The Christie
NHS Foundation Trust

Board of Directors meeting
Thursday 28th March 2024 at 12.45 pm

Paterson Meeting Room G-103

Agenda

Patient story / clinical presentation: The Christie Clinical Research Facility **–** Rebecca Shearer, NIHR Manchester CRF Operations Lead / Helen Donovan, Matron CRF / Prof Fiona Thistlethwaite, Director Christie CRF / Jasmin David, patient **30 - 40 mins**

	Public items	**Decision**		**Lead**	**Page**	**Timing**
06/24	**Standard business**					
a	Apologies			Chair		
b	Declarations of interest			Chair		
c	Minutes of previous meeting – 25th January 2024		*	Chair	2	5 mins
d	Action plan rolling programme, action log & matters arising		*	CEO	8	
07/24	**Strategy and forward planning**					
a	Draft Green Plan	Review	*	DCEO	11	15 mins
08/24	**Performance & finance**					
a	Trust report	Note	*	CEO	33	10 mins
b	Research & Innovation Strategy progress	Note	*	DR&I	42	15 mins
09/24	**Culture**					
a	Cultural Audit Outcome and Next Steps	Approve	*	DCEO	63	20 mins
b	NHS Staff survey results 2023	Note	*	DoW	77	15 mins
10/24	**Governance (regulatory / statutory compliance)**					
a	GGI assurance review action plan	Approve	*	DCEO	83	
b	Board assurance framework 2023/24	Note	*	CEO	99	
c	Fit & Proper Persons Compliance report	Approve	*	Chair	106	
d	Reports from Committees					30 mins
	- Quality Assurance January 2024		*	Committee chair	124	
	- Audit Committee February 2024	Note				
	- Workforce Assurance Committee March 2024					
e	Annual reporting cycle 2024/25	Approve	*	CEO	148	
11/24	**Any other business**					
	Papers for information only					
	Integrated performance, quality & finance report		*			
	Date and time of the next meeting					
	Thursday 25th April 2024 at 12:45pm					

D/CEO	Deputy / Chief Executive Officer	*	paper attached
DoW	Director of Workforce	v	verbal
DR&I	Director of Research & Innovation	p	presentation

Public meeting of the Board of Directors
Thursday 25th January 2024 at 12.45 pm
Seminar Room 4 / 5 Education Centre

Present: Chair: Edward Astle (EA), Chairman
Roger Spencer (RS), Chief Executive Officer
Tarun Kapur (TK), Non-Executive Director
Robert Ainsworth (RA), Non-Executive Director
Alveena Malik (AM), Non-Executive Director
Grenville Page (GP), Non-Executive Director
Prof Kieran Walshe (KW), Non-Executive Director
Dr Diana Tait (DT), Non-Executive Director
Prof Chris Harrison (CJH), Deputy CEO
Bernie Delahoyde (BD), Chief Operating Officer
Theresa Plaiter (TP), Interim Chief Nurse
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
Prof Rikki Goddard-Fuller (RGF), Director of Education

Minutes: Louise Westcott (LW), Company Secretary

In attendance: Jo D'Arcy, Assistant Company Secretary
[redacted]

Clinical presentation: Radiotherapy at the Withington site - Rachael Edwards, Clinical Service Manager, Radiotherapy, Alix Robertson, Band 5 Radiographer & Mark Williams, Salford prostate patient.

RE introduced Mark Williams, a patient who had radiotherapy at Salford. Mark noted that the appointment system was excellent and the reception staff were really helpful. The treatment was fine and there were always staff on hand to answer questions and concerns. The experience was excellent.
RE noted that there was only 1 machine at the time of Mark's treatment due to the linac replacement programme being underway. Mark noted that it didn't impact him at all and neither did it impact the other patients who were there for treatment at the time.
EA asked about any improvements that could be made. Mark responded that he couldn't think of any, the staff were extremely responsive, he didn't have to wait and his existing medical conditions were addressed and taken account of.
DT asked about how he felt after the end of treatment. Mark noted that he was called afterwards, and he was also given a number to call should he need to. The symptoms he had were explained to him and he's managed the symptoms himself.
CH asked if he felt like he was part of The Christie having treatment at Salford. Mark said he felt like it was even better than at the main site, which he's familiar with as a driver in the patient transport service. He felt very well looked after.
RS asked about parking and access, Mark felt like this was great and worked well if he came in through the Stott Lane entrance. It was excellent.
KW asked what he expected when he was told he would have radiotherapy and if he felt prepared for the treatment. Mark responded that it was all explained very clearly and was OK, he found it very interesting.
AR introduced herself as a band 5 radiographer, she's been at the Trust for a year. The various sites were outlined, including the Proton site. She noted how welcoming the site feels as a new member of staff.

AR explained what both the Proton Beam Therapy and the main radiotherapy unit do. All areas of the body are treated from head to feet.
The number of machines were outlined across all sites and it was noted that the sites support each other and the technology is top of the range. There are about 400 staff working in radiotherapy in total.
The patient pathway was outlined from consent, scans, planning, preparation and imaging and delivery of the treatment. There's also management of physical side effects, and the patients psychosocial and spiritual needs are assessed. Adjustments are made to treatment as it goes on. Teaching is also delivered.
The different treatment schedules were described, patients attend daily and have 1 to 35 treatments, patients feed back that they really enjoy seeing the staff every day.
The patient support infrastructure was explained with multiple members of the team across different specialties.
Recent improvements were outlined including the patient experience team, and mental health first aiders, who are brilliant for staff support and for patients, the careers & education group, and the linac replacement programme.
Audit is on going for radiographers and there's a clear career path.

GP asked about utilisation in proton beam. RE responded that it has decreased slightly due to a drop in research work but will increase again when more trials come in.
BD asked AR what it is like to work here. AR noted that having amazing services to refer patients to is excellent, e.g. the wig service. It's significantly busier than other places and there's a great team.
AM asked what AR would change if she could. AR responded that the national shortage of staff impacts everyone. The decision-making process is different here and band 7's make a lot of decisions and this could be done by band 6's, it would be good to have more responsibility. Band 7's could be more focussed on research & innovation and less on decision making.
AM asked Mark what he would want more of or to be different. He noticed how busy the staff were and the impact of patients coming late etc, that obviously caused a problem for the staff, but they work to the finest of margins and were extremely good.
DT asked about the radiographer workforce and what the difficult things are for the department. RE noted that there's a lack of radiographers out there, mitigations are in place, but this will take time. Apprentices have been taken on and international recruitment is being looked at. As a new service manager, ER is looking at all centres to see how others use their staff and what can be improved in our staffing model here. Conditional progression through the banding is also being looked at to facilitate upskilling and progression to retain staff.
GP asked about leavers and what we do to understand why people leave. RE said that they do exit interviews, finish times are one reason as this site works until 8:30pm. Processes and efficiencies of the machines has been looked at. There could be learning from others.
TP noted that it would be good to share experience about the work that's been done in nursing around similar problems and offered to share learning with RE.

EA thanked everyone for their presentation and for taking time to speak to the Board.

Item		Action
01/24	**Standard business**	
a	**Apologies**	
	Prof Fiona Blackhall (FB), Director of Research	
b	**Declarations of Interest**	
	None noted.	
c	**Minutes of the previous meeting – 30th November 2023**	

	The minutes were accepted as a correct record.	
d	**Action plan rolling programme, action log & matters arising**	
	All items from the rolling programme are complete or noted on the agenda. EA noted that we will look at how we pick up the sustainability issue as part of the GGI follow up. EA invited Board members to identify anything that they would want considering at Board.	
02/24	**Key Reports**	
a	**Trust report**	
	RS noted that key quality indicators for December show no significant adverse variances or issues for escalation. • Operational performance indicators in December shows no significant adverse variances other than our compliance against some of the national Cancer Waiting Times standards. • 62-day consolidated cancer standard was 70.8% - consistent with the trajectory to meet the operational standard by March 2024. There is expected deterioration in the cancer wait standards due to disruptions in referral pathways as a result of recent industrial action. • Cumulative financial performance at the end of December (Month 9) is a £1.1m deficit against a planned £6.0m deficit. This is a positive variance of £4.9m to plan and is a function of improved performance against plan, income to negate the costs of industrial action combined with releases from the Trust balance sheet. We anticipate a forecast of breakeven. The commercial income will not subsidise NHS care. Formal turnaround arrangements continue in the ICS, the Trust have been informed that we are no longer required in the turnaround meetings. • Key financial performance indicators in month 9 show no adverse variances other than the level of recurrent efficiency achieved, this is £2.0m against a year-end target of £6.4m. • Planning process for 2024/25 has continued with Divisions providing the anticipated level of activity and resource to deliver in 2024/25. NHSE have not produced their planning assumptions yet. This will be collated for the first cut of the Trust's annual plan which will be the focus of the Board's planning day in February and subsequent submission to GM ICB in March. • Workforce indicators for December show a slight decrease in sickness absence rates • The annual staff vaccination programme continues. Our compliance rates are the highest in Greater Manchester • Work is in place to ensure we can transfer to PSIRF by April, the policy & plan are included in the papers and this has been considered and approved by the Quality Assurance Committee. Progress is on track. There will be a move from root cause analysis for an incident to a themed approach under PSIRF. This builds on the strong learning & improvement culture. RA asked about fewer investigations but better quality and any risks in the changed approach. TP noted that we have robust processes and will look at broader oversight of moderate and minor incidents.	

	DT asked for a worked example of the old approach versus the new. TP noted that falls is an example where minor harms weren't looked at previously, there's a big socialisation of PSIRF in the organisation to ensure staff are aware of the shift. NB noted that we have a just culture and look at systems and processes, the move to PSIRF allows us to do this in a much more helpful way. Psychological safety is key in the new model. There's a multi-disciplinary approach to this. KW noted that this is less of change for the Christie than for others as learning has always been a focus with incidents here. This is an evolving process and we will continue to learn and be involved in regional and national learning. EA noted the cultural changes in PSIRF, this is part of the overall culture work underway. • Our Cultural Audit report has been published on the trust intranet alongside a plan for further engagement events. Further work is underway. Further reporting to March Board. No significant adverse reactions, good feedback and contributions from staff. • The governance review, with a focus on assurance about the CQC fundamental care standards, is nearing completion and will be reported in February where Board will see plans for improvements. RS noted the Performance report with further detail on performance metrics. GP asked about the transfer of the Bolton chemotherapy activity. RS noted that non-surgical oncology has been delivered at other sites, supervised by our oncologists but delivered by other Trusts. It has taken a long time to move this activity, there are commissioning and safety issues in the transfer. Further transfer is planned at MFT and Wythenshawe as well as Stockport, Leighton hospital and Oldham.	**TP** **CH**
b	**Progress report of the Trust Strategy 2023-28**	
	The Strategy was refreshed in 2023. Delivery against the key objectives is detailed, examples include the imaging centre and frailty service. Flexibility is required as opportunities present, and the strategy will be regularly refreshed. Each of the objectives are cross referenced to our key themes of reducing inequalities, improving outcomes and reducing waits as well as the Annual Corporate Objectives. There are potential threats or risks to the delivery of our Strategy. These relate to finance and capacity. The NHS remains under significant financial pressure and several programmes require capital or revenue to proceed. Post COVID, the NHS remains under heightened service pressure with increased demand and waiting lists. Ensuring the appropriate balance between day-to-day requirements and our longer-term ambition will be critical to successful delivery of the Strategy. A forward look on activities that will support the delivery of the Strategy is ongoing. Members of the Board were requested to note the contents of the report and the progress in the months since the Strategy was approved. Noted. AM asked about global risks and how we are looking at this. JW noted that we are aware of the possibility of being destabilised. RA asked about the risks of capacity & finance and how prioritisation will happen. JW noted that teams involved, executives and the Management Board	

	are engaged. This would come to Board dependent on the scale and impact. NB noted that the divisional and clinical teams own and manage these to ensure sustainability. EA noted that we are in a new world in terms of capital funding that Board will spend time understanding. RS noted that capital constraints is around the ways NHS organisations are allowed to operate. We must navigate this and find ways through the challenges. Our rolling capital programme has deployed roughly £250 million every 5 years. This needs a different approach going forward in the context of rule changes. EA asked what projects are behind plan. JW noted that there are things planned for future years of the strategy, we need to get clarity on the next 12 months.	
03/24	**Approvals**	
a	**National Cost Collection 2023 Submission**	
	SP noted that this is a regulatory requirement. This paper provides a summary of the National Cost Collection (NCC) for Financial Year 2022/23 submitted in December 2023, including issues and recommendations for future collections. This has limited value as a specialist trust as there are not many other trusts that do what we do. Costs have increased by 2% year on year and the prediction is within tolerance. The Board approved the outputs of this year's National Cost Collection (NCC) as outlined in the paper following Director of Finance delegated sign-off. TK asked about feedback. SP noted that this is of limited value. We have benchmarked with The Marsden and Clatterbridge. This is more useful. GP asked for delegated authority in future years to SP and GP to approve on behalf of the Board. Approved.	**SP**
b	**Trust nomination of Charity Trustee**	
	In line with the articles of the charity, the Executive of the Trust are responsible for making a recommendation to the Board of Directors as to who they will nominate to be FT Trustees. The Board of Directors are asked to approve the recommendation of the Executive Directors to appoint Dr Neil Bayman, Executive Medical Director as a Foundation Trust trustee from 1st April 2024 to replace Kathryn Riddle. Approved.	
04/24	**Board Assurance**	
a	**Quality Assurance Committee report – November 2023**	
	The items listed in the report were all presented to the Quality Assurance Committee for assurance in November. An assurance level was discussed and agreed for each listed item. A further meeting took place last week. KW invited questions. The issue of PSIRF was discussed earlier in the meeting.	
b	**Board assurance framework 2023/24**	
	The Board are asked to note the Board Assurance Framework (BAF) 2023/24 that reflects the risks to achievement of the corporate objectives and note assurance levels assigned by the Assurance Committees following review of the risks, as detailed in the committee reports to Board. The Cancer Wait target risk has increased due to the impact of the industrial	

	action on referral pathways leading to late referral of patients on these pathways. GP highlighted the difference between the in-year financial risk versus the strategic financial risk. CH noted that going forward we will start with the risks and then see how they impact on the objectives rather than the other way round. There is a need to look at the annual and longer-term impact of risks. There will be more focus on risk mitigation discussion.	
05/24	**Any other business**	
	No items raised.	
	Date and time of the next meeting	
	Thursday 25th January 2024 at 12:45pm	
	Papers for information only	
	Integrated performance, quality & finance report	
	PSIRF Policy & Plan	

The Christie NHS Foundation Trust

Agenda item 06/24d

Meeting of the Board of Directors - March 2024

Action plan rolling programme after January 2024 meeting

C Culture P Performance S Strategy G Governance

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
March 2024		C	Patient story	CEO	To hear a patient story	
	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	10/24b
		P	Research & Innovation Strategy Update	DoR	Six monthly review	08/24b
		S	Draft New Green Plan	DCEO	Review	07/24a
		C	Culture Audit outcome / next steps	DCEO/DoW	Approve	09/24a
		G	GGI assurance review action plan	DCEO	Approve	10/24a
	Annual reporting cycle	G	FPPT Compliance report	Chair	Approve annual compliance	10/24c
April 2024		C	Patient story	CEO	To hear a patient story	
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	
		G	Register of matters approved by the board	CEO	April 2022 to March 2023	
	Provider licence	G	Self certification declarations	EDoF&BD	To approve the declarations	
	Annual reporting cycle	S	Annual Corporate Objectives review 2023/24 & strategy update	DoS/CEO	Review 2023/24 progress	
		S	Digital Strategy Update	DCEO / CIO	Annual Review	
		G	Modern Slavery Act update	CEO	Approve	
		G	Board effectiveness review	Chairman	Undertake survey	
		C	Freedom to speak up Guardian report	FTSUG	Quarterly update	
	Annual reporting cycle	S	Risk Management strategy 2023-24 annual review	ECN	Annual Review	
May 2024 - no meeting	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	By email
Planning & Development Day			Culture			
			Planning			
June 2024		C	Patient story	CEO	To hear a patient story	
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	
	Annual reporting cycle	G	Annual reports from audit, quality and workforce assurance committees	Committee chairs	Assurance	
	Annual reporting cycle	G	Annual compliance with the CQC requirements	ECN	Declaration / approval	
		S	Education Strategy Update	DoE	Review	
		S	Quality Strategy annual update	ECN	Review	
			Board effectiveness review	Chair	Report	
	Annual reporting cycle	G	Annual report, financial statements and quality accounts (incl Annual governance statement / Statement on code of governance)	EDoF&BD	Approve	
July 2024 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
Planning & Development Day			Service Review day with senior leadership teams			
August 2024 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
September 2024		C	Patient story	CEO	To hear a patient story	
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	
		S	Research & innovation Strategy Update	DoR	Six monthly review	
		G	Standing Financial Instructions (SFI's)	DoF	Approve	
		S	Digital Strategy update	DCEO/CIO		
October 2024 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
Planning & Development Day			Planning with Divisional leadership teams			
			Strategy deep dive			
November 2024		C	Patient story	CEO	To hear a patient story	
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	
		C	Freedom to speak up guardian	FTSUG	Annual report	
		S	Strategy update	DoS	Six month review	
		S	Clinical Outcomes Strategy review	EMD	Review	
		S	SACT Strategy review	COO	Review	
	Annual reporting cycle	P	Interim review of annual objectives	CEO	Review progress	
		S	Boards responsibility for Carbon Net Zero	DCEO	Report	
December 2024 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
Planning & Development / Council of Governors Day			Board planning / culture training			
			Council / Board - strategy update			
January 2025		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance report	COO	Monthly report	For information
		S	Education Strategy update	DoE	Review	
		S	Review of Trust strategy & annual objectives 2023-2029	DoS	Report	
		S	Sustainability Annual Report	DCEO	Report	
February 2025 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
	Annual reporting cycle	G	Letter of representation & independence	Chair	Circulate	By email
	Annual reporting cycle	G	Register of directors interests / FPPT annual declaration	Chair		
	Annual reporting cycle	G	Declaration of independence (non-executive directors only)	Chair		
Planning & Development Day			Planning			
			Strategy deep dive			

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Agenda item: 06/24d

Action log following the Board of Directors meetings held on

Thursday 25th January 2024

No.	Agenda	Action	By who	Progress	Board review
1	02/24a	PSIRF – worked example to be included in the next update	TP	To be included in the report to QAC June 2024	QAC June 24
2	02/24a	Plans for improvement relating to Governance review to be reviewed by Board	CH	Plans reviewed at February Board Planning Day	Agreed actions presented to March Board following review
3	03/24a	delegated authority in future years to SP and GP to approve National Cost Collection submission on behalf of the Board.	SP/GP	Noted and added to future plan	N/A

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Agenda item 07/24b

Meeting of the Board of Directors

Thursday 28th March 2024

Subject / Title	The Christie Green Plan 2024-2027
Author(s)	Will Blair - Sustainability Manager
Presented by	Professor Chris Harrison - Deputy Chief Executive Officer Alex Beedle - Head of Facilities Will Blair - Sustainability Manager
Summary / purpose of paper	In accordance with the NHS Standard Contract Service Conditions 2024/25, The Trust must maintain and deliver a Green Plan, approved by its Governing Body, in accordance with Green Plan Guidance. This paper outlines the Draft Christie Green Plan.
Recommendation(s)	The Board are asked to provide any comment on the draft Green Plan and to note the next steps outlined.
Background papers	Sustainable Development Management Plan (2021-2024)
Risk score	9 (BAF Risk 8.4)
EDI impact / considerations	Workforce and patient impacts of the Green Plan
Link to: ➢ Trust strategy ➢ Corporate objectives	1. To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer 6. To maintain excellent operational, quality and financial performance 7. To be an excellent place to work and attract the best staff 8. To play our part in the local health care economy and community
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	DCEO Deputy Chief Executive Officer GM Greater Manchester

Agenda item 07/24b

Board of Directors
Thursday 28th March 2024

The Christie Green Plan 2024 – 2027

1. Introduction

This report brings the Trust's draft Green Plan 2024-2027 to the attention of the board of directors and is to note.

2. Background

In accordance with the NHS Standard Contract Service Conditions 2024/25, we are required to maintain and deliver a Green Plan, approved by the Trust Board of Directors, in accordance with Green Plan Guidance.

The board approved the previous Green Plan in June 2021. This included work on the statutory (Health and Care Act 2022) ambitions set by "Delivering a Net Zero NHS". The new Green Plan (Appendix 1) is attached for information.

The Green Plan covers eleven modules –

- Assurance and governance
- Workforce and system leadership
- Clinical transformation
- Digital transformation
- Travel and transport
- Estates and facilities
- Medicines
- Supply chain and procurement
- Food and nutrition
- Adaptation
- Green Space
- Biodiversity

The Green Plan has been developed through the Sustainable Development Committee and working groups. Oversight has been provided through the Net Zero and Climate Adaptation Committee (chaired by the DCEO).

3. Next Steps

The draft Green Plan (2024-2027) will go through staff consultation and an informal high-level review by the GM NHS Associate Net Zero Programme Director (April-24)

4. Recommendation

The Board are asked to provide any comment on the draft Green Plan and to note the next steps outlined.

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The Christie Green Plan 2024-2027

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Climate crisis and health X
Delivering a Net Zero National Health Service report X
Sustainable Clinical Practice X
Legislation and drivers for change X
Trust Carbon Footprint X
- Trust baseline X
- NHS carbon footprint (2022/23) X

Areas of focus X
- Assurance and governance
- Workforce and system leadership
- Clinical transformation
- Digital transformation
- Travel and transport
- Estates and facilities
- Medicines
- Supply chain and procurement
- Food and nutrition
- Adaptation
- Green space and biodiversity

Communication Plan X
Tracking Progress X
Challenges and Risk X
Conclusion X
Appendix 1: Green Plan Actions X

Professor Chris Harrison
Executive Director/ Deputy Chief Executive

Foreword

As the net zero board lead, I am delighted to introduce our Green Plan, which details how The Christie NHS Foundation Trust will support the NHS to become a net zero health service. The Trust recognises that the NHS needs to respond to the health emergency that climate change brings, which will need to be embedded into everything we do now and in the future. To ensure we continue providing health and high-quality care for all, now and for future generations.

About us

The Christie specialises in cancer treatment, research and education and is one of the largest cancer centres in Europe.

Treating more than 60,000 patients a year from across the UK, we became the first UK centre to be officially accredited as a comprehensive cancer centre and are supported by an independent charity.

The Christie employs over 3,000 staff, all of whom are determined to provide the best possible cancer care and patient experience. Some of the developments we have made in the last few years are outlined here. During our last strategy, we have built a state-of-the-art proton therapy centre as well as creating facilities in Macclesfield.

Our experts have been pioneering cancer research breakthroughs for more than 100 years and The Christie is well known for many world-firsts which have advanced cancer treatment on a global scale.

Housing the largest single site early phase clinical trials unit in the UK, we have an excellent reputation as an international leader in research and innovation, which is further strengthened by being a partner in the Manchester Cancer Research Centre (MCRC) and Health Innovation Manchester. In 2023 we opened the new Paterson building to further our scientific discoveries in partnership with the University of Manchester and Cancer Research UK.

A core element of The Christie is education. With its own School of Oncology, the first of its kind in the UK, The Christie educates healthcare professionals from across the country, enhancing the patient experience and promoting developments in cancer care.

Our partnerships

The Christie places high importance on the establishment of long-term, mutually beneficial partnerships. This is in recognition of the immense value they bring in terms of clinical excellence, academic leadership and commercial benefits.

The Christie works with world-leading organisations including Cancer Research UK and the University of Manchester. We also work closely with organisations such as HCA Healthcare to fulfil The Christie Private Care, The Christie Pharmacy Company and The Christie Pathology Partnership.

Our vision

The Christie strategy 2023 to 2028 sets out how we will continue to deliver our mission - to care, discover and teach. It has been developed following extensive consultation with staff, patients and public, and our Board of Directors.

It sets out a clear vision of how we will transform cancer treatments, care and support, and improve outcomes for our patients. Our Strategy is focused on 4 main themes:

1. **Leading cancer care**
2. **The Christie experience**
3. **Local and specialist care**
4. **Best outcomes**

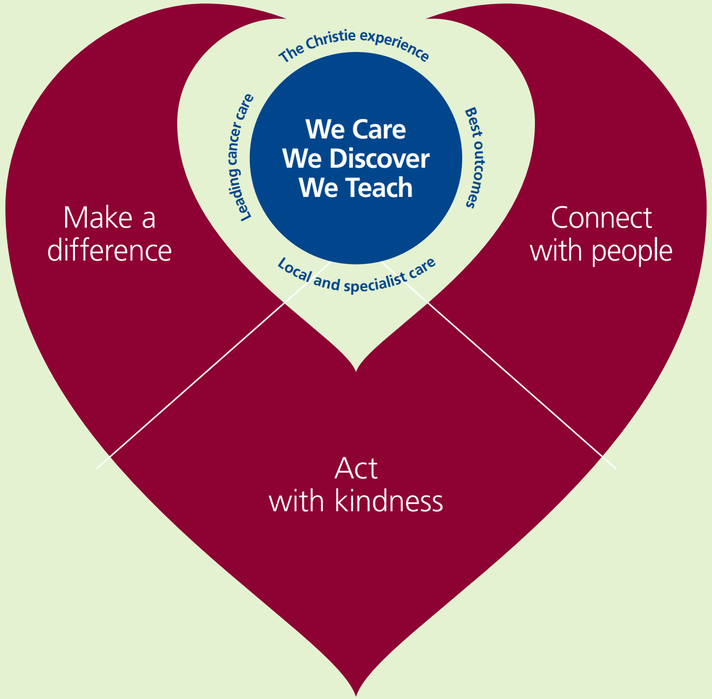
The refreshed Trust strategy has been built from integrating our clinical strategies (made up from the ambitions of our internationally recognised clinical teams and the future plans of our state-of-the-art clinical services) with our Research and Innovation, Education and Clinical Outcomes strategies which have each been renewed in parallel.

Not only do our plans ensure that the patient is at the heart of everything we do, but they also demonstrate that the key service developments will be undertaken ensuring that the Trust remains operationally, clinically and financially sustainable.

To enable our team to focus upon improving the experience and outcomes of all our oncology patients, our plans not only define the investment we intend to make into facilities and expertise, but also how we wish to work with the health professionals in Manchester and Cheshire to provide a more integrated, caring and personalised experience for our patients.

Our vision: To be a leader in both local and specialist cancer care and ensure that every patient receives the best experience and outcomes.

Our core purpose is:
to care – with compassion for our patients and staff
to discover – through world leading cancer research
to teach – using pioneering cancer education



Our Values and Behaviours

Our **values and behaviours** define how we approach our work and our mission. They sit at the heart of how we treat each other to enable us to achieve our Christie vision.

Make a difference

We are courageous and try new ideas.

We are honest and take responsibility.

Act with kindness

We care for each other and our environment.

We show appreciation and celebrate success.

Connect with people

We are inclusive.

We work together as one team.

Climate crisis

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

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

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

The world faces unavoidable multiple climate hazards over the next two decades with the 1.5°C warming threshold expected to be crossed this decade. In 2022 heat records were broken in all continents and 2023 saw the highest global temperatures in over 100 000 years. The Met Office forecasts for 2024 had suggested for the first time that values of 1.5 °C or above cannot be ruled out (see figure 1).

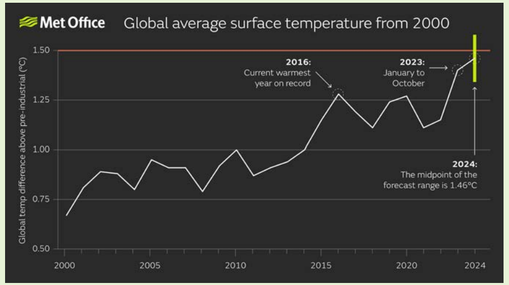


Figure 1: Met Office - Global average surface temperatures[1].

The EU's climate service confirmed in February 2024 that for the first time, global warming had indeed exceeded 1.5C across an entire year. Even temporarily exceeding 1.5 °C will result in additional severe impacts, some of which will be irreversible.

The temperatures in Manchester have also increased with many of the hottest years occurring in the last few decades (see Figure 2). A significant moment occurred in July 2022 when the UK Health Security Agency (UKHSA) declared a national state of emergency with a level 4 heat-health alert. The level 4 alert is the highest warning and the first time it had been issued on a national level. At level 4 illness and death can occur among the fit and healthy. Also, that the impacts could go beyond health and social care with potential effects on transport systems, food, water, energy supplies and businesses. On 19 July, a record temperature of 40.3 °C was recorded and verified by the Met Office in Coningsby, England, breaking the previous record set in 2019 of 38.7 °C. The same day Greater Manchester temperature reached record high of 37.7°C, with the previous record of 33.9°C from July 25th, 2019. As climate change has driven such unprecedent severe weather events it can be difficult to make the best decisions because the heat was far more intense and widespread than previous comparable heatwaves.

Risks for society will increase, including to infrastructure and low-lying coastal settlements. The cumulative scientific evidence is unequivocal: Climate change is a threat to human well-being and planetary health. Any further delay in concerted anticipatory action on adaptation and mitigation will miss a brief and rapidly closing window of opportunity to secure a liveable and sustainable future for all.

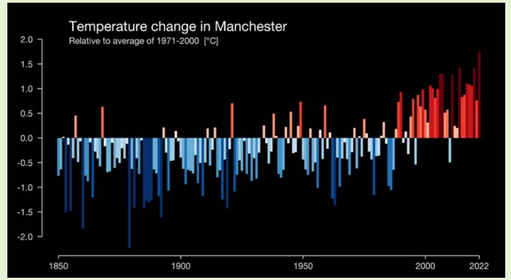


Figure 2: Temperature changes in Manchester 1884-2022

Climate crisis and health

Climate change, caused by human greenhouse gas emissions, is already harming people's health and driving widespread losses and damages.

The health impacts of climate change are happening now and are worsening. They overwhelmingly affect disadvantaged and marginalised communities and exacerbate existing health inequities. As climate change threatens the foundations of good health, with direct and immediate consequences for our patients, the public and the NHS.

The UKHSA and the Office for National Statistics (ONS) estimate that between 17 to 20 July 2022, when temperatures were at their highest, there were 1,012 excess deaths in those aged over 65. These figures demonstrate the possible impact that hot weather can have on the elderly and how quickly such temperatures can lead to adverse health effects vulnerable groups.

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

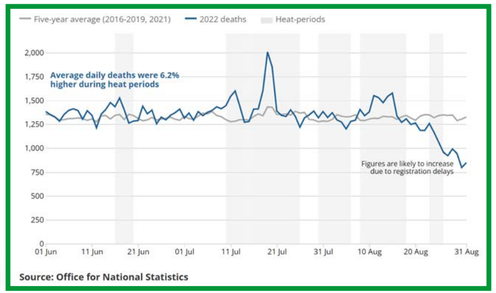


Figure 3: Daily death occurrences increase during heat-periods

Delivering a Net Zero National Health Service Report

The Delivering a 'Net Zero' National Health Service report provides targets to reduce system wide emissions within direct control (NHS Carbon Footprint) to net zero by 2040, and wider indirect emissions including the supply chain (NHS Carbon Footprint Plus) by 2045 (see figure 4). The commitments were enshrined in law with the passing of the Health and Care Act 2022.

Looking at the wider scope of the NHS Carbon Footprint Plus, Figure 5 shows that the greatest areas of opportunity – or challenge – for change are in the supply chain, estates and facilities, pharmaceuticals and medical devices, and travel.

The report also includes interim targets that are defined as defined equivalent to:

- **Reducing NHS Carbon Footprint by at least 47% from 2019/20 levels by 2028-2032;**
- **Reducing NHS Carbon Footprint Plus by at least 73% from 2019/20 levels by 2036-2038**

These are the most ambitious targets of any healthcare system in the world to address the impact of the sector and address the climate and health emergency. The Trust is committed to address the climate and health emergency, and we recognise it is our duty to contribute towards the level of ambition set out in report.

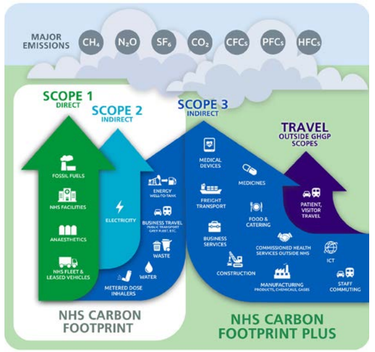


Figure 4: Green house gas scopes in the context of the NHS

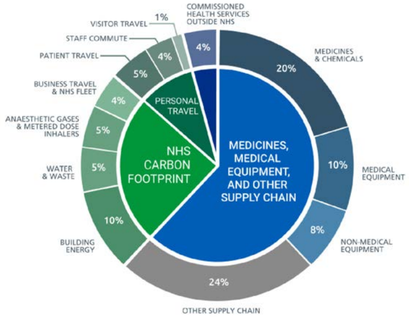


Figure 5: Sources of carbon emissions by proportion of NHS Carbon Footprint Plus

Sustainable clinical practice

The provision of healthcare incurs not just financial costs, but also contributes to significant environmental ones, in the form of greenhouse gas emissions, soil degradation, desertification, the decline of life in the oceans, species extinctions, deforestation, and water and air pollution.

This could be viewed as spending ecological capital, which is equally essential to population health. The medical profession can therefore be seen as having a particular responsibility to lead the fight against climate change and wider environmental impacts.

Once the contribution of clinical activity to environmental impact is recognised, the need to create a service which is health promoting as well as skilled in responding to immediate clinical need becomes clear. This can be addressed by considering the four principles of sustainable clinical practice. Furthermore, by adopting sustainable quality improvement into service improvement and considers the 'tiple bottom line' of social, environmental and financial benefits.

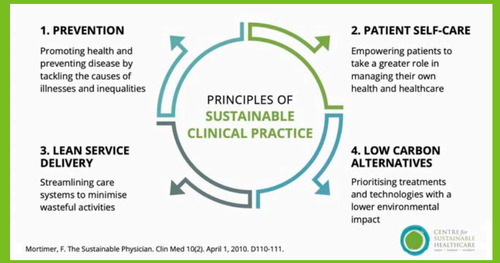


Figure 6: Sustainable principles of clinical practice

Legislation and drivers for change

Outline of statutory, regulatory and policy requirements which were consider as part of the Green Plan.

International	
UN sustainable development goals	The Sustainable Development Goals (SDGs), also known as the Global Goals, were adopted by the United Nations in 2015 as a universal call to action to end poverty, protect the planet, and ensure that by 2030 all people enjoy peace and prosperity. The 17 SDGs recognise that that development must balance social, economic and environmental sustainability.
Climate change 2023 synthesis report summary for policymakers	Summarises the state of knowledge of climate change, its widespread impacts and risks, and climate change mitigation and adaptation.
The 2023 report of the Lancet Countdown on health and climate change	Report tracks the relationship between health and climate change across five key domains and 47 indicators, providing the most up-to-date assessment of the links between health and climate change.
National	
Climate Change Act (2008)	Established powers for the government to ensure that organisations in key sectors are aware of and prepared for the impact of a changing climate. Commits the UK government by law to reducing greenhouse gas emissions by at least 100% of 1990 levels (net zero) by 2050.
Environment Act (2021)	Includes provisions to establish a post-Brexit set of statutory environmental principles, a new environmental watchdog and provisions relating to waste, air, water and biodiversity.
Health and Care Act (2022)	The legislation states that NHS organisations must be compliant with the UK's Climate Change Act 2008 and the Environment Act 2021. The NHS must also "adapt to any current or predicted impacts of climate change" as identified in the climate change reports that the government is required to put before parliament at least every five years.
UK Health Security Agency report on Health Effects of Climate Change in the UK	This report provides an authoritative summary of the scientific evidence on the health effects of climate change, potential implications for public health, and gaps in evidence.
UK Climate Risk Independent Assessment (CCRA3) -Health and Social Care Sector Briefing (2021)	The UK Climate Risk Independent Assessment (CCRA3) was developed at a UK-wide scale involving scientists, economists, and stakeholders from across the United Kingdom. This briefing summarises how health and social care have been assessed and what types of action to adapt to climate change risks and opportunities would be beneficial in the next five years.
NHS Standard Contract Service Conditions	NHS Standard Contract Service Conditions are updated on an annual basis and include obligations that the Provider must take all reasonable steps to minimise its adverse impact on the environment.

Legislation and drivers for change (continued)

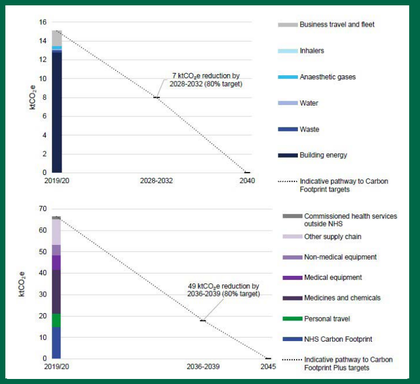
National	
NHS clinical waste strategy	The NHS clinical waste strategy aims to improve waste management practices amongst NHS trusts, NHS foundation trusts and primary care to make them more efficient and sustainable in order to save on cost, improve hospital function, and reduce the impact on the environment in line with NHS net zero carbon commitments.
Net Zero travel and transport strategy	This strategy outlines how the NHS will have fully decarbonised its fleet by 2035, with its ambulances following in 2040.
NHS Estates 'Net Zero' Carbon Delivery Plan	This delivery plan aims to address the aspects of the net zero strategy pertinent to estates and facilities activities. It sets out a clear, sequential four step investment approach to decarbonising NHS sites.
Estates Net Zero Carbon Delivery Plan - Technical Annex	This Technical Annex has been produced to support the Estates Net Zero Carbon Delivery Plan and details the interventions, activities and target dates required to achieve the eleven strategic actions within the Estates Delivery Plan.
NHS Net Zero Building Standard	The NHS Net Zero Building Standard provides technical guidance to support the development of sustainable, resilient, and energy efficient buildings that meet the needs of patients now and in the future.
Local	
GMCA 5-Year Environment Plan for Greater Manchester 2019-2024	Sets out the aim and priorities for Greater Manchester to be a carbon neutral city region by 2038.
Greater Manchester Transport Strategy 2040	Sets out Greater Manchester's long-term ambition for transport.
Manchester Climate Change Framework 2020-2025	Manchester's high-level strategy for tackling climate change.
The NHS Greater Manchester Integrated Care Green Plan 2022–2025	The Green Plan from NHS Greater Manchester Integrated Care has at its heart a commitment to achieve a net zero carbon footprint by 2038, in collaboration with partners as part of the Greater Manchester Combined Authority Environment Plan. By 2045, this net zero commitment will also include the carbon impact of goods and services in line with a national NHS target.

Trust carbon footprint

Trust baseline

2019/20 is the base year from which trajectories to Net Zero were defined in the Delivering a Net Zero NHS report, and therefore NHS England defined the required average contributions from NHS trusts. The footprint data provided is to be used for baselining, identifying emissions hotspots, and understanding contributions to the national emissions set out in the Delivering a Net Zero NHS report.

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



NHS Carbon Footprint (2022/23)

The carbon data shown demonstrates our impact since the baseline year of 2019/20. This does not represent the most complete and accurate data set, as currently data for the Carbon Footprint Plus is incomplete. This Green Plan aims to address this gap going forward for completion of impact.

Source	2018/1	/21	2021/22	2022/23
Total Energy	11,2	376	8,923	9,945
Total Waste	394.9	2.335	271.647	297.686
Total anaesthetic gases	365.	0.91	72.62	33.51
Total Business travel	158	589	1589	1589
Total	13,6	,418	10,856	11,865

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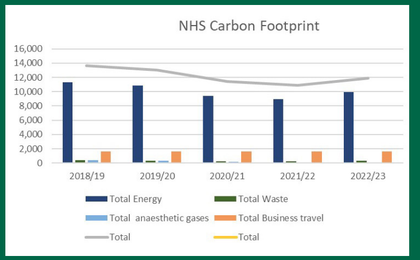


Areas of focus

This Green Plan is aligned to the main drivers of change and sources of carbon emissions across Trust activities. The aim is to further develop actions completed in the previous Green Plan and to also incorporate new ideas.

A full detailed list of the actions can be found in appendix 1.

Assurance and governance

Workforce and system leadership

Clinical transformation

Digital transformation

Travel and transport

Estates and facilities

Medicines

Supply chain and procurement

Food and nutrition

Adaptation

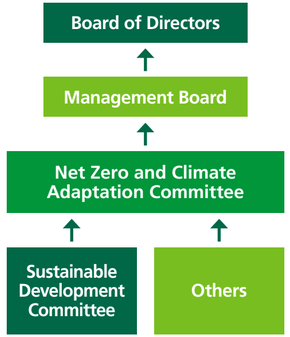
Green space and biodiversity

Assurance and governance

The Green Plan is approved by the Trust Management Board and Board of Directors. This is to ensure that it is embedded and aligned with the strategic direction of the organisation.

The Green Plan is led by a designated board-level net zero lead who chairs the Trust Net Zero and Climate Adaptation Committee. This is a senior strategic and advisory committee the meet quarterly with responsibility for delivering of Green Plan and ensuring relevant legislative and NHS England guidance compliance. The committee meetings are reported to Trust Management Board meeting by exception. Any items of specific concern or those which require Board approval will be the subject of a separate report.

The Sustainable Development Committee meets monthly and consists of stakeholders from across the organisation. This group provides operational leadership, coordination and guidance to the Trust for integration of sustainability principles and practices throughout the Trust's core activities. The committee meetings are reported to the Trust Net Zero and Climate Adaptation Committee. Additional working groups are set up when required and will also report to Trust Net Zero and Climate Adaptation Committee.



Where we are	Where we are going
• Net Zero Board Lead • Sustainability Manager • Governance structure in place • Sustainability annual report with qualitative progress data	• Publish sustainability annual report with quantitative progress data. • Monthly greenhouse gas emission for waste, business travel and medical gases reported in tonnes. • Quarterly dashboard report covering progress against Greener NHS deliverables and Green Plan progress

Workforce and System Leadership

This area looks at how the Trust approaches engaging, educating and developing our workforce and system partners in defining and delivering carbon reduction initiatives and broader sustainability goals. Furthermore, how sustainability is incorporated into decision making processes.

Where we are	Where we are going
• Net Zero Board Lead • Sustainability Manager • Governance structure in place • Sustainability annual report with qualitative progress data	• Develop Climate Crisis Policy. • Sustainable Impact Assessment for business cases and policy. • Provision of leadership development and education series. • Repackage relevant benefits as green benefits and update recruitment materials. • Job documentation and appraisal guidance to reference net zero target and/or healthcare emergency. • Introduce signposting to wellbeing advice and support linked to eco-anxiety.

Clinical transformation

The NHS Long Term Plan set out a commitment to deliver a new service model for the 21st century. If the NHS is to reach net zero emissions, that new service model must include a focus aon sustainability and reduced emissions. This will require a focus on the 'triple bottom line' of environmental, finance and social pillars in clinical pathway design and improvement.

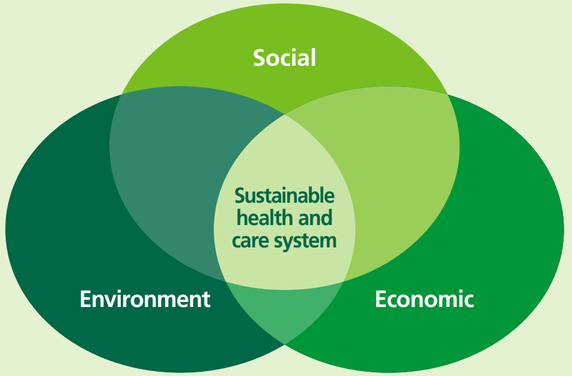


Figure 7: Three 'pillars' of sustainability

Where we are	Where we are going
• Estimating the carbon footprint of external beam radiotherapy. • Participated in Centre of Sustainable Healthcare's Green Team Competition. • Bloods Closer to Home (BCTH) to reduce travel for patients and transport organised by the Trust). • All clinic outcome forms are now to be done via the e-outcome form reducing paper. • Treatment closer to home through our three satellite centres.	• Facilitate Sustainable Quality Improvement (SusQI) training for leads across the Trust. • Incorporate SusQI into implementation plan for NHS IMPACT • Review the use of disposable gloves and blue roll • Measuring the carbon footprint of a move to hypofractionation in radiotherapy • Estimating the carbon footprint of Proton Beam Therapy. • Measure carbon footprint of MRL in collaboration with the manufacturer. • Measure carbon footprint of nuclear medicine with a specific aim on SPECT

Digital transformation

The direct alignments between the digital transformation agenda and a net zero NHS are clear. This Trust seeks to focus on ways to harness existing digital technology and systems to streamline service delivery and supporting functions while improving the associated use of resources and reducing carbon emissions.

Where we are	Where we are going
• Recycling/reselling/ donating ICT resources - ensure no IT waste is sent to landfill. • All new IT procured meets or exceeds current government buying standards.	• Reduce energy consumption including moving to Cloud and low CO2 data centres. • Digital First Travel Policy - eLearning and online learning • Power saving initiatives • Improved digital communications removing the need for paper.

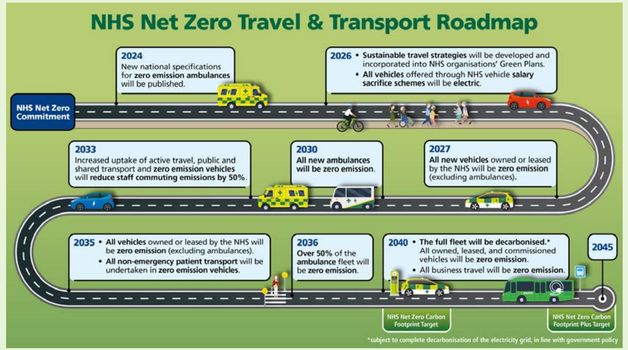


Figure 8: The NHS net zero travel and transport roadmap

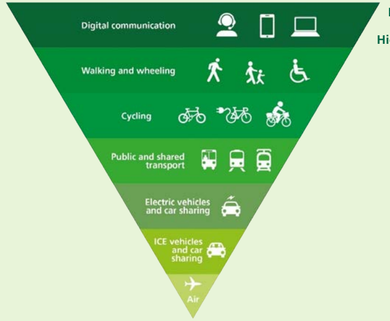


Figure 9: Travel Hierarchy

Travel and transport

NHS England has developed an NHS Net Zero Travel & Transport Strategy that describes the interventions and modelling underpinning the commitments that the NHS will have fully decarbonised its fleet by 2035, with its ambulances following in 2040 (see figure 8).

The Trust recognises its role in its delivery and as an anchor institution is committed to taking ambitious action to tackle the twin challenges of climate change and air pollution. Through adopting the transport hierarchy in the delivery of services (see figure 9). Actions to cut carbon emissions can also reduce air pollution which leads to direct improvements to health while also addressing health inequality.

Where we are	Where we are going
• Award winning Green travel plan • Annual staff travel survey (average response rate 41% since 2013) • A 12% model swing towards sustainable travel from 2013 baseline (46% of staff using sustainable travel in 2022). • Twelve electrical vehicle charge points in staff car park. • Annual Modal Shift Report • Car park eligibility process	• Revised Green Travel Plan in line with NHS Net Zero Travel and Transport Strategy • Fleet management centralised. • Air Quality Risk Assessment • Electric vehicle infrastructure strategy • Review of car parking rates and eligibility • Restrict salary sacrifice car scheme to zero emission vehicles.

Estates and facilities

The Trust estates and facilities have a critical role to play in achieving net zero as it is an area where the NHS can take direct action needed to help reduce Carbon Footprint and also a proportion of the Carbon Footprint Plus.

Interventions have been identified in the NHS Estates Net Zero Carbon Delivery Plan four step approach to decarbonise the NHS estate by 2040 (see figure 8).

Furthermore, the NHS's clinical waste strategy published in March 2023 (see figure 9), sets out NHS England's ambition to transform the management of clinical waste by eliminating, reusing and processing it in the most cost effective and sustainable way.

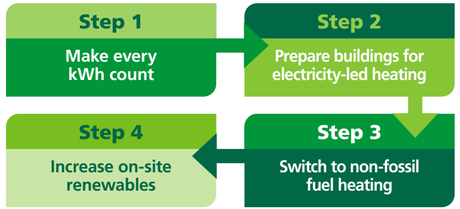


Figure 10: Four step approach to decarbonise the NHS estate by 2040. These are indicative numbers not actuals.

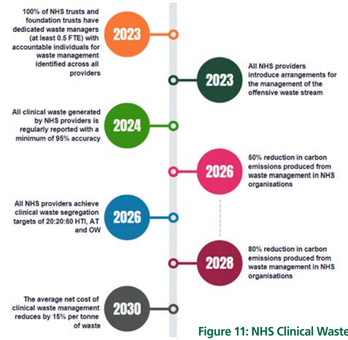


Figure 11: NHS Clinical Waste Strategy

Where we are

Estates decarbonisation schemes

The Christie put £6.9 million towards decarbonisation and also received a grant of £8 million from the government. This led to the development of the following schemes:

- Solar power system
- Battery energy storage system
- Heat pump system
- LED lighting upgrade
- Other energy infrastructure upgrades including;
  - New higher efficiency combined heat and power
  - Steam System Improvements

The schemes will deliver circa one tonne of carbon emission savings and circa £500k annually in energy cost savings.

Where we are going

- Aim to deliver of NHS waste strategy targets.
- Ward Auditing to highlight changes of disposal methods moving to lower/cleaner waste disposal waste methods.
- Implementation of reusable sharp containers across the Trust.
- Implementation of metal recyclable waste streams.
- Trust wide waste training.
- Improve energy metering (gas and electric) across site where feasible and develop a sub-metering strategy.
- Where financially feasible return to the policy of purchasing electricity which is from 100% renewable sources
- Development of a decarbonisation plan and strategy.
- Where possible new roofing projects to have additional insulation installed to decrease heat loss.
- Incorporate sustainability into handover process to communicate and induct staff into the new building or area.
- Deliver our first redevelopment heated soley by electricity.
- Sustainability manager to included at design stage for projects

Medicines

Medicines account for 25% of emissions within the NHS carbon footprint plus primarily within the manufacturing and freight inherent in the supply chain. Interventions that should be considered include optimising prescribing, substituting high carbon products for low-carbon alternatives, and improvements in production and waste processes.

Where we are

- Decommissioning of the nitrous oxide manifolds across site
- The proportion of desflurane to all volatile gases used in surgery to 2% or less by volume.

