The Christie
NHS Foundation Trust

Board of Directors Public meeting
Thursday 25th June 2026 at 2.00pm
Trust meeting room

Agenda

Patient story / clinical presentation: SACT @ Home – patient in their home / Crawford Meek, Senior Charge Nurse, SACT services and Gemma Jones, Lead Nurse SACT/Outpatient services

30 mins

	Public items	Decision		Lead	Page	Timing
16/26	**Standard business**					
a	Apologies	Note		Chair		
b	Declarations of interest	Note		Chair		
c	Minutes of previous meeting – 30th April 2026	Approve	*	Chair	2	5 mins
d	Action plan rolling programme, action log & matters arising	Review	*	CEO	13	
17/26	**Performance & finance**					
a	Trust report	Review	*	CEO	16	
b	Integrated performance quality & finance report	Review	*	COO	24	15 mins
c	Value Improvement Programme update	Review	*	COO	68	
d	Annual compliance with CQC requirements	Review	*	ECN	72	10 mins
e	Standing Financial Instructions (SFI) update	Approve	*	EDoF	77	5 mins
18/26	**Governance (regulatory / statutory compliance)**					
a	Reports from committees (April/May meetings) • Audit Committee • Senior Management Committee	Review	*	Committee chair	139 143	10 mins
b	Board assurance framework	Review	*	CEO	145	5 mins
c	Strategic & Annual Objectives and strategic risks 2026/7	Review	*	COO	155	10 mins
d	Independent well-led developmental review	Approve	*	CEO	162	10 mins
e	Annual reports from audit, quality and workforce assurance committees	Note	v	Committee chair		5 mins
f	Annual report, financial statements and quality accounts 2025/26	approval	v	CEO		
19/26	**Any other business**					
	For information					
	Reflections on the meeting					
	Date and time of the next meeting Thursday September 2026 at 2:00pm					

D/CEO	Deputy / Chief Executive Officer
EMD	Executive Medical Director
DFC	Director of Future Christie
COO	Chief Operating Officer
ECN	Executive Chief Nurse

*	paper attached
v	verbal
p	presentation

The Christie
NHS Foundation Trust

Public meeting of the Board of Directors
Thursday 30th April 2026 at 2.00 pm
Trust Meeting Room

Present:	Chair:	Prof Joe Rafferty (JR), Chair Roger Spencer (RS), Chief Executive Officer Alveena Malik (AM), Non-Executive Director Amanda Oates (AO), Non-Executive Director Dr Marisa Logan-Ward (MLW), Non-Executive Director Sarah Corcoran (SC), Non-Executive Director Roy Dudley-Southern (RDS), Non-Executive Director Dr Diana Tait (DT), Non-Executive Director Dan Bate (DB), Non-Executive Director Jim Hughes (JH), Non-Executive Director Nick Williams (NW), Non-Executive Director Eve Lightfoot (EL), Director of Workforce Prof Fiona Blackhall (FB), Director of Research, Prof Chris Harrison (CJH), Senior Adviser Governance & Strategy John Wareing (JW), Director of Strategy Claire McPeake (CM), Chief Operating Officer Vicky Sharples (VS), Chief Nurse and Executive Director of Quality Sally Parkinson (SP), Executive Director of Finance Dr Neil Bayman (NB), Executive Medical Director Prof Adrian Bloor (AB), Director of Future Christie Prof Rikki Goddard-Fuller (RGF), Director of Education
Minutes:		Louise Westcott (LW), Company Secretary
In attendance:		Jeanette Livings (JL), Director of Communications Fi Jenkinson (FJ), Freedom to Speak Up Guardian

Clinical presentation: A patient story - Engaging with the Christie patient portal and ePROMs – Dr James Price, Clinical Oncologist, Dr Pao Nuamek, Fellow in Health Inequalities and Angela McMorris (patient).

JP introduced himself as a Head & Neck clinical oncologist and chair of ePROMs, he noted he is also doing this presentation on behalf of Prof Faive-Finn. Poa was introduced and Angela as a patient who has engaged with the service.

As background, JP described ePROMs – electronic patient reported outcome measures. This sits on a patient's phone / laptop and allows feedback from patients on how they are feeling and what they are going through without a clinician influencing what is entered. Trial evidence shows that this reduces admissions, results in better treatment compliance and improved outcomes.

The National Cancer Plan covers the use of ePROMs. They feature throughout the document, and it is all about empowering patients to transform how we deliver care. The Trust will be expected to publish on outcome data. We launched ePROMs in 2019 as a tool, funded by UoM and MCRC and the charity. We have an excellent tool that asks patients to complete a questionnaire. The responses elicit different advice from no intervention to an immediate response. The questionnaire is issued prior to an appointment.

This has been adopted by many specialties and continues to be implemented across the organisation. Evaluation has been done and the feedback has been very good. ePROMs gives opportunity to change the way we do things. This is not a research tool but does mean we can change services; it also means that we are able to be much more efficient with patient interactions.

Examples of service changes were described in breast and prostate follow up services. The biggest application is in the SACT service, this saves significant amounts of time in SACT pre-assessment and reduction in wastage from same day cancellations.

There has been a pilot of using ePROMs instead of using the hotline. The patient feedback is visible on a large screen to the hotline team who can respond appropriately. The connections to the use of ePROMs and the role out of Neighbourhood Oncology was outlined to try and minimise the need for patients to come into hospital. The implementation of ePROMs on a large scale is a Christie first internationally and we have had interest from across the world in the use of the approach.

Angela was introduced, she has been a patient for 8 years and has filled out the questionnaire many times. Angela said she's had a very good and straight forward approach to communicating with her team about how she's doing. Angela described having had to call the hotline on a number of occasions, and she feels that it has been very helpful to be able to do this at all hours of the day. She described how the hotline is helpful for advice and to escalate things when needed, it's a clear service and the number is made very obvious by the team and what it is for. It is clear what you need to do and that the hotline is the right call if you're struggling.

Angela said that she thinks care closer to home is better. She talked about there being 2 sorts of patients, those that go along with what they're told and those who want to know more and want to question how things are done.

NB asked what Angela thought about the forms she's filled in through ePROMs. She responded that the revised questionnaire is much better than the previous version, the questions are more specific and that is good. The form should also include sleep patterns and how the patient has felt over the last few days. The form is easy to complete but wouldn't be if English wasn't their first language. Forms need to be simple.

DT asked if this was an option or if she was told that this was the way to go. Angela said it was described as the way the care worked and said she'd spoken to other patients who also found it a good way to communicate.

Questionnaires are sent 24 hours ahead of clinical contacts so if a response is needed then the patient will be seen quickly.

There is work underway to change how ePROMs are used and as an alternative to the hotline.

SC asked Angela what the main difference using ePROMs has made. She responded that she doesn't need to go over things from scratch and the team will respond and use it as a prompt – there's a need to be honest or there is no point and it means you can think ahead of time and not forget things when you're in front of the clinician.

JH asked about whether the impact of using ePROMs is fed back to patients. JP noted that we don't and we should. We have developed patient videos that will include this impact feedback that will be shared going forward.

MLW asked about the process and if we use it as a bridge between Christie and Primary Care. JP responded that we don't use this in the long term follow up process, patients don't currently feed back to us and we don't see the survivorship details. This is linked to clinic activity and pragmatically we can't act on the data if the patient has moved on to be cared for in primary care.

AB noted that this is a digitisation of a paper approach, if we're jumping ahead, where do we see this going. JP responded that the multiple number of systems we have means we can't link with the radiotherapy system (Mosaic) or EPIC systems. Our forms do talk to the iQemo system so that could be a development. To take this to the next level we need to implement its use across all clinical teams. Digital inequality is an issue, and we don't want to make this worse, so this has to be very carefully considered.

AM asked about what Angela thinks would be important to make this useable in communities. She responded that she feels that this is straight forward to use, and it's easier to use now than it was. Patients could use it with family or carers.

DT asked if you think you can lose anything by having a new doctor who doesn't know her. Angela responded that she thinks that the information should be used by anyone who she speaks with at her appointment so it shouldn't make a difference.

SC thanked Angela for feeding back her experience and for being honest as this really helps the Board to better understand what we do and to shape how we develop services for patients.

RS asked Angela what the worst thing has been while she's been having care and treatment at The Christie. Angela responded that waiting around for bloods is not good. Coming in late in the day and waiting for treatment and having to wait until late was also difficult but this has improved a lot and is now much better. Can wait a long time for bloods very occasionally but it's got much better in recent appointments.

JP noted that it would be great to have some directive from the top to get this implemented in hard-to-reach areas. This is to benefit patients, and we need to get it implemented across all specialties.

Thanks were extended to Angela and JP and PT.

Reflections – NB noted that ePROMs has been established across most teams but its not everywhere. New care models all use ePROMs, it's now the default for new treatments. This will be necessary in Neighbourhood oncology and must be in place for an increase in care at home and in communities.

AB noted that the principal is excellent but there may be other vehicles to do this going forward. We need to be aware of all other models.

EL noted that it's important to involve the other presenters that come and we need to understand how we take forward feedback received.

SC noted that Board members must introduce themselves to the patient and not use jargon.

Item		Action
11/26	**Standard business**	
a	**Apologies**	
	Grenville Page (GP), Non-Executive Director	
b	**Declarations of Interest**	
	No declarations made relating to the items on the agenda	
c	**Minutes of the previous meeting – 26th March 2026**	
	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.	
12/26	**Performance & Finance**	
a	**Trust Report**	
	• There are no adverse variances against our objectives at month 12 and we are on green in all 6 NHS oversight framework domains. There is no adverse performance to note. • NHSE have accepted our medium-term plan and given us written feedback that confirms their acceptance of our plan with the conditions that we comply with the	

	elements outlined in it. • Monitoring has been stood down for the 1st month of the year by NHSE. Questions • GP (via written submissions ahead of the meeting) noted that it's good to see the time to set up clinical trials reducing. Any thoughts/aims as to when we can expect to be at 60-day benchmark? FB responded that April performance is at 50% and higher than similar organisations e.g. The Royal Marsden. Expecting to have consistency above 60% by Q3. • It was noted that delivering the real ambitions of neighbourhood health will demand significant culture and behavioural changes; and addressing accountability, financial and target regimes to provide levers and incentives to realise the ambitions. Report noted	
b	**Integrated performance quality & finance report**	
	• CM outlined that we have delivered everything that we said we would in year at year end. • Quality & outcomes – we have sustained robust reporting and performance against the cancer targets (FDS / 31 days / 62 days), diagnostics and all quality indicators. • DT asked about reporting of radiology scans. CM responded that the measures shown relate to when the scan is done not when it is reported. Reporting is also monitored. • Financial performance – £13.29m surplus at year end, we have £120.3m cash demonstrating strong liquidity. This cash balance reflects capital constraints in recent years restricting the level of cash that could be deployed. We delivered £25.3m value improvement programme in line with the plan. • Workforce stability – we are successfully aligning clinical capacity to forecast demand and maintaining operational resilience. • What we learnt from last year – we can make performance more predictable and less reactive. We are moving to a future resilient proactive delivery of the 5-year delivery plan. • CM outlined the research trial set up times for commercial trials that reflects capacity and complexity. Lots of targeted work to improve this. • Clinical outcomes – mortality is consistent with national benchmarks and previous performance. • Understanding performance variability – in a better position for delivery this year. • IPQFR – we are positioned well under the NHS Oversight Framework. We are looking to predict the impact of the new indicators for 2026/27. Questions • NW asked what the mode time people take on the 62-day pathway is and what the maximum wait is for patients. CM responded that cancer waiting times are measured on breaches, the patients are tracked and harm reviews are undertaken for any delays. Every patient is closely managed. • Noted that about 23% of our overall patient population are in the 62-day pathways, the vast majority of patient are in the 31-day pathway. • We have 1400 new referrals per month, about 320 are on the 62-day pathway. • There are variable timeframes for the different clinical specialty pathways.	

	• MLW asked about complaints and convergence with PALs. VS noted that as activity increases, we are getting more complaints. This reflects the national position. There is training and support to our teams around supporting patients without them getting into a formal process and dealing with issues raised quickly. • DT asked about surgical cancellations on the day and noted there are none since 20th March. CM noted the targeted work around critical care capacity and scheduling of surgery. Patient flow and enhanced care on the wards is also being looked at. • AO asked about the health inequalities analysis of 62 days. CM noted the targeted work on the statistics; due to the very small numbers this isn't significant. We are working with the system to address inequalities. • JR asked about a delivery plan for the 5-year plan. CM noted some of the work we've undertaken to assess this. There's an overarching plan that looks at all of this and is monitored through operational governance. • AM noted the impressive 62-day results and asked what's changed. CM noted that we have focused more closely on what's in our control, spreading best practice and continuing to work with the system. • Query raised on the 3 extreme risks, any changes or concerns re mitigating actions or progress. VS responded that they have all been reviewed and the detail discussed at Risk & Quality Governance and reported to SMC. There are no concerns to escalate. • Noted that Board can't lose sight of the level of non-recurrent dependency in the 2026/27 VIP plan.	
c	**Value Improvement Programme update**	
	• Paper shows the monthly update and the year-end position. • The paper gives a breakdown of the approach, governance arrangements, quality impact assessments and the framework that's in place • 2025/26 target has been delivered - £25.3m. We delivered more non-recurrent VIP than we planned to. • VIP aligns to the strategy and the systems in place are maturing and described. • Looking at reducing variation and aligning quality and safety. • Plans for 2026/27 are being developed with support from National benchmarking and local data. • Schemes have been clinically led. • £25.3m target, have identified all but £2.9m of this. • Governance for the VIP schemes was illustrated and described including quality and equality impact assessments. The process for signing off these assessments was outlined with clinical oversight and reporting through Risk & Quality Governance. • Confidence for delivery is good and aligns to planning requirements. Questions • Comment that the delivery of the operational plan and the inherent transformation and value improvements that will be gained are crucial to successful delivery of VIP longer term. • Capacity and capability in overseeing and delivering is critical. Noted that the non-execs have been raising this over recent meetings.	

d	**Risk Management strategy 2025-26 annual review**	
	• VS summarised the paper that provides annual Board assurance on the implementation and effectiveness of the Risk Management Strategy 2025–2027 • In February 2025 a new process of risk management was implemented across the organisation to strengthen the identification, assessment and management of risk. • MIAA audit has looked at our controls and identified a small number of improvement areas. • Overall risk profile has been rationalised, there's a substantial reduction in the number of active risks and a decrease in extreme-rated risks. • Now better oversight, more dynamic and effective review and more risk confidence. • Overseen by Risk & Quality Governance and Quality Assurance Committee. • The Trust will complete remaining audit actions, continue embedding risk management as business as usual, and further develop risk training. • In terms of risk appetite, we previously had an approved & published statement. Looking to use a different approach to risk appetite going forward – GGI or other established methodology. • SC noted that the risk strategy has come on and agreed that it will be good to look more on risk appetite in line with the advice. • Noted that the National Quality Strategy will be published in June – focus on quality tools, modern service frameworks, refreshing national quality board to oversee quality elements of the 10-year plan. Questions invited • Noted that we will need to formally review our risk appetite in the context of our strategy and operational plan. Question around whether we are prepared to take some more calculated and informed risks to secure transformation and better patient outcomes. Risk/reward balance. • VS agreed that this will be part of the Boards consideration. • NB added that we should use some Board time to talk about risk appetite when we think about the big plans we have going forward. • AM reflected on the recent session with Board around risk and that this was helpful and further discussion would build on this. • VS noted that there are models for risk appetite and we need to adopt an existing approach that shows a disaggregation of our appetite aligned to the strategic objectives. • RDS asked what an increased risk appetite will do in practice and enable us to do that we can't do now. • VS noted this is about evidencing decision making and investment and having evidence around why we've made the decisions we have made in line with our risk appetite. • AB noted that this is also about investment, for example around big investments in digital projects and what risks we are prepared to take to deliver our objectives. • SC noted that this is around documenting our decisions and being specific about this and our appetite for risk.	LW

13/26	**Culture**	
a	**Freedom to Speak Up Guardian report**	
	• FJ attended to present the latest update • The report covers the last 6 months of data plus the 2025 staff survey that looks at the speak up culture. • The survey indicates that staff broadly feel psychologically safe to raise concerns, and the Trust continues to perform above the national average on all four Speak Up indicators. • A gap persists between feeling able to speak up and believing the organisation will act on concerns • We outperform the national average on all four indicators, with the strongest margin in confidence that action would be taken. This suggests that challenges with follow-up are not unique to the Trust, though improvement is still required. • Differences between directorates – highlights some hotspots in certain departments that need to be addressed with specific interventions. • Some staff indicate that detriment is an issue. • Practical issues around time to report etc put people off reporting. • EDI survey shows that those with a protected characteristic are happy to report but are less positive about response. • FJ highlighted that we are working on a targeted focus on EDI aspects and improved visibility of outcomes. • There is also targeted support to lower performing areas. • Staff survey confirms that the Trust performs well but need to focus on confidence in follow up. Questions • EL noted that a lot of work has already been done. • FJ noted that we have been working on the development of the champions network from across the Trust and from different backgrounds. Have just appointed the 21st champion – ranging from band 2 to consultants. • Targeted training is being put in as well as active recruitment in other Christie sites. • Spike in cases in Autumn came after FTSU week. Proactive work leads to more people speaking up. • AO thanked FJ for the transparency and detail in the report but cautioned around people being identifiable due to small numbers. • AO asked about how we get assurance on the hot spots. • VS responded that there are live examples where interventions are taking place to support leadership teams. This triangulates with other data. FJ is very well connected to the Exec. • AO asked about resolution and who decides when this has been met. • VS agreed that this is difficult and we can't always give what people want. • Definitions around Just Culture and restorative culture were discussed, these are defined in the National Patient Safety Strategy. Further discussion to take place with VS/AO/EL/SC • Congratulations on the excellent staff survey results.	VS/EL

	• RS thanked FJ for her excellent work in the role, her activities have moved us on and reflect what the organisation needs.	
b	**Addressing Health Inequalities**	
	• JW presented the paper that summarises the statutory and regulatory requirements and our response in relation to health inequalities. • This outlines a baseline of some of the work that the organisation undertakes that talk to compliance. • We use data to understand the population we serve, our approach to addressing inequalities has been something we've been doing for many years and has been embedded in our strategy. • The establishment of our other radiotherapy centres and chemotherapy delivery model are designed to address health inequalities. • One of the challenges is that this is embedded throughout the organisation and is therefore not always explicit. • Our role as an Anchor Institution also supports this work. • NHS Alliance have a self-assessment framework that our assessment against this will be brought back to the Board. • Board asked to note the summary. Questions invited • AM noted that this is about being explicit, this has got much better over time. AM asked about what we do in Research & Education. • FB noted the many projects in research that have dedicated funding for addressing health inequalities. Our data also shows that delivery of SACT services is skewed towards patients from a lower socioeconomic background unlike other centres. This is significant when we look at how we are benchmarked with other centres where this is not the case. • Inclusion is a whole workstream in Education focusing on lived experience and how we support patients in very deprived circumstances. We have the population that enables us to focus on these groups. • Noted that our mortality data is within standard deviations from the mean, we can add in the data around deprivation alongside this. • Added that the EHIAs are driving the planning and strategic objectives. It was recognised that these need to be done more and we need to demonstrate how they are visible. • JH commented that the research here is done where the need is, rather than where the funding is. We could make more of this in how we present our approach. • FB noted that we attract funding for trials in the cancers that are prevalent in the population because we serve that whole population. • Research is being done in the area where the need is the greatest. • JR asked about observed versus expected – describing the gap – sets where we would expect to be. We need to give an indicator set for neighbourhood oncology. • RS noted that describing effectiveness of interventions is key so that we can do more of them and at scale. Examples include implementation at scale of targeted lung screening – this is the most effective intervention the NHS has seen in many years.	JW

	• AM commented that GMCA and the mayor have a focus on this. We need to know how we can work within this context. • CH noted that this is about focusing on what we can practically do and measure it. We have been addressing health inequalities and access for a number of years that's translating into better survival rates. In our activities this must be front and centre and we must focus on not widening them. We must contribute to the discussion in GM. • Challenge around whether we have any stats/hard evidence that highlights that in comparison with 2 or 3 years individuals from ethnic backgrounds / protected characteristics / deprived areas in GM now have access/services or outcomes that have improved? • Noted that lung cancer screening is a specific area of significant progress. • RS noted that we have asked CH to do a piece of work on our impact over time.	CH
c	**Patient Voice, Involvement and Engagement across Trust Governance**	
	• VS noted the paper gives the Board some additional background information on what is going on across the organisation in patient / public involvement. • We are looking at a more structured way of addressing further engagement of patients. One approach is a new group that engages many patients and carers who can be engaged and involved in our planning and brought in as and when to specific issues. • VS gave the example of a patient who is deaf who's been very involved in helping us in the design of future space and buildings. • There are many other examples of patients who will be asked for their views. • Patient voice will be brought through more explicitly in future papers. • SC noted that it's also important to give thought to what we did in response to feedback and how this is fed back. • AO noted that we must look at what the governor group is doing. • This is part of our consideration of the whole approach to engagement going forward. • JH noted that this is really encouraging and in terms of data we need to engage patients more widely and in a more comprehensive way using digital tools – prospective and retrospective data. • RS noted that this is part of the development of what we want to do to further improve and aligns to the initial feedback on the well-led review.	VS
14/26	**Governance (regulatory / statutory compliance)**	
a	**Reports from Committees (March 2026)**	
i	**Workforce Assurance Committee**	
	Paper updated verbally at the last Board. The Board noted the assurance received on the items presented and the AAA report that summarises the meeting. • Medical devices training audit & role essential training – medium assurance • Fit & Proper Persons test – strong assurance • Workforce dashboard, reducing sickness absence, national training survey – high assurance. • Board assurance framework – risks 3 & 12 discussed ○ Recruitment and retention - no change to score.	

	• Staff engagement - staff survey 2025 results to come in June, will provide assurance on controls	
ii	**Quality Assurance Committee**	

	2 alerts – verbal update given at the last meeting on these.
	• Aseptics unit risk – low assurance, coming back in June
	• Lost to follow up risk – low assurance, coming back in June
	• Risk Management strategy 24-27, Quality Strategy 26-28 – high assurance
	• Integrated governance report – strong assurance
	• Performance against national Anti-Microbial Resistance (AMR) targets – high assurance
	• Board Assurance Framework:
	  ○ NICE risk score reduced to 6 following implementation of model of care.
	  ○ PSIRF risk is a 9 – aligned to operational risk
	  ○ 62 day risk remains at a 12 to reflect ongoing issues	

iii	**Audit Committee**	
	Met last week, verbal update given. Critical committee for reviewing key elements of year end accounts and performance. Key points: • Drafts of the annual governance statement and the accounts themselves endorsed • Head of Internal Audit opinion for year is substantial assurance • Counter Fraud report for year positive - Green • Annual audit committee report signed off and effectiveness review extremely positive • Supply chain risk raised but being kept under review as a result of conflict • Will receive assessment from internal audit re Cyber risk/DSPT toolkit at the July meeting. Will consider at this stage whether committee recommends it becomes separate BAF risk - currently part of emergency planning risk.	AB/LW
b	**Board Assurance Framework**	
	• BAF has been updated to show the current position against the strategic risks. • Changes to the risk scores are outlined in the cover paper with explanations. • Q4 risk scores have been added. • Noted that most current amber risks have remained static during the whole year outside of target risk. The target risk should align with our risk appetite in that area. • Acknowledged that we intend to implement a risk appetite framework and that this will follow and be reflected in the BAF.	
c	**Register of matters approved by the Board**	
	• Board noted the paper and the summary of approvals across the financial year. • Noted	
d	**NHSE Self-certification declarations**	
	• Noted our compliant self-certification declarations that we hold for NHSE.	

	• Approved	
15/26	**Any other business**	
	• No items raised.	
	Reflections of the meeting	
	Clear that the FTSU process has shifted and is in a better place. Continuity / links with the patient story and the agenda was appreciated and very helpful.	
	Date and time of the next meeting	
	Thursday 25th June 2026 at 2pm	

The Christie
NHS Foundation Trust

Agenda item 16/26d

Meeting of the Board of Directors - 25th June 2026
Action plan rolling programme after April 2026 meeting

C Culture P Performance S Strategy G Governance

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
June 2026		C	Patient story	CEO	To hear a patient story	
	Annual reporting cycle	P	Integrated performance & qualityand finance report	COO	Monthly report	17/26b
	Annual reporting cycle	G	Annual reports from audit, quality and workforce assurance committees	Committee chairs	Assurance	At joint meeting
	Annual reporting cycle	G	Annual compliance with the CQC requirements	ECN	Declaration / approval	17/26d
		P	Value Improvement Programme	COO	Review	17/26c
		S	Annual objectives / BAF 2026/27		Approve	18/26b/c
	Annual reporting cycle	G	Annual report, financial statements and quality accounts (incl Annual governance statement / Statement on code of governance)	EDoF	Approve	18/26e
July 2026 - no meeting		P	Integrated performance & quality and finance report	COO	Monthly report	By email
Planning & Development Day	**Planning session**	S	Service Review day with senior leadership teams			
August 2026 - no meeting		P	Integrated performance & quality and finance report	COO	Monthly report	By email
September 2026		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance & quality and finance report	COO	Monthly report	
		P	Value Improvement Programme	COO	Review	
		S	Future Christie update	DFC	Review	
		S	Strategy refresh engagement plan	DoS	Review	
October 2026		C	Patient story	CEO	To hear a patient story	Board presentation
		P	Integrated performance & quality and finance report	COO	Monthly report	
		P	Value Improvement Programme	COO	Review	
		S	Future Christie update	DFC	Review	
		P	EPRR Compliance statement	COO	Approve	
		G	Regulatory preparedness update	ECN	Review	
		C	Freedom to speak up guardian	FTSUG	Annual report	
	Planning & Development Day	S	Board Planning & Development	Chair	Board development programme - externally facilitated	N/A
November 2026		C	Patient story	CEO	To hear a patient story	
	Annual reporting cycle	P	Integrated performance & quality and finance report	COO	Monthly report	
		S	Strategy update	DoS	Six month review	
		P	Value Improvement Programme	COO	Review	
		S	Future Christie update	DFC	Review	
		S	Higher Education Institute update	DoE	Note	
		S	Annual Sustainabiltiy Report - Boards responsibility for Carbon Net Zero	DCEO	Note approval by Audit Committee	

Month	From Agenda No	Category	Issue	Responsible Director	Action	To Agenda no
December 2026 - no Board meeting		P	Integrated performance & quality and finance report	COO	Monthly report	By email
	Planning & Development / Council	S	Board planning			
		S	Council / Board - strategy update			
January 2027		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Interim review of annual objectives	CEO	Review progress	
	Annual reporting cycle	P	Integrated performance report	COO	Monthly report	
		S	Future Christie update	DFC	Review	
		P	Value Improvement Programme	COO	Review	
February 2027 - no Board meeting		P	Integrated performance & quality report and finance report	COO	Monthly report	By email
	Annual reporting cycle	G	Letter of representation & independence	Chair	Circulate	By email
	Annual reporting cycle	G	Register of directors interests / FPPT annual declaration	Chair		
	Annual reporting cycle	G	Declaration of independence (non-executive directors only)	Chair		
	Planning & Development Day	S	Board development & planning	Chair	Board Development programme	N/A
March 2027		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance & quality and finance report	COO	Monthly report	
		S	Future Christie update	DFC	Review	
		P	Value Improvement Programme	COO	Review	
	Annual reporting cycle	S	Annual reporting cycle	Executive directors	Approve	
		C	Staff survey initial results	DoW	Review	
	Annual reporting cycle	G	FPPT Compliance report	Chair	Approve annual compliance	
April 2027		C	Patient story	CEO	To hear a patient story	Board presentation
	Annual reporting cycle	P	Integrated performance & quality and finance report	COO	Monthly report	
		G	Register of matters approved by the board	CEO	Approve	
	Provider licence	G	Self certification declarations	CEO	To approve the declarations	
		G	Modern Slavery Act statement (in Trust Report)	CEO	Approve	
		C	Freedom to speak up Guardian report	FTSUG	6 monthly update	
	Annual reporting cycle	P	Risk Management strategy 2025-26 annual review	ECN	Approve	
May 2027 - no meeting Planning & Development Day	Annual reporting cycle	P	Integrated performance & quality and finance report	COO	Monthly report	By email
	Planning session	S	Planning			
June 2027		S	Green Plan refresh	DoS	Approve	

NHS
The Christie
NHS Foundation Trust

Agenda item: 16/26dii

Action log following the Board of Directors meetings held on

Thursday 30th April 2025

No.	Agenda	Action	By who	Progress	Board review
1	12/26d	Include discussion on risk appetite in future Board planning session	All	Included in Board development plan with The Value Circle	Part of Board development plan
2	13/26a	Definitions around Just Culture and restorative culture were discussed, these are defined in the National Patient Safety Strategy.	VS/AO/ EL/SC	Further discussion to take place with VS/AO/EL/SC - meeting arranged	N/A
3	13/26b	Health inequalities assessment to be undertaken	CH	Review commissioned	October 2026
4	13/26c	Make visible what we did in response to patient/carer feedback and how this is fed back.	VS	Included in patient experience plan	Through QAC reporting
5	14/26aiii	Review Cyber risk and determine how this is presented on the Board Assurance Framework	AB/LW	Presentation to July Audit Committee meeting	BAF in September Board papers

The Christie NHS Foundation Trust

Agenda item 17/26a

Meeting of the Board of Directors

Thursday 25th June 2026

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 review the contents of the paper
Background Papers	Integrated Performance, Quality and Finance Report Finance Report
Risk Score	See Board Assurance Framework
EDI impact / considerations	Positive impact relating to compliance with standards
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	1. To deliver safe, effective & equitable care 2. To deliver excellent financial and operational performance 3. To provide integrated clinical, research and education services 4. To be an excellent place to work and attract the best staff 5. To transform our services to improve access and reduce health inequalities 6. To provider leadership within the wider NHS cancer system
Acronyms or abbreviations contained in the report	NHSE NHS England FDS Faster Diagnosis Standard PDR personal development review GM Greater Manchester VIP Value Improvement Programme EPR electronic patient record AI Artificial Intelligence NIHR National Institute for Health & Care Research

The Christie
NHS Foundation Trust

Trust Report

June 2026 (May data)

Introduction

We continue to perform well with no current issues requiring escalation and a projected achievement of annual objectives across all domains.

This consolidated view of the Trust's operational and strategic performance summarises the current position with regard to board capability assessment, compliance with operational requirements, progress against our annual strategic milestones within the context of national policy developments. Further details on the items in the report can be obtained from the links provided. Risks to our strategic milestones are reported in the Board Assurance Framework and details of operational performance are in the Integrated Performance, Quality & Finance report.

NHSE have reviewed our Medium-Term Plan for 2026/27 – 2028/29 and our five-year Integrated Delivery Plan. They have confirmed their assessment of its compliance subject to the conditions that the standards and performance requirements set out in the plan are delivered.

The new NHS Oversight Framework 2026/27 has been published with a number of additional metrics added in that will make up future assessments NHS England » NHS Oversight Framework 2026/27. Trust monthly reporting will be updated to reflect the new framework going forward.

Board Capability

The Christie's Board Capability self-assessment set out assurance of the board's leadership capacity, governance maturity, and preparedness to meet performance expectations.

Our self-assessment of full compliance against the NHS England provider capability domains was made at our September 2025 Public Board and submitted to NHSE in October 2025.

NHSE confirmed that our overall capability rating was assessed as 'Green' for 2025/26.

The table below summarises the position with all domains rated Green, with no escalation required.

NHSE Board capability domain	Relevant Indicators	Evidence	RAG rating
1. Strategy & Leadership	Oversight Framework segment; national ranking	NOF Segment 1, Q4 ranked 2nd nationally NHS Acute & Specialist Trusts.	
2. Quality of Care	62-day cancer standard; Faster Diagnosis Standard; nurse staffing	62-day and FDS remain above target. Nurse staffing consistently exceeding the minimum target of 80% planned levels	
3. Workforce	Sickness absence; PDR compliance; training compliance	Sickness 4.33% (lowest in GM). PDR compliance (90.0%) and mandatory training compliance (94.9%)	
4. Partnerships & System Role	GM Collaborative contributions; national audits	Leadership in Cancer Alliance. Lead GM aseptic programme. OECI reaccreditation confirms global top-tier status.	

NHSE Board capability domain	Relevant Indicators	Evidence	RAG rating
5. Financial Sustainability	Monthly surplus; VIP delivery	Surplus (£1.28m) on plan; value improvement plan target on track.	
6. Improvement & Innovation	Clinical trial set-up; AI pilots; EPR milestones	Research set-up below 60-days. Digital/AI projects and Future Christie milestones progressing to plan.	

Operational Performance – Month 1 Position

We continue to perform strongly across all domains. We are in Segment 1 of the NHS Oversight Framework, the highest possible rating, and at Q4 are ranked 2nd nationally among acute and specialist providers. Our international standing ranks us as one of the top 25 global cancer centres as reported at the September 2025 board meeting. Our overall NHSE provider capability rating is assessed as 'Green' for 2025/26.

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

Strategic Objectives – Month 1 Position

Progress against the 2026/27 annual milestones of each of our six strategic objectives is currently rated Green, with risks actively managed and oversight of risks clearly assigned to committees or the board and tracked through the Board Assurance Framework.

Strategic Objective 1: Safe, Effective and Equitable Care

Quality remains consistently high, with proactive risk management and a maturing learning culture providing strong assurance on patient safety.

