The Christie
NHS Foundation Trust

Board of Directors meeting
Thursday 28th September 2023 at 12.45 pm
Paterson Research Building

Agenda

Clinical presentation: Dr Maria Serra, Consultant Clinical Oncologist – Brachytherapy patient pathway

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26/23	**Standard business**				
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27/23	**Board assurance**				
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28/23	**Key Reports**				
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b	Care Quality Commission (CQC) action plan update	*		ECN	127
c	CQC Adult Inpatient survey results	*		ECN	134
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f	Integrated Care System mandated support	*		EDoF	157
29/23	**Approvals**				
a	Revised Standing Financial Instructions (SFIs)	*		EDoF	167
b	Trust proposal of nomination of FT Trustee to Christie Charity Board	*		CEO	236
30/23	**Any other business**			Chair	

Date and time of the next meeting
Thursday 26th October 2023 at 12:45pm

CEO	Chief Executive Officer	*	paper attached
COO	Chief Operating Officer	v	verbal
EDoF	Executive Director of Finance	p	presentation
ECN	Executive Chief Nurse	#	separate pack

The Christie
NHS Foundation Trust

Public meeting of the Board of Directors
Thursday 29th June 2023 at 12.45 pm
Seminar Room 4 & 5, Education Centre

Present: Chair: Chris Outram (CO), Chairman
Roger Spencer (RS), Chief Executive Officer
Dr Jane Maher (JM), Non-Executive Director
Robert Ainsworth (RA), Non-Executive Director
Alveena Malik (AM), Non-Executive Director
Tarun Kapur (TK), Non-Executive Director
Grenville Page (GP), Non-Executive Director
Prof Kieran Walshe (KW), Non-Executive Director
Prof Chris Harrison (CJH), Deputy CEO
Bernie Delahoyde (BD), Chief Operating Officer
Prof Janelle Yorke (JY), Executive Chief Nurse
Dr Neil Bayman (NB), Executive Medical Director
Sally Parkinson (SP), Interim Executive Director of Finance
Prof Fiona Blackhall (FB), Director of Research
Eve Lightfoot (EL), Director of Workforce
John Wareing, Director of Strategy
Prof Richard Fuller, Director of Education

Minutes: Louise Westcott, Company Secretary

In attendance: Jo D'Arcy, Assistant Company Secretary
Mr Chelliah Selvasekar, Clinical Director Surgery
Jeanette Livings, Director of Comms & Marketing

David Fitzgerald, Director – Policy and Strategy, NHS Cancer Programme, NHS England

CO introduced DF.

DF noted that the team set NHS wide policy, strategy & operational performance for the cancer standards. He noted that the Christie are always at the forefront of policy changes such as the targeted lung health checks. Stage of diagnosis and health inequality position have significantly improved because of this work. In terms of the national early diagnosis position, data has flatlined currently, and the aim is to improve this by 20 percentage points. He noted the development and imminent implementation of a very ambitious policy around this that RS is involved in. It is working and the data set show us that stage of diagnosis is improving. There's a long way to go but it's a good start, and signs are promising.

CO thanked DF and noted that we are always looking to improve.

JY asked about the National Cancer Research Institute (NCRI) closing down and wondered what will replace it. DF noted that this is a charity, and it was their trustees who decided to wind down. The national team are looking at this but there's no solution yet. Options are being assessed.

GP asked about cancer targets and specialist commissioning coming into the ICS footprint at a time where resources are tight. DF noted that cancer will continue to be a political priority heading to the general election. The shift to ICBs is important for the NHS and is about greater accountability to the communities it serves. The size of ICBs differs so Cancer Alliances have been set up, as ICBs assume their specialised commissioning responsibilities they will look to the cancer alliances for guidance in decision making.

KW wondered about the workforce plan. DF responded that there has been a long wait for this and there will be detail on cancer to follow this plan.

CH noted that work has been going on for some time around lung health checks and local piloting that has captured the imagination of the national team. CH asked if the consistency of roll out is the most important thing in having the impact. DF replied that there's a need for local uptake as well as national roll out. There are many examples of this and the funding relationship with cancer alliances helps to push these early diagnosis priorities. Fair share funding is also being pushed out – a pot of £250m for all cancer alliances

Clinical presentation: Bloods closer to home / Homecare, Claire Adams, Head of SACT services, Crawford Meek, Senior Charge Nurse, Gemma Jones, Matron for Chemotherapy Services and Hollie Cowley, Deputy Service Manager, Chemotherapy Services.

CA noted that there are 7 outreach sites plus Christie @ Macclesfield as well as 10 bloods closer to home sites – 6 hospices, 1 health & wellbeing centre, 1 medical practice a Macmillan unit and a Christie @ site. 89000 treatments were delivered last year, expect to deliver well over 90000 this year.

We have doubled the number of bloods we do locally. The sites are regularly reviewed, and we change the landscape based on where the patients are. Anyone who has an outpatient appointment can book online to have them done locally.

Outreach was outlined. In 2021 we opened Macclesfield plus 7 other outreach sites across GM. Many are run in hospices and are nurse led. Treatments are assessed so they can be delivered safely. This saves a huge amount of travel for patients.

The Christie at Home service was described which has delivered 32,000 treatments since 2016. Lead by the charge nurse, the team of 14 nurses and 2 admin treat an average of 660 patients a month, with 7842 patients treated in 2022/23.

Natalie O'Hara, sister in chemotherapy outreach based in New Mills joined the meeting from the service that is set up in a GP surgery and covers a lot of the Peak District. These patients live a big distance from the main Christie site. Patients come for bloods on a Tuesday then treatment on a Thursday. A band 6 & a band 5 run the service.

A patient agreed to speak to the meeting. Dean Stafford joined to speak to Board. Dean is having his treatment at New Mills today. He originally had treatments at the main site and then was told he could have his treatment at New Mills. He said it is much easier to have treatment this way. CO asked if there is any downside. He said that he only sees plus's and no downside. He actively promotes it, one thing that is missing is advertising it to patients. The Trust should publicise the service as it's fantastic. Christie at Home is advertised but not local treatment in the community. He said that the service is brilliant.

CH asked about telephone consultations. Dean responded that he has no problem with them and doesn't get put off by not being face to face. He's very happy to discuss his care in that way. He usually preps himself and makes notes ahead of the call, so he doesn't forget any key points. It's a slightly different way to have the conversation but works well. Saves a lot of driving and waiting around.

Gemma mentioned that she would like better technology in the Oak Rd treatment centre to show videos on a loop to show facts about the service and advertising the services we provide. This would have given patients more information about the service. Dean noted that that's a good idea and he would have liked to know what was available and it would be good for other patients. He felt that anything to publicise the bloods and treatment locally would be a big advantage.

KW asked about efficiency / productivity and how you manage workload with much smaller sites delivering care. CA noted that we need to look at larger sites to deliver locally but the locations we have are based on postcode. We need to have more chairs at some of these sites so choosing the sites is key. KW asked if we know the potential. CA noted that this is ever evolving, and the

strategy is being developed, the service has evolved and developed significantly. We need to constantly change the landscape, consider the governance and what can be done safely.

JM asked about delivery of chemo in different settings and whether we've seen different relationships developing through contacts with these units. HC responded that the hospices have found that they have seen an increase in the awareness of what they do and the services they deliver. They described the Christie patients as a 'breath of fresh air'. JM asked about the GP links and the practice nurses and if they get more from this. HC agreed that there have been big advantages for phlebotomists in GP surgeries and the educators are also supporting staff with lines / ports etc. There is a benefit for our staff as well as the staff in the GP/hospices. Christie staff go to these sites to deliver the care and this is key for the patients, they get the same care and links to Christie services.

TK asked if there is any delay because treatments are being given far from the main sites. GJ noted that the systems are set up and deliveries are done on set days by very reliable couriers.

GP asked about the capacity issue and whether we are sufficiently engaged with new developments and the sites built to support those developments. JW noted that we want to do more of this and the ICS structure and integration of planning of public services should improve this.

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

Item		Action
21/23	**Standard business**	
a	**Apologies**	
	None noted.	
b	**Declarations of Interest**	
	None noted.	
c	**Minutes of the previous meeting – 25th May 2023**	
	The minutes were accepted as a correct record.	
d	**Action plan rolling programme, action log & matters arising**	
	All items from the rolling programme are noted on the agenda.	
22/23	**Board Assurance**	
a	**Board assurance framework 2022/23**	
	RS noted the BAF 2023/24. The risks against the approved annual objectives are reflected in the framework. This will be continuously reviewed, and assurance assigned against the risks through the assurance committees and reported back to Board. No additional changes or updates were highlighted. GP asked whether we have clarity around the principal risks where we have a target score that is much lower than the current risk. Are we clear about actions required. RS reminded us that the BAF doesn't set out the work programme, but we can add in some key timescale headlines in some of these risks. This could be added in the control column. FB joined the meeting.	

b	**Workforce Assurance Committee summary report to Board – May 2023**	
	TK outlined 3 things. Several areas received medium assurance as activities have not been embedded and the outcomes are yet to be seen. Guardian of Safe Working Hours was received, and this was discussed. EDI was considered to need more full Board attention and that this may be an important issue for training. EL noted that Sue Mahjoob attended the meeting and outlined the Board self-assessment, we will be looking at a full Board discussion around this to assess how we think we do and how we assess ourselves. EL noted that AM is now the NED FTSU lead. CO noted that we will ensure we have time as a full Board to discuss these issues and this will be planned in. CO also noted the importance of reviewing the staff survey as a full Board. CH noted that with EDI we want assurance around the EDS22 requirements as a Board and our achievements of this. TK also noted that we need a better understanding of EDI in the organisation.	
23/23	**Key Reports**	
a	**Trust report**	
	RS presented the report and drew attention to the financial position. We are ahead of plan at month 2. There are challenges with the setting of the plans and it's good to note that we are ahead of plan at month 2. Other ICB activities were pointed to and the development of the joint forward plan as well as the operating model clarification. Operational performance is achieving all requirements except for 62 days. A lot of this relates to delays in pathways and referrals to us. RS noted that we have a CQC update on the agenda. He noted that we have submitted our action plan in response to our report. Today we have received the draft report following the inspection of radiotherapy and IR(ME)R regulations. There are no regulatory actions outlined. RS noted SP's appointment as substantive Director of Finance. Paul Baxter has also been identified nationally for his work on cyber security, one of the top risks. RS also noted that there have been further notifications around industrial action, 5 days for junior doctors and 2 days for consultants. We are in the planning for these dates. Questions invited. CO congratulated those mentioned in the report. GP noted that the CIP programme is showing red. BD to cover this in the performance report.	
b	**Integrated performance, quality & finance report**	
	BD outlined the month 2 performance. Areas of under performance or variation were outlined. There were no SI incidents, no Never Events, no Major and 7 Moderate incidents and 4 risks at 15+ and 4 falls in month (per 1000 bed days), this is slightly above threshold, 1 moderate and 3 minor harms. There have been 3 cases of C.diff with no lapses in care, one case of MSSA, no cases of MRSA, 4 cases of E-Coli and no cases of Covid nosocomial infections. Performance against some access targets is still low and we continue to monitor	

	them closely. 18 Weeks was at 96.5%, 62 day performance was at 66.9%, 24 day performance achieved 75.5% and 31 day performance was at 97.9%. There were 42 x 104-day waiters, and 1 patient was a 52 week wait for complex reasons that came to us late. There's been an impact from industrial action and late referrals on performance. There were 4 cancelled operations on the day, all rebooked. Referrals were above average in month, this reflects catch up from bank holidays in May. Activity is broadly over plan at month 2. Mandated training is at 92.1%, for any areas where compliance against a specific element of the training is below 80% a risk assessment is in place. PDR compliance was at 84.5% and sickness was 3.81% overall. Turnover is reducing month on month and the voluntary yearly turnover is 14.03%. BD noted the gaps between headcount and establishment are improving. We are focusing on filling vacancies. In terms of the financial position, we achieved a £875k deficit against £1,340k expected deficit. Capital performance to month 1 is £7k over the NHSEI plan. £833k of in year CIP has been delivered year to date against a target of £2m. There is detail of the schemes we have in work up and there is focus on when the recurrent and in year funding can be taken out. There should be improvements from next month. Questions were invited. JM asked about the 24-day internal target and why this is under performing. BD noted that late referrals mean that we need to do more diagnostics but there are also delays in outpatient appointments and in radiotherapy. The reason for breaches changes each month. The faster diagnostic standard will also be added and we are not currently meeting that. RA asked about radiation incidents. BD noted that this is always shown and shows very good performance. **Report noted**	
c	**Annual compliance with the CQC requirements**	
	JY noted the annual update with CQC activities. The report shows progress and the new strategy and format of CQC assessment. The team are looking at the new inspection process and undertaking self-assessment against the new approach. RS noted that we have a further dedicated assurance meeting on 20th July where we will give comprehensive attention to elements that came from the last inspection.	
d	**The Christie Strategy 2023 – 2028 implementation plan**	
	JW noted that when the strategy was approved in March, we noted that we would come back with an implementation plan for the key elements of the strategy. The plan outlines the connections with each aim and the corporate objectives as well as the year 1 milestones. Further discussion will take place at the service review day and in further Board sessions. RA asked how delivery will be scored. JW noted that dependent on the aim they will be different but tangible e.g. a business case. CO thanked JW for the report. Board noted and endorsed the plan.	

24/23	**Approvals**	
a	**Annual report, financial statements and quality accounts (incl Annual governance statement / Statement on code of governance)**	
	RS noted that the Annual Report & Accounts were scrutinised and commented on by the Board and was formally approved by the joint assurance committee subject to one outstanding aspect stipulated by the Auditors. Board approved the final version subject to the outstanding approval from NHSE/Treasury. This is the final approval before being submitted to be laid before parliament. SP noted that we are waiting for Grant Thornton to come back to us after a meeting today. Approved.	
b	**Fit & Proper Persons Policy**	
	RS presented the updated standalone policy around CQC Regulation 5 Fit & Proper Persons. RS noted that Fit & Proper Persons was raised by the CQC in their inspection report. The Board are the parent committee for the policy and responsible for approval. JM asked about whether the responsibilities around what the CQC hold is new. LW confirmed that this is standard wording. The Board approved the policy for publication and dissemination.	
25/23	**Any other business**	
	No items raised.	
	Date and time of the next meeting	
	Thursday 28th September 2023 at 12:45pm	

The Christie NHS Foundation Trust

Agenda item 26/23d

Meeting of the Board of Directors - September 2023

Action plan rolling programme after June 2023 meeting

Month	From Agenda No	Issue	Responsible Director	Action	To Agenda no
Sep-23	Annual reporting cycle	Integrated performance & quality report and finance report	COO	Monthly report	28/23b
		Standing Financial Instructions (SFI's)	DoF	Approve	29/23a
October 2023	Annual reporting cycle	6 monthly review of annual objectives / review of strategy	DCEO	Interim review & update	
		Christie role in addressing healthcare inequalities	DCEO	Report	
		Integrated performance & quality report and finance report	COO	Monthly report	
		Freedom to speak up guardian	FTSUG	Annual report	
November 2023	Annual reporting cycle	Integrated performance & quality report and finance report	COO	Monthly report	
		Greater Manchester Cancer update	GM Cancer lead	Report	
December 2023 - no meeting		Integrated performance & quality report and finance report	COO	Monthly report	By email
January 2024	Annual reporting cycle	Integrated performance report	COO	Monthly report	
		Integrated performance & quality report and finance report	COO	Monthly report	By email
February 2024 - no meeting		Integrated performance & quality report and finance report	COO	Monthly report	By email
	Annual reporting cycle	Letter of representation & independence	Chair	Circulate	
	Annual reporting cycle	Register of directors interests / FPPT annual declaration	Chair		
	Annual reporting cycle	Declaration of independence (non-executive directors only)	Chair		
March 2024	Annual reporting cycle	Corporate planning (corporate objectives / BAF 2023/24)	Executive directors	Approve next year's BAF	
	Annual reporting cycle	Integrated performance & quality report and finance report	COO	Monthly report	
		5 year strategy 2023-29 - year 1 review	DCEO		
		Digital Update	EMD/Dep CEO	Update	
		Workforce update	DoW	Quarterly review	
		Annual reporting cycle	Chair	Approve	
	Annual reporting cycle	FPPT Complaince report	Chair	Approve annual compliance	
April 2024	Annual reporting cycle	Integrated performance & quality report and finance report	COO	Monthly report	
		Register of matters approved by the board	CEO	April 2022 to March 2023	
	Annual reporting cycle	Annual Corporate Objectives	CEO	Review 2022/23 progress	
	Annual reporting cycle	Risk Management strategy 2021-24	CN&EDoQ	Annual Review	
		Modern Slavery Act update	CEO	Approve	
		Board effectiveness review	Chairman	Undertake survey	
		Freedom to speak up Guardian report	FTSUG	Quarterly update	

Month	From Agenda No	Issue	Responsible Director	Action	To Agenda no
May 2024	Annual reporting cycle	Integrated performance & quality report and finance report	COO	Monthly report	
	Provider licence	Self certification declarations	EDoF&BD	To approve the declarations	
		Responsible Officer report	EMD	Medical Appraisal & Revalidation Annual report	
	Annual reporting cycle	Annual compliance with the CQC requirements	ECN	Declaration / approval	
	Annual reporting cycle	Risk Management strategy 2021-24 annual review	CN&EDoQ	Annual Review	
June 2024	Annual reporting cycle	Integrated performance & quality report and finance report	COO	Monthly report	
	Annual reporting cycle	Annual reports from audit, quality and workforce assurance committees	Committee chairs	Assurance	
	Annual reporting cycle	Annual compliance with the CQC requirements	ECN	Declaration / approval	
	Annual reporting cycle	Annual report, financial statements and quality accounts (incl Annual governance statement / Statement on code of governance)	EDoF&BD	Approve	
July 2024 - no meeting		Integrated performance & quality report and finance report	COO	Monthly report	By email
August 2024 - no meeting		Integrated performance & quality report and finance report	COO	Monthly report	By email

The Christie NHS Foundation Trust

Agenda item: 26/23d

Action log following the Board of Directors meetings held on

Thursday 29th June 2023

No.	Agenda	Action	By who	Progress	Board review
		No actions noted in the minutes			

The Christie
NHS Foundation Trust

Agenda Item 27/23a

Thursday 28th September 2023

Board Assurance Framework 2023/24

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

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Agenda Item 27/23a

Board of Directors meeting

Thursday 28th September 2023

Board Assurance Framework 2023/24

1 Introduction

The board assurance framework (BAF) 2022/23 was presented to the Board of Directors and Quality Assurance Committee in June and the Audit Committee in July.

2 Updates to risks

The risks in the 2023/24 framework have been reviewed to reflect the annual objectives against each of the 8 agreed corporate objectives.

In line with the improvements suggested by MIAA in their annual review of the Board Assurance Framework additional columns have been added to outline actions and target dates for each risk. This is not an action plan but outlines high level actions and monitoring.

Risk 6.5 - Reputational damage, service disruption and financial loss due to cyber-attack. The risk score has been reduced in line with the divisional risk register from 15 (3/5) to 12 (3/4). This reflects the considerable work in this area to protect the Trust from an attack.

Risk 8.4 - Reduced ability to provide services and support to patients due to national / global influences (supplies / fuel costs / strikes etc) has been split into separate elements to reflect the increasing risk relating to the ongoing industrial action. The score for this element of the risk has been increased from 9 (3/3) to 20 (5/4) to reflect the cumulative impact of the on-going industrial action, particularly the junior doctors and consultant's industrial action.

3 Suggested updates

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

4 Assurance on NHSE priorities

Attached to this paper at appendix 1 for further assurance is a list of current NHSE patient safety priorities for Board oversight. The table provides Board with an update on each priority and notes where and when the Board will receive further detail and oversight of the issues. Risks relating to the priorities identified are contained in the BAF and the Trust risk register.

5 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.

Board are asked to note the update and source of oversight for the NHSE priorities for patient safety (appendix 1).

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

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

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

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

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

	Principal Risks	Exec Lead	Likelihood	Impact	Key Control established	Key Gaps in Controls	Current Risk Score	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Risk appetite (Averse / Cautious / Eager)	Responsible committee	Assurance level achieved (High / Medium / Low)	Opening Position	Position at end of Q1	Position at end of Q2	Position at end of Q3	Position at end of Q4	Target risk score	Target date for completion
3.1	Risk to delivery of the Christie Education strategy due to reduction in demand	DoE	3	3	Review the deliverables and prioritise in line with financial investment available. Maximise the potential of external income. Refresh the Christie Education focus on integration of objectives with clinical and research divisions. Work with finance to review funding options, develop business cases for high priority initiatives and look at alternative funding sources. Christie Education board reports to Management Board. 6 monthly assessment of progress.	Continuing inability to deliver all strategic objectives due to difficulty in accessing curent investment funds to deliver new initiatives.	**9**	Reporting to Workforce Assurance Committee and Board	None identified	Divisional Board being restructured. Reporting to Management Board and DCEO	Divisional Board to manage timelines of actions	Cautious	Workforce		**9**	9					**3**	Year end
3.2	External factors / pipeline of high quality clinical and teaching staff	DoE	3	3	Monitoring of workforce numbers / turnover. Active recruitment and investment in Christie pipeline.	External factors / pipeline of high quality oncologists	**9**	Reporting to Workforce Assurance Committee and Board	None identified	Active recruitment practices / investment	Divisional Board to manage timelines of actions	Cautious	Workforce		**9**	9				**3**	Year end
3.3	Lack of progress with organisational governance arrangements for Christie Education	DoE	3	3	Project group in place. Plans established and resourse identified. Project progress reported to Board of Directors.	External factors	**9**	Reporting to Workforce Assurance Committee and Board	None identified	Project group identified actions and timelines, reported through Education Board.	Divisional Board to manage timelines of actions	Cautious	Workforce		**9**	9				**3**	Year end

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

	Principal Risks	Exec Lead	Likelihood	Impact	Key Control established	Key Gaps in Controls	Current Risk Score	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Risk appetite (Averse / Cautious / Eager)	Responsible committee	Assurance level achieved (High / Medium / Low)	Opening Position	Position at end of Q1	Position at end of Q2	Position at end of Q3	Position at end of Q4	Target risk score	Target date for completion
4.1	Lack of evidence to show progress against the ambition to be leading comprehensive cancer centre	DoR	2	3	Reaccreditation by OECI - reinspection due. Baseline measures identified and presented to Board of Directors. Looking at how we can be part of International Benchmarking. MCRC Strategy. Designated as the most technologically advanced cancer centre in the world outside North America. In segment 1 (System oversight framework).	Availability of comprehensive data with which to compare ourselves	**6**	Updates to Board Time Outs / Board of Directors meetings	None identified	OECI project lead appointed and coordinating OECI reaccreditation application.	Deadline for submission of data	Cautious	Board		**6**	6					**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		**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				**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				9	Year end
5.2	Failure to implement 2023/24 objectives of the SACT strategy	COO	3	4	Strategy on track but constrained by other trusts. Expansion on Withington site. 6 monthly assessment of progress.	None identified	**12**	Regular reports to Management Board and Board of Directors. Six monthly assurance reports to Quality Assurance Committee.	None identified	SACT team report to Board on progress June 2023. On going assessments of demand and response in place	SACT Board manages action progress and reports through QAC	Averse	Quality		**12**	12				**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				**9**	Year end

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

	Principal Risks	Exec Lead	Likelihood	Impact	Key Control established	Key Gaps in Controls	Current Risk Score	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Risk appetite (Averse / Cautious / Eager)	Responsible committee	Assurance level achieved (High / Medium / Low)	Opening Position	Position at end of Q1	Position at end of Q2	Position at end of Q3	Position at end of Q4	Target risk score	Target date for completion
6.1	Key performance targets not achieved	COO	3	4	Executive led monthly divisional performance review meetings. Integrated performance & quality report to Management Board and Board of Directors monthly. Weekl;y performance reporting via trust operational group. Escalation internally & across GM of delays impacting waiting time targets. Monitoring cancer waiting time standards through GM Cancer & IPR.	Impact of ongoing Industrial Action	**12**	Executive Team monitor activity weekly. Integrated performance report to Management Board, Quality Assurance Committee and Board of Directors.	None identified	Weekly monitoring through Executive Team, actions discussed and escalated as appropriate	Monthly review of annual targets	Cautious	Quality	Mediu m	**12**	12				**4**	Year end
6.2	Change in financial regime resulting in inability to deliver the Trust's strategic plan.	EDoF	4	4	Participating at national level and ICS (Greater Manchester) level to influence the new financial framework and its implementation. Development of mitigating strategies including efficiency and transformational programmes. Identification and consideration of new models of working to deliver and finance the Trust's strategic plan.	Changes in national funding arrangements and delegation of commissioning functions.	**16**	To continue to report through Managment Board and Board of Directors via financial reports and updates. Executive Team monitor activity weekly. MIAA audit - CIP Q2 / financial systems Q3 / Critical Apps Q3	None identified	External advice sought on new models of working. Close working with national & regional team	Monthly assessment of progress towards annual plan	Cautious	Audit		**16**	16				**4**	Year end
6.3	Digital programme unable to support delivery of operational objectives	COO	3	4	CWP (clinical web portal) on stable platform. Review of digital programme and to align ditial strategy with Service strategies. Key projects moving forward e.g.Order comms. EPMA, ePROMs, clinical outcomes.	Internal capability & expertise to support system going forward.	**12**	Reports to Management Board & Board of Directors. MIAA audit - Data Protection Toolkit (DPST) Q4	None identified	Progress and objectives set/reviewed by Quarterly Digital board. Esaclations through Management Board.	Monthly assessment of progress towards annual plan	Cautious	Audit		**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		**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		**15**	15				**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				**4**	Year end

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

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

Corporate objective 8 - To work with others in promoting a sustainable environment and eliminating health inequalities																						
	Principal Risks	Exec Lead	Likelihood	Impact	Key Control established	Key Gaps in Controls	Current Risk Score	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Risk appetite (Averse / Cautious / Eager)	Responsible committee	Assurance level achieved (High / Medium / Low)	Opening Position	Position at end of Q1	Position at end of Q2	Position at end of Q3	Position at end of Q4	Target risk score	Target date for completion
8.1	Impact on our ability to obtain planning approval for future capital developments.	EDoF	2	3	Close working with Manchester City Council (MCC) planning and development issues as well as implementation of the Trust's green travel plan. Strategic planning framework approved which includes current and future requirements for travel to site. Regular communication with residents through the Neighbourhood Forum and newsletters and with local councillors. Agreement by MCC of strategic development plan and delivery of the Trust's 5 year Capital Plan delivery	None identified	**6**	Monitored through Management Board & Board of Directors. Capital programme shared with MCC and Board of Directors.	None identified	MCC aware of current and future plans and timelines. Planning team engaged in discussions alongside Neighbourhood Forum	Dates in line with capital plan	Cautious	Board		**6**	6				**3**	Year end
8.2	Not able to progress our role as an Anchor Institution	DoS	2	3	Engagement in relevant GM meetings	None identified	**6**	Monitored through Board of Directors.	None identified	Continued attendance at relevant GM meetings	6 monthly review of progress	Cautious	Board		**6**	6				**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		**8**	8				**4**	Year end
8.4	Reduced ability to provide services and support to patients due to national / global influences (supplies / fuel costs / strikes etc)	COO	5	4	Industrial Action - close working with unions. Business continuity plans in place. Planning meetings in place around strike acton and incident management approach used. Management of demand. Risk assessments undertaken.	Impact of ongoing Industrial Action	**20**	Reports to Management Board and Board of Directors	Impact of ongoing Industrial Action	Detailed planning of patient demand and catch up. Staff cover planned. Liaision with unions and national team.	On going dependent on mandate to take action	Averse	Board		**9**	9				**3**	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				**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		**9**	9				**3**	Year end

The Christie
NHS Foundation Trust

Appendix 1 **Agenda item 27/23a**

Status of NHS patient safety strategy priorities at The Christie

Priority	Context	Current Status	Exec Lead	Reporting
Implementing the Patient Safety Incident Response Framework (PSIRF)	All providers should be planning and working towards Patient Safety Incident Response Framework being implemented in their organisation from autumn 2023, subject to working with and agreement from their integrated care boards (ICBs). PSIRF represents a significant shift in how the NHS plans for and responds to patient safety incidents and replaces the Serious Incident Framework (SIF).	• PSIRF engagement/awareness sessions delivered. • Governance structure and toolkit agreed • PSIRF Policy and Plan (Local strategy) is planned to be signed off at BOD on 25th January 2024 with a go live date of 01.03.2024. • Patient Safety Team working in collaboration with ICB and Specialist Commissioner colleagues on the plan and policy for the Christie.	Chief Nurse	Quality Assurance Committee Last reported - 15th June 2023 Next update to QAC September 2023
Improving the quality of patient safety incident reporting and supporting transition to the Learn from Patient Safety Events (LFPSE) service	All organisations are required to transition to the new Learn From Patient Safety Events service. Organisations connected to the legacy system, the National Reporting and Learning System (NRLS), via a local risk management system were asked, as a minimum, to begin local testing of LFPSE-compliant local risk management systems from the end of March 2023 and to be implementing LFPSE within their local risk management systems by the end of September 2023.	- Datix programme will support LFPSE compliance, completion date delayed by 12 weeks to 01.01.2024 from 30.09.2023. - NHS England released the letter on this link Update on LFPSE implementation deadline - Patient Safety Learning explaining the compliance criteria to the end of the financial year is that *"Trusts will only need to ensure this is underway by the 30 September 2023, rather than fully implemented"*	Chief Nurse	Quality Assurance Committee Last reported - 15th June 2023 Risk to be discussed at R&QG Committee September 2023

Priority	Context	Current Status	Exec Lead	Reporting
Medical examiners	Medical examiners are senior medical doctors who provide independent scrutiny of the causes of non-coronial deaths. In scrutinising deaths, they: • seek to confirm the proposed cause of death by the medical doctor and the overall accuracy of the medical certificate of cause of death • discuss the proposed cause of death with bereaved people and establish if they have questions or any concerns relating to the death • support appropriate referrals to senior coroners • identify cases for further review under local mortality arrangements and contribute to other clinical governance processes. Medical examiner scrutiny of deaths is now being extended from deaths in the acute setting to deaths in non-acute settings.	• The Christie Medical Examiner's Office was established in 2020 and provides independent scrutiny of all on-site deaths. • Current establishment is 1x Medical Examiner Officer and 4x trained Medical Examiners who provide a 5-day service. • If issues related to patient care are identified by the Medical Examiner a mortality review is triggered through the trust's Learning from Deaths process which reports to the Patient Safety Committee and Quality Assurance Committee.	Medical Director	Quality Assurance Committee Last reported - 15th June 2023
National Patient Safety Alerts	National Patient Safety Alerts require executive oversight and for senior leaders in each organisation to manage the implementation of all relevant actions for each alert.	• Continued management of National Patient Safety Alerts in timely manner co-ordinated by Quality and Standards • Monitored weekly via ERG.	Chief Nurse	Quality Assurance Committee Last reported - 15th June 2023
Patient safety culture development	Trusts should ensure a just culture guide or equivalent is in place, alongside learning from best practice and	• Introduction of Patient Safety Champions for all key areas- to enable shared learning and facilitate open	Chief Nurse	

Priority	Context	Current Status	Exec Lead	Reporting
	monitoring safety cultures to identify where work is needed to improve, are key actions. The National Patient Safety Team has published a Patient Safety Culture Practical Guide to support organisations to improve safety culture.	discussion of patient safety priorities and areas for improvement • Awareness and teaching sessions incorporating patient safety culture as a key theme and how we enable this • World Patient Safety Day awareness stand to engage staff and patients • Learning Improvement Bulletin- sharing learning trust wide including acknowledging good practice • Alignment with Globis work • FTSU Guardianship • From October Patient Safety Culture and PSIRF is a 30 minute session on Trust Induction		
Implement the framework for involving patients in patient safety	The Framework for Involving Patients in Patient Safety published in 2021 is supporting NHS organisations to ensure the vital perspective and insight patients bring is embedded into local patient safety work. The framework asks all trusts, ICBs and regions to appoint at least two 'patient safety partners' to their relevant patient safety committee(s) to ensure the patient perspective is heard. All providers should be including a minimum of two patient safety partners on their safety related clinical governance committees. It is intended this will become a contractual requirement in the NHS Standard Contract for 2024/25.	- This is linked to the Involvement Strategy overseen by Associate Chief Nurse for Patient Experience - Business Case for PSP has been submitted - Budget of 20k requested for 23/24 financial year	Chief Nurse	Quality Assurance Committee Last reported - 15th June 2023

Priority	Context	Current Status	Exec Lead	Reporting
Patient safety education and training	The first ever NHS Patient Safety Syllabus was published in May 2021. Level 1 (Essentials for patient safety) and Level 2 (Access to practice) training, suitable for all NHS staff, were launched in October 2021. NHSE ambition is for all NHS staff to undertake Patient Safety Syllabus Level 1 (essentials) training. Level 2 (access to practice) is designed for those who have an interest in understanding more about patient safety and/or who want to go on to access the higher levels of training. Training in levels 3 and 4 will be launched for patient safety specialists from September 2023 ensuring they are fully trained in patient safety science and systems thinking.	• Patient Safety Syllabus Level 1 and 2 available for all staff on Christie Learning Zone • NEDs asked to self declare training using handbook for "PSIRF for Those in Oversight Roles" • E-Learning for Executive Directors. • Patient Safety have undertaken HSIB Level 2 training • Trust Patient Safety Specialist has a place on the L3 & L4 Training, this is provided through Loughborough university	Chief Nurse	Quality Assurance Committee Last reported - 15th June 2023
Patient safety improvement	National safety improvement priorities are aligned to the delivery of the Patient Safety Strategy, the NHS Long Term Plan and the NHS Operational Planning Guidance. They are informed by national professional leadership and policy teams across NHS England. The priorities for delivery in 2022/23 were deterioration, maternity, medication, mental health, and PSIRF, some of which continue through 2023/24.	As detailed above.	Chief Nurse	Quality Assurance Committee Last reported - 15th June 2023

The Christie
NHS Foundation Trust

Agenda Item 27/23b

Meeting of the Board of Directors
Thursday 28th September 2023

Subject / Title	Audit Committee report – June 2023
Author(s)	Company Secretary's Office
Presented by	Committee chair
Summary / purpose of paper	This paper provides the board with a summary of the assurance items considered by the Audit Committee at their June meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions
Background papers	Audit Committee papers 22nd June 2023
Risk score	BAF references noted within report
Link to: ➢ Trust strategy ➢ Corporate objectives	• Trust's strategic direction • Divisional implementation plans • Our Strategy • Key stakeholder relationships
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	DoF Director of Finance CIO Chief Information Officer

The Christie
NHS Foundation Trust

Agenda item 27/23b

Meeting of the Board of Directors
Thursday 28th September 2023

Audit Committee report – June 2023

1 Introduction

The Audit Committee took place on 22nd June 2023. The following summary gives the Board information on the items that were considered and any actions required by the Board.

2 Audit Committee agenda items

The items listed below were all presented to the Audit Committee for assurance.

Agenda item	BAF reference	Assurance rating suggested	Comments and associated action (where applicable)
Executive Director of Finance report	6.2	High	• The annual accounts for The Christie Charitable Fund are being audited by Crowe LLP and will be presented and approved by The Christie Charity Board at the September 2023 meeting. • The Christie Pharmacy Limited accounts have been audited, these will be signed in June 2023 and then submitted to Companies House. • The annual accounts for 2022-23 have been prepared on a going concern basis. The Trust has submitted the 2023/24 annual plan for consolidation into a Greater Manchester plan to be submitted to NHSE. • In terms of the valuation of land and buildings, an increase in asset valuation of £9,950,290 has now been processed and updated in the audited accounts. • The Trust's revenue and capital plans for 2023/24 must be agreed by the Greater Manchester Integrated Care Board (GM ICB). GM ICB submitted a balanced plan for revenue, and a capital expenditure plan which is £71m above the system's allocation in the final submission in May 2023. Delivery of the revenue plan remains a significant challenge and includes system savings of £123m (which remains in the ICB plan and hasn't been allocated to individual providers) with no current identified mitigation. This is in addition to

Agenda item	BAF reference	Assurance rating suggested	Comments and associated action (where applicable)
			significant levels of cost improvement plans (CIP) in individual provider plans. • Following the NHS staff survey results, the Trust's finance department was contacted to inform them they had scored highest in the country on average score. **Action:** SP to provide information from HFMA to Committee members to provide an overview of NHS finances and clarification on the process of the setting of the financial envelope to aid understanding.

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

3 Recommendation

The Board are asked to note the reports received for assurance by the Audit Committee in June.

Assurance level descriptions:

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

The Christie
NHS Foundation Trust

Agenda Item 27/23b(i)

Meeting of the Board of Directors
Thursday 28th September 2023

Subject / Title	Audit Committee report – July 2023
Author(s)	Company Secretary's Office
Presented by	Committee Chair
Summary / purpose of paper	This paper provides the board with a summary of the assurance items considered by the Audit Committee at their July meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions
Background papers	Audit Committee papers 27th July 2023
Risk score	BAF references noted within report
Link to: ➢ Trust strategy ➢ Corporate objectives	• Trust's strategic direction • Divisional implementation plans • Our Strategy • Key stakeholder relationships
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	DoF Director of Finance CIO Chief Information Officer

The Christie
NHS Foundation Trust

Agenda item 27/23b(i)

Meeting of the Board of Directors
Thursday 28th September 2023

Audit Committee report – July 2023

1 Introduction

The Audit Committee took place on 27th July 2023. The following summary gives the Board information on the items that were considered and any actions required by the Board.

2 Audit Committee agenda items

The items listed below were all presented to the Audit Committee for assurance.

Agenda item	BAF reference	Assurance rating suggested	Comments and associated action (where applicable)
Executive Director of Finance report	6.2	High	• Outstanding audit recommendations review is progressing and a further updated will be provided to the October meeting. • The Trust is still awaiting approval of the Charity Gift Deed expenditure from the DHSC and HM Treasury before the annual report and accounts can be finalised and signed off. • The Greater Manchester ICB 2023/24 financial plan to breakeven, the current forecast does not indicate breakeven. The Christie's forecast financial position does forecast that we will achieve plan (£8m deficit) but many others dol not. GM ICB submitted a balanced plan for revenue, and a capital expenditure plan which is £71m more than the system's allocation in the final submission in May 2023. • The Trust has reviewed the new standardised financial controls and estimates that the current controls in place mean that we are c95% compliant. The main exception is the requirement for executive sign off of non-clinical agency. This compliance is similar across GM. Reporting in relation to this will be implemented through the ICB. Actions: • HFMA licences for finance e-learning and email requirements to be confirmed and course details on NHS Finances to be circulated to

Agenda item	BAF reference	Assurance rating suggested	Comments and associated action (where applicable)
			members. • Waiver process to be reviewed for those where only a single supplier option given the time constraints and issues this can cause.
Digital six-monthly update	6.3, 6.5	Medium	• The last quarter saw 3 awards for the Digital team; National Winners for 'Best Hospital Placement (Nominated by Nurses)' at the Nursing Times Awards. Paul Baxter, Cyber Security Manager won national 'Individual of the Year' at the Cyber Associates Network Awards, and Service Delivery won 'TCG Industry Placement Partner 2023'. • Digital have also further developed their front door process, introducing Monday.com, and reinitiated projects with Outpatients and Research and Innovation. • The Trust has recently achieved cyber essentials plus accreditation. • The NHS staff survey provided pleasing results for Digital Services, they have improved in every area in the last year and are also above average. • With regards to operational performance, there is a need to improve on first time fix rates via the Tech Bar, progressing a full-service desk replacement system which should help with this. • The Digital risks are provided in the report for information, noted that the cyber risk has reduced but this will be ever present. Actions: • Patient or staff member journey as a result of Digital impact to be incorporated into next update.

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

3 Recommendation

The Board are asked to note the reports received for assurance by the Audit Committee in July.

Assurance level descriptions:

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

The Christie
NHS Foundation Trust

Agenda item: 27/23c

Meeting of the Board of Directors
Thursday 28th September 2023

Subject / Title	Quality Assurance Committee report – June 2023
Author(s)	Company Secretary's Office
Presented by	Committee chair
Summary / purpose of paper	This paper provides the board with a summary of the assurance items considered by the Quality Assurance Committee at their June meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions
Background papers	Quality Assurance Committee papers 15th June 2023
Risk score	BAF references noted within the report
Link to: ➢ Trust strategy ➢ Corporate objectives	• Trust's strategic direction • Divisional implementation plans • Our Strategy • Key stakeholder relationships
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	

The Christie
NHS Foundation Trust

Agenda item: 27/23c

Meeting of the Board of Directors
Thursday 27th April 2023

Quality Assurance Committee report – June 2023

1 Introduction

The Quality Assurance Committee took place on 15th June 2023. The following summary gives the Board information on the items that were considered, and any actions required by the Board.

2 Quality Assurance Committee agenda items

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

Agenda item	Patient Safety Quarterly Report January – March 2023
BAF reference	1.1, 1.3, 1.5
Assurance rating given	High
Key points and associated action (where applicable): • The incident management policy has also been reviewed, there have been some updates to roles and the policy in place is a holding position while moving to the PSIRF. Through quality oversight there has been improvement on how long incidents are with incident handlers. • The last 12 months has seen an increase in incident activity but remaining as low severity, there was a dip during the pandemic and now seeing the recovery so should start to see incidents now sitting around the level they are currently. • 98% of incident activity is represented by the Trust's two biggest departments, CSSS and NWS. • Medicines safety has seen a big focus with the first Medicines and Transfusion Improvement Group meeting during Q4 to begin to consider prominent themes in medication related incidents. • The SI panel within the quarter related to a patient receiving incorrect IV medication. A thorough investigation was undertaken with agreed actions at panel completed with changes to the system. • 2 incidents reported to StEIS were approved in the quarter, through a meeting with the specialist commissioners they were satisfied, and the incidents were closed down. No actions identified.	
Agenda item	Patient Experience Quarterly Report January – March 2023
BAF reference	1.4
Assurance rating given	High
Key points and associated action (where applicable): • Achievements for Q4; the involvement in the green team competition was felt to be successful through the savings identified financially and the green and sustainability aspects.	

- Positive feedback continues through the Friends and Family Test (FFT).
- In terms of the challenges, there have been some gaps within the workforce, two new members of staff are joining the PALS team in July and work is being done to engage with Solicitors while the Complaints and Claims Manager goes on maternity leave.
- There are 2 main targets for the team when dealing with complaints; acknowledgement within 3 days and response within 6 months, which is the regulatory timescale. Not currently where we want to be but there has been a real focus in the team to get to where we need to be regulatory wise, and complaints are taken through ERG on a weekly basis. A reporting timetable is now in place to show where are things are up to.

No actions identified.

Agenda item	Health and Safety Quarterly Report January – March 2023
BAF reference	7.3
Assurance rating given	High

Key points and associated action (where applicable):

- The highest accident categories show an increase of 16% for needlesticks and 75% for moving and handling but this reflects a small increase in accidents; 14 for needlesticks and 7 for moving and handling.
- The Health and Safety Executive (HSE) has written to all Trusts to inform them of inspections for next year. An awareness group has been established to look at giving Trust assurance on the inspection related areas.

