The Christie
NHS Foundation Trust

Board of Directors meeting
Thursday 24th April 2025 at 12.45 pm
Trust meeting room

Agenda

Patient story / clinical presentation: Haematology, with a focus on Christie@ Macclesfield and the overarching Haematology strategy - Faye Sharpley, Clinical Director for Haematology and David, a patient. **30 mins**

	Public items	Decision		Lead	Page	Timing
14/25	**Standard business**					
a	Apologies			Chair		
b	Declarations of interest			Chair		
c	Minutes of previous meeting – 27th March 2025	Approve	*	Chair	2	5 mins
d	Action plan rolling programme, action log & matters arising	Review	*	CEO	9	
15/25	**Performance & finance**					
a	Trust report	Approve	*	Execs	12	15 mins
b	Planning update 2025/26	Review	p	EDoF		10 mins
c	Standing Financial Instructions (SFI's)	Approve	*	EDoF	22	2 mins
16/25	**Strategy**					
a	Risk Management Strategy annual review	Review	*	ECN	104	15 mins
b	Annual corporate objectives	Review	*	DoS	110	10 mins
c	Future Christie update	Review	p	DoFC	120	
17/25	**Culture**					
a	Freedom to Speak Up Guardian report	Review	*	DoW	126	20 mins
18/25	**Governance (regulatory / statutory compliance)**					
a	Reports from committees • Workforce Assurance Committee – March 2025 • Quality Assurance Committee – March 2025 • Audit Committee – April 2025 (verbal)	Review	*	Committee chair	143	10 mins
b	Board assurance framework 2024/25	Review	*	CEO	155	5 mins
c	Register of matters approved by the Board	Approve	*	CEO	164	
d	Self-certification declarations	Approve	*	CEO	167	5 mins
e	Trust nomination of Charity Trustee	Approve	*	CEO	171	
19/25	**Any other business**					
20/25	**Papers for information**					
a	Integrated performance, quality & finance report month 12		*			

Date and time of the next meeting
Thursday 26th June 2025 at 12:45pm

D/CEO	Deputy / Chief Executive Officer
EDoF	Executive Director of Finance
ECN	Executive Chief Nurse
DoW	Director of Workforce
DoS	Director of Strategy
DoFC	Director of Future Christie

*	paper attached
v	verbal
p	presentation

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Public meeting of the Board of Directors
Thursday 27th March 2025 at 12.45 pm
Trust Meeting Room

Present: Chair: Edward Astle (EA), Chairman

Roger Spencer (RS), Chief Executive Officer
Tarun Kapur (TK), Non-Executive Director
Alveena Malik (AM), Non-Executive Director
Grenville Page (GP), Non-Executive Director
Sarah Corcoran (SC), Non-Executive Director
Dr Diana Tait (DT), Non-Executive Director
Roy Dudley-Southern (RDS), Non-Executive Director
Prof Chris Harrison (CJH), Executive Director / Deputy CEO
Vicky Sharples (VS), Executive Chief Nurse
Claire McPeake (CM), Interim Chief Operating Officer
Sally Parkinson (SP), Executive Director of Finance
Dr Neil Bayman (NB), Executive Medical Director
Eve Lightfoot (EL), Director of Workforce
John Wareing (JW), Director of Strategy
Tom Thornber (TT), Director of Future Christie
Prof Fiona Blackhall (FB), Director of Research

Minutes: Louise Westcott, Company Secretary

In attendance: Jo D'Arcy, Assistant Company Secretary
Jeanette Livings, Director of Communications
Anika Ephraim, NED Lancashire & South Cumbria NHS Trust
Linda Seddon, Public Governor

Clinical presentation: Engaging staff to improve patient pathways, Network Services – David Thomson (DTh), Clinical Oncology Consultant and Trish Murray (TM) Head and Neck CNS

DTh and TM introduced themselves and apologised that Steve, the patient representative from the Head & Neck (H&N) Board was unable to attend due to a family bereavement. DTh thanked Steve for his work with the team to influence service innovation.

H&N cancer treatment – 550 new patients per year, 450 to 500 are treated with curative intent. Radiotherapy given upfront or after surgery. Radiotherapy can improve long term impacts. Patients need 6 to 7 weeks of daily radiotherapy and sometimes chemotherapy alongside. It is intense treatment and there's a need for a large multiprofessional team.

There is a holistic approach to supporting patients with a great team.

Changes in the last year show collaboration with other Trusts, MFT & Christie do the H&N work, surgery is at MFT. There is now a single MDT with integrated clinics. A rapid H&N radiotherapy pathway is now in place. There is a move away from inpatient treatment. This is effective because of great support from the physics department too.

Previously had 3 MDT's with no standardisation, now have a single combined MDT for all GM patients. Benefits are shared skills & knowledge and smoother transfer of care for patients (agreed datasets and systematic approach). This is a slick process with no waiting list.

There is a shared rota that includes ward rounds, MDT, triage and clinics – means shared decision making and equity of work across the team. Gives more time for new patients and reduces duplication. Research nurses come to the clinics, so uptake is better for trials.

Rapid H&N cancer pathway data shown to illustrate patient journey and impact of the new approach. Impact on all targets is significant and patients are getting a much better experience as well as significant improvements in efficiency.

Evidence was shown around the way chemotherapy is delivered to reduce toxicity and kidney damage that has given good results. Issues with patient's swallow have also been experienced by many patients and a day case approach is being trialled to avoid inpatient stays.

Radiotherapy & Proton Physics – we have a UK leading service that's also internationally impactful in H&N innovation and research. Team approach with world leading recognition.

TM outlined how patient feedback is used to inform changes in practice – information booklets have been updated following feedback as well as other ways of delivering the information so that the information is correct and current. A survey is planned on the new pathway and the patient information. Video shown that is given to the patients.

Focus on collaboration, benefits for patients care, research & training, supports staff morale & engagement where all staff can bring innovation to the team.

SC asked if there's been any work to share the team approach across other specialties. DTh noted that this has been done informally but could be done more systematically.

DT noted that the steps to improve the service are fantastic – changing job plans etc is difficult. DTh noted the work across organisations is essential to deliver the improvements - must acknowledge all the people who contribute from both organisations.

AM asked what the team has learnt are the essential aspects of making team changes – DTh responded that involvement of the patients and their voice guiding the decisions as well as everyone sharing the vision and agreeing it's a good idea, need to make the case for why its important. Senior management sponsorship is also key.

RDS asked how the surgical / radiotherapy pathways are decided on. DTh noted that options are discussed and the MDT are part of the discussion with the patient to ensure the patient has the correct information to make the decisions.

DTh noted that as a single stand alone cancer centre we must deliver above and beyond in our bit of the pathway to support the system.

TT asked what the next steps are in terms of patient empowerment, supporting patients at home etc. DTh noted that this is central to innovation and ePROMs is being used, also looking at care closer to home in the future because the focus has been on the Withington site because of the complexity of the treatment. There may be some patients that can be safely treated in the other sites.

EA thanked DTh and TM for coming to present to Board and noted that there is much that could be learned from the great approach.

Item		Action
07/25	**Standard business**	
a	**Apologies**	
	Prof Rikki Goddard-Fuller (RGF), Director of Education	
b	**Declarations of Interest**	
	None noted.	
c	**Minutes of the previous meeting – 30th January 2025**	
	The minutes were accepted as a correct record.	

d	**Action plan rolling programme, action log & matters arising**	
	All items from the rolling programme are complete or noted on the agenda. EL noted the first action has been completed.	
08/25	**Performance & Finance**	
a	**Trust Report**	
	• RS confirmed that we continue to achieve the cancer waiting time targets. • Quality indicators are all stable and no issues to escalate. • Financial position is good and to plan against a very difficult system position. Will finish the year better than plan. • Changes announced in March regarding NHSE being dissolved, this is all about a requirement for a financial reset for the NHS. • We are engaged in setting the final plan for 2025/26 in this context. • GP asked about challenges that are being made around corporate services and actions that may be taken. RS noted that some are being asked to cut costs by 50% by end of Q2 (ICS's / Networks). If Trusts are not delivering the control total there will be pressure to make cuts to corporate costs. We will look at efficiencies in corporate services alongside other areas. • YTD data will be added at year end to the scorecard. • IPQFR – patient safety incidents are a bit higher in month. VS noted that this is natural variation in reporting and no particular issues are highlighted as a result of the reviews. High reporting is very good. SC noted that this has been discussed at QAC and good assurance given, scores are often changed from the initial assessment. QAC are looking at themes that need more attention. • One MRSA bacteraemia in February – learning has come from this and the patient is doing very well. • GP asked whether there's confidence on management of high operational risks. RS noted that we will show movement of scores in future presentation. • EA noted conversations NEDs had with the CODU team re health inequalities and how we can show our impact on this. NB noted that the QAC have looked at what data we collect. There are issues with what is collected where and how this is shared across organisations. • The H&N team have done a lot of work on health inequalities. • JW noted that we are working on our approach to health inequalities in patient pathways and this will evolve as we continue. How Board can track our progress as part of the system should be considered. • RDS noted that this improvement must be done by the cancer system. • RS noted the CRUK report that describes health inequalities issues in cancer. • RS noted that the biggest impact on health inequalities of any intervention is the targeted lung checks, developed with Christie colleagues. This focuses on socially deprived areas and taking scanning to local areas – shopping centre car parks etc.	JW
b	**Planning update 2025/26**	
	• RS noted the significant work and movement in planning to get us to a plan the Board can approve. There will be further discussion in part 2 of the session. • SP reminded Board that in the January planning meeting there was a detailed	

	review of the draft plan. • Negotiations have led us to a breakeven plan on exchequer funding with a £7.5m joint venture profit. • Capital plan data in the pack is out of date as the position outlined will be improved. • We are planning to meet operational targets in 2025/26 – many Trusts are not. • GP congratulated the team on getting to this position. • GP asked about confidence in recurrent VIP in 2025/26. SP noted that there is 50% on recurrent and 50% non-recurrent. We are encouraging teams to do more. We started looking at VIP for 2025/26 in the summer, a lot of schemes were identified early. We have a different approach and our approach to VIP is very different to other organisations. Noted.	
09/25	**Strategy**	
a	**Trust strategy update**	
	• JW noted the research focus on the elements of the Strategy identified. • Increasing access to trials locally – work is ongoing that will support the health inequality work. • We have an integrated approach to the strategy to look at different aspects of our approach together – research and education alongside service. • FB noted the outreach of research is difficult because of the requirement to have an expert team to treat patients who are exposed to serious complications. • Radiology services at other sites struggle to provide the level of service required for some trial patients so these factors make this very challenging. Pharmacy requirements mean similar issues. • There are also impacts on other centres of having more trials that they will struggle to provide in the current time. • AM asked if this is to tap into a different demographic. FB noted that this is about reducing impact on patients travelling. • Outreach will work for some trials but not for others. • The aim of the number of trials in set up per month indicates a financial objective. • Huge progress in immune therapies means that aims of any strategy can change as impacts and new treatments change. • Supportive care directorate has developed that incorporates research & education. This is the service end that is now structured as a directorate associated with a BRC workstream. • Education & research are fully integrated in the strategy and the service delivery. OECI commended us on this integrated approach.	
10/25	**Culture**	
a	**Shaping our culture; insights from the staff survey 2024**	
	• High level results were outlined that show very good results. • We have improved results in year against a backdrop of financial challenge, burnout and industrial action. • Cultural audit actions have contributed and improved the feedback we have	

	received. • Leadership comes through as does wellbeing of staff. • Not all actions have been centrally led, the divisions have taken forward actions with success. • FTSU responses are positive, and the Board will hear more on this next month. • The next year will see the first year of the Christie Inclusive Culture plan. • There is work to do on sexual safety and violence & aggression plans that we anticipate will lead to improvements. • We are gaining feedback on a regular basis as well as using the staff survey. • TK noted the great work at Trust level as well as in the divisions. The every-day work shows impact that's being shown and discussed at WAC. • GP noted the positive responses and asked about the raising concerns feedback. EL noted there's a new guardian in place and that with the work planned we hope to see an improvement. • National deterioration in sexual safety and violence & aggression scores. National and regional groups to share resources on approaches to address issues. Internal work described including resources (communication), workshops and clear guidance as well as anonymous reporting on Datix. • Information to be shared across all committees. • A strong line has been taken on some of these issues in recent times and work is being done to communicate the actions taken to the organisation. • Impressive early indication of success. Regional NHSE office write to us to commend our performance. • Will consider re-auditing the Trust at an appropriate time, potentially in about 12 months. Need to allow further work to continue.	EL
11/25	**Governance (regulatory / statutory compliance)**	
a	**Reports from Committees**	
i	**Workforce Assurance Committee – January 2025**	
	• TK summarised the report noting that assurance levels are medium for many areas as work is in progress. • Committee focus on exit interviews, now called 'Your next chapter'. This will come back to a future meeting. • Following discussion with committee chairs we have moved to 4 categories of assurance in future – strong / high / medium / low. **Noted**	
ii	**Quality Assurance Committee – January 2025**	
	• SC summarised the report. • Research report gave high assurance – move to different systems came through. • Interdependencies and changes to systems has been a theme in discussions, this risk needs to be captured and described with potential of adding this to the BAF. • Detailed look at lost to follow up – further update in June as not where it needs to be. • PSIRF – learning coming through and committee seeing great progress.	

	• MIAA low assurance report on medicines management – coming back in September due to safety issues, management response was very good. **Noted**	
iii	**Audit committee – February 2025**	
	• GP noted deep dive on cyber risk and layers of protection outlined. Confidence of actions being taken but risk remains. • Internal audit plan discussed, less activity in this plan. Balance queried and further discussion in April when this is finalised. • TCP – deep dive, high assurance on control environment. Some issues with systems that links to the possible BAF risk. • Internal audit of financial processing was substantial. • When joint committees meet to consider accounts, asking for authority to sign off the accounts as all Board present as well as the auditors. **Approved**	
b	**Board Assurance Framework**	
	• Updates and amendments outlined in the paper including changes to risk scores and additions of detail in controls, gaps and assurances. • The BAF has been updated in line with the MIAA review 2024/25 and the actions from the development session on risk led by NHS Providers in February. • Financial risk scores have been reduced significantly in line with position at this point in the year. • Legal & regulatory compliance risk score is high and is due for further discussion in April Audit Committee. This is a broad description and the committee have asked for clarity on how they can be assured. • Changes in the legal & regulatory environment at the current time create risk – the way in which regulators are behaving and proposals to disestablish NHSE may impact and much of this is unknown but needs constant assessment. • Suggested that we should disaggregate the description of this risk. • Operational risks – Haematology service risk has not reduced since the recent Consultant appointment. This will be reviewed once the impact is discussed and the finance element also taken into account. The transfer of the service takes place next week. • New risk re aseptics that includes the fabric of the unit & processes. Detailed action plan describes approach and this is being monitored.	LW
c	**Annual reporting cycle**	
	• Summary of the key elements for the Board to review on a monthly basis outlined in the paper. • Updates will be made as changes come through in the year. Approved.	
d	**FPPT compliance report**	
	• EA presented the compliance report that has been discussed and noted through the WAC. • Board noted compliance. Approved to be sent to NHSE.	

12/25	**Any other business**	
	• Recruitment process for new chair going well and interviews will be conducted next week. Inclusive Boards are supporting the process.	
	Date and time of the next meeting	
	Thursday 24th April 2025 at 12:45pm	
	Papers for information only	
	Integrated performance, quality & finance report	

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Agenda item 14/25d

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

C Culture P Performance S Strategy G Governance

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
April 2025		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	For information
		G	Register of matters approved by the board	CEO	Note April 2023 to March 2024	18/25c
	Provider licence	G	Self certification declarations	CEO	To approve the declarations	18/25d
	Annual reporting cycle	S	Annual Corporate Objectives review / BAF 2024/25	CEO	Review progress	16/25b
		G	Modern Slavery Act statement	CEO	Approve	15/25c
		G	Standing Financial Instructions (SFI's)	DoF	Approve	15/25c
		C	Freedom to speak up Guardian report	FTSUG	6 monthly update	17/25a
	Annual reporting cycle	P	Risk Management strategy 2024-25 annual review	ECN	Annual Review	16/25a
May 2025 - no meeting	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	By email
Planning & Development Day		G	BAF review	CEO	Review	
		S	Planning			
June 2025		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	For info section
	Annual reporting cycle	G	Annual reports from audit, quality and workforce assurance committees	Committee chairs	Assurance	Joint Audit/Quality
	Annual reporting cycle	G	Annual compliance with the CQC requirements	ECN	Declaration / approval	
		P/S	Education Strategy Update	DoE	Review	
		G	Board effectiveness review	Chair	Report	
		P	Value Improvement Programme	COO	Review	
	Annual reporting cycle	G	Annual report, financial statements and quality accounts (incl Annual governance statement / Statement on code of governance)	EDoF	Approve	
July 2025 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
Planning & Development Day		S	Service Review day with senior leadership teams			
August 2025 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
September 2025		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	For information
		C/P	Health inequalities self -assessment	DCEO	Review	
		P	Value Improvement Programme	COO	Review	
		P	Quality Strategy update	ECN	Review	
Development session		S	Strategy / planning			

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
October 2025		C	Patient story	CEO	To hear a patient story	Board presentation
		P	Integrated performance & quality report and finance report	COO	Monthly report	For information
		P	EPRR Compliance statement	COO	Approve	
		C	Freedom to speak up guardian	FTSUG	Annual report	
Planning & Development Day		S	Planning with Divisional leadership teams			
		S	Strategy deep dive			
November 2025		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	For information
		S	Strategy update	DoS	Six month review	
		S	Inclusive Culture strategy	DoW	Approve	
		P	Digital Strategy update	DCEO / CIO	Annual Review	
	Annual reporting cycle	P	Interim review of annual objectives	CEO	Review progress	
		S	Annual Sustainabiltiy Report - Boards responsibility for Carbon Net Zero	DCEO	Note approval by Audit Committee	For information
December 2025 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
Planning & Development / Council of Governors Day		S	Board planning			
		S	Council / Board - strategy update			
January 2026		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance report	COO	Monthly report	For information
		P	Value Improvement Programme	COO	Review	
February 2026 - no meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
	Annual reporting cycle	G	Letter of representation & independence	Chair	Circulate	By email
	Annual reporting cycle	G	Register of directors interests / FPPT annual declaration	Chair		
	Annual reporting cycle	G	Declaration of independence (non-executive directors only)	Chair		
Planning & Development Day		S	Planning			
		S	Strategy deep dive			
March 2026		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance & quality report and finance report	COO	Monthly report	For information
	Annual reporting cycle	G	Annual reporting cycle	Executive directors	Approve	
		P	Trust Strategy Update	DoS	Review	
		C	Culture update	DCEO/DoW	Approve	
		G	BAF review	CEO	Review	
		C	Staff survey initial results	DoW	Note	
	Annual reporting cycle	G	FPPT Compliance report	Chair	Approve annual compliance	

The Christie NHS Foundation Trust

Agenda item: 14/25d

Action log following the Board of Directors meetings held on Thursday 27th March 2025

No.	Agenda	Action	By who	Progress	Board review
1	08/25a	Health inequalities in patient pathways - how Board can track our progress as part of the system should be considered	JW	To be incorporated in IPQFR	Monthly from September 2025
2	10/25a	Culture audit - consider re-auditing the Trust at an appropriate time, potentially in about 12 months.	EL	To be considered in line with monitoring of Inclusive Culture Plan	April 2026
3	11/25b	Legal & regulatory risk - disaggregate the description of this risk	LW	Complete	April Board papers

The Christie
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Meeting of the Board of Directors
Thursday 24th April 2025

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

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Trust Report
April 2025 (March data)

Board Scorecard

Board Scorecard 2024/25

The Christie NHS Foundation Trust

Corporate objective	Indicators	Tolerances			Current month	Year to date
All	CQC rating	N/A			Good	Good
All	SOF Rating	N/A			2	2
Quality of Care & Performance						
1,6	Proportion of incidents that are low/no harm (%)	90%+			97.8%	N/A
1,6	31 day compliance (%)	96%			99.2%	N/A
1,6	Patients meeting the faster cancer diagnosis standard (%)	75%			82.6%	N/A
1,6	MRSA bacteraemia infection (attributable) (N)	TBC			0	3
1,6	Clostridium difficile infection (attributable) (N)	TBC			3	50
Finance and Use of Resources						
6	Financial sustainability / liquidity (days)	>21	21 to 14	<14	- 6	- 6
6	Overall financial position (% variance to control total)	0% below plan	0 - 10% below plan	>10% below plan	0.0%	0.0%
6	Recurrent VIP performance (% achieved)				75%	75%
6	Current cash balance (£'000)				£129,441	£129,441
6	Exchequer capital spend to date (variance to plan %)	within 10%	10 to 20%	>30%	(58.7%)	0.0%
6	Average length of time debt is outstanding	<15	>16 - 20	>20	12	12
6	Public Sector Payment Policy - trade creditors paid within 30 days (number and volume)	>95%	95 - 85%	<85%	98%	98%
People and Culture						
7	PDRs completed (%)				87.9%	N/A
7	Mandatory training (%)	>80%		<79%	94.0%	N/A
7	Voluntary turnover in first 2 years (%)	<31%		>32%	12.75%	N/A
Research						
4	New trails open per month (N)	>10	9-10	<8	8	166
4	No. patients consented into studies (N)	>250	200-249	<199	215	3003
4	Christie Sponsored research: new studies opening (N)	>2	1	0	0	16
4	Research patient experience - % strongly agree they would participate in research again	90%	75-89%	<75%	0 (0%)	61 (71%)
Education						
3	Undergraduate placement activity	>165	135-165	<135	334	1913
3	CPD activity (internal & external)	>440	340-440	<340	676	8299
System						
1,6	62 days (%)	>70%		<69.9%	74.3%	N/A
1,6	Priority patients not admitted (deferred)	0		>1	0	0
Digital						
4	Customer Satisfaction score of "Good"	>95%	85-94%	<85%	100.0%	97.5%

Executive Summary

- We are rated Good overall by the CQC.
- We are in segment 2 of the System Oversight Framework.
- Patient quality indicators for March show no significant adverse variances and no issues for escalation. We remain high reporting and low harm.
- Performance in March for the 62-day consolidated cancer standard was 74.3% which is above the operating plan standard of 70%.
- 4 operational risks are scored at 15 or above on the risk register.
- Cumulative financial performance at the end of March (Month 12) is a £15.0m surplus against a planned £7.0m surplus. This is a favourable variance of £8.0m to plan.
- The forecast position for Month 12 was a surplus of £15m which has been achieved.
- Key financial performance indicators show one adverse variance which is the level of recurrent VIP delivered being £10.5m identified against a £14m annual target.
- Workforce indicators for March show a decrease in sickness absence rates from the previous month.
- PDR performance and mandatory training performance is over the required thresholds.
- Capital schemes are progressing to plan across the Trust.
- New Performance Assessment Framework 2025/26 has been published (NHS England » The NHS Performance Assessment Framework for 2025/26)

Quality of Care

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

Pressure ulcers and falls were in line with internally set trajectory in March. There were 13 complaints in March. The number of contacts with the Patient Advice and Liaison Service (PALS) service in March was 31 which is lower than in previous months.

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

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

1. Not identifying and delivering 2025/26 recurrent VIP programme impacting on financial sustainability and ability to treat patients (16)
2. There is a risk of a patient inadvertently receiving an unintended blood component or product (15)
3. There is a risk to the safe and effective delivery of the Trust's Aseptic service (15)
4. Breach of trust compliance target 28-day Faster Diagnosis Standard (FDS) for patients with a possible haematology malignancy (15)

Operational Performance

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

- The 62-day consolidated standard was 74.3% against a threshold of 70%.
- We achieved 82.6% against the 75% threshold for the Faster Diagnosis Standard which measures initial referral to diagnosis.

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

- We have continued to achieve the 31-day standard for treatment to start within 31 days of the decision to treat at 99.2% against a target of 96%.

During March there were 2 operations cancelled on the day for non-clinical reasons. They were both booked within 28 days.

Financial Performance

Revenue: Financial performance is ahead of plan by (£8.0m) as illustrated in the table below. The Trust has achieved a £15.0m surplus against a £7.0m planned surplus position. The better than plan position is primarily due to:

- over-achievement of clinical income
- Improved performance from the joint ventures
- Underspends on pay

Month 12 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(424,744)	(424,744)	(444,154)	(19,410)
Other Income	(77,916)	(77,916)	(99,024)	(21,109)
Pay	235,252	235,252	245,538	10,285
Non Pay (incl drugs)	241,824	241,824	264,749	22,925
Operating (Surplus) / Deficit	**(25,584)**	**(25,584)**	**(32,892)**	**(7,308)**
Finance expenses/ income	30,932	30,932	34,114	3,181
(Surplus) / Deficit	**5,349**	**5,349**	**1,222**	**(4,127)**
Exclude impairments/ charitably funded capital donations	(12,355)	(12,355)	(16,256)	(3,901)
Adjusted financial performance (Surplus) / Deficit	**(7,006)**	**(7,006)**	**(15,034)**	**(8,027)**

Capital: The capital plan for 2024-25 of £17.4m has been achieved in full and has been deployed on:

- ward refurbishment and replacements
- ongoing digital projects
- replacement assets
- backlog maintenance

Value Improvement Programme

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

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

Measure of Financial Performance	Red / Amber / Green rating
Revenue: Trust Control Total compared to plan	£8.0m ahead of plan
Capital: Capital expenditure against plan	£0.8m **under** plan
VIP delivered (recurrent) against target of £14m	£10.5m identified
Debtor days compared to 15-day target	12 days
Cash balance	£129.4
Better Payment Practice Code (95% target)	98%

Workforce

Our workforce performance indicators show mandatory training compliance and personal development plan rates are both above (better than) thresholds at 94% and 87.93% respectively. Sickness absence rates decreased in March to 3.99% (threshold of 4.25%). The overall turnover for the Trust has reduced from last month to 11.04%. These issues and the associated plans for improvement have been considered by the Workforce Assurance Committee.

The NHS People Pulse survey for is now open for responses until 30 April 2025.
These short surveys give staff the opportunity to report on their current experience of working at the Trust. They also allow us to maintain an up-to-date picture of how things are going from your perspective and to make any adjustments and improvements.

Staff are encouraged to take the time to give us their views. Staff can complete the survey here. - Complete survey here

EDI Annual Report 2024
We are proud to publish our 2024 Equality, Diversity, and Inclusion (EDI) Annual Report, highlighting our continued commitment to building a workplace where everyone feels valued, respected, and empowered to thrive. This report reflects the progress we've made over the past year, the challenges we've faced, and the steps we are taking to create a more inclusive and equitable environment for all. You can read the report here.

NHSE have written to Trusts urging them to ensure that Trusts reinforce their commitment to antiracism and include specific ambitions around EDI in annual plans for 2025/26. This will be further discussed with NHSE as part of 2025/26 planning.

Stress Awareness Month has been held every April since 1992 to raise awareness of the causes and cures for stress. It provides an opportunity for an open conversation on the impact of stress. We are raising awareness in April with information, resources and staff offers published on the HIVE pages here.

Leadership & Management Competency Framework
At The Christie, we recognise that strong, compassionate leadership is essential to creating a positive workplace culture and delivering the highest standards of care. To support our managers and aspiring leaders, we have developed the leadership and management competency framework – a clear, structured guide outlining the knowledge, skills, and behaviours expected at each leadership stage. More details can be found here - HIVE - The Christie leadership & management competency framework

NHS Staff Survey 2024
Thank you to everyone who responded to the annual staff survey. More of you completed it this year, providing valuable insight on your wellbeing, engagement, and satisfaction at The Christie. We're delighted to see an increase in all People Promise themes as well as in our engagement and morale scores. The Christie was one of the top performing Trusts in the region, with the NHS England people experience team keen to learn from our success and share this with other organisations.

The significant achievement has been recognised by NHSE with a certificate that recognises the hard work of staff to improve staff experience in the organisation. This is appended at Appendix 1 of this report.
You can view the results on our new internal staff survey dashboard here

Research
The year end position for the number of studies open per month is up 33% from 2023/24. Recruitment to vacant posts in the study set up team has been completed with recruitment checks and notice periods underway.

In terms of Christie sponsored trials, whilst March has shown no sponsored studies open, there is a healthy pipeline of 2- 4 to open in April 2025.

For Research Participant Experience, the response rate target was not reached which means no response for March 2025.

Education
Education activity across all of our portfolio remains strong, with sustained growth in both external CPD and digital clinical placement areas with accompanying highly positive learner evaluation. On April 23rd, a Christie Education roadshow, dedicated to Christie workforce education and development opportunities takes place, complementing the first in a series of clinical education supervisor training launched by the PGME Team.

Our Experts by Experience panel is now well established and seeks to improve patient, carer and service user engagement and co-creation in cancer education and health inequalities, reflected in our ALKnowledge platform, co-created by the ALK+ve national patient group, Christie/GM Lung cancer teams and Christie Education (https://alknowledge.org)

Excellent progress continues with our Higher Education Initiative development/partnership project. Pre-procurement concept/market testing has been strongly received by all HEIs in this phase of the project, with strong confidence in, and feedback about, the quality of Christie Education and its offer.

International Activity
As part of our ongoing partnership with Peter Mac/Victoria Cancer Alliance, we are proud to announce two new practice exchange fellowships to support radiographers and our wider Christie AHP group in professional development opportunities with outputs including clinical practice quality improvement initiatives, education provision and development, or research activity.

Continued discussion with the Organisation of European Cancer Institutions has focused on capacity building/funding streams in European observer/fellow programmes for both specialist cancer care practice and primary/generalist care cancer education. This network will be coordinated by the OECI, Christie in partnership with other key European centres and provide practice exchange opportunities for a wide range of staff groups.

Strategic and Service Developments

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

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

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

The new inpatient pharmacy robot & the associated refurbishment of Dept 36 is complete two weeks ahead of programme. The pharmacy team have occupied the new pharmacy.

Linear accelerator 11 is being installed in the newly refurbished area, planned to be operational in June.

Partnership with the Marsden: Representatives of the Royal Marsden Hospital including the Deputy CEO, medical, finance and operational leads joined Christie colleagues in a full day workshop focussed on service partnership. Specific sessions on ambulatory care, acute oncology and multi-disciplinary teams took place. Specific areas of activity have been identified and a commitment from both leadership teams to work closely and have additional sessions have been identified for diagnostics, research and use of data.

Future Christie Project

Approach to change: To meet the ambitions of the Future Christie programme work has taken place on the approach to change. This is underpinned by the key principles of pace and wholesale adoption of high impact changes to be implemented in an organisational cycle of modernisation.

Building the team: Expressions of interest have been received for the Medical Director of the Future Christie programme and interview will be taking place in May. The advert is out for

the Associate Director of Transformation that will coordinate the collective transformation functions that operate across the organisation.

Modern Slavery Statement
The Modern Slavery Act 2015 (the Act) establishes a duty for commercial organisations to prepare an annual slavery and human trafficking statement. This is a statement of the steps the organisation has/is taking to ensure that slavery and human trafficking is not taking place in any of its supply chains or in any part of its own business. Part of the requirement of the Act is to produce a statement that is approved by the board and published on the website.

Christie contracts include specific clauses relating to the Act and when undertaking formal procurement exercises, we include an assessment where bidder responses are assessed on a PASS/FAIL basis.

Assurance around our procurement arrangements are reviewed by our internal auditors and reported to Audit Committee. This was last undertaken in 2023 with a particular focus on commercial partnerships.

The updated statement for 2025/26 is appended to this report for approval as Appendix 2. Following Board approval, the statement will be published on the trust website.

Greater Manchester System

In a letter dated 16th April, Louise Shepherd, NHSE Regional Director North West and Mark Fisher, CEO GM ICB have confirmed the Provider Oversight Arrangements for 2025/26, to assure operational delivery in the coming financial year.

NHS England will require detailed assurance of delivery across all key metrics but will be working through Greater Manchester ICB to gain this in the first instance. Provider oversight meetings will continue to be led and chaired by the ICB with attendance from NHS England as required. This approach will be refined as necessary in line with the new operating model for ICBs and NHS England.

New Performance Assessment Framework 2025/26 (NHS England » The NHS Performance Assessment Framework for 2025/26)

- Every ICB and provider will be allocated a segment. This indicates its level of delivery from 1 (high performing) to 4 (poorly performing) with an additional segment 5 to indicate the most intensive support requirement.
- Each organisation is assessed on their relative performance on a 1-4 scale, (broadly reflecting quartile of performance), and metrics are combined in each domain and combined to give an overall delivery score for each organisation.
- Segmentation scores for providers will be based on the organisational delivery score only. Providers scores will not be adjusted for system considerations, i.e. their delivery scores cannot be moderated for system performance, instead the extent to which they are collaborating will be included in a separate capability rating which will be used to inform our regulatory response
- High performing organisations in segment 1 will receive greater autonomy, such as those proposed in the capital planning guidance. Organisations in segments 3 and 4 will be considered for further support and interventions which may include enforcement activity. Organisations with a segment of 4 will receive a diagnostic review, and this will determine whether they will enter segment 5 and receive support under the Recovery Support Programme for the most challenged organisations.
- As part of the assessment process, we will also assess leadership capability in ICBs and providers. Providers will be measured against the six domains of the insightful provider board using a combination of self-assessment, third party information and measures of their track record. Guidance on the capability assessment is under

development and will be published in due course as part of our wider package of support related to the NHS Performance Assessment Framework.
- Overrides have been included for finance which means organisations in deficit/or that score a 4 in finance domain have their overall segment score limited to 3.

There are 14 performance areas, 78 measures of which circa 32 relate to Trusts in general. There are 2 trust related cancer targets (Faster Diagnosis Standard (FDS) and 62 days). Early Diagnosis is an ICB metric.

The framework is being tested in Q1 and would expect it to be live from Q2 onwards. Relevant metrics will be reported through the Integrated Performance & Quality Finance Report and the Trust Report dashboard will be updated to reflect the framework.

We are recognised and rewarded

NHS England

CERTIFICATE OF RECOGNITION AWARDED TO

The Christie NHS Foundation Trust

With thanks and in acknowledgement of your achievement in improving the experience and engagement of colleagues within your organisation.

Em Wilkinson-Brice — *15th April 2025*

Em Wilkinson-Brice, Director for Staff
Experience and Leadership Development
NHS England

Living the People Promise

Appendix 2

The Christie
NHS Foundation Trust

SLAVERY AND HUMAN TRAFFICKING STATEMENT

Introduction from the Board
We are committed to improving our practices to combat slavery and human trafficking.

Organisations Structure
The Christie is a specialist cancer centre serving a primary population of 3.2 million across Greater Manchester and Cheshire. We are an NHS Foundation Trust with over 4,000 employees and an annual turnover of approximately £500m.

Our business
We are a specialist cancer centre and we treat approximately 60,000 patients a year. We are a world pioneer in the care, treatment and research of cancer. We operate out of our main site in Withington, South Manchester and have radiotherapy centres at Salford, Oldham and Macclesfield as well as chemotherapy and outpatient services at sites across 14 other sites in Greater Manchester and Cheshire. We also provide chemotherapy service and treatment in patients' homes.

