NHS
The Christie
NHS Foundation Trust

Public meeting of the Board of Directors
Thursday 28th January 2021 at 12.45 pm
By virtual means

Present: Chair: Chris Outram (CO), Chairman
Prof Jane Maher (JM), Non-executive Director
Tarun Kapur (TK), Non-executive Director
Kathryn Riddle (KR), Non-executive Director
Robert Ainsworth (RA), Non-executive Director
Neil Large (NL), Non-executive Director
Prof Kieran Walshe (KW), Non-executive Director
Roger Spencer (RS), Chief Executive
Wendy Makin (WPM), Executive Medical Director
Bernie Delahoyde (BD), Chief Operating Officer
Eve Lightfoot (EL), Director of Workforce
Prof Chris Harrison (CJH), Executive Medical Director (strategy)
Sally Parkinson (SP), Interim Executive Director of Finance
Prof Janelle Yorke (JY), Executive Chief Nurse

In attendance: Dr Pavan Najran, Consultant Radiologist
Rachael Bailey, Staff Governor, other clinical professionals
Janet Morley, Public Governor, Manchester
Sam Vickerman (SV), Public Governor, Tameside & Glossop
Colin Bamford, Public Governor, Trafford
Maurice Gubbins, Public Governor, Cheshire
Stuart Keen, Director of Capital & Estates
Neil Bayman, Consultant Clinical Oncologist

Minutes: Louise Westcott (LW), Company Secretary

Clinical presentation: Interventional Radiology – changes to services during the Covid-19 pandemic - Dr Pavan Najran (PN), Consultant Radiologist

CO introduced Dr Najran. Interventional radiology treatments are done in emergency / palliative patient's and are a minimally invasive intervention for issues such as a blocked kidney or liver. During covid the service have been getting a lot more patients.

PN noted that they have expanded the team and now have 5 nurses. They have an extra interventional suite and have 5 consultants plus a locum who has recently been appointed. Lots of patients come with liver issues and the interventional radiologists deliver radioactive treatment direct to the liver. We are now offering a one day service for the entire procedure which reduces bed stay and exposure to the hospital in this period. We are providing cancer care to patients across the country and get patients from beyond Manchester.

PN described a fatigue element during covid, colleagues have really felt the pressure but there is so much good will and patients have continued to be seen.

PN took the meeting through a brief video tour of the interventional suite and showed both rooms and the equipment that is used for the procedures.

The team deal with a huge variety of tumours and cancers with a variety of practitioners including radiographers, nurses and doctors.

PN outlined the main differences in day to day practice during the pandemic. Any aerosol generated procedures mean use of full PPE and the gaps in between patients has increased because of the need for decontamination. In order to avoid delays as a result of this the team now use both rooms simultaneously. Procedures have been truncated into one day procedures where

they were previously done over 2 weeks. This is the case for SIRT and the approach has been taken on by other centres also. We are a centre of excellence for this treatment. PN also outlined the negatives in terms of workload & pressure. There has been a mental & physical impact on staff. He described that there has also been lots of good will from staff.

PN described some of the patients in their care. This includes patients at the end of life that require procedures to improve their quality of life and those who come for procedures as treatment. These are often cancers of the liver and also cancers of the urinary tract / kidney where the team put drains in the kidney, this can be lifesaving. They also see patients with cancers of the biliary tract, blockages of the liver, stomach or oesophagus. Patients with sepsis or an acute bleed are also treated, often in the liver of pelvis and these are treated very quickly and often feel well very quickly after treatment.

CO thanked PN and his colleagues for all their superb work and commitment.

CO welcomed everyone to the meeting and explained that during this period the priority is dealing with the covid emergency. We have received a letter from NHSEI to tell us to reduce the burden on teams by keeping board meetings to a minimum. We therefore have a reduced approach to the meeting and will deal with the business in a slightly more streamlined way.

It has been agreed that the NEDs will have a separate meeting to discuss the Workforce report in more detail should they wish and NEDs will have this opportunity to meet EL and Workforce colleagues.

Item		Action
01/21	**Standard business**	
a	**Apologies**	
	Joanne Fitzpatrick (JF), Executive Director of Finance	
b	**Declarations of Interest**	
	None received	
c	**Minutes of the previous meeting – 26th November 2020**	
	Accepted with no changes	
d	**Action plan rolling programme, action log & matters arising**	
	All items from the rolling programme are noted as on the agenda, no actions noted	
02/21	**Reports**	
a	**Chief executive's report**	
	RS updated on the current SITREP. The system is in the most stressed position it has ever seen. The role of the Christie is to continue to provide cancer services and play our part in the system with mutual aid so others can continue to provide acute and covid services. We are looking after all of our patients on treatment and with acute problems. We therefore do get patients who are impacted by covid. We have maximum biosecurity measures on site to enable us to deliver our standard treatment. Unlike in the first wave there has been a national directive to prioritise treatment for covid patients as well as cancer patients. In our GM system super surge plans means an increase in critical care and general & acute care beds. In terms of critical care, normally there are about	

160 beds available, currently there are around 300 critical care beds in GM. All elective & planned patients have been stepped down.

We are providing care for acutely ill cancer patients and in addition we are providing additional surgical capacity so that surgical procedures for cancer patients in other hospitals can be treated by us where they are unable to do so.

The Nightingale Hospital is for patients being stepped down from acute care and there are 75 beds available there.

For both radiotherapy & surgery our staff resource is the rate limiting factor. We've had an increased absence because of covid and currently about 130 staff are off work. This is a relatively reducing number. We have had up to about 175 staff off at any one time. Notwithstanding this we continue to deliver all required treatments.

Our biosecurity measures mean that we test all staff regularly.

RS updated on the vaccination campaign for staff where 3485 staff have received their 1st dose. This will hopefully reduce the number of staff that are off and represents at least 82% of frontline staff. It may be more than this as the numbers are currently being validated.

CH updated on the Cancer Hub arrangements. He noted that we're at the height of the pressure at the moment. We attend daily Gold Command meetings. The surgical cancer patient system capacity is very limited at the moment because of staff and critical care availability. The system has been agreed that each hospital in GM have set up a system for monitoring patients waiting for surgery on a frequent basis to make sure they are put forward for their surgery at The Christie. These are patients that require surgery within 28 days. Capacity for these patients is now limited and the discussion is around how the system makes sure all patients defined as priority 2 (P2) whether they are neuro, vascular, orthopaedic etc, as well as cancer, are prioritised. The cancer patients that can't be operated on locally are assessed by a clinical panel and then those suitable are brought to The Christie. We've made arrangements to take extra patients safely and to operate over 7 days. We see in the region of an extra 20 to 30 patients per week. The system is trying to ensure that the highest priority patients do get their operations as soon as possible. The big problem is that the priority 3 (P3) patients will progress and become more urgent. This increases the pressure all the time. We are storing up a big issue for the future that is being discussed at this point. We are doing everything we can to address this.