- Overall Status: Green
- BAF Risks: 0 ≥15
- Committee Oversight: Quality Assurance Committee
- Executive Lead: Executive Chief Nurse

There were no significant adverse quality variances in May. Four operational risks currently score above 12 and risks are actively monitored via the Risk & Quality Governance Committee, with mitigation plans in place.

Safe staffing was maintained, with nurse staffing consistently exceeding the minimum target of 80% planned levels.

Strategic Objective 2: Excellent Financial and Operational Performance

The Trust is financially stable and operationally compliant, with no deviation from plan and full delivery against agreed improvement targets.

- Status: Green
- BAF Risks: 1 ≥15
- Committee Oversight: Board of Directors
- Executive Lead: Executive Director of Finance

At Month 2, the Trust is delivering a financial surplus of £1.28 million, in line with plan. The Value Improvement Plan for 2026/27 has been achieved, and operational performance remains

compliant against all major cancer standards, including the 62-day, 31-day and Faster Diagnostic Standard (FDS) metrics.

NHSE's Head of Cyber Security has written to Trusts to ask Boards and executives to assure themselves that cyber security risks are being managed effectively through governance structures. Assessment of the cyber risks sits with the Audit Committee, and a report will be presented to the July meeting. This will then be reported through to the Board of Directors in September.

Strategic Objective 3: Integrated Clinical, Research and Education Services

The Trust is strengthening its research and academic profile, with national investment secured and a strategic education proposal in development.

- Status: Green
- BAF Risks: 0 ≥15
- Committee Oversight: Board of Directors
- Executive Lead: Director of Research and Director of Education

We are working towards the national 60-day benchmark for research trial set-up times. YTD performance, 48% met the 60 day timeline the median time to study set-up was 64 days, an improvement from 100 days in the previous year, reflecting progress across both commercial and non-commercial studies. We have achieved two global first site activation and one European first. Further process improvements are underway to sustain and build on this position. We are on target to move over to EDGE- clinical trial management system from R Peak in July and are currently finalising Set up workstream for Florence- Digital Trial Master File.

Progressive improvement in external quality markers of education include those related to NOF ratings, National Education & Training Survey 81.5% (72% 2022) and National Training Survey 80% (71% 2022). Undergraduate learner experience within the Christie remains stable with overall satisfaction scores of 91-99% across disciplines. Workforce Education activity updates include a 40% increase in colleagues accessing CPD funding for education opportunities with WRES data demonstrating equal access/activity for racially minoritised staff.

Plans to establish a credentialled Masters level education suite and achieve recognised Higher Education Provider status continue to progress smoothly with funding released to support the remainder of the design and procurement phase, learner recruitment and initial delivery. This work represents a significant transformation that reinforces our position as a centre of excellence in cancer education.

Strategic Objective 4: Excellent Place to Work and Attract the Best Staff

The Christie maintains a high performing, engaged workforce with strong, nationally leading, indicators of morale, inclusion and leadership visibility.

- Status: Green
- BAF Risks: 0 ≥15
- Committee Oversight: Workforce Assurance Committee
- Executive Lead: Director of Workforce

Workforce indicators remain strong. Mandatory training compliance stands at 94.9%, and PDR completion is at 90.0%. Sickness absence is currently at 4.33%, the lowest in Greater Manchester. The Christie continues to be rated in the top category nationally for compassionate and inclusive culture, staff engagement, safe & healthy, morale and flexibility, as confirmed by the NHS Staff Survey 2025.

The original intention was to publish the NHS Staff Standards in April. Due to the local elections the publication date was delayed, so their launch coincides with that of the National Oversight Framework technical guidance. The latest position is that they will now be contained within the 10YWP. The standards will cover health and wellbeing, effective line management, promoting flexible working, preventing and reducing violence against staff, improving sexual safety, and tackling racism. They will be mandatory and feed into the 2026/27 Oversight Framework.

The government has published the Mann Review into antisemitism and other forms of racism in the NHS, alongside its response and next steps. Lord Mann review into tackling racism and antisemitism

The review makes clear that racism in the NHS is a serious workforce, culture and safety issue, and that employers must play a leading role in preventing incidents, responding consistently and learning from them. The government response includes new NHS staff standards on tackling racism, stronger leadership accountability, updated training requirements and clearer national guidance for employers.

We are now reviewing the recommendations and considering any local action needed. This will be discussed through the Workforce Assurance Committee.

Our new staff portal which will replace HIVE is planned to launch in July. While work goes on in the background to upgrade and enhance what information staff will be able to see and search for on the portal.

Strategic Objective 5: Transform Services and Reduce Inequalities

Transformation is progressing as planned, with digital infrastructure and service equity both advancing in line with strategic commitments.

- Status: Green
- BAF Risks: 0 ≥15
- Committee Oversight: Board of Directors
- Executive Lead: Future Christie Director, and Director of Strategy

Our Future Christie transformation programme remains on track. The Patient Portal has been successfully rolled out, connected to the NHS App. An outline business case for a new electronic patient record (EPR) was approved by the Board in February. The capital programme is progressing to plan and remains within budget.

We continue to address inequalities in access to services. Notably, we have consistently achieved the Faster Diagnostic Standard target for haematology patients in Mid-Cheshire, demonstrating our commitment to equitable care across the region.

Strategic Objective 6: Leadership Within the Wider NHS Cancer System

The Christie's leadership role within the regional and international cancer system is recognised and expanding.

- Status: Green
- Key Updates: OECI reaccreditation; GM Collaborative leadership; network expansion
- BAF Risks: 0 ≥15
- Committee Oversight: Board of Directors
- Executive Lead: Director of Strategy

The Trust continues to play a leading role within the Greater Manchester Provider Collaborative, contributing to all eight shared priorities and leading the GM Aseptic programme. Our haematology network has expanded to include Macclesfield and Crewe with active plans to extend to additional sites, further consolidating our system leadership.

The table below summarises our current delivery status against the six strategic objectives, including risk ratings and committee oversight.

	Strategic Objective	Risk rating	Committee oversight
1	Safe, Effective and Equitable Care		Quality Assurance Committee
2	Excellent Financial and Operational Performance		Board of Directors
3	Integrated Clinical, Research and Education Services		Board of Directors
4	Excellent Place to Work and Attract the Best Staff		Workforce Assurance Committee
5	Transform Services and Reduce Inequalities		Board of Directors
6	Leadership Within the Wider NHS Cancer System		Board of Directors

National Policy Developments

The Trust is appraised of and involved in shaping current NHS policy and well positioned to take advantage of emerging opportunities.

Recent updates to NHS England policy frameworks are directly relevant to our strategic planning.

These include;

1. NHS Planning Priorities & Operating Guidance (2026/27) Published: 1 April 2026

Key policy content

- Sets out system priorities for 2026/27 & medium-term delivery aligned to the 10 Year Health Plan.
- Emphasises:
  - Delivery against elective (RTT) and urgent & emergency care targets
  - Implementation of neighbourhood health models
  - Strengthening strategic commissioning and system working
- Introduces a multi-year planning approach, requiring systems to articulate 3-year transformation narratives and how partners will deliver change together.

Operational changes / expectations

- Launch of an Intensive Recovery Programme for underperforming systems.
- Greater focus on:
  - Outpatient transformation (reducing follow-ups via advice & guidance)
  - Urgent care access reform
  - Use of digital tools and productivity technologies
  - Expansion of the NHS App as the 'digital front door'

Why it matters for Boards

- Sets the core performance and transformation expectations for 2026/27.
- Reinforces shift to system accountability (ICBs + providers) rather than organisational silos.
- Requires demonstrable progress on access, productivity and service redesign.

2. Financial Framework Confirmation for 2026/27 - effective from April 2026

Key content

- Financial directions (published late March but operationalised from April) confirm:
  - £215bn revenue resource limit

  - £5bn capital limit for NHS England and the wider system

Why it matters

- Establishes tight financial envelope underpinning April planning.
- Reinforces pressures on:
  - productivity improvement
  - cost control
  - capital prioritisation

3. Emerging Legislative Reform – NHS Structural Changes

Key proposals

- Abolition of NHS England and transfer of functions to:
  - Department of Health and Social Care (DHSC)
  - Integrated Care Boards (ICBs)
- Aims to:
  - Reduce duplication and bureaucracy
  - Strengthen central accountability
  - Enable faster delivery of the 10 Year Health Plan

Why it matters

- Represents major system architecture reform (most significant in recent years).
- Implications for:
  - National vs local accountability
  - Role of Boards and ICBs
  - Governance structures and oversight lines (removal of governors)

The Health Bill

The Health Bill (the 'Bill') was introduced in the House of Commons on 14 May 2026 following the King's Speech. The Bill gives legislative effect to a number of policy commitments associated with the NHS 10 Year Health Plan and wider reforms to the organisation, governance and accountability of the health and care system.

In particular, the Bill provides the legal basis for:

- the abolition of NHS England and the transfer of its functions to the Department of Health and Social Care, Integrated Care Boards and/or the Secretary of State, depending on the function;
- the statutory framework to enable a Single Patient Record across the NHS;
- the abolition of Healthwatch England and the transfer of local Healthwatch functions into Integrated Care Boards and local authorities;
- changes to the governance of NHS foundation trusts, including removing the statutory requirement for Councils of Governors and members;
- the transfer of NHS England's provider oversight and regulatory functions to the Secretary of State;
- the ability for the Secretary of State to de-authorise NHS foundation trusts in cases of serious failure.

The Bill also includes a number of further provisions, including the transfer of the Health Services Safety Investigations Body into the Care Quality Commission, changes to Integrated Care Board governance and commissioning responsibilities, and the removal of the statutory requirement for local areas to have an Integrated Care Partnership.

The Bill also strengthens local democratic accountability by requiring Integrated Care Boards (ICB) to include a member nominated by each mayor of a mayoral strategic authority within the ICB's area. In a related policy development, the Government has announced that Greater Manchester and South Yorkshire will trial arrangements under which newly appointed

ICB chairs will also serve as the Mayor's health commissioner, reporting jointly to the health service and the elected mayor. This creates a new local democratic accountability mechanism, but may also create a more complex accountability environment for the NHS.

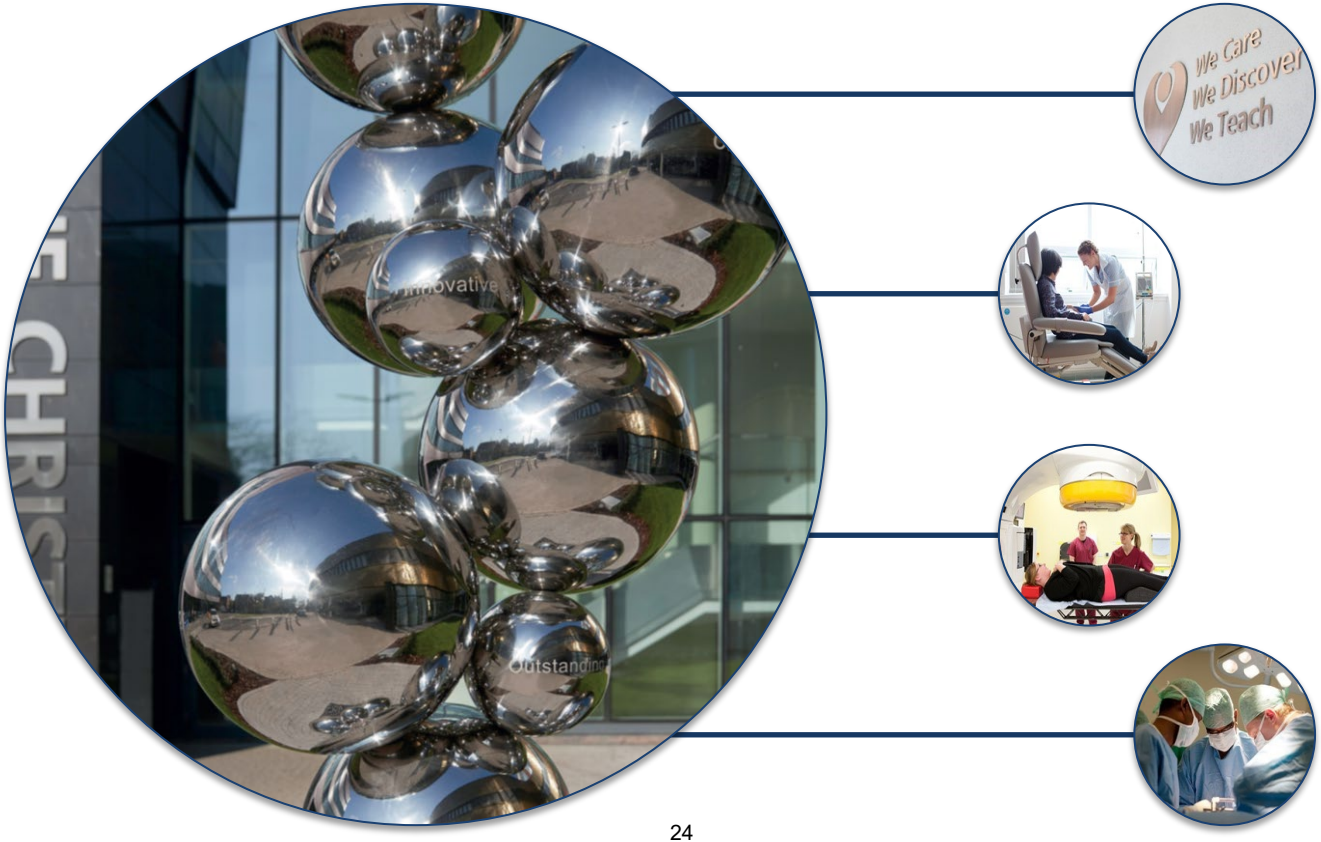
The English Devolution and Community Empowerment Act 2026 also creates a new duty for Mayors and Strategic Authorities to consider local health improvement and health inequalities when making policy decisions.

Although still in the legislative process, the Bill has raised a number of significant issues, including:

- the potential centralisation of formal powers in the hands of the Secretary of State, which may appear to sit uneasily alongside the stated policy intention of devolving power to local systems and providers;
- the information governance, data protection and cyber-security implications of implementing a Single Patient Record;
- the risk that abolishing Healthwatch could weaken the independent patient voice within the health and care system;
- the potential complexity created by new mayoral health roles and the relationship between local democratic accountability, ICB statutory duties and national NHS accountability.

The Bill remains subject to parliamentary scrutiny. Its final form and implementation timetable will depend on parliamentary passage, any amendments and commencement arrangements.

NHS
The Christie
NHS Foundation Trust



EXECUTIVE SUMMARY

NHS
The Christie
NHS Foundation Trust

Safety (slides 3-15): Incident reporting remains strong, with 1,002 incidents recorded in May 2026, 98% resulting in low or no harm and 15% identified as near misses, indicating a positive reporting culture and adherence to expected reporting trends. Risk management processes are robust, with 97% of risks reviewed within required timeframes and all extreme risks compliant with Trust review standards, alongside continued structured surveillance and improvement actions for HCAIs.

Finance (slides 16-20): The Trust is reporting a small year-to-date surplus of £0.03m, broadly in line with plan, with strong liquidity (£104.5m cash balance) and continued compliance with payment targets. Delivery of the Value Improvement Programme is on track in-year (£25.3m identified), although there remains a recurrent shortfall and a risk-adjusted gap of £7.7m requiring ongoing mitigation.

Access & Performance (slides21-30) :. Performance trajectories show overall improvement, with cancer pathway delivery (including 62-day performance) demonstrating sustained recovery and recent performance consistently above 80%, although variability and pathway-level risk remain. Other operational standards show stable or improving delivery, with some areas achieving sustained high performance above 90%, but continued focus is required to embed consistency and meet higher internal targets

Workforce (slides 31-36): Workforce-related indicators show increasing reliance on temporary staffing, with both agency and bank spend rising month-on-month, particularly within medical staffing, indicating underlying capacity pressures. Despite this, overall service delivery improvements suggest that workforce deployment and operational controls are supporting performance, though sustainability remains a consideration.

Outcomes (slides 37-38): Clinical outcomes remain within expected ranges, with 30-day post-Systemic Anti-Cancer Therapy mortality consistent with national benchmarks and within statistical control limits. This indicates stable and safe delivery of treatment outcomes aligned with both Trust and national performance.

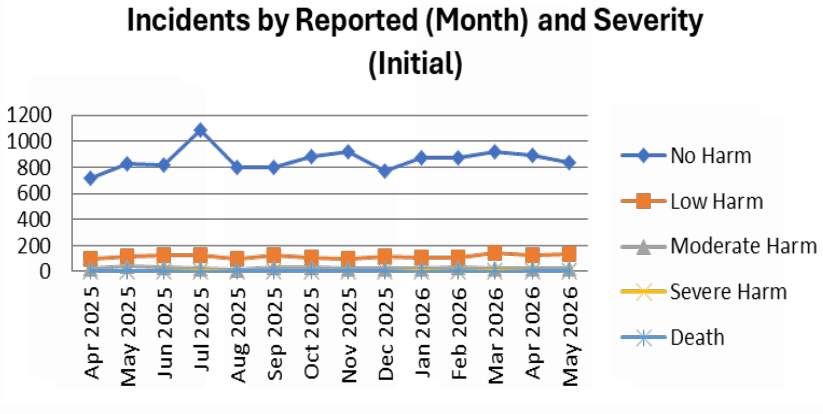
Research (Slides 39-42: Research performance has strengthened, with a marked improvement in commercial study set-up times (43% within 60 days, up from 30%) and a reduction in median time to 67 days compared to 100 days previously. While a backlog of complex studies remains, active management and digital transformation initiatives are in place to improve flow and sustain progress.

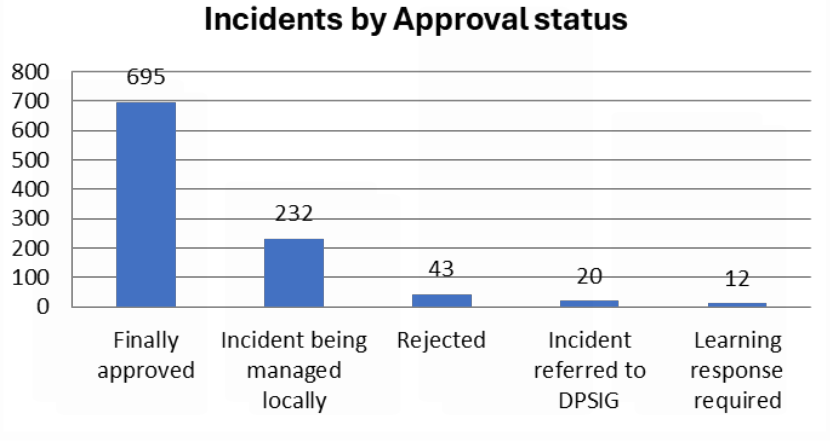
Overall Assessment: The Trust demonstrates a generally stable and improving position across safety, performance, outcomes, and research, with financial delivery broadly on plan and clear evidence of strengthened operational grip. This is reflected in a strong comparative position, with an NHS Oversight Framework ranking of 2nd out of 134 providers, although continued focus is required on performance consistency, recurrent financial delivery, and workforce sustainability to maintain this position.

Incident Reporting

A total of 1002 incidents were reported to DCIQ in May 2026.

- At the time of reporting, 69% of incidents have been finally approved. 4% of incidents have been rejected for reasons such as duplication and incidents which involve care provided by an external trust.
- 98% of all incidents reported resulted in low/no harm.
- 15% of incidents were reported to be a 'near miss', evidencing a positive reporting culture.
- Reporting trends in May were within the expected limits.



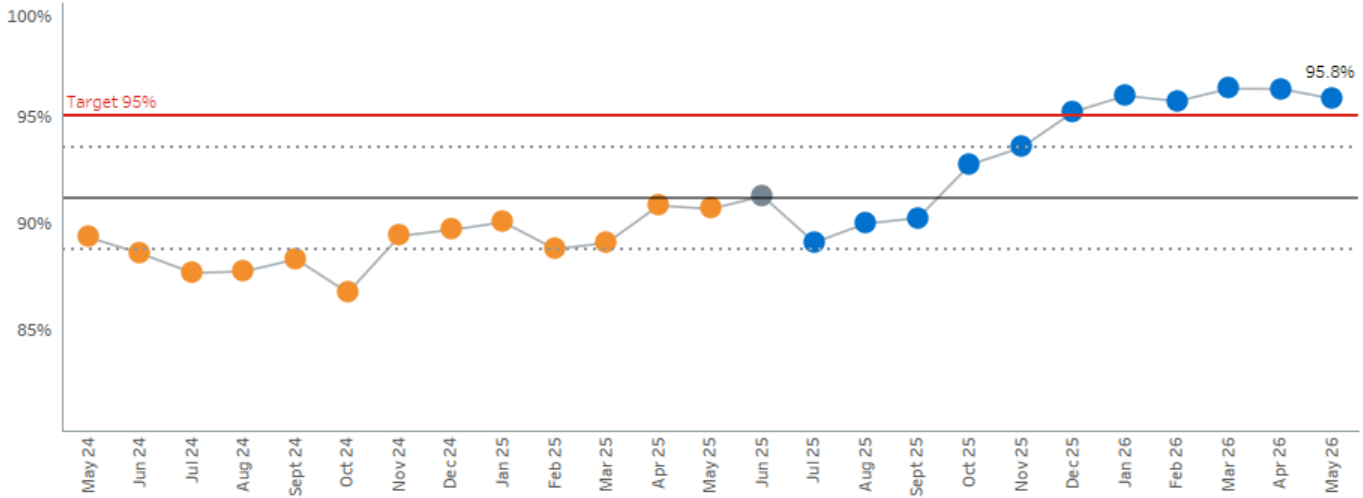


Integrated Performance Report - Patient Care Metrics Summary

NHS
The Christie
NHS Foundation Trust

Metric	Month	Measure	Target	Variation	Assurance
Sepsis - screening (presenting as an emergency)	May	97.00%	90.00%		
Sepsis - timely treatment with IV antibiotics (established inpatients)	May	91.00%	90.00%		
VTE Assessment Within 14 Hours of Admission	May	95.81%	95.00%		
Falls per 1000 bed days	May	3.9	3.8		
Pressure sores per 1000 bed days	May	0.8	0.5		
Category 3 pressure ulcers	May	0.0	0.0		
Hospital Cancelled Operations on the day for non clinical reasons	May	4.0	0.0		

VTE Assessment Within 14 Hours of Admission



Icons

Improving

Failing

Summary

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

Failing If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.

Understanding the performance

Performance has improved from c.87–90% to 95.8%, with a sustained upward trend since autumn 2025, indicating that recent process changes are having a consistent impact against the 95% standard.
Variation earlier in the period caused be inconsistent completion within 14 hours at the point of admission, linked to workflow, ownership, or timing of assessment.

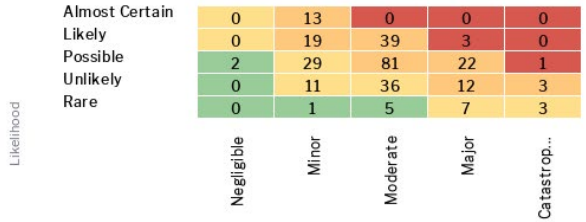
Actions (SMART)

Implement new form checklist in CWP, monitored daily, with compliance reported at ward level.
Weekly exception reporting at operational management group.
Sustained performance ≥95% for three consecutive months by embedding real-time tracking and targeted support to outlier areas.

Risk Profile

New	New longer than 3 days	Active	Rating over 12	Due next 30 days	Overdue
5 Risks	5 Risks	282 Risks	4 Risks	197 Risks	9 Risks

Risks Matrix



Risks by Level

Current rating	# Risks
Low	8
Moderate	86
High	189
Extreme	4

- In May 2026 there were 282 open risks recorded in DCIQ
- Of the risks open, 67% (n=189) were rated as high
- 4 risks were rated as being 'extreme', 2 of which were pending divisional review and assessment and so have not been included under the movement of extreme risks slide (≥15)
- 97% of all active risks were reviewed within planned timeframes (9 risks were overdue scheduled review)

Trust wide risk register

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	Target rating	Movement	Next Review Date
101	There is a risk to the Trust's ability to demonstrate compliance and adherence to it's regulatory and statutory requirements under PSIRF	Trust wide	External Risk	Strategic Planning Risk	Active	Katerina Pearson	10/03/2025	16	3	3	9	6	↔	15/06/2026
267	Risk of; Ineffective management and application of procedural and clinical documents due to fragmented document control systems.	Trust wide	Operational Risk	Change Risk	Active	Benjamin Vickers	28/02/2019	15	4	3	12	3	↔	10/06/2026
496	There is a risks that patients may experience delays to their care and treatment due to limited medical resources within the anaesthetic service	Trust wide	Clinical Risk	Patient Safety / Outcomes Risk	Active	Ben Smeeton	23/07/2025	9	3	3	9	6	↓	15/06/2026
514	There is a risk that patients may experience harm due to significant delays in the management of patients with colorectal cancers.	Trust wide	Clinical Risk	Patient Safety / Outcomes Risk	Active	Tracey Jones	05/09/2025	16	3	4	12	8	↔	14/06/2026
530	There is a risk that may impact patient safety due to non-compliance with mandatory training	Trust wide	Workforce Risk	Workforce Performance Risk	Active	Mr David Smithson	22/09/2025	12	4	3	12	6	↔	30/06/2026
548	If the Trust does not deliver the 2026/27 recurrent Value Improvement Programme (VIP) target due to the challenging scale of savings, then there is risk of limited capacity to invest in and improve patient care, leading to reduced ability to achieve	Trust wide	Financial Risk	Financial Management / Waste Reduction Risk	Active	Jo Leece	30/09/2025	12	4	4	16	8	↔	05/06/2026
617	There is a risk of a patient coming to harm due to unclear and non-standardised operational processes for clinical correspondence	Trust wide	Clinical Risk	Patient Safety / Outcomes Risk	Active	Suzanne MacGregor	19/12/2025	9	4	3	12	6	↔	25/06/2026
630	Risk that the Aseptic unit will be unable to deliver required capacity during a period of recovery following shutdown due to a recognised inability to maintain required operational & safety standards	Trust wide	Operational Risk	Business Continuity Risk	Active	Joanne McCaughey	26/01/2026	20	3	4	12	4	↔	01/07/2026
640	(Business continuity risk) Failure of back up isolator resulting in inability to produce trial / critical medications.	Trust wide	Operational Risk	Business Continuity Risk	Active	Jackie Wrench	11/02/2026	15	3	5	15	5	↔	26/06/2026

The Trust wide risks are defined as those that need impact Trust wide or need organisation wide involvement to resolve. Associate Director of Governance hold responsibility for this; agreeing new risk and overseeing controls, reviews and actions.

Movement of extreme risks

Risk ID	Risk	Risk register	Type	Subtype	Status	Risk owner	Date opened	Initial rating	Current likelihood	Current consequence	Current rating	Target rating	Movement	Next Review Date
548	If the Trust does not deliver the 2026/27 recurrent Value Improvement Programme (VIP) target due to the challenging scale of savings, then there is risk of limited capacity to invest in and improve patient care, leading to reduced ability to achieve	Trust wide	Financial Risk	Financial Management / Waste Reduction Risk	Active	Jo Leece	30/09/2025	12	4	4	16	8	↔	05/06/2026
640	(Business continuity risk) Failure of back up isolator resulting in inability to produce trial / critical medications.	Trust wide	Operational Risk	Business Continuity Risk	Active	Jackie Wrench	11/02/2026	15	3	5	15	5	↔	26/06/2026

- As of the current reporting period, 2 risks have a score of 15 and above.
- In May 2026, all extreme risks were reviewed within the required Trust timescales and were therefore compliant with the Trust's risk review process.

Integrated Performance Report - Safer Staffing

WARD	Day Reg Fill Rate	Night Reg Fill Rate	CHPPD - Registered	Day Unreg Fill Rate	Night Unreg Fill Rate	CHPPD - Unregistered	Month total inpatients at 23:59 each day	CHPPD - Overall
Oncology Critical Care Unit	98%	103%	26.3	71%	N/A	1.6	163	27.9
Palatine Ward	88%	94%	6.2	90%	129%	2.1	899	8.3
Ward 10	93%	95%	4.6	79%	145%	3.1	778	7.8
Ward 11	101%	102%	5.4	94%	118%	4.3	604	9.7
Ward 12	102%	107%	4.0	101%	124%	3.3	830	7.4
Ward 4 and 4a	99%	108%	4.3	97%	107%	3.2	783	7.6
Ward 2	99%	99%	4.5	140%	126%	3.5	545	8.0
Acute Assesment Unit	94%	102%	7.2	82%	90%	2.9	535	10.0
TOTAL	96%	101%	5.8	94%	119%	3.1	5,137	8.9

Care Hours Per Patient Day (CHPPD)= Hours of registered ward-based staff + Hours of non-registered ward based staff / Total number of inpatients at 23.59

Understanding the performance

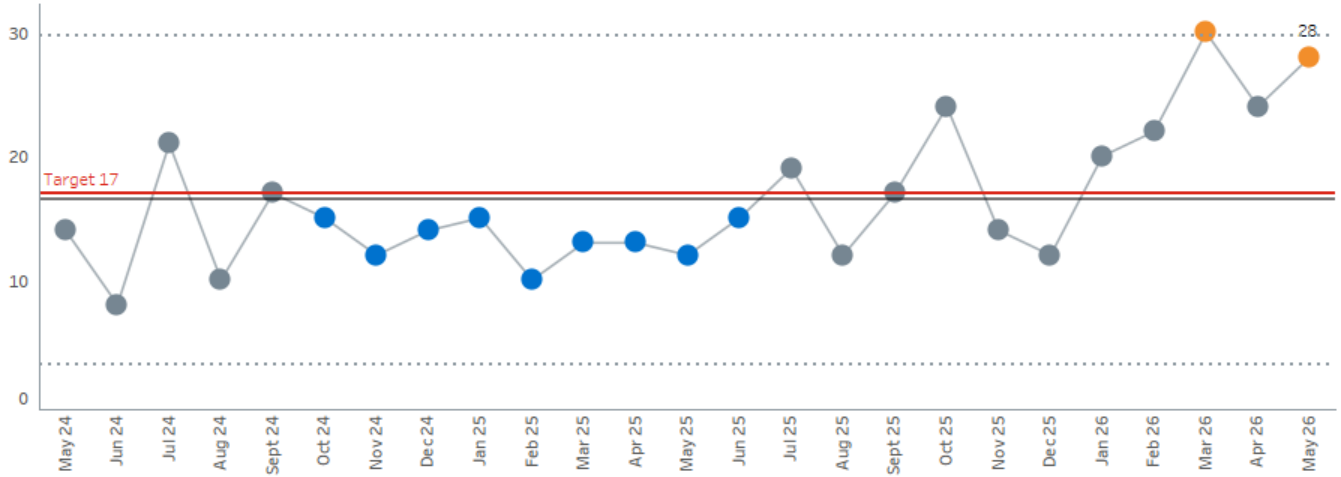
Increased enhanced observations of care requirements across the Trust, with not all bank shifts covered during the day. Staff redeployed according to acuity and dependency to ensure all areas safely staffed with senior oversight at twice daily staffing meetings.

Integrated Performance Report - Friends & Family Test & Patient Experience

NHS
The Christie
NHS Foundation Trust

Metric	Month	Measure	25/26 Avg	Variation	Assurance
Inpatient Response Rate	May	32.30%	34.00%		
Inpatient Recommended Score	May	98.50%	97.00%		
Outpatient Recommended Score	May	96.40%	96.00%		
Number of new complaints	May	24	17		
Number of PALS	May	44	48		

Integrated Performance Report - Complaints



Icons

Concerning

Hit & Miss

Summary

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

Hit or Miss The process limits on SPC charts indicate the normal range of numbers expected. If a target lies within those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean the more likely the target will be achieved or missed at random.

Understanding the performance

Over the last few months complaints received by the Trust have increased steadily however PALS have reduced slightly.

Actions (SMART)

A review of the complaints process is being undertaken which will focus on early resolution prior to formal complaint needing to be logged.

Healthcare Associated Infections

The Christie NHS Foundation Trust

HCAIs against thresholds 2025-26 – HOHA & COHA only

Indicator	Threshold	Position	YTD	Threshold adjusted to month 2	Difference
C.*Difficile*	≤ 52	Below trajectory	12	8	+4
E.coli BSI	≤ 43	Above trajectory	8	7	+1
Klebsiella spp. BSI	≤ 24	Above trajectory	5	4	+1
P.Aeruginosa BSI	≤ 8	Above trajectory	0	1	-1

HCAIs being monitored

Indicator	Target	Position	YTD	Threshold adjusted to month 2
MRSA BSI	Zero tolerance	Above trajectory	0	-
MSSA BSI	No target	No target	3	-

Thresholds set by NHSE for 2026/27 not agreed; working to 2025/26 thresholds until received.

HCAI Surveillance, Learning and Improvement Assurance

Surveillance and oversight: Continuous monitoring of all reportable HCAIs with routine reporting and escalation through governance structures.
Learning response (PSIRF): All cases are subject to proportionate learning responses to identify contributory factors and assess avoidability.
Improvement actions: Targeted interventions (e.g. antimicrobial stewardship, device care, hygiene standards) are implemented and tracked.
Embedding learning: Themes are shared across teams to support sustained improvement and prevent recurrence.