Our policies on slavery and human trafficking
We are committed to ensuring that there is no modern slavery or human trafficking in any part of our business and in so far as is possible we require our suppliers to hold a similar ethos.

The Christie NHS Foundation Trusts' guidance on Modern Slavery is to:

- Comply with legislation and regulatory requirements
- Make suppliers and service providers aware that we promote the requirements of the legislation
- Consider modern slavery factors when making procurement decisions
- Develop awareness of modern slavery issues

We will:

- Aim to include modern slavery conditions or criteria in specification and tender documents wherever possible,
- Evaluate specifications and tenders with appropriate weight given to modern slavery points,
- Encourage suppliers and contractors to take their own action and understand their obligations to the requirements.

Trust staff must:

- Contact and work with the Procurement department when looking to work with new suppliers so appropriate checks can be undertaken.

Procurement staff will:

- Undertake awareness training where possible.
- Aim to check and draft specifications to include a commitment from suppliers to support the requirements of the Act.
- Will not award contracts where suppliers do not demonstrate their commitment to ensuring that slavery and human trafficking are not taking place in their own business or supply chains.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ending 31 March 2025.

SIGNATURE:

POSITION: Chief Executive Officer, The Christie NHS Foundation Trust
DATE: 24th April 2025

NHS
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Agenda item 15/25c

Meeting of the Board of Directors

Tuesday 24th April 2025

Subject / Title	Updates to Trust Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD)
Author(s)	Richard Postill, Deputy Director of Finance
Presented by	Sally Parkinson, Executive Director of Finance
Summary / purpose of paper (assure / alert / **advise**)	This paper highlights proposed changes to Trust documentation for Trust Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD)
Recommendation(s)	Approve the changes to Trust Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD) following review and approval by the Audit Committee.
Background papers / source of assurance	n/a
Risk score / BAF reference	BAF Risk 14
EDI impact/considerations	none
Link to: ➢ Trust strategy ➢ Corporate objectives ➢ CQC Quality standard ➢ Regulation	➢ Corporate objective 6. ➢ To maintain excellent operational and financial performance. ➢ None ➢ None
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 SoD = Scheme of Delegation

Agenda item 15/25c

Meeting of the Board of Directors

Tuesday 24th April 2025

Updates to Trust Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD)

1. Proposal

The Trust Standing Financial Instructions (SFIs) have been reviewed and updated to reflect latest changes in: -

- Procurement Regulations including the Procurement Act 2023
- Delegated Authority for Joint Assurance Committee to approve the Trust Annual Report and Accounts

The Trust Scheme of Delegation (SoD) has been reviewed and updated to reflect: -

- Updated committee structure and governance
- Procurement regulations including the Procurement Act 2023
- Changes of post titles and divisional structures

Both files appear in full below with all the changes highlighted

2. Recommendation

The Board of Directors is asked to approve the revised SFIs and SoD following review and approval by the Audit Committee.

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Document Reference:	**Standing Financial Instructions**	**Version:**	**V 12**
Document Owner:	Sally Parkinson Executive Director of Finance and Business Development	**Document Author:**	Richard Postill Deputy Director of Finance
Accountable Committee:	Board of Directors	**Date Approved:**	TBC
Ratified by:	Audit Committee	**Date Ratified:**	TBC
Date issued:	TBC	**Review Date:**	3/4/28
Target Audience:	Trust Wide	**Equality Impact Assessment:**	N/A
Consultation process	Senior Management Committee, Finance, HR	**Associated policies and documents**	Page 2

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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

April 2025

NHS
The Christie
NHS Foundation Trust

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) "**procurement regulations**" means the applicable procurement legislation relevant to the procurement requirement, namely the Public Contracts Regulations 2015, the Provider Selection Regime 2023, the Procurement Act 2023

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

~~x)~~y) **"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)~~z) **"Trust"** means The Christie NHS Foundation Trust

~~z)~~aa) **"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.

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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

4.3 Approval of Annual Accounts and Report

4.3.1 The Board gives delegated authority to the Joint Assurance committee to approve the Annual Accounts and Report. Approval is given following completion of the External Audit and ahead of submission to the regulators to achieve the submission deadline.

5 **Banking**

~~5.1~~**5.2 Bank accounts**

~~5.1.1~~5.2.1 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

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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 goods

8.1 The Trust 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 1

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)~~e) be raised in advance of receiving goods and services

~~g)~~f) be raised for the full contract life

~~h)~~g) 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)~~h) 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)~~i) 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~~latest relevant procurement legislation 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~~ required under the ~~Public Contracts Regulations 2015~~ relevant procurement legislation applicable to the order

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 should be approved by the Director of Finance

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 Ceonstruction Iindustry Ttax dDeduction Sscheme 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 l 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~~ digital 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~~ digital 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~~ digital 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~~ digital service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

15.5 Where ~~computer~~ digital 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 at end of life~~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 procurement regulations applicable ~~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~~Provider Selection Regime)

Where the Trust has a requirement to procure healthcare services it will do so in accordance with the Provider Selection Regime and associated statutory requirements. ~~(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~~Provider Selection 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~~12,000 (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~~12,000 but below the ~~Public Contracts Regulations~~ latest procurement legislation threshold, the need to obtain a minimum of 3 written quotations or undertake formal tendering procedures may be waived in the following circumstances:

~~(h)~~(g) 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)~~ (h) 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

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~~(j)~~(i) 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)~~(j) 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)~~(k) 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)~~(l) 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)~~(m) 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~~the latest relevant procurement legislation 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~~ these 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~~ the latest relevant procurement legislation 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 the latest relevant procurement legislation ~~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 the latest relevant procurement legislation ~~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 the latest relevant procurement legislation ~~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 latest relevant procurement legislation ~~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.

1.6.4Opening 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.

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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.

~~c)~~d) In addition it may also be necessary to seek approval for expenditure that falls within the Cabinet Office spend controls process.

~~d)~~e) Variation to contract must follow the business case and tender award approval process.

~~e)~~f) The use of these procedures must demonstrate that the award of the contract ~~was~~:

i) was 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~~ was made on the basis of the most advantageous tender ("MAT").

~~f)~~g) 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, verbal or written quotations must be obtained. Verbal quotations are required where the intended expenditure or income is reasonably expected to be below £12,000 (excluding VAT). A~~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~~12,000 (excluding VAT) or above but is not reasonably expected to exceed £50,000 (excluding VAT).

1.7.2 Verbal Quotations

a) A minimum of one verbal quotation for good or services up to £999 (excluding VAT) (per item) must be obtained

b) A minimum of two verbal quotations (unless sole supplier) must be obtained for goods ~~-~~or services from £1000 up to £11,999 (excluding VAT) (per item) must be obtained

~~1.7.2~~1.7.3 **Written Quotations**

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a) Written qQuotations 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 £1012,000 (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.

1.7.31.7.4 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.

In addition it may also be necessary to seek authorisation for expenditure that falls within the Cabinet Office spend controls process.

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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

The Christie
NHS Foundation Trust

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).

The Christie
NHS Foundation Trust

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).

NHS
The Christie
NHS Foundation Trust

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.

Reference Documents	Duties Delegated	Delegated to: (original)		Amended 'reference documents' column: If to remain the	Amended 'duties delegated' column: If to remain the same copy text over so can sign off final wording	Amended 'Delegated to: (original)' column: If to remain the same copy text over so can sign off final wording	Highlight Change
Appendix 1	**Quotations, Tendering And Contracting Procedure**			**Appendix 1**	**Quotations, Tendering And Contracting Procedure**		
1234	Waiving of quotations & tenders for goods & services over £9,999 (excluding VAT)	Level 1 (b) or (d) or Level 2 (e) or nominated officer and procurement manager		Appendix 1 : 1.5.3	Waiving of quotations & tenders for goods & services over £11,999 (excluding VAT)	Level 1 (b) or (d) or Level 2 (e) or nominated officer and Assistant Director - Procurement or Deputy Head of Procurement	Increased to £11,999 in line with Procurement Act Contract Details Notice requirement.
Appendix 1 : 1.5.3	Providing list of all waivers issued for review by Audit Committee	Level 1 (b)		Appendix 1 : 1.5.3	Providing list of all waivers issued for review by Audit Committee	Level 1 (b)	
Appendix 1 : 1.6.4 (i) a	Opening all tenders below £100,000	Level 1 or 2 (not from originating department) nominated by Level 1 (a)		Appendix 1 : 1.6.4 a) (i)	Opening all electronically received tenders	Procurement officers	All tenders, regardless of value, are issued and received electronically via the e-procurement portal (currently Atamis)
Appendix 1 : 1.6.4 (ii) b	Opening tenders from £100,000 and above	Level 1 and 2 (not from originating department) nominated by Level 1 (a) – one to be a member of the board		Appendix 1 : 1.6.4 b) (ii)	Opening hard copy tenders from £100,000 and above	Level 1 and 2 (not from originating department) – one to be a member of the board	Added hard copy tenders as this is the only time Level 1 and 2 would need to open tenders. Removed nomintated by Level 1(a)
Appendix 1 : 1.6.7	Acceptance of a tender which exceeds budget amount allocated by the trust	Management board		Appendix 1 : 1.6.7	Acceptance of a tender which exceeds budget amount allocated by the trust	Investment and Capital Planning Committee; Senior Management Committee; Board of Directors in line with approval limits.	Amended to mirror contract award approval process.
Appendix 1 : 1.6.7	All contracts for goods & services (within delegated financial limit and following the appropriate approval process)	Level 3 (a)		Appendix 1 : 1.6.7	All contracts for goods & services (within delegated financial limit and following the appropriate approval process)	Level 3 (a)	
Appendix 1 : 1.6.7	Acceptance of a tender up to £150,000 (excluding VAT) subject to being within the budget amount allocated by the trust	Level 1 (a) or (b) or (d)		Appendix 1 : 1.6.7	Acceptance of a tender up to £150,000 (excluding VAT) subject to being within the budget amount allocated by the trust	Level 1 (a) or (b) or (d)	
Appendix 1 : 1.6.7	Acceptance of tender of over £150,000 up to £500,000 (excluding VAT) subject to being within the budget amount allocated by the trust	Capital and Workforce Planning Group		Appendix 1 : 1.6.7	Acceptance of tender of over £150,000 up to £500,000 (excluding VAT) subject to being within the budget amount allocated by the trust	Investment and Capital Planning Committee	Updated Committee
Appendix 1 : 1.6.7	Acceptance of tender of over £500,001 up to £3m (excluding VAT) subject to being within the budget amount allocated by the trust	Management board		Appendix 1 : 1.6.7	Acceptance of tender of over £500,001 up to £3m (excluding VAT) subject to being within the budget amount allocated by the trust	Investment and Capital Planning Committee, and Senior Management Committee	Added ICPC amended MB to SMC
Appendix 1 : 1.6.7	Acceptance of tender over £3m (excluding VAT) subject to being within the budget amount allocated by the trust	Board of directors		Appendix 1 : 1.6.7	Acceptance of tender over £3m (excluding VAT) subject to being within the budget amount allocated by the trust	Investment and Capital Planning Committee, and Senior Management Committee, and Board of Directors	Added ICPC and SMC
Appendix 1 : 1.6.7	Acceptance of tender over £10m (excluding VAT) subject to being within the budget amount allocated by the trust	Board of Directors by written resolution		Appendix 1 : 1.6.7	Acceptance of tender over £10m (excluding VAT) subject to being within the budget amount allocated by the trust	Investment and Capital Planning Committee, and Senior Management Committee, and Board of Directors by written resolution	Added ICPC and SMC
				Appendix 1 : 1.6.7	Acceptance of tender over £20m (excluding VAT) subject to being within the budget amount allocated by the trust	Investment and Capital Planning Committee, and Senior Management Committee, and Board of Directors by written resolution, and Cabinet Office	New reference to cabinet office
Appendix 1 : 1.6.7	Acceptance of a tender other than the lowest (if payment is to be made by the trust) <£150,000	Level 1		Appendix 1 : 1.6.7	Acceptance of a tender other than the lowest (if payment is to be made by the trust) <£150,000	Level 1	

Colour code if wording reviewed and complete

Blue text where amended or new

Appendix 1 : 1.6.7	Acceptance of a tender other than the lowest (if payment is to be made by the trust) >£150,000	Capital and Workforce Planning Group, Management Board and Board of Directors in line with approval limits		Appendix 1 : 1.6.7	Acceptance of a tender other than the lowest (if payment is to be made by the trust) >£150,000	Investment and Capital Planning Committee, and Senior Management Committee, and Board of Directors in line with approval limits.	Updated Committee
Appendix 1 : 1.6.7	Acceptance of a tender other than the highest (if payment is to be received by the trust)	Capital and Workforce Planning Group, Management Board and Board of Directors in line with approval limits		Appendix 1 : 1.6.7	Acceptance of a tender other than the highest (if payment is to be received by the trust)	Investment and Capital Planning Committee, Senior Management Committee and Board of Directors in line with approval limits	Updated Committee
Appendix 1 : 1.7.1	Obtaining 1 minimum verbal quote for goods & services up to £999 (excluding VAT) (per item)	Level 4		Appendix 1 : 1.7.2	Obtaining 1 minimum verbal quote for goods / services up to £999 (excluding VAT) (per item)	Level 4	
Appendix 1 : 1.7.1	Obtaining 2 minimum verbal quotations (unless sole supplier) for goods /services from £1,000 to £9,999 (excluding VAT) (per item)	Level 4		Appendix 1 : 1.7.2	Obtaining 2 minimum verbal quotations (unless sole supplier) for goods /services from £1,000 to £11,999 (excluding VAT) (per item)	Level 4	Uplift limit to £11,999
Appendix 1 : 1.7.1	Obtaining 3 written quotations for goods & services from £10,000 to £50,000 (excluding VAT) (per item)	Level 4 or procurement officers		Appendix 1 : 1.7.3	Obtaining 3 written quotations for goods & services from £12,000 to £50,000 (excluding VAT) (per item)	Level 4 or procurement officers	Uplift limit from £12,000
Appendix 1 : 1.7.2	Obtaining a minimum of 3 competitive tenders for goods & services over £50,000 (excluding VAT)	Level 4 or procurement officers		Appendix 1 : 1.6.1	Obtaining a minimum of 3 competitive tenders for goods & services over £50,000 (excluding VAT)	Level 4 and procurement officer	
Appendix 3	**Authorisation of sponsorship deals**			**Appendix 3**	**Authorisation of sponsorship deals**		
Appendix 3	Medical / Clinical	Level 1 (a), Level 2 (m) or Ethics Committee		Appendix 3	Approval of employees outside levels of delegation to approve expenses and salaries for medical / clinical staff via e-pay	Level 1 (a), Level 2 (m)	clarificaiton of duty delegated and remove refernce to Ethics Committee
Appendix 3	Other (Including Commercial Participators)	Level 1 (a) or Appeals Committee		Appendix 3	Approval of employees outside levels of delegation to approve expenses and salaries for other staff (Including Commercial Participators)	Level 1 (a), (b) or (d) and level 2	clarificaiton of duty delegated and change sign off to level 2 and remove reference to Appeals Committee
SFI section 1	**Standing Financial Instructions Purpose**			**SFI section 1**	**Standing Financial Instructions Purpose**		
SFI section 1	Maintenance & update on trust financial procedures	Level 1 (b), (d) or nominated officer		SFI section 1	Maintenance & update on trust financial procedures	Level 1 (b), (d) or nominated officer	
SFI section 1	Review of trust's compliance with the Access to Health Records Act 1990	Level 2 (q)		SFI section 1	Review of trust's compliance with the Access to Health Records Act 1990	Level 2 (q)	
SFI section 1	Review of the trust's compliance with all applicable code of practices and/or guidance on the for handing of confidential information in the contracting environment	Level 1 (b)		SFI section 1	Review of the trust's compliance with all applicable code of practices and/or guidance on the for handing of confidential information in the contracting environment	Level 1 (b)	
SFI section 1	The keeping of a declaration of interests register	Level 1 (a)		SFI section 1	The keeping of a declaration of interests register	Level 1 (a)	
SFI section 1	The keeping of the hospitality register	Level 1 (a)		SFI section 1	The keeping of the hospitality register	Level 1 (a)	
SFI section 2	**Audit - Reporting of incidents to the police**						
SFI section 2	Where a criminal offence is suspected	Level 2 or security officer		SFI section 2	Where a criminal offence is suspected	Level 2 or security officer	
SFI section 2	Where a fraud is involved in accordance with Secretary of State directions	Level 1 (b)		SFI section 2	Where a fraud is involved in accordance with Secretary of State directions	Level 1 (b)	
SFI section 2	Implementation of internal and external audit recommendations	Level 1 (b), (d) or nominated officer		SFI section 2	Implementation of internal and external audit recommendations	Level 1 (b), (d) or nominated officer	
SFI section 2	The role of the Senior Information Risk Owner	Level 1 (b)		SFI section 2	The role of the Senior Information Risk Owner	Level 1 (b)	
SFI section 3	**Business planning, budgets, budgetary control and monitoring**			**SFI section 3**	**Business planning, budgets, budgetary control and monitoring**		
SFI section 3	***Responsibility for keeping expenditure within budgets (excluding grants from external bodies and charitable funds)***			SFI section 3	***Responsibility for keeping expenditure within budgets (excluding grants from external bodies and charitable funds)***		
SFI section 3	**Management of budget / virements**			SFI section 3	**Management of budget / virements**		
SFI section 3	At individual budget level (pay and non pay)	Nominate officer determined by relevant Level 1, 2 or 3		SFI section 3	At individual budget level (pay and non pay)	Nominate officer determined by relevant Level 1, 2 or 3	
SFI section 3	At service level	Level 3 (b)		SFI section 3	At service level	Level 3 (b)	
SFI section 3	For the totality of departmental services	Level 1 (c) and Level 2		SFI section 3	For the totality of departmental services	Level 1 (c) and Level 2	
SFI section 3	For all other areas	Level 1 (b) or nominated officers		SFI section 3	For all other areas	Level 1 (b) or nominated officers	
SFI section 3	Virements between divisional budgets	Level 2		SFI section 3	Virements between divisional budgets	Level 2	
SFI section 3	Non-pay to pay budget virements	Level 1 (d) or Level 2 €		SFI section 3	Budget virements across categories (pay, non-pay & income) - up to £50,000	Level 2 (e)	New line inserted - to replace/ expand rows 50 to 52
				SFI section 3	Budget virements across categories (pay, non-pay & income) - £50,001 to £100,000	Level 1 (d)	New line inserted - to replace/ expand rows 50 to 52

			SFI section 3	Budget virements across categories (pay, non-pay & income) - above £100,001	Level 1 (b)	New line inserted - to replace/ expand rows 50 to 52
SFI section 3	£50,001 to £100,000 (excluding VAT)	Level 1 (b)				Replaced with lines 46 to 48
SFI section 3	Up to £10,000 (excluding VAT)	Level 2 (e)				Replaced with lines 46 to 48
SFI section 3	£10,001 to £50,000 (excluding VAT)	Level 2 (d)				Replaced with lines 46 to 48
SFI section 3	Non-recurrent virements from Trust reserves to any budget - unlimited	Level 1 (b), (d) or Level 2 (e)	SFI section 3	Non-recurrent virements from Trust reserves to any budget - unlimited	Level 1 (b), (d) or Level 2 (e)	
SFI section 5	**Maintenance/operation of bank accounts**		**SFI section 5**	**Maintenance/operation of bank accounts**		
SFI section 5	Payments up to £50,000 (excluding VAT) shall be supported by two authorised signatories on a cheque or authority to pay, as appropriate	The banking mandate (schedule A & B) or Level 1 or Level 2 (l) or (m)				removed no longer issue cheques
SFI section 5	Individual payments over £50,000 (excluding VAT) on a cheque shall be supported by two authorised signatures of which at least one will be an executive director (or Deputy Director of Finance) of	The banking mandate (schedule A & B) and Level 1 or Level 2 (l) or (m)				removed no longer issue cheques
SFI section 6	**Setting of fees and charges**		**SFI section 6**	**Setting of fees and charges**		
SFI section 6	The setting of fees for income generation & other patient related services	Level 1 (b), (d) or nominated officer	SFI section 6	The setting of fees for income generation & other patient related services	Level 1 (b), (d) or nominated officer	
SFI section 6	Price of NHS activity which falls outside of the national published tariff	Level 1 (b) or (d)	SFI section 6	Price of NHS activity which falls outside of the national published tariff	Level 1 (b), (d) or nominated officer	
SFI section 6	The approval of credit notes against debtor invoices	Level 1 (b), (d) or head of financial services	SFI section 6	The approval of credit notes against debtor invoices	£0 to £1,600 Financial Services Team Leader £1,601 to £6,000 Assistant Financial Services Manager £6,001 to £30,000 Financial Services Manager £30,000 and above Level1(b), (d) or Level 2 (e)	
SFI section 6	**Agreements/licences**		SFI section 6	**Agreements/licences**		
SFI section 6	Preparation and signature of all tenancy agreements/licences for all staff subject to trust policy on accommodation for staff	Level 1 (b) or (c) or Level 2 (q)	SFI section 6	Preparation and signature of all tenancy agreements/licences for all staff subject to trust policy on accommodation for staff	Level 1 (b) or (c) or Level 2 (q)	
SFI section 6	Extensions to existing leases	Level 1 (b)	SFI section 6	Extensions to existing leases	Level 1 (b)	
SFI section 6	Letting of premises to outside organisations	Level 1 (b)	SFI section 6	Letting of premises to outside organisations	Level 1 (b)	
SFI section 6	Approval of rent based on professional assessment	Level 1 (b)	SFI section 6	Approval of rent based on professional assessment	Level 1 (b)	
SFI section 8	**Signing of any agreement or document that enters the trust into a legally binding contract (non sealable).**		**SFI section 8**	**Signing of any agreement or document that enters the trust into a legally binding contract (non sealable).**		
SFI section 8	Monitoring of proposals for contractual arrangements between the trust and outside	Level 1 (a)	SFI section 8	Monitoring of proposals for contractual arrangements between the trust and outside	Level 1 (a)	
SFI section 8	Attention of sealings in accordance with standing orders	Chair or Level 1 (a)	SFI section 8	Attention of sealings in accordance with standing orders	Chair or Level 1 (a)	
SFI section 8	The keeping of a register of sealings	Company secretary	SFI section 8	The keeping of a register of sealings	Company secretary	
SFI section 8	Zero value	Level 3 (a)	SFI section 8	Zero value up to £50,000 (excluding VAT)	Level 3 (a)	
SFI section 8	Up to £50,000 (excluding VAT)	Level 3 (a)	SFI section 8			Combined with row above to streamline
SFI section 8	Between £50,001 and £100,000 (excluding VAT)	Level 2	SFI section 8	Between £50,001 and £100,000 (excluding VAT)	Level 2	
SFI section 8	Over £100,000 (excluding VAT)	Level 1	SFI section 8	Over £100,000 (excluding VAT)	Level 1	
SFI section 8	Over £1,000,000	Level 1 (a) and (b)	SFI section 8	Over £1,000,000	Level 1 (a) and (b)	
SFI section 8	Approving and signing all building, engineering property or capital documents and the sealing of these documents. *Refer to Extract from the Constitution: Appendix 3*	Approved by Level 1 (b) and nominated officer and countersigned by Level 1 (a) or nominated officer not from originating department and sealed by the company secretary	SFI section 8	Approving and signing all building, engineering property or capital documents and the sealing of these documents.	Approved by Level 1 (b) and nominated officer and countersigned by Level 1 (a) or nominated officer not from originating department and sealed by the company secretary	Removed *'Refer to Extract from the Constituion: Appendix 3'* as it is not in the SFIs
SFI section 8	Signing of any agreement or document to extend a contract	Officers within delegated financial limits	SFI section 8	Signing of any agreement or document to extend a contract (subject to procurement regulations and Cabinet Office Spend Controls)	Officers within delegated financial limits	Added new detail to capture Cabinet Office Spend Controls requirement
SFI section 8	All contract need updating to the trust electronic contracts register	Level 2				Remove this reference as covered in the Procurement Strategy
SFI section 9	**Terms of service, allowances and payment of members of the board and employees**		**SFI section 9**	**Terms of service, allowances and payment of members of the board and employees**		
	Engagement of staff not on the establishment			**Engagement of staff not on the establishment**		
SFI section 9	Engagement of independent consultants / agency staff	Level 2	SFI section 9	Engagement of independent consultants / agency staff	Level 2	

SFI section 9	Engagement of trust's solicitors	Level 2 or Procurement Manager		SFI section 9			Removed - covered by delegated limits
SFI section 9	**Personnel & pay, All authorities to be exercised in accordance with the relevant policy and procedure of the trust as amended from time to time.**			SFI section 9	**Personnel & pay, All authorities to be exercised in accordance with the relevant policy and procedure of the trust as amended from time to time.**		
SFI section 9	Appointment of temporary and permanent staff to the funded establishment (following the Vacancy Vetting Procedure)	Level 3 (a)		SFI section 9	Appointment of temporary and permanent staff to the funded establishment (following the Change of Establishment procedure)	Level 3 (a)	Amended vacancy vetting procedure to change of establishment procedure
SFI section 9	**Additional increments**			SFI section 9	**Additional increments**		
SFI section 9	The granting of additional increments to staff within the limit of the relevant approved budget and funded establishment	Level 1 (b) and Level 2 (k)		SFI section 9	The granting of additional increments to staff within the limit of the relevant approved budget and funded establishment	Level 1 (b) and Level 2 (k)	
SFI section 9	**Upgrading & re-grading**			SFI section 9	**Upgrading & re-grading**		
SFI section 9	Upgrading and re-grading within the limit of the relevant approved budget and funded establishment	Level 2 (k)		SFI section 9	Upgrading and re-grading within the limit of the relevant approved budget and funded establishment	Level 2 (k)	
SFI section 9	**Remuneration Changes**			SFI section 9	**Remuneration Changes**		
SFI section 9	Agreeing changes to any aspect of remuneration within the limit of the relevant approved budget and funded establishment	Level 2 (k)		SFI section 9	Agreeing changes to any aspect of remuneration within the limit of the relevant approved budget and funded establishment	Level 2 (k)	
SFI section 9	Agreeing changes over and above national approved pay spines within the limit of the relevant approved budget and funded establishment	Level 1 (b) and (c)		SFI section 9	Agreeing changes over and above national approved pay spines within the limit of the relevant approved budget and funded establishment	Level 1 (b) and (c)	
SFI section 9	Approval of performance related pay assessment for executives	Remuneration committee		SFI section 9	Approval of performance related pay assessment for executives	Remuneration committee	
SFI section 9	Authority to complete standing data forms affecting pay, new starters, variations and leavers	Level 2 or nominated officer		SFI section 9	Authority to complete standing data forms affecting pay, new starters, variations and leavers	Level 2 or nominated officer	
SFI section 9	Authority to complete and authorise attendance record on personnel systems	Line Managers		SFI section 9	Authority to complete and authorise attendance record on personnel systems	Line Managers	
SFI section 9	Authority to authorise overtime within the limit of the relevant approved budget	Level 4 or nominated officer		SFI section 9	Authority to authorise overtime within the limit of the relevant approved budget	Level 4 or nominated officer	
SFI section 9	Authority to authorise travel & subsistence expenses	Level 4 or nominated officer		SFI section 9	Authority to authorise travel & subsistence expenses	Level 4 or nominated officer	
SFI section 9	**Authorised leave**			SFI section 9	**Authorised leave**		
SFI section 9	Approval of annual leave	Level 4 or nominated officer		SFI section 9	Approval of annual leave	Level 4 or nominated officer	
SFI section 9	Approval of the carrying forward of up to maximum of 5 days annual leave accrued but untaken at the end of the relevant holiday year.	Level 4 or nominated officer		SFI section 9	Approval of the carrying forward of up to maximum of 5 days annual leave accrued but untaken at the end of the relevant holiday year.	Level 4 or nominated officer	
SFI section 9	Approval of the carrying forward of in excess of 5 days but not exceeding 10 days of annual leave accrued but untaken at the end of the relevant holiday year.	Level 1 (b) (c) or level 2 (l), (m)		SFI section 9	Approval of the carrying forward of in excess of 5 days but not exceeding 10 days of annual leave accrued but untaken at the end of the relevant holiday year.	Level 1 (b) (c) or level 2 (l), (m)	
SFI section 9	Authorisation of paid bereavement leave up to 5 days per bereavement	Line manager		SFI section 9	Authorisation of paid bereavement leave up to 5 days per bereavement	Line manager	
SFI section 9	Authorisation of additional paid bereavement leave of up to a further 5 days per bereavement	Level 1 (b) (c) or level 2 (l), (m)		SFI section 9	Authorisation of additional paid bereavement leave of up to a further 5 days per bereavement	Level 1 (b) (c) or level 2 (l), (m)	
SFI section 9	Special leave arrangements: Paid Care leave Up to 5 days in any one year	Line Manager		SFI section 9	Special leave arrangements: Paid Care leave Up to 5 days in any one year	Line Manager	
SFI section 9	Special leave arrangements: Paid Care leave Up to an additional 5 days in any one year	Level 1 (b) (c) or level 2 (l), (m)		SFI section 9	Special leave arrangements: Paid Care leave Up to an additional 5 days in any one year	Level 1 (b) (c) or level 2 (l), (m)	
SFI section 9	Special leave arrangements: Paternity leave	Line Manager		SFI section 9	Special leave arrangements: Paternity leave	Line Manager	
SFI section 9	Special leave arrangements: Other Leave	Line Manager		SFI section 9	Special leave arrangements: Other Leave	Line Manager	
SFI section 9	Special leave arrangements: Leave without pay or time off in lieu	Line Manager		SFI section 9	Special leave arrangements: Leave without pay or time off in lieu	Line Manager	
SFI section 9	Special leave arrangements: Senior medical staff leave of absence	Level 2 (m)		SFI section 9	Special leave arrangements: Senior medical staff leave of absence	Level 2 (m)	
SFI section 9	Special leave arrangements: Maternity leave-paid and unpaid	Line Manager		SFI section 9	Special leave arrangements: Maternity leave-paid and unpaid	Line Manager	
SFI section 9	Special leave arrangements: Adoption leave – paid and unpaid	Line Manager		SFI section 9	Special leave arrangements: Adoption leave – paid and unpaid	Line Manager	

SFI section 9	Extension of sick leave on full pay for up to three months after normal contractual entitlement to full pay has been exhausted. (Additional full payment period to be off set against half pay period.)	Level 1 (b) and (c) or Level 2 (l), (m)		SFI section 9	Extension of sick leave on full pay for up to three months after normal contractual entitlement to full pay has been exhausted. (Additional full payment period to be off set against half pay period.)	Level 1 (b) and (c) or Level 2 (l), (m)	
SFI section 9	Extension of sick leave on half pay for up to three months after normal contractual entitlement to half pay has been exhausted	Level 1 (b) and (c) or Level 2 (l), (m)		SFI section 9	Extension of sick leave on half pay for up to three months after normal contractual entitlement to half pay has been exhausted	Level 1 (b) and (c) or Level 2 (l), (m)	
SFI section 9	Return to work part-time on full pay to assist recovery	Line manager		SFI section 9	Return to work part-time on full pay to assist recovery	Line manager, following guidance from Occupational Health	
SFI section 9	Non-medical staff: paid study leave in the UK and overseas	Level 2 or nominated officer		SFI section 9	Non-medical staff: paid study leave in the UK and overseas	Level 2 or nominated officer	
SFI section 9	Medical staff paid study leave in the UK and overseas	Chair of medical staff committee		SFI section 9	Medical staff paid study leave in the UK and overseas	Chair of medical staff committee	
SFI section 9	**Other HR duties**			SFI section 9	**Other HR duties**		
SFI section 9	Agreeing that the Trust should pay removal expenses incurred by an employee taking up a new appointment up to £5,000	Level 2 (k) or Deputy Director of Workforce and Level 2		SFI section 9	Agreeing that the Trust should pay removal expenses incurred by an employee taking up a new appointment up to £5,000	Level 2 (k) or Deputy Director of Workforce and Level 2	
SFI section 9	Agreeing that the Trust should pay removal expenses incurred by an employee taking up a new appointment between £5,001 - £8,000	Level 2 (k) or Deputy Director of Workforce and Level 2 and Level 1 (d) or Level 2 (e)		SFI section 9	Agreeing that the Trust should pay removal expenses incurred by an employee taking up a new appointment between £5,001 - £8,000	Level 2 (k) or Deputy Director of Workforce and Level 2 and Level 1 (d) or Level 2 (e)	
SFI section 9	All grievances cases must be dealt with strictly in accordance with the Trust's Grievance Procedure and the advice of a human resource officer must be sought	Level 2 and Level 2 (k) or Deputy Director of Workforce		SFI section 9	All grievances cases must be dealt with strictly in accordance with the Trust's Grievance Procedure and the advice of a human resource officer must be sought	Level 2 and Level 2 (k) or Deputy Director of Workforce	
SFI section 9	Redundancy: compulsory and voluntary	Level 2 and Level 2 (k) or Deputy Director of Workforce		SFI section 9	Redundancy: compulsory and voluntary	Level 2 and Level 2 (k) or Deputy Director of Workforce	
SFI section 9	Redundancy: Non renewal of fixed term	Level 2 and Level 2 (k) or Deputy Director of Workforce		SFI section 9	Redundancy: Non renewal of fixed term	Level 2 and Level 2 (k) or Deputy Director of Workforce	
SFI section 9	Decision to support an employee's application for retirement on the grounds of ill-health	Level 2 and Deputy Director of Workforce or nominated officer with advice from Occupational Health		SFI section 9	Decision to support an employee's application for retirement on the grounds of ill-health	Level 2 and Deputy Director of Workforce or nominated officer with advice from Occupational Health	
SFI section 9	Disciplinary procedure: All disciplinary cases must be dealt with strictly in accordance with the Trust's Disciplinary Procedure and the advice of a HR officer must be sought	Level 2 and Level 2 (k) or Deputy Director of Workforce		SFI section 9	Disciplinary procedure: All disciplinary cases must be dealt with strictly in accordance with the Trust's Disciplinary Procedure and the advice of a HR officer must be sought	Level 2 and Level 2 (k) or Deputy Director of Workforce	
SFI section 9	Issuing all employees with an employment contract in a form approved by the board and which complies with employment legislation and Agenda for Change and/or the trust's own terms and conditions as the case may be.	Level 2 (k) or Deputy Director of Workforce or delegated HR officer		SFI section 9	Issuing all employees with an employment contract in a form approved by the board and which complies with employment legislation and Agenda for Change and/or the trust's own terms and conditions as the case may be.	Level 2 (k) or Deputy Director of Workforce or delegated HR officer	
SFI section 9	Varying contracts of employment (excluding remuneration)	Level 2 (k) or Deputy Director of Workforce		SFI section 9	Varying contracts of employment (excluding remuneration)	Level 2 (k) or Deputy Director of Workforce	
SFI section 9	**Facilities for staff not employed by the trust to gain practical experience**			SFI section 9	**Facilities for staff not employed by the trust to gain practical experience**		
SFI section 9	Professional recognition	Level 2 (m)					Not in SFIs - remove
SFI section 9	Honorary contracts: Medical	Level 2 (m)		SFI section 9	Honorary contracts: Medical	Level 2 (m)	
SFI section 9	Honorary contracts: Nursing	Level 2 (l)		SFI section 9	Honorary contracts: Nursing	Level 2 (l)	
SFI section 9	Honorary contracts: Other	Level 1 (b) or (c)		SFI section 9	Honorary contracts: Other	Level 1 (b) or (c)	
SFI section 9	Work experience students	Level 2 (k)		SFI section 9	Work experience students	Level 2 (u)	Moved responsibility from from HR to Education to reflect practice
SFI section 9	Agreeing to new temporary or permanent posts within the limit of the relevant approved budget and funded establishment (following the Change of Establishent Procedure)	Level 2 and Deputy Director of Workforce or Director of Workforce		SFI section 9	Agreeing to new temporary or permanent posts for bands 8b and above within the limit of the relevant approved budget and funded establishment (following the Change of Establishent Procedure)	Level 2 and Deputy Director of Workforce or Director of Workforce	Updated as only relates to posts above 8b
SFI section 9	Agreeing to new temporary or permanent posts with no approved budget and funded establishment (following the Change of Establishent Procedure)	Level 1 (b) and (c)		SFI section 9	Agreeing to new temporary or permanent posts with no approved budget and funded establishment (following the Change of Establishent Procedure)	Level 1 (b) and (c)	
SFI section 10	**Non pay requisitioning and ordering of goods & services and payment of invoices (to be read in conjunction with Appendix 1 of the SFI & section 8 of scheme of delegation of power)**			**SFI section 10**	**Non pay requisitioning and ordering of goods & services and payment of invoices (to be read in conjunction with Appendix 1 of the SFI & section 8 of scheme of delegation of power)**		