CO noted how flexible and cooperative the Christie staff have been and thanked them for that. CO invited questions.

RA asked if anyone will fall outside of the prioritisation and not get their surgery. CH noted that all priority 1 (P1) patients, acute emergencies, are being operated on. We currently have the capacity for all P2 cancer patients but there will be longer waits for other P2 patients.

Radiotherapy & Chemotherapy patients are not waiting longer because of some of the changes we have made. One of the impacts in the reduction in surgery is fewer patients flowing into the non-surgical treatments. WM noted that some patients who miss out on surgery may be referred for radiotherapy & systemic therapy. The challenge is how we accommodate other patients who previously had surgery elsewhere. This doesn't compromise other treatments that we give to patients.

RS added that on a daily basis the GM system is looking at whether it will escalate into a full major incident. Even if we move into this status it wouldn't

	signify anything other than a continuation of the pressures described. Colleagues have gone above & beyond to respond and to carry on delivering services in this huge challenge. We have done incredibly well to ensure we are continuing to deliver services. We are delivering incredibly well comparatively in continuing to provide treatments.	
b	**Integrated performance, quality & finance report**	
	BD presented the month 9 report and noted the executive summary. **Safe** • There were no serious incidents or never events in month, 7 moderate incidents still progressing through to full root cause analysis. A new corporate risk score of 20 has been added to the risk register relating a financial risk due to suggested changes to NHS payment methods and system approach to distribution of capital spend 2021/22. **Responsive** • Meeting the cancer waiting time standards has been challenging, this month we achieved 73.4% against the 62 day standard and 80.7% against the 24 day standard. This is mainly due to delays in receiving referrals. • Referrals are beginning to recover but are still below 19/20 outturn. • Activity in some aspect is beginning to recover in line with the phase 3 plans. New attendances are behind plan in line with the lower rates of referrals, outpatient follow ups are above plan. Surgical operations and radiotherapy fractions remain behind plan. **Effective** • There have been no cases of MRSA bacteraemia and 1 C-Difficile attributable to the trust but with no lapses in care. We have noted a slight increase in other infections felt to be seasonal and some related to the changes implemented due to COVID-19 such as the use of hand gel as opposed to hand washing. This is in line with national statistics. • We had 1 nosocomial outbreak of Covid-19 in month on the surgical unit. Regular testing of asymptomatic staff and patients continues **Well – Led** • Finance – The trust has an improved financial position at the end of month 9, delivering a surplus of £2,096K • The Trust's year end forecast has been reviewed a from a deficit of £1.472m to a surplus of £4.0m • The cash balance is £151,704K • Capital spend is underspent at month 9 by £4.8m we are working with the GM wide system to manage the current capital underspends. CO noted that cancer waiting times have been examined at the Quality Assurance Committee. BD noted that we still make sure we see our patients as quickly as possible and that there are no delays with radiotherapy or chemotherapy. There are delays for surgery due to additional requirements. The waiting list is manageable. RA asked about cancelled operations. BD noted that there was an outbreak in surgery in December so patients had to be cancelled and moved to January. Admissions were stopped to the surgical ward in that time. NL asked about the covid infections and the outbreak. He asked for the detail to come to board around the Infection Prevention & Control BAF.	BD/JY

	NL noted finances are looking excellent. The concern is the underlying position. Board must be sighted on the underlying position to allow decision making on future business cases. Planning information is being prepared and will be presented to Board. CO noted the uncertainty with finances. CO also thanked the executives and their teams for their hard work throughout this period.	SP
c	**Revenue business cases approved under delegated authority**	
	The Board noted the paper relating to the impact of the revised SFI's.	
d	**Workforce report**	
	CO noted the great information in the report and that a group of NEDs will meet with EL and her team to get further detail outside of this meeting. EL introduced the quarterly report which provides the Board with an update on The Christie People Plan, the Trust's workforce Covid 19 response and other key strategic developments. EL drew attention to a review undertaken by the Workforce Committee in November of the overall Trust Workforce risk. Prior to the review the risk score was 16 for Trust wide staffing gaps. A data review indicated there has been a reduction in key workforce gaps in our key areas such as nursing, radiotherapy and junior doctors. We are now over established with our nursing numbers. Turnover has improved from 13.01% to 11.42% across all staff groups over the last 12 months. As a result of this the workforce committee agreed to reduce the risk score to 12. We have been working with Timewise on an accreditation programme to develop flexible working solutions to help us attract and retain staff. In December we learned that we have become a Timewise accredited Trust. We will continue progressing our plans through the Workforce committee and Timewise are using us as a case study to share with other Trusts. EL noted the section relating to our plans to review and embed the Christie values. These have become confused as we developed principles and behaviours and the Christie Commitment. The aim is to have one clear set that are clear and memorable and are embedded thoroughly in everything we do. We have received data through the model hospital from a new tool developed around culture and engagement. The number of FTSU cases per 1000 WTE are the same as the peer group median however our bullying & harassment cases over a 12 month rolling average are higher. Patient safety issues are lower. EL stressed that we have very small numbers of cases but the low denominator results in the percentages looking significant. Over the last 3 months we have had two bullying and harassment cases and no new cases opened. Our staff are raising concerns through the FTSU Guardian which is positive. EL noted the section on Employee Health and Wellbeing. The section provides information on the latest offers of support we have introduced. EL noted that in line with the requirements of the NHS People Plan to implement a wellbeing guardian it has been agreed that TK will be the wellbeing guardian for the Christie. The role is a board level assurance role that supports the board in ensuring the health & wellbeing of our staff. We are currently finalising a role description and how we integrate this into our existing wellbeing plans and governance framework. TK noted that he is very pleased to take this on, and that he would like to come and report to the Board at a future meeting.	

	CO noted that we must deal with bullying reports, she stressed our commitment to dealing with such issues. SV asked about mental wellbeing and how we support staff. EL responded that we offer counselling, are working with external agencies to support staff and are looking at how we support staff in the long term through the NHS resilience hub. JM noted the sustained work being done and noted its worth looking at what charities have around support for healthcare professionals e.g. Macmillan. CO thanked EL for the reports.	
03/21	**Board assurance**	
a	**Board assurance framework 2020/21**	
	RS noted the updated BAF and the updated risk scores. No changes were suggested.	
b	**Quality Assurance Committee report**	
	KW noted the content of the meeting and invited questions. No questions were asked.	