Christie CODE Quality Assurance Programme

The Christie NHS Foundation Trust

CODE = Care, Observation, Documentation, Experience

31st May 2026

Ward/dept	CODE outcome	Last inspection date
Palatine Ward	Green	April 2026
Withington Ward	Gold	September 2025
Ward 2	Gold	October 2025
Ward 4	Green	March 2026
Ward 10	Gold	December 2025
Ward 11	Gold	November 2025
Ward 12	Green	April 2026
CRF	Gold	June 2025
AAU	Gold	May 2026
Ward/dept	**Quality Mark outcome**	
Outpatients	Gold	October 2025
Ambulatory Care	Gold	September 2025
Christie at Macclesfield	Gold	May 2023
Christie at Oldham	Gold	May 2023
Christie at Salford	Gold	March 2023
Christie at Tameside		To be assessed in 2026
Withington radiotherapy	Gold	November 2022
Integrated procedure unit	Gold	January 2026

The CODE (inpatients) Quality Mark (non-ward-based areas) Quality Scheme Tool translates gathered/observed evidence against standards into an overall colour-rated status for the ward

Gold status = 10 or more gold standards, no red standards

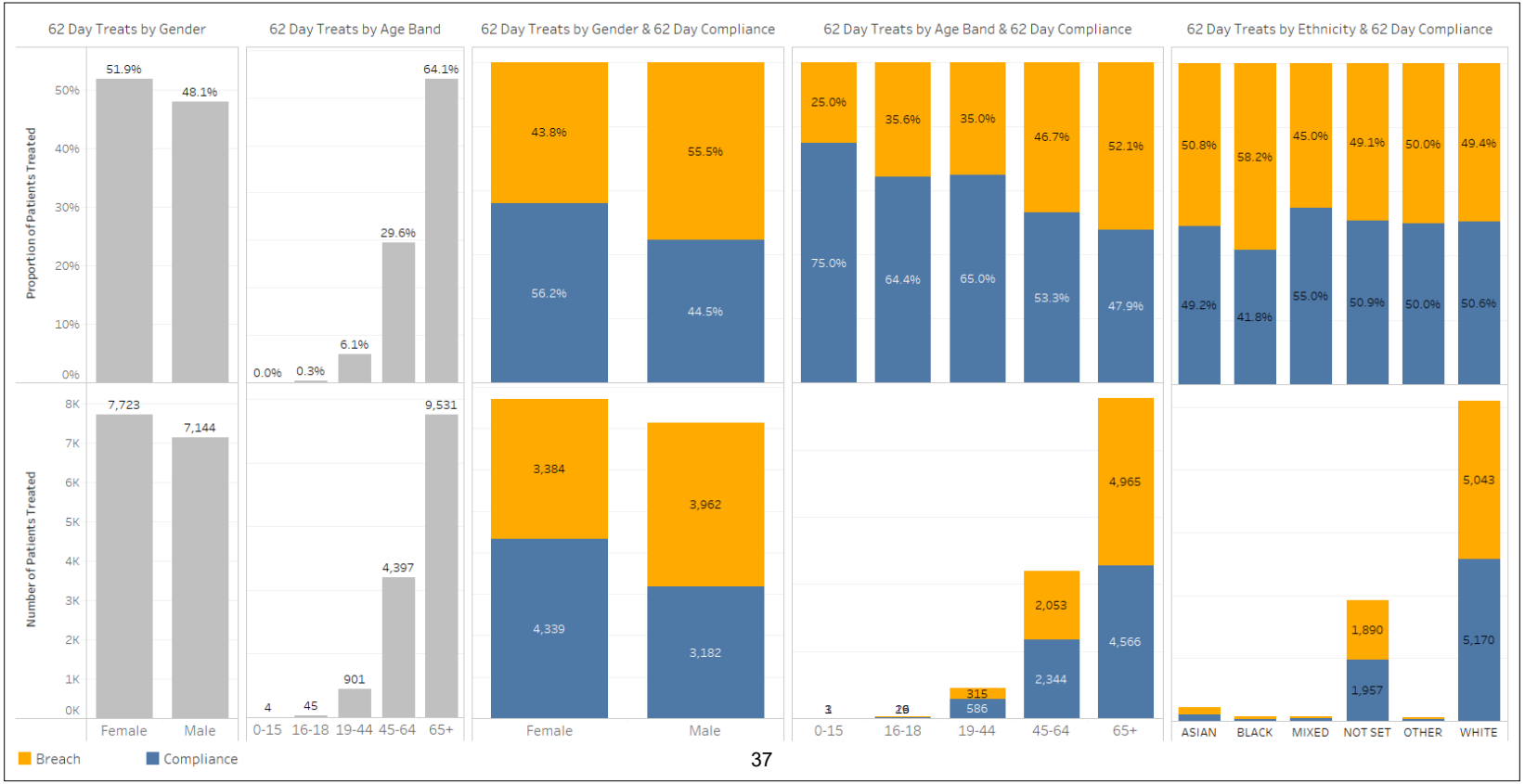
Green status = All standards green or gold

Red status = One or more standards red

- Networked sites at Macclesfield, Oldham, Salford and Tameside along with Withington radiotherapy will be re-accredited in 2026.
- Care quality assurance monthly audit process (mini-CODE) and quality improvement programme forms basis of annual assessment process.

Cancer Standards – Health Inequalities Analysis

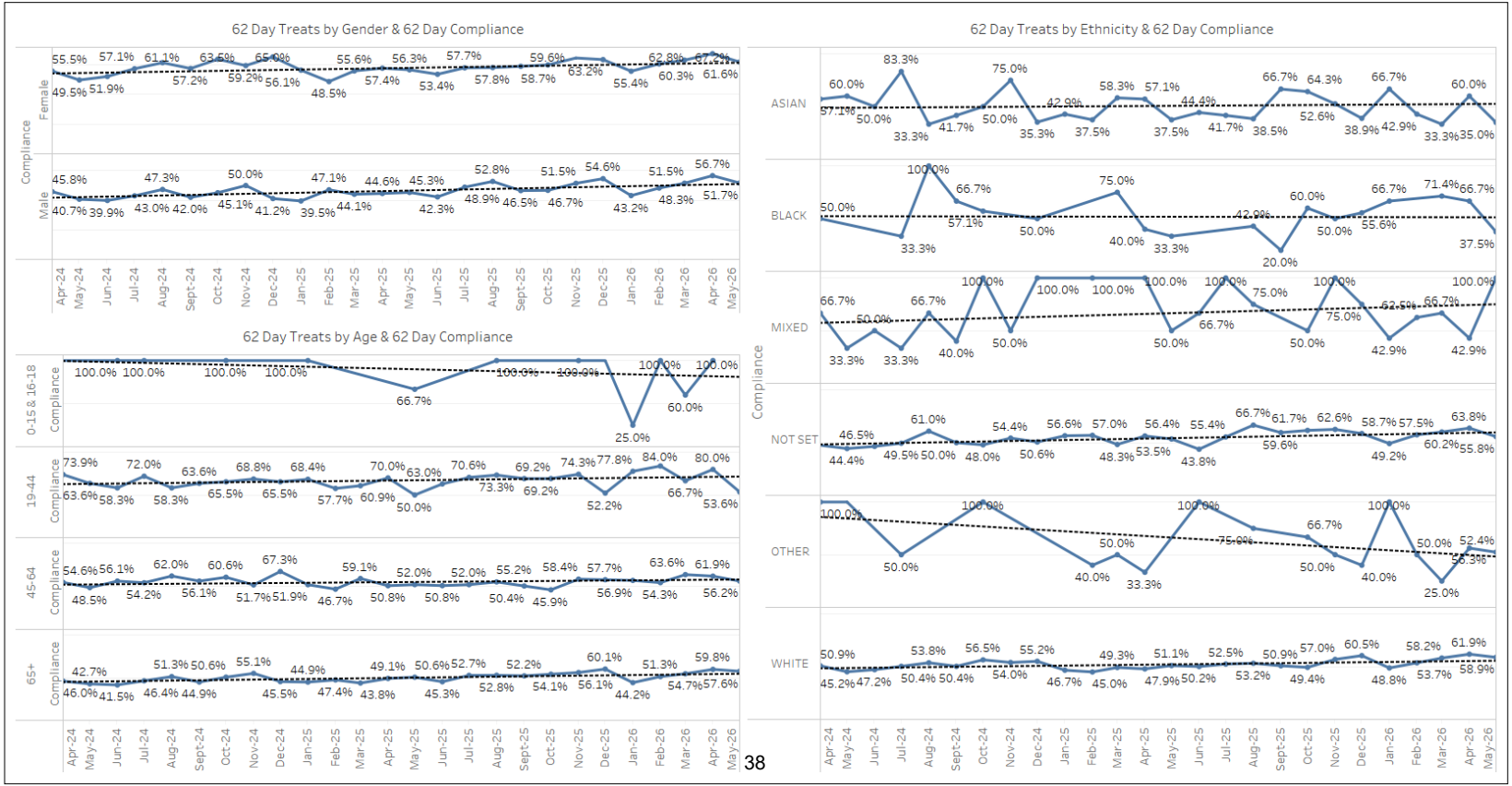
62 Day Treatments between 01/04/2023 – 31/05/2026 analysed by gender, age and ethnicity.



Cancer Standards – Health Inequalities Analysis

NHS
The Christie
NHS Foundation Trust

62 Day Treatments between 01/04/2023 – 31/05/2026 analysed by gender, age and ethnicity.



NWLMDS Ethnicity Summary

NHS
The Christie
NHS Foundation Trust

What is the NWLMDS?

The National Waiting List Minimum Data Set is a weekly return at patient level which focuses on the number of patients currently on an open referral to treatment pathway. This is effectively a measure of how many patients are currently awaiting treatment at each Trust. Several data points are submitted for each patient which cover all the relevant pathway dates and waiting times can be calculated. Patient demographics are also included within the return including Ethnicity Code which is based on the national data set.

What are we submitting?

The Ethnicity code field is currently being completed on the weekly return using the available data we have within our master patient index. The data is extracted live and so is as timely as possible. As the weekly return includes patients registered on a pathway up to the previous Sunday, this provides a challenge to ensure ethnicity data is captured at the point of registration. The return is a snapshot each week and whilst some patients will appear in multiple returns, there is a short window to update the ethnicity code and therefore report correctly. There are no opportunities to backdate the data.

Each return contains approximately between 3500 – 4000 records. The breakdown of the ethnicity coding in the latest April return is below;

		Return Week Ending													
		19/04/2026		26/04/2026		03/05/2026		10/05/2026		17/05/2026		24/05/2026		01/06/2026	
	Ethnicity Category	TOTAL	%	TOTAL	%	TOTAL	%	TOTAL	%	TOTAL	%	TOTAL	%	TOTAL	%
A	White - British	1593	41.9%	1564	44.3%	1569	44.5%	1579	44.8%	1721	48.8%	1712	48.5%	1715	48.6%
B	White - Irish	24	0.6%	16	0.5%	19	0.5%	20	0.6%	23	0.7%	28	0.8%	31	0.9%
C	White - Any other White background	34	0.9%	44	1.2%	48	1.4%	49	1.4%	50	1.4%	63	1.8%	63	1.8%
D	Mixed - White and Black Caribbean	7	0.2%	7	0.2%	6	0.2%	9	0.3%	8	0.2%	10	0.3%	12	0.3%
E	Mixed - White and Black African	8	0.2%	9	0.3%	8	0.2%	8	0.2%	8	0.2%	9	0.3%	12	0.3%
F	Mixed - White and Asian	6	0.2%	5	0.1%	5	0.1%	6	0.2%	6	0.2%	6	0.2%	5	0.1%
G	Mixed - Any other mixed background	7	0.2%	7	0.2%	12	0.3%	10	0.3%	15	0.4%	14	0.4%	17	0.5%
H	Asian or Asian British - Indian	12	0.3%	20	0.6%	22	0.6%	25	0.7%	29	0.8%	29	0.8%	21	0.6%
J	Asian or Asian British - Pakistani	34	0.9%	35	1.0%	33	0.9%	39	1.1%	44	1.2%	49	1.4%	52	1.5%
K	Asian or Asian British - Bangladeshi	4	0.1%	5	0.1%	3	0.1%	6	0.2%	9	0.3%	8	0.2%	10	0.3%
L	Asian or Asian British - Any other Asian background	18	0.5%	18	0.5%	11	0.3%	15	0.4%	19	0.5%	18	0.5%	18	0.5%
M	Black or Black British - Caribbean	6	0.2%	7	0.2%	6	0.2%	9	0.3%	17	0.5%	18	0.5%	17	0.5%
N	Black or Black British - African	28	0.7%	28	0.8%	32	0.9%	30	0.9%	32	0.9%	34	1.0%	29	0.8%
P	Black or Black British - Any other Black background	3	0.1%	6	0.2%	7	0.2%	6	0.2%	5	0.1%	7	0.2%	8	0.2%
R	Other Ethnic Groups - Chinese	12	0.3%	12	0.3%	13	0.4%	17	0.5%	20	0.6%	22	0.6%	21	0.6%
S	Other Ethnic Groups - Any other ethnic group	17	0.4%	66	1.9%	70	2.0%	71	2.0%	81	2.3%	81	2.3%	97	2.7%
Z	Not stated	73	1.9%	346	9.8%	396	11.2%	420	11.9%	474	13.4%	487	13.8%	945	26.8%
99	Not Known	1912	50.3%	1333	37.8%	1218	34.5%	1157	32.8%	906	25.7%	822	23.3%	311	8.8%
	TOTAL	3798		3528		3478		3476		3467		3417		3384	

Next Steps & Measuring Progress

The table shows that the initial investigation into the weekly returned a compliance that was roughly in line with our overall MPI analysis that shows that we have recorded ethnicity data for approximately 50% of our patients.

To improve this percentage, we implemented a more robust process of capturing the data using any available sources and means at the point of referral. This will include checking the Greater Manchester Care Record for each patient who has one and also contacting referring Trust's. As the subsequent weeks show these processes have started to yield some improvement in the weekly return coverage.

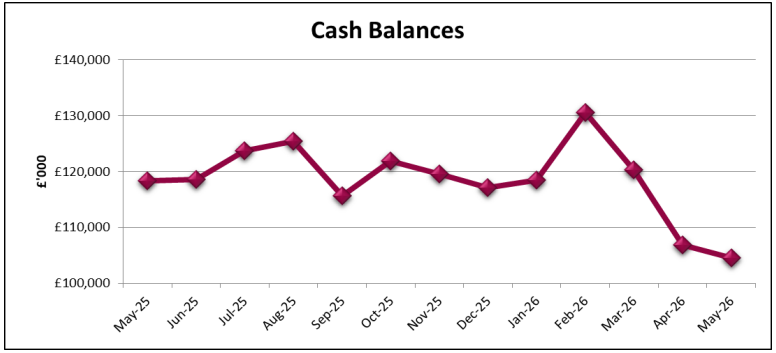
The Performance & Data Insights team are also investigating if there are any other data sources that we can use that will provide better coverage as part of the process to produce the weekly return.

Finance (Executive Summary)

The Christie NHS Foundation Trust

This report outlines the M2 consolidated financial performance of The Christie NHS Foundation Trust and its wholly owned subsidiary The Christie Pharmacy Ltd.

Month 02 YTD position	Annual Plan	YTD Budget	YTD Actual	Variance
	£'000	£'000	£'000	£'000
Clinical Income	(504,426)	(84,071)	(85,541)	(1,470)
Other Income	(93,459)	(15,574)	(14,873)	701
Pay	286,089	47,525	47,223	(302)
Non Pay (incl drugs)	283,556	47,413	48,062	649
Operating (Surplus) / Deficit	**(28,240)**	**(4,707)**	**(5,128)**	**(422)**
Finance expenses/ income	25,292	4,215	4,601	386
(Surplus) / Deficit	**(2,948)**	**(491)**	**(527)**	**(36)**
Exclude impairments/ charitably funded capital donations	(4,552)	(759)	(752)	7
Adjusted financial performance (Surplus) / Deficit	**(7,500)**	**(1,250)**	**(1,279)**	**(29)**



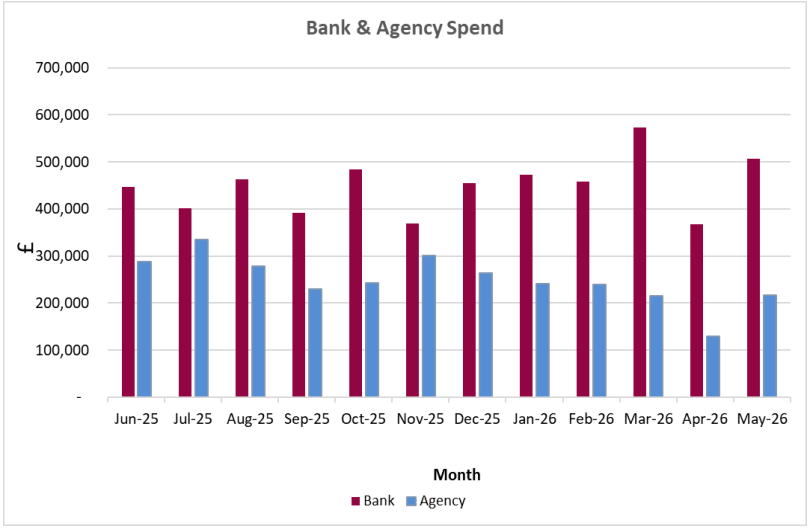
I&E

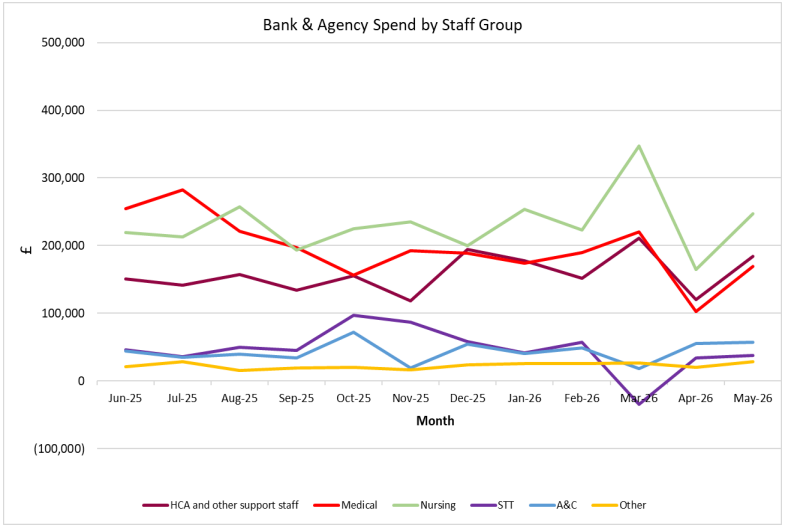
- The Trust is reporting a surplus at the end of month 02 of (£1.28m) against a YTD plan of (£1.25m), which gives a YTD surplus of (£0.03m).
- Identified in-year VIP is £25.3m against a target of £25.3m. The VIP shortfall against the recurrent VIP target is £1.9m (RAG rated shortfall of £7.7m), where £10.7m has been identified against a target of £12.6m (85% of recurrent target identified). Non-recurrent identified VIP is £14.6m against a target of £12.6m, overachieving by (£1.9m).

Balance sheet / liquidity

- The cash balance as at 31st May 2026 is £104.5m with a forecast for the 31st March 2027 of £88.3m.
- Capital spend for month 02 is £2.7m, this was £2.3m above the plan submitted to NHSE.
- Targets have been achieved against payment of creditors paid within the 30-day Better Payment Practice Code target.

Finance (Expenditure)

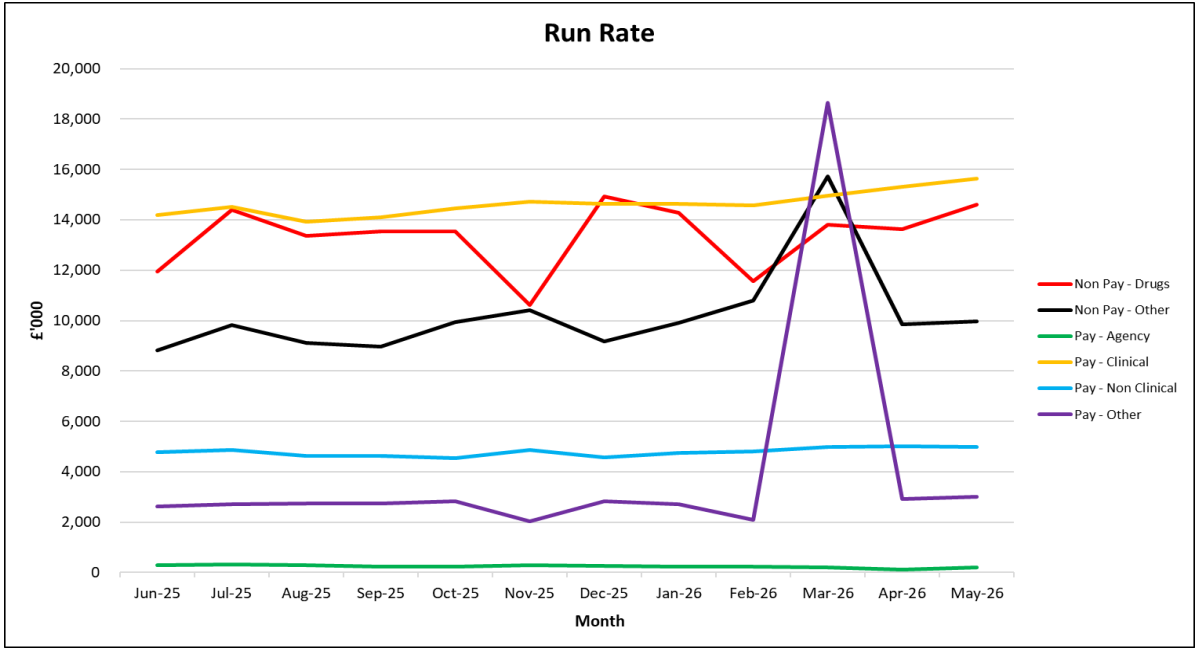




Agency spend in month 02 is £0.22m, an increase of (£0.09m) from month 01. The spend is predominantly on medical agency.

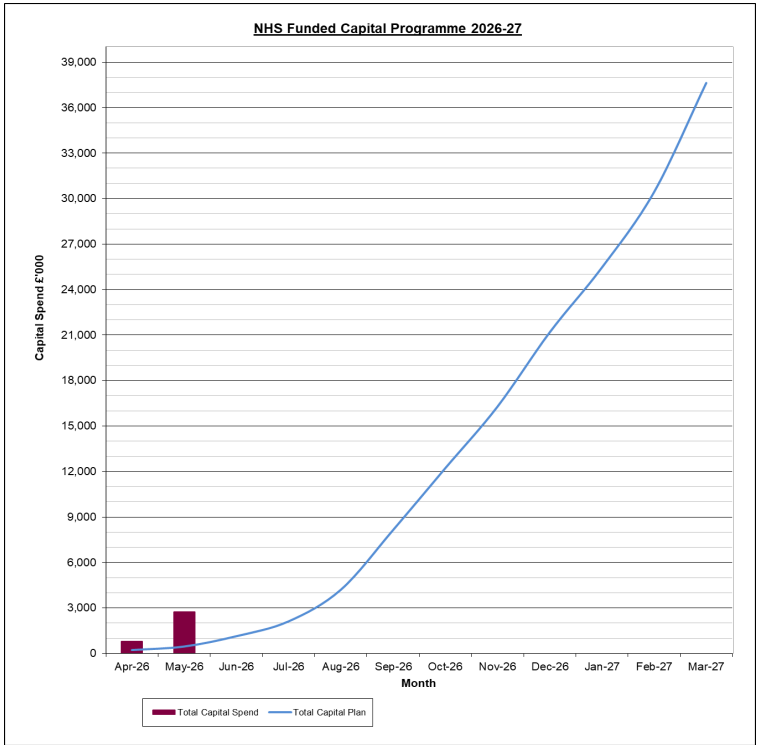
Alongside this, bank spend in month 02 is £0.51m, an increase of (£0.14m) from month 01.

Finance (Expenditure)



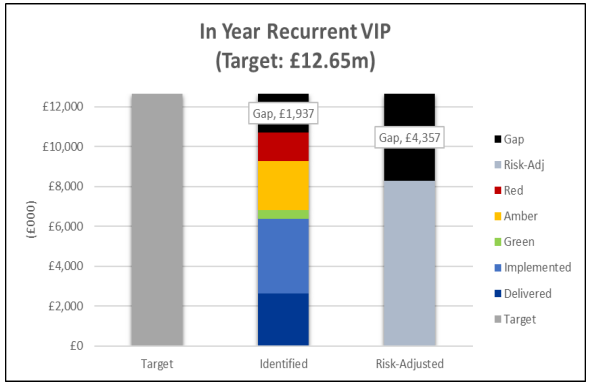
- Drugs spend in month 02 is £14.6m, an increase of £1.0m from month 01 driven by an increase in cost and volume drug expenditure.
- Non-Pay – Other spend in month 02 is £10.0m, a decrease of £0.1m from month 01. The balance is driven by decreased spend on clinical supplies and services as well as education and training.
- Key elements of 'Non-Pay Other' spend consist of clinical supplies and services, premises and infrastructure costs and R&I costs.
- Pay – Agency spend in month 02 is £0.2m, an increase of £0.1m from month 01.
- Pay – Clinical spend in month 02 is £15.6m, an increase of £0.3m from month 01.
- Pay – Other spend in month 02 is £3.0m, an increase of £0.1m from month 01.

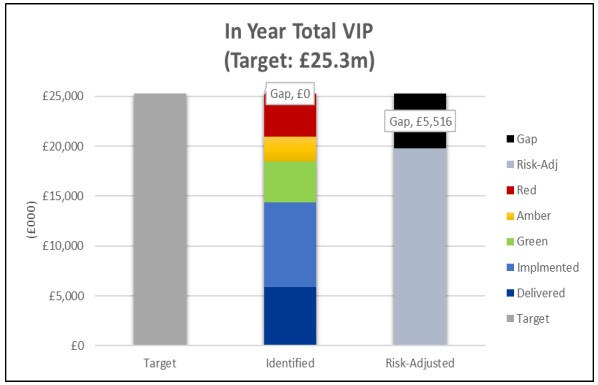
Finance (Capital)



The 2026-27 Capital plan is £37.6m The Trust has incurred £2.7m to the end of month 2 on capital schemes overspending by £2.3m against the 2026-27 plan.

Finance (CIP)





Total In year CIP

- Total identified VIP schemes reported are £25.3m (£14.6m non recurrent / £10.7m recurrent).
- Risk adjusted identified schemes value £17.6m, leaving £7.7m unidentified.

Recurrent

- Schemes totalling £10.7m have been identified recurrently against a recurrent target of £12.6m.
- This leaves £1.9m of the recurrent target unidentified, RAG rated unidentified £4.4m.

Delivering	Green	Amber	Red	Unidentified
100%	75%	50%	25%	0%

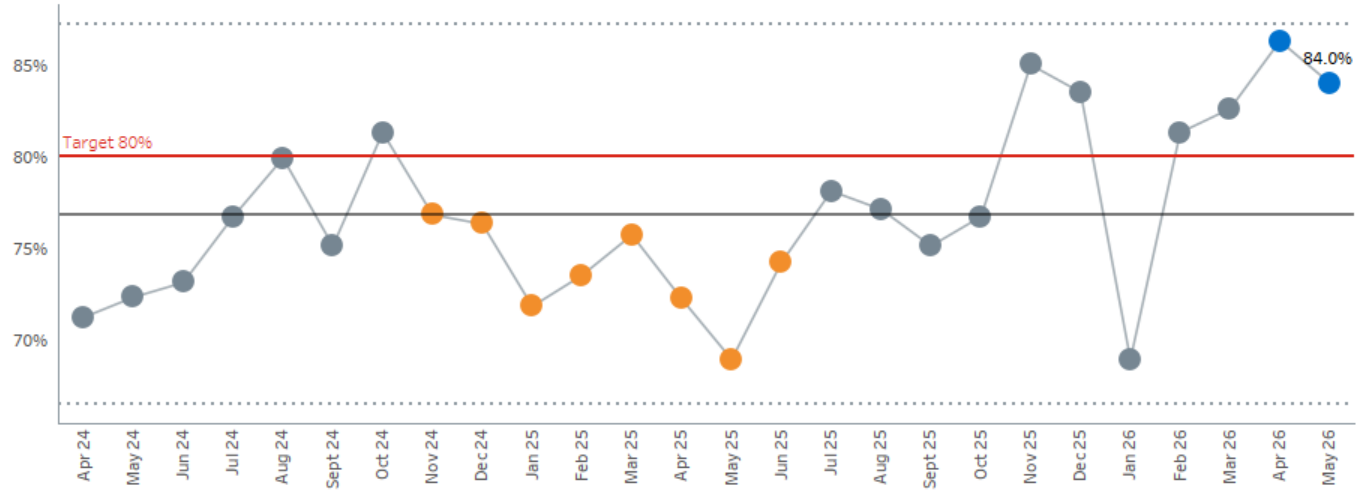
	Annual					Year To Date		
	Target (£000)	Identifed (£000)	Unidentified (£000)	Risk-Adjusted Identified (£000)	Risk-Adjusted Unidentified (£000)	Target (£000)	Delivered (£000)	Variance (£000)
Total VIP	**25,298**	**25,298**	**0**	**17,590**	**7,708**	**4,217**	**4,217**	**0**
Recurrent VIP	12,649	10,712	1,937	8,292	4,357	2,108	1,001	1,107
Non-Recurrent VIP	12,649	14,586	(1,937)	9,298	3,351	2,108	3,215	(1,107)

Integrated Performance Report - Cancer Standards Summary

NHS
The Christie
NHS Foundation Trust

Metric	Month	Measure	Target	Variation	Assurance
18 weeks	May	96.00%	92.00%		
24 day (Internal Target)	May	83.00%	85.00%		
28 Day FDS	May	100.00%	80.00%		
31 day	May	99.50%	96.00%		
62 Day	May	84.00%	80.00%		
Waiting >52 Weeks	May	0.00%	0.00%		

Percentage of patients treated for cancer within 62 days of referral



Icons

Improving

Hit & Miss

Summary

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

Hit or Miss The process limits on SPC charts indicate the normal range of numbers expected. If a target lies within those limits we know that the target may/may not be achieved. The closer the target line lies to the mean the more likely the target will be achieved or missed at random.

Understanding the performance

Performance improved overall, rising from 71.3% in April 2024 to 84.0% in May 2026, indicating a sustained upward trajectory despite some month-to-month volatility

Against the 70% target for April 2024 to March 2025, performance was largely compliant, with only January 2025 at c.72.0% still above target and most months between 73% and 81%, showing a generally stable position in year one.

Following the target increase to 75% from April 2025, performance became more mixed initially, suggesting the service did not immediately absorb the higher standard.

From July 2025 onwards, performance recovered and was mostly sustained at or above the 75% target, with a marked improvement in November 2025 (85.1%) and December 2025 (83.6%), although there was a notable one-month deterioration in January 2026 (69.0%).

The most recent position is positive, with performance from February to May 2026 consistently above the 80% standard (81.2%, 82.5%, 86.5%, 84.0%), suggesting recent improvement is becoming more embedded, though the January 2026 dip indicates continued operational grip is still required.

Actions (SMART)

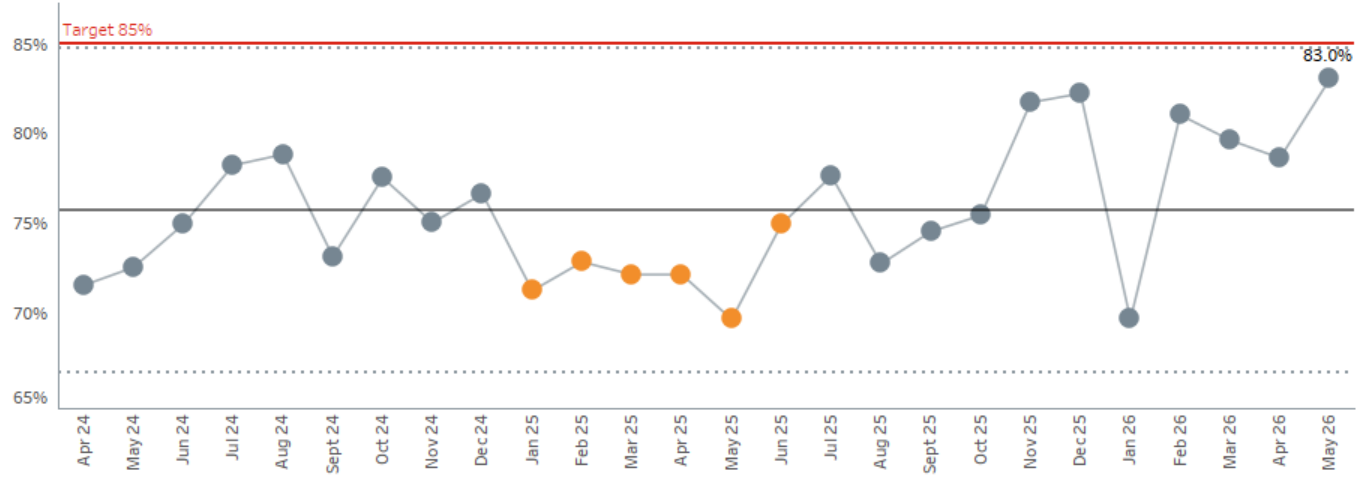
Embed weekly 62-day pathway reviews through OMG from July 2026, focusing on all patients >38 and >52 days, with clear recovery plans for each patient cohort and escalation to OMG where trajectory risk is identified.

Strengthen divisional accountability through OMG by August 2026, ensuring each tumour pathway has a named clinical and operational lead responsible for maintaining ≥80% performance, with weekly variance reporting and documented action tracking.