SFI section 10	Approving requisitions and invoices up to £50,000 excluding VAT	Level 3 (a), financial limit to be determined by Level 1 & 2 (good practice guidelines for selecting delegation limit available from Head of financial systems)		SFI section 10	Approving requisitions and invoices up to £50,000 excluding VAT	Level 3 (a), financial limit to be determined by Level 1 & 2 (good practice guidelines for selecting delegation limit available from Head of financial systems)	
SFI section 10	Approving requisitions and invoices between £50,001 to £100,000 per item (excluding VAT)	Level 2		SFI section 10	Approving requisitions and invoices between £50,001 to £100,000 per item (excluding VAT)	Level 2	
SFI section 10	£50,001 to £100,000 (excluding VAT) (total cost over life of contract)	Level 1 (b)		SFI section 10	£50,001 to £100,000 (excluding VAT) (total cost over life of contract)	Level 1 (b)	
SFI section 10	Up to £10,000 (excluding VAT) (total cost over life of contract)	Level 2 (e)		SFI section 10	Up to £10,000 (excluding VAT) (total cost over life of contract)	Level 2 (e)	
SFI section 10	£10,001 to £50,000 (excluding VAT) (total cost over life of contract)	Level 2 (d)		SFI section 10	£10,001 to £50,000 (excluding VAT) (total cost over life of contract)	Level 2 (d)	
SFI section 10	Approving requisitions and invoices over £100,001 per item (excluding VAT)	Level 1 (a), (b), (c) or Level 2 (l), (m)		SFI section 10	Approving requisitions and invoices over £100,001 per item (excluding VAT)	Level 1 (a), (b), (c) or Level 2 (l), (m)	
SFI section 10	Advance payments for goods and services before being received.	Head of financial systems or Level 2 (e) or (d)		SFI section 10	Advance payments for goods and services before being received.	Head of financial systems or Level 2 (e) or (d)	
SFI section 10	Credit Card	Level 1 (b)		SFI section 10	Credit Card	Level 1 (b)	
SFI section 10	Authorisation of named holder of approved credit card and relevant financial limit (to be used in conjunction with the credit card policy)	Audit Committee		SFI section 10	Authorisation of named holder of approved credit card	Level 1(d) or level 2 (b)	
SFI section 10	Credit card usage up to £25,000 (used in conjunction with SFIs and relevant policies and procedures)	Level 1 or Level 2 (l) or (m) or Head of financial systems		SFI section 10	Credit card usage (used in conjunction with SFIs and relevant policies and procedures)	Level 1(d) or level 2 (b)	
SFI section 10	Authorisation of new drugs	Drugs management committee		SFI section 10	Authorisation of new drugs	Drugs and Therapeutics Committee	Committee name change
SFI section 10	**Petty cash disbursements**						
SFI section 10	a) Expenditure up to £25 (per receipt)	Cashiers					
SFI section 12.1	**Capital schemes including charity funded** *schemes (to be read in conjunction with Appendix 1 of the SFIs).All schemes must be supported by a business case*			**SFI section 12.1**	**Capital schemes including charity funded** ***schemes*** *(to be read in conjunction with Appendix 1 of the SFIs).All schemes must be supported by a business case*		
SFI section 12	Granting of and termination of leases and annual rent up to £100k (excluding VAT)	Level 1 (a), (b), (d), Head of capital planning or nominated officer		SFI section 12	Granting of and termination of leases and annual rent up to £100k (excluding VAT)	Level 1 (a), (b), (d), Level 2 (r) or nominated officer	
SFI section 12	Granting of and termination of leases and annual rent over £100k (excluding VAT)	Board of directors		SFI section 12	Granting of and termination of leases and annual rent over £100k (excluding VAT)	Board of directors	
SFI section 12.1	**Capital Investment**			**SFI section 12**	**Capital Investment**		
SFI section 12.1	Approval of capital programme	Board of directors		SFI section 12	Approval of capital programme	Board of directors	
SFI section 12.1	Schemes up to £1m (excluding VAT)	Management board and CFC		SFI section 12	Schemes up to £1m (excluding VAT)	Senior Management Committee	
SFI section 12.1	Schemes above £1,000,000 (excluding VAT)	Board of directors		SFI section 12	Schemes above £1,000,000 (excluding VAT)	Board of directors	
SFI section 12.1	Schemes above £10,000,000 (excluding VAT)	Board of Directors by written resolution		SFI section 12	Schemes above £10,000,000 (excluding VAT)	Board of Directors by written resolution	
SFI section 12.1	Approval of post contract increases on all contracts up to an overall limit of £200,000 (excluding VAT)	Capital and Workforce Planning Group and CFC (where applicable)		SFI section 12	Approval of post contract increases on all contracts up to an overall limit of £200,000 (excluding VAT)	Investment and Capital Planning Committee (ICPC)	
SFI section 12.1	Approval of post contract increases on all contracts between an overall limit of £200,001 and £1,000,000 (excluding VAT)	Management board and CFC (where applicable)		SFI section 12	Approval of post contract increases on all contracts between an overall limit of £200,001 and £1,000,000 (excluding VAT)	Senior Management Commitee)	
SFI section 12.1	Approval of post contract increases on all contracts above £1,000,000 (excluding VAT)	Board of directors and CFC (where applicable)		SFI section 12	Approval of post contract increases on all contracts above £1,000,000 (excluding VAT)	Board of directors	
SFI section 12.1	Selection of architects, quantity surveyors, consultant engineer and other professional advisors within EU regulations	Level 1 (a), (b), (d), Head of capital planning or nominated officer		SFI section 12	Selection of architects, quantity surveyors, consultant engineer and other professional advisors within EU regulations	Level 1 (a), (b), (d), Level 2 ® or nominated officer	
SFI section 12.1	Financial monitoring and reporting on all capital scheme expenditure	Level 1 (b) or nominated officer(s)		SFI section 12	Financial monitoring and reporting on all capital scheme expenditure	Level 1 (b) or nominated officer(s)	
SFI section 12.2	**Business Cases**			**SFI section 12.2**	**Business Cases**		

SFI section 12.2	Between £50,001 and £200,000 (excluding VAT)	Capital and Workforce Planning Group (CWPG)		SFI section 12.2	Between £0 and £200,000 (excluding VAT)	Investment and Capital Planning Committee	Updated committee
SFI section 12.2	£200,001 up to £1,000,000 (excluding VAT)	Management board		SFI section 12.2	£200,001 up to £1,000,000 (excluding VAT)	Investment and Capital Planning Committee, Senior Management Committee	Updated committee
SFI section 12.2	Over £1,000,000 (excluding VAT)	Board of directors		SFI section 12.2	Over £1,000,000 (excluding VAT)	Investment and Capital Planning Committee, Senior Management Committee, Board of Directors	Updated committee
SFI section 12.2	Over £10,000,000 (excluding VAT)	Board of Directors by written resolution		SFI section 12.2	Over £10,000,000 (excluding VAT)	Board of Directors by written resolution	
SFI section 12.2	Up to £50,000 (excluding VAT) in line with FRG Terms of Reference	Financial Review Group (FRG)					Removed - no longer exists
SFI section 12.2	Up to £50,000 (excluding VAT) outside of FRG Terms of Reference	Capital and Workforce Planning Group (CWPG)					Removed - no longer exists
SFI section 14	**Disposals and condemnations, losses and special payments**			**SFI section 14**	**Disposals and condemnations, losses and special payments**		
SFI section 14	Disposals: Obtaining best sale price for revenue assets with an estimated sale value of less than £1,000 (excluding VAT)	Level 3 (a) or procurement manager		SFI section 14	Disposals: Obtaining best sale price for revenue assets with an estimated sale value of less than £1,000 (excluding VAT)	Level 3 (a)	Removed Procurement Manager
SFI section 14	Disposals: Competitive offers for revenue assets with an estimated sale price of £1,000 (excluding VAT) or over	Level 1 (b), (d) or procurement manager		SFI section 14	Disposals: Competitive offers for revenue assets with an estimated sale price of £1,000 (excluding VAT) or over	Level 1 (b), (d)	Removed Procurement Manager
SFI section 14	Disposals: Tenders for any asset (whether capital or revenue) with an estimated sale price of £5,000 (excluding VAT) or over	Level 1 (b) or (d)		SFI section 14	Disposals: Tenders for any asset (whether capital or revenue) with an estimated sale price of £5,000 (excluding VAT) or over	Level 1 (b) or (d)	
SFI section 14	Losses of each due to theft, fraud, overpayment; fruitless payment (including abandoned capital schemes); bad debts and claims abandoned, private patients, overseas visitors; damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to culpable causes (e.g. fraud, theft, arson); extra contractual payments to contractors; & others up to £50,000	Level 1 (a) or (b)		SFI section 14	Losses of each due to theft, fraud, overpayment; fruitless payment (including abandoned capital schemes); bad debts and claims abandoned, private patients, overseas visitors; damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to culpable causes (e.g. fraud, theft, arson); extra contractual payments to contractors; & others up to £50,000	Level 1 (a) or (b)	
SFI section 14	All losses over £50,000	Board of directors		SFI section 14	All losses over £50,000	Board of directors	
SFI section 14	Compensation payments made under legal obligation	Level 1 (a) or (b)		SFI section 14	Compensation payments made under legal obligation	Level 1 (a) or (b)	
SFI section 14	Ex-gratia payments: Patients and staff for loss of personal effects up to £10,000	Level 1 (b) or (c)		SFI section 14	Ex-gratia payments: Patients and staff for loss of personal effects up to £10,000	Level 1 (b) or (c)	
SFI section 14	Ex-gratia payments: £10,000 to £50,000	Level 1 (a) or (b)		SFI section 14	Ex-gratia payments: £10,000 to £50,000	Level 1 (a) or (b)	
SFI section 14	Other, except cases of maladministration where there was no financial loss by claimant, up to £50,000	Level 1 (a) and (b)		SFI section 14	Other, except cases of maladministration where there was no financial loss by claimant, up to £50,000	Level 1 (a) and (b)	
SFI section 14	For clinical negligence up to £1,000,000 (negotiated settlements) (including plaintiff's costs)	Level 1 (a) and (b) and Level 2 (l) in consultation with NHS Litigation Authority		SFI section 14	For clinical negligence up to £1,000,000 (negotiated settlements) (including plaintiff's costs)	Level 1 (a) and (b) and Level 2 (l) in consultation with NHS Resolution	
SFI section 14	For personal injury claims involving negligence where legal advice has been obtained and guidance applied up to £1,000,000 (including plaintiff's costs)	Level 1 (a) and (b) and Level 2 (l) in consultation with NHS Litigation Authority		SFI section 14	For personal injury claims involving negligence where legal advice has been obtained and guidance applied up to £1,000,000 (including plaintiff's costs)	Level 1 (a) and (b) and Level 2 (l) in consultation with NHS Resolution	
SFI section 14	For all negligence claims over £1,000,000 (including plaintiff's costs)	Board of directors in consultation with NHS Litigation Authority		SFI section 14	For all negligence claims over £1,000,000 (including plaintiff's costs)	Board of directors in consultation with NHS Resolution	
SFI section 14	Write-off of individual NHS and non-NHS debtors over £5,000 and an annual report of all debtors written off in total	Level 1 (b) (Reported to audit committee for information)		SFI section 14	Write-off of individual NHS and non-NHS debtors over £5,000 and an annual report of all debtors written off in total	Level 1 (b) (Reported to audit committee for information)	
SFI section 17	**Expenditure on charitable funds**			**SFI section 17**	**Expenditure on charitable funds**		
SFI section 17	Up to £25,000 per request up to maximum of uncommitted funds	Charity fund holder		SFI section 17	Up to £25,000 per request up to maximum of uncommitted funds	Charity fund holder	
SFI section 17	Above £25,000 per request up to maximum of uncommitted funds	Charity fund holder and Charitable Funds Committee		SFI section 17	Above £25,000 per request up to maximum of uncommitted funds	Charity fund holder and The Christie Charity Board	Board name updated

SFI section 17	Cost of fundraising	Level 2 (q)				Removed
SFI section 17	**Expenditure on non-charitable grants**		**SFI section 17**	**Expenditure on non-charitable grants**		
SFI section 17	Up to the limit of the non-charitable grant awarded and in line with SFI Section 3 (business cases)	Grant holder	SFI section 17	Up to the limit of the non-charitable grant awarded and in line with SFI Section 3 (business cases)	Grant holder	
SFI section 17	Investment of funds (including charitable funds)	Level 1 (b), (d) or nominated officer	SFI section 17	Investment of funds (including charitable funds)	Level 1 (b), (d) or nominated officer	
SFI section 18	**Receiving hospitality**		**SFI section 17**	**Acceptance of gifts by staff and other standards of Business Conduct**		
SFI section 18 and appendix 2b	Hospitality received by an individual on any occasion to a value in excess of £25 requires to be disclosed	All staff. Declaration required in trust's hospitality register	SFI section 17	Hospitality received by an individual on any occasion should be declared through the Declaration of Interest register		
SFI section 19	**Rention of Documents**		**SFI section 19**	**Rention of Documents**		
SFI section 19	Retention of records	Level 1 (a)	SFI section 18	Retention of records	Level 1 (a)	Correct SFI reference
SFI section 20	**Risk management and insurance**		**SFI section 20**	**Risk management and insurance**		
SFI section 20	Clinical audit	Chair of clinical audit committee	SFI section 20	Clinical audit	Chair of Risk and Quality Governance Committee and Quality Assurance	Updated the committee reference
SFI section 20	Insurance policy and risk management	Level 1 (a) or (b)	SFI section 19	Risk Management and insurance	Level 1 (a) or (b)	
SFI section 21	**Expenses**		**SFI section 20**	**Expenses, travel and subsistence**		
SFI section 21	Expenses, travel and subsistence policy - refer to expenses policy	Level 2 (k) and Level 1 (b)	SFI section 20	Expenses, travel and subsistence policy - refer to expenses policy	Level 2 (k) and Level 1 (b)	
SFI section 22	**Hospitality**		**SFI section 22**	**Hospitality**		
SFI section 22	a) Claims will not be eligible for alcohol consumed on site. (This is in line with the trust policy on alcohol)	Level 1 (b)	SFI section 21	a) Claims will not be eligible for alcohol consumed on site. (This is in line with the trust policy on alcohol)	Level 1 (b)	
SFI section 22	b) In advance approval for offsite hospitality events related to work, food and beverages up to a maximum of £30 per head per financial year where funds from a commercial source and /or specific grant income exist. If there are no such funds available and the event is necessary, expenses at standard NHS rates will be reimbursed (the current standard meal allowance is £5).	Level 1 (b) or (d)				Remove as this is not monitored and should be managed within the available budget, or referred to the expenses and claims section
SFI section 22	Meetings/courses/conferences and travel	Refer to the Expenses, Travel and Subsistence policy and the staff travel booking form	SFI section 22	Meetings/courses/conferences and travel	Refer to the Expenses, Travel and Subsistence policy and the staff travel booking form	
	Other Trust Policies			**Other Trust Policies**		
Trust Policy	Authorisation of research projects up to £1,000,000	Ethics committee and Clinical Trials Resource Group and For R&D - Level 2 (o) or Director of R&D For CMPE - Level 2 (n) or Level 2 (i)	Trust Policy	Authorisation of Research & Innovation projects up to £1,000,000 (threshold relates to Income)	Level 2 (o)	Removed CMPE as all income will flow through R&I, removed ethics committee and Clinical Trials Resource Group as no longer exists
Trust Policy	Relationships with press	Level 2 (p) or Head of Communications	Trust Policy	Relationships with press	Level 2 (p) or Director of Communications	Name change
Trust Policy	Infectious diseases & notifiable outbreaks	Level 2 (l)	Trust Policy	Infectious diseases & notifiable outbreaks	Level 2 (l)	
Trust Policy	**Patient services**			**Patient services**		
Trust Policy	Variation of operating and clinic sessions within existing numbers: Outpatients, Theatres, Other	Level 1 (c) or Level 2	Trust Policy	Variation of operating and clinic sessions within existing numbers: Outpatients, Theatres, Other	Level 1 (c) or Level 2 (q)	Changed to divisional directors
Trust Policy	All proposed changes in bed allocation and use: Temporary change	Level 1 (c) or Level 2 or nominated officer	Trust Policy	All proposed changes in bed allocation and use: Temporary change	Level 1 (c) or Level 2 or nominated officer	
Trust Policy	All proposed changes in bed allocation and use: Permanent change	Management board	Trust Policy	All proposed changes in bed allocation and use: Permanent change	Senior Management Committee	Committee name change
Trust Policy	All proposed changes in bed allocation and use: Contract monitoring & reporting	Level 1 (c) or Level 2	Trust Policy	All proposed changes in bed allocation and use: Contract monitoring & reporting	Level 1 (c) or Level 2	
Trust Policy	Review of fire precautions	Head of facilities	Trust Policy	Review of fire precautions	Level 2 (w)	Role name change
Trust Policy	Review of all statutory compliance legislation and health and safety requirements including Control of Substances Hazardous to Health Regulations 2002	Level 2 (l)	Trust Policy	Review of all statutory compliance legislation and health and safety requirements including Control of Substances Hazardous to Health Regulations 2002	Level 2 (l)	
Trust Policy	**Review of Medicines Inspectorate Regulations** including but not limited to:		Trust Policy	**Review of Medicines Inspectorate Regulations** including but not limited to:		

Trust Policy	• The Medicines (Homeopathic Medicinal Products for Human Use) Amendment Regulations 2005 (SI 2005/2753) •The Medicines (Marketing Authorisations Etc.) Amendment Regulations 2005 (SI 2005/2759) •The Medicines (Advertising Amendments) Regulations 2005 (SI 2005/2787) •The Medicines for Human Use (Manufacturing, Wholesale Dealing and Miscellaneous Amendments) Regulations 2005 (SI 2005/2789) 1998	Level 2 (m)		Trust Policy	• The Medicines (Homeopathic Medicinal Products for Human Use) Amendment Regulations 2005 (SI 2005/2753) •The Medicines (Marketing Authorisations Etc.) Amendment Regulations 2005 (SI 2005/2759) •The Medicines (Advertising Amendments) Regulations 2005 (SI 2005/2787) •The Medicines for Human Use (Manufacturing, Wholesale Dealing and Miscellaneous Amendments) Regulations 2005 (SI 2005/2789) 1998	Level 2 (m)	
Trust Policy	Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Level 1 (c)		Trust Policy	Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Level 1 (c)	
Trust Policy	Review of trust's compliance with the Data Protection Act	Level 2 (f)		Trust Policy	Review of trust's compliance with the Data Protection Act	Level 2 (f)	
Trust Policy	Authorisation of research projects over £1,000,000	Ethics committee and Clinical Trials Resource Group and For R&D - Level 2 (o) or Director of R&D and countersigned by Level 1 (a), (b) or (c) For CMPE - Level 2 (n) or Level 2 (i) and countersigned by Level 1 (a), (b) or (c)		Trust Policy	Authorisation of Research & Innovation projects over £1,000,000 (threshold relates to Income)	Level 2 (o) and countersigned by Level 1 (a), (b) or (c)	Removed CMPE as all income will flow through R&I, removed ethics committee and Clinical Trials Resource Group as no longer exists
Trust Policy	Authorisation of clinical trials up to £1,000,000	Ethics committee and Clinical Trials Resource Group and Level 2 (o) or Director of R&D		Trust Policy	Authorisation of Research studies up to £1,000,000 (threshold relates to Income)	Level 2 (o)	Removed Director of R&D, covered in level 2 (o)
Trust Policy	Authorisation of clinical trials over £1,000,000	Ethics committee and Clinical Trials Resource Group and Level 2 (o) or Director of R&D and countersigned by Level 1 (a), (b) or (c)		Trust Policy	Authorisation of Research studies over £1,000,000 (threshold relates to Income)	Level 2 (o) and countersigned by Level 1 (a), (b) or (c)	Removed ethics committee and Clinical Trials Resource Group as no longer exists
Trust Policy	Publication of useful results of charitable funded research in line with Charity Commission guidance	Director of R&D		Trust Policy	Publication of useful results of charitable funded research in line with Charity Commission guidance	Director of R&I	Title changed

Exchequer, Research and Capital - Levels of Delegation (net of VAT)

Level 1	£m	Level 2	£,000	Level 3(a)	£,000	Level 4	
(a) Chief Executive	10	(e) Assistant Director of Finance/ Procurement	100	Associate Director of Education	50		
(b) Director of Finance	10	(f) Chief Information Officer	100	Head of Research - Operations	50	Delegated to budget holders / nominated officers from Level 1-2, or above	remove this role and replace with Business Manager Research and Innovation
(c) Chief Operating Officer	2	(i) Director of CMPE	100	Head of Research - Business Development	50		remove this role - no longer needed as above role covers both
(d) Deputy Director of Finance	1	(j) Director of Pharmacy	100	Head of Capital Planning	50		
		(k) Director of Workforce	100	Head of Estates & Facilities	50		
		(l) Chief Nurse	100	Deputy Chief Information Officers	50		
		(m) Exec Medical Director	100	Deputy Director of Workforce	50		
		(n) BLANK	100	Assistant Director of Nursing	50		remove (n) as John Adams has retired
		(o) Director of Research and Innovation	100	Assistant Director GM Cancer	50		
		(p) Director of Communications	100	Head of Education	50		
		(q) Divisional Director	100	Divisional Associate Chief Nurses	50	request to add to reflect R & I operational structure	
		(r) Director of Capital	100	Business Manager Research & Innovation	50	Replaces Head of Research	
		(s) Deputy Chief Exec	100	**Level 3(b)**	**£,000**		
		(t) Director of Strategy	100	Service Managers	30		
		(u) Director of Education	100	Nurse Matrons band 8b	30	request to add to reflect R & I operational structure	
		(v) Managing Director GM Cancer	100	CMPE Operations Manager	30	request to add - email from Steve Drain	
		(w) Head of Estates and Facilities	100				

Charitable Funds - Levels of Delegation (net of VAT)

Level 1	£m		£,000	Level 3 (c)	£,000
Chief Executive	10	(q)Director of Communications	100	Head of Corporate Affairs and Engagement	12
Director of Finance	10			Charity Fund Holders (gross)	25

Add in committee levels and approval limits

The Christie NHS Foundation Trust

Agenda item 16/25a

Meeting of the Board of Directors

Thursday 24th April 2025

Subject / Title	Risk Management Strategy and Policy 2021-2024 annual review **The Trust has been in a transitional period between two strategies; the new strategy was published and supported by implementation of Datix DCIQ Local Risk Management System in Q3 of 2025.*
Author(s)	Ben Vickers, Associate Director of Quality Governance
Presented by	Vicky Sharples, Chief Nurse and Executive Director of Quality
Summary / purpose of paper	This paper provides an update on progress against the Risk Management Strategy implementation 2025-2027
Recommendation(s)	The Board are asked to note the progress against the 3 objectives in the strategy and the response to the recommendations of the MIAA Audit.
Background papers	Risk Management Strategy and Policy 2021-2024 MIAA Risk management Audit Q3 2025
Risk score	n/a
Link to: ➢ Trust strategy ➢ Corporate objectives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness.
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.	MIAA Mersey Internal Audit Agency CODE Care, Observation, Documentation, Experience CRF Clinical Research Facility PSIRF Patient Safety Incident Response Framework

The Christie NHS Foundation Trust

Agenda item 16/25a

Meeting of the Board of Directors

Thursday 24th April 2025

Risk Management Strategy and Policy 2021-2024 annual review

1) Introduction

Throughout 2024/25 the Trust has been developing its approach to risk management and has implemented risk management strategy 2025-2027 in February 2025.

This report provides an update on the progress made in implementing the new strategy, Datix risk management module and progress on actions from audits under the 2021-2024 risk management strategy.

2) Purpose of Report

As part of the Trusts system for internal control around Risk Management, The Board of Directors are asked to review the Risk Management Strategy annually. The Board are asked to note the progress against the objectives and the response to the recommendations of the MIAA Audit.

3) Background

The Trust has a holistic approach to Risk Management across the organisation, which embraces financial, corporate, reputational, clinical, non-clinical and project risks. The Trust takes all reasonable steps in the management of risk with the overall objective of protecting patients, staff and its assets.

The primary concern is the provision of a safe environment together with having systems and processes in place to identify, assess, evaluate, and assign responsibilities to manage risks within the Trust. This is achieved by ensuring that risk management and corporate governance is an integrated process through which the organisation will identify, assess, analyse, and manage risks and incidents at every level of the organisation and aggregate the results at a corporate level.

Strategic risks and risks to the achievement of the corporate objectives are presented to the Board through the Board Assurance Framework and assurance on their management is monitored through the assurance committees.

The reporting of risks, and progress against associated actions, are reported through the Trust governance structures, including the relevant assurance committee and the Board of Directors.

An update on progress against the three objectives of the Risk Management Strategy are detailed in figure 1.

In February 2025, MIAA undertook a review of Risk Management Core Controls. As a mandated review, MIAA assigned the strategy and risk management systems an assurance level of substantial noting the transition period between the two strategies and supporting systems. They made no recommendations requiring a management response.

Delivery against the 3 objectives of the Risk Management Strategy 2021-2024 (as of April 2023)

Figure 1

Objective	Progress	Status
1) Increase involvement, knowledge and accountability of all staff in the risk management process and integrated governance	Training needs analysis completed Risk management training rolled out to risk owners. Level 2 of the Patient Safety Syllabus is now essential to role for all staff managing incidents or risks.	Complete – ongoing risk management literacy to be improved through regular training under BAU Board training session of Risk held by NHS Providers.
2) Greater insight, transparency and triangulation of data	Patient Safety Incident Response Framework (PSIRF) is now operationalised from 1 April 2024. This included the publication of patient safety incident response plan and policy to external facing website, ICB and NHSE. Datix DCIQ is operational, supporting the Trust in compliance with Learning From Patient Safety Events (LFPSE) since 4 March 2024. The Enterprise Risk Management Module is due to go live by 31 May 2024. Level 1 of the Patient Safety Syllabus is now mandatory for all staff and monitored through Patient Safety Committee. The Trust Corporate Induction now includes a session on Patient Safety & Risk for all staff who join The Christie. Work is in its early stages to adopt data into the Data Warehouse to improve insights into legacy and contemporaneous risk and incident data.	Complete - The use of Datix DCIQ ensures controls and mitigation can be mapped to other intelligence sources such as incidents, complaints, claims, inquest and mortality data. Actions and controls can be linked to give greater clarity on the Trust priorities in mitigating risk, improving patient experience and the safety of practice in one system.
3) Refine and improve processes and systems to build effective risk management	Audit of risk registers, including compliance with risk review dates, and confirmation of associated risk assessments –	Completed March 2025. All addressed within DCIQ risk management module

Action plan to continue improvement against the 3 Risk Management Objectives, and address learning identified from both the internal risk audit, and the MIAA audit:

Figure 2

No	Issue	Action required (reference to detail)	Action Lead responsibility	Deadline Date	Expected Evidence of Completion/RAG
1	Review Risk Management Strategy 2021-2024	Undertake a review of the current Risk Management Strategy to address the following Areas: 1. Divisional governance arrangements for risk assessment and acceptance prior to adding to risk registers 2. Roles & Responsibility of risk oversight at Divisional and Board Level 3. Review and ratify risk appetite statement of the Board 4. Publish risk appetite statement on Trust website 5. Align the Board Assurance Framework (BAF) to the revised Risk Management Strategy	Ben Vickers, Associate Director of Quality Governance	Complete	Revised Risk Management Strategy 2025-2027 in place *Published 2025-27 risk management strategy in February 2025.*
2	Risk Management Thresholds and Assurance Reporting	To undertake a review of the current risk thresholds and management / oversight of risks at a Service, Divisional or Trust Wide Level. 1. Review the standard risk reporting produced by the Patient Safety and Risk Team to ensure robust assurance and accountability is obtained at Risk & Quality Governance Committee 2. Review the definitions of “Corporate Risk Register”, “Top 5 Trust wide Risks” and “Key Risks Report”	Ben Vickers, Associate Director of Quality Governance	Complete	*Datix DCIQ Module for risk management went live 11 March 2025.* *New reporting structure and risk registers mapped to org, division and directorate presented to risk committee in April 2025.*

No	Issue	Action required (reference to detail)	Action Lead responsibility	Deadline Date	Expected Evidence of Completion/RAG
		3. Confirm accountable roles for risk management and oversight at a divisional level 4. Confirm process for escalation of risks 5. Confirm process for interconnected / risk dependencies and decision making on where to oversee such risks *e.g. a digital risk in a clinical setting or an operational risk with a proposed digital solution unknown to stakeholders.*			*Governance process within division built into Datix DCIQ for oversight.*
3	The Trust should ensure its risk assessment form is reviewed and updated, to ensure compliance with best practice in the management of risk.	Update current Risk Assessment form; 1) Within divisional governance arrangements form to be assessed prior to adding to Risk Register 2) Revised format to include additional fields: Hazards, Impact, Contributing Factors. To be included in DATIX Cloud Risk Module.	Ben Vickers, Associate Director of Quality Governance	Complete	Risk is now assessed in Datix System – removing the requirement of MS Word assessment form. Assessed risks accepted onto relevant risk register by risk register owner.
4	Undertake Bi-Annual internal Risk Management Audit Q2 and Q4 of each financial year to measure compliance with current policy at divisional level.	Q2 of 2022-2023 – Completed Q4 2022-2023 Completed Q2 – 2023 2024 July 2023	Ben Vickers, Associate Director of Quality Governance	Complete	As part of the transfer process from DWEB to DCIQ – 10 months of data was audited against previous policy. Presented to Risk Committee March 2025. No recommendations

No	Issue	Action required (reference to detail)	Action Lead responsibility	Deadline Date	Expected Evidence of Completion/RAG
					were made by the audit as issues addressed with implementation of new system and new reporting methods. Q2 AND Q4 Audits in place going forward.
5	Risk Management Training for Risk Owners	1. Add to Christie Learning Zone. 2. 181 Risk Owners in Datix as numerator 3. Monitor compliance through ERG and Risk and Quality Governance Committee.	Ben Vickers, Associate Director of Quality Governance	Complete	Complete. Requires updating in Q2 of 2025 due to implementation of new DCIQ system. Risk Management steering group meeting fortnightly through Q1 to develop.

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Agenda item 16/25b

Meeting of the Board of Directors
Thursday 24th April 2025

Subject / Title	Trust Strategy and annual objectives update
Author(s)	Louise Westcott, Company Secretary John Wareing, Director of Strategy
Presented by	John Wareing, Director of Strategy
Summary / purpose of paper (alert / advise/ assure)	This paper provides the Board of Directors with an update on progress against the annual objectives for 2024/25 and in year delivery against the Trust Strategy.
Recommendation(s)	The board of directors are asked to; • Note the update on progress against the annual objectives
Background papers	N/A
Risk score / BAF reference	See BAF risks (agenda item 18/25b)
Link to: ➢ Trust strategy ➢ Corporate objectives	All Corporate objectives (as set out in appendix 1)
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.	LCC Leading Cancer Care BO Best Outcomes L&S Local & Specialist CE Christie Experience R&I Research & Innovation GM Greater Manchester MFT Manchester Foundation Trust CODU Clinical Outcomes Data Unit SDE Secure Data Environment EPR electronic patient record PAS patient administration system EPMA electronic prescribing & medication administration KPI key performance indicator OCIO operational chief information officer

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Agenda item 16/25b

Meeting of the Board of Directors
Thursday 24th April 2025

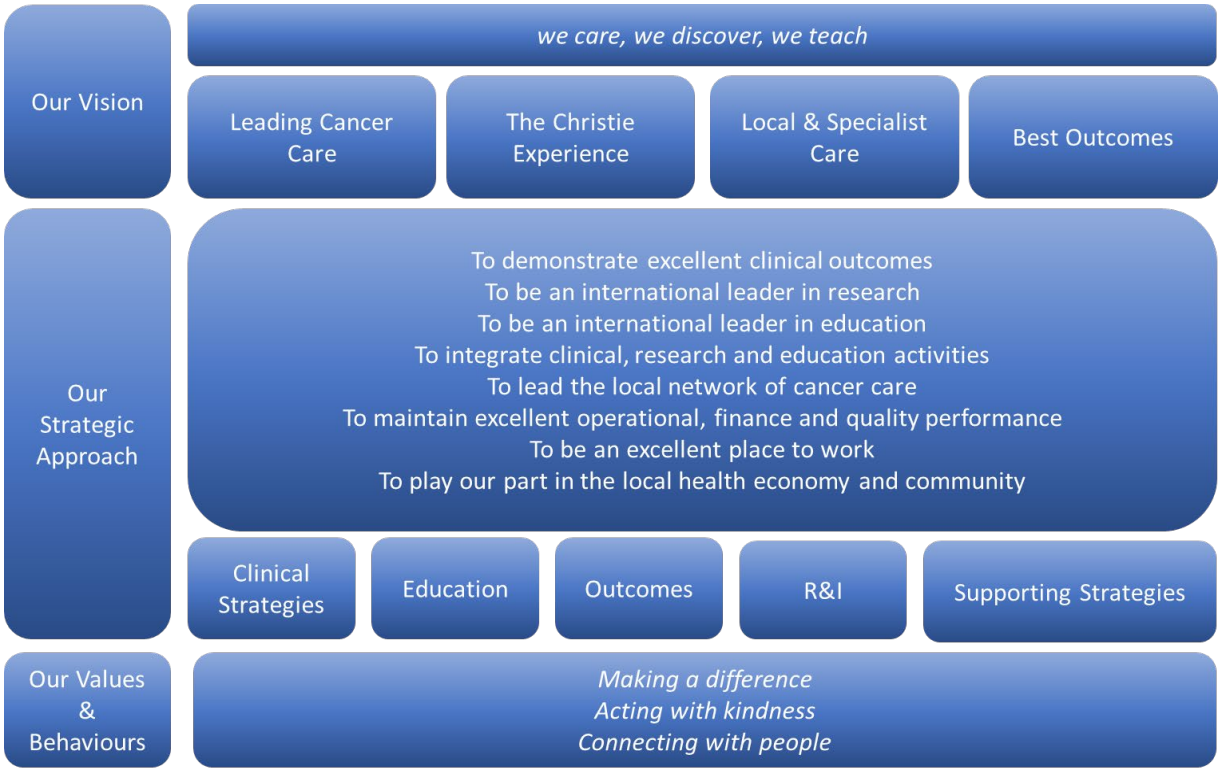
1 Background

A refreshed Trust Strategy was approved by the Board of Directors in March 2023. This followed an extensive period of work within the Trust to engage staff, Governors, and the Board in the process to review the previous 5-year Strategy and refresh it for the 2023 – 2028 period.

