£13,996k	£10,495k	£3,501k	£10,329k	£3,667k	£12,862k	£9,312k	(£3,550k)
Non-Recurrent VIP	£7,400k	£10,901k	(£3,501k)	£10,849k	(£3,449k)	£6,787k	£10,336k	£3,549k