Introduce a formal escalation framework from OMG to OPIG (effective July 2026) for any pathway forecast to breach 80%, including agreed recovery trajectories, capacity interventions, and executive oversight until sustained improvement is demonstrated.

Provide a standardised monthly 62-day performance and exception report to OPIG from July 2026, summarising breaches, root causes, and delivery of agreed actions, to ensure performance above 80% is sustained and variation (such as January 2026) is reduced.

Percentage of patients treated for cancer within 24 days of IPT (Internal Target)



Icons

Common Cause

Failing

Summary

Common Cause This system or process is currently not changing significantly. It shows the level of natural variation you can expect from the process or system itself.

Failing If a target lies outside of those limits in the wrong direction then you know that the target cannot be achieved.

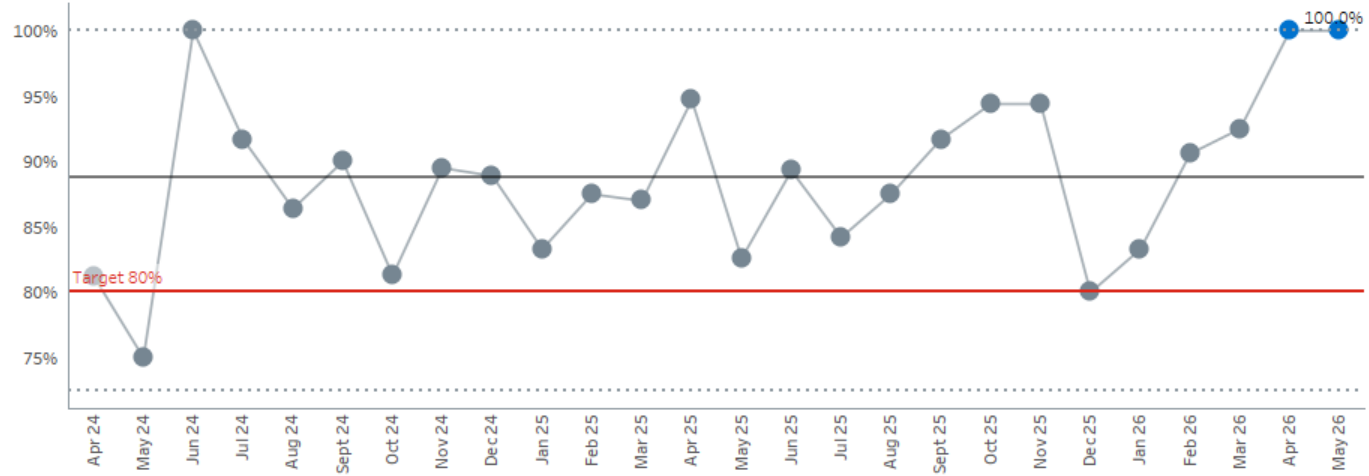
Understanding the performance

Performance has remained consistently below the 85% internal target across the full period shown, although there has been clear improvement in the most recent six months.
There is evidence of common cause variation, with most monthly results clustering within a relatively narrow range, suggesting the current process is stable but not yet capable of reliably delivering the target
A period of weaker performance is visible from around January to June 2025, with several months around the low-70% range and a low point of around 70% in May 2025.
Performance improved substantially, with several months above 80%, but this has not been sustained consistently, as shown by the sharp dip to around 70% in January 2026.The latest reported position of 83.0% in May 2026 is the strongest result shown and indicates progress, but it remains 2 percentage points below target, so further improvement and greater consistency are still required.

Actions (SMART)

Complete a focused review by the end of July 2026 of all patients not treated within 24 days of IPT over the last three months, identifying the main delay points and quantifying the contribution of each to underperformance.
Introduce a weekly exception review from July 2026 for all pathways at risk of breaching 24 days, with named operational and clinical leads responsible for recovery actions and escalation within 48 hours where delays are identified.
Set a trajectory to achieve at least 84% by August 2026 and 85% by October 2026, monitored weekly through divisional performance review with clear accountability for delivery.
Report progress monthly through the performance governance route using a simple narrative on trend, exceptions, causes and actions, so that improvement is tracked not only by the headline percentage but by whether gains are being sustained.

Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks



Icons

Improving

Hit & Miss

Summary

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

Hit or Miss The process limits on SPC charts indicate the normal range of numbers expected. If a target lies within those limits we know that the target may/may not be achieved. The closer the target line lies to the mean the more likely the target will be achieved or missed at random.

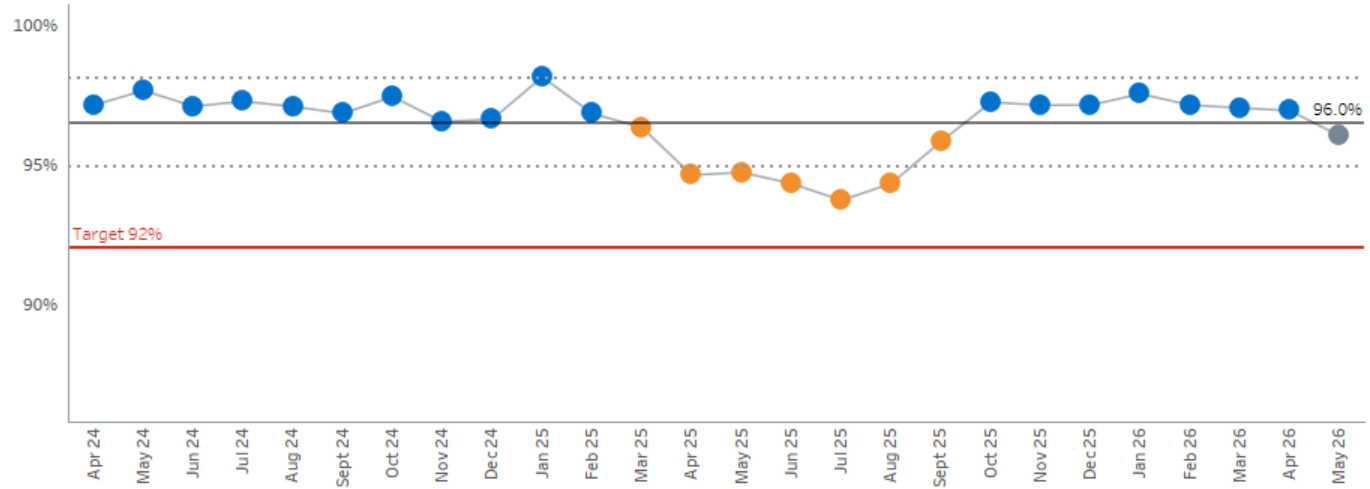
Understanding the performance

Performance is consistently above the 80% target, with the centreline sitting close to ~89–90%, indicating a stable and capable process rather than random variation.
There is evidence of sustained improvement over time, particularly from late 2025 onwards, with multiple consecutive months above 90% and a recent peak at 100%.Earlier variation (mid-2024 to mid-2025) shows some volatility, including isolated dips (lowest around mid-70s and ~80%), but these are not sustained and sit within expected control limits.
The most recent period demonstrates a clear upward shift, suggesting that changes implemented during 2025 are now embedded and delivering more reliable performance.
Overall, this is an "improving" system with performance now consistently achieved and trending towards upper control limits, indicating strengthened pathway management and reduced delays

Actions (SMART)

Maintain performance ≥90% for the next 6 months by maintaining current pathway controls, with weekly assurance reporting to OMG.
Sustain workforce and capacity alignment by confirming diagnostic and clinic capacity plans for winter period by October 2026, ensuring resilience against seasonal demand variation that impacts haem services at DGH's

Percentage of patients treated within 18 weeks



Icons

Common Cause

Passing

Summary

Common Cause This system or process is currently not changing significantly. It shows the level of natural variation you can expect from the process or system itself.

Passing If a target lies outside of those limits in the right direction then you know that the target can consistently be achieved.

Understanding the performance

Sustained delivery above the 92% standard across the period, with most months operating around 96–98%, indicating a stable and capable pathway once embedded.
A clear, time-limited dip is visible (Apr–Aug 2025), with performance falling to c.94–95%; this aligns with the transfer of the haematology service at Leighton, reflecting a system disruption rather than underlying process failure.
Recovery is evident from Sep 2025, with a return to previous control levels (c.96–97%) and reduced variation, suggesting that operational stabilisation actions have been effective.
Recent performance (late 2025 into 2026) shows consistency above target with tight clustering of results, indicating the pathway is now operating within expected control limits.
Overall pattern is consistent with a "common cause with a one-off special cause variation", where the service transfer temporarily impacted flow but did not alter the underlying capability of the system.

Actions (SMART)

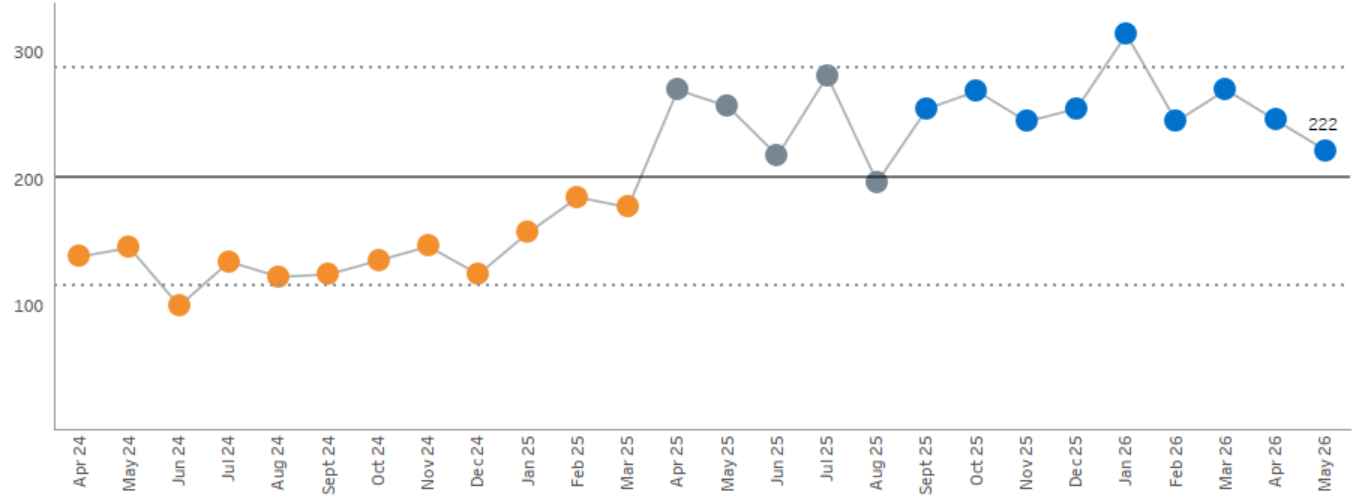
Monthly pathway capacity and demand reviews for haematology (owner: Service Manager), with clear thresholds for escalation if forecast RTT 18-week performance falls below 96%.
Weekly RTT risk review at specialty level (owner: Operational Lead), focusing on long-waiters and pathway blockers to prevent re-emergence of variation.
Triangulate RTT performance with diagnostics and treatment capacity (owner: Divisional Triumvirate), providing a single oversight report to ensure continued stability and early identification of risks.

Integrated Performance Report - External Referrals Received Summary

The Christie NHS Foundation Trust

Metric	Month	Measure	Variation	Assurance
External Referrals Received - ALL Specialties	May	2,148	H	No Target
External Referrals Received -Clinical Oncology	May	914		No Target
External Referrals Received -Haematology	May	222	H	No Target
External Referrals Received -Medical Oncology	May	597	H	No Target
External Referrals Received -Surgical Specialties	May	378		No Target

External Referrals Received - Haematology



Icons

Improving

No Target

Summary

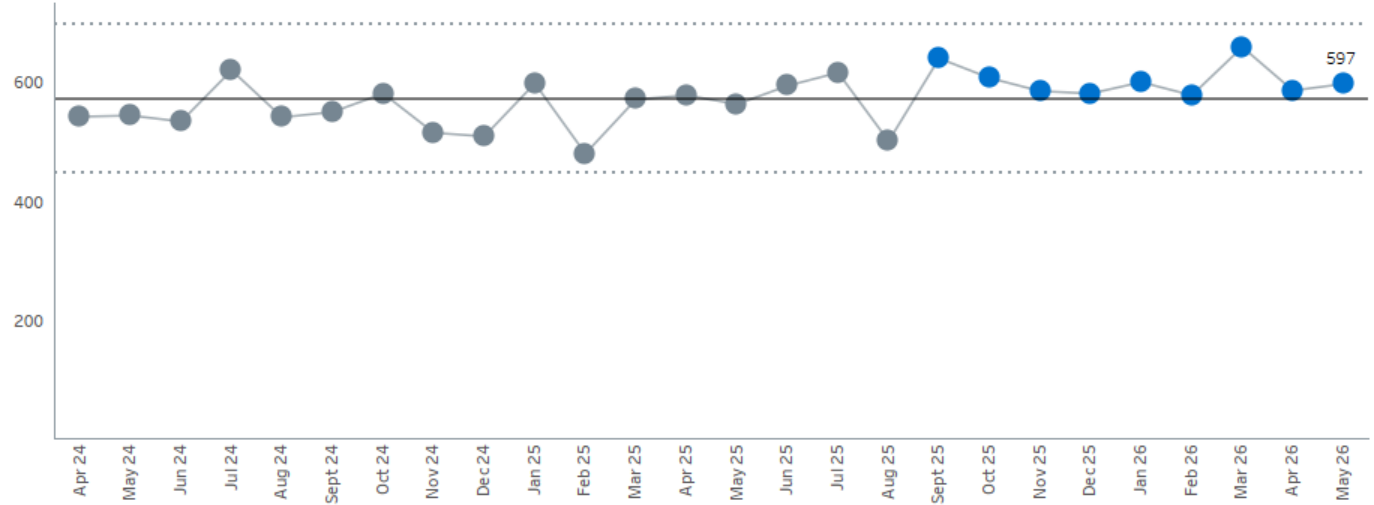
Improving Something good is happening! Something, a one-off or a continued trend or shift of numbers in the right direction.

No Target There is no set target for this data

Understanding the performance

The change in numbers of referrals since April 2025 is due to the Mid Cheshire hospital Haematlogy service takeover. Additional Two Week Wait patients as well as non-cancer Haematology referrals are being accepted and therefore there has been a step change in the baseline number. As the reporting timeframe progresses a new consistent average will be seen and the performance icon will reflect that.

External Referrals Received - Medical Oncology



Icons

Improving

No Target

Summary

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

No Target There is no set target for this data

Understanding the performance

Integrated Performance Report - Inpatient Length of Stay Averages

NHS
The Christie
NHS Foundation Trust

Metric	Month	Measure	25/26 AVG	Variation	Assurance
Inpatient LOS - All Patients (excluding zero LOS)	May	7.5	7.2		
Inpatient LOS - Elective Patients (excluding zero LOS)	May	7.1	5.9		
Inpatient LOS - Non-Elective Patients (excluding zero LOS)	May	7.7	7.5		
Inpatient LOS - Transfer Patients (excluding zero LOS)	May	36.7	16.4		

Integrated Performance Report - Diagnostic 6 Week Waiting Times Summary

The Christie NHS Foundation Trust

Metric	Month	Measure	Target	Variation	Assurance
Magnetic Resonance Imaging	May	99.60%	99.00%		
Computed Tomography	May	99.70%	99.00%		
Non-obstetric Ultrasound	May	100.00%	99.00%		
Dexa Scan	May	96.00%	99.00%		
Cardiology - Echocardiography	May	100.00%	99.00%		
Flexi Sigmoidoscopy	May	90.00%	99.00%		
Cystoscopy	May	100.00%	99.00%		
Barium Enema	May	100.00%	99.00%		
Colonoscopy	May	100.00%	99.00%		
Gastroscopy	May	100.00%	99.00%		
DM01 Return - All Scans	May	99.50%	99.00%		

*Lastest month figures are taken from the National Waiting List Weekly Return. Historical data trends are based on monthly DM01 figures. Latest data is refreshed with DM01 data once submitted.

Integrated Performance Report - Summary

Area Selection

Please select your area using the filters below. This will affect all other sections of the dashboard.

Division
The Christie

Directorate
All Directorates

Summary Table

The table below summarises the position as of the end of the previous month for the main HR KPI metrics.

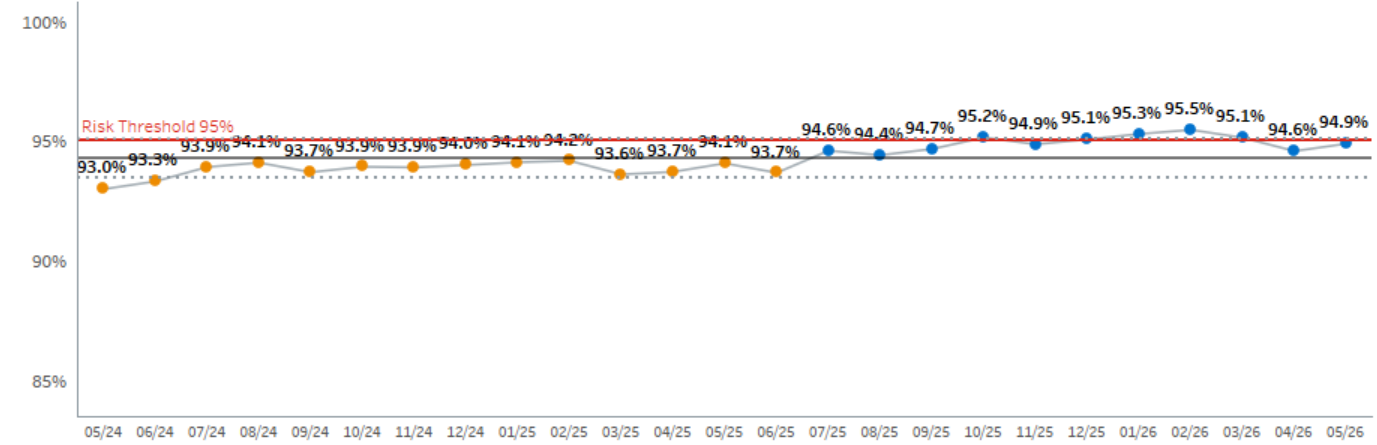
Metric - the KPI metric
Measure - the value of the **Metric** as of the end of the **Month**
Target - the Trust defined minimum or maximum limit for each **Metric**
Mean - the average of the **Measure**s over the past 12 months

Metric	Month	Measure	Risk Threshold / Target	Mean	Performance	Assurance
Appraisal	May 2026	**89.99%**	90.00%	88.05%		
Mandatory Training	May 2026	**94.90%**	95.00%	94.30%		
Absence	May 2026	**4.33%**	4.10%	4.79%		
All Turnover	May 2026	**11.52%**	11.00%	11.52%		
Voluntary Turnover	May 2026	**9.15%**	9.00%	9.23%		
Vacancy Rate	May 2026	**9.12%**	5.00%	8.07%		

Our People - Mandatory Training and Appraisal Compliance

The Christie: All Directorates

Mandatory Training

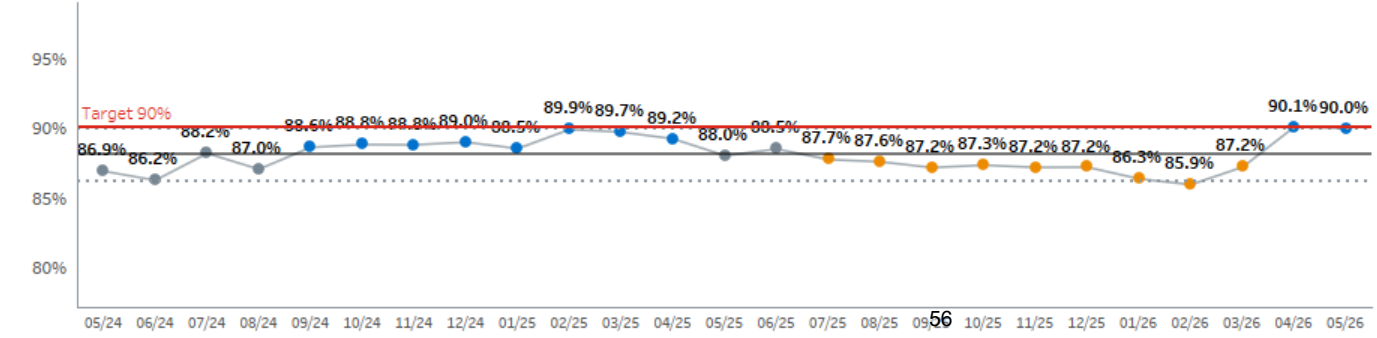


Performance	Assurance
Improving	Hit & Miss

Summary

- There are **3,332** outstanding modules.
- The Face to Face training compliance % for May is **85.8%**
- The online training compliance % for May is **95.8%**

Appraisal



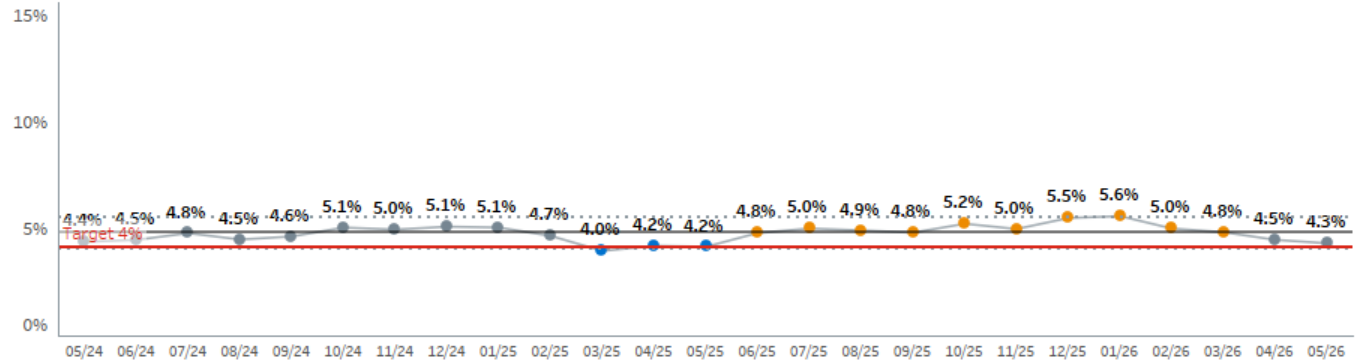
Performance	Assurance
Improving	Failing

Summary

- There are **360** outstanding appraisals.

Our People - Sickness Absence

All Absence



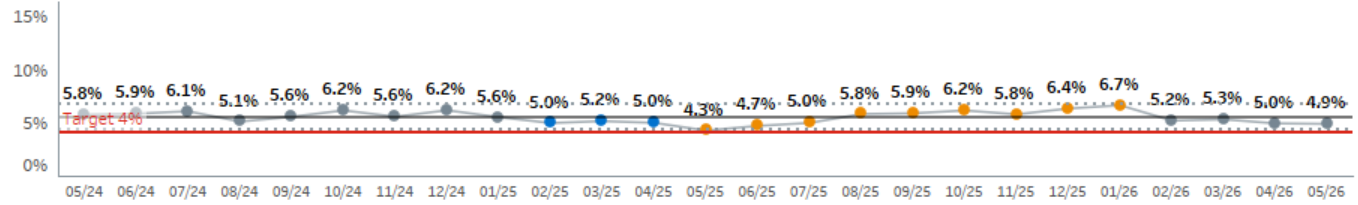
Performance	Assurance
Common Cause	Hit & Miss

Summary

- The rolling yearly sickness absence % is 5.0% as of May.

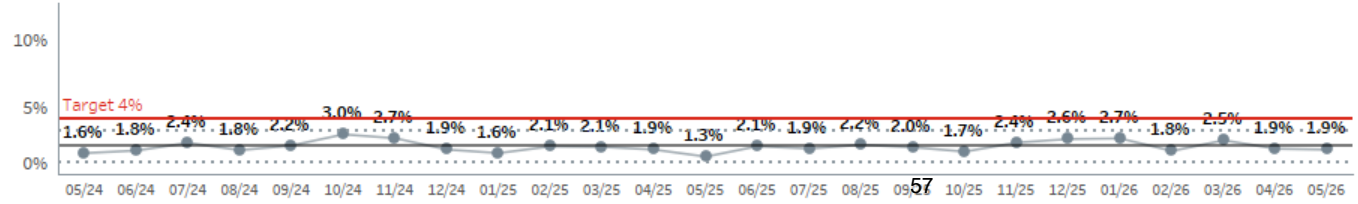
- There were 155 absences still open at the end of May.

Nursing and Midwifery



Performance	Assurance
Common Cause	Failing

Medical and Dental

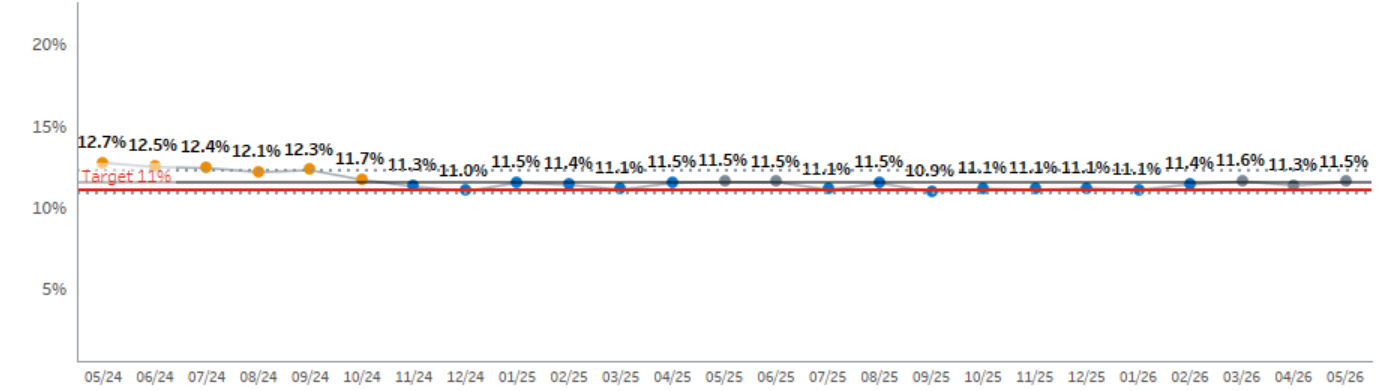


Performance	Assurance
Common Cause	Passing

Our People - Turnover

The Christie: All Directorates

All Turnover



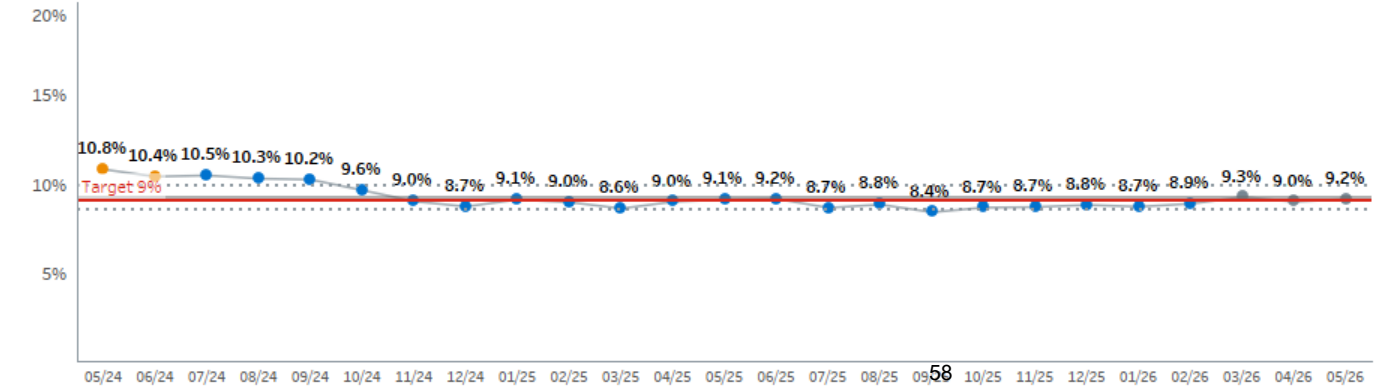
Performance	Assurance
Common Cause	Hit & Miss

Summary

- 40 colleague(s) left the Trust in May.

- The top non-voluntary leaving reason was **End of Fixed Term Contract**.
- The top non-voluntary leaving reason was **Employee Transfer**.

Voluntary Turnover



Performance	Assurance
Common Cause	Hit & Miss

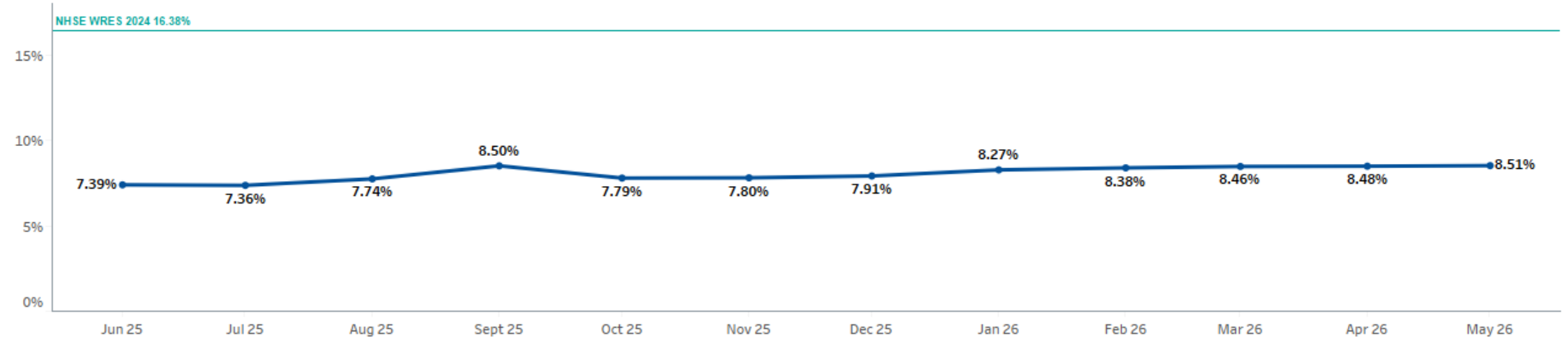
Summary

- 30 colleague(s) left the Trust in May for voluntary reasons.

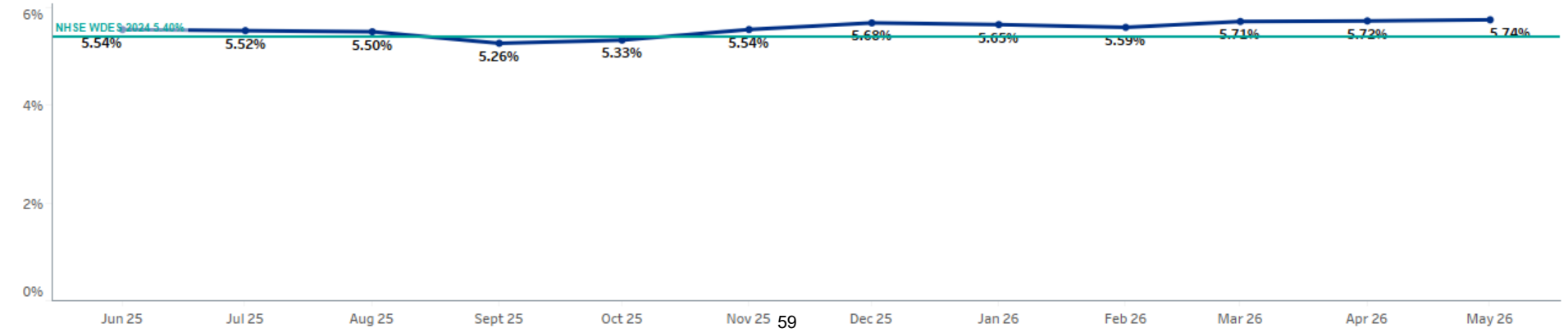
- The top voluntary leaving reason was **Voluntary Resignation - Relocation**.
- The top voluntary leaving reason was **Voluntary Resignation - Promotion**.
- The top voluntary leaving reason was **Voluntary Resignation - Other/Not Known**.