Alongside this the Trust also revised its Values and Behaviours which underpin our approach to delivering the Strategy.

2 Introduction

The Trust Strategy brings together a number of key elements of the Trusts activity, specifically, Clinical, Education, Research & Innovation and Outcomes strategies. The diagram below details how these various elements come together to support the Trust delivering its overall mission, '*to care, to discover, to teach*'.



As in the previous strategy, the mission is supported by four pillars, Leading Cancer Care, The Christie Experience, Local & Specialist and Best Outcomes. These pillars provided the framework for the development of a number of strategic objectives which will be delivered during the next 5 years.

3 Main Strategy Themes

The table below outlines the main themes of the 2023-28 Strategy. The colours indicate how these key themes and projects address issues of cancer waits, improving patient outcomes

and addressing health inequalities. These themes inform the production of the annual objectives each year.

Leading cancer care	The Christie experience	Local & specialist care	Best outcomes
LCC 1 Realise the potential of the Paterson development - seamless integration of research with clinical care	CE1 Improve in-patient experience and efficiencies through emerging / next generation ward environments	L&S 1 Lead a single Christie non-surgical oncology service with equitable care for all patients across GM	BO 1 Drive improvements in quality, safety and patient experience through real-time data for 'data-enhanced clinicians'
LCC 2 Grow pipeline of Christie leaders with regional, national, and international influence through an active model of staff development	CE 2 Establish system-wide Christie Research Outreach - access to research for every patient across Greater Manchester	L&S 2 Collaborate with system partners to improve access to cancer diagnosis and treatment targeting areas of greatest need	BO 2 Accelerate the use of real-world data and improving outcomes through launching a multidisciplinary Clinical Outcomes & Data Unit (CODU)
LCC 3 Accelerate research delivery through efficiencies and innovation - tomorrow's treatments to patients faster	CE 3 Personalise the Christie out-patient experience embedding digital healthcare tools	L&S 3 Expand cancer survivorship programme with system leadership for managing late effects, supportive care and research	BO 3 Develop a secured-data environment with regional/national capability in collaboration with research partners
LCC 4 Create sustainable opportunities for our staff to work within international partnerships to tackle cancer inequalities locally and globally	CE 4 Embed cancer partnerships beyond GM by building on the success of national service networks and hosting Operational Deliver Networks	L&S 4 Establish a Christie Advanced Cancer Scanning Centre for state-of-the-art diagnostics and increasing system capacity	BO 4 Work in partnership with the GM Cancer Alliance to establish and report cancer equality metrics and KPIs
LCC5 Amplify accessible and inclusive cancer care education and training for Christie staff, external colleagues, and patients	CE5 Grow active patient and public engagement opportunities across cancer education priorities	L&S 5 Work with partner organisations to integrate a sustainable next-generation cancer pathology service in cytogenetics, histopathology, and blood sciences	BO 5 Improve outcomes for older patients with cancer through the Christie Senior Adult Oncology service

	Cancer waits
	Outcomes
	Inequalities

4 Annual objectives

The Board approved the annual objectives for 2024/25 in June 2024. The table at appendix 1 summarises the progress against the objectives at year end. The annual objectives relate to the in-year delivery of the overall strategy and the table shows where each objective links to a theme within the strategy as well as any link to a risk on the Board Assurance Framework. There are no issues to escalate to Board following the assessment of progress at year end.

5 Risk

There are potential threats or risks to the delivery of our Strategy and Annual Objectives, these are articulated through the Board Assurance Framework.

6 Summary

There has been good progress with the annual objectives that continue to deliver on aspects on the overall Trust Strategy and no issues require escalation to the Board.

7 Recommendation

The Board are asked to note the contents of the report and progress against the Annual Objectives and Trust Strategy.

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Appendix 1: Annual Objectives 2024/25

1. To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer.							
	BAF risk	Strategy Theme ref	Annual objective	Reporting	Timescale	Director	Progress
1.1	14		Publish all information required under the NHS Code of Governance for Provider Trusts – including relevant oversight framework metrics (See below)	Trust Annual Report & Accounts and other governance documents prepared and reported to board with appropriate audit opinion	30.6.24	CS	Complete
1.2	14		Publish information on our quality of care in 2023/24 in our annual Quality Report and Accounts	Annual Quality Report prepared and reported to board with appropriate audit opinion	30.06.24	ECN	Complete
1.3	14		Publish relevant metrics as set out in the NHS oversight metrics for 2024/25	Monthly report to board	Monthly	COO	Complete
1.4	1	BO1/O2 /03/05	To deliver the 2024/25 milestones in our Clinical Outcomes Strategy	Annual report to Quality Assurance Committee	31.3.25	EMD	Progressing to plan
1.5	13		Publish progress with EDS 2022 self-assessment action plan	Effective web site page – six monthly report to Workforce Assurance Committee	6 monthly	DoW	On Trust website
1.6	6 13		Publish self-assessment and action plan for health inequalities based on socio-economic deprivation, ethnicity, and other community characteristics	Effective web site page – six monthly report to Board	6 monthly	DCEO	NHS Providers self-assessment completed and reported to the Board.
1.7	5		Develop the ASIC business case to HMT principles for Board consideration and support for wider funding strategy	Board approved business case	31.3.25	EDoF	Progressing to plan
1.8	4		Prepare for the new CQC inspection regime	QAC and Board reports	31.3.25	ECN	Regular reporting in place

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1. To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer.							
	BAF risk	**Strategy Theme ref**	**Annual objective**	**Reporting**	**Timescale**	**Director**	**Progress**
1.9		LSC3 BO5	Deliver the benefits of the Senior Adult Oncology service across a wider range of tumour pathways	Senior Management Committee reports	31.3.25	EMD	Progressing to plan

2. To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey							
	BAF risk	**Strategy Theme ref**	**Annual objective**	**Reporting**	**Timescale**	**Director**	**Progress**
2.1	3 6 12	LCC 1/3 CE 2	Implement 2024/25 (year 2) milestones of Research & Innovation division strategy	Six monthly report to Quality Assurance Committee Annual report to board Effective web site page	31.3.25	DRI	Progressing to plan
2.2		LCC 1	Ensure plan for relocation of research teams into Paterson facility implemented	Regular reporting to Quality Assurance Committee	31.3.25	DRI	Teams relocated as planned

3. To be an international leader in professional and public education for cancer care							
	BAF risk	**Strategy Theme ref**	**Annual objective**	**Reporting**	**Timescale**	**Director**	**Progress**
3.1	3 12	LCC 2/5 CE 5	Implement the 2024/25 milestones of the Christie Education strategy	Six monthly report to Workforce Assurance Committee / Annual report to Board Effective web site page	31.3.25	DE	Progressing to plan
3.2			Implement future organisational governance arrangements for Christie Education and relationship to Education Sector	Six monthly reporting to Workforce Assurance Committee Report to Board	31.3.25	DCEO/ DE	Progressing to plan. Board report October 2024

4. To integrate our clinical, research and educational activities as an internationally recognised and leading comprehensive cancer centre							
	BAF risk	Strategy Theme ref	Annual objective	Reporting	Timescale	Director	Progress
4.1			Ensure the website carries accurate, up to date information on our services as a Comprehensive Cancer Centre	Annual report to Audit Committee on publication scheme	31.3.25	DCEO	Publication scheme audit complete
4.2			Prepare for and secure reaccreditation with the OECI as a Comprehensive Cancer Centre	Achievement of reaccreditation	September 25	DCEO	OECI visit completed, initial feedback consistent with reaccreditation. Formal confirmation expected September
4.3			Develop our network of international relationships through the OECI by participating in OECI working groups	Reporting of attendance / involvement in working groups	31.3.25	DCEO	Fully participating
4.4			Secure agreement on new governance arrangements for MCRC partnership with University of Manchester and CRUK	Agreement in place and reported to board	31.3.25	DCEO	On going discussions with UoM
4.5			Promote the reputation of The Christie internationally by supporting attendance and scholarly contributions at prestigious international professional and corporate events.	Reporting of attendance at international meetings	31.3.25	DCEO	Continues across the Trust
4.6		LCC 4	Continue to develop partnerships in Australia, Kenya and Uganda, and others as appropriate	Include in regular international programme reports to board of directors	31.3.25	DCEO	Progressing
4.7	2, 4		Implement year 1 milestones of the Patient and Public Involvement & Engagement plan	Annual report to the Quality Assurance Committee	31.3.25	DCEO	Progressing to plan
4.8		LCS 5	Reprocure joint venture partner for The Christie Pathology Partnership	Regular report to Board	31.12.24	DoS	Progressing to plan

5. To promote equality, diversity & sustainability through our system leadership for cancer care							
	BAF risk	Strategy Theme ref	Annual objective	Reporting	Timescale	Director	Progress
5.1	6 7		Provide direction and guidance as chair of GM cancer board and represent cancer at Trust Provider Collaborative	Reporting to Board of attendance /involvement	31.3.25	CEO	Regular reporting / involvement in place
5.2	6 7	LSC 2	Participate as part of senior leadership team of Greater Manchester Cancer	Reporting to Board of attendance/involvement	31.3.25	DoS	Progressing as planned
5.3	6 7	LSC 2	Fully implement the GM Cancer operating model	Regular reporting to Board	31.3.25	CEO	Model in place, Board chaired by CEO
5.4	6		Continue transfer of management and accountability of local outpatient oncology care (including systemic therapy) – contracts to be held by The Christie NHS FT	Regular reporting to Senior Management Committee and Board	31.3.25	COO	Progressing as planned
5.5	6	LSC 1	Develop and increase access to local systemic anti-cancer therapy in line with agreed plan	Regular reporting to Senior Management Committee and Board	31.3.25	COO	Progressing as planned
5.6	6		Increase local access to Christie led & hosted trials	Regular reporting to Senior Management Committee and Board	31.3.25	DoR	Progressing with limitations, report in January 2025
5.7	6 7	CE 3	Transfer haematology services from Leighton to The Christie	Regular reporting to Senior Management Committee and Board	31.3.25	COO	Case approved subject to funding
5.8	7	CE 3	Building on existing partnerships beyond Greater Manchester	Regular reporting to Senior Management Committee and Board	31.3.25	COO	Progressing to plan

6. To maintain excellent operational, quality and financial performance							
	BAF risk	Strategy Theme ref	Annual objective	Reporting	Timescale	Director	Progress
6.1	2 4		Implement 2024/25 (year three) milestones of our 2022/24 Quality Strategy including CODE & Quality Mark	Annual report to Board of Directors	6 monthly	ECN	Progressing to plan
6.2	2		Implement the 2024/25 milestones of our Patient Experience plan	6 monthly report to Quality Assurance Committee	6 monthly	ECN	Progressing to plan
6.3	2		Implement the 2024/25 milestones of the Trust Risk Management Strategy	Annual report to Board	31.3.25	ECN	Progressing to plan
6.4	1, 7, 10		Achieve the agreed operational activity plan for 2024/25	Monthly performance reports to Senior Management Committee and Board	Monthly	COO	On plan
6.5	7		Achieve relevant national targets set out in 2024/25 NHS planning guidance	Monthly performance reports to Senior Management Committee and Board	Monthly	COO	On plan
6.6	11		Implement 2024/25 (Year 2) milestones of the Digital Strategy	Six monthly reporting to Audit Committee	31.3.25	DCEO	
6.7			Achieve the Trust's 2024/25 revenue plan	Monthly financial performance reports to Senior Management Committee & Board	Monthly	EDoF	On plan
6.8		CE 1	Deliver the Trust's 2024/25 capital plan within the available allocated CDEL	Monthly financial performance reports to Senior Management Committee & Board	Monthly	EDoF	On plan
6.9			Achieve the agreed level of the value-improvement programme	Monthly financial performance reports to Senior Management Committee and Board	31.3.25	COO	On plan overall
6.10			Develop the Trust group structure to deliver the Trust strategy	Regular reports to Board	31.3.25	EDoF	Plans progressing
6.11		CE 1	Complete new ward accommodation (TIF scheme) and operationalise	Regular reporting to Senior Management Committee and Board	31.3.25	COO	Complete

7. To be an excellent place to work and attract the best staff							
	BAF risk	Strategy Theme ref	Annual objective	Reporting	Timescale	Director	Progress
7.1	3 12		Achieve year 2 milestones of The Christie People & Culture Plan 2023/26	Regular reporting to Workforce Assurance Committee	31.3.25	DoW	Progressing to plan
7.2	3 12		Development of refreshed Equality, Diversity and Inclusion (EDI) plan 2024-29	Regular reporting to Workforce Assurance Committee	31.3.25	DoW	Complete
7.3	3 12		Progress agreed actions from Culture Audit	Board and Workforce Assurance Committee reports	31.3.25	DCEO	In Inclusive Culture Plan

8. To play an active part in the local health care economy and community							
	BAF risk	Strategy Theme ref	Annual objective	Reporting	Timescale	Director	Progress
8.1	4, 5, 6,7		Demonstrate effective collaboration in the GM System through active participation in relevant fora	Regular reports to Board	31.3.25	DoS	In place
8.2	8		Achieve 2024/25 milestones for Trust Sustainability Plan (Green Plan)	Six monthly reports to Audit Committee	31.3.25	DCEO	Complete
8.3	14		Participate in Anchor institutions initiative	Six monthly reports to Board	31.3.25	DoS	Participating
8.4			Regularly engage local residents regarding the Trust's plans	Continued meetings of the Neighbourhood Forum reported through Senior Management Committee as part of capital reporting	31.3.25	EDoF	Progressing to plan

KEY:

BAF – Board assurance framework	DoS – Director of Strategy
(D)CEO – (Deputy) Chief Executive Officer	DoW – Director of Workforce
EDoF – Executive Director of Finance	ECN – Executive Chief Nurse
COO – Chief Operating Officer	

Strategy Themes;

LCC	Leading Cancer Care
CE	Christie Experience
LCS	Local & Specialist Care
BO	Best Outcomes

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FUTURE CHRISTIE

- Approach to organisational change and planning for 2025/26
- Building the team
- Partnership with Royal Marsden

Approach to Organisational change and planning for 2025/26

Principles

- Increase the pace of change.
- Total adoption
- Focused resource on fewer but significant changes
- Significant visible resource and support with workforce throughout implementation
- Broad communication and commitment to specific change on specific date
- Remove option for previous practice

Approach to Organisational change and planning for 2025/26

Plan 25/26: Implement Real time Patient interface, patient correspondence available on the same day.

Phase	Plan and Preparation			Implementation			Embed and Bridge	
Time scale	1 month			1 month			1 month	
Stages	Plan	Leadership Engagement	Operational readiness	Leadership confirmation	Organisational engagement	Implementation	Review	Organisational engagement
Activity	What change to be enacted and target date	Detail scope and implementation plan	Preparations for go live on planned date	Review readiness and risk mitigations. Confirmation of plan	Communicate specific plan for implementation and support.	Implement change with focussed resource and support on areas of change for full cycle of activity.	Review implementation and sustained adoption support areas of non-adoption. Remove workarounds.	Communicate success and impact and signal next change.
Responsibility	Executive team	Senior Management committee	Management teams	Senior Management committee	Team brief plus broad organisational comms	Whole organisation	Operational teams	Senior Management committee

Building the team

- Expression of Interest for Future Christie Medical Director
- Associate Director of Transformation proceeding to advert

Marsden Partnerships Outputs

Primary collaboration	•Develop model of remote support for SACT services
Additional areas	•ANP models of development and service deployment •Pharmacy SACT screening collaboration to catalyse roll out
Joint publications	•Acute Oncology protocols •Cancer MDT modernisation
Future Sessions	•Research and Innovation (inc software as medical device) •Radiotherapy and adoption of AI •Radiology and Diagnostics •Approach to Data

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Next Steps

- Build transformation capacity focussed around new approach
- Develop Clinical and Corporate delivery plans
- Explore partnerships in specific areas of innovation
  - Patient Interface
  - AI in auto contouring
  - Logistics

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Agenda item 17/25a

Meeting of the Board of Directors
Thursday 24th April 2025

Subject / Title	Freedom to Speak Up report - 1st October 2024 to 31st March 2025
Author(s)	Jane Kimberley, Freedom to Speak Up Guardian (interim)/ Fiona Jenkinson Freedom top Speak up Guardian
Presented by	Jane Kimberley, Freedom to Speak Up Guardian (interim)
Summary / purpose of paper	This paper provides an update on Freedom to Speak Up activity within the Trust.
Recommendation	The Board of Directors is asked to note the detail in the report and receive a further update in six months' time.
Background papers	Previous six-month Freedom to Speak Up report
Risk score / BAF reference	N/A
EDI impact/considerations	FTSUG attends EDI network steering group meetings
Link to: ➢ Trust strategy ➢ Corporate objectives	Achievement of corporate objectives The Christie People and Culture 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.	FTSU – Freedom to Speak Up FTSUG – Freedom to Speak Up Guardian NGO – National Guardian's Office EDI – Equality, Diversity, and Inclusion NHSE – NHS England PC – personal computer PSIRF – Patient Safety Incident Response Framework HR – Human Resources

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Agenda item 17/25a

Meeting of the Board of Directors

Thursday 24th April 2025

Freedom to Speak Up report 1st October 2024 to 31st March 2025

1. Background

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

Due to the retirement of the Freedom to Speak Up Guardian (FTSUG) in November 2024, an interim Guardian was appointed to provide a FTSU service to cover FTSU during the recruitment process for a permanent FTSUG. The interim guardian service was provided by one of the FTSU Champions who underwent National Guardian Office (NGO) formal FTSU training. This recruitment was via a fair and equitable process amongst the current Champion group.

On recruitment of the new FTSU guardian there was a month overlap in March of the 2 Guardians to facilitate a smooth hand over process.

In effect, this 6-month report covers the work of 3 Guardians. Case load is confidential for each Guardian and therefore gaps in the report reflect this as specifics relating to actions on cases from the retiring Guardian is not available.

As there are now 2 trained Guardians in the Trust, discussions are progressing to facilitate the Interim Guardian to maintain their training to cross cover for periods of leave /extended leave or to cover any conflict of interest of the newly appointed Guardian.

This report presents the six-monthly update on activity to the Board of Directors.

2. Activity

To highlight the importance of speaking up and listening, the FTSUG continues to attend meetings as required, Trust induction has been covered by a FTSU video during the interim Guardian period.

The local induction pack template provides details on the role of the FTSUG and reference to speaking up and listening.

Promotion of speaking up was supported by focused activity during October, Freedom to Speak Up month.

3. Staff survey

During the reporting period the Trust received the annual NHS staff survey results. Appendix 1 provides full benchmarked data.

In terms of 'we each have a voice that counts' there are 4 questions that contribute to the sub-score "raising concerns":-

- Q20a - I would feel secure raising concerns about unsafe clinical practice.

- Q20b - I am confident that my organisation would address my concern.
- Q25e - I feel safe to speak up about anything that concerns me in this organisation.
- Q25f - If I spoke up about something that concerned me, I am confident my organisation would address my concern.

3.1 Benchmark of each question relating to Specialist Cancer Trust by question

The benchmarking has shown that the Christie has remained consistent with last year or has improved.

- 75.59 % of staff said they would feel secure raising concerns about unsafe clinical practice- a 4% improvement on 2023 (highest percentage since 2020).
- 64.61% of staff said I am confident that my organisation would address my concern. This is a 6% improvement on previous years,
- Reviewing divisional data, divisions with least confidence in concerns being addressed were digital services and estates and facilities. In terms of banding and staff group, Band 4, estates and ancillary staff and additional professional scientific and technical staff had least confidence.

The 2025/2026 FTSU plan will focus activity based on this data.

- 70.42 % of staff said I feel safe to speak up about anything that concerns me in this organisation. This is a 5% improvement in year.
- 59.87% of staff said if I spoke up about something that concerned me, I am confident my organisation would address my concern. This is a 6% improvement on 2023.

3. 2 Benchmark of each of the 4 questions relating to Greater Manchester Hospitals show that-

- Q20a The Christie ranks 3rd with 75.59% (highest score at 77.49%)
- Q20b The Christie ranks 1st
- Q25e The Christie ranks 2nd with 70.42 % (highest score 70.68 %)
- Q25f The Christie ranks 1st

3.3 The Christie added two additional questions to the staff survey relating to speaking up: -

- Q19 What would make you more likely to speak up about a concern?
- Q20 If you have previously spoken up about a concern, how satisfied were you with your experience? Part 2: If the previous question regarding your experience was applicable to you, please explain the reason for your answer.

66% of staff indicated the need for assurance of confidentiality, 64% said that having examples of speaking up and what action was taken would be helpful and 37% of staff indicated additional support / or information on how to speak up would be beneficial in making them more likely to speak up. 14% felt easier access to a PC to access information or to log an incident on Datix would be required.

66% responded that this question was not applicable to them in relation to their experience of speaking up. Of the remaining responses, 14 % were satisfied overall, and 13 % were dissatisfied overall.

Themes drawn out of the comments indicate that lack of change or action, follow up & communication and culture were all relevant factors to their experience.

Survey summary

It is important to recognise that speaking up is related to all forms of speaking up, not just that via the formal freedom to speak up process.

The divisions will be required to develop priority action plans for presentation at Workforce Committee. This provides assurance that focused action is being taken in response to the feedback from staff Additionally it also provides opportunity for cross divisional learning.

3.4 Patient Safety Incident Response Framework (PSIRF)

The Christie is currently embedding PSIRF which sets out the approach to responding to patient safety incidents with an emphasis on the system and culture. FTSU concerns have been raised about the PSIRF culture during this reporting period. The guardian is working with the Quality & Standards team and HR to refine the process and to enable anonymous reporting.

4. National guidance and reports

Throughout the last six months the following reports/ guidance was issued and reviewed.

- National Guardians Office Making speaking up business as Usual (March 2025)

  The report described that Guardians handled more cases than ever before (over 32,000 cases in 2023/24, a 27% increase on the previous year).[1.]

  By comparison 2024/25 has seen the highest number of cases for The Christie (55 versus previous highest of 49) which equates to an 11% increase.

  The report highlighted that ‘there is a strong correlation between results for the question about inclusion (‘I think that my organisation respects individual differences (for example, cultures, working styles, backgrounds, ideas)’ and the speak up question, ‘If I spoke up about something that concerned me, I am confident my organisation would address my concern.’

  Those organisations that people feel are more inclusive, are also those where people feel more confident their concerns will be addressed. We are also seeing improvements in the confidence of some ethnic minority workers who respond to the survey’.

  The 2025/2026 FTSU action plan will targeting barriers to speaking up, particularly for those with protected characteristics.

- Detriment Guidance for Guardians (January 2025)
  In the National 23/24 data submitted by Freedom to speak up Guardians, 4% (1285) of cases indicated workers believed they experienced some form of disadvantageous and/or demeaning treatment as a result of speaking up.

  The report indicates the requirement for organisations to highlight that detriment will not be tolerated, ensure line managers receive appropriate training to listen well and respond to difficult matters. A checklist has been created for when detriment has been reported to a line manager or freedom to speak up Guardian.

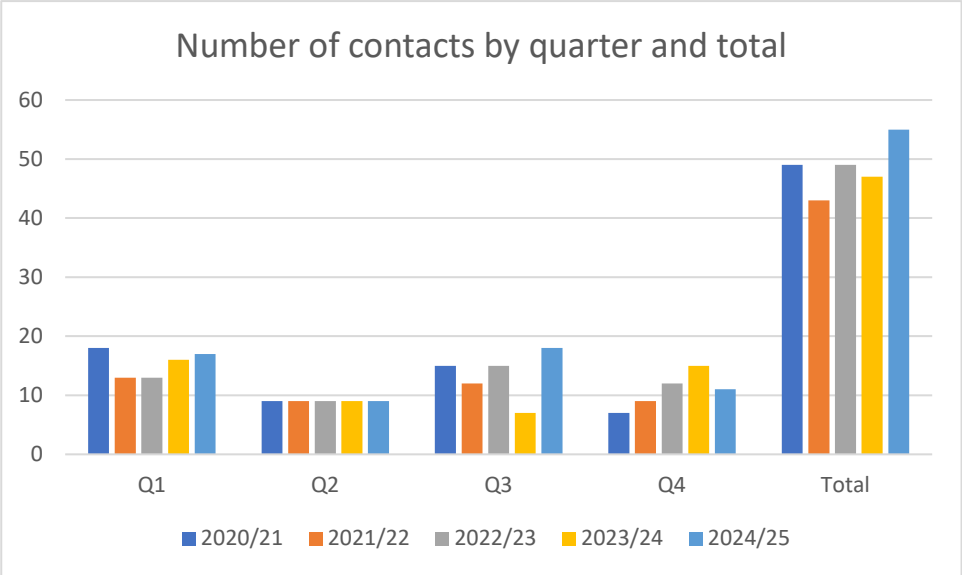
  We will include the checklist as an appendix to the trust FTSU policy.

1 staff member (2% of cases) reported detriment because of speaking up in 2024/25.

We have also produced a guide to support managers who receive a concern.

5. Contacts

5.1 Number of contacts by quarter and total last 5 years



5.2 Type of contact

The table below describes the activity from 1st October 2024 to 31st March 2025. Concerns are reported as the primary concern but may have more than one issue.

Note: - Due to the confidentiality requirements of case work, the interim Guardian is unable to access case files to report on actions taken for cases covered by the previous Guardian.

Quarter	Number of contacts	Issue category	Description	Action
2024/25 Q3	18	Policies, procedures and processes (9)	Potential to access unauthorised information (x1) Advice re dealing with a formal complaint against them (x2) Management of trust policies / patient safety (x1)	No access to data No access to data Staff member decided not to proceed. FTSUG raised generically with Patient Safety and Risk lead. Assurances related to this concern have

				been discussed at patient safety committee and processes put in place.
			Advice re dealing with difficulties with line manger over trust policy (x1)	Staff member raised with HR (however as yet unresolved)
			Unsupportive manager relating to management of trust policies (x1)	Staff member did not respond to FTSUG.
			Support of a colleague and concerns re detriment for supporting them in relation to Trust policies (x1)	Options discussed, no further response.
			Following of Trust HR processes / behaviour of colleague / (x1)	Advice provided, no need to take any further
			Improper handling of genuine concerns following procedures/ treatment of a colleague (x1)	Advice provided, Staff member to monitor and raise again with FTSUG if required.
		Attitudes and behaviour (x6)	Advice re handling a negative atmosphere (x1)	No access to data
			Advice re how to deal with manager behaviour (x1)	No access to data
			Attitude of staff member (x1)	No access to data
			Behaviour of colleague (x1)	Line manager to escalate.
				Raised to FTSUG by third party. Advice taken by FTSUG- unable

			Bullying and harassment (another organisation x1)	to take further due to lack of consent from individuals involved. Raised to FTSUG by third party. - unable to take further due to lack of consent from the individuals involved.
			Microaggressions relating to EDI in communications. (x1)	
		Other (x2)		No access to data
			Advice on support re finances (x1)	No access to data
			Lack of parking for staff and subsequent personal safety compromise (x1)	No access to data
		Performance capability (x 1)	Colleagues' ability and lack of support (x1)	
2024/25 Q4	11	Attitudes and behaviour (x8)	Behaviour of senior colleagues (x5)	Staff member met with line manager and HR. Ongoing Escalated directly to relevant Director / Associate Medical Director by staff member. Elements relating to patient safety also raised with Patient Safety and Risk Lead Escalated to line management and Director by staff member. Ongoing Ongoing
			Bullying by colleague (x1)	Request to HR for formal mediation made by staff member.
			Difficult relationship with line manager (x1)	Advice provided.

			Behaviour of colleague (x1)	Escalation to line manager with informal mediation and apology received.
		Blank (x1)	No detail given in initial contact.	Contact made with no detail; staff member did not respond to FTSUG contact.
		Quality and Safety (x2)	Anonymous letter re patient safety and staff banding.	Escalated to Patient Safety and Risk Lead. Datix completed Investigated by HR and line management. Summary statement written in response to points raised in letter.
			Concern regarding exposed asbestos in area of high staff traffic/ availability of related trust policies	Raised with relevant Service Manager and external asbestos consultants contacted to review area and monitor air quality if required (ongoing)

5.3 Summary

In summary, over the last six months (Q3 & Q4), there have been 29 contacts with the FTSU Guardian. Due to the change in the Guardian and the level of confidentiality required in relation to case management, the Interim Guardian is unable to provide baseline data relating to the actions of 8 of those cases, all live cases were handed over to the interim Guardian.

10 cases had more than 1 theme- the report references the primary theme for each case.

48% of primary themes had an element relating to attitudes and behaviours, 31% policies, procedures, and processes.

There are slightly higher levels of concerns relating to behaviour of senior colleagues and several of these carry a theme of medical colleagues' behaviour.

Concerns relating to policies, procedures and processes are varied but highlight there is inconsistency with application and availability of trust polices.

There was a clear link between primary theme of attitudes and behaviours and secondary theme of policies procedures and processes (or vice versa). The Trust People plan, and Inclusive Culture strategy describe our approach to address this .

The FTSUG has also developed a guide to support managers who receive a concern.

6. Who is raising the concern?

A review of who is raising concerns and how they are raised helps to identify if there are groups of staff who are not speaking up. The data below shows that Healthcare Scientists, Students, Estates and Facilities staff and Additional professional, scientific and technical staff all have low numbers of reporting. The 25/26 plan will include objectives to address this.

6.1 Number of FTSUG contacts by staff group

Staff group	Q3&4 23/24	Q1&2 24/25	Q3+4 24/25	Total for 18 months
Additional clinical services	3	2	4	9
Additional professional, scientific and technical	1	1	2	4
Administrative and clerical	10	10	8	28
Allied health professionals	1	8	4	13
Estates and ancillary	2	1	1	4
Healthcare scientists	1	0	0	1
Medical and dental	1	1	2	4
Nursing and midwifery	2	3	5	10
Students	0	0	0	0
Unknown	1	0	1	2
Other	0	0	2	2
Total	22	26	29	77

6.2 Role

Role	Q3&Q4 2023/2024	Q1&2 2024/2025	Q3&4 2024/2025
Senior leader	0	0	0
Manager	36%	27%	21%
Worker	59%	73%	76%
Anonymous	5%	0	3%
Denominator – number of cases	22 (1 anonymous)	26	29 (1 anonymous)

6.3 Method of speaking up

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

Method	Q3&Q4 2023/2024	Q1&Q2 2024/2025	Q3+4 2024/2025
Face to face	9	13	5
MS Teams	7	12	2
Telephone	5	1	0
Form on intranet	0	0	2
Email	1	0	19
Letter	0	0	1

6.4 Timeliness of FTSUG response

A new metric is now being recorded to assess the timeliness of the FTSUG service when a case is raised.

Of the 20 cases from Q3 &Q4 where this metric was recorded, the average response time from date concern raised to response by the Guardian was 0.8 days which overall is compliant with the 2-day timeframe within the FTSU policy (2 responses were outside of this due to leave of the Guardian) The average time between Guardian response and first meeting (where applicable) was 3 days.

7. FTSU plan

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

The FTSU plan for 2024/2025 was developed in conjunction with activity following the cultural audit, the launch of PSIRF and feedback from staff via the staff survey to ensure that it meets the ambition to progress improvements in speaking up culture.

Over the six months the deliverables achieved were:-

- Raising awareness of FTSUG and the speaking up and listening message at team meetings, via HIVE and team brief and via an animated video at staff induction as part of the Values & Behaviours session
- Development of an animated version of the FTSU policy
- Development of posters and daily programme of items to support October's Freedom to Speak Up
- Development of guide to support managers who receive a concern. (This is complete but needs a launch campaign)
- Feedback on Datix a mandatory requirement so all staff can review the outcomes of an incident they report and are able to challenge outcomes.
- Refresh NHSE board self-assessment of leadership and governance arrangements in relation to speaking up (presented at Workforce Assurance Committee January 2025)
- Staff survey results 2023 and cultural audit informing activity to support a positive raising concern culture - Divisional presentations to Workforce Committee

We are currently in the process of developing the 2025- 2026 Freedom to speak up action plan which will be monitored through the workforce committee.

8. National Freedom to Speak Up month.

October was National Freedom to Speak month and the focus for organisations was Listening and the role it plays in encouraging speaking up. Each day during October, there was a different activity linked to listening promoted via the weekly bulletin. Activity included links to short videos from staff highlighting the benefits of listening in helping the organisation improve, guides, policies, and training and a variety of promotional events led with the Director of Workforce and the FTSUG across the network sites and within the Trust.

9. Freedom to Speak Up Training

The National Guardian's Office, in association with Health Education England launched Freedom to Speak Up e-learning training divided into three modules, Speak Up for all staff, Listen Up for managers at all levels and Follow Up for Senior leaders. The Speak Up module is part of the Trust mandatory training programme and 97.03% of staff are compliant.

10. FTSU service effectiveness

The NGO requires that Guardians ask those who contact the FTSUG if they would speak up again or have experienced detriment. Additional questions are asked about support and communication. The feedback tool is completed via a link so that responses are anonymous. The questionnaire is

sent when a case is closed and not all cases are closed in the quarter they are reported and not all questions are answered.

Appendix 2 reports all comments received

11 contacts replied in Q3 and Q4 2024/2025.

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

All said they felt very well supported.

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

All said they were communicated with very well.

3 said they were informed of learning that happened as a result, 5 said there was no learning and 2 said they were not informed of learning identified.

10 respondents said they felt they did not suffer disadvantageous or demeaning behaviour as a result of speaking up, 1 replied they didn't know.