Where we are going

- System wide campaign to encourage patient to bring own medicines into hospital on admission.
- Campaign to encourage patients to be discharged with their controlled drugs.
- Reduction in paper pharmacy documents.
- Reduction in plastics wastage supplied by sponsors in study kits.
- Fleet cars for out of hours medicine at homes delivery service.

Supply chain and procurement

The Trust uses a network of suppliers to produce and deliver the goods and services needed to deliver healthcare. The emissions associated with the supply chain account for the largest proportion of the overall NHS Carbon Footprint Plus. Whilst we don't have direct control over these emissions, we have significant influence and purchasing power.

NHS Net Zero Supplier Roadmap

NHS Net Zero Supplier Roadmap

From April 2022
Net Zero and Social Value
All NHS procurements include a minimum 10% net zero and social value weighting. The net zero and social value guidance for NHS procurement teams helps to unlock health-specific outcomes (building on PPN 06/20). Net Zero and Social Value will be applied via the Evergreen assessment for NHS England Medicines tenders.

From April 2023/24
Carbon Reduction Plan
For all new contracts above £5 million per annum, the NHS requires suppliers to publish a Carbon Reduction Plan for their UK Scope 1 and 2 emissions and a subset of scope 3 emissions as a minimum (aligning with PPN 06/21).

From April 2024, this requirement will be proportionately extended to cover all new procurements.

From April 2027
Carbon Reduction Plan for all emissions
All suppliers will be required to publicly report targets, emissions and publish a Carbon Reduction Plan for global emissions aligned to the NHS net zero target, for all of their Scope 1, 2 and 3 emissions.

From April 2028
Product-level requirements
New requirements will be introduced overseeing the provision of carbon footprinting for individual products supplied to the NHS. The NHS will work with suppliers and regulators to determine the scope and methodology.

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Where we are

- All tenders include minimum 10% net zero and social value.
- All tenders require a copy of company's Environmental / Sustainability Certificate (ISO 14001 or equivalent).
- All tenders require company's CSR (Corporate social responsibility) policy.
- Optional questions added to tenders:
  - Policy towards reducing the amount of single use plastics.
  - Plans to reduce your carbon output, in line with the NHS targets for decarbonisation.
  - Plans to reduce the amount of plastic packaging and future plans to utilise recycled packaging.
  - Carbon footprint of the product throughout the whole life cycle, including the manufacturing, use and disposal of the product.

Where we are going

- Develop standard sustainability specific key performance indicators.
- Understand carbon footprint of "Gold" suppliers.
- Obtain and monitor carbon reduction plans.
- Walking aids reuse scheme
- Sustainable Procurement Policy

Food and nutrition

The nutritional quality of food served to patients has a direct impact on their health and recovery. A well-balanced plate is also a low carbon plate, consisting of minimally processed foods and seasonal, ideally locally sourced, fruit and vegetables. Improving the quality of the food served within hospitals has the potential to significantly benefit the patient experience and recovery rates, as well as improve staff health and wellbeing.

Where we are	Where we are going
• Identified opportunities to make menu options healthier and lower carbon by increasing the proportion of fruit, vegetables, beans, pulses or other low carbon ingredients/proteins. • Tackling obesity by empowering adults and children to live healthier lives by preventing advertising on site of unhealthy food advertising and encouraging healthier alternatives. • Plastic bottled water phased out of restaurant.	• Electronic Menu book being explored for patients. • Adapt menus for patient meals to use more seasonal produce. • Review suppliers to meet GBSF Standards • Review how waste is processed on site

	2030s	2050s	2080s	
Summer Average Air Temperature (°C)	+0.9 to +1.9	+1.4 to +3.3	+2.6 to +6.4	↑
Summer Maximum Air Temperature (°C)	+0.9 to +2.2	+1.6 to +3.8	+2.9 to +7.4	↑
Winter Average Air Temperature (°C)	+0.7 to +1.7	+1.1 to +2.6	+1.7 to +4.5	↑
Winter Minimum Air Temperature (°C)	+0.7 to +1.7	+1.2 to +2.8	+1.7 to +4.9	↑
Annual Average Air Temperature (°C)	+0.8 to +1.5	+1.2 to +2.5	+2.0 to +4.7	↑
Summer Precipitation Rate (%)	-2 to -21	-11 to -35	-19 to -52	↓
Winter Precipitation Rate (%)	+2 to +11	+4 to +18	+9 to +32	↑

Table 1: Predicted Climate Impacts for Manchester

Where we are	Where we are going
• Climate Change Risk Assessment • Flood Risk Assessment • Major Incident Plan • Heatwave Plan	• Review Heatwave Plan in line with latest UK Climate Projections • Review flood risk assessment in line with latest UK Climate Projections • Review Major Incident Plan in line with latest UK Climate Projections • Climate Adaptation Plan

Adaptation

Climate change adaptation seeks to manage this risk to services, adapting or designing buildings and processes to ensure continuity of care, in a rapidly changing global climate.

Adaptation measures will complement the existing Emergency Preparedness, Resilience and Response (EPRR) measures which are developed to react to individual incidents when they occur. The Met Office has published a "Manchester Climate Pack" predicting likely climate impacts for Manchester (see Table 1).

The Climate Change Act 2008 established under section 56 that a five-yearly cycle of Climate Change Risk Assessments (CCRA) and the UK National Adaptation Programme.

- The third Climate Change Risk Assessment (CCRA3) was published June 2021. Chapter 5 covers Health, Communities and the Built Environment.
- The Third Health and Social Care Adaptation Report was published by the NHS and the UK Health Security Agency in December 2021 as part of that process.

The Health and Care act 2022 legislated that Trust must adapt to any current or predicted impacts of climate change identified in the most recent report under section 56 of the Climate Change Act 2008.

Green space and biodiversity

The benefits of access to nature and green space for mental and physical health, include positive outcomes for heart rates and blood pressure, stress levels, mood and self-esteem, obesity, type 2 diabetes, post-operative recovery, birth weight, children's cognitive development and cardiovascular disease.

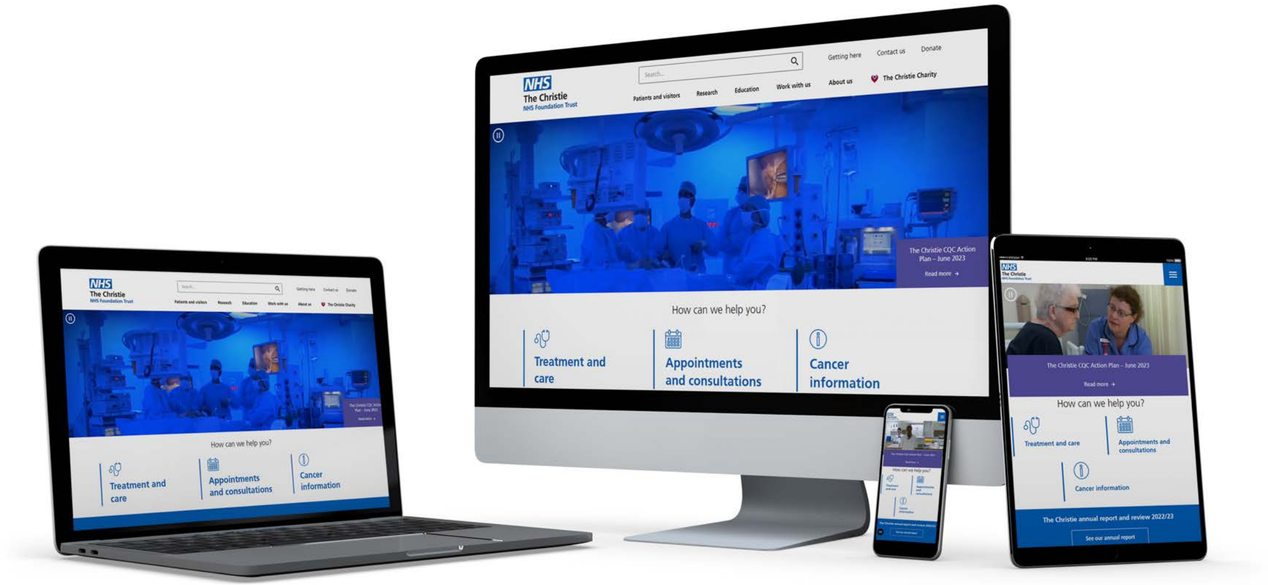
When people have more access to green space where they live, income-related health inequalities are less marked. In England alone, it has been calculated that the NHS could save an estimated £2.1 billion every year in treatment costs if everyone had access to good quality green space.

Where we are

- **Wildflower gardens**
- **Fruit trees and vegetable**
- **Bug hotels**
- **Outdoor education spaces for children**
- **Living walls**
- **Permeable concrete**
- **Indigenous plant species prioritised in landscaping.**
- **Reuse of materials on site.**
- **Birdhouses and bat boxes.**
- **Tree registers.**

Where we are going

- **Biodiversity strategy to maintain and further develop green spaces onsite.**



Communication plan

The success of the plan requires engaging and accessible communications with all stakeholders. Achieving net zero and adapting to the impacts of climate change will require collaboration with all stakeholders as all skills on knowledge will be required to build a truly sustainable healthcare service.

Our main focus will be to use existing communications channels to promote our work, encouraging staff and others to consider green issues in all they do. Key channels of communications include our intranet Hive, internal newsletter Chinwag and the monthly Team Briefing. All communications activity will link in with work carried out by our Organisational Development team.

Externally, we will also use existing channels to promote our best practice work in the area. This includes media relations for any projects of particular significance, social media and The Christie's website.

The Trust's communications team will lead on all communications activity.

Tracking progress

To support the delivery of the Green Plan a range a reports and data collections will be used to monitor progress. These are both internal and external reporting methods to ensure good governance and transparency. The reports will utilise a combination of qualitive and quantitative data. The reporting methods may be subject to change throughout the delivery Green Plan to ensure compliance with local, regional and national requirements.

Monthly	Quarterly	Six monthly	Annual
• Waste tonnage/emissions • Medical gas emissions • Fleet milage/emissions • Business travel emissions	• Greener NHS Data Collection • Quarterly dashboard report to Net Zero and Climate Adaptation Committee • Presentation to Development and sustainability committee.	• Written report to the Trust Audit Committee	• Trust Annual report • Trust Sustainability Report • NHS Fleet Data Collection • Greener NHS Green Plan Support Tool • Estates Returns Information Collection • NHS Premises Assurance Model • Annual staff travel survey modal shift report

Challenges and risks

Training will help to embed sustainability into operations and governance, create sustainable improvements and change culture.

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

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

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

Finance
Budget constraints and access to financial capital is limited, if the Trust is to reach the NHS net zero targets, we will require significant access to capital. The cost to achieve net zero is not included here as there is no reliable way of doing this at present. In addition, there current is no sustainability budget that reflects the requirements of delivering the Green Plan annual work programme.

Adaptation
Climate change is already happening. There is a clear and immediate need for the reducing our carbon emissions to net zero, and to adapt to the impacts of climate change that can't be avoided. Building resilience into the system as it protects and promotes the health of populations now and in the future. To meet our obligations to adapt the premises and the manner in which services are delivered to reduce risks associated with climate change and severe weather a climate change needs adding to the Trust risk register. In addition, an adaptation plan needs developed.

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

Conclusion

We have seen a significant increase in levels of interest and engagement, as public consciousness grows. The frequency of staff enquiries has grown as they see opportunities in their own work areas.

This will only intensify, as people will come to expect large public sector organisations like ours to be leading from the front on sustainability and climate change. This will undoubtedly present challenges, but we will continue to find innovative ways of engaging staff with this agenda.

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

Appendix 1

Keep up-to-date with all our news from the latest Christie developments to charity events.

The Christie NHS Foundation Trust
Wilmslow Road
Manchester M20 4BX
United Kingdom

Phone **0161 446 3000**
www.christie.nhs.uk

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Agenda item 08/24a

Meeting of the Board of Directors
Thursday 28th March 2024

Subject / Title	Trust report
Author(s)	Executive Directors
Presented by	Roger Spencer, Chief Executive
Summary / purpose of paper	This report brings together the key issues for the Board of Directors in relation to our performance, strategy, workforce, the Greater Manchester system landscape, the regulatory landscape and other pertinent matters within the scope of the board's responsibilities.
Recommendation(s)	The board is asked to note the contents of the paper.
Background Papers	Integrated Performance, Quality and Finance Report Finance Report
Risk Score	See Board Assurance Framework
EDI impact / considerations	
Link to: ➢ Trust's Strategic Direction ➢ Corporate Objectives	Achievement of corporate plan and objectives
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	CEO Chief Executive Officer MCRC Manchester Cancer Research Centre NHSI NHS Improvement JFP Joint Forward Plan CQC Care Quality Commission GM Greater Manchester ICB Integrated Care Board ICS Integrated Care System CIP Cost Improvement Programme

The Christie
NHS Foundation Trust

Trust Report

March 2024

Executive Summary

- Key quality indicators for February show no significant adverse variances or issues for escalation.
- Our operational performance indicators in February shows an adverse variance in the 62 day cancer waiting time standard. This is the result of referral delays from the industrial action at other providers.
- Performance in February for the 62-day consolidated cancer standard was 66.9% which is below the new standard of 70%, but a significant improvement on the January position.
- Cumulative financial performance at the end of February (Month 11) is a £5.3m surplus against a planned £7.4m deficit. This is a positive variance of £12.7m to plan.
- Planning for 2024/25 continues with both of the Trust's main commissioners supported by the PwC turnaround team.
- Key financial performance indicators in month 11 show no adverse variances other than the level of recurrent efficiency achieved, £2.0m against a year-end target of £6.4m.
- Workforce indicators for February show a slight decrease in sickness absence rates with plans to address this being reviewed by the Workforce Assurance Committee
- The annual staff vaccination programme continues. Our compliance rates are the highest in Greater Manchester
- The NHS Staff Survey 2023 results have been published, for six of the eight reported People Promise main themes The Christie has scored better than the average for our comparator group, and for two themes has scored the same as the average.
- Engagement events have continued following the publication of our Cultural Audit report and a report outlining the next steps is going to Board in March.
- We remain rated overall as Good by the CQC and we have completed our CQC Action Plan.
- We continue to be in segment 2 of the System Oversight Framework.
- Our governance review, with a particular focus on assurance about the CQC fundamental care standards, is complete and an action plan will be presented to Board in March.

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.

There were 15 complaints in February which is just above the monthly average. The number of contacts with the Patient Advice and Liaison Service (PALS) service in February was 21, lower than the previous month.

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

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

1. Restrictions on our ability to use capital funding in 2024/25 (25)
2. Risk of not achieving the financial plan including the cost improvement programme (20)
3. Risk that patients may experience harm due to significant delays in the management of patients with penile cancer (16)
4. Risk of delayed cancer referral and treatments due to not meeting 24 / 62-day targets (15).

Operational Performance

Compliance at the end of February against the three key cancer standards was;

- The 62-day consolidated standard was 66.9% against a threshold of 70%. This reduction in performance has been driven by referral delays from other Trusts as the result of industrial action.
- We have continued to achieve the 31-day standard for treatment to start within 31 days of the decision to treat at 98.6% against a target of 96%.
- We have missed the 75% threshold for the Faster Diagnosis Standard which measures initial referral to diagnosis. This is for a very small number of patients (average 12 per month), that we have taken over from district general hospital haematology services. This pathway is being redesigned and we expect to be compliant in Q1 2024/25.

During February there were 5 operations cancelled on the day for non-clinical reasons, all were rebooked within 28 days.

The latest position for seasonal vaccinations among frontline staff show that we have the highest rate of compliance for both Covid-19 (41%) and Flu (58%) vaccinations in Greater Manchester.

The launch of the new version of our risk management and incident system, DATIX-DCIQ took place on Monday 4th March. The Patient Safety Team are leading the implementation of DATIX and have provided various methods of support throughout this process including virtual and in-person drop-in sessions. The roll out has gone very well with minimal issues.

The Fuller Inquiry is conducting a survey of trusts via a questionnaire. The first phase of the Inquiry, on matters relating to Maidstone and Tunbridge Wells NHS Trust, concluded in November 2023 with the publication of the Phase 1 Report. Phase 2 of the Inquiry will look at the broader national picture and consider if procedures and practices in other hospital and non-hospital settings, where deceased people are kept, safeguard the security and dignity of the deceased.

Financial Performance

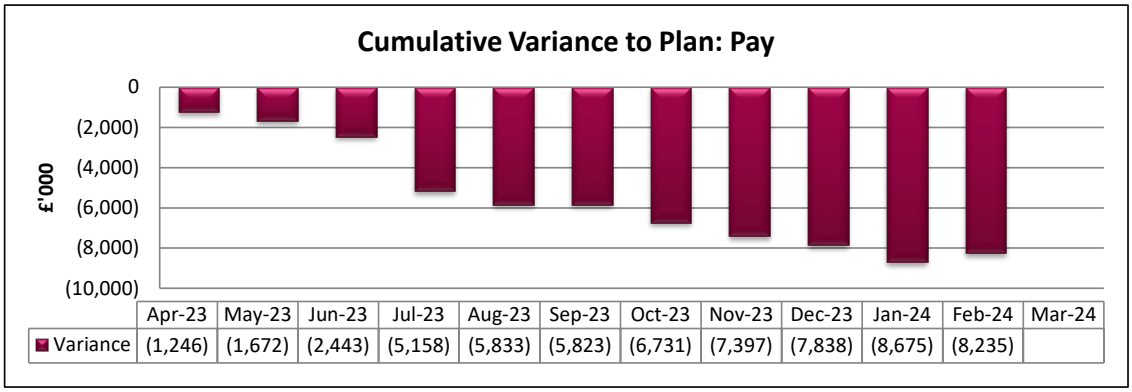
Revenue: Financial performance is ahead of plan as illustrated in the table below. The Trust is reporting a £5.3m surplus against a £7.4m planned deficit position. This is due to:

- pay underspends arising from vacancies
- interest received on the Trust's cash balances above planned levels
- income to negate the costs of industrial action
- inclusion of £5.4m of commercial profit from the Trust's Joint Venture

The significant variances in clinical income and non-pay are both related to the overspend (and associated over achievement of income) in relation to pass through drugs.

Month 11 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(373,973)	(342,824)	(366,894)	(24,070)
Other Income	(68,922)	(63,169)	(58,087)	5,083
Pay	212,392	194,673	186,438	(8,235)
Non Pay (incl drugs)	218,455	200,276	217,309	17,033
Operating (Surplus) / Deficit	**(12,048)**	**(11,044)**	**(21,234)**	**(10,190)**
Finance expenses/ income	28,723	26,330	21,723	(4,607)
(Surplus) / Deficit	**16,675**	**15,285**	**489**	**(14,797)**
Exclude impairments/ charitably funded capital donations	(8,637)	(7,918)	(5,772)	2,145
Adjusted financial performance (Surplus) / Deficit	**8,038**	**7,368**	**(5,284)**	**(12,652)**

The cumulative pay underspend of £8.2m is illustrated in the graph below (note £5.2m relates to income backed services, including GM Cancer, R&I and The Christie Charity, hence there is an equivalent reduction in expenditure).



Capital: Of the latest revised capital plan of £30.6m, the Trust has spent £21.9m to M11. The remainder of the capital programme will be spent in Q4 on the following scheduled projects:

- Digital projects
- Delivery of the CT simulator and superficial skin unit
- Installation of the second linear accelerator at Salford
- TIF ward
- Backlog maintenance and other small assets

Cost improvement: The level of recurrent CIP identified to date is under plan at £2.0m compared to a target of £6.4m. Whilst divisions are working on the delivery of cost improvement schemes, this has been significantly impacted by the management of industrial action. The annual CIP target of £12.5m is forecast to be delivered but predominantly through non-recurrent measures; this will create associated pressures for 2024/25.

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

Measure of Financial Performance	Red / Amber / Green rating
Revenue: Trust Control Total compared to plan	£5.3m surplus
Capital: Capital expenditure against plan	£4.7m under plan
CIP identified (recurrent) against target of £6.4m	£2.0m identified
Debtor days compared to 15-day target	12 days
Cash balance	£140m
Better Payment Practice Code (95% target)	97%

GM Recovery: The GM system continues to be supported by the PwC turnaround team in the delivery of 2023/24 outturn; the Trust is fully engaged in this process. This work included optimising the 2023/24 year-end position, identifying any flexibilities in balance sheet position and assessing the underlying run rate.

Reforecast: As previously report to Board, the Trust has reviewed the risks and opportunities in delivery of the Trust's operational plan combined with the financial and operation performance to date to inform a revised year end forecast which now includes funding for industrial action and the Trust's share of the joint venture profit. Incorporating these two elements result in a year end forecast of £6.4m surplus.

2024/25 planning
PwC are also supporting the GM system with the 2024/25 planning round. The Trust is forecasting significant levels of growth in services arising from referral demand and implementation of NICE guidance. This is causing significant pressure on the Trust's commissioners to fund this growth with on-going conversations with the Trust's two main commissioners, GM Integrated Care Board (ICB) and specialised commissioning.

Workforce

Our workforce performance indicators show mandatory training compliance and personal development plan rates are both above (better than) thresholds at 92% and 86.5% respectively. Sickness absence rates have decreased slightly in February to 4.56% (threshold of 3.4%). The overall all year turnover is 14.32%. These issues and the associated plans for improvement have been considered by the Workforce Assurance Committee.

Staff are reminded that they can access a range of key information including Trust workforce policies, information on Health & Wellbeing, recruitment resources and information on leadership and PDRs through this link MeetWorkforceTeam - 1 (pagetiger.com).

The Christie Annual Staff Health and Wellbeing Day ran on Wednesday 20th March. There was a full programme of activities, information, sessions, and workshops which were well attended. Some activities were drop-in so staff could decide on the day, but most required advance booking.

Neurodiversity Celebration Week (18th – 24th March 2024) is a worldwide initiative that aims to challenge stereotypes and misconceptions about neurological differences, including ADHD, autism, dyslexia and dyscalculia. Find out more about neurodiversity on the Neurodiversity Celebration Week website.

NHS Employers have made a number of resources and events available for NHS Staff:

- Download resources and join free events such as how to build a neurodiversity-friendly workplace culture, see Neurodiversity Celebration Week.
- Lexxic have a wealth of resources about neurodiversity.
- Patient Voices have created some digital stories which embrace complexity in neurodevelopment.
- NHS England are running a Coaching for Neurodiversity course on 11 April.

Get involved in Neurodiversity Celebration Week, join the conversation on Twitter using #NeurodiversityCelebrationWeek and follow @NCWeek.

The results of the 2023 NHS national staff survey have now been published. The survey was conducted between 2 October and 24 November 2023 and open to all staff. 1,675 (48%) of 3,454 eligible colleagues completed the survey, matching the national response rate of 48% and up 4% from our response rate of 44% in 2022.

For the third consecutive year, the staff survey questions have been mapped to the themes within the NHS People Promise. We have been rated above average or average on all 7 aspects of the NHS People Promise. Our morale score has improved each year for the last three years. There has been an improvement in a number of our scores when compared to 2022, including the themes of 'we are recognised and rewarded', 'we are always learning' and 'we work flexibly.'

Further work to analyse the results will now be undertaken and information will be communicated throughout the Trust before a period of focussed action planning. The results and the action plans will be scrutinised through the Workforce Assurance Committee in June.

The Muslim holy month of Ramadan started on Sunday 10th March and will end around sundown on Tuesday 9th April ending with Eid-ul-Fitr, a day of gratitude and celebration. For further information please click on:

- Ramadan guidance for details around additional prayer space during Ramadan.
- Prayer guidance
- Nil by mouth should you be interested in participating.

We celebrated International Women's Day on 8 March 2025 and had colleagues and leaders from across the Trust to support the theme #InspireInclusion. To raise the profile of this event, we invited colleagues to share an inspirational story or statement on this Padlet to inspire other women into leadership roles.

It is essential that we all demonstrate a commitment to gender equality, and we hope that colleagues will be supportive of the new Equality, Diversity and Inclusion Women and Gender Identity Staff Network Group. If anyone wants more information about this group or to join it, please get in touch with the Equality, Diversity and Inclusion Team at the-chrisitie.equality@nhs.net.

In 2017, the Government introduced legislation that made it statutory for organisations with 250 or more employees to report annually on their Gender Pay Gap. These regulations underpin the Public Sector Equality Duty and require the Trust to publish their Gender Pay Gap data annually by 30 March. Our median gender pay gap for 2023 is 5.3%, an increase of 1.12% compared to 2022.

On 20th March, the BMA confirmed that following a further ballot for industrial action of junior doctors that that have voted to take strike action. We await further information from the BMA on the details of planned strike days.

Research

The R&I Division is working closely with Pharmacy regarding Aseptic Service Unit capacity for Clinical Trials, with weekly focus at Executive level to address this risk and weekly operational meetings.

Congratulations to Martin Swinton and Prof Ananya Choudhury for a BRC funding award for radiotherapy research in prostate cancer. ECMT won the Social Impact Award at BioNow 2024, partnering with Intercare to redistribute excess clinical trial supplies through this charity (to date over 10000 items) which sends surplus medical aid to around 100 clinics in Africa, providing vital medical care and supporting medical training to some of Africa's most disadvantaged people.

Our aged debt remains high, despite a focussed 2 months to work with our sponsors. An assessment is underway to address gaps and will be supported by our newly appointed Industry Partnership Manager.

Research Teams from Observational, Head & Neck and Lymphoma are moving into the Patterson over the next 8 weeks.

A review of how we record, and mandate Good Clinical Practice training in ESR. Gaps in data quality have been recognised regards ESR updates, and who has GCP assigned in their ESR profiles. Compliance is higher than reported and assurance is provided to the board of internal and external checks at Study Set up and Monitor visits of our studies.

We have been awarded 4 years of new NIHR funding for iMATCH (Innovate Manchester Advanced Therapy Centre Hub) as part of the ATTC (Advanced Therapy Treatment Centre) network Click here to read the Press Release. The new funding is for a network-wide programme with a focus on increasing Advanced Therapy clinical trials activity across the UK incorporating:

1. **Clinical Trials Acceleration:** Streamlining processes and implementing innovative methodologies to expedite the progression of ATMP clinical trials
2. **Training and Education:** Developing specialised training programs to equip researchers and healthcare professionals with the necessary skills and knowledge to navigate the complexities of ATMP trials
3. **Data Collection and Use:** Enhancing data infrastructure and analytics capabilities to optimise decision-making and drive evidence-based advancements in ATMP research
4. **Patient Identification and Recruitment:** Implementing strategies to improve patient access and recruitment for ATMP trials, ensuring diverse and representative participation
5. **Public and Patient Involvement and Engagement:** Engaging with the public and patient communities to foster understanding, awareness, and involvement in ATMP clinical trials
6. **Logistics:** Enhancing logistical capabilities to streamline the supply chain and ensure seamless coordination of ATMP trial activities

iMATCH will be the lead centre in the northwest of England with the expectation that we will add additional clinical and academic partners, but that commercial partners will now form an extended industry advisory group (rather than being formal partners as occurred when the network was funded by Innovate UK). The total funding for iMATCH is just over £3M over the 4 years.

We have received confirmation from the CRUK panel on our successful application for the Cancer Research UK Manchester Centre Clinical Academic Training Programme (ARCTIC2) with the University of Leeds. This will lead to increased positions in Clinical Research

Training Fellow (CRTFs) and MB-PhDs. Overall, the Panel concluded that the CRUK Manchester Centre, with the University of Leeds, had submitted an excellent application with appropriate ambition and innovation. It was impressed by the world-class research environment and high-quality research and training offered.

Education

Leadership of professional/public education: Our Gateway C / Primary Care Oncology programme has passed 17,000 active registered users and the completion of over 11,500 courses to date, including celebrating the launch of the programme's 25th module of online learning. In support of effective learning for Christie Colleagues and external learners.

A new hybrid learning/teaching platform (SpotMe) has been successfully launched to improve the experience of Christie colleagues and external learners, including our recent delivery of ESMO/Christie Lung Cancer Preceptorship Programme to a range of European oncology colleagues.

Supporting a pipeline of high quality clinical and education staff: The NW oncology education collaborative group (chaired by Rikki Goddard-Fuller) continues to work on regional initiatives focused on excellent training experience for both StRs and their supervisors. This includes work led by Christie StRs to support recruitment to combined oncology programmes.

Strategic and Service Developments

Pathology JV Re-procurement – the project team have completed review of the Supplier Questionnaires and three suppliers have been invited to the next stage of the procurement. Site visits took place in January, and we should have all initial bid submissions in mid-March. Following review by the project team the Competitive Dialogue will commence.

Work continues on the formation of a 20-bedroom ward in the former Trust Administration and Digital floors. Internally, the partitions are mostly complete and work on the decoration of some areas has commenced and the mechanical and electrical work is progressing. Externally, the steel frame, staircase and floors are complete with attention now turning to the external cladding. Several risks were identified in respect of the delivery of the project and these continue to be managed.

Work on the refurbishment of the existing Art Room has commenced and is scheduled to complete in May 2024 with the structural works complete and work in progress on the internal partitions. This project is funded by The Christie Charity and the art service has been moved to a temporary location to allow the service to continue during the works.

Planning Permission for the next major strategic development, the Advanced Scanning and Imaging Centre development along Wilmslow Road was received in December 2023; ahead of programme and without any objections being received.

Our Carbon Energy Fund Scheme is a key project in our sustainability aspirations and puts us a step closer towards achieving the NHS Net Zero targets. All works are complete with the transition from the old steam services in progress together with commissioning and validation testing. The scheme is anticipated to be fully operational in the summer 2024. This project is a key part of the Trust and NHS aspiration to reach Net Zero in the future

The replacement of the Superficial Treatment unit and the CT SIM2 have both commenced and are due to complete in May 2024.

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

Greater Manchester System

NHSE North West England Specialised Commissioning Team have written to us to inform us that the delegation of the commissioning of specialised services has been moved from NHS England to Integrated Care Boards (ICBs). They describe how moving to ICB led commissioning enables ICBs to have responsibility and budget for the whole pathway. ICB led commissioning supports joined up care, enabling a focus on population health management, improving the quality of service, tackling health inequalities and ensuring best value. The overarching intention of introducing integrated commissioning is to improve patient health and patient care. The North West is one of three English regions that will delegate the budget and commissioning responsibility for most specialised services from 1 April 2024. The remaining four regions will achieve delegation on 1 April 2025.

Of the 177 specialised services currently commissioned by NHS England, 59 are suitable and ready for ICB commissioning. These services tend to be large services, typically serving a population of one to three million. Approximately 82% of the specialised commissioning budget is associated with the 59 services. Roughly 8% of the overall budget is linked to 89 services that will remain nationally commissioned. Many of these services are supra regional and provided in England at four or fewer centres. About 10% of the budget is for 29 services suitable but not yet ready for greater ICB leadership. Prior to 1 April 2025, for each service, it will be decided if the service is added to the 59 services already delegated to ICBs or to the 89 services remaining with NHS England.

NHS England is responsible for negotiating and agreeing contracts with providers for 2024/25. Once agreed, the contract will be varied to replace NHS England with the relevant ICB as the commissioner. Where appropriate, NHS England will be an associate to the contract for specialised services that have not been delegated to the ICB.

NHS will retain legal accountability for the entire portfolio of specialised services. Additionally, NHS England will keep responsibility for developing national standards, service specifications and clinical access policies. NHS England will also maintain commercial and funding approaches for high cost drugs and devices across all specialised services.

Regulatory

The NHS foundation trust annual reporting manual 2023/24 has been published and contains the formal accounts direction for foundation trusts and the basic structure requirements for reports. Foundation Trusts are also required to follow the Group accounting manual 2023 to 2024 for detailed requirements for their accounts. Work has commenced to bring the Annual Report & Accounts together based on the manuals.

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Agenda item 08/24c

Meeting of the Board of Directors

Thursday 28th March 2024

Subject / Title	Research & Innovation Strategy Performance Update
Author(s)	Prof Fiona Blackhall, Director of Research & Innovation
Presented by	Prof Fiona Blackhall, Director of Research & Innovation
Summary / purpose of paper	This report outlines the progress with the year one priorities against each of the 6 areas of the Research & Innovation strategy.
Recommendation(s)	The Board are asked to note the progress made against the 6 priority areas of the Research & Innovation Strategy and the plans for areas that are progressing more slowly than planned.
Background Papers	Research & Innovation Strategy 2023 - 2028
Risk Score	See Board Assurance Framework risks 4.1, 4.2, 4.3
EDI impact / considerations	Aim to increase access for patients to clinical trials in more locations across GM & Cheshire
Link to: ➢ Trust's Strategic Direction ➢ Corporate Objectives	Achievement of the overall Trust corporate plan and objectives Achievement of the Research & Innovation 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.	R&I Research & Innovation RAG Red, Amber, Green KPI key performance indicator NIHR National Institute for Health & Care Research CRN Clinical Research Network ACP Advanced Clinical Practitioners CRPS Clinical Research Practitioners Role

The Christie
NHS Foundation Trust
Agenda item 08/24c

Board of Directors
Thursday 28th March 2024
R&I Strategy Performance Update

1 Executive Summary

The Research & Innovation (R&I) Strategy was discussed with the Board of Directors throughout 2022 at their planning days and approved by the Management Board in January 2023 then launched in Spring 2023.

This paper outlines the progress with the year one priorities against each of the 6 areas of the R&I strategy. Each is RAG rated and linked to the key strategic themes of inequalities, outcomes and waits as well as the corporate objectives.

The Research & Innovation Strategy is appended to this update (appendix 2).

2 Highlights & exceptions

The table attached to this paper (appendix 1) details progress against each of the milestones in the R&I Strategy for 2023/24.

Excellent progress has been made in many areas of the strategy, particularly with divisional workforce plans including;

- Recruitment to the senior leadership team – Divisional Manager & Deputy
- Restructure of nursing leadership within division
- Expansion of clinical research practitioner roles
- Appointment of a patient experience manager
- Appointment of central team infrastructure posts for real world data research and RedCAP database management.

Other areas of progress include;

- Embedding RedCAP database capability at The Christie for sponsored research
- Input into UK wide KPI setting for clinical trials & outcome measures – oncology specific examples to set targets
- Identifying and addressing operational barriers to improve capacity for clinical trials requiring aseptics production

The areas that are behind plan are;

- To complete a baseline analysis using the NIHR Race Equality Framework Tool for Clinical Research Facilities by Q4 2023/24 – this has commenced in Q4 2023/24
- Recruit Trust wide Research Champions – this will be done in Q3 2024/25
- Expand outreach trials to Salford / Oldham sites – delays caused by competing demands on resource and lack of baseline data for infrastructure; scoping of requirements to complete Q3 24/25
- Achieve set up time of < 120 days for 80% of studies – we anticipate that this will be achieved by Q4 2024/25
- Increase grant applications by 25% on 2022/23 – we anticipate that this will be achieved by Q4 2024/25

3 Recommendation

The Board are asked to note the progress made against the 6 priority areas of the Research & Innovation Strategy and the plans for areas that are progressing more slowly than planned.

The Christie
NHS Foundation Trust

Appendix 1: R&I Strategy 2023-2028 - Year 1 Deliverables & Progress

Strategic Principle	Strategic Aim year 1 priority (May '23 to June '24)	Progress / Update Q3 Actions to achieve or develop strategic aim	Inequalities	Outcomes	Waits	Corporate Objective	RAG Score
P#1 Research for all patients	To increase Clinical Research Network (CRN) recruitment to 2000 patients	Monitoring monthly via divisional board Tracking slightly behind Target additional resource to boost trials in supportive oncology; radiotherapy trial finder for NW ODN Aseptics and trials pharmacy action plan implemented to maintain / expand capacity	✔	✔		4	Amber
	To complete a gap analysis of research & recruitment according to deprivation index by Q3 2023/24 (with GM cancer; Prof David Thomson)	Information gathering to inform gap analysis completed; Shared at the Inaugural Breaking Barriers Meeting October '23. Initiate real time capture of protected characteristics and demographics including deprivation index into monthly performance data March 2024	✔			4	Green
	To complete a baseline analysis using the NIHR Race Equality Framework Tool for Clinical Research Facilities by Q4 2023/24	To commence Q4 Apply framework tool to benchmark current position	✔			4	Red
P#2 Valuing and promoting our Staff	Recruit to senior leadership team – Divisional Manager & Deputy	Divisional Manager commenced in post Dec '23 Deputy post start date TBC		✔		4 7	Green
	Restructure of nursing leadership within division	Associate Chief Nurse, 2 Head nurse secondment roles appointed		✔		4 7	Green
	Expansion of Advanced Clinical Practitioners (ACPs) in Research Roles	ACP posts expanded Roles embedding into Clinical Research Facility		✔	✔	4 7	Green
	Development Programme expansion: B5-6 Research Nurse roles. CRM progression roles; Roll out Sept. B6-7	B5 to B6 roles framework to be submitted to workforce for approval in September 2023 approved		✔		4 7	Green

Strategic Principle	Strategic Aim year 1 priority (May '23 to June '24)	Progress / Update Q3 Actions to achieve or develop strategic aim	Inequalities	Outcomes	Waits	Corporate Objective	RAG Score
	Expansion of Clinical Research Practitioners Role (CRPS).	Clinical Research Practitioners Role expanded		✔	✔	4 7	Green
	Recruit Trust wide Research Champions	Aim deferred to Q3 24/25	✔	✔	✔	4 7	Red
	Agile Research Team development	CRN funding used to pump prime posts to expand recruitment to trials of observational and supportive care			✔	4 7	Amber
P#3 Time to lead & train the next generation	Review of funding model (and charity assets) towards increased investment in protected research time	MD clinical fellowships development plan Training needs analysis RRR Training Academy		✔	✔	4 7	Amber
P#4 Expanding our research environment	Increase outreach trials at Wigan / East Cheshire	Increase in number of trials open at outreach 3 to 7 with further trials in feasibility and set up	✔	✔	✔	4 5	Amber
	Expand outreach trials to Salford / Oldham sites	Benchmarking infrastructure requirements Q 24/25					Red
	Scope requirements for expansion of Clinical Research Facility capacity from 5 day to 24 hour / 7 day opening	Scoping work to understand demand occupancy utilisation initiated			✔	4 5	Amber
	Establish the Pipeline for paperless clinical trial consent and data collection by 2028	Scoping and discovery work in progress			✔	4 5	Amber
	Invest in technology clinical trials (evolve current 'digital ECMT')	In progress, CRN funding to support research delivery			✔	4 5	Amber
	Embed RedCAP database capability at The Christie for sponsored research	Database installed - platform qualification in progress Due to go live Q1 24/25				4 5	Green
	Adopt and embed the single national contract value review	Achieved Q3 23/24 with reduction in time for costings in study set up			✔	4 5	Green

Strategic Principle	Strategic Aim year 1 priority (May '23 to June '24)	Progress / Update Q3 Actions to achieve or develop strategic aim	Inequalities	Outcomes	Waits	Corporate Objective	RAG Score
	Achieve set up time of < 120 days for 80% of studies	Target indicated nationally is < 90 days from expected start date ; process mapping and change in progress			✔	4 5	Red
P#5 Delivering Research to patients faster	Demonstrate improvements in processes for invoicing and financial reconciliation	Weekly financial meeting MIAA audit action plan implemented Development of milestone trackers and reporting through weekly meetings for sponsored research Adoption of Monday.com in progress			✔	4	Amber
	Input into UK wide KPI setting for clinical trials & outcome measures – oncology specific examples to set targets	Process for NCVR adoption to early phase (Phase I trials) now in discussion	✔		✔	4	Green
P#6 Driving Research from idea to impact	Process map of current blocks and barriers in Christie sponsored / investigator led research to inform quality improvement plan	Workshops planned for September through Q4 2023/24 – achieved; action plan in preparation for 24/25 QIP	✔		✔	4	Green
	Design & adopt standard templates	A number of standard contract templates already in use. Review of standard delegation of responsibilities for consideration of adoption into collaboration agreements				4	Amber
	Launch successful Pilot of RedCAP database	Server installed, platform qualification in progress – manuals and guidance tools in development Governance and costing model in development – close collaboration with CODU			✔	4	Green
	Increase grant applications by 25% on 2022/23	Inadequate database to map accurately		✔		4	Red
	Decrease set up times by 50% compared to historical studies	Metrics under review and consideration of further business intelligence requirements to support baseline data to enable proportionate set up timelines to be agreed based on study type			✔	4	Amber

Research and Innovation Strategy

2023 - 2028

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Foreword

Fiona Thistlethwaite
Director of The Christie Clinical Research Facility

Fiona Blackhall
Director of Research and Innovation

Evelyn Dolan
Lead Research Nurse

The Christie has a proud 100 year history of cancer research. This strategy will reset our culture, environment and economy to continue this legacy for future generations.

Research is essential for best outcomes and is at the heart of our clinical care. For decades patients have come from far and wide to access trials of tomorrow's treatments today. We owe them a debt of gratitude and must continue to provide trials for more patients to benefit from now and in the future. We recognise that at present clinical trials are not sufficiently representative and inclusive of all patients within our diverse region. We need to look beyond traditional research practices and towards real world evidence, clinical outcomes, and innovative trial design to enable the inclusion of patients who are currently under-represented in research.

We are on the brink of a new era for The Christie Research and Innovation Division. In 2023 The Paterson state of the art facility will bring clinicians, surgeons, allied health professionals, scientists and skilled clinical research managers together in a truly collaborative environment. The Christie, The University of Manchester, and the Cancer Research UK Manchester Institute will realise The Manchester Cancer Research Centre vision of research leading to life-enhancing and life-saving treatments. Our multidisciplinary teams, whether working from laboratory benches, outpatient clinics, surgical theatres, outreach centres or ambulatory care wards will focus on answering the key questions to enable better care and outcomes for our patients.

We are grateful to all of our staff and colleagues who have contributed their time and energy to this 'R and I reset'. It is our privilege and responsibility to deliver this strategy to keep pace with the evolving research landscape. We aim to do this through modernising processes, harnessing digital innovation, expanding our capabilities and being agile to the diverse and changing needs of our patients and expert research community.

Executive summary

Introduction

The Christie Research and Innovation Division Strategy 2023-28 sets in motion a reset centred on 6 guiding principles to realise our vision of learning from every patient, enabling every patient to participate in research and applying this knowledge to improve life-enhancing and life-saving treatment for our patients now and in the future.

Research and Innovation is at the foundation of the four cornerstones of The Christie Vision encompassing Leading Cancer Care, The Christie Experience, Local and Specialist Care, and Best Outcomes. Our research spans discovery science through proof-of-concept early phase trials to phase II and III trials that translate to new clinical guidelines and real-world evidence research to inform health service implementation and individualised care.

Over 200 staff participated in feedback and engagement sessions to inform this strategy. A fresh focus on our economy, culture and environment is vital for a sustainable future. Our strategy is aligned to local, regional and national drivers for research delivery in healthcare. Through 2023 to 2028 we will secure research career pathways, remodel our processes and empower our researchers to serve the needs of our patients.

This strategy intends to:

- Provide **essential underpinning mechanisms** to **enable** the **research endeavours** of our **colleagues**
- **Democratise research** to our **expert leaders** and **early career researchers** in their bespoke fields by providing **unbiased, expert** and **equitable** support

Our 6 guiding principles are :

- **Research for all patients**
- **Valuing and promoting our staff**
- **Time to lead research and train the next generation**
- **Expanding our research environment**
- **Delivering research to patients faster**
- **Driving research from idea to impact**

Our vision: A Research and Innovation reset

Aligned to wider Trust strategies, we will undergo a 'Research and Innovation reset' in readiness for a new era of Christie Research, where we aim to:

Learn from **every patient**

Enable every patient to **participate** in research

Apply this knowledge to **improve the lives of patients** with cancer **now and in the future**

Summary: Our guiding principles

The R&I Divisional Strategy is based around six guiding principles, each of which comprises a vision statement and set of key aims. All future projects and programmes of work will be aligned to a guiding principle.

(Further detail on the strategy guiding principles, aims and objectives can be seen on pages 14-25)

Principle	Vision	Aims
1. Research for all patients	*'Our research serves the needs of our diverse patient population, is inclusive and redresses inequalities'*	■ Actively involve and engage patients in research at The Christie ■ Use real-world data to inform and enable equitable, diverse and inclusive research ■ Invest in areas of unmet research need across the North West ■ Enhance patient focused communications initiatives
2. Valuing and promoting our staff	*'Our staff are recognised for their skills and rewarded for their work'*	■ Evolve the organisational structure of the R&I Division ■ Develop a modern dynamic R&I centric HR process ■ Create new roles to meet the needs of the changing workforce market ■ Standardise progression roles for clinical and research management staff ■ Offer wider professional development opportunities to staff at all levels ■ Enhance staff recognition across the division ■ Create new models for staff retention
3. Time to lead research and train the next generation	*Our research leaders set the standards for others to follow'*	■ Provide time to staff to pursue research opportunities ■ Solidify a research leadership pipeline for early career researchers across all speciality groups and disciplines ■ Establish links to internationally recognised and renowned research fellowships for next generation cancer research leaders
4. Expanding our research environment	*'Our environment is safe, secure and quality assured'*	■ Expand our outreach capabilities to reach more patients ■ Explore decentralised research approaches ■ Use the Pater son development to our advantage ■ Leverage our supporting departments ■ Embed cancer research into the Integrated Care System ■ Digitally enable our division
5. Delivering research to patients faster	*'Our research brings tomorrows treatments to patients faster'*	■ Create a transparent and dynamic funding model which benefits the whole division ■ Redesign our research set-up and delivery processes ■ Enable change management process across the division ■ Evolve our divisional metrics to optimise performance ■ Promote sustainable research practices ■ Digitally enable our research operations
6. Driving research from idea to impact	*'We enable and empower our researchers'*	■ Develop a fit for purpose funding model to protect and invest in Christie led and sponsored research ■ Establish a research design and support unit ■ Develop in house Clinical Trial Unit capabilities ■ Streamline operations for Christie Sponsored Research ■ Build our in-house data science capabilities

Strategic context

Our Organisation with Research at the Core

The Christie serves a local population of 3.2 million across Greater Manchester and Cheshire. Approximately 27% of our patients come from outside this locality to receive specialist care.[1]

Our organisation with research at the core

100 Principal Investigators

150 Clinical Delivery staff

150 Research Management staff

Our Research Facilities

At The Christie, we benefit from state-of-the-art buildings and international standard facilities that support our world-class skills and expertise.

The National Institute for Health Research (NIHR) Manchester Clinical Research Facility (CRF) at The Christie NHS Foundation Trust specialises in early-phase and first-in-human clinical research trials. The CRF houses outpatient, phlebotomy and day-care treatment areas and a pre-analytic processing laboratory. It also provides specialist staff, monitors patients in clinical trials, administers treatments, and processes and stores samples.

The Wade Centre is a dedicated radiotherapy research facility. It is one of the largest radiotherapy units in the world. The Centre provides radiotherapy-based cancer researchers with advanced level imaging equipment that is only available at a limited number of sites worldwide.

The Proton Beam Therapy Centre at The Christie is the first of its kind in the NHS. Its unique research room is used in clinical research studies for children and young people.

The new state-of-the-art cancer research centre being built on the site of our former Paterson building will bring together scientists, clinicians and allied health professionals to enable world leading collaborative research at The Christie.

Research in the National Health Service

National Policy for Research in the NHS

The Future of UK Clinical Research Delivery Implementation Plan,[2,3] developed by the National Institute for Health and Care Research sets out 5 key themes for NHS research providers to address:

1. **Clinical research embedded in the NHS**
2. **Patient-centred research**
3. **Streamlined, efficient and innovative research**
4. **Research enabled by data and digital tools**
5. **A sustainable and supported research workforce**

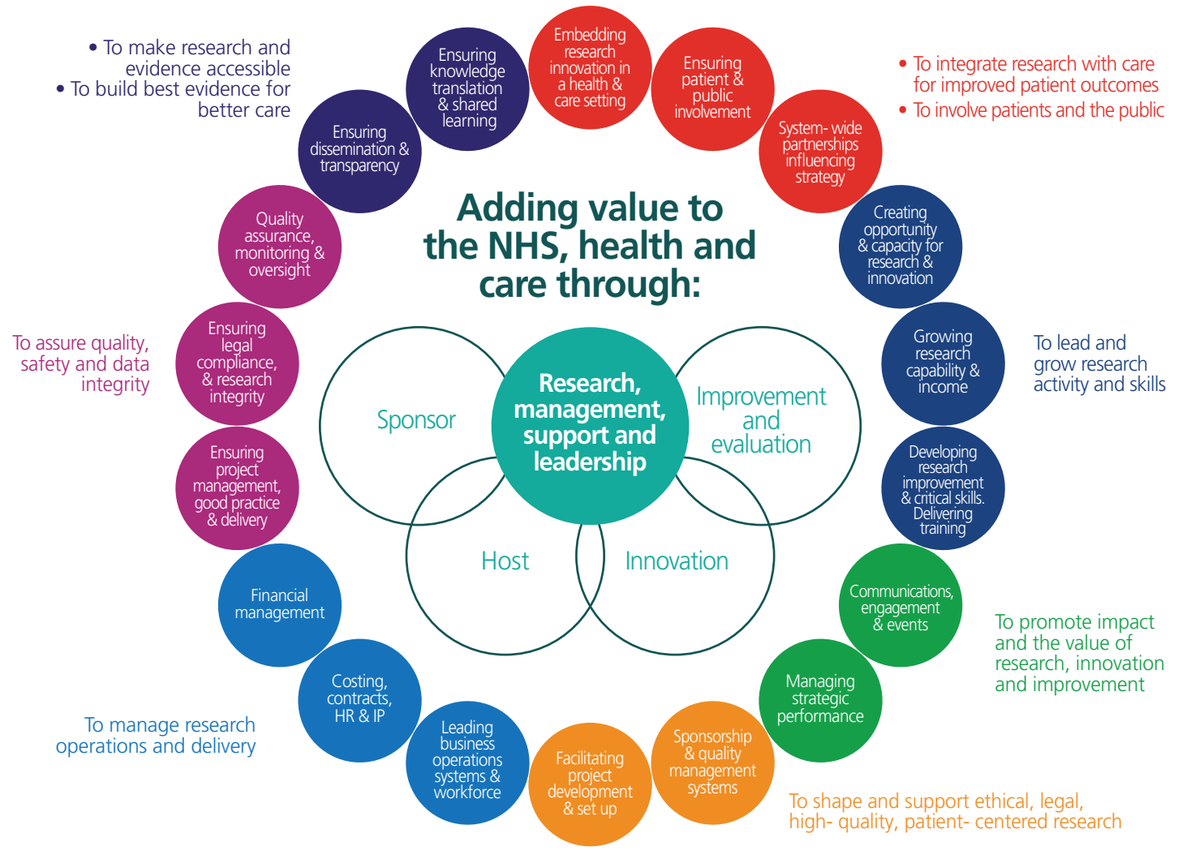
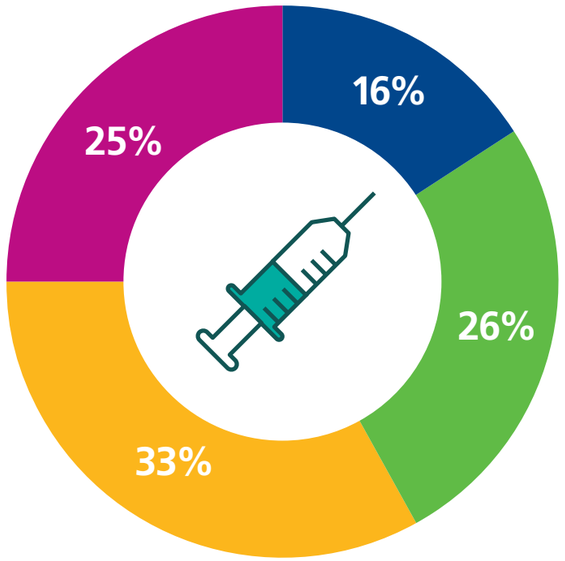


Figure 1: Research adding value to the NHS. Diagram demonstrating the potential roles and activities of a model Research and Innovation Division within the NHS. Outer circles depict high level activities. Outer boxes depict general linked purposes. Inner circles depict functions that different Research and Innovation Offices might undertake.[4]

Our clinical trials portfolio

Our current portfolio spans 871 phase I, II, III, IV or observational research studies that are in set-up, actively open to participation of patients or closed to recruitment undergoing active follow up of patients enrolled and analysis of clinical outcomes. We currently work with >220 clinical trial sponsors, with 54% of trials attributed to commercial activity and 46% attributed to non-commercial clinical trial activity.