Our People - Senior Management Representation

Senior Management (Band 8A - VSM) BAME %

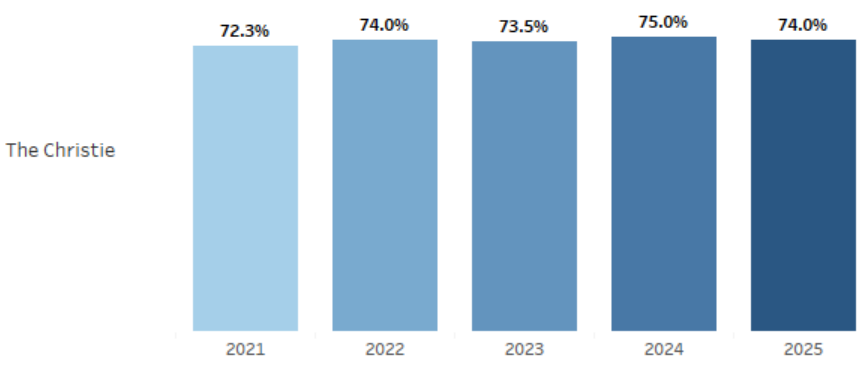


Senior Management- (Band 8A - VSM) Disability %



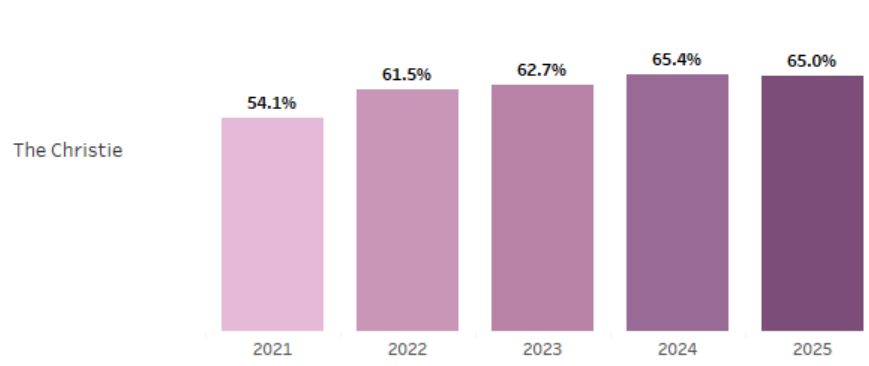
Our People - Staff Survey

Staff Engagement Score



	2021	2022	2023	2024	2025
Advocacy sub-score	82.7%	79.5%	77.9%	80.7%	81.0%
Involvement sub-score	69.7%	72.7%	72.2%	73.0%	72.0%
Motivation sub-score	64.7%	69.9%	70.4%	71.3%	70.0%

Morale Score

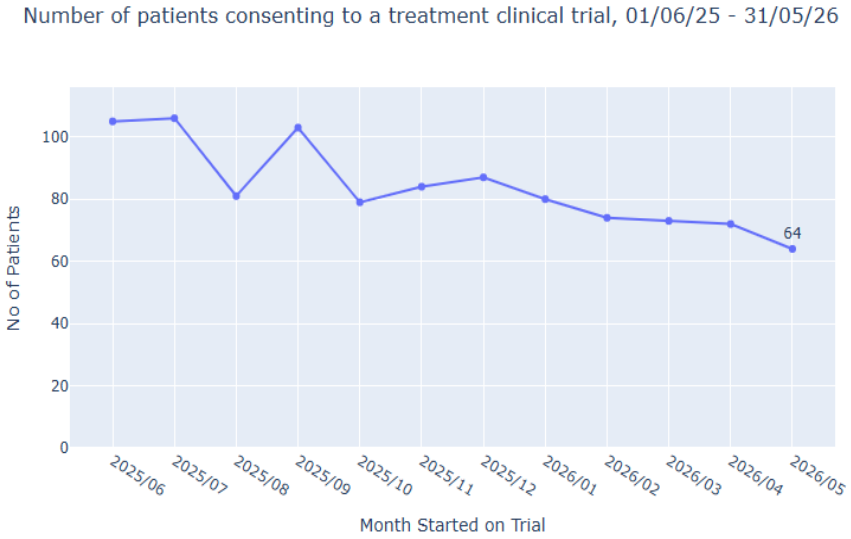


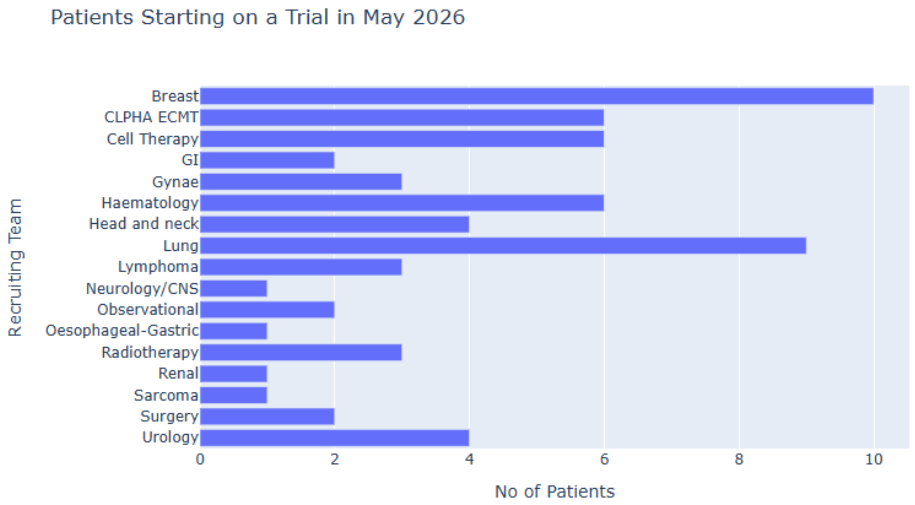
	2021	2022	2023	2024	2025
Stressors sub-score	60.4%	66.8%	66.7%	68.1%	68.0%
Thinking about leaving sub-score	54.0%	62.0%	64.6%	67.1%	66.0%
Work pressure sub-score	48.0%	55.6%	56.8%	61.1%	61.0%

Clinical Outcomes

The Christie NHS Foundation Trust

Clinical Trial Entries





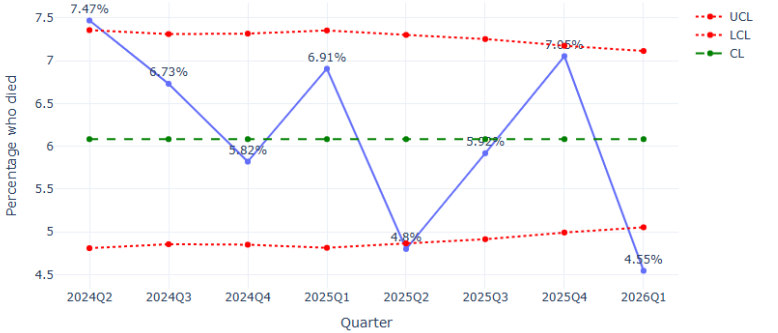
Breast have recruited the highest number of patients per month throughout February, March and April and May.

Clinical Outcomes

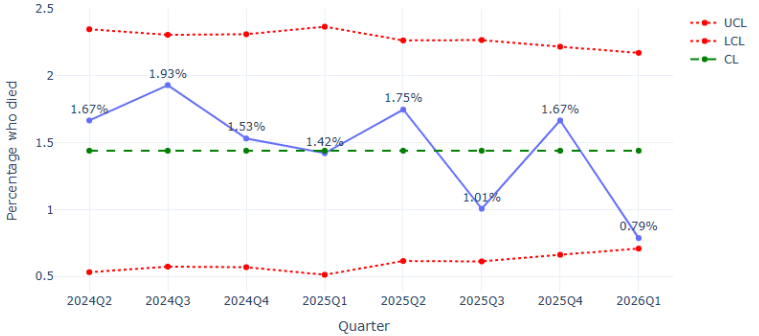
The Christie NHS Foundation Trust

30-Day SACT Mortality

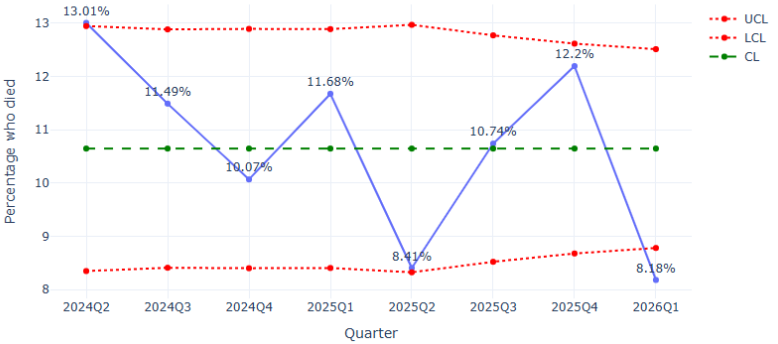
Unadjusted 30 day mortality rate - Patients who died within 30 days of receiving their final **Any treatment intent**



Unadjusted 30 day mortality rate - Patients who died within 30 days of receiving their final **Curative treatment intent**



Unadjusted 30 day mortality rate - Patients who died within 30 days of receiving their final **Palliative treatment intent**



The control line shows the 30-day mortality rate over the entirety of time frame shown (Last administrations up to 31/03/2026 (end of Q4)).

The UCL and LCL are the upper and lower confidence limits (respectively) around the CL. 95% Confidence limits.

Current rates of 30-day post SACT mortality are within the normal range expected and are consistent with those published by NDRS* for The Christie and for national average rates.
*30-day mortality post-Systemic Anti-Cancer Therapy - Case-Mix Adjusted Rates – NDRS

Research and Innovation

The Christie NHS Foundation Trust

% studies opening within 60 days (commercial)

New studies opened per month

Setup over time

% Location capacity confirmed within 60 days by DO | Summary chart | Summary position including ongoing studies | Summary table for FY2627 | Study list

Trust name	Trust code	Studies where capacity confirmed	Studies where capacity confirmed within 60 days	Studies where capacity confirmed after 60 days	Median - Site capacity confirmed times (in Days)	Studies ongoing setup within 60 days	Studies ongoing setup over 60 days
The Christie NHS Foundation Trust	RBV	29	15	14	60	0	0
University Hospitals Birmingham NHS Foundation Trust	RRK	26	9	17	73	16	9
Barts Health NHS Trust	R1H	24	13	11	54.5	21	9
Guy's and St Thomas' NHS Foundation Trust	RJ1	24	16	8	52.5	29	6
University College London Hospitals NHS Foundation Trust	RRV	21	16	5	45	12	12
Cambridge University Hospitals NHS Foundation Trust	RGT	19	17	2	40	3	2
University Hospitals of Leicester NHS Trust	RWE	19	12	7	55	2	5
The Royal Marsden NHS Foundation Trust	RPY	18	12	6	47.5	6	3
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	RTD	17	13	4	16	5	1
King's College Hospital NHS Foundation Trust	RJZ	15	11	4	37	5	0
Imperial College Healthcare NHS Trust	RYJ	15	10	5	41	11	3
Manchester University NHS Foundation Trust	R0A	14	3	11	121.5	0	0
Royal Free London NHS Foundation Trust	RAL	13	3	10	110	4	2
University Hospital Southampton NHS Foundation Trust	RHM	12	6	6	52.5	11	6
Totals		522	295	227	57	249	139

Overall Position
YTD 52% of commercial studies within 60 days (□ from 30% 25/26)
Current median days for commercial studies is 60 v 100 last year.

Key Risks
Long tail of 19 studies already in breach > 60 days, under active weekly review with plans being finalised to move studies to C&C status. This will clear the historic pipeline backlog. The impact can be seen in June.

Assurance
The backlog of long tail studies will create pressure in reported performance as well as the impact of EDGE implementation in July.
EDGE on track for implementation on 13th July which will yield efficiencies, but will impact whilst system is embedding.
We are managing the largest volume of commercial volume and pipeline.
We are maintaining weekly review and all Directorates expected to deliver Operational Plans for 26/27 by end of July 2026, which includes sustaining and meeting 60,30 and 90 day targets.

Oversight Framework 25/26

The Christie NHS Foundation Trust

The new NHS Oversight Framework 2025/26 describes a consistent and transparent approach to assessing ICBs and NHS trusts and foundation trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement. The data below relates to Q4 (Access to services module data has been excluded for specialist cancer Trusts whilst the national team work on a different way of displaying this data). Metrics have been grouped into domains and will be scored individually and across each domain, with Trust's being segmented into an overall score for comparison against other Trusts. The information is to be publicised on the Model Hospital platform.

Select a trust

The Christie NHS Foundation Trust (RBV)

View the glossary page

Average score

1.26

Lower by 0.10 from previous quarter

Trusts are scored on up to 30 measures of performance (metrics).
Scores range from 1.00 (high performing) to 4.00 (low performing).

How has average score been calculated?

Trust in financial deficit?

No

No change from previous quarter

If an organisation is reporting a financial deficit or in receipt of deficit support, that organisation's segment can be no greater than 3.

How is financial deficit applied?

Segment

1 - High performing

Previous quarter's segment: 1

Each trust is assigned to a segment ranging from 1 – 4 based on average metric score and taking into consideration the financial deficit override.

How has segment been calculated?

Trust rank

2 out of 134

Previous quarter's rank: 3 out of 134

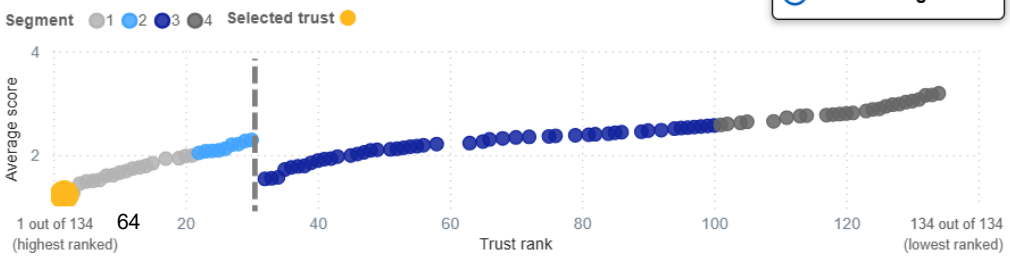
Each trust is ranked first on segment and then average score within that segment. Ranks range from 1 (the segment one trust with lowest average score) to 134 (segment four trust with the highest average score).
How has rank been calculated?

Performance domains

Access to services	(Blank)
Finance and productivity	1 - High performing
Effectiveness and experience	1 - High performing
Patient safety	1 - High performing
People and workforce	1 - High performing

Average score by trust rank placement

View full league table



Oversight Framework 25/26

The Christie NHS Foundation Trust

Quarter	Segment	Finance and productivity domain segment	
Q4 2025/26	1 - High performing	1 - High performing	Return to overview

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
Finance and productivity	Finance	Planned surplus/deficit	2025/26 plan	1.39	%	0.00 →	1.00	5 out of 134	-1.54	0
Finance and productivity	Finance	Variance year-to-date to financial plan	Month 12 2025/26	0.99	%	0.98 ↑	1.00	6 out of 134	0.03	
Finance and productivity	Finance	Combined finance	Q4 2025/26				1.00			
Finance and productivity	Productivity	Implied productivity level	Q3 2025/26 vs Q3 2024/25	13.75	%	5.45 ↑	1.02	2 out of 134	2.57	

Quarter	Segment	Effectiveness and experience domain segment	
Q4 2025/26	1 - High performing	1 - High performing	Return to overview

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
Effectiveness and experience	Effective flow and discharge	Average number of days from discharge ready date to actual discharge date (including zero days)	Mar-26	0.00	days	-0.20 ↑	1.00	1 out of 128	0.80	
Effectiveness and experience	Patient experience	CQC inpatient survey satisfaction rate	2024		score		1.00			

Oversight Framework 25/26

The Christie NHS Foundation Trust

Quarter	Segment	Patient safety domain segment
Q4 2025/26	1 - High performing	1 - High performing

Return to overview

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
Patient safety	Patient safety	Number of MRSA bacteraemia cases (12 months)	Mar-26	2.00	count	-1.00 ↑	2.27		3.50	0
Patient safety	Patient safety	Proportion of E. coli bacteraemia	Mar-26	1.58	rate	0.23 ↓	3.78		1.17	1
Patient safety	Patient safety	NHS Staff survey - raising concerns sub-score	2025	6.94	out of 10	0.01 ↑	1.07	4 out of 134	6.32	
Patient safety	Patient safety	Proportion of C. difficile infections	Mar-26	0.75	rate	-0.06 ↑	1.00		1.09	1

Quarter	Segment	People and workforce domain segment
Q4 2025/26	1 - High performing	1 - High performing

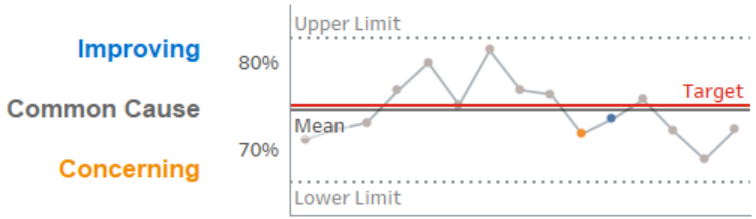
Return to overview

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
People and workforce	Retention and culture	Sickness absence rate	Q3 2025/26	5.06	%	0.28 ↓	1.65	40 out of 134	5.59	
People and workforce	Retention and culture	NHS staff survey engagement theme sub-score	2025	7.44	out of 10	-0.07 ↓	1.02	2 out of 134	6.80	

Integrated Performance, Quality & Finance Report - New Reporting Guidance

SPC Charts

A Statistical Process Control (SPC) chart is a graphical tool used to monitor, control, and improve a process by tracking data points over time and identifying variations that may indicate potential problems. Depending on the metric, a positive result could be either an upward or downward trend.



SPC Rules

These judgements are calculated based on the following set of rules:

- a data point is part of a series of 6 or more points in an upward or downward trend
- a data point is part of a series of 6 or more points above or below the mean
- a data point is part of a series of 3 points that are approaching the control limits
- a single data point is outside the control limits

Please note:
SPC charts can be an effective tool for identifying important variations in a dataset. However, the results can become less reliable when based on a sample that is too small.

Interpreting Performance Icons

Common Cause This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.

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

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

Interpreting Assurance Icons

No Target There is **no** set target for this data

Hit or Miss The process limits on SPC charts indicate the normal range of numbers expected. If a target lies **within** those limits then we know that the target may or may not be achieved. ..

Passing If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.

Failing If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.

The Christie NHS Foundation Trust

Agenda item 17/26c

Meeting of the Board of Directors
Thursday 25th June 2026

Subject / Title	Value Improvement Programme (VIP) 2025/26
Author(s)	Jo Bolger Leece, Assistant Director for Value Improvement
Presented by	Claire McPeake Chief Operating Officer
Summary / purpose of paper	This paper provides: • An overview of the Month 2 position for the Value Improvement Programme (VIP) • A summary of progress in delivery of the full years target • The approach for 26/27 linked to operational planning guidance
Recommendation(s)	The committee is asked to note: • The content of the report and • The associated actions identified to improve delivery.
Background papers	NA
Risk score	Risk 3629 – Score 16
Link to: ➢ Trust strategy ➢ Corporate objectives	Executive objective: 1 -To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer. 6 - To maintain excellent operational, quality and financial performance Board Assurance Framework: Risk 1, Risk 6, Risk 7, Risk 9, Risk 10
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.	Value Improvement Programme: VIP Quality Impact Assessment: QIA Equality Impact Assessment: EIA NHS England: NHSE Getting it Right First Time (GIRFT) Model Health System (MHS) Clinical Advisory Group (CAG)

Board of Directors

Value Improvement Programme (VIP)

1.0 Background and Introduction

The Christie strategy 2023 to 2028 sets out how we will continue to deliver our mission - to care, discover and teach - through the 4 themes of our vision: leading cancer care, the Christie experience, local and specialist care and best outcomes.

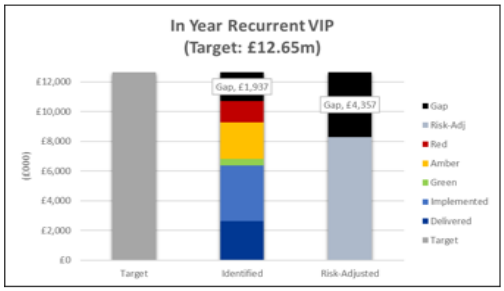
Our 5 Year Integrated Delivery Plan describes how we will achieve our vision alongside the NHS 10 Year Plan, and Operational Plan. A key enabler of achieving our 5 year goals, is ensuring financial sustainability to support and drive innovation and improvement, while continuing to invest in our capital and services. In line with the rest of the NHS, in 2026/27 the Christie has a challenging cost improvement target of £25.5m.

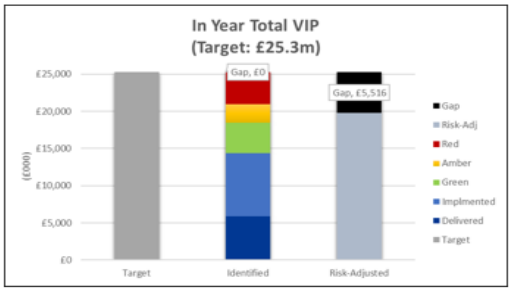
To support delivery and as previously presented, building on successful delivery of the 2025/26 target our governance and framework was reviewed and strengthened based on lessons learnt, and updated in line with best practice

Our Value Improvement Programme focused on delivering improved outcomes for patients by getting the basics right, daily management, ensuring the services we provide are equitable and seeking innovative approaches to improve productivity and efficiency. This is delivered by bringing cost and quality together into a Quality Management System (QMS). The approach aims to embed a system and culture where improvement is part of our daily work and we have an approach to empower, engage and support our staff to achieve this.

This paper describes the current position of VIP for month 2.

2.0 Financial Overview: VIP month 2





Delivering	Green	Amber	Red	Unidentified
100%	75%	50%	25%	0%

	Annual					Year To Date		
	Target (£000)	Identified (£000)	Unidentified (£000)	Risk-Adjusted Identified (£000)	Risk-Adjusted Unidentified (£000)	Target (£000)	Delivered (£000)	Variance (£000)
Total VIP	25,298	25,298	0	17,590	7,708	4,217	4,217	0
Recurrent VIP	12,649	10,712	1,937	8,292	4,357	2,108	1,001	1,107
Non-Recurrent VIP	12,649	14,586	(1,937)	9,298	3,351	2,108	3,215	(1,107)

Delivering	Green	Amber	Red	Unidentified
100%	75%	50%	25%	0%

3.0 2026/27 Value Improvement Programme (VIP)

The 2026/27 Value Improvement Programme (VIP) will build on the established framework and further strengthen our approach to delivering recurrent financial efficiencies, aligned to national expectations set out in the NHS Operational Planning Framework. The programme will continue to embed the NHS IMPACT model, ensuring a disciplined, evidence-based approach to improvement that connects strategy to action.

Key enhancements for 2026/27 include:

- Recurrent delivery focus: Strengthening the financial baseline by reducing reliance on non-recurrent savings.
- Improved use of benchmarking tools: Embedding Model Health System (MHS), Getting It Right First Time (GIRFT), and costing data to drive targeted improvements.
- Operational alignment: Integrating with the Operational Improvement Plan, including digital transformation opportunities through Future Christie.
- Daily management and waste reduction: Driving continuous improvement through divisional ownership and structured improvement methods. A rapid improvement event model has been tested in Radiology with measurable results achieve
- Breakthrough projects: Delivering high-impact initiatives aligned to strategic priorities, to reducing time away from home, improve productivity, develop pathway redesign, NHS App roll out, and workforce efficiency.
- Value-based prioritisation: developing new ways as part of the service reviews to define value based health care to balance financial impact, outcomes, equity, and patient experience.
- Capability building: Expanding staff training and engagement, linked to Proud2bOps and improvement awareness sessions. Over 40 staff have now completed the NHS IMPACT operational excellence programme.
- Clinical leadership: Launching a new programme to reduce unwarranted variation in diagnostic testing.

4.0 Benchmarking and Assurance

Benchmarking remains central to the VIP, ensuring that improvement opportunities are evidence-based and nationally consistent.

- GIRFT and MHS metrics are directly embedded into the VIP to identify and drive improvement with governance for monthly review in place.
- Staff engagement sessions have been held to build understanding of MHS and continue to share learning from other Trusts.
- GIRFT productivity packs are received from the national team quarterly and are reviewed to seek areas for improvement.

The Christie continues to report VIP progress weekly to NHSE. As of month 2 the Trust is benchmarking strongly against national peers.

5.0 National Alignment

The Christie's VIP is fully aligned with national expectations and frameworks, supporting our position in Segment One of the NHS Oversight Framework. This requires demonstrable progress against financial and operational metrics, supported by robust governance and delivery.

This includes:

- NHS IMPACT supports embedding leadership behaviours, daily management, and breakthrough change.
- MHS and GIRFT provide data to target unwarranted variation and identifying productivity opportunities.
- System-wide priorities in support of Greater Manchester goals for population health and financial sustainability.
- Robust delivery plans with schemes supported by QIA/EIA and documented assurance processes.

6.0 Governance and Oversight

- The Value Improvement Programme (VIP) is supported by a robust and well-established governance framework designed to provide the Board with clear oversight of delivery, risk, and alignment with national expectations.
- Executive leadership of the programme is strong, with joint sponsorship from the Chief Operating Officer and Director of Finance. Delivery is subject to disciplined weekly review, ensuring that progress is actively managed, risks are identified early, and corrective action is taken where required.
- Board-level oversight is maintained through regular reporting to formal committees, with structured Alert, Advise and Assure (AAA) reports providing transparency on trajectory, emerging risks, and areas requiring escalation. This ensures that the Board retains clear line of sight to both delivery and associated risk.
- At an operational level, the programme is governed through established forums, including the Operational Performance Improvement Group (OPIG) and the Operational Management Group (OMG). These forums provide routine scrutiny of delivery, enable timely escalation, and maintain grip on scheme performance and implementation.
- Risk management is embedded within the programme. All schemes are subject to Quality Impact Assessments and Equality Impact Assessments, with risks formally recorded and monitored through the Corporate Risk Register. This is complemented by clinical oversight from the Medical Director and Chief Nurse, ensuring that quality and patient safety considerations are integral to decision-making rather than retrospective.
- The programme also benefits from external challenge and benchmarking, including the use of Model Health System data, GIRFT benchmarks and established audit methodologies. This strengthens the credibility of the programme and ensures that planned improvements are aligned with best practice.
- Delivery risk is actively managed through a structured programme approach, including phased milestones, defined trajectories and early escalation of underperformance. There is a clear focus on building a sustainable pipeline of recurrent schemes, reducing reliance on non-recurrent measures and strengthening the underlying financial position.
- Recognising the central role of workforce in delivery, the programme includes targeted actions to reduce reliance on temporary staffing, alongside improvements in recruitment, roster management and job planning. These actions are critical to both financial sustainability and service resilience.
- Engagement with staff is a core component of the approach. Regular communication, training and structured improvement forums – including initiatives such as “Do You Have an Idea?” and the use of HIVE resources – are in place to support frontline ownership and continuous improvement.

7.0 Next Steps

Deep dive into the risk rated position to determine status of schemes still to be delivered and ensure mitigating schemes are in place to manage any slippage.

Agenda item 17/26d

Meeting of the Board of Directors

Thursday 25th June 2026

Subject / Title	Annual compliance with CQC requirements
Author(s)	Chief Nurse and Executive Director of Quality Compliance Lead
Presented by	Chief Nurse and Executive Director of Quality
Summary / purpose of paper	This paper provides a summary update on Trust wide regulatory compliance and inspection preparation
Recommendation(s) (assure / alert / advise)	Note CQC inspection activity across the Trust in 2025/26 Note the continued progress of the Trust's regulatory preparedness for the Well-Led domain and the ongoing delivery of the Excellence in Action programme. Acknowledge the engagement of staff across clinical and non-clinical areas in evidence mapping, peer mock inspections, and review activities.
Background papers / source of assurance	• Data • Soft intelligence • Benchmarking • External assessments • Risks and mitigation • Trajectory and changes over time
EDI impact	The Trust's regulatory preparedness programme promotes equitable, consistent, and person-centred care by aligning services with CQC quality statements, ensuring that the needs, experiences, and outcomes of all patients, including those from protected and underserved groups, are considered and addressed within assurance and improvement activity.
Risk score / BAF reference	BAF Risks 4
Link to: ➢ Trust strategy/objectives ➢ CQC Quality standard ➢ Regulation	Trust strategy CQC regulations (all key questions and quality statements)
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	AHP – Allied health professional CQC - Care Quality Commission MIAA – Mersey Internal Audit Agency TCPC – The Christie Private Care

The Christie NHS Foundation Trust

Agenda item 17/26d

Meeting of the Board of Directors
Thursday 25th June 2026

Annual compliance with CQC requirements

Executive Summary

Context and background

Since early 2025, the Trust has implemented a structured, organisation wide approach to regulatory preparedness aligned to the CQC assessment framework. The Excellence in Action programme underpins this work, embedding compliance, governance, and continuous improvement into routine practice.

Scope of the paper

This paper provides an overview of progress on the 2025/26 regulatory inspection outcomes and preparedness programme delivery including: evidence collation, assurance activities, and external validation. It outlines current levels of readiness against the CQC's five key questions and planned actions for 2026/27.

Key insights

The Excellence in Action programme is well embedded, with strong engagement across clinical, corporate, and support services. A comprehensive and dynamic evidence matrix is in place, mapping assurance to all CQC quality statements.

Internal assurance activities, including mock inspections and board-level interviews, demonstrate a high level of organisational readiness. External assurance (legal review and MIAA audit) confirms the robustness of governance, systems, and evidence, with substantial assurance achieved.

A strong culture of safety, quality improvement, and person-centred care is evident across the services assessed, with identified improvements being addressed.

Implications

The Trust is well positioned to demonstrate compliance with the CQC assessment framework. Continued focus is required to sustain momentum, ensure consistency of evidence across all services, and respond to any future changes in regulatory requirements.

Inspection activity

The Trust received positive regulatory assurance in 2025/26, with CQC and IR(ME)R inspections across its services and joint ventures reporting good practice, no enforcement actions, and no concerns relating to the Trust's own registered activity.

Next steps or options

- Continue delivery of the Excellence in Action programme across 2026/27.
- Maintain and further develop the dynamic evidence matrix.
- Sustain mock inspection and peer review activity across all sites.
- Strengthen Board and divisional engagement and visibility.
- Respond to emerging CQC consultations and adapt to any framework changes.

Recommendation

The Board is asked to receive and take assurance on the Trust's compliance against CQC requirements and ongoing readiness for inspection.

1. Overview

The Trust continues to make strong progress in its regulatory preparedness programme, ensuring full alignment with the Care Quality Commission (CQC) Assessment Framework. Since focused preparation began in early 2025, a structured approach has been embedded across the organisation to evidence compliance, strengthen governance, and promote a culture of continuous improvement. Recent service-level inspections and mock assessments have also provided positive assurance regarding the quality of care, governance, and organisational readiness.

2. Progress to Date

Excellence in Action Programme

Launched in April 2025, this Trust-wide initiative embeds regulatory readiness into daily practice. The 2025/26 programme has engaged staff through quarterly cycles focused on each of the CQC key questions; Safe, Caring, Responsive, Effective, and Well-Led, linking everyday activity to regulatory expectations.

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

Evidence Matrix and Mapping

A comprehensive evidence matrix across all 5 key questions has been developed to map Trust activities and assurance materials at corporate, divisional and service level against the CQC quality statements and six evidence categories. This ensures a clear and accessible repository of evidence demonstrating compliance and best practice. This is a dynamic matrix designed to be continually updated.

Collaborative Preparation

The compliance team has worked closely with divisions, the Executive Chief Nurse, and external legal advisors to review and validate the evidence base.

Key question collaboration sessions have been undertaken each quarter with the divisional and corporate Associate Chief Nurses and relevant others. Dedicated review days with external legal advisors followed, who have confirmed the robustness of documentation, governance structures, and quality systems supporting ongoing regulatory readiness.

3. Assurance Activities

Evidence Validation

Comprehensive evidence reviews have been completed for all five of the CQCs key questions.

Mock assessments and Interviews

Peer-led multi-disciplinary / multi-professional mock assessments and board level interviews have taken place to test readiness, validate assurance processes, and familiarise teams with

CQC methodology. These activities demonstrate a mature approach to regulatory engagement and continuous improvement.

Throughout 2025/26 peer mock assessments have been undertaken across the 5 key questions. These include:

- Well-led - Palatine ward and the OCCU (including the Critical care outreach team)
- Safe - Radiotherapy (Withington) service and the CRF.
- Effective – End of life core service assessment (clinical areas visited included OCCU, Ward 10, AAU, Palatine, Ward 11)
- Caring and Responsive – Outpatients including phlebotomy (Withington site) and Oak Road Treatment Centre

In summary all areas assessed have demonstrated a strong safety culture and leadership, engagement in quality improvement, effective partnerships, delivery of person-centred care and responsiveness to people's needs. Areas for improvement have been identified and are being addressed locally.

External assurance

In additional to internal regulatory preparedness activities, third line assurance has been obtained through a range of activities:

- Legal expert input providing independent validation and assurance on the quality and completeness of evidence and preparations was undertaken in 2025/26.
- An external Well-Led assessment has taken place in Q4 2025/26.
- A MIAA audit reviewing progress against the action plan agreed with the CQC following the inspection was completed and provided substantial assurance in April 2026.

4. Inspection activity

During 2025/26, the Trust underwent CQC inspection under the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R for its PET-CT service and pathways, and for its radiotherapy service with a particular focus on satellite service provision. Both inspections reported areas of good practice and recommendations for improvements. No formal recommendations or enforcement actions were reported and both inspections have been formally closed by the CQC. IR(ME)R inspections do not result in formal ratings.

The CQC undertook a routine inspection of one of the Trusts joint ventures, TCPC. The scope of the assessment did not include any activity undertaken as part of the Trusts CQC registration and was the activity of TCPC only, however, did involve inspectors visiting areas of the Trust where patients are seen in any shared facilities.

A second joint venture, The Christie Pathology Partnership, is currently undergoing an unannounced inspection. While the scope of the inspection does not include services delivered under the Trust's CQC registration, inspectors have engaged with staff working across the partnership to understand collaborative working arrangements. The Trust has also provided information in response to requests as part of the inspection process.

5. Next Steps (2026/27)

- The Trust will continue to engage with the CQC through regular relationship meetings, responding to information requests and maintain momentum through continued delivery of the Excellence in Action programme, informed by staff feedback to support improvement at individual and service level.
- Continue to collate and support the divisions in dynamic evidence mapping for all key questions.
- Ongoing Board and divisional engagement through review days, staff handbooks, and communication campaigns.
- Continued peer review and mock inspection programme to sustain confidence and readiness across all services, across the network sites. These will include a combination of observational assessment, staff, service and patient feedback and service presentations with a focus on quality improvement.
- Engage with CQC consultations on sector specific draft assessment frameworks responding to any changes that may occur during 2026/27.