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Public meeting of the Board of Directors
Thursday 25th March 2021 at 12.45 pm
By virtual means

Present:	Chair:	Chris Outram (CO), Chairman
		Dr Jane Maher (JM), Non-executive Director
		Tarun Kapur (TK), Non-executive Director
		Robert Ainsworth (RA), Non-executive Director
		Neil Large (NL), Non-executive Director
		Prof Kieran Walshe (KW), Non-executive Director
		Roger Spencer (RS), Chief Executive
		Wendy Makin (WPM), Executive Medical Director
		Bernie Delahoyde (BD), Chief Operating Officer
		Eve Lightfoot (EL), Director of Workforce
		Prof Chris Harrison (CJH), Executive Medical Director (strategy)
		Joanne Fitzpatrick (JF), Executive Director of Finance
		Prof Janelle Yorke (JY), Executive Chief Nurse
In attendance:		Prof Fiona Blackhall, Honorary Academic Consultant Medical Oncology
		Prof John Radford, Director of Research
		Wes Dale, Managing Director of Research
		Janet Morley, Public Governor, Manchester
		Colin Bamford, Public Governor, Trafford
		Paula Turner, Public Governor, Manchester
		Deborah Matier, Value Solutions Manager, Amgen Ltd
Minutes:		Louise Westcott (LW), Company Secretary

Clinical presentation: Surgical Services and the response to the Covid-19 pandemic, Miss Eva Myriokefalitaki & Rachel Aziz, Theatre Manager

EM introduced the presentation and noted the changes that have been made in the last year for surgical services. Anaesthetic resource and critical care availability have been impacted and elective work was initially suspended. There was an assessment of what role The Christie could play and the team focussed on our strengths and we have continued to provide cancer care. We were established as a green site and worked through the cancer hub to continue to provide surgery & care for patients from across GM using a system of prioritisation.

A video was shown to summarise the challenges, successes and changes across surgery including the wards and in the theatres. A minimal amount of surgery was postponed during the year. Changes to PPE requirements and infection control procedures, testing of staff and patients and the changes to the physical space were shown. Preparation and rehabilitation of surgical patients was outlined as well as changes in practice and the need to update standard operating procedures (SOP's). Footfall was reduced for staff and patients to make the site safe and social distancing put in place. Clinics have been reviewed and suitable patients 'seen' virtually.

The system for booking patients was outlined as well as the safety measures put in place and the way the team have worked together virtually. Our elective care programme has continued, this is reviewed daily, all patients have been clinically prioritised including patients from across GM.

EM noted that it's been a very challenging year that required a lot of cross team working. Staff have never been short of PPE, the response has been managed very well and we have maintained a green site.

EM outlined that the Cancer Hub was proposed early on so that we maintained ourselves as a green site to carry on elective activity for cancer for patients across GM by priority group. This ensured that urgent surgery for cancer continued and waiting times for the cancers we provide surgery for were kept down.

CO thanked the team for the presentation and invited questions.

CB noted his thanks to the team for presenting the video that allows us to see what's happening in the Trust.

CO conveyed her thanks to the surgical team for presenting to the Board and for updating the meeting.

Item		Action
04/21	**Standard business**	
a	**Apologies**	
	Kathryn Riddle (KR) Non-executive Director	
b	**Declarations of Interest**	
	None received	
c	**Minutes of the previous meeting – 28th January 2021**	
	Noted that JF was not marked as apologies and the date had not been updated. Amendments were noted and changes made.	
d	**Action plan rolling programme, action log & matters arising**	
	All items from the rolling programme are noted as on the agenda, no actions noted	
05/21	**Reports**	
a	**Chief executive's report**	
	RS drew attention to the SITREP report and was pleased to note that we are now at the lowest point of escalation. We continue to deliver our normal activity across the range of treatments we provide. We are also continuing to provide surgery to patients across GM The staff vaccination programme for the second dose is going very well and we have delivered approximately 1200 jabs since Monday. This is excellent progress. RS noted that our medical director, Dr Wendy Makin is retiring at the end of April. She's been with us since 1984 and has given incredible service to the Trust in this time. On behalf of the Board RS thanked WM for her amazing contribution. CO also thanked WM for her incredible work and service. WM has pioneered palliative care services and has led incredible work to develop this as a speciality for cancer patients. CO congratulated the ward sisters for their shortlist for the BAME awards. CH confirmed the results of the interviews for the Research Director. Prof Fiona Blackhall has been appointed and will come into post on 1st June.	
b	**Integrated performance, quality & finance report**	
	BD outlined the key points from the report.	

	No SI's or never events. 6 moderate incidents. 1 new corporate risk at 16, 1 risk at 20, 8 risks at 16 and 5 risks at 15. 0 MRSA, 3 C Diff with no lapses in care. 3 E-Coli post 48 hours and 15 covid nosocomial infections. This was an outbreak in the surgical ward and details were pointed to in the paper. 3 new complaints, 50 pals contacts, 3 inquests and 1 clinical negligence claim. Access target progress was outlined. 18 weeks at 98.6%. 62 day performance is at 80%, 24 day 84.9% and 31 days at 99%. There are 22 104 day waiters. 0 cancelled operations in month. Improvements in LOS and recovering referral rates, surgery is still slightly low. Activity levels were shown for chemotherapy, radiotherapy and surgery. Workforce metrics were outlined, PDR and essential training rates are under plan and now being monitored through regular review. In terms of the financial position at the end of February; • EBITDA surplus is **£25.182m** • I&E surplus is **£691k** • Deficit of **£4.618m** • Cash balance **£171,235k** • Debtor days of 9 • Capital expenditure at **76.8%** against the revised NHSI plan CO invited questions. NL asked about the clinical incidents. JY responded that they have gone down to 98, the majority are related to chemotherapy reactions that were expected. The team are looking into this in more details. Radiation incidents have peaked in November - thresholds for reporting have changed so there are now minor incidents that are reportable that were not previously. Incidents are reviewed by theme and learning and are reviewed in detail by the Quality Assurance Committee for trends etc. NL asked about the recovery plans and when these will be revised. BD responded that this is being done at the current time and will be ready for the new financial year. RS stressed that there is not a backlog of activity for us, we are treating the activity that is referred to us. NL noted that we must match our resource to the peaks we anticipate. BD noted that we are looking at early indicators of what will be referred to us and this is a key part of our planning. KW asked about the consequences of the changes to capacity on how we can address the demand. BD responded that we are getting better at this and have changed scheduling, opened new areas etc, we will be comfortable to deliver the 19/20 activity levels. Radiotherapy are likely to keep some of the changes to fractionation rates that will help us maintain more activity. JM asked about the income consequences of the changes to fractionation rates. BD responded that we are mapping this through.	
c	**Revisions to the Scheme of Delegation**	
	JF noted that the SFI's were amended at the beginning of the pandemic to give delegated authority for investments up to £10m that was then reported to Board. We now propose to revert to our previous SFI's and stand back up our governance committees to enable the normal approval process.	