Suggestions for improvement of the FTSU service will be reviewed and included in the 2025-226 FTSU plan

11. Conclusion

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

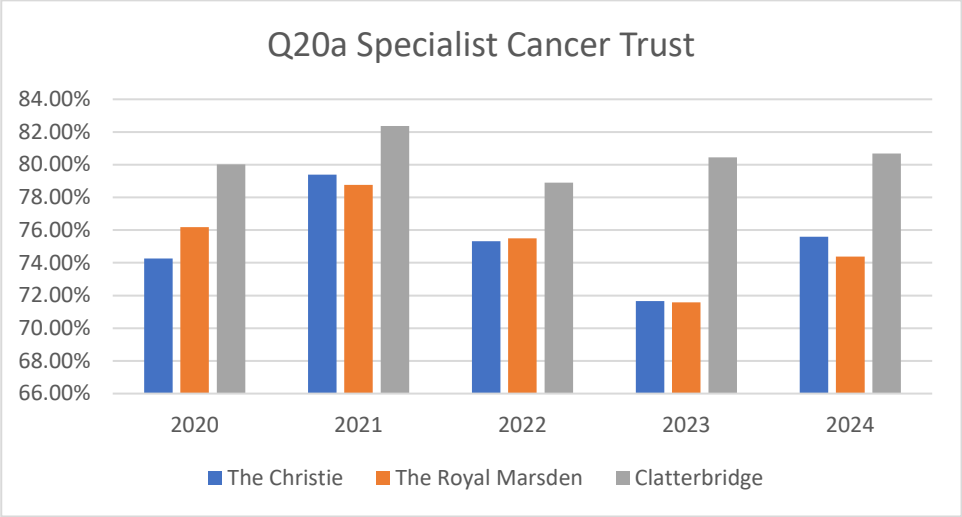
12. References

1) Making Speaking up business as usual, National Guardian's Office Annual report 2025 :- Making Speaking Up business as usual

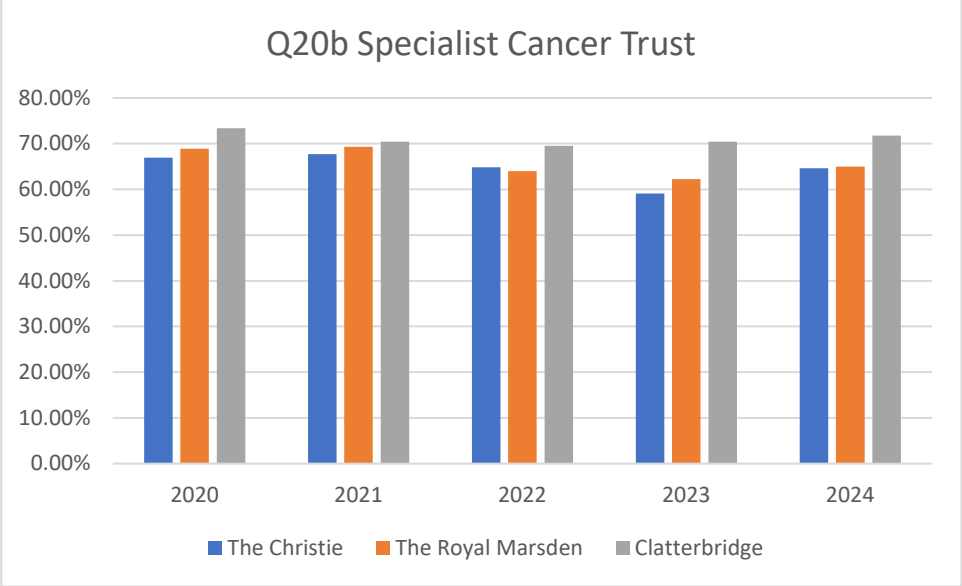
Appendix 1 Staff Survey results - Graphs to support text in the report.

Staff survey benchmark for 3 Specialist Cancer Trusts:-

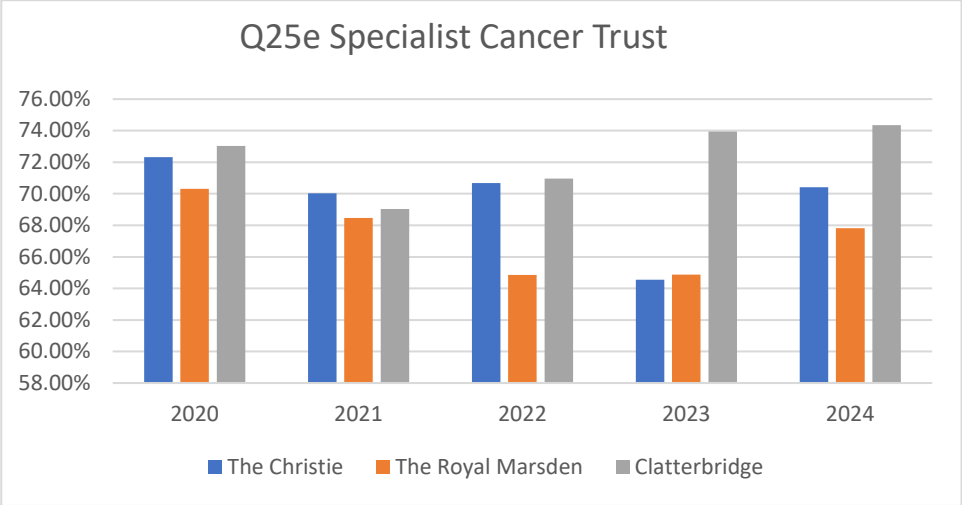
Q 20a - I would feel secure raising concerns about unsafe clinical practice.



Q20b - I am confident that my organisation would address my concern.



Q25e - I feel safe to speak up about anything that concerns me in this organisation.



Q25f - If I spoke up about something that concerned me, I am confident my organisation would address my concern

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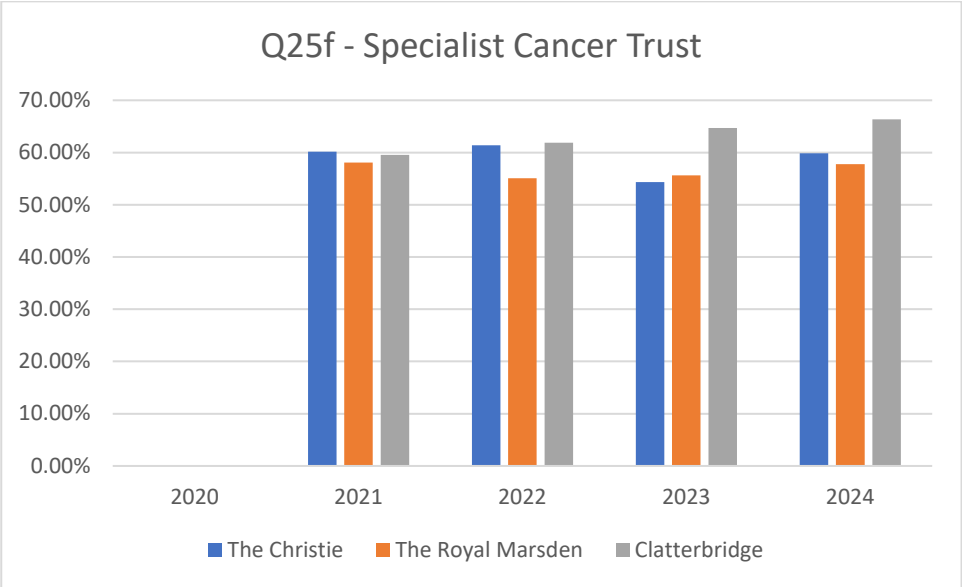
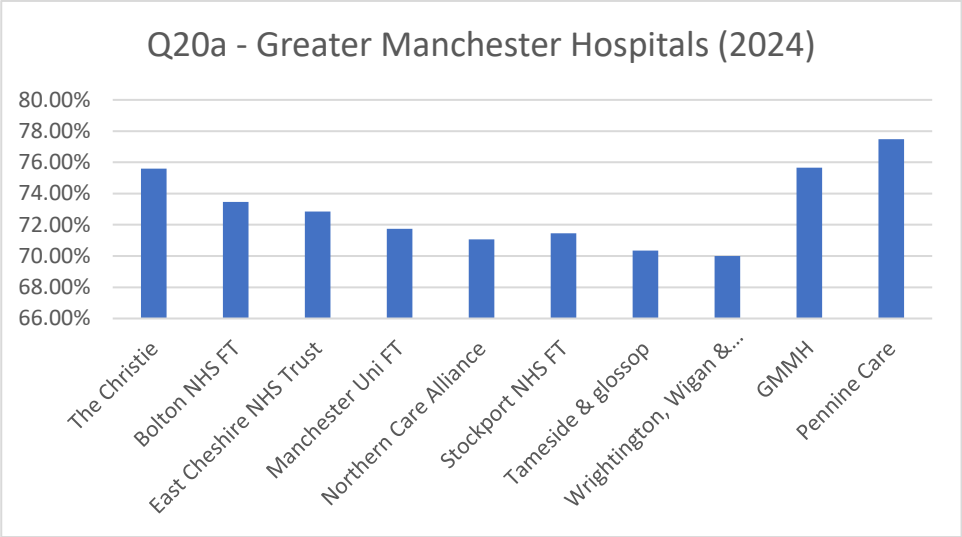
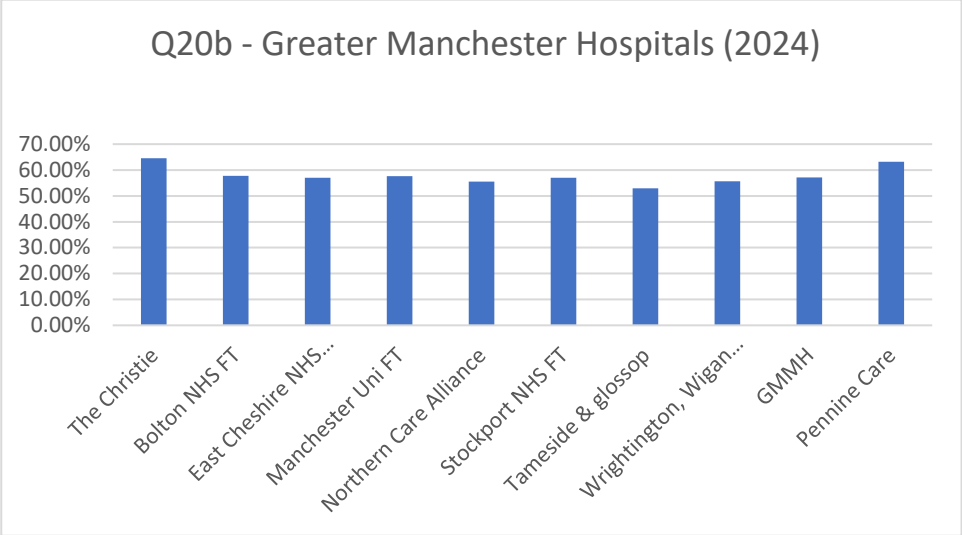


Staff survey benchmark of Greater Manchester Hospitals

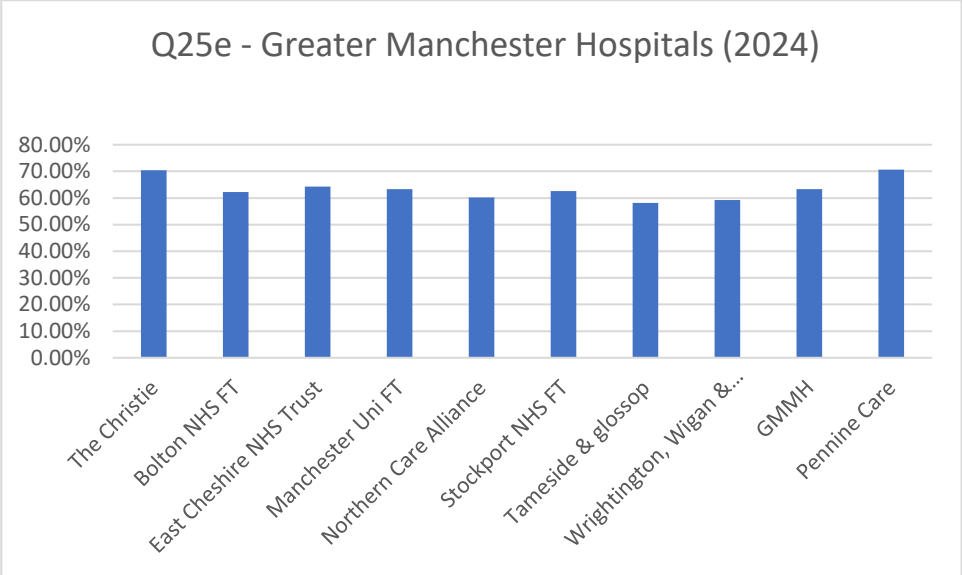
Q 20a - I would feel secure raising concerns about unsafe clinical practice



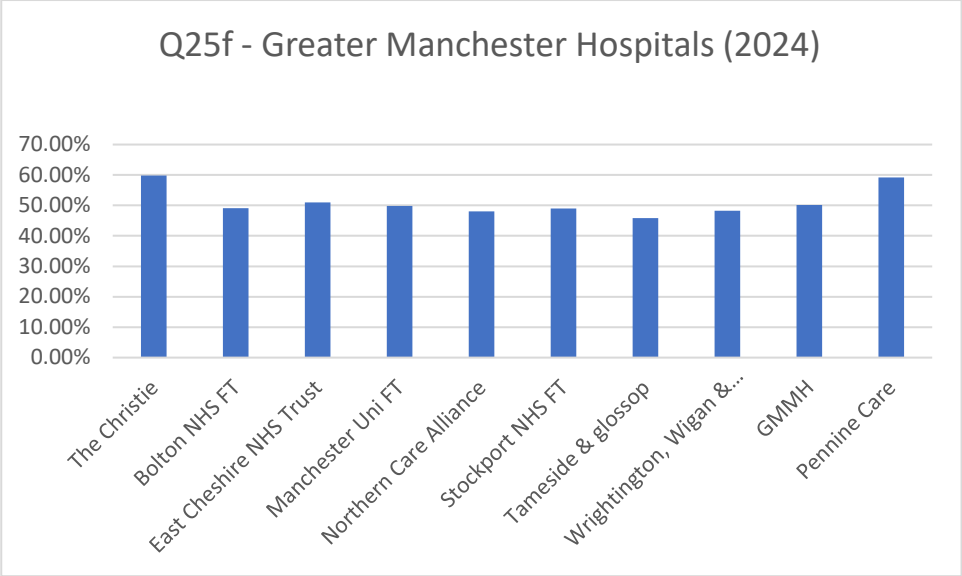
Q20b - I am confident that my organisation would address my concern.



Q25e - I feel safe to speak up about anything that concerns me in this organisation.



Q25f - If I spoke up about something that concerned me, I am confident my organisation would address my concern



Appendix 2 FTSU Service Survey- Staff comments

The person who said they didn't know if they had suffered disadvantageous or demeaning behaviour said:

- *I still have a long way to go for the issue to be either resolved or discussed within the department but feel that this is possible and hopefully will prevent further distress to colleagues in the future. My experience so far has been very positive and i could not fault the system.*

The comments are reproduced in their entirety so that complete transparency is maintained to provide assurance that the service is delivering the required standard of support for the staff and can be found in appendix 2.

- *Raising the concern in itself was a clear, defined process of which we were informed at each step. Because there were so many separate groups raising a concern and issues with availability of key stakeholders the process did take some time, which may have heightened the anxiety within the team during the process.*
- *An ideal opportunity to raise concerns anonymously but having reassurance that there is a formal process that is followed and actioned.*
- *Very long process due to the member of staff raising concerns regarding not being present in work so process went on a long time.*
- *It provided me an opportunity to express myself in a confident place.*
- *After communication got the right path to solve the problem. Thanks*
- *Helpful to talk through and just feel heard.*
- *I appreciated being consulted about how to take the concern forward. I expected the FTSP service to judge the concern on its merits and take action without my involvement and it did take a bit of consideration to realise that involving me was a good thing.*
- *I still have a long way to go for the issue to be either resolved or discussed within the department but feel that this is possible and hopefully will prevent further distress to colleagues in the future.*
- *I think the powers that be just keep getting away with no accountability. I felt compelled to drop my case because one of the victims involved was completely gaslit by higher director level staff, and she resigned. Another of the victims just wanted to move on and not think or stress herself further or risk her work position. Honestly, I don't think this FTSU session worked in benefit of any of the victims involved.*
- *Still awaiting outcome of the issue but the support made be feel that i could move forward and that it was a good thing to speak up.*

Suggestions for improvement of the FTSU service: -

- *Now the process has been completed I'm left a little unsure of whether there are any follow-up steps. A proforma of actions to be taken by the recipient and their manager and signed by each party might be useful for those involved in the speaking up process to see what has been agreed to going forward and provide reassurance concerns have been taken onboard.*
- *an online link/ QR code circulated/added to posters for those staff that don't always have the opportunity to consider reporting this. Also giving staff an insight of the process and that it takes very little of their time.*
- *Keep service as it is.*

- *Perhaps some examples of how the service has been used effectively would encourage staff to come forward.*
- *My experience so far has been very positive and i could not fault the system.*
- *Needs to have much better reassurances that jobs will not be put at risk, and that victims will not be ostracised by their teams. I do not trust that the FTSU offers enough protection from higher levels of staff. If directors want someone fired or passed up for promotions, they will.*

The Christie
NHS Foundation Trust

Agenda Item 18/25a(i)

Meeting of the Board of Directors
Thursday 24th April 2025

Subject / Title	Workforce Assurance Committee report – March 2025
Author(s)	Assistant Company Secretary Committee Chair
Presented by	Committee Chair
Summary / purpose of paper	This paper provides the Board with a summary of the items considered by the - Workforce Assurance Committee at their March meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions.
Background papers	Workforce Assurance Committee papers – 20th March 2025
Risk score	Board Assurance Framework (BAF) references noted within the report.
EDI impact / considerations	Ensure governance arrangements provide assurance and appropriate oversight of EDI requirements for the organisation.
Link to: ➢ Trust strategy ➢ Corporate objectives	• Trust's strategic direction • Divisional implementation plans • Our Strategy • Key stakeholder relationships
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	

The Christie
NHS Foundation Trust

Agenda item 18/25a(ii)

Meeting of the Board of Directors
Thursday 24th April 2025

Workforce Assurance Committee report – March 2025

1 Introduction

The Workforce Assurance Committee took place on 20th March 2025. The meeting was quorate. The following summary gives the Board information on the items that were considered by the committee at their meeting under the headings of Assure / Alert / Advise.

2 Workforce Assurance Committee agenda items

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

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

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

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

3 Recommendation

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

The Christie NHS Foundation Trust

Appendix 1

Agenda item	BAF ref	CQC regulation reference	Assurance rating given	Key points and associated actions (where applicable)
09/25a	3, 12	18	High	**Workforce dashboard and risk review**
Assure				• Sickness rate – downward trend (positive) from last month, YTD 4.68%. Split by division presented, highest area categories remain the same. Performance team figure appears high but a small team and relates to one person being absent. • PDRs – 88.49% compliance as at end of Feb, highest position in the last 12 months. Quality on feedback and learning has seen an improvement. No concerns. • Mandatory training – compliance being maintained at 93.94%, no concerns. • Staff turnover – downward trend (positive). • Establishment against paid FTE gap – end of Feb 336 FTE vacancies, closed by around 150 since August 2024, running at around 8.5% vacancy factor. • Recruitment activity – 263 FTE in pipeline and being actively recruited to, forecasted gap 188 FTE. • Staff survey snapshot – all areas up significantly, more detailed report to go to Board of Directors in March. • Risk in terms of workforce supply remains at a 9 and regularly reviewed at Workforce Committee. • Committee discussion noted pleasing to see the upward trend in all areas of staff survey considering the current NHS position and periods of industrial action in the last 12 months. The family and friends question has also seen a significant shift in improvement on staff recommending as a place of work, wellbeing also increased. Positive messages to be communicated to staff through work with the marketing team, looking at different methods. Survey results have also been sent to managers for dissemination within their teams and for discussions within divisions. Openness to staff welcomed.
Alert				• No alert points to raise.
Advise				• Next chapter league table – new data on new process for leavers. 103 left since process started, 44 people engaged in the process. Further development of data to come, no patterns at present.
Actions				• No actions noted.
09/25b	3	19	High	**Recruitment: Compliance with CQC Regulation 19 (BAF risk 3 deep dive)**
Assure				• Weekly process audit undertaken each week on a sample of files, file note made of any gaps or queries, and fed back through weekly team meetings. Internal risk review process undertaken where deemed necessary, informed decisions are made.

Alert				• Identification of any red flags in data discussed, process in place to identify and applicants removed from process where required.
Advise				• Standards and checks remain the same since last year. • Queries raised during audits helps identify learning for staff. • Cost effectiveness of using Trust ID discussed, process is better than undertaking ID checks manually, technology has surpassed this process. There has been a recent saving of around £40k for centralising the procurement through GM.
Actions				• No actions noted.
09/25c	3	N/A	Medium	**Role essential training assurance update**
Assure				• Clear plan in place to progress required actions.
Alert				• Managing data and central point of access, suppliers unable to deliver Trust requirements. Decision made to go back to ESR for central reporting as deemed best place in terms of risk management. Three cross cutting competencies in CLZ to be moved across to ESR, all other data was already being backed up in ESR. Creation of competency reporting for the 11 Core Clinical Skills. Data insight reports to be created to cover all aspects of role-specific training.
Advise				• Central framework in place for managers to use to capture local role specific clinical skills, this is now being populated by clinical areas. This is 40% complete. Managers to be accountable for frameworks for their areas, for nursing and AHPs the new professional workforce lead will provide support to ensure consistency.
Actions				• Further update on role essential training assurance to be presented to the committee in September 2025.
10/25a	3, 12	18, 19	High	**The Christie people and culture plan update**
Assure				• Recruitment and Selection Policy currently being reviewed, due to staff forum in April 2025. • The element focussed on exit interviews/your next chapter has changed to green based on implementation of new process.
Alert				• Recruitment attraction changed to amber due to possible issue with funding on working with partner on attraction work going forward.
Advise				• End of Year 2 milestone review to come to committee in June.
Actions				• No actions noted.

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

Assure	• EDI annual report - report has been amplified to include education activity compared to last year. Ensuring of regulatory requirements outlined to reflect compliance. The unity in diversity annual cultural celebration held in September 2024 was well attended by members and governors. **Action** noted for spiritual care and multi faith chaplaincy to be made more explicit for future reports. • Compliance with safe staffing report - processes are robust, meetings and huddles to review safe staffing take place. Evidence-based establishment review undertaken using the Safer Nursing Care Tool (SNCT) data from the 30-day period in January 2025. A benchmark of RN: HCA ratio of 65:35 has been utilised, above the standard required. Recommendations and key actions outlined. • FPPT compliance report - all required elements of the FPPT framework have been completed for all Board members as confirmed in the report's compliance statement. **Actions** agreed were for (1) compliance report to be presented to the March Public Board of Directors meeting, (2) Chair sign off for fit and proper governance forms for 2024/25 to be completed by the end of March 2025 and recorded in ESR and (3) Annual NHS FPPT submission reporting template to completed and returned to NHSE to reflect compliance. • Employee relations report - all formal cases reviewed, 23 cases one of which involved a patient safety concern – treated appropriately and reported through Datix. A further patient safety case was reported anonymously, followed process but unable to provide feedback to reporter due to anonymity. Process flow discussed confirmed process working effectively to ensure cases are managed appropriately. • WAC annual report – approved by the committee. **Action** for report to be presented to joint assurance committee in June.
Alert	• No alert points to raise.
Advise	• BAF - risk appetite, additional quarterly coverage and target date columns added. Risk 3 has been updated to include confirmation of the agreement to recruit to the onboarding post on a permanent basis. • Committee effectiveness review report - increase in committee effectiveness % from last year noted. Committee Chair and Exec Lead to review suggested improvements. Introduction of an Education representative at all future meetings noted.

The Christie
NHS Foundation Trust

Agenda Item 18/25a(ii)

Meeting of the Board of Directors
Thursday 24th April 2025

Subject / Title	Quality Assurance Committee report – March 2025
Author(s)	Assistant Company Secretary Committee Chair
Presented by	Committee Chair
Summary / purpose of paper	This paper provides the Board with a summary of the items considered by the Quality Assurance Committee at their March meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions.
Background papers	Quality Assurance Committee papers – March 2025
Risk score	Board Assurance Framework (BAF) references noted within the report.
EDI impact / considerations	Ensure governance arrangements provide assurance and appropriate oversight of EDI requirements for the organisation.
Link to: ➢ Trust strategy ➢ Corporate objectives	• Trust's strategic direction • Divisional implementation plans • Our Strategy • Key stakeholder relationships
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	

The Christie
NHS Foundation Trust

Agenda item 18/25a(ii)

Meeting of the Board of Directors
Thursday 24th April 2025

Quality Assurance Committee report – March 2025

1 Introduction

The Quality Assurance Committee took place on 20th March. The meeting was quorate. The following summary gives the Board information on the items that were considered by the committee at their meeting under the headings of Assure / Alert / Advise.

2 Quality Assurance Committee agenda items

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

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

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

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

3 Recommendation

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

The Christie NHS Foundation Trust

Appendix 1

Agenda item	BAF ref	CQC regulation reference	Assurance rating given	Key points and associated actions (where applicable)
09/25a	13	9	Low	**Patient demographics data quality update (Deep Dive)**
Assure				• During 2023 – mapping exercise completed looking at how data is captured, dashboard developed to monitor completeness and access to the data (i.e. through GPs). Patient registration form (paper based) reviewed and updated including ethnicity data. Work also completed to update CareFlow to match the form as much as possible. • During 2024 - all letter templates reviewed, patient engagement enacted through a focus group, engagement with all outpatient reception managers, awareness sessions with staff, and launch of digital registration form. • Ongoing plan outlined in terms of short term actions (by June 2025), medium term actions (by October 2025) and long term actions (by March 2026). Key action highlighted as the need for tackling where patients are not receiving letters/forms; looking to seek approval for sending patients text messages with appointment and link to QR code for form completion, to go to Caldicott for approval. • Working with areas where compliance is particularly low.
Alert				• Low level of assurance assigned given that we do not know the level of missing data and the effect this has on characteristics. Understanding of the problem is a lot clearer with appropriate actions in place.
Advise				• Did not see as much improvement as would have liked from work undertaken in 2024; issues identified with forms being sent out, forms being sent but not returned, last minute appointments resulting in patients not receiving forms – all led to more actions through the improvement group. • Audit completed in year which identified lower compliance particularly in specific areas (haematology, protons, peripheral sites), no letter or form sent for last minute appointments, possible issue with admin staff training on CareFlow. • Expectation that text messaging for patients regarding appointments and link to QR code for form completion is to go live in 3 months but that there will then be a lag in the data.
Actions				• Update on patient demographics data quality to come to the January 2026 meeting (unless requirement identified to escalate earlier based on risk).

09/25b	2	12,20	High	**Patient Safety Quarterly Report October - December 2024**
Assure				• Scorecard indicators – 97% learning from patient safety events (LFPSE) low or no harm. Local management of under 10 days target now at around 50% compliance and heading in the right direction. Duty to candour – compliant on both parts 1 and 2. • Based on the report, response to questions and committee discussion on the progress made with seeing the appropriate response and overall assurance coming through on PSIRF, a move to a high level of assurance agreed.
Alert				• Incidents overdue in locally managed has seen an improvement journey since April 2024; >2800 legacy incidents have been managed to final approval across DWEB and DCIQ whilst simultaneously reducing the overall number of open incidents within any stage by more than half since August 2024. Insight from incident management, risk, complaints and staff / patient feedback has prompted the establishment of an additional Patient Safety Priority – care of the dying patient, this will be added to the Trust PSIRP and the group chaired by the Deputy Chief Nurse. • A deep dive on incident management will be undertaken in June to help to inform the workstreams, overall patient safety workstream with other sub workstreams sitting beneath.
Advise				• Q2 report update from previous query raised by the committee; 6 deaths reported in incidents, 5 cardiac arrests as clinical events and one SI undertaken into the death of a patient who did not receive prescribed GCSF as per protocol. • 15 incidents reported in quarter to the national reporting database triggered a learning response. This reduction in incident investigations enables resource to be focused on improvement work.
Actions				• Incident management deep dive outcome to be presented to the committee in September 2025.
09/25c	1	9, 10, 12, 16	Medium	**Patient Experience Quarterly Report October - December 2024**
Assure				• Normal level of complaints seen in the quarter. No breaches in terms of regulatory timescales. Work on patient experience and engagement plan continues. Friends and Family Test (FFT) responses remain steady >96% in the quarter.
Alert				• No alerts to raise.

Advise	• 1 new PHSO referral and 1 closed (not upheld) in this quarter. • Discussion on lessons learnt section in report noted as mainly actions referring to 'reminding staff' to do things and unsure as to the level of assurance can be taken from this. Divisional responsibility for the actions, which are fed into DCIQ. DCIQ has a better way of joined up working with incidents and claims. Going to be utilising this data to better coordinate actions and education. Complaints team also working with the patient safety team which will help further develop this and draw from experience to put into the improvement workstreams. Communication is a key theme, need to triangulate within the teams to work together and the new DCIQ gives the opportunity to do this.
Actions	• No actions noted.

09/25d	1	9, 10, 12, 16	High	**Clinical Effectiveness Quarterly Report October - December 2024**
Assure				• This quarter has seen an above average number of projects completed and the number of overdue projects halved. • Taking action to escalate outstanding core projects.
Alert				• Concern on overall number of projects, higher than potentially have the capacity to deliver.
Advise				• Looking to do a communication piece on informing that low priority projects will not be followed up, this will help to see if prioritisation is working correctly.
Actions				• No actions noted.

09/25e	N/A	N/A	High	**Health and Safety Quarterly Report October - December 2024**
Assure				• Staff incidents – positive increase of proportion of no harm v harm incidents, no incidents above minor report in the quarter. • Moving and handling incidents – incident report rate remains low. • Violence prevention and reduction incidents - 4 reported incidents of physical abuse to staff and 2 verbal abuse towards staff in quarter, verbal abuse remains low. Reviewing policy in line with NHSE Violence Prevention Reduction standard. • Accidents involving patients or members of the public – improvement in number of reported patient accidents. Seen a continued deterioration in the trend of accidents involving members of the public (although remain low), themed review to take place and look at what the data entails to understand the increase. • Confirmed through discussion that the key risks noted within the report are all recorded on the operational risk register with an action plan in place.
Alert				• No alerts to raise.
Advise				• RIDDOR reportable incidents – error in reporting and 2 should not have been reported. To work with staff on what is RIDDOR reportable and have regular updates with Associate Director of Quality Governance.
Actions				• No actions noted.

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

Alert	• No further alerts to raise.
Assure	• Board Assurance Framework - Risk score for risk 2 reduced from 12 to 9 due to the progress made with PSIRF implementation, completion of PSIRF training and improved timeframe for incident management. Draft report for MIAA audit of PSIRF processes confirms substantial assurance. • Report from the Risk and Quality Governance Committee (RQGC) - Incidents managed within target timeframe has significantly improved since 12 months ago. Evacuation plans risk discussed and confirmed will be looking to reduce the risk score. • Consent practice audit presented, key areas for improvement and actions outlined. • Quality Assurance Committee – draft annual report reviewed by the committee. **Action** for report to be presented to joint assurance committee in June.
Advise	• Report from the Risk and Quality Governance Committee (RQGC) – new operational risk based on aseptic unit with risk score of 15 noted and action plan in place. Risk management policy – task and finish group in place to migrate risks to new system. New risk oversight and reporting process will be operational from April and will include descriptions to identify changes to risks. Procedural documents – a large amount of ratification work completed during March, expected to be no outstanding policies by the end of March. **Action** Report on aseptic unit risk and associated action plan to come to the committee in June. • Annual clinical audit plan presented and supported. • Committee effectiveness review outcome report – positives noted and areas for improvement discussed.