871 active clinical trials*



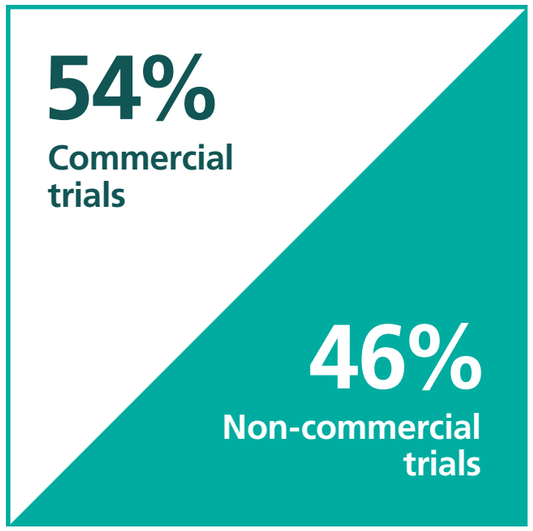


Figure 2: Topline metrics snapshot for clinical trials portfolio at The Christie NHS Foundation Trust.
*Active studies defined as those in set-up, actively recruiting patients or in follow-up. Other Studies inclusive of basic science, biobank and observational studies. Activity snapshot taken 10 January 2023.

Translational Research: The Big Picture

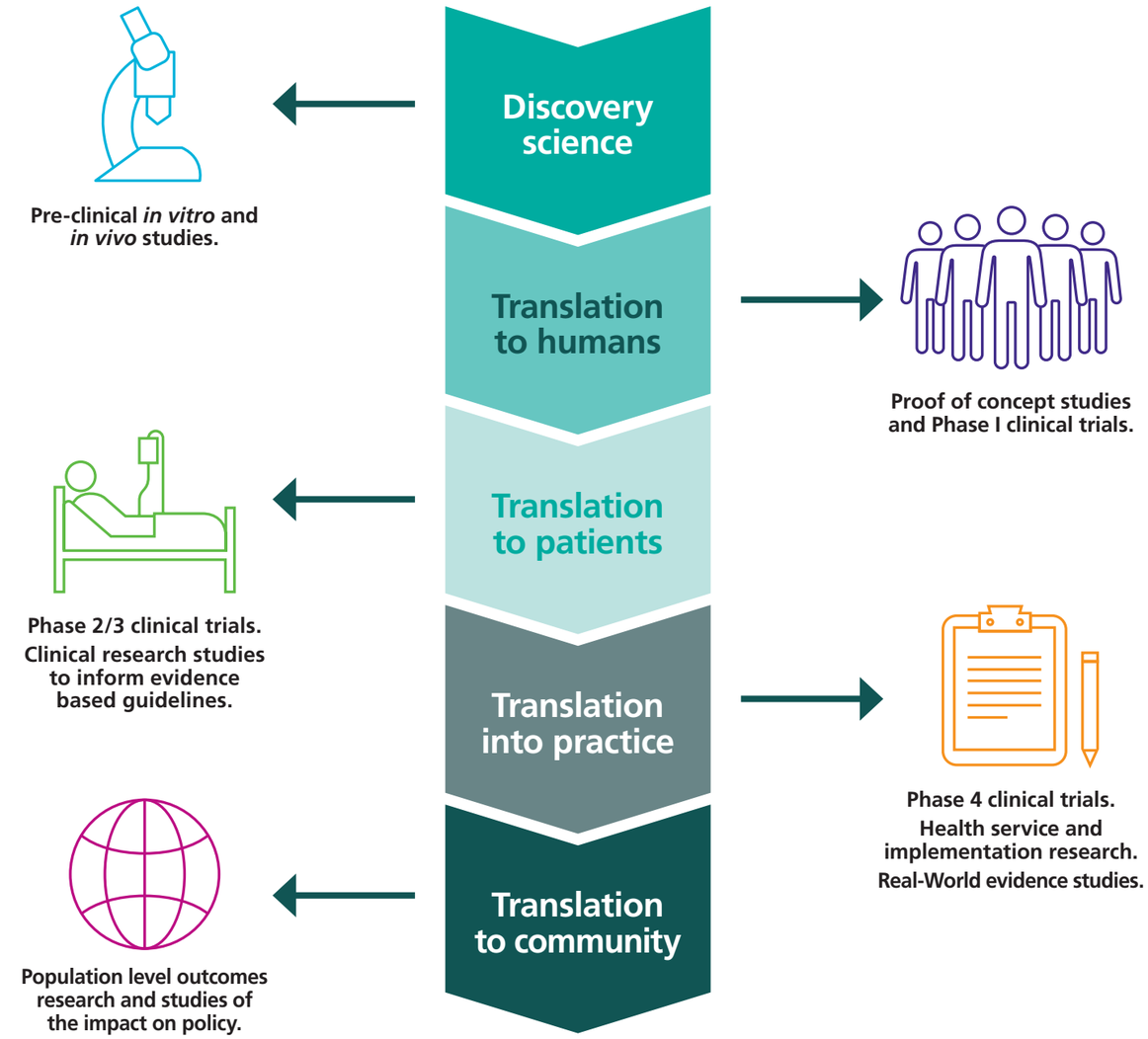


Figure 3: The translational research journey. Diagram depicting the bigger picture of translational research. The journey begins at pre-clinical scientific discovery, and progresses through to volunteers and patients in clinical trial phases. The research journey then continues into clinical practice where real world evidence research is featured before larger scale research endeavours are undertaken at a population level.

Our collaborative networks

Research at The Christie is interconnected and collaborative at a regional, national and international level. Our researchers lead strategies in our networks to achieve world leading impactful cancer research excellence.

Figure 4: The Christie Research and Innovation Division at the heart of regional and national world leading collaborative cancer research strategies. Specific details of individual strategies can be found on the respective websites.[5-20]

The Scope of this Strategy: An R & I reset

Overview

This strategy aims to ensure that all patients, all types of cancer, all cancer treatments and all specialisms are included in the guiding principles that define it.

At The Christie, our doors are open to all patients and our research needs to match their diversity. This strategy is an opportunity to modernise our services and to establish new ways of directing and prioritising our research for the benefit of all researchers and all patients.

With this strategy we will:

- Provide a common ethos for our research community by setting out our shared purpose and research culture
- Focus on facilitating the research endeavours of our expert colleagues
- Support our diverse and multi-professional workforce
- Ensure that the patient voice and patient need is a central focus in how we prioritise individual research plans
- Leverage our research environment to extend our reach to more patients

Empowering our Researchers

We aim to enable the research endeavours of our colleagues by providing essential underpinning support mechanisms.

We intend to democratise research to our expert leaders and early career researchers in their bespoke fields and do not intend to dictate specific research questions or the types of research that we use to find the answers. Our colleagues will be supported in an unbiased fashion where all research areas and specialisms are supported equitably.

The strategy aims to ensure that

are included in the guiding principles that define it

Development of this strategy

In developing this strategy we:

- Conducted a **key stakeholder analysis** to formulate a **targeted engagement plan**
- **Engaged** with **all research staff members** and groups via our **R & I Divisional Meeting**
- Held **focused strategy planning workshops** to **reflect on key challenges, develop solutions** and **proactively plan for the future**
- Used **data from staff surveys** and **patient feedback** in its development
- **Aligned** our strategy to that of **other divisions and departments** across the Trust
- Ensured that our **strategic aims** were **complementary** to those within the strategies of our **external collaborative networks.**

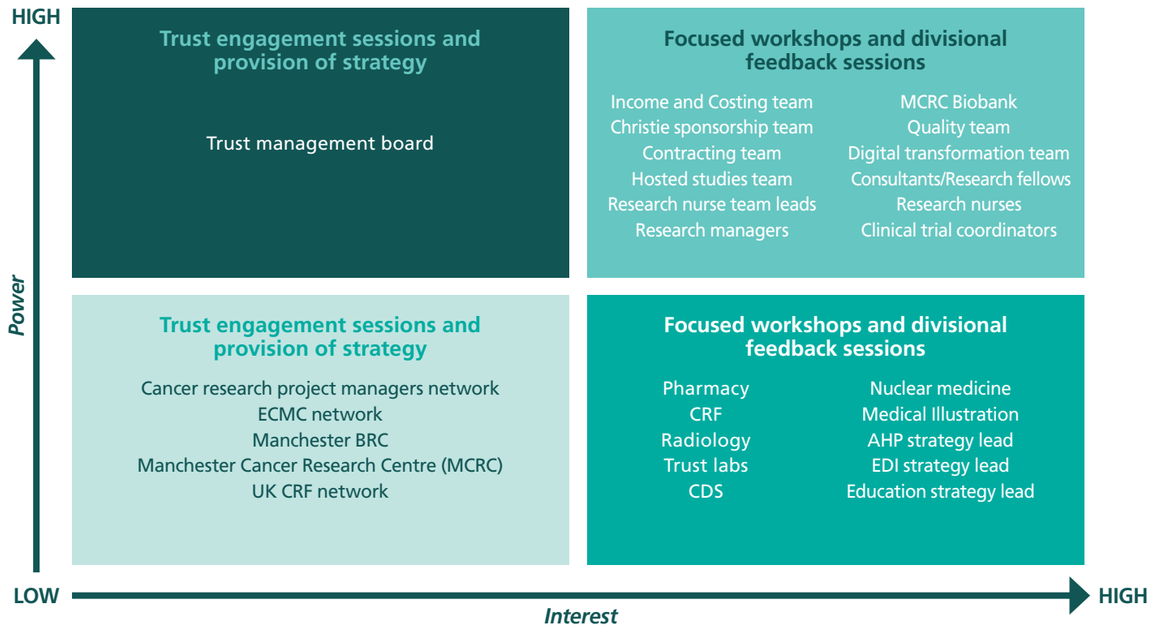


Figure 5: Stakeholder analysis and engagement plan used during formulation of this strategy. The R&I Divisional meeting enabled division wide feedback to be fed into the strategy. Focused strategy planning workshops, data from staff surveys and patient feedback was also a key feature in its development. This strategy was also aligned to that of other divisions and departments across the Trust.

Our implementation plan

How will we implement our strategy?

This strategy document sets out the scope and intent of our divisional plans for the next five years. The next steps will feature a full implementation phase where we will proactively engage with our mutiprofessional teams to collaboratively develop specific roadmaps, key metrics and set realistic targets as measures of our success.

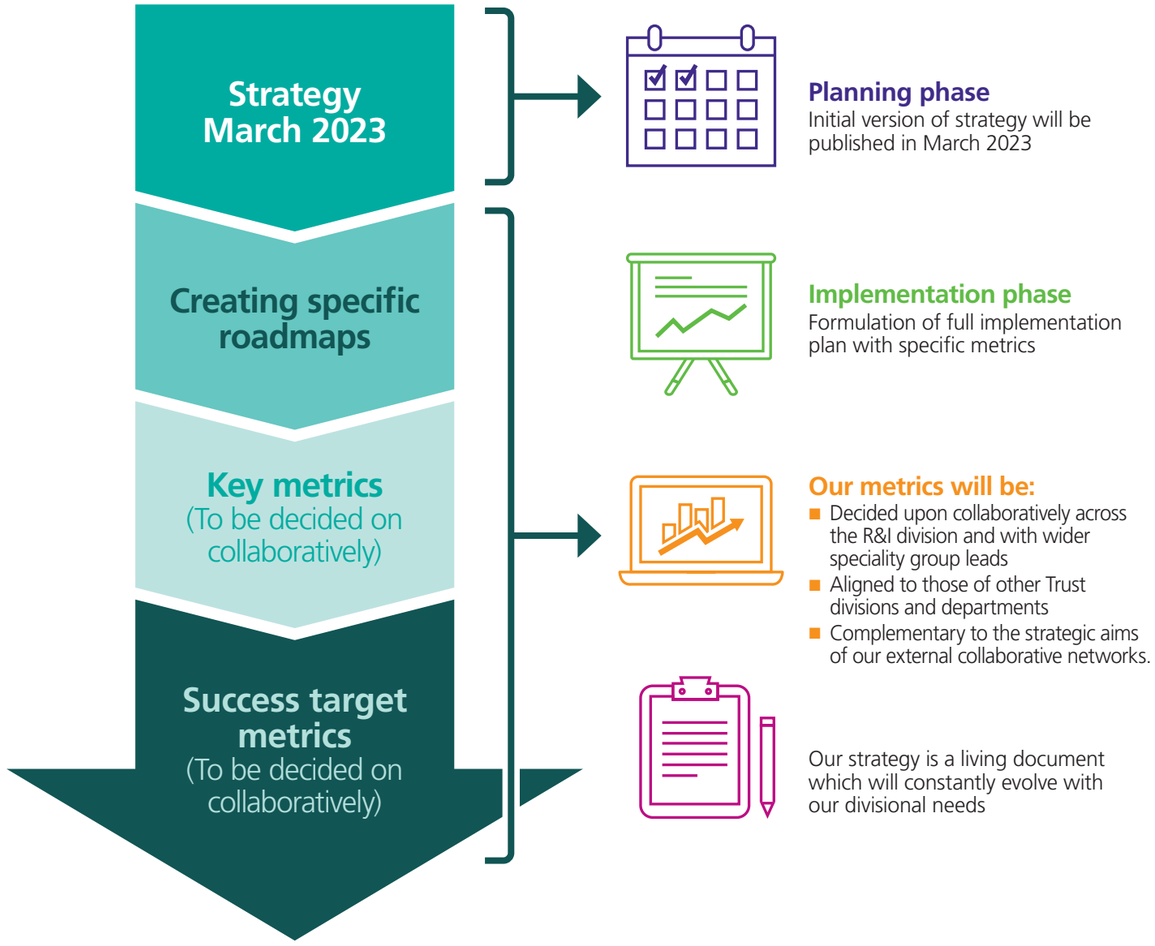


Figure 6: Initial next steps for rollout of strategy. The initial strategy document will be published in March 2023 as part of initial planning phase. This will be followed by an implementation phase during which specific roadmaps and key metrics are decided upon collaboratively across the division, and with wider speciality leads. An annual report will be implemented to inform on progress and develop the strategy over time.

Principle 1: Research for all patients

Vision

'Our research serves the needs of our diverse patient population, is inclusive and redresses inequalities'

Why is this important?

- Greater Manchester has a **growing** and **increasingly diverse population** of **over 2.8 million citizens** [21]
- The region's Integrated Care System serves the **third most deprived** English **population** [21]
- The **unequal distribution** of **social, environmental** and **economic conditions** causes **preventable differences in health status** between individuals and groups [22]
- The region is the **highest recruiter by population size to cancer research trials** in England yet despite this, **most cancer patients are not offered a research opportunity** [23-26]

Key evidence link:

Key aims of this guiding principle

- Actively involve and engage patients in research at The Christie
- Use real-world data to inform and enable equitable, diverse and inclusive research
- Invest in areas of unmet research need across the North West
- Enhance patient focused communications initiatives

Trust strategic goal this principle links to:

Grow the pipeline of Christie Leaders with regional, national and international influence

Principle 1: Our plan

Key aim	Objectives
Actively involve and engage patients in research at The Christie	■ Develop operational links to existing patient and public Involvement and engagement groups across Greater Manchester with a view to: – Co-creating Christie-led research with patients – Enabling patient peer-review of investigator-led clinical trial materials for Christie Sponsored Research – Holding workshops with patients to gain their insights on research initiatives for NIHR grant applications – Involving patients in the design of large-scale research events designed to reach patients and promote research at The Christie such as International Clinical Trials Day
Use real-world data to inform and enable equitable, diverse and inclusive research	■ Develop pathways for real-time clinical outcomes data and analytics to inform on current inequalities in research and innovation at The Christie ■ Embed clinical leadership including a nurse lead with expertise to drive inequalities research ■ Progress initiatives to tackle these inequalities underpinned by measurable objectives
Invest in areas of unmet clinical need across the North West	■ Perform a complete gap analysis of current research efforts and local patient population by cancer type ■ Create resource for research projects in underserved clinical areas
Enhance patient focused communications initiatives	■ Scope out the best position for communications support within the R&I division with a view to: – Developing patient focused materials to showcase and raise awareness in Research and Innovation at The Christie – Providing a complete overhaul of the R&I pages on the externally facing website to provide research content suitable for patients – Rolling out patient facing research showcase events

Principle 2: Valuing and promoting our staff

Vision

'Our staff are recognised for their skills and rewarded for their work'

Why is this important?

- Cancer research requires a **sustainable** and **supported research workforce**
- A **career in cancer research** should offer **exciting opportunities** for **all healthcare** and **research staff** of **all professional backgrounds** [2]
- Opportunities should **span** the **length and breadth** of **commercial** and **non-commercial research** [2]
- There is a **current recruitment** and **retention crisis** for **clinical research staff** which requires immediate attention [27]

Key evidence link:

Key aims of this guiding principle

- Evolve the organisational structure of the R&I Division
- Develop a modern dynamic R&I centric HR process
- Create new roles to meet the needs of the changing workforce market
- Standardise progression roles for clinical and research management staff
- Offer wider professional development opportunities to staff at all levels
- Enhance staff recognition across the division
- Create new models for staff retention

Trust strategic goal this principle links to:

Accelerate reputation as a progressive educational organisation through demonstrable impact of culture and educational scholarship on practice

Principle 2: Our plan

Key aim	Objectives
Evolve the organisational structure of the R&I division	■ Restructure of the R&I division to: – Enable a collaborative style of leadership that aligns structurally to the Trust model – Embed dedicated R&I positions across all supporting departments
Develop a modern dynamic R&I centric human resources process	■ Realigning dedicated human resources to support the unique needs of the R&I division with a view to: – Streamlining the recruitment process to enable faster recruitment – Facilitating the recruitment process – Promoting Christie research specific roles across universities and other external sites – Enabling advertising of research roles across communication channels such as social media – Developing webpage profiles for our unique research roles – Creating proportionate time within job plans to enable staff management
Create new roles to meet the needs of the changing workforce market	■ Map out the current gaps in expertise across the division while: – Streamlining the recruitment process to enable faster recruitment – Developing new roles to enhance our research structure and address our current needs e.g. advanced clinical practitioners, research practitioners, research project managers – Rebranding our current roles to reflect the expertise of our workforce – Formulating a clear leadership support structure for clinical and non-clinical (research management) staff ■ Create a dynamic clinical trials resource to support our teams as they transition towards new ways of working.
Standardise progression roles for clinical and research management staff	■ Develop clear progression pathways for all our staff – Clearly promote these opportunities internally and externally ■ Expand existing apprenticeship programme roles into all teams within our division.
Offer wider professional development opportunities to staff at all levels	■ Offer bespoke opportunities to meet the career ambitions of all our staff including: – Leadership qualifications – Specialist degrees – Research governance skills – Management skills – Apprenticeship programmes ■ Map out the skills needed within our workforce to realise the potential of our division ■ Facilitate inter-departmental job shadowing to enable staff to recognise how different roles work together to meet the needs of our patients to actively encourage team work and collaborative working ■ Promote and expand multi-layered educational opportunities across the division e.g. implementation of knowledge champions.
Enhance staff recognition across the division	■ Recognise staff achievements at divisional and Trust level meetings ■ Celebrate the research success of our staff at division wide, Trust wide and national events ■ Ensure PDR objectives are linked to the key principles of this strategy, so staff recognise their contribution at a divisional level.
Create new models for staff retention	■ Actively promote new hybrid work models across the division ■ Ensure permanent roles are offered to all staff rather than fixed term contracts ■ Enable clear communication of our promotion opportunities internally and externally so that career progression is recognised.

Principle 3: Time to lead research and train the next generation

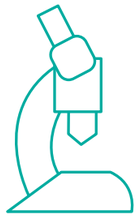
Vision

'Our research leaders set the standards for others to follow'

Why is this important?

- Patients treated in research-active healthcare settings have better outcomes and receive better care yet **NHS staff increasingly lack the capacity** to **engage with research** due to **lack of dedicated research time** and **funding** [28-29]
- Due to this, the **number of clinical-academic research leads** is **declining** leading to a **widening gap between the NHS and academia** [28-29]
- It is imperative that these **issues are addressed** to **accelerate** the **translation of research** into **patient benefit,** achieve **better population health** and **increase the appeal of the UK** as a **global hub** for life sciences [28-29]

Key evidence link:



Key aims of this guiding principle

- Provide time to staff to pursue research opportunities
- Solidify a research leadership pipeline for early career researchers across all speciality groups and disciplines
- Establish links to internationally recognised and renowned research fellowships for next generation cancer research leaders

Trust strategic goal this principle links to:

Grow the pipeline of Christie Leaders with regional, national and international influence.

Principle 3: Our plan

Key aim	Objectives
Provide time to staff to pursue research opportunities	■ Enable time for staff to do research by working towards the following: – Providing job plans with protected research time across all disciplines, specialities, and staff groups – Ensuring a personal research goal is embedded into PDR objectives for all staff – Resourcing research leaders to enable them to deliver research specific outputs – Providing incentives for research success ■ Develop a sustainable funding model for substantive research posts within the NHS
Solidify a research leadership pipeline for early career researchers across all speciality groups and disciplines	■ Recognise our ambition of embedding research leadership posts at an executive level into our leadership structure ■ Look towards establishing coordinated training programmes for next generation cancer research leaders ■ Formalise research support posts across the division e.g. research project managers ■ Develop expertise in emerging research fields
Establish links to internationally recognised and renowned research fellowships for next generation cancer research leaders	■ Begin the process of establishing fellowship posts across all speciality groups and disciplines underpinned by a sustainable funding model

Principle 4: Expanding our research environment

Vision

'Our environment is safe, secure, and quality assured'

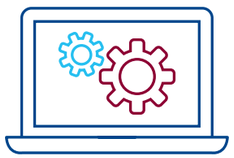
Why is this important?

- It is critical that our research delivery environment is **embedded in the NHS** and **enabled by digital infrastructure** to **improve patient lives** and **address health inequalities** [2]
- Advances in **digital health technology** and **home care models** have **increased** the **feasibility** of **decentralised trials** in oncology
- This **decentralised research** approach has the potential to make **research available** to patients **regardless of location** and substantially **increase acces**s to clinical trials, **enhancing participant diversity** and the **generalisability of results** [30]
- Facilitating these approaches will require a **major shift** in **clinical trial operations.**

Key evidence link:

Key aims of this guiding principle

- Expand our outreach capabilities to reach more patients
- Explore decentralised research approaches
- Use the Paterson development to our advantage
- Leverage our supporting departments
- Embed cancer research into the Integrated Care System
- Digitally enable our division



Trust strategic goal this principle links to:

Develop a secured-data environment with regional and national capability in collaboration with research partners.

Principle 4: Our plan

Key aim	Objectives
Expand our outreach research capabilities to reach more patients	■ Evolve the roadmap for increasing the number of Christie Outreach Sites over the next 5 years e.g. Sites at Salford and Oldham
Explore decentralised research approaches	■ Begin identifying decentralised research models and explore how our research capabilities can be adapted ■ Link in with our Trust digital team to roll out e-consenting capabilities across the R&I Division
Use the Paterson development to our advantage	■ Use this facility for collaborative working with cancer research scientists to enable bench to bedside treatment realisation ■ Actively promote the value and expertise of our Christie clinical colleagues to engage scientists in clinician-led translational research ■ Take opportunity to bring the patient into focus with our scientific collaborators ■ Horizon scan to assess the impact of enhanced translational research endeavours as a result of the Paterson development and create resource accordingly
Leverage our supporting departments	■ Build research capacity in support services to enable growth ■ Work collaboratively to develop new models of sustainable delivery e.g. Pharmacy, Radiology, Nuclear Medicine, Pathology ■ Enable the academic research endeavours of our expert colleagues within our supporting departments ■ Leverage the current excellence in care provided on the Clinical Research Facility to enable a 24 hour, 7 days per week patient service.
Embed cancer research into the Integrated Care System	■ Explore the integration of other services with clinical trial protocols e.g. Christie at Home ■ Increase the number of Advanced Clinical Practitioners acting as Principal Investigators on clinical trials ■ Actively engage with other departments to promote research and demonstrate how their roles are part of the research journey
Digitally enable our division	■ Promote the Trust digital solutions available across the R&I division with a view to: – Enabling hybrid meeting spaces to function effectively – Finding solutions for our divisional space issues ■ Explore the right Trusted Research Environment for The Christie ■ Establish links with the Clinical Outcomes and Data Unit to develop models for real world evidence research services.

Principle 5: Delivering research to patients faster

Vision

'Our research brings tomorrow's treatments to patients faster'

Why is this important?

- Data from the ABPI in conjunction with the NIHR CRN suggested that **patient access to industry led clinical trials** in the UK **fell by 44%** between 2017/18 and 2021/22 [31]
- This **reduced access** to **interventional industry clinical trials** represents **diminished access** to **innovative treatments,** with **significant consequences** for **patients** [31]
- Particularly **serious implications** are linked to the health outcomes of **patients with limited treatment options** in routine care such as **rare diseases** and **cancer** [31]
- Consistently **slow** and **variable study set-up timelines** in the **NHS** are **implicated in driving** this **decline** and **must be addressed.** [31]

Key evidence link:

Key aims of this guiding principle

- Create a transparent and dynamic funding model which benefits the whole division
- Redesign our research set-up and delivery processes
- Enable change management process across the division
- Establish a data driven culture across the division
- Promote sustainable research practices
- Digitally enable our research operations

Trust strategic goal this principle links to:

Accelerate research delivery through efficiencies and innovation to bring tomorrow's treatments to patients faster

Principle 5: Our plan

Key aim	Objectives
Create a transparent and dynamic funding model which benefits the whole division	■ Provide refreshed transparency on divisional finances ■ Develop a culture of investment and growth across the division ■ Facilitate regular business reviews with all teams to enable proactive redistribution of funds relevant to team ambitions (e.g. CRN funding) ■ Demonstrate financial best practices e.g. full audit trails documenting all key decisions, updated design of financial overview packs as useful tools for making business decisions
Redesign our research set-up and delivery processes	■ Form a hosted research studies working group with the goal of redesigning our research set-up and delivery processes to improve NIHR metrics and user experience ■ Roll out the NIHR National Contract Value Review process ■ Explore resource to enable teams to better deliver commercial Real World Data clinical trial protocols
Enable change management process across the division	■ Begin scoping the possibility of incorporating a dynamic transformation team (project management function) into our divisional structure ■ Fully map processes at all levels including current responsible persons so that gaps can be identified in personnel and bureaucracy can be reduced ■ Proactively communicate to teams how they can implement change at a divisional level ■ Review and reorganise divisional meetings to enable change management
Establish a data driven culture across the division	■ Provide training to all teams on how they can use Christie Data to make local strategic improvements ■ Map out metric requirements for annual reports and create pathways for their proactive provision ■ Highlight best channels for teams to communicate their future data needs
Promote sustainable research practices	■ Form an R&I focused sustainability working group with a view to promoting best practices internally and externally ■ Link in with Trust led sustainability leads to promote initiatives at a divisional level ■ Promote our digital initiatives internally and externally which enable sustainability in research e.g. paperless clinical trials, remote monitoring, e-consenting, lab kit recycling ■ Establish paperless ways of working across the division via a dedicated programme of work
Digitally enable our research operations	■ Work jointly with digital services to integrate digital tools and systems into a seamless clinical care and research interface.

Principle 6: Driving research from Idea to Impact

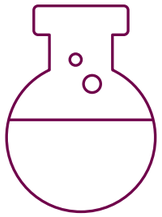
Vision

'We enable and empower our researchers'

Why is this important?

- Our **experts** drive research in areas of **unmet clinical need** to **improve the lives of patients**
- Our **investigator-led research** is **time critical** and we must **implement** and **adopt systems** to **accelerate** the time taken for an **idea** to progress **from scientific discovery** to **clinical impact** [32]
- Driving **research outputs** is key in **creating** more **research opportunities** and is fundamental to **our reputation** and **success** as a **world-class research destination**
- This focus serves as **investment** in the **needs** of our **future patients**

Key evidence link:



Key aims of this guiding principle

- Develop a fit for purpose funding model to protect and invest in Christie Sponsored Research
- Establish a research design and support unit
- Develop in house Clinical Trials Unit capabilities
- Streamline operations for Christie Sponsored Research
- Build our in-house data science capabilities

Trust strategic goal this principle links to:

Realise the potential of the Paterson development with seamless integration of research with clinical care

Principle 6: Our plan

Key aim	Objectives
Develop a fit for purpose funding model to protect and invest in Christie Sponsored Research	■ Refresh the current funding model to enable investment in investigator-led Christie branded research across the division ■ Provide enhanced facilitation of grant applications for our Christie investigators to increase divisional income e.g. grant writing, costings, project management ■ Advertise new clinical posts to project managers and academics for incorporation into grant applications which are relevant to the work being undertaken and better value for money e.g. research practitioner posts for non-interventional protocols
Establish a research design and support unit	■ Reorganise current staff and recruit to new positions to enable end to end research design and support from concept to completion ■ Develop an effective resource allocation system for project management and medical writing to drive a pipeline of flagship and pilot projects ■ Promote current capabilities and ambitions of the Christie Sponsorship team across the division ■ Develop digital tools and systems including a staff app for research to sign post users to administrative and regulatory requirements ■ Provide a regular project scoping board to fully leverage local expertise, team science and capabilities also external CRUK-MI with Paterson move ■ Formation of a translational research forum to inform researchers on multidisciplinary requirements for their research projects
Develop in house Clinical Trials Unit capabilities	■ Collaborate with external Clinical Trial Unit specialists to evolve new models of Clinical Trial Unit capability ■ Define and embed an operating system and staff to enable regulatory compliance in study delivery ■ Scope digital system requirements for attracting business and streamlining operations such as: – Data management systems – A sponsor 'self-serve' portal for low risk, observational studies ■ Engage with Clinical Trial Units to inform on required expertise e.g. Information Governance, Intellectual Property, medical writing, data management, statisticians and clinical trial monitors
Streamline operations for Christie Sponsored Research	■ Pragmatically reduce unnecessary research bureaucracy ■ Develop Standard Operating Procedures which are proportionate to risk ■ Launch a sponsor 'self-serve' portal for low risk, observational studies
Build our in-house data science capabilities	■ Build data science capability for real world evidence research in collaboration with the clinical outcomes group ■ Provide a safe, secure and maintained database platform for research data.

You spoke and we listened

Figure 7: Depicting key themes most important to our staff. Feedback from dedicated strategy planning workshops were used in the generation of this word-cloud. These topics have been recognised as being most important to our staff and will be addressed with the implementation of this strategy.

References

1 A profile of the Christie, The Christie NHS FT [2022]
2 Saving and Improving Lives: The Future of UK Clinical Research Delivery [2021]
3 The Future of UK Clinical Research Delivery: 2022 to 2025 implementation plan [2022]
4 Adding Value to the NHS, Health and Care, through Research Management, Support and Leadership [2017]
5 North West Genomic Laboratory Hub [2023]
6 Greater Manchester Cancer Alliance [2023]
7 Experimental Cancer Medicine Centre Network [2023]
8 Cancer Research Project Manager's Network [2023]
9 University of Manchester, Division of Cancer Sciences [2023]
10 Cancer Research UK Manchester Institute [2023]
11 International Alliance for Cancer Early Detection (ACED) [2023]
12 Manchester Cancer Research Centre [2023]
13 NIHR Manchester Biomedical Research Centre [2023]
14 Health Innovation Manchester [2023]
15 NIHR Manchester Clinical Research Facility [2023]
16 Digital Experimental Cancer Medicine Team [2023]
17 CRUK Lung Cancer Centre of Excellence [2023]
18 CRUK RadNet Manchester [2023]
19 Innovate Manchester Advanced Therapy Centre Hub (iMATCH) [2023]
20 Manchester Breast Centre [2023]
21 Greater Manchester Combined Authority Census 2021 First Results [2022]
22 Ethic Inequalities in Manchester: A Need for Local Partnerships and Solutions [2017]
23 The English Indices of Deprivation [2019]
24 Integrated Care Systems: What do they Look Like? [2022]
25 National Cancer Patient Experience Survey [2021]
26 Health Inequalities in a Nutshell [2021]
27 Clinical Trial Management: A Profession in Crisis? [2022]
28 Transforming Health Through Innovation: Integrating the NHS and Academia [2020]
29 Creating Time for Research [2021]
30 Decentralized Clinical Trials in Oncology: Are We Ready for a Virtual-First Paradigm? [2022]
31 Rescuing patient access to industry clinical trials in the UK [2022]
32 Our Strategy: Health Research Authority 2022-2025 [2022]

Contact us:
0161 446 8281

www.christie.nhs.uk/research

The Christie Research
The Christie NHS Foundation Trust
Wilmslow Road
Withington
Manchester M20 4BX
United Kingdom

NHS
The Christie
NHS Foundation Trust

Agenda item 09/24a

Public Meeting of the Board of Directors

Thursday 28th March 2024

Subject / Title	Cultural Audit Outcome and Next Steps
Author(s)	Prof Chris Harrison, Deputy Chief Executive
Presented by	Executive Directors
Summary / purpose of paper	This paper brings to the attention of the board the outcome of the Cultural Audit undertaken by Globis Limited together with the subsequent staff engagement and discussion process, the key themes and proposed action plan.
Recommendation(s)	To receive and approve the proposals set out in this paper
Background papers	The Christie NHSFT Cultural Audit
Risk score	Risk in relation to Objective 7 Likelihood of affecting objective 3 Impact on objective 3 Overall risk 9
EDI Impact / considerations	Ensuring a consistent experience for all staff regardless of protected characteristics
Link to: ➢ Trust strategy ➢ Corporate objectives	Relevant to Objective 7: People – To be an excellent place to work and attract the best staff
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.	NHSFT – NHS Foundation Trust ED – Executive Director (Prof C Harrison) F2F – Face to Face GM – Greater Manchester EHIA – Equality Health Impact assessment BAME – Black and Minority Ethnic OD – Organisational Development RADA – Royal Academy of Dramatic Arts

The Christie
NHS Foundation Trust
Agenda item 09/24a

Board of Directors
Thursday 28th March

Cultural Audit Outcome and Next Steps

1 Summary

An audit of organisational culture confirmed that staff at The Christie are extremely passionate about the specialist nature of the work they carry out. They have a huge desire to provide exceptional patient care, to support and enhance the reputation of the Trust, and to encourage improvements to working practices in line with our values.

Our values are:

- Making a Difference: We are courageous and try new ideas, and we are honest and take responsibility.
- Acting with Kindness: We care for each other and our environment, and we show appreciation and celebrate success.
- Connecting with People: We are inclusive, and we work together as one team.

The audit identified frustration about workload, communication, variable leadership styles, certain working practices, behaviour toward colleagues, inconsistent teamwork, and resources. This is affecting the way some people feel about their roles, as well as their overall wellbeing and levels of stress. No evidence of systematic discrimination or bullying was found. This is consistent with insights from the staff survey and other data which also shows notable differences between parts of the organisation.

The audit report was published in full on the Trust website. Its 16 recommendations have been the subject of an extensive internal engagement and discussion process with staff. This process led to the recommendations being grouped under seven key themes, each with proposed actions.

Cross references have been made to the cultural audit recommendations to demonstrate they have all been addressed in some way and implementation of the actions will be tracked.

The plan does not replace wider organisational development activities led by the Workforce Director and team on behalf of the board and all staff. The detailed action plan, based on the audit findings, and outlined in this paper, will complement and augment existing measures.

It recognises that many of the necessary programmes, initiatives and services are already in place, but they may require additional capacity, improved coordination through divisions, and wider communication.

Leadership is vital. This process of refreshing and developing our culture cannot be achieved by the executive team alone; it requires the efforts of all of us, especially the approximate 1000 staff members who have some form of line management responsibilities at B7 and above, including our medical staff; recognising that staff below B7 also have line management responsibility. The leadership role of the board is of particular importance and whilst referred to in this paper will, as part of the action plan, be the subject of a separate paper with further recommendations for consideration.

Over 1000 of our staff have some form of line management responsibility and it is for all of us to shape and nurture the culture of the organisation.

2 Purpose

This paper brings to the attention of the board the key themes and proposed action plan resulting from the Cultural Audit undertaken by Globis Limited and the subsequent staff engagement and discussion process.

3 The Cultural Audit

The Cultural Audit was commissioned to explore comments made in the 2023 CQC reports and to help us make improvements.

Globis Limited is nationally recognised for their expertise ~~i~~n organisational culture diagnosis. Globis Limited was commissioned by the executive team with advice and support from an advisory group convened by the Prof Chris Harrison and consisting of the four elected staff governors (including Medical Staff Committee chair), Staff Side Partnership Officer, Head of Engagement and Organisational Development and Company Secretary. Whilst discussions of the advisory group were invaluable in overseeing the audit and discussing the results, the proposals made in this paper are the responsibility of the executive team.

The audit involved a review of relevant documents, 107 individual staff interviews, 16 staff focus groups, site visits and a questionnaire survey of all staff. Contributions were made by 1171 individual staff members.

The audit also considered the feedback from an initial engagement exercise following publication of the CQC report, with information from staff from across the organisation including open sessions for clinical staff. Following this some immediate actions were taken, for example improvements in our safe sustainable waste arrangements, the facilities management service area configuration, canopy arrangements over some areas, changes in switchboard etc.

The audit was not designed to identify subcultures within the organisation. It was not possible, for example, to identify differences between departments, clinical teams, or professions. However, the more recently undertaken and published staff survey does provide more specific information which will be used, together with other intelligence, to help prioritise and target the actions described in this paper.

The report and recommendations were published in full on the Trust website. In accepting the findings and recommendations it was decided to develop an action plan ~~response~~ through a process of engagement and discussion within the organisation and to help identify ~~those~~ practical aspects that staff felt would make the most difference. The recommendations are shown in the Appendix 1 with cross referencing to the proposed action plan.

4 Staff Engagement Process

Throughout January and February 2024 a period of discussion and feedback took place, allowing initial thoughts about the priority actions to be developed and then tested through further discussion.

This stage involved focused formal sessions (e.g., chief nurse forum, admin & clerical forum, staff forum etc), discussion as an item on agendas of committees & forums, cascade and discussion via divisional meetings, drop-in/informal sessions with advisory group members and executives. The focus has been on listening/dialogue balanced with moving forwards and action, gathering insights on the priorities, main issues, work underway, quick wins, actions to

accelerate, potential blockers and support required. Written feedback has been received from all these forums and analysed to identify key themes for action.

5 Key Themes

Seven key themes emerged from the process of audit and engagement

1. *To ensure that all senior leaders (including clinical leaders) in the organisation have specific training and are provided with support for those activities known from research to promote a healthy organisational culture.*

Feedback from our staff is that in some departments, inconsistent application of basic management processes leads to a sense of unfairness and discrimination. Senior leaders (Band 7 and above) may lack knowledge of basic processes or not be confident in their application. This may particularly apply to clinical leaders, for example clinical directors. Whilst a wide range of leadership training and development is on offer to our leaders (see Appendix 2) the Trust has not had a systematic process to ensure leaders undertake such training and are provided with support to ensure consistently high standards.

Daniels et al (2022) undertook a rapid evidence review of the general cultural benefits of supporting good organisational and management practices. Research by Lewis et al (2019) identified application of the following specific processes to be essential in promoting a healthy organisational culture: managing difficult conversations, EDI awareness, dispute resolution methods, managing allegations of bullying and harassment, managing employment processes (recruitment, induction, mandatory training, development, appraisal, and PDR, exit interviews), the power of apologies, job planning, sickness management and return to work processes.

In response to the audit and feedback our focus is on improving these basic management processes whilst ensuring that additional leadership development opportunities are also available.

To address this we will:

- Build on the existing programmes (See Appendix 2) to create a comprehensive programme of support and training for senior leaders to equip them with competency in the essential processes identified by Lewis and reflected in the cultural audit recommendations.
- Set an expectation and requirement that all senior leaders can demonstrate that they have undertaken training in these essential processes, with initial focus on training and support for teams and departments identified as priorities based on the staff survey and other information.
- Develop a method of capturing and assessing the completeness of training in these areas.

2. *To ensure that all staff are aware of the accountability, decision-making and communication mechanisms, and the expectations, responsibilities, and accountabilities of senior clinical and operational leaders within the organisation.*

Feedback from our staff is that accountability, decision making and communication processes in our organisation have become seen as over complex. The roles of the management board, board of directors, and divisional boards and how decisions are made and can be influenced

is not widely understood. The cascade of internal information from the management board has not been effective. The divisional tier of the organisation has become perceived as managerially rather than clinically focussed.

To address this we will:

- Revise the terms of reference and membership of the management board (renamed senior management committee in line with the concurrent governance review) and its sub-groups to ensure that its role and decision-making powers are clear and the responsibility of attendees to cascade information is explicit.

- Strengthen both the accountability and advisory roles of clinical staff by making the divisional medical directors operationally accountable for the clinical divisions (including Research & Innovation and Education) and formalising the role of the clinical advisory group as a source of clinical advice to the senior management committee.

- Develop an internal communications strategy which uses multiple channels of real-time communication (including digitised approaches) to both provide information and receive feedback.

- Develop, publicise, and make easily accessible a Functions and Decisions Map (Chart of decision making and advisory groups) which sets out the roles and decision-making powers and accountabilities of key groups in the organisation with the aim of facilitating transparent decision-making and foster the culture and behaviours that enable collective working.

- Develop, publicise, and make easily accessible an Accountabilities and Responsibilities Map (Description of roles and responsibilities of key positions) which sets out the roles, accountabilities of corporate and divisional leadership team roles in the organisation, with the aim of increasing transparency and clarifying expectations.

- As a priority make it mandatory that all line managers arrange regular face to face or virtual meetings with the staff that report directly to them and use this as an opportunity to increase visibility of leaders, cascade key information, drive engagement and build trusting relationships.

- Develop ways for best leadership practice to be shared between teams.

3. *Ensure that our speaking up policies are designed to enable the raising of clinical concerns.*

Feedback from our staff is that they are less sure about how to raise concerns about clinical issues and clinical practice than about other matters. This is supported by the results of the staff survey. There is less clarity about how concerns about clinical matters will be assessed and responded to and concerns about it being seen as disloyal to speak up on clinical issues. Feedback from medical staff also drew attention to opportunities to raise and have considered ideas for innovation and improvement rather than concerns about poor practice.

To address this we will:

- Review and update our Freedom to Speak Up Policy in the light of the cultural audit.

- Continue to monitor this issue and continue dialogue with clinical staff about how a safer environment for speaking up on clinical matters can be developed.

- Ensure that in implementing the new Patient Safety Incident Response Framework we incorporate clear mechanisms for raising concerns about clinical safety and putting forward ideas for improvement.

- Ensure that we support staff and help develop their skills so they feel sufficiently empowered to introduce improvements in line with our Trust behaviour 'we are courageous and try new ideas'; ensuring that managers are clear on their role in responding to concerns and suggestions.

- Strengthen the mechanism by which divisional medical directors are responsible for ensuring that clinical concerns have been properly investigated and escalated to the appropriate executive director if needed.

4. *Ensure all leaders are aware of the key workforce policies and procedures, and these are all up to date and accessible to all staff.*

Feedback from our staff is that there is no easy way of accessing our key workforce policies and procedures and that this contributes to inconsistent implementation by senior leaders with and between teams. Audits and scrutiny by our Workforce Assurance Committee demonstrate that our key policies are up to date and conform to best practice. Workforce policies are agreed and reviewed with staff and staff representatives through the Staff Forum and, for medical staff, the Local Negotiating Committee. Lack of awareness of the practical application of these policies leads to the inconsistency in implementation.

To address this we will:

- Produce a defined list of key workforce policies (we will work with our staff to identify this key list) to ensure that they are up to date and easily accessible in digital and other formats

- Put in place an accessible digital platform to ensure the accessibility of workforce policies, procedures, guidance, FAQs, key contacts, and training support for managers; to include first line HR advice and support.

- Include in the Workforce Policy Handbook a description of the role of the HR Business partners and other staff available to provide support to leaders when implementing the key policies.

- Build awareness of key HR policies and procedures into the mandatory programme of training and support for supervisors and line managers described in Theme1.

5. *Ensure all staff are aware of the range of staff-wellbeing and support services available to them and how to access them.*

Feedback from our staff is that how to access the wide range of wellbeing and support services available is not well-known to staff or some senior leaders despite being published on the

intranet. It is felt that this lack of awareness may inhibit or delay uptake of support services when they would be of most value.

To address this we will:

- Continue to see staff well-being from a holistic perspective.
- Review the provision of key staff wellbeing and support services (including safe spaces and emotional support) to identify and take action on possible areas for improvement.
- Publish accessible collated information on the services available and how to access them, making this easily available to staff electronically and via a portal
- Further review access to safe spaces and emotional support
- Ensure that the practical staff wellbeing and support mechanisms are a key part of management training, as referenced in Theme 1, as well as a broader understanding of how to create the conditions for people to be healthy and well in psychologically safe teams.

6. *Ensure the board of directors demonstrates clear leadership in developing an inclusive culture based on our agreed values (*Make a Difference, Act with Kindness, Connect with People*) and behaviours and in which we all support each other so we can provide the best possible care.*

Feedback from our staff is that they look to the board of directors to take a lead in addressing the impact of the many current pressures and challenges on the NHS. The board is seeking to find ways of doing things which enable excellent patient care whilst looking after staff needs.

Daniels et al (2021) conclude that board members have a responsibility to use multiple sources of data to monitor staff culture and wellbeing and understand the challenges in their locality or organisation. The data used should cover multiple dimensions.

The board of directors at The Christie has previously considered its role in setting culture and receives regular reports on relevant metrics, initiatives, and activities. Publication of the cultural audit and development of the associated programme of work offers the opportunity to review and strengthen the board's current approach.

To address this we will:

- Consider a more detailed paper setting out the specific role of the board and of individual directors in setting organisational culture and options for the board to adopt. To include considerations around the visibility of directors.
- Restructure our board agenda so that consideration of organisational culture, relevant metrics and other information is explicitly identified as a key agenda item.
- Retain a continued focus on creating equitable, inclusive and diverse cultures as a key thread in Board development activity.

7. *Ensure that we continue the conversation with and between our staff*

Many staff have told us that they have been pleased to be involved in the discussion about the cultural audit. We need to find ways of using multiple communication channels to keep staff informed and to listen to staff experiences and feedback. Staff also told us that communication between teams and departments has been disrupted in recent years in part due to changes in working practices and clinical technology advancements. This has resulted in some people feeling isolated in the organisation.

To address this we will:

- Develop a new multi-channel communication approach to internal communications using innovative technologies as well as traditional channels.
- Explore mechanisms for enabling staff from clinical teams and other departments to meet colleagues from other parts of the organisation.
- Continue advisory group meetings to help track progress.

6 Conclusions

As described by Daniels et al (2022) there is no quick fix to address the current challenges of culture and staff wellbeing across the NHS. In the wake of the global pandemic, long standing pressures on the public sector and recent industrial action by clinical staff, systematic and sustained attention to culture and workforce wellbeing are required, nationally and locally.

The CQC inspection, undertaken in the later stages of the pandemic, the cultural audit and our subsequent engagement process have identified some specific issues that we can address at The Christie alongside on-going programmes of organisational development including those set out in the The Christie People & Culture Plan. Targeting of improvements will be guided by information from the staff survey supplemented by possible additional research on professional sub-cultures which is being considered.

The audit has shown areas I n
which we need to improve, the themes from the engagement process and our values together describe the characteristics of the culture we wish to develop and we are now starting to develop the plan. We will continue to look for insights from the audit data and bring forward proposals for how the board will provide future leadership on this issue.

7 Next Steps

Subject to approval of the overall approach the action plan will now be developed and taken forward noting that our divisions will be expected to lead within their areas of responsibility and for some of the next steps further discussion and dialogue will be needed as plans are “co-produced”. Approximately 1000 of our staff have some form of line management responsibility and it is for all of us to shape and nurture the culture of the organisation.

It is anticipated that additional resource will be required to develop and deliver parts of this work, especially for activity required by the organisational to be delivered at pace and at scale. A key next step is for this to be scoped and fully costed.

A revised time limited steering group will be established to coordinate and monitor implementation. The steering group will report regularly, through the DCEO, to the

management board (which will become the senior management committee). The first progress report will be made in July 2024.

Scrutiny for board assurance purposes will be through the Workforce Assurance Committee. The role of the board will be as recommended and as agreed through a separate paper.