	Board approved the return to normal SFI's. JF noted that there was nothing approved in month.	
d	**Six monthly compliance with NICE safe staffing guidelines**	
	JY presented the report. The requirements to report safe staffing is still paused nationally but we have continued to assess and report this as normal. Fill rate for nursing has been above 97% and we haven't used any agency nursing for a year and have no breaches in registered nurse to patient ratio. The Ward Sisters reports are very positive. We have an amazing group of ward sisters who are very proud of their areas and they have delivered a high standard of care to patients. Challenges have been managed well including ward changes. The acuity of patients on ward 11 has changed and the nursing is being assessed to respond to this. Critical care has been a challenge as has an outbreak on ward 10. During the outbreak a group of nurses stayed within the covid area to provide consistent care to those patients. Access to HCA's has been a challenge so a pool has been established of staff who are happy to move around and they can be flexed demanding on demand. This has reduced the need to move qualified nurses. CO noted that it's interesting to see ward managers talking about financial pressures. JY agreed and noted that we have been very fortunate to keep recruitment high. We are also using year 4 aspirant nurses that gives us a good flow of nurses. We are looking at retention of these nurses. We are also looking at the skill mix to prepare for higher acuity of patients as a result of later diagnosis during the pandemic. Board noted the report.	
e	**Infection Prevention and Control Board Assurance Framework**	
	JY presented the BAF that follows on from further guidance that has been received. We have done a True for Us review that's shown improvements we needed to make e.g. fit testing. The MIAA audit gave moderate assurance around data collection and a new appointment has now been made to collect the required data. Compliance with testing at day 1, 3 and 7 is closely monitored. Ward sisters have taken charge of ensuring compliance. Patients are also tested every 7 days after day 7. NL noted that it is good to see this document. He asked if staff undertake lamp testing and about guidance around non-clinical environments. BD noted that we are not participating with lamp testing – we use PCR testing and all front facing staff are tested. About 1600 staff are tested every week. Our guidance also covers non-clinical areas.	
f	**Responsible Officer Report: Appraisal and Revalidation 2020-21**	
	WM presented her last report as RO. CH will be taking over as RO. One of our Associate Medical Directors is training as an RO to work alongside CH. Appraisal and revalidation was paused earlier in the year, this has recommenced from October and about 50% of staff have had appraisal in year. Those that were missed are classified as 'approved missed appraisal' and there are no consequences. Processes are now flowing again. The 'Fair to refer' report from the GMC	

	tasked us with looking at how we handle concerns about doctors. The outcome report shows no concerns about any bias in the way we are handling concerns. Questions were invited. JM asked about the scope within appraisal and whether it included private practice. WM confirmed that it does include private practice and any work a doctor does. The responsibility is on the doctor to bring the data. Most of our doctors who undertake private practice do so through the Christie clinic, if not they must obtain a letter through the organisation to say there are no issues. This is part of the scrutiny through appraisal. KW thanked WM for setting the revalidation up at The Christie and asked how well this works for those that are not full time staff. WM noted that we offer appraisal for those who work with us, the system now works very well to keep track of all doctors and they are sighted in the system. It works well. CH added that the doctors who have short term appointments are the risk in the system but what we have now works significantly better than it ever did before. This is not an issue or risk for The Christie.	
g	**Staff survey 2020 results**	
	EL presented a summary of the 2020 staff survey. The results are benchmarked and are presented in the context of the best, average and worst results for Acute Specialist Trusts. There are also details of changes made from the previous year. For the NHS Staff Survey 2020, a full census was carried out with 1,505 of our staff completing questionnaires. This represents a 49% response rate, our best response since 2016. Overall the Trust 2020 results are positive & the organisation scores best in one thematic area and higher than average in six, with only the quality of care lower than the national average for specialist Trusts. Overall the Trust scored better than average for Equality, diversity & inclusion. Overall the Trust scored equal to average for Health and Wellbeing. However it should be noted that the Trust has a higher score in the Health & wellbeing theme (6.5) when compared to the trust's 2019 score (6.3). • 64.6% of our staff were satisfied or very satisfied with the opportunities for flexible working patterns. This is over 10% better than the Trust's 2019 score (53.9%) which demonstrates a strong improvement. • 26% of our staff said they had experienced musculoskeletal problems (MSK) as a result of work activities which is just below the average of 26.6%. This is the highest this score has been for over 5 years. • 39.4% of our staff said they have felt unwell as a result of work related stress during the last 12 months. This highlights a need to do more to support staff to manage stress at work which is being looked at as part of the current Stress Risk Assessment review. Overall the Trust scored equal to average for Immediate managers. • 74.8% of our staff reported they were satisfied or very satisfied with the support they get from their immediate manager compared to 72.8% in 2019. • 64% of our staff felt that their immediate manager gives them clear feedback on their work which is below the average of 65.7%.	

- 75.2% of our staff felt that their immediate manager takes a positive interest in their health and wellbeing and 76.7% of our staff felt that their immediate manager values their work which is also above the average of 76.0%.

The Trust has re-launched the ‘Managing for Success’ manager development programme which is now being delivered virtually and continues to develop its positive working environment plans. The Christie Leadership programme sees its first cohort complete the programme on the 31st March and we have implemented our coaching and mentoring programme.

Overall the Trust scored better than average for morale.

- 75.2% of our staff believed they receive the respect they deserved from colleagues at work. This is above the average score of 72.4%.
- 53.6% of our staff felt that relationships at work were never or rarely strained which is above the average score of 49.1%.
- Fewer of our staff reported their intention to leave the Trust, their intention to look for a job at a new organisation in the next 12 months or their intention to leave the Trust as soon as they can find another job when compared to the average scores for the benchmarking group.

Overall the Trust scored worse than average for quality of care.