The Christie NHS Foundation Trust

Agenda Item 18/25b

Meeting of the Board of Directors

Thursday 24th April 2025

Subject / Title	Board Assurance Framework 2024/25
Author(s)	Louise Westcott, Company Secretary
Presented by	Roger Spencer, CEO
Summary / purpose of paper	This paper provides the Board with the Board Assurance Framework 2024/25. The risks outlined impact on achievement of the corporate objectives and the relevant objectives are indicated for each risk. The paper includes a snapshot of the risks ordered by current risk score and a report with the detail relating to each risk. The risks are reviewed alongside the risks on the Trust risk register and the top operational risks are also listed.
Updates to note in month	Changes to lead executive for risks as follows: • Risk 8 now falls under Director of Strategy • Risk 11 now falls under Executive Medical Director The **Q4 risk score has been added** to the BAF to show progress of scoring over the year so far. Risk 14 – Legal & Statutory compliance – following Board discussion at the March meeting this risk has been amended to specifically refer to DHSC/NHSE and CQC. Risk scores have been checked against operational risks.
Recommendations (assure / **alert** / advise)	The Board of Directors are asked to; • note the Board Assurance Framework (BAF) 2024/25 and updates made. • consider if there are any further risks that need to be added to the BAF. • reflect the review of the risks in the BAF for the next meeting. • Note the operational risks scoring 15 and above
Background papers	Board assurance framework 2023/24. Corporate objectives 2024/25, operational plan and revenue and capital plan 2024/25. MIAA Assurance Framework review 2024/25.
Risk score	N/A
Link to: ➢ Trust strategy ➢ Corporate objectives	• Trust's strategic direction • Divisional implementation plans • Our Strategy • Key stakeholder relationships
Acronyms or abbreviations in the attached paper	BAF Board assurance framework MDT multi-disciplinary team NICE National Institute for Health & Care Excellence PSIRF Patient Safety Incident Response Framework IP(QF)R Integrated Performance Quality & Finance Report GM Greater Manchester

BOARD ASSURANCE FRAMEWORK 2024/25 OVERVIEW OF RISKS

RISK No.	Risk Title	Risk Description	Responsible Committee	Risk Appetite	Inherant Risk Score	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	Q1 25/26	Q2 25/26	Target Risk Score	Current Risk Score	Target date
RISK 14	**Legal and statutory compliance**	If we do not maintain an awareness of and respond to changing statutory and legal requirements (DHSC/NHSE/CQC) there is a risk that we will fail to comply leading to being sanctioned for being in regulatory or statutory breach.	Audit Committee	Averse	20	16	16	12	12			4	12	Review Q1 25/26
RISK 7	**Ineffective Greater Manchester system-wide cancer pathways**	If diagnostic, MDT and referral processes at local hospitals across the GM system are not efficient there is a risk that we receive patients on 62-day pathways late leading to them not being treated within 62 days.	Quality Assurance Committee	Cautious	25	16	12	12	12			8	12	Reviewed Q3 24/25
RISK 11	**Cyber attack**	If we or our suppliers are subjected to a cyber-attack there is a risk of loss of data and operational disruption leading to patient care being delayed or cancelled	Audit Committee	Averse	25	12	12	12	12			4	12	Reviewed Q4 24/25
RISK 4	**Changes in quality regulation**	If the CQC or other regulatory body changes their approach to regulation there is a risk that we will not be able to demonstrate compliance leading to us being assessed as not meeting the fundamental care standards.	Board of Directors	Averse	15	12	12	12	12			4	12	Review Q1 25/26
RISK 16	**Supply chain**	If we can't maintain supply of essential products for the treatment and care of our patients there is a risk that their treatment and care will be adversly impacted or delayed	Audit Committee	Averse	16	N/A	N/A	12	12			4	12	Review Q2 25/26
RISK 2	**Learning from patient safety incidents**	If we are unable to fully implement the new Patient Safety Incident Response Framework (PSIRF) there is a risk that we will miss opportunities to learn lessons and improve patient safety leading to preventable patient harm.	Quality Assurance Committee	Averse	15	6	15	12	9			4	9	Reviewed Q4 24/25
RISK 3	**Recruitment and retention of skilled staff**	If we are unable to maintain current levels of skilled staff there is a risk that they will not have the time or expertise required for excellent care and communication leading to a reduction in the standards of patient safety and experience.	Workforce Assurance Committee	Averse	20	9	9	9	9			4	9	Reviewed Q4 24/25
RISK 6	**Insufficient contractual support for networked cancer care provision**	If the GM system does not continue to support local provision of cancer care with contractual and funding flow changes there is a risk that we are unable to devolve more systemic therapy, clinical trials and radiotherapy treatments to local communities leading to persistence or increases in inequalities in provision to economically deprived and ethnically diverse communities.	Quality Assurance Committee	Cautious	12	9	9	9	9			6	9	Review Q1 25/26
RISK 8	**Extreme weather events**	If there is an extreme weather event (heat wave, freeze, floods etc) due to climate change there is a risk of business disruption (increased staff absence, increased patient non-attendance and equipment malfunction) leading to delayed or cancelled care.	Audit Committee	Averse	16	8	8	8	8			4	8	Reviewed Q3 24/25
RISK 12	**Ineffective response to cultural audit**	If our response to the cultural audit is insufficient there is a risk that a negative culture will persist in some specific parts of our organisation leading to an increase in the number of staff reporting a poor experience.	Workforce Assurance Committee	Averse	16	8	8	8	8			4	8	Review Q3 & Q4 24/25
RISK 13	**Insufficient data on patient protected characteristics**	If we are unable to capture data on the protected characteristics of our patients there is a risk we will be unable to assess any inequalities in access, experience or outcomes leading to lack of focus in addressing health inequalities	Quality Assurance Committee	Cautious	10	8	8	8	8			4	8	Within tolerance
RISK 1	**New technologies and increased standards of care**	If there are changes to NICE guidance or other advances in practice that we have not anticipated (diagnostic, therapeutic, care) there is a risk that there will be a delay in their introduction leading to a delay in patients obtaining the benefits of new treatments.	Quality Assurance Committee	Cautious	20	9	9	6	6			4	6	Within tolerance
RISK 15	**Patient confidence in services**	There is a risk that adverse events will attract media coverage resulting in a decrease in public confidence in our services	Board of Directors	Averse	12	9	9	6	6			4	6	Reviewed Q4 24/25
RISK 10	**Financial balance**	If we do not achieve the planned activity levels and our target efficiency savings there is a risk that we won't achieve financial balance leading to us having to repay the difference to our agreed plan in the following year	Board of Directors	Averse	25	20	12	12	5			5	5	Reviewed Q4 24/25
RISK 5	**Impact of the system capital allocation framework**	If the capital planning and allocation system does not enable full use of our charitable and commercial reserves there is a risk that we may not be able to fund our capital and asset replacement programmes leading to delays, cancellations or reprioritising of planned projects and equipment not being replaced when needed.	Board of Directors	Eager	25	16	16	12	4			4	4	Reviewed Q4 24/25 / Within tolerance

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

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

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

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

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

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	3	5	15	2	3	6	3	5	15	3	4	12	3	3	9			0

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

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

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

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

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

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

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

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

Scoring	Inherant Risk			Q1			Q2			Q3			Q4			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	5	**25**	4	4	**16**	4	4	**16**	4	3	**12**	1	4	**4**			**0**

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

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

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

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

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

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

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

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
Actions	What we have in place to prevent the risk materialising (reduce likelihood): Sustainable Development Management Plan (SDMP) - with aims to reduce system wide emissions within direct NHS control (NHS Carbon Footprint) by 80% by 2028-2032 What we have in place to reduce the impact of the risk if it materialises (reduce impact): Business Continuity Plan (BCP) - sections on extreme weather conditions	In development - Climate Change Adaptation Plan (CCAP) - adapt normal business processes to changed environment	Level 1 – Data and management reports • SDMP compliance • BCP compliance and effectiveness Level 2 – Management team and committee scrutiny • Emergency Planning & Resilience Committee • Quarterly Net Zero and Climate Adaptation Committee (NZACAC) advises Executive Director • Annual SDMP report to MB and BoD (Assurance Scrutiny by Quality Assurance Committee) • Statutory disclosures in Trust Annual Report Level 3 – External assurances • Internal audit of compliance with NHS requirements • NHSE review of plans and progress - agreement of current compliance (as in self-assessment)	Not at 100% compliance for self-assessment / external assessment	•Developing methodology to assess carbon footprint in collaboration with other Trusts •Developing a CC •Annual Report - Check what audit scrutiny this receives	Reviewed Q3 24/25

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
	Engagement in national updates and regulatory briefings. Designated leads for statutory requirements across the Trust reporting into committee structure. Policies and procedures in place e.g. conflicts of interest, SFI's, Document ratification processes. Membership of NHS Providers to recieve most up to date advice and guidance. Exec Team engagement in national briefings. Close working with regulators, GM ICS / ICB and NHSE. Attendance at system level and national meetings. Leads identified internally for each statutatory requirement e.g. health & safety / IRMER / CQC etc	Uncertainty around what / when. External political factors	Level 1 – Data and management reports • Regular reports to Executive Team□ • Monthly IPQFR□ Level 2 – Management team and committee scrutiny • Board self-assessments April 2024□ • Board reporting on regulatory changes□ • Work of the 3 assurance committees Level 3 – External assurances • CQC Inspection Reports (IR(M)ER)□ • SOF Rating 2 • MIAA role specific training audit (CQC Reg 19) - Limited assurance Oct 24□ • MIAA data quality audit Oct 24 - moderate assurance	SOF rating - currently 2	Take MIAA checklists / advisory notes to appropriate assurance committees Agreed exit criteria from SOF 2 to SOF 1 agreed and being monitored for compliance to specified timeframes.	Review Q1 25/26

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

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

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

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

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

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for completion
Actions	Pharmacy - TCP procurement team work closely with regional & national drug procurement teams. Mutual aid MOU in place in NW. Management with clinicians to avoid imapct on care Medical Physics - close relationship with national supply chains and management of demand based on availability of radioactive materials. BCP in place for Radiopharmacy to maintain supplies and regular discussions with supplier of FDG for the PETCT scanner. Procurement - policies & processes in place for management of supplies incl escalations & triggers / communication.	National / international shortages / supply issues	Level 1 – Data and management reports • Regular reports to relevant committee • Monitoring & review by management team Level 2 – Management team and committee scrutiny • Reports to The Christie Pharmacy Company Board and Audit Committee, via Trust Drug & Therapeutics Committee • Esclations from Risk & Quality Governance to Senior Management Committee Level 3 – External assurances • MIAA audits commissioned to review specific issues where appropriate	None identified	Review of alerts	Review Q2 25/26

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

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NHS Foundation Trust

Operational Risks

Risk ID	Risk	Risk Register	Type	Subtype	Status	Risk owner	Date opened	Initial rating	Current likelihood	Current consequence	Current rating	Movement	Trend	Next Review Date
108	Breach of trust compliance target 28- day Faster Diagnosis Standard (FDS) for patients with a possible haematology malignancy	Haematology Teenage and Young Adults		Patient Experience Risk	Active	Chloe Read	12/03/2025	12	5	3	15	↑		12/05/2025
357	There is a risk of a patient inadvertently receiving an unintended blood component or product			Patient Safety / Outcomes Risk	Active	Sharon Jackson	16/06/2023	10	3	5	15	↑		18/04/2025
361	There is a risk to the safe and effective delivery of the Trust's Aseptic Service	Pharmacy		Patient Safety / Outcomes Risk	Active	Anna Mcnichol... Dawn Gillibrand	17/02/2025	15	3	5	15	↔		30/04/2025
389	Not Identifying and Delivering 25/26 recurrent VIP programme impacting on financial sustainability and ability to treat patients			Financial Management / Waste Reduction Risk	Active	Claire Mcpeake	30/10/2024	16	4	4	16	↔		01/04/2025

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NHS Foundation Trust

Agenda item 18/25c

Meeting of the Board of Directors
Thursday 24th April 2025

Subject / Title	Register of matters approved by the board – 1st April 2024 to 31st March 2025
Author(s)	Company secretary
Presented by	Chief Executive
Summary / purpose of paper	For the board of directors to note the matters approved by the board from 1st April 2024 to 31st March 2025
Recommendation(s)	For the board to note
Background Papers	Complete register from April 2007 (available to directors on request from the company secretary)
Risk Score	n/a
Link to: ➢ Trust's Strategic Direction ➢ Corporate Objectives	Corporate objective 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.	GDPR General Date Protection Requirement GM Greater Manchester CQC care quality commission

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Register of matters approved by the board of directors in public– 1st April 2024 to 31st March 2025

Item	Date of meeting	Agenda item	Subject and minute	Remarks/ Follow up
269	25.04.2024	16/24a	Corporate and Annual Objectives 2024/25 & risk appetite statement	Approved
270	25.04.2024	16/24b	Modern Slavery statement	Approved
271	25.04.2024	16/24e	NHS Provider License conditions: self-certification declarations	Approved
272	27.06.2024	21/24a	Green plan	Approved
273	27.06.2024	21/24b	Annual report, financial statements, and quality accounts (incl Annual governance statement / Statement on code of governance)	Approved
274	31.10.2024	33/24c	Emergency Preparedness & Resilience Response statement of compliance	Approved
275	28.11.2024	37/24b	Inclusive Culture Strategy	Approved
276	27.03.2025	11/25c	Annual reporting cycle	Approved
277	27.03.2025	11/25d	Fit & Proper Persons Test (FPPT) compliance report	Approved

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Register of matters approved by the board of directors in public– 1st April 2024 to 31st March 2025

Item	Date of meeting	Agenda item	Subject and minute	Remarks/ Follow up
269	25.04.2024	16/24a	Corporate and Annual Objectives 2024/25 & risk appetite statement	Approved
270	25.04.2024	16/24b	Modern Slavery statement	Approved
271	25.04.2024	16/24e	NHS Provider License conditions: self-certification declarations	Approved
272	27.06.2024	21/24a	Green plan	Approved
273	27.06.2024	21/24b	Annual report, financial statements, and quality accounts (incl Annual governance statement / Statement on code of governance)	Approved
274	31.10.2024	33/24c	Emergency Preparedness & Resilience Response statement of compliance	Approved
275	28.11.2024	37/24b	Inclusive Culture Strategy	Approved
276	27.03.2025	11/25c	Annual reporting cycle	Approved
277	27.03.2025	11/25d	Fit & Proper Persons Test (FPPT) compliance report	Approved

The Christie
NHS Foundation Trust

Agenda item 18/25d

Meeting of the Board of Directors
Thursday 24th April 2025

Subject / Title	NHS Improvement self-certification declarations
Author(s)	Company Secretary
Presented by	Chief Executive
Summary / purpose of paper	NHS foundations trusts are required to undertake the following self-certification declarations: • G6 (systems for compliance with licence conditions) & CoS7 (continuity of service – availability of resources) • FT4 (corporate governance statement) • Training of governors
Recommendation(s)	To approve the declarations
Background papers	NHS Improvement's annual plan review
Risk score	BAF risks under corporate objective 6
Link to: ➢ Trust strategy ➢ Corporate objectives	Strategic objective 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.	CoS continuity of service

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates | **2024/25** | Please complete the explanatory information in cell E36

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed	Please fill details in cell E22

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	Confirmed	Please fill details in cell E22

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.	Confirmed	Please fill details in cell E22

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

We have achieved a Single Oversight Framework rating of 2 for finance and use of resources (reduced from 1 due to CQC rating - action plan now complete) and achieved our NHSE control total

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Roger Spencer	**Name**	Edward Astle
Capacity	Chief Executive	**Capacity**	Chair
Date	24 April 2025	**Date**	24 April 2025

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

N/A

Worksheet "FT4 declaration" **Financial Year to which self-certification relates** **2024/25**

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	No material risks identified
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS England from time to time	Confirmed	No material risks identified
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	No material risks identified. There are a wide range of controls in place including the Scheme of Delegation and Standing Financial Instructions. There are clear terms of reference for all committees and we undertake an annual committee effectiveness review. All board members are subject to an annual appraisal (the NEDs and the CEO have appraisals led by the chairman, the chairman has an appraisal led by the senior independent NED and the executive directors have appraisals led by the chief executive). There is a clear organisational structure with clear reporting lines. MIAA have conducted their internal audits according to the agreed plan and recommendations agreed and being implemented. These have all been reviewed through the committee structure. In year we asked Good Governance Improvement to undertake a review of our governance and assurance arrangements and actions have been agreed and are being implemented to improve existing arrangements.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	There are a range of systems and/or processes in place which evidence the Trust's on-going compliance. The trust holds 8 board of directors meetings per year and receives a monthly Integrated Performance Report structured to reflect performance against key indicators. The trust also holds monthly meetings of one of its assurance committees (Quality Assurance, Workforce Assurance and Audit) in line with the trust's constitution. The board receives and approves the Annual Plan and receives regular updates from the Executive Director of Finance. The Board Assurance Framework is discussed at each meeting of the board and the assurance committees and has received a green rating from our internal auditors. Further assurance is gained via the external audit opinion, Internal Audit annual plan (approved by the Audit Committee) and the risk & quality governance committee meetings. The clinical divisions feed into monthly management board meetings, attended by senior clinicians and managers, which in turn feeds into the board of directors. In regard to the Single Oversight Framework our finance and use of resources score has again been rated as 2, the reduction from 1 relates to the CQC rating of Good. We have had confirmation that all actions from the must do's in the CQC report are complete. The overall Head of Internal Audit opinion for the period 1st April 2024 to 31st March 2025 provides Substantial Assurance, that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate	Confirmed	No material risks identified. There are a range of systems and/or processes in place which evidence the Trust's on-going complaince with this requirement, including the composition of the board of directors . The quality assurance committee reviews quality of care including approval of the annual clinical audit plan, learning from deaths, reports on patient safety and experience, health & safety and updates from the risk & quality governance committee. We have been rated as Good by the health regulator. Single Oversight Framework - we have been rated as 2 for all of the five themes of:• Quality of care• Finance and use of resources• Operational performance• Strategic change• Leadership and improvement capability (well-led). Board's direct engagement with patients through visits and patient/clinician presentations at Board meetings.
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	There are a range of controls in place to mitigate staffing risks. These include ward staffing reviews, e-rostering for all ward staff and a centralised bank for nursing posts. The board of directors receives a monthly safe staffing update via the integrated performance report. All Board members have been assessed and declared as Fit & Proper under the CQC Regulation 5. Board skill mix matrix.

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature  **Signature** 

Name Roger Spencer **Name** Edward Astle

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

Worksheet "Training of governors"

Financial Year to which self-certification relates 2024/25 Please Respond

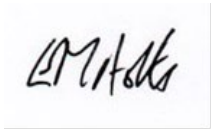
Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed	OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Roger Spencer	**Name**	Edward Astle
Capacity	Chief Executive Officer	**Capacity**	Chairman
Date	24 April 2025	**Date**	24 April 2025

The Christie
NHS Foundation Trust

Agenda item 18/25e

Meeting of the Board of Directors

Thursday 24th April 2025

Subject / Title	Trust nomination of Charity Trustee
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 Joe Rafferty as a Foundation Trust trustee from 1st May 2025
Recommendation(s)	The Board is asked to approve the appointment of Joe Rafferty as a Foundation Trust trustee from 1st May 2025
Background papers	Charity Articles of Association
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.	FT Foundation Trust AoA Articles of Association

The Christie
NHS Foundation Trust

Agenda item 18/25e

Meeting of the Board of Directors

Thursday 24th April 2025

Trust nomination of Charity Trustee

1. Introduction

This paper asks the Board of Directors to consider a recommendation for a replacement Foundation Trust trustee to replace Edward Astle, when he leaves the Trust on 30th April 2025.

2. 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 Foundation Trust 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 Foundation Trust Trustees. It is noted that the Foundation Trust 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 Foundation Trust Board is required to approve these 2 Trustee nominations. The term for the nominated Foundation Trust Trustees in the AoA is 3 years followed by two further terms of three years.

Edward Astle was nominated by the Board as a Foundation Trust Trustee from 1st October 2023 when he joined the Trust as Chair. The Board is now therefore asked to consider a recommendation from the Executive for a replacement Foundation Trust Trustee.

Joe Rafferty has been appointed as Trust Chair from 1st May 2025.

3. Recommendation

The Board of Directors are asked to approve the recommendation of the Executive Directors to appoint Joe Rafferty, as a Foundation Trust trustee of the Christie Charity from 1st May 2025.

The Christie NHS Foundation Trust

EXECUTIVE SUMMARY

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

Safety

- 2 incidents in March were identified as meeting the criteria of a notifiable safety incident and so required statutory duty of candour.
- There are 4 Trust level risks scored at 15+. Details of these can be found on slide 8.
- Safer staffing numbers have met the required acuity levels to ensure appropriate levels of safety and care for our patients. Indicative staffing, in line with nursing establishments, is set to maintain a 1:7 nurse to patient ratio. On occasion this has been extended to 1:8 which is in line with recommended national staffing ratios. While we have seen an increase in patient safety incidents, following thematic review, these were not related to nurse staffing ratios.
- There were 3 cases of C-Difficile, 6 cases of E-Coli, 2 cases of Klebsiella and 4 cases of MSSA reported in March that were deemed attributable to the Trust. No lapses in care were identified.

Performance

- In March the combined 62-day performance subject to validation was at 74.3% which is above the standard of 70%. The combined 31-day performance was 99.2% which is above the standard of 96%. The internal 24-day performance was below our internal standard at 71.5%. All 62 and 24-day breaches are reviewed to ensure any delays are understood and plans can be implemented to mitigate any future delays. The Trust's RTT 18-week performance is well above standard at 97.7%. The Trust achieved the 75% faster diagnosis standard in March with a compliance score of 82.6%.
- There were no patients waiting over 52 weeks at the end of March.
- Referral numbers in March increased from February. Referrals cumulatively for 24/25 were well above the 23/24 average.

HR

- Staff absence decreased from February to a position of 3.99% against a target of 3.4%.
- PDR performance decreased slightly from February's position. Mandatory training remained at the same level and remains well above the set standard.

Finance

- The Trust is reporting a surplus at the end of M12 of (£15.0m) against a M12 YTD plan of (£7.0m), which gives a month 12 variance of (£8.0m) better than plan.
- The forecast for the Trust for M12 was £15m surplus position which has been met.
- Capital spend for 2024-25 was £17.6m, this was (£0.8m) below the revised plan submitted to NHSE in June 24.
- The Trust has incurred £17.6m on capital schemes in 2024-25, primarily on the TIF ward refurbishment as well as ongoing digital projects and small replacement assets.

SUMMARY DASHBOARD

NHS
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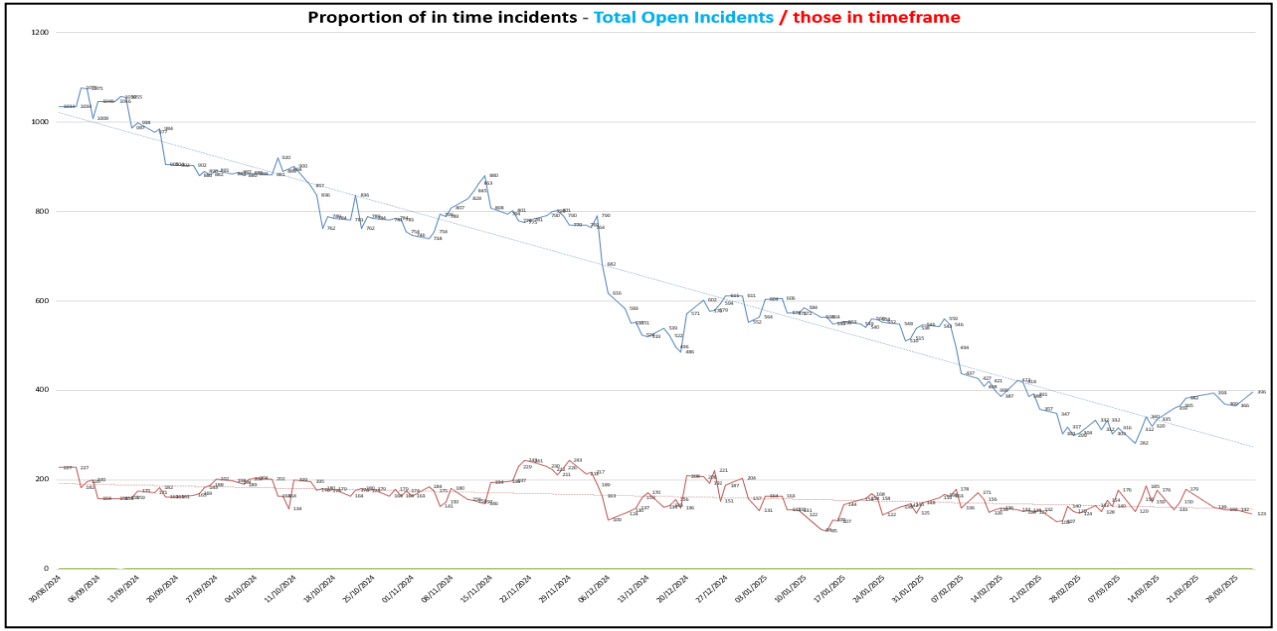
NHS Foundation Trust

Indicator	Threshold / Standard 24/25	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	YTD
Patient Safety Incident Investigations	-	1	2	1	0	0	3	1	0	2	1	4	2	17
Never Events	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Radiation Incidents Reported (IRMER Reportable)	0	1	3	1	3	1	2	2	3	1	3	2	0	22
Radiation Incidents Reported (IRMER Reportable - Grade 2 or above)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sepsis - timely treatment with IV antibiotics (established inpatients)	90%	90.0%	87.0%	96.4%	94.4%	92.4%	91.4%	93.0%	94.2%	95.8%	93.8%	95.2%	97.0%	-
Sepsis - screening (presenting as an emergency)	90%	94.9%	100.0%	100.0%	97.5%	96.9%	98.1%	97.4%	97.4%	99.2%	99.2%	98.2%	97.2%	-
Number of Trust-Wide Risks Grade 15 or Above	-	6	6	9	13	8	8	8	6	4	3	4	4	-
28 Day Faster Diagnosis Standard	75%	81.3%	75.0%	100.0%	91.7%	86.4%	90.0%	81.3%	89.5%	88.9%	83.3%	87.5%	82.6%	-
62 Day Compliance	70%	71.2%	72.3%	73.1%	76.7%	79.9%	75.1%	81.3%	76.8%	75.8%	71.2%	73.3%	74.3%	-
24 Day Compliance	85%	71.5%	72.5%	74.9%	78.2%	78.8%	73.1%	77.5%	75.0%	76.6%	71.1%	72.7%	71.5%	-
31 Day Compliance	96%	99.2%	99.6%	99.3%	99.2%	99.3%	98.8%	98.6%	98.0%	99.1%	98.8%	98.8%	99.2%	-
18 Weeks Compliance - Incomplete Pathways	92%	97.1%	97.6%	97.1%	97.2%	97.1%	96.8%	95.9%	97.4%	97.6%	97.4%	98.1%	97.7%	-
Patients waiting >52 Weeks	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Patients waiting >62 days at end of month (62 Day Classic)	80	129	119	100	95	93	101	108	105	101	112	110	108	-
Patients waiting >104 days at end of month (All 62 Day Targets)	-	47	51	42	49	49	42	43	50	57	61	61	61	-
Length Of Stay (Elective & Non-Elective Inpatients)	-	7.81	6.39	6.39	7.16	6.54	6.76	7.29	6.65	7.12	6.9	6.37	6.4	-
Patients Discharged Beyond Ready for Discharge Date	-	14	2	7	18	13	6	14	13	6	10	7	14	124
Patients Discharged Beyond Ready for Discharge Date - Total Bed Days Lost (days counted in the month of discharge)	-	213	15	90	296	97	33	108	91	133	183	32	133	1424
Patients Discharged Beyond Ready for Discharge Date - Average Bed Days Lost (days counted in the month of discharge)	-	15.2	7.5	12.9	16.4	7.5	5.5	7.7	7.0	22.2	18.3	4.6	9.5	-
Hospital Cancelled Operations on the day for non clinical reasons	0	3	2	0	0	2	2	14	3	2	2	0	2	32
Hospital Cancelled Operations on the day for non clinical reasons - NOT rebooked within 28 days	0	0	0	0	0	0	0	1	0	0	0	0	0	0
Complaints Received	12 (23/24 Avg)	12	14	8	21	10	17	15	12	14	15	10	13	161
PALS Contacts	35 (23/24 Avg)	32	67	39	37	44	29	42	22	26	43	35	31	447
MRSA	0	0	2	0	0	0	0	0	0	0	0	1	0	3
C-Difficile - All Attributable Cases (Pre & Post 48 Hours)	<52	2	3	4	6	5	4	7	3	3	6	4	3	50
C-Difficile - Attributable Cases Due To Lapse In Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MSSA Bacteraemia - Attributable	No Target	1	2	3	1	0	2	1	2	3	1	1	4	21
E-Coli - Attributable	<57	6	4	4	1	4	5	5	4	2	2	3	6	46
Klebsiella Species - Attributable	<25	1	2	2	1	2	5	2	3	1	4	1	2	26
Pseudomonas Aeuriginosa - Attributable	<8	2	0	0	1	1	2	2	1	1	0	2	0	12
Staff Sickness	3.4%	4.57%	4.39%	4.47%	4.80%	4.50%	4.64%	5.06%	4.96%	5.08%	5.03%	4.65%	3.99%	-
Staff Mandatory Training	>80%** <80%	92.7%	92.7%	93.2%	93.7%	93.8%	93.7%	93.7%	93.6%	94.0%	93.9%	93.9%	94.0%	-
Staff PDRs	-	84.6%	85.7%	85.3%	86.6%	88.0%	87.2%	87.1%	87.3%	87.5%	87.2%	88.5%	87.93	-

Compliance if <80% & risk assessment in place

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

Incident Management



At the time of reporting, 32% of incidents were managed locally within 10 calendar days.

The trust target for in time locally managed incidents is to above 80%.

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

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

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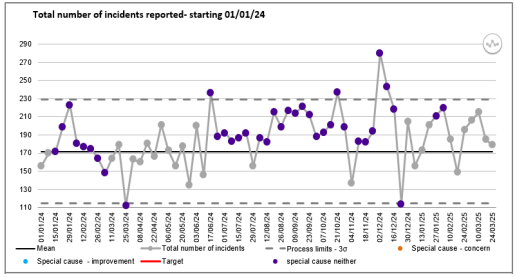
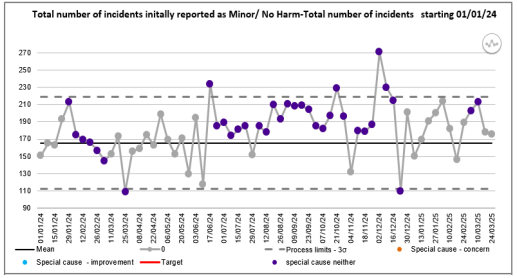
Incident Reporting

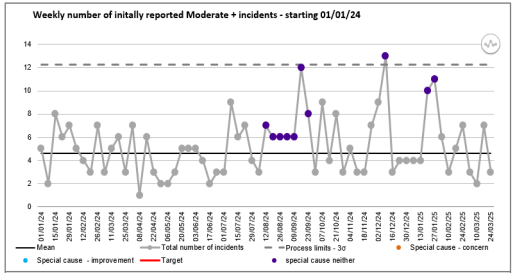
A total of 824 incidents were reported to DCIQ in March 2025.

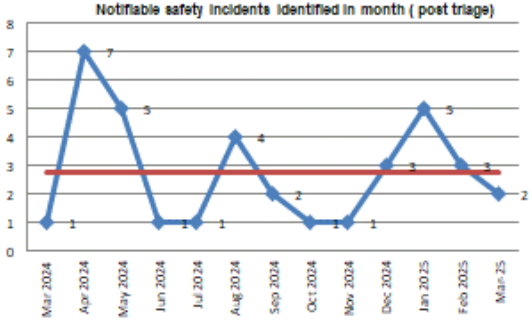
- 85 % of incidents reported (702/824) were classed as 'Incidents affecting a patient' and therefore reported to LFPSE (Learning from Patient Safety Events).
- 2 incidents in March were identified as meeting the criteria of a notifiable safety incident and so required statutory duty of candour.

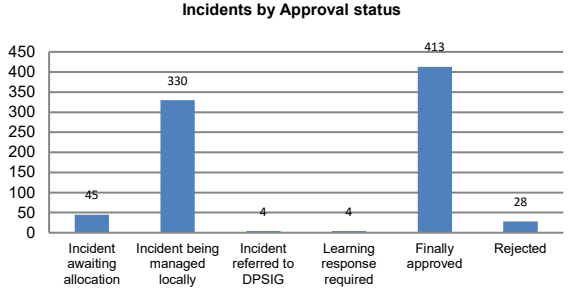
At the time of reporting, 50% of incidents have been finally approved. 3% of incidents have been rejected for reasons such as duplication and incidents which involve care provided by an external trust. Reporting trends in March were in line with trust expected limits.











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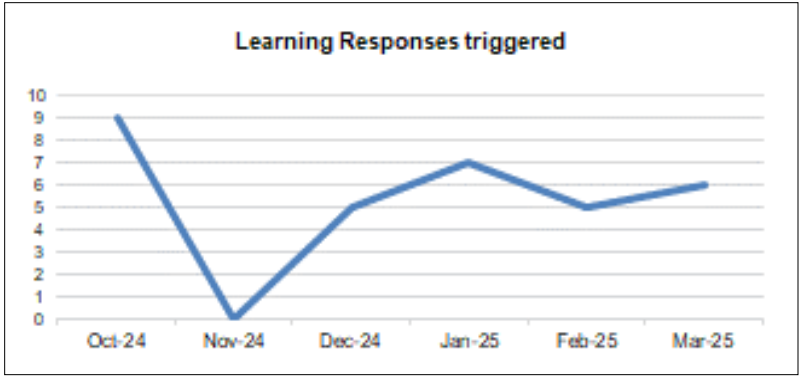
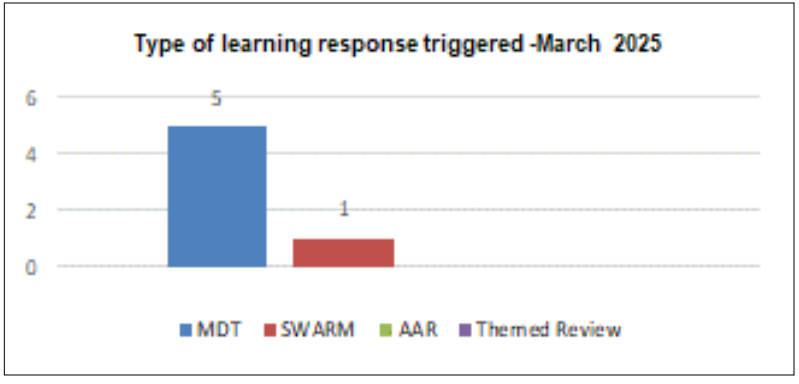
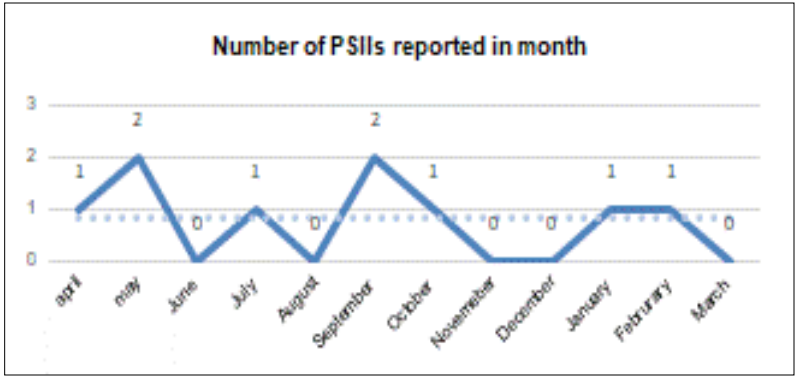
Incidents identified that require a Learning Response



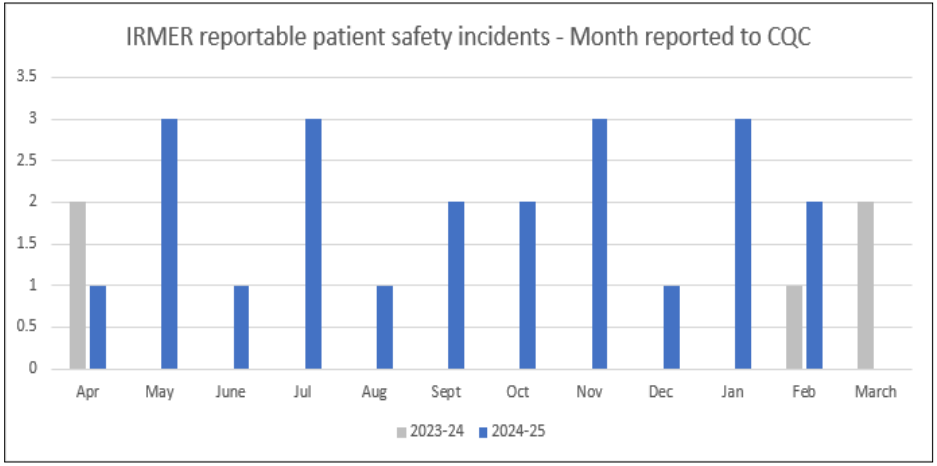
- Learning responses are triggered when an opportunity for new learning is identified. Learning responses are not triggered based on harm and do not stipulate whether statutory duty of candour is commenced
- 6 learning responses were triggered by divisional governance teams and via the divisional PSIGs in March 2025.