8 Recommendations

To receive and approve the proposals set out in this paper

References

Daniels, K et al. (2022). NHS staff wellbeing: Why investing in organisational and management practices makes business sense - A rapid evidence review and economic analysis. London: EPPI Centre, UCL Social Research Institute, University College London (https://eppi.ioe.ac.uk/CMS/Portals/0/IPPO%20NHS%20Staff%20Wellbeing%20report_LO160622-1849.pdf accessed February 2024)

Lewis et al. (2019). Workplace mediation: Is it helpful for evidence-based organisation diagnosis in the NHS? Globis Mediation Limited. www.globis.co.uk (accessed February 2020 – website now not available)

Appendix 1 – Cultural Audit Recommendations

The table shows the recommendations of the cultural audit undertaken by Globis together with the action theme under which each is being addressed. This is presented to provide board assurance that the recommendations are all being addressed, albeit presented differently in line with the engagement and discussion with staff. In some cases the recommendations are being dealt with outside the scope of this paper.

No	Recommendation	Plan Theme
1	Establish a mechanism for staff to gain a greater understanding of job descriptions, different roles, departmental structures and decision-making processes and ensure that communication channels are clear.	2
2	Provide safe spaces and access to emotional support for all staff.	5
3	Support managers throughout the Trust to perform their role to the highest standard.	1, 2, 4
4	Review procedures that relate to PDRs and access to training and development opportunities.	1, 4
5	Review the Freedom to Speak Up process and the options and support available to staff who raise concerns and those dealing with the process.	3
6	Implement activities to encourage all colleagues to reflect upon their behaviour and improve the level of kindness, civility and respect in the workplace.	1, 4
7	Equip all staff with the skills to better manage difficult conversations and deal with challenging behaviour.	1, 4
8	Exit interviews to be carried out for all leavers and the data analysed.	1, 4
9	Produce transparent and consistent recruitment and selection criteria for every role and development opportunity to reduce perceptions of 'cronyism' or favouritism.	1, 4
10	Continue and enhance activities that promote equal treatment of staff regardless of race, religion or any other characteristic.	1, 4
11	All leaders should communicate and behave in a way that makes it clear bullying/racist behaviour in the workplace in unacceptable. A transparent and robust grievance process should be well documented and easily accessible.	1, 4, 6
12	Create more opportunities for staff to shadow, mentor, learn from and meet with those from other teams and in other roles, to improve understanding, share best practice and encourage.	2
13	Senior managers to acknowledge the importance of listening and learning to make improvements and display behaviour that reassures staff of their commitment to improvement.	7
14	Review and prioritise 'quick fixes' in terms of equipment, repairs and space to work/conduct meetings/meet as a team etc.	See App 1
15	Issue clear policies on remote working.	5
16	Comprehensive policy development across the whole organisation, rather than decisions being made at managers discretion. Policies should be tailored to the specific needs of The Christie and regularly updated as needed.	Being dealt with by policy approval committee

Appendix 2 – Leadership Development Overview – March 2024

This appendix details the existing extensive programmes overseen by our OD and Engagement Team.

Rebecca Coles, Head of OD & Engagement

1. We continue to provide access to a range of leadership modules and education support for leaders. Over the past quarter this has included:
    a. Promoting access to the NW Leadership Learning Zone modules for leaders
    b. Quarterly Christie Leadership Series run by the School of Oncology with spotlight sessions on mental health and resilience from renowned external speakers.
    c. Internal Managing for Success modules run by Workforce colleagues
    d. Resilience training for managers during Stress Awareness Week

2. Our internal Christie Leadership Development Programme is in its third year and provides 6 months of development for small cohorts of Band 4 to 7 colleagues with line management responsibilities. This is delivered by our partner Delve.

3. Leadership qualifications are offered. The most recently promoted being the Elizabeth Garrett Anderson apprenticeship for a May 2023 start, which includes a PG Diploma in Healthcare Leadership and NHS Leadership Academy award in Senior Healthcare Leadership which can be topped up to an MSc.

4. Work is underway to enhance the leadership of our nursing services across the Trust, starting with a facilitated Leadership Away Day in Dec 2022 with the Associate Chief Nursing team, and subsequent leadership focused conversations. Focus on this continues to ensure we develop our senior nursing leaders to meet the complex and internal and system challenges we face with a clear, aligned focus, a strong team ethos and sufficient leadership expertise.

5. We are working to make our leadership offer more accessible to under-represented groups within the organisation as part of the EDI Delivery Plan. An example being the 'GM Lead Positive Programme' running in the second half of 2023. We have supported 15 BAME colleagues to attend this GM programme, after giving personalised development advice to the 40+ who expressed interest. GM have now offered them an opportunity for additional development.

6. During 2023 we offered Chartered Management Institute (CMI) Level 3 training in leadership and management to all colleagues via a GM initiative with The Growth Company. This did not require line management as a pre-requisite and is a useful addition to our skills development offer. We had 369 people express interest and many colleagues completed (from Porters upwards through the bands).

7. Work in development (as part of the new People & Culture Plan) includes a more comprehensive approach to internal management skills and knowledge training, clearer curation of leadership options and resources, and activity around leadership behaviours and leadership culture.

8. A leadership section ('Leading the Way') has been built into our new values and behaviours framework to anchor this work with a common understanding of what good leadership behaviour looks like at The Christie.

9. The Real-World Leader behavioural assessment tool was brought in from Jan 2023 for new leaders appointed at B8C+ following a summer 2022 trial. This creates a better experience for new appointees and sets a focus on conversations about leadership behaviour from the outset of employment, ensuring leadership is given equal focus alongside role specific competency. A review of this at Workforce Committee in March 2024 indicated this is offering strong value and a decision was made to extend to other role and bands, using a peer support model of delivery to make more sustainable.

10. An action learning programme for new consultants ran from Sept 2023 to Jan 2024 with an external leadership development specialist to develop coaching skills, joint reflection on issues, and an awareness of leadership behaviours. They also received skills development sessions in Finance and Governance.

11. A review of our Managing for Success modules is taking place as part of the broader work on strengthening management skill and capability.

12. Our management induction is currently patchy and work is underway to create a clear strengthened set of expectations around this. This may be established as a separate activity or be linked directly to the new management development programme outlined in the People & Culture Plan. Approach TBD.

13. EHIA leadership training has taken place from mid-2023 to ensure that our leaders know how to properly analyse through an EDI lens when looking at their work. This is being supported by additional EDI training resources on Christie Learning Zone and conversations.

14. Delve Talent Tool trial in 2023 in Christie Education, Digital and Workforce included management training to support the leadership of different types of appraisal conversation, putting purpose and career development as the primary focus. This aimed to support our staff survey feedback of only 17% of staff finding the current appraisal conversations useful. However, a review of the trial found that the training, whilst excellent, did not make sufficient difference to appraisal conversation quality due to the underlying lack of a foundation of management skills in colleagues.

15. Our NW Leadership Academy focuses on providing leadership development primarily for colleagues at B7+. Over recent months we have been strengthening our relationship with our account manager to improve how we increase usage of this provision. The includes executive level coaching for 3 board or sub-board colleagues.

16. Apprenticeships in leadership and management continue to be promoted and offered, with an increasing appetite in teams taking this up.

17. The Resourcing Team deliver recruitment training for hiring managers. This is in the process of being enhanced and is a key priority to bring in diverse, good quality talent during recruitment.

18. RADA Business training on presenting, storytelling and vocal presence to aid senior leader competency in presenting and engaging large groups.

19. Respectful Resolution training online and 3-hour workshops to build ability to have better conversations about behaviour and culture, and resolve team conflict; with consideration of impact of self and own leadership practice on culture.

20. From February 2024, the delivery of health and wellbeing focused line management skills sessions, including menopause awareness, and having better wellbeing conversations.

21. The OD Team continue to have regular consultancy-style conversations with divisional leaders and managers to support shaping culture and leadership, as well as delivery as local interventions and away days.

<u>In the process of developing/purchasing these to enhance our offer:</u>

22. Leadership transitions framework to clarify the skills, behaviours and knowledge required for each level of (1) management and (2) leadership. This includes a focus on the transition points of progression between stages to ensure sufficient a understanding of expectation and required development.

23. 'NHS Elect', a suite of management and leadership webinars and courses, along with 20 bespoke delivery days which can be focused on internal need and/or coaching services.

24. New offer for incoming and existing consultants (externally delivered)

25. Leadership development programme for clinical directors focused on the psychological elements of leading effective teams (externally delivered)

26. Two-session course on building and applying insight of impact of self as a leader, to help embed values and behaviours (externally delivered).

27. Insights psychometric team solutions (externally delivered)

28. Continue to build a bank of commissioned partners and coaches that we can tap into for interventions.

<u>Overall, working towards these main factors:</u>

In acknowledgement that the **NHS model will be ineffective by 2030**, our upcoming leadership development aims need to take these drivers into account:

- **Support new ways** of talent management - sideways moves, harnessing talent, retaining and enabling people's skills and capability (not defined 'jobs')
- Creation of **open productive learning (and listening) environments** to address privilege, bias & B&H
- Strong **need to work differently** and build compassionate inclusive cultures - work beyond boundaries, transform roles, spread innovative practice, digital, purposely drive OD capability & culture change
- Focus on **addressing inequalities in health & wellbeing** and throughout NHS system
- Recruitment, talent pipelines, development **approaches redefined to address under-representation**

- **What people value at work is changing**. Need to shift from our old view of engagement (pay, reward, career progression) towards 'good work' (meaningful, autonomy, making a contribution, listened to)

A Restorative Just & Learning Culture is the position that we are working towards, although as we are culturally some way off this, we need to lay the groundwork first. This fundamentally focuses on developing leaders who can establish and maintain psychological safety in teams, where people feel comfortable to raise issues and report concerns, rather than fearing retribution. This is a key part of the NHS People Plan and approach to shaping our culture nationally, so it is critical that we translate what this means for our local culture and start this journey. One part of the groundwork is to lead in accordance with our new approach to Respectful Resolution to address grievance and B&H.

Key components of overall culture work:

- Leadership transitions and **clarifying LINE MANAGER SKILL & CAPABILITY:** Know what 'good' looks like for us. Define and shape the competency expectations and points at which leaders & managers progress.
- **Focus on COMPASSIONATE & INCLUSIVE RESOURCES for leaders and line managers:** How to recruit, onboard, and lead compassionately and inclusively.
- **Focus on TEAM DEVELOPMENT:** Evidence shows high performing teams = patient safety
- **Focus on STAFF ENGAGEMENT:** Evidence shows this is the single biggest predictor of positive patient care outcomes. Elevate to Board level focus.

As we do this, also need to paying attention to developing these emerging cultural themes:

- Decision making behaviours (internal)
- Innovation and creativity (internal)
- Reflective conversations (internal)
- Health inequalities (external)
- Closing the gap on inequitable thinking (interrupting bias through process change, self-reflection/ learning or active conversations)

Agenda item 09/24b

Meeting of the Board of Directors

Thursday 28th March 2024

Subject / Title	NHS Staff Survey Results 2023
Author(s)	Jane Hanson - Engagement and OD Manager
Presented by	Eve Lightfoot, Director of Workforce
Summary / purpose of paper	To provide the Board of Directors with an initial overview of the NHS Staff Survey results 2023, likely areas of focus for action planning and suggested next steps
Recommendation(s)	The board are asked to note the staff survey results update and the work that is planned over the coming months in response to the survey results.
Background papers	NHS Staff Survey Benchmark report 2023 (nhsstaffsurveys.com) NHS Staff Survey 2022 Results
Risk score	BAF Risks 7.1 (scored 6), 7.2 (scored 9), 7.4 (scored 9)
EDI impact / considerations	Analysis of responses by staff group and background where possible to determine areas for action.
Link to: ➢ Trust strategy ➢ Corporate objectives	Achievement of Corporate Plan and objectives, The Christie People Plan and Independent Cultural Review
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.	EDS Equality Delivery System BUILD Behaviour, Understand, Impact, Listen, Do differently PSIRF Patient Safety Incident Response Framework E&OD engagement and organisational development HRBP Human Resources Business Partner

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Agenda item: 09/24b

Meeting of the Board of Directors
Thursday 28th March 2024

NHS Staff Survey Results 2023

1 Introduction and Summary

This paper provides an initial high-level overview of the 2023 NHS national staff survey results with a summary of key themes and how they relate to other organisational plans.

The survey was conducted between 2 October and 24 November 2023 and open to all staff. 1,675 (48%) of 3,454 eligible colleagues completed the survey, matching the national response rate of 48% and up 4% from our response rate of 44% in 2022.

The survey used mixed modes including the option of paper responses where appropriate.

For six of the eight reported People Promise main themes The Christie has scored better than the average for our comparator group, and for two themes has scored the same as the average. For 14 of the 19 reported People Promise subthemes The Christie has scored better than the average for our comparator group, for two themes has scored the same as the average and for 3 subthemes slightly below the average. (Benchmark Report Page 13 NHS Staff Survey Benchmark report 2023 (nhsstaffsurveys.com))

For seven of the eight People Promise themes for which this is reported The Christie has improved its score since 2021. For 14 of the 19 People Promise subthemes for which it is reported The Christie has improved its score since 2021 with 2 scores being the same and 3 scores having deteriorated. For the 3 that have deteriorated we remain at or above the benchmark average for 2 and below for 1 (raising concerns).

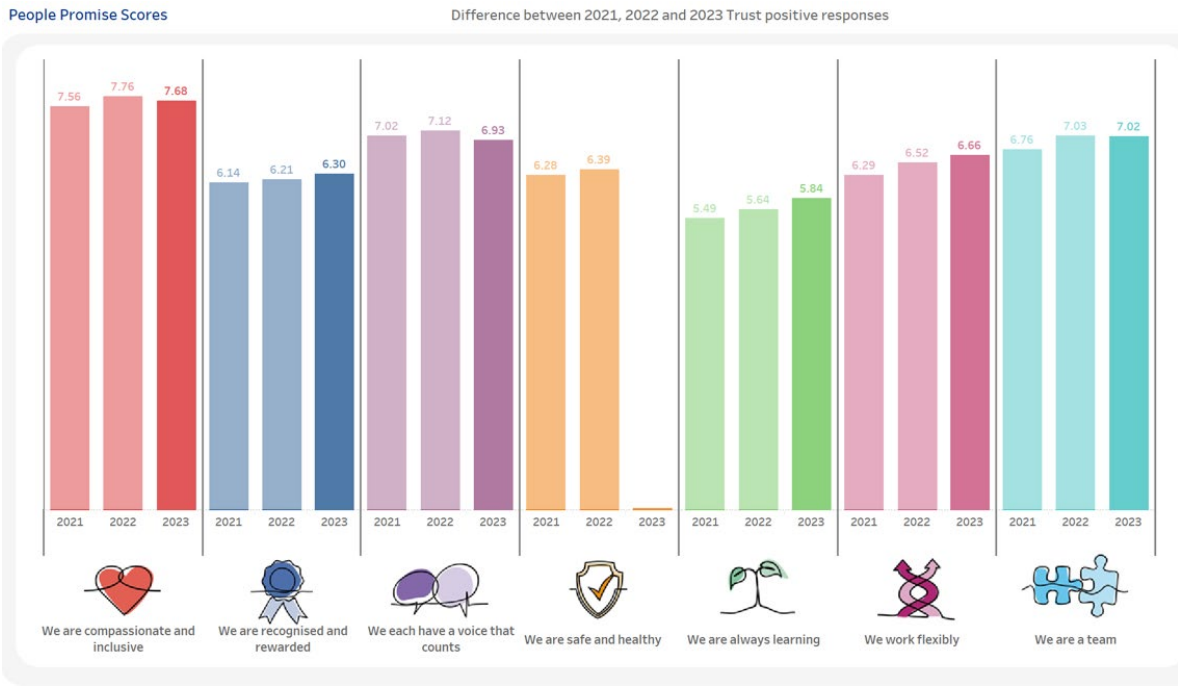
In the context of the challenging position of the NHS, (For example, Industrial action, financial challenges and reports of stress and burnout) including within Greater Manchester, the results are good. The detailed scores reflect the findings of our cultural audit and point to similar areas of good practice and areas for improvement.

2 Highlights

We have been rated above average or average on all 7 aspects of the NHS People Promise. Our morale score has improved each year for the last three years.

There has been an improvement in scores across the People Promise Themes when compared to 2022 as can be seen in Figure 1 below. The Trust has increased scores in ‘we are recognised and rewarded’. We re-introduced the Annual Colleague Awards in 2023 and moved the long service award presentations to quarterly instead of annually so that colleagues received their recognition much closer to their anniversary date. ‘We are always learning’ and ‘we work flexibly’ also saw increases in the scores, the latter possibly due to continued opportunities for hybrid working.

Figure 1 shows our People Promise scores over the last 3 years.



Morale has also seen an increase when compared to 2022 as seen in Figure 2 below and is also higher than the benchmark average of 6.2. This could be in response to the introduction of colleague events such as Colleague Winter Wellbeing Event, Summer Party, Rounders tournaments, End of Year Quiz and Annual Colleague Awards.

Across all themes, we scored either higher or the same as the benchmark average.

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

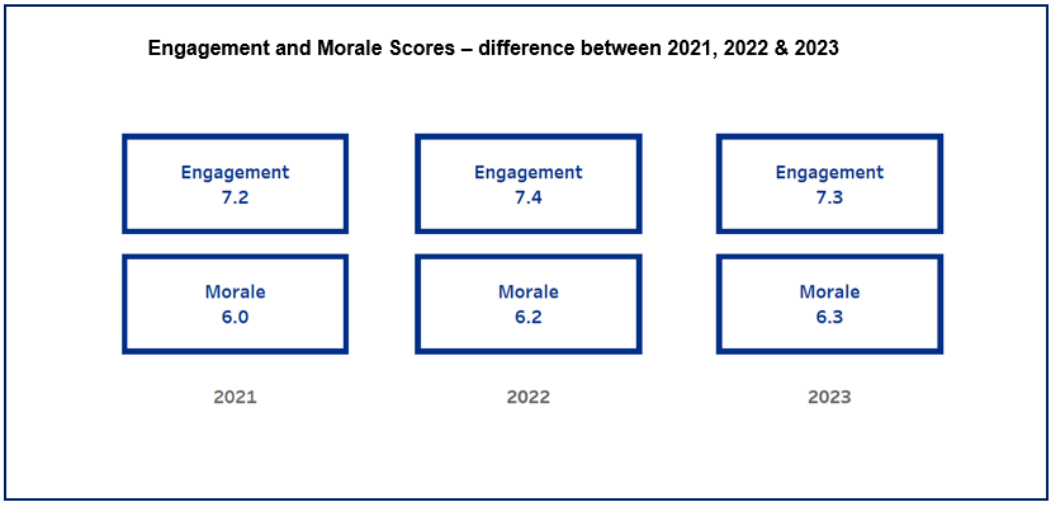


Figure 3 shows our most improved/declined scores compared with our own 2022 survey results.

Most improved scores	Org 2023	Org 2022
q13d. Last experience of physical violence reported	74%	55%
q14d. Last experience of harassment/bullying/abuse reported	51%	43%
q23b. Appraisal helped me improve how I do my job	25%	17%
q23c. Appraisal helped me agree clear objectives for my work	37%	31%
q4c. Satisfied with level of pay	36%	30%

Most declined scores	Org 2023	Org 2022
q25f. Feel organisation would address any concerns I raised	55%	61%
q25e. Feel safe to speak up about anything that concerns me in this organisation	65%	70%
q20b. Would feel confident that organisation would address concerns about unsafe clinical practice	59%	64%
q31b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	80%	85%
q20a. Would feel secure raising concerns about unsafe clinical practice	70%	74%

When looking at the most improved scores there has been a significant improvement of 19% when asked Q13d Last experience of physical violence reported. There have also been improvements when asked about appraisals and satisfaction with levels of pay.

When looking at the most declined scores most of the questions relate to speaking up. There's is a 6% reduction when asked Q25f Feel the organisation would address any concerns I raised, all questions in respect of raising concerns have declined. Speaking up and raising concerns has already been identified as one of the proposed key themes for action planning arising from the independent cultural review.

58% think the organisation is taking positive action on health and wellbeing which is lower than compared to 2022 (61%). Work is already underway utilising the NHS Health and Wellbeing Diagnostic Tool and working collaboratively with the Healthy Workplace Steering Group to understand if colleagues may value a different type of health and wellbeing provision/service. Working more closely with the comms team will ensure consistent, regular messaging around health and wellbeing support is accessible to all colleagues. This has also been identified as one of the proposed key themes for action planning arising from the independent cultural review.

The 2023 survey included three new questions. Figure 4 below are the findings.

Question	Description	% of respondents
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 / service users, their relatives or other members of the public? (Q17a)	Selected Never	95%
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? (Q17b)	Selected Never	97%
I can eat nutritious and affordable food while I am working. (Q22)	Selected Often / Always	63%

We have signed up to the Sexual Safety in the Workplace Charter and are progressing with associated actions arising from this which will help to address this issue.

In terms of staff feeling they cannot often or always eat nutritious and affordable food while they are working, the work proposed to reconfigure the dining room and make it more accessible to colleagues outside of normal opening hours may contribute to addressing this issue.

3 Areas of focus for action planning

- Respectful Resolutions and Build on BUILD
- Focus on health and wellbeing
- Continued focus on retention mechanisms
- Safety in clinical practice
- Speaking Up

Respectful Resolutions training has recently been launched and is being embedded throughout the Trust. Build on BUILD is a half day workshop developed by The Maguire Team to support learners navigate the reflection and feedback elements of the Respectful Resolution pathway, those who give feedback and find this challenging.

A health and wellbeing review is currently underway, and we are systematically reviewing support via the NHS health and wellbeing diagnostic framework and EDS action plans.

Whilst the focus on retention mechanisms is ongoing, our scores have improved across all 3 survey questions relating to leaving the organisation. This can also be seen in our turnover data which has seen a reduction from 14% to 11.5% over the last 6 months.

Reporting concerns about safety in clinical practice is one of the areas we have continued to see a decrease when compared to our 2022 results (4%) along with feeling confident the organisation would address concerns about unsafe clinical practice (5% decrease). The recent launch of the new Datix system and PSIRF will support our plans to respond to this feedback.

4 Conclusion

There has been a degree of consistency in the findings when synthesised with other pieces of work for example the People and Culture Plan, Health and Wellbeing Diagnostic Tool and more recently the independent cultural review. We've achieved good results in most areas and for those areas where we know we have more work to do, a deeper dive into the results will be conducted.

The Trust's colleague engagement journey continues to grow, and it's acknowledged that 2023 was a particularly challenging year with significant operational pressures, financial challenges, industrial action, staffing issues and cost of living rises. The NHS national staff survey is a snapshot in time and it's important that these results are viewed amongst the context within divisions and teams where the richness of the data can truly be understood.

5 Next Steps

The table below describes the key milestones for disseminating further information, communicating across the organisation and focused action planning.

Activity	Timeline 2024
- Gain access to our data breakdown and develop reports	March/April
- Divisional comms via E&OD Manager & HRBPs	April
- Local deep dive on results. Dissemination of Divisional packs and action planning	April
- Trust-wide comms - Develop and share results infographic	End March/early Ap (due to embargo)
- Focus on action - Collaborative sharing of best practice and ideas - Review mechanisms/conversations/check-ins established (TBD)	April - July
- Monitor action plans via Workforce Committee accountability - Preparations for next survey in Q3	June onwards

6 Recommendation

The board are asked to note the staff survey results update and the work that is planned over the coming months in response to the survey results.

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Agenda item 10/24a

Meeting of the Board of Directors
Thursday 28th March 2024

Subject / Title	GGI assurance review action plan
Author(s)	Professor Chris Harrison, Deputy Chief Executive Officer Louise Westcott, Company Secretary
Presented by	Professor Chris Harrison, Deputy Chief Executive Officer
Summary / purpose of paper	This paper sets out proposals for further development of the Trust's mechanisms for board assurance following receipt of the governance review undertaken by Good Governance Improvement (GGI). The paper included an action plan. Most of the changes identified are to be introduced from April 2024, some have already been implemented.
Recommendation(s)	Board are asked to formally approve the actions identified in the action plan at Appendix 4 and receive further updates on progress against the actions in September 2024
Background Papers	Good Governance Improvement – The Christie NHS FT, Enhancing Board Assurance January 2024
Risk Score	See Board Assurance Framework
EDI impact / considerations	Ensure governance arrangements provide assurance and appropriate oversight of EDI requirements for the organisation
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.	GGI Good Governance Improvement CQC Care Quality Commission

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Agenda item 10/24a

Board of Directors Meeting
Thursday 28th March 2024

GGI assurance review action plan

1 Purpose

This paper sets out proposals for further development of the Trust's mechanisms for board assurance. Most of the changes identified are to be introduced from April 2024, some have already been implemented.

2 Background

The recent Good Governance Improvement (GGI) review found that our assurance processes are basically sound. However, it recommended some changes to reduce the risk of unanticipated outcomes of future regulatory assessments by the CQC and others, and to maintain best practice.

The proposals in this paper are based on:

- The views and observations of board members, including the newly appointed chair.
- The experience of responding to the CQC inspections
- The observations and recommendations of a review by GGI commissioned by the Trust as part of the response to the CQC findings and "should do" recommendations.
- A discussion with the chairs and executive sponsors for the assurance committees.

For simplicity the proposals that have emerged are presented without background analysis. Much of this is in the GGI report which was shared with the Board in February 2024.

There are many other aspects of good governance and board process which are not covered here. The focus in these proposals is on confirming where we are actively deciding to maintain an activity (or keep it under review) or we are proposing a specific change in relation to assurance.

Many of the GGI recommendations are administrative in nature and will be implemented by the Company Secretary as a matter of good practice. For transparency Appendix 4 lists all the GGI recommendations, shows which we accept, which are already adopted and how we propose to respond. Other governance changes discussed with the Board to supplement the report are also included in the action plan. It is implementation of the proposals in this paper that will be monitored and reported as described in the conclusion.

3 General recommendations

- Maintain the overall arrangements for the board and its committee structure (Appendix 2) including starting each public board meeting with a patient story.
- Rebalance the board agenda to ensure an appropriate (and greater) focus on strategy.
- Responsibility for overall strategy and supporting strategies (Quality, finance, digital, workforce, EDI, sustainability, research, education, etc.) to remain with the board who will also seek reports on performance against delivery of the strategies.
- Ensure a clearer distinction between the performance monitoring and assurance roles of the board and committees. See bullet points below under board committees and matrix in Appendix 1 for themes for assurance and sources of assurance. See Appendix 3 for distinction between reassurance and assurance.
- Adopt the nomenclature of "board" for the board of directors only and "committee" for those groups reporting directly to the board of directors only:

- Statutory committees e.g. remuneration committee.
- Assurance committees i.e. audit, workforce, quality committees.
- Operational committee i.e. senior management committee.

- Refer to other forums as “team” or “group” as appropriate and update the terms of reference accordingly.
- Adopt a higher-level summary style of minute taking across the board and committees reflecting a shortening of the length of papers and an increasingly assurance led approach to paper composition (i.e., requirements, current achievement, level of assurance, sources of assurance, actions to address variances).

3.1 The Council of Governors

- The council remains the formal mechanism for accountability to the community at large.
- Demonstration of board accountability includes presentation of the reports of our assurance committees on council agendas with the committee chairs available to answer questions and attendance of NEDs at council sub-committees to provide assurance to governors.
- Continue attendance of governors in an observer role at board and to extend this to board committees with appropriate clarification of roles.
- Confirm the roles of board members’ contributions at council meetings:
  - Chair – to chair the council meetings and present a trust report.
  - Committee Chairs to attend council meetings and present their reports.
  - Non-Executive Directors – attend council meetings and sub-committees and respond as appropriate to issues raised by governors.
  - Chief Executive – to attend council meetings and respond to questions.
  - Executive Directors – to attend council meetings for specific items or to support NEDs (e.g., board committee executive sponsors).

3.2 The Board

1. <u>General</u>
   - Continue the focus on the unitary nature of the board.
   - Continue the attendance of the research, education, workforce, and strategy directors at board meetings, seminars, and away days.
   - The SID will deputise for the chair when necessary.
2. <u>Recruitment, Induction and Development</u>
   - Continue to use the skills audit - to be updated every 2 years, to inform the plan for future recruitment of directors.
   - Increase the diversity and skills of the board by actively seeking and welcoming applications from those with all protected characteristics and who are representative of the communities we serve.
   - Consider the options of associate NEDs and participants in NHSE’s NeXT Director Programme as suggested by GGI as ways of developing future NEDs and increasing diversity.

- Maintain the broad based board development programme incorporating GGI suggestions.
- Consider the best way to obtain structured stakeholder feedback as part of our future strategy development.

3. Business
   - Review the current schedule of board meetings, committee meetings and development sessions
   - The detailed regular agenda structure to be agreed by Chair and Company Secretary but in principle:
     - Appropriate (and increased) balance of time to be devoted to strategic issues.
     - Reporting will be under 5 main themes: Strategy and forward planning, financial performance, service performance & delivery, regulatory & statutory compliance and culture.
     - Appropriate board level metrics for these themes to be reported as a dashboard with exception reporting on variances.
     - Integrated Quality Finance & Performance Report will continue to be provided but for information only (key points reported through dashboard and exception reports).
     - Maintain discussion of financial information by whole board with greater balance towards public discussion, backed by key metrics with confidential (including commercially sensitive) issues discussed in private i.e., we will not be creating a separate finance committee.
     - Standardise board papers with maximum length of 6 pages for reports (and maximum 5 pages of appendices where possible) and clear summaries according to guidelines to be issued by Company Secretary.
   - Strategic risk to be managed using an updated Board Assurance Framework which focuses on smaller number of key risks to objectives and is restructured to take risks as starting point rather than starting from the objectives as is currently the case.
   - Deep dives on progress in key strategy areas to be maintained as part of away day and development programme.
   - Use more structured minutes as the vehicle for reporting by the chair of each board committee to the public board (and council of governors) on matters considered and assurance taken using sources such as metrics and data, soft intelligence, benchmarking and external comparison, external assessments, risks and mitigation, trajectory and changes over time.

3.3 Board Committees

Assurance Committees

- Maintain three board assurance committees – audit, workforce and quality and the current statutory committee arrangements.
- Hold a quarterly meeting of assurance committee chairs which includes executive sponsors.
- Review and confirm committee terms of reference to ensure:
  - Top priority is assurance for governance purposes.

- Each committee is explicitly allocated responsibility for scrutiny and assurance of specific policies, regulatory requirements, CQC requirements and specific risks, using appropriate second line and third-line assurance sources.
- Each committee is explicitly allocated responsibility for scrutiny of appropriate strategic, performance and culture issues (as agreed by Board).
- Assurance levels are to be assessed only to those governance issues allocated to the committee.

- Review the composition and make up of each committee to ensure that each has the appropriate balance of skills and experience, including for the chair role.
- Use more structured minutes as the vehicle for reporting by the chair of each board committee to the public board (and council of governors) on matters considered and assurance taken using sources such as metrics and data, soft intelligence, benchmarking and external comparison, external assessments, risks and mitigation, trajectory and changes over time.
- Review support for committee chairs to promote best practice in chairing including providing summaries, reflecting on meeting effectiveness, assurance reporting and balance of agenda items – to include GGI observations on meeting conduct.

Statutory Committees

- Current arrangements for remuneration committee will continue but with explicit additional responsibility for board succession planning incorporated in the Terms of Reference

Operational Committee

- Revise the terms of reference and membership of the current Management Board to include changing its name to Senior Management Committee to emphasise its role as a board committee with delegated authority to be the main operational management decision making forum of the Trust.
- Confirm and simplify the terms of reference and reporting lines of those groups reporting into the Senior Management Committee (currently Management Board).

4 Conclusion

Following agreement at the Board Planning Day in February 2024, it is proposed that the approach suggested in this paper is adopted from the start of April 2024 (start of Q1) with complete implementation by the end of September 2024 (end of Q2).

Implementation of these changes will be monitored, using a structured template, through the quarterly meetings of committee chairs and executive sponsors and progress reported to the Board.

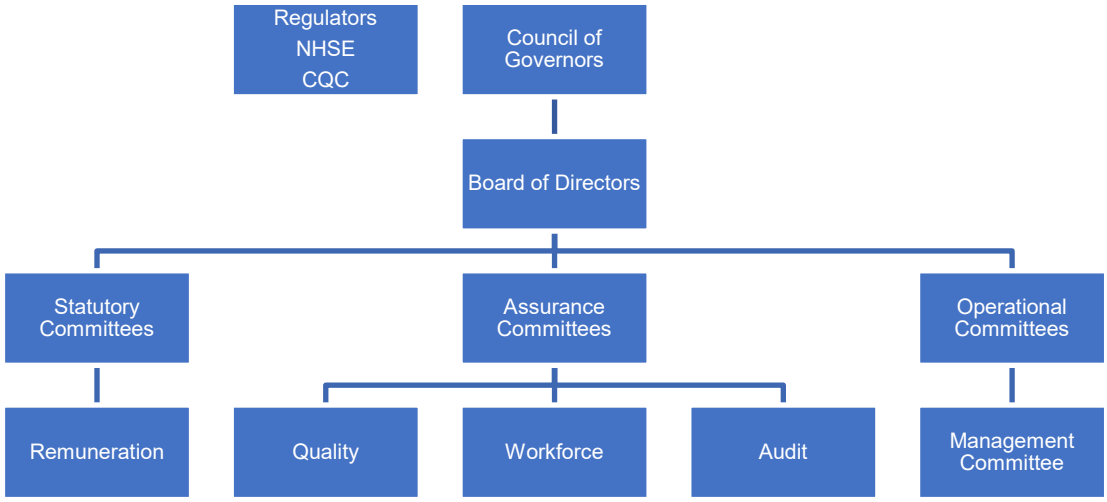
5 Recommendation

Board are asked to formally approve the actions identified in the action plan at Appendix 4 and receive further updates on progress against the actions in September 2024.

Appendix 1 – Suggested Assurance Matrix

		Themes for Reporting/Assurance				
		Strategy	Financial	Service Delivery	Regulatory and Statutory compliance	Culture
Sources of Assurance	Data					
	Soft intelligence					
	Benchmarking					
	External assessments					
	Risks and mitigation					
	Trajectory and changes over time					

Appendix 2 - Board Committee Structure



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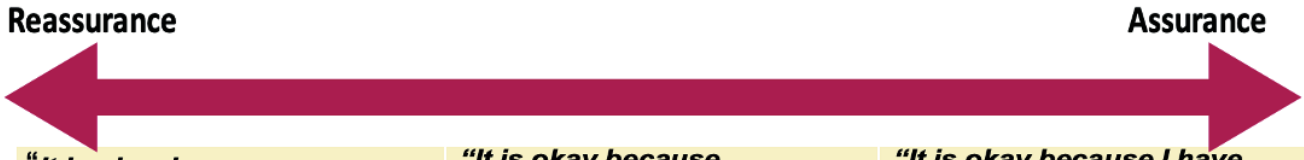
Appendix 3 – Assurance v Reassurance



"It is okay because management say it is"	*"It is okay because management have responded to questions from the board & this has given me confidence"*	*"It is okay because I have reviewed various reliable sources of information"*
• Strong management personalities may dominate	• Clear & logical explanations from board members	• Independence of information source
• Track record of success	• What has happened; why it has happened & what is the response	• Evidence of historic progress, outcomes
• Professional background or expertise	• Management explanations are consistent	• Triangulation with other information
• No contradictory evidence		

Source: Monitor's Quality Governance Guidance 2013

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Appendix 4
GGI Recommendations and action plan 2024

The table shows the GGI recommendations and how they are to be addressed. The majority of the actions are dealt with in some way through the overall proposals. We will monitor the GGI recommendations through the agreed set of actions set out in this paper (the plan) as reported to the committee chairs and executive sponsors meetings and to the board.

No.	Recommendations	Accept Y/N	Action	Responsible	Progress
1.	The board should complete a skills audit to identify what experience and professional backgrounds should be sought when recruiting non- executives.	Y	Already in place – reviewed at December 2023 Board Planning Day	Company Secretary	Audit to be completed by new Board members as they join and reviewed every 2 years (due December 2025)
2.	The board may also wish to consider establishing associate non- executive director roles as a means of broadening the skill mix.	Y	Join NHSE NExT Director scheme	Chair / Company Secretary	Use current NED recruitment to source candidates working alongside NHSE – have in place by end 2024/25
3.	The trust should start to plan the induction of non-executive directors in advance of the recruitment process for these vacancies.	Y	Induction reviewed 2023 & detail updated	Company Secretary	Induction planned in advance and course dates / induction calls arranged ahead of start date
4.	In view of the pending changes in membership of the board, the future board development programme should cover not just high-profile topics affecting the NHS, but also soft skills required for governance, such as working together as a board and asking the right questions.	Y	Board Development programme 2024/25 to include soft skills once new appointments in post	Chair / Chief Executive	Soft skills element of the programme to be planned for late 2024 / early 2025.
5.	The board should consider whether it would like to receive a separate, regular report from the director of strategy, covering strategic developments at the trust and in the integrated care system.	Y	Update included in Trust Report and through Strategy updates six monthly	Director of Strategy	Complete and in rolling programme for Board
6.	The trust should systematically, through a formal 360-degree exercise, elicit feedback from stakeholders and partners.	Y	Similar exercise undertaken as part of current strategy. More structured approach will be incorporated into plans for future strategy development	Director of Strategy	Timing of future stakeholder feedback to align with current strategy implementation (every 2 years)

No.	Recommendations	Accept Y/N	Action	Responsible	Progress
7.	The board should consider whether to establish a subcommittee with responsibility for finance.	N	Part 2 of the Board of Directors will fulfill this requirement	Company Secretary / Director of Finance	In place for Part 2 of Board of Directors
8.	The trust should undertake a mapping and evaluation exercise of the management groups in the organisation and update all terms of reference to a standard template including reporting groups.	Y	Review & update of ToR of committees - including reference to regulations / performance / policies for review & provide assurance	DCEO / Company Secretary	Updated terms of reference to be reviewed by each committee. To be completed end Q1 24/25.
9.	The trust should rename management groups to clarify their role and purpose.	Y	Renaming to be included in reviews of ToR	Committee chairs/ Company Secretary	Included in review of terms of reference
10.	The board should introduce chair's reports from each committee, to summarise the committees' business for the board's benefit in 3A format (assure, alert, advise).	Y	Reports in form of more structured minutes agreed from January 2024	Committee chairs / Company Secretary	Agreed that summary style minutes be included in future papers. In place from January 2024
11.	The board should review the style in which minutes are taken, and move towards a more high-level, summary style of minute taking.	Y	New minute style to be introduced from January 2024 meetings	Assistant / Company Secretary	
12.	The audit committee should review its remit in line with the NHS Audit Committee Handbook.	Y	Reviewed annually	Director of Finance	Reviewed annually
13.	The agendas of the board, its committees and management groups should include time at the end to reflect on the meeting.	Y	Added to the committee agendas or managed through NED pre-meet for Board	Company Secretary	Complete
14.	The trust should review the board's programme of business to ensure an appropriate balance towards strategic items.	Y	Board agenda restructured	Chair/ Company Secretary	Complete – in place from March 2024 meeting
15.	Meeting chairs should be reminded that it is good practice to complete each agenda item with a brief summary.	Y	Committee chairs	Company Secretary	Added into Board guidelines Complete

No.	Recommendations	Accept Y/N	Action	Responsible	Progress
16.	The trust should take a 'zero-based' approach to its performance indicators. In other words, it should start with a blank canvas every four or five years and work out what it needs to measure based on national standards and regulations, commissioners' contractual requirements, and its own strategic and operational objectives. A good time to commence this work is when a new strategy has been adopted.	Y	Metrics to be developed for board dashboard	Company Secretary/D CEO	This approach will be taken for the setting of the next 5 year strategy. Metrics to evidence current performance will be presented in a new dashboard from April 2024
17.	The board assurance framework should be used more systematically to identify any gaps in assurance against standards and objectives.	Y	BAF to be updated	Company Secretary/D CEO	2024/25 BAF to be updated in line with recommendation and draft presented to Board in March 24.
18.	The trust should regularly seek assurance on the quality of data included in management information reported to the board or committees. This is a service performed by internal audit in many organisations.	Y	In place through internal audit and other mechanisms	Director of Finance	In the internal audit programme for 2024/25
19.	The trust should ensure that it has fully prepared itself for any future CQC announced inspections, for example by briefing the workforce at all levels, and completing (and keeping up to date) a full and candid self-assessment against the regulator's quality standards.	Y	In progress as normal business	Chief Nurse	Testing taking place into compliance with 2022 inspection report Must Do's. Further mock inspections and communications planned.
20.	Papers reported to the board or its committees should be cross- referenced to the CQC quality standards, and any other regulations that may be relevant, on their covering sheets.	Y	To be included in guidance on board and committee papers ToR's updated with regulations	Company Secretary	Cover sheet / rolling programmes updated and included in Board guidelines
21.	The trust should seek outside assurance on any action plans arising from critical regulatory inspections, for example by asking internal audit to review the evidence showing whether actions have been completed.	Y	This is normal practice and will be undertaken in the future if needed	Executive Directors	In place CQC action plan assessed by specialised commissioning quality committee

No.	Recommendations	Accept Y/N	Action	Responsible	Progress
22.	The trust should also consider establishing its own small in-house compliance and assurance team, which would gather and maintain evidence of compliance with regulatory standards (not limited to the CQC's quality standards), horizon scan for legislative and regulatory developments, co-ordinate planning for reviews by external bodies, and monitor development / implementation of action plans	N	Quality & Standards team in place with reporting via relevant assurance committee	Chief Nurse	Quality & Standards team in place
23.	The trust should consider expanding the use of statistical process control techniques to identify variations of concern, where appropriate.	Y	Where appropriate – can extend the use of these in assurance committees	Chief Operating Officer	SPC charts used in the Integrated Performance Finance and Quality report
24.	The board and committees should discuss whether they find it useful to allocate assurance levels to each paper, or if a different approach would be better.	Y	Agreed to allocate assurance only to governance issues allocated to the committee	Committee Chairs / Company Secretary	In place for governance issues allocated to each committee and picked up in minutes / BAF. This will be reviewed by committee chairs going forward.
25.	The trust should consider procuring a document management system for policies and guidelines.	Y	The Trust has a long-standing document management system	COO/CIO	We will look to update existing system when appropriate
26.	The trust should redesign its board assurance framework to make it a more engaging and user-friendly document.	Y	New version to be implemented in 2024/25 – initial draft of 1 risk per page. Looking to use a Tableau dashboard	Company Secretary/D CEO	2024/25 BAF to be updated in line with recommendation and draft presented to Board in March 2024. Once risks agreed BAF will be presented in more engaging/user friendly format
27.	The BAF should include graphics such as 'heat maps' showing the risk profile in visual form and how this has changed over time.	Y	Appropriate format being developed – link to Datix / Tableau	Company Secretary/D CEO	To be incorporated into BAF 2024/25. Exploring ways of linking this with the new Datix system once in place
28.	Committees need only be presented with those risks in the BAF for which they are the lead	Y	In place from January 2024 meetings	Committee Chairs/	Complete

No.	Recommendations	Accept Y/N	Action	Responsible	Progress
	committee.			Company Secretary	
29.	The trust should review GGI's report in conjunction with the report of the cultural review carried out by Globis, consider any themes common to the two, and ensure a consistent approach.	Y	This is what has always been intended	DCEO	Analysis undertaken alongside Globis report and reported to Board in March 2024
30.	The board should consider how it can best gain ongoing assurance that the trust has the right culture, by thinking about the different sources of data and intelligence (HR statistics, local and national staff surveys, FTSU concerns, employee relations issues, etc.), and how these are analysed and reported.	Y	Reporting on culture will be through scorecard and other reports in restructured agenda	Company Secretary/D CEO and HRD	Scorecard in development alongside reviewed reporting for committees / new agendas – to be completed by end Q1 2024/25
31.	The trust should ensure that staff networks have sufficient resources at their disposal to be effective.	N/A	Outside ToR of review	N/A	N/A
32.	Governors should be encouraged to observe meetings of board subcommittees (on the understanding that they are there as observers and not as participants in committee business).	Y	Offer to be made to governors for 1 or 2 to observe per meeting	Company Secretary	Discussed at February Council of Governors and managed through Company Secretaries office. Offer sent to governors
33.	The trust secretary and a sub-group of governors should work together to identify any unmet training needs for the council of governors.	Y	Already in place	Company Secretary	Induction refreshed and delivered annually to new & existing governors. Training offered throughout the year with NHS Providers programme 'GovernWell' plus locally delivered to suit need
34.	The trust should consider how governors could be enabled to communicate with the foundation trust membership, for example email bulletins, a social media group, etc.	Y	Being taken forward by Membership & Community Engagement Committee of CoG	Membership Team	Membership & Community Engagement Committee taking action forward

No.	Recommendations	Accept Y/N	Action	Responsible	Progress
35.	The trust should enable more frequent contact between governors and non-executives, in order that the governors can better hold NEDs to account.	Y	NED committee chairs to present their report to full CoG – minutes to be added to agenda. NEDs attend governor committees. Governors invited to Assurance Committees	NED committee chairs / Company Secretary	NED reporting to full Council of Governors February 2024 onwards. Invite sent to Governors to attend Assurance Committees.

Other Actions outside of GGI Review

No.	Recommendations	Action	Responsible	Progress
36.	Responsibility for overall strategy and supporting strategies (Quality, finance, digital, workforce, EDI, sustainability, research, education, etc.) to remain with the board with committees seeking assurance on delivery.	Rolling programmes updated	Company secretary & Executive Leads	All rolling programmes updates
37.	Board / committee agendas to be re-organised into sections on strategy / performance / culture / governance following Board agreement of allocation of responsibility for scrutiny	Agendas to be restructured following agreement of allocation by Board	Company Secretary	Agendas restructured. Delegation of specific items to be presented to Board for agreement then reflected in ToR
38.	Adopt the nomenclature of “board” for the board of directors only and “committee” for those groups reporting directly to the board of directors only: • Statutory committees e.g. remuneration committee. • Assurance committees i.e. audit, workforce, quality committees. • Operational committee i.e. senior management committee. Refer to other forums as “team” or “group” as appropriate and update the terms of reference accordingly.	Update committee ToR’s to reflect change in name and communicate change across the Trust	Executive Directors	ToR’s updated for Management Board – to be approved in March 2024

No.	Recommendations	Action	Responsible	Progress
39.	Increase the diversity and skills of the board by actively seeking and welcoming applications from those with all protected characteristics and who are representative of the communities we serve.	Include requirement in brief to external recruitment partners. Use best practice advice on language / presentation of recruitment materials. Ensure recruitment panels (including governors) are appropriately trained in EDI.	Chair	Nominations Committee members trained in EDI. Included in recent recruitment briefs to external search partners. Looking to appoint someone on the NHSE NExT Director Scheme by end Q1 2024/25.
40.	Maintain the current schedule of board meetings, committee meetings development sessions and other meetings but keep under review with a view to reducing the frequency (subject to on-going discussion and agreement with board committee chairs).	Review rolling programmes. Proposed to remove Board meetings in May and October, schedule WAC & QAC on the same day (increasing WAC meetings from 4 to 5 per annum)	Company Secretary and Chief Executive Officer	WAC & QAC meetings rescheduled to take place on the same day. May Board meeting replaced with Planning Day. Consideration of October Board date following discussion.
41.	Deep dives on progress in key strategy areas to be maintained as part of away day and development programme	To add to Board Planning / Development Plan for 2024/25	Company Secretary	Added to forward plan for Board Planning / Development sessions.
42.	Review the composition and make up of each committee to ensure that each has the appropriate balance of skills and experience, including the chair role.	Assessment to be carried out once 2 new NEDs in place – end Q1 2024/25	Company Secretary / Exec Leads	Planned for end Q1 2024/25
43.	Review support for committee chairs to promote best practice in chairing including providing summaries, reflecting on meeting effectiveness, assurance reporting and balance of agenda items – to include GGI observations on meeting conduct.	Training offered to committee chairs through NHS Providers	Company Secretary	Training offer communicated with NEDs
44.	Current arrangements for remuneration committee will continue but with explicit additional responsibility for board succession planning incorporated in the Terms of Reference	Add to Terms of Reference	Company Secretary	Added to Terms of Reference

No.	Recommendations	Action	Responsible	Progress
45.	Revise the terms of reference and membership of the current management board to include changing its name to senior management committee to emphasise its role as a board committee with delegated authority to be the main operational management decision making forum of the Trust	Update Terms of Reference Communicate change to key stakeholders	Deputy Chief Executive Officer	Revised Terms of Reference approved March 2024 Key stakeholders informed of decision and rationale
46.	Confirm and simplify the terms of reference and reporting lines of those groups reporting into the senior management committee (currently management board).	Review of groups / committees reporting to Senior Management Committee	Deputy Chief Executive	To be completed by end Q1 2024/25
47.	Reconfirm the allocation of the responsibility to each committee from the Board	To be included in terms of reference of each committee	Company Secretary	Discussion with committee chairs / exec leads in April
48.	The Board will receive a comprehensive revised dashboard as part of the public papers	Dashboard being developed for April 2024	DCEO / COO	To be presented from April 2024

The Christie
NHS Foundation Trust

Agenda Item 10/24b

Thursday 28th March 2024

Board Assurance Framework 2023/24

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

The Christie
NHS Foundation Trust

Agenda Item 10/24b

Board of Directors meeting

Thursday 28th March 2024

Board Assurance Framework 2023/24

1 Introduction

The board assurance framework (BAF) 2022/23 was presented to the Board of Directors, Workforce Assurance Committee and Quality Assurance Committee in November.

2 Updates to risks

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

- Target risk scores updated.
- Where a risk has been assessed by an assurance committee the level of assurance has been added.
- Outcomes of MIAA audits have been added to the assurance column where appropriate.
- Risk scores have been updated to reflect the risk at month 11 and the current level of performance against the measures that inform the risks.
    - 1.1 Not meeting national requirements of Patient Safety Incident Response Framework (PSIRF) – preparation on plan

      Risk score reduced from 8 (2/4) to 2 (1/2)
    - 1.4 Failure to learn from patient feedback (patient satisfaction survey / external patient surveys / complaints / PALS) – feedback shows high satisfaction and complaints compliance is strong

      Risk score reduced from 4 (2/2) to 2 (1/2)
    - 1.5 Risk of exceeding the thresholds for harm free care indicators (falls, pressure ulcers, venous thromboembolism) – performance against indicators is better than trajectory

      Risk score reduced from 8 (2/4) to 2 (1/2)
    - 1.6 Lack of preparedness for a CQC inspection leading to a poor performance – work is underway to prepare for future inspections. In year risk is mitigated.