No actions identified.

Agenda item	Infection Control Annual Report 2022/23
BAF reference	1.3
Assurance rating given	High

Key points and associated action (where applicable):

- The team are now operating at full establishment in accordance with the structure devised in 2021-22, with further investment agreed in 2022/23. The Lead Nurse role will focus on quality improvement.
- Through the alert organism surveillance, there have been identified spikes around viruses in AAU, Palatine Ward and Ward 12 which relate to viruses detected on admission. Both MRSA and MSSA are mainly through AAU admissions.
- The Trust has gone over the thresholds set by NHSE for reported cased of C.Difficile and E.coli; total of 51 cases of C.Difficile in year and 59 for E.coli. Nationally, around 80% of Trusts have gone over. Antibiotics are known to impact C.Difficile rates, root cause analysis done for all cases which includes an assessment as to whether the antibiotics were given at the right time and appropriately, have good assurance that they are.
- A new IPC BAF is also being developed.

No actions identified.

Agenda item	Learning from deaths
BAF reference	N/A
Assurance rating given	High

Key points and associated action (where applicable):

- Now have 12 more reviewers trained. In year, 66 deaths were triggered for a structured casenote review (SCR), 56 of which have been completed. Any cases needing to be prioritised were done and an additional 14 deaths from 2020/21 and 53 deaths from 2021/22 were also reviewed in 2022/23. All 2021 and 2022 reviews have been validated by the MSG.

- 1 patient had an overall poor care score of 2, this was due to concerns regarding a lack of clarity in the documentation over issue of faecal incontinence. Poor care was identified around care after death involving communication. Related procedures / practices were not followed. Care after death updated guidance being rolled out. The mortality reviews for these patients included input from the supportive care team and no significant lapses in care were identified.
- One case referred to LeDeR was due to the patient's history of autism and learning needs. He was capable of self-care and had no previous concerns regarding capacity. Waiting to hear back from the LeDeR reviewers team.
- In terms of learning from deaths, good practices are noted in the structured case note review and areas for improvement are fed back to the appropriate clinician. Any concerns identified are also shared within directorates or more widely, especially if associated with an incident or complaint.

No actions identified.

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

3 Recommendation

The Board are asked to note the reports received for assurance by the Quality Assurance Committee in June 2023.

Assurance level descriptions:

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

The Christie
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Agenda item: 27/23d

Meeting of the Board of Directors
Thursday 28th September 2023

Subject / Title	Workforce Assurance Committee Report – July 2023
Author(s)	Company Secretary Office
Presented by	Committee Chair
Summary / purpose of paper	This paper provides the board with a summary of the assurance items considered by the Workforce Assurance Committee at their July meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions
Background papers	Workforce Assurance Committee papers 13th July 2023
Risk score	BAF references noted within the report
Link to: ➢ Trust strategy ➢ Corporate objectives	• Trust's strategic direction • Divisional implementation plans • Our Strategy • Key stakeholder relationships
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	EDG Ethnic Diversity Group BAF Board Assurance Framework WRES Workforce Race Equality Standard WDES Workforce Disability Equality Standard FTSU Freedom to Speak Up

The Christie
NHS Foundation Trust

Agenda item: 27/23d

Meeting of the Board of Directors
Thursday 28th September 2023

Workforce Assurance Committee report – July 2023

1 Introduction

The Workforce Assurance Committee took place on 13th July 2023. The following summary gives the Board information on the items that were considered, and any actions required by the Board.

2 Quality Assurance Committee agenda items

The items listed below were all presented to the Workforce Assurance Committee for assurance in July.

Agenda item	**Workforce Risk Review**
BAF reference	**7.2**
Assurance rating given	**High**
Key points and associated action (where applicable): The workforce risk 'Trust wide staffing gaps due to national shortages in some occupations. Risk of negative impact on engagement levels, staff health & wellbeing and delivery of services'; is currently scored as a 12, previously a 16. Key elements were summarised as follows: establishment has increased, more growth posts to be added, turnover has decreased, sickness is decreasing in line with seasonal trends, positive activity is taking place in key risk areas, Admin and Clerical is still in a worrying position. In terms of mitigation, recent Nurse Recruitment event was well attended with 30+ appoints made, an additional senior appointment has been made in the medical staffing team, successful SWAP with Trafford College and DWP for HCSW's generated 20 candidates, exciting opportunity to work with Southway Housing and Athena group to reach under represented area of the community, Facebook campaigns continue to support the pipeline of Nurses and HCSW's. This campaign and the international nurses recruitment has really helped with the nursing pipeline.	
Agenda item	**The Christie People Plan**
BAF reference	**7.1, 7.2, 7.4**
Assurance rating given	**Medium**
Key points and associated action (where applicable): The NHS Long Term Workforce Plan published June 2023 is the first long term workforce plan produced by the NHS and sets out plans to address existing and future workforce challenges. It has 3 clear themes Train, Retain and Reform. Pledges are set out within each of the three themes. An assessment of this plan aligned to the Trust's own plans and strategy will be brought to the next meeting. The following areas of The Christie People Plan are currently behind: • The Essential Training programme; a business case has been approved which will provide the resource to progress this programme of work and reduce risk. • A review of Manager Training was commissioned and this is almost complete. A large proportion of managers at bands 4-7 require support and development of their skills to deliver effective line management. • There are two areas focused on recruitment and retention; one is in terms of fair	

and inclusive recruitment and the other is in relation to the development of the exit interview process. Proposals are going to the next Workforce Committee to agree how to proceed with the exit interview process.

Are issues of capacity in the Workforce Team that are being addressed.

Agenda item	**Public Sector Equality Duty Update**
BAF reference	**7.4**
Assurance rating given	**Medium**

Key points and associated action (where applicable):

WRES data is a positive picture with the majority of domains presenting an upward trend. Need to focus on how to address the areas which haven't performed as well, these include: equity of access to training, board composition and staff reporting incidents of bullying and harassment.

WRES - majority of actions remain on plan. Areas that are behind on plan:

- Violence and aggression policy in line with new national framework.
- Monitoring of ethnicity data of staff who attend internal development programmes.
- Roll out of Respectful Resolution programme, this work is underway.

WDES data is also a positive picture compared to last year's submission. Areas of focus are the appointment process, experience of bullying and harassment and staff engagement. WDES is more of a challenge as there is limited data available through the Trust's ESR records, there is a need to work to encourage staff to declare where they have a disability.

WDES - slightly behind with plan due to focus on completion of national submissions. Difficulties in engaging with the network due to limited staff members wishing to participate. Actions to focus on supporting managers to support our disabled staff members. A new EDI advisor starting whose priority will be to review and engage with the network groups and work on the WDES actions.

Governance around the WDES and WRES through reporting to the EDI programme board and Management Board.

Agenda item	**Monitoring use of agency staffing**
BAF reference	**7.2**
Assurance rating given	**High**

Key points and associated action (where applicable):

The aim in 2023/24 is to reduce the total agency spending by Trusts (in aggregate) to 3.7% of the total estimated NHS Pay bill. Currently the national average is 4.4% and the Northwest average is 4.3%. GM have agreed to report on the compliance against the following standards:

- Price Cap Compliance – Northwest target 60% of agency usage to be compliant
- Off Framework Usage – Less than 3% of off framework agency usage
- Total Bank usage as a % of Temporary staffing – Bank Fill rates to be at 75%
- Agency Spend as a % of Trust pay bill – less than 3.7% of the annual total staff pay bill

The Trust is an outlier as currently meeting the target of reducing off framework agency usage and have been consistently at 0% for the last 12 months and is also achieving the target of the total agency spend remaining under 3.7% of the monthly pay bill.

There are 2 areas the Trust need to work on:

- Price cap compliance with agency usage, this will be achieved in May.
- More internal bank fills, currently at between 50-60%

The Trust's main priority is to boost recruitment and fill with bank staff to reduce agency use. Will report back to the Committee in 6 months on progress.

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

3 Recommendation

The Board are asked to note the reports received for assurance by the Workforce Assurance Committee in July 2023.

Assurance level descriptions:

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

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Agenda item 27/23e

Meeting of the Board of Directors
Thursday 28th September 2023

Subject / Title	Fit & Proper Person Test Framework and updated Policy
Author(s)	Louise Westcott, Company Secretary
Presented by	Roger Spencer, Chief Executive Officer
Summary / purpose of paper	This paper outlines the new requirements of the NHS England Fit and Proper Persons Test Framework 2023. The paper summarises the changes and shows progress against the MIAA checklist relating to the introduction of the Framework. The paper gives a progress update on the actions relating to the F&PPT identified in the CQC action plan. The paper also includes the updated Fit & Proper Persons Policy that outlines the Trusts responsibilities and processes around CQC Regulation 5: Fit & Proper Persons and reflects the additional requirements of the 2023 NHSE Framework.
Recommendation(s)	The Board are asked to; • Note the introduction of the NHSE FPPT Framework August 2023 and the additional requirements • Note the completion of the actions from the CQC action plan 2022 relating to Regulation 5 Fit and Proper Persons requirements • Approve the updated Fit & Proper Persons Test Policy and note the requirement to review the policy in line with the review date • Note the progress against the MIAA checklist and plans for further reports on compliance to committees of the Board
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
Risk score	8 (2/4)
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

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Agenda item 27/23e

Meeting of the Board of Directors
Thursday 28th September 2023

1. Introduction

NHS England (NHSE) published a new Fit and Proper Persons Test (FPPT) 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 expect 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 will still be required.

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) – awaited from NHSE
- FPPT fields in NHS Electronic Staff Record (ESR) to record testing – added to the system and data quality checks undertaken to ensure correct staff captured
- A Board Member Reference (BMR) – requirements included in updated policy
- 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 (to be available from NHSE later in 2023/2024)
- specific reference requirements for board members (the Board Member Reference - BMR)

3. Key Principles

The FPPT should be a key element of patient safety and good leadership in organisations, and this should be recognised by all board members; and poorly performing managers and

directors are prevented from moving between health organisations. The FPPT Framework aims to be fair and proportionate.

The Framework supports transparency and should be the start of an ongoing dialogue between board members about probity and values. It should be seen as a core element of a broader programme of board development, effective appraisals and values-based (as well as competency-based) appointments – all of which are part of the good practice required to build a 'healthy' board.

Organisations can choose to extend the scope, but we are only requested to make an annual submission for our board members. NHSE has committed to a review of the FPPT Framework within 18 months.

4. Roles and responsibilities

There are changes to the roles and responsibilities of the Chair, CEO, Company Secretary, Director of Workforce and the Senior Independent Director as well as additional responsibilities for the Board of Directors and Council of Governors in terms of assurance. These have all been reflected in the updated FPPT policy. We have also requested for a review of compliance with the standard and framework to be included in the 2024/25 annual Internal Audit Plan.

5. Timeline

From 30 September 2023 we must:

- use the new board member reference template for references for all new board appointments – this does not include the most recent appointments to the Board (Director of Finance and Chair both of which were pre the guidance) but will be used for the upcoming NED appointment
- complete and retain locally the new board member reference for any board member who leaves the board for whatever reason and whether or not a reference has been requested

NHSE are currently finalising the new NHS Leadership Competency Framework (LCF) for board level roles and have said they will share this by the end of September, so that it can be implemented by 31 March 2024, alongside the FPPT Framework.

By 31 March 2024 we must:

- fully implement the FPPT Framework incorporating the LCF, including:
  - First full FPPT annual review of all board members – this will be presented to Workforce Assurance Committee and Board of Directors in March 2024
  - Individual self-attestations completed for board members – updated form added to policy
  - Annual submission form completed to go to the relevant regional director – to follow March meetings
  - ESR database updated – dashboard from ESR to be used as part of the annual review / compliance paper

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 (will be published, incorporating the LCF, by March 2024).

In future years, the appraisal, Leadership Competency Framework and FPPT assessment should all align.

6. Strengthened Fit and Proper Person Test (FPPT) assessment

Under CQC Regulation 5 (and as part of standard recruitment checks), we already assess board members to ensure that they are fit and proper by obtaining evidence to reach a conclusion. In addition, there are strengthened arrangements required around training and development, appraisal, disciplinary findings, an employment tribunal judgement check, and the introduction of a Board Member Reference (BMR).

7. Electronic Staff Record (ESR)

There are additional requirements to collect FPPT data in the ESR. Fields in ESR will be used to record that testing has been conducted and that the chair has reviewed and 'signed off' as complete for everyone. We also use a Chair sign off form for each Board appointment that is held in the hard copy files. Separate records must also be retained for mitigating actions or additional considerations considered in reaching a conclusion for each board member's FPPT. This is held in hard copy and kept up to date by the company secretary.

Personal data in ESR relating to the FPPT for board members will not routinely be accessible beyond an individual's own organisation. There are no substantive changes to the data controller arrangements from those already in place for ESR.

A Data Protection Impact Assessment has been drafted by NHSE setting out the relevant lawful basis for processing the data on ESR. As participating data controllers, we must communicate with all board members whose details will be included in ESR what data we hold. This allows directors the opportunity to object. The privacy notice relating to the processing of personal data on ESR is attached at appendix 3 of the Trust FPP policy.

NHS organisations are not expected to collect historic information to populate ESR or local records, but to use the Framework for all new board level appointments or promotions and for annual assessments going forward.

8. CQC inspection 2022 – action plan update

The actions identified in response to the CQC Well-Led Inspection 2022 relating to Regulation 5: Fit & Proper Persons – Directors were;

- Implement a standalone Fit & Proper Persons Policy addressing gaps in assurance – action complete – policy was approved by Board of Directors at their June 2023 meeting and evidence included in the supporting evidence to the action plan (pre-publication of the FPPT Framework August 23).
- Update checklist in line with the Fit & Proper Persons Policy – action complete – this was updated in line with the requirements in April 2023 (pre-publication of the FPPT Framework August 23) and a copy included in the supporting evidence to the action plan
- Include in the annual programme of the Workforce Assurance Committee and Board of Directors – action complete – rolling programmes have been updated to include this requirement and copies included in the supporting evidence to the action plan

As of August 2023, all actions were complete, and evidence added to the action plan to demonstrate the completion for each action. The introduction of the NHS FPPT Framework in August 2023 means that there are further requirements in addition to these actions and this paper and the supporting documentation outlines where and how we are addressing the additional requirements.

In November, the Workforce Assurance Committee will receive a report for assurance on completion of the Regulation 5 actions from the CQC inspection as outlined above, including all supporting evidence. The final full CQC action plan will be presented for final sign off at the October Public Board of Directors meeting.

9. Fit and Proper Persons Policy

The existing Trust policy has been updated in line with the new Framework and is presented here for approval (Appendix 1). The duties for the key individuals and for the responsible committees have been updated as well as the associated appendices. A further report on compliance with the FPPT is part of the rolling programme for Workforce Assurance Committee and Board of Directors and for Council of Governors (for non-executive directors) in line with the new requirements. The MIAA FPPT checklist has been used in the development of the policy to ensure there are no omissions.

10. MIAA FPPT Checklist

Attached at Appendix 2 is a checklist produced by MIAA relating to the FPPT Framework. The checklist is presented to Board to show the actions taken against each requirement and identify where there is further to be done to comply by the deadlines.

The checklist demonstrates that we are compliant with the elements of the FPPT framework that need to be in place by 30th September 2023. The outstanding actions relate to the publication of the new NHS Leadership Competency Framework (LCF) and completion of Board Member References (BMR's) for directors who leave or are employed from this point on. All steps have been completed for those currently on the Board. The updated Trust policy details covers all the requirements identified by the checklist.

11. Next steps

- Share detail of data fields in ESR that are completed for each director. Note the privacy notice is available as an appendix to the updated policy (appendix 1 of this report)
- Implement Board Member References from 1st October for Board members and respond to requests as appropriate.
- Assess completeness of the new FPPT fields in ESR for existing staff and update where possible in line with policy requirements. This is over and above the outlined requirements (NB. NHS organisations are not expected to collect historic information to populate ESR or local records, but to use the Framework for all new board level appointments or promotions and for annual assessments going forward).
- Implement new policy in full including use of the updated checklist and new annual attestation form and get Chair sign off (by March 2024).
- Produce compliance report for Workforce Assurance Committee and Board of Directors in March 2024 and get sign-off of full compliance.
- Submit our annual compliance submission form to the relevant Regional Director.

12. Recommendation

The Board are asked to;

- Note the introduction of the NHSE FPPT Framework August 2023 and the additional requirements
- Note the completion of the actions from the CQC action plan 2022 relating to Regulation 5 Fit and Proper Persons requirements
- Approve the updated Fit & Proper Persons Test Policy and note the requirement to review the policy in line with the review date
- Note the progress against the MIAA checklist and plans for further reports on compliance to committees of the Board

FIT & PROPER PERSONS POLICY

Document reference:	HR69	Version:	V3.0
Document owner:	Company Secretary	Document author:	Company Secretary
Accountable committee:	Board of Directors	Date approved:	29th June 2023
Ratified by:	Document Ratification Committee	Date ratified:	May 2023
Date issued:	29th June 2023	Review date:	June 2027
Target audience:	Board directors, board members and equivalents, including any other individuals who are members of the board, irrespective of their voting rights or if in interim positions.	Equality impact assessment:	5th April 2023

Key points

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

CONTENTS

1. ASSOCIATED DOCUMENTS

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

2. INTRODUCTION

2.1 Statement of intent

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

2.2 Equality and Health Inequality Analysis

As part of its development, this policy was analysed to consider its impact on different groups protected from discrimination by the Equality Act 2010. The requirement is to consider if there are any unintended impact for some groups, and to consider if the policy will minimise discrimination for all protected groups in accessing services across the Trust.

This analysis has been undertaken and recorded using the Trust's Equality and Health Inequality Analysis (EHIA) toolkit, and appropriate measures incorporated to remove barriers and advance equality in the delivery of this policy.

2.3 Good Corporate Citizen

As part of its development, this policy was reviewed in line with the Trust's Corporate Citizen ideals. As a result, the document is designed to be used electronically to reduce any associated printing costs.

2.4 Values and Behaviours

Our Trust's Values and Behaviours define how we approach our work and treat each other and sits alongside what we do. It applies to all colleagues and outlines the behaviours that is required when we interact with each other, our patients, and our visitors.

2.5 Purpose

The purpose of this policy is to ensure the Trust complies with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 5: Fit and Proper Persons Requirement and the NHS England Fit and Proper Person Test Framework for board members, August 2023.

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

2.6 Scope

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

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

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

3. DEFINITIONS

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

4. DUTIES

4.1 Trust Chair

The Chair is accountable for taking all reasonable steps to ensure the FPPT process is effective and that the desired culture the Trust is maintained to support an effective FPPT regime. As such, the chairs' responsibilities are:

a) Ensure the Trust has proper systems and processes in place so it can make the robust assessments required by the FPPT.

b) Ensure the results of the full FPPT, including the annual self-attestations for each board member, are retained in the hard copy files by the company secretary and in the appropriate fields within the electronic staff record (ESR).

c) Ensure that the FPPT data fields within ESR are accurately maintained in a timely manner.

d) Ensure that the board member references/pre-employment checks (where relevant) and full FPPT (including the annual self-attestation) are complete and adequate for each board member.

e) Ensure an appropriate programme is in place to identify and monitor the development needs of board members.

f) On appointment of a new board member, consider the specific competence, skills and knowledge of board members to carry out their activities, and how this fits with the overall board.

g) Conclude whether the board member is fit and proper.

h) Complete an annual self-attestation that they themselves are in continued adherence with the FPPT requirements. On an annual basis, confirm that all board members have completed their own FPPT self-attestation and that the FPPT is being effectively applied in their NHS organisation.

i) Ensure that for any board member approved to commence work or continue in post despite there being concerns about a particular aspect of the FPPT, they document the reason(s) as to why there has been an issue about whether a board member might not be fit and proper and the measures taken to address this. A local record of this should be retained. A summary of this should also be included in the annual FPPT submission form (Appendix 5) to the relevant NHS England regional director.

Accountability for ensuring a new board member meets the FPPT assessment criteria will reside with the chair. In making such decisions the chair will be supported by existing processes and committees.

In considering their overall assessment of board members, chairs should confirm points d) and g) are adequately addressed, and where relevant for point i), appropriate action has been taken to address any concern.

The chair will present a report on completion of the annual FPPT in accordance with this policy, to the board in a public meeting and, where applicable, to the Council of Governors for Non-Executive Directors, for information.

The chair will provide an annual declaration to NHSE Regional Office to confirm compliance.

If the individual becomes ‘unfit’ the Chair is responsible for ensuring that the regulator is notified.

The Chair should ensure that a Board Member Reference (BMR) is completed and maintained for the Chief Executive and Non-executive directors when they leave the organisation. They should send a copy of the BMR to another NHS organisation on request within 14 days.

4.2 Senior Managers and individuals as applicable

4.2.1 Chief Executive

The Chief Executive will review the fit & proper persons test dashboard report (from ESR) and evidence presented by the Director of Workforce for executive directors and assess whether they

are fit and proper. This assessment will form part of the annual submission to the Regional Director NHS England.

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

The Chief Executive is responsible for ongoing appraisal of the executive directors.

The Chief Executive is responsible for completing and maintaining Board Member References (BMR's). A BMR must be completed for any executive director leaving the organisation.

If the individual becomes 'unfit' the Chief Executive must notify the Chair who will be responsible for ensuring that the regulator is notified.

4.2.2 Director of Workforce

The Director of Workforce will be responsible for ensuring that all recruitment and selection processes to Executive and Non-Board Directors and subsequent recruitment checks comply with the Fit and Proper Persons requirements under the Health and Social Care Act 2008 (Regulated Activities) Regulations. This assurance will be presented to the Chief Executive Officer and will be included in the dashboard from ESR.

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

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

The Director of Workforce is responsible for completing the FPPT for joint appointments where the Trust is the designated host/employing organisation. This must include input from the chair of the other contracting NHS organisation. A 'letter of confirmation' should be provided and passed to the Company Secretary for inclusion in the hard copy file in these cases. The Director of Workforce is also responsible for communicating any matters that may impact the FPPT assessment with the other contracting organisation.

The Director of Workforce is responsible for ensuring that the ESR team maintain the FPPT fields in ESR and produce a dashboard for inspection.

4.2.3 Company Secretary

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

The Company Secretary, with the Workforce Team, will ensure that DBS checks are undertaken for all Board members at least every 3 years after appointment.

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

The Company Secretary will ensure that annual declarations are completed and stored appropriately for all relevant directors.

The Company Secretary will ensure that appropriate personal data relating to FPPT assessment is retained in local record systems and specific data fields populated in ESR.

The Company Secretary will undertake an annual review of compliance on behalf of the Chair to be reported to the Workforce Assurance Committee for all relevant board members (and then reported to Board) and to the Council of Governors for the non-executive directors.

The Company Secretary must communicate with all board members whose details will be included in ESR which allows directors the opportunity to object. The privacy notice relating to the processing of personal data on ESR is attached at Appendix 3.

4.2.4 Board Director & Non-Board Directors

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

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

4.2.5 Senior Independent Director

The Senior Independent Director should review the FPPT evidence to ensure the Chair meets the FPPT requirements annually. The review should form part of the compliance report to Board of Directors.

4.3 Committees in level of hierarchy

4.3.1 Board of Directors

The Board of Directors are responsible for approval of the fit & proper persons policy in line with the review date and for receiving a report on compliance annually in addition to the assurance from the Workforce Assurance Committee on FPPT compliance.

4.3.2 Workforce Assurance Committee

The Workforce Assurance Committee are responsible for receiving assurance on compliance with this policy annually and reporting this to the Board of Directors.

4.3.3 Council of Governors

Receive an annual report on compliance with the FPPT from the Chair for the non-executive directors.

5. FIT & PROPER PERSONS REGULATION

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

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

5.1 Good Character

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

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

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

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

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

5.2 Unfit

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

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

5.3 Requirement for standard / enhanced DBS check

In January 2018 the CQC issued revised guidance for providers and CQC inspectors in respect of Regulation 5 of the 2014 Regulations. Specifically, the CQC made a minor change to its guidance to make it explicit that they expect providers to undertake an "enhanced Disclosure and Barring Service (DBS) check for directors to check that they are not on the children's and / or safeguarding

barred list where they meet the eligibility criteria". However, Executive/Non-Executive Directors are only eligible for such an enhanced DBS check if the role that they take falls within the definition of a "regulated activity" as defined by the Safeguarding Vulnerable Groups Act 2006.

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

The appropriate DBS checks will be undertaken every 3 years for Board members following appointment.

Those staff covered by the policy are added to the DBS update service which alerts the Trust via the electronic staff record of any notifications relevant to their check.

6. PROCEDURE

6.1 New Appointments

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

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

Executive search companies will also be required to confirm compliance with the FPPR and provide relevant evidence for inspection by the Trust.

The Trust's comprehensive pre-employment checking processes are determined by the NHS employment standards and include the following:

1. Proof of identity / address
2. Evidence of the right to work in the UK
3. Disclosure and Barring Service (DBS) check as relevant to the role
4. Occupational Health Clearance as relevant to the role
5. Evidence of a competency and values-based interview process
6. Proof of qualifications / professional registration applicable to role
7. A check of employment history. Specifically, this includes validating a minimum of three years continuous employment including details of any gaps in service.
8. Two references one of which must be the most recent employer.
9. Social media / internet checks
10. FPPT self-attestation

In addition, the following registers will be checked:

a) Disqualified directors
b) Bankruptcy and insolvency
c) Removed Charity Trustees

The Chair will be responsible for ensuring compliance supported by the Workforce Team and the Company Secretary. A sign off form will be completed at appointment and will be retained on the

post holder's personal file for the purposes of audit (Appendix 1). A record should also be made in ESR

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

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

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

If the candidate has a disability, wherever possible, reasonable adjustments will be made to enable the individual to carry out the role that they have been appointed to.

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

6.1.2 Electronic Staff Record

ESR will be used to record that testing has been conducted and that the chair has reviewed and 'signed off' as complete for each individual, this is in addition to the Chair sign off form (Appendix 1) that is held in the hard copy files. Separate records must also be retained for mitigating actions or additional considerations taken into account in reaching a conclusion for each board member's FPPT. This is held in hard copy and kept up to date by the company secretary using an updated checklist.

Additional fields relating to the FPPT must be updated for relevant staff to record testing and annual attestations and a dashboard produced for review as part of the reporting around compliance that is assessed by the chair and presented to the Workforce Assurance Committee for review.

Personal data in ESR relating to the FPPT for board members will not routinely be accessible beyond an individual's own organisation. There are no substantive changes to the data controller arrangements from those already in place for ESR.

A Data Protection Impact Assessment has been drafted by NHSE setting out the relevant lawful basis for processing the data on ESR. The privacy notice relating to the processing of personal data on ESR is attached at Appendix 3.

6.2 Annual attestations

The FPPT requires all employees to complete a Fit and Proper Person's Declaration form (Appendix 2) annually. This will be coordinated by the Company Secretary and copies held in individual files and recorded in ESR. Completion of the annual attestations will form part of the evidence for the annual compliance report to Workforce Assurance Committee.

6.3 Board Member References (BMR)

Board member references should be 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.
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.

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.

Board member annual appraisals from the past three years should be used to guide board member references

6.4 Care Quality Commission (CQC)

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

Where a director is associated with serious misconduct or responsibility for failure in a previous role, the CQC will have regard to the seriousness of the failure, how it was managed, and the individual's role within that. There is no time limit for considering such misconduct or responsibility. Where any concerns about an existing Director come to the attention of the CQC, they may also ask the Trust to provide the same assurances.

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

7. CONSULTATION PROCESS

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

8. DISSEMINATION, IMPLEMENTATION & TRAINING

8.1 Dissemination

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

8.2 Implementation

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

8.3 Training/Awareness

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

9. PROCESS FOR MONITORING EFFECTIVE IMPLEMENTATION

Compliance with the policy will be monitored through annual audit by the Company Secretary's office and reported through the Workforce Assurance Committee against MIAA's checklist. Evidence is maintained in personnel files for inspection by the CQC and on ESR in line with the NHSE F&PPT Framework.

10. REFERENCES (IF APPLICABLE)

- Health and Care Act 2022 (legislation.gov.uk)
- Care Act 2014 (legislation.gov.uk)
- Companies Act 2006 (legislation.gov.uk)
- Companies Act 2006 (legislation.gov.uk)
- Employment standards and regulation | NHS Employers
- Safeguarding Vulnerable Groups Act 2006 (legislation.gov.uk)
- Standards of conduct, performance and ethics | (hcpc-uk.org)
- Principles in practice - Committee on Standards in Public Life (blog.gov.uk)
- CQC regulation-5-fit-proper-persons-directors
- NHS England Fit and Proper Person Test Framework for board members
- NHS England » Directory of board level learning and development opportunities

11. VERSION CONTROL SHEET

Version	Date	Author	Status	Comment
1.0	December 2022	Louise Westcott Company Secretary	Approved	Feedback from parent committee and document ratification committee (DRC) reflected in final version
2.0	June 2023	Louise Westcott Company Secretary	Approved	Updates to duties and approving committee changed to Board of Directors
3.0	September 2023	Louise Westcott Company Secretary	Approved	Updated to reflect requirements in the NHS England Fit and Proper Person Test Framework for board members (August 2023).

APPENDICES

Appendix 1:

Board of Directors' recruitment

Chair FPPT sign off form

Recruiter (delete as appropriate)	**Nominations committee NED led interview panel**		
SUCCESSFUL CANDIDATE			
Name of Candidate:			
Job Title:			
Line Manager:			
Start Date			
Salary:		**Hours:**	
Permanent / Fixed Term:		**Fixed Term End Date:**	
FPPT checks complete including all pre-employment checks (see attached checklist)		**Date:**	
Name (Chair):			
Title:			
Signature:			
Date:			

Fit and Proper Person Test (FPPT) checklist

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
First name	✓	✓	✓	x – unless change	✓	✓	Application and recruitment process.	Recruitment team to populate ESR. For NHS-to-NHS moves via ESR / Inter-Authority Transfer/ NHS Jobs. For non-NHS – from application – whether recruited by NHS England, in-house or through a recruitment agency.
Second name/surname	✓	✓	✓	x – unless change	✓	✓		
Organisation (ie current employer)	✓	x	✓	N/A	✓	✓		
Staff group	✓	x	✓	x – unless change	✓	✓		
Job title Current Job Description	✓	✓	✓	x – unless change	✓	✓		
Occupation code	✓	x	✓	x – unless change	✓	✓		
Position title	✓	x	✓	x – unless change	✓	✓		
Employment history Including: • job titles • organisations/ departments • dates and role descriptions • gaps in employment	✓	x	✓	x	✓	✓	Application and recruitment process, CV, etc.	Any gaps that are because of any protected characteristics, as defined in the Equality Act 2010, do not need to be explained. The period for which information should be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that a career history of no less than six years and covering at least two roles would be the minimum. Where there have been gaps in employment, this period should be extended accordingly.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Training and development	✓	✓	✓	✓	✓	*	Relevant training and development from the application and recruitment process; that is, evidence of training (and development) to meet the requirements of the role as set out in the person specification. Annually updated records of training and development completed/ongoing progress.	* NED recruitment often refers to a particular skillset/experience preferred, eg clinical, financial, etc, but a general appointment letter for NEDs may not then reference the skills/experience requested. Some NEDs may be retired and do not have a current professional registration. At recruitment, organisations should assure themselves that the information provided by the applicant is correct and reasonable for the requirements of the role. For all board members: the period for which qualifications and training should look back and be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that key qualifications required for the role and noted in the person specification (eg professional qualifications) and dates are recorded however far back that may be. Otherwise, it is suggested that a history of no less than six years should be the minimum. Where there have been gaps in employment, this period should be extended accordingly.
References Available references from previous employers	✓	✓	✓	x	✓	✓	Recruitment process	Including references where the individual resigned or retired from a previous role
Last appraisal and date	✓	✓	✓	✓	✓	*	Recruitment process and annual update following appraisal	* For NEDs, information about appraisals is only required from their appointment date forward. No information about appraisals in previous roles is required.
Disciplinary findings That is, any upheld finding pursuant to any NHS organisation policies or procedures concerning employee behaviour, such as misconduct or mismanagement	✓	✓	✓	✓	✓	✓	Reference request (question on the new Board Member Reference). ESR record (high level)/ local case management	The new BMR includes a request for information relating to investigations into disciplinary matters/ complaints/ grievances and speak-ups against the board member. This includes information in relation to open/ ongoing investigations, upheld findings and discontinued investigations that are relevant to FPPT. This question is applicable to board members recruited both from inside and outside the NHS.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Grievance against the board member	✓	✓	✓	✓	✓	✓	system as appropriate.	
Whistleblowing claim(s) against the board member	✓	✓	✓	✓	✓	✓		
Behaviour not in accordance with organisational values and behaviours or related local policies	✓	✓	✓	✓	✓	✓		
Type of DBS disclosed	✓	✓	✓	✓	✓	✓	ESR and DBS response.	Frequency and level of DBS in accordance with local policy for board members. Check annually whether the DBS needs to be reapplied for. Maintain a confidential local file note on any matters applicable to FPPT where a finding from the DBS needed further discussion with the board member and the resulting conclusion and any actions taken/required.
Date DBS received	✓	✓	✓	✓	✓	✓	ESR	
Date of medical clearance* (including confirmation of OHA)	✓	X	✓	x – unless change	✓	✓	Local arrangements	
Date of professional register check (eg membership of professional bodies)	✓	X	✓	✓	✓	X	Eg NMC, GMC, accountancy bodies.	
Insolvency check	✓	✓	✓	✓	✓	✓	Bankruptcy and Insolvency register	Keep a screenshot of check as local evidence of check completed.
Disqualified Directors Register check	✓	✓	✓	✓	✓	✓	Companies House	
Disqualification from being a charity trustee check	✓	✓	✓	✓	✓	✓	Charities Commission	

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Employment Tribunal Judgement check	✓	✓	✓	✓	✓	✓	Employment Tribunal Decisions	
Social media check	✓	✓	✓	✓	✓	✓	Various – Google, Facebook, Instagram, etc.	
Self-attestation form signed	✓	✓	✓	✓	✓	✓	Template self-attestation form	Appendix 3 in Framework
Sign-off by Chair/CEO	✓	x	✓	✓	✓	✓	ESR	Includes free text to conclude in ESR fit and proper or not. Any mitigations should be evidence locally.
Other templates to be completed								
Board Member Reference	✓	✓	x	x	✓	✓	Template BMR	To be completed when any board member leaves for whatever reason and retained career-long or 75th birthday, whichever latest. Appendix 2 in Framework.
Letter of Confirmation	x	✓	✓	✓	✓	✓	Template	For joint appointments only - Appendix 4 in Framework.
Annual Submission Form	x	✓	✓	✓	✓	✓	Template	Annual summary to Regional Director - Appendix 5 in Framework.
Privacy Notice	x	✓	x	x	✓	✓	Template	Board members should be made aware of the proposed use of their data for FPPT – Example in Appendix 6.
Settlement Agreements	x	✓	✓	✓	✓	✓	Board member reference at recruitment and any other information that comes to light on an ongoing basis.	Chair guidance describes this in more detail. It is acknowledged that details may not be known/disclosed where there are confidentiality clauses.

Appendix 2: Annual self-attestation form

Fit and Proper Person Test new starter & annual self-attestation – The Christie NHS Foundation Trust

I declare that I am a fit and proper person to carry out my role. I:

- am of good character
- have the qualifications, competence, skills and experience which are necessary for me to carry out my duties
- where applicable, have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals
- am capable by reason of health of properly performing tasks which are intrinsic to the position
- am not prohibited from holding office (eg directors disqualification order)
- within the last five years:
  - I have not been convicted of a criminal offence and sentenced to imprisonment of three months or more
  - been un-discharged bankrupt nor have been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors and has not discharged
  - nor is on any 'barred' list.
- have not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) while carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

The legislation states: if you are required to hold a registration with a relevant professional body to carry out your role, you must hold such registration and must have the entitlement to use any professional titles associated with this registration. Where you no longer meet the requirement to hold the registration, and if you are a healthcare professional, social worker or other professional registered with a healthcare or social care regulator, you must inform the regulator in question. Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the chair.

Name and job title/role:	
Professional registrations held (ref no):	
Date of DBS check/re-check (ref no):	
Signature:	
Date of last appraisal, by whom:	
Signature of board member:	
Date of signature of board member:	
For chair to complete	
Signature of chair to confirm receipt:	
Date of signature of chair:	

Appendix 3

Board Member Fit and Proper Person Test (FPPT) Privacy Notice

The Christie NHS Foundation Trust is required to provide you with details on the type of personal information which we collect and process. In addition to any other privacy notice which we may have provided to you, this notice relates to the information collected and processed in relation to the Fit and Proper Person Test (FPPT).

The FPPT in the Electronic Staff Record (ESR) is commissioned by NHS England.

Contact: the-christie.dpo@nhs.net
Address: Trust Administration, Wilmslow Rd, Withington, M20 4BX
Phone Number 0161 446 3700

Email: the-christie.dpo@nhs.net

The type of personal information we collect is in relation to the FPPT for board members and is described below, much of which is already collected and processed for other purposes than the FPPT:

1. Name, position title (unless this changes).
2. Employment history – this includes details of all job titles, organisations, departments, dates, and role descriptions.
3. References.
4. Job description and person specification in their previous role.
5. Date of medical clearance.
6. Qualifications.
7. Record of training and development in application/CV.
8. Training and development in the last year.
9. Appraisal incorporating the leadership competency framework has been completed.
10. Record of any upheld, ongoing or discontinued disciplinary, complaint, grievance, adverse employee behaviour or whistle-blow findings.
11. DBS status.
12. Registration/revalidation status where required.
13. Insolvency check.
14. A search of the Companies House register to ensure that no board member is disqualified as a director.
15. A search of the Charity Commission's register of removed trustees.
16. A check with the CQC, NHS England and relevant professional bodies where appropriate.
17. Social media check.
18. Employment tribunal judgement check.
19. Exit reference completed (where applicable).
20. Annual self-attestation signed, including confirmation (as appropriate) that there have been no changes.

Processing of this data is necessary on the lawful basis set out in Article 6(1)(e) UK GDPR as the foundation for the database. This is because it relates to the processing of personal data which is

necessary for the performance of the fit and proper person test which is carried out in the public interest and/or in the exercise of official authority vested in the controller.

For CQC-registered providers, ensuring directors are fit and proper is a legal requirement for the purposes of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and organisations are required to make information available connected with compliance to the CQC.

How we get the personal information and why we have it

Most of the personal information we process is provided to us directly by you as part of your application form and recruitment to satisfy recruitment checks and the FPPT requirements.

We may also receive personal information indirectly, from the following sources in the following scenarios:

- References when we have made a conditional offer to you.
- Publicly accessible registers and websites for our FPPT.
- Professional bodies for FPPT to test registration and or any other 'fitness' matters shared between organisations.
- Regulatory bodies, e.g., CQC and NHS England.

We use the information that you have given us to:

- conclude whether you are fit and proper to carry out the role of board director
- inform the regulators of our assessment outcome.

We may share this information with NHS England, CQC, future employers (particularly where they themselves are subject to the FPPT requirements), and professional bodies.

Under the UK General Data Protection Regulation (UK GDPR), the lawful bases we rely on for processing this information are:

- We need it to perform a public task.

How we store your personal information

Your information is securely stored. We keep the ESR FPPT information including the board member reference, for a career long period. We will then dispose of your information in accordance with our policies and procedures.

Your data protection rights

Under data protection law, you have rights including:

- Your right of access – You have the right to ask us for copies of your personal information.
- Your right to rectification – You have the right to ask us to rectify personal information you think is inaccurate. You also have the right to ask us to complete information you think is incomplete.
- Your right to erasure – You have the right to ask us to erase your personal information in certain circumstances.
- Your right to restriction of processing – You have the right to ask us to restrict the processing of your personal information in certain circumstances.
- Your right to object to processing – You have the right to object to the processing of your personal information in certain circumstances.

- Your right to data portability – You have the right to ask that we transfer the personal information you gave us to another organisation, or to you, in certain circumstances.
- You are not required to pay any charge for exercising your rights. If you make a request, we have one month to respond to you.

Please contact us at the-christie.information.governance@nhs.net if you wish to make a request.

How to complain

If you have any concerns about our use of your personal information, you can make a complaint to us at the-christie.information.governance@nhs.net. You can also complain to the ICO if you are unhappy with how we have used your data.

The ICO's address

Information Commissioner's Office

Wycliffe House

Water Lane

Wilmslow

Cheshire

SK9 5AF

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

September 2023

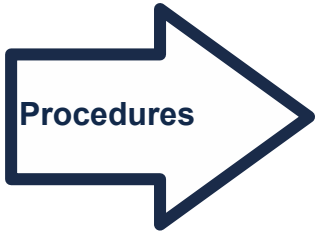
On 2nd August 2023 NHS England published the *Fit and Proper Person Test Framework for board members*. The Framework has been developed in response to the recommendations of the Kark Review (2019) outlining requirements for recording Fit and Proper Person Test (FPPT) details on NHS Electronic Staff Record (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 on the Public Board agenda for September 2023 for approval. Communication of the policy will follow approval. Policy will be 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	Policy updated to include responsibility for populating fields in ESR under Company Secretary duties. This will be done for all new appointments.

Areas for NHS organisations to consider		Organisation's Response
	retained in local record systems and specific data fields populated in ESR?	Initial audit undertaken of data field completeness. Additional information updated for existing directors. Workforce information team engaged and producing 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	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 a updated checklist that covers all requirements.

Areas for NHS organisations to consider		Organisation's Response
	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 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:	
	▪ 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.	Yes

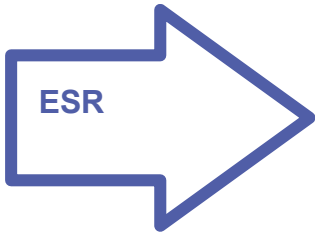
Areas for NHS organisations to consider		Organisation's Response
	• Have processes been established to ensure every board member completes an annual self-attestation confirming adherence to FPPT requirements?	Yes, annual declarations in place and on file for relevant board members. Form has been updated 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.
	• 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. b) Existing board members at one NHS organisation who move to another NHS organisation in the role of a board member.	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
	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. We will move to the new BMR for future appointments.
	• 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 currently required. BMR will be implemented from 1st October.
	• Are processes in place for the organisation to take reasonable steps to obtain appropriate references from current employers as well as previous employers within the past six years for Board members joining from another NHS organisation?	Yes

Areas for NHS organisations to consider		Organisation's Response
	• 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
	• Are mechanisms in place to store information relating to references so it is available for future checks?	Yes
	• 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	To be implemented

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?	Requirement communicated to ESR Workforce Team. This will be put in place once the fields are available.
	• Has access to ESR been restricted to ensure there is no access to FFPT information by other organisations?	Requirement communicated to ESR Workforce Team. This will be put in place once the fields are available.
	• 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 to be circulated to Board members

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.
	• 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	Company Secretary will be required to provide information with support from the Director of Workforce

Areas for NHS organisations to consider		Organisation's Response
	the board member and to provide this information to the CQC within 10 days?	
	• 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 will be added to the audit plan for 2024.