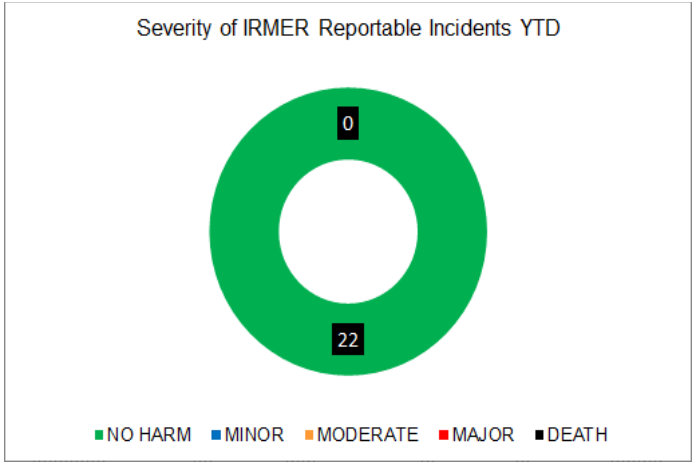
- Patient Safety Incident Investigations (PSII) are triggered when there is a significant opportunity for learning and improvement. PSIIs are extensive investigations which result in specific outcomes recommended by trained investigator.
- No PSIIs were reported in March.





Radiation Incidents





There were no IRMER reportable incidents reported in March 2025.

Operational Risks

NHS
The Christie
NHS Foundation Trust

Risk ID	Risk	Risk Register	Type	Subtype	Status	Risk owner	Date opened	Initial rating	Current likelihood	Current consequence	Current rating	Movement	Trend	Next Review Date
108	Breach of trust compliance target 28- day Faster Diagnosis Standard (FDS) for patients with a possible haematology malignancy	Haematology Teenage and Young Adults		Patient Experience Risk	Active	Chloe Read	12/03/2025	12	5	3	15	↑		12/05/2025
357	There is a risk of a patient inadvertently receiving an unintended blood component or product			Patient Safety / Outcomes Risk	Active	Sharon Jackson	16/06/2023	10	3	5	15	↑		18/04/2025
361	There is a risk to the safe and effective delivery of the Trust's Aseptic Service	Pharmacy		Patient Safety / Outcomes Risk	Active	Anna Mcnichol... Dawn Gillibrand	17/02/2025	15	3	5	15	↔		30/04/2025
389	Not Identifying and Delivering 25/26 recurrent VIP programme impacting on financial sustainability and ability to treat patients			Financial Management / Waste Reduction Risk	Active	Claire Mcpeake	30/10/2024	16	4	4	16	↔		01/04/2025

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	16979	13286	4859	6.1
	Total monthly ACTUAL	16603	12871		
	Average Fill Rate %	97.8%	96.9%		
Care Staff	Total monthly PLANNED	11265	7423	4859	3.3
	Total monthly ACTUAL	9123	6918		
	Average Fill Rate %	81.0%	93.2%		
ALL Staff	Total monthly PLANNED	28244	20709	4859	9.4
	Total monthly ACTUAL	25726	19789		
	Average Fill Rate %	91.1%	95.6%		

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	2340	2230	95.3%	2152	1930	89.7%	177	23.5
Palatine Ward	3230	2825	87.5%	2494	2116	84.8%	830	6.0
Ward 10	2388	1914	80.2%	1722	1551	90.1%	770	4.5
Ward 11	2152	2208	102.6%	1593	1588	99.7%	845	4.5
Ward 12	1765	1956	110.8%	1519	1545	101.7%	596	5.9
Ward 4	1815	1857	102.3%	1492	1497	100.3%	758	4.4
Ward 2	1009	1282	127.1%	529	949	179.4%	416	5.4
Acute Assessment Unit	2280	2331	102.2%	1785	1695	95.0%	467	8.6
TOTAL	16979	16603	97.8%	13286	12871	96.9%	4859	6.1

Registered Nursing Associates	DAY			NIGHT		
	Hours Planned	Hours Actual		Hours Planned	Hours Actual	
Critical Care Unit						
Palatine Ward						
Ward 10						
Ward 11		17				
Ward 12						
Ward 4		12				
Ward 2						
Acute Assessment Unit						

Care Staff	DAY			NIGHT			Cumulative count over the month of patients at 23:59 each day	CHPPD (Care Hours Per Patient Per Day)
	Hours Planned	Hours Actual	% Fill Rate	Hours Planned	Hours Actual	% Fill Rate		
Critical Care Unit	767	342	44.6%	95	149	100.0%	177	2.8
Palatine Ward	1235	1078	87.3%	972	863	88.8%	830	2.3
Ward 10	1892	1256	66.4%	1002	937	93.5%	770	2.8
Ward 11	2064	1539	74.6%	1339	1231	91.9%	845	3.3
Ward 12	1863	1763	94.6%	1451	1388	95.7%	596	5.3
Ward 4	1730	1545	89.3%	1406	1343	95.5%	758	3.8
Ward 2	562	577	102.7%	430	448	104.2%	416	2.5
Acute Assessment Unit	1152	1023	88.8%	728	559	76.8%	467	3.4
TOTAL	11265	9123	81.0%	7423	6918	93.2%	4859	3.3

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

Patient Experience

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Positive feedback received…..

"I finished my 6 rounds of chemotherapy and wanted to let the Department/Unit management know what absolutely fantastic hard-working staff they have from the receptionist to the domestics to the lovely HCA who brings the tea and food trolly round. As for the medical personnel they are absolutely outstanding. I just wanted to pass some positivity to all and say a very big thank you and continue all the excellent work all staff are doing."

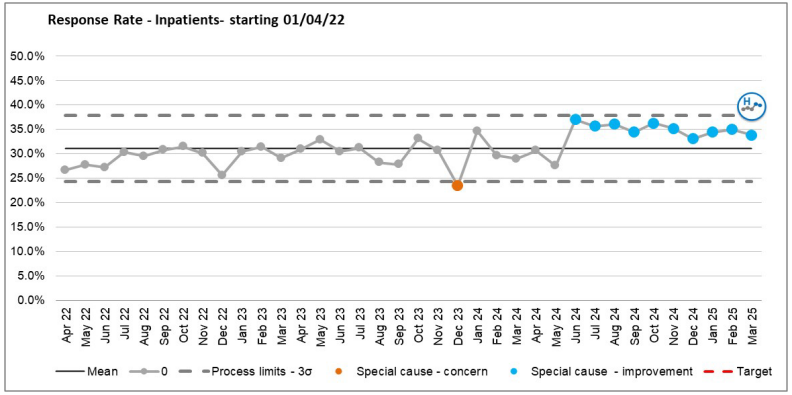
"I received outstanding care from the complementary therapy team. As a person with needle phobia, I was very anxious about having a procedure under local anaesthetic. The complementary therapy team phoned me frequently, reassured me, rehearsed breathing techniques with me and sent some aids to help me through the post. On the day, a wonderful member of staff was assigned to be with me through the surgery. He was so kind and understanding. I could not be more grateful to the whole team. Thank you."

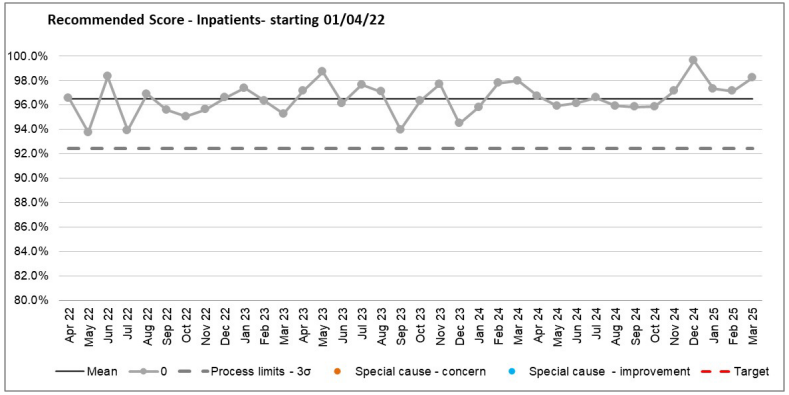
"Everyone at Christie's seem to be happy in their work & really are caring & supportive, this level of care is the Christie's way of care & they all deserve recognition for their hard work daily & always having a smile. Their model of care is exceptional. Every visit to the hospital is distressing, I feel so vulnerable & frightened every time, but a simple smile, reassurance & recognition goes such a long way. The Christie's teams should never underestimate the impact they have made, the importance & difference they really make to each of our lives & those of our families & close friends."

Friends & Family Test

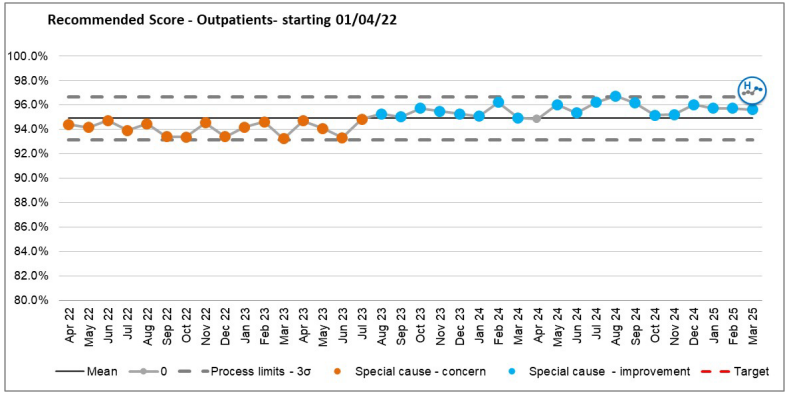
The Christie NHS Foundation Trust

Monthly Summary

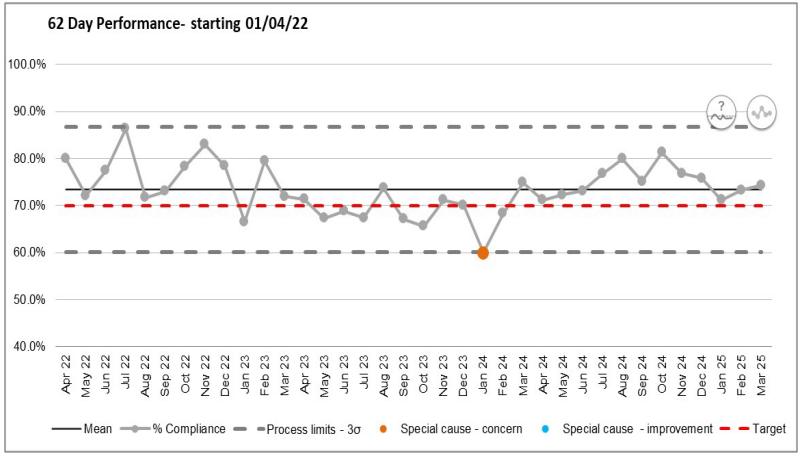


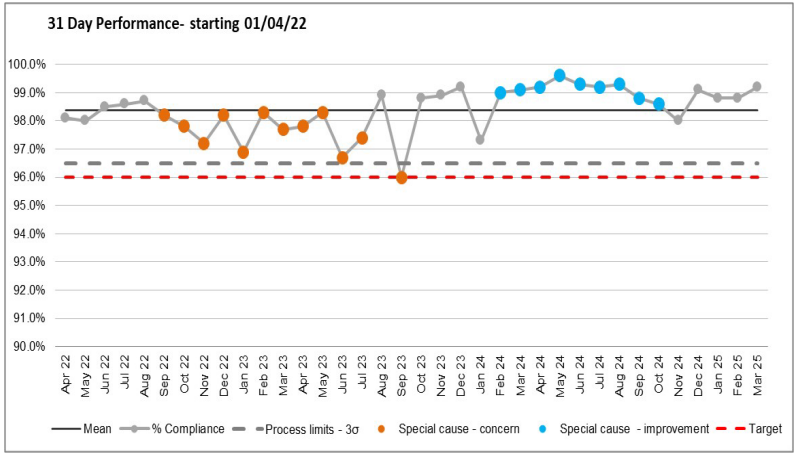


The Inpatient response rate continues to show improvement in recent months. Both the recommended percentage scores for Outpatients and Inpatients remain high with Outpatients maintaining a sustained period of high performance.



Cancer Standards





National Standard	Standard	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
62 Day	70%	71.2%	72.3%	73.1%	76.7%	79.9%	75.1%	81.3%	76.8%	75.8%	71.2%	73.3%	**74.3%**
28 Day FDS	75%	81.3%	75.0%	100.0%	91.7%	86.4%	90.0%	81.3%	89.5%	88.9%	83.3%	87.5%	**82.6%**
24 Day Internal	85%	71.5%	72.5%	74.9%	78.2%	78.8%	73.1%	77.5%	75.0%	76.6%	71.1%	72.7%	**71.5%**
31 Days	96%	99.2%	99.6%	99.3%	99.2%	99.3%	98.8%	98.6%	98.0%	99.1%	98.8%	98.8%	**99.2%**
18 Weeks - Incomplete	92%	97.1%	97.6%	97.1%	97.2%	97.1%	96.8%	99.6%	97.4%	97.6%	97.4%	98.1%	**97.7%**

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

Cancer Standards – Health Inequalities Analysis

62 Day Treatments between 01/04/2023 – 31/03/2025 analysed by gender, age and ethnicity.

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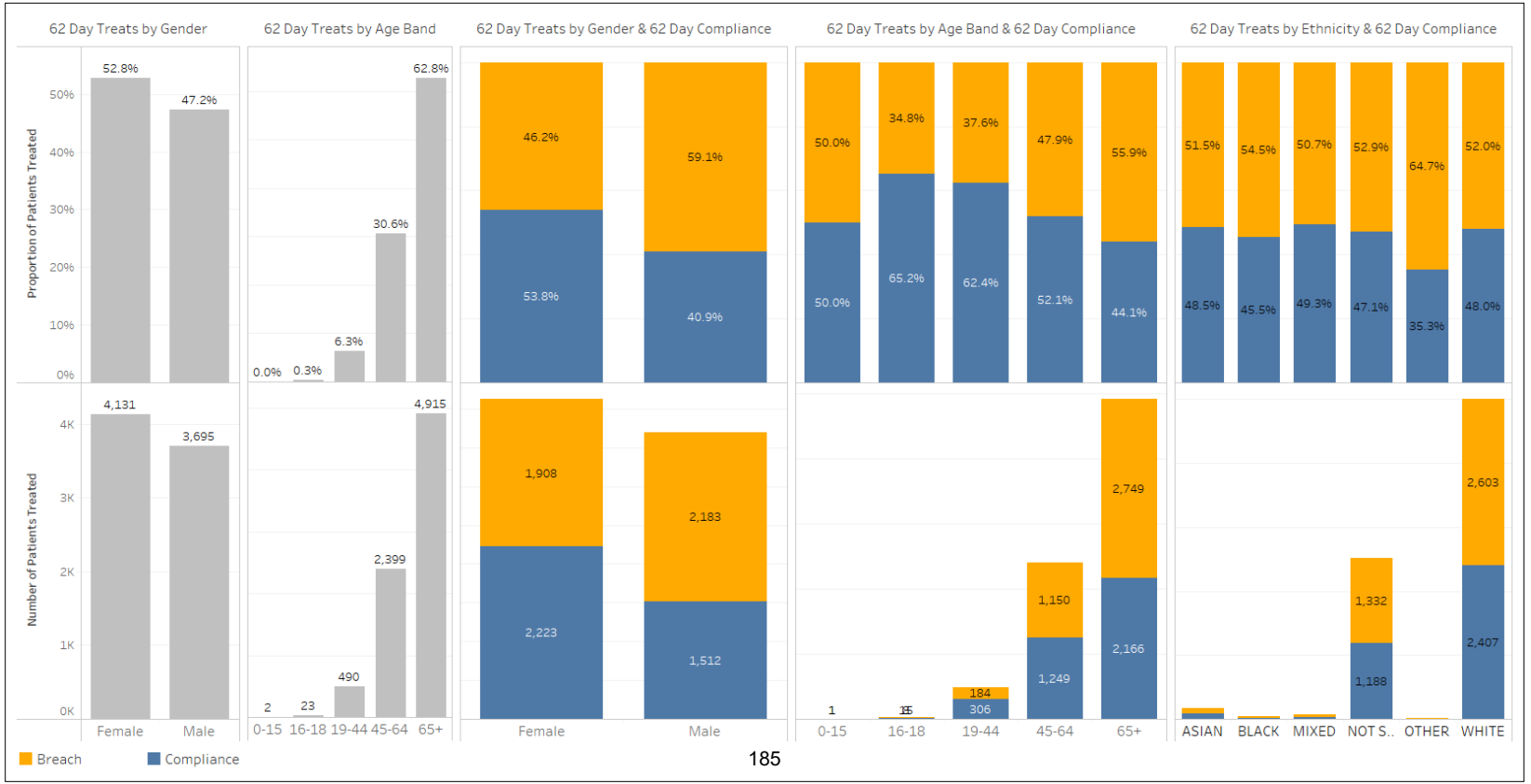

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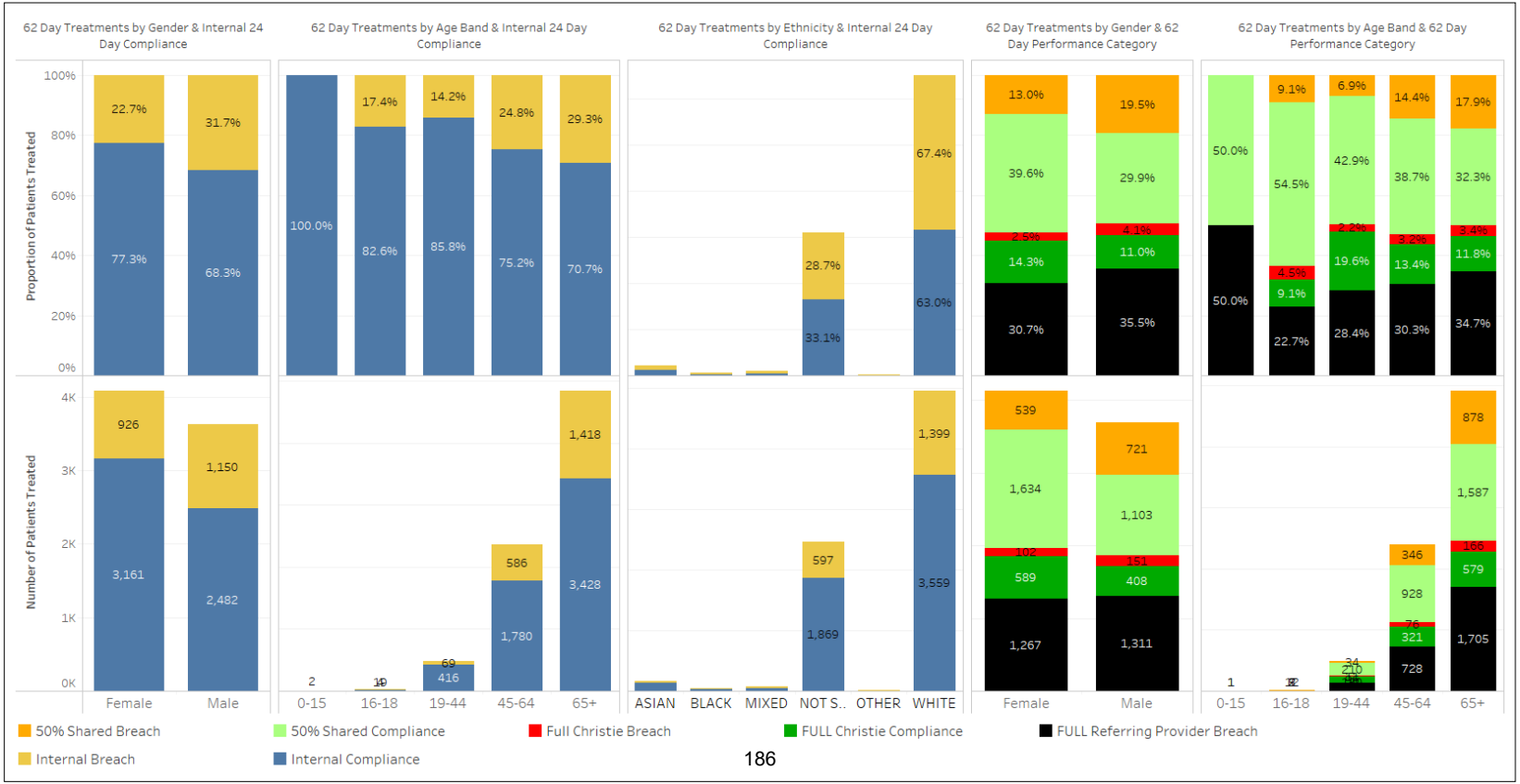
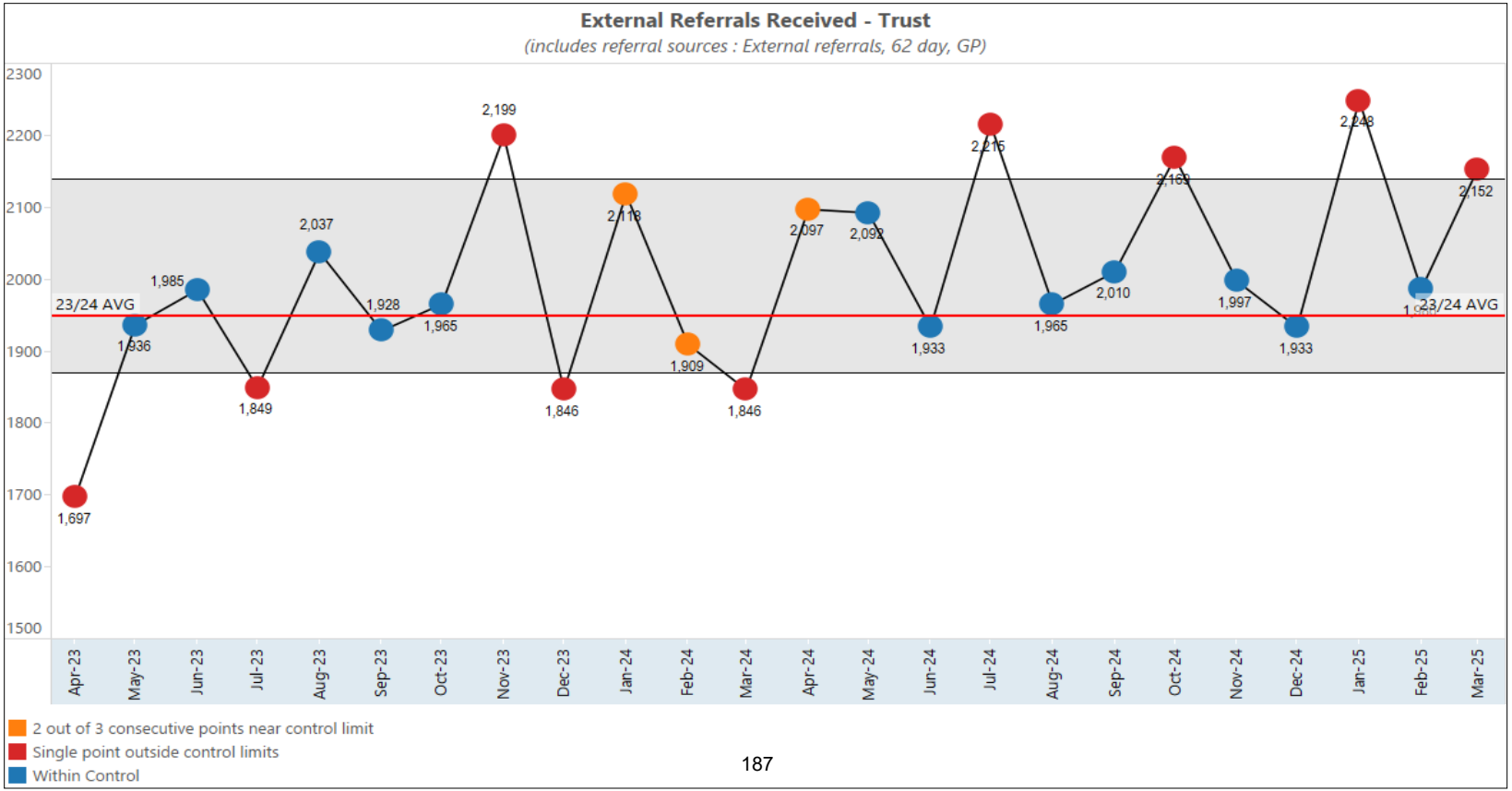
Cancer Standards – Health Inequalities Analysis

62 Day Treatments between 01/04/2023 – 31/03/2025 analysed by gender, age and ethnicity.

The Christie NHS Foundation Trust



Referrals Analysis



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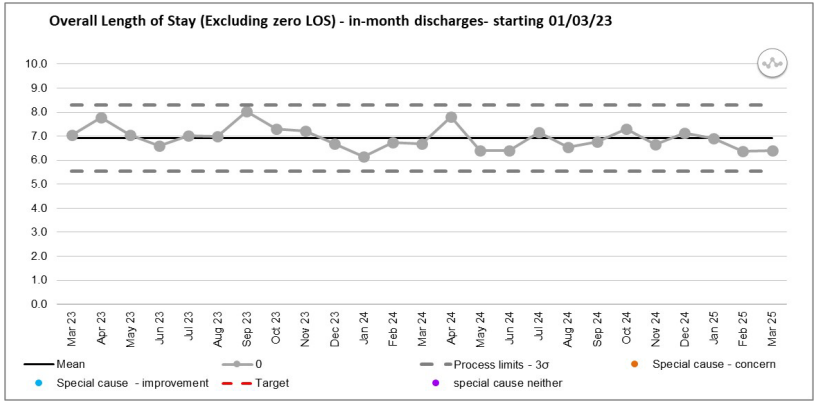
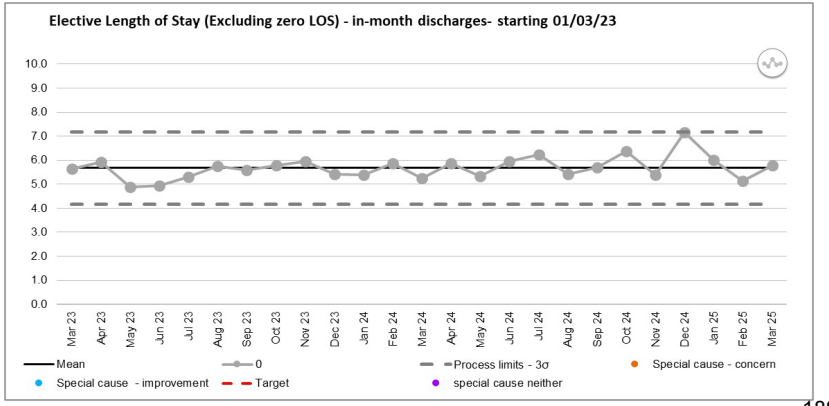
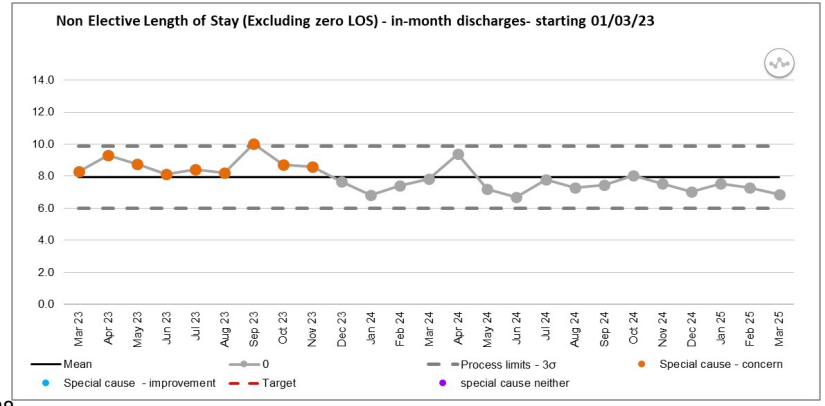
Length of Stay



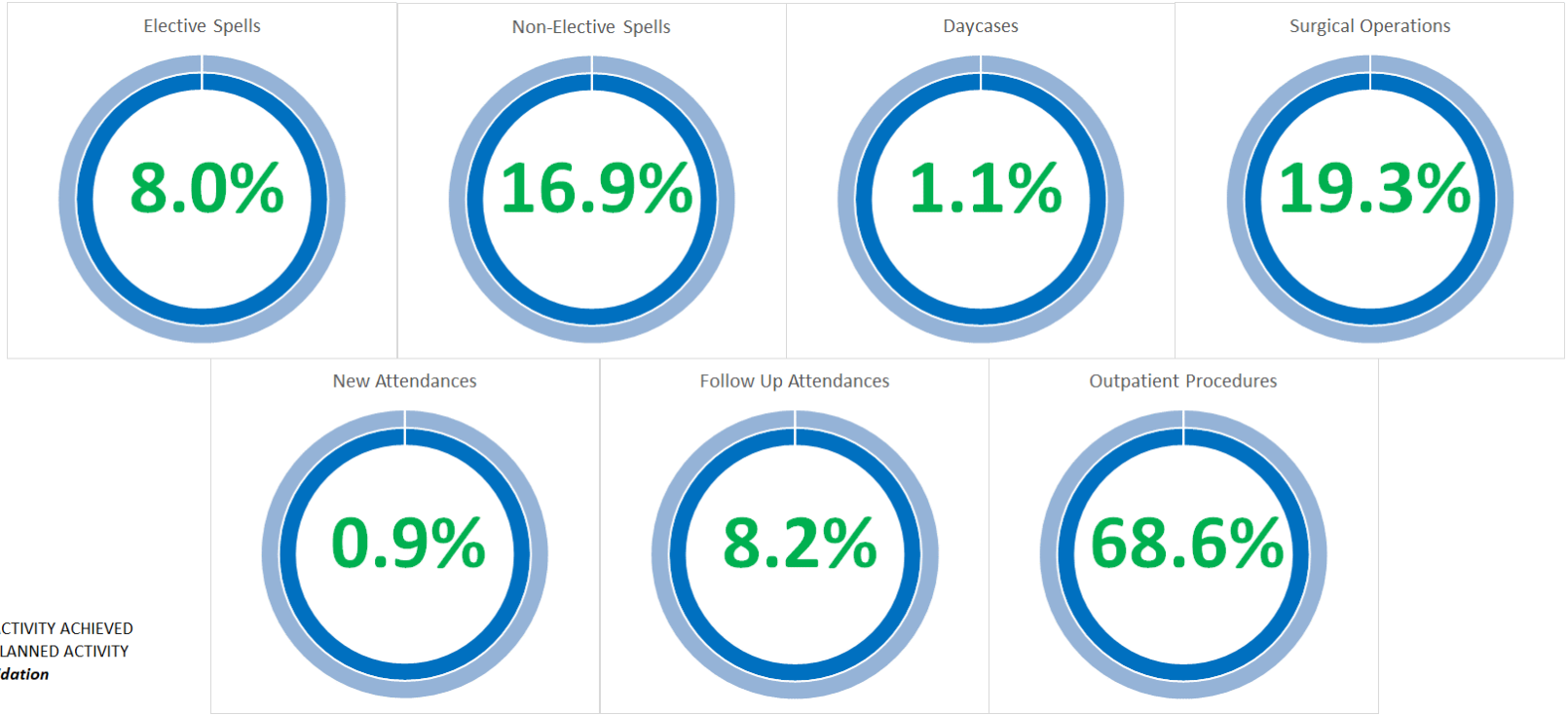
Overall length of stay, elective and non-elective spells continue to be well within control limits.





Activity – YTD Progress

Trust level activity - progress against YTD plan



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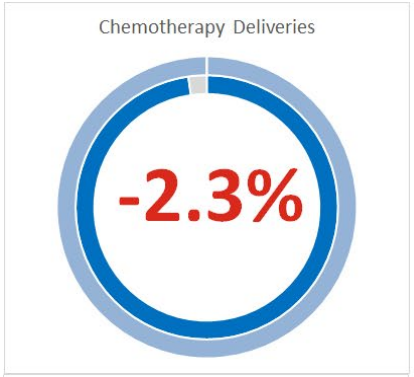
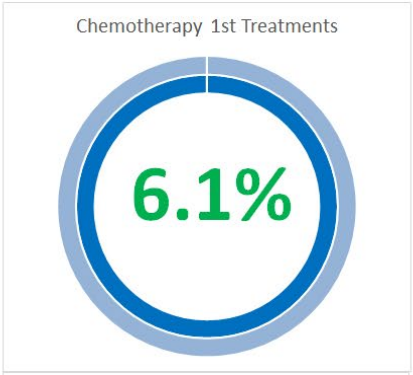
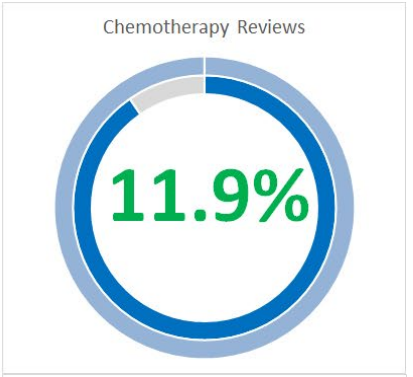
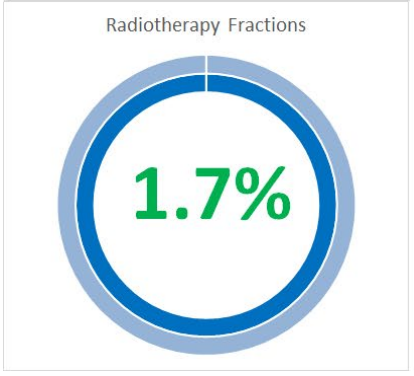
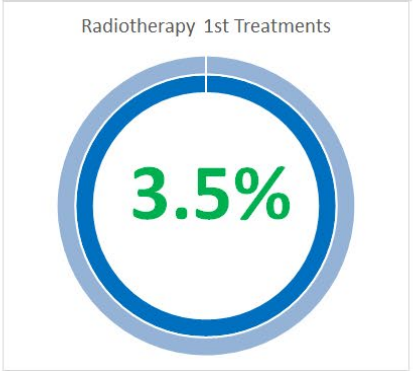
Activity – YTD Progress

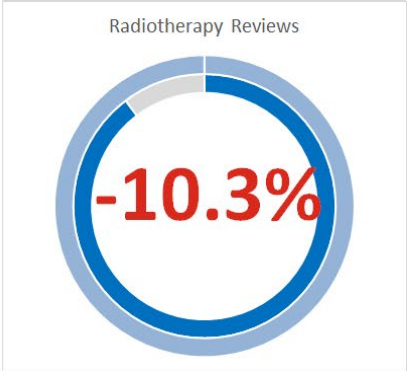








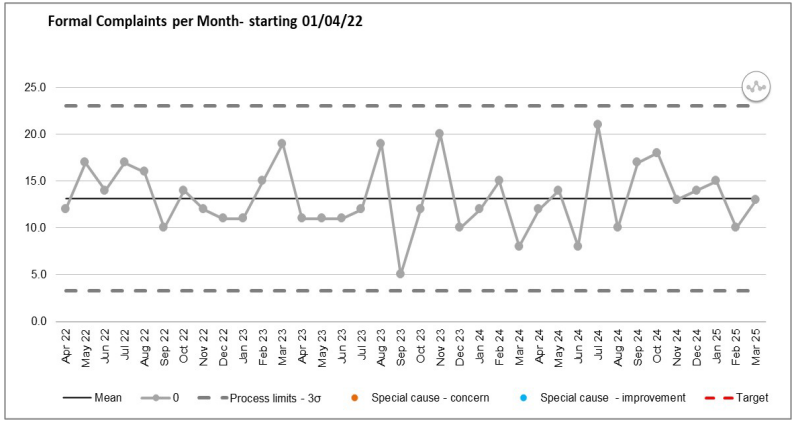


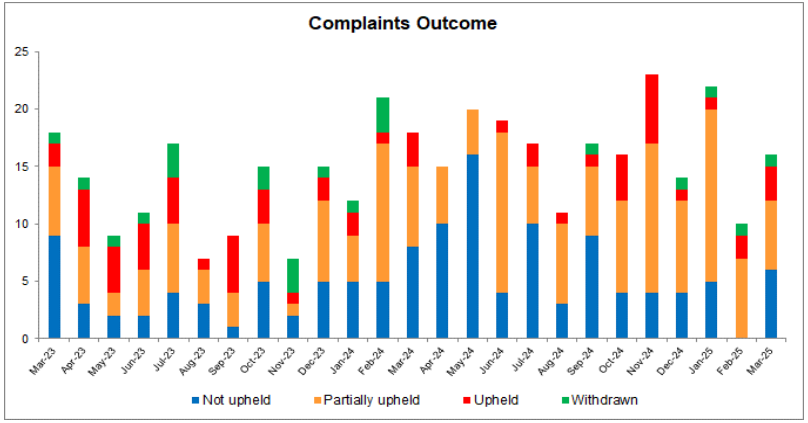


SACT 1st Treatments, 1st Fractions & Surgical Operations do not form part of the 24/25 activity plan and are used as supplementary guides to productivity. The figures are monitored against the previous year's month for comparison.