      Risk score reduced from 8 (2/4) to 4 (1/4)
    - 5.2 Failure to implement 2023/24 objectives of the SACT strategy – strategy is on track and activity has moved in line with plan

      Risk score reduced from 12 (3/4) to 8 (2/4)
    - 6.1 Key performance targets not achieved – year end impact assessed as a 4

      Risk score reduced from 15 (3/5) to 12 (3/4)

3 Suggested updates

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

4 Recommendation

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

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

Number	Principal Risks	Exec Lead	Likelihood	Impact	Key Control established	Key Gaps in Controls	Current Risk Score	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Risk appetite (Averse / Cautious / Eager)	Responsible committee	Assurance level achieved (High / Medium / Low)	Opening Position	Position at end of Q1	Position at end of Q2	Position at end of Q3	Position at end of Q4	Target risk score	Target date for completion
1.1	Not meeting national requirements of Patient Safety Incident Response Framework (PSIRF)	ECN	1	2	Associate Chief Nurse for Quality and Patient Safety and Associate Medical Director for Patient Safety leading training and implementation programme. Progress monitored through Risk & Governance Committee and Quality Assurance Committee. Updates presented to ICB	None identified	**2**	Monitoring of reporting requirements through reports / asurance committee rolling programmes. Plan approval at Management Board January 2024	None identified	Team progressing implementation of PSIRF. Detail & dates in September 23 Board paper	September Board paper	Averse	Quality	High	**8**	8	8	8		**2**	Year end
1.2	Lack of data to fully understand equity of access to services & its impact on outcomes	COO	4	2	Project established to address data quality gap with clinical leadership. Go live date of July 2023 for identified projects. Impact assessed in January 2024. Publish information on website.	Incomplete data set	**8**	Local audit of compliance reported to Executive Team. MIAA audit re GM cancer Q3	None identified	Regular review and reporting to executive team. System changes identified	July implementaion of actions. Review in January 24	Cautious	Quality	Mediu m	**12**	12	12	12		**4**	Year end
1.3	Risk to patients and reputational risk to trust of exceeding healthcare associated infection (HCAI) standards	ECN	2	3	Patients with known or suspected HCAI are isolated. Medicines management policy contains prescribing guidelines to minimise risk of predisposition to C-Diff & other HCAI's. RCA undertaken for each known case. Review of harm undertaken. Induction training & bespoke training if issues identified. Close working with NHS England at NIPR meetings. Clinical advisory group in place. Following national guidance. IPC BAF in place	None identified.	**6**	Levels reported through performance report to Management Board and Board of Directors and quarterly to NHS Improvement. MIAA audit planned Q2 - moderate assurance	None identified	Actions relating to IPC BAF identified with target dates - full report to Sept 23 QAC	Monthly assessment of progress	Averse	Quality	High	**6**	6	6	6		**6**	Year end
1.4	Failure to learn from patient feedback (patient satisfaction survey / external patient surveys / complaints / PALS)	ECN	1	2	Monthly patient satisfaction survey undertaken and reported through performance report. Negative comments fed back to specific area and plans developed by ward leaders to address issues. Action plans developed and monitored from national surveys. Complaints and PALs procedures in place. Action plans monitored through the Patient Experience Committee	None identified	**2**	Management Board and Board of Directors monthly Integrated performance and quality report. National survey results presented to Board of Directors. MIAA audits - complaints Q1 - substantial assurance / risk management Q4. CQC Inpatient survey results. National Cancer Patient Experience Survey results	None identified	Team progressing implementation of PSIRF	September 23 / January 24 Board papers	Averse	Quality	High	**4**	4	4	4		**2**	Year end
1.5	Risk of exceeding the thresholds for harm free care indicators (falls, pressure ulcers, venous thromboembolism)	ECN	1	2	All falls with low harm come through Friday-Focus and moderate/above through ERG. Falls prevention group operational. Training required for all nursing/HCA staff. All hospital acquired pressure ulcers reviewed through Friday-Focus. Monitoring of VTE assessment compliance through Thrombosis Committee. Continuous assessment of progress against thresholds. At 6 monthly position will further assess likely year end position and risk score.	Risk assessments for falls and skin assessment not always completed in a timely manner	**2**	QI project evaluating introduction of bedside handover to improve compliance with risk assessments. Risk assessment compliance added to CWP and monitored daily. Regular reports to Quality Assurance committee. MIAA audit risk management Q4	None identified	Continuous monitoring through monthly reports. Escalations in place where appropriate. No current concerns.	Monthly assessment of progress	Averse	Quality	High	**8**	8	8	8		**2**	Year end
1.6	Lack of preparedness for a CQC inspection leading to a poor performance	ECN	1	4	Assessment against standards ongoing. Timetable of mock inspections being arranged. Looking at Trust wide requirements. Assessment of assurance process to ensure all regualtions assessed. GGI review & actions. Assessment of impact of new regulatory approach undertaken.	Full understanding of CQCs new approach to inspection	**4**	Good rating 2023. MIAA audit - risk management Q4	None identified	Engagement in CQC's regulation updates / webinars re new assessment framework. Review of compliance against 2022 Must Do actions underway	Regular engagement meetings in diary	Averse	Quality	High - for comple tion of action plans	**8**	8	8	8		**4**	Year end

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

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

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

	Principal Risks	Exec Lead	Likelihood	Impact	Key Control established	Key Gaps in Controls	Current Risk Score	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Risk appetite (Averse / Cautious / Eager)	Responsible committee	Assurance level achieved (High / Medium / Low)	Opening Position	Position at end of Q1	Position at end of Q2	Position at end of Q3	Position at end of Q4	Target risk score	Target date for completion
3.1	Risk to delivery of the Christie Education strategy due to reduction in demand	DoE	2	2	Review the deliverables and prioritise in line with financial investment available. Maximise the potential of external income. Refresh the Christie Education focus on integration of objectives with clinical and research divisions. Work with finance to review funding options, develop business cases for high priority initiatives and look at alternative funding sources. Active monitoring of regulated education funding tariffs (NHS WT&E, previously HEE) and funding opportunities.Balanced focus on maximising opportunities for Christie Workforce through People Development Group.	Continuing inability to deliver all strategic objectives due to difficulty in accessing current investment funds to deliver new initiatives.	**4**	Reporting to Workforce Assurance Committee and Board Creation/launch of Executive Education Oversight Group to scrutinise opportunities for alternative legal/financial vehicles for Christie Education	None identified	Market/competitor analysis undertaken to review current/future alignment of output/product alongside local capacity/commitment. Expansion of external sub-brand activity to maintain diverse income streams	Divisional Board to manage timelines of actions	Cautious	Workforce	Medium	**9**	9	9	4		**4**	Year end
3.2	External factors / pipeline of high quality clinical and teaching staff	DoE	3	2	Monitoring of workforce numbers / turnover. Active recruitment and investment in Christie pipeline.	External factors / pipeline of high quality oncologists	**6**	Reporting to Workforce Assurance Committee and Board	None identified	Active recruitment practices / investment	Divisional Board to manage timelines of actions	Cautious	Workforce	Medium	**9**	9	9	6		**3**	Year end
3.3	Lack of progress with organisational governance arrangements for Christie Education	DoE	2	2	Project group in place. Plans established and resourse identified. Project progress reported to Board of Directors.	External factors	**4**	Reporting to Workforce Assurance Committee and Board	None identified	Project group identified actions and timelines, reported through Education Board.	Divisional Board to manage timelines of actions	Cautious	Workforce	Medium	**9**	9	9	4		**4**	Year end

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

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

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

	Principal Risks	Exec Lead	Likelihood	Impact	Key Control established	Key Gaps in Controls	Current Risk Score	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Risk appetite (Averse / Cautious / Eager)	Responsible committee	Assurance level achieved (High / Medium / Low)	Opening Position	Position at end of Q1	Position at end of Q2	Position at end of Q3	Position at end of Q4	Target risk score	Target date for completion
5.1	Inability to fully implement the 2023/24 Greater Manchester Cancer operating model	CEO	3	4	CEO chairs Manchester Cancer Board. Director of Strategy attendance at key meetings. Christie Strategy 2023-28 approved	None identified	**12**	Reports to Management Board and Board of Directors	None identified	GM Cancer Board monitoring progress and sharing & reviewing progress through regular meetings	Annual objectives assessed at 6 and 12 months	Averse	Board		**12**	12	12	12		9	Year end
5.2	Failure to implement 2023/24 objectives of the SACT strategy	COO	2	4	Strategy on track but constrained by other trusts. Expansion on Withington site. 6 monthly assessment of progress. Bolton activity agreed & transferring from April 2024	None identified	**8**	Regular reports to Management Board and Board of Directors. Six monthly assurance reports to Quality Assurance Committee.	None identified	SACT team report to Board on progress June 2023. On going assessments of demand and response in place	SACT Board manages action progress and reports through QAC	Averse	Quality	Mediu m	**12**	12	12	12		**3**	Year end
5.3	Inequity of access for patients to Christie trials due to delays in implementing governance arrangements for Christie led & hosted trials at the networked centres	DoR /COO	3	4	Research & Innovation Strategy approved. Approval for the trust to further expand the management of local oncology and chemotherapy services across GM. Focus on improved digital access e.g. appointments / ePROMs and Shared Decision Making. Chemotherapy services in locations across GM & Cheshire - strategy on track but constrained by other trusts.	Workforce and engagement from other trusts.	**12**	Regular reports to Quality Assurance Committee and Board of Directors	None identified	Working with other Trusts to understand issues and actions. Monitored through R&I / SACT boards	SACT Board manages action progress and reports through QAC	Averse	Quality	High	**12**	12	12	12		**9**	Year end

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

	Principal Risks	Exec Lead	Likelihood	Impact	Key Control established	Key Gaps in Controls	Current Risk Score	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Risk appetite (Averse / Cautious / Eager)	Responsible committee	Assurance level achieved (High / Medium / Low)	Opening Position	Position at end of Q1	Position at end of Q2	Position at end of Q3	Position at end of Q4	Target risk score	Target date for completion
6.1	Key performance targets not achieved	COO	3	4	Executive led monthly divisional performance review meetings. Integrated performance & quality report to Management Board and Board of Directors monthly. Weekl;y performance reporting via trust operational group. Escalation internally & across GM of delays impacting waiting time targets. Monitoring cancer waiting time standards through GM Cancer & IPR.	Impact of ongoing Industrial Action leading to delays in referrals	**12**	Executive Team monitor activity weekly. Integrated performance report to Management Board, Quality Assurance Committee and Board of Directors.	None identified	Weekly monitoring through Executive Team, actions discussed and escalated as appropriate. Weekly escalation meeting with divisions / execs	Monthly review of annual targets	Cautious	Quality	Mediu m	**12**	12	12	15		**12**	Year end
6.2	Change in financial regime resulting in inability to deliver the Trust's strategic plan.	EDoF	4	4	Participating at national level and ICS (Greater Manchester) level to influence the new financial framework and its implementation. Development of mitigating strategies including efficiency and transformational programmes. Identification and consideration of new models of working to deliver and finance the Trust's strategic plan.	Changes in national funding arrangements and delegation of commissioning functions.	**16**	To continue to report through Managment Board and Board of Directors via financial reports and updates. Executive Team monitor activity weekly. MIAA audit - CIP Q2 - moderate assurance / financial systems Q3 - substantial assurance / Critical Apps Q3 - moderate assurance	None identified	External advice sought on new models of working. Close working with national & regional team	Monthly assessment of progress towards annual plan	Cautious	Audit	High	**16**	16	16	16		**4**	Year end
6.3	Digital programme unable to support delivery of operational objectives	COO	3	4	CWP (clinical web portal) on stable platform. Review of digital programme and to align ditial strategy with Service strategies. Key projects moving forward e.g.Order comms. EPMA, ePROMs, clinical outcomes. Projects on plan. Roll out to clinical areas in early 2024/25.	Internal capability & expertise to support system going forward.	**12**	Reports to Management Board & Board of Directors. MIAA audit - Data Protection Toolkit (DPST) Q4	None identified	Progress and objectives set/reviewed by Quarterly Digital board. Esaclations through Management Board.	Monthly assessment of progress towards annual plan	Cautious	Audit	Mediu m	**12**	12	12	12		**4**	Year end
6.4	Not delivering the objectives of our commercial partnerships resulting in negative financial / patient experience or reputational impact	EDoF	3	3	Partnership Boards in place. Review of contract arrangemnts for CPP. TCP - Internal and external auditors in place. MIAA governance audit gave significant assurance. KPI's reported via partnerhip board structure.	None identified	**9**	Close contact with partners & management of joint incidents. Regular reports to Board and Audit Committee	None identified	Issues outlined and escalated through Boards	Regular assessment of progress towards annual plan	Averse	Audit / Board	High	**9**	9	9	9		**3**	Year end
6.5	Reputational damage, service disruption and financial loss due to cyber-attack.	COO	3	4	Risk committee regular reporting on cyber security alerts established. Digital Programme progression of key cyber security improvement projects continues. Digital Board reporting. NHS Digital linked monitoring tools being deployed. Internal scanning tools deployed. External summary reports provided. Regular testing and reporting of security vulnerabilities. Staff training mandatory. Cyber incident response support established via NHS Digital. Cyber essential assessment underway.	The Trust does not currently have cyber security insurance.	**12**	Data Security and Protection Toolkit submissions with audits undertaken. Digital board reporting. Board level Senior Information Risk Owner in place.MIAA audit - Data Protection Toolkit (DPST) Q4	None identified	Actions identified through MIAA DSPT review. Progress monitored on target dates through divisional meetings.	Monthly review of identified actions	Averse	Audit	Mediu m	**15**	15	12	12		**12**	Year end
6.6	Not implementing the in year objectives of the Trust strategy and its underpinning plans (Quality / Patient Experience / Risk Management / Operational)	DCEO	3	4	Strategy / plans approved and reported through assurance committees. 6 monthly assessment reported to Board.	None identified	**12**	Published Trust Strategy	None identified	Objectives monitored through appropriate divisional board	Annual objectives assessed at 6 and 12 months	Averse	Board		**12**	12	12	12		**4**	Year end

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

	Principal Risks	Exec Lead	Likelihood	Impact	Key Control established	Key Gaps in Controls	Current Risk Score	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Risk appetite (Averse / Cautious / Eager)	Responsible committee	Assurance level achieved (High / Medium / Low)	Opening Position	Position at end of Q1	Position at end of Q2	Position at end of Q3	Position at end of Q4	Target risk score	Target date for completion
7.1	Failure to achieve the year 1 milestones of the People and Culture Plan 2023/26	DoW	2	3	Plan approved and actions underway against each element with regular updating and reporting	None identified	**6**	Workforce Assurance Committee reports. MIAA audit EDS 22 Q4.	None identified	Target dates for all elements of the plan identified	Monthly review of identified actions	Averse	Workforce	Medium	**12**	12	12	12		**4**	Year end
7.2	Risk of negative impact on delivery of services and staff engagement levels due to Trustwide staffing gaps in some occupations and ability to recruit and retain	DoW	4	3	Recruitment & Retention Trust wide group in operation reporting to the workforce committee. Commenced programme of work with an external organisation to develop our recruitment offer, advertising and brand. Commenced a programme of recruiting international nurses over a 6 month period. Quarterly oversight of Trust wide vacancies and recruitment activity presented to the workforce committee. Divisional oversight of recruitment activity and vacancies discussed at the monthly service review meetings. Turnover analysis and exit interview data presented and discussed six monthly at the workforce committee.	National staff shortages impacting recruitment	**9**	National staff survey 2021 results. Reports to Management Board . Agency spend. Workforce Committee Oversight. MIAA audit - sickness absence Q1 - substantial assurance	None identified	Recrutiment and retention workplan in place - monitored through Workforce Assurance Committee	Regular assessment of progress towards annual plan	Averse	Workforce	High	**12**	12	12	12		**6**	Year end
7.3	Management of Board succession and appointment of new Chair / NEDs	DoW/CS	3	3	External search agency appointed to undertake Chair recruitment process. Plan outlined for future requirements to replace NEDs as they come to end of term. New Chair successfully appointed to start October 2023. Process for recruitment of 2 NEDs commenced July 2023. One NED appointed from Jan 23, Second appointment to be completed by April 24.	None identified	**9**	Nominations Committee decisions reported to Council of Governors. Adherence to Fit & Proper Persons regulation - report to Workforce Assurance Committee and Board on compliance. Use of external search partner.	None identified	NED recruitment underway and plans outlined for further recruitment with timelines. Skill mix assessment updated and Board discussion undertaken as part of Dec Planning session.	Year end review of succession plan to determine future NED requirements	Averse	Board	Medium	**9**	9	9	9		**9**	Year end
7.4	Race/Disability discrimination impacting staff experience and therefore patient care	DoW	3	3	Staff networks established, Board development sessions planned across the year focussing on discrimination. EDI programme board monitors delivery of the EDI plan, monitoring of risks and WRES/WDES action plans. EDS2022 progress against plans monitored at the Management Board. Workforce Assurance Committee oversight of progress.	None identified	**9**	Reports to Workforce Committee, Management Board and Workforce Assurance committee. Staff story at each Workforce Assurance Committee. MIAA audit EDS 22 Q4.	None identified	WRES / EDS2022 action plans identify actions & timelines	Regular assessment of progress towards annual plan	Averse	Workforce	Medium	**9**	9	9	9		**6**	Year end

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

The Christie
NHS Foundation Trust

Agenda item 10/24c

Board of Directors meeting
Thursday 28th March 2024

Subject / Title	Fit & Proper Person Test Compliance Report 2023/24
Author(s)	Louise Westcott, Company Secretary
Presented by	Louise Westcott, Company Secretary
Summary / purpose of paper	This paper outlines the compliance with the new requirements of the NHS England Fit and Proper Persons Test Framework 2023. The paper summarises the changes introduced with the framework and details the steps taken to achieve compliance for 2023/24 against the framework. In addition, an MIAA checklist relating to the introduction of the Framework is attached for additional assurance on the work undertaken to ensure compliance.
Recommendation(s)	It is recommended that subject to the outstanding BMR's; • this compliance report is updated with any further information and presented to the March Public Board of Directors meeting. • the Chair signs off that the relevant directors are fit and proper for 2023/24 by the end of March 2024 and that this is recorded in ESR. • the Annual NHS FPPT submission reporting template is completed and returned to NHSE to reflect compliance.
Background papers	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 Public Board Paper Agenda item 27-23e - Fit & Proper Person Test Framework and updated Policy
Risk score	8 (2/4)
EDI impact / consideration	In line with NHS Employment legislation and the F&PP Regulation
Link to: ➢ Trust strategy ➢ Corporate objectives	Trust Strategy 2023-2028 Corporate objective 7 – To be an excellent place to work and attract the best staff
Acronyms or abbreviations used	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

Board of Directors meeting
Thursday 28th March 2024

Fit & Proper Person Test Compliance Report 2023/24

1. Introduction

NHS England (NHSE) published a new Fit and Proper Persons Test (FPPT) Framework (the Framework) on 2nd August 2023 alongside guidance for chairs and for 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 30 September 2023 with full implementation by 31 March 2024.

The Framework introduces new and more comprehensive requirements around board appointments and annual review and supports transparency. This includes 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.

There are also new requirements to populate fields within the Electronic Staff Record (ESR) related to FPPT checks and references. This will provide a standard way to record and report compliance internally. Retrospective population of data is not proposed. Hard copy files are still required.

A review of compliance with the standard and framework has been included in the 2024/25 annual Internal Audit Plan.

2. Summary of changes

The Fit and Proper Persons Test Framework and assessment includes all **current** elements relating to CQC Regulation 5: fit and proper persons: directors.

New elements relating to recommendations made by Tom Kark KC in his review of the Fit and Proper Person Test;

- The NHS Leadership Competency Framework (LCF) – received 28th February 2024 and circulated for use in current appraisals
- FPPT fields in NHS Electronic Staff Record (ESR) to record testing – added to the system and completed for all relevant staff including backdated completion for Directors employed pre- September 2023
- A Board Member Reference (BMR) – requirement included in updated policy, requests sent for new Directors
- 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 – requirements included in updated policy

The new 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. Process followed

Since the introduction of the F&PPT Framework in August 2023 we have updated and approved a new F&PPT Policy that aligns to the framework. We have been working to this policy in any subsequent recruitment to the Board.

We have also updated the new F&PP fields in the electronic staff record (ESR) for all existing Board members as well as using these fields for new members. This was done through cross referencing the evidence we hold in the electronic and paper files held by the Company Secretary. The guidance does not ask for retrospective population of the fields so this is above and beyond the requirements of the framework and was done as a one-off exercise to ensure compliance with all the new requirements for all relevant directors.

4. Changes to the Board

There have been several changes in directors since the introduction of the framework. One non-executive director was appointed from 1st January 2024. The Executive Chief Nurse left at the end of December 2023 and was replaced by an interim in November 2023 until the permanent recruitment was completed. This post was permanently appointed to in February 2024 and the successful candidate will start in May 2024, checks are underway for this person. The Chief Operating Officer is retiring at the end of March 2024 and this role is being covered by a 12-month secondment from the beginning of March 2024. The updated requirements have been followed for all posts.

5. Compliance

New checklists have been added to all relevant files to enable each file to be updated in line with the new requirements. The Company Secretaries office and the Recruitment and Workforce Information teams have worked closely to ensure that each requirement is complete for all relevant directors in line with the policy. Hard copy files have been updated and created in line with the checklists and information shared between the teams to ensure ESR is updated correctly.

The directors who have been appointed since the new framework came in have all had the appropriate checks undertaken. All checks are complete for Theresa Plaiter and Claire McPeake with no concerns. A Board Member Reference (BMR's) have been requested for Diana but not yet received, all other checks are complete with no concerns. All fields are complete in ESR for these individuals. Where the BMR has not been received we have 2 valid references and continue to chase the BMR, evidence of the request is kept on file.

The new annual attestation has been signed by each director and where DBS checks are over 3 years old these have been requested, not all have been received yet and the team are chasing those that are outstanding with the DBS service. Social media checks have also been undertaken for all directors by a specialist external company on our behalf, all are now complete and no issues identified.

The teams are satisfied that the appropriate checks have been undertaken and recorded except for the outstanding BMR.

No concerns around the fit and proper test requirements have come up from the checks undertaken for any of the directors.

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.

MIAA issued a checklist in September 2023 against the new framework. This was presented to Board in September 2023. For completeness this has been updated and is presented at appendix 2.

6. Additional requirements

By the end of Q1 2024/2025 we must incorporate the Leadership Competency Framework into annual appraisals of all board directors for 2023/2024, using the new board appraisal framework. This is being included in the current round of appraisals for all Board members and evidence included in the hard copy / electronic files.

7. 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 subject to the one outstanding BMR;

- the Chair signs off that the relevant directors are fit and proper for 2023/24 by the end of March 2024 and that this is recorded in ESR.

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

The Christie
NHS Foundation Trust

Appendix 1 – ESR fit & proper persons dashboard

Last Name	First Name	Title	Job Role	Employment History	Date of Qualifications Check	References Check Date	Board Member Reference Complete / Retained	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 (now 3 yearly)	Date of Medical Clearance	Not Found on Insolvency Register	Date Prof Reg Check	Self Attestation
Ainsworth	Robert	Mr.	Non Executive Director	16/10/2023	N/A	03/03/2016		17/10/2023			12/01/2024	20/09/2023	20/09/2023	20/09/2023	With DBS	12/05/2016	20/09/2023	N/A	07/04/2023
Astle	Edward	Mr.	Chair	17/10/2023	N/A	15/06/2023		Not yet due			18/01/2024	20/09/2023	20/09/2023	20/09/2023	Checked	21/08/2023	20/09/2023	N/A	03/07/2023
Bayman	Neil	Dr	Medical Director	06/12/2023	09/09/2021	10/09/2021		23/03/2023			12/01/2024	20/09/2023	20/09/2023	20/09/2023	Checked	18/02/2009	20/09/2023	01/10/2021	04/04/2023
Blackhall	Fiona	Prof	Board Level Director	01/06/2021	01/06/2021	02/06/2021		29/11/2023			12/01/2024	20/09/2023	20/09/2023	20/09/2023	Checked	18/02/2009	20/09/2023	01/10/2023	10/05/2023
Delahoyde	Bernadette	Mrs.	Chief Operating Officer	06/12/2023	01/09/2010	19/12/2015		15/02/2024			12/01/2024	20/09/2023	20/09/2023	20/09/2023	Checked	14/10/2021	20/09/2023	N/A	03/04/2023
Goddard-Full	Rikki	Prof	Board Level Director	06/12/2023	01/10/2021	01/09/2021		29/11/2023			19/01/2024	20/09/2023	20/09/2023	20/09/2023	Checked	10/09/2021	20/09/2023	10/09/2021	20/04/2023
Harrison	Christopher	Prof	Medical Director	14/03/2016	14/03/2016	15/03/2016		28/02/2024			18/01/2024	20/09/2023	20/09/2023	20/09/2023	Checked	04/02/2016	20/09/2023	10/03/2016	03/04/2023
Kapur	Tarun	Mr.	Non Executive Director	16/10/2023	N/A	28/04/2016		19/06/2023			02/02/2024	20/09/2023	20/09/2023	20/09/2023	With DBS	16/06/2016	20/09/2023	N/A	21/04/2023
Lightfoot	Eve	Miss	Chief People Officer	06/12/2023	01/09/2008	09/09/2008		05/03/2024			15/01/2024	20/09/2023	20/09/2023	20/09/2023	Checked	01/09/2008	20/09/2023	01/07/2024	03/04/2023
Malik	Alveena	Mrs.	Non Executive Director	17/10/2023	N/A	03/08/2021		08/06/2023			14/03/2024	20/09/2023	20/09/2023	20/09/2023	Checked	23/09/2021	20/09/2023	N/A	10/05/2023
Mcpeake	Claire	Mrs.	Chief Operating Officer	14/12/2010	19/10/2010	14/12/2010	Complete	Not yet due			12/02/2024	12/02/2024	12/02/2024	12/02/2024	Checked	01/11/2010	22/01/2024	19/10/2010	24/01/2024
Page	Grenville	Mr.	Non Executive Director	17/10/2023	N/A	03/08/2021		17/10/2023			24/01/2024	20/09/2023	20/09/2023	20/09/2023	Checked	24/08/2021	20/09/2023	24/08/2021	05/04/2023
Parkinson	Sally	Ms.	Finance Director	02/12/2019	12/07/2023	02/12/2019		29/02/2024			18/01/2024	20/09/2023	20/09/2023	20/09/2023	Checked	25/11/2019	20/09/2023	31/12/2024	03/04/2023
Plaiter	Theresa	Mrs.	Director of Nursing	06/12/2023	10/01/2022	24/10/2009	N/A	14/06/2023			12/01/2024	02/10/2023	02/10/2023	02/10/2023	Checked	09/10/2009	02/10/2023	06/08/2021	26/10/2024
Spencer	Roger	Mr.	Chief Executive	06/12/2023	24/03/2015	06/12/2023		05/09/2023			12/01/2024	20/09/2023	20/09/2023	20/09/2023	Checked	09/11/2011	20/09/2023	N/A	03/04/2023
Tait	Diana	Dr	Non Executive Director	22/1//2023	19/12/2023	22/1//2023	Requested	Not yet due			16/01/2024	22/11/2023	22/11/2023	22/11/2023	Checked	12/12/2023	22/11/2023	22/11/2023	29/02/2024
Walshe	Kieran	Prof	Non Executive Director	16/10/2023	N/A	11/06/2015		20/06/2023			02/02/2024	20/09/2023	20/09/2023	20/09/2023	Checked	22/04/2016	20/09/2023	N/A	10/05/2023
Wareing	John	Mr.	Chief Strategy Officer	15/03/2023	20/12/2022	15/03/2023		23/11/2023			01/03/2024	20/09/2023	20/09/2023	20/09/2023	Checked	22/09/2022	20/09/2023	N/A	03/04/2023

NB – the directors highlighted in yellow were appointed after the implementation of the new F&PPT Framework 2023 and are required to have all data contained in ESR.

Appendix 2

MIAA
2023/2024 Checklist Series – Fit and Proper Person Test

September 2023

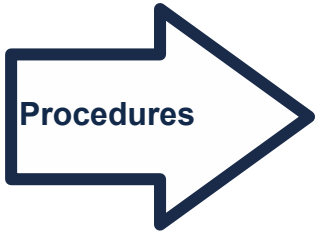
On 2nd August 2023 NHS England published the *Fit and Proper Person Test Framework for board members*. The Framework has been developed in response to the recommendations of the Kark Review (2019) outlining requirements for recording Fit and Proper Person Test (FPPT) details on NHS Electronic Staff Record (ESR), mandatory reference requirements and extending coverage to commissioners (including ICBs) and other appropriate arm's length bodies. The Framework is effective from 30th September 2023 and all NHS boards should ensure the implementation of the Framework's requirements from that date (historic data collection is not required but NHS organisations should apply the Framework for new board level appointments, promotions and for annual assessments going forward).

The revised Framework incorporates the following Kark Review (2019) recommendations:

- All directors should meet specified standards of competence to sit on the board of any health-providing organisation. Where necessary, training should be available.
- That a central database of directors should be created to hold relevant information about qualifications and history.
- A mandatory reference requirement for each director should be introduced.
- The FPPT should be extended to all commissioners and other appropriate arm's length bodies.
- Remove the words 'privy to' from regulation.

This checklist is designed to provide assurance on an NHS organisation's preparedness to adopt the Framework from the 30th September and provide assurance of ongoing compliance following implementation of revised arrangements.

Fit and Proper Person Test Checklist

Areas for NHS organisations to consider		Organisation's Response
	**FPPT Process and Procedures**	
	• Have FPPT policies and procedures been updated to reflect the NHSE Framework? Have revised policies/procedures been communicated to relevant staff?	Policy updated in line with Framework and approved by the Public Board in September 2023. Policy published on the website and shared with the Workforce Team for inclusion in their raft of policies.
	• Do FPPT processes cover all board members as per the NHSE definition (i.e. executive directors (irrespective of voting rights), non-executive directors (irrespective of voting rights), interim (all contractual forms) appointments and those individuals called 'directors' within Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014)?	FPPT processes cover all board members as per the definition.
	• In the case of ICBs has your Chair established a process to consider FPPT assessment on a member-by member basis taking into account assurance received from other recruiting/appointing organisations?	N/A
	• Have processes been established to ensure personal data relating to FPPT assessment is retained in local record systems and specific data fields populated in ESR?	Policy updated to include responsibility for populating fields in ESR. This will be done for all new appointments. Initial audit undertaken of data field completeness. Additional information updated for existing directors.

Areas for NHS organisations to consider		Organisation's Response
		Workforce information team engaged and updating and sharing dashboard from ESR
	• Do FPPT processes clearly provide assurance of compliance with Regulation 5 requirements (in line with elements outlined in the NHSE Framework) that board members be: ○ individuals of good character (this relates to whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence and/or whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals); ○ individuals having the qualifications, competence, skills and experience that are necessary for the relevant office or position or the work for which they are employed; ○ individuals that are able by reason of their health, after reasonable adjustments are made, of properly performing tasks that are intrinsic to the office or position for which they are appointed or to the work for which they are employed; ○ individuals which have not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) while carrying out a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity: ○ not subject to any of the grounds of unfitness specified in part 1 of Schedule 4 apply to the individual (e.g. a) the person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged; b) the person is the subject of a bankruptcy restrictions order or an interim	Trust FPPT processes follow the Trust policy which is in line with the requirements of the Framework. Evidence relating to the outlined elements is held in hard copy files and checked against an updated checklist that covers all requirements.

Areas for NHS organisations to consider		Organisation's Response
	bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland; c) the person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986; d) the person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it; e) the person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland and f) the person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment)?	
	• Are evidenced processes in place to undertake a formal assessment of the fitness and properness of each board member annually? Is this assessment carried out alongside annual appraisals?	An annual appraisal of fitness and properness is carried out and evidence retained in hard copy files and will be updated in ESR. Annual checks are done in line with policy and alongside annual appraisals. Checks inform compliance report to Board (for all) and Council of Governors (for NEDs).
	• Are FPPT requirements included in systems and processes for recruitment, induction, training, appraisals, governance arrangements, disciplinary and dismissal processes?	FPPT requirements are included in processes for recruitment / induction / training / appraisals etc and evidence held in hard copy files and on ESR in relation to training and completion of appraisals.
	• Are processes in place to ensure a documented full FPPT assessment is undertaken in the following circumstances:	

Areas for NHS organisations to consider		Organisation's Response
	a) New appointments in board member roles, whether permanent or temporary, where greater than six weeks, this covers:	Yes
	▪ new appointments that have been promoted within an NHS organisation;	Yes
	▪ temporary appointments (including secondments) involving acting up into a board role on a non-permanent basis	Yes
	▪ existing board members at one NHS organisation who move to another NHS organisation in the role of a board member; and	Yes
	▪ individuals who join an NHS organisation in the role of board member for the first time from an organisation that is outside the NHS.	Yes
	b) When an individual board member changes role within their current NHS organisation (for instance, if an existing board member moves into a new board role that requires a different skillset, e.g. chief financial officer).	Yes
	c) Annually; that is, within a 12-month period of the date of the previous FPPT to review for any changes in the previous 12 months.	Yes
	For points b and c above, the board member reference check is not needed.	

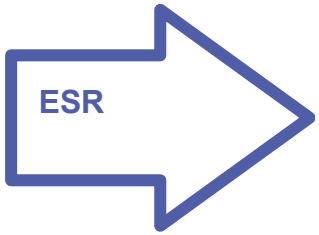
Areas for NHS organisations to consider		Organisation's Response
	• Have processes been established to ensure every board member completes an annual self-attestation confirming adherence to FPPT requirements?	Yes, annual declarations in place and on file for relevant board members. Form has been updated based on the template in the NHSE FPPT Framework
	• Do FPPT processes include, for the initial appointment of NHS trust chairs and ICB chairs only, once the NHS organisation has obtained board member references and completed the fit and proper person assessment, FPPT approval is sought from the NHS England Appointments Team before they commence their role?	The new chair has been appointed prior to 1 October 2023, NHSE FPPT Implementation Team confirmed that we do not need to use the board member reference (BMR). As a Foundation Trust the arrangements are different than those for non-foundation trusts and ICBs where the chairs are appointed by NHS England. As an NHS foundation trust, we do not need to seek approval from NHS England (as described in section 4.5 of the FPPT Framework).
	• Have processes been established for completing FPPT for joint appointments where the organisation is the designated host/employing organisation (including input from the chair of the other contracting NHS organisation)? Do these mechanisms include provision of a 'letter of confirmation' and processes for all parties to keep each other updated on matters that may impact FPPT assessment?	Yes – included in the Trust policy as part of the responsibility of the Director of Workforce.
	• Are processes in place to ensure a FPPT assessment is completed for individuals who hold two or more separate roles?	The FPPT applies to all relevant board members in line with the Framework.

Areas for NHS organisations to consider		Organisation's Response
	• Are processes in place to ensures a full FPPT assessment is undertaken for interim roles exceeding six weeks?	The FPPT applies to all relevant board members in line with the Framework.
	• Does the senior independent director (SID) or deputy chair annually review and ensure the chair meets FPPT requirements?	This requirement is in the Trust policy and the review will form part of the compliance report to the Workforce Assurance Committee and then Board of Directors. The annual review uses the template from the Learning & Competency Framework.
	• Are processes in place to undertake DBS checks at least every three-years for board members following initial appointment?	Yes – this is managed / monitored by the company secretary's office and supported by the Workforce Team. Level of DBS undertaken determined by the Trust policy.

Areas for NHS organisations to consider		Organisation's Response
References	**Board member references**	
	• Have processes been established to ensure Board member references are included as part of the FPPT assessment when there are new board member appointments, specifically: a) New appointments that have been promoted within an NHS organisation.	Board member references / ESR fields in place and will be populated as part of the process for appointments. The requirement to use ESR fields and BMR's has been added to the Trust policy.

Areas for NHS organisations to consider		Organisation's Response
	b) Existing board members at one NHS organisation who move to another NHS organisation in the role of a board member. c) Individuals who join an NHS organisation in the role of board member for the first time from an organisation that is outside of the NHS. d) Individuals who have been a board member in an NHS organisation and join another NHS organisation not in the role of board member, that is, they take a non-Board level role.	
	• Do Board member reference processes require a minimum of two references, from different employers, where possible, (using the board member NHSE reference template) for individuals appointed from outside the NHS or from within the NHS but in their first Board role?	Yes – 2 references are currently required. BMR requests submitted to other Trusts for new appointments (1 NED, 2 ED's).
	• For individuals moving between NHS Board roles does the organisation where possible obtain one reference from a separate organisation in addition to the board member reference for their current Board role?	2 references are required. BMR is in addition to the latest / current NHS employer.
	• Are processes in place for the organisation to take reasonable steps to obtain appropriate references from current employers as well as previous	Yes

Areas for NHS organisations to consider		Organisation's Response
	employers within the past six years for Board members joining from another NHS organisation?	
	• Have processes been established to ensure the organisation makes every practical effort to obtain references that fulfil the board member reference requirements when employing individuals from outside the NHS?	Yes – including through external search partners.
	• Are mechanisms in place to store information relating to references so it is available for future checks?	Yes – stored in hard copy files.
	• Have processes been established to utilise board member annual appraisals from the past three years to guide board member references?	Added to the Trust policy
	• Where board member reference requests are received by your organisation from another NHS organisation what processes are in place to ensure the provision of the requested reference within 14 days?	Request will be managed by the Workforce Team with support from the Company Secretary when a request is received
	• Are you using NHSE's board member reference templates? If not, how are you ensuring you obtain all required information for board member references	Yes – we have adopted the NHE template

Areas for NHS Organisations to consider		Organisation's Response
	**FPPT and ESR**	
	• Have policies and procedures been established to collate the relevant FPPT information in accurate, complete and timely manner for updating ESR? Does this include checks to ensure all required data fields have been completed for each board member as appropriate?	Yes – data quality checks undertaken within ESR to identify gaps. Data provided to populate fields for existing Board members. Dashboard produced to check status of all fields for relevant staff from ESR
	• Do annual FPPT checks include validation of all fields in ESR as specified in the framework?	Yes
	• Has access to ESR been restricted to ensure information held on ESR about board members is only accessible to a limited number of senior individuals in the organisation?	Yes
	• Has access to ESR been restricted to ensure there is no access to FFPT information by other organisations?	Yes

Areas for NHS Organisations to consider		Organisation's Response
	• Are processes in place to enable individuals to access and exercise their rights in connection with the information held about them in accordance with data protection law?	Privacy notice circulated to Board members, signed & kept in electronic / hard copy files

Areas for NHS organisations to consider		Organisation's Response
	**Governance and Reporting**	
	• Does the Chair present a report on the completion of the annual FPPT to a public board meeting and where applicable the Council of Governors?	This has been added to the annual Board reporting cycle and rolling programme for Workforce Assurance Committee who report on assurance received to Public Board of Directors. It has also been added to the rolling programme for Council of Governors
	• How does the annual FPPT review process ensure the Chair signs off the annual FPPT submission form and it is submitted to Regional Director NHS England?	Chair to review ESR dashboard and compile compliance report with support of company secretary and report to Board (plus CoG for NEDs). Added to policy.

Areas for NHS organisations to consider		Organisation's Response
	• Are processes in place to report the high-level outcome of FPPT assessments in your annual report or elsewhere on your website?	To be actioned in line with the Annual Reporting Manual
	• CQC – where the CQC notify your organisation of concerns relating to a board member what processes do you have in place to detail the steps the organisation has taken to assure the fitness of the board member and to provide this information to the CQC within 10 days?	Company Secretary will be required to provide information with support from the Director of Workforce
	• When was an internal audit of FPPT processes last undertaken? *Going forward NHS organisations should have an internal audit on FPPT every three years.*	We have not had an internal audit of FPPT processes. This has been added to the internal audit plan for 2024/25.

The Christie
NHS Foundation Trust

Agenda Item 10/24d

Board of Directors

Thursday 28th March 2024

Subject / Title	Reports from Board Committees
Author(s)	Committee secretaries
Presented by	Committee Chairs
Summary / purpose of paper	For the board to note the discussions held at the following meetings: • Quality Assurance Committee draft minutes January 2024 • Audit Committee February 2024 • Workforce Assurance Committee March 2024
Recommendation(s)	To note
Background papers	Full papers from the Quality Assurance, Audit and Workforce Assurance Committees
Risk score	See Board Assurance Framework Corporate Objective 1 - 7
Link to: ➢ Trust strategy ➢ Corporate 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.	

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DRAFT

Meeting of the Quality Assurance Committee
Thursday 18th January 2024 at 1.00pm
Education Centre Seminar Room 4/5 and MS Teams
Minutes

Present

Chair:	Kieran Walshe (KW) Chair	Non-Executive Director
Members:	Alveena Malik (AM)	Non-Executive Director
In attendance:	Theresa Plaiter (TP)	Interim Chief Nurse & Executive Director of Quality
	Neil Bayman (NB)	Executive Medical Director
	Bernie Delahoyde (BD)	Chief Operating Officer
	Eve Lightfoot (EL)	Director of Workforce
	Louise Westcott (LW)	Company Secretary
	Phil Higham (PH)	Patient Experience & Improvement Lead
	Joanne Woolley (JW)	Clinical Audit Manager
	James Fortune-Clubb (JFC)	Health and Safety Manager
	Matt Bilney (MB)	Associate Chief Nurse
	Vidya Kasipandian (VK)	Associate Medical Director
	Fabio Gomes (FG)	Director of Clinical Outcomes
	Jackie Wrench (JW)	Divisional Director, Clinical Networked Services
	Rachel Ellis (RE)	Divisional Director, Clinical Networked Services
	Simon Davies (SD)	MIAA
Minutes:	Jo D'Arcy (JD)	Assistant Company Secretary
Observers:	Edward Astle (EA)	Trust Chair
	Eleanor Jones (EJ)	Clinical Patient Safety and Risk Manager

Agenda item		**Action**
01/24	**Standard Business**	
a	**Apologies for absence**	
	Tarun Kapur, Diana Tait, Ben Vickers, Zoe Gale	
b	**Declarations of interest**	
	None declared	
c	**Minutes of the last meeting**	
	The minutes of the last meeting held on 23rd November 2023 were accepted as a correct record.	
d	**Rolling programme, action log and matters arising**	
	Rolling programme - Health and Safety Annual Report deferred to March meeting to allow for the report to be presented to the Health and Safety Committee for approval. **Action Log** – PH gave an update on the case referrals to the PHSO; • 5 cases between April – September 2023, which is unusual. An investigation didn't find any links between the cases. • Currently 6 cases in total with the PHSO; 1 case where the report has been issued and the complaint was not upheld, 4 under investigation (including 1 where PHSO has provided 'emerging thoughts' and not identified any failings and 1 case at assessment stage with the PHSO.	

	• There have been no more cases to date since September. • Will continue to monitor through the quarterly report to the Committee. • No concerns to raise at present and feel assured. **Action:** PH to report back to the Committee as further reports from the PHSO are received and data for comparison received from other specialist Trusts. **Matters arising** - EL noted the item referring to the link with patient safety issues / employee relations issues was discussed at the Board Time Out in December, for due process this is provided to the Committee for information. No comments or questions raised.	**PH**
e	**Board assurance framework (BAF)**	
	LW informed the Committee the extract of the BAF presented details the relevant risks to the Committee. The cover paper highlights the changes since the BAF was last seen by the Committee, target scores have been updated and risk scores have been added for the end of Q3. Nothing to bring to the Committee's attention. Opened out for any comments or questions. No comments or questions raised. Committee **noted** and **accepted** the BAF.	
02/24	**Items for reporting on assurance level**	
a	**Health and Safety Quarterly Report July - September 2023**	
	JFC presented the report to the Committee noting the following key points: • New format from next report, which will be aligned to that of the patient safety and experience quarterly reports seen by the Committee. Data within the new format will provide better representation. The Committee discussion led to: • Medium assurance being agreed based on waiting to see the change in report format. **Action:** • To revisit whether the reporting aligns appropriately with either the Quality Assurance Committee or the Workforce Assurance Committee, based on the assurance being sought from the report. **Noted** **Assurance level agreed (BAF risk 7.3): Medium** JFC left the meeting.	**Chair/Exec Lead**
b	**Patient Safety Incident Response Framework (PSIRF) plan**	
	MB presented the PSIRF plan update to the Committee noting the following key points: • PSIRF is due to be implemented nationally from 1st April 2024. The Patient Safety Specialist role is a key role in leading on the implementation of the framework. • Actions required for the next 10 weeks were summarised; agree policy and plan in January with ICB and NHSE sign off in February – these are currently with the ICB for comment. New working groups to process incident reporting and investigation to be established from Feb/March in readiness for April implementation date. • Divisions will take ownership of their own incidents through divisional patient safety improvement groups (PSIG). • Operational working groups and assurance processes were described, these are more structured. • Patient safety priorities at a national and local level were presented,	

	confirming that all incidents of this nature would require a PSII. The Committee discussion led to: • Assurance on the implementation of the PSIRF will form part of the patient safety quarterly report and a difference will be seen in the reporting of learning from incidents. • Acceptance of coroner input noted as a challenge that was recognised at the beginning of the framework given the change in reporting to coroners that will now be in the form of a learning response. • Policy and plan **approved** by the Committee. • Medium assurance being agreed given that the framework is only just to be introduced and assurance will be reliant on future reporting. No actions identified. **Assurance level agreed (BAF risk 1.1): Medium**	
c	**Clinical Outcomes Strategy – six monthly update including patient demographics data quality update**	
	FG presented the strategy and data quality update to the Committee noting the following key points: • Within the first 3 quarters of 2023/24 have achieved 65% of objective goals. • The highlights from May to December 2023 were presented. • Challenges; recruitment of skilled staff in a competitive market, growing internal demand for data and complex analysis, CWP redevelopment and data quality and growing external demand for national data submissions. Changing the way data is captured while still using it is a challenge and risk. • The several layers of governance were described; CODU reports to Digital Board (3 monthly), QAC six monthly and CREC six monthly. • Ethnicity data completeness presented from 2018 to 2023, shows a gradual decline in data. A summary of the work completed during 2023 to look at improving data completeness was described. There is a significant problem to tackle, have a proposed plan for 2024; new electronic registration form to be launched for patients which will be on CareFlow and accessible to patients via QR code, patient engagement initiative and staff engagement initiative also planned. New registration form due to be live by March this year. • The use of the data will include a growing number of audits involving protected characteristics. in particular ethnicity. The Committee discussion led to: • Question raised as to whether different ethnic groups are being engaged and asked what the challenges are as part of the patient engagement initiative. It was confirmed that there has been engagement from a research perspective and work around access to research in different communities. There are issues with the paper-based process approach which is being targeted through the use of the electronic form to improve the process and the data held. Data will become easier to maintain through the use of a patient accessible portal, which is what other Trusts have been doing. In terms of access to data on our patients held elsewhere, this is reliant on data sharing agreements, which mainly covers non-identifiable data. • High assurance being agreed. No actions identified. **Noted** **Assurance level agreed (BAF risk 1.2, 1.5 CQC Regulation 9): High** FG left the meeting	
d	**SACT strategy implementation**	

	JW presented the report to the Committee noting the following key points: • Background into strategy and review process presented. Biggest challenges are capacity and meeting needs of clinical trial patients. Key messages from the strategy review included investment in main site, change to network model, focus on R&I and innovations in workforce. • The total activity growth over 10 years was presented; predicted 13% increase for 2023/24 and further 10% for 2024/25. • The risk of 'failure to implement 2023/24 objectives of the SACT strategy' has a current risk score of 12, the risk mitigations were described. Risk remains around providing access to clinical trials and having the capital to provide the Network model required to support this. There is pressure on capital spend, future plans include opening full Saturday service to meet demand. • The option of rewriting the strategy and continuing with the current working and outreach models was presented along with the option to mitigate all risks by making a full case for changes to the Trust's Network model as originally planned along with a diagram as to how the potential network model would look. The Committee discussion led to: • Noting that R&I clinical trials are a challenge and need to look at how this is linked into clinical outcome measures. Need to make sure governance processes in place are equitable wherever treatment is received. Capacity management and growth, the move to oral therapy helps a little. Planning on an annual basis for the growth is a challenge. Christie @ sites – opportunity to expand at Wigan, the main purpose is to move to bigger sites, constraints will be the allocation of ICS financial capital, can look to the Christie Charity for some of it. Nationally, capacity for delivery of SACT is a challenge. • SACT has to be delivered by trained nurses. Work is being done to look at what administration can be done by other team members to release more capacity for trained nurses for delivery. • High assurance agreed. No actions identified. **Noted** **Assurance level agreed (BAF risk 5.2): High** BD and JW left the meeting.	
e	**Learning from deaths update**	
	VK presented the report to the Committee noting the following key points: • Assurance given from the MIAA audit, which received moderate assurance. Previous backlog has been completed and improvements identified from the audit have been done. • On track for this year, assurance to ERG on a weekly basis for cases being triggered and allocated within 7 days and reviewed within required timescale. All cases reviewed and validated on time. 2 cases where death was possibly avoidable (score 4), 0 cases where score was less than 3. Overview of cases and lessons learned described. The Committee discussion led to: • A patient safety grand round was completed in November where learning from deaths was described and well received. • Key thing to assure on is following the audit and CQC inspection, mortality reviews are now back on track and this is being maintained. • High assurance agreed. No actions identified. **Noted**	

	Assurance level agreed: High	
f	**Learning from Claims**	
	PH presented the report to the Committee noting the following key points: • As at 1st April 2023, 13 clinical negligence and 8 employer's liability, 0 public liability open claims. • 7 new employer's liability cases during 2022/23, all reviewed and no linkage between the cases identified, no further cases received since to date. Closed 9 cases in 2022/23, all settled out of court or withdrawn. Lessons learned done for all cases. • Total settlement spent this year for claims has decreased from £1,579,821.91 in 2021/22 to £324,093.61 in 2022/23. The Committee discussion led to: • Noting that all claims relate to Datix incidents already logged, the exception noted where any public liability claims are received. This adds value as the investigation has already been completed. • High assurance agreed. No actions identified. **Noted** **Assurance level agreed (BAF risk 1.4 CQC Regulation 16): High**	
g	**Update on lost to follow up risk**	
	RE presented the report to the Committee noting the following key points: • Waiting list functionality now live; there are a few things to be ironed out to ensure the process is running as expected and the process is reliant on clinicians providing an 'on hold' reason. Currently unsure as to how much work will be generated. • Backlog of open referrals figure has reduced from over 78,000 to c66,000 since September. • 88% of all referrals reviewed have been closed, 9% remain open for appropriate clinical reasons and 4% have been identified as lost to follow up. • Of those patients identified as lost to follow up, 68% have been confirmed as no harm and 31% are being reviewed. Harm was identified for one patient, and this has been subject to full root cause analysis and ERG review. • Review of the backlog numbers with senior clinicians led to a proposal to 'auto-close' any open referrals which are greater than 5 years. This was thought to be appropriate given the low rate of harm observed to date and the 4% lost to follow up rate identified in the more recent cohort. This proposal has been agreed by Clinical Advisory Group (CAG) and will now go to Patient Safety Committee for approval. System solutions for auto-close are being explored, need resource to undertake review and find a system to auto close rather than relay on manual. • Work continues to review the more recent open referrals through a combination of additional hours and scheduled work. The Committee discussion led to: • Confirming the clinical risks have been considered for auto-close of cases prior to 2018, the risk of any potential harm is mitigated by patients would have re-entered the system since before this date. • There is a reputational risk associated with the issue. • Medium assurance agreed based on the actions that have been put in place but further assurance is reliant on the resource question to clear backlog. **Action**: • Need to understand what resource would be required to clear the backlog by	**RE**

	end of 2024. **Noted** **Assurance level agreed: (BAF risk 1.2): Medium** RE left the meeting.	
03/24	**Governance**	
a	**Briefing from the Risk and Quality Governance Committee**	
	NB presented the briefing to the Committee confirming that the slide provided summarises the November and December minutes which are also provided in the papers. New Chair for CREC noted. Opened out for any questions. No comments or questions raised. **Noted**	
b	**Audit Recommendation Tracker Report**	
	MB provided an update on the Risk Management review recommendations; the recommendation on needing to be clear on the risk appetite has been completed and led to work within the Q&S team to review the risk management strategy and policy, this was also aligned to work on the new Datix system. Next step is to develop a new risk model in Datix, will review the strategy at the same time. Opened out for any questions. No comments or questions raised. **Noted**	
c	**Internal Audit Progress Report**	
	SD presented the report to the Committee noting the following key points: Infection control review completed and received moderate assurance. Patient consent review currently at fieldwork stage. Appendix C of the paper details the outcome of the infection control review leading to the outcome of moderate assurance and resulting in 1 high risk, 2 medium risk and 1 low risk recommendation. The review looked at 6 areas and wards and identified that the required standards were not being met in all areas. The recommendations were summarised. Opened out for any questions. MB noted the useful audit, fairly new IPC team and the review identified a couple of areas that can be included in local audits. No further comments or questions raised. **Noted**	
d	**True for Us Review**	
	VK presented the review to the Committee noting the following key points: Reviews are based on learning from other organisations. The Bewick report looked at 3 main concerns and identified 4 recommendations to improve following a review at University Hospitals Birmingham (UHB), these were summarised to the Committee. The recommendations from the report, UHB's response and assurance based on the Christie True for us or not review comments were described for each area; clinical safety – haemato-oncology, never events, clinical safety – neurosurgery, and mortality and governance and leadership. Phase 2 of the Bewick report has been published, which covers a different angle and this will be picked up separately with Workforce. Opened out for any questions.	