6. Conclusion

The Trust's structured approach to regulatory preparedness provides clear assurance that systems, evidence, and engagement are in place to demonstrate compliance with the CQCs assessment framework. The Excellence in Action programme is embedded across the organisation, fostering a culture of quality, safety, and improvement. Ongoing activity throughout 2026/27 will ensure sustained readiness, enhanced confidence, and continuous understanding and alignment with regulatory expectations to deliver safe and effective high-quality person-centred care.

7. Recommendation

The Board is asked to receive and take assurance on the Trust's compliance against CQC requirements and ongoing readiness for inspection.

NHS
The Christie
NHS Foundation Trust

Agenda item 17/26e

Meeting of the Board of Directors
Thursday 25th June 2026

Subject / Title	Updates to Trust Standing Financial Instructions (SFIs)
Author(s)	Sarah Keevil, Head of Financial Management Richard Postill, Deputy Director of Finance Sally Parkinson, Executive 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).
Recommendation(s)	Approve the changes to Trust Standing Financial Instructions (SFIs) following review and approval by the Audit Committee.
Background papers / source of assurance	n/a
Risk score / BAF reference	BAF Risk 10 Financial balance: Current risk score 10 BAF Risk 4 Compliance with regulatory standards: Current risk score 12
EDI impact/considerations	No direct EDI impact identified: The subject matter has been assessed and found to have no foreseeable implications for equality, diversity, inclusion, or opportunity.
Link to: ➢ Trust strategy/ objectives ➢ CQC Quality standard ➢ Regulation	➢ Board Assurance Framework: Risks 4, 5, 6, 10 ➢ Corporate objective 6: to maintain excellent operational and financial performance. ➢ NHS Oversight Framework: Finance and Productivity domains
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

Agenda item 17/26e

Meeting of the Board of Directors

Thursday 25th June 2026

Updates to Trust Standing Financial Instructions (SFIs)

1. Proposal

The Trust's Standing Financial Instructions were previously ratified by the Audit Committee on the 24th April 2025 and approved by the Board of Directors on the 24th April 2025. They are due to be reviewed in April 2028.

In the interim period a request has been submitted to update to include details relating to consultancy payments. It is suggested these are added to Section 9 - Terms of service, allowances and payment of members of the Board and employees of the SFI. Appendix A includes the additional narrative relating to consultancy payments.

A further change has been made to section 9.1.3 to align the narrative to the Remco Terms of Reference. Appendix B includes the extract from the SFIs, with the amendment included at item 9.1.3 (red text).

The above changes were approved at Audit Committee on 21st April 2026.

2. Recommendation

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

Appendix A

Additional Wording added for consultancy payments

Consultancy, Advisory Board, Speaker Honoraria and Payments

1. General Requirements

1.1 All employees, officeholders, secondees and contractors must comply with the Trust's Management of Conflicts of Interest Policy (Code of Conduct) and NHS England's *Managing Conflicts of Interest* requirements when undertaking consultancy, advisory, speaker or educational work for external organisations.
1.2 All consultancy activity must be declared, irrespective of whether it is undertaken in NHS time or in personal time. This must be logged on the trust's declarations of Interest site and The University of Manchester's register of interests site (for Clinical Academic Staff associated with the university).

The Christie NHS Foundation Trust

Register of Interests | Governance office | StaffNet | The University of Manchester

1.3 Where relevant, staff must comply with the ABPI Disclosure UK transparency requirements.

It is also advised that staff undertaking work with pharmaceutical companies make themselves aware of the full ABPI Guidelines.

Staff undertaking consultancy in their own time may not use NHS resources in the delivery of their service.

Consultants should comply with the requirements in the Code of Conduct for Private Practice

---

2. Consultancy Undertaken in NHS Time

2.1 Under trust and HMRC guidance, consultancy or advisory work undertaken **during NHS contracted hours** or included within an individual's **agreed job plan** must have all associated fees paid **directly to the Trust**. No payment may be made to the individual.

2.2 Consultancy income received by the Trust is absorbed into central Trust budgets and **cannot** be earmarked or retained for:

- Personal benefit
- Departmental expenditure
- Conference/travel costs
- Educational activity
- Creation or support of posts (e.g., clinical fellowships)

2.3 Consultancy income earned in NHS time does not create any entitlement for the individual or their department to direct or influence the use of those funds.

---

3. Consultancy Undertaken Outside NHS Time

3.1 Work undertaken during annual leave

3.1.1 When consultancy work is performed during approved annual leave, it is deemed wholly personal. Fees may be paid directly to the individual.
3.1.2 The individual is personally responsible for:

- Declaring income to HMRC
- Ensuring appropriate professional indemnity cover
- Contracting directly with the external organisation

3.2 Work undertaken in personal time (not requiring annual leave)

3.2.1 Consultancy work may be undertaken in personal time if:

- It is wholly outside NHS working hours
- No NHS resources or facilities are used
- It does not conflict with NHS duties

3.2.2 Fees may be paid directly to the individual, who is responsible for HMRC declarations and their own indemnity

The Individual is responsible for their own review and execution of the relevant contract; review by Trust staff will not be undertaken.

---

4. Indemnity

4.1 NHS indemnity does **not** extend to any private consultancy or advisory work.
4.2 Individuals must obtain appropriate professional indemnity for any consultancy performed outside NHS duties.

---

5. Charitable Donations of Consultancy Fees

5.1 Personal donations of consultancy income must be voluntary, irrevocable, and not be made with the expectation of later gaining access to said income for personal or departmental benefit.

5.2 Individuals may waive consultancy fees in favour of a charity, resulting in a donation being made directly from the external organisation to a charity, noting that donations

received through this route must not be made with the expectation of later gaining access to said income for personal or departmental benefit.

5.3 Use or prioritisation of charitable funds for personal expenses, or team benefit not in demonstrable adherence with a charity's legal objects is strictly prohibited.

---

6. Prohibited Arrangements

6.1 The following are not permitted:

- Routing consultancy income through charitable funds with the expectation of later gaining access to said income for personal or departmental benefit
- Informal or undocumented agreements relating to donated funds
- Any arrangement that may be construed as tax avoidance or misuse of charitable assets"

Appendix B

Revised wording to section 9.1.3

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) Replace with - Review updates on Board succession planning

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.

Document Reference:	**Standing Financial Instructions**	**Version:**	**V 14**
Document Owner:	Executive Director of Finance and Business Development	**Document Author:**	Deputy Director of Finance
Accountable Committee:	Board of Directors	**Date Approved:**	TBC 25/06/26
Ratified by:	Audit Committee	**Date Ratified:**	21/4/26
Date issued:	24/4/25	**Review Date:**	24/4/28
Target Audience:	Trust Wide	**Equality Impact Assessment:**	N/A
Consultation process	Senior Management Committee, Finance, HR	**Associated policies and documents**	Scheme of Delegation Code of Conduct for Directors and employees

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 2026

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 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 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 an 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

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

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

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

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.

1.3 Responsibilities and delegation

1.3.1 The Board has resolved that the Board may only exercise certain powers and decisions i n 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 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 pay 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 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 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

e) coordinate its work with the Trust Quality Assurance Committee and Workforce 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 m u s t 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 w i l l :

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 projects 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

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 Bank accounts

5.1.1 The Director of Finance is responsible for:

a) all bank accounts

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

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

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

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

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

5.2 Banking procedures

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

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

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

b) the limit to be applied to any overdraft

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

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

5.3 Tendering and review of banking arrangements

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

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

5.3.3 The Board shall approve the banking arrangements.

6 Income, fees and charges

6.1 Income systems

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

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

6.2 Fees and charges

6.2.1 The Trust shall follow the regulators guidance on the national payment system and any other applicable guidance in setting prices for contracts with NHS commissioners for all services falling within national tariff from time to time.

6.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the D H S C 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 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

7.3 All cash shall be banked intact. Disbursements shall not be made from cash received.

7.4 The holders of safe keys shall not accept unofficial funds for depositing in the safes

7.5 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 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 consider 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 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 recommendations 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) review updates on Board succession planning

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

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 responsiblefor:

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 t r u s t 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 paycontrol 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

9.7 Consultancy, Advisory Board, Speaker Honoraria and Payments

9.7.1 General Requirements

All employees, officeholders, secondees and contractors must comply with the Trust's Management of Conflicts of Interest Policy (Code of Conduct) and NHS England's Managing Conflicts of Interest requirements when undertaking consultancy, advisory, speaker or educational work for external organisations.

All consultancy activity must be declared, irrespective of whether it is undertaken in NHS time or in personal time. This must be logged on the trust's declarations of Interest site and The University of Manchester's register of interests site (for Clinical Academic Staff associated with the university).

The Christie NHS Foundation Trust

Register of Interests | Governance office | Staff Net | The University of Manchester

Where relevant, staff must comply with the ABPI Disclosure UK transparency requirements.

It is also advised that staff undertaking work with pharmaceutical companies make themselves aware of the full ABPI Guidelines.

Staff undertaking consultancy in their own time may not use NHS resources in the delivery of their service.

Consultants should comply with the requirements in the Code of Conduct for Private Practice

9.7.2 Consultancy Undertaken in NHS Time

Under trust and HMRC guidance, consultancy or advisory work undertaken **during NHS contracted hours** or included within an individual's **agreed job plan** must have all associated fees paid **directly to the Trust**. No payment may be made to the individual.

Consultancy income received by the Trust is absorbed into central Trust budgets and **cannot** be earmarked or retained for:

- Personal benefit
- Departmental expenditure
- Conference/travel costs
- Educational activity

- Creation or support of posts (e.g., clinical fellowships)

Consultancy income earned in NHS time does not create any entitlement for the individual or their department to direct or influence the use of those funds.

9.7.3 Consultancy Undertaken Outside NHS Time

a) Work undertaken during annual leave

When consultancy work is performed during approved annual leave, it is deemed wholly personal. Fees may be paid directly to the individual.

The individual is personally responsible for:

- Declaring income to HMRC
- Ensuring appropriate professional indemnity cover
- Contracting directly with the external organisation

b) Work undertaken in personal time (not requiring annual leave)

Consultancy work may be undertaken in personal time if:

- It is wholly outside NHS working hours
- No NHS resources or facilities are used
- It does not conflict with NHS duties

Fees may be paid directly to the individual, who is responsible for HMRC declarations and their own indemnity

The Individual is responsible for their own review and execution of the relevant contract; review by Trust staff will not be undertaken.

9.7.4 Indemnity

NHS indemnity does **not** extend to any private consultancy or advisory work.

Individuals must obtain appropriate professional indemnity for any consultancy performed outside NHS duties.

9.7.5 Charitable Donations of Consultancy Fees

Personal donations of consultancy income must be voluntary, irrevocable, and not be made with the expectation of later gaining access to said income for personal or departmental benefit.

Individuals may waive consultancy fees in favor of a charity, resulting in a donation being made directly from the external organisation to a charity, noting that donations received through this route must not be made with the expectation of later gaining access to said income for personal or departmental benefit.

Use or prioritisation of charitable funds for personal expenses, or team benefit not in demonstrable adherence with a charity's legal objects is strictly prohibited.

9.7.6 Prohibited Arrangements

The following are not permitted:

- Routing consultancy income through charitable funds with the expectation of later gaining access to said income for personal or departmental benefit
- Informal or undocumented agreements relating to donated funds
- Any arrangement that may be construed as tax avoidance or misuse of charitable assets

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

10.1.1 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

10.1.2 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.

10.1.3 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 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.

10.1.4 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 (considering 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

10.1.5 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) be raised in advance of receiving goods and services

f) be raised for the full contract life

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.

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.

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

10.1.6 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 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 while 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 required under the 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

10.1.7 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.

11.1 Public dividend capital

11.1.1 On authorisation as a Foundation Trust the public dividend capital held immediately prior to authorisation continues to be held on the same conditions.

11.1.2 Additional public dividend capital may be made available on such terms the Secretary of State (with the consent of the Treasury) decides.

11.1.3 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.

11.1.4 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.

11.2 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.

11.3 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.

12.1 Business cases

12.2.1 The Chief Executive:

a) shall ensure that there is an adequate appraisal and approval process in place for determining capital and revenue expenditure priorities and the effect of each proposal upon business plans

b) shall ensure that appropriate management arrangements are in place for all stages of capital and revenue schemes and for ensuring that schemes are delivered on time and to cost

c) shall ensure, where appropriate, that the capital and revenue investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges

12.2.2 The Chief Executive shall ensure that management's arrangements are in place for capital and revenue expenditure to ensure:

a) that a business case is produced in line with guidance issued by the Director of Finance. This should include:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs

(ii) appropriate project management and control arrangements

(iii) the involvement of appropriate Trust personnel, committees and external agencies

b) that the Director of Finance or their nominated officer has certified professionally to the costs and revenue consequences detailed in the business case

12.2.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive via a nominated officer will issue procedures for their management, incorporating best practice guidelines.

The Director of Finance or their nominated officer shall assess on an annual basis the requirement for the operation of the Construction Industry Tax Deduction Scheme in accordance with HM customs & revenue guidance.

The Director of Finance or their nominated officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

12.2.4 The approval of a capital program shall not constitute approval for the initiation of expenditure on any scheme.

The Chief Executive shall ensure there is an approval process in place for:

a) specific authority to commit expenditure through a business case

b) authority to proceed to tender

c) approval to accept a successful tender

12.2.5 The Director of Finance's nominated officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

12.2 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.

12.3 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.

14.1 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:

15.1.1 be responsible for ensuring the design, implementation and documentation of effective financial information systems

15.1.2 devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and digital hardware for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998

15.1.3 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

15.1.4 ensure that adequate controls exist such that the operation of the finance computer system is separated and safeguarded from development, maintenance and amendment activities

15.1.5 ensure that an adequate management (audit) trail exists through the digital system

and that regular 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 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 digital service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

15.5 Where digital systems have an impact on financial systems, the Director of Finance shall satisfy themselfthat:

15.5.1 systems acquisition, development and maintenance are in line with corporate policies such as an information technologystrategy

15.5.2 data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists

15.5.3 finance staff have access to suchdata

15.5.4 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.

16.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admissionby:

16.2.1 notices and information booklets

16.2.2 hospital admission documentation and property records

16.2.3 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' money, 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 more than £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:

19.2.1 a process of identifying and quantifying risks and potential liabilities

19.2.2 engendering among all levels of staff a positive attitude towards the control of risk

19.2.3 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

19.2.4 contingency plans to offset the impact of adverse events

19.2.5 audit arrangements including internal audit, clinical audit, health and safety reviews

19.2.6 arrangements to review the risk management strategy

19.2.7 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.
management program the relevant Directors shall ensure that documented procedures cover these arrangements.

19.11 Where the risk pooling schemes are used, the relevant Directors shall ensure that the arrangements entered 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 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 Authoritywhere:

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 and all requirements binding on the Trust 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 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.

Where the Trust considers that the circumstances require it to advertise for the supply of healthcare services (and/or other services captured by the Provider Selection Regime), the Constitution and SFIs will apply although at all times the Trust should consider its

duties under paragraph 1.2 of this appendix above.

1.5.3 Exceptions and instances where a minimum of 3 written quotations need not be obtained, or formal tendering need not be applied

A minimum of 3 written quotations **need not be obtained** where:

(a) the estimated expenditure or income does not or is not reasonably expected to exceed £10,000 (excluding VAT); (such amount to be reviewed annually by the Board).

Formal tendering procedures need not be applied where:

(b) the estimated expenditure or income does not or is not expected to exceed £50,000 (excluding VAT); (such amount to be reviewed annually by the Board).

A minimum of 3 written quotations **need not be obtained** or formal tendering procedures need not be applied where:

(c) the supply can be obtained under a framework agreement that has itself been procured in compliance with the duties set out at paragraph 1.2 of this appendix above and where the Trust is entitled to access such framework agreement

(d) under SFI 14, in the case of disposal of assets, formal tendering procedures are not always required

(e) the requirement is covered by an existing contract

(f) 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

Subject to the duties at paragraph 1.1 and 1.2 of this appendix (and to obtaining appropriate advice from the Trust's procurement department and where considered necessary external professional advice) for estimated expenditure or income exceeding £10,000 but below the 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:

(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

(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

(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

(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"

(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

(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

(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 (g) to (m) 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 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.

If any member of staff or any person working on behalf of the Trust has a connection with a supplier that may take part in a tender process they are involved in, they must declare this as a Conflict of Interest prior to the tender process starting or as soon as they become aware.

These circumstances would include the member of staff or person supporting pre-market engagement, the development of business cases and specifications and the setting of contract evaluation and award criteria (this is not an exhaustive list).

Conflicts of Interest must be requested and declared when establishing a team to undertake a project that has the potential to result in a procurement tender exercise.

Any declared or perceived conflict of interest must be carefully managed to ensure that such involvement does not allow any bidders or potential bidders to gain or perceived to gain an unfair advantage in any future tender process or disadvantage other parties taking part in any future tender process.

If a conflict of interest or perceived conflict of interest cannot be reasonably mitigated, then the member of staff or person working on behalf of the Trust must be removed from the process immediately and their involvement to date and reason for removal documented. This information may be called upon should any challenge be received.

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 wherever possible, that the firms/individuals invited to tender (and where appropriate, quote) are among those on approved frameworks (if such a list is maintained by the Trust or accredited body for such goods, services or works).

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 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 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 latest relevant procurement legislation 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 threshold):

I. If following a contract award approval, the contract value needs to increase, then approval will need to be obtained by the original approval process for the excess amount. A s this could be a breach of the latest relevant procurement legislation; advice must be sought from the procurement department as this may require a retendering exercise.

1.5.7 Disaggregation of Spend

A disaggregation of spend to avoid obtaining 3 written quotations or undertaking a formal tender exercise is not permissible. Multiple orders raised to one supplier below the relevant threshold for a category of spend for the same requirement or requirement similar in nature, is a breach of the SFI financial limits and potentially a deliberate disaggregation of spend.

The anticipated ongoing / whole life cost of a requirement or requirement similar in nature should be considered before a direct award commitment with one supplier is made.

1.5.8 Cumulative Spend

If the cumulative spend by an individual area/division with any one supplier in a financial year for goods/services for a category of spend, for the same requirement or multiple requirements that are similar in nature is anticipated to exceed or exceeds

i. £10,000 (exec VAT), then a minimum of 3 written quotations must be obtained

ii. £50,000 (exec VAT), then a formal tender exercise must be undertaken

iii. the procurement regulations threshold value, then a procurement procedure in accordance with the Procurement Act regulations must be undertaken.

If necessary, to determine whether costs are related, seek advice from senior members of the procurement team.

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 threshold value.

b) Tenders should be obtained from at least three firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust

c) The Trust uses an e-tendering system to issue and receive all tenders electronically.

1.6.2 Invitation to tender

a) All invitations to tender shall state the date and time that is the latest time for the receipt of tenders.

b) All invitations to tender shall state that no tender will be accepted unless:
   i) submitted electronically using the e-tendering system, or

   ii) in exceptional circumstances, i.e., where it is not possible to submit electronically using the e-tendering system; submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the trust (or the word "tender" followed by the tender reference and the subject to which it relates) and the latest date and time for the receipt of such tender addressed

to the Chief Executive or nominated manager. Any such tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

c) Every tender for goods, materials, services or disposals shall contain and comprise appropriate terms and conditions regulating the conduct of the tender and shall contain appropriate terms and conditions on which the contract is to be awarded and shall be substantively based to regulate the provision of the goods, materials, services to be provided or in relation to the disposal.

d) Every tender for building or engineering works (except for maintenance work, when Estman code guidance is followed) must contain terms and conditions on which the contract is awarded substantively based on the terms of the current edition of a suitable and recognised industry form of contract including but not limited to one of the Joint Contracts Tribunal Standard Forms of Building Contract or the NEC standard forms of contract or Department of the Environment (GC/Wks.) Standard forms of contract.

e) When the content of the work is primarily engineering, the general conditions of contract recommended by the Institution of Mechanical and Electrical Engineers or the (ACE) Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the general conditions of contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. The form of contract can be amended (in minor respects only), to the specific requirements of the individual projects.

1.6.3 Receipt and safe custody of tenders

a) Electronic tenders

Tenders will be held and locked electronically until the time and date allocated for opening.

b) Hard copy tenders (accepted in exceptional circumstances only)

The Chief Executive or their nominated officer will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

The date and time of receipt of each tender shall be endorsed by the Chief Executive or their nominated officer on the tender envelope/package.

1.6.4 Opening tenders and register of tenders

a) Electronic tenders

i) The Chief Executive will designate and agree a list of officers who will be able to access the electronic tenders and release them once the sealed date and time has passed. This list will exclude the originating manager.

ii) A full electronic record of the tenders received will be available in accordance with the agreed parameters of the system.

b) Hard copy tenders (accepted in exceptional circumstances only)

i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, every tender received shall be opened by two senior officers/managers. Such officers should not be from the originating department.

ii) A member of the Board will be required to be one of the two approved persons present for the opening of tenders estimated above £100,000 (excluding VAT). The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Reservation of Powers and detailed Scheme of Delegation document.

iii) The 'originating' department will be taken to mean the department sponsoring or commissioning the tender.

iv) The involvement of Finance Directorate staff in the preparation of a tender proposal will not preclude the Director of Finance or any approved senior manager from the Finance Directorate from serving as one of the two senior managers to open tenders.

v) All Executive Directors will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

The Company Secretary will count as a director for the purposes of opening tenders.

vi) Every tender received shall be marked with the date of opening and initialed by those present at the opening.

vii) A register shall be maintained by the Chief Executive, or a person authorised by them, to show for each set of competitive tender invitations dispatched:

- the name of all firms/individuals invited
- the names of firms/individuals from which tenders have been received
- the date the tenders were opened
- the persons present at the opening
- the price shown on each tender
- a note where price alterations have been made on the tender
- Each entry to this register shall be signed by those present

A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

viii) Incomplete tenders, i.e. those from which information necessary for evaluation of the tender is missing, and amended tenders i.e., those amended by the tenderer upon their own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders may at the discretion of the Chief Executive or their nominated officer be rejected, provided that the terms and conditions applicable to such tender process permit such rejection.

1.6.5 Admissibility of Tenders

a) If for any reason the nominated officers are of the opinion that the tenders received are not competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

b) Where only one tender is sought and/or received, the Chief Executive and Director of Finance shall, as far as practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

1.6.6 Late tenders

a) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or their nominated officer decides that there are exceptional circumstances, for example a tender dispatched in good time but delayed through no fault of the tenderer.

b) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or their nominated officer or if the process of evaluation has not started.

c) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or their nominated officer.

1.6.7 Acceptance of formal tenders

a) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.

b) The Trust shall accept the most 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 more than that which has been allocated by the Trust, and which is not in accordance with these SFIs except with the authorisation of the Chief Executive or Director of Finance.

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

e) Variation to contract must follow the business case and tender award approval

process.

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

i) was not more than the going market rate price current at the time the contract was awarded

ii) was made based on the most advantageous tender ("MAT").

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 £10,000 (excluding VAT). A minimum of three written quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds or is reasonably expected to be £10,000 (excluding VAT) or above but is not reasonably expected to exceed £50,000 (excluding VAT).

1.7.2 Verbal Quotations

a) A minimum of one verbal quotation, followed by written confirmation, for goods or services up to £999 (excluding VAT) (per item) must be obtained

b) A minimum of two verbal quotations (unless sole supplier), followed by written confirmation of the accepted quotation, for goods or services from £1000 up to £9,999 (excluding VAT) (per item) must be obtained

1.7.3 Written Quotations

a) Written quotations should be obtained from at least three firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust.

b) All quotations for any requirement estimated to be £10,000 (excluding VAT) or above should be in writing unless the Chief Executive or t h e I r 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, via the waiver process, as a permanent record.

1.7.4 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.

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 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 the 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

November 2024

Code of Conduct for Directors and Employees

For NHS staff

Code of Conduct for Directors and Employees

The Christie
NHS Foundation Trust

Appendix 3 – Letter below

Letter 3 – Delegated ePay authorisation

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

Version	Date	Author	Status	Comment
V13	Apr 25	Deputy Director of Finance	Closed	Full review. Approved and ratified by Audit Committee
13.1	Oct 2025	Deputy Director of Finance	Closed	Minor amends, approved by audit committee
13.2	Oct 2025	Deputy Director of Finance	Approved	Minors amend – update to Appendix 1, section 1.5.4. Approved and ratified by Audit Committee 16/10/25. Version control sheet included after approval.
V14	April 2026	Deputy Director of Finance	Awaiting BoD Approval	Additional section – section 6.4 added

The Christie
NHS Foundation Trust

Agenda Item 18/26a

Meeting of the Board of Directors

Thursday 25th June 2026

Subject / Title	Audit Committee report – April 2026
Author(s)	Jo D'Arcy, Assistant Company Secretary Grenville Page, Committee Chair
Presented by	Grenville Page, Committee Chair
Summary / purpose of paper (alert / advise / assure)	This paper provides the Board with a AAA summary of the items considered by the Audit Committee at their April meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions required.
Background papers / sources of assurance	Audit Committee papers – 21 April 2026
EDI impact / considerations	The report has a neutral to positive indirect EDI impact. The committee's oversight of governance, risk management, internal control and declarations of interest supports fair, transparent and consistent decision-making across the organisation. Endorsement of the Annual Governance Statement and assurance over audit, financial reporting and committee effectiveness provide confidence that statutory duties, including equality, diversity and inclusion obligations, are appropriately considered within the Trust's overall governance framework.
Link to: ➢ Board Assurance Framework ➢ NHS Oversight Framework ➢ Corporate objectives ➢ Regulation	• Board Assurance Framework – Risks 4,5, 6, 8, 10 and 14 • Corporate objective 1 - To deliver safe, effective & equitable care • NHS Oversight Framework: Finance and Productivity domains • CQC Regulations – 15 and 17
Risk score	N/A
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.	EDI – Equality, Diversity & Inclusion MIAA – Mersey Internal Audit Agency PDR – Performance Development Review

The Christie
NHS Foundation Trust

Agenda Item 18/26a

Meeting of the Board of Directors

Thursday 25 June 2026

Audit Committee summary report – April 2026

1 Introduction

The committee took place on 21 April 2026. Quoracy met with 6 of 6 members present, including the Chair. All decisions are valid.

2 AAA summary from committee meeting

The summary in Appendix 1 gives the Board information on the items that were considered by the committee at their meeting and the key items agreed for reporting under the headings of Alert / Advise / Assure.

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

Strong	High	Medium	Low
Controls are suitably designed, being consistently applied and are effective in practice	Some issues identified that if not addressed, could increase the likelihood of the risk materialising	Some assurances in place or controls are still maturing so effectiveness cannot be fully assessed but should improve	Assurance indicates poor effectiveness of controls

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

3 Recommendation

The Board are asked to note the summary report from the committee in April 2026.

Appendix 1

Alert	Assurance rating (if applicable)	Action (to be taken)	By Whom	Target Date
No alerts to raise				

Advise:	Assurance rating (if applicable)
The committee endorsed the unaudited accounts (subject to external audit), noting a £13.3m surplus, strong cash balances, and confirmation of going concern, with no material concerns raised. External audit of accounts is scheduled to be completed by the end of June.	N/A
Risk 14 score (supply chain risk) within the Board Assurance Framework (BAF) has increased due to geopolitical instability in the Middle East. While mitigations and controls are in place, this represents an external risk pressure requiring continued awareness and oversight.	N/A
The committee advised that the digital risk should be reconsidered once the June DSPT assessment outcome is available, with specific consideration to be given at the July Audit Committee meeting. This may inform changes to BAF risk scoring.	N/A
The committee agreed the following: • an amendment to the Trust's SFIs to include details relating to consultancy payments. • an amendment to the Trust's Anti-Fraud, Bribery and Corruption Policy to include details relating to the new corporate fraud offence of "failure to prevent fraud".	N/A

Assure:	BAF reference	CQC reference	Assurance rating
Annual Governance Statement endorsed, with confirmation that new requirements (Advanced Foundation Trust preparation and Board Capability Assessment) have been appropriately incorporated.	N/A	N/A	N/A
Substantial assurance provided through Head of Internal Audit opinion for 2025/26. Conclusion reached through risk-based work undertaken in-year, management responses and the utilisation of the board assurance framework.	N/A	N/A	N/A
Internal audit plan approved.	N/A	N/A	N/A
Strong committee effectiveness evidenced through the outcome of the annual committee effectiveness review. Areas for improvement discussed.	N/A	N/A	N/A

Risks discussed (including any new risks identified):

- BAF risk 14 (supply chain risk) and risk 8 (emergency events) reviewed and discussed (see advise items above)
- Estates valuation and financial reporting judgements identified as significant risk areas for external audit, including valuation methodology and management override of controls.

The following agenda items were also discussed during the meeting:

- Approval of previous minutes and a review of actions
- Executive Director of Finance report

- Declarations of interest annual update
- Audit committee annual report
- Internal audit progress report
- Internal audit follow up report Q4
- Assurance framework assignment report 2025/26
- Internal audit charter
- Anti-fraud annual report 2025/26
- External audit progress report and sector update

The Christie
NHS Foundation Trust
Agenda Item 18/26ai

Meeting of the Board of Directors

Thursday 25th June 2026

Subject / Title	Senior Management Committee report – May 2026
Author(s)	Louise Westcott, Company Secretary
Presented by	Roger Spencer, Committee Chair
Summary / purpose of paper **(alert / advise / assure)**	This paper provides the Board with a AAA summary of the items considered by the Senior Management Committee at their May meeting and any subsequent actions required by the Board.
Recommendation(s)	To note the report and any actions required.
Background papers / sources of assurance	Senior Management Committee papers – May 2026
EDI impact / considerations	The report has a neutral to positive indirect EDI impact. The committee's oversight of governance, risk management, internal control and declarations of interest supports fair, transparent and consistent decision-making across the organisation.
Link to: ➢ **Board Assurance Framework** ➢ **NHS Oversight Framework** ➢ **Strategic objectives** ➢ **Regulation**	• Board Assurance Framework • Strategic objectives • NHS Oversight Framework • CQC Regulations
Risk score	N/A
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.	EDI – Equality, Diversity & Inclusion MIAA – Mersey Internal Audit Agency PDR – Performance Development Review

Meeting of the Board of Directors

Thursday 25 June 2026

Senior Management Committee – AAA Report (May 2026)

ALERT (Key risks / issues requiring Board attention)

- **EPR Programme Delivery Risk and Uncertainty**
  Delivery timeline for the Electronic Patient Record (EPR) may slip beyond May 2028, compounded by uncertainty regarding Cabinet Office approval and procurement timelines.
- **VIP Programme and Strategic Programme Risks**
  The VIP programme remains rated high risk (score 16) with multiple red-rated elements; there is ongoing reliance on strengthened assurance processes.
- **Quality Concerns – Inpatient Falls and Sepsis Screening**
  Inpatient falls remain above trajectory and sepsis screening performance has dipped, with improvement programmes underway.

ADVISE (Strategic direction / decisions / emerging issues)

- **Strategic Transformation and New Governance Arrangements**
  Proposal to establish an executive-led Transformation Assurance Committee to strengthen delivery of major programmes and provide clearer oversight to Board.
- **Advanced Foundation Trust Application and Strategy Refresh**
  Application progressing to Board in June; wider strategy refresh planned to align with national reforms and organisational transformation priorities.
- **7th Floor Paterson Strategic Development**
  Proposal for a data and collaboration hub endorsed in principle; further clarity required on funding, delivery model, and market appetite before progression.
- **National Policy and System Reform Implications**
  NHS Modernisation Bill including abolition of NHS England progressing through parliament.

ASSURE (Positive performance / controls / progress)

- **Strong Cancer Performance and Operational Grip**
  Delivery against key national cancer standards (62-day, 31-day, Faster Diagnosis Standard, RTT) with continued focus on pathway improvement and clinical engagement.
- **Robust Risk Management and Governance**
  98% of risks reviewed on time, improving quality of risk controls, and reduction in key regulatory risks (e.g., PSIRF compliance).
- **Positive CQC Preparedness and Staff Engagement**
  Strong engagement with mock inspections and workforce preparedness activity, with positive feedback from divisions and inpatient areas.
- **Delivery Against Key Approvals and Strategic Investments**
  Approval and progress of major capital and digital investments, e.g., proton beam therapy system, PET scanner, EPR partner extension, supporting long-term capability.

The Christie
NHS Foundation Trust

Agenda Item 18/26b

Board of Directors meeting
Thursday 30th April 2026

Subject / Title	Board Assurance Framework
Author(s)	Louise Westcott, Company Secretary
Presented by	Louise Westcott, Company Secretary
Summary / purpose of paper	This paper provides the Board with the Board Assurance Framework that summarises the risks to achievement of the strategic objectives. The cover paper gives detail of the updates.
Recommendation(s)	• To note the risks and controls relating to the strategic risks on the Board Assurance Framework, • To note that updates will be made to the risks that are the responsibility of the Board following discussion. • To scrutinise and review the assigned risks, controls and assurances and confirm any changes for Board approval.
Background papers	Board assurance framework. Strategic objectives 2025/26, operational plan and revenue and capital plan 2025/26.
Risk score	N/A
Link to: ➢ Trust strategy ➢ Strategic objectives	• Trust's strategic direction • Divisional implementation plans • Our Strategy • Key stakeholder relationships
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	BAF Board assurance framework ECN Executive chief nurse EDoF Executive director of finance EMD Executive medical director COO Chief operating officer DoW Director of workforce DCEO Deputy chief executive officer WAC Workforce Assurance Committee

The Christie
NHS Foundation Trust
Agenda Item 18/26b

Board of Directors meeting
Thursday 30th April 2026

Board Assurance Framework

1 Introduction

The board assurance framework (BAF) is presented to each Board and assurance committee meeting. The risks identified in the framework relate to achievement of the strategic objectives.