- 87.2% of our staff are satisfied with the quality of care they give to our patients/service users. This is below the average of other Trusts in the benchmark group.
- 92.7% of our staff feel that their role makes a difference to patients/service users compared to an average of 90.8%.
- 76.8% of our staff feel that they are able to deliver the care they aspire to which is below the benchmarking average of 79.1%.

Overall the Trust scored better than average for Safe environment – Bullying & Harassment. The number of our staff who said they have experienced bullying and harassment from colleagues or managers has increased since 2019 however, our results remain better that the national average.

The Christie People Plan 2021/21 includes actions to embed the Trust’s RESPECT campaign and to develop an action plan/strategy aimed at reducing bullying and harassment.

Overall the Trust scored the best score for Safe environment – Violence

when compared to the benchmarking group.

Overall the Trust scored better than average for Safety culture when compared to the benchmarking group of Acute Specialist Trusts.

- 69.9% of our staff said that the organisation treat staff who are involved in an error, near miss or incident fairly.
- 69% of our staff feel that they are given feedback about changes made in response to reported errors, near misses and incidents which is above the benchmarking score and is the highest this score has been in the last five years.
- 74.3% of our staff would feel secure in raising concerns about unsafe clinical practice which is below the benchmarking average of 75.6%.
- Particularly pleasing is that 66.8% of our staff feel confident that the Trust would address their concern and 85.3% of our staff believe that the Trust acts upon patient concerns, both of which are above the benchmarking scores for these questions.

Overall the Trust scored better than average for Staff engagement when compared to the benchmarking group.

- 90.7% of our staff agree or strongly agree that the care of patients/service users is the organisation's top priority which is above the benchmarking average score of 89.2%.
- 92.6% of staff would recommend The Christie as a place to receive treatment and 76.5% of staff would recommend the Trust as a place to work which is the highest this score has been over the past five years.

Overall the Trust scored equal to average for Team working when compared to the benchmarking group.

New for the NHS Staff Survey is a breakdown of the theme scores for staff in COVID-19 classification subgroups given the context of the past year. Staff were asked four classification questions relating to their experience during the COVID-19 pandemic. The data shows that the experiences of staff shielding (either for self or for a household member) are below that of all staff in the majority of the 10 themes. Those staff who have been redeployed or required to work remotely/from home show better scores when compared to the scores of all staff.

The benchmarking for us against all other specialist Trusts was shown and we are within the top four for all domains out of 14, number one for Violence and Aggression and number two for EDI.

Local benchmarking shows us equal to or first in seven domains which is a fantastic achievement.

EL summarised the results are really positive and above the benchmarking average. There are some key areas of focus including where staff feel they have been discriminated against compared to others. Focus around health & wellbeing in particular to the management of stress and supporting staff with musculoskeletal conditions, enabling and supporting staff to feel they deliver excellent quality care to our patients, bullying & harassment and staff engagement.

EL noted that we are already progressing a number of programmes of work to address some of our areas of focus for example on stress risk assessments and also the Trust Respect campaign.

CO congratulated the team on a great set of results and noted the valuable information.

RA noted the really impressive results in a difficult year and wondered about the quality of care. EL noted that we looking at what is behind this response. There's a risk we can misinterpret what staff are trying to tell us, when this is looked at alongside what patients are telling us we do not see problems. Staff set themselves very high standards and have been frustrated by the limitations that the circumstances of the pandemic have had and this may be what we are seeing in the feedback.

TK noted that staff are very hard on themselves and staff under pressure may feel they are not providing the best care even when they are. Considering the pressure of the last year, these are remarkable results.

EL noted that the Grand Round is very useful and we get good engagement from staff in these sessions. An invite will be sent to Board for the workforce session.

NL noted that we always learn from the surveys. The results are excellent and compare incredibly favourably. It would be good to see the response rates

	improve. EL noted that we have tried to incentivise staff to complete the survey. There will be a big focus on feeding back to staff around what we do in response to the feedback we get from these surveys – this has been very difficult in 2020 but we will do this more going forward. CH noted that we have also undertaken a nationally validated medical staff survey in recent months. We have had around a 63% response rate. Headline figures show that we are above average in terms of medical engagement. In the 10 categories we are higher than average in 5 areas, 4 in the average range and 1 in the lower. This will also help us to focus on where we can improve for this group of staff.	
06/21	**Approvals**	
a	Board governance i Directors letters of representation ii Register of directors interests iii Fit & proper persons declaration iv Declaration of independence v General data protection requirement (GDPR)	
	Letters have been circulated to Board members. Everyone was asked to complete the forms and return them to the company secretary's office by email or hard copy.	All directors
b	**Annual reporting cycle 2021/22**	
	CO noted the reporting cycle for the Board and asked for approval. Approved.	
c	**Corporate objectives and board assurance framework 2021/22**	
	RS noted the paper. Normally we would have a full set of annual objectives, however due to the delays in the planning framework and the continuation of the incident this process of objective setting has been delayed for 2021/22 and will be picked up at the appropriate time. The draft BAF for 2021/22 was noted. RA asked about corporate objective 4 and consideration of the wording.	Exec directors
07/21	**Board assurance**	
a	**Board assurance framework 2020/21**	
	RS noted the updated BAF and the updated risk scores. No changes were suggested.	
b	**Audit Committee report**	
	NL noted the content of the meeting and invited questions. CH asked about the list of reports that were reviewed and what the outcome of the audits were. Action to share the outcomes of the audits to executives not on the committee.	LW

NHS
The Christie
NHS Foundation Trust

Public meeting of the Board of Directors
Thursday 29th April 2021 at 12.45 pm
By virtual means

Present: Chair: Chris Outram (CO), Chairman
Dr Jane Maher (JM), Non-executive Director
Robert Ainsworth (RA), Non-executive Director
Neil Large (NL), Non-executive Director
Kathryn Riddle (KR), Non-executive Director
Prof Kieran Walshe (KW), Non-executive Director
Roger Spencer (RS), Chief Executive
Wendy Makin (WPM), Executive Medical Director
Bernie Delahoyde (BD), Chief Operating Officer
Eve Lightfoot (EL), Director of Workforce
Prof Chris Harrison (CJH), Executive Medical Director (strategy)
Joanne Fitzpatrick (JF), Executive Director of Finance
Prof Janelle Yorke (JY), Executive Chief Nurse
Prof Adrian Bloor (AB), Interim Medical Director

In attendance: Prof John Radford, Director of Research
Wes Dale, Managing Director of Research
Sue Mahjoob (SM), Freedom to Speak Up Guardian
Colin Bamford, Public Governor, Trafford
Maurice Gubbins, Public Governor, Cheshire
Jo Darcy, Assistant Company Secretary

Minutes: Louise Westcott (LW), Company Secretary

Clinical presentation: Supportive Care services at The Christie during the pandemic, Dr Richard Berman, Supportive Care Consultant; Eileen Hackman, Deputy Clinical Lead, Complimentary Therapy; Andrew Bradley, Chaplain; Alex Langstaff, CNS Supportive Care; Caroline Morris, CNS Supportive Care

RB introduced the supportive care services and described them as the glue that brings other services together. End of life is an important part of the work but patients are also supported through their treatment, issues such as pain, mobility and psychological issues. The team also support patients on a curative pathway and survivors who have problems as a result of treatment.