The Christie
NHS Foundation Trust

Agenda item 28/23a

Meeting of the Board of Directors
Thursday 28th September 2023

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
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 IR(ME)R Ionising radiation medical exposure regulations

The Christie
NHS Foundation Trust

Trust Report

September 2023

Executive Summary

- Measures of Patient Experience including the CQC Adult Inpatient Survey and Cancer Patient Experience Survey show excellent results, with overall scores of 9 out of 10 and 9.1 out of 10 respectively.
- Our Quality indicators showed some adverse variances: radiation incidents, falls and hospital acquired COVID.
- We have not met the 62-day referral to treatment standard.
- We are implementing our plan to manage the impact of industrial action; this has led to some rescheduling but has not affected radiotherapy and chemotherapy treatments.
- Our financial performance is cumulatively £1.5m better than plan at £1.9m deficit against a £3.3m deficit plan.
- Two of our medical staff (Agata Rembielak and David Thomson) have been appointed as MAHSC professors.
- One of our Medical Oncologists (Sara Valpione) has been recognised nationally for a research project using Artificial Intelligence to improve safety.
- The 2023 National Training Survey has shown sustained improvement in the experiences of doctors in training at the Christie.
- The Paterson building is operational with several of the groups from the Trust having moved into the premises.
- We have appointed a suitably qualified and experienced inspector to verify previous assessments that we do not have risks related to Reinforced Aerated Autoclaved Concrete (RAAC).
- We remain rated as overall Good by the CQC
- We remain on trajectory to complete our CQC Action Plan by the end of October.
- We remain in System Outcome Framework (SOF) Segment 1 pending a review being undertaken by the ICB on behalf of NHSE.
- At the end of July (Month 4), the cumulative revenue position for the GM ICB was £105m adverse variance to plan.
- GM ICB has been moved to SOF Segment 3 and is receiving additional external support.
- Greater Manchester ICB has formally approved its Operating Framework.
- We are reviewing our leadership and culture development approaches in the light of the Letby verdict and NHSE guidance
- Our Cultural Audit has completed the data collection phase and will report in November.
- We are undertaking a review of our assurance committees with a particular focus on assurance about the CQC fundamental care standards.

Quality of Care
Indicators of the Safety and Effectiveness of our services showed no significant adverse variances in August except for radiation incidents, falls and hospital acquired COVID. Details of these exceptions are given in the appendix (IPQFR).

There were 19 formal complaints in August which is above the monthly average, the number of contacts with the Patient Advice and Liaison Service (PALS) service in August was 42, a small increase on the previous month.

Nurse staffing numbers have met the levels to ensure appropriate levels of safety and care with indicative staffing is set to maintain a 1:6 nurse to patient ratio which is better than the nationally recommended 1:8. When necessary, a ratio of 1:8 has been adopted for short periods.

The actions to address recommendations of the 2022 CQC inspection reports are on trajectory to be completed by the specified deadlines.

In the CQC Adult Inpatient Survey patients gave the Trust an overall care score of 9 out of 10. Of the 11 survey sections the Trust results showed scores in eight which were 'much better than most trusts', two were 'better than other trusts' and one was the 'same'.

In the National Cancer Patient Survey patients scored care at The Christie as 9.1 out of 10 which is excellent and is above the expected range. For 12 questions the Trust's score was above the expected range. The Trust performed strongly on the Hospital Care, Living with and Beyond section, Support to Family and Carers and Discussions about Research Opportunities. For 2 questions the Trust's score was below the expected range, of which the most relevant to The Christie is the experience reported regarding waiting times for clinics and the day unit.

Five 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. Risk of not achieving the financial plan including the cost improvement programme.
2. Risk of delayed cancer referral and treatments due to not meeting 24 / 62-day targets.
3. Risk of patients being lost to follow up.
4. Risk that patients may experience harm due to significant delays in the management of patients with penile cancer.
5. Risk that the IPU Endoscopy could lose JAG accreditation by not being able to maintain the standards for environment.

The Christie Clinical Outcomes & Data Unit (CODU) was launched on 28th July. It operates from the Paterson building and will collaborate closely with Manchester University and Christie teams.

Operational Performance
Our operational performance indicators show no significant adverse variances other than for the national 62-day Cancer Standard which was not met in August with a performance of 74.7% prior to month end validation. We have continued to achieve the 31-day standard for treatment to start within 31 days of the decision to treat. During August nine operations were cancelled on the day for non-clinical reasons in August, all have been rebooked.

Plans for the coming winter are in place incorporating guidance from NHSE on 8 core objectives and 10 high impact actions and the anticipated increase in respiratory illnesses including Covid 19 variants over the next six months. Our key aims are to avoid diverting patients to other trusts for emergency care unless it is clinically necessary and to manage the timely transfer of patients from other trusts for treatment at The Christie. This includes avoiding admissions through our AACU and supportive oncology, improving flow through

"Assertive Boarding" and supporting early discharge as well as reviewing discharge processes at key later part of the day.

Industrial action by junior doctors and consultants has taken place on 19th September (consultants), 20th September (consultants and juniors) 21st September (junior doctors), 22nd September (juniors). We have manged this according to extensive plans including an operational incident room and communications to patients and staff. Our aim has been to maintain services where possible but there has been some disruption with some patients having to have their attendances rescheduled.

The cumulative effect of several days of industrial action is leading to increased waiting. This has not had an impact on radiotherapy or chemotherapy treatments. Further action is planned for 2nd to 5th October (consultants and junior doctors). We continue to advise patients that they should attend for their appointments as normal unless they have been contacted in advance with a rescheduled appointment. We are extremely grateful to all those Christie staff who have helped to maintain patient safety in this period.

Financial Performance
Financial performance is ahead of plan. The Trust is reporting a £1,861k deficit against £3,349k expected deficit planned position. This is mainly due to interest received being above planned levels and a pay underspend due to vacancies and industrial action. Capital expenditure is £0.5m above draft plan although Trust still awaiting formal confirmation of capital expenditure limits from ICB.

As shown in the table there are no significant variances from the planned financial performance against key measures other than the level of recurrent CIP delivered to date. Whilst divisions are working up cost improvement schemes, the level of these assessed as delivering is currently low.

Measure of Financial Performance	Red / Amber / Green rating
Revenue: Trust Control Total compared to plan	£1,861k deficit
Capital: Capital expenditure against plan	£483k over plan
CIP achieved (recurrent) against target of £6.4m	£1.6m identified
Debtor days compared to 15-day target	10 days
Cash balance	£132,971k

Workforce
Our workforce performance indicators show mandatory training compliance and personal development plan rates are both above (better than) thresholds at 92.4% and 86.4% respectively. Sickness absence rates have increased in August to 4.34% (threshold of 3.4%). The overall all year turnover is 15.75%. These issues and the associated plans for improvement have been considered by the Workforce Assurance Committee.

We have reviewed our existing approach and governance arrangements in relation to leadership and culture development in the light of lessons from the Lucy Letby verdict and the subsequent advice letter from NHSE. This includes good governance in relation to speaking up arrangements and our obligations under the Fit and Proper Person requirements. This work will be further informed by the findings of the cultural audit currently being undertaken by Globis Mediation Limited. The board of directors has received a more detailed paper on Leadership and Culture initiatives at The Christie.

We are undertaking an exercise to document senior leadership potential, the diversity of potential future leaders, potential gaps, areas of strength, and visibility of successors. We are currently holding career conversations with our senior managers. This will inform our contribution to that the NW Leadership and Succession Planning process led by the NW Talent Team and

The annual staff vaccination programme commences on Monday 25th September 2023. Both covid and influenza vaccines will be available for all staff with the opportunity to receive

both vaccines at one appointment. There will also be the opportunity to receive each vaccine independently for those who wish to do so. We aim to complete covid vaccination by mid-December with influenza vaccines available into the new year.

The People Development Group (PDG) is a newly launched joint initiative between the Education and Workforce teams focused on supporting current and future workforce education and training needs. The group provides an effective bridge between learner experiences (through learner voices and stories), shared education development across the organisation and a focus on effective education and training design.

The Christie Leadership Programme, a key component of workforce education, has completed its 7th cohort, inspiring new development work including a consultant leadership programme, expanded numbers of staff undertaking Masters qualification in leadership via apprenticeships and a series of RADA Business events to support senior staff in presentation skills.

Research

There has been continued development of the management and leadership structure within the Division. Nursing leadership has been strengthened with the appointment of two 8b Lead Research Nurse posts on one-year secondments. The posts will provide support for the Divisional Associate Chief Nurse role and will contribute to the implementation and delivery of strategic aims. Following a competitive recruitment process the Divisional Manager post has been successfully appointed to. The post will provide strategic and operational leadership within the Division. A new role has been created (Patient Experience Manager) with responsibility for driving forward the divisional Equality Diversity & Inclusion (EDI) agenda.

In Radiotherapy related research, May and June 2023 saw the highest enrolment of research patients through the radiotherapy departments since consistent recording was established in 2017, with the enrolment of 63 and 61 trial patients, respectively.

There has been continued expansion of the number of research studies delivered in our outreach locations. There are six research studies now open to patient recruitment with several at the feasibility review stage.

The Cancer Vaccine Launch Pad (CVLP) led by NHS England in partnership with Genomics England has been established. This initiative will help to rapidly identify cancer patients who could be eligible for potential trials. The Trust will have a key role as a vaccine delivery site as part of this initiative.

Following the launch of the R&I Strategy in May 2023 year 1 objectives have been defined. Good progress is being made towards the successful delivery of these objectives. For example, Principle 5, Delivering Research to patients faster - a collaborative working group has been initiated and work to understand what works well and the key barriers and challenges is in progress.

We are trialling a way to spare the top of the heart during radiotherapy for lung cancer patients by using artificial intelligence (AI) to precisely and quickly map out which area to target. A link to an article published in the Telegraph is available here: AI lung cancer patients & heart disease This was also mentioned by Rishi Sunak in a tweet, naming Sara Valpione, Medical Oncology consultant Rishi-Sunak high-risk-but-high-reward-research

Many congratulations Consultant Clinical Oncologists Agata Rembielak and David Thomson who have been successful in appointments to MAHSC chairs. The MAHSC Honorary Clinical Chairs are awarded on an annual basis by The University of Manchester's Faculty of Biology, Medicine and Health Promotions Committee. They are awarded to individuals from across Greater Manchester who have made a major contribution to their clinical specialty, including excellence in research and education.

Education
The 2023 National Training Survey (applied to all doctors in training posts nationally) has shown sustained improvement in overall experiences of doctors in training at The Christie. Initial analysis has shown improvements across several areas, reflecting a really excellent articulation between colleagues in clinical service and education to improve support for these colleagues. One of our areas of greatest improvement has been in the experiences of our cohort of Foundation Year 2 doctors for whom moving to practice acute care in a specialist cancer centre with the complexity of inpatient care can be a challenging experience. The collaborative nature of working across education and division and the application of educational theory led interventions has resulted in the best result for 5 years.

Strategic and Service Developments
The Paterson building is operational with several of the groups from the Trust having moved into the premises. These include clinical outcomes and data, pathology and acute oncology and surgery. Arrangements for the remaining groups are being developed to include identifying and closing the old, vacated Estate when the groups have moved. The final account with the main contractor is agreed and the established overall project governance will continue.

The outpatient pharmacy and new dispensing robot on the Withington site is now open with positive feedback being received from both staff and patients. The new facility has supported a significant reduction in the waiting time for outpatients.

Works have commenced on the formation of a 20-bedroom ward in the former Trust Administration and Digital floors with the original staircase demolished and the construction of the new foundations about to commence. The replacement of X-ray machines on the Withington site has been completed together with some other small schemes. The development of the new Art Room design and cost plan remains in progress and works to reform the landscaping around the Tree of Hope has commenced.

The Trust has commenced the early-stage engagement with HS2 on the impact of their proposals to ensure that the experience of patients, visitors and staff are not adversely impacted by their works.

The design and engagement for the proposed Advanced Scanning and Imaging Centre development along Wilmslow Road continues. The main contractor has been selected and the design sufficiently developed to support the submission of a planning application within the next period, subject to satisfactory consultations. The design of the ancillary works to decant existing uses to facilitate the new development has commenced and the overall cost plan is being developed to include the management of risks to the project.

Our Carbon Energy Fund Scheme which has previously been reported to the board and committees is being commissioned and going live by the end of September, after over 2 years in development and construction. This is a key project in our sustainability aspirations and puts us a step closer towards achieving the NHS Net Zero targets. The scheme will deliver circa one tonne of carbon emission savings and circa £1m annual in energy cost savings.

Previous assessments and current site analysis indicates that we do not have any issues with Reinforced Aerated Autoclaved Concrete (RAAC) which has been the subject of publicity recently. We are appointing a suitably qualified and experienced professional to undertake a predominantly visual, but with local opening-up of areas, inspection. This will include a review of the as-built records we hold. This process will take about 6 weeks and will enable us to respond definitively to NHSE that we have appropriate arrangements in place and are compliant with regulations.

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

Greater Manchester System Developments
In line with the recommendations set out in the review by Carnall-Farrar, the Greater Manchester Integrated Care Board (GM ICB) approved its Operating Model at its September meeting. This sets outs how the Greater Manchester Health System will be organised. The overall structure of the system remains in line with the statutory legislation i.e. a statutory organisation - the Integrated Care Board (ICB) and a statutory committee - the Integrated Care Partnership (ICS). A key feature of the operating model is the focus on the ten 'places' in GM. These are aligned with the previous CCGs and Local Authority boundaries and are known as Place-based Partnership Committees.

Within the system Operating Model The governance arrangements for the GM Cancer Alliance have not changed and it remains part of the Trust Provider Collaborative; the Alliance Board is chaired by The Christie Chief Executive. The Trust Provider Collaborative also holds responsibility for programmes on Elective Recovery, Diagnostics and Sustainable Services.

At the end of July (Month 4), the cumulative revenue position for the GM ICB was £105m adverse variance to plan. This position does not include any risk associated with the non-achievement of Elective Recovery Fund income which is estimated to be c£20m and which could add to this adverse variance.

On 30th August 2023, NHS England published "segmentation" decisions for all Integrated Care Boards (ICBs). This is an assessment of the support requirements and is part of the System Oversight Framework management activities previously reported to the board of directors. The GM ICB has been allocated segment 3 which is a decrease from the previous assessment of segment 2.

In relation to the segmentation assessment GM ICB is now to receive intensive support**.** The intensive support will include all Providers and the ICB but is not currently expected to focus on Capital Expenditure. NHSE has appointed PwC to undertake the support; initially to focus on three areas:

1. **Underlying position**
   This is expected to consider the system's current financial and operational performance. This will result in PwC undertaking a review of Trust balance sheets and likely focus on key areas challenged by NHSE i.e. productivity metrics and workforce growth.
2. **Forecast Scenarios**
   Considerations of financial scenarios, particularly linked to a review of grip and control across the system. The grip and control process is expected to test controls are in place as well as the strength of those controls, as an example are trust vacancy panels all making equally difficult decisions.
3. **Turnaround**
   Monthly detailed assessments and review meetings with Stephen Hay, expected to last 90 minutes.

PwC have also been commissioned to undertake a review of trusts and the ICB's balance sheets to identify the potential for further balance sheet flexibility to contribute to improvements to the financial position. To support this work, all trusts have articulated the rationale for key movements in their balance sheets, which will be part of the PwC review.

As part of the move to Integrated Care Systems (ICS), Specialised Commissioning budgets (except for some regional and national services, e.g. proton beam therapy) will be delegated to Integrated Care Boards (ICBs) from 24/25 financial year. In preparation, all ICBs are subject to national assessment and moderation process (in Autumn 2023) to assess the system's readiness to take on the delegated specialised commissioning function. This creates several additional financial risks resulting from increased pressure from the delegated budgets, changes to the resource allocation formula which are likely to disadvantage Greater Manchester and the significant level of the budget changes. As most

The Christie's services are funded from these budgets we are working with MFT, the NCA and NW Specialised Commissioning colleagues to contribute to the process and ensure risks are understood, minimalised and mitigated as far as possible.

Regulation and Governance
Care Quality Commission
As previously noted, the actions to address recommendations of the 2022 CQC inspection reports are on trajectory to be completed by the specified deadlines. We are addressing both the must do and should do recommendations and providing evidence to confirm that we are compliant with the regulations. The must do actions are scheduled for implementation by the end of October 2023 and the full action plan progress report will be scrutinised by the relevant assurance committees before being reported to the board for final approval.

As previously reported to the board the CQC have undertaken an assessment of our compliance with the IRMER (Ionising Radiation Medical Exposure Regulations). The findings are very positive and show that we are complaint with the regulations. The CQC has identified three areas for improvement but there are no "Must Do" requirements. We have published the report and action plan on our web site. The CQC does not itself publish this report externally and makes no separate rating score. This assessment is not included in the calculation of our overall CQC rating.

Single Oversight Framework Rating
Within the Single Oversight Framework The Christie is in segment 1 (requiring least support). We have been told by the GM ICB that the CQC rating has triggered a segmentation review. Whilst the ICB is in the process of taking on this responsibility and is undertaking the review, decisions at present remain with NHS England. We have been asked to provide information to inform the process.

Board Assurance Review
In line with good practice, we want the board to be assured that its assurance committee structure remains effectively organised and is receiving appropriate information. In the light of the CQC report we want to understand how we can best provide future assurance on quality of care including adapting our reporting and assurance arrangements to the changing regulatory frameworks of both NHSE and the CQC.

We have commissioned the Good Governance Institute to undertake a review and provide a report with recommendations. GGI are a market leading specialist governance and leadership consultancy with a UK-wide reputation and international networks. They have supported over 750 boards and leadership teams in different sectors and contexts over the past 14 years, and more than 50 in the last year, to improve their governance with a significant track record of success. They have been recommended by several recent clients. The review will start in late September with the report expected 10 weeks after initiation. The process will include document reviews, board and committee observations, interviews with board members and senior leaders. The output will be a summary baseline report which captures our findings and makes recommendations for development and development of an action plan for taking our recommendations forward.

Cultural Audit
Following the CQC inspections we have commissioned Globis Mediation Limited to undertake a wide-ranging audit of our organisational culture. The purpose is to better understand some of the CQC feedback and comments from staff, triangulating these with other sources of information such as the NHS Staff Survey. The full background and terms of reference of the cultural audit have been published on our website.

The data collection phase of the work is now almost complete has comprised 20 focus groups, circa 110 semi-structured interviews, a survey of all staff with 1,073 responses (30.48%), and a desktop review of relevant reports and data. Site visits for observations are being arranged. The results of the audit are planned for publication in November 2023.

Whilst the audit work and report writing are the responsibility of Globis a small advisory group has been supporting the work with advice on content, documentation availability and the logistics of surveys. Membership is: Executive Director/DCEO (Coordinator), Medical Staff Governor, Registered Nursing Staff Governor, Other Clinical Staff Governor, Non-Clinical Staff Governor (vacant), Partnership Officer, Staff Side, Workforce team representative, Company Secretary.

Covid-19 Public Inquiry

As part of Module 3 of the UK Covid-19 Public Inquiry we are required to provide a formal witness statement with relevant associated documentation about the management of colorectal cancer by The Christie from 1st March 2020 to 28th June 2022. This is part of the Inquiry's assessment the effect of the Covid-19 pandemic on the care and management of patients with conditions other than Covid-19. We are in the process of compiling the statement which will be a draft at this stage, the inquiry team could then come back to us with any further questions prior to the statement being finalised.

National Policy Initiatives

Fit & Proper Persons Test Framework

NHS England (NHSE) published a new Fit and Proper Persons Test (FPPT) 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 expect elements of the framework to be used from 30th September 2023 with full implementation by 31st 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 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 with 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.

The full framework should be fully implemented by 31st March 2024. A full FPPT against the core elements of the framework should be undertaken whenever new appointments are made, if a board member moves to a new board role in their current organisation, and annually thereafter. Annual self-attestations by board members to confirm adherence to the regulations will continue.

Major Conditions Strategy

The Department of Health & Social Care has published the 'Major Conditions Strategy: A case for change and strategic framework' on 14th August 2023. The Strategy addresses six major conditions that account for 60% of mortality and morbidity, namely cancer, dementia, musculo-skeletal disorders, mental ill health, cardiovascular disease and chronic respiratory disease. For Cancer the strategy focusses on reducing risk factors (weight, smoking, exercise, and alcohol), early diagnosis and treatment and living well and beyond cancer. As a specialist hospital, focussed on a single condition, we have continued to evolve our models of care, for example through the development of the Senior Adult Oncology service[1] which is a recognition that patients are not only presenting later in life but with more complex needs.

Cancer Waiting Times Changes

NHS England and the department of health and social care have made changes to the Cancer waiting times standards that come into effect from the 1st October 2023. There are currently ten different waiting times standards applied to NHS cancer diagnosis and treatment.

[1] see Senior adult oncology service (christie.nhs.uk) (accessed 22/08/2023)

The changes to the CWT standards are:

1. Removal of the 2-week wait standard in favour of a focus on the Faster Diagnosis Standard (75%)
2. One headline 62-day referral to treatment standard (85%). The 4 individual 62-day standards (Classic, Upgrade, Screening, Symptomatic) will be consolidated in to one 62 Day referral to treatment standard (85%)
3. One headline 31-day decision to treat to treatment standard (96%). The 4 individual 31-day standards (31 day first definitive treatments, 31-day subsequent Drugs, 31-day subsequent Surgery & 31-day subsequent Radiotherapy) will be consolidated in to one 31-day decision to treat to treatment standard (96%).

These changes do not directly affect our current levels of performance significantly. The trust needs to continue with the improvement plans to achieve the 85% compliance against the 62-day RTT standard and the FDS standard which internally relates to the haematology service. Compliance across the 31-day standard will need to be maintained and the internal 24-day measure will remain in place.

NHS Enforcement Guidance

Following introduction of the Health and Care Act 2022 NHS England has revised the regulatory framework to include a single System Oversight Framework for all NHS bodies and to extend the Provider licence to all NHS bodies (and some others). This is accompanied by the new NHS Enforcement Guidance' (the 'Guidance') with the same system applicable to Integrated Care Boards, NHS Foundation Trusts and NHS Trusts.

The Guidance details how NHS England will exercise its enforcement powers. The Guidance provides NHSE a degree of flexibility and discretion but sets parameters for NHSE's level of intervention and support for NHS bodies falling into one of the four segments defined in the Oversight Framework. Segment 1 indicates the least intervention and support, with Segment 4 indicates significant intervention and support.

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

- No serious incidents were reported in August. There were 5 incidents reported in month with the classification of moderate, details of which can be found on slide 7. All the incidents are still progressing through to full root cause analysis. No never events were reported in month.
- There are 5 Trust level risks scored at 15+. Details of these can be found on slide 15.
- Safer staffing numbers have met the required acuity levels to ensure appropriate levels of safety and care for our patients. Indicative staffing, in line with nursing establishments, is set to maintain a 1:6 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 3 cases of C-Difficile, 8 cases of E-Coli, 2 cases of Klebsiella, 1 case of Pseudomonas and 4 cases of MSSA in August that were deemed attributable to the Trust. No lapses in care have been identified.
- There was 1 nosocomial Covid-19 infection outbreak affecting 7 patients and 2 staff members in August.

Performance

- Performance against the 62 day standard has improved significantly from July, however the standard has not been met with a performance of 74.7%, subject to validation. The 62 day unvalidated upgrade performance has also not met the standard with a performance of 76.9%, subject to validation. The internal 24 day target is below standard and is at 75.3%. All 62 and 24 day breaches are reviewed to ensure any delays are understood and plans can be implemented to mitigate any future delays. All 31 day targets and 18 week RTT standards have been achieved in August subject to validation. Performance against the CWT thresholds is constantly monitored and action plans are in place to improve performance going forward.
- The two patients waiting over 52 weeks at the end of August are both patients referred to us after long waits in secondary care. One patient had an extremely complex diagnosis pathway whilst the other patient has a pathway that includes several postponements and delays due to patient choice.
- Referral numbers in August increased significantly from July and are also higher than August 2022. Overall YTD referral levels are higher than 22/23 levels.

HR

- Staff absence levels increased slightly from July to a position of 4.34% against a target of 3.4%.
- PDR performance has improved from July's position. Mandatory training performance has also improved from July. Both measures are above the set standard.

Finance

- At month 5 the Trust is reporting a month end deficit of £1,861k compared to an expected £3,349k, giving a variance against plan of £1,488k. The main reason for an improved position relates to interest received above plan and continued underspends on pay whilst growth vacancies are recruited to.
- Capital expenditure is above CDEL plan by £483k. The cash balance is £132,971k.
- Performance for month 5 was an overspend of £483k against the CDEL plan submitted to NHSE&I.
- The Trust has incurred £4,930k on capital schemes to month 5, primarily on the backlog maintenance programme, the linac and CT scanner replacements, Digital Services Electronic Health Records projects, final works on the Paterson scheme and the TIF ward.

SUMMARY DASHBOARD

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Safe

Indicator	Threshold / Standard 23/24	Apr-23	May-23	Jun-23	Jul-23	Aug-23	YTD
Serious Incident Reported	-	0	0	0	2	0	2
Never Events	0	0	0	0	0	0	0
Radiation Incidents Reported (IRMER Reportable)	0	0	0	0	1	3	4
Radiation Incidents Reported (IRMER Reportable - Grade 2 or above)	0	0	0	0	0	0	0
Number of Pressure Ulcers (Post admission - Grade 2 or above) - Rate per 1000 occupied bed days	0.4 (22/23 Avg)	0.2	0.4	0.2	0.2	0.8	-
Inpatient Falls Resulting in Harm (Grade 2 or above) - Rate per 1000 occupied bed days	3.6 (22/23 Avg)	2.6	4	4	2.7	2.9	-
VTE Assessments Completed	95.0%	98.0%	98.2%	98.8%	97.9%	98.7%	-
Sepsis - timely treatment with IV antibiotics (established inpatients)	90.0%	96.9%	95.1%	90.2%	92.2%	90.1%	-
Sepsis - screening (presenting as an emergency)	90.0%	95.0%	95.3%	98.7%	96.1%	96.0%	-
Number of Corporate Risks Grade 15 or Above	-	4	4	4	4	5	-
Safe Staffing (% of planned hours vs actual hours across all inpatient areas)	-	82.7%	87.4%	85.7%	86.5%	84.1%	-

Responsive

Indicator	Threshold / Standard 23/24	Apr-23	May-23	Jun-23	Jul-23	Aug-23	YTD
62 Day Compliance	85.0%	71.30%	67.30%	70.30%	67.60%	74.70%	-
62 Day Compliance - Upgrades	85.0%	67.10%	74.00%	87.90%	74.40%	76.90%	-
62 Day Compliance - Screening	90.0%	75.00%	63.60%	100.00%	58.30%	33.30%	-
24 Day Compliance	85.0%	73.80%	74.60%	76.60%	68.90%	75.30%	-
31 Day Compliance	96.0%	97.80%	97.80%	96.70%	97.30%	99.20%	-
31 Day Compliance - Subsequent Drug Therapy	98.0%	100.00%	100.00%	100.00%	100.00%	100.00%	-
31 Day Compliance - Subsequent Radiotherapy	94.0%	99.20%	99.20%	100.00%	99.80%	99.70%	-
31 Day Compliance - Subsequent Surgery	94.0%	98.80%	100.00%	98.60%	100.00%	100.00%	-
18 Weeks Compliance - Incomplete Pathways	92.0%	96.50%	96.91%	97.50%	97.80%	97.60%	-
Patients waiting >52 Weeks	0	1	1	1	1	2	6
Patients waiting >104 days at end of month (All 62 Day Targets)	-	34	42	44	46	40	-
Length Of Stay (Elective & Non-Elective Inpatients)	-	7.77	7.1	6.59	7.02	6.99	-
Hospital Cancelled Operations on the day for non clinical reasons	0	2	4	2	5	9	22
Hospital Cancelled Operations on the day for non clinical reasons - NOT rebooked within 28 days	0	0	1	1	1	0	3
Complaints Received	14 (22/23 Avg)	11	11	11	12	19	64
PALS Contacts	44 (22/23 Avg)	46	51	42	35	42	216
Inquests	-	2	5	2	2	1	12
Coroner Request	-	11	12	4	3	4	34

SUMMARY DASHBOARD

NHS
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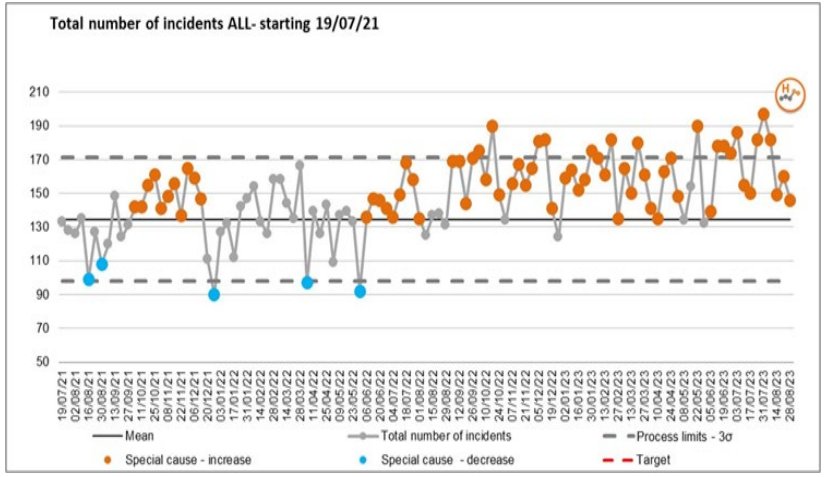
Effective

Indicator	Threshold / Standard 23/24		Apr-23	May-23	Jun-23	Jul-23	Aug-23	YTD
MRSA	0		1	0	0	1	0	2
C-Difficile - All Attributable Cases (Pre & Post 48 Hours)	51		2	3	4	4	3	16
C-Difficile - Attributable Cases Due To Lapse In Care	0		0	0	0	0	0	0
MSSA Bacteraemia - Attributable	25		1	1	1	2	4	9
E-Coli - Attributable	58		5	4	7	6	8	30
Klebsiella Species - Attributable	17		4	2	0	1	2	9
Pseudomonas Aeuriginosa - Attributable	10		1	0	2	1	1	5
COVID infections - Hospital Aquired	0		2	1	0	0	7	10
Palliative Radiotherapy 30 Day Suvival Rate	-		92.2%	92.1%	92.2%	88.7%	-	-
Final Chemotherapy 30 Day Survival Rate	-		99.0%	99.3%	99.5%	99.4%	-	-
Surgery 30 Day Survival Rate	-		100.0%	100.0%	100.0%	100.0%	-	-
Staff Sickness	3.4%		3.97%	3.83%	4.06%	4.28%	4.34%	-
Staff Mandatory Training	>80%**	<80%	89.4%	92.1%	92.9%	91.9%	92.2%	-
Staff PDRs	-		84.7%	84.5%	85.6%	85.9%	86.5%	-

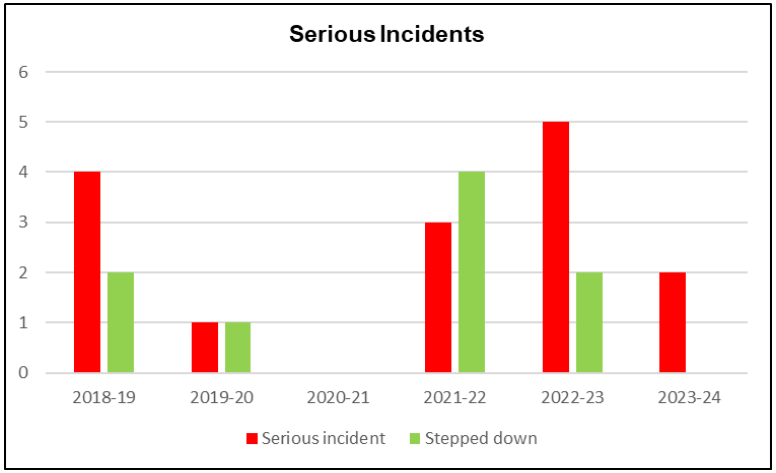
***Compliance if <80% & risk assessment in place**

Incident Reporting



The Trust experienced a reduction in incident reporting throughout the period July 2020 to July 2022 due to the COVID-19 Pandemic, it is felt that the last 6 month increases in incident reporting are recovery to pre pandemic levels of incident reporting as well as proportionate to activity increasing.

Serious Incidents and Never Events



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

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

Serious incidents
There were no serious incidents identified in August 2023.

Incidents identified that require a Learning Response

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August 2023 – RCA identified through PSIG/ERG		
Reference	**Description**	**Reported Harm Level**
W79846	A patient became severely agitated and physically aggressive towards staff, causing some staff to be injured.	Moderate
W79831	Medication given at a faster rate than was required.	Moderate
W79973	CMV prophylaxis was not prescribed for 8 days after a stem cell transplant. Patient went on to develop CMV reactivation	Moderate
W77588	Patient was not planned for radiotherapy after chemotherapy, and went on to develop local reoccurence	Moderate
W79996	Patient with a pathological # to right hip was advised physio that she could mobilise under supervision with WZF; attempted to stand from bed and fell	Moderate

Learning - Patient Safety Incidents

The Christie NHS Foundation Trust

Agreed learning and revised severity outcome following executive reviews August 2023

Ref	Description	Root cause	Learning	Outcome
W74890	Delayed Herceptin due to lost referral	IT issues which are being raised with Tech Bar. EPRO is not able to send emails, process changed to ensure that referral goes to the HER2 team inbox from the secretaries	• EPRO New practice and processes required • Audit to be completed for June to August 2022 to provide assurance that no other Herceptin referrals for patients were not received by the HER2 team • Chemotherapy Nurses are to ensure patients have appointments for the next cycle of Her2 treatment as the last cycle of chemotherapy is not the last oncology treatment. • Nurses have been reminded to discuss with patients at the last SACT treatment date that they have a plan in place for next steps i.e. appt/ referral to other services	Moderate
W76699	Percentage Tc99m thyroid uptake, as part of thyroid imaging (NTTCU), has been calculated incorrectly. This is in part due to the gamma camera saving the incorrect Actual Frame Duration into the DICOM header	One patient (RBV202210468) has had their percentage thyroid uptake of [99mTc]Tc-pertechnetate overestimated. There was no clinical impact of this overestimate – it would not have influenced their management differently	• Change camera protocol to acquire only anterior phantom images. This will prevent any further incorrect percentage thyroid uptake reports. • Remove the requirement to image the phantom and calculate camera sensitivity for each patient. Camera sensitivity is assessed biannually as part of routine QC. This will increase efficiency and remove any potential phantom setup error introducing erroneous results • Communicate with GE regarding DICOM issue. Inform MHRA as necessary (dependent on GE response)	No Harm

Learning - Patient Safety Incidents

The Christie NHS Foundation Trust

Agreed learning and revised severity outcome following executive reviews August 2023

Ref	Description	Root cause	Learning	Outcome
W77906	Patient was prescribed and given chemotherapy at 80% rather than 62% dose. No harm was caused by this and next dose reduced to compensate.	Incorrect incrementation which was not identified because not all staff were aware of relevancy SOP/protocol	• Promote awareness of SOP by adding to presentation for new pharmacists and communicated via email to the team • SACT committee to review protocol with regards to the standardising increment increases • Circulate updated DPYD protocol to all disease groups • Investigate whether there is the capability within iQEMO to flag dose increase variances against the guidelines	No Harm
W78450	Granulocyte colony stimulating factor (GCSF) not supplied to patient after chemotherapy	GCSF stored in fridge and not supplied to patient on day 1 of treatment	• Ambulatory Care nursing staff informed to not store GCSF on unit for patient and to be supplied on Day 1 as per prescription • Consultant review to include bloods review and compliance with post chemotherapy GCSF	Minor

Learning - Patient Safety Incidents

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

Ref	Description	Root cause	Learning	Outcome
W75065	Patient did not receive an appointment letter that was sent in August 2022 for an appointment in clinic on 23.09.2022 The DNA outcome to clinic was not entered onto CWP, so a further appointment was not made which resulted in the patient not being referred for consideration of radiotherapy.	Administration and clinic outcome error	• The updated processes for 'cashing up' clinics that have now been implemented, would have prevented this error.	No Harm
W76591	Delayed HRD testing resulted in a patient who was HRD/GIS positive (and therefore eligible for maintenance combination Bevacizumab + Olaparib) not being able to receive it.	The initial opportunity to test for HRD failed which was not detected until after the threshold for administration has passed.	• Mandatory field to be added to MDT proforma for HRD testing	No harm

Learning - Patient Safety Incidents

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Agreed learning and revised severity outcome following executive reviews August 2023

Ref	Description	Root cause	Learning	Outcome
W77116	Patient did not receive adjuvant Herceptin treatment following chemotherapy as required.	Referral to HER2 team did not occur as part of treatment planning	• Learning shared within team to prevent future errors • Crib sheet produced by breast consultant Backstop checks at cycle 5, to review ongoing treatment plan and that all that is expected for the patient is in place • Retrospective audit to be completed to ensure no other patients have not received their adjuvant Herceptin treatment • Above documentation to be shared with and discussed with the	Minor
W77700	Unwitnessed fall in bathroom resulted in fractured neck of femur	This fall was not assessed as accidental	• Post fall protocol shared with team	Moderate
W78436	Patient fell whilst dismounting radiotherapy couch. Resulted in fracture neck of femur.	Unavoidable patient fall.	• Post fall protocol shared with team	Major
W76924	Patient was incorrectly prescribed Edoxaban when it was contra-indicated due to a previous gastro-intestinal bleed.	The medic incorrectly prescribed edoxaban after utilising the GM Care record for a drug history. This record was not up to date and stated the patient was on edoxaban.	• Pharmacy to look how communication can be improved between AAU and Ward pharmacists to highlight if a patient has been transferred prior to screening • Circulate a case study with the medical staff. • Highlight to staff that GM Care may not be up to date in the learning bulletin.	Moderate

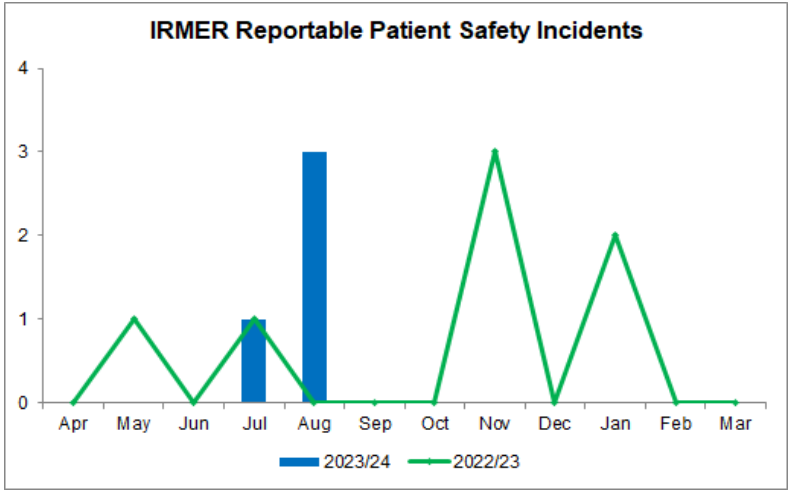
Learning - Patient Safety Incidents

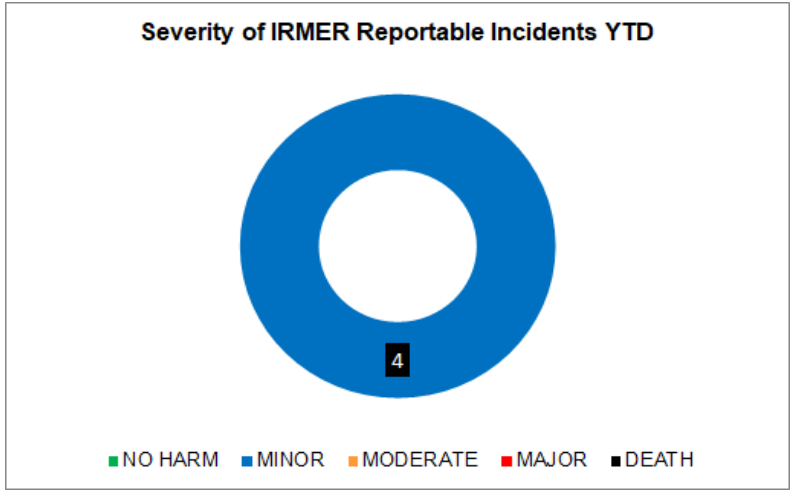
The Christie NHS Foundation Trust

Agreed learning and revised severity outcome following executive reviews August 2023

Ref	Description	Root cause	Learning	Outcome
W78383	Delay in initial identification, escalation and review of a patient who met the emergency sepsis pathway for consideration of appropriate IV antibiotic cover. This resulted in Emergency Sepsis Pathway IV administration breach by 3 hours 35 minutes.	Poor communication/documentation; Failure to trigger the Sepsis pathway earlier.	• A) Bite sized session for ward 10 staff, B) increase compliance with sepsis training, C) increase compliance IVAB PGD • Reiteration of NEWS2 escalation process. • Reminder to trainee doctors of the importance of documenting the course of the patients care and ensure any outstanding urgent reports are discussed at handover. • Case to be discussed at CSSS governance day. • Review whether surgical team can be included in the junior doctor rotation training for the sepsis pathway.	No Harm

Radiation Incidents





There were 3 IRMER reportable patient safety incident in August classed as no harm.

Harm Free Care

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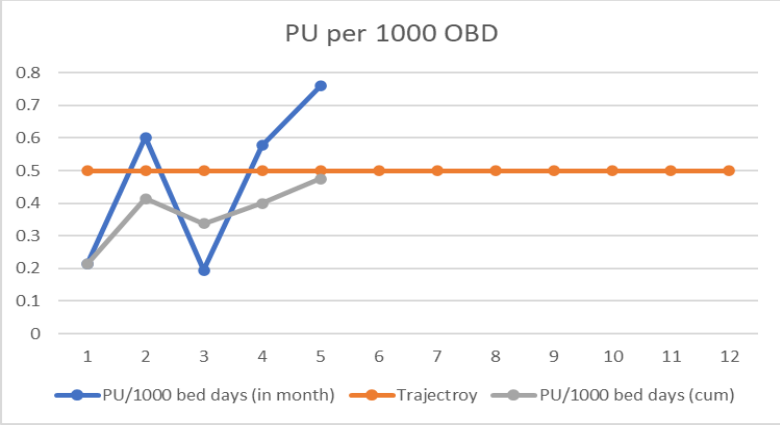
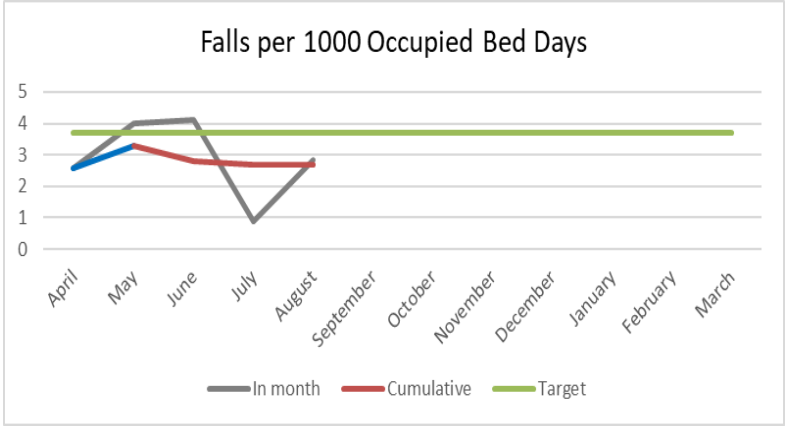
Pressure ulcers per 1000 occupied bed days



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

Falls per 1000 occupied bed days



2.85 falls per 1000 occupied bed days in month and cumulative
Rolling average is 2.7 which is well below Trust average of 3.8, and national average of 6.6
One moderate or above harm falls in month.