YTD ACTIVITY ACHIEVED
YTD PLANNED ACTIVITY
subject to validation

Complaints





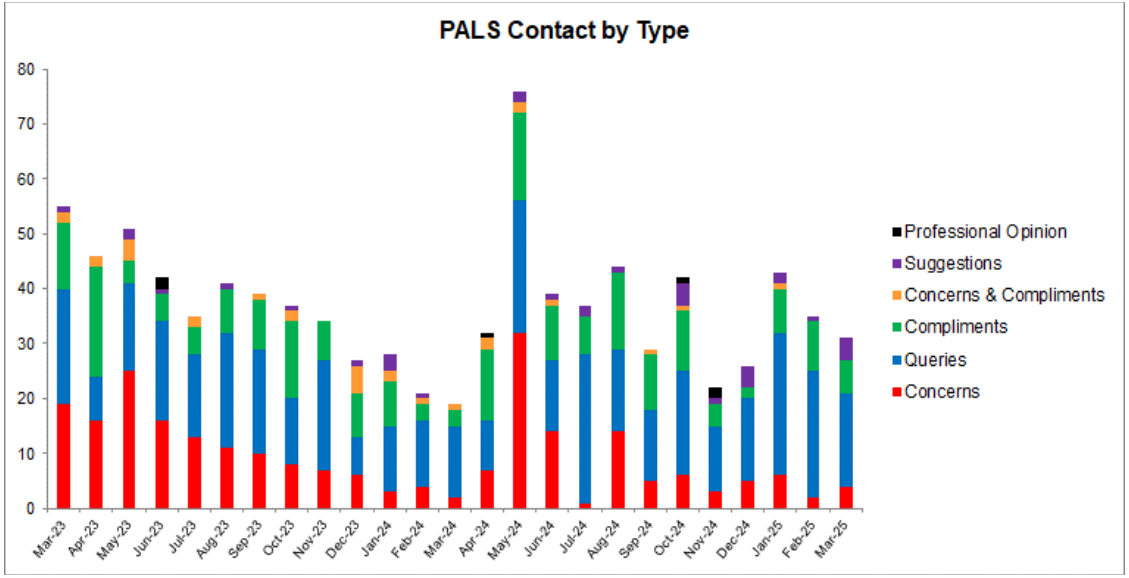
13 new complaints received in March 2025

16 complaints were closed in March 2025

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

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

PALS



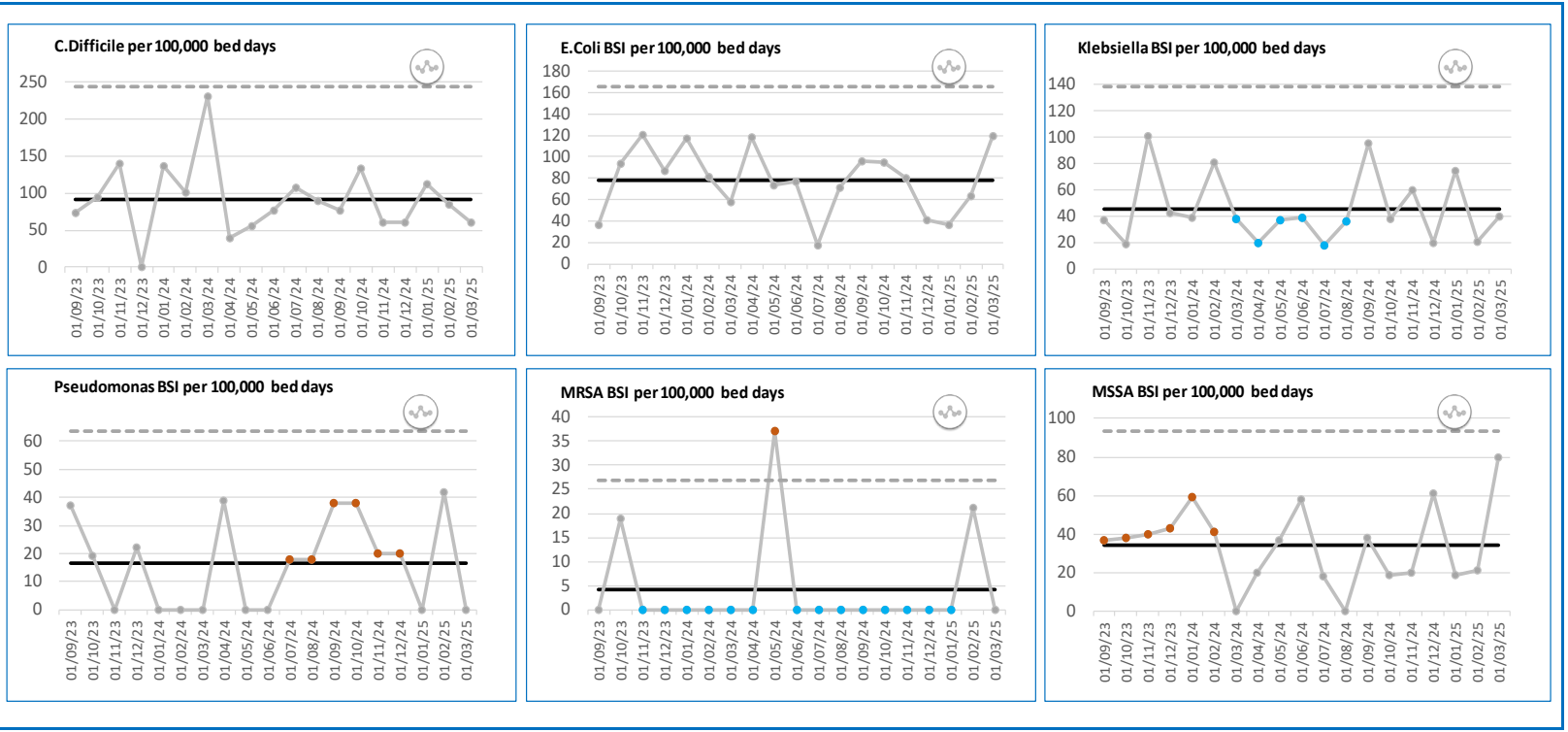
31 new PALS contacts have been received in March 2025.

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

Healthcare Associated Infections

The Christie NHS Foundation Trust

HCAIs per 100,000 bed days – rolling 12 months



All cases reviewed through IPC team and reported through NIPR.

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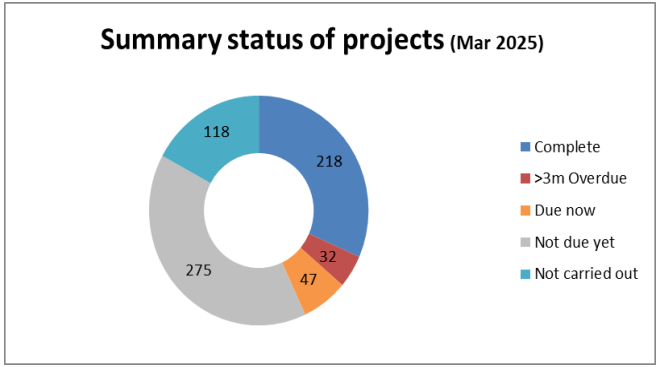
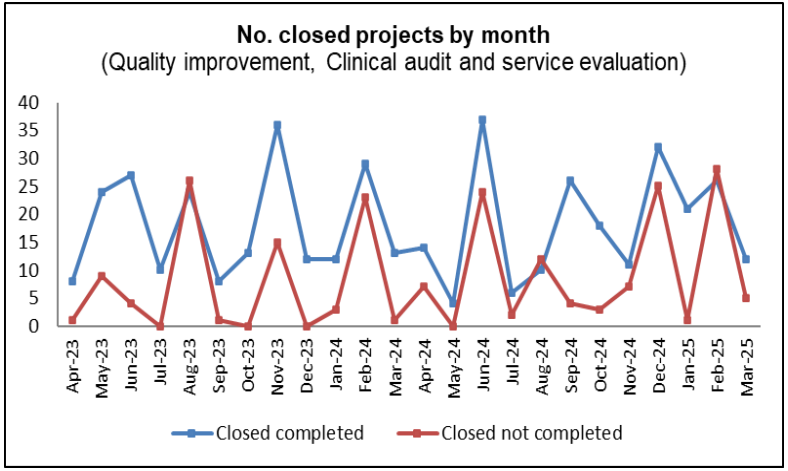
Quality Improvement & Clinical Audit

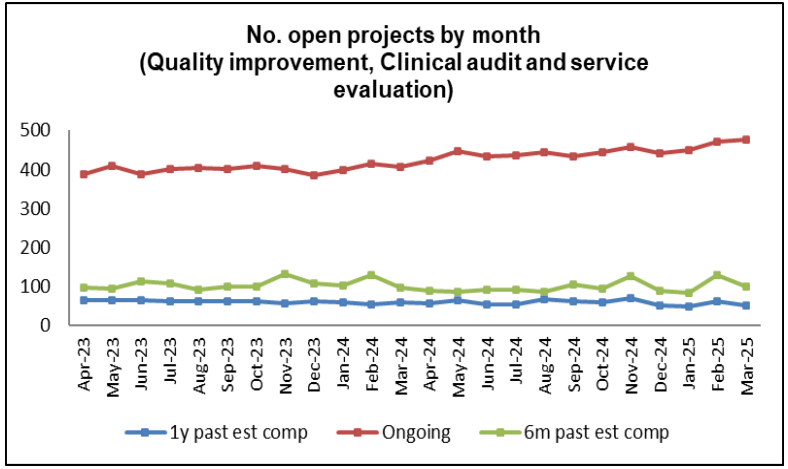
The Christie NHS Foundation Trust

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

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







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HR Metrics Sickness

The Christie NHS Foundation Trust

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

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

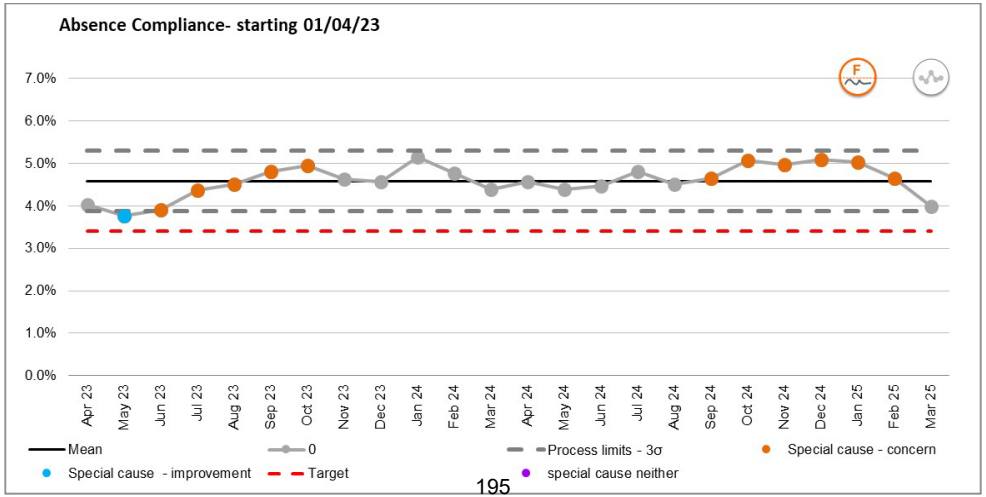
Last updated: 10/04/2025

Performance | Absence

Monthly Sickness %	Yearly Sickness %	Absences Ended	Long Term	Short Term
3.99%	4.68%	494	39	455

Trust Overview

Jan 01	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
4.68%	4.57%	4.39%	4.47%	4.80%	4.50%	4.64%	5.06%	4.96%	5.08%	5.03%	4.65%	3.99%



HR Metrics – Mandatory Training

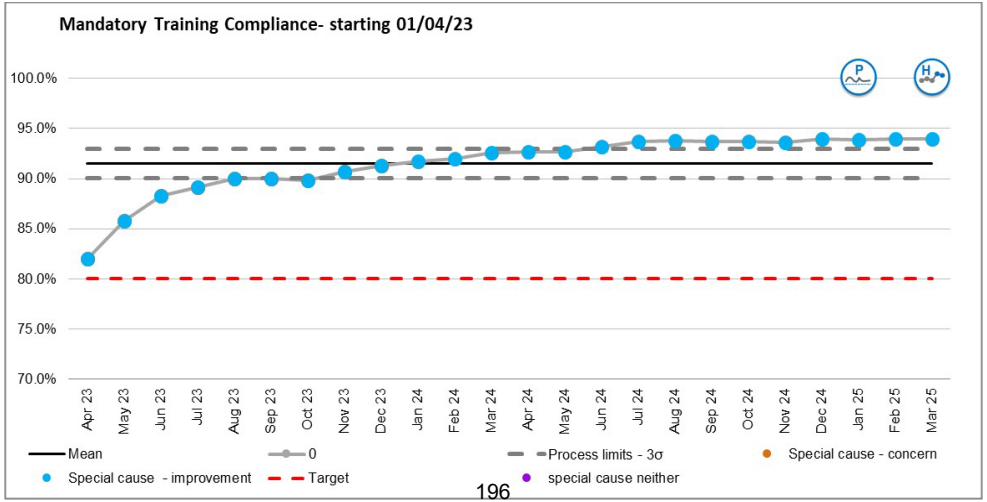
The Christie NHS Foundation Trust

Performance | Mandatory Training

Overall Compliance	Modules Outstanding	F2F Compliance	Online Compliance
93.95%	3,643	85.65%	94.75%

Trust Compliance

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



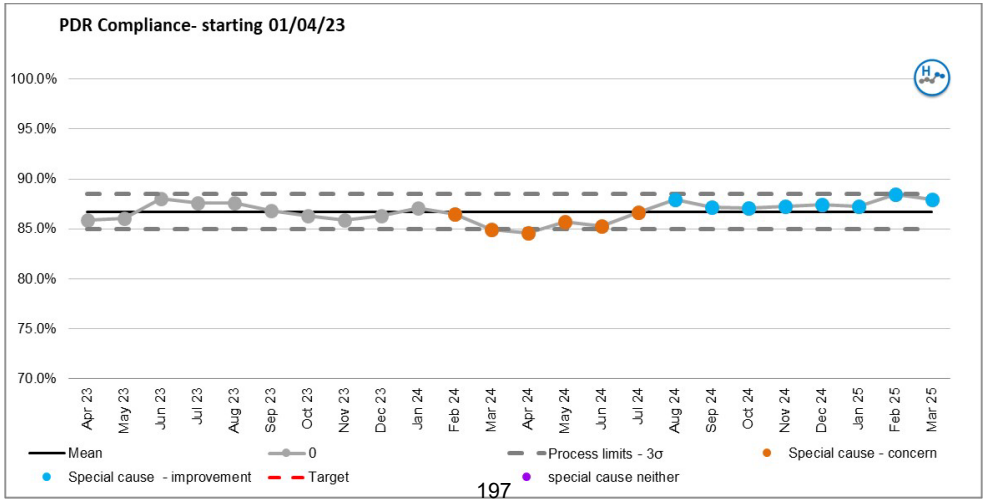
HR Metrics - PDR

The Christie NHS Foundation Trust

Performance | Appraisal

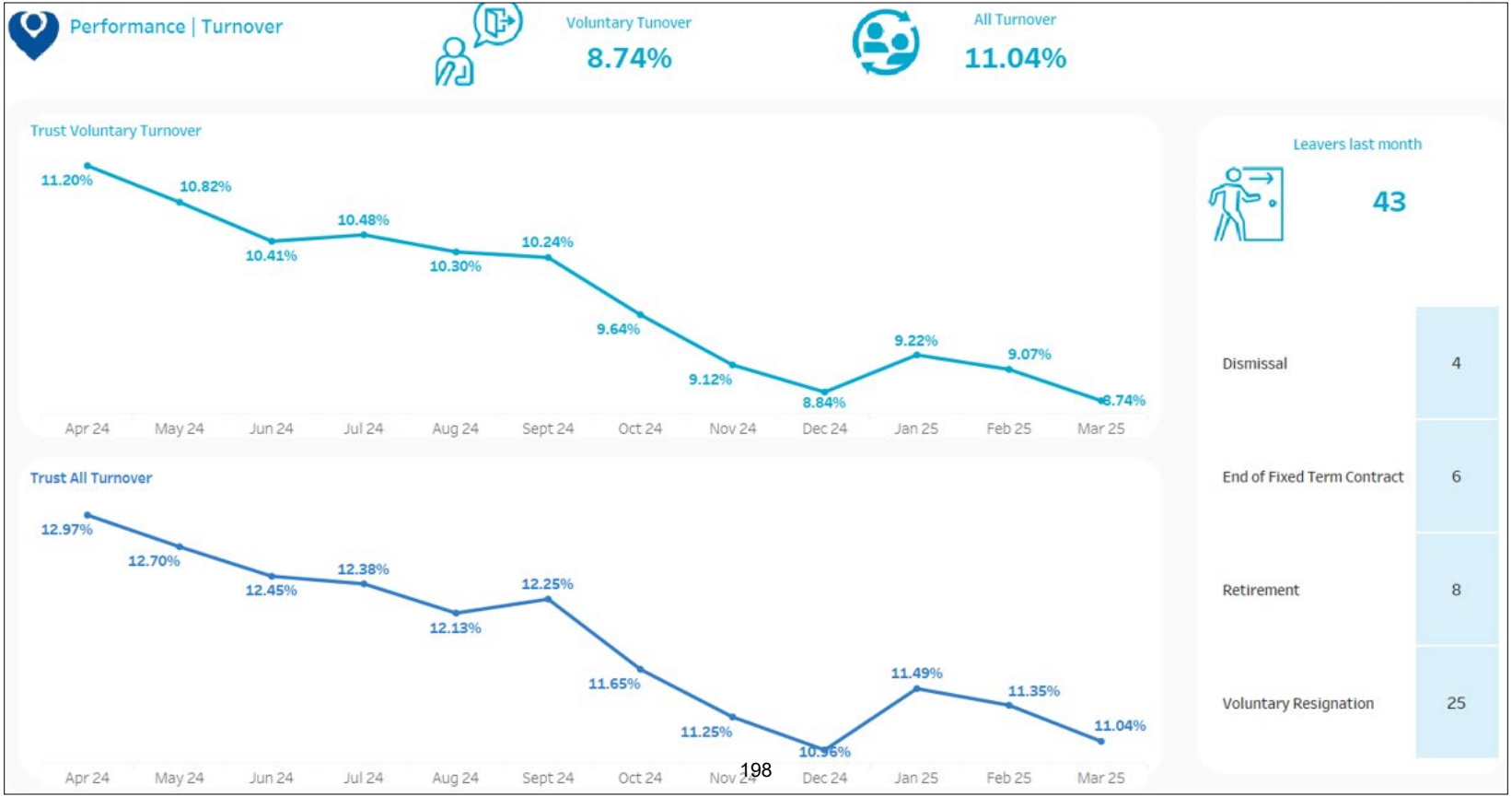
Overall Compliance	Expired Appraisals	Appraisals Due Soon
88.49%	397	601

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
84.61%	85.68%	85.28%	86.63%	87.95%	87.18%	87.05%	87.27%	87.46%	87.22%	88.49%	87.93%



Workforce Metrics - Turnover

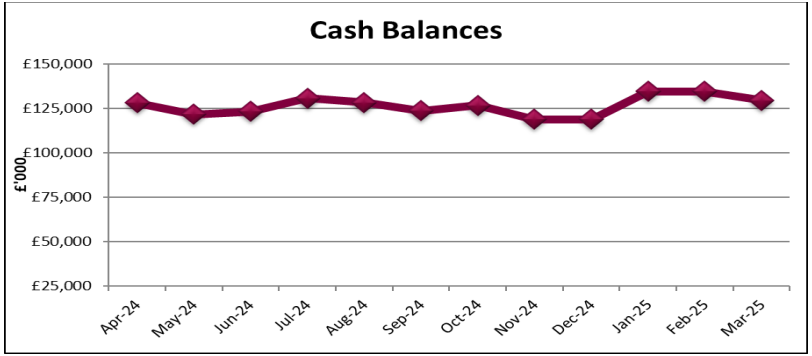
The Christie NHS Foundation Trust



Finance (Executive Summary)

The Christie NHS Foundation Trust

Month 12 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(424,744)	(424,744)	(444,154)	(19,410)
Other Income	(77,916)	(77,916)	(99,024)	(21,109)
Pay	235,252	235,252	245,538	10,285
Non Pay (incl drugs)	241,824	241,824	264,749	22,925
Operating (Surplus) / Deficit	**(25,584)**	**(25,584)**	**(32,892)**	**(7,308)**
Finance expenses/ income	30,932	30,932	34,114	3,181
(Surplus) / Deficit	**5,349**	**5,349**	**1,222**	**(4,127)**
Exclude impairments/ charitably funded capital donations	(12,355)	(12,355)	(16,256)	(3,901)
Adjusted financial performance (Surplus) / Deficit	**(7,006)**	**(7,006)**	**(15,034)**	**(8,027)**



This report outlines the M12 consolidated financial performance of The Christie NHS Foundation Trust and its wholly owned subsidiary The Christie Pharmacy Ltd.

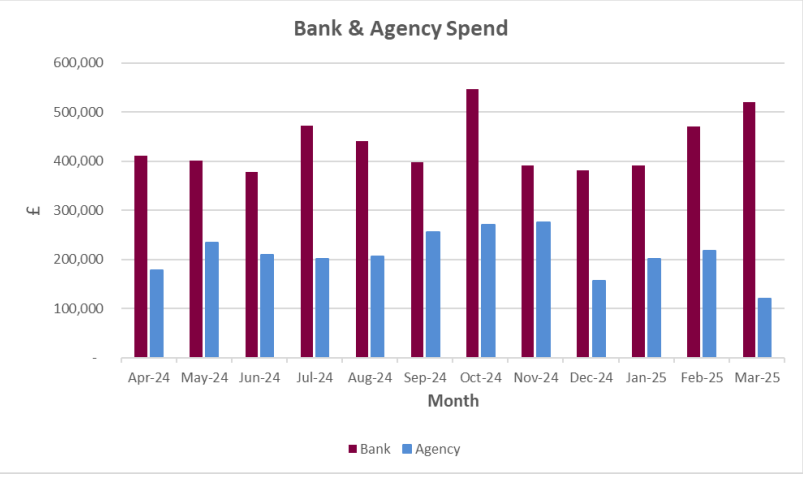
I&E

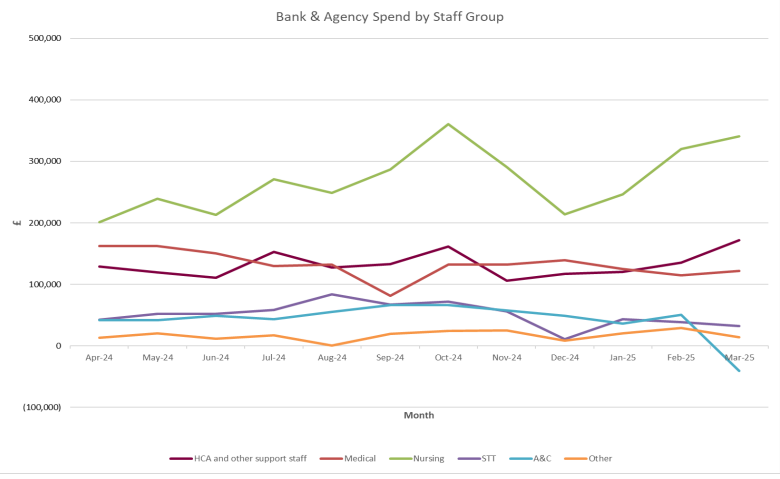
- The Trust is reporting a surplus at the end of M12 of (£15.0m) against a M12 YTD plan of (£7.0m), which gives a month 12 variance of (£8.0m) better than plan.
- The forecast for the Trust for M12 was £15m surplus position which has been met.
- In month the Trust reported a surplus position of £3.7m against a plan of £0.5m.
- Delivered in-year VIP is £21.4m against a target of £21.4m. The VIP shortfall against the recurrent VIP target is £3.5m, where £10.5m has been delivered against a target of £14.0m (75% of recurrent target delivered). Non-recurrent delivered VIP is £10.9m against a target of £7.4m, overachieving by (£3.5m).

Balance sheet / liquidity

- The cash balance is £129.4m.
- Capital spend for 2024-25 was £17.6m, this was (£0.8m) below the revised plan submitted to NHSE in June 24.
- Targets have been achieved against payment of creditors paid within the 30-day Better Payment Practice Code target.

Finance (Expenditure)

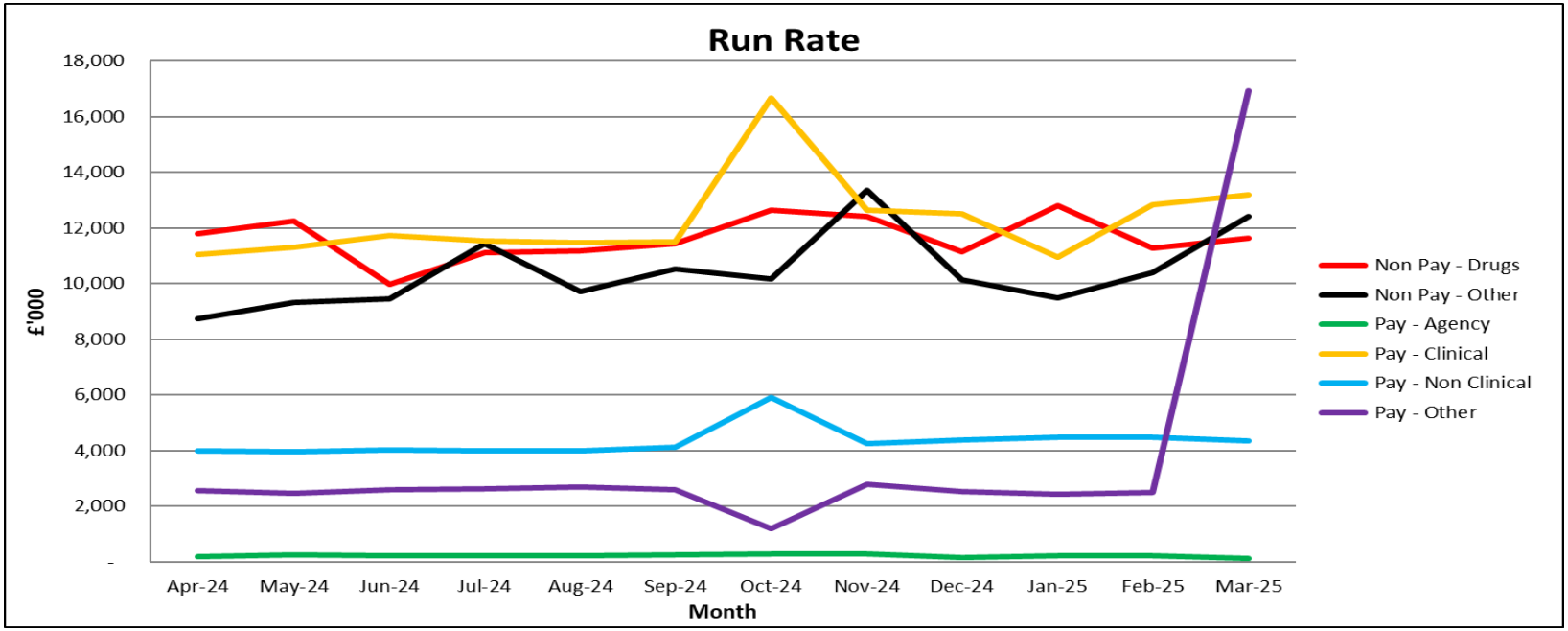




Agency spend in month 12 is £0.1m, £2.5m YTD. The spend is predominantly on medical agency with decreases in month on nursing agency compared to month 11. A (£0.1m) adjustment was made in M12 to remove non-agency spend included in prior months.

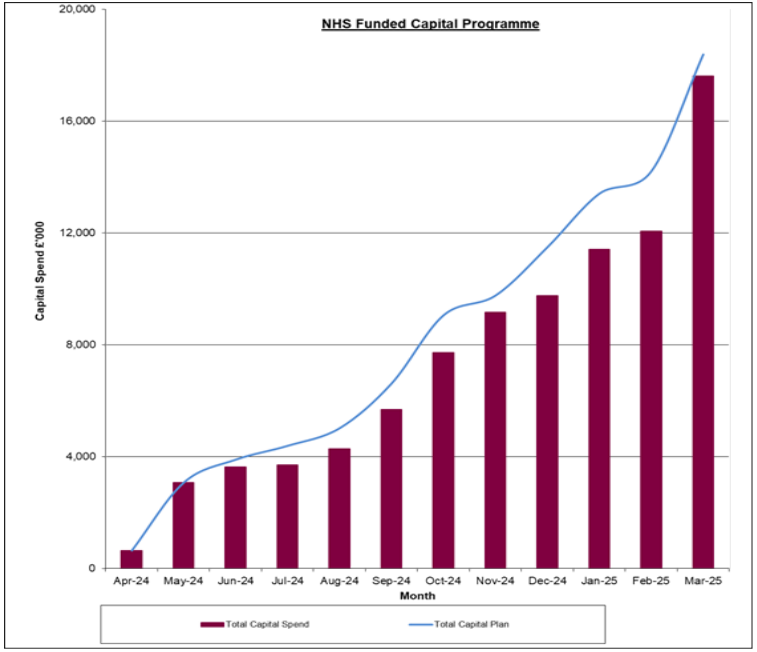
Alongside this, bank spend remained consistent in month 12 compared to M11, giving £0.5m in month 12 and £5.2m YTD.

Finance (Expenditure)



- Drugs spend in month 12 is £11.6m, an increase from month 11 of £0.3m linked to fluctuations in pass through drug spend.
- Pay – Clinical spend in month 12 is £13.2m, an increase from month 11 of £0.4m due to M12 including year to date pay accrual corrections.
- Pay – Agency spend in month 12 is £0.1m, a decrease from month 11 of (£0.1m).
- Pay – Other spend in month 12 is £16.9m, an increase from month 12 of £14.5m driven by Employers pension contribution of £14.0m.
- Non Pay – Other spend in month 12 is £12.4m, an increase of £2.0m from month 11 driven by PET CT scan costs for non-oncology scans circa £2.1m
- Key elements of 'Non-Pay Other' spend consist of clinical supplies and services, premises and infrastructure costs and R&I costs.

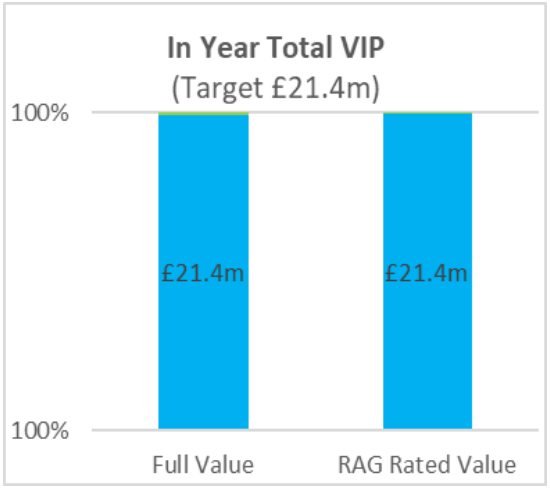
Finance (Capital)

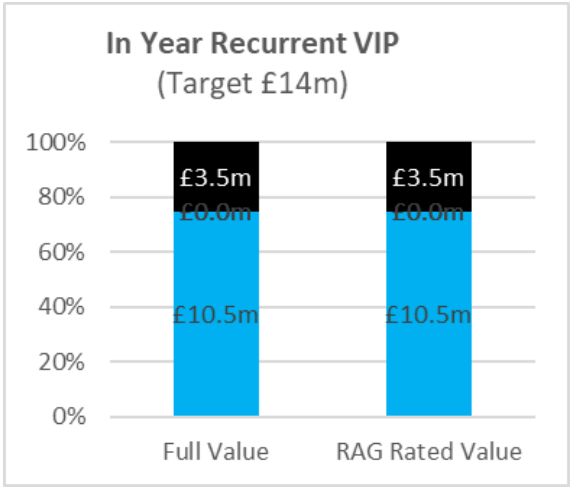


The Trust has incurred £17.6m on capital schemes in 2024-25, primarily on the TIF ward refurbishment as well as ongoing digital projects and small replacement assets.

The Trust has a small underspend of (£0.8m) below the revised plan submitted to NHSE in June 24.

Finance (CIP)





Total In year CIP

- Total delivered VIP schemes reported are £21.4m (£10.9m non recurrent / £10.5m recurrent).
- Risk adjusted delivered schemes value £21.4m, leaving £0.0m undelivered.

Recurrent

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

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

	Annual					Year to Date		
	Target	Identified value	Unidentified Value	Identified RAG Value	Unidentified RAG Value	Target	Delivered	Variance
Total VIP	**£21,396k**	**£21,396k**	**£0k**	**£21,396k**	**£0k**	**£21,396k**	**£21,396k**	**(£0k)**
Recurrent VIP	£13,996k	£10,495k	£3,501k	£10,495k	£3,501k	£13,996k	£10,495k	(£3,501k)
Non-Recurrent VIP	£7,400k	£10,901k	(£3,501k)	£10,901k	(£3,501k)	£7,400k	£10,901k	£3,501k