RB thanked the team for their work over the last 12 months and acknowledged the new ways of working that have been implemented. The use of technology to communicate made non-oncology services think about how they work more cohesively in terms of service & research. RB noted that the team have come up with the new term of 'supportive oncology' that brings these various specialties together.

RB commented that the team are coming out of the pandemic stronger and feeling positive with good plans for the future.

Communication with relatives has been a major issue – Caroline talked about the difficulties of breaking bad news and the stress this has caused for families and patients and staff. Alex talked about staff being the replacement for the family member when they can't have family in hospital with them. There has been some discretion applied to visiting. The lack of visitors has caused additional pressure to patients and staff as has the lack of community support groups etc.

Andrew Bradley noted that the last lock down has been one of the busiest periods ever for spiritual care. Staff have been referred to the service to help to support patients when family couldn't come. Staff have tried as best they can to provide additional support to our patients.

Remote working has been necessary & it's been amazing how much can be done virtually. Pain problems have been addressed through a system that enabled patients to get what they needed quickly and relations with community colleagues / community care have improved.

Eileen Hackman noted that the complimentary care team remained a visible presence on site to support patients that were physically distressed. The team created an algorithm to triage patients and identify when they could be supported over telephones and advising on techniques they could do themselves as well as talking therapies. Touch therapies have been used with PPE for staff and this has been successful. On line resources have been used successfully and this has also helped staff. This has been very innovative and feedback has been excellent.

An 'Essentials in palliative & end of life care' course was recently done virtually and it got 3 times more delegates than usual as it is now very accessible.

Questions were invited.

CO thanked the team for the fantastic presentation.

KR noted that she was surprised that PPE wasn't a barrier to emotional contact and also that conferences have been better attended.

Caroline noted that breaking bad news and some other communication is very difficult with PPE and has been a barrier sometimes. Psych-oncology have found the mask wearing very challenging and there's been feedback from some patients where this has been very difficult, for example with patients who have impaired hearing.

CO thanked the team for their great efforts to continue services and develop them in this difficult time.

Item		Action
09/21	**Standard business**	
a	**Apologies**	
	Tarun Kapur (TK), Non-executive Director	
b	**Declarations of Interest**	
	None received	
c	**Minutes of the previous meeting – 25th March 2021**	
	Minutes accepted as a correct record.	
d	**Action plan rolling programme, action log & matters arising**	
	All items from the rolling programme are noted as on the agenda	
10/21	**Reports**	
a	**Chief executive's report**	
	RS updated the board on the situation report. Incident response has reduced from national control (level 4) to regional control (level 3). Covid activity is very low and we are running at business as usual. We have no backlog in treatment or diagnostics. We continue to provide support to the GM system. RS drew attention to the award of platinum accreditation from Transport for Greater Manchester for our work in supporting 'on foot' and 'by bike' travel and using electric vehicles. It is 4 years since we had the fire in the Paterson building. RS noted the update in the report on progress with the replacement build.	

	CO commented that the People Pulse didn't get a lot of people responding. RS noted that this is about to be stepped down but that detail will be picked up in the Workforce report. This was seen as a quick temperature take during the covid period. RA asked about the CAR-T ward and what it will do in the future. AB responded that the ward is relatively small and this will sit alongside the ambulatory unit. It will provide flexibility and allow us to future proof CAR-T ambitions. This is an incremental change and we may need to look at a more ambitious plan in the future. This enables us to deliver treatment in an ambulatory setting. The Modern Slavery statement was approved to be published on the website.	
b	**Integrated performance, quality & finance report**	
	BD outlined the key points from the report for month 12. **Safe** • There were no serious incidents or never events in month, 1 moderate incident still progressing through to full root cause analysis. One corporate risk increased its score to 20 in March relating to digital. Increase in PALs contacts in line with activity increase. **Responsive** • Our performance against the cancer waiting time standards has improved from February. This month we achieved 82.2% against the 62 day standard and 81.6% against the 24 day standard. 31 days at 98.4%. There are 26 104 day waiters. Length of stay is improving. • Referrals increased in March and were back at levels consistent with 2019/20. • Activity in some aspects is beginning to recover in line with the phase 3 plans. New attendances are behind plan in line with the lower rates of referrals, outpatient follow ups' are above plan. Surgical operations and radiotherapy fractions remain behind plan. • Research recruitment is increasing, new studies are still behind plan but improving. **Effective** • There have been no cases of MRSA bacteraemia. There have been 5 C-Difficile cases attributable to the trust in month and 38 attributable cases year to date with no lapses in care identified. • There have been no cases of Covid-19 in month & no covid nosocomial infections. **Well – Led** • Finance – the Trust has an improved financial position at the end of month 12, delivering a (Control Total) surplus of £7.84m • EDITDA surplus £32.4m • The month 12 I&E surplus is £1.642m, prior to adjusting for donated depreciation, charitably funded capital donations and impairments. • The cash balance is £153.117m • Capital spend is underspent at month 12 by £8.5m we are working with the GM wide system to manage the current capital underspends. CO invited questions. RA asked about the commercial clinical trials delivered to time & target, best	