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

Corporate Risks

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There are 5 Trust-wide 15+ risks in August

Description	Score	Controls
Financial Risk 2023-24 (ID 3378)	16	M2 outturn is a deficit of £0.9m against a deficit plan of £1.3m so ahead of plan but still a financial deficit. Recurrent CIP of £0.7m has been identified against an annual target of £6.4m which will remain a challenging target. Capital plans still to be finalised.
Post clinic appointments processes are contributing to a risk to patients being lost to follow up (ID 3299)	15	Work continues on action plan, working with MIAA to assess actions and assurance. Work continues on developing the wait list and all teams are working through the Open referrals.
Risk to delayed cancer referral and treatments due to not meeting 24 / 62 day target (ID 2407)	15	Action plan in place. Service leads and heads of service working on capacity and pathways
There is a risk that patients may experience harm due to significant delays in the management of patients with penile cancer (ID 3319)	16	Awaiting confirmation on start dates for two consultants recruited on 28/06/2023. Additional Penile Theatre lists on Fridays. To commence on Friday 28/07/2023. Bi Weekly Extended Thursday Theatre session for Penile work
There is a risk that the IPU Endoscopy could lose JAG accreditation by not being able to maintain the standards for environment (ID 3534)	15	Jag standard states that Endoscopy patients' privacy and dignity be maintained throughout the endoscopy patient pathway on IPU.

Safe Staffing

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	17760	13659	5191	5.2
	Total monthly ACTUAL	14771	12280		
	Average Fill Rate %	83.2%	89.9%		
Care Staff	Total monthly PLANNED	10578	6264	5191	2.5
	Total monthly ACTUAL	7384	5819		
	Average Fill Rate %	69.8%	92.9%		
ALL Staff	Total monthly PLANNED	28338	19923	5191	7.8
	Total monthly ACTUAL	22296	18289		
	Average Fill Rate %	78.7%	91.8%		

Registered Nurses	DAY			NIGHT			Cumulative count over the month of patients at 23:59 each day	CHPPD (Care Hours Per Patient Per Day)
	Hours Planned	Hours Actual	% Fill Rate	Hours Planned	Hours Actual	% Fill Rate		
Critical Care Unit	2373	2199	92.7%	2177	2058	94.5%	181	23.5
Palatine Ward	3217	2611	81.2%	2668	2221	83.3%	920	5.3
Ward 10	2591	2051	79.2%	1668	1597	95.7%	815	4.5
Ward 11	2014	1627	80.8%	1688	1297	76.9%	719	4.1
Ward 12	1914	1707	89.2%	1562	1458	93.4%	818	3.9
Ward 4	1756	1649	93.9%	1472	1409	95.7%	820	3.7
Ward 2	1074	953	88.7%	564	645	114.4%	361	4.4
Acute Assessment Unit	2822	1974	70.0%	1861	1594	85.7%	557	6.4
TOTAL	17760	14771	83.2%	13659	12280	89.9%	5191	5.2

Registered Nursing Associates	DAY			NIGHT		
	Hours Planned	Hours Actual		Hours Planned	Hours Actual	
Ward 11					42	
Ward 12					55	
Ward 4		141			93	

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	635	226	35.5%	0	46	100.0%	181	1.5
Palatine Ward	1386	998	72.0%	1000	857	85.7%	920	2.0
Ward 10	2521	1406	55.8%	1011	809	80.0%	815	2.7
Ward 11	1363	958	70.3%	910	817	89.7%	719	2.5
Ward 12	1361	1260	92.6%	1100	1106	100.5%	818	2.9
Ward 4	1685	1321	78.4%	1162	1093	94.1%	820	2.9
Ward 2	399	365	91.4%	311	334	107.4%	361	1.9
Acute Assessment Unit	1228	852	69.4%	770.5	759	98.5%	557	2.9
TOTAL	10578	7384	69.8%	6264	5819	92.9%	5191	2.5

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.

Safer staffing numbers have met the required acuity levels to ensure appropriate levels of safety and care for our patients.

Patient Experience

NHS
The Christie
NHS Foundation Trust

Positive feedback received…..

"If you can feel reassured in a strange environment Christie's is the place . Quality care in this day and age is priceless. Attentive nurses and doctors throughout my procedure. And you still feel human, cared for and listened to. Fantastic team, carry on being top quality."

"Compliments to IPU staff. Patient was very apprehensive about a procedure she had to have due to past negative experiences, but found the team put her mind at ease and were generally very lovely, kind and supportive."

"Pleasant, friendly, caring, informative staff, clean and well presented hospital - I attended the Endocrinology unit. The Consultant, Doctors, admin staff all take the time to listen and support. Lots of free information booklets, leaflets to take home, tasty soup, tea, cake, sandwiches offered to support you."

"I felt the need to email to say how wonderful your team were today while I was in having my procedure. Their care was kind and professional, each and every one. I was very anxious and they helped me hugely. The system was streamline and very well organised. Please pass on my thanks to all the team. I'm afraid there were too many names to remember but they were all great. Especially the lovely theatre nurse who held my hand throughout!

"Thanks to Gynae team for all the care, support and understanding given during care over the last 5 years."

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%
YTD Total	1179	102	16	8	8	3	4284	1316	30.72%	97.34%

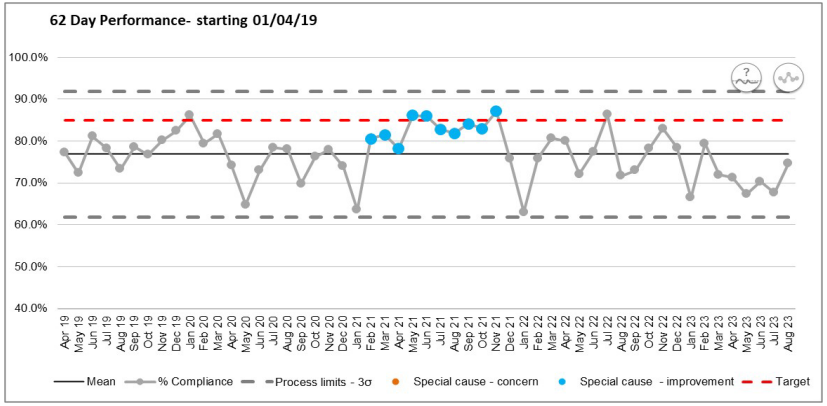
	OUTPATIENT RESPONSES						Total responses	% Recommended
	1 - Very Good	2 - Good	3 - Neither Good nor Poor	4 - Poor	5 - Very Poor	6 - Don't Know		
Apr-23	1348	165	38	19	10	18	1598	94.68%
May-23	1336	166	52	18	13	12	1597	94.05%
Jun-23	1458	181	54	23	21	20	1757	93.28%
Jul-23	1310	148	35	16	13	16	1538	94.80%
Aug-23	1215	167	29	14	10	16	1451	95.24%
YTD Total	6667	827	208	90	67	82	7941	94.37%

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)	10	0	0	0	0	0	84	10	11.9%
10 Ward-Surg Onc Unit (Dept 4)	30	0	2	2	0	0	132	34	25.8%
11 Ward (Dept 4)	1	0	0	0	0	0	83	1	1.2%
12 Ward (Dept 4)	5	0	0	0	0	0	63	5	7.9%
The BMR Unit (Dept 16)	14	1	0	0	0	0	46	15	32.6%
Endocrine Ward (Dept 63)	5	0	0	0	0	0	20	5	25.0%
Haematology Day Unit (Dept 26)	46	0	0	1	0	0	139	47	33.8%
Integrated Procedure Unit (Dept 2)	107	7	1	0	1	0	213	116	54.5%
Palatine Ward (Dept 27)	4	0	0	0	0	0	61	4	6.6%
Total	222	8	3	3	1	0	841	237	28.2%

Cancer Standards

The Christie NHS Foundation Trust

62 Day / 31 Day / 18 Weeks



			62 Days			
			62 Classic		Upgrades	
			Pts	Acc Num	Pts	Acc Num
62 Compliance	**(CaRP Rec)**	**Total Timeframe**	**225**	**93.0**	**125**	**52**
FULL Christie Compliance	> 38 Days	<= 62 Days	39	39	8	8
FULL Christie Breach	<= 38 Days	> 62 Days	4	4	4	4
50% Shared Breach	> 38 Days	> 62 Days, Treat > 24 Days	39.0	19.5	16.0	8.0
50% Shared Compliance	<= 38 Days	<= 62 Days	61.0	30.5	64.0	32.0
FULL Referring Provider Breach	> 38 Days	> 62 Days, Treat <= 24 Days	82	82	33	33
TOTAL Compliances			100.0	69.5	72.0	40.0
TOTAL Breaches			43.0	23.5	20.0	12.0
% Compliance				74.7%		76.9%

National Standard	Standard	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
62 Day	85%	71.70%	73.00%	78.30%	83.00%	78.40%	66.50%	79.40%	71.90%	71.30%	67.30%	70.30%	67.60%	74.70%
62 Day Upgrades	85%	84.30%	86.50%	84.40%	83.00%	82.00%	78.00%	79.10%	77.80%	67.10%	74.00%	87.90%	74.40%	76.90%
62 Day Screening	90%	57.10%	50.00%	88.90%	50.00%	83.30%	77.80%	100.00%	100.00%	75.00%	63.60%	100.00%	58.30%	33.30%
24 Day Internal	85%	79.90%	82.40%	87.60%	84.10%	82.30%	72.40%	86.50%	77.00%	73.80%	74.60%	76.60%	68.90%	75.30%
31 Days	96%	98.70%	98.20%	97.80%	97.20%	98.20%	96.90%	98.30%	97.70%	97.80%	97.80%	96.70%	97.30%	99.20%
31 Day Subsequent Drug	98%	100.00%	99.60%	100.00%	99.70%	99.20%	99.20%	100.00%	99.60%	100.00%	100.00%	100.00%	100.00%	100.00%
31 Day Subsequent XRT	94%	99.60%	99.60%	99.20%	99.50%	99.60%	99.00%	99.50%	99.30%	99.20%	99.20%	100.00%	99.80%	99.70%
31 Day Subsequent Surgery	94%	100.00%	99.10%	99.10%	99.10%	100.00%	99.00%	100.00%	98.40%	98.80%	100.00%	98.60%	100.00%	100.00%
18 Weeks - Incomplete Pathways	92%	97.30%	97.60%	98.10%	98.40%	96.70%	97.10%	96.70%	96.50%	96.50%	96.91%	97.50%	97.80%	97.60%

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

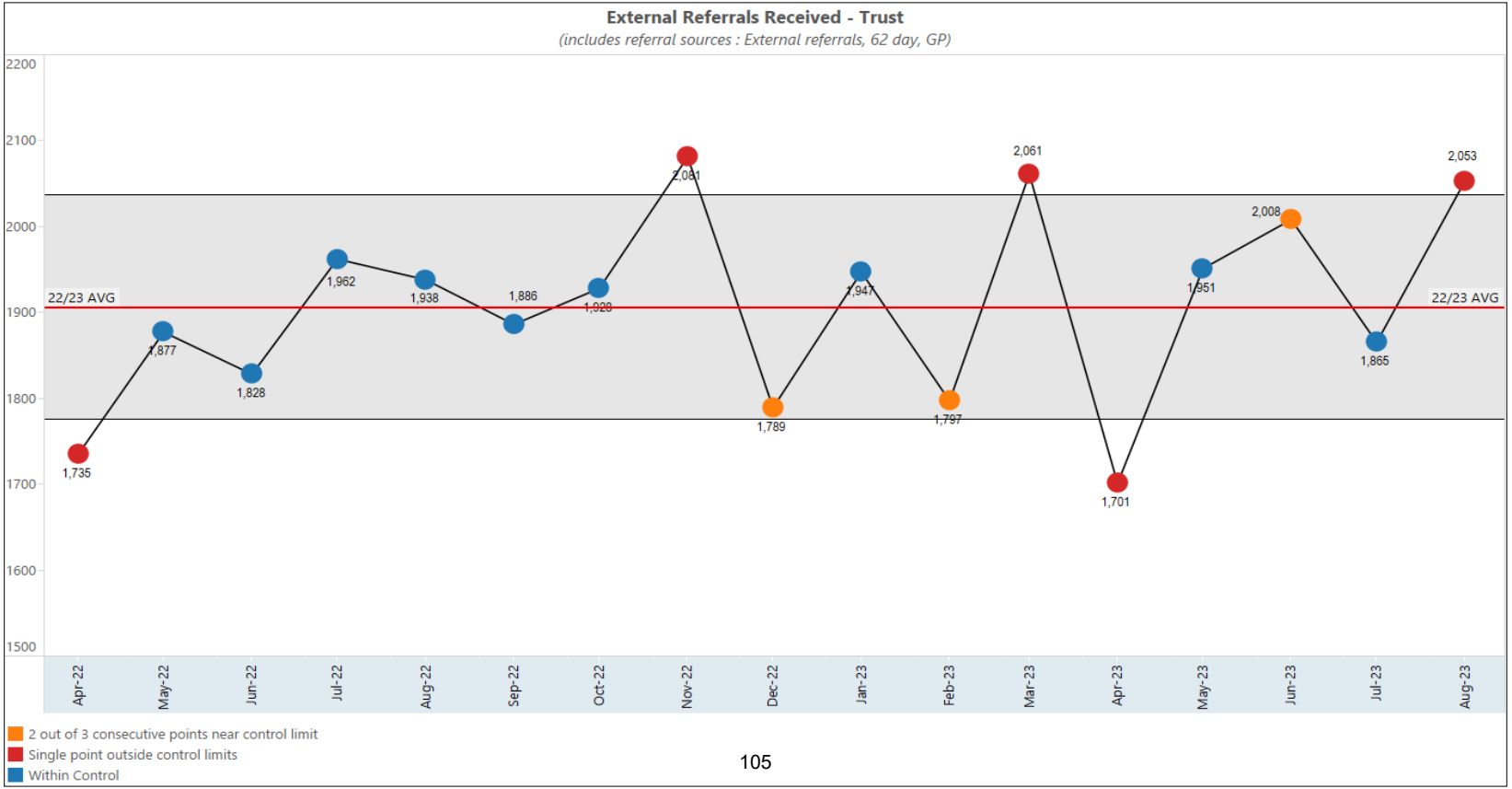
*Patients are reported in the month the compliance/breach occurs.

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

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

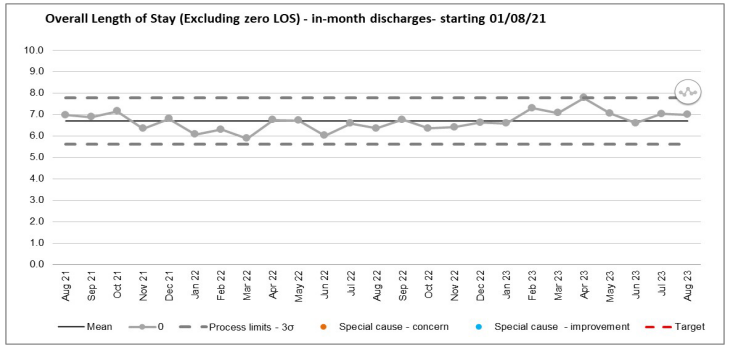
All target positions are subject to validation and are correct as of the time of reporting.

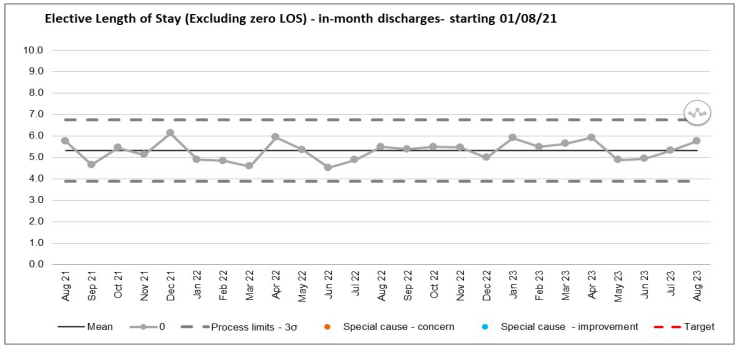
Referrals Analysis

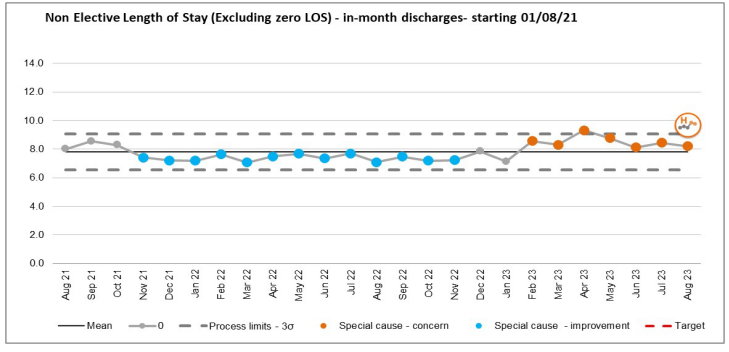


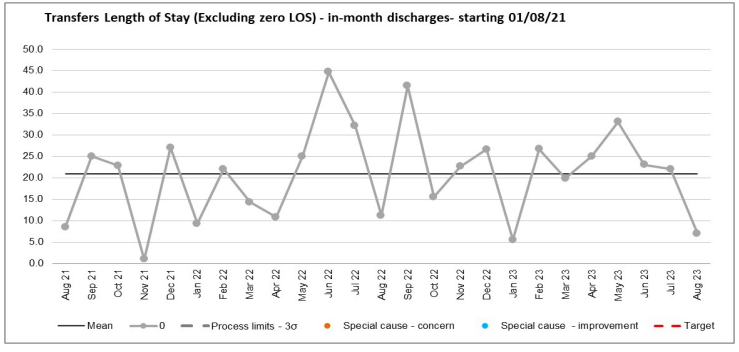
105

Length of Stay





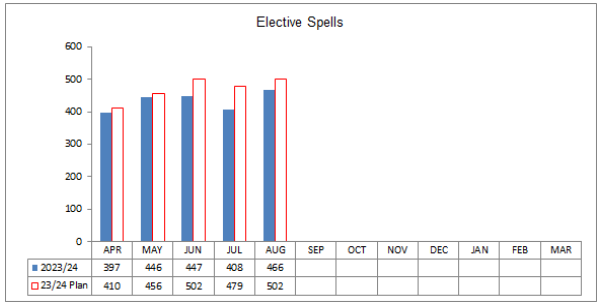




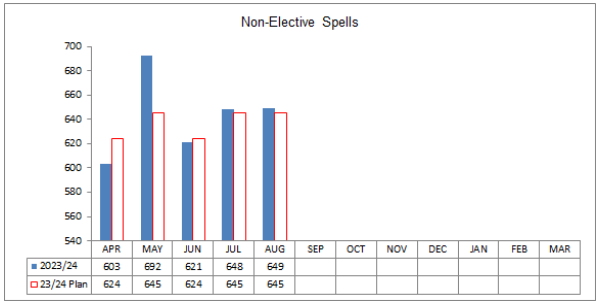
Elective, transfer patients and overall length of stay continues to be well within control limis – note special cause variation increase in non-eletive LoS impacting on flow

Activity

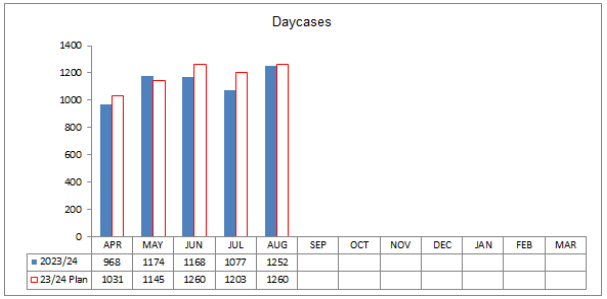
The Christie NHS Foundation Trust



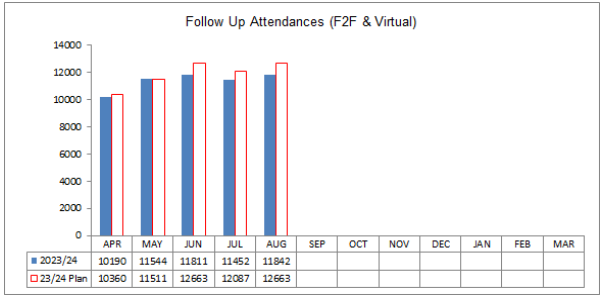
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	397	446	447	408	466							
23/24 Plan	410	456	502	479	502							



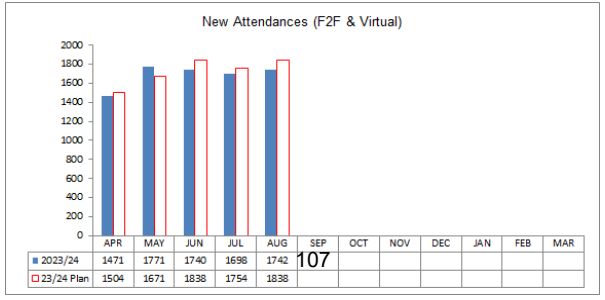
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	603	692	621	648	649							
23/24 Plan	624	645	624	645	645							



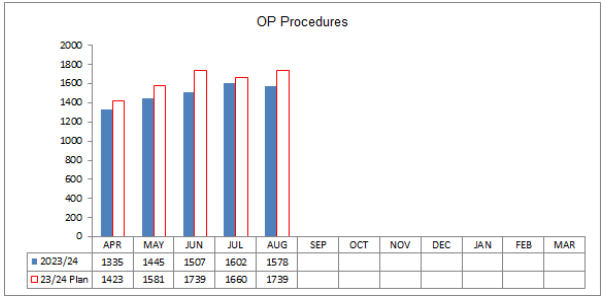
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	968	1174	1168	1077	1252							
23/24 Plan	1031	1145	1260	1203	1260							



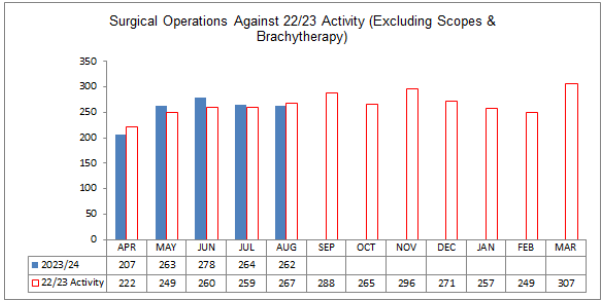
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	10190	11544	11811	11452	11842							
23/24 Plan	10360	11511	12663	12087	12663							



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	1471	1771	1740	1698	1742							
23/24 Plan	1504	1671	1838	1754	1838							



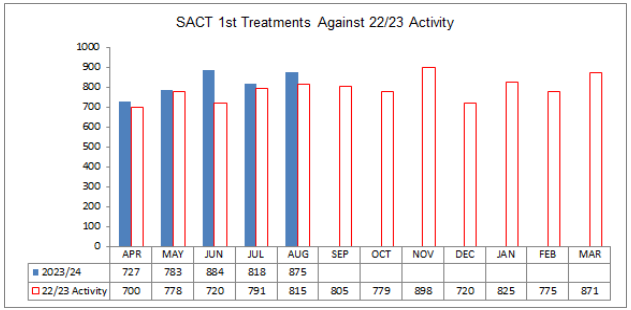
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	1335	1445	1507	1602	1578							
23/24 Plan	1423	1581	1739	1660	1739							



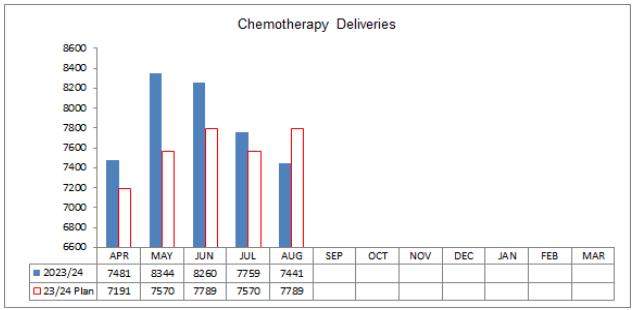
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	207	263	278	264	262							
22/23 Activity	222	249	260	259	267	288	265	296	271	257	249	307

Activity

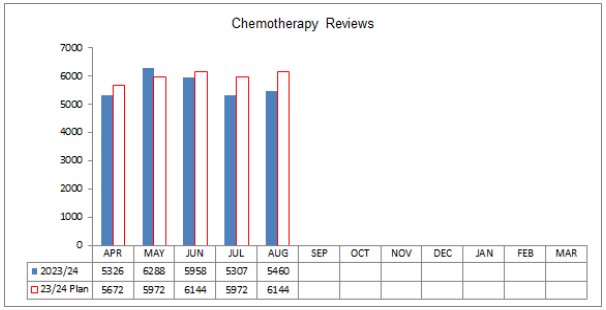
The Christie NHS Foundation Trust



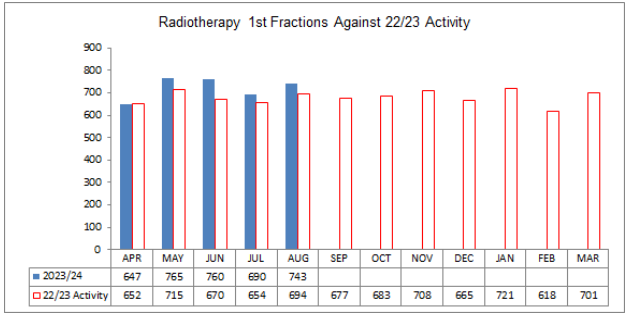
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	727	783	884	818	875							
22/23 Activity	700	778	720	791	815	805	779	898	720	825	775	871



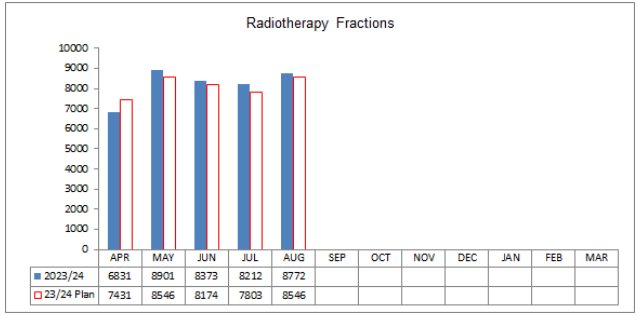
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	7481	8344	8260	7759	7441							
23/24 Plan	7191	7570	7789	7570	7789							



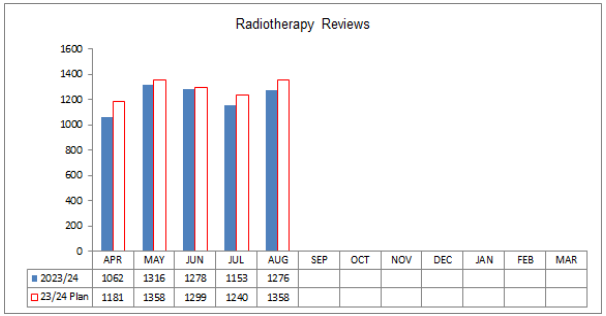
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	5326	6288	5958	5307	5460							
23/24 Plan	5672	5972	6144	5972	6144							



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	647	765	760	690	743							
22/23 Activity	652	715	670	654	694	677	683	708	665	721	618	701



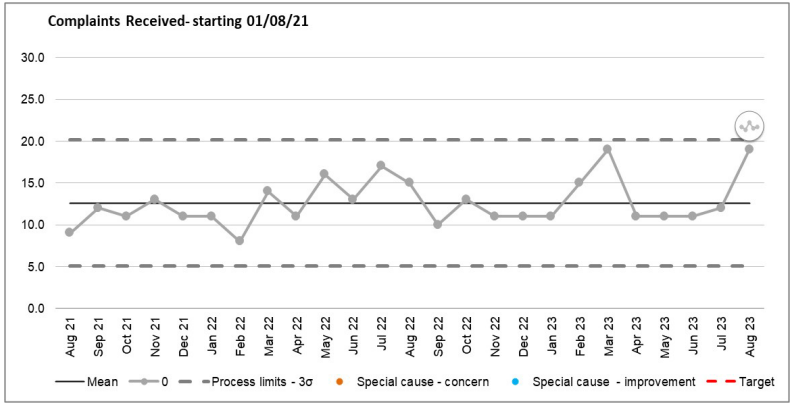
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	6831	8901	8373	8212	8772							
23/24 Plan	7431	8546	8174	7803	8546							

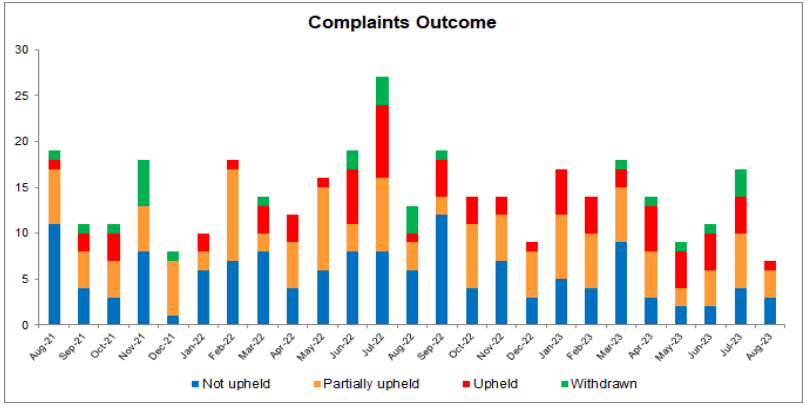


	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2023/24	1062	1316	1278	1153	1276							
23/24 Plan	1181	1358	1299	1240	1358							

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



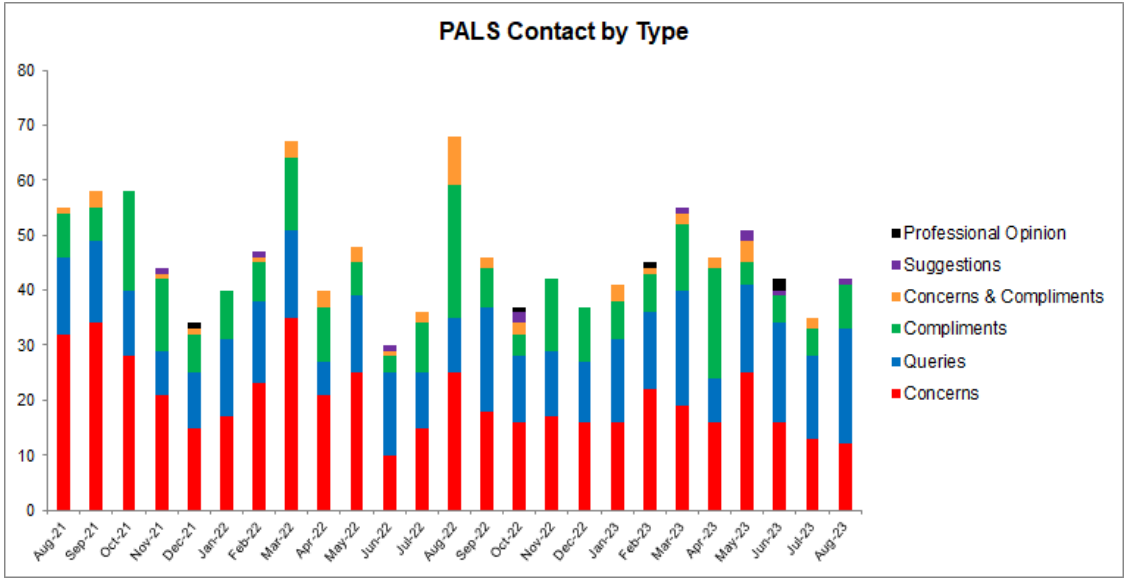


19 new complaints received in August 2023

7 complaints were closed in August 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 case was referred to the PHSO in August 2023. 5 cases in total with the PHSO.

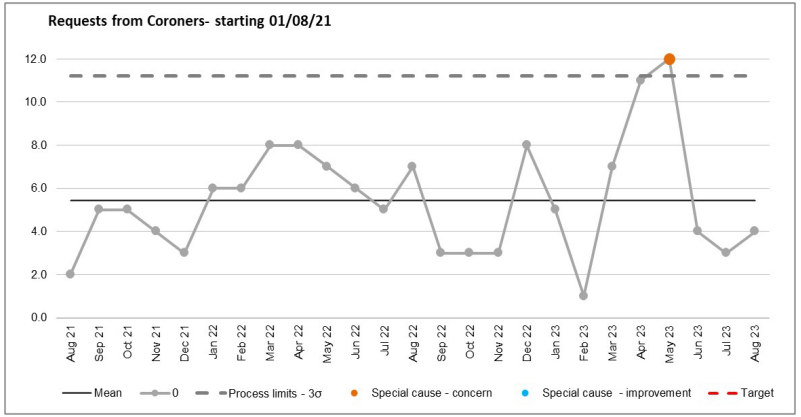
PALS

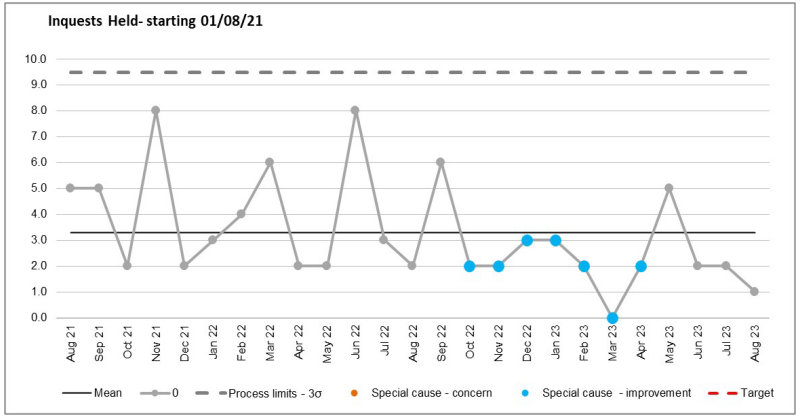


42 PALS contacts have been received in August 2023.

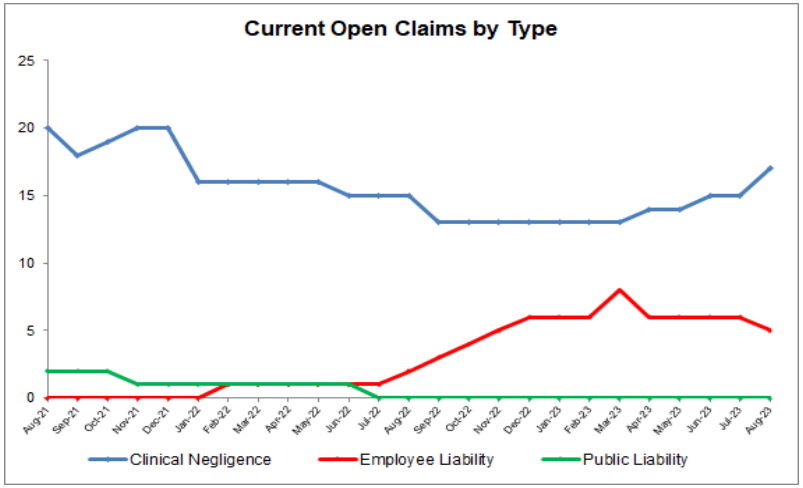
12 of those raised concerns about their experience at The Christie but did not wish to take them down the formal complaints route. The other reasons for contacting PALS are captured in the graph.

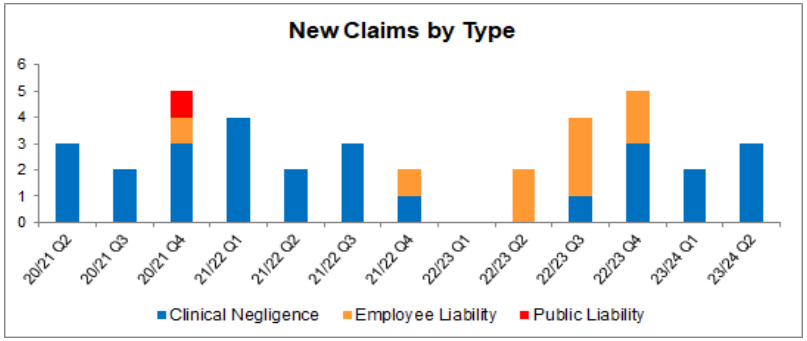
Inquests


Requests from Coroners- starting 01/08/21
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22
Oct 22
Nov 22
Dec 22
Jan 23
Feb 23
Mar 23
Apr 23
May 23
Jun 23
Jul 23
Aug 23
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


Inquests Held- starting 01/08/21
10.0
9.0
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22
Oct 22
Nov 22
Dec 22
Jan 23
Feb 23
Mar 23
Apr 23
May 23
Jun 23
Jul 23
Aug 23
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

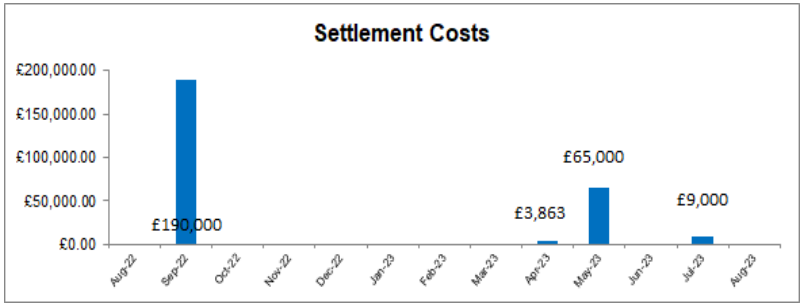
Claims





2 new 'Clinical Negligence' claim received in August 2023.