	Committee welcomed the review. **Action:** Discussion led to the Committee wanting to spend more time looking at the review at a future meeting, incorporated with the work recently undertaken by Globis Mediation within the Trust. To review and allocate time on rolling programme. **Noted**	**LW/JD** **NB/VK**
e	**Self- assessment of the Quality Assurance Committee**	
	KW informed the Committee that the questionnaire for the committee effectiveness review will be issued to members for completion and the draft report will come to next meeting in March. **Action:** Questionnaires to be sent out to Committee members and draft report prepared following received responses.	**JD**
04/24	**For information**	
a	**Learning for Improvement Bulletin**	
	Provided for information.	
05/24	**Non-Executive Director feedback from department visit**	
	KW visited CODU prior to the meeting, work of department covered as part of agenda item 02/24c.	
06/24	**Assurance / Escalations to the Board of Directors**	
	Assurances to be noted in the summary report to Board. The Committee identified the following item/s as requiring escalation to the Board of Directors: • Update on lost to follow up risk.	
07/24	**Reflections of the meeting**	
	No comments raised.	
08/24	**Any other business**	
	None raised.	
	Date and time of next meeting: Thursday 21st March 2024, 1pm	

DRAFT

Audit Committee
Thursday 15th February 2024
Seminar Room 4/5, Education Centre and MS Teams
Minutes

Present:	Grenville Page (GP) Robert Ainsworth (RA)	Committee Chair, Non-Executive Director Non-Executive Director
In Attendance:	Sally Parkinson (SP) Theresa Plaiter (TP) Louise Westcott (LW) Sharon Hassall (SH) Alistair Reid-Pearson (ARP) Shaun Atherton (SA) Clare Triffitt (CT) Rob Riley-Ditchfield (RRD) Catherine Watts (CW) Simon Davies (SD) Kevin Howells (KH) Michael Green (MG) Matt Derrick (MD) Edward Astle (EA)	Executive Director of Finance Interim Chief Nurse and Executive Director of Quality Company Secretary Assistant Director of Finance - Financial Services Chief Information Officer HCS Service Manager Principal Therapeutic Radiographer Digital Infrastructure Lead MIAA MIAA MIAA Grant Thornton Grant Thornton Trust Chair (observing)
Minutes:	Jo D'Arcy (JD)	Assistant Company Secretary

01/24	Standard Items	Action
a	**Apologies**	
	Kieran Walshe (KW), Bernie Delahoyde (BD), Anne-Marie Harrop (AMH), Richard Postill (RP)	
b	**Declarations of interest**	
	No declarations made.	
c	**Minutes of the previous meetings held on 20th October 2023 and 8th December 2023**	
	The minutes from the meetings on 20th October 2023 and 8th December 2023 were approved as correct records.	
d	**Rolling programme, action log & matters arising**	
	• All rolling programme items noted as on the agenda for the meeting. • Rolling programme will be subject to review following the recommendations from the good governance review. • Action log reviewed noting that the finance items are detailed within the Executive Director of Finance report. **Action:** Item 6 on the action log needs review following the movement of Digital to the Board of Directors agenda going forward.	**SP/LW/JD**
02/24	**Items for reporting on assurance level**	
a	**Executive Director of Finance report**	
	SP presented the report to the Committee noting the following key points: • Report focusses on the year-end audit, month 9 agreement of balances and information on group accounting manual and policies with attention drawn to The Christie Charity now being independent, currently in discussions with NHSE and external audit as to how this will be accounted for. GP asked if the 2022/23 figures will need to be restated,	

	SH was hopeful this will not be the case but will confirm. • Section 5 of the report provides an update on the tender process for the Internal Audit Contract and the Counter Fraud Contract, waiting for the process to conclude and will then announce the outcome. • Losses and special payments relates to 40 invoices totalling £2,250 being written off as old debt which has previously tried to be recovered, mainly salary overpayments. • Anti-Bribery and Corruption policy has been updated with the changes highlighted in the report. • Section 10 provides an update on annual planning and the system. The Committee discussed the following: • The new (Preventing) Fraud offence will likely become law by the end of Summer, training to support will be provided by Counter Fraud, KH noted that the Trust is in a good position to deal with any changes. • With reference to the writing off of salary overpayments, the question was raised on if this relates to a control issue or a need for clarity for managers on the actions they need to take when someone leaves to avoid overpayments. It was confirmed that work has been done to address this; the requirement to terminate employment promptly through ESR is on the exit checklist, have seen a reduction in amounts but SH confirmed will follow up again. SP referenced to the counter fraud progress report noting there are sometimes significant delays in identifying and trying to recover overpayments and the process needs tightening up. • GP asked if the Committee were confident that the sole supplier requirements are definitely identifying where there is only a sole supplier. SP confirmed that all sole supplier requests are challenged and confident that the ones that go through are all sole suppliers. • GP asked on section 4.5 of the Anti-Bribery and Corruption policy and whether there is clarity as to the hierarchy on who has lead responsibility when stating that 'managers' have responsibility. SP confirmed that staff are good at raising any issues for any clarification required. Assurance was provided on the review process for the policy before it reaches the Committee; SP confirmed the policy has been reviewed by the Counter Fraud Specialist, KH also confirmed the template used is that provided by the Counter Fraud Authority as the governing body, the policy is also reviewed within Finance. TP summarised the Trust governance process for policies before publication. • Typing error noted within accounting policies where references made to 2021/22. • The Committee discussion led to high assurance being agreed. **Action:** SH to revisit with Workforce for more clarity on the leavers process with the aim to reduce salary overpayments. **Action:** SH to update incorrect reference to 2021/22 within the accounting policies. The Committee were asked to: 1. agree the final accounts timetable and plans. **Agreed** 2. review and approve the accounting policies. **Approved, subject to correction of typo noted.** 3. note the Tender waiver approvals. **Noted** 4. review and approve Anti-Fraud, Bribery and Corruption Policy.	**SH** **SH**

	Approved 5. note the details of the Annual Plan 2023-24. **Noted** 6. note the contents of the report. **Noted** **Assurance level given (BAF ref 6.2):** High.	
b	**Digital six-monthly update**	
	ARP attended to present the update to the Committee noting the following key points: • The Data Security and Protection Toolkit (DSPT) audit for this year is a full audit against all the standards. Baseline audit has been completed. • Cyber risk is the current highest risk for Digital with lots of sub risks. The Data Security Working Group reviews the risks and collates the SIRO report together for SIRO sign off. • The compliance work and checks in relation to the information asset register are detailed in the report. • Recent complaints audit has led to a better working relationship between the Information Governance and Complaints teams. • GP referenced to the high-level summary of the cyber risk noting that many of the risks are scored as a 20 indicating that the risks are either happening or likely to happen and asked what action is being taken to reduce the level of risk with the number of unknown leavers accounts remaining live. ARP confirmed that NHS clinical staff leave regularly and move to another NHS Trust resulting in the need to move their account to the new Trust provider. Trying to enhance the leavers process but the risk is limited to what users have access to when working at the Trust. When it is known the staff member is leaving the Trust, access to the Clinical Web Portal is locked automatically and access is restricted to other systems and active directory. • CW added there is also the need to consider cloud-based systems and the reliance on asset owners. LW noted through recent work done on the Declare system and following up on those who are not declaring identified a data quality issue with bounce back emails received from staff who have left the Trust, this has been fed back to Workforce to close the accounts down. • EA asked on the confidence based on mitigations in place to prevent a cyber-attack. ARP confirmed there has been increased investment, the Trust has Cyber Essentials Plus accreditation and monitoring tools in place, have not been affected despite working relationships with others who have been attacked. Constantly managing, got the right investment and right controls in place. Would escalate if became worried. GP asked if there is anything stopping the Trust doing as much as possible or if it is already doing all it can. ARP confirmed could apply lots of other controls but this would prevent people from doing their jobs, can provide further information as part of a future update. • CW added that NHSE are pushing multi factor authentication (MFA), this now forms part of policy which comes into force in June. ARP confirmed the Trust are implementing this at the moment. • The risks in the report provide a snapshot of the portal, this helps to tailor what needs to be focused on. One of the biggest risks relating to insufficient software licensing was highlighted and it was asked how this is being managed. ARP confirmed this is about making sure we have sufficient funds for enough licences. Have also seen increase in some	

	licensing costs. This is a regional and national issue. • In terms of disaster recovery, it was confirmed that the Trust is reliant on departments and divisions having provisions in place for managing without IT. There is a disaster recovery plan in place although this has not yet been very well rehearsed, this is in progress. • An update on AI is outlined in the paper, building the AI vision in principle and this will lead to forming the strategy, policies, procedures and framework around it in a safe way. • A programme summary update provided in the paper confirms the current status of all projects. RA referred to the ePROMs project and if there will be an impact given that the project sponsor has now left the Trust. ARP confirmed that, from a digital perspective, the project has not been affected as the project is now live. • RA referenced to the GM care records project and asked on how the risks on access to records is managed. ARP confirmed that he works 2 days a week on the GM care record, both Trusts use Graphnet as a provider and working to ensure the data is fit for purpose for the Trust. Complex project but in a good place. • The Committee discussion led to medium assurance being agreed. **Action:** ARP to provide further information on cyber security controls in place at the Trust (as part of next update to Board of Directors). **Assurance level given (BAF ref 6.3/6.5):** Medium.	**ARP**
c	**Mosaiq system assurance**	
	SA, CT and RRD attended to present the update to the Committee noting the following key points: • An overview of the Mosaiq system was provided and confirmed that the Trust cannot treat patients without the system. • An update on the outstanding audit actions was provided; Business continuity plan (BCP) - required to be in place for reliance on manufacturer, digital and clinical. Escalation process in place for issues with manufacturer. In terms of clinical requirement, Mosaiq needs to be recovered as soon as possible as cannot deliver treatment without the system. If any problems, would work closely with digital and the manufacturer to resolve. Trying to get to a place whereby a completely managed service via a cloud solution, conversations going on at present. • Challenges around bring Mosaiq back up quickly due to the size of the system and it being hosted on site. Within the Radiotherapy BCP points to the manufacturer and digital to resolve. Have not had an issue where downtime has been more than a couple of hours, which is manageable. The Committee discussed the following: • SP referenced to the audit recommendation to review the Radiotherapy BCP and asked if there is a documented procedure as to how to manage an incident. SA confirmed this is in place and continually reviewed. SP sought confirmation from CW as to if this satisfies the recommendation. CW asked if the document had been updated since 2017 and subject to regular testing. SA confirmed that with trying to look for a cloud solution this will change things. • Progress on movement to the cloud solution was discussed; SA confirmed the business case has gone to Divisional Board, needs changes and then will go back to the Divisional Board next month prior to then going to ICPC. Moving to a cloud solution also helps with future	

	upgrades. CW added that if moving to the cloud, it is a big change and if it does not work there needs to be assurance that the BCP works. SA agreed. • RRD gave an overview of what is currently in place in terms of the BCP. New back-up system in place which can bring up an entire system very quickly as takes snap shots of servers. The challenge is Mosaiq and where it currently sits. In terms of testing, there is a need to create a separate isolated network, this is still in progress. For Mosaiq, would need to take the live system down, test it by bringing it back over a weekend which would not be enough time due to the size of the system. • CW noted Mosaiq not being linked to active directory so user accounts have to be managed manually. • EA asked on timing for moving to the cloud solution. RRD confirmed that once approved the move would take a few months due to the implementing of lines required. • GP summarised confirming the cloud solution is progressing through the management channels for approval but there are still some things that need to be done around current BCP arrangements for the system that is on site. High risk with arrangements in place. Committee cannot approve or support as not within its remit, needs to continue to progress through management processes. • Noted for escalation to Board of Directors. • **Action:** GP to escalate to Board. ARP, SA, CT and RRD left the meeting.	**GP**
03/24	**Governance**	
a	**Audit recommendation tracker report**	
	SP confirmed the following to the Committee: • Mosaiq system (update covered in previous agenda item) remains an issue with little progress, presenting a risk for the Trust. • Christie Sponsored Research recommendations will need a review by the Committee. • GP referred to the 23 actions being implemented noting that all are overdue actions, message needs to be re-enforced on getting actions implemented. SP suggested that all future Committee papers are circulated to all Executives as the audit recommendation tracker updates are helpful and will work better with Executive input. • RA noted that there are fewer outstanding actions now than a few months ago so progress has been made. • SD added that MIAA are also in the process of completing audit follow ups and the follow up report will come to the April Audit Committee. **Action:** Lead for Christie Sponsored Research audit recommendations to be invited to present update to future Audit Committee. **Action:** Message to be re-enforced on getting overdue actions implemented. **Action:** Future Committee papers to be circulated to all Executive Directors. **Action:** Executives to ensure progress on closure of audit actions are a regular item on executive meetings The Committee **acknowledged** the update.	**SP/JD** **SP** **JD** **JD/LW/SP**
b	**Board assurance framework (BAF) 2023/24**	
	LW presented the BAF to the Committee noting the following key points:	

	• The cover paper summarises the changes made since the BAF was last seen and presents the risks relevant to the Audit Committee. • The format of the BAF will be changing, current format will remain until the end of this financial year. • SP noted the change to the financial framework risk, this has reduced as we approach the financial year-end and the plan to be achieved. The Committee **acknowledged** the update.	
c	**Declarations of Interest update – Q3 2023/24**	
	LW presented the report to the Committee noting the following key points: • The new system was implemented from 1st April 2023. • There has been more contact from across the organisation in the last quarter relating to approvals and clarifications in relation to the policy; this shows good overall use of the system. • Compliance has seen 75% of decision makers declare as at the end of Q3. • There is currently an issue with leavers remaining in the system, which is being addressed. • Working with Civica (system provider) to enhance the reporting format and show declaration values. • Important to note from an assurance aspect that the new process has an approval process and is highlighting any breaches with policy. Additional training and communications have been done to help raise awareness of policy compliance. • Honorariums were previously declared as hospitality but now has separate reporting functionality which is good to see this separation and transparency. The Committee discussed the following: • GP raised whether there was enough clarity clear that any cash or cash equivalent is not permitted regardless of amount. LW confirmed the message is clear, causes an issue for some staff more than others when in patient facing roles. Have done lots of comms, this is an ongoing exercise. The Trust policy is in line with NHS guidance. TP added within Nursing there is confidence that individuals would not take a gift personally, it is more when gifts are given to a team. This has been addressed and there is confidence in the teams now on policy adherence and understanding. • SD noted that MIAA are currently doing a Declarations of Interest audit review as part of the audit plan. • The importance that individuals who receive honorariums or payments for delivering training confirm that their time was outside of The Christie time. The Committee **acknowledged** the update.	
d	**Self-assessment of committee effectiveness**	
	• GP informed the Committee that the questionnaire for the committee effectiveness review will be issued to members for completion and the draft report will come to next meeting in April. **Action**: Questionnaires to be sent out to Committee members and draft report prepared following received responses.	**JD**
04/24	**Internal Audit**	

a	**Internal Audit Progress Report**	
	SD presented the report to the Committee noting the following key points: • 6 audit reviews completed since last report in October as noted in report Executive Summary. • Follow ups will be done and reported to April Audit Committee. • Appendix A of the report provides an update on the audit plan, everything noted as currently in progress to complete plan to time. • Appendix C provides the details of the completed Sponsored Research Programme review, the report received limited assurance with 3 high risk, 4 medium risk and 1 low risk recommendations. The review outcome and recommendations were summarised from the report. • SP noted that the Director of Research has responsibility for the recommendations but will work with them to check on a number of areas. • Complaints and Learning review (substantial assurance) and Infection Control review (moderate assurance) both reported to Quality Assurance Committee. GP expressed concern on the infection control review, SD confirmed that all issues were addressed at the time of the audit. • Key Finance Systems review received substantial assurance with 1 medium risk and 2 low risk recommendations, these were summarised from the report. • Cost Improvement Programme review received moderate assurance with 1 high risk, 4 medium risk and 2 low risk recommendations, the recommendations were summarised from the report. SP noted that the actions for the review fall to the Chief Operating Officer and not the Director of Finance. • CW provided the update on the Critical Apps (Finance Systems) review; as part of the review the Finance lead sought assurance from the supplier in relation to a recent cyber incident. The supplier assured the Trust that data had not been exfiltrated as a result of the cyber incident. The review received moderate assurance with 1 high risk and 3 medium risk recommendations, these were summarised from the report. SP noted that the Trust had asked for this review and found it very useful. The Committee **acknowledged** the update and the agreed management responses to the audit recommendations.	
05/24	**Anti-fraud**	
a	**Anti-fraud Progress Report**	
	KH presented the report to the Committee highlighting the following key points: • A summary of the strategic governance and counter fraud activities undertaken since the last meeting was provided from the report. • The NHS Counter Fraud Authority (CFA) have started an external reporting suite, which provides data covering the period up to the end of December 2023 and will continue to be updated on a quarterly basis. An initial review of the data contained in these reports does not highlight any negative or exception issues in relation to the Trust. • 2 fraud awareness presentations have taken place since the last Audit Committee meeting: Fraud Awareness session to Nurse Leaders on 31st October 2023. A reminder of the Gifts and Hospitality rules was provided in advance of the festive season. A Fraud Awareness training was also delivered and well received to the GM Cancer Alliance on 11th January	

	2024. • 2 fraud prevention notices have been issued since the last Committee meeting; no related frauds have been reported in relation to either of these notices and KH is working with the Trust to ensure controls are in place to prevent both types of fraud. • KH visited the Trust and manned a promotional stand on 13th November to meet with staff and answer questions around Fraud, Bribery and Corruption in the NHS, and discussed counter fraud measures and current issues. • The Trust has now signed up to the ESR mandatory fraud e-learning, this means that Component 11 can now be graded as Green (previously it had been expected to be graded Amber). • Work required in relation to the national fraud initiative all scheduled to be done by the end of the financial year. • KH has received 10 fraud referrals since the last Committee meeting, the majority related to mandate frauds or phishing emails received by the Trust many of which were stopped by Finance before any payment made. The details in relation to the 3 ongoing investigations are provided in Appendix C of the report. • Appendix D of the report summarises the current status with the recovery of losses as a result of fraud. • Appendix E summarises the Anti-Fraud recommendations made to the Trust which have been followed up periodically and outlines the current status in relation to their implementation. The Committee discussed the following: • SP referred to the third case in Appendix C noting this was reported a year ago and seems to be taking a long time to resolve, questioned whether these cases need escalation quicker to hope for recovery. TP added that the case also states it relates to a Bank HCA but this is not the case as an agency worker was used so the referenced to 'bank' needs amending. KH noted the required amendment. The Committee **acknowledged** the update.	
06/24	**External Audit**	
a	**External Audit Progress Report & sector update**	
	MG presented the report to the Committee noting the following key points: • Audit planning work has started and intend to bring the audit plan to the next Committee meeting, do not anticipate any changes to previous years. • In relation to the Value for Money work, there are recommendations to follow up from last year, planning has started. No significant weaknesses identified at this stage. • Report also includes links for information on sector update. The Committee **acknowledged** the update and the proposed audit plan.	
07/24	**Non-Executive Director feedback from department visit**	
	• GP and RA visited Radiotherapy to understand the Mosaiq system and how the system feeds the information to the linac machines. • Controls and checks were discussed, informative visit. • Complex system which the Trust is dependent on.	
08/24	**Reflections of the meeting and escalations to Board**	

	• SP noted it had been helpful to have the Radiotherapy and Digital team members attend regarding the Mosaiq system audit recommendations but felt no additional assurance had been gained. • GP noted on timings for agenda items and to ensure enough time is given on more technical items for discussion. • Internal audit reports and assurances to be reported to the Board. • Escalation required to Board on Mosaiq system risk.	**GP**
09/24	**Any other business**	
	None.	
	Date of next meeting:	
	Tuesday 23rd April 2024, 1.00pm	

NHS
The Christie
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DRAFT

Meeting of the Workforce Assurance Committee
Tuesday 12th March 2024 at 11.00am
Seminar Room 4/5 Education Centre and MS Teams

Minutes

Present

Chair:	Tarun Kapur (TK)	Non-Executive Director
Members:	Alveena Malik (AM)	Non-Executive Director
	Diana Tait (DT)	Non-Executive Director
In attendance:	Eve Lightfoot (EL)	Director of Workforce
	Theresa Plaiter (TP)	Interim Chief Nurse and Executive Director of Quality
	Neil Bayman (NB)	Executive Medical Director
	Bernie Delahoyde (BD)	Chief Operating Officer
	Claire McPeake (CM)	Interim Chief Operating Officer
	Louise Westcott (LW)	Company Secretary
	David Smithson (DS)	Deputy Director of Workforce
	Rebecca Coles (RC)	Head of Engagement and Organisational Development
	Richard Wilkinson (RW)	Head of Workforce Transformation & Systems
	Natalie Marshall (NM)	Head of Operational HR
Minutes:	Jo D'Arcy (JD)	Assistant Company Secretary

Staff story presentation:
RT, who joined The Christie as Senior Catering Manager in June 2023, attended to presented his journey to the Committee:

- RT oversees a team of 45 members responsible for catering, including patient feeding, restaurant services, and event catering, operating 365 days a year.
- With a background in cooking since the age of 13, he has a desire to contribute to the NHS after his mother was treated at The Christie in 2017.
- He has been instrumental in implementing the new food and drink standards which came in 2022 with the catering team and found it difficult to see the catering staff stuck in process prior to this. He shared his passion about food and it being a part of everything we do and how in hospitals it is about creating something different for patients to make them feel comforted. Embarked on a journey to get the team onboard, recruited internal team members into chef positions as well recruiting to some higher banded posts. Now also have an 18-year-old in post and 2 further new trainees coming from Stockport College.
- Working closing with NHS supply chain on making more fresh food while adopting the new procurement processes to ensure comply with standards.
- The team has seen significant achievements in just 9 months, which were presented to the Committee, RT is very proud of the team. plans to introduce more nutritious and seasonal menus for both patients and staff were highlighted, as well as initiatives like grab-and-go options and food tasting events to enhance choices and quality.
- A video was presented on why the catering team 'do what we do', focussing on a history of nutrition for patients to where we are now.

The following points were noted from the Committee discussion following the presentation:

- The Day Nursery staff speak very highly of RT and the catering team.
- RT was thanked for his help on catering for workforce events and asked what activities there are in mind to help improve the catering provision to support health and wellbeing for staff. RT confirmed that all patient menus have to go through dietitians and aiming to adopt a similar approach in terms of staff catering offerings. Looking to introduce a whole bank of menu for staff events which will be nutritionally balanced. Also wants to bring in seasonality to the menus and create more flair for the chefs. More pop-up menus will also feature in the future. Looking at more healthier choices for staff, grab and go elements, fruit area, more homemade produce. Will also look to do some food tasting events. Looking to

constantly evolve and change food options. Got the skills in the team to build the confidence to try new things. Portion size and control also being reviewed.

- Question was raised on staff nutrition and catering availability for those staff working out of hours. RT confirmed the same meals are available as available on patient wards, these are packaged meals. Part of the refurbishment plan will have an area that is cordoned off as a 'grab and go' area for staff which will have fridges with fresh food available.
- The relationship between food and cancer being key was highlighted and RT was asked if there is a cost issue around providing the right food for our patients and how he sees future plans evolving. RT confirmed that the quality of food is there for patients and their comments evidence this. In relation to cost, these are covered but face the same challenges in trying to identify savings year on year. Catering is a key element for hospitals, money for catering needs to be ring fenced.

RT was thanked for his presentation.
RT left the meeting.

Agenda item		Action
01/24	**Standard Business**	
a	**Apologies for absence**	
	Simon Davies	
b	**Declarations of interest**	
	None declared	
c	**Minutes of the last meeting – Tuesday 14th November 2023**	
	The minutes of the last meeting were noted as an accurate record.	
d	**Rolling programme and matters arising**	
	• Rolling programme - all items as required from the rolling programme were noted as on the agenda for this meeting. • Matters arising – TK noted to the Committee that for future meetings he would like those presenting papers to highlight the key points so more time can be allowed for discussion and it is for Committee members to have read the papers ahead of the meeting.	
e	**Board Assurance Framework (BAF)**	
	LW noted to the Committee that there was nothing to highlight for this meeting as we approach year-end, the next meeting will see the closed off position for the year. **Noted**	
f	**Committee Terms of Reference (ToR)**	
	TK drew the Committee's attention to the tracked changes within the ToR noting that the updates have been made to reflect the addition of where the Committee seeks assurance against compliance with CQC regulations. **Approved**	
02/24	**Assurance**	
a	**Workforce dashboard and risk review**	
	DS presented the dashboard and risk review to the Committee noting the following key points: • Summary slides provides an overview by division. • Sickness absence – January at 5%, up from last year and previous years but when comparing to others in GM we are performing better. Main reasons for sickness are stress and anxiety. Seen reduction in long term sickness compared to last year. • PDRs and mandatory training – performance up from last report. Question asked on appraisals and what happens if an employee misses a cycle. This was confirmed as for line managers to pick up, tools are available to track where all	

	staff are in the process. Pay step process now also in place, which affects pay if PDR and mandatory training compliance are not in place. • Junior doctor training compliance improving significantly. • Staff turnover continues to improve, end of Q3 stood at 12%, the trajectory was presented. Question asked if the data is available by ethnic breakdown. This was confirmed and is monitored as part of the WRES reporting. Information on this will be provided to the next Committee meeting. • Establishment against paid FTE, shows improvement in vacancy gap. • Pipeline – 357 vacancies but actively continuing to fill, 250 already in pipeline at offer stage or start dates booked. Question asked about chronic vacancies not getting repeatedly filled. Information on this will be provided to the next Committee meeting. • Agency spend currently 2% less than pay bill. • Workforce risk presented – risk level currently scored as 9 based on review a month ago, risk score has reduced given actions taken. The Committee discussion led to: • Staff turnover and the reducing workforce risk noted as excellent given the current climate. This was confirmed as being due to the vacancy gap recruiting at pace and also working with an external party on employer brand and social media tools has helped improve pipeline significantly. • On Nursing, also seen a high uptake of registered nurses, which is an important part of the pipeline. • Weekly monitoring also in place and work done through the service and operational reviews. • A lot of proactive work takes place, members of the Workforce team were at the Trafford Centre for a recruitment fair last weekend which produced 850 contacts. • Divisional managers are also taking hold and sticking to KPIs which helps things move quicker whilst also remaining compliant. • Assurance level discussion led to agreement of high assurance. **Actions:** • Staff turnover data by ethnic breakdown to be provided to next Committee meeting. • Information on chronic vacancies not getting repeatedly filled to be provided to the next committee meeting. **Assurance level given (BAF Risk 7.1, 7.2): High**	**DS** **DS**
b	**The Christie people and culture plan update**	
	DS presented the update to the Committee noting the following key points from the amber and red risk areas: • Manager training - were waiting for publication of national tools to adopt. Training was a significant theme that came out of the globis cultural review. Have been through a review process but needs a holistic review which will take a significant amount of resource to pull together. Difficult to see how can be delivered with the resource that we have. Conversations with DCEO happening to see how can deliver. • Fair and inclusive recruitment - made significant progress this year including getting out into the community. A piece of work has been done on selection and recruitment training focussing on fair and inclusive recruitment; 50 managers have done the training so far. Recruitment process also being reviewed as to how this can be made more fair and inclusive. There is also a need to ensure that interview panel demographics are appropriate. Working with GM cancer to look at using patient representatives on the panels. The Committee discussion led to:	

	• Need to take a stocktake on who we have as managers, needs to be focus on areas where issues are more significant. A number of people have gone on leadership programmes but not seeing the output. • A paper will go to Board in March describing the cultural themes and one is about management and training, this will be monitored by the Board. Noted that there needs to be a rational based on the risk and to describe what is being done to manage the risk. • Fair and inclusive recruitment approach supported. There is a balance of having lay panel members and training. • Chair welcomed briefing to be able to summarise to Board. • Assurance level discussion based on outcomes led to agreement of high assurance. **Actions:** • Briefing on people and culture plan key risks and progress for summarising to Board to be provided to TK. **Assurance level given (BAF Risk 7.1, 7.2 and 7.4, CQC Regulation 18 and 19): High**	**DS**
c	**Compliance with recruitment requirements**	
	RW presented the report to the Committee noting the following key points: • Assurance given to Committee that CQC Regulation 19 is being complied with through the detail provided in the paper. • No gaps in processes. The Committee discussion led to: • Questions raised on use of agencies and who regulates that they go through the same robust processes. It was confirmed that, through the use of the procurement framework, there is a high level of confidence that the agencies follow the same standards as they are also regulated and are also audited. • Assurance level discussion led to agreement of high assurance. **Assurance level given (CQC Regulation 19): High**	
d	**Bank & Agency monitoring report**	
	DS presented the report to the Committee noting the following key points: • Report focussed on 4 KPIs as detailed in the report. • Trust is achieving or exceeding on 3 KPIs; price cap KPI not met. There is an upper limit as to what should be paid per hour; particularly challenging due to skills required for our required agency staff. • Using more bank and less agency as recruited more bank staff, good engagement from divisions. • Agency spend for the year so far £2.4m, links to areas where it is difficult to fill vacancies. This is a challenge across the country. The Committee discussion led to: • Assurance level discussion led to agreement of high assurance. **Assurance level given (BAF Risk 7.2): High**	
e	**Compliance with CQC safe staffing six monthly report**	
	TP presented the report to the Committee noting the following key points: • Report supports the bi-annual process on nursing establishment. • Process of triangulated information and data, end point of process is for Band 7 and nurses to present the information to the Chief Nurse and whether it is accurate and they are able to provide safe care. • Ambitions to review skills in workforce although no patient safety incidents occurred as a result of safe staffing. The Committee discussion led to: • Question asked as to whether previous reports are considered at the time of	

	review for the next report. Core individuals are involved in the process and do look back at past reports, known concerns are reviewed and issues raised. Data over time also reviewed. • Question asked as to what the top issues are; increase of enhanced supervised care of patients (1 to 1 care where needed) is a struggle across with GM and results in agency spend. Staff would like improved nurse to patient ratio but we already significantly better than other Trusts. Links to recruitment and retention and new and emerging roles for nursing. Some of it is around availability, people choose where they want to work so its how we attract staff and then support them. • Assurance level discussion led to agreement of high assurance. TK thanked staff involved. **Assurance level given (BAF Risk 7.1 and 7.2, CQC Regulation 18): High**	
f	**Violence and Aggression standards report**	
	JFC presented the report to the Committee noting the following key points: • The reason for delay in reporting was confirmed as waiting on a self-assessment tool from NHSE which has not materialised. • Report sets out the standards that have been assessed against and a produced gap analysis. • Risk profile reduced as no A&E but we do have some instances of violence and aggression. • Lots of good systems and practices in place across the Trust. • Two key areas where currently do not have assurance; (1) do not have a strategy although do have a policy. Need to have written strategy in place and looking to develop a task and finish group to work on this. (2) Need to look at having local risk assessments in departments. The Committee discussion led to: • Noted importance of training as well as a strategy. Hard to assure something if people are not confident with how to deal with instances of violence and aggression. • Question asked on if there are any themes, how behaviours are monitored and any lessons learned on how we deal with it rather than prevent it. The numbers are very low, sometimes due to post operative delirium or dementia which have their own training programmes. There are no particular themes due to low numbers to be able to do lessons learned. • The oversight committee for monitoring is the Health and Safety Committee. • In summary, work to be done, agreed to return to the Committee in six months with progress update with a view to being in a position to take to the Board for assurance. • Assurance level discussion led to agreement of medium assurance. **Action** • Further report on progress to come to the Committee in six months, to be added to rolling programme. **Assurance level given: Medium**	**JFC**
g	**FPPT compliance report**	
	LW presented the report to the Committee noting the following key points: • NHSE published guidance in August last year to strengthen the regulation already in place. • Appendix 1 details the additional requirements in place. A lot of work has been undertaken to ensure compliance. We have completed for all our Directors and not just those in post since the guidance (which is the requirement). • We are compliant with all requirements subject to the receipt of Board Member References which have been requested from the respective Trusts for the 2	

	newly recruited Board members. • Assurance provided that compliant on all other areas and asked for report to be approved for sending to Board. **Approved** • Assurance level discussion led to agreement of high assurance. **Assurance level given (CQC Regulation 5): High**	
03/24	**Governance**	
a	**Audit Recommendation Tracker Report - Workforce**	
	EL confirmed that the recommendations from the report are now all complete. **Noted**	
b	**Guardian of working hours report**	
	NB presented the report to the Committee noting the following key points: • Had 16 exception reports in reporting period, escalations come from a small number of doctors and in comparison to other Trusts the numbers are small. • BMA officer working with the guardian on the detail within the report to help identify in any emerging themes. **Noted**	
c	**Committee effectiveness outcome report**	
	TK thanked the Committee for the completed self-assessments that formed the report. • Good suggestions on improvements for the Committee. • Will look at areas of deep dive focus for the Committee. • Will meet with EL to look at themes and suggested improvements, others welcome to join the discussion. • Noted as an evolving Committee, important to get to the point where we have a track record and seeing this through the workforce dashboard, will all help to give higher levels of Committee effectiveness in the future. • The updates to the ToR will also help drive further assurance areas. • Education noted as a key area for assurance. • Also looking at more divisional involvement for the Committee as the Committee is NED/Exec led and centrally led by the workforce team so be good to look at involving other leaders. **Action** • Committee members to be invited to join discussion on reviewing areas for improvement and further development of the Committee. **Noted**	**JD**
d	**Workforce Assurance Committee - draft annual report**	
	TK asked the Committee to pass any review comments to JD for incorporating into the final version before presentation at the joint assurance committee in June. Subject to any amendments being received, report **approved.**	
04/24	**Non-Executive Director feedback from department visit**	
	TK noted to the Committee that he and EL visited the catering department ahead of the meeting to meet with RT and the catering team.	
05/24	**Escalations to other Committees or Board of Directors**	
	No escalations noted.	
06/24	**Reflections of the meeting**	
	TK thanked all for their contributions to the meeting.	

	No further comments noted.	
07/24	**Any other business**	
	No other business raised.	
	Date and time of next meeting: Thursday 13th June 2024, 10.15am	

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Agenda item 10/24e

Meeting of the Board of Directors
Thursday 28th March 2024

Subject / Title	Annual board reporting cycle 2024/25
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 2024/25
Background papers	Annual board reporting cycle 2023/24
Risk score	N/A
Link to: ➢ Trust strategy ➢ Corporate objectives	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 10/24e

Meeting of the Board of Directors

Thursday 28th March 2024

Annual board reporting cycle 2024/25

1. Introduction

The annual board reporting cycle 2024/25 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.

It is noted that following the assessment of the regularity of Board meetings that is an action from the recent GGI Governance Review, the reporting cycle will be amended appropriately.

2. Recommendation

The board is asked to approve the annual board reporting cycle 2024/25.

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Annual board reporting cycle 2024/25

Apr 2024 – Sep 2024

Item	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sept 2024
***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

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Annual board reporting cycle: Oct 2024 – Mar 2025

Item	October 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	March 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	✓
Strategic and annual items:						
5-year strategy		✓				Reported in corporate objectives
Corporate plan and objectives 2024/25		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

The Christie NHS Foundation Trust

EXECUTIVE SUMMARY

The Christie NHS Foundation Trust

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

Safety

- Two serious incidents were reported in February, details of which can be found on slide 6. There were 6 incidents in total reported in February which require a learning response. 2 of the incidents were reported with the classification of death, 3 as moderate and one as no harm. Details of each incident can be found on slide 7. All the incidents are still progressing through to full root cause analysis. No never events were reported in month.
- There are 4 Trust level risks scored at 15+. Details of these can be found on slide 13.
- Safer staffing numbers have met the required acuity levels to ensure appropriate levels of safety and care for our patients. Indicative staffing, in line with nursing establishments, is set to maintain a 1:7 nurse to patient ratio. On occasion this has been extended to 1:8 which is in line with recommended national staffing ratios. While we have seen an increase in patient safety incidents, following thematic review, these were not related to nurse staffing ratios.
- There were 5 cases of C-Difficile, 4 cases of E-Coli, 4 cases of Klebsiella and 2 cases of MSSA in February that were deemed attributable to the Trust. No lapses in care were identified.
- There were 3 sperate outbreaks of nosocomial Covid-19 during February that effected 18 staff and 30 patients.

Performance

- In February the new combined 62-day performance subject to validation was at 66.9% which is below the new standard of 70%, but a significant improvement on the January position. The new combined 31-day performance was 98.6% which is above the new standard of 96%. The internal 24-day performance is below standard and is at 71.84%. All 62 and 24-day breaches are reviewed to ensure any delays are understood and plans can be implemented to mitigate any future delays. Improvement plans are in place and performance is expected to improve before the end of the financial year. The Trust's RTT 18-week performance is well above standard at 98.2%. The Trust did not achieve the 75% faster diagnosis standard in February with a compliance score of 54.5%.
- There was one patient waiting over 52 weeks at the end of February. The long wait can be attributed to long periods of patient choice to delay the proposed treatment.
- Referral numbers in February expectedly decreased from a high point in January and were higher than in the same period in 2023. Overall YTD referral levels continue to remain higher than 22/23 levels.

HR

- Staff absence decreased from January to a position of 4.56% against a target of 3.4%.
- PDR performance has slightly decreased from January's position whilst mandatory training has improved. Mandatory training performance remains well above the set standard.

Finance

- At month 11 The Trust is reporting a year-to-date surplus of (£5,284k) against a year-to-date plan of £7,368k, which gives a positive year to date variance of (£12,652k).
- The month 11 position is a surplus of £1,576k against a deficit in month plan of £670k which gives a positive in month variance of £2,246k.
- Performance to month 11 was £4,883k below the original plan submitted to NHSE&I in April 23. Whilst there is slippage on some schemes including the TIF Ward, other projects are ahead of plan. The Trust has incurred £21,725k on capital schemes to month 11, primarily on the backlog maintenance programme, the linear accelerators and CT scanner replacements, Digital Services Electronic Health Records projects, final works on the Paterson scheme, the Proton treatment planning system and the TIF ward refurbishment. This includes £163k capital expenditure on the charity funded Art Room refurbishment.
- All Providers within GM agreed to reduce annual capital spend against original plans by a proportionate amount as the original GM ICS plan was oversubscribed. The impact of this was a £3.6m reduction to original forecast planned capital spend for the Christie however this is now offset by an additional £5m increase to our plan agreed with GM following an additional transfer of capital envelope from Cheshire & Merseyside ICB.

SUMMARY DASHBOARD

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Indicator	Threshold / Standard 23/24	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	New Standards	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	YTD
Serious Incident Reported	-	0	0	0	2	0	0		0	0	1	2	2	7
Never Events	0	0	0	0	0	0	0		0	0	0	0	0	0
Radiation Incidents Reported (IRMER Reportable)	0	2	1	0	0	0	0		0	0	0	1	2	6
Radiation Incidents Reported (IRMER Reportable - Grade 2 or above)	0	0	0	0	0	0	0		0	0	0	0	1	1
Number of Pressure Ulcers (Post admission - Grade 2 or above) - Rate per 1000 occupied bed days	0.5	0.2	0.4	0.2	0.2	0.8	0.6		0.2	0.2	0.4	0.4	0.2	0.4
Inpatient Falls Resulting in Harm (Grade 2 or above) - Rate per 1000 occupied bed days	3.7	2.6	4	4	0.9	2.9	4.4		9	2.6	4.7	2.5	3.8	3.8
VTE Assessments Completed	95%	98.0%	98.2%	98.8%	97.8%	98.6%	98.7%		98.3%	98.6%	98.3%	99.2%	99.0%	-
Sepsis - timely treatment with IV antibiotics (established inpatients)	90%	96.9%	95.1%	90.2%	92.2%	90.1%	97.7%		93.0%	96.9%	90.0%	88.8%	90.0%	-
Sepsis - screening (presenting as an emergency)	90%	95.0%	95.3%	98.7%	96.1%	96.0%	97.1%		95.1%	95.6%	98.3%	96.9%	98.0%	-
Number of Corporate Risks Grade 15 or Above	-	4	4	4	4	5	5		5	5	4	5	4	-
Safe Staffing (% of planned hours vs actual hours across all inpatient areas)	-	82.7%	87.4%	85.7%	86.5%	84.1%	87.8%		87.1%	87.4%	88.8%	89.0%	88.3%	-
28 Day Faster Diagnosis Standard	75%	50.0%	45.5%	52.4%	41.2%	50.0%	53.8%	75%	85.0%	66.7%	81.8%	52.9%	54.5%	-
62 Day Compliance	85%	71.3%	67.3%	68.8%	67.4%	73.7%	67.1%							-
62 Day Compliance - Upgrades	85%	67.1%	74.0%	87.7%	74.4%	75.5%	78.7%	70%	65.5%	70.7%	71.0%	59.6%	66.9%	-
62 Day Compliance - Screening	90%	75.0%	63.6%	100.0%	58.3%	33.3%	66.7%							-
24 Day Compliance	85%	73.8%	74.6%	75.4%	69.0%	75.5%	70.6%	85%	68.2%	69.2%	73.7%	63.3%	71.8%	-
31 Day Compliance	96%	97.8%	98.3%	96.7%	97.4%	98.9%	96.0%							-
31 Day Compliance - Subsequent Drug Therapy	98%	100.0%	100.0%	100.0%	100.0%	98.9%	99.3%	96%	98.7%	98.2%	98.6%	97.4%	98.6%	-
31 Day Compliance - Subsequent Radiotherapy	94%	99.2%	99.5%	100.0%	100.0%	98.9%	98.6%							-
31 Day Compliance - Subsequent Surgery	94%	98.8%	100.0%	100.0%	100.0%	98.9%	96.8%							-
18 Weeks Compliance - Incomplete Pathways	92%	96.5%	96.9%	97.4%	96.7%	96.7%	97.8%	92%	97.7%	97.2%	97.2%	97.4%	98.2%	-
Patients waiting >52 Weeks	0	1	1	1	1	2	2		1	0	1	1	1	12
Patients waiting >62 days at end of month (62 Day Classic)	80	89	84	102	109	105	114		114	136	132	136	119	-
Patients waiting >104 days at end of month (All 62 Day Targets)	-	34	42	44	46	40	52		64	58	72	72	45	-
Length Of Stay (Elective & Non-Elective Inpatients)	-	7.77	7.1	6.59	7.02	6.99	8.04		7.31	7.21	6.68	6.16	6.74	-
Patients Discharged Beyond Ready for Discharge Date	-					2	17		14	12	19	8	8	80
Patients Discharged Beyond Ready for Discharge Date - Total Bed Days Lost (days counted in the month of discharge)	-	*Reporting commenced last week of Aug*				31	159		263	114	167	211	151	1096
Patients Discharged Beyond Ready for Discharge Date - Average Bed Days Lost (days counted in the month of discharge)	-					15.5	9.4		18.7	9.5	8.8	26.4	18.9	13.7
Hospital Cancelled Operations on the day for non clinical reasons	0	2	4	2	5	9	0		12	5	4	1	5	49
Hospital Cancelled Operations on the day for non clinical reasons - NOT rebooked within 28 days	0	0	1	1	1	0	0		0	0	0	0	0	3
Complaints Received	14 (22/23 Avg)	11	11	11	12	19	5		12	20	10	12	15	138
PALS Contacts	44 (22/23 Avg)	46	51	42	35	42	42		37	34	27	28	21	405
Inquests	-	2	5	2	2	1	2		0	4	1	3	1	23
Coroner Request	-	11	12	4	3	4	3		3	3	1	6	7	57

SUMMARY DASHBOARD

NHS
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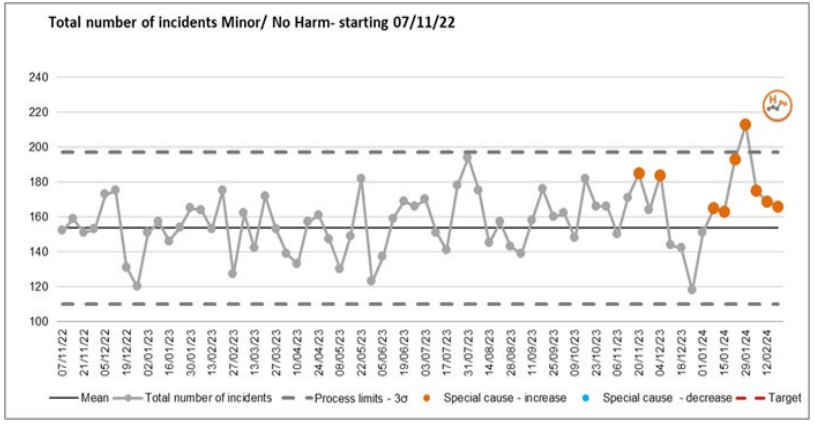
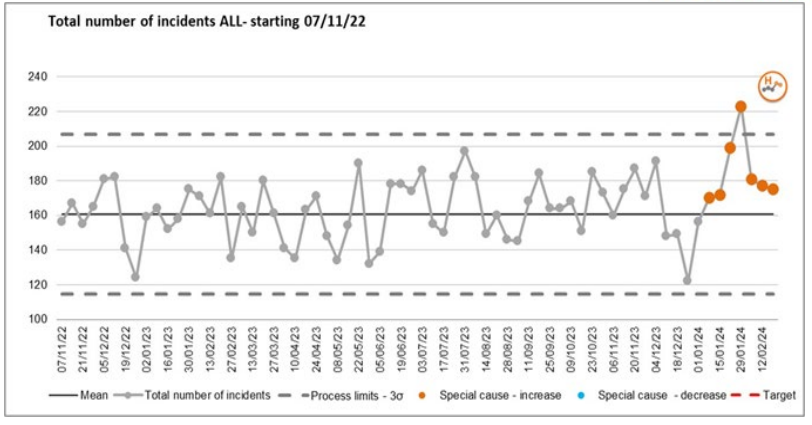
Indicator	Threshold / Standard 23/24	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	YTD
MRSA	0	1	0	0	1	0	0	1	0	0	0	0	3
C-Difficile - All Attributable Cases (Pre & Post 48 Hours)	36	2	3	4	4	3	4	5	7	0	7	5	44
C-Difficile - Attributable Cases Due To Lapse In Care	0	0	0	0	0	0	0	0	0	0	0	0	0
MSSA Bacteraemia - Attributable	25	1	1	1	2	4	2	2	2	2	3	2	22
E-Coli - Attributable	29	5	4	7	6	8	2	5	6	4	6	4	57
Klebsiella Species - Attributable	14	4	2	0	1	2	2	1	5	2	2	4	25
Pseudomonas Aeuriginosa - Attributable	10	1	0	2	1	1	2	1	0	1	0	0	9
COVID infections - Hospital Aquired	0	2	1	0	0	8	8	0	0	0	25	30	74
Palliative Radiotherapy 30 Day Suvival Rate	-	91.4%	91.2%	91.0%	86.1%	90.9%	90.0%	92.1%	89.4%	91.7%	91.9%	-	-
Final Chemotherapy 30 Day Survival Rate	-	98.9%	99.3%	99.5%	99.4%	99.4%	99.3%	99.5%	99.3%	99.4%	99.3%	-	-
Surgery 30 Day Survival Rate	-	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	-	-
Staff Sickness	3.4%	4.09%	4.03%	3.87%	4.29%	4.35%	4.58%	4.89%	4.49%	4.48%	5.04%	4.56%	-
Staff Mandatory Training	>80%,** <80%	83.0%	86.5%	88.8%	89.6%	90.4%	90.0%	89.9%	90.7%	91.3%	91.8%	92.0%	-
Staff PDRs	-	85.9%	86.1%	88.0%	87.6%	87.6%	86.8%	86.3%	85.8%	86.3%	87.0%	86.5%	-