2 Background

The Board Assessment Framework reflects the risks to achievement of the strategic objectives. These are regularly reviewed by the company secretary and executive directors.

3 Updates to risks

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

Following discussion at the Workforce Committee in May, it has been proposed that the Workforce Assurance Committee (WAC) approve a change to the risk description relating to workforce. This is to better reflect current Christie data and updated information relating to the Five-Year Integrated Delivery Plan and assessment through the updated NHS Oversight Framework 2026/27.

The proposal is for the following risks to be removed;

- 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.

- If we do not maintain levels of staff engagement there is a risk that turnover and sickness absence will increase leading to workforce shortages, poor staff experience and a deterioration in the quality of patient care.

The new risk description that is proposed to replace these 2 risks is;

- ***"If the Christie does not maintain an adequate and sufficient workforce, it will be unable to deliver the five-year Integrated delivery plan"***

Following discussion at the June Workforce Assurance Committee, it was agreed that further discussion is needed to agree the risk description. It will then be updated for September meetings.

5 Recommendation

The Board are asked;

- To note the risks and controls relating to the strategic risks on the Board Assurance Framework,
- To note that updates will be made to the risks that are the responsibility of the Board following discussion.
- To scrutinise and review the assigned risks, controls and assurances and confirm any changes for Board approval.

BOARD ASSURANCE FRAMEWORK - OVERVIEW OF RISKS

RISK No.	Risk Title	Risk Description	Responsible Committee	Risk Appetite	Inherant Risk Score	Q4 24/25	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	Target Risk Score	Current Risk Score	Review /Target date
RISK 10	**Financial balance**	If we do not achieve the operational plan and our planned efficiency savings there is a risk that we won't achieve financial balance on NHS activity.	Board of Directors	Averse	25		5	5	15	15	5	15	**Relates to VIP 26/27**
RISK 15	**Technological advancements**	If we do not keep pace with technological advancements, there is a risk that we will not provide the best possible experience to our patients and carers	Board of Directors	Cautious	20		12	12	12	12	8	12	**Reviewed Q4 25/26**
RISK 7	**Ineffective Greater Manchester system-wide cancer pathways**	If diagnostic, MDT and referral processes at local hospitals across the GM system are not efficient there is a risk that we receive patients on 62-day pathways late leading to them not being treated within 62 days.	Quality Assurance Committee	Cautious	25		12	12	12	12	8	12	**Reviewed Q1 26/27**
RISK 4	**Compliance with regulatory standards**	If we do not continuously review our compliance with the regulatory standards and take corrective action where needed there is a risk that we will fall below required fundamental standards and quality of care will be reduced.	Board of Directors	Averse	15		12	12	12	12	4	12	**Q1 26/27**
RISK 13	**Transformational capacity & capability**	If we do not develop transformational capacity & capability, there is a risk that we will not transform services to improve access and reduce health inequalities	Board of Directors	Cautious	20		12	12	12	12	8	12	**Reviewed Q4 25/26**
RISK 14	**Supply chain**	If there are disruptions to the supply of essential products and services for the treatment and care of our patients, there is a risk of service disruption leading to delayed or cancelled care.	Audit Committee	Averse	12	9	9	9	9	12	3	12	**Reviewed Q4 25/26**
RISK 8	**Emergency event**	If there is a serious emergency event (pandemic/cyber-attack/extreme weather event etc) there is a risk of business disruption (increased staff absence, increased patient non-attendance and equipment malfunction) leading to delayed or cancelled care.	Audit Committee	Averse	20	12	10	10	10	10	5	10	**Review Q4 25/26**
RISK 2	**Learning from patient safety incidents**	If we do not follow the Patient Safety Incident Response Framework (PSIRF) there is a risk that we will miss opportunities to learn lessons and improve patient safety leading to preventable patient harm	Quality Assurance Committee	Averse	15		12	12	9	9	4	9	**Q4 26/27**
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	6	9	**Reviewed Q4 25/26**
RISK 6	**NHSE Financial Framework and support for growth**	If the changes in the NHSE financial framework do not maintain the level of income needed to support the planned growth in activity there is a risk that we will not be able to provide optimum care	Board of Directors	Cautious	16		16	16	16	8	4	8	**Reviewed Q2 25/26**
RISK 12	**Staff engagement**	If we do not maintain levels of staff engagement there is a risk that turnover and sickness absence will increase leading to workforce shortages, poor staff experience and a deterioration in the quality of patient care.	Workforce Assurance Committee	Averse	16		8	8	8	8	4	8	**Review June 26 - recommend to remove / replace**
RISK 9	**Integrated research, education & service**	If our research, education and clinical services do not operate as an integrated whole there is a risk that we will not secure the benefits of high-quality research and education on patient care and that this will lead to less-than-optimal quality of care.	Board of Directors	Averse	12	8	8	8	8	8	4	8	**Reviewed Q4 25/26**
RISK 1	**New technologies and increased standards of care**	If there are changes to NICE guidance or other advances in practice that we have not anticipated (diagnostic, therapeutic, care) there is a risk that there will be a delay in their introduction leading to a delay in patients obtaining the benefits of new treatments.	Quality Assurance Committee	Cautious	20	6	6	6	12	6	4	6	**Review Q4 25/26**
RISK 5	**Capital funding**	If we don't receive adequate CDEL there is a risk that we won't deliver the planned improvements resulting in delays in providing the best possible environment & equipment to provide care	Board of Directors	Eager	15		5	5	5	5	5	5	**Reviewed Q3 25/26 / 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 Jun-26	6
Associated Strategic Objectives	To deliver safe, effective & equitable care	Executive Lead	Exec Medical Director
		Responsible Committee	**Quality Assurance Committee**
		Assurance Level	Medium
		Risk Appetite	Cautious

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date
Actions	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 Model for delivery of upcoming NICE guidance established and in place	Uncertainty around what / when. External factors. Issue with breast cancer treatment - scale of impact	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	None identified	Review Q4 25/26

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	4	20	2	3	6	2	3	6	4	3	12	2	3	6	2	2	4

RISK 2	**Learning from patient safety incidents**	Date Risk Opened	Current Risk Score
Description	**If we do not follow the Patient Safety Incident Response Framework (PSIRF) there is a risk that we will miss opportunities to learn lessons and improve patient safety leading to preventable patient harm**	Jun-25 Date of Last Jun-26	9
Associated Strategic Objectives	To deliver safe, effective & equitable care	Executive Lead	Exec Chief Nurse
		Responsible Committee	**Quality Assurance Committee**
		Assurance Level	Medium
		Risk Appetite	Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	The Trust has undertaken external training for the patient safety strategy covering all components of the patient safety strategy. The patient safety team have/ will continue to host training for incident handlers to ensure management of incidents across teams is standardised. Improvement workstreams have been established to implement recommendations following the publication of learning responses. Review through Patient Safety & Experience Committee and Risk & Quality Governance. Introduction of new DATIX system	New ways of working require new skills across the organisation and resource at a team level to manage incidents.	Level 1 – Data and management reports • PSIRF reports to Patient Safety Committee / Risk & Quality Governance / Senior Management Committee • ERG Level 2 – Management team and committee scrutiny • Review compliance through patient safety reports to QAC Level 3 – External assurances • MIAA review of PSIRF processes confirms substantial assurance • Updates presented to ICB • MIAA Health & Saftey - substantial assurance	Embed quality improvement methodology across the Trust	Embed agreed Quality Improvement methodology across the Trust by Q4 26/27	Q4 26/27

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	3	5	15	3	4	12	3	4	12	3	3	9	3	3	9	2	2	4

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 Jun-26	**9**
Associated Strategic Objectives	To deliver safe, effective & equitable care To deliver excellent financial and operational performance To be an excellent place to work and attract the best staff	Executive Lead	Workforce Director
		Responsible Committee	**Workforce Assurance Committee**
		Assurance Level	High
		Risk Appetite	Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	Staffing levels maintained through coordinated and risk based utilisation of bank and agency Christie People and Culture Plan 2023-26 Quarterly oversight of Trust wide vacancies and recruitment activity presented to the workforce committee & WAC Divisional oversight of recruitment activity and vacancies discussed at the monthly service review meetings Turnover analysis and 'next chapter' data presented and discussed six monthly at the workforce committee Robust sickness absence management and health and wellbeing offer Connect & reflect sessions in place for new starters within first 3 months of employment Weekly executive led vacancy management panel in place Recruitment of onboarding coordinator Nursing workforce lead appointed Completion and reporting to WAC of progress against the 10 point plan to improve resident doctors lives.	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 and update on compliance with CQC regulation • F&PP Compliance report to WAC / Board • Safe staffing 6 monthly reviews to external standard Level 3 – External assurances • National staff survey • CQC Inpatient survey • OECI accreditation • MIAA Bank & Admin audit - Moderate assurance	None identified	None identified	Reviewed Q4 25/26

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	5	20	3	3	9	3	3	9	3	3	9	3	3	9	2	3	6

RISK 4	**Compliance with regulatory standards**	Date Risk Opened	Current Risk Score
Description	**If we do not continuously review our compliance with the regulatory standards and take corrective action where needed there is a risk that we will fall below required fundamental standards and quality of care will be reduced.**	Jun-25 Date of Last Jun-26	**12**
Associated Strategic Objectives	To deliver safe, effective & equitable care To deliver excellent financial and operational performance To be an excellent place to work and attract the best staff	Executive Lead	Exec Chief Nurse
		Responsible Committee	**Board of Directors**
		Assurance Level	Medium
		Risk Appetite	Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	Self assessments underway against 2022 must do actions and well-led quality indicators. Attendance at CQC briefings / NHS Providers briefings Engagement in national updates and regulatory briefings. Designated leads for statutory requirements across the Trust reporting into committee structure. Policies and procedures in place e.g. conflicts of interest, SFI's, Document ratification processes. Membership of NHS Providers to 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 Excellence in action programme underway.	External political factors	Level 1 – Data and management reports • Self assessment against 2022 Must Do's • Self assessment against Well Led / Safety quality indicators Level 2 – Management team and committee scrutiny • QAC /WAC review of CQC regulations - all on rolling programmes • Board level training on new CQC assessment framework Feb 24 • Board reporting on regulatory changes • Work of the 3 assurance committees • Board capbility self-assessment Level 3 – External assurances • CQC Inspection Reports (IR(M)ER) • NOF Rating 1 (Q1 rated 3/134 acute & specialist trusts) • MIAA role specific training audit (CQC Reg 19) - Limited assurance Oct 24 • MIAA data quality audit Oct 24 - moderate assurance • OECI accreditation • MIAA Medical devices Training - limited assurance • MIAA Key Financial systems - substantial assurance • MIAA Health & Safety - substantial assurance	External well-led review (underway, will report Q1 26/27)	Plan in development for full review of all domains (1 per quarter) Actions relating to role specific training data reporting and compliance - reporting to WAC March 26	Q1 26/27

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	3	15	4	3	12	4	3	12	4	3	12	4	3	12	4	1	4

RISK 5	**Capital funding**	Date Risk Opened	Current Risk Score
Description	**If we don't receive adequate CDEL there is a risk that we won't deliver the planned improvements resulting in delays in providing the best possible environment & equipment to provide care**	Jun-25 Date of Last Jun-26	5
Associated Strategic Objectives	To deliver excellent financial and operational performance	Executive Lead Responsible Assurance Level Risk Appetite	Exec Director of Finance **Board of Directors** High Eager

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	Financial planning includes utilisation of 'capital freedoms' (CDEL) to increase the CDEL allocation to deliver our plan. Capital planning is part of our planning process and based on risk assessment within divisions. NHSE rules for 26/27 allow greater freedom with CDEL / capital spend	National / local funding rules / arrangements.	Level 1 – Data and management reports • Monthly finance reports Level 2 – Management team and committee scrutiny • summary of progress with capital plan/strategy implementation at Board / Planning Days • Regular reporting to Senior Management Committee & Board of Directors Level 3 – External assurances • ICB allocation - maximum capital freedoms	None identified	None identified	Reviewed Q3 25/26 / Within tolerance

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	3	5	15	1	5	5	1	5	5	1	5	5	1	5	5	1	5	5

RISK 6	**NHSE Financial Framework and support for growth**	Date Risk Opened	Current Risk Score
Description	**If the changes in the NHSE financial framework do not maintain the level of income needed to support the planned growth in activity there is a risk that we will not be able to provide optimum care**	Jun-25 Date of Last Jun-26	8
Associated Strategic Objectives	To deliver excellent financial and operational performance	Executive Lead Responsible Assurance Level Risk Appetite	Exec Director of Finance **Board of Directors** High Cautious

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	Senior team attendance at national and regional meetings to keep updated on policy changes and influence discussions on cancer. Monthly service & operational reviews to ensure efficient delivery of service. Board member attendance at national events to influence policy. 2026/27 contract signed	External political factors	Level 1 – Data and management reports • SOR's • Divisional Boards reports Level 2 – Management team and committee scrutiny • SMC reporting Level 3 – External assurances • External Audit VfM assessment • Signed contract for 26/27 in line with activity • MIAA Key Financial systems - substantial assurance	None identified	Continued attendance at regional & national events and on going discussions with ICB to understand funding	Reviewed Q2 25/26

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	4	16	4	4	16	4	4	16	4	4	16	2	4	8	1	4	4

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 Jun-26	12
Associated Strategic Objectives	To deliver safe, effective & equitable care To deliver excellent financial and operational performance	Executive Lead Responsible Assurance Level Risk Appetite	Chief Operating Officer **Quality Assurance** Medium Cautious

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	Executive led monthly divisional performance review meetings. Integrated performance & quality report to Management Board and Board of Directors monthly. Weekly performance reporting via trust operational group. Escalation internally & across GM of delays impacting waiting time targets. Monitoring cancer waiting time standards through GM Cancer & IPQFR.	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 • The PSC Independent assessment and assurance of 62-Day Standard in the 5 year Integrated Delivery Plan -	Evidence of progress in underperforming parts of the pathway	Pathway improvement workstream in GM Cancer - reporting on progress 6 monthly to QAC	Reviewed Q1 26/27

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	5	25	4	3	12	4	3	12	4	3	12	4	3	12	4	2	8

RISK 8	**Emergency event**	Date Risk Opened	Current Risk Score
Description	**If there is a serious emergency event (pandemic/cyber-attack/extreme weather event etc) there is a risk of business disruption (increased staff absence, increased patient non-attendance and equipment malfunction) leading to delayed or cancelled care.**	Apr-24 Date of Last Jun-26	**10**
Associated Strategic Objectives	To maintain excellent operational, quality and financial performance.	Executive Lead Responsible Assurance Level Risk Appetite	Chief Operating Officer **Audit Committee** Medium Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	No ability to reduce likelihood as an organisation, however we do have an Annual Assurance process that is externally reviewed to develop our Statement of Compliance Adaptations to existing buildings / equipment to manage temperature rises. GM approach. Business Continuity Plans (BCP) - regularly tested and reviewed Extreme weather plan approved & published on intranet Data Security and Protection Toolkit submissions with audits undertaken. Digital board reporting. Board level Senior Information Risk Owner in place. Reviews of risk registers, alerts, reports, actions and observations MIAA audit - Data Protection Toolkit (DPST) 2024/25 approaching standards (new assessment) - improvement plan submitted to NHSE, actions completed (pendng MIAA audit review) - report to July Audit Committee.	The Trust does not currently have cyber security insurance.	Level 1 – Data and management reports • SDMP compliance • BCP compliance and effectiveness • Approved Extreme weather plan • Regular updates from NHS Digital - Vulnerability Monitoring Service Level 2 – Management team and committee scrutiny • Emergency Planning & Resilience Committee - reporting of regular testing of BCP's • Quarterly Net Zero and Climate Adaptation Committee (NZACAC) advises Executive Director • Annual SDMP report to MB and BoD (Assurance Scrutiny by Quality Assurance Committee) • Statutory disclosures in Trust Annual Report • Reports to Senior Management Comittee and Audit Committee • Annual Assurance Report and Statement of Compliance- substantial compliance Level 3 – External assurances • Internal audit of compliance with NHS requirements • NHSE review of plans and progress - agreement of current compliance (as in self-assessment) • MIAA Data Protection Toolkit assessment (DPST) - Substantial assurance July 2024 / met standards for 2024/5 (new assessment)	Not at 100% compliance for self-assessment / external assessment	Developing methodology to assess carbon footprint in collaboration with other Trusts Developing a CC Adaptation plan in development for future developments	Review Q4 25/26

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	4	**20**	5	2	**10**	5	2	**10**	5	2	**10**	5	2	**10**	5	1	**5**

RISK 9	**Integrated research, education & service**	Date Risk Opened	Current Risk Score
Description	**If our research, education and clinical services do not operate as an integrated whole there is a risk that we will not secure the benefits of high-quality research and education on patient care and that this will lead to less-than-optimal quality of care.**	Jun-25 Date of Last Jun-26	**8**
Associated Strategic Objectives	To provide integrated clinical, research and education services	Executive Lead Responsible Assurance Level Risk Appetite	Chief Executive Officer **Board of Directors** High Averse

	Key Control established	Key Gaps in Controls	Assurance	Gaps in assurance	Actions to address gaps	Target date for implementation	Target date for completion
Actions	Research / Education / CODU plans all approved and being monitored through divisional boards and SMC OECI accreditation achieved and reported to Board Business case for expansion of CRF approved at January 2026 Board. Well-led review undertaken to assure on governance		Level 1 – Data and management reports • Divisional Board reports Level 2 – Management team and committee scrutiny • Regular reports on progress to Board and assurance committees Level 3 – External assurances • OECI accreditation	None identified	None identified		Reviewed Q4 25/26

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	3	4	**12**	2	4	**8**	2	4	**8**	2	4	**8**	2	4	**8**	1	4	**4**

RISK 10	**Financial balance**	Date Risk Opened	Current Risk Score
Description	**If we do not achieve the operational plan and our planned efficiency savings there is a risk that we won't achieve financial balance on NHS activity.**	Apr-24 Date of Last Jun-26	**15**
Associated Strategic Objectives	To maintain excellent operational, quality and financial performance.	Executive Lead	Exec Director of Finance
		Responsible	**Board of Directors**
		Assurance Level	High
		Risk Appetite	Averse

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
	Activity plans agreed with Divisions and progress monitored weekly at TOG and monthly at Senior Management Committee. Variable income performance tracked as part of month end financial position and reviewed in the clinical Divisions monthly financial meetings. Development of mitigating strategies including efficiency and transformational programmes. Identification and consideration of new models of working to deliver and finance the Trust's strategic plan. Agreed governance of VIP schemes and escalating VIP reporting and responsibility to SMC. VIP delivery at a divisional level monitored via the Trusts Service Operational Review framework Board has recieved monthly financial report showing performance 2025/26 VIP achieved from month 6 - focus on 2026/27 Prices locked in for gas / electricity prior to escalations in Middle East resulting in control of price for 80% of power requirement.	Commissioning intentions. Funding growth. Impact of cost increases (power/medicines etc) as a result of global factors (war in Middle East)	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 • MIAA Key Financial systems - substantial assurance	None identified	Complete Quality Impact Assessments for all identified schemes as they arise	Relates to VIP 26/27

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	5	**25**	1	5	**5**	1	5	**5**	3	5	**15**	3	5	**15**	1	5	**5**

RISK 12	**Staff engagement**	Date Risk Opened	Current Risk Score
Description	**If we do not maintain levels of staff engagement there is a risk that turnover and sickness absence will increase leading to workforce shortages, poor staff experience and a deterioration in the quality of patient care.**	Jun-25 Date of Last Jun-26	**8**
Associated Strategic Objectives	To be an excellent place to work and attract the best staff	Executive Lead	Director of Workforce
		Responsible	**Workforce Assurance**
		Assurance Level	Medium
		Risk Appetite	Averse

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
	Inclusive Culture Strategy developed through extensive engagement with staff and approved by Board. Board responsibilities outlined. Service & Operational reviews include 'people & culture' focus for all divisions. Progress reports to WAC. Divisions report staff engagement activity / priorities to Workforce Committee on rolling programme Workforce Assurance committee recieve regular presentations from divisions on cultural activities. Strategic Leaders Forum - scheduled across the year Divisional plans in place for events and meetings across the year	None identified	Level 1 – Data and management reports • Divisional action plans from staff survey • Service & operational reviews 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 • Annual CQC Staff Survey 2024 / 2025	None identified	Implementation of next phase of People & Culture Plan - reporting to WAC June 2026	Review June 26 - recommend to remove / replace

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	4	4	**16**	2	4	**8**	2	4	**8**	2	4	**8**	2	4	**8**	2	2	**4**

RISK 13	**Transformational capacity & capability**	Date Risk Opened	Current Risk Score
Description	**If we do not develop transformational capacity & capability, there is a risk that we will not transform services to improve access and reduce health inequalities**	Jun-25 Date of Last Jun-26	**12**
Associated Strategic Objectives	To transform our services to improve access and reduce health inequalities	Executive Lead	Dir of Future Christie
		Responsible Committee	**Board of Directors**
		Assurance Level	Medium
		Risk Appetite	Cautious

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
	Future Christie Director and Medical Director in place. Director of Transformation appointed. Service Planning day with senior leadership team. Communication plan with wider organisation commenced. Alignment of Digital & Transformation under Future Christie. Year 1 objectives on track for delivery - patient portal / expanded AI / EPR outline case / staff engagement Strategic projects scoped and resource described - use of commercial partner to provide short term resource where identified as necessary. Transformation Committee meeting weekly. External assessments commissioned for AFT application process - financial / Well-led / content of application	None identified	Level 1 – Data and management reports • Exec review weekly Level 2 – Management team and committee scrutiny • Monthly to SMC and Board • Board approved EPR OBC • Transformation Committee reporting Level 3 – External assurances • Deliotte engaged in options appraial for new EPR • MIAA Key Financial systems - substantial assurance • PWC undertaking assessment of financial modelling • AuditOne Well-led review / assessment of AFT application	External assessment of capability and readiness to be developed	Year 1 objectives on track for delivery - patient portal / expanded AI / EPR outline case / staff engagement	Reviewed Q4 25/26

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	4	**20**	3	4	**12**	3	4	**12**	3	4	**12**	3	4	**12**	2	4	**8**

RISK 14	**Supply chain**	Date Risk Opened	Current Risk Score
Description	**If there are disruptions to the supply of essential products and services for the treatment and care of our patients, there is a risk of service disruption leading to delayed or cancelled care.**	Nov-24 Date of Last Jun-26	**12**
Associated Strategic Objectives	To deliver safe, effective & equitable care To deliver excellent financial and operational performance	Executive Lead	Chief Operating Officer
		Responsible Committee	**Audit Committee**
		Assurance Level	Medium
		Risk Appetite	Averse

Actions	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
	Pharmacy - TCP procurement team work closely with regional & national drug procurement teams. Mutual aid MOU in place in NW. Management with clinicians to avoid 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 - may result in price increases	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	Continuous review of alerts March 2026 - Comprehensive review undertaken of all aspects of supply chain risk in the context of escalated conflict in the Middle East	Reviewed Q4 25/26

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	3	4	**12**	3	3	**9**	3	3	**9**	3	3	**9**	4	3	**12**	3	1	**3**

RISK 15	**Technological advancements**	Date Risk	Current Risk Score
Description	**If we do not keep pace with technological advancements, there is a risk that we will not provide the best possible experience to our patients and carers**	Jun-25 Date of Last Jun-26	**12**
Associated Strategic Objectives	To transform our services to improve access and reduce health inequalities	Executive Lead	Dir of Future Christie
		Responsible Committee	**Board of Directors**
		Assurance Level	Medium
		Risk Appetite	Cautious

	Key Control established	Key Gaps in Controls	Assurance	Gaps in	Actions to address	Target date for
Actions	Future Christie team leading service change ambitions incorporating technological advances with partners. Engaing with other health providers around effective systems on the market. Development of strategic outline case for new EPR Year 1 objectives on track for delivery - patient portal / expanded AI / EPR outline case / staff engagement	Recognition of fast moving market	Level 1 – Data and management reports • reports to Board of Directors Level 2 – Management team and committee scrutiny • Execs, SMC and Board reports Level 3 – External assurances • Deliotte engaged in options appraial for new EPR • OECI accreditation	Development of full business cases	EPR business case to Board July 2026. Seeking expertise internally & externally around best option - 'expert customer'	Reviewed Q4 25/26

Scoring	Inherant Risk			Q1 25/26			Q2 25/26			Q3 25/26			Q4 25/26			Target Risk		
	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score	L	I	Score
	5	4	**20**	3	4	**12**	3	4	**12**	3	4	**12**	3	4	**12**	2	4	**8**

The Christie
NHS Foundation Trust

Agenda Item 18/26c

Meeting of the Board of Directors
Thursday 25th June 2026

Subject / Title	Strategic & Annual Objectives and strategic risks
Author(s)	Louise Westcott, Company Secretary
Presented by	Chief Executive Officer
Summary / purpose of paper	For the Board of Directors to receive the refreshed Strategic Objectives and annual objectives for 2026/27 and to consider the updated strategic risks and risk appetite statement.
Recommendation(s)	The board of directors are asked to; • Approve the 2026/27 strategic and annual objectives • Note the strategic risks relating to the strategic and annual objectives for inclusion in a revised Board assurance framework (BAF) following approval of the objectives
Background papers	Strategic objectives, board assurance framework
Risk score	N/A
Link to: ➢ Trust strategy ➢ Corporate objectives	• Trust's strategic direction • Divisional implementation plans • Key stakeholder relationships
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.	BAF Board assurance framework ECN Executive Chief nurse EDoF Executive director of finance EMD Executive medical director COO Chief operating officer DoW Director of workforce NHSE NHE England

The Christie
NHS Foundation Trust

Agenda item 18/26c

Meeting of the Board of Directors
Thursday 25th June 2026

Strategic and Annual Objectives 2026/27

1. Introduction

This paper seeks approval of the refreshed annual objectives for 2026/27 (appendix 1) and outlines the strategic risks relating to achievement of the strategic objectives that make up the Board Assurance Framework. The Trust Risk Appetite Statement is also presented in its current form.

2. Background

Our Strategy 2023-28 describes where the Trust wants to be, and the operational plan describes how we will achieve this in year. The 6 strategic objectives are outlined. No changes are proposed to these existing objectives. The annual objectives are built on previous years objectives and also relate to major strategic projects underway at the Trust.

3. Strategic objectives

The strategic objectives are a fundamental element in the development of the operational plan and enable the executives and divisions to align their proposed programme of activity to the Trust's ambitions.

The 6 strategic objectives are detailed at Appendix 1 with the proposed cascade to the annual objectives which feed into divisional objectives. Monitoring of the objectives is done through the integrated performance report and reports to board. Assurance is managed through the board assurance framework and the assurance committees.

The Strategic Objectives are;

1. To deliver safe, effective & equitable care
2. To deliver excellent financial and operational performance
3. To provide integrated clinical, research and education services
4. To be an excellent place to work and attract the best staff
5. To transform our services to improve access and reduce health inequalities
6. To provider leadership within the wider NHS cancer system

4. Board Assurance Framework (BAF)

The Board Assurance Framework outlines the risks to achievement of the strategic objectives. The document is regularly reviewed by the company secretary and the executive directors and presented to each Board meeting and assurance committee. The risks within the framework determine the focus of the assurance committees and Board discussion so that the Board can get appropriate assurance against each risk.

The BAF will continue to evolve through regular review. The executive team undertake a more detailed review of the BAF on a quarterly basis to ensure the risks remain relevant and the target risk scores reflect any changes as the year progresses.

5. Risk Appetite Statement

A Board approved risk appetite statement supports the Board Assurance Framework, particularly the identified appetite against each risk that is outlined in the BAF. The statement is

published on our website. The Board need to review this annually. The statement is also contained within the Risk Management Policy for the Trust that is published on the intranet.

The existing statement is;

> *The Trust recognises that its long-term sustainability depends upon the delivery of its strategic objectives and its relationships with patients, staff and the public and strategic partners. It operates within a low overall risk range; it will not accept risks that have a likelihood of a detrimental impact on patient/staff safety or to compliance and regulatory objectives.*
>
> *However, the Trust has a marginally higher risk appetite to take considered risks in terms of its impact on the strategic, reporting and operations objectives in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment. The highest risk appetite relates to our pursuance of innovation and transformation objectives.*

The Board have previously agreed that following external review of the Risk Management Strategy by MIAA in 2025/6 and the well-led development review undertaken in May 2026 that an established risk appetite methodology will be implemented this year. The Board Development Plan 2026/7 incorporates a session on risk appetite where this approach will be further explored and an amended statement will be published following agreement.

6. Recommendation

The board of directors are asked to;

- Approve the 2026/27 annual objectives
- Note the corresponding strategic risks of the board assurance framework (BAF) following approval of the objectives
- Note that a new risk appetite methodology will be implemented in year and approved by Board at a future meeting.

The Christie
NHS Foundation Trust

Strategic & annual objectives and strategic risks 2026/27

1. To deliver safe, effective, patient orientated & equitable care	
Annual Objectives 2026/27	**Strategic Risks**
• Achieve the year 1 actions of the Quality Plan 2026-2028 • Achieve the year 2 actions of the Risk Strategy • Achieve the year 1 actions of Patient Experience and Engagement Plan 2026-2028 (as part of the overall Quality Plan) • Ensure compliance with the CQC regulations & quality standards • Embed reliable end to end cancer pathway standards • Complete in year milestones of the ASICs programme	• If we do not follow the Patient Safety Incident Response Framework (PSIRF) there is a risk that we will miss opportunities to learn lessons and improve patient safety leading to preventable patient harm. • If we do not continuously review our compliance with the regulatory standards and take corrective action where needed there is a risk that we will fall below required fundamental standards and quality of care will be reduced. • If there is a serious emergency event (pandemic/cyber-attack/extreme weather event etc) there is a risk of business disruption (increased staff absence, increased patient non-attendance and equipment malfunction) leading to delayed or cancelled care. • 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. • If there are disruptions to the supply of essential products and services for the treatment and care of our patients there is a risk of service disruption leading to delayed or cancelled care.

2. To deliver excellent financial and operational performance	
Annual Objectives 2026/27	**Strategic Risks**
• Achieve the agreed revenue financial plan including value-improvement programme VIP. • Achieve mandated national targets as per the NHS Oversight Framework (NOF) for 2026/27. • Achieve the agreed Trust capital plan in 2026/27. • Ensure compliance with the CQC Regulations & quality standards. • Achieve the annual objectives of the Five-Year Integrated Delivery Plan 2026/27 • Align workforce capacity, capability and job planning to demand	• If the changes in the NHSE financial framework do not maintain the level of income needed to support the planned growth in activity there is a risk that we will not be able to provide optimum care. • If we don't receive adequate CDEL there is a risk that we won't deliver the planned improvements resulting in delays in providing the best possible environment & equipment to provide care • If we do not continuously review our compliance with the regulatory standards and take corrective action where needed there is a risk that we will fall below required standards and quality of care will be reduced. • If we do not achieve the operational plan and our planned efficiency savings there is a risk that we won't achieve financial balance on NHS activity. • 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.

3. To provide integrated clinical, research and education services	
Annual Objectives 2026/27	**Strategic Risks**
• Achieve the year 4 actions of the Research Plan • Achieve the year 4 actions of the Education Plan • Achieve the year 4 actions of the Clinical Outcomes Plan • Achieve the year 4 objectives of the Trust Strategy • Progress strategy for MCRC in collaboration with the University and CRUK-MI Director	• If our research, education and clinical services do not operate as an integrated whole there is a risk that we will not secure the benefits of high-quality research and education on patient care and that this will lead to less-than-optimal quality of care.

4. To be an excellent place to work and attract the best staff	
Annual Objectives 2026/27	**Strategic Risks**
• Achieve the year 2 actions of the Inclusive Culture Strategy aligned to Five-Year Integrated Delivery Plan • Achieve the year 1 milestones of The Christie People & Culture Plan 2026/30 • Achieve the delivery of objectives set in EDS 2026/27. • Deliver modern staff portal	• If the Christie does not maintain an adequate and sufficient workforce, it will be unable to deliver the five-year Integrated delivery plan (risk description subject to approval through Workforce Assurance Committee).

5. To transform our services to improve access and reduce health inequalities	
Annual Objectives 2026/27	**Strategic Risks**
• Achieve the year 2 objectives of the Future Christie programme focusing on patient access to information • Achieve the next steps in our plans to develop modern imaging capability • Achieve year 2 objectives for implementation of new clinical model for acute oncology & inpatient care • Achieve the annual health inequalities milestones set out in the Equality Delivery System (EDS). • Achieve the annual milestones set out in our Green Plan. • Implement Total Body PET by end Q4 2026/27 • Develop a Trust wide Data Strategy	• If we do not develop transformational capacity & capability, there is a risk that we will not transform services to improve access and reduce health inequalities • If we do not keep pace with technological advancements, there is a risk that we will not provide the best possible experience to our patients and carers

6. To provider leadership within the wider NHS cancer system	
Annual Objectives 2026/27	**Strategic Risks**
• Lead agreed improvements to cancer care pathways across Greater Manchester and Cheshire • Achieve Advanced Foundation Trust status • Develop plans for Neighbourhood Cancer Care centre at Leighton • Expand neighbourhood models of care	• If we do not develop transformational capacity & capability, there is a risk that we will not transform services to improve access and reduce health inequalities • If the Christie does not maintain an adequate and sufficient workforce, it will be unable to deliver the five-year Integrated delivery plan (risk description subject to approval through Workforce Assurance Committee).