0 'Clinical Negligence' claims settled in August 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	1		1	2	0	(W4x1)(WWx1)(AAUx1)
E.coli Bacteraemia		2	4	4	0	(W12x2)(W10x1)(OCCUx1)(AACUx1)(AAUx1)(W2x1)(Procedures x1)
Klebsiella spp.		1	2		0	(Procedures x1)(PWx1)
Pseudomonas aeruginosa bacteraemia				1	0	(PWx1)
MSSA Bacteraemia		1	2	2	0	(W4x2)(Procedures x1)(IPUx1)
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	2	5	4	12	0
E.coli Bacteraemia		14	15	15	0
Klebsiella spp.		4	5	4	0
Pseudomonas aeruginosa bacteraemia		2	1	4	0
MSSA Bacteraemia		5	5	4	0
MRSA Bacteraemia			2		0

Organism	Location	Date OB identified	Date OB closed	Staff Positives
COVID-19	Nursery	11/07/2023	02/08/2023	9
COVID-19	Tech Bar	18/07/2023	03/08/2023	6
COVID-19	Proton Beam Dept	31/07/2023	16/08/2023	4
COVID-19	Ward 12	07/08/2023		3

Organism	Number of Cases (YTD)	Area(s) Occurred	Lapses in care
CPE colonisation / infection	3		0

There were 3 cases of C-Difficile, 8 cases of E-Coli, 2 cases of Klebsiella, 1 case of Pseudomonas and 4 cases of MSSA in August that were deemed attributable to the Trust. **No lapses in care have been identified.**

Definitions

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

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

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

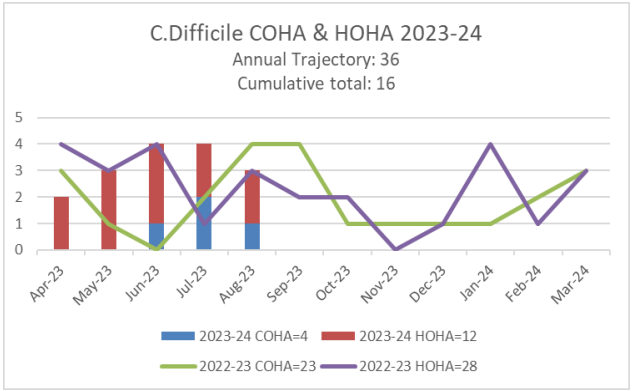
COHA - Symptoms commenced within first two days of admission and inpatient in the past 12 weeks (but not past 4 weeks)

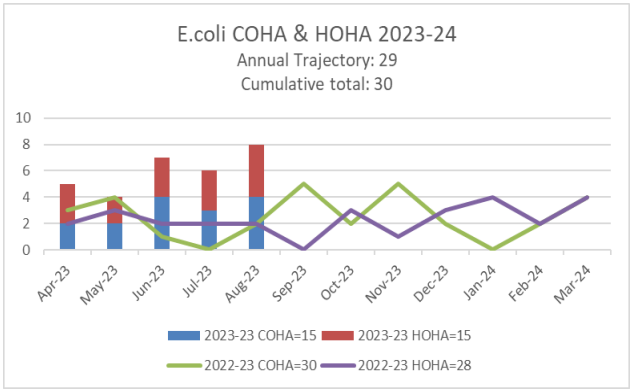
HOHA - Symptoms commenced within first two days of admission (No admission in past 12 weeks)

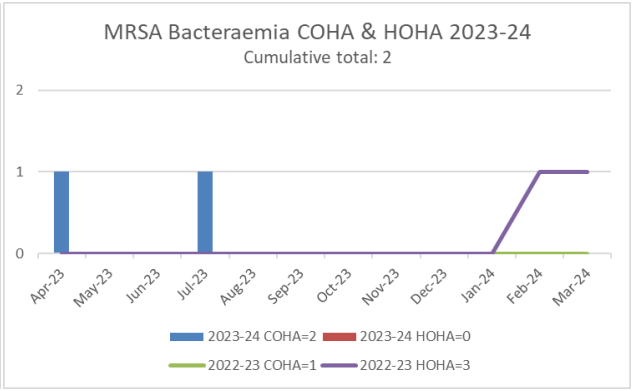
Healthcare Associated Infections

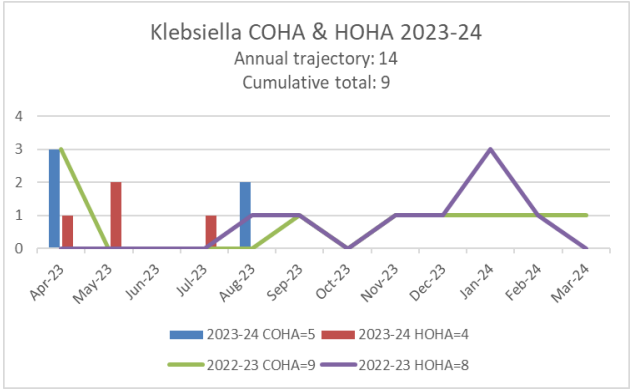
The Christie NHS Foundation Trust

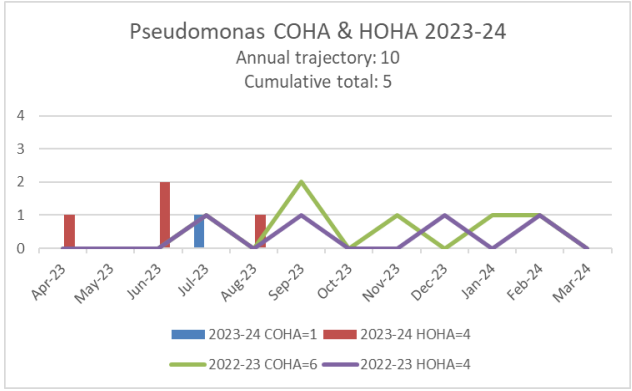
Alert Organisms

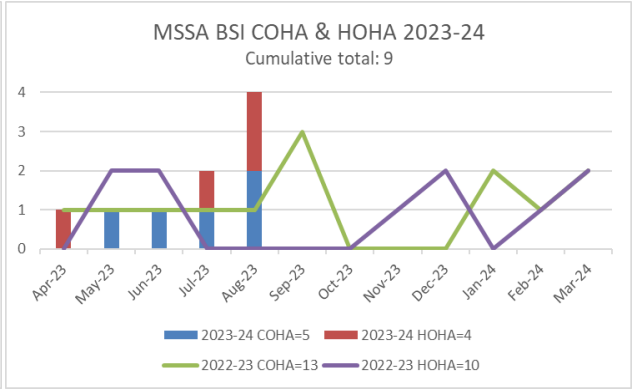












Mortality Indicators & Survival Rates

The Christie NHS Foundation Trust

Survival Rates

Inpatient Deaths – Onsite Deaths

		Aug-23
Number of NHS Christie onsite deaths	Elective/planned admission	3
	Non Elective/emergency admission	20
	TOTAL	**23**
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) - 1	**7**
	Bereaved families raised concern – 0	
	Medical Triggers - 4	
	Nursing Triggers - 3 (inc in family concern)	
	COVID-19 - 0	
	(note there may be more than one trigger)	

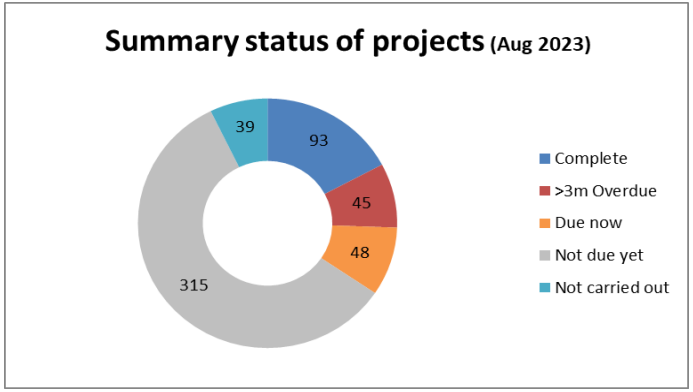
The Christie process for learning from deaths follows the 2017 NHSI guidance. All in-patient deaths are screened and where flagged by one or more triggers an independent structured case note review (SCR) is undertaken. Reviews are discussed by the Mortality Surveillance Group and the findings and actions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

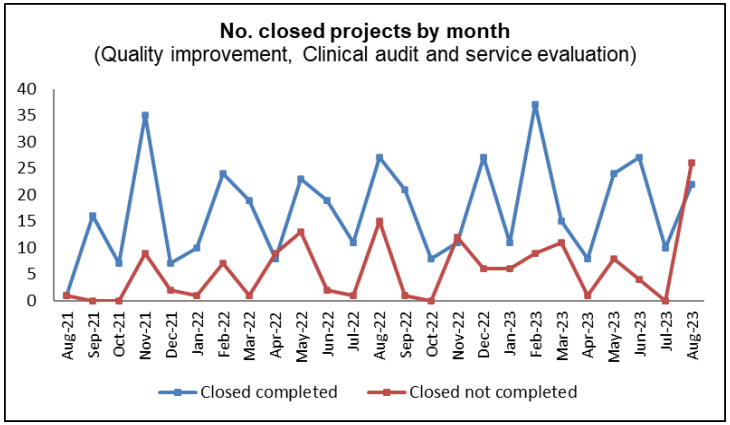
Quality Improvement & Clinical Audit

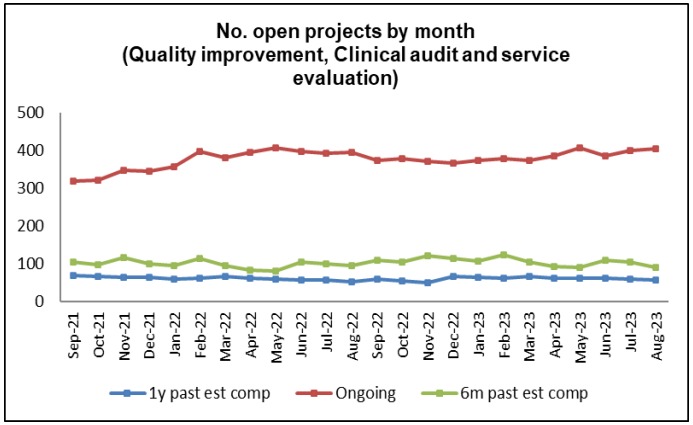
The Christie NHS Foundation Trust

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

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







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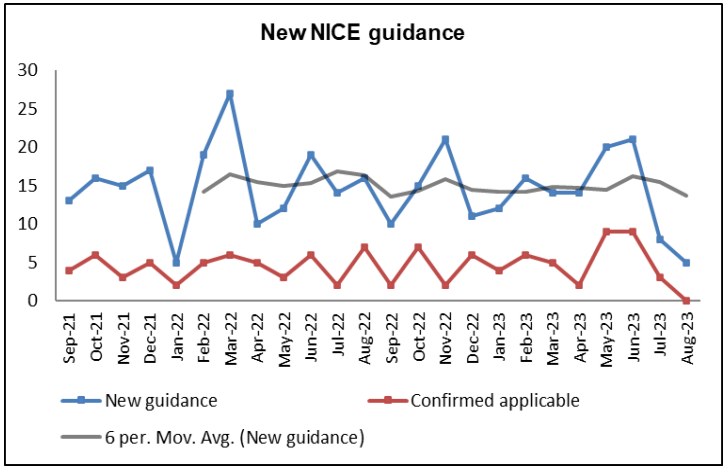
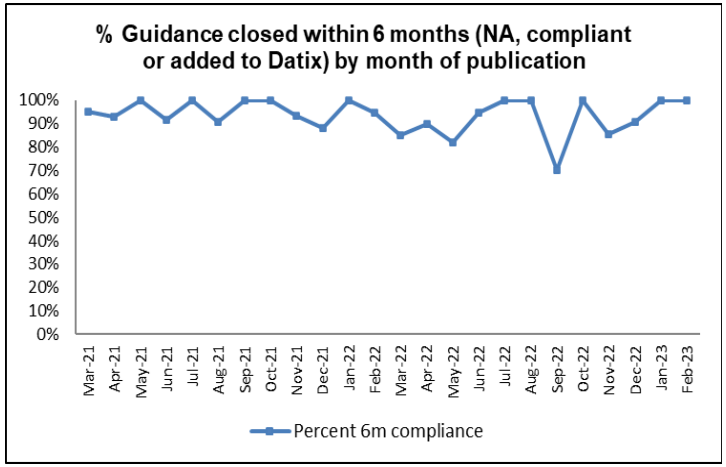
NICE Guidance





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

NHS
The Christie
NHS Foundation Trust

4.34%
Monthly Absence

4.62%
Yearly Absence

188
Returned Last Month

547
No. of Employees on Long Term Sick

1,955
No. of Employees on Short Term Sick

Division	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
Christie Medical Physics & Engineering	3.05%	2.55%	1.70%	3.07%	3.24%	2.45%	2.26%	1.67%	2.32%	3.24%	3.35%	3.65%
Clinical Networked Services	4.29%	5.27%	4.70%	5.50%	4.67%	3.68%	4.27%	3.82%	3.50%	3.89%	4.71%	4.61%
Clinical Support & Specialist Surgery	4.76%	4.91%	6.79%	8.23%	5.66%	5.05%	5.00%	4.92%	5.51%	4.66%	4.70%	4.96%
Corporate Development	1.86%	1.71%	0.89%	2.77%	0.55%	0.52%	0.29%	0.00%	0.00%	0.00%	0.00%	0.00%
Digital Services	1.78%	4.69%	4.99%	4.25%	1.80%	1.55%	1.65%	1.83%	2.53%	1.23%	1.27%	3.01%
Education (School of Oncology)	1.86%	1.57%	0.51%	3.72%	4.60%	3.35%	1.42%	1.86%	0.93%	0.43%	0.20%	0.65%
Estates & Facilities	9.86%	11.02%	12.52%	13.49%	11.11%	8.97%	9.79%	8.93%	5.89%	5.81%	7.64%	7.36%
Finance & Business Development	1.47%	2.86%	4.45%	3.91%	2.75%	1.83%	2.43%	1.88%	3.43%	2.50%	2.06%	1.26%
GM Cancer	1.50%	1.08%	0.22%	3.47%	3.78%	1.36%	0.00%	0.35%	0.86%	0.00%	0.73%	0.00%
Medical Director's Office	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
Performance	8.53%	5.17%	11.12%	6.47%	4.01%	4.32%	7.10%	7.40%	9.78%	8.85%	9.24%	8.46%
Quality & Standards	3.41%	6.01%	6.71%	9.36%	7.96%	6.44%	5.78%	4.25%	5.93%	3.95%	2.43%	6.04%
Research & Innovation	3.65%	4.46%	4.08%	5.24%	4.42%	3.13%	3.73%	3.73%	3.62%	3.32%	3.23%	3.13%
Strategy	7.93%	6.00%	6.00%	8.28%	3.70%	0.00%	0.00%	2.19%	0.00%	0.00%	0.00%	0.45%
Trust Administration	6.43%	5.85%	6.21%	7.07%	6.42%	6.21%	5.85%	6.65%	6.88%	6.21%	6.23%	5.87%
Workforce	2.33%	2.82%	4.48%	3.83%	1.75%	0.93%	1.40%	0.52%	0.35%	1.93%	3.30%	1.62%

Absence Trend

HR Metrics – Mandatory Training

The Christie NHS Foundation Trust

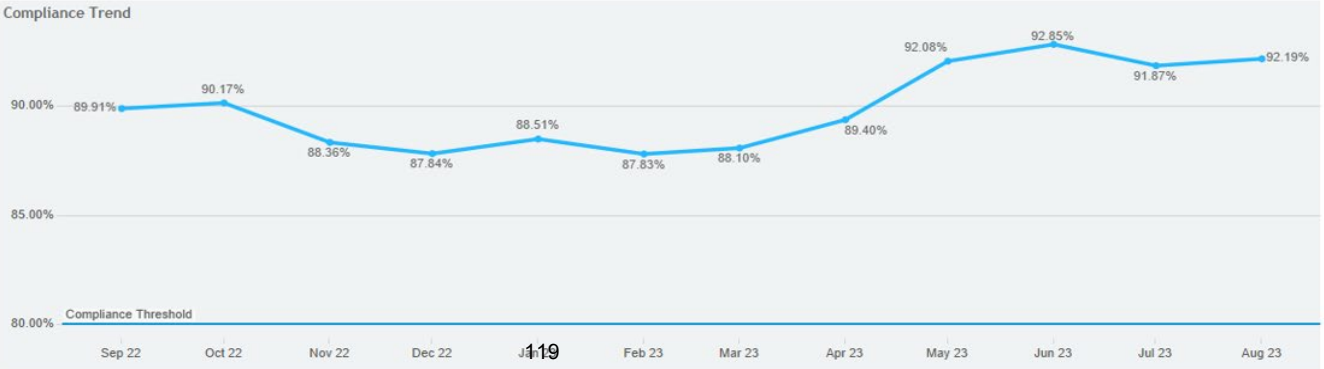
92.19% Compliance

3,248 Outstanding Modules

84.65% Face to Face

94.06% Online

Division	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
Christie Medical Physics & Engineering	93.08%	94.94%	95.48%	95.55%	95.37%	94.95%	95.06%	96.03%	96.20%	95.32%	95.46%	95.99%
Clinical Networked Services	89.47%	89.85%	87.27%	87.11%	87.62%	87.45%	85.86%	87.05%	90.05%	90.84%	90.10%	90.63%
Clinical Support & Specialist Surgery	84.91%	85.29%	83.59%	82.47%	83.39%	81.15%	81.96%	84.99%	88.93%	90.30%	89.00%	88.96%
Corporate Development	97.93%	98.17%	96.94%	95.76%	96.19%	95.58%	95.71%	96.12%	100.00%	100.00%	100.00%	100.00%
Digital Services	94.14%	93.50%	96.24%	95.22%	94.86%	96.21%	98.97%	98.35%	98.55%	98.38%	96.79%	96.46%
Education (School of Oncology)	95.27%	96.38%	95.09%	93.86%	93.91%	94.14%	94.81%	94.11%	96.06%	96.70%	95.27%	94.77%
Estates & Facilities	94.13%	92.61%	92.98%	92.97%	93.65%	93.13%	95.21%	93.98%	94.46%	95.03%	93.81%	94.33%
Finance & Business Development	99.39%	98.39%	98.74%	98.25%	97.14%	97.75%	99.67%	97.93%	99.11%	99.37%	99.44%	99.54%
GM Cancer	79.12%	77.89%	82.20%	81.66%	82.66%	80.54%	86.04%	87.44%	92.97%	95.42%	91.29%	91.32%
Medical Director's Office	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	
Performance	95.88%	96.57%	94.74%	93.91%	95.03%	96.39%	95.06%	95.32%	93.38%	94.12%	98.80%	96.20%
Quality & Standards	93.51%	93.27%	88.80%	89.07%	92.26%	92.17%	92.86%	94.08%	93.04%	94.48%	94.97%	93.76%
Research & Innovation	94.43%	94.19%	93.42%	92.88%	94.20%	93.53%	93.57%	94.32%	96.53%	97.33%	96.68%	96.97%
Strategy	90.91%	90.91%	90.21%	85.57%	95.49%	93.22%	93.85%	94.17%	98.26%	96.80%	93.33%	97.50%
Trust Administration	92.86%	98.74%	95.88%	95.88%	97.99%	98.33%	93.15%	93.56%	96.04%	95.45%	95.57%	94.42%
Workforce	88.10%	89.61%	88.17%	89.12%	88.84%	92.94%	91.61%	92.72%	96.12%	96.30%	91.18%	96.50%



HR Metrics - PDR

NHS
The Christie
NHS Foundation Trust

86.46%
Compliance

382
Expired

537
Due Soon (3 Months)

67.42%
Predicted Compliance
(If the Due Soon were to expire)

Division	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
Christie Medical Physics & Engineering	86.13%	83.75%	84.58%	89.58%	88.84%	88.07%	90.00%	90.46%	92.08%	91.97%	93.12%	91.94%
Clinical Networked Services	88.47%	74.31%	86.45%	86.04%	83.43%	81.33%	80.90%	81.26%	86.13%	86.71%	89.15%	89.18%
Clinical Support & Specialist Surgery	83.70%	72.34%	82.72%	83.83%	84.59%	84.94%	87.08%	85.64%	82.19%	83.71%	81.02%	80.43%
Corporate Development	96.88%	96.97%	96.97%	93.94%	88.57%	75.68%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Digital Services	74.71%	79.31%	87.06%	84.27%	91.11%	89.36%	93.62%	93.75%	89.69%	88.00%	81.00%	83.00%
Education (School of Oncology)	61.02%	77.78%	92.06%	87.30%	92.19%	90.48%	92.31%	94.03%	89.39%	91.18%	92.42%	92.31%
Estates & Facilities	78.15%	79.24%	84.32%	83.05%	83.40%	82.68%	84.28%	80.60%	72.10%	78.21%	81.47%	85.41%
Finance & Business Development	90.91%	88.89%	95.24%	87.30%	90.63%	88.89%	96.67%	89.06%	95.24%	90.63%	92.06%	92.19%
GM Cancer	65.63%	66.67%	63.64%	61.76%	57.14%	53.85%	71.79%	61.90%	65.96%	65.31%	73.47%	80.39%
Medical Director's Office	100.00%	100.00%	0.00%	0.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	
Performance	87.50%	86.96%	91.30%	91.30%	91.30%	90.91%	91.30%	82.61%	72.73%	68.42%	70.00%	70.00%
Quality & Standards	82.14%	78.57%	75.00%	79.31%	82.76%	76.67%	87.10%	78.79%	82.35%	88.24%	90.91%	94.29%
Research & Innovation	90.97%	88.21%	87.96%	82.01%	82.08%	87.02%	90.71%	88.24%	85.37%	86.56%	86.15%	88.28%
Strategy	50.00%	37.50%	37.50%	30.00%	33.33%	30.00%	30.00%	30.00%	50.00%	60.00%	60.00%	60.00%
Trust Administration	86.67%	76.47%	80.00%	80.00%	66.67%	80.00%	85.71%	92.86%	92.86%	92.86%	92.86%	86.67%
Workforce	89.66%	93.22%	91.67%	87.93%	94.92%	98.28%	94.74%	91.38%	98.28%	95.16%	95.00%	95.08%

120

Workforce Metrics - Turnover

NHS
The Christie
NHS Foundation Trust

52
Leavers

12.53%
Voluntary Yearly Turnover

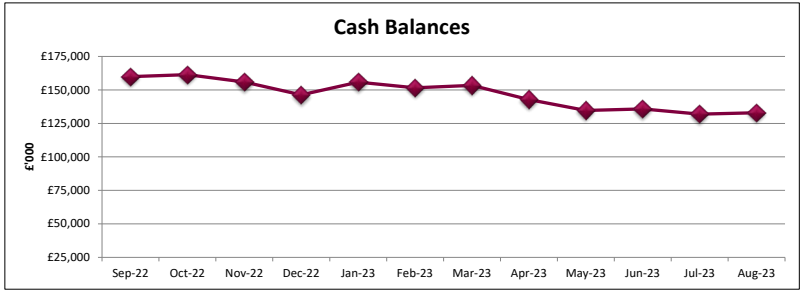
15.75%
All Yearly Turnover

3,548
Headcount

Dismissal	2
End of Fixed Term Contract	13
Retirement	6
Voluntary Resignation	28
End of Fixed Term Contract - External Rotation	2
Voluntary Early Retirement - no Actuarial Reduction	1
Grand Total	52

Finance (Executive Summary)

Month 5 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(373,706)	(155,861)	(160,532)	(4,671)
Other Income	(68,727)	(28,588)	(28,578)	11
Pay	211,654	88,258	82,425	(5,833)
Non Pay (incl drugs)	218,730	91,172	98,812	7,641
Operating (Surplus) / Deficit	**(12,048)**	**(5,020)**	**(7,872)**	**(2,852)**
Finance expenses/ income	28,723	11,968	13,305	1,336
(Surplus) / Deficit	**16,675**	**6,948**	**5,432**	**(1,516)**
Exclude impairments/ charitably funded capital donations	(8,637)	(3,599)	(3,571)	28
Adjusted financial performance (Surplus) / Deficit	**8,038**	**3,349**	**1,861**	**(1,488)**



This report outlines the month 5 consolidated financial performance of The Christie NHS Foundation Trust and its wholly owned subsidiary The Christie Pharmacy Ltd.

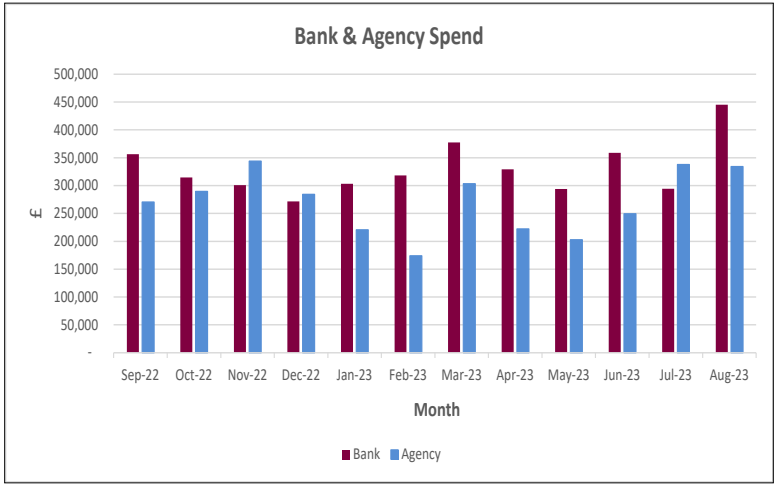
I&E

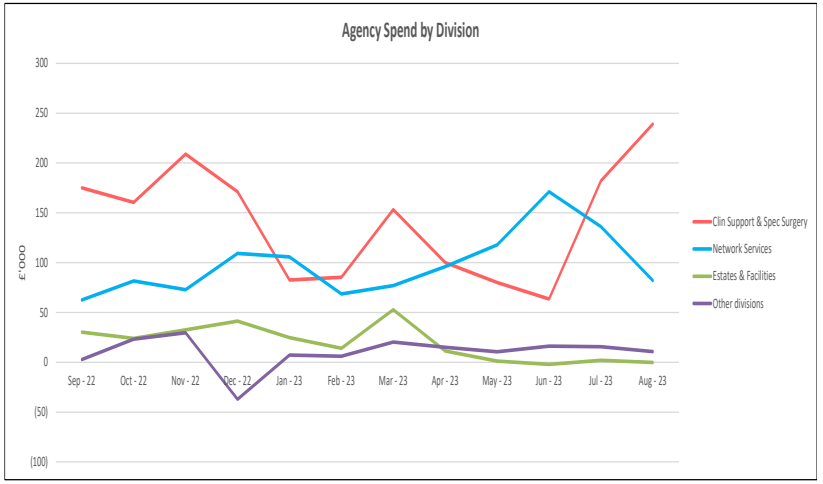
- The Trust is reporting a month end deficit of £1,861k compared to an expected £3,349k, giving a variance against plan of £1,488k. The main reason for an improved position relates to interest received above plan and continued underspends on pay whilst growth vacancies are recruited to.
- The in month variance against plan reports a surplus of £494k.
- 2023-24 CIP – Identified in year CIP is £11.8m (£10.2m non- recurrent / £1.6m recurrent) and is 95% of the in year target of £12.5m.

Balance sheet / liquidity

- The cash balance is £132,971k.
- Capital expenditure is above CDEL plan by £483k.
- Targets have been achieved against payment of our NHS creditors paid within the 30 day Better Payment Practice Code target.

Finance (Expenditure)

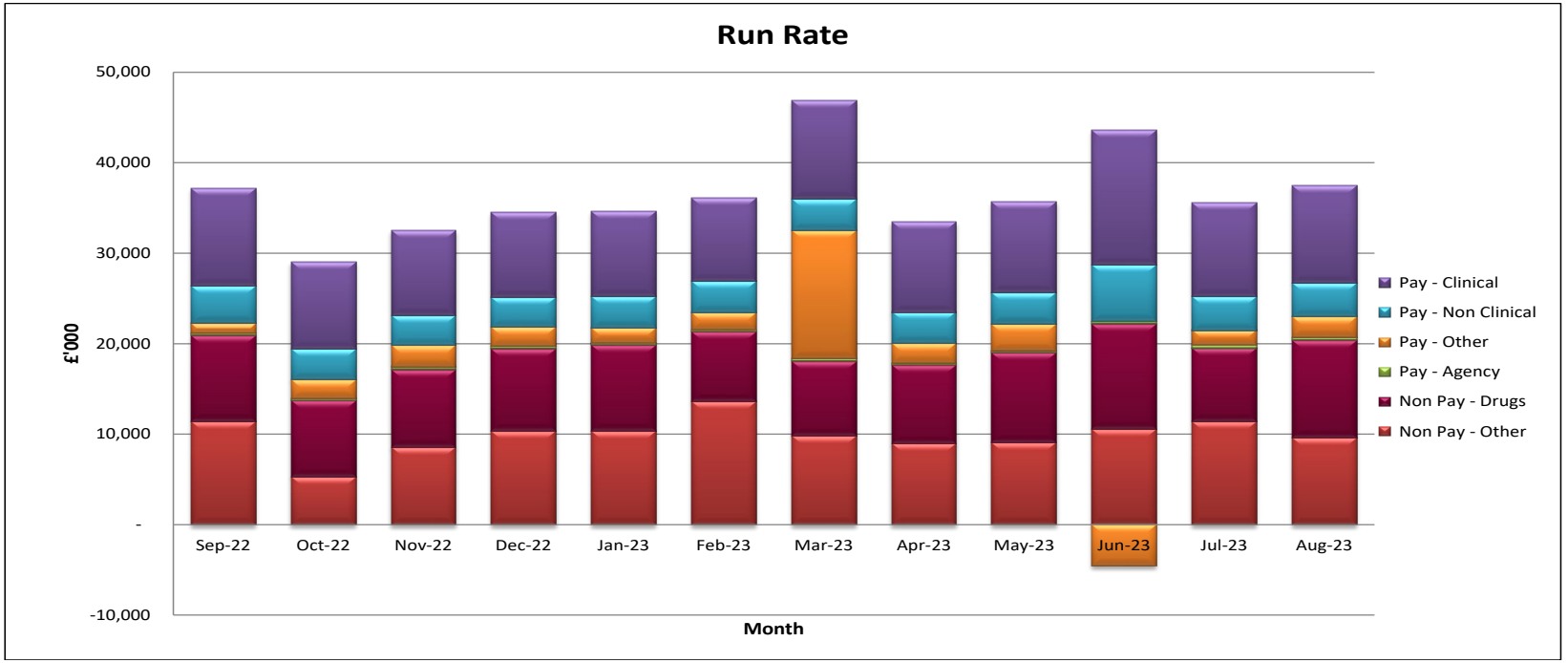




The agency spend is £334k in month 5, a decrease of £3k from month 4. There is a decrease in medical agency usage at satellite sites, this is offset with an increase in nursing agency in CCU and inpatient wards.

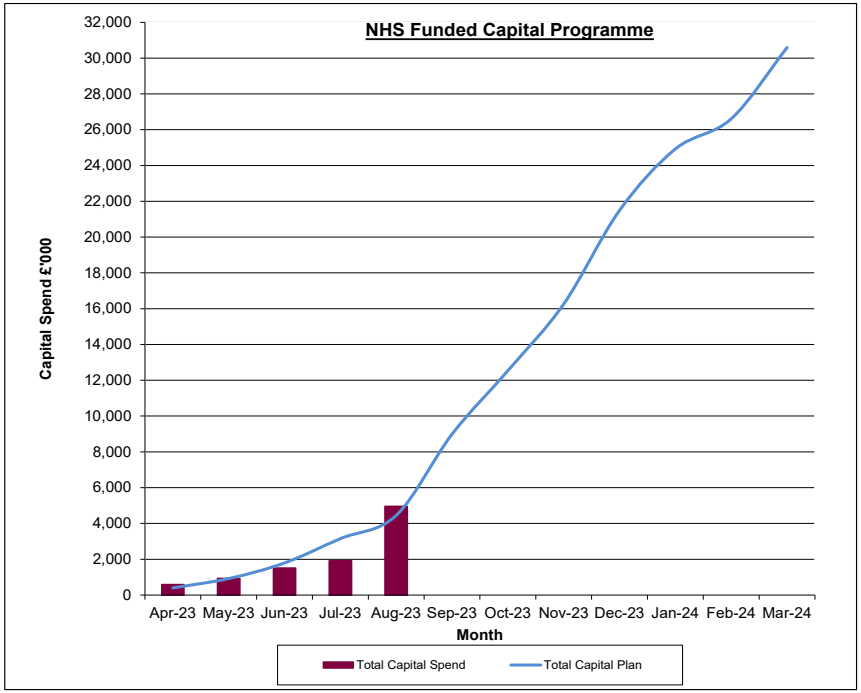
Alongside this, bank usage has increased by £151k in month compared to M4, mainly due to bed pressures on wards and CCU.

5.2 - Finance (Expenditure)



- Drugs spend in month 5 is £10,744k, an increase on month 4 of £2,674k.
- Pay - Agency spend in month 5 is £334k, a decrease of £3k from month 4.
- Pay – industrial action pressure in month of £280k.
- Key elements of 'Non Pay Other' spend consist of clinical supplies and services, premises and infrastructure costs

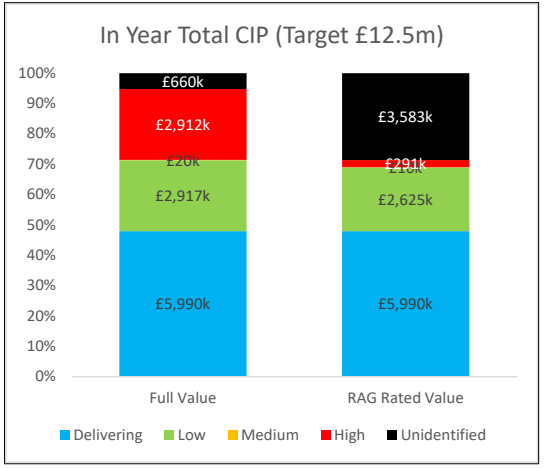
Finance (Capital)

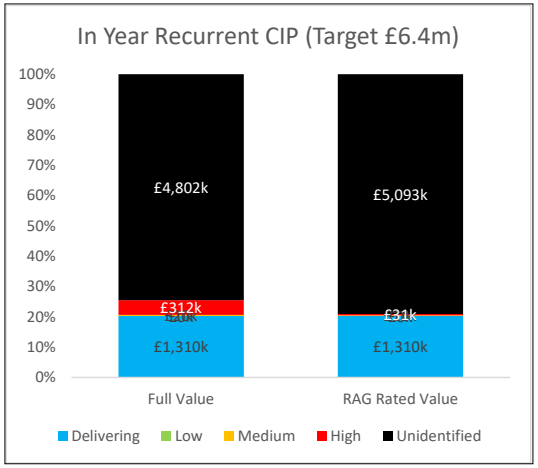


	Annual Plan	YTD - Plan	YTD - Actual	YTD - Variance
	£k	£k	£k	£k
Annual depreciation charge 2023-24	**21,370**	**7,409**	**7,846**	**(437)**
GM capital plan control total - Trust own cash	**19,820**	**2,647**	**4,345**	**(1,698)**
PDC capital funded schemes	**10,083**	**1,800**	**585**	**1,215**
Loan and lease funded schemes	**686**	**0**	**0**	**0**
Total annual capital programme under CDEL	**30,589**	**4,447**	**4,930**	**(483)**

Performance for month 5 was an overspend of £483k against the CDEL plan submitted to NHSE&I
The Trust has incurred £4,930k on capital schemes to month 5, primarily on the backlog maintenance programme, the linac and CT scanner replacements, Digital Services Electronic Health Records projects, final works on the Paterson scheme and the TIF ward.

Finance (CIP)





Total In year CIP

- Total identified CIP schemes reported are £11.8m (£10.2m non recurrent / £1.6m recurrent).
- This is 95% of the in year target of £12.5m leaving £660k unidentified.
- Risk adjusted identified schemes value £8.9m leaving £3.5m unidentified.

Recurrent

- Schemes totalling £1.6m have been identified recurrently against a recurrent target of £6.4m.
- This leaves £4.8m of the recurrent target unidentified, this increases to £5.1m 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**	**£11,839k**	**(£660k)**	£8,917k	(£3,583k)	**£5,208k**	**£5,208k**	**(£0k)**
Recurrent CIP	£6,445k	£1,642k	(£4,802k)	£1,351k	(£5,093k)	£2,685k	£527k	(£2,158k)
Non-Recurrent CIP	£6,055k	£10,197k	£4,142k	£7,565k	£1,510k	£2,523k	£4,680k	£2,157k

The Christie
NHS Foundation Trust

Agenda item 28/23c

Meeting of the Board of Directors

Thursday 28th September 2023

Subject / Title	Care Quality Commission (CQC) action plan update
Author(s)	Chief Nurse & Executive Director of Quality Trust CQC Project Lead
Presented by	Chief Nurse & Executive Director of Quality
Summary / purpose of paper	To provide the Board of Directors with progress to date on: • Our response to the CQC inspection 2022 and the • CQC IR(ME)R inspection 2023
Recommendation(s)	The Board are asked to note the progress in the report.
Background papers	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Care Quality Commission (Registration) Regulations 2009
Risk score	BAF Risks 1.1 – 1.4 / 2.1 / 2.2 / 4.1 / 5.1 – 5.2 / 6.1 – 6.2 / 7.1 – 7.6
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
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.	CQC - Care Quality Commission IPQFR - Integrated Performance, Quality and Finance report IR(ME)R – Ionising Regulations (Medical Exposure) Regulations

The Christie
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Agenda item 28/23c

Meeting of the Board of Directors

Thursday 28th September 2023

Care Quality Commission (CQC) action plan update

1. Background

The Trust as part of its registration with the Care Quality Commission (CQC) has been required to demonstrate standards set out by the CQC under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009.

This is part of an overall response to the CQC report which as previously reported to the Board, comprises.

1. CQC Action Plan – the main substance of this paper
2. Initial Internal Engagement and Listening Programme – undertaken by the CEO and other Directors and findings addressed and fed into Cultural Audit.
3. Cultural Audit – undertaken by Globis Mediation Limited in July to September 2023, details are contained in the September Trust Report.
4. Board Governance Assurance – we have engaged external support from the Good Governance Institute (GGI) to advise us on how to optimise the analysis and presentation of evidence to provide future assurance on our compliance with the fundamental care standards. Further detail is contained in the September Trust Report.
5. CQC inspection process – we have raised issues and learning points from the CQC inspection process directly with the CQC and await a response.

The Board of Directors through its governance processes has established an approach to demonstrate on-going compliance and this is through the board committees of Audit, Workforce and Quality Assurance, through operational governance committees, through the integrated performance, quality and finance report (IPQFR) and through internal and external audit reports.

2. Inspection activity and progress update

2.1 Medical core service and well led inspection

The Christie NHS Foundation Trust's medical core service was inspected 11-12 October 2022 followed by a well led inspection 15-17 November 2022. On 12th May 2023, the Trust was rated overall as 'Good' by the Care Quality Commission

The final report published identified 7 'must do' actions to meet regulatory requirements. These include:

- The trust must ensure staff complete mandatory training, including safeguarding training in accordance with the relevant schedule and receive relevant training, supervision and appraisal to perform their duties competently. (Regulation 18 (1)(2)(a)
- The trust must ensure that policies are reviewed and ratified in a more timely manner. (Regulation 17 (1))

- The trust must ensure that serious incidents and mortality reviews are investigated in a timely manner and learning is shared across the organisation as required. (Regulation 12 (2)(b))
- The trust must ensure there is an effective process to manage complaints, in particular, ensuring the timeliness of responses. (Regulation 16 (2))
- The trust must ensure there is an effective process to manage the administration of the fit and proper persons checks. (Regulation 5)
- The trust must ensure that patient risk assessments are consistently completed and reviewed in a timely manner for all patients. (Regulation 12 (1)(2)(a)(b))
- The service must ensure the proper and safe management of medicines, to include the completion of antimicrobial documentation for safe prescribing in line with trust policies. (Regulation 12(1)(2)(g))

On the 5th June 2023, a comprehensive action plan was submitted to the CQC. Progress and completion of the actions are being monitored through the Trusts governance and assurance structure, designated weekly action plan meetings and via the routine quality meetings with our Specialist Commissioners.

2.1.1 Medical Core service and well led inspection progress update

Good progress has been made to date as demonstrated in Appendix A and is on target to complete by the 31 October 2023 deadline.

2.2 Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection

On the 21 April 2023 the CQC gave notification to inspect the radiotherapy department at the Trust for compliance with the Ionising Radiation (Medical Exposure) Regulations. The inspection was done using the CQC's new process. This involved completion and submission of a self-assessment questionnaire followed by discussion with key personnel and meetings with staff where necessary which took place 31 May 2023.

The final report published 12 July 2023 identified 3 areas for improvement:

- The employer must ensure that written procedures in respect of those matters described in Schedule 2 are reflective of local practice and that they contain sufficient detail for all duty holders. Regulation 6.
- The employer must ensure that clinically significant incidents are clearly defined within the employer's procedures. Regulation 6(1)(a).
- The employer must ensure that procedures for making pregnancy enquiries are inclusive of all individuals of childbearing potential. Regulation 6(1)(a).

An action plan to address the areas for improvement has been submitted to the CQC on 26 July 2023. An outcome letter from the CQC dated 09 August 2023 confirmed the CQC as satisfied that the actions taken, or are intending to take, will address the recommendations made with a view to maintaining compliance with IR(ME)R in the future and the inspection file closed.

2.2.1 IR(ME)R progress update

Good progress has been made as demonstrated in Appendix B and has been completed ahead of the 30 September 2023 deadline.

3 Conclusion

The Trust continues to meet the outcomes required by the CQC under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009.

4 Recommendation

The Board is asked to note the progress of the CQC action plan and overall response.

5 Appendix A – CQC Medical core service and well led inspection progress

Rating	Descriptor
Red	Action not progressing
Blue	Action progressing
Amber	Verbal update of progress and completion – awaiting evidence for review and closure
Green	Action complete and evidence available

Regulation 5: Fit and Proper Persons (target completion date 28 July 2023)	Rating
Implement a standalone Fit & proper Persons Policy addressing gaps in assurance.	
Update checklist in line with the Fit & Proper Persons Policy.	
Include in the annual programme of the Audit Committee and Board of Directors.	

Regulation 12: Safe care and treatment (target completion date 29 September 2023)	Rating
Allocation of all incident lead investigators and mortality reviewers for cases reported in the previous 7-days to be confirmed at weekly Executive Review Group and monitored through Risk & Quality Governance Committee.	
Implement a traffic light system to identify and escalate cases at risk of not meeting timeliness requirements.	
Enhance surveillance through the Executive Review Group to ensure compliance with guidance.	
Implementation of the new Datix Mortality software to support timely reviews.	
Increase frequency of Learning for Improvement Bulletin from every 2 months to every month	
Align internal policies to national guidelines for falls, nutrition, pressure ulcers and VTE.	
Update ward coordinator checklist to reflect daily monitoring of risk assessments.	
Introduce an alert for patient risk assessments within our electronic patient records.	
Implement ward level view of live risk assessment compliance.	
Include nursing risk assessment requirements in the local induction.	
Continue to measure compliance through bedside handover quality improvement project.	
Update of prescriber induction and other training to document clinical indication and duration of all antimicrobials.	
Monitor compliance through ward pharmacists undertaking surveillance of completeness of inpatient antimicrobial prescriptions.	

Regulation 16: Receiving and acting on complaints (target completion date 29 September 20023)	Rating
Report as required by the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.	
Implement a traffic light system to identify and escalate cases at risk of not meeting timeliness requirements.	
Enhance surveillance through Executive Review Group to ensure compliance with national guidelines.	
Immediate learning to be identified through Executive Review Group and shared with divisional governance leads and through Friday Focus.	

Regulation 17: Good governance (target completion date 29 September 2023)	Rating
Review all trust policies against expiry dates.	
Review Trust Procedural Documents policy and policy template.	
Develop and implement a Document Management Standard Operating Procedure.	

Regulation 18: Staffing (target completion date 31 October 2023)	Rating
Allocate dedicated time for all new starters to attend induction and complete mandatory training before commencing duties.	
Allocate dedicated time for all staff to refresh mandatory training.	
Align our mandatory training including safeguarding training to the Core Skills Training Framework.	
Review and update our Mandatory Training Policy.	
Communicate our mandatory training requirements to all staff.	
Implement a mandatory training dashboard to improve visibility and monitoring of compliance with the mandatory training policy.	
Review our PDR policy, training, tools and processes to improve accessibility.	
Implement a PDR dashboard to improve visibility and monitoring of compliance with the PDR policy.	
Pilot Talent Tool as an alternative approach to PDR.	
Align supervision requirements to professional standards for Agenda for Change roles / Postgraduate medical training grades / local employed doctors (SAS + Consultants).	

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Appendix B – CQC IR(ME)R inspection progress

Rating	Descriptor
Red	Action not progressing
Blue	Action progressing
Amber	Verbal update of progress and completion – awaiting evidence for review and closure
Green	Action complete and evidence available

Regulation 6: Employer's duties	Rating
The employer must ensure that written procedures in respect of those matters described in Schedule 2 are reflective of local practice and that they contain sufficient detail for all duty holders.	
The employer must ensure that clinically significant incidents are clearly defined within the employer's procedures.	
The employer must ensure that procedures for making pregnancy enquiries are inclusive of all individuals of childbearing potential.	

NHS
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Agenda item: 28/23c

Meeting of the Board of Directors
Thursday 28th September 2023

Subject / Title	2022 Adult Inpatient Survey results
Author(s)	David Wright and Theresa Plaiter
Presented by	Theresa Plaiter
Summary / purpose of paper	This paper provides a summary of the results from the 2022 Adult Inpatient Survey.
Recommendation(s)	To note the contents of the report.
Background papers	The Christie NHS Foundation Trust - Care Quality Commission (cqc.org.uk)
Risk score	
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
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.	CQC : Care Quality Commission

The Christie
NHS Foundation Trust

Agenda item: 28/23c

Meeting of the Board of Directors
Thursday 28th September 2023

2022 Adult Inpatient Survey results

1. Introduction

The 2022 survey of adult inpatients' experiences involved 133 NHS acute trusts in England. The Care Quality Commission (CQC) uses the results for their regulation, monitoring and inspection of NHS acute trusts in England. Individual trust reports are published, and data is standardised to age, sex and method of admission (emergency or elective) of respondents to reflect the 'national' age-sex-admission type distribution (based on all respondents to the survey). This helps to ensure that no trust will appear better or worse than another because of its respondent profile.

2. Methodology

Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital during November 2022. Fieldwork for the survey (the time during which questionnaires were sent out and returned) took place between January and April 2023.

558 patients of The Christie responded to the survey; the response rate was 47.77%. This compares with the national response rate of 40.2%.

3. Results

Results are displayed based on an analysis technique referred to as the 'expected range'. It determines the range within which a trust's score could fall without differing significantly from the average score of all trusts taking part in the survey. If the trust's performance is outside of this range, its performance is significantly above or below what would be expected. If it is within this range, its performance is 'about the same'

Trust results 2022

The Trust results were excellent, with patients giving the Trust an overall care score of 9 out of 10. The survey is divided into 11 sections and the Trust results showed scores in 8 which were 'much better than most trusts', two were 'better than other trusts' and one was the 'same'.
The survey included questions regarding hospital admission and discharge, the hospital and ward environment, care and treatment, their operations and procedures, communication with staff, involvement in decisions and being treated with respect and dignity.

The results showed that more than half the questions were scored as better than most trusts. This breaks down to:

- Scores were much better than most trusts for **22** questions (2021 20 questions).
- Scores were better than most trusts for **14** questions (2021 16 questions).
- Scores were somewhat better than most trusts for **5** questions (2021 5 questions).