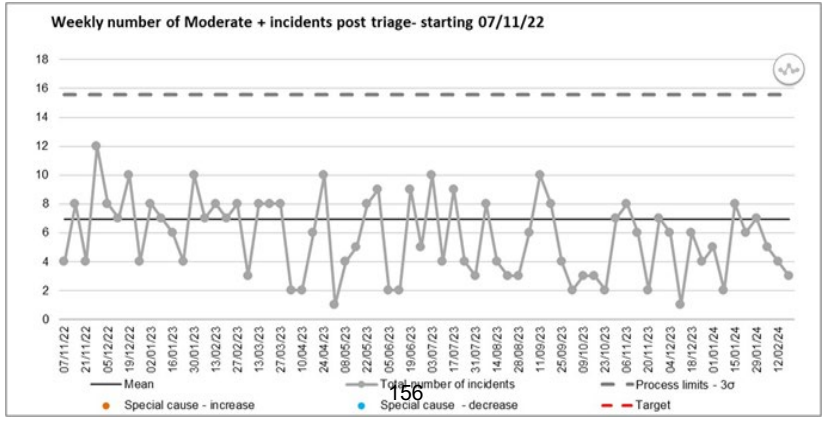
Compliance if <80% & risk assessment in place

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

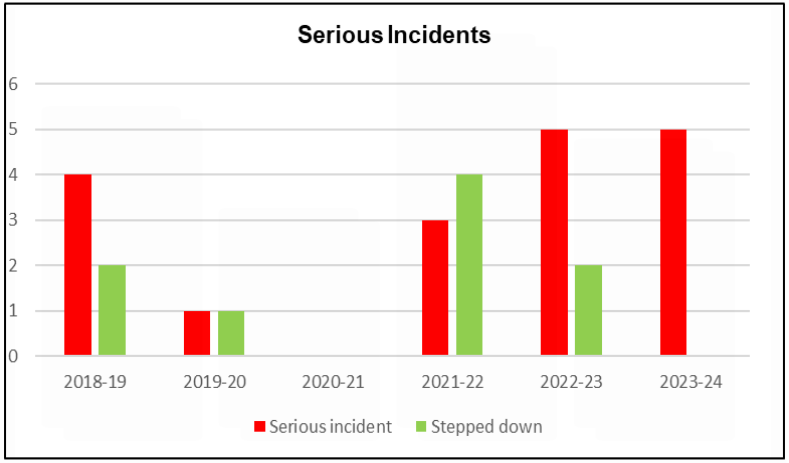
Incident Reporting







Serious Incidents and Never Events



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

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

Serious incidents
There were 2 serious incidents identified in February 2024:

W83647 – aspiration on anaesthetic induction
W84159 – inpatient fall

Incidents identified that require a Learning Response

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February 2024 – RCA/learning response to be presented to ERG		
Reference	**Description**	**Reported Harm Level**
W83962	Patient had CT scan as part of clinical trial follow-up. Research team notified by radiologist that patient has features of pregnancy on scan. According to trial protocol, patient was due a pregnancy test at baseline screening visit on 10th Nov 2023. There is no evidence of this test being performed on CWP.	Moderate
W83877	Emergency Sepsis Pathway IVAB administration breach by 55mins. Patient developed severe sepsis	Moderate
W83749	Electronic transfer of GP correspondence via the docman connections via the MFT hub failed resulting in a minimum of 420 letters being delayed in the system.	Moderate
W83647	Aspiration on induction of anaesthesia.(SI investigation underway).	Death
W84159	Unwitnessed fall from commode. Patient deteriorated from bleeding into liver mets.	Death
W84083	Complications arising post embolism care.	No Harm

Learning - Patient Safety Incidents

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Agreed learning and revised severity outcome following executive reviews February 2024

Ref	Description	Root cause	Learning	Outcome
W81888	Patient was referred to Clinical Oncology in 2015 and appropriate treatment was given with chemotherapy and hormone therapy, There was no change to the liver lesions over several years of regular CT scans which are deemed not to be cancerous. No physical harm has come from this incident but psychologically this has been very difficult for the patient.	The patient was initially diagnosed with Breast cancer which had metastasised to the liver. A series of CT scans have taken place since which have reported stable liver metastases. MRI scan undertaken on 11.08.2023, showed 'fatty' lesions which means that the lesions are more likely to be benign than cancerous	• Explore further with district general regarding re-instating MDT for patients or the possibility of holding the MDT @ The Christie • Additional radiology staff to be allocated to the Breast MDT rota.	**Moderate**
W82175	Overrun in Theatre list, and unavailability of additional staff member led to Consultant Anaesthetist working for 16 hours	The escalation process was not clear when the clinical support role was unavailable and there was an over run in theatre.	• SOP for escalation process to be agreed • To discuss representation at Anaesthesia business meeting / Anaesthetist to sign off lists at 6-4-1 meeting • Review of on call arrangements to determine appropriateness of a 2nd on call to allow for emergency cover as well as out of hours elective list support. • Paper & JD/PS to be for anaesthetic specialist le to be presented to Workforce Committee, • Anaesthetic rota review to occur to ensure service is being delivered to optimum efficiency. (As part of divisional strategy away day) • Consultant recruitment planned to be advertised August 2024 and interviews to take place early September 2024, currently two vacancies, one of which is being covered by a locum for a fixed term 12 months	**No harm**

Learning - Patient Safety Incidents

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Agreed learning and revised severity outcome following executive reviews February 2024

Ref	Description	Root cause	Learning	Outcome
W81615	Patient with relapsed/refractory lymphoid blast crisis of chronic myeloid leukaemia, admitted with sepsis and pain. Had a syringe driver in situ for pain management. Re-prescribed on admission with 1/10th of the required morphine dose resulting in inadequate pain control and significant patient and family distress.	Insufficient knowledge/awareness within PW medical/nursing teams of appropriate syringe driver prescribing	• Education re. supportive care in haematology and syringe driver prescribing for medical and nursing staff on PW • Amend existing haematology prescribing guidance to evidence specific cases • Explore opportunities to enhance education opportunities re. syringe driver prescribing/access to supportive material /information for junior doctors during trust induction • Increase awareness of 'Greater Manchester Palliative Care pain and symptom control guideline for adults' Handbook - Link to handbook made available via qpulse	**Moderate**
W82287	Staff member along with another colleague moved a patient on a bed from Palatine Ward to IPU ultrasound. Whilst moving the patient staff member obtained an injury resulting in them being off work for more than four weeks.	Safe principles of Moving and Handling (M&H) not adhered to and dynamic risk assessment not done. Likely contributing factors: - Not in date with moving and handling (but they are an experienced member of staff)	• A M&H risk assessment to be undertaken to advise on current practice and what level of M&H is to be undertaken by the staff member. • To undertake M&H refresh session. • Expression of interest for 2 M&H link workers in Radiology . • Risk assessment to be put place regarding patient transfers by Radiology staff.	**Moderate**

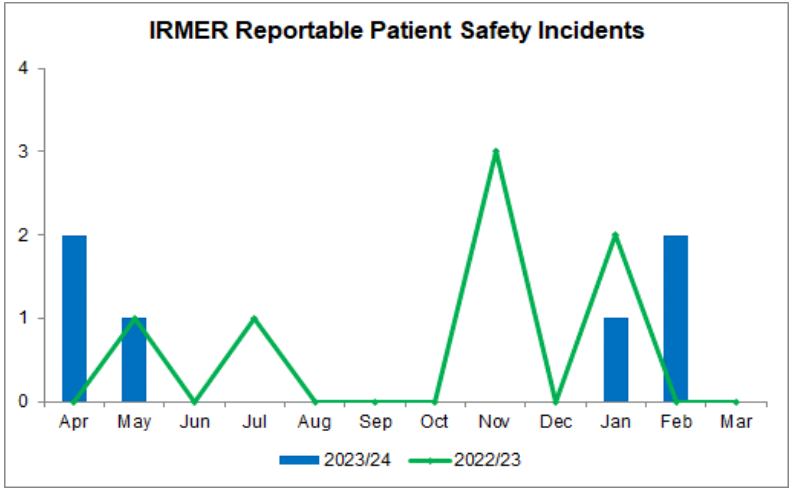
Learning - Patient Safety Incidents

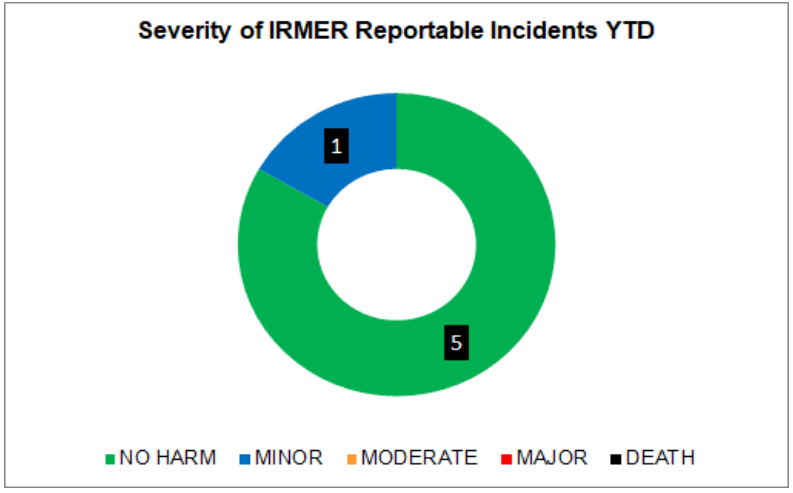
The Christie NHS Foundation Trust

Agreed learning and revised severity outcome following executive reviews February 2024

Ref	Description	Root cause	Learning	Outcome
W82197	A patient attended Ward for immunotherapy as an outpatient. Due to increased toxicities, the treatment was deferred, and decision made to admit. When the patient was transferred to the inpatient area at 5pm the patient had a NEWS of 9. There were a number of missed opportunities to try to stabilise a patient's deteriorating condition and increasing NEWS2 score whilst awaiting transfer.	Failure to follow a number SOPs, policies and pathways in place to support the timely management, escalation and transfer of an unwell, deteriorating patient.	• Escalation process to be updated to remind staff (clinical and Nurses) on ORTC that an urgent call must always be used when updating the outreach team on urgent concerns. Discussed in team huddles and with wider teams • Update all ORTC staff of transfer policy with particular attention on patient escort	Minor

Radiation Incidents





There were 2 IRMER reportable patient safety incidents in February 2024:
W84377 – minor
W84634 – no harm

There was 1 IRMER reportable patient safety incident in January that was not included in last report (due to reporting date):
W83929 – no harm.

Harm Free Care

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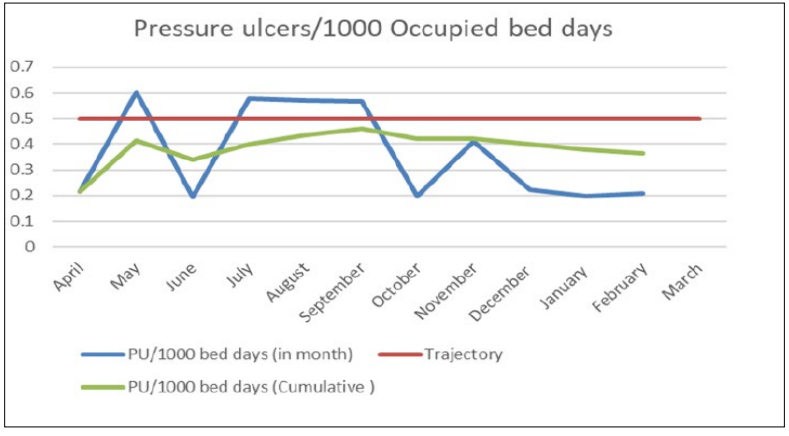
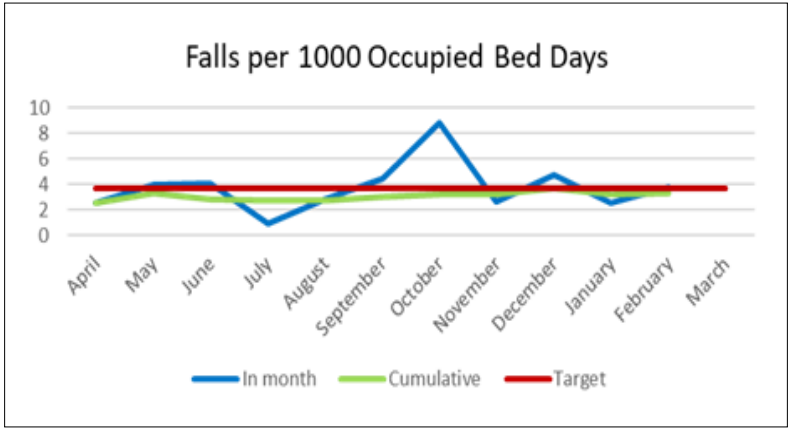
Pressure ulcers per 1000 occupied bed days



1 Category 2 pressure ulcer reported
To date, 20 patients (0.36/1000 OBD Cumulative) acquired pressure ulcers during the admission – against Trust ambition of <0.5

No patients have developed category 3 or 4.

Falls per 1000 occupied bed days



19 falls in month on inpatient Wards. Currently at 3.3 falls per 1000 occupied bed days.

This is against the ambition of no more that 3.8 per 1000 OBD.

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

Corporate Risks

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There are 4 Trust-wide 15+ risks in February

Description	Score	Controls
24/25 Capital Envelope Restrictions	25	All capital bids have been collected from Divisions including the level of priority and impact on patient care and activity should the bid not be approved. All capital bids have been reviewed by EDOF, COO and capital team to assess priority and risk score are appropriate before submitting to GM. Exec and other senior staff representing CFT at relevant GM and national meetings to support our highest risk bids and also lobbying that a local system prioritisation process doesn't adequately support Trust's providing national tertiary services. Work undertaken by EDOF and capital team to maximise the 23/24 CDEL available and reduce the risk in subsequent years
24/25 Financial Revenue Risk	20	The Trust has senior finance staff representing the Christie on all key GM ICB 24/25 financial groups in order to be able to influence and ensure parity on all allocations plus impact on cancer services of any efficiency schemes. Trust CIP plans are in development with full review to be included in ICPC from Feb'24 All aspects of planning are already well underway with experienced staff and divisional support ahead of the first submission deadline in March 2024. All financial pressures will be reviewed in internal divisional challenge sessions and any business cases will be subject review and challenge at ICPC
There is a risk that patients may experience harm due to significant delays in the management of patients with penile cancers.	16	Weekly clinical prioritisation of waiting list by Consultant Penile Team. Weekly review and oversight of waiting list jointly by operational team and Clinical team as part of weekly Diary Meeting Automatic upgrade to P2 status of any P3 patient waiting longer than expected 3 months. Discussion of current waiting list position at weekly Executive led escalation meeting. Patients added to waiting list clearly signposted to contact clinical team if any changes to condition
Risk of delayed cancer treatments due to failure to meet 24 / 62 day target	15	Twice weekly PTL meetings chaired by a divisional director and attended by department leads, performance team and trackers. Monitoring all patients on the PTL at these meetings with the aim to start treatment as soon as possible.

Safe Staffing

The Christie NHS Foundation Trust

		DAY	NIGHT	Cumulative count over the month of patients at 23:59 each day	CHPPD (Care Hours Per Patient Per Day)
		Hours	Hours		
Registered Nurses	Total monthly PLANNED	15867	12603	4769	5.5
	Total monthly ACTUAL	14405	11896		
	Average Fill Rate %	90.8%	94.4%		
Care Staff	Total monthly PLANNED	9973	5798	4769	2.7
	Total monthly ACTUAL	7497	5277		
	Average Fill Rate %	75.2%	91.0%		
ALL Staff	Total monthly PLANNED	25840	18401	4769	8.2
	Total monthly ACTUAL	21913	17173		
	Average Fill Rate %	84.8%	93.3%		

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	2232	1802	80.7%	1944	1670	85.9%	144	24.1
Palatine Ward	3027	2814	93.0%	2420	2207	91.2%	804	6.2
Ward 10	2157	1742	80.8%	1506	1427	94.8%	750	4.2
Ward 11	1684	1750	103.9%	1531	1498	97.8%	767	4.2
Ward 12	1818	1847	101.6%	1486	1559	104.9%	791	4.3
Ward 4	1735	1681	96.9%	1414	1342	94.9%	752	4.0
Ward 2	965	907	94.0%	535	550	102.8%	283	5.1
Acute Assessment Unit	2249	1862	82.8%	1767	1643	93.0%	478	7.3
TOTAL	15867	14405	90.8%	12603	11896	94.4%	4769	5.5

Registered Nursing Associates	DAY			NIGHT		
	Hours Planned	Hours Actual		Hours Planned	Hours Actual	
Critical Care Unit						
Palatine Ward						
Ward 10					11	
Ward 11					7	
Ward 12						
Ward 4		130			11	
Ward 2		60			23	
Acute Assessment Unit		11				

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	597	237	39.7%	0	34	100.0%	144	1.9
Palatine Ward	1416	1039	73.4%	989	862	87.2%	804	2.4
Ward 10	1762	1093	62.0%	740	587	79.3%	750	2.2
Ward 11	1486	1265	85.1%	1075	1069	99.4%	767	3.0
Ward 12	1609	1334	82.9%	1022	1046	102.3%	791	3.0
Ward 4	1486	1139	76.6%	953	804	84.4%	752	2.6
Ward 2	440	473	107.5%	299	311	104.0%	283	2.8
Acute Assessment Unit	1177	917	77.9%	720	564	78.3%	478	3.1
TOTAL	9973	7497	75.2%	5798	5277	91.0%	4769	2.7

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

Patient Experience

NHS
The Christie
NHS Foundation Trust

Positive feedback received…..

"My brother was asked to attend AAU due to feeling unwell after chemotherapy treatment. I took him to the Christie, to AAU, we were met by a sister and a nurse they were incredibly caring and welcoming to me and my brother. Despite how busy they are they couldn't have been more supportive or attentive. ."

"All staff on Dept 26 could not be more professional and accommodating through son's treatment since 2018."

"I apologise from not knowing the names but want to thank you and your staff who looked after Tracey for so many years through this terrible disease myeloma.
I know how much she valued your care and expertise and indeed that you helped her to extend her life for longer than might have been the case."

"Compliments to Dr Clamp and team for helping a patient's husband who fell unwell during an appointment. "

"Thanks to all staff on ward 11 for being so kind and supportive during the end of uncles life."

Friends & Family Test

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Monthly Summary

	INPATIENT & DAYCASE RESPONSES						Total Number of people eligible to respond	Total Responses	Response Rate	% Recommended
	1 - Very Good	2 - Good	3 - Neither Good nor Poor	4 - Poor	5 - Very Poor	6 - Don't Know				
Apr-23	207	27	4	0	2	1	780	241	30.9%	97.10%
May-23	280	20	1	2	0	1	926	304	32.8%	98.68%
Jun-23	247	24	6	2	3	0	927	282	30.4%	96.10%
Jul-23	223	23	2	1	2	1	810	252	31.1%	97.62%
Aug-23	222	8	3	3	1	0	841	237	28.2%	97.05%
Sep-23	208	25	8	2	4	1	894	248	27.7%	93.95%
Oct-23	237	26	4	4	2	0	827	273	33.0%	96.34%
Nov-23	265	28	5	1	0	1	980	300	30.6%	97.67%
Dec-23	168	19	2	3	4	2	846	198	23.4%	94.44%
Jan-24	295	23	5	5	0	4	960	332	34.6%	95.78%
Feb-24	235	25	2	2	1	1	899	266	29.6%	97.74%
YTD Total	2587	248	42	25	19	12	9690	2933	30.27%	96.66%

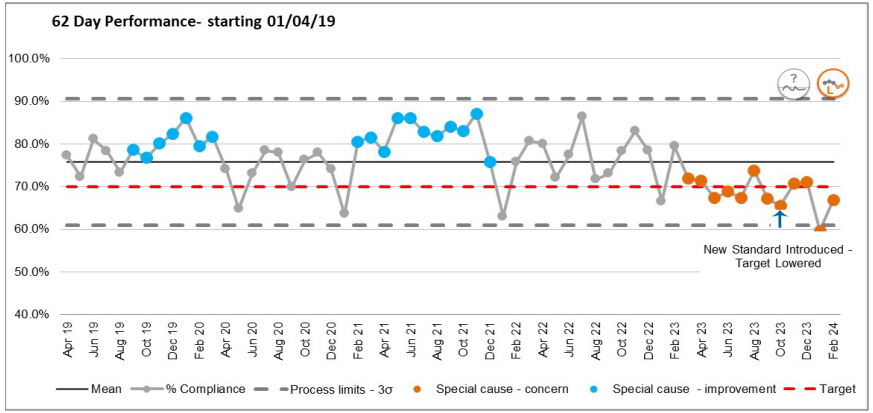
	OUTPATIENT RESPONSES						Total responses	% Recommended
	1 - Very Good	2 - Good	3 - Neither Good nor Poor	4 - Poor	5 - Very Poor	6 - Don't Know		
Apr-23	1348	165	38	19	10	18	1598	94.68%
May-23	1336	166	52	18	13	12	1597	94.05%
Jun-23	1458	181	54	23	21	20	1757	93.28%
Jul-23	1310	148	35	16	13	16	1538	94.80%
Aug-23	1215	167	29	14	10	16	1451	95.24%
Sep-23	1396	140	40	17	5	19	1617	94.99%
Oct-23	1606	170	47	17	7	9	1856	95.69%
Nov-23	1770	227	42	22	11	20	2092	95.46%
Dec-23	1079	144	30	14	9	8	1284	95.25%
Jan-24	1850	200	54	20	19	14	2157	95.04%
Feb-24	1449	146	33	12	6	12	1658	96.20%
YTD Total	15817	1854	454	192	124	164	18605	94.98%

Ward name	INPATIENT & DAYCASE RESPONSES - BY WARD						Total Number of people eligible to respond	Total responses for each ward	Response rate for each ward
	1 - Very Good	2 - Good	3 - Neither Good nor Poor	4 - Poor	5 - Very Poor	6 - Don't Know			
04 Ward (Dept 52)	14	3	0	1	0	0	92	18	19.6%
10 Ward-Surg Onc Unit (Dept 4)	26	7	0	0	0	0	130	33	25.4%
11 Ward (Dept 4)	2	1	0	0	0	0	82	3	3.7%
12 Ward (Dept 4)	5	1	0	0	0	0	66	6	9.1%
The BMR Unit (Dept 16)	9	1	0	0	0	0	42	10	23.8%
Endocrine Ward (Dept 63)	13	1	0	0	0	0	27	14	51.9%
Haematology Day Unit (Dept 26)	50	4	0	1	0	1	134	56	41.8%
Integrated Procedure Unit (Dept 2)	107	7	2	0	1	0	223	117	52.5%
Palatine Ward (Dept 27)	8	0	0	0	0	0	85	8	9.4%
CTU Inpatient Ward (Dept 1)	1	0	0	0	0	0	18	1	5.6%
Total	235	25	2	2	1	1	899	266	29.6%

Cancer Standards

The Christie NHS Foundation Trust

62 Day / 31 Day / 18 Weeks



National Standard	Standard	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	New Standard	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
62 Day	85%	66.50%	79.40%	71.90%	71.3%	67.3%	68.8%	67.4%	73.7%	67.1%	70%	65.5%	70.7%	71.0%	59.6%	66.9%
62 Day Upgrades	85%	78.00%	79.10%	77.80%	67.1%	74.0%	87.7%	74.4%	75.5%	78.7%						
62 Day Screening	90%	77.80%	100.00%	100.00%	75.0%	63.6%	100.0%	58.3%	33.3%	66.7%						
24 Day Internal	85%	72.40%	86.50%	77.00%	73.8%	74.6%	75.4%	69.0%	75.5%	70.6%	85%	68.2%	69.2%	73.7%	63.3%	71.8%
31 Days	96%	96.90%	98.30%	97.70%	97.8%	98.3%	96.7%	97.4%	98.9%	96.0%	96%	98.7%	98.2%	98.6%	97.4%	98.6%
31 Day Subsequent Drug	98%	99.20%	100.00%	99.60%	100.0%	100.0%	100.0%	100.0%	98.9%	99.3%						
31 Day Subsequent XRT	94%	99.00%	99.50%	99.30%	99.2%	99.5%	100.0%	100.0%	98.9%	98.6%						
31 Day Subsequent Surgery	94%	99.00%	100.00%	98.40%	98.8%	100.0%	100.0%	100.0%	98.9%	96.8%						
18 Weeks - Incomplete Pathways	92%	97.10%	96.70%	96.50%	96.5%	96.9%	97.4%	96.7%	96.7%	97.8%	92%	97.7%	97.2%	97.2%	97.4%	98.2%

		Feb
50% Shared Breach		64
50% Shared Compliance		100
Full Christie Breach		9
FULL Christie Compliance		33
FULL Referring Provider Breach		114
Grand Total		320
62 Combined		66.9%
24 Day Compliance		71.84%
31 Day	Breach	5
	Compliance	321
Grand Total		326
31 day - Subsequents	Breach	4
	Compliance	331
Grand Total		335
31 day - Combined	Breach	9
	Compliance	652
Grand Total		661
31 day - Combined		98.6%

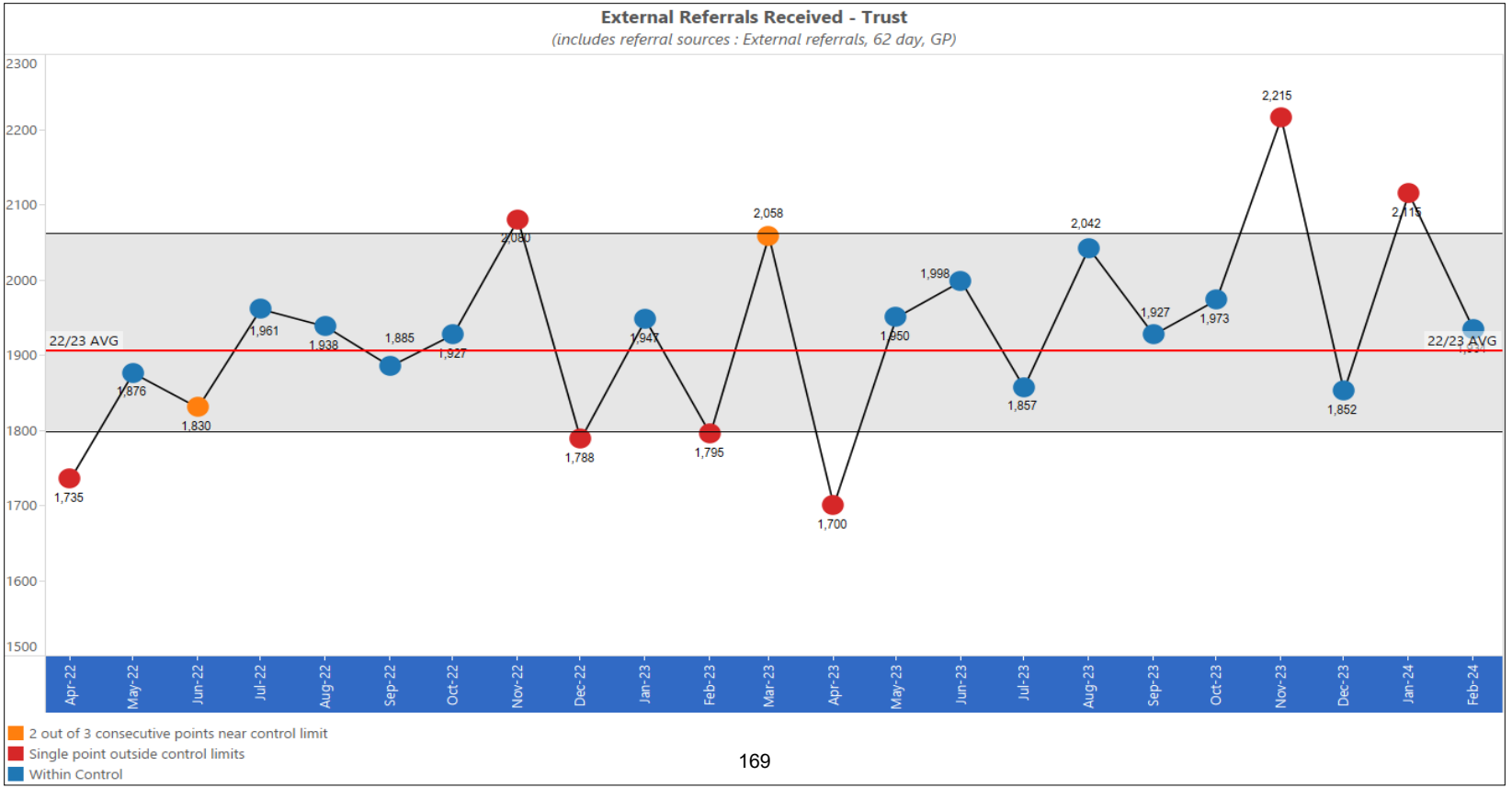
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Compliances	2	5	11	7	5	7	17	10	9	9	6
Breaches	2	6	10	10	5	6	3	5	2	8	5
%	50.0%	45.5%	52.4%	41.2%	50.0%	53.8%	85.0%	66.7%	81.8%	52.9%	54.5%

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

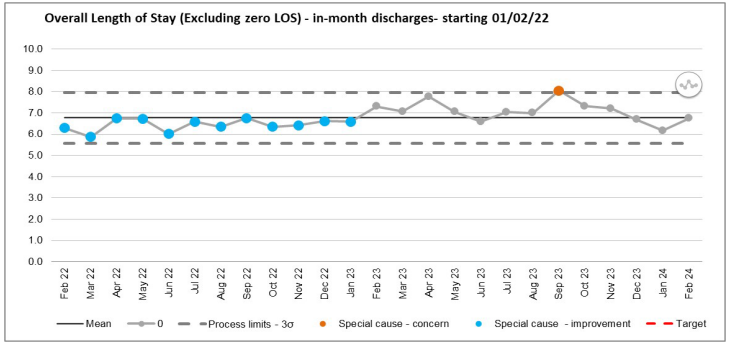
As of October 2023, all 62-day standards are merged in to one 62-day standard and all 31-day standard types are merged in to one combined 31-day standard. The Targets have been lowered from 85% to 70% for the new combined 62-day standard and a new combined target of 96% assigned to the new 31-day combined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

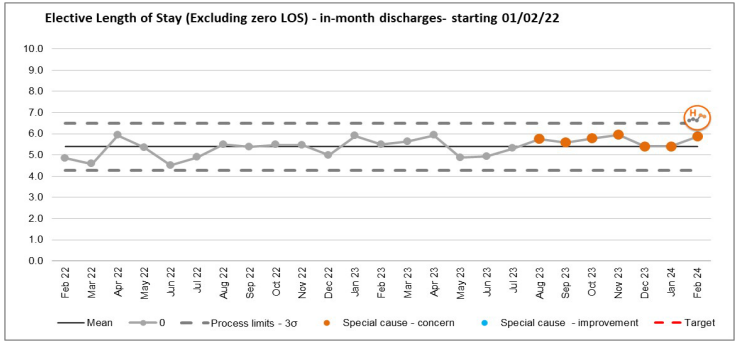
Referrals Analysis

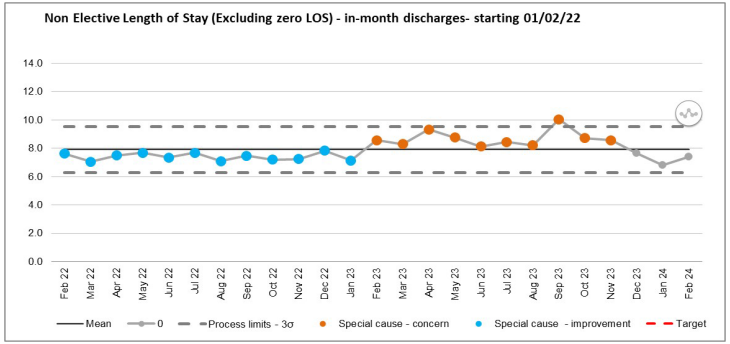
The Christie NHS Foundation Trust

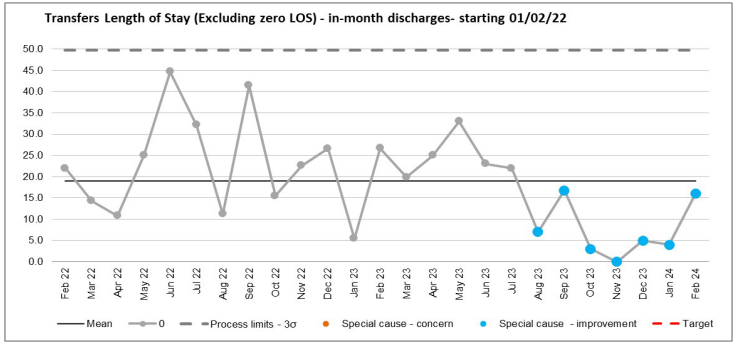


Length of Stay







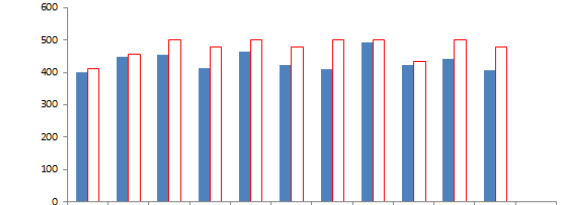


Elective, transfer patients and overall length of stay continues to be well within control limits – note special cause variation increase in non-elective LoS impacting on flow.

Activity

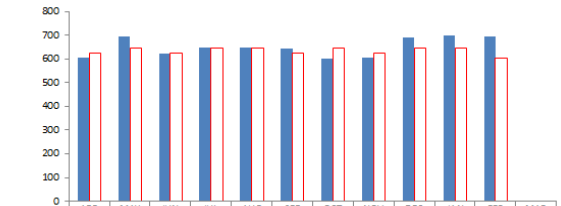
The Christie NHS Foundation Trust

Elective Spells



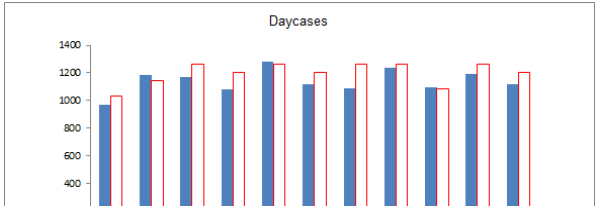
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	401	448	454	412	465	421	409	494	423	442	408	
23/24 Plan	410	456	502	479	502	479	502	502	433	502	479	

Non-Elective Spells



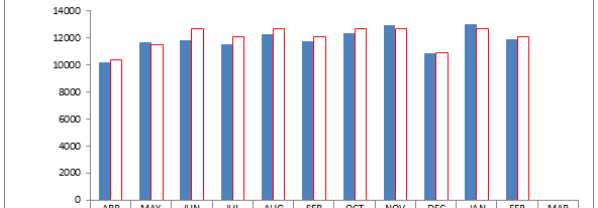
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	604	693	621	648	648	645	600	606	691	700	695	
23/24 Plan	624	645	624	645	645	624	645	624	645	645	603	

Daycases



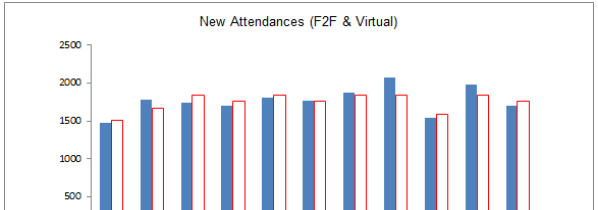
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	969	1186	1171	1081	1279	1119	1090	1238	1093	1195	1119	
23/24 Plan	1031	1145	1260	1203	1260	1203	1260	1260	1088	1260	1203	

Follow Up Attendances (F2F & Virtual)



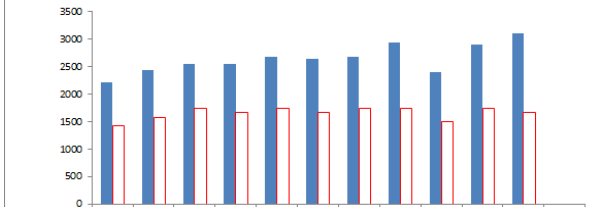
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	10236	11673	11836	11514	12246	11761	12330	12928	10844	13018	11926	
23/24 Plan	10360	11511	12662	12087	12662	12087	12662	12662	10936	12662	12087	

New Attendances (F2F & Virtual)



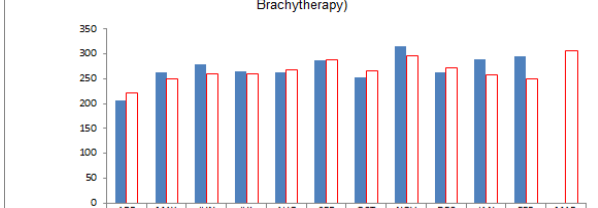
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	1479	1782	1739	1705	1804	1764	1875	2068	1540	1980	1705	
23/24 Plan	1504	1671	1838	1754	1838	1754	1838	1838	1587	1838	1754	

OP Procedures



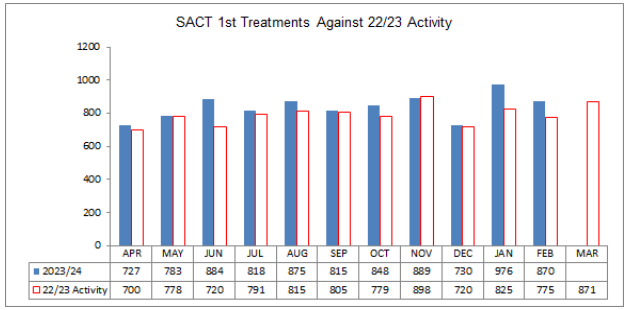
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	2217	2437	2549	2558	2688	2638	2684	2948	2410	2900	3106	
23/24 Plan	1423	1581	1739	1660	1739	1660	1739	1739	1502	1739	1660	

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

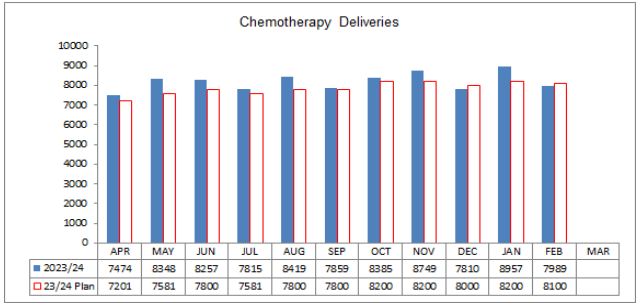


	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	207	263	278	264	262	286	252	316	262	288	294	
22/23 Activity	222	249	260	259	267	288	265	296	271	257	249	307

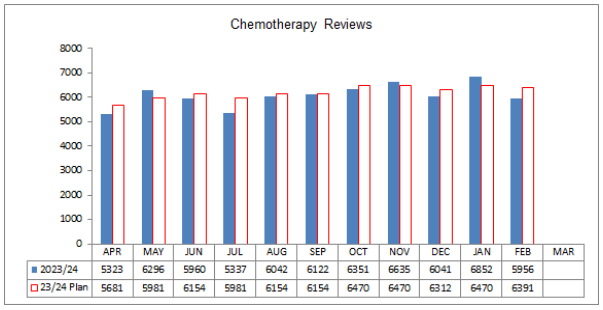
Activity



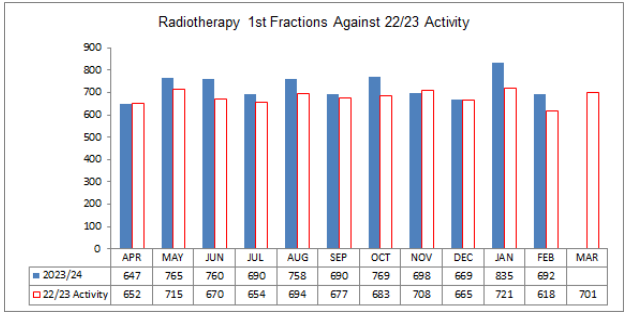
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	727	783	884	818	875	815	848	889	730	976	870	
22/23 Activity	700	778	720	791	815	805	779	898	720	825	775	871



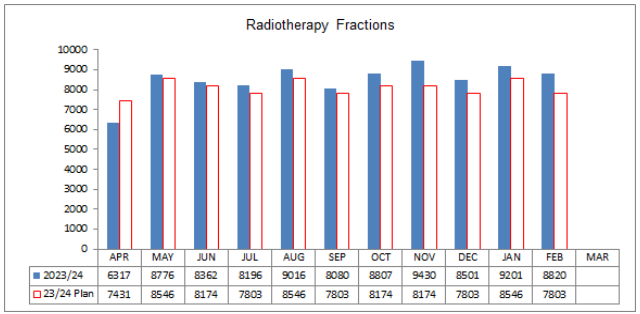
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	7474	8348	8257	7815	8419	7859	8385	8749	7810	8957	7989	
23/24 Plan	7201	7581	7800	7581	7800	7800	8200	8200	8000	8200	8100	



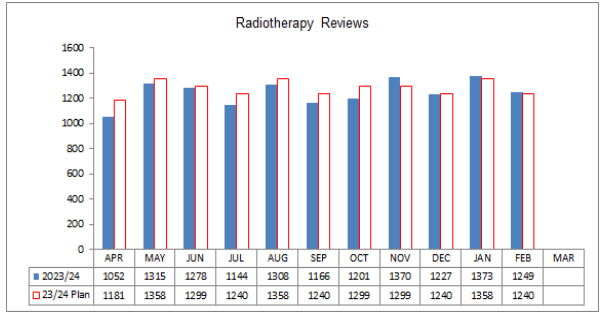
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	5323	6296	5960	5337	6042	6122	6351	6635	6041	6852	5956	
23/24 Plan	5681	5981	6154	5981	6154	6154	6470	6470	6312	6470	6391	



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	647	765	760	690	758	690	769	698	669	835	692	
22/23 Activity	652	715	670	654	694	677	683	708	665	721	618	701



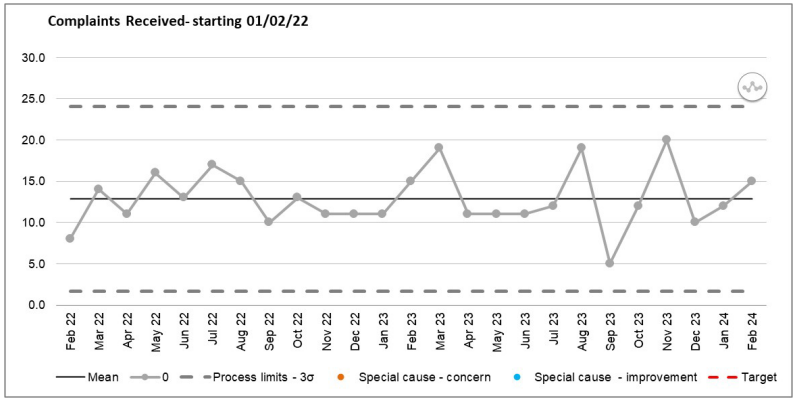
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	6317	8776	8362	8196	9016	8080	8807	9430	8501	9201	8820	
23/24 Plan	7431	8546	8174	7803	8546	7803	8174	8174	7803	8546	7803	

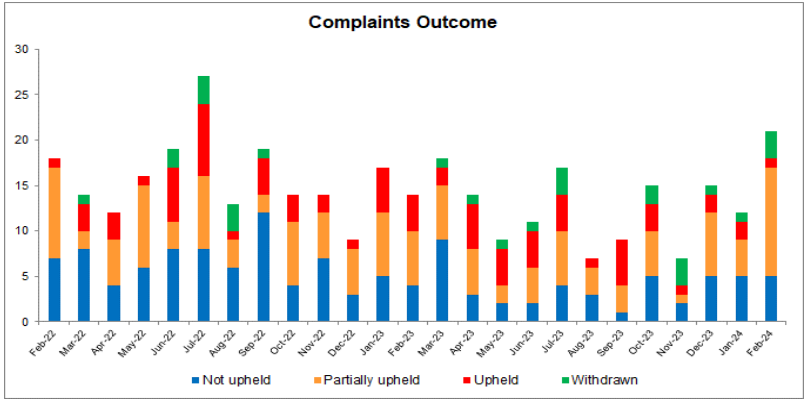


	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	1052	1315	1278	1144	1308	1166	1201	1370	1227	1373	1249	
23/24 Plan	1181	1358	1299	1240	1358	1240	1299	1299	1240	1358	1240	

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

Complaints



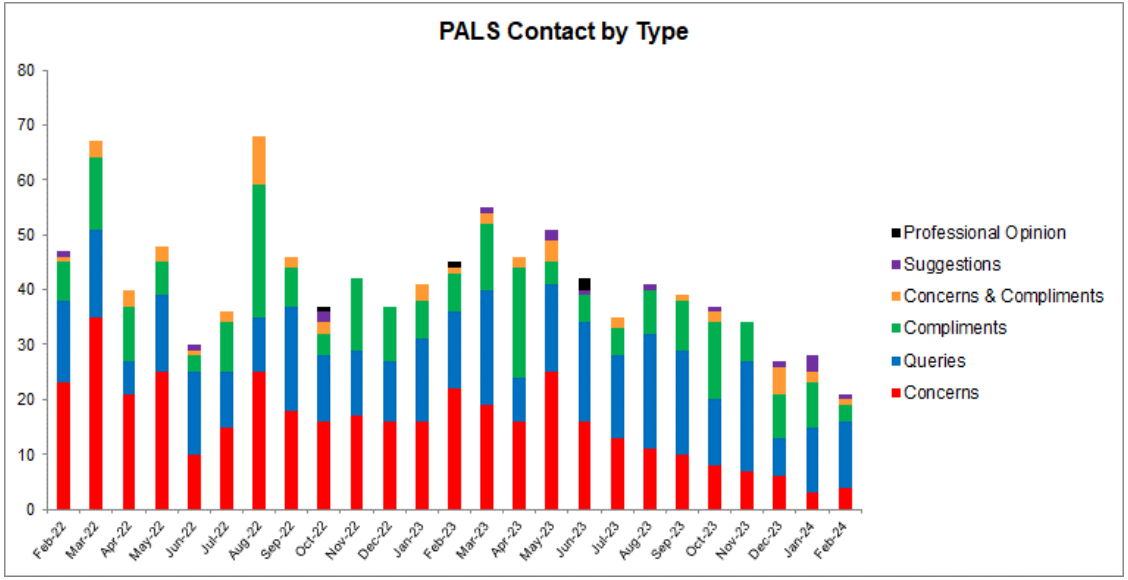


15 new complaints received in February 2023

21 complaints were closed in February 2023

Ombudsman Cases
Complainants have the right to refer their case to the Parliamentary and Health Service Ombudsman (PHSO) if they are not satisfied it has been resolved by the Trust. 0 cases were referred to the PHSO in January 2024. 5 active cases in total with the PHSO.

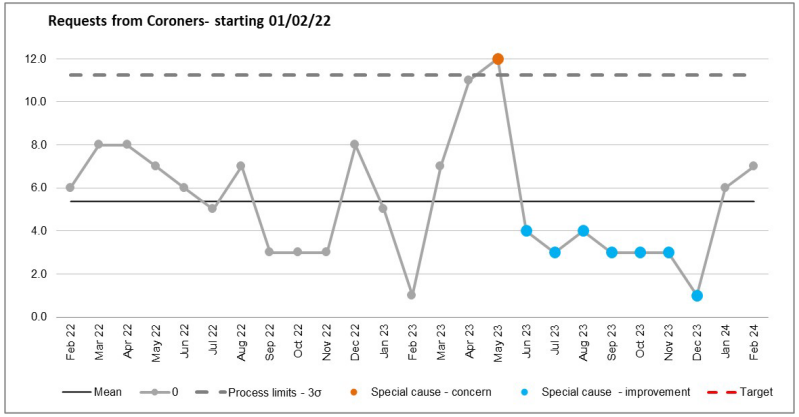
PALS

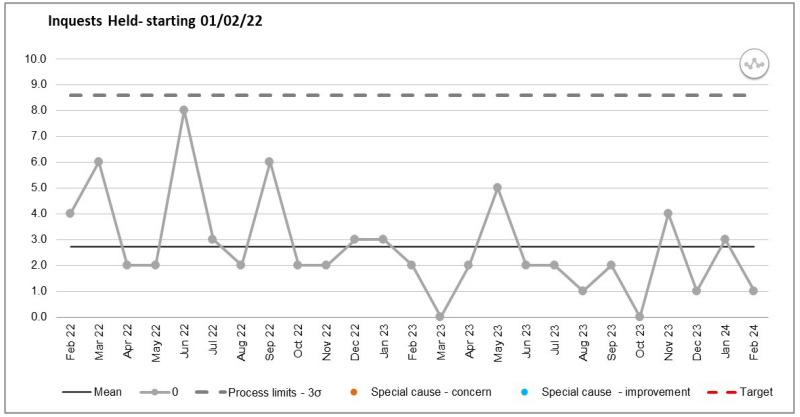


21 PALS contacts have been received in February 2024.

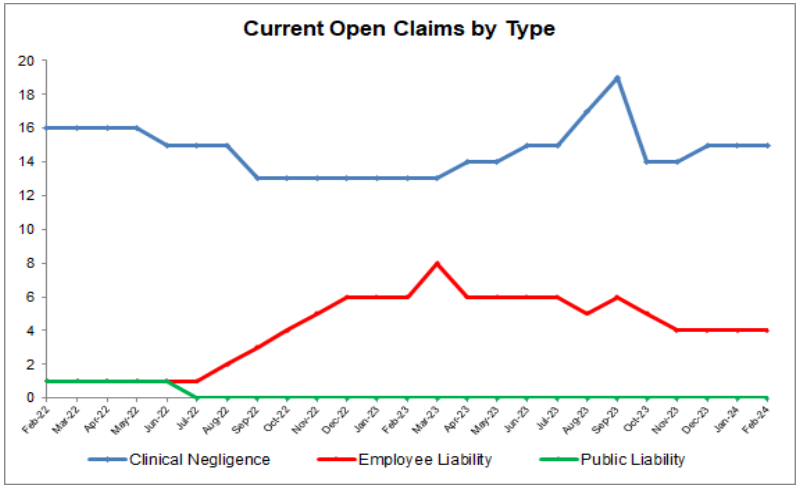
4 of those raised concerns about their experience at The Christie but did not wish to proceed with a formal complaint. The other reasons for contacting PALS are captured in the graph.