The Christie NHS Foundation Trust

Agenda item 18/26c

Meeting of the Board of Directors

Thursday 25th June 2026

Subject / Title	Independent well-led development review
Author(s)	Louise Westcott, Company Secretary
Presented by	Roger Spencer, Chief Executive Officer
Summary / purpose of paper	This paper outlines the plan to respond to the Independent Well-led Development review undertaken by ConsultOne in May 2026. This response outlines what we are doing to address the recommendations made in the review to further strengthen our governance and oversight arrangements in line with the CQC Well-led requirements.
Recommendation(s)	The Board are asked to; • Receive the independent well-led developmental assessment • Note confirmation of overall compliance with the well-led framework • Note the developments outlined under the 6 themes • Note that these developments will be aligned to further recommendations from the additional independent reviews into a single development plan that will come to a future Board meeting.
Background Papers	ConsultOne Well-led Development Review (appendix 1)
Risk Score	See Board Assurance Framework
EDI impact / considerations	The paper has a **positive EDI impact**, with a clear focus on strengthening equality, diversity and inclusion within leadership, governance and workforce culture. The independent well-led review explicitly identifies **EDI as a core quality statement**, alongside leadership, culture and governance, reinforcing its central role in organisational effectiveness. Key EDI considerations include: • **Workforce equality and inclusion:** The review highlights the need to improve Board oversight of EDI, increase leadership diversity and strengthen the impact and visibility of staff networks, supporting a more inclusive workforce. • **Data and insight on inequalities:** There are recognised gaps in the quality and use of workforce and patient demographic data, limiting the Trust's ability to fully understand and address inequalities; improvements are planned to support more informed decision-making. • **Staff experience and speaking up:** Enhancing Freedom to Speak Up arrangements and better capturing protected characteristics data will support equitable staff voice and help identify differential experiences across groups. • **Culture and leadership:** Actions to strengthen inclusive

	leadership, culture, and Board ownership of the EDI agenda will support fair treatment, improved staff experience and better outcomes. • **Health inequalities:** The Trust is already taking steps to reduce health inequalities (e.g. improving access to services in deprived areas), but further work is required to strengthen data and systematic oversight. Overall, the proposed development plan is expected to **advance EDI objectives**, with no adverse impacts identified. Strengthened governance, improved data, and enhanced engagement with staff and patients will support more equitable outcomes and align with the CQC Well-led framework.
Link to: ➢ **Trust's strategic direction** ➢ **Strategic Objectives**	Strategic Objectives CQC Well-led framework NHS Oversight Framework
Acronyms or abbreviations contained in the report	AFT Advanced Foundation Trust FTSU freedom to speak up EDI equality, diversity, inclusion MTP medium term plan PMO programme management office ToR terms of reference CQC Care Quality Commission

The Christie
NHS Foundation Trust

Agenda item 18/26c

Meeting of the Board of Directors

Thursday 25th June 2026

1 Introduction

The Trust last had a CQC well-led inspection in October 2022 (reported May 2023). The overall rating for the comprehensive inspection was Good, the rating given for the well-led element was Requires Improvement. An improvement plan was completed and submitted together with assurance evidence, this was signed off as completed by the CQC (November 2023). In October 2025, organisations were required to submit a provider capability self-assessment to NHSE. Following review by NHSE our submission was rated as Green (February 2026). Provider capability assessment includes key components of well-led quality statements.

As part of the Trust's preparation for an Advanced Foundation Trust (AFT) application, one of the elements required to progress with an application was a Well-led rating of Good or better. As the last CQC assessment was not contemporaneous, an independent review was procured in April 2026. This review could then form part of the evidence for any future AFT application.

2 Background

ConsultOne (a wholly owned subsidiary of AuditOne) undertook the review, led by Mike Gill. The aim of the review was to assess the leadership and governance of the Trust as described within the Single Assessment Framework jointly developed by the Care Quality Commission (CQC) and NHS England (NHSE) and to identify areas of developmental action to secure and sustain future performance as part of continuous improvement and development. The review was undertaken in line with the new well-led guidance and considered existing and planned practice against the eight quality statements set out in the guidance:

- Shared direction and culture.
- Capable, compassionate, and inclusive leaders.
- Freedom to speak up.
- Workforce equality, diversity and inclusion.
- Governance, management and sustainability.
- Partnerships and communities.
- Learning, improvement and innovation; and
- Environmental sustainability.

Their report is structured around these eight quality statements with each section of the report detailing existing good practice, findings and further developmental areas.

3 Outcome and next steps

The findings from the assessment confirmed that overall, the Trust demonstrates good levels of compliance with the well-led framework, with clear strengths in strategic direction, financial stability, compassionate Board leadership, research integration, and system partnerships. Governance structures are broadly effective, risk management is well developed, and there is a maturing learning and safety culture supported by strong incident reporting and adoption of PSIRF.

It suggests some areas for further development to strengthen consistency and impact: notably improving strategy deployment and staff / patient engagement in planning, enhancing Board visibility and ownership of culture, EDI, and FTSU, and strengthening operational oversight, quality governance, and assurance flows. There is also a need to address fragmentation across plans and forums, improve closure and impact of audit and improvement activity, and enhance the use of qualitative insight, workforce data, and health inequalities data in decision-making. Sustaining

financial performance without reliance on non-recurrent savings, aligning workforce capacity with growth ambitions, and embedding clearer leadership for sustainability and external stakeholder management will be key to supporting future strategic ambitions.

A development plan will take account of this feedback, together with the findings from two further independent assurance reviews (performance and finance), that have been undertaken as part of the process for preparation for the AFT application. These are: an assessment & assurance of our ability to deliver our Medium Term Plan (MTP) including achievement of Cancer standards being undertaken by The PSC, and an assessment of our financial plans and modelling by PWC. In addition to these assurance reviews a compliance and quality assessment of our AFT application, has also been carried out by ConsultOne.

A summary of the main developments that are being progressed relating to the well-led review are outlined below by theme.

Recommendation	Response
Strategy & Transformation	
• Refresh and align strategies, with clear measures and reporting • Ensure strategy drives decision-making and investment • Clarify Future Christie Programme • Align transformation capacity with ambition	• Timetable for the refresh of the Trust Strategy with engagement plan at September Board • Future Christie & Strategy Delivery Committee in place • Strategic PMO & Delivery Unit established
Board Effectiveness & Governance	
• Strengthen Board oversight, focus, and assurance structures • Improve committee effectiveness • Enhance evidence of challenge, decision-making and follow-up • Improve use of data and triangulated information	• Transformation Assurance Committee in place – first meeting 1st October • Amendments made to committee Terms of Reference / rolling programmes • Minutes to reflect challenge
Leadership, Culture & Workforce (incl. EDI)	
• Strengthen Board ownership of culture • Improve succession planning and performance management • Enhance EDI oversight, leadership diversity, and staff network impact	• Increased reporting to Workforce Assurance Committee of EDI agenda • Refocused Workforce Committee ToR to cover Performance management of workforce metrics • Extend consultant development programme / review of strategic leader's forum. • Review of staff network groups
Engagement, Voice & Communication	
• Strengthen use of patient, staff, and stakeholder feedback • Improve FTSU oversight and accessibility • Enhance internal communications and "you said, we did" • Clarify role of governors and stakeholder engagement approach	• Triangulation reporting of `your next chapter`, connect and reflect sessions and divisional engagement activity reported to Workforce Committee from a learning perspective • Promotion of FTSU champion network • Staff Survey communication plan `you said, we did` implemented • Divisional engagement activity presented to Workforce Committee • Refresh Stakeholder map development

Recommendation	Response
Quality, Risk & Operational Governance	
• Strengthen operational governance and accountability frameworks • Improve oversight of quality, fundamental standards, and learning • Enhance use of risk appetite in decision-making • Improve connectivity across governance layers (divisional to Board)	• Updated operational governance framework in place • Rolling programmes updated • Updated risk appetite approach being implemented
Sustainability	
• Strengthen measurement and delivery of the Green Plan • Embed sustainability into routine decision-making	• Visibility of sustainability considerations being embedded into documentation

4 Recommendations

The Board are asked to;

- Receive the independent well-led developmental assessment
- Note confirmation of overall compliance with the well-led framework
- Note the developments outlined under the 6 themes
- Note that these developments will be aligned to further recommendations from the additional independent reviews into a single development plan that will come to a future Board meeting.

consultone
expertise . insight . improvement

Well-Led Developmental Review

The Christie NHS FT

May 2026

Contents

Introduction

This report has been prepared by ConsultOne (which is a wholly owned subsidiary of AuditOne) for the Board of The Christie NHS Foundation Trust (The Trust). The report highlights existing strengths drawn from the review and identifies areas for further focus and development to strengthen the leadership of the Trust and its governance structure.

The matters raised in this report are limited to those that came to our attention during this assignment and are not necessarily a comprehensive statement of all the opportunities or weaknesses that may exist, nor of all the improvements that may be required. ConsultOne has taken every care to ensure that the information provided in this report is as accurate as possible, based on the information provided and documentation reviewed. However, no complete guarantee or warranty can be given regarding the advice and information contained herein. This work does not provide absolute assurance that material errors, loss or fraud do not exist. This report is prepared solely for use by The Christie NHS Foundation Trust.

The aim of this review was to assess the leadership and governance of the Trust as described within the Single Assessment Framework jointly developed by the Care Quality Commission (CQC) and NHS England (NHSE).

As described in the guidance, the aim of this review is to identify areas of developmental action to secure and sustain future performance as part of continuous improvement and development. This review should inform further targeted development work by the Trust.

We undertook the review in line with the new well-led guidance and considered existing and planned practice against the eight quality statements set out in the guidance:

- Shared direction and culture.
- Capable, compassionate, and inclusive leaders.
- Freedom to speak up.
- Workforce equality, diversity and inclusion.
- Governance, management and sustainability.
- Partnerships and communities'.
- Learning, improvement and innovation; and
- Environmental sustainability.

Our report is structured around the eight quality statements described above with each section of the report detailing existing good practice, our findings and further developmental areas.

We would like to place on record our gratitude to the Trust staff who have supported the successful delivery of this review and to thank staff and stakeholders who have engaged with the review, all of whom have engaged in a positive and constructive manner which has helped shape the outcome. In particular, we would like to thank Louise Westcott and Joanne D'Arcy who acted as key contact points during the review.

Limitations

This review focuses on Trust leadership, governance structures and underpinning processes that the Trust uses to govern itself. The scope of the review did not include the Trust's subsidiary companies beyond seeking to understand and comment on how the Trust retains effective oversight of any activities undertaken by its subsidiary companies.

The review is limited to the documentation provided to ConsultOne during the time period described and confined to the information provided by those we interviewed as part of this process or observed at those meetings we attended. The review was carried out between January and April 2026 and included reviewing documentation covering the period January and December 2025.

The matters raised in this report are limited to those that came to our attention during this assignment and are not necessarily a comprehensive statement of all the opportunities or weaknesses that may exist, nor of all the improvements that may be required. ConsultOne has taken every care to ensure that the information provided in this report is as accurate as possible, based on the information provided and documentation reviewed. However, no complete guarantee or warranty can be given regarding the advice and information contained herein.

This report is prepared solely for use by The Christie NHS Foundation Trust. Details may be made available to specified external agencies, including regulators and external auditors, but otherwise the report should not be quoted or referred to in whole or in part without prior consent of ConsultOne No responsibility to any third party is accepted as the report has not been prepared and is not intended for any other purpose.

Overview – summary of findings

We have set out below an overview of our findings (pages 5-10) and more detailed findings which support our overview, by individual quality statement area (pages 11-60). We have included a complete list of recommendations on page 15.

Shared direction and culture

The Trust's strategic framework, 'Our Strategy 2023-2028', is recognised for its clarity and manageable focus on themes such as leading cancer care and improving patient outcomes. The strategy appears relatively well-embedded due to its consistency with previous strategic drivers, though there is a recognised need to refresh it, and the Trust's enabling strategies, to more explicitly align with the NHS 10-Year Health Plan, including neighbourhood healthcare, digital advances, and artificial intelligence. Opportunities exist to strengthen engagement in strategy development with patient involvement currently limited, relying largely on governors rather than direct co-production. Similarly, staff we engaged with report a lack of meaningful input into strategic planning.

The recently published Five-Year Integrated Delivery Plan (2026-2031) attempts to align various existing strategies with national directives, introducing new goals centred on clinical excellence, financial sustainability, and research integration. Despite its positive intent, there are concerns that this additional publication may increase confusion regarding how various Trust plans interconnect. Evidence suggests a need for improved strategy deployment to ensure goals are meaningful at both operational and individual staff levels.

The Trust is allocating strategic discussion time to address the opportunity of becoming an Advanced Foundation Trust and subsequent Integrated Health Organisation, to further address health inequalities, accelerate innovation and improve cancer care.

The Trust maintains a patient-centred "culture of kindness" that is highly regarded by both patients and senior leaders. Staff survey results demonstrate greater variability in terms of both strategy awareness and evidence of pockets of culture that do not align well with the Trust Values and Behaviour Framework. We noted the Trust response to cultural concerns including development and implementation of the Inclusive Culture Strategy and manager training programmes; however, there is more to do with an opportunity to strengthen demonstrable Board ownership and drive of this area.

Financially, the Trust is an outlier, delivering a surplus and maintaining segment one performance within the National Oversight Framework. This stability allows quality to be prioritised with no concerns expressed to us that money is trumping quality. However, the Trust relies heavily on non-recurrent savings including bank interest, which may decrease as capital spending increases as the Trust seeks to deliver its strategic ambitions. We also noted some tension between the Trust's ambitious annual growth targets and the capacity of clinical staff and infrastructure to deliver, which the Board is encouraged to monitor closely to avoid quality risks appearing.

Capable, compassionate, and inclusive leaders

We noted capable and compassionate leadership at Board level and noted that the Board culture has transitioned from an adversarial environment characterised by a divide between Non-Executive Directors (NEDs) and executives to one described to us as having trust, candour, and feeling safer. This shift is largely attributed to the appointment of the new Chair, which has allowed the Board to transition away detailed forensic scrutiny towards a more strategic focus while delegating much of the scrutiny and challenge over delivery to its committees. Board members acknowledge the ongoing challenge of balancing this strategic shift with retaining

sufficient oversight of operational fundamentals and core service delivery. Our review has identified opportunities to strengthen operational oversight including in relation to quality governance.

Visibility and connectivity by Board members across the Trust could be strengthened including a more coordinated approach to service visits, including having a programme of regular visits which includes the Trust's satellite sites and a formal feedback mechanism to support qualitative triangulation at Board and committees. While the CEO is highly praised for being visible and approachable through initiatives like 'coffee with Roger', many staff feel that leadership visibility could be better integrated into business as usual operations rather than attendance at celebration events. Board visibility was said to diminish for less senior staff and those located at satellite sites, such as Macclesfield, who report feeling isolated and in need of greater executive presence.

The Board has proactively identified skills gaps, particularly in strategic digital expertise, and is currently recruiting new NEDs to bolster this area along with commercial and strategic financial experience. A comprehensive skills mapping exercise is in place, though it does not yet explicitly take into account any future requirements in relation to the Trust's aspirations to become both an Advanced Foundation Trust (AFT) and Integrated Health Organisation (IHO). Also positively, we noted the introduction of an externally facilitated Board development programme to strengthen the unitary board dynamic and improve mutual understanding of roles.

More widely while we noted some evidence of succession planning and leadership development, opportunities exist to strengthen the coherence of these across the Trust and provide more explicit linkage between the Trust strategic ambitions, its leadership skills requirements and its development programmes. This would support strengthened Board oversight over building the Trust's capacity, capability and resilience to support delivery of its strategic deliverables.

Freedom to speak up

The Trust's Freedom to Speak Up (FTSU) Guardian works three days a week and balances this responsibility with a chaplaincy role. The Guardian is an active member of the Equality and Diversity Steering Group and meets bi-monthly with the Chief Nurse and Executive Director of Quality (CNEDQ) to triangulate speaking up themes with incident data and complaints to identify departmental hotspots. Over the past year, the number of FTSU Champions has increased from three to thirteen, with a specific focus on increasing the diversity of these. While the Guardian feels supported by the Board and personally presents reports into Board every six months, there is a noted risk regarding the Guardian being line managed by the Director of Workforce, which can create a perceived conflict of interest or lead staff to view the role primarily as a route for HR issues rather than patient safety concerns. Regarding wider Board oversight, opportunities exist for the Board to demonstrate more active interest and focus in this area, with Board minutes capturing limited discussion of FTSU reports.

FTSU cases saw a significant increase in 2025, which the Trust tentatively attributes to the high profile of the current Guardian. Documentation shows that data regarding protected characteristics in these cases has been limited, and the Guardian is currently exploring better ways to collect this information for future triangulation. There is also an ambition to establish FTSU Champion representation at satellite sites to ensure these staff members have equal access to the speaking up process.

Workforce equality, diversity and inclusion

The Trust's Inclusive Culture Strategy (2025-2030) is well-recognised by senior leaders and integrated into core documentation, such as the People and Culture plan. The organisation has shifted its approach by disaggregating EDI responsibilities across various functions to weave these principles into

business as usual, though this may have contributed to limited awareness and understanding among frontline staff of EDI activities being undertaken by the Trust. We noted some progress against WRES/WDES metrics within the latest annual reports; however, interviewees and survey responses recognise that there is more to do. We noted that the Trust has recently relaunched and re-energised its staff networks including executive sponsorship to further support progress on the EDI agenda. However, executive sponsorship of networks was described as variable. We also noted an opportunity to strengthen the networks direct connection to the Board to help amplify their voice and increase the range of qualitative 'voice of' feedback being received by Board.

Governance and oversight of the EDI agenda shows opportunities to strengthen Board ownership of the agenda. Although the EDI annual report is comprehensive and visually accessible, it lacks an executive summary to focus discussions on critical data, such as declining metrics in staff disciplinary processes and the increasing grievances among staff with disabilities. Senior leaders have candidly observed a lack of workforce diversity at senior leadership levels, and while initiatives such as anti-racism training are in development, measurable progress in global majority career progression is yet to be evidenced.

More positively, the Trust offers a comprehensive wellbeing package, including menopause support and physiotherapy, and has introduced "Connect and Reflect" sessions to successfully reduce staff turnover within the first year of employment.

Regarding health inequalities, the Trust has made positive operational strides by deploying mobile scanners into socially deprived areas and increasing local access to clinical trials. However, we heard of some ongoing frustration among Board members regarding the lack of, and poor quality of health inequality data, to inform decision-making. Progress in improving the quality of patient demographic data has been slow, and previous Board commitments to track these inequalities have lacked consistent follow-up in minutes or action logs.

Governance, management and sustainability

Overall, the Trust operates a broadly effective governance structure at Board and committee level with opportunities to strengthen the effectiveness of challenge and ensure appropriate alignment of Board and committee focus across strategy, operational delivery and culture. We noted opportunities to streamline Trust inputs at governor level and to focus more on supporting discharging governors' legal duties. At executive and operational management levels greater opportunity exists to review the purpose and role of certain forums and ensure that these are fit for purpose and meet the needs of the organisation. For example, opportunities exist to strengthen engagement at Senior Management Committee (SMC) and better support devolved divisional management accountability through re-positioning relationships at Service and Operational Review (SOR) meetings and clarifying the purpose of divisional board meetings. This should also be supported by investment in divisional triumvirate governance training in order to maximise the benefit of any refresh of arrangements.

In terms of quality governance arrangements, we noted opportunities to clarify the flow of assurance and escalation routes from divisions through to Board. We also noted the need to review the capacity of the Quality Improvement and Clinical Audit team given the number of open projects that require closing down and any learning being extracted and shared across the organisation.

We noted evidence of clear investment in the Trust's risk management arrangements including enhanced software, training and a positive profile of the Board Assurance Framework (BAF) at Board and committee. We also noted good alignment of the BAF with the Trust strategic

objectives. Opportunities exist to strengthen risk reporting to further support an appropriate focus on the management of risk including the Trust's risk appetite statement which requires further development to ensure it is actively utilised to help direct focus and discussion and is used in day to day prioritisation and decision-making considerations.

We noted positive improvement in the Trust's Emergency Preparedness, Resilience, and Response (EPRR) compliance rating. The Trust has achieved significant progress, moving from a 1% compliance rating in 2023 to 89% 'substantial compliance' in 2025. This improvement is supported by a new incident response plan, and a structured work programme is in place for 2026/27 aimed at addressing the remaining areas of partial compliance, such as communications resilience and countersurveillance.

Partnerships and communities

Staff feedback suggests a reduction in engagement with Trust senior leaders referencing that team briefings, which were once open to all pre-pandemic, are now restricted to senior leadership attendance with the onus on them to further cascade down into the Trust. Staff survey responses reflect mixed views regarding whether staff feel listened to, with a perceived decline in engagement regarding significant changes occurring within the Trust including relating to IT and service changes compared to past practices.

Patient and carer engagement is strong at the service level, as exampled by an active young people's network and significant patient involvement in research activities. However, this positive service level engagement is not reflected in a richness of available feedback at Board and committee level, with an imbalance towards a reliance on quantitative data with a need for greater triangulation with qualitative data too. We noted that the Trust is launching a Patient and Carer Experience Forum (PCEF) to provide a more direct reporting line to the Board which is positive. Overall patient feedback to us was generally positive, with many examples of outstanding care and compassionate staff experiences. However, as always, such positivity was also balanced with a number of ongoing frustrations with service delivery which the Board and its relevant committees should be hearing. Specific concerns were raised regarding long waits for clinic appointments, delays in receiving scan results, and inconsistent empathy in bereavement care. Additionally, patients highlighted administrative frustrations such as unreliable appointment letters and a lack of integration between different healthcare applications.

Externally, the Trust is viewed as a highly effective system partner for research and education and has many positive relationships in place. The Trust demonstrates an explicit commitment to reducing health inequalities through initiatives such as radiotherapy centres and the 'Christie@home' service. We heard about the innovative model of education being offered alongside higher and further education partners which is opening up opportunities beyond Trust and local system boundaries. We also heard from these partners that in their view their relationship with the Trust is 'exemplary' and a positive example of how other NHS trusts could and should engage with the sector.

As the Trust moves ahead with its Advance Foundation Trust application (AFT) and wider aspiration to become an Integrated Health Organisation (IHO), there is a recognised need for a more formal stakeholder plan to manage its extensive, and growing, external relationships and partnerships.

Learning, improvement and innovation

We noted a significant challenge in relation to closing the loop of audit and improvement projects with approximately 500 active projects and clinical audits without clear outcomes at the time of our review, falling somewhat short of the strategic goal to complete 90% of registered initiatives.

In terms of patient safety, the Trust demonstrates a maturing learning culture characterised by high incident reporting rates, with a significant majority being no-harm or near-miss events. The transition to the Patient Safety Incident Response Framework (PSIRF) is viewed as a positive move away from traditional root cause analysis, with implementation being seen as positive and effective. We also noted a really positive example of a data led approach to the identification of the Trust's quality priorities within the Patient Safety Incident Response Plan (PSIRP). We also noted good progress in relation to triangulation of quality data including the introduction of an integrated governance assurance report. We also noted some opportunities to further strengthen the triangulation with some areas currently reported outside of the integrated governance assurance report capable of being integrated. We also heard of opportunities to strengthen greater collegiate working on quality governance matters with some staff feedback noting the professional siloes that staff currently tend to operate within. We also heard of a need for greater parity of engagement from all staff groups in auditing and learning activities and for all staff groups to recognise the importance of delivery basic standards and fundamentals of care such as hand hygiene and fundamental audit practices.

Research and education are central pillars of the Trust's identity, with both divisions led by Board-level directors. Both divisions benefit from having a high profile within the Trust and by being embedded and integrated into day to day activities and discussions. The research portfolio is significant, managing 800 active trials and generating £20 million in annual turnover. Although research is successfully integrated into day to day activities, we heard that there are opportunities to strengthen this within inpatient settings with feedback to us suggesting that this is more mature in outpatient areas. We also heard many positives in relation to the Trust's education offer, including offering an innovative, digital offer in partnership with educational partners which extends the Trust's reach well beyond local boundaries. We also noted that the Trust was strong in relation to capturing learner feedback although we noted opportunities to further integrate oversight of educational outcomes into business as usual reporting including incorporation of metrics into the Trust's IPQFR. We noted that the Trust maintains a strong ambition to attain Higher Education Institute status through its strategic partnerships.

Environmental sustainability

The Trust's Green Plan (2024-2027) was approved in June 2024 and is considered by the organisation to be compliant with the updated 2025 NHS England guidance. While the plan covers mandated areas, there are opportunities to strengthen it by incorporating SMART objectives, quantitative progress metrics, and additional items contained within the latest national guidance.

Oversight is provided by the executive-level Sustainability Committee, which reports to SMC quarterly and the Board on an annual basis. We heard conflicting information regarding executive ownership of the environmental sustainability agenda with a need for clear leadership. Operationally we noted the presence of a Green Travel Plan (2025-2030), the installation of electric vehicle charging points, the use of a fully electric fleet for the 'Christie@home' service and the Trust working with resident associations, in support of its anchor institute role.

We noted that the Trust is also engaged in the development of a Greater Manchester-wide climate change adaptation plan and is working with the Energy Saving Trust to access the low carbon skills fund. These collaborative efforts include exploring funding options for heating infrastructure, developing sustainable impact assessments for business cases, and defining clinical leadership roles in sustainability.

Recommendations

Ref	Recommendation
1.	Refresh strategies to align with national guidance and the Five-Year Plan including clear measures and more frequent reporting.
2.	Show how strategy drives decision-making and investment priorities.
3.	Review scope and purpose of the Future Christie Programme.
4.	Demonstrate appropriate Board ownership and oversight of culture.
5.	Strengthen succession planning for senior roles.
6.	Improve performance management to increase local ownership and decision-making.
7.	Strengthen use of patient, staff and stakeholder feedback at Board level.
8.	Review Board sponsorship of the FTSU process.
9.	Review ease of access to the Trust FTSU process at satellite sites
10.	Improve Board oversight of EDI, leadership diversity, and staff network support.
11.	Increase impact and visibility of EDI (WRES/WDES) activity.
12.	Clarify Board focus between strategy, delivery, and culture with effective committee assurance.
13.	Consider how the Audit Committee can more effectively demonstrate fulfilment of its delegated duties.
14.	Review committee membership to reflect unitary Board responsibilities.
15.	Improve evidence of challenge, actions, and follow-up in governance forums.
16.	Review rationale for not having a finance committee.
17.	Clarify and streamline the role of governors
18.	Improve operational governance forums and accountability frameworks.
19.	Review QICA capacity to ensure effective audit, improvement, and learning.
20.	Strengthen use of risk appetite in decision-making.
21.	Improve internal communications and visibility of feedback (“you said, we did”).
22.	Review the effective use of triangulated qualitative and quantitative information at Board and committees.
23.	Develop a formal stakeholder engagement plan (incl. AFT application).
24.	Strengthen connectivity between divisional governance and Trust wide quality processes.
25.	Strengthen oversight of fundamental standards and core care quality.
26.	Ensure transformation capacity and capability match strategic ambition.
27.	Insert more quantitative measures of progress into the Trust’s Green Plan.
28.	Embed sustainability into day-to-day decision-making across the Trust.

Appendix 1 – Engagement Schedule

Interviews

Name	Role	Organisation
Professor Joe Rafferty	Chair	The Christie NHS FT
Dr Marisa Logan-Ward	Senior Independent Director	The Christie NHS FT
Alveena Malik	NED	The Christie NHS FT
Grenville Page	NED	The Christie NHS FT
Dr Diana Tait	NED	The Christie NHS FT
Sarah Corcoran	NED	The Christie NHS FT
Roy Dudley-Southern	NED	The Christie NHS FT
Roger Spencer	CEO	The Christie NHS FT
Professor Chris Harrison	Deputy CEO	The Christie NHS FT
Dr Neil Bayman	Executive Medical Director	The Christie NHS FT
Claire McPeake	Chief Operating Officer	The Christie NHS FT
Vicky Sharples	Chief Nursing and Executive Director of Quality	The Christie NHS FT
Sally Parkinson	Executive Director of Finance and Business Development	The Christie NHS FT
Eve Lightfoot	Director of Workforce	The Christie NHS FT
Louise Westcott	Company Secretary	The Christie NHS FT
Professor Adrian Bloor	Interim Director of Future Christie	The Christie NHS FT
John Wareing	Director of Strategy	The Christie NHS FT
Ben Vickers	Risk, Patient Safety, QI and Clinical Effectiveness lead	The Christie NHS FT
Matt Barker-Hewitt	Interim CIO	The Christie NHS FT
Jeanette Livings	Communications lead	The Christie NHS FT
Fi Jenkinson	FTSU Guardian	The Christie NHS FT
Sam Vickerman	Lead Governor	The Christie NHS FT
David Wright	Patient Engagement lead	The Christie NHS FT
Professor Fiona Blackhall	Director of Research and Innovation	The Christie NHS FT
Professor Rikki Goddard-Fuller	Director of Christie Education	The Christie NHS FT
Rebecca Coles	EDI lead (workforce)	The Christie NHS FT
Alex Beedle	Estates lead	The Christie NHS FT
Will Blair	Environmental sustainability lead	The Christie NHS FT
Ashley Blom	Vice-President and Dean of the Faculty of Biology	University of Manchester
Colin Scales	Acting Chief Executive	NHS Greater Manchester ICB
Claure O'Rourke	Managing Director	Greater Manchester Cancer Alliance
Mark Duggan	CEO	Manchester University NHS FT
Gary Doherty	Programme Director	Greater Manchester Provider Federation Board
Clare Hammell	Medical Director	Mid Cheshire NHS FT

Focus Groups

Name	Date
Patient Focus Group	3rd March 2026
Governor focus groups	17th February 5th March
Staff Focus Groups	Lead Nurses/Matrons – 18th February 2026 Associate Chief Nurses/AHPs – 2nd March 2026
Senior Leaders Focus Groups	23rd February 2026 4th March 2026

Meeting observations

Forum	Date
Board	29th January 2026
Audit Committee	19th February
Quality Assurance Committee	25th March 2026
Workforce Assurance Committee	19th March 2026
Council of Governors	11th February 2026
Senior Management Committee	19th February 2026
Executive / CSSS Review Meeting	17th February 2026
Executive / Network Servs Review Meeting	17th February 2026
CSSS Divisional Board Meeting	17th February 2026
Network Services Divisional Board Meeting	13th February 2026

Surveys

Name	Number of responses
Board members and regular attendees	10
Senior Leaders	18
External Stakeholders	1
Staff	101

Appendix 2 – Well Led survey responses

Summary survey results are shown below and set out per the four separate surveys that we issued: Board members and regular attendees, senior leadership, external stakeholders and staff. The key headlines for each survey are outlined below.

Graphical analysis of the scores including the free text comments that accompanied the responses are incorporated into a separate document 'Appendix 2 – Survey Results' issued under separate cover.

Trust Board

- We received **10** completed responses.
- Of the 280 individual responses across our range of statements, only six responses (2%) slightly disagreed with our positive statements.
- Overall, 88% of responses either strongly agreed or agreed with our statements, with 10% showing slight agreement.
- One response show as not observed/unable to comment (nine)
- When the responses are weighted, the areas showing least confidence or agreement are (least confidence first):
    - In general, I am confident that information technology systems are used effectively to monitor and improve the quality of care
    - In general, I am confident that staff regularly take time out to work together to resolve individual and team objectives, processes and performance.
    - In general, I am confident that there are standardised improvement tools and methods in place.
    - In general, I am confident that equality and diversity are promoted within and beyond the organisation.

Senior Leadership survey

- We received **18** completed responses.
- Of the 450 individual responses that we received against our statements, there were seven responses (2%) which strongly disagreed and 22 responses (5%) which disagreed with our positive statements. 41 responses (9%) slightly disagreed.
- Overall, 61% of responses either strongly agreed or agreed with our statements, with 23% showing slight agreement.
- The areas showing least confidence or agreement are (lowest confidence score first):
    - Action is taken to address behaviour and performance that it inconsistent with the vision and values, regardless of seniority.
    - Information technology systems are used effectively to monitor and improve the quality of care.
    - There are processes in place to evaluate and share the results of improvement work.
    - There are standardised improvement tools and methods in place which are used effectively.

Staff survey

- We received **101** completed responses.
- Of the 2,222 individual responses to our statements, there were 436 responses (20%) disagreed with our positive statements to some extent. 223 either strongly disagreed or disagreed, and 213 slightly disagreed.
- Overall, 62% of responses either strongly agreed or agreed with our statements, with 17% showing slight agreement.
- 11 responses were unanswered/no response.
- The areas showing least confidence or agreement with our statements are:
    - I am trained to use the Trust-wide standard quality improvement tools and methodology
    - Action is taken to address behaviour and performance that it inconsistent with the vision and values, regardless of seniority
    - Quality and sustainability of services receive appropriate coverage in meetings
    - My team regularly take time out to review individual and team objectives, processes and performance
    - The vision, values and strategy have been developed in collaboration with staff

External stakeholder survey

- We received **2** completed responses.
- Of the 38 individual responses to our statements, there were 11 responses (29%) which disagreed with our positive statements to some extent.
- Overall, 50% of responses either strongly agreed or agreed with our statements, with 3% showing slight agreement.
- 7 responses (18%) were categorised as ‘not observed / unable to comment’
- The areas showing least confidence or agreement with our statements are:
    - I have confidence that The Christie NHS FT effectively monitors the quality of services it provides