The Christie results were about the 'same as other trusts' for **4** questions (2021 6 questions).

Highest scores

It is positive to see the number of high scores that have been achieved by the Trust. The results showed that 21 questions had a score of 9.0 or greater with 4 having a score of 9.6 or above, these were:

- During your time in hospital, did you get enough to drink? (9.8)
- Were you given enough privacy when being examined or treated? (9.7)
- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital? (9.6)
- Overall, did you feel you were treated with respect and dignity while you were in the hospital? (9.6)

Lowest scores

Positively, there were no questions where The Christie was 'much worse', 'worse' or 'somewhat worse' than most trusts. The lowest score related to patients being asked for their feedback on the quality of the care received, this area will form part of the action plan that will be developed in September 2023.

Comparison with 2021 results

In comparison with the 2021 results there were two questions that showed a significant change upwards:

- Being told different information by different members of staff 8.1 to 8.6 (much better than other trusts).
- Understanding information in regard to discharge 9.2 to 9.4 (much better than other trusts).

Three questions showed a significant change downwards when compared to 2021 results, however the score for these three questions was still very positive at 9.4

- Cleanliness of the hospital room or ward, 9.7 to 9.4 (better than most trusts)
- Confidence and trust in doctors treating them, 9.7 to 9.4 (somewhat better than most trusts)
- Information about condition or care 9.7 to 9.4 (much better than most trusts).

4. Next Steps

In September 2023, an action plan in response to the survey results will be developed in collaboration with the Associate Chief Nurses and the Equality, Diversity and Inclusion Lead.

This will establish key actions to be monitored over the next 12 months whilst also sharing and celebrating exceptional results.

5. Recommendation

To note the contents of the report.

The Christie NHS Foundation Trust

Agenda item 28/23d

Meeting of the Board of Directors
Thursday 28th September 2023

Subject / Title	Cancer Patient Experience Survey 2022 Results
Author(s)	David Wright and Theresa Plaiter
Presented by	Theresa Plaiter
Summary / purpose of paper	This paper provides a summary of the results from the Cancer Patient Experience Survey 2022.
Recommendation(s)	To note the contents of the report.
Background papers	CPES-2022-Trust-The-Christie-NHS-Foundation-Trust-RBV-1.pdf
Risk score	
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
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	

The Christie
NHS Foundation Trust

Agenda item 28/23d

Meeting of the Board of Directors
Thursday 28th September 2023

Cancer Patient Experience Survey 2022 Results

1. Background

The National Cancer Patient Experience Survey 2022 is the 12th iteration of the survey first undertaken in 2010. It has been designed to monitor progress in cancer care; to provide information to drive local quality improvements; to assist commissioners and providers of cancer care; and to inform the work of the various charities and stakeholder groups supporting cancer patients. The survey is overseen by a national Cancer Patient Experience Advisory Group, which establishes the principles and objectives of the survey programme and guided questionnaire development. The survey is commissioned and managed by NHS England. The survey provider, Picker, is responsible for designing, running, and analysing the survey which involved 133 NHS Trusts with a national patient response rate of 53%.

The sample for the survey included all adult (aged 16 and over) NHS patients, with a confirmed primary diagnosis of cancer, discharged from an NHS Trust after an inpatient episode or day case attendance for cancer related treatment in the months of April, May and June 2022.

2. Introduction

The Cancer Patient Experience Survey is an important annual survey of 61 questions covering all aspects of experience from diagnosis to post treatment support.

The survey covered 14 areas including support from a patient's GP practice to diagnosis, hospital care and living with and beyond cancer and therefore not all questions are directly related to care provided at The Christie.

However, the survey allows the Trust to monitor patient experience by comparing results with the previous year and benchmarking with other Trusts nationally.

In 2022 1408 Christie patients received the survey with 729 responding, a response rate of 52%.

3. Results

The results are shown as a percentage score. Trusts whose score is above the upper limit of the expected range are positive outliers, with a score statistically significantly higher than the national mean. This indicates that the Trust performs better than Trusts of the same size and demographics are expected to perform. The opposite is true if the score is below the lower limit of the expected range; these are negative outliers. For scores within the expected range, the score is what we would expect given the Trust's size and demographics.

The overall care score from patients was 9.1, which is excellent and is above the expected range

The Christie results show that for 12 questions The Trust's score was above the expected range. The Hospital Care section was particularly strong with 8 out of 9 questions having a

score above the expected range. The Trust also performed strongly in the Living with and Beyond section, the support provided to family and carers and regarding discussions about research opportunities.

The Christie results show that for 2 questions The Trust's score was below the expected range. Most relevant to The Christie is the experience reported regarding waiting times for clinics and the day unit.

These results will form the basis of a combined action plan, also collating results from the National Inpatient Survey

Comparison with 2021 results

The 2022 results showed that over half the questions had an improved score compared to the 2021 results, with 3 questions having a statistically significant improvement, these were:

- Q12. Patient was told they could have a family member, carer or friend with them when told diagnosis.
- **2021 score 67%**
- **2022 score 79%**
- Q22. Family and/or carers were definitely involved as much as the patient wanted them to be in decisions about treatment options.
- **2021 score 67%**
- **2022 score 79%**
- Q49. Care team gave family, or someone close, all the information needed to help care for the patient at home.
- **2021 score 53%**
- **2022 score 63%.**

Other key areas of note

The survey not only provides data in relation to patient experience, but also a wealth of information in relation to participants demographics i.e. ethnicity, tumour type, age, and deprivation.

Due to suppression of some results and a wide variation in response numbers, it is challenging to quantify meaningful data. However, understanding and utilising this information will be included in future survey sampling and associated actions.

4. Next steps

In September 2023, an action plan in response to the survey results will be developed in collaboration with the Associate Chief Nurses and the Equality, Diversity and Inclusion Lead.

This will establish key actions to be monitored over the next 12 months whilst also sharing and celebrating exceptional results.

5. Recommendations

To note the contents of the report.

The Christie
NHS Foundation Trust

Agenda item 28/23e

Board of Directors meeting
Thursday 28th September 2023

Subject / Title	Leadership & Culture update
Author(s)	David Smithson, Deputy Director of Workforce
Presented by	Eve Lightfoot, Director of Workforce
Summary / purpose of paper	In response to two recent NHSE publications, this paper summarises the actions that have been taken at the Christie to improve leadership and culture in response to the strategic context. It then provides the Trust Board an update on our response to the outcome of the trial of Lucy Letby and how we are improving governance considering NHS recommendations.
Recommendation(s)	The Trust Board is asked to note the contents of the paper
Background papers	n/a
Risk score	
Link to: ➢ Trust strategy ➢ 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.	HR Human Resources ACAS The Advisory, Conciliation and Arbitration Service EDI Equality, Diversity & Inclusion

Meeting of the Board of Directors
Thursday 28th September 2023

Leadership & Culture update

1. Background

Collaborative, inclusive, and compassionate leadership and a healthy organisational culture are essential to deliver the highest quality care for patients.

NHS England have published 'Current NHS context on leadership and culture' (**see appendix 1**). The publication summarises the strategic direction in the NHS on people, leadership, and culture, recaps relevant recent reviews and sets out the current priorities for management and leadership.

In addition, NHS England wrote to NHS Trusts on 18th August (**see appendix 2**) following the outcome of the trial of Lucy Letby. We join NHS England in welcoming the independent enquiry by the Department of Health and Social Care into these tragic events. The letter outlines the importance of good governance in relation to speaking up arrangements and reminds Trusts of their obligations under Fit and Proper Person requirements.

This paper summarises the actions that have been taken at the Christie to improve leadership and culture in response to this strategic context and sets out the on-going activities.

2. Verdict in the Trial of Lucy Letby

Freedom to Speak Up Arrangements

We want everyone at the Christie to feel safe to speak up and have confidence that the Trust will address issues when they are raised. The NHS letter highlights the importance of good governance in this area and provides specific guidance for NHS Boards in terms of implementation and oversight. **Appendix 3** assesses the strength of our arrangements against the specific guidance.

HR Procedures & Patient Safety Incidents

Whilst not specifically addressed by NHS England in their letter, we recognise the relationship between some HR procedures and our systems for responding to patient safety incidents. This report makes recommendations to strengthen the links between these processes.

There is often a relationship between HR procedures such as disciplinary investigations, grievances or positive working relationship cases and patient safety incidents. Our HR processes are compliant with ACAS guidance and our Incident Reporting & Investigation Policy is robust and aligns to NHS England's Patient Safety Incident Response Framework. However, it is also important that both integrate and that outcomes from related patient safety incident investigations are included when issues are dealt with under HR processes.

The Trust's Scrutiny Panel was established in March 2020 in response to recommendations made by Baroness Dido Harding following the tragic death of an NHS employee who took his own life after being dismissed from his job at Imperial College. The Scrutiny Panel oversees the application of the Trust disciplinary investigation process with specific responsibilities to review and approve all decisions in relation to suspension and investigation and to oversee communication and support for staff involved in formal cases. The Scrutiny panel is chaired by the Head of Operational HR and attended by the Trust Partnership Officer and EDI Manager. The following actions will be taken to develop the Scrutiny Panel to improve governance and better integrate employee relations and patient safety incident procedures: -

- Co-opt the Deputy Chief Nurse (or nominated deputy) to attend the Scrutiny Panel to advise on patient safety issues. This includes ensuring any patient safety concerns raised through HR processes have been identified, reported and investigated appropriately.
- Extend the remit of the Panel to oversee all employee relations cases (to include grievances and PWR cases).
- Adopt the principles of 'Just Culture' to guide decision making thus supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents. The fair treatment of staff supports a culture of fairness, openness and learning by making staff feel confident to speak up when things go wrong, rather than fearing blame.
- Use the Just Culture Guide to determine how the Trust will respond to incidents identified during a HR process. i.e., whether to treat as a patient safety incident, HR issue or both.
- Implement the review of all hearing/ investigation outcomes to ensure all patient safety incidents have been fully investigated and all recommendations have been followed up actioned and monitored.
- Identify any opportunities for learning and make recommendations for improvement.
- Ensure feedback is given to all staff involved in a process particularly to staff who raise concerns
- Provide regular reports on investigations and outcomes to Workforce Assurance Committee and the Trust Board highlighting any relationship with patient safety incidents, providing assurance that all patient safety issues have been addressed.

3. Current NHS Context on Leadership and Culture

The Christie People & Culture Plan 2023-2026 was launched in January 2023. It was developed to reflect the priorities of the NHS People Plan and NHS People Promise as well as local priorities. Leadership and culture change are central to our plan; this reflects where we are on our journey as a Trust, and in the NHS, into more system-based ways of working. There is much to do and the work on our practices, habits, behaviours, capabilities, and systems will take time. The culture work outlined in the Christie People Plan focuses on laying the groundwork, which has started with us co-creating a clear set of values and behaviours during 2022.

The next step of our journey will be informed by an independent cultural review that is currently being carried out by Globis Mediation Group. The review is an objective, qualitative and quantitative assessment of the organisation's culture.

The NHS Long Term Workforce Plan was published on 30 June 2023. It sets out how the NHS will address existing and future workforce challenges by recruiting and retaining thousands more staff over a 15-year period and working in new ways to improve staff experience and patient care. While it is a national plan, it allows for priority decisions to be taken at system and local level and sets out key areas of action for employers. We are currently reviewing the plan to ensure the Christie People and Culture Plan continues to reflect these national priorities. This review will be an integral part of our planning process and a further update on this will be presented to Management Board in October.

Over the last few years there has been a series of national reviews which have highlighted the importance of leadership, management, and culture and often, but not always, in a context of concerns with the quality and safety of clinical care. The summary at **appendix 4** sets out how we have responded to these where relevant.

A separate report will be submitted to the Trust Board outlining our plan to strengthen the Trust's Fit and Proper Persons processes in line with the latest national framework.

4. Recommendation

The Trust Board is asked to note the contents of this report.

Current NHS context on leadership and culture

Strategic direction on people, leadership and culture

The Interim NHS People Plan (2019) set the aspiration to make the NHS the best place to work in order to attract and retain the staff the NHS needs to deliver the Long Term Plan, and also recognised the need to improve the leadership culture of the NHS to make it more positive, inclusive and person-centric.

The NHS People Plan (2020) built on this with actions for trusts and arm's length bodies to deliver the goal of 'more people, working differently, in a compassionate and inclusive culture'. The People Plan put a strong emphasis on belonging and inclusion. It also introduced the NHS People Promise, made up of the 7 elements which staff said were most important to them and their overall experience of work. Our Leadership Way further set out the compassionate and inclusive behaviours that all leaders at every level should show to all staff members.

In 2021 the NHS Staff Survey was redesigned to align with the People Promise providing a way to understand and improve staff experience over time, recognising that it is a driver of quality of care and retention.

The Future of NHS HR and OD (2021) report built on the NHS People Promise and laid out a vision to 2030 of how human resources and organisational development will evolve to support delivery of the People Plan. This includes supporting line managers on the people management aspects of their role.

Now in 2023 the Long Term Workforce Plan (LTWP) takes these themes forward with a longer-term commitment to grow the workforce, as well as continuing to innovate ways of working and build a culture which people want to work in and develop and extend their careers. The 3 core pillars of the LTWP are Train, Retain, Reform.

The launch of the NHS IMPACT (Improving Patient Care Together) approach to improvement puts further emphasis on the importance of leadership and management behaviours and investing in people and culture. This takes forward and builds on Developing People, Improving Care (2016), an evidence-based national framework to guide action on improvement skill-building, leadership development and talent management in the NHS.

Recent reviews

Over the last few years there has been a series of national reviews which have

highlighted the importance of leadership, management and culture and often, but not always, in a context of concerns with the quality and safety of clinical care:

- **Kark Review (2019)** which reviewed the Fit and Proper Person Test (FPPT) and recommended the development of competencies and a fit and proper persons database and mandatory referencing for directors.
- **Ockenden Review (2020, 2022)** which was a review of maternity services, initially at Shrewsbury and Telford Hospital, identifying failures in governance and leadership.
- **Kirkup Review (2022)** into maternity services at East Kent, which identified standards of clinical behaviour and aspects of organisational behaviour ('looking good while doing badly') as a thematic concern.
- **Messenger Review (2022)** of management and leadership of health and social care which highlighted the importance of the capability of leaders and managers, and the need for clear and consistent expectations.
- **Fuller Stocktake Report (2022)** into primary care and integrated care systems made recommendations for local and national leaders, including pivoting towards local leadership and the need to back new models of leadership.
- **Hewitt Review (2023)** into the governance of integrated care systems which identified the need for a shift in culture to one of learning and improvement with 'self-improving systems'.

There are many recommendations from these reviews which relate to improving aspects of leadership, management, behaviour and culture and the potential impact this can have, not only on patients and users of NHS services, but also on NHS staff.

Current priorities for management and leadership

There are seven main priorities for 2023/24:

1. **Fit and Proper Persons Test Framework** (published August 2023) and Board Leadership Competency Framework (LCF). The LCF will be published by October and will support a consistent and inclusive approach to the recruitment, development and appraisal of board level leaders. A corresponding board appraisal framework will be available by March 2024.

2. **A national induction toolkit** will be published by March 2024 to support local induction processes, and both the NHS and social care will be able to use it for the induction of all new staff members.

3. **A set of initiatives to support board induction** will be launched during Q3-Q4 and will include welcome days for all new-in-post chairs, chief executives and non-executive directors, together with online resources including handbooks, modules on key topics and signposting to existing networks/programmes.

4. **Events to support Leading for Improvement** will be available from November

to support boards following completion of the NHS IMPACT maturity self-assessment tool. This will enable sharing learning and agreeing what support is needed to develop leadership, management and organisational cultures for improvement. Events for Chairs and Chief executives including regional sessions and peer support from organisations and systems who are advanced in the use of proven quality improvement methods will be designed with regional teams and take place from February 2024.

5. **Plans for an NHS manager code and standards** are being considered for managers at all levels, clinical and non-clinical. A feasibility study is being undertaken and will be completed by January 2024.

6. **Aspiring Director programmes** will relaunch shortly. The next cohort of the Aspiring Chief Executive programme will open for application during Q3 and a revised Aspiring Executive Director programme will follow shortly. A revised Aspirant Chair programme will launch in 2024/2025.

7. **A 3-5 year roadmap** for NHS management and leadership development is being co- created with frontline leaders, setting out an implementation plan to further strengthen standards and competencies for all NHS leaders and managers. The roadmap will be published by March 2024 and will support professional and career development through a structured, NHS-wide approach to leadership and management development and talent management.

Resources and support to improve leadership and culture

Culture and Leadership Programme

NHS England's Culture and Leadership Programme (CLP) was originally developed in 2016 in partnership with The King's Fund and the Centre for Creative Leadership to develop practical support and resources to help health and care organisations to improve their culture. It was co-created with three pilot trusts and has since been applied by over 100 NHS organisations and some healthcare organisations internationally.

CLP is a modular programme which enables boards and organisations to understand their own culture using evidence-based tools to develop tailored leadership strategies for developing compassionate, inclusive and collective leadership and deliver culture change. It provides a practical, evidence-based approach to help organisations and systems understand how people working within the organisation or system perceive the current culture. It provides insights to create and implement a collective, compassionate and inclusive leadership strategy structured around six cultural elements and leadership behaviours.

An independent impact evaluation of the programme carried out in 2021 found that on average trusts that had applied CLP showed greater improvements on CQC and SOF ratings, and on staff engagement and nursing turnover than the national average. The report also identified a number of success factors including: stable,

mature boards with high levels of team functioning; recruitment and organisation development for the change team; focus on equality, diversity, and inclusion in culture; NHS England modelling trust and support in relationships with organisations.

National retention programme

As part of the national retention programme, a cohort of 23 Exemplar trusts have been implementing a locally-determined bundle of actions aligned to the People Promise since July 2022, and are now seeing retention rates improving faster than the rest of the NHS as a result.

Fit and Proper Person Test (FPPT) Framework

The Fit and Proper Person Test Framework was launched on 2 August 2023 in response to the recommendations from the Kark Review (2019).

The scope of the Framework in the first instance is board directors of ICBs and NHS providers as well as board directors of NHS England and CQC. Five of the seven recommendations from the review have been taken forward, including establishing standards of competence for directors, a central fit and proper person database and a board member referencing requirement. The two recommendations not taken forward at this point are the power to disbar directors for serious misconduct and examination of how the FPPT works in social care. An independent review of the effectiveness of the approach will be undertaken within 15 to 18 months.

NHS England has worked with a senior steering group to implement these recommendations with the key principles being that the FPPT should be a key element of patient safety and that poorly performing directors should be prevented from moving between health organisations.

What has been launched?

- A Fit and Proper Person Test Framework, together with guidance documents – including guidance for Chairs.
- A set of dedicated ESR data fields to record the results of the FPPT for board directors and accompanying guidance on using these data fields.
- A board member reference template for use in all board appointments and for all departing board directors.
- The supporting Leadership Competency Framework will follow by October.

Roles and responsibilities in FPPT

The ICB or provider Chair has accountability for ensuring FPPT assessments are

carried out on all board members on appointment, annually and if new information comes to light; and for updating ESR and submitting an annual summary to the NHS England Regional Director. Deputy Chairs / Senior Independent Directors should undertake the FPPT for the Chair.
CEOs should support the Chair and undertake the FPPT for their executive directors, and HRDs / Chief People Officers and Trust Secretaries should support the updating of ESR and the annual return.

Board level learning and development offers

To help NHS board directors to continually grow and develop competence and confidence in role, a directory of current board level learning and development offers has been published to help navigate the various offers available. The offers listed include development programmes, networks, peer to peer support, coaching and mentoring offers. All have been evaluated against high level criteria as being appropriate for board level leaders.

Appendix 2- Letter from NHSE

To:
- All integrated care boards and NHS trusts:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses
  - heads of primary care
  - directors of medical education
- Primary care networks:
  - clinical directors

cc.
- NHS England regions:
  - directors
  - chief nurses
  - medical directors
  - directors of primary care and community services
  - directors of commissioning
  - workforce leads
  - postgraduate deans
  - heads of school
  - regional workforce, training and education directors / regional heads of nursing

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

18 August 2023

Classification: Official

Dear Colleagues,

Verdict in the trial of Lucy Letby

We are writing to you today following the outcome of the trial of Lucy Letby.

Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

Colleagues across the health service have been shocked and sickened by her actions, which are beyond belief for staff working so hard across the NHS to save lives and care for patients and their families.
On behalf of the whole NHS, we welcome the independent inquiry announced by the Department of Health and Social Care into the events at the Countess of Chester and

will co- operate fully and transparently to help ensure we learn every possible lesson from this awful case.

NHS England is committed to doing everything possible to prevent anything like this happening again, and we are already taking decisive steps towards strengthening patient safety monitoring.

The national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems.

This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS – representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

We also wanted to take this opportunity to remind you of the importance of NHS leaders listening to the concerns of patients, families, and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level.

We want everyone working in the health service to feel safe to speak up – and confident that it will be followed by a prompt response.

Last year we rolled out a strengthened Freedom to Speak Up (FTSU) policy. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest.

That alone is not enough. Good governance is essential. NHS leaders and Boards must ensure proper implementation and oversight. Specifically, they must urgently ensure:

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where

everyone feels safe to speak up should also be put in place.

4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
5. Boards are regularly reporting, reviewing, and acting upon available data.

While the CQC is primarily responsible for assuring speaking up arrangements, we have also asked integrated care boards to consider how all NHS organisations have accessible and effective speaking up arrangements.

All NHS organisations are reminded of their obligations under the Fit and Proper Person requirements not to appoint any individual as a Board director unless they fully satisfy all FPP requirements – including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not). The CQC can take action against any organisation that fails to meet these obligations.
NHS England has recently strengthened the Fit and Proper Person Framework by bringing in additional background checks, including a board member reference template, which also applies to board members taking on a non-board role.

This assessment will be refreshed annually and, for the first time, recorded on Electronic Staff Record so that it is transferable to other NHS organisations as part of their recruitment processes.

Lucy Letby's appalling crimes have shocked not just the NHS, but the nation. We know that you will share our commitment to doing everything we can to prevent anything like this happening again. The actions set out in this letter, along with our full co-operation with the independent inquiry to ensure every possible lesson is learned, will help us all make the NHS a safer place.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive

Sir David Sloman
Chief Operating Officer
NHS England

Dame Ruth May
Chief Nursing Officer, England

Professor Sir Stephen Powis
National Medical Director
NHS England

The Christie
NHS Foundation Trust

Appendix 3 – Assessment of FTSU Arrangements at the Christie

NHSE Guidance	Current Assurance	Planned Activity
All Trusts are expected to adopt updated national Freedom to Speak Up policy by January 2024	• The Christie Freedom to Speak Up (FTSU) policy was updated to reflect the national policy and ratified in May 2023.	
All staff have easy access to information on how to speak up	• Information on how to speak up is on the staff internet (HIVE) • Posters with the Freedom to Speak Up Guardian's (FTSUG) contact information are visible in staff areas. • FTSUG attends induction in person so that all staff are aware of role in providing support and advice. • Electronic booklet is available on HIVE • The FTSU policy, which contains information on how to speak up, has been publicised via Team Brief. • HIVE banners have been used to promote Freedom to Speak Up month, FTSU champions, examples of concerns raised, and action taken posters. • Physical presence during FTSU month on staff engagement stall. • Permanent FTSUG poster present on staff engagement stall.	
Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.	• The national Speaking Up Support Scheme was publicised in June 2023 Team brief ahead of the deadline of the application process. • FTSUG and HR colleagues are aware they can refer or can signpost people that meet the criteria to the scheme for 2024. • Scheme will continue to be promoted via Team Brief and HIVE.	• Further session with full HR team to promote the national speaking up support scheme
Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have	• The Ethnic Diversity Staff Network were supported to produce a video of their experiences for the purpose of learning. These have been publicised during October Freedom to Speak Up month and February via team brief. • Speak Up training is mandatory and the FTSUG attended the Speak Up training face to face sessions for Facilities staff. • FTSU champions have been recruited, some with protected characteristics to increase diversity in who staff can speak up to.	• Questions have been added to the 2023 staff survey to identify what would help staff feel more able to speak up. • To undertake a mapping exercise of the staff groups and the barriers that stop them speaking up with consultation as to how these

access to the policy or processes supporting speaking up		barriers could be overcome.
Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place	• Communication methods include: ➢ Team brief ➢ Information on the staff internet recent activity included a supportive message from the Chief Nurse & Director of Quality and the Medical Director ➢ FTSUG attendance at induction ➢ FTSUG attendance at team meetings ➢ Senior leader videos on their experiences of speaking up ➢ Posters showcasing examples of concerns raised and action taken ➢ Focus in induction on Values and Behaviours, which includes the importance of speaking up ➢ Roll out of Respectful Resolutions package which includes tool to help speak up ➢ Virtual and in person Schwartz rounds on Speaking up	• Management training in development, which will support managers to develop psychologically safe teams
Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.	• The FTSU policy emphasises that an individual who has raised a concern should not be subject to unacceptable behaviour as a result of raising that concern. Recent policy revision sets out process for staff who feel they have suffered a detriment because of speaking up • Six monthly update reports are presented to the Board on FTSU • A Board Development session was held in June 2022 focused on speaking up • Those who raises a concern with the FTSUG are asked for feedback which includes whether individuals feel they have suffered a detriment.	• Completion of the Board self-assessment tool • Questions have been added to the staff survey 2023 to enable a better understanding of staff satisfaction if they raised a concern. This will help identify how the process and support could be improved.
Boards are regularly reporting, reviewing, and acting upon available data	• The Board receives a FTSU six-month report that highlights activity and types of concern. • February 2023 - the Audit committee received a report with responses to the MIAA (FTSU checklist) • The NHSEI examples of information the Board should receive, examples of assurance, and content of the FTSU report was reviewed and the information the Board receives meets the requirements.	• Completion of the Board self-assessment

The Christie
NHS Foundation Trust

Appendix 4 – Christie Response to Reviews

Review	Key Relevant Themes/ Recommendations	Christie Response
Kark Review (2019) which reviewed the Fit and Proper Person Test (FPPT) and recommended the development of competencies and a fit and proper persons database and mandatory referencing for directors.	• All directors (executive, non-executive and interim) 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 holding relevant information about qualifications and history • The creation of a mandatory reference requirement for each Director • The FPPT should be extended to all Commissioners and other appropriate Arms-Length Bodies (including NHSI and NHSE) • The power to disbar directors for serious misconduct	• Full review of FPPT processes in line with latest national guidance. • Policy updated and approval sought at September Board • ESR updates implemented • Reporting cycle updated for annual compliance reports • MIAA to add review to Audit plan 2024
Ockenden Review (2020, 2022) which was a review of maternity services, initially at Shrewsbury and Telford Hospital, identifying failures in governance and leadership.	• Workforce planning & sustainability • Safe staffing • Escalation & accountability • Clinical governance – leadership • Clinical governance – investigations & complaints • Multi-disciplinary training • Bereavement care • Supporting families	• Full review was undertaken with Immediate and Essential Actions taken and reported via Quality & Safety Committee
Messenger Review (2022) of management and leadership of health and social care which highlighted the importance of the capability of leaders and managers, and the need for clear and consistent expectations.	• Targeted interventions on collaborative leadership and organisational values • Positive equality, diversity, and inclusion (EDI) action • Consistent management standards delivered through accredited training • A simplified, standard appraisal system for	• New values and behaviours, integration into employee life cycle (induction, recognition, recruitment etc). Christie Leadership Programme, Managing for Success programme and RESPECT training for managers • Measurable and achievable EDI Plan. EDS

Review	Key Relevant Themes/ Recommendations	Christie Response
	the NHS • A simplified, standard appraisal system for the NHS • Encouraging top talent into challenged parts of the system	2022, WRES & WDES action plans. Monitoring via EDI Programme Board • Strong focus in Christie People Plan, develop an internal 'leadership transitions' framework • Review of PDR approach, inclusion of wellbeing and values discussions. Piloting new Talent Conversation approach. • Talent Management is a development area for the Christie
Fuller Stocktake Report (2022) into primary care and integrated care systems made recommendations for local and national leaders, including pivoting towards local leadership and the need to back new models of leadership.		No action for the Christie to take.
Hewitt Review (2023) into the governance of integrated care systems which identified the need for a shift in culture to one of learning and improvement with `self-improving systems.		No action for the Christie to take.

The Christie
NHS Foundation Trust

Agenda item 28/23f

Board of Directors meeting

Thursday 28th September 2023

Subject / Title	Integrated Care System mandated support
Author(s)	Sally Parkinson, Executive Director of Finance
Presented by	Sally Parkinson, Executive Director of Finance
Summary / purpose of paper	To notify the Board regarding the support that GM ICS will be receiving from PwC.
Recommendation(s)	To note the paper
Background papers	BAF – risk 6.2
Risk score	16
Link to: ➢ Trust strategy ➢ Corporate objectives	Corporate Objectives 6 – to maintain excellent operational, quality and financial performance.
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	GM ICS – Greater Manchester Integrated Care System NHSE – NHS England

The Christie
NHS Foundation Trust

Agenda item 28/23f

Board of Directors meeting

Thursday 28th September 2023

Integrated Care System mandated support

Introduction

1. The Greater Manchester Integrated Care System (ICS) is facing a large financial challenge in 2023/24 against the breakeven plan submitted to NHS England (NHSE) in May 2023. As at month four the system reported a £125m deficit, representing a £105m overspend against a planned deficit of £16m, with efficiency delivery £35m behind the year-to-date target.

2. As a consequence of the year-to-date financial performance, there is increasing regional and national scrutiny over the system financial performance by NHSE. As a system we are collectively required to take greater action to mitigate and manage our financial position as we strive to achieve the breakeven plan we set out at the start of the year.

3. As such, PwC have been commissioned to provide a deep dive into provider and system finances as described in the attached brief (appendix 1)

Recommendation

4. The Board are asked to note the mandated support to the GM ICS and the Trust's on-going participation in the required data requests and meetings.

Appendix 1

NHS
Greater Manchester
Integrated Care

4th Floor
3 Piccadilly Place
London Road
Manchester
M1 3BN

Email: mark.fisher11@nhs.net

1 September 2023

Roger Spencer
Chief Executive
The Christie NHS Foundation Trust

Dear Roger

Greater Manchester ICS (GM ICS) financial recovery programme - Monthly Finance Recovery Boards

As you are aware, the ICS is facing a large financial challenge in 2023/24 against the breakeven plan submitted to NHSE in May of this year. As at month four the system reported a £125m deficit, representing a £105m overspend against a planned deficit of £16m, and within this our collective efficiency delivery was £138m, £35m behind the year to date target of £172m.

As a consequence of the year-to-date financial performance, there is increasing regional and national scrutiny over our financial performance by NHS England (NHSE). As a system we are collectively required to take greater action to mitigate and manage our financial position as we strive to achieve the breakeven plan we set out at the start of the year.

Next steps

NHSE has authorised additional external support to GM ICS to support us in rapidly improving the position across the system. This support includes (full scope included in Appendix A):

1. Appointing a Turnaround Director to oversee and support the turnaround, including supporting monthly Finance Recovery Meetings (FRM). The PMO will provide standardised templates for most effective collation of data;
2. Producing an understanding of the baseline (underlying) financial performance for 2023/24;
3. Building on the work undertaken in February 2023, to further understand key balance sheet movements and enhance balance sheet availability to support the financial position this year;
4. Reviewing, commenting and challenging into our 2023/24 financial scenario analysis;
5. Reviewing compliance with the pay and non-pay grip and control measures that the ICB and Providers have agreed to implement, and provide recommendations to further optimise these if appropriate; and
6. To provide support and guidance with development of a multi-year financial recovery plan for the ICS, (timings TBA).

PwC has been appointed to deliver this work, with Stephen Hay acting as Turnaround Director. This work will be led by Damien Ashford and Jonathan House, both of whom we have worked with recently.

I am sure you will give them and their team the full support required to achieve the above and ultimately enable us as a system to deliver improvements on our financial position.

As such, PwC will be in contact with each of you directly with regards to support areas 3, 4, and 5, with the timing of work on a multi-year financial recovery plan to still be agreed.

Monthly Finance Recovery Meetings (FRM)

To maintain momentum in our turnaround, work is underway to set up monthly FRMs. While the exact timings are being finalised (my PA Cath Oliver will be in touch to confirm and a monthly timetable will be shared in due course); these will be towards the end of the month to allow time for reporting.

In advance of this a summary of the FRM approach is outlined below:

- **Frequency**: Monthly (commencing September) and each Provider (see Appendix B) and the ICB will be required to attend one session per month
- **Duration**: 1h 30mins - 2 hours
- **Location**: 3 Piccadilly Place. All meetings will be in person
- **Attendees**:
    - ICB leadership - Mark Fisher to chair the meeting
    - Provider representation (with deputies in attendance in the case of absence) - Chair; CEO; CFO; COO; and Chair of Finance Committee or equivalent.
    - Turnaround Director - Stephen Hay
    - NHSE regional team - Richard Barker (CEO) and/or Nikhil Kashu (CFO)
    - PwC - support and administrative role
- **Agenda** (see Appendix C)

To support this process we will need to capture standardised dataset from each Provider in line with the FRM timetable. PwC are working closely with the ICB Finance team to set up any supplementary reporting requests and working to avoid any duplication of data and effort.

Given the scale of the challenge we face as a system, this support is essential. I welcome and thank you in advance for your and your Provider's full support and engagement with this work.

Yours sincerely

Mark Fisher
Chief Executive
NHS Greater Manchester Integrated Care
mark.fisher11@nhs.net

Enclosures

Appendix A - Scope of PwC Support

Below are extracts from the scope of work that NHSE have requested from PwC for your information. Each scope area will require input from and the cooperation of you and your team.

1.1 - Turnaround support

The services

Stephen Hay will act as the GM ICS Turnaround Director. Stephen will manage monthly Finance Recovery Board meetings with each of the Providers and the ICB focussed upon the financial and operational performance. The ICB CEO will chair Provider meetings, with NHS-NW chairing the ICB meeting, Stephen will however conduct the business of these meetings.

To support Stephen in his role as Turnaround Director, we (PwC) will provide:

1. Support to Stephen in preparation, during and after each meeting; and
2. A selection of templates based on our experience of similar situations to identify, monitor and measure delivery against the revised 2023/24 plans, the implementation of grip and control measures and other financial recovery actions as needed.

1.2 - Review and establish the baseline (underlying) ICS financial performance for 2023/24

The services

1. Review and comment on historical financial performance for the year ending 31 March 2023, together with the financial performance for the current financial year to 31 March 2024. This may include comparison of actual income and expenditure to budgets and annual plan submissions together with, where necessary, review of management information to identify key areas of variance from budget.
2. Review and comment on analysis of the underlying financial performance as at 31 March 2023 to establish a financial baseline for 2023/24, including adjustments for one-off/non-recurring items, and full year impacts of changes occurring part way through the financial year.
3. Preparation of templates for the ICB to share with the Providers and the ICB to collate the 2022/23 underlying position and the non-recurrent or full year effects that impact on 2023/24.

Whilst we will not do a review of years prior to 2023/24, we may need to request information regarding earlier years to complete the work.

1.3 - Balance sheet review

The service

1. To review and compare the balance sheets of 5 years (years ending 31/03/19 to 31/03/2023) especially in relation to the component parts of net current assets – to the equivalent figures for the following balance sheet dates for each Provider in the ICS as defined in Appendix B.
2. To provide a commentary on the key ICS movements in lines of the balance sheets across each of those time periods.
3. Utilising publicly available information and where appropriate available external audit reports, to review the accounting policies which have impacted on the treatments reflected in the above balance sheets and to provide a commentary on material changes.
4. Compare consistency of accounting policies and judgements.
5. Provide recommendations on the appropriate standardisation of accounting treatment across Providers, including examining the scope for the delivery of non-recurrent financial flexibility (cash and income and expenditure) through this process.

1.4 - Review, comment and challenge the GM ICS on the 2023/24 financial scenario analysis

The service

1. We will review and comment upon the ICS's 2023/24 financial scenario analysis. This will focus upon
    a. Identification and review of key movements between the original and revised plan
    b. Key lines of enquiry where we would expect there to be movement based upon months 1-3 reported position
2. We will provide a template to the ICS for circulation to the ICB and the Providers to support the revised 2023/24 financial plan.
3. Operational - Review and comment on the elective (to include Cancer) improvement trajectories by Provider against National performance standards for the year ending 31 March 2024, to include assumptions and planning for winter resilience, further industrial action, COVID-19 etc with a specific focus on the financial assumptions (investments and provisions) that are being made.
4. Operational - Review and comment on the urgent and emergency care performance improvements against National performance standards for the year ending 31 March 2024, with a specific focus on the financial assumptions that are being made.

1.5 - Review, comment and provide detailed recommendations on grip and control measures across the ICS

The services

1. Review and comment upon the robustness and effectiveness of the grip & control measures;
2. Identify and report to the ICB detailed recommendations for improvement; and
3. Provide support to improve and enhance the grip and control.

The exact scope of item 3 together with the resources for the support is to be agreed between you and us once items 1 and 2 are completed.

1.6 - Financial recovery plan ("FRP") development

Note: The commencement and duration of this service is still to be agreed.

The service

1. Support GM ICS to develop an ICS level recovery plan.
2. Working with individuals identified by the ICS, we will assist the ICS to produce an FRP which will be owned by the ICS. The FRP will build upon the existing work already being undertaken by management teams at the Providers across the ICS. The FRP will cover the [tbc] year period from [date] to [date]. The FRP is likely to include the following content:
    a. Cost Improvement Programme;
    b. Financial context;
    c. Leadership, stakeholder engagement and communications;
    d. Financial recovery governance and how the plan will be implemented;
    e. Other aspects of the recovery including cash management; and,
    f. Strategic challenges and opportunities as it impacts on recovery ahead of the strategic /plan.

Appendix B - The Providers

Provider	Abbreviation	Collectively	Collectively
Greater Manchester Integrated Care Board	“the ICB”	-	“the ICS”
Tameside and Glossop Integrated Care NHS Foundation Trust	“T&G”	“the Providers”	
Stockport NHS Foundation Trust	“Stockport FT”		
Manchester University NHS Foundation Trust	“MFT”		
The Christie NHS Foundation Trust	“The Christie”		
Northern Care Alliance NHS Foundation Trust	“NCA”		
Bolton NHS Foundation Trust	“Bolton FT”		
Wrightington, Wigan and Leigh NHS Foundation Trust	“WWL”		
Pennine Care NHS Foundation Trust	“Pennine Care”		
Greater Manchester Mental Health NHS Foundation Trust	“GMMH”		

Appendix C - DRAFT: Agenda items for monthly Finance and Performance Recovery Board meetings

NHS Greater Manchester Integrated Care

Finance Recovery Meeting

AGENDA

Meeting date [TBC]

Meeting location 3 Piccadilly Place

Meeting time [TBC]

Attendees

- ICB leadership - Mark Fisher to chair the meeting
- Provider (with deputies in attendance in the case of absence): Chair; CEO; CFO; COO; and Chair of Finance Committee or equivalent
- Turnaround Director: Stephen Hay
- NHSE regional team: Richard Barker (CEO) and/or Nikhil Kashu (CFO)(with deputies in attendance in the case of absence)
- PwC: support and administrative role

	Summary	Papers	Links	Purpose	Presenter
1.	Welcome and apologies	Verbal		For information	Mark Fisher ICB CEO
2.	Declarations of Interests / Conflicts of Interests	Register		For noting	PwC
3.	Summary of minutes from previous meeting	Papers		For approval	PwC
4.	Actions from previous meetings	Action tracker		For approval	Stephen Hay / PwC

5.	Financial Performance ○ In month vs plan ○ Year to date vs plan ○ Underlying, forecast and improvement trajectory ○ Run rate detail ○ Narrative on variances	Meeting pack		For discussion	Provider Team
6.	Efficiency performance: ○ In month vs plan ○ Year to date vs plan ○ Forecast outturn and improvement trajectory	Meeting pack		For discussion	Provider Team
7.	Workforce movement (WTE and cost): ○ In month movement ○ Year to date vs plan ○ Forecast and improvement trajectory	Meeting pack		For discussion	Provider Team
8.	Financial position ○ Cash balance and key movements ○ Capex: plan vs actual and forecast ○ Releases to date and planned further releases	Meeting pack		For discussion	Provider Team
9.	Grip and control measures: ○ Update on implementation of agree measures ○ Temporary pay: run rate; performance vs agency cap	Meeting pack		For discussion	Provider Team
10.	Operational performance: ○ Productivity metrics	Meeting pack		For discussion	Provider Team
11.	AOB	Verbal		For discussion	Mark Fisher ICB CEO

The Christie
NHS Foundation Trust

Agenda item: 29/23a

Board of Directors meeting

Thursday 28th September 2023

Subject / Title	Standing Financial Instructions (SFIs)
Author(s)	Sally Parkinson, Executive Director of Finance
Presented by	Sally Parkinson, Executive Director of Finance
Summary / purpose of paper	To approve the review and update of the Trust SFIs which set put the financial responsibilities policies and procedures to be adopted by the Trust. The document regulates the conduct of the Trust, its Directors, Officers and agents in relation to all matters.
Recommendation(s)	To approve the revised SFIs
Background papers	
Risk score	
Link to: ➢ Trust strategy ➢ Corporate objectives	Corporate Objectives 6 – to maintain excellent operational, quality and financial performance.
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.	SFIs – Standing Financial Instructions

The Christie
NHS Foundation Trust

Agenda item: 29/23a

Board of Directors meeting

Thursday 28th September 2023

1 Standing Financial Instructions (SFIs)

The Trust Standing Financial Instructions (SFIs) are issued for the regulation of the conduct of the Trust, its Directors, officers and agents in relation to all financial matters.

The SFIs are reviewed and updated on a periodic basis and changes reviewed by the Audit Committee who endorsed the revised SFIs in their meeting in July 2023.

The revised version requires Board of Directors approval.

2 Recommendation

Following review of the changes by the Audit Committee, the Board of Directors are asked to approve the revised SFIs.

The Christie
NHS Foundation Trust

Document Reference:	**Standing Financial Instructions**	**Version:**	**V 11**
Document Owner:	Sally Parkinson Executive Director of Finance and Business Development	**Document Author:**	Richard Postil Deputy Director of Finance
Accountable Committee:	Board of Directors	**Date Approved:**	28/09/2023
Ratified by:	Audit Committee	**Date Ratified:**	27/07/2023
Date issued:	28/09/2023	**Review Date:**	28/09/2025
Target Audience:	Trust Wide	**Equality Impact Assessment:**	N/A
Consultation process	Internal audit, Counter Fraud and Management Board	**Associated policies and documents**	Page 2

Purpose

To set out the financial responsibilities, policies and procedures to be adopted by the Trust. The documents regulate the conduct of the Trust, its directors, officers, and agents in relation to all matters.

Standing Financial Instructions

September 2023

Standing financial instructions: contents	Page

1. Introduction

1.1 Purpose

1.1.1 The Standing Financial Instructions (SFIs) are issued for the regulation of the conduct of the Trust, its Directors, officers and agents in relation to all financial matters. They should be read in conjunction with the Reservation of Powers, the detailed Scheme of Delegation and the Constitution adopted by the Trust.