	performance around 66%, worst 33%. Is this typical, good, bad and how does this compare. JR noted that this is an NIHR metric that's reported centrally. This is about recruiting patients in the time we said we would – this performance is fairly average compared to national performance but there is room for improvement. CO asked about activity and pressure from DoH about recovery. There has been discussion about later presentation of cancer patients as a result of covid, has this happened. CH responded that the work across GM and their figures does not show this at the moment but it is too early for this to be clear. Clinicians are saying that they are seeing patients at a later stage but we should get more evidence coming through soon. CH also noted that in the GM system many of these patients are waiting for things in local hospitals so we haven't seen this impact coming through yet. JR added that for some specialties patients present late as the norm for other specialties this will feed through in time.	
c	**Medical directors report - Research & Innovation update**	
	CH introduced the regular report. CO thanked JR for his tenure as Director of Research and for his contribution to the development of the research function over many years. JR noted that Prof Fiona Blackhall is starting on 1st June as Director of Research and also that Prof Fiona Thistlethwaite has started as Director of the CRF. A refresh of the strategy in CRF will be presented in due course. Renewal for the BRC is underway. A forth theme has been identified. The renewal process to designate and fund BRCs has been launched with stage 1 applications due on the 26th May 2021. An expression of Interest (EoI) by MCRC for CRUK Major Centre funding (2022-2027) was made on the 12th April. There was only a 6 week period when trial recruitment was paused, this impact was minimised and our research effort has continued. This has been great for patients. There has been an impact on some aspects of research studies in terms of elements where patients are required to come on site. In terms of commercial income it was anticipated that there would be a 20% reduction but the reality was a 7% reduction. This was helped by the redeployment of research staff, deferral of the R&I levy and CRN money. It is anticipated that the next year will be very tough. There have been huge successes in the last year, of 11 impact cases submitted, 6 came from cancer. A number of Christie staff contributed to these. JR outlined some of the new research and breakthroughs and how treatment has been improved as a result. Grants and partnerships were also exemplified showing reach and focus on patient outcomes and experience. JR outlined some of the pressures and issues that are causing challenge including delay in delivery of equipment due to covid and Brexit as well as issues with capacity that the team are working to resolve. JR thanked the Board for their support and reflected on the team effort of the research division and the excellent impact of individuals on the work. KR asked about the mitigations for the risks identified and the impact of the ECMC review submission. JR noted that the ECMC issue is not our decision and impacts everyone but means we have to change the way we respond. JR	

	noted that we hope the mitigations we have will be effective and we are working with the Trust risk management system to manage these issues. This is integrated in the organisation and R&I are not dealt with separately. KW noted the step change with R&I and thanked JR for his contribution to this. Post-covid there is a lot of thinking about delivery of research and a focus of system level delivery. He asked how we embrace this approach. JR noted that it is apparent that prioritisation of research is becoming more important and we need to focus on national priorities and setting these priorities. It's a change in thinking and we are engaging in this process and thinking about our resources and funding options. The Research Strategy will address this different focus. RS added that we are engaged in research in the GM system and we have taken steps forward in recent years to work with BRC as a collaboration across GM. There is currently an absence of guidance around research arrangements. AB added that in the system wide approach to cancer care, research becomes entwined in this and this gives a new opportunity and allows us to influence. This is in its early stages but gives us opportunity to do this better. CH noted that there aren't many other strong health care related programmes in GM other than cancer. We now have JY on the Board bringing the perspective of senior academics alongside medical colleagues. JY noted that we have a really strong commercial and now academic competitive research portfolio that is both medical, nurse and AHP led. CO thanked JR and WD for their hard work.	
11/21	**Other Reports**	
a	**Register of matters approved by the board**	
	RS noted the requirement to report this to Board and the report was noted.	
b	**Workforce quarterly report incl. FTSU quarterly update**	
	EL presented the update. The paper is themed relating to the themes of the NHS People Plan. EL highlighted the turnover and noted that this has decreased in the last 6 months, 80% of band 5 leavers had more than 1 years' service. Risk around radiotherapist turnover has decreased. The data is used to look at workforce plans. There is more work going on around exit interviews and why people leave the organisation. EL noted the longer term flexible and remote working policy that is being looked at alongside staff wellbeing. EL updated on the appointment of the Health & Wellbeing Guardian. TK has been appointed into this role and we are looking at how this links with existing roles. People Pulse was noted. This was offered to all staff as a check in to provide feedback during the pandemic. This feedback has been linked into actions from the staff survey. This will now cease as there is a mandated national requirement to undertake a staff survey quarterly. We haven't seen what this requirement is yet. EL noted that the FTSU plan that SM will present is draft and will be updated to reflect the report that comes from the R&I NHSEI Rapid Review. SM presented the data from the last 6 months of FTSU. She noted a reduction in contacts. 42% of contacts relate to attitudes & behaviours, 35% to policies,	

	procedures and processes and 15% to covid-19 measures. One case reported detriment and this was reviewed by a senior manager. Contact numbers compare to other organisations. Concerns are taken very seriously, there are a number of initiatives being undertaken about respect and support to staff. The importance of keeping people informed around delays was stressed. SM noted that any action from the NHSEI review will be added to the plan for FTSU over the next year. Staff survey feedback on speaking up is good and compares well to other specialist trusts. We perform better than most other trusts. The new Patient Safety Specialist role is being implemented that will support the Trusts approach going forward. BAME results are less positive and our BAME network are engaging and sharing stories to make change across staff networks. Key objectives of the FTSU plan were outlined including the introduction of FTSU champions, speaking up & training modules, enhancing support mechanisms and further triangulation of information with other metrics to identify action required early. Results of the NHSEI review will be built in to this plan once we have received it. SM noted that we continue to focus on speaking up and listening well and this message was given to Management Board. CO stressed the support that the Board give to this work. JY commented that the EDI groups have been very helpful and these groups may help support the BAME work. We put forward 2 nurses for the BAME nurse of the year and they have been nominated. We will find out the results next week. CH noted that national policy around FTSU can create some confusion although we fully support its aims. He asked what makes the biggest difference to encourage staff to speak up. SM noted that there is a need to have a service around FTSU, it's a lot harder to speak up about issues about relationships, easier with issues that relate to patients. Feedback is absolutely key and stories that are fed back around positive experiences of speaking up are very powerful. EL noted that we are working on culture and speaking up as the norm. CO noted that we have a high reporting culture around incidents relating to patients, the NHS are still working on how we do this properly. KR thanked EL and SM for all their work. She noted that this was originally about patient care and this has now been widened. We must focus in on listening and hearing what is said and then giving feedback around what has been done or not done and why. This is about trust and relationships. AB noted that we must disarticulate FTSU from Whistle blowing. We need people to use this comfortably with things that are not huge issues that can be dealt with and we can then move forward on. CO thanked all for their support and work. Report noted.	
c	**Emergency Preparedness, Resilience and Response (EPRR) annual report 2020/21**	
	BD presented the annual EPRR report for 2020/21 and noted the learnings that	

	we are considering and taking forward. Questions were invited, none asked. Report noted and approved.	
12/21	**Board assurance**	
a	**Board assurance framework 2020/21 – closing position**	
	RS noted the updated BAF with the updated risk scores and the closing position for 2020/21. The report also shows where risks have been carried over to the next year. The next BAF will reflect changing circumstances in the NHS.	
b	**Audit Committee report**	
	NL noted the items that the Audit Committee received at their last meeting. Next years' plans are in place and end of year work is going well.	
13/21	**Any other business**	
	No items raised.	