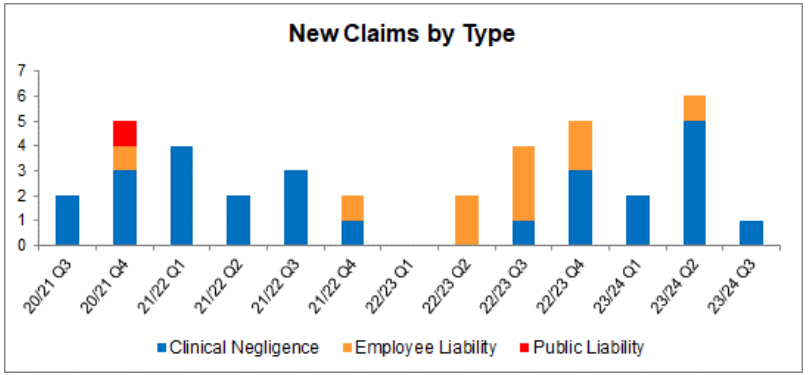
Inquests


Requests from Coroners- starting 01/02/22
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22
Oct 22
Nov 22
Dec 22
Jan 23
Feb 23
Mar 23
Apr 23
May 23
Jun 23
Jul 23
Aug 23
Sep 23
Oct 23
Nov 23
Dec 23
Jan 24
Feb 24
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


Inquests Held- starting 01/02/22
10.0
9.0
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22
Oct 22
Nov 22
Dec 22
Jan 23
Feb 23
Mar 23
Apr 23
May 23
Jun 23
Jul 23
Aug 23
Sep 23
Oct 23
Nov 23
Dec 23
Jan 24
Feb 24
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

Claims





0 new claims received in February 2023.

0 claims closed in February 2023.

Healthcare Associated Infections

NHS
The Christie
NHS Foundation Trust

Curent Month	Community Onset - Indeterminate Acquisition (COIA)	Community Onset - Community Acquired (COCA)	Community Onset - Healthcare Acquired (COHA)	Healthcare Onset - Healthcare Acquired (HOHA)	Lapses in Care	Area(s) Occurred
Clostridium Difficile	2	2	3	2	0	(W4 X2) (PW X1) (AAU X1) (WW X1)
E.coli Bacteraemia		5		4	0	(AAU X1) (PW X1) (W4 X1) (W12 X1)
Klebsiella spp.		2	1	3	0	(AAU X1) (PW X1) (W4 X1) (AACU X1)
Pseudomonas aeruginosa bacteraemia					0	
MSSA Bacteraemia			2		0	(IPU X1) (W4 X1)
MRSA Bacteraemia					0	

YTD	Community Onset - Indeterminate Acquisition (COIA)	Community Onset - Community Acquired (COCA)	Community Onset - Healthcare Acquired (COHA)	Healthcare Onset - Healthcare Acquired (HOHA)	Lapses in Care
Clostridium Difficile	8	14	17	27	0
E.coli Bacteraemia		36	26	31	0
Klebsiella spp.		12	12	13	0
Pseudomonas aeruginosa bacteraemia		6	4	5	0
MSSA Bacteraemia		7	11	11	0
MRSA Bacteraemia		1	2	1	0

Organism	COVID 19 first positive 3 – 7 days from admission (HO-iHA)	COVID 19 first positive 8 – 14 days from admission (HO-pHA)	COVID 19 first positive 15 or more days from admission (HO-dHA)	TOTAL (YTD)	Lapses in care
COVID-19	30	24	20	74	0

Organism	Number of Cases (YTD)	Lapses in care
CPE colonisation / infection	9	0

There were 5 cases of C-Difficile, 4 cases of E-Coli, 4 cases of Klebsiella and 2 cases of MSSA in February that were deemed attributable to the Trust. There were also 3 sperate outbreaks of Covid during February that effected 18 staff and 30 patients. **No lapses in care have been identified.**

Definitions

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

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

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

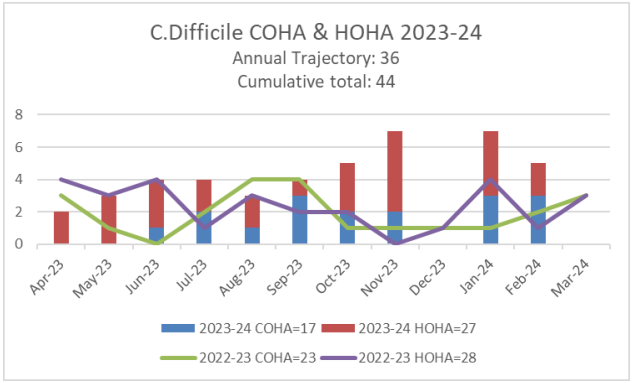
COHA - Symptoms commenced within first two days of admission and inpatient in the past 12 weeks (but not past 4 weeks)

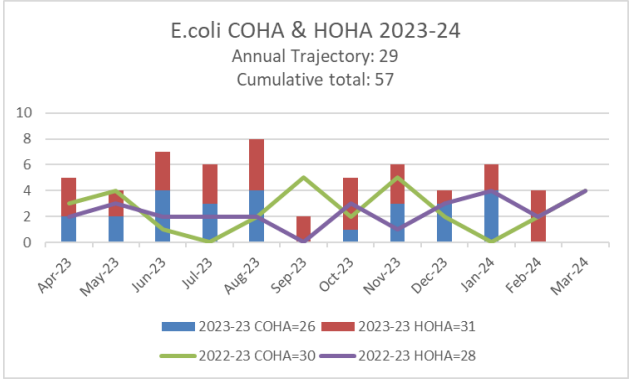
HOHA - Symptoms commenced within first two days of admission (No admission in past 12 weeks)

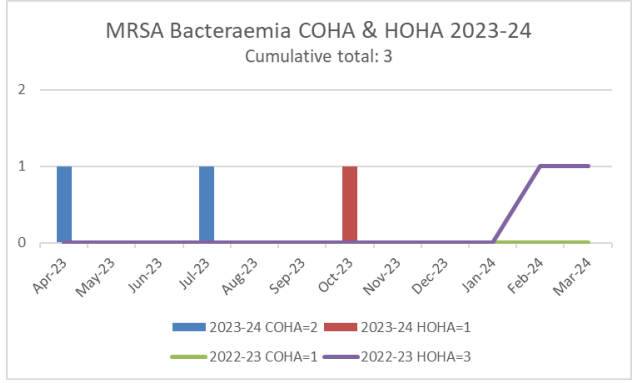
Healthcare Associated Infections

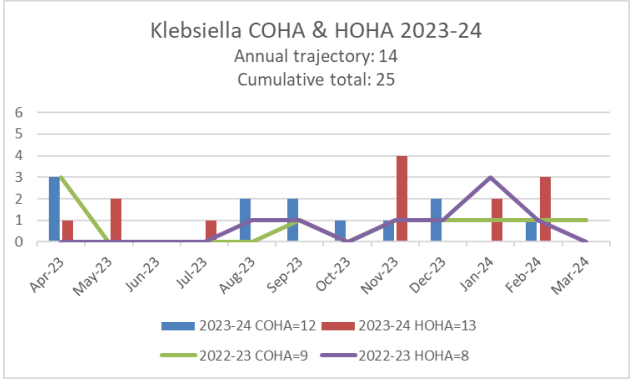
The Christie NHS Foundation Trust

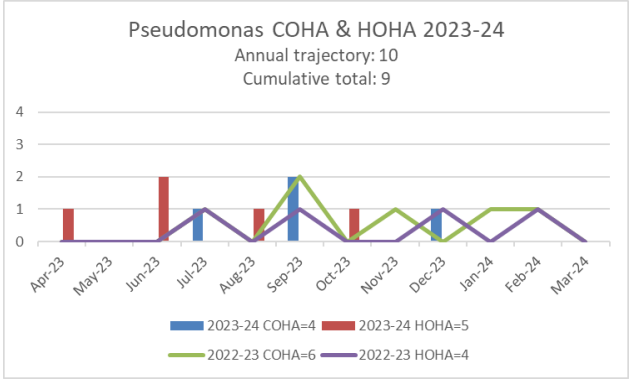
Alert Organisms

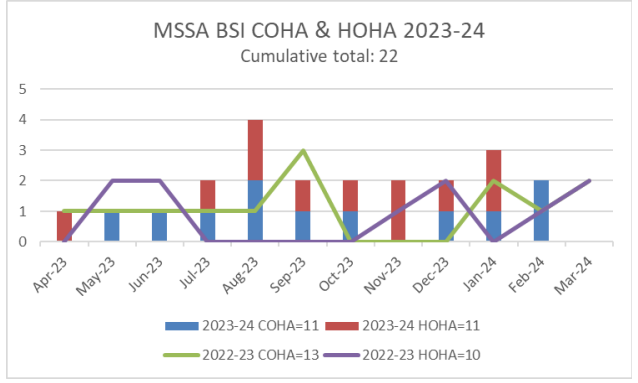








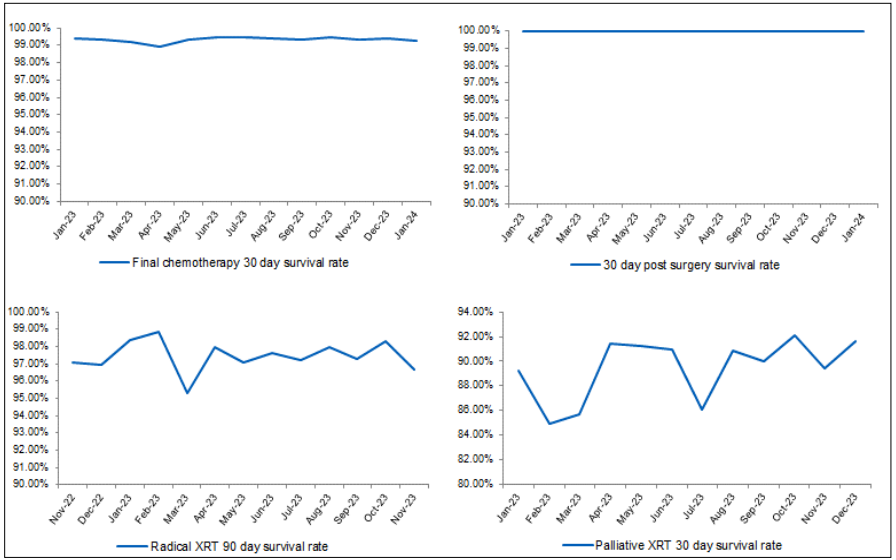




Mortality Indicators & Survival Rates

The Christie NHS Foundation Trust

Survival Rates



Inpatient Deaths – Onsite Deaths

		Feb-24
Number of NHS Christie onsite deaths	Elective/planned admission	6
	Non Elective/emergency admission	22
	TOTAL	**28**
Number of deaths that have triggered Structured Casenote Review (SCR) Note: screening is ongoing so further triggers may be identified	Mortuary screened triggers (including reported to the coroner) - 0	**3**
	Bereaved families raised concern – 0	
	Medical Triggers - 2	
	Nursing Triggers - 1 (inc in family concern)	
	(note there may be more than one trigger)	

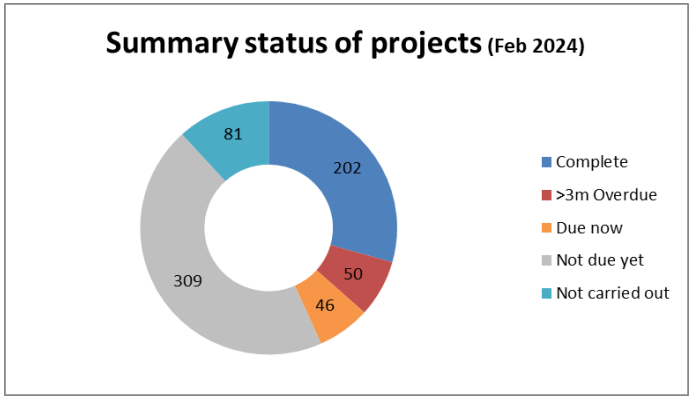
The Christie process for learning from deaths follows the 2017 NHSI guidance. All in-patient deaths are screened and where flagged by one or more triggers an independent structured case note review (SCR) is undertaken. Reviews are discussed by the Mortality Surveillance Group and the findings and actions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

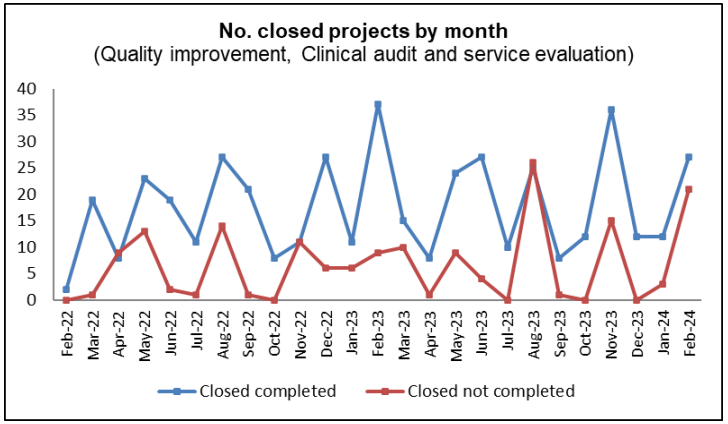
Quality Improvement & Clinical Audit

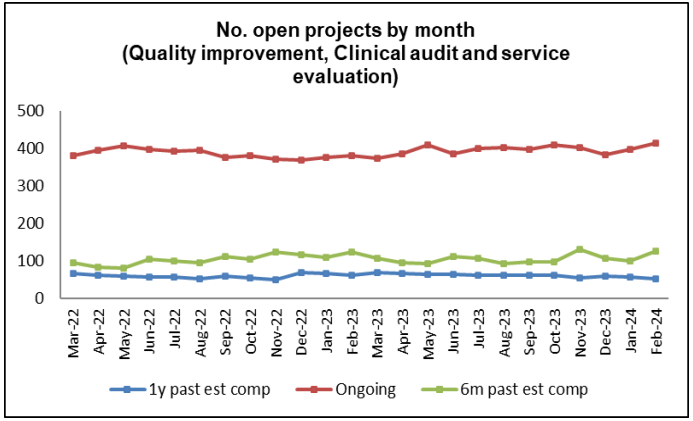
The Christie NHS Foundation Trust

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

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

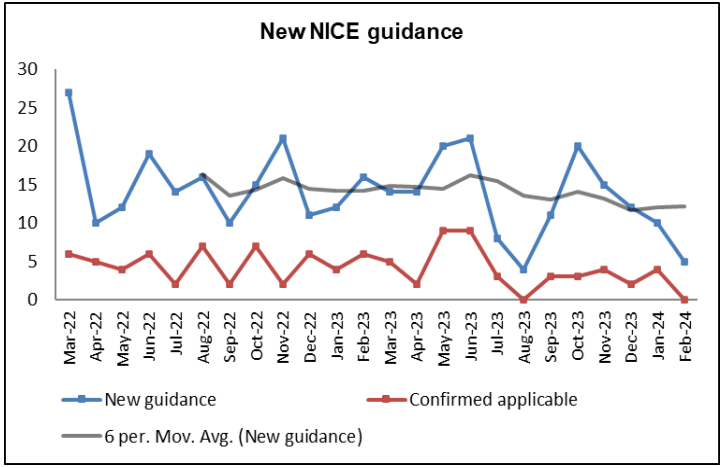


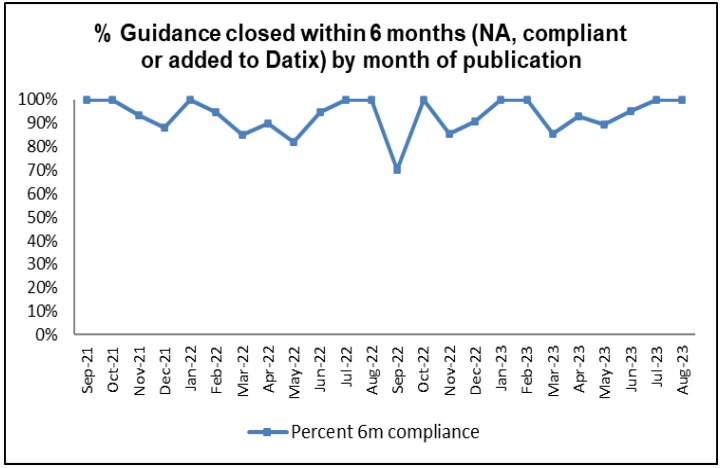




180

NICE Guidance





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

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

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

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

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

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HR Metrics Sickness

The Christie NHS Foundation Trust

Last updated: 11/03/2024

Performance | Absence

Monthly Sickness %	Yearly Sickness %	Absences Ended	Long Term	Short Term
4.56%	4.45%	528	40	488

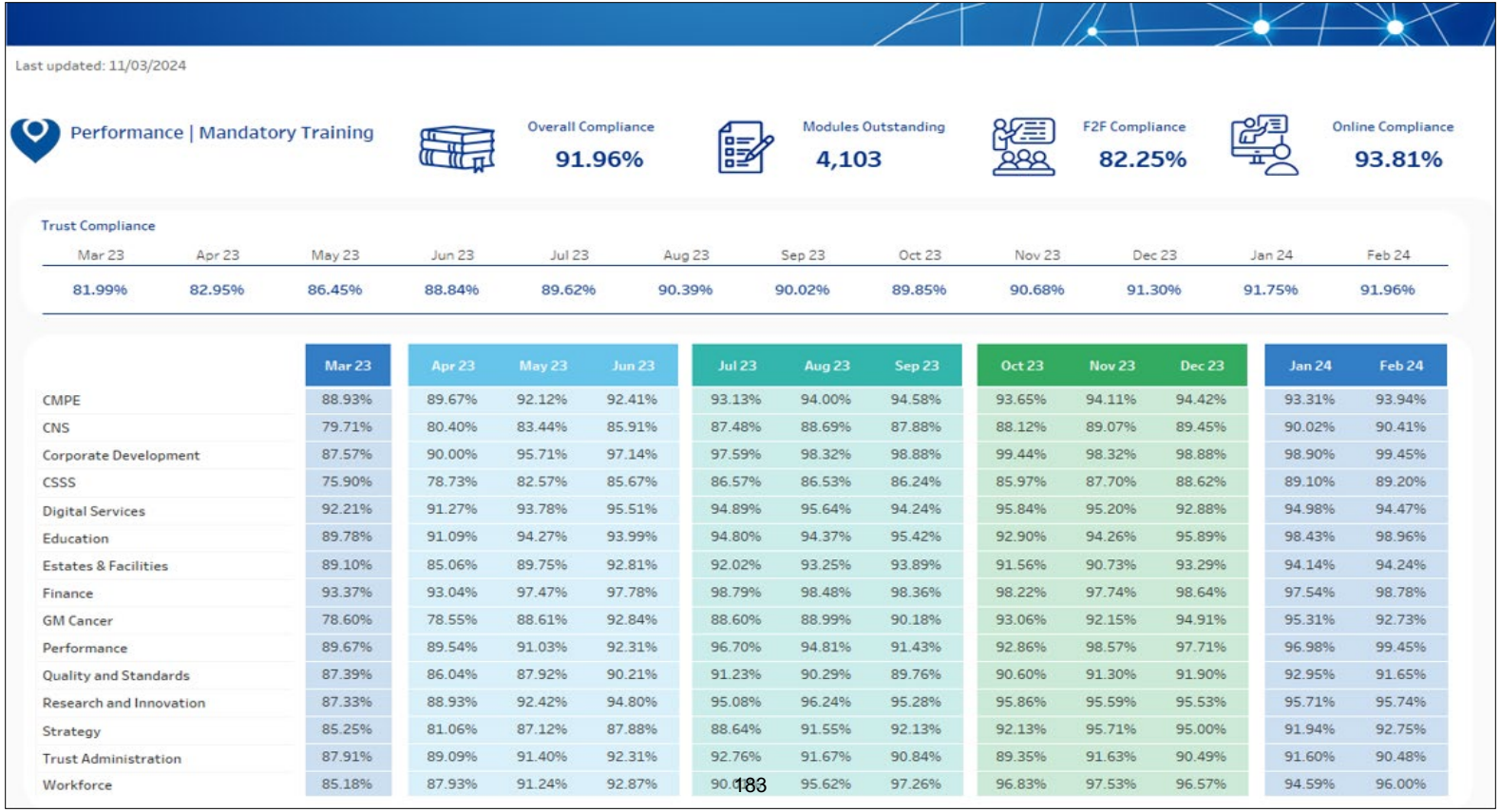
Trust Overview

Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24
4.52%	4.02%	3.77%	3.88%	4.34%	4.44%	4.74%	4.90%	4.59%	4.49%	5.04%	4.56%

	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24
CMPE	2.30%	1.60%	1.33%	2.94%	3.41%	3.63%	3.47%	3.24%	3.89%	2.71%	3.55%	2.92%
CNS	4.61%	3.82%	3.49%	3.84%	4.71%	4.57%	4.53%	5.40%	4.46%	4.43%	5.08%	4.90%
Corporate Development	0.31%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.80%	0.00%	0.66%	0.00%	0.00%
CSSS	5.07%	4.70%	4.97%	4.63%	4.61%	5.07%	5.95%	6.16%	5.33%	5.81%	6.43%	5.64%
Digital Services	1.66%	1.96%	3.11%	1.26%	1.65%	3.51%	3.84%	1.39%	1.51%	1.91%	2.75%	1.83%
Education	1.46%	1.75%	0.85%	0.72%	0.32%	0.62%	2.27%	2.98%	4.27%	2.34%	3.88%	1.81%
Estates & Facilities	9.94%	8.47%	5.55%	5.96%	7.76%	7.38%	7.27%	6.77%	7.63%	6.55%	6.48%	5.12%
Finance	3.62%	3.15%	3.19%	2.50%	2.06%	1.26%	1.75%	2.29%	2.27%	2.40%	1.05%	2.30%
GM Cancer	0.00%	0.35%	1.02%	0.19%	0.73%	0.12%	0.54%	0.29%	2.23%	0.00%	1.76%	1.95%
Performance	7.10%	6.91%	8.84%	8.85%	9.24%	8.46%	2.67%	3.42%	6.91%	10.66%	4.98%	6.06%
Quality and Standards	6.03%	4.03%	5.43%	6.87%	5.76%	9.06%	11.93%	9.97%	9.79%	7.17%	6.06%	4.25%
Research and Innovation	3.84%	3.73%	3.55%	3.37%	3.39%	3.37%	3.59%	3.26%	3.07%	3.15%	3.95%	4.33%
Strategy	0.00%	2.33%	0.00%	0.00%	0.00%	0.45%	1.21%	0.00%	0.00%	0.00%	1.15%	0.00%
Trust Administration	5.85%	6.21%	6.21%	6.21%	6.23%	5.87%	5.83%	5.51%	5.51%	5.51%	5.76%	5.76%
Workforce	1.69%	0.57%	0.50%	2.27%	3.46%	1.72%	2.42%	1.31%	3.22%	4.97%	5.49%	3.55%

HR Metrics – Mandatory Training

NHS
The Christie
NHS Foundation Trust



Last updated: 11/03/2024

Performance | Mandatory Training

Overall Compliance
91.96%

Modules Outstanding
4,103

F2F Compliance
82.25%

Online Compliance
93.81%

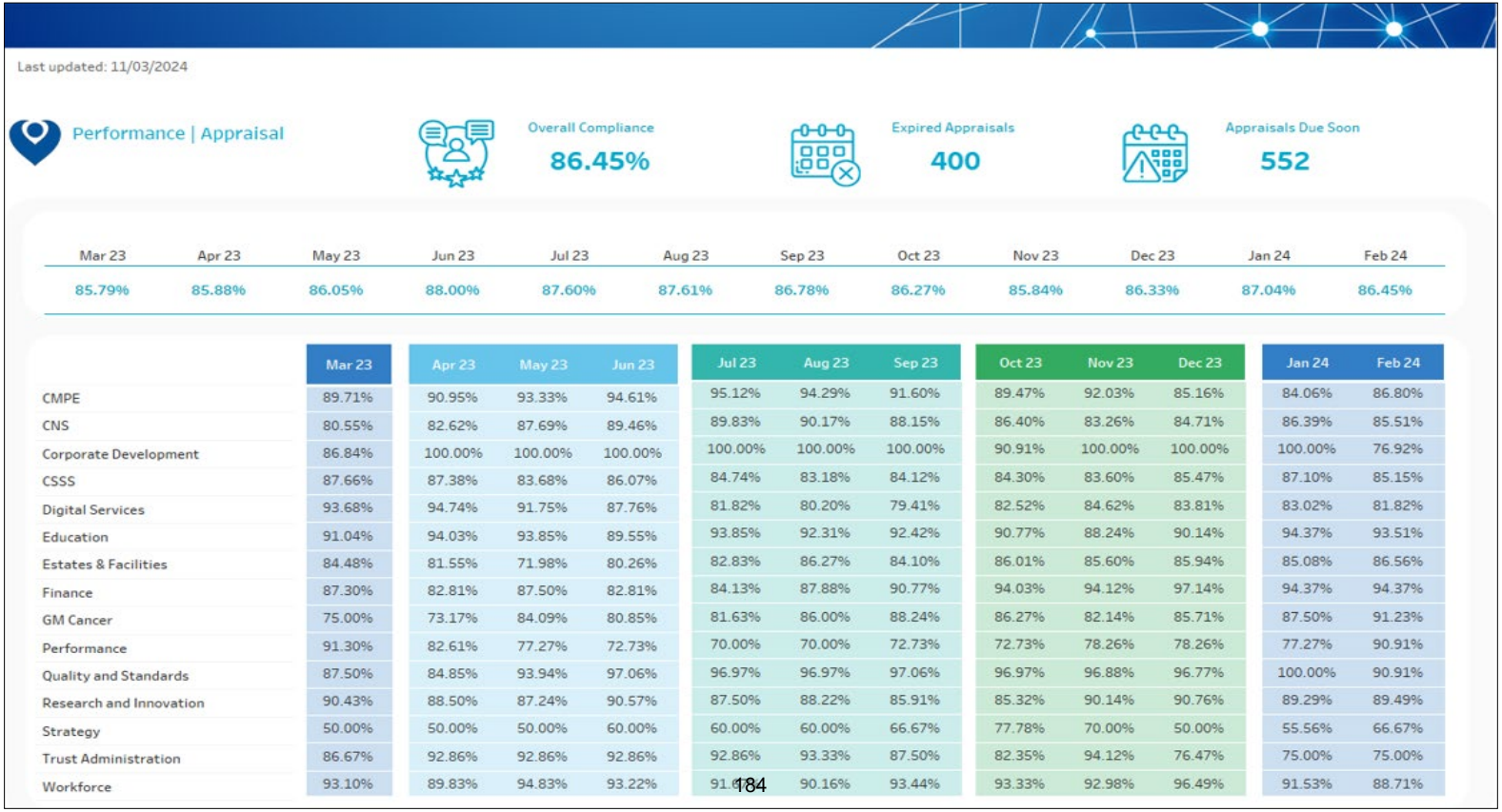
Trust Compliance

Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24
81.99%	82.95%	86.45%	88.84%	89.62%	90.39%	90.02%	89.85%	90.68%	91.30%	91.75%	91.96%

	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24
CMPE	88.93%	89.67%	92.12%	92.41%	93.13%	94.00%	94.58%	93.65%	94.11%	94.42%	93.31%	93.94%
CNS	79.71%	80.40%	83.44%	85.91%	87.48%	88.69%	87.88%	88.12%	89.07%	89.45%	90.02%	90.41%
Corporate Development	87.57%	90.00%	95.71%	97.14%	97.59%	98.32%	98.88%	99.44%	98.32%	98.88%	98.90%	99.45%
CSSS	75.90%	78.73%	82.57%	85.67%	86.57%	86.53%	86.24%	85.97%	87.70%	88.62%	89.10%	89.20%
Digital Services	92.21%	91.27%	93.78%	95.51%	94.89%	95.64%	94.24%	95.84%	95.20%	92.88%	94.98%	94.47%
Education	89.78%	91.09%	94.27%	93.99%	94.80%	94.37%	95.42%	92.90%	94.26%	95.89%	98.43%	98.96%
Estates & Facilities	89.10%	85.06%	89.75%	92.81%	92.02%	93.25%	93.89%	91.56%	90.73%	93.29%	94.14%	94.24%
Finance	93.37%	93.04%	97.47%	97.78%	98.79%	98.48%	98.36%	98.22%	97.74%	98.64%	97.54%	98.78%
GM Cancer	78.60%	78.55%	88.61%	92.84%	88.60%	88.99%	90.18%	93.06%	92.15%	94.91%	95.31%	92.73%
Performance	89.67%	89.54%	91.03%	92.31%	96.70%	94.81%	91.43%	92.86%	98.57%	97.71%	96.98%	99.45%
Quality and Standards	87.39%	86.04%	87.92%	90.21%	91.23%	90.29%	89.76%	90.60%	91.30%	91.90%	92.95%	91.65%
Research and Innovation	87.33%	88.93%	92.42%	94.80%	95.08%	96.24%	95.28%	95.86%	95.59%	95.53%	95.71%	95.74%
Strategy	85.25%	81.06%	87.12%	87.88%	88.64%	91.55%	92.13%	92.13%	95.71%	95.00%	91.94%	92.75%
Trust Administration	87.91%	89.09%	91.40%	92.31%	92.76%	91.67%	90.84%	89.35%	91.63%	90.49%	91.60%	90.48%
Workforce	85.18%	87.93%	91.24%	92.87%	90.1	95.62%	97.26%	96.83%	97.53%	96.57%	94.59%	96.00%

HR Metrics - PDR

The Christie NHS Foundation Trust



Last updated: 11/03/2024

Performance | Appraisal

Overall Compliance **86.45%**

Expired Appraisals **400**

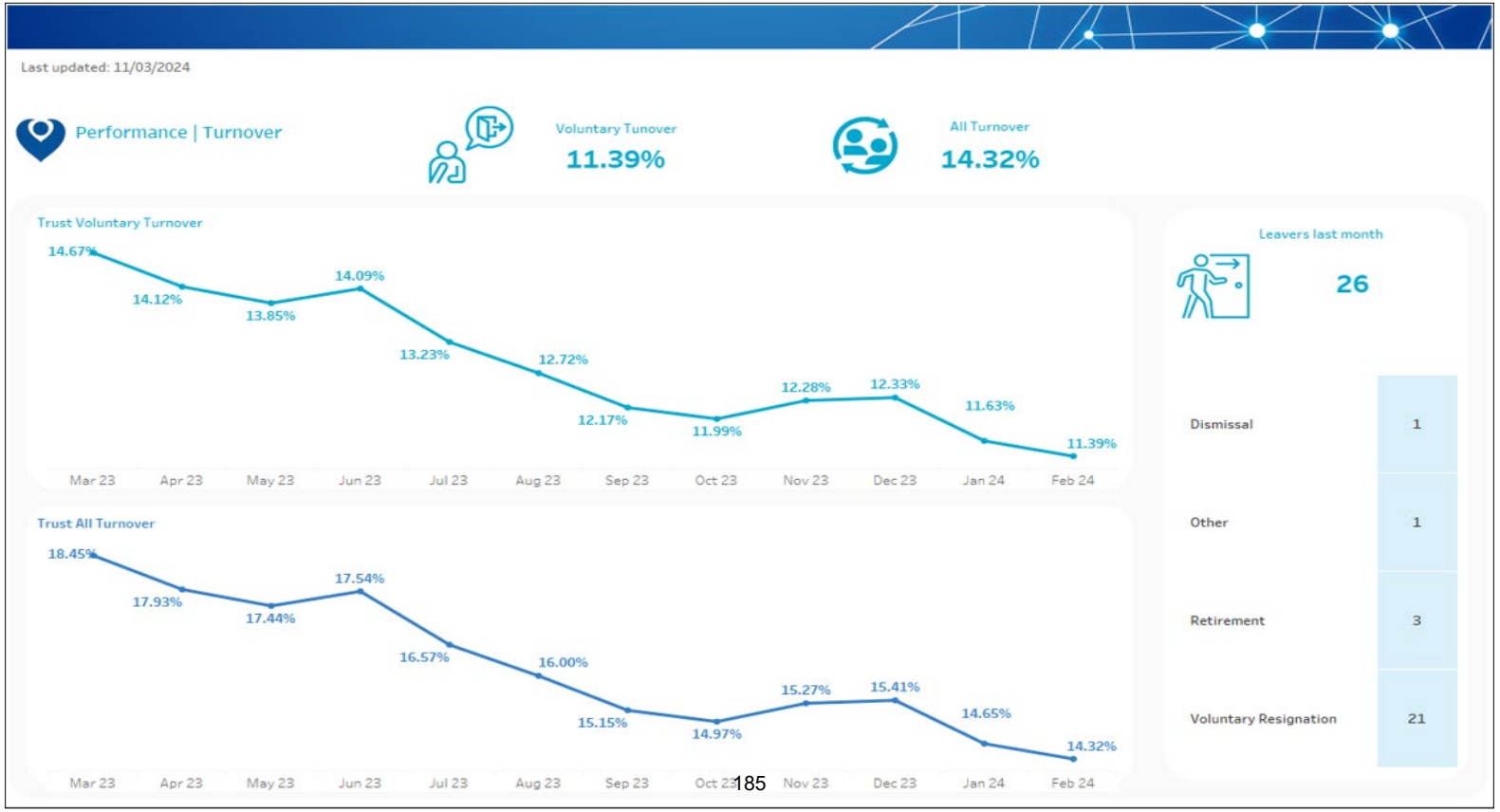
Appraisals Due Soon **552**

Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24
85.79%	85.88%	86.05%	88.00%	87.60%	87.61%	86.78%	86.27%	85.84%	86.33%	87.04%	86.45%

	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24
CMPE	89.71%	90.95%	93.33%	94.61%	95.12%	94.29%	91.60%	89.47%	92.03%	85.16%	84.06%	86.80%
CNS	80.55%	82.62%	87.69%	89.46%	89.83%	90.17%	88.15%	86.40%	83.26%	84.71%	86.39%	85.51%
Corporate Development	86.84%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	90.91%	100.00%	100.00%	100.00%	76.92%
CSSS	87.66%	87.38%	83.68%	86.07%	84.74%	83.18%	84.12%	84.30%	83.60%	85.47%	87.10%	85.15%
Digital Services	93.68%	94.74%	91.75%	87.76%	81.82%	80.20%	79.41%	82.52%	84.62%	83.81%	83.02%	81.82%
Education	91.04%	94.03%	93.85%	89.55%	93.85%	92.31%	92.42%	90.77%	88.24%	90.14%	94.37%	93.51%
Estates & Facilities	84.48%	81.55%	71.98%	80.26%	82.83%	86.27%	84.10%	86.01%	85.60%	85.94%	85.08%	86.56%
Finance	87.30%	82.81%	87.50%	82.81%	84.13%	87.88%	90.77%	94.03%	94.12%	97.14%	94.37%	94.37%
GM Cancer	75.00%	73.17%	84.09%	80.85%	81.63%	86.00%	88.24%	86.27%	82.14%	85.71%	87.50%	91.23%
Performance	91.30%	82.61%	77.27%	72.73%	70.00%	70.00%	72.73%	72.73%	78.26%	78.26%	77.27%	90.91%
Quality and Standards	87.50%	84.85%	93.94%	97.06%	96.97%	96.97%	97.06%	96.97%	96.88%	96.77%	100.00%	90.91%
Research and Innovation	90.43%	88.50%	87.24%	90.57%	87.50%	88.22%	85.91%	85.32%	90.14%	90.76%	89.29%	89.49%
Strategy	50.00%	50.00%	50.00%	60.00%	60.00%	60.00%	66.67%	77.78%	70.00%	50.00%	55.56%	66.67%
Trust Administration	86.67%	92.86%	92.86%	92.86%	92.86%	93.33%	87.50%	82.35%	94.12%	76.47%	75.00%	75.00%
Workforce	93.10%	89.83%	94.83%	93.22%	91.[illegible]	90.16%	93.44%	93.33%	92.98%	96.49%	91.53%	88.71%

Workforce Metrics - Turnover

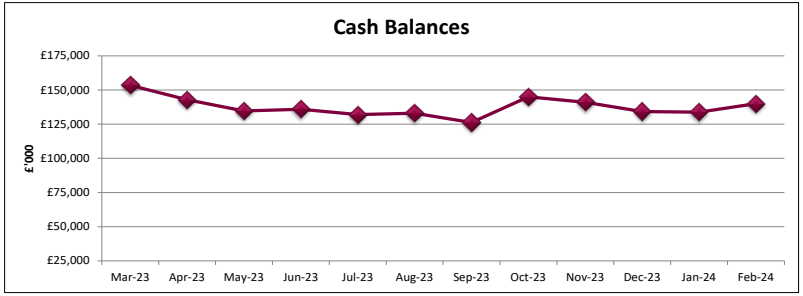
The Christie NHS Foundation Trust



Finance (Executive Summary)

NHS
The Christie
NHS Foundation Trust

Month 11 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(373,973)	(342,824)	(366,894)	(24,070)
Other Income	(68,922)	(63,169)	(58,087)	5,083
Pay	212,392	194,673	186,438	(8,235)
Non Pay (incl drugs)	218,455	200,276	217,309	17,033
Operating (Surplus) / Deficit	**(12,048)**	**(11,044)**	**(21,234)**	**(10,190)**
Finance expenses/ income	28,723	26,330	21,723	(4,607)
(Surplus) / Deficit	**16,675**	**15,285**	**489**	**(14,797)**
Exclude impairments/ charitably funded capital donations	(8,637)	(7,918)	(5,772)	2,145
Adjusted financial performance (Surplus) / Deficit	**8,038**	**7,368**	**(5,284)**	**(12,652)**



This report outlines the month 11 consolidated financial performance of The Christie NHS Foundation Trust and its wholly owned subsidiary The Christie Pharmacy Ltd.

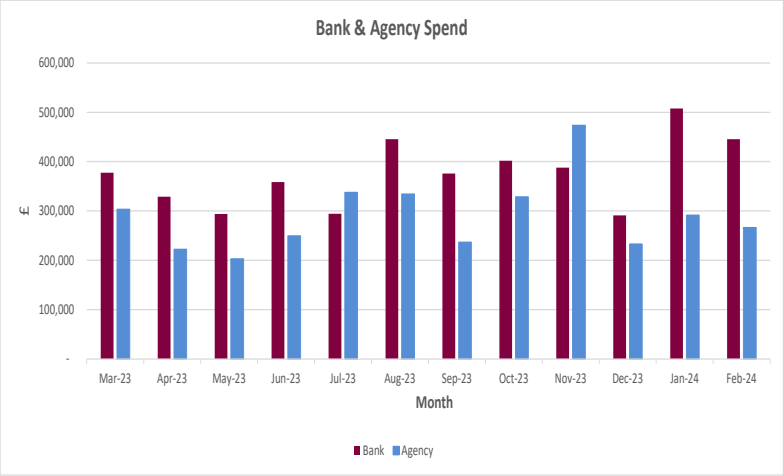
I&E

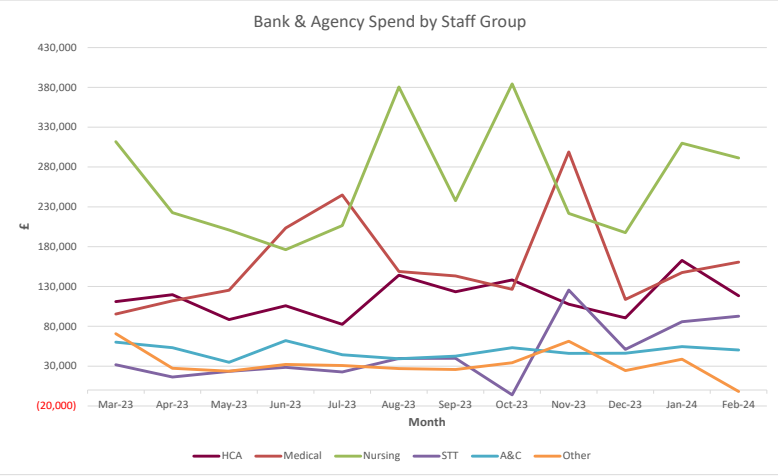
- The Trust is reporting a year-to-date surplus of (£5,284k) against a year to date plan of £7,368k, which gives a positive year to date variance of (£12,652k).
- The month 11 position is a surplus of £1,576k against a deficit in month plan of £670k which gives a positive in month variance of £2,246k.
- 2023-24 CIP – Identified in year CIP is £12.5m (£10.5m non recurrent / £2m recurrent).

Balance sheet / liquidity

- The cash balance is £139,966k.
- Capital expenditure is under CDEL original plan by £4,883k.
- Targets have been achieved against payment of our NHS creditors paid within the 30 day Better Payment Practice Code target.

Finance (Expenditure)

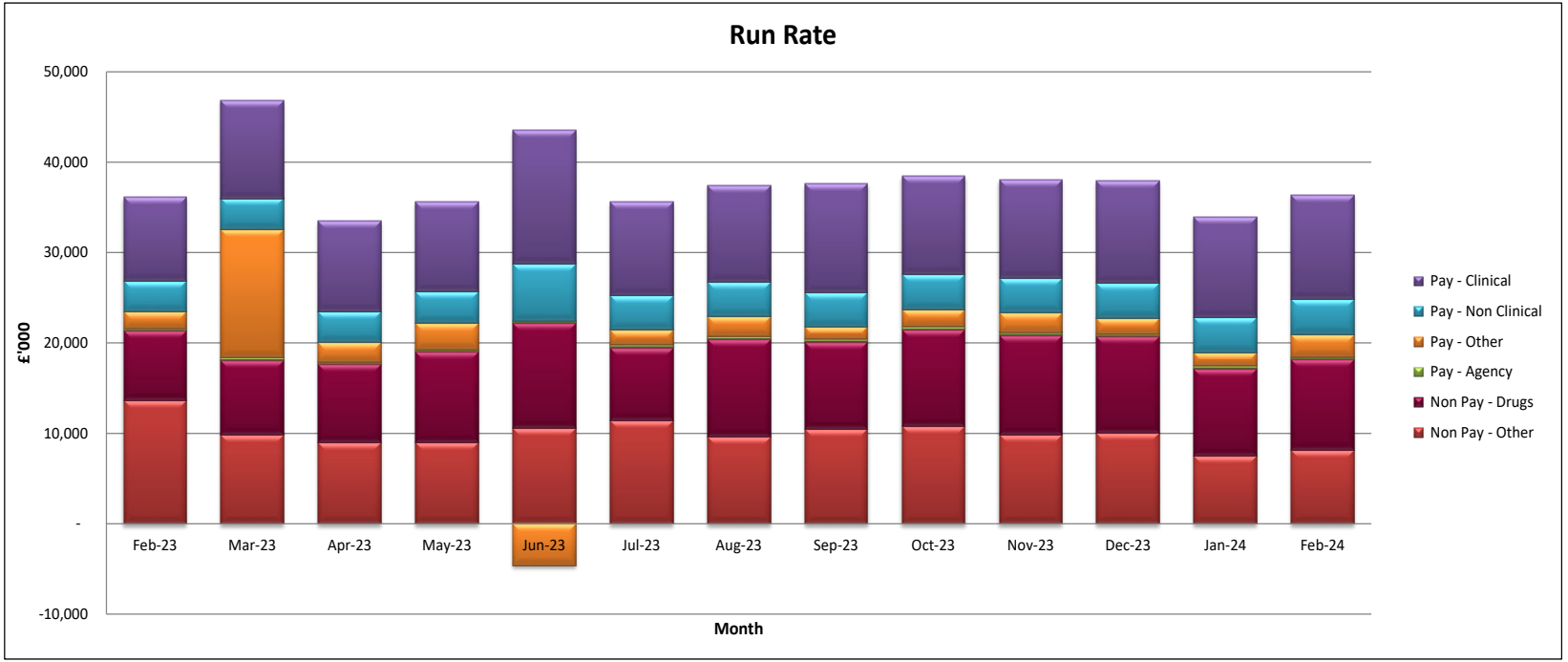




The agency spend is £266k in month 11, a decrease of £25k from month 10. This is mainly due to a decrease on scientific, technical, and therapeutic agency spend within CSSS and Network Services.

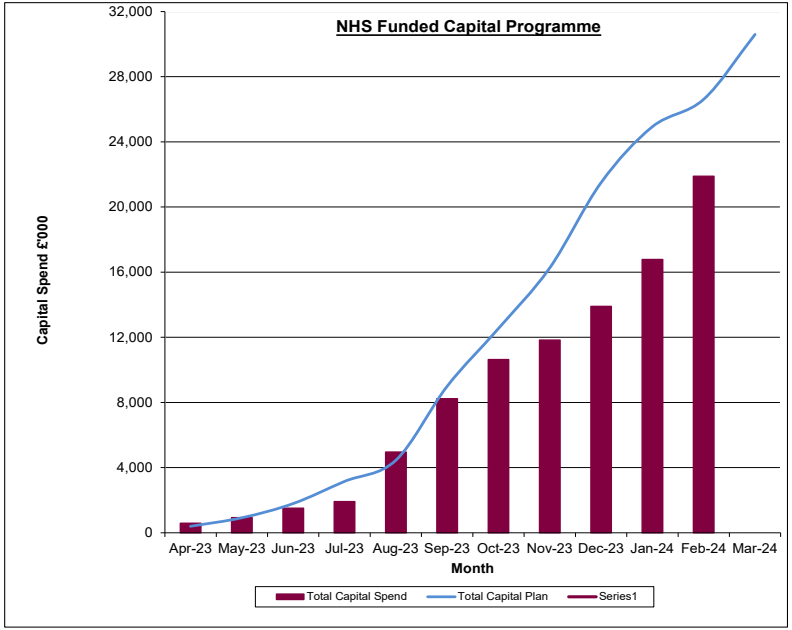
Alongside this, bank usage has decreased by £62k in month compared to month 10, largely driven by lower spend on Nursing and HCA bank, and a year-to-date recharge for Charity Contribution bank pay.

5.2 - Finance (Expenditure)



- Drugs spend in month 11 is £9,999k, an increase from month 10 of £352k.
- Pay – Agency spend in month 11 is £266k a decrease of £25k from month 10.
- Pay – Clinical spend in month 11 is £3,944.
- Key elements of 'Non Pay Other' spend consist of clinical supplies and services, premises and infrastructure costs.

Finance (Capital)

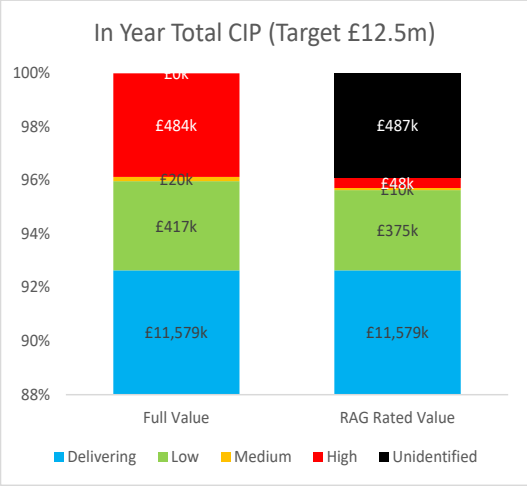


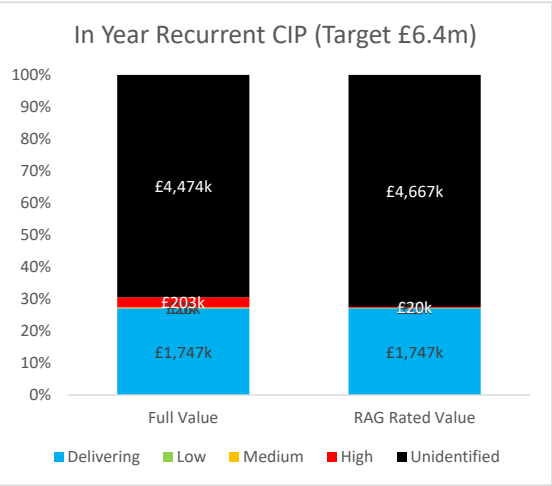
	Original Plan	Revision	Revised plan/ forecast		Year to date- original plan	Year to date - actual	Year to date - variance
	Apr-23 £k	£k	o/s £k		£k	£k	£k
Annual depreciation charge 2023-24	**21,370**	**1,630**	**23,000**		**19,589**	**21,085**	**(1,496)**
GM capital plan control total - Trust own cash	**19,820**	**2,592**	**22,412**		**15,847**	**12,854**	**2,993**
PDC capital funded schemes	**10,083**	**525**	**10,608**		**10,075**	**8,871**	**1,204**
Loan and lease funded schemes	**686**	**(686)**	**0**		**686**	**0**	**686**
Total annual capital programme under CDEL	**30,589**	**2,431**	**33,020**		**26,608**	**21,725**	**4,883**
ASIC development	**0**	**0**	**0**		**0**	**0**	**0**
Art room refurbishment	**0**	**163**	**163**		**0**	**163**	**(163)**
Charity funded programme	**0**	**163**	**163**		**0**	**163**	**(163)**
Total Trust Annual Capital Programme	**30,589**	**2,594**	**33,183**		**26,608**	**21,888**	**4,720**

Performance to month 11 was £4,883k below the original plan submitted to NHSE&I in April 23. Whilst there is slippage on some schemes including the TIF Ward, other projects are ahead of plan.
The Trust has incurred £21,725k on capital schemes to month 11, primarily on the backlog maintenance programme, the linear accelerators and CT scanner replacements, Digital Services Electronic Health Records projects, final works on the Paterson scheme, the Proton treatment planning system and the TIF ward refurbishment. This includes £163k capital expenditure on the charity funded Art Room refurbishment.

All Providers within GM agreed to reduce annual capital spend against original plans by a proportionate amount as the original GM ICS plan was oversubscribed. The impact of this was a £3.6m reduction to original forecast planned capital spend for the Christie however this is now offset by an additional £5m increase to our plan agreed with GM following an additional transfer of capital envelope from Cheshire & Merseyside ICB.

Finance (CIP)





Total In year CIP

- Total identified CIP schemes reported are £12.5m (£10.5m non recurrent / £2m recurrent).
- Risk adjusted identified schemes value £12m leaving £487k unidentified.

Recurrent

- Schemes totalling £2m have been identified recurrently against a recurrent target of £6.4m.
- This leaves £4.5m of the recurrent target unidentified, this increases to £4.7m when risk adjusted.

	Annual					Year to Date		
	Target	Identified value	Unidentified Value	Identified RAG Value	Unidentified RAG Value	Target	Delivered	Unidentified
Total CIP	**£12,500k**	**£12,500k**	**(£0k)**	£12,013k	(£487k)	**£11,462k**	**£11,467k**	**£6k**
Recurrent CIP	£6,445k	£1,970k	(£4,474k)	£1,777k	(£4,667k)	£5,909k	£1,635k	(£4,274k)
Non-Recurrent CIP	£6,055k	£10,529k	£4,474k	£10,235k	£4,180k	£5,552k	£9,832k	£4,280k