1.1.2 The SFIs identify the financial responsibilities that apply to everyone working for the Trust and its constituent organisations including any satellite sites. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. The Director of Finance must approve all financial procedures. The SFIs do not set out in full the requirements of the regulator's guidance and all relevant guidance of the regulator should be consulted. Such guidance will also change over time; the SFIs do not record or reference all such applicable guidance.

1.1.3 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Director of Finance must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Constitution

1.1.4 Failure to comply with SFIs and the Constitution may be treated as a disciplinary matter.

1.1.5 If for any reason these SFI's are not complied, with full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non- compliance with these SFIs to the Director of Finance as soon as possible.

1.1.6 Officers of the Trust should note that the SFIs, the Constitution and the Reservation of Powers and detailed Scheme of Delegation do not contain every legal obligation applicable to the Trust. The Trust and each officer of the Trust must comply with all requirements of legislation, (which shall mean any statute, subordinate or secondary legislation, any enforceable community right within the EU Withdrawal Act 2018 and any applicable judgment of a relevant court of law which is a binding precedent in England) and all guidance and directions binding on the Trust. Legislation, guidance and directions will impose requirements additional to the Constitution, SFIs, Reservation of Powers and detailed Scheme of Delegation. All such legislation and binding guidance and directions shall take precedence over these SFIs, the Constitution and the Reservation of Powers and detailed Scheme of Delegation. The SFIs, the Constitution the Reservation of Powers and detailed Scheme of Delegation shall be interpreted accordingly.

1.1.7 All policies and procedures of the Trust, to the extent that they are consistent with these SFI's, must be followed by all governors, Directors and officers of the Trust in addition to the provisions of this SFIs (whether specifically referenced in this schedule or not).

1.2 Terminology

1.2.1 Any expression to which a meaning is given in the Health and Social Care Community Health and Standards Act 2012 and/or the National Health Services Act 2006 and the Health and Care Act 2022 shall have the same meaning in these SFIs. The following terms shall where the context permits have the meanings set out below:

a) **"absence"** a period of time deemed as acceptable to allow delegation of authority to be awarded to a nominated deputy.

b) **"accounting officer"** means the person who from time to time discharges the functions specified in paragraph 25(5) of schedule 7 to the National Health Services Act 2006 For the trust it shall be the Chief Executive.

c) **"Board"** means the Board of Directors, formally constituted in accordance with the Constitution and consisting of the Chair, Non-Executive Directors appointed by the Council of Governors and the Executive Directors.

d) **"budget"** a resource expressed in financial terms, proposed by the Board for the purpose of carrying out for a specific period any or all of the functions of the Trust.

e) **"budget holder"** means the Director or employee with delegated authority to manage finances (income and expenditure) for a specific area of the organisation.

f) **"Chair"** is the person appointed by the Council of Governors to lead the Board, and to ensure that it discharges its overall responsibility for the Trust as a whole.

g) **"Chief Executive**" means the Chief Accountable Officer of the Trust.

h) **"commercial Framework"** means the system of documents and guidance setting out the trusts strategy, policy and procedures applicable to business development, procurement and strategic projects.

i) **"commissioning"** means the process for determining the need for and obtaining the supply of healthcare and related services by the trust within available resources.

j) **"committee"** means the Board of Directors.

k) **"the Constitution"** sets out the purpose and powers, and governance arrangements of the organisation.

l) **"contracting"** means the system for putting in place and managing all aspects of a contract for commissioned healthcare and related services.

m) **"Council of Governors"** means the Council of Governors of the Trust as constituted by the Constitution.

n) **"Director of Finance "** means the Executive Director of Finance of the Trust.

o) **"Executive Director"** means a member of the Board who is an officer of the Trust.

p) **"funds held on trust"** means those funds which the Board holds on the date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under the National Health Service Act 2006. Such funds may or may not be charitable.

q) **"Non-Executive Director"** means a Non-Executive Director of the Trust who satisfies the independence criteria as set out in the NHS Foundation Trust Code of Governance

r) **"legal adviser"** means the properly qualified person appointed by the Trust to provide legal advice

s) **"nominated committee"** is any sub-committee of the Board

t) **"nominated officer"** means an officer charged with the responsibility for discharging specific tasks within the Constitution and SFIs

u) **"officer"** means an employee of the Trust or any other person holding a honorary or office with the Trust

v) **"procurement officer"** means the Director or employee with delegated authority to commit the Trust to contract for supplies, services or works. This is separate and distinct delegated authority not to be confused with a budget holder.

w) **"regulator"** means the independent regulator of NHS Foundation Trusts.

x) **"Company Secretary"** means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust's compliance with the law, its terms of authorisation, Standing Orders, and Department of Health guidance

y) **"Trust"** means The Christie NHS Foundation Trust

z) **"ultra vires"** an act beyond the scope of powers granted by the organisation

1.2.2 Wherever the title Chief Executive, Director of Finance, or other nominated officer is used in these instructions, it shall be deemed to include such other Director or employees who have been duly authorised to represent them.

1.2.3 Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the trust when acting on behalf of the Trust.

1.2.4 References to any statute, statutory provision, statutory instrument or guidance in these SFIs include reference to that statute, provision, instrument or guidance as replaced, amended, extended, re-enacted or consolidated from time to time.

1.3 Responsibilities and delegation

1.3.1 The Board has resolved that the Board may only exercise certain powers and decisions in formal session. These are set out in the 'Reservation of Powers to the Board'.

1.3.2 The Board exercises financial supervision and control by:

a) ensuring the financial strategy is consistent with, and an integral part of, the business plan

b) requiring the submission and approval of budgets within approved allocations/overall income

c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money)

d) defining specific responsibilities placed on Directors and employees as indicated in the Reservation of Powers and detailed Scheme of Delegation

1.3.3 The Board will delegate responsibility for the performance of its functions in accordance with the Reservation of Powers and detailed Scheme of Delegation adopted by the Trust. The extent of delegation shall be kept under review by the Board.

1.3.4 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as accounting officer, to the regulator, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chair and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.3.5 The Chief Executive and Director of Finance may, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

1.3.6 It is a duty of the Chief Executive to ensure that existing Directors and officers, employees and all new appointees are notified of, and understand, their responsibilities within these instructions.

1.3.7 It is a duty of the Chief Executive to ensure any offer of gifts, reward or benefit over £25 (whether refused or accepted) or small gifts totaling over £100 in a 12 month period must be disclosed on the gift / hospitality declaration register as soon as practicable;

1.3.8 The Director of Finance is responsible for:

a) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies

b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of preparation of duties and internal checks are prepared, documented and maintained to supplement these SFIs

c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time.

d) Without prejudice to any other functions of the Trust, and the duties of other employees of the Trust, the duties of the Director of Finance include:

- the provision of financial advice to other members of the Board and employees
- the design, implementation and supervision of systems of internal financial control
- the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties

1.3.9 All members of the Board and employees, severally and collectively, are responsible for:

a) the security of the property of the Trust

b) avoiding loss

c) exercising economy and efficiency in the use of resources; and

d) conforming to the requirements of the Constitution, SFIs, general financial procedures and other specific financial procedures which the Director of Finance may issue that have been agreed by the Board, the Reservation of Powers and detailed Scheme of Delegation

1.3.10 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income for or on behalf of the Trust, shall be covered by these SFIs. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.11 For any and all members of the Board and employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties, must be to the satisfaction of the Director of Finance.

1.4 Nominated Officers and their Delegated Levels

1.4.1 Nominated officers will be formally delegated responsibility from level 1 – 3 (a) from the detailed Scheme of Delegation. The Trust standard letter (Appendix 3) must be signed and returned to finance to allow the financial controls to be updated as appropriate.

1.4.2 The following activities cannot be delegated permanently using the above delegation process and can only be delegated during periods of absence in line with SFI section 1.2.1 (a) and within the detailed scheme of delegation:

a) Contract Signing - Signing of any agreement or document that enters the Trust into a legally binding contract must be within delegated limits, in accordance with the detailed scheme of delegation.

b) Procurement - Signing of any agreement or document that enters the Trust into a legally binding agreement must be within delegated limits, in accordance with the detailed Scheme of Delegation.

c) Requisitioning - Requisitions can only be raised within delegated limits in accordance with the detailed Scheme of Delegation. Divisions providing an in-house service to other divisions will be given access to raise and approve requisitions for goods and services on the delegating divisions behalf.

d) Invoice Approvals – Invoices can only be approved within delegated limits in accordance with the detailed Scheme of Delegation. Acting divisions may approve invoices on behalf of the delegating division, providing appropriate checks have been carried out in line with the invoice approval process

e) Recruitment of temporary medical staff – Acting divisions may arrange medical cover based on the requirements and needs of the department and will ensure payment for locums is charged to the delegating department.

1.4.3 With an approved declaration form, a nominated officer charged with a specific task may have delegated authority to approve activity or expenditure in other divisions independently of their employed division, but this must not contradict section 1.4.1

1.4.4 Nominated officers with delegated responsibility to approve expenses and salaries through the ePay system that do not have a financial authorisation limit, must complete an ePay delegation letter and submit to finance.

2 Audit

2.1 Audit committee

2.1.1 In accordance with the Constitution, the Board shall formally establish an Audit Committee, with clearly defined terms of reference, to provide assurances to the Board that the Trust is properly governed and well managed across the full range of its activities.

The Audit Committee will provide an independent and objective view of internal control by:

a) monitoring compliance with Standing Financial Instructions

b) reviewing schedules of losses and compensations and making recommendations to the Board

c) review the establishment and maintenance of effective systems of corporate governance, risk management and internal control

d) review the adequacy and effectiveness of:

i) the underlying assurance processes that indicate the degree of achievement of corporate objectives, effectiveness of risk management and the appropriateness of the above disclosure statements

ii) the policies for ensuring compliance with regulatory, legal and code of conduct requirements, as they relate to corporate, financial and investment

iii) policies and procedures for all work related to fraud, bribery and corruption, equivalent to the counter fraud measures as prescribed by the NHS Counter Fraud Authority (NHSCFA) in the Government Functional Standard 013 for Counter Fraud.

iv) the policy on data quality particularly as it relates to the data, which forms the basis of self assessments or disclosures to the regulator around the non-compliance, shall be reported to the next formal meeting of the Audit Committee for referring action or ratification.

v) review arrangements, by which staff of The Christie may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters

vi) all risk and control related disclosure documents (in particular the Statement of Internal Control and the relevant areas of the Care Quality Commission Essential Standards of Quality & Safety) together with any appropriate independent assurances, prior to endorsement by the Board

vii) the compliance with The Christie's Equality and Diversity policy

e) coordinate its work with the Trust Quality Assurance Committee, as specified in both committees' terms of reference

f) ensure there is an effective internal audit function, that meets the Audit Code for NHS Foundation Trusts and the Guide for Governors: Audit Code for NHS Foundation Trusts and provides appropriate independent assurances to the committee, the Chief Executive and the Board. This will include:

i) agreeing terms of reference for the internal audit function, consistent with the Audit Code for NHS Foundation Trusts and the Guide for Governors: Audit Code for NHS Foundation Trusts

ii) considering any questions regarding the appointment of the internal audit service or revisions to/termination of the internal audit service contract

iii) reviewing and approving the internal audit strategy, operational audit plans and detailed work programs

iv) considering the findings of internal audit reports, and management responses

v) ensuring adequate internal audit resource is identified and purchased

vi) reviewing the performance and effectiveness of the internal audit service on an annual basis

vii) review the work and findings of the external auditor and consider the implications and management's responses to their work

viii) review the findings of other significant assurance functions and consider the corporate/financial governance implications for the trust; and

ix) review the annual report, financial statements and annual governance statement for the Trust prior to submission to the Board

2.1.2 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the regulator.

2.1.3 The terms of reference of the Audit Committee, including its role and the authority delegated to it by the Board and by the Council of Governors, should be made publicly available.

2.2 Senior Information Risk Owner

2.2.1 The Board shall nominate an Executive to be responsible to the Board for information risk management (the Senior Information Risk Owner).

2.2.2 The role of the Senior Information Risk Owner is defined in the Information Governance toolkit. The Senior Information Risk Owner is the leading advocate for information risk to the Board, advising how information security risks could affect the strategic goals of the Trust.

2.3 Director of Finance

2.3.1 The Director of Finance is responsible for:

a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit and counter fraud function

b) ensuring that the internal audit is adequate and meets the NHS internal audit standards, the Audit Code for NHS Foundation Trusts and the Guide for Governors: Audit Code for NHS Foundation Trusts

c) deciding at what stage to involve the police in cases of fraud, bribery, corruption, misappropriation and other regularities

d) ensuring there are appropriate terms of reference for both the internal audit and counter fraud functions, and that these are reflected in the SFIs

2.3.2 The Director of Finance or designated auditors are entitled, without necessarily giving prior notice, to require and receive:

a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature

b) access at all reasonable times to any land or premises

c) access to all members of the Board or officers of the Trust

d) the production of any cash, stores or other property or assets of the Trust under a member of the Board and/or officer's control

e) explanations concerning any matter under investigation

2.4 Role of internal audit

2.4.1 Internal audit provides an independent and objective opinion to the Chief Executive, the Audit Committee and the Board on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives.

2.4.2 The head of internal audit will provide an annual opinion statement, in accordance with applicable guidelines, which will be based on a systematic review and evaluation of risk management, control and governance which comprises the policies, procedures and operations in place to:

a) establish, and monitor the achievement of, the Trust's objectives

b) identify, assess and manage the risks to achieving the Trust's objectives

c) ensure the economical, effective and efficient use of resources

d) ensure compliance with established policies (including behavior, cultural and ethical expectations), procedures, laws and regulations

e) safeguard the Trust's assets and interests from losses of all kinds, including those arising from fraud, irregularity or corruption

f) ensure the integrity and reliability of information, accounts and data, including internal and external reporting and accountability processes

2.4.3 Where key systems are being operated on behalf of the Trust by parties external to the Trust, the head of internal audit must ensure arrangements are in place to form an opinion on their effectiveness.

2.4.4 Where the Trust operates systems on behalf of other bodies, the head of internal audit must be consulted on the audit arrangements proposed or in place.

2.4.5 Whenever a matter arises which involves, or is thought to involve, irregularities concerning cash, stores or other property, or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

2.4.6 The head of internal audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.

2.4.7 The Director of Finance shall produce written procedures for the issue and clearance of audit reports. These shall include the appropriate following action and the steps to be taken when managers fail to take remedial action within the appropriate period.

2.4.8 Where, in exceptional circumstances, the use of normal reporting channels could be seen as a possible limitation on the objectivity of the audit, the head of internal audit shall have access to report directly to the Chair, or Vice Chair, chair of the Audit Committee or Chief Executive.

2.4.9 The head of internal audit shall be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit

Committee and the head of internal audit. The agreement shall be in writing and shall comply with any guidance on reporting contained in the Audit code for NHS Foundation Trusts and the Guide for Governors: Audit code for NHS Foundation Trusts. The reporting system shall be reviewed at least every three years.

2.5 Fraud, Bribery and corruption

2.5.1 The Trust shall take all necessary steps to counter fraud in accordance with the requirements set out in the Government Functional Standard 013 for Counter Fraud and in accordance with:

a) the NHS Counter Fraud Manual published by the NHS Counter Fraud Authority (NHS CFA)

b) the policy statement "Applying appropriate sanctions consistently" published by NHS CFA and any other reasonable guidance or advice issued by NHS CFA that affects efficiency, systemic and/or procedural matters

c) in line with The NHS Counter Fraud Authority (NHSCFA) advice, the Trust has an appointed Counter Fraud Champion to work closely with the LCFS

The role and duties of the Counter Fraud Champion include:

- promoting awareness of fraud, bribery and corruption within the Trust
- understanding the threat posed by fraud, bribery and corruption
- understanding best practice on counter fraud
- committing to promoting a zero-tolerance approach to fraud within the Trust

The Chief Executive and Director of Finance shall monitor and ensure compliance with the above.

2.5.2 The Trust shall nominate a suitable person to carry out the duties of the local counter fraud specialist (LCFS).

2.5.3 The LCFS shall report to the Director of Finance and shall work with staff in the NHS CFA in accordance the NHS CFA Counter Fraud Manual.

2.6 External audit

2.6.1 The external auditor is appointed by the Council of Governors.

2.6.2 The Audit Code for NHS Foundation Trusts ("The Audit Code") contains directions of the regulator under Schedule 7 paragraph 24 of the National Health Service Act 2006, with respect to the standards, procedures and techniques to be adopted by the auditor.

2.6.3 The Trust shall apply comply with the Audit Code.

2.6.4 The auditor shall be required by the Trust to comply with the Audit Code.

2.6.5 SFIs 2.6.3 and 2.6.4 relate equally to internal and external audit.

2.6.6 In the event of the auditor issuing a public interest report the Trust shall forward a report

to the regulator within 30 days (or such shorter period as the regulator may specify) of the report being issued. The report shall include details of the Trust's response to the issues raised within the public interest report.

3 Business planning, budgets, budgetary control and monitoring

3.1 Preparation and approval of annual plans and budgets

3.1.1 The Chief Executive will compile and submit to the Board, on an annual basis, an annual operational plan and a multi-year strategic plan in accordance with the requirements of the regulator. The annual plan will contain:

a) statement of the significant assumptions on which the plan is based

b) details of major changes in workload, delivery of services or resources required to achieve the plan

c) full compliance with the regulator's requirements as detailed in the authorisation

3.1.2 Prior to the start of each financial year, the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

a) be in accordance with the aims and objectives set out in the operational plan and strategic plans

b) accord with workload and resource plans

c) be produced following discussion with appropriate budget holders

d) be prepared within the limits of available funds

e) identify potential risks

f) enable the Trust to comply with the prudential borrowing code set out by the regulator

3.1.3 The Director of Finance shall monitor and review financial performance against budget and plans and report to the Board.

3.1.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

3.1.5 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets successfully.

3.2 Budgetary delegation

3.2.1 The Director of Finance on behalf of Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must have a clear definition of:

a) the amount of the budget

b) the purpose(s) of each budget heading

c) individual and group responsibilities

d) authority to exercise virement (if applicable and permitted)

e) achievement of planned levels of service

f) the provision of regular reports

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board. The Chief Executive may vary the budgetary limit of an officer within the Chief Executive's own budgetary limit.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Director of Finance, subject to any authorised use of virement.

3.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Director of Finance.

3.2.5 Expenditure for which no provision has been made in an approved budget and not subject to funding will need to be approved through the appropriate authorisation process.

3.3 Budgetary control and reporting

3.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

a) monthly financial reports to the Board in a form approved by the Board containing:

i) income and expenditure to date showing trends and forecast year-end position
ii) movements in working capital
iii) capital project spend and projected outturn against plan
iv) explanations of any material variances from plan
v) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation
vi) key performance indicators
vii) financial risk and mitigating actions
viii) management and virement of Trust reserves

b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible

c) investigation and reporting of variances from financial, workload and resource budgets

d) monitoring of management action to correct variances

e) arrangements for the authorisation of budget transfers

3.3.2 The Director of Finance shall keep the Chief Executive and the Board informed of the financial consequences of changes in policy, pay awards, and other events and trends affecting budgets and shall advise on the financial and economic aspects of future plans and projects.

3.3.3 Each budget holder is responsible for ensuring that:

a) any likely overspend or reduction of income that cannot be met by virement is not incurred without the consent from the appropriate committee

b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised

c) no permanent employees are appointed without the approval of the Director of Finance and Chief Operating Officer other than those provided for within the available resources and manpower establishment as approved by the Board

3.3.4 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives delivering the requirements of the annual plan.

3.4 Capital expenditure

3.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure (the specific applications relating to capital are contained in SFI 12).

3.5 Monitoring returns

3.5.1 The Chief Executive is responsible for ensuring that the requisite monitoring forms are submitted to all appropriate monitoring regulators within the required timescale.

4 Annual accounts and reports

4.1 The Director of Finance, on behalf of the Trust, will:

a) ensure that, in preparing the annual accounts, the Trust complies with any directions given by the regulator with the approval of the treasury as to:

i) the methods and principles according to which the accounts are to be prepared

ii) the information given in the accounts

b) ensure that a copy of the annual accounts and any report by the external auditor on them, are laid before parliament and that copies of these documents are sent to the regulator, within the prescribed timetable

4.2 Annual Report

4.2.1 The Trust will prepare annual reports as required by the Health and Care Act 2022. This will be presented to the Board for approval and received by the Council of Governors at a public meeting. A copy will be forwarded to the regulator. The report will give:

a) Information on any steps taken by the Trust to secure that the actual membership of its public constituency and the patients' constituency is representative of those eligible for membership

b) any information the regulator or DHSC requires

5 Banking

5.1 Bank accounts

5.1.1 The Director of Finance is responsible for:

a) all bank accounts

b) establishing separate bank accounts for the Trust's non-exchequer funds

c) ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made

d) reporting to the Board all instances where bank accounts may become or have become overdrawn (together with the remedial action taken)

5.1.2. All funds will be held in accounts in the name of The Christie NHS Foundation Trust. No officer other than the Director of Finance shall open any bank account in the name of the Trust and they will report to the Board on new accounts opened or existing accounts closed.

5.1.3 The Director of Finance must seek the approval of the Board prior to opening any bank account in the name of the Trust.

5.2 Banking procedures

5.2.1 The Director of Finance is the only employee authorised to open a bank account on behalf of the Trust or bearing the Trusts name and / or address.

5.2.2 The Director of Finance will prepare detailed instructions, approved by the Board, on the operation of bank and Government Banking Services (GBS) accounts which must include:

a) the conditions under which each bank account is to be operated

b) the limit to be applied to any overdraft

c) those authorised to sign cheques or other orders drawn on the trust's accounts

5.2.3 The Director of Finance must advise the Trust bankers in writing of the conditions under which each account will be operated.

5.3 Tendering and review of banking arrangements

5.3.1 The Director of Finance will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money. Following such reviews, the Director of Finance shall determine whether to seek competitive tenders for the Trust's banking business.

5.3.2 The results of such reviews will be reported to the nominated committee.

5.3.3 The Board shall approve the banking arrangements.

6 Income, fees and charges

6.1 Income systems

6.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and budget coding of all monies due.

6.1.2 The Director of Finance is also responsible for the prompt banking of all monies received.

6.2 Fees and charges

6.2.1 The Trust shall follow the regulators guidance on the national payment system and any other applicable guidance in setting prices for contracts with NHS commissioners for all services falling within national tariff from time to time.

6.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the DHSC or by statute. Independent professional advice on matters of valuation may be taken as necessary.

6.2.3 All employees must inform their appropriate finance manager promptly, of money due arising from transactions for which they are responsible, including all contracts, leases and tenancy agreements.

6.3 Debt recovery

6.3.1 The Director of Finance is responsible for the appropriate recovery action being carried out on all outstanding debts. The Director of Finance will establish procedures for the write off of debts after all reasonable steps have been taken to secure payment.

6.3.2 Income not received should be dealt with in accordance with losses procedures. (see section 14).

6.3.3 Overpayments should be prevented wherever possible, otherwise detected and recovery initiated.

7. Security of cash and cheques

7.1 The use of cash is limited; cheques are only used for payment by the Trust in exceptional circumstances and are not received for payment to the Trust.

7.2

7.3 The Director of Finance is responsible for:

a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable

b) ordering and securely controlling any such stationery

c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes and the procedures for keys

d) prescribing systems and procedures for handling cash on behalf of the Trust

e) reporting, recording and safekeeping of the cash and cheques

7.4 All cash shall be banked intact. Disbursements shall not be made from cash received.

7.5 The holders of safe keys shall not accept unofficial funds for depositing in the safes

7.6 Where cash collection is undertaken by an external organisation, this shall be subject to such security and other conditions as required by the Director of Finance.

8 Contracting for provision of services or the purchase of good

8.1 The Board of the Trust shall regularly review and shall at all times maintain and ensure the capacity and capability of the Trust to provide the mandatory goods and services referred to in the terms of authorisation and related schedules.

8.2 The Chief Executive, as the accounting officer, is responsible for ensuring the Trust enters into suitable contracts with commissioners for the provision of NHS services.

8.3 All contracts shall be legally binding, comply with best costing practice and manage contractual risk, in so far as is reasonably achievable in the circumstances of each contract, whilst optimising the Trust's opportunity to generate income.

8.4 All contracts must be included in the Trusts contracts register.

8.5 In carrying out these functions at SFI 8.2 above, the Chief Executive should take into account the advice of Directors regarding:

a) costing and pricing of services and/or goods

b) payment terms and conditions

c) invoicing systems and cash flow management

d) the contract negotiating process and timetable

e) the provision of contract data

f) contract monitoring arrangements

g) amendments to contracts

h) any other matters relating to contracts of a legal or non-financial nature

8.6 The Chief Operating Officer and the Director of Finance shall produce regular reports detailing actual and forecast service activity income with a detailed assessment of the impact of the variable elements of income.

8.7 Where the Trust enters into a relationship with another organisation for the supply or receipt of other services, the responsible officer should ensure that an appropriate contract is present and signed by both parties in accordance with the detailed Scheme of Delegation.

8.8 Sealing of documents

The seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or of a committee established by the Board where the Board has delegated its powers to authorise the application of the Trust's seal.

Before any building, engineering, property or capital document is sealed, it must be approved and signed by the Director of Finance, or an officer nominated by them and authorised and countersigned by the Chief Executive, or an officer nominated by them who shall not be within the originating directorate.

All deeds entered into by the Trust and all documents conveying an interest in land must be executed by the application of the Trust's seal.

9 Terms of service, allowances and payment of members of the Board and employees

9.1 Remuneration and terms of service

9.1.1 The Council of Governors (CoG) is responsible for setting the remuneration of Non-Executive Directors and the Chair. The CoG should consult external professional advisors to market test the remuneration levels of the Chair and the other Non- Executive Directors at least once every three years or if they intend to make a significant change to the remuneration of a Non-Executive Director.

9.1.2 In accordance with the Constitution, the Board shall establish a remuneration committee, with clearly defined terms of reference, specifying which posts are within its area of responsibility, its composition, and the arrangements for reporting.

9.1.3 The remuneration committee will:

a) Advise the Board about appropriate remuneration and terms of service for the Chief Executive, other Executive Directors employed by the Trust and other senior employees including:

i) All aspects of salary (including any performance-related elements/bonuses)
ii) provisions for other benefits, including pensions
iii) arrangements for termination of employment and other contractual terms

b) make such recommendations to the Board on the remuneration and terms of service of the Board members (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust, having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate

c) monitor and evaluate the performance of Executive Directors (and other senior employees)

d) advise on and oversee appropriate contractual arrangements for such staff including the calculation and scrutiny of termination payments taking account of such national guidance as is appropriate

e) report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions but remain accountable for taking decisions on the remuneration and terms of service of Executive Directors. Minutes of the Board's meetings should record such decisions.

9.1.4 The Board will consider and approve proposals presented by the Chief Executive for the setting of the remuneration and conditions of service for those officers not covered by the committee.

9.2 Establishment

9.2.1 The resource plans incorporated within the annual budget will form the funded establishment.

9.2.2 The funded establishment of any department may not be varied without the approval of

the Chief Operating Officer or nominated officers authorised by them to do so (refer to the Reservation of Powers and detailed Scheme of Delegation).

9.2.3 Increased establishment within available budget cannot be varied without the approval of finance (see Delegation of Powers)

9.2.4 Increased establishment without available budget cannot be varied without the approval of Director of Finance and Chief Operating Officer

9.3 Staff appointments

9.3.1 No Executive Director or employee may engage, re-engage, or re-grade employees, on a permanent or temporary basis, hire agency staff, or agree to changes in any aspect of remuneration:

a) unless authorised to do so by the Chief Operating Officer (see the Reservation of Powers and detailed Scheme of Delegation)

b) within the limit of the delegated approved budget and funded establishment

9.3.2 In line with the Trust policy of relocation and removal policy where a post is demonstrated to be essential and difficult to recruit to, staff who incur removal and relocation expenses can be reimbursed in order for the employee to reside within a reasonable travelling distance of place of work, but authorisation must be granted at interview as per the human resources removal and relocation policy

9.4 Processing payroll

9.4.1 The Director of Workforce is responsible for:

a) specifying timetables for submission of properly authorised time records and other notifications

b) verifying that rates of pay have been calculated in accordance with national or trust agreements

c) making payment on agreed dates

d) agreeing method of payment.

9.4.2 The Director of Workforce will issue instructions regarding:

a) verification and documentation of data
b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances
c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay
d) security and confidentiality of payroll information
e) checks to be applied to completed payroll before and after payment
f) authority to release payroll data under the provisions of the relevant statutory acts

9.4.3 The Director of Finance will issue instructions regarding:

a) maintenance of regular and independent reconciliation of pay control accounts

b) a system to ensure the recovery from leavers any sums owing and/or Trust assets

9.4.4 Appropriate nominated managers have delegated responsibility for:

a) maintaining and submitting time records, and other notifications, in accordance with agreed timetables

b) completing time records and other notifications in accordance with the human resources instructions and in the form prescribed by the human resources

c) submitting termination forms in the prescribed format immediately upon knowing the effective date of resignation, termination or retirement. Where an employee fails to report for duty or to fulfill obligations in circumstances that suggest they have left without notice, the human resources manager and delegated officer must be informed immediately.

For the avoidance of doubt, documentation should not be self-certified i.e. signed and authorised by the same person.

9.4.5 Notwithstanding the overall responsibility of the Director of Workforce for the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal control, that audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.5 Contracts of employment

9.5.1 The Board shall delegate (except in relation to matters which are the responsibility of the remuneration committee) responsibility to a manager for:

a) ensuring that all employees are issued with a contract of employment in a form approved by the Board, and which complies with employment legislation

b) dealing with variations to, or termination of, contracts of employment

c) removal expenses will be awarded as specified in the Trust relocation and removal policy

9.6 Employment Policies and procedures

The Director of Workforce shall ensure that policies and procedures are prepared to cover the following areas

a) annual leave including special leave arrangements

b) study leave

c) management of absence

d) grievance procedures

e) and all other relevant Trust approved policies relating to human resource matters

10 Non-pay expenditure

10.1 Delegation of authority (in conjunction with section 1.1.3 and Appendix 1)

10.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget holders.

10.1.2 The Chief Executive will set out:

a) the list of managers who are authorised to place requisitions for the supply of goods and services

b) the maximum level of each requisition and the system for authorisation above that level

c) periodic reviews and updates by purchasing and supplies

10.2 Choice, requisitioning, ordering, receipt and payment for goods and services

10.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the Trusts procurement advice on the supply shall be sought and taken. All requisitions should meet the requirements of Appendix 1. Where goods and services are procured using the corporate credit card the approved credit card policy applies in addition to the requirements at Appendix

10.2.2 The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms.

10.2.3 The Director of Finance will:

a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained and once approved, are regularly reviewed.

b) prepare procedural instructions incorporated as per Appendix 1 on obtaining of goods, works and services incorporating the thresholds.

c) be responsible for the prompt payment of all properly authorised accounts and claims

d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) ensuring a segregation of duties
(ii) delegation for approval per the detailed Scheme of Delegation

(iii) certification that:

- requisitions are appropriate, coded correctly and authorised prior to receiving goods and services
- goods have been duly received, examined and are in accordance with specification and the prices are correct
- work done or services rendered have been satisfactorily carried out in accordance with the order
- all necessary authorisations have been obtained for all expenditure
- the account is arithmetically correct
- the account is in order for payment

(iv) a timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment

(v) instructions to all officers regarding the handling and payment of accounts within the finance department

e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received and have a valid purchase order, unless identified on the finance exemption list (except as below).

f) A requisition for goods will not be raised by a junior member of staff and approved by their manager if the purpose of the purchase is a benefit to the manager.

10.2.4 Prepayments are only permitted where exceptional circumstances apply.

In such instances:

a) prepayments are only permitted where the financial advantages outweigh the disadvantages

b) the appropriate Executive Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments

c) the Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the public procurement rules as referenced in Appendix 1)

d) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate director or chief executive if problems are encountered

e) payments in advance of goods or services being received are approved by finance

10.2.5 Purchase orders must:

a) be authorised by the requisition and supplies team

b) be consecutively numbered and accounted for

c) be in a form approved by the Director of Finance

d) state the Trust's terms and conditions of trade or where to access them

e) only be issued to, and used by approved supplier per the vendor list

f) be raised in advance of receiving goods and services

g) be raised for the full contract life

h) If an additional requisition is required for a contract previously awarded, evidence must be provided to prove the contract variation has followed the business case and tender award approval process.

i) If the supplier is on a framework, the framework agreement reference and if applicable, the Trust contract reference must be specified in the body of the requisition.

j) If the contract is awarded following a Trust procurement exercise, the Trust contract reference number must be specified in the body of the requisition

10.2.6 Managers and officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

a) all contracts (other than for purchases permitted within the Reservation of Powers and detailed Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments that may result in a liability are notified to the Director of Finance in advance of any commitment being made

b) contracts must be advertised and awarded in accordance with UK and GATT rules on public procurement and in accordance with Appendix 1

c) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars
(ii) conventional hospitality, such as lunches in the course of working visits

d) visits at supplier's expense should not be undertaken without the prior written approval of the relevant Executive Director

e) no requisition/order shall be placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive in the usual approval process

f) all goods, services, or works are ordered on an official order and works and services

executed in accordance with a contract, contractors will be notified that they should not accept an order unless on an official form

g) verbal orders must only be issued very exceptionally - by a nominated officer in cases of emergency or urgent necessity. These must be confirmed by an official order no later than the next working day and clearly marked "confirmation order"

h) orders are not split or otherwise placed in a manner devised to avoid the financial thresholds contained in these SFIs or the Reservation of Powers and detailed Scheme of Delegation or as are applicable under the Public Contracts Regulations 2015

i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase

j) overseas purchases from within the EU will incur VAT and import tax additional to the purchase price. Purchases from outside the EU will incur other import duties

k) changes to the list of nominated officers included in the “Levels of Delegations” as documented in the Scheme of Delegation

l) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the director of finance

m) petty cash records are maintained in a form as determined by the Director of Finance

10.2.7 The Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with all applicable guidance.

11 External borrowing and investments

11.1 General

11.1.1 The Board shall approve the treasury management strategy in accordance with all applicable guidance which may be issued by the regulator.

11.1.2 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

11.1.3 The Director of Finance must ensure that all covenants attached to borrowings by any lender are adhered to.

11.2 Public dividend capital

11.2.1 On authorisation as a Foundation Trust the public dividend capital held immediately prior to authorisation continues to be held on the same conditions.

11.2.2 Additional public dividend capital may be made available on such terms the Secretary of State (with the consent of the Treasury) decides.

11.2.3 Draw down of public dividend capital should be authorised in accordance with the mandate

held by the DHSC cash funding team and is subject to approval by the Secretary of State.

11.2.4 The Trust shall be required to pay annually to the department of health a dividend on its public dividend capital at a rate to be determined periodically by the Secretary of State.

11.3 Commercial borrowing

11.3.1 The Trust may borrow money from any commercial source for the purposes of or in connection with its functions

11.3.2 The Trust may invest money for the purposes of or in connection with its functions. Such investment may include forming, or participating in forming, or otherwise acquiring membership of bodies corporate.

11.3.3 The Trust may also give financial assistance (whether by way of loan, guarantee or otherwise) to any person for the purposes of or in connection with its functions.

11.4 Investment of Temporary Cash Surpluses

11.4.1 Temporary cash surpluses must be held only in such public and private sector investments as approved in the Trust's treasury management policy which should be drawn up by the Director of Finance and pursuant to all applicable guidance including Managing Operating Cash in NHS Foundation Trusts published by the regulator.

11.4.2 The Director of Finance shall report periodically to the Trust Board concerning the performance of investments held.

11.4.3 The Director of Finance will prepare detailed procedural instructions on investment operations and on the records to be maintained. The Trusts treasury management policy will incorporate guidance from the regulator as appropriate.

11.4.4 The Trust shall comply with all relevant guidance published on investments.

12 Capital investment, private financing, fixed asset registers and security of assets

12.1 Capital investment

12.1.1 The Board shall approve a program of building, engineering and design schemes ("the capital program"), as part of the budgetary process. In addition, a further list of schemes shall be provided for situations where additional funding, CDEL (Capital Department Expenditure Limit) or slippage on existing schemes etc. The Chief Executive or Director of Finance shall approve the commencement of such reserve schemes as required.

12.1.2 Where a requirement for a capital scheme not already in the approved program arises during the course of the year, approval for its commencement shall be in accordance with the Reservation of Powers and detailed Scheme of Delegation and a report shall be made to the next meeting of the Board, showing the impact of the new scheme on the capital program and the revenue consequences.

12.1.3 The Trust shall comply with all relevant guidance published on capital investments and the arrangement of capital schemes.

12.1.4 All schemes must be within the Trust's approved capital budget and CDEL limit as authorised by the GM ICB. Any increased or additional budget requirement must be approved via the appropriate approval process within the Trust and in accordance with the GM ICB CDEL limit.

12.2 Business cases

12.2.1 The Chief Executive:

a) shall ensure that there is an adequate appraisal and approval process in place for determining capital and revenue expenditure priorities and the effect of each proposal upon business plans

b) shall ensure that appropriate management arrangements are in place for all stages of capital and revenue schemes and for ensuring that schemes are delivered on time and to cost

c) shall ensure, where appropriate, that the capital and revenue investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges

12.2.2 The Chief Executive shall ensure that management's arrangements are in place for capital and revenue expenditure to ensure:

a) that a business case is produced in line with guidance issued by the Director of Finance. This should include:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs

(ii) appropriate project management and control arrangements

(iii) the involvement of appropriate Trust personnel, committees and external agencies

b) that the Director of Finance or their nominated officer has certified professionally to the costs and revenue consequences detailed in the business case

12.2.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive via a nominated officer will issue procedures for their management, incorporating best practice guidelines.

The Director of Finance or their nominated officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with HM customs & revenue guidance.

The Director of Finance or their nominated officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

12.2.4 The approval of a capital program shall not constitute approval for the initiation of expenditure on any scheme.

The Chief Executive shall ensure there is an approval process in place for:

a) specific authority to commit expenditure through a business case

b) authority to proceed to tender

c) approval to accept a successful tender

12.2.5 The Director of Finance's nominated officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

12.3 Asset registers

12.3.1 As Accountable Officer, the Chief Executive is responsible for safeguarding the Trust's assets. The recording of assets is discharged through the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register against an agreed program.

12.3.2 The Trust shall maintain asset registers recording fixed assets. The minimum data set to be held within these registers shall be as specified in the NHS Foundation Trust I Reporting Manual.

12.3.3 Additions to the capital fixed asset registers must be clearly identified to an appropriate budget holder and be validated by reference to:

a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties

b) lease agreements in respect of assets held under a finance lease and capitalised

12.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate). No capital asset shall be disposed of without the prior approval of the Director of Finance's nominated officer (part exchange is deemed to be a disposal).

12.3.5 The Trust may not dispose of any protected property without the approval of the regulator. This includes the disposal of part of the property or granting an interest in or over it.

12.3.6 The Director of Finance shall approve procedures for reconciling balances on capital fixed assets accounts in ledgers against balances of capital fixed asset registers.

12.3.7 The value of the Trust's capital assets are considered with reference to current accounting standards and other relevant guidance to support the preparation of accounts and their statutory audit. Annual land and building valuations are assessed by independent valuers

as part of this.

12.3.8 The value of each capital asset shall be depreciated using methods and rates in accordance with current accounting standards.

12.4 Security of assets

12.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

12.4.2 Asset control procedures (including fixed assets, cash, cheques and including donated assets) must be approved by the Director of Finance's nominated officer. This procedure shall make provision for:

a) recording managerial responsibility for each asset

b) identification of additions and disposals

c) identification of all repairs and maintenance expenses

d) physical security of asset

e) periodic verification of the existence of, condition of, and title to, assets recorded

f) identification and reporting of all costs associated with the retention of an asset

g) reporting, recording and safekeeping of cash and cheques

12.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance's nominated officer.

12.4.4 Whilst each officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to trust property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with instructions.

12.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

12.4.6 An employee discovering or suspecting a loss of any kind must immediately inform their head of department, the head of internal audit, the local counter fraud specialist or, if no other route is appropriate, the Chief Executive.

12.4.7 Where practical, assets should be marked as Trust property.

13 Stores and receipt of goods

13.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

a) kept to a minimum

b) subjected to annual stock take

c) valued at the lower of cost and net realisable value

13.2 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an officer by the Chief Executive. The day-to-day responsibility may be delegated to departmental officers and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance.

13.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the nominated officer. Wherever practicable stocks should be marked as Trust property.

13.4 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

13.5 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store annually.

13.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

13.7 The nominated officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The nominated officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (*see also paragraph 14, disposals and condemnations, losses and special payments*). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

13.8 The delivery of receipted goods will be distributed to departments promptly to ensure prompt payments of goods may be undertaken.

14 Disposals and condemnations, losses and special payments

14.1 Disposals and condemnations

14.1.1 The Director of Finance's nominated officer must prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to managers. This SFI should be read in conjunction with the Reservation of Powers and detailed scheme of delegation and Appendix 1 to the SFIs. The Trust may not dispose of any protected property without the regulator's consent.

14.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy must liaise with finance to determine and advise the Director of Finance's nominated officer of the estimated market value of the item, taking account professional advice where appropriate, and the recommended disposal mechanism to adopt (including whether competitive bids should be sought) in order to ensure best value is

achieved.

14.1.3 Where any item of equipment is disposed of by the Trust, the Trust shall take all reasonable steps to ensure that it minimises its risk of any claim against the Trust under product liability legislation (including taking professional advice where necessary) including ensuring that:

a) the item of equipment is safe, complies with all applicable regulations and has been properly maintained by the Trust

b) that any defects are brought to the recipient's attention before transfer and that the recipient has the opportunity to inspect the equipment before transfer

c) that the manufacturer's instructions for the use and maintenance of the equipment are transferred to the recipient

14.1.4 No officer shall transfer any equipment to a consumer without the prior authority of the Director of Finance.

14.1.5 All unserviceable articles shall be:

a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance

b) recorded by the condemning officer in a form approved by the Director of Finance's nominated officer that will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance

14.1.6 The condemning officer shall satisfy themself as to whether there is evidence of negligence in use and shall report any such evidence to the Director of Finance's nominated officer who will take the appropriate action.

14.2 Losses and special payments

14.2.1 The Director of Finance's nominated officer must prepare procedural instructions on the recording and accounting for condemnations, losses and special payments. The Director of Finance must also prepare a 'fraud policy and response plan' that sets out the action to be taken by both persons detecting a suspected fraud and those persons responsible for investigating it.