NHS
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Public meeting of the Board of Directors
Thursday 27th May 2021 at 12.45 pm
By virtual means

Present: Chair: Chris Outram (CO), Chairman
Dr Jane Maher (JM), Non-executive Director
Robert Ainsworth (RA), Non-executive Director
Neil Large (NL), Non-executive Director
Kathryn Riddle (KR), Non-executive Director
Prof Kieran Walshe (KW), Non-executive Director
Tarun Kapur (TK), Non-executive Director
Roger Spencer (RS), Chief Executive
Bernie Delahoyde (BD), Chief Operating Officer
Eve Lightfoot (EL), Director of Workforce
Prof Chris Harrison (CJH), Executive Medical Director (strategy)
Joanne Fitzpatrick (JF), Executive Director of Finance
Prof Janelle Yorke (JY), Executive Chief Nurse
Dr Dan Saunders (DS), Interim Medical Director

In attendance: Tom Thornber, Director of Strategy
Prof Richard Cowan, Director of Education
Janet Morley, Public Governor, Manchester
Dr Amit Patel, Staff Governor
Jo Darcy, Assistant Company Secretary

Minutes: Louise Westcott (LW), Company Secretary

Clinical presentation: Clinical Advisory Group formation and impact during Covid-19, Dr Mike Leahy, Consultant Medical Oncologist & Chair of the Clinical Advisory Group (CAG)

CO noted that we have been clinically led in our response to the Covid-19 pandemic and this was done through the CAG. Dr Mike Leahy was the chair from the start, he was welcomed to the meeting.

ML introduced himself and noted that he was originally the chair of the CAG that is now chaired by multiple clinicians. ML is one of the associate medical directors.

Initially there was a lot of fear, priorities were to protect patients, services and staff. The risk to patients was thought to be an increase in contracting covid at hospital, increased risk of a worse outcome to their underlying condition (cancer) and an increased risk of a worse outcome due to treatment (radiotherapy / chemotherapy).

The risk to services was around staff shortage as a result of quarantining due to symptoms or family members having symptoms. We also anticipated an increase in emergency demand – a system overwhelm.

Lots of mitigations were put in place very early on and the CAG was formed in March 2020. This was set up as part of the planning and preparing for things getting worse. A drastic reduction in footfall on site was implemented early on. PPE was introduced for all staff, screening and distancing was put in place as well as eventually testing.

Coordination was difficult and ever changing from NHSE, PHE, GM, Oncology UK etc.

The Clinical Advisory Group was set up to advise on patient & treatment stratification across service & research. Membership was quite small but this rapidly increased. The group met twice weekly and the consensus advice was sent to the Strategic Team to take action. It covered a wide range of topics.

Categorisation of benefit was a major piece of work initially and a 6 category system was devised based on all treatments – category 1 – curative therapy up to category 6 – non-curative therapy. All treatments were measured against these categories to enable there to be an approach to prioritising treatment.

Weekly teleconferences were set up nationally that were originally chaired by Dr Wendy Makin. This was Christie led and went national within a couple of weeks. Detailed mapping was undertaken against the categories of benefit (850 SACT regimes). In the vast majority of cases there were individual conversations between clinician and patient to decide on modifications of treatment to make them safer to deliver e.g. intravenous to oral chemotherapy, monitoring done over the phone etc.

Service wide withdrawal of category 5 & 6 took place for 2 weeks only until there was a reduction in the risk.

Reflection of success – the group worked very well in making rapid decisions and provision of advice on essential & difficult clinical questions. The membership was widened to nursing and AHP colleagues.

Post pandemic the group are looking at what to keep and what to change. Positives include - telemedicine, working from home, biosecurity, enhanced infection prevention and control and clinical input to decision making.

Going forward the CAG will remain but other areas are also being looked at for clinical engagement.

CO thanked ML for the presentation and noted the importance of the focus on clinical engagement.

DS thanked ML for the reminder of what has been done and the important role of CAG as well as how well we did to maintain capacity and continue services. The NW Radiotherapy regional network was also really important in ensuring consistency. There has been enhanced clinical engagement through this route and this will be taken forward in whatever way is seen to be appropriate.

KW asked how much will be kept in terms of changes to treatment. ML responded that in many cases we will go back to the previous treatments, in terms of radiotherapy fractionation rates some will remain as there is evidence that the outcomes are the same. Many patients prefer virtual outpatient appointments but many don’t. There will be a mixed approach. Telemedicine will be kept for some patients.

RC noted that international literature will demonstrate efficacy of the reduced fractionation rates in some cases. Evaluations have been done with patients on virtual approaches and there will need to be a blended approach in the future.

RS noted that whilst we pulled together the views of the national oncology centres, ML was the lead clinician on the categorisation of patients that was used nationally. This was a very difficult issue that was led by ML. RS thanked ML for this work.

CO agreed and thanked the clinical team for their leadership on this and for keeping patients as safe as possible.

Item		Action
15/21	**Standard business**	
a	**Apologies**	
	Apologies received from Cathy Heaven (CHv)	
b	**Declarations of Interest**	
	No declarations of interest received	

c	**Minutes of the previous meeting – 29th April 2021**	
	Minutes accepted as a correct record.	
d	**Action plan rolling programme, action log & matters arising**	
	All items from the rolling programme are noted as on the agenda.	
16/21	**Reports**	
a	**Chief executive's report**	
	RS drew attention to the following items in his report; The situation report shows a sustained period of being at the lowest level of escalation, this is business as usual with biosecurity measures in place. We are still being vigilant due to increased incidence in some parts of the region. During the course of this week we have been hosting the virtual cancer week. A different theme has been looked at every day and this is going very well and colleagues have been involved. The resources are available on line. We continue to participate in the developments in Greater Manchester and the creation of integrated care systems (ICS's). Questions were invited. None were received. CO noted the partnership with Kenya as an interesting development.	
b	**Integrated performance, quality & finance report**	
	BD outlined the key points from the report for month 1. There were no SI incidents, no Never Events, 6 moderate incidents, 3 of which