14.2.2 An employee discovering or suspecting a loss of any kind must immediately inform their head of department, the head of internal audit, the local counter fraud specialist or, if no other route is appropriate, the Chief Executive. The head of department or the head of internal audit must immediately inform the Director of Finance. If theft or arson is involved, the head of department must inform the police immediately or the security manager. In cases where the speed of response from the police is of the essence, such as a crime in progress, employees may contact the police directly, but must inform, immediately thereafter, their head of department, who must then inform the Director of Finance promptly. Out of office hours, if the head of department is not on duty, the most senior manager on site should be contacted.

14.2.3 The Director of Finance's nominated officer must notify the department of health directorate of counter fraud & security management service, the external auditor and local counter fraud office of all frauds.

14.2.4 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except where such losses are deemed in the reasonable opinion of the Director of Finance to be trivial, the Director of Finance must immediately notify:

a) the Audit Committee

b) the Board, and

c) the external auditor

14.2.5 All losses over £5,000 shall be reported to the Audit Committee.

14.2.6 The Director of Finance's nominated officer shall be authorised to take any necessary steps to safeguard the trust's interest in bankruptcies and company liquidations.

14.2.7 For any loss, the Director of Finance's nominated officer should consider whether any insurance claim could be made.

14.2.8 The Director of Finance shall maintain a losses and special payments register in which write off action is recorded.

14.2.9 No special payments exceeding delegated limits shall be made without the prior approval of the regulator.

15 Information technology

15.1 The Director of Finance, who is responsible for the accuracy and security of the electronic financial data of the Trust, shall:

a) be responsible for ensuring the design, implementation and documentation of effective financial information systems

b) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which they is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998

c) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the financial system

d) ensure that adequate controls exist such that the operation of the finance computer system is separated and safeguarded from development, maintenance and amendment activities

e) ensure that an adequate management (audit) trail exists through the computer

system and that regular computer audit reviews are carried out in respect of the financial system

15.2 The Director of Finance shall satisfy themself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

15.3 The Director of Finance shall ensure that contracts for computer services for financial applications with another NHS organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

15.4 Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

15.5 Where computer systems have an impact on corporate financial systems, the Director of Finance shall satisfy themself that:

a) systems acquisition, development and maintenance are in line with corporate policies such as an information technology strategy

b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists

c) finance staff have access to such data

d) such computer audit reviews are carried out as are considered necessary

16 Patients' property

16.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter in this SFI referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

16.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

a) notices and information booklets

b) hospital admission documentation and property records

d) the oral advice of administrative and nursing staff responsible for admissions, that;

"the Trust will not accept responsibility or liability for patients' property brought into Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt".

16.3 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all officers whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money to maximise the benefits to the patient.

16.4 Where relevant, guidance requires the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Director of Finance.

16.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965), the production of probate or letters of administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

16.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

16.7 Where patients' property or income is received for specific purpose keeping the property or income shall be used only for that purpose unless any variation is approved by the donor or patient in writing.

17 Acceptance of gifts by staff and other standards of Business Conduct

17.1 The Director of Finance shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy should follow the guidance contained in the department of health standards of business conduct for NHS staff set out in “Code of Conduct for Directors and employees”.

17.2 The DHSC guidance “Standards of Business Conduct” is annexed to these SFIs. It shall be incorporated into these SFIs to the extent that its provisions do not conflict or are not inconsistent with the terms of those SFIs or the Constitution or the Reservation of Powers and detailed Scheme of Delegation. Where such conflict or inconsistency exists, the provisions of the SFIs, the Constitution or Reservation of Powers and the detailed Scheme of Delegation will prevail.

17.3 The acceptance, of gifts, hospitality or consideration of any kind from contractors and other suppliers or goods or services as an inducement or reward is not permitted under the Bribery Act 2010. The Trust’s code of conduct for Directors, governors and employees must be followed.

17.4 The Trust operates a zero-tolerance approach to any form of bribery, fraud or corruption. Any such concerns in these areas should be reported to the Director of Finance or the Trust’s local counter fraud specialist in the first instance.

17.5 Where offers of goods and services do not involve inducement or reward, officers should not accept gifts from commercial sources other than inexpensive articles such as calendars or diaries. If such gifts arrive unsolicited, the advice of the Director of Finance should be sought.

18 Retention of documents

18.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained in accordance with DHSC's records management code of practice.

18.2 The documents held in archives shall be capable of retrieval by authorised persons.

18.3 Documents held in accordance with all applicable guidance on records management shall only be destroyed at the express instigation of the Chief Executive, and records shall be maintained of documents so destroyed.

19 Risk management and insurance

19.1 The Chief Executive will ensure that the Trust has a risk management strategy that will be approved and monitored by the Board.

19.2 The risk management strategy will include:

a) a process of identifying and quantifying risks and potential liabilities

b) engendering among all levels of staff a positive attitude towards the control of risk

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover and decisions on the acceptable level of retained risk

d) contingency plans to offset the impact of adverse events

e) audit arrangements including internal audit, clinical audit, health and safety reviews

f) arrangements to review the risk management strategy

g) decision on which risks shall be insured through arrangements with either the NHS litigation authorities pooling schemes or commercial insurers

19.3 The existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of internal control within the annual report and accounts.

19.4 The Chief Executive in consultation with their nominated officer(s) shall be responsible for ensuring adequate insurance cover is affected in accordance with risk management policy approved by the Board.

19.5 Each officer shall promptly notify the designated officer of all new risks or property under their control, which require to be insured, and of any alterations affecting existing risks or insurances.

19.6 The nominated officer shall ascertain the amount of cover required and shall affect such insurances as are necessary to protect the interests of the Trust.

19.7 The Chief Executive or their nominated officer shall make all claims arising out of policies of insurance and each officer shall furnish the Director of Finance immediately with full particulars of any occurrence involving actual or potential loss to the Trust and shall furnish an estimate of the probable cost involved.

19.8 The Chief Operating Officer shall ensure that all engineering plant under the Trust's control is inspected by the relevant insurance companies within the periods prescribed by legislation.

19.9 The value of all assets and risks insured shall be reviewed or index-linked on an annual basis by the nominated officer.

19.10 The relevant Directors shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority or enter into arrangements with commercial insurers.

19.11 Where the risk pooling schemes are used, the relevant Directors shall ensure that the arrangements entered into are appropriate and complementary to the risk management program the relevant Directors shall ensure that documented procedures cover these arrangements.

19.12 The risk pooling scheme for Trusts requires members to contribute to the settlement of claims. The relevant Directors shall ensure documented procedures also cover the management of claims and payments below the deductible in each case.

19.13 The relevant Directors shall ensure documented procedures cover the management of claims and payments in respect of the arrangements with commercial insurers.

19.14 The Trust may purchase and maintain insurance against this liability for its own benefit and for the benefit of members of the Council of Governors and the Board.

20 Expenses, travel and subsistence

The Trust accepts that business travel is an integral part of work for many of our staff and the right that reasonable travelling expenses incurred should be reimbursed.

All staff business travel for staff on and off the Christie payroll that want to travel using Christie funds, should be booked through the staff travel team (refer to the staff travel booking form and the expenses, travel and subsistence policy)

Reimbursement to the Chair and Non-Executive Directors for their travel to and from the Trust is the responsibility of the Director of Finance.

The Board will approve the level of expenses to be funded from exchequer funds

The following principles will apply:

a) expenses must be moderate and reasonable

b) claims will not be eligible for alcohol

c) claims must be made via the electronic ePay system, checked and authorised by a signatory or nominated officer and must be submitted within three months of the claim period

d) authorisers of expenses and salaries in the ePay system that do not have a financial limit for other Trust operational activities, must complete a letter of delegation (Appendix 3)

e) expense claims must be supported by a properly itemised receipt which provides sufficient detail to substantiate the claim. In the case of travel associated with courses and conferences evidence of attendance and proof of payment will be expected. Payment will only be made for individuals in addition to the claimant, where there is a clear and direct working relationship and approved by the Director of Finance or Chief Executive

f) relocation expenses as specified in the Trust relocation and removal policy

g) expense claims over 90 days will require further approval, refer to the detailed Scheme of Delegation

h) ePay claims for travel expenses that should have been booked through the staff travel service, will require further approval from the Director of Finance. Details of staff and travel costs will be reported to the Audit Committee (refer to the detailed Scheme of Delegation)

i) Non-Christie payroll staff that have incurred additional costs from their travel, can submit paper claims to the finance department for reimbursement of incidental and subsistence only.

21 Hospitality

Refer to the Code of Conduct Appendix 2 and detailed Scheme of Delegation.

22 Consultation

22.1 The Trust should take into account the legal duties of consultation that are applicable to the Trust when considering any changes to service provision at an early stage and seek advice where necessary.

22.2 National Health and Social Care Act 2012 sets out the Trust's duty, as respect to health services for which it is responsible, that persons to whom those services are being or may be provided or, directly or through representatives, included in and consulted on:

a) the planning of the provision of those services

b) the development and consideration of proposals for changes in the way those services are provided

c) decisions to be made by that body affecting the operation of those services

22.3 Regulation 4A of the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 sets out that the Trust needs to consult with the Overview and Scrutiny Committee of a Local Authority where:

d) the Trust proposes to make an application to the regulator to vary the terms of its authorisation

e) that application, if successful, would result in a substantial variation of the provision by the Trust of protected goods or services in the area of that local authority

Appendix 1

1. QUOTATIONS, TENDERING AND CONTRACTING PROCEDURE

1.1 Duty to comply with the Constitution and SFIs

The procedure for making all contracts by or on behalf of the Trust shall comply with the Constitution and SFIs and the commercial framework (except where the constitution 4.8 (contained in Annex 8 of the constitution of the Trust) is applied)

1.2 Legislation and Guidance Governing Public Procurement

The Trust shall comply with the Public Contracts Regulations 2015 and any relevant EC Directives and all requirements binding on the Trust derived from the EU Treaty relating to procurement by the Trust relating to the processes to be applied when awarding all forms of contract. Such legislation shall be incorporated into the Constitution and SFIs

1.3 Reverse eAuctions

The Trust shall review the use of Reverse eAuctions. Any use of Reverse eAuctions shall be in accordance with policies and procedures in place for the control of all the tendering activity carried out through Reverse eAuctions.

1.4 Capital Investment

The Trust shall comply with the requirements of the guidance published on capital investment and protection of assets in respect of capital investment and estate and property transactions.

1.5 Written Quotations and Formal Competitive Tendering

1.5.1 General Applicability

Subject to paragraph 1.5.3 and 1.12 of this appendix, the Trust shall ensure that quotations are requested, or competitive tenders are invited for:

a) the supply of goods, materials and manufactured articles

b) the rendering of services including all forms of management consultancy services

c) the design, construction and maintenance of building and engineering works including construction and maintenance of grounds and gardens

d) disposals of any tangible or intangible property (including equipment, land and intellectual property)

1.5.2 Health Care Services (and other services captured by the Light Touch Regime)

Where the Trust has a requirement to procure healthcare services (and/or other services captured by the Light Touch Regime for the purposes of the Public Contracts Regulations 2015) (whether by way of sub-contract or otherwise) the Trust shall consider its duties under the EU Treaty and whether such service requirement should be advertised.

Where the Trust considers that the circumstances require it to advertise for the supply of healthcare services (and/or other services captured by the Light Touch Regime for the

purposes of the Public Contracts Regulations 2015), the Constitution and SFIs will apply although at all times the Trust should consider its duties under paragraph 1.2 of this appendix above.

1.5.3 Exceptions and instances where a minimum of 3 written quotations need not be obtained or formal tendering need not be applied

A minimum of 3 written quotations **need not be obtained** where:

(a) the estimated expenditure or income does not, or is not reasonably expected to exceed £10,000 (excluding VAT) (such amount to be reviewed annually by the Board)

Formal tendering procedures need not be applied where:

(b) the estimated expenditure or income does not or is not expected to exceed £50,000 (excluding VAT); such amount to be reviewed annually by the Board

A minimum of 3 written quotations **need not be obtained** or formal tendering procedures need not be applied where:

(c) the supply can be obtained under a framework agreement that has itself been procured in compliance with the duties set out at paragraph 1.2 of this appendix above and where the Trust is entitled to access such framework agreement

(d) where under SFI 14, in the case of disposal of assets, formal tendering procedures are not always required

(e) where the requirement is covered by an existing contract

(f) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members including the Trust

(g) where 3 or more requests for quotations/tenders are issued and less than 3 responses are received

Subject to the duties at paragraph 1.1 and 1.2 of this appendix (and to obtaining appropriate advice from the Trust's procurement department and where considered necessary external professional advice) for estimated expenditure or income exceeding £10,000 but below the Public Contracts Regulations threshold, the need to obtain a minimum of 3 written quotations or undertake formal tendering procedures may be waived in the following circumstances:

(h) in exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record

(i) where the timescale genuinely precludes competitive tendering. However, failure to plan the work properly may not be regarded as a justification for a single tender

(j) where specialist goods/service or expertise is required and can be demonstrated to be available from only one source, this will include the provision of maintenance services licenses, membership and subscriptions

(k) where the requirement is for equipment which has been approved by the Medical Devices and Procurement Committee as Trust standard and detailed on the "Trust standard list"

(l) where the requirement is essential to complete or maintain continuity with an earlier project, and engaging with an alternative provider for the additional/associated work or task would be impracticable

(m) where there are a limited number of suppliers in the market, and it is not possible to request a minimum of 3 written quotations or tenders

(n) for the provision of legal advice and services providing that any legal firm for England or Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned

The Director of Finance will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

The waiving of formal tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a supplier or consultant originally appointed through a competitive procedure.

Where it is decided that obtaining a minimum of 3 written quotations or formal tendering is not applicable and should be waived, in accordance with (h) to (n) above, the fact of the waiver and the reasons, should be documented and recorded in an appropriate trust record and reported to the Audit Committee at the next meeting scheduled to consider the waiver of requirements to tender formally. For this purpose, the completion of a waiver must be undertaken. The Audit Committee shall consider such waivers at alternate meetings.

1.5.4 Fair transparent and adequate competition

Except where the exceptions set out at paragraph 1.5.3 of this appendix apply and permit the use of a single tender action, the Trust shall ensure that for all invitations to tender, whether regulated by the Public Contracts Regulations 2016 or not, that the tender process adopted is considered in a fair and transparent manner. Where a tender process is conducted the Trust shall, in order to assure that best value is obtained, invite tenders from a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than three firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

1.5.5 Use of framework

Where the Trust is satisfied under its duties at paragraph 1.2 of this appendix above that an open tender process is not necessary, the Trust shall ensure that the firms/individuals invited to tender (and where appropriate, quote) are among those on approved framework (if such a list is maintained by the Trust or accredited body for such goods, services or works).

Where, in the opinion of the Director of Finance, it is desirable to seek tenders from firms not on the approved framework, the reason shall be recorded in writing (see paragraph

1.6.9 of this appendix below List of Approved Firms). A framework agreement is a formal agreement with selected (shortlisted) suppliers under which specific purchases can be made. Framework agreements may allow for further (mini) competitions between the suppliers or direct award.

1.5.6 Requirements that subsequently breach thresholds after original approval

(a) Requirements estimated to be below the limits set in this SFIs for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive and be recorded in an appropriate Trust record.

(b) Requirements that subsequently breach original contract approval amount (below Public Contracts Regulations threshold):

- If following approval of a contract award the contract value needs to increase by 50% or more, then approval will need to be obtained by the original approval process for the excess amount.

- Increases to the original contract value which take the contract value above the Public Contracts Regulations threshold, advice must be sought from the procurement department before submission to determine if a tendering exercise is required, and if not, which approval process needs to be followed.

(c) Requirements that subsequently breach original contract amount (above Public Contracts Regulations threshold):

- If following a contract award approval, the contract value needs to increase by 50% or more, then approval will need to be obtained by the original approval process for the excess amount. As this could be a breach of the Public Contracts Regulations, advice must be sought from the procurement department as this may require a retendering exercise.

1.6 Contracting/Tendering Procedure

1.6.1 General position on tenders

a) Except where the exceptions set out in paragraph 1.5.3 of this appendix above apply a minimum of three invitations to tenders are to be invited where the intended expenditure or income is reasonably expected to be £50,000 (excluding VAT) or above but is not reasonably expected to exceed the Public Contracts Regulations threshold (including VAT).

b) Tenders should be obtained from at least three firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust

c) The Trust uses an e-tendering system to issue and receive all tenders electronically.

1.6.2 Invitation to tender

a) All invitations to tender shall state the date and time that is the latest time for the receipt of tenders.

b) All invitations to tender shall state that no tender will be accepted unless:
   i) submitted electronically using the e-tendering system, or

   ii) in exceptional circumstances, i.e., where it is not possible to submit electronically using the e-tendering system; submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the trust (or the word "tender" followed by the tender reference and the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated manager. Any such tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

c) Every tender for goods, materials, services or disposals shall contain and comprise appropriate terms and conditions regulating the conduct of the tender and shall contain appropriate terms and conditions on which the contract is to be awarded and shall be substantively based to regulate the provision of the goods, materials, services to be provided or in relation to the disposal.

d) Every tender for building or engineering works (except for maintenance work, when Estman code guidance is followed) must contain terms and conditions on which the contract is awarded substantively based on the terms of the current edition of a suitable and recognised industry form of contract including but not limited to one of the Joint Contracts Tribunal Standard Forms of Building Contract or the NEC standard forms of contract or Department of the Environment (GC/Wks) Standard forms of contract.

e) When the content of the work is primarily engineering, the general conditions of contract recommended by the Institution of Mechanical and Electrical Engineers or the (ACE) Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the general conditions of contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. The form of contract can be amended (in minor respects only), to the specific requirements of the individual projects.

1.6.3 Receipt and safe custody of tenders

a) Electronic tenders

Tenders will be held and locked electronically until the time and date allocated for opening.

b) Hard copy tenders (accepted in exceptional circumstances only)

The Chief Executive or their nominated officer will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

The date and time of receipt of each tender shall be endorsed by the Chief Executive or their nominated officer on the tender envelope/package.

1.6.4 Opening tenders and register of tenders

a) Electronic tenders

i) The Chief Executive will designate and agree a list of officers who will be able to access the electronic tenders and release them once the sealed date and time has passed. This list will exclude the originating manager.

ii) A full electronic record of the tenders received will be available in accordance with the agreed parameters of the system.

b) Hard copy tenders (accepted in exceptional circumstances only)

i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, every tender received shall be opened by two senior officers/managers designated by the Chief Executive. Such nominated officers should not be from the originating department.

ii) A member of the Board will be required to be one of the two approved persons present for the opening of tenders estimated above £100,000 (excluding VAT). The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Reservation of Powers and detailed Scheme of Delegation document.

iii) The 'originating' department will be taken to mean the department sponsoring or commissioning the tender

iv) The involvement of Finance Directorate staff in the preparation of a tender proposal will not preclude the Director of Finance or any approved senior manager from the Finance Directorate from serving as one of the two senior managers to open tenders.

v) All Executive Directors will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

The Company Secretary will count as a Director for the purposes of opening tenders.

vi) Every tender received shall be marked with the date of opening and initialed by those present at the opening.

vii) A register shall be maintained by the Chief Executive, or a person authorised by them, to show for each set of competitive tender invitations dispatched:

- the name of all firms/individuals invited
- the names of firms/individuals from which tenders have been received
- the date the tenders were opened
- the persons present at the opening
- the price shown on each tender
- a note where price alterations have been made on the tender
- Each entry to this register shall be signed by those present

A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

viii) Incomplete tenders, i.e. those from which information necessary for evaluation of the tender is missing, and amended tenders i.e., those amended by the tenderer upon their own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders may at the discretion of the Chief Executive or their nominated officer be rejected, provided that the terms and conditions applicable to such tender process permit such rejection.

1.6.5 Admissibility of Tenders

a) If for any reason the nominated officers are of the opinion that the tenders received are not competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

b) Where only one tender is sought and/or received, the Chief Executive and Director of Finance shall, as far as practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

1.6.6 Late tenders

a) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or their nominated officer decides that there are exceptional circumstances, for example a tender dispatched in good time but delayed through no fault of the tenderer.

b) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or their nominated officer or if the process of evaluation has not started.

c) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or their nominated officer.

1.6.7 Acceptance of formal tenders

a) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.

b) The Trust shall accept the most economically advantageous tender unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

i) experience and qualifications of team members

ii) understanding of client's needs

iii) feasibility and credibility of proposed approach

iv) ability to complete the project on time

The factors considered in selecting a tenderer must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest priced tender (if payment is to be made by the Trust) or the highest (if payment is to be received by the Trust) clearly stated.

c) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these SFIs except with the authorisation of the Chief Executive or Director of Finance.

d) Variation to contract must follow the business case and tender award approval process.

e) The use of these procedures must demonstrate that the award of the contract was:

i) not in excess of the going market rate price current at the time the contract was awarded

ii) that best value for money was achieved

f) All tenders should be treated as confidential and should be retained for inspection.

1.7 Quotations

1.7.1 General position on quotations

Except where the exceptions set out at paragraph 1.5.3. of this appendix apply, a minimum of three written quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds or is reasonably expected to be £10,000 (excluding VAT) or above but is not reasonably expected to exceed £50,000 (excluding VAT).

1.7.2 Quotations

a) Quotations should be obtained from at least three firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust.

b) All quotations for any requirement estimated to be £10,000 (excluding VAT) or above should be in writing unless the Chief Executive or their nominated officer determines that it is impractical to do so in which case quotations may be obtained verbally. Confirmation of verbal quotations should be obtained as soon as possible and the reasons why, a verbal quotation was obtained should be set out in a permanent record.

c) All quotations should be treated as confidential and should be retained for inspection.

d) The Chief Executive or their nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made, and the reasons why should be recorded in a permanent record.

1.7.3 Quotations to be within financial limits

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with SFIs or the relevant delegation in the Reservation of Powers and detailed Scheme of Delegation except with the authorisation of either the Chief Executive or Director of Finance.

1.8 Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these SFIs have been fully complied with, formal authorisation and awarding of a contract will be as set out in the Reservation of Powers and detailed Scheme of Delegation.

Formal authorisation must be put in writing. In the case of authorisation by the Board this shall be recorded in their minutes.

1.9 Private Finance for capital procurement (in conjunction with SFI 12)

When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) the Chief Executive shall demonstrate that the use of private finance represents value for money as against a public sector comparator and genuinely transfers risk to the private sector

(b) the Trust must seek all applicable approvals and the requirements of all guidance by the regulator including Risk Evaluation for Investment Decisions by NHS Foundation Trusts

(c) the proposal must be specifically agreed by the Board

(d) the selection of a contractor/finance company must be based on competitive tendering or quotations compliant with the duties set out at paragraph 1.2 of this appendix above

1.10 Compliance requirements for all contracts

The Board may only enter into contracts on behalf of the Trust within the statutory powers of the Trust.

1.11 Personnel and Agency or Temporary Staff Contracts

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

1.12 Disposals

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

a) any matter in respect of which best value can be obtained only by negotiation or sale by auction as determined (or pre-determined) by the Chief Executive or their nominated officer

b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust

c) items to be disposed of with an estimated sale value of less than £1,000; this figure to be reviewed on a periodic basis

1.13 In-house services

1.13.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be bench-marked, or market tested by competitive tendering.

1.13.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

a) specification group, comprising the Chief Executive or nominated officer/s and a relevant specialist in that field

b) in-house tender group, comprising a nominee of the Chief Executive and technical support

c) evaluation team, comprising normally a specialist officer, a supplies officer and a representative of the Director of Finance. For services having an expected annual expenditure exceeding £100,000, an Executive or Non-Executive Director should be a member of the evaluation team.

1.13.3 All groups should work independently of each other, and individual officers may be a member of more than one group, but no member of the in-house tender group may participate in the evaluation of term.

1.13.4 The evaluation team shall make recommendations to the Board following any benchmarking process or a market testing exercise carried out pursuant to paragraph 1.2 above.

1.13.5 The Chief Executive shall nominate an officer to oversee any market testing or benchmarking exercise including an in-house bid on behalf of the Trust.

These SFIs shall not only apply to expenditure from exchequer funds but also to works, services and goods purchased from the Trust's private resources.

The Christie
NHS Foundation Trust

Appendix 2

January 2012

Code of Conduct for Directors and Employees

For NHS staff

Appendix 3 – Letter below

Letter 3 – Delegated ePay authorisation

The Christie
NHS Foundation Trust

Wilmslow Road
Manchester
M20 4BX

Direct tel: 0161 446 xxxx
Switchboard tel: 0161 446 3000
Email : first.second@nhs.net
Web: www.christie.nhs.uk

Date

To the Head of Financial Systems

Delegated Responsibilities for nominated officer for ePay

As an authorised signatory from Level 1 - 3 (a) identified in the Scheme of Delegation, I hereby formally delegate to INSERT NAME OF NOMINEE with immediate effect, to act as an authorising officer for the approvals of expenses and salaries through the ePay system.

I have the assurance that;

- The approval process for salary enhancements outside of ePay will satisfy audits requirements and be checked and approved by an authorised signatory before submission to ePay.
- The nominee has completed ePay training and has the technical competence and understanding that each ePay entry must be checked before approval of each submission.

This is in line with section 1.4 of the Trust Standing Financial Instructions.

Kind regards

print name

sign name

position

The Christie
NHS Foundation Trust

Appendix 4

January 1993

Standards of Business conduct

For NHS staff

B1784-nhse-standards-of-business-conduct-policy.pdf (england.nhs.uk)

Part A

Prevention of corruption acts 1906 and 1916 - summary of main provisions

Acceptance of gifts by way of inducements or rewards

1. Under the prevention of corruption acts, 1906 and 1916, it is an offence for employees corruptly to accept any gifts or consideration as an inducement or reward for:

- doing, or refraining from doing, anything in their official capacity; or
- showing favour or disfavour to any person in their official capacity

2 Under the prevention of corruption act 1916, any money, gift or consideration received by an employee in public service from a person or organisation holding or seeking to obtain a contract will be deemed by the courts to have been received corruptly unless the employee proves the contrary.

Part B

Department of Health (DoH) – general guidelines

Introduction

1. These guidelines, which are intended by the DoH to be helpful to all NHS employers (i) and their employees, re-state and reinforce the guiding principles previously set out in circular HM (62) 21 (now cancelled), relating to the conduct of business in the NHS.

Responsibility of NHS employers

2 NHS employers are responsible for ensuring that these guidelines are brought to the attention of all employees; also, that machinery is put in place for ensuring that they are effectively implemented.

Responsibility of NHS staff

3 It is the responsibility of staff to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their NHS duties. This primary responsibility applies to *all NHS staff,* i.e. Those who commit NHS resources directly (e.g., By the ordering of goods) or those who do so indirectly (e.g., By the prescribing of medicines). A further example would be staff who may have an interest in a private nursing home and who are involved with the discharge of patients to residential facilities.

Guiding principle in conduct of public business

4 It is a long-established principle that public sector bodies, which include the NHS, must be impartial and honest in the conduct of their business, and that their employees should remain beyond suspicion. It is also an offence under the prevention of corruption acts 1906 and 1916 for an employee corruptly to accept any inducement or reward for doing, or refraining from doing anything, in his or her official capacity, or corruptly showing favour, or disfavour, in the handling of contracts (see part a).

Staff will need to be aware that a breach of the provisions of these acts renders them liable to prosecution and may lead to loss of their employment and superannuation rights in the NHS.

Principles of conduct in the NHS

5 NHS staff is expected to:

- ensure that the interest of patients remains paramount at all times
- be impartial and honest in the conduct of their official business
- use the public funds entrusted to them to the best advantage of the service, always ensuring value for money

6 It is also the responsibility of staff to ensure that they do **not:**

- abuse their official position for personal gain or to benefit their family or friends

- seek to advantage or further private business or other interests, in the course of their official duties

Implementing the guiding principles

Casual gifts

7 Casual gifts offered by contractors or others, e.g. At Christmas time, may not be in any way connected with the performance of duties so as to constitute an offence under the prevention of corruption acts. Such gifts should nevertheless be politely but firmly declined. Articles of low intrinsic value such as diaries or calendars, or small tokens of gratitude from patients or their relatives, need not necessarily be refused. In cases of doubt staff should either consult their line manager or politely decline acceptance.

Hospitality

8 Modest hospitality provided it is normal and reasonable in the circumstances, e.g. Lunches in the course of working visits, may be acceptable, though it should be similar to the scale of hospitality which the NHS as an employer would be likely to offer.

9 Staff should decline all other offers of gifts, hospitality or entertainment. If in doubt they should seek advice from their line manager.

Declaration of interests

10 NHS employers need to be aware of all cases where an employee, or his or her close relative or associate, has a controlling and/or significant financial interest in a business (including a private company, public sector organisation, other NHS employer and/or voluntary organisation), or in any other activity or pursuit, which may compete for an NHS contract to supply either goods or services to the employing authority.

11 All NHS staff should therefore declare such interests to their employer, either on starting employment or on acquisition of the interest, in order that it may be known to and in no way promoted to the detriment of either the employing authority or the patients whom it serves.

12 One particular area of potential conflict of interest that may directly affect patients is when NHS staff holds a self-beneficial interest in private care homes or hostels. While it is for staff to declare such interests to their employing authority, the employing authority has a responsibility to introduce whatever measures it considers necessary to ensure that its interests and those of patients are adequately safeguarded. This may for example take the form of a contractual obligation on staff to declare any such interests. Advice on professional conduct issued by the general medical council recommends that when a doctor refers a patient to a private care home or hostel in which they have an interest, the patient must be informed of that interest before referral is made.

13 In determining what needs to be declared, employers and employees will wish to be guided by the principles set out in paragraph 5 above.

14 NHS employers should:

- ensure that staff are aware of their responsibility to declare relevant interests (perhaps by including a clause to this effect in staff contracts)
- consider keeping registers of all such interests and making them available for inspection by the public
- develop a local policy, in consultation with staff and local staff interests, for implementing this guidance. This may include the disciplinary action to be taken if an employee fails to declare a relevant interest, or is found to have abused his or her official position, or knowledge, for the purpose of self-benefit, or that of family or friends

Preferential treatment in private transactions

15 Individual staff must not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of their NHS employer. (this does not apply to concessionary agreements negotiated with companies by NHS management, or by recognised staff interests on behalf of all staff - for example, NHS staff benefits schemes).

Contracts

16 All staff who are in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign purchase orders, or place contracts for goods, materials or services, are expected to adhere to professional standards of the kind set out in the ethical code of the chartered institute of purchasing and supply (CIPS), reproduced at part c below.

Favouritism in awarding contracts

17 Fair and open competition between prospective contractors or suppliers for NHS contracts is a requirement of the Constitution and of EC directives on public purchasing for works and supplies. This means that:

- no private, public or voluntary organisation or company which may bid for NHS business should be given any advantage over its competitors, such as advance notice of NHS requirements. This applies to all potential contractors, whether or not there is a relationship between them and the NHS employer, such as a long-running series of previous contracts

- each new contract should be awarded solely on merit, taking into account the requirements of the NHS and the ability of the contractors to fulfil them

18 NHS employers should ensure that no special favour is shown to current or former employees or their close relatives or associates in awarding contracts to private or other businesses run by them or employing them in a senior or relevant managerial capacity. Contracts may be awarded to such businesses where they are won in fair competition against other tenders, but scrupulous care must be taken to ensure that the selection process is conducted impartially, and that staff that are known to have a relevant interest play no part in the selection.

Warnings to potential contractors

19 NHS employers will wish to ensure that all invitations to potential contractors to tender for NHS business include a notice warning tenderer of the consequences of engaging in any corrupt practices involving employees of public bodies.

Outside employment

20 NHS employees are advised not to engage in outside employment that may conflict with their NHS work or be detrimental to it.

They are advised to tell their NHS employing authority if they think they may be risking a conflict of interest in this area: the NHS employer will be responsible for judging whether the interests of patients could be harmed, in line with the principles in paragraph 5 above. NHS employers may wish to consider the preparation of local guidelines on this subject.

Private practice

21 Consultants (and associate specialists) employed under the terms and conditions of service of hospital medical and dental staff are permitted to carry out private practice In NHS hospitals subject to the conditions outlined in the handbook “a guide to the management of private practice in the NHS". (see also pm (79) 11). Consultants who have signed new contracts with trusts will be subject to the terms applying to private practice in those contracts.

22 Other grades may undertake private practice or work for outside agencies, providing they do not do so within the time they are contracted to the NHS, and they observe the conditions in paragraph 20 above. All hospital doctors are entitled to fees for other work outside their NHS contractual duties under "category 2" (paragraph 37 of the tcs of hospital medical and dental staff), e.g., Examinations and reports for life insurance purposes. Hospital doctors and dentists in training should not undertake locum work outside their contracts where such work would be in breach of their contracted hours. Career grade medical and dental staff employed by NHS trusts may agree terms and conditions different from the national terms and conditions of service.

Rewards for initiative

23 NHS employers should ensure that they are in a position to identify potential intellectual property rights (IPR), as and when they arise, so that they can protect and exploit them properly, and thereby ensure that they receive any rewards or benefits (such as royalties) in respect of work commissioned from third parties, or work carried out by their employees in the course of their NHS duties. Most IPR are protected by statute, e.g., Patents are protected under the patents act 1977 and copyright (which includes software programmes) under the copyright designs and patents act 1988. To achieve this NHS employers should build appropriate specifications and provisions into the contractual arrangements that they enter into *before* the work is commissioned or begins. They should always seek legal advice if in any doubt in specific cases.

24 With regard to patents and inventions, in certain defined circumstances the patents act gives *employees a right* to obtain some reward for their efforts, and employers should see that this is affected. Other rewards may be given voluntarily to employees who within the course of their employment have produced innovative work of outstanding benefit to the NHS. Similar rewards should be voluntarily applied to other activities such as giving lectures and publishing books and articles.

25 In the case of collaborative research and evaluative exercises with manufacturers, NHS employers should see that they obtain a fair reward for the input they provide. If such an exercise involves additional work for an NHS employee outside that paid for by the NHS employer under his or her contract of employment, arrangements should be made for some share of any rewards or benefits to be passed on to the employee(s) concerned from the collaborating parties. Care should however be taken that involvement in this type of arrangement with a manufacturer does not influence the purchase of other supplies from that manufacturer.

Commercial sponsorship for attendance at courses and conferences

26 Acceptance by staff of commercial sponsorship for attendance at relevant conferences and courses is acceptable, but only where the employee seeks permission in advance and the employer is satisfied that acceptance will not compromise purchasing decisions in any way.

27 On occasions when NHS employers consider it necessary for staff advising on the purchase of equipment to inspect such equipment in operation in other parts of the country (or exceptionally, overseas), employing authorities will themselves want to consider meeting the cost, so as to avoid putting in jeopardy the integrity of subsequent purchasing decisions.

Commercial sponsorship of posts – "linked deals"

28 Pharmaceutical companies, for example, may offer to sponsor, wholly or partially, a post for an employing authority. NHS employers should not enter into such arrangements, unless it has been made abundantly clear to the company concerned that the sponsorship will have no effect on purchasing decisions with the authority. Where such sponsorships accepted, monitoring arrangements should be established to ensure that purchasing decisions are not, in fact, being influenced by the sponsorship agreement.

Under no circumstances should employers agree to "linked deals" whereby sponsorship is linked to the purchase of particular products, or to supply from particular sources.

"Commercial in-confidence"

29 Staff should be particularly careful of using, or making public, internal information of a "commercial in confidence" nature, particularly if its disclosure would prejudice the principle of a purchasing system based on fair competition. This principle applies whether private competitors or other NHS providers are concerned, and whether or not disclosure is prompted by the expectation of personal gain (see paragraphs 16 – 18 above and Part E).

30 However, NHS employers should be careful about adopting a too restrictive view on this matter. It should certainly not be a cause of excessive secrecy on matters which are not strictly commercial per se. For example, the term "commercial in confidence" should not be taken to include information about service delivery and activity levels, which should be publicly available. Nor should it inhibit the free exchange of data for medical audit purposes, for example, subject to the normal rules governing patient confidentiality and data protection. In all circumstances the overriding consideration must be the best interests of patients.

(i) in these guidelines "NHS employer" means all "for action' addressees listed on the title page of HSG (93) 5.

Part C

Action checklist for NHS managers

References are to paragraphs in Part B of "Standards of business conduct for NHS staff" (Annex to HSG(93)5)

You must:

- Ensure that all staff are aware of this guidance (2) and (4);
- Develop a local policy and implement it (2 and 14);
- Show no favouritism in awarding contracts (e.g., to businesses run by employees, ex-employees or their friends or relatives) (17 – 18);
- Include a warning against corruption in all invitations to tender (19);
- Consider requests from staff for permission to undertake additional outside employment (20);
- Apply the terms of PM (79)11 concerning doctors' engagements in private practice (21).
- Receive rewards or royalties in respect of work carried out by employees in the course of their
- NHS work and ensure that such employees receive due rewards (24).
- Similarly ensure receipt of rewards for collaborative work with manufacturers, and pass on to participating employees (25);
- Ensure that acceptance of commercial sponsorship will not influence or jeopardise purchasing decisions (26-27);
- Refuse "linked deals" whereby sponsorship of staff posts is linked to the purchase of particular products or supply from particular sources (28);
- Avoid excessive secrecy and abuse of the term "commercial in confidence" (30).

Part D
Short guide for staff

References are to paragraphs in Part B of "Standards of business conduct for NHS staff" (Annex to HSG(93)5)

Do:

- Make sure you understand the guidelines on standards of business conduct and consult your line managers if you are not sure.
- Make sure you are not in a position where your private interests and NHS duties may conflict (3);
- Declare to your employer any relevant interests (10-14). If in doubt, ask yourself:
  - i) am I, or might I be, in a position where I (or my family/friends) could gain from the connection between my private interests and my employment?
  - ii) do I have access to information which could influence purchasing decisions?
  - iii) could my outside interest be in any way detrimental to the NHS or to patients' interests?
  - iv) do I have any other reason to think I may be risking a conflict of interest?

If still unsure – Declare it!

- Adhere to the ethical code of the Institute of Purchasing and Supply if you are involved in any way with the acquisition of goods and services (16);
- Seek your employer's permission before taking on outside work, if there is any question of it adversely affecting your NHS duties (20). (Special guidance applies to doctors);
- Obtain your employer's permission before accepting any commercial sponsorship (26);

Do not:

- Accept any gifts, inducements or inappropriate hospitality (see 7 – 9)
- Abuse your past or present official position to obtain preferential rates for private deals (15)
- Unfairly advantage one competitor over another (17) or show favouritism in awarding contracts (18)
- Misuse of make available official "commercial in confidence" information (29).

Part E

THE CHARTERED INSTITUTE OF PURCHASING AND SUPPLY

CODE OF CONDUCT

As a member of The Chartered Institute of Purchasing & Supply, I will:

Enhance and protect the standing of the profession, by:

- Never engaging in conduct, either professional or personal, which would bring the profession or the Chartered Institute of Purchasing & Supply into disrepute
- Not accepting inducements or gifts (other than any declared gifts of nominal value which have been sanctioned by my employer)
- Not allowing offers of hospitality or those with vested interests to influence, or be perceived to influence, my business decisions
- Being aware that my behaviour outside my professional life may have an effect on how I am perceived as a professional.

Maintain the highest standard of integrity in all business relationships, by:

- Rejecting any business practice which might reasonably be deemed improper Never
- using my authority or position for my own financial gain
- Declaring to my line manager any personal interest that might affect, or be seen by others to affect, my impartiality in decision making
- Ensuring that the information I give in the course of my work is accurate and not misleading
- Never breaching the confidentiality of information, I receive in a professional capacity
- Striving for genuine, fair and transparent competition
- Being truthful about my skills, experience and qualifications.

Promote the eradication of unethical business practices, by:

- Fostering awareness of human rights, fraud and corruption issues in all my business relationships
- Responsibly managing any business relationships where unethical practices may come to light, and taking appropriate action to report and remedy them
- Undertaking due diligence on appropriate supplier relationships in relation to forced labour (modern slavery) and other human rights abuses, fraud and corruption
- Continually developing my knowledge of forced labour (modern slavery), human rights, fraud and corruption issues, and applying this in my professional life

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Enhance the proficiency and stature of the profession, by:

- Continually developing and applying knowledge to increase my personal skills and those of the organisation I work for
- Fostering the highest standards of professional competence amongst those for whom I am responsible
- Optimising the responsible use of resources which I have influence over for the benefit of my organisation

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Ensure full compliance with laws and regulations, by:

- Adhering to the laws of countries in which I practice, and in countries where there is no relevant law in place, I will apply the standards inherent in this Code
- Fulfilling agreed contractual obligations
- Following CIPS guidance on professional practice

This code was approved by the CIPS Global Board of Trustees in September 2013.

The Christie
NHS Foundation Trust

Agenda item 29/23b

Board of Directors

Thursday 28th September 2023

Subject / Title	Trust proposal of nomination of FT Trustee to Christie Charity Board
Author(s)	Company Secretary
Presented by	Roger Spencer, CEO
Summary / purpose of paper	To ask the Board of Directors to approve the recommendation of the Executive Directors to appoint Edward Astle, Chairman as a Foundation Trust trustee from 1st October 2023
Recommendation(s)	The Board is asked to approve the appointment of Edward Astle as a Foundation Trust trustee from 1st October 2023
Background papers	
Risk score	N/A
Link to: ➢ Trust strategy ➢ Corporate objectives	Our Strategy NHS Long Term Plan GM Cancer Plan
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	

The Christie
NHS Foundation Trust
Agenda item 29/23b

Board of Directors meeting

Thursday 28th September 2023

Trust proposal of nomination of FT Trustee to Christie Charity Board

1. Introduction

This paper asks the Board of Directors to consider a recommendation on the replacement Foundation Trust trustee following the end of the term of office of the current Chair and charity trustee, Chris Outram.

4. Process

In line with the approved Articles of Association (AoA), the Christie Charity is required to have 9 Trustees: 4 Foundation Trust Trustees and 5 non- Foundation Trust Trustees.

The Trust provides two ex officio officers, the postholders of 1) the Trust Chief Executive role and 2) the postholder of the Director of Finance role as well as 2 nominated FT Trustees.

In line with the agreed articles, the Executive of the Trust are responsible for making a recommendation to the Board of Directors as to who they will nominate to be the other two FT Trustees. It is noted that the FT does not have to nominate members of its own Board but will select the individuals based on their ability to bring value to the Charity Board. The FT Board is required to approve these 2 Trustee nominations. The term for the nominated FT Trustees in the AoA is 3 years followed by two further terms of three years.

The Board of Directors agreed that the 2 nominated FT Trustees from 1st April 2023 were Kathryn Riddle, and Chris Outram, Chair of the FT. To ensure continuity during the transitional period Kathryn, was nominated to serve for a minimum of 1 year from 1st April 2023. This will be reviewed by the FT in early 2024.

Chris Outram will finish her maximum 9 years as Chair of the FT at the end of September 2023. Chris has served as a Trustee of the Independent Charity until this date (a 6-month term). The Board is now therefore asked to consider a recommendation from the Executive for a replacement FT Trustee.

3 Recommendation

The Board of Directors are asked to approve the recommendation of the Executive Directors to appoint Edward Astle, who starts as Chairman of the Trust from 1st October, as a Foundation Trust trustee from 1st October 2023.

Edward has extensive experience on charity Boards and has agreed to take on this role as a key part of his work with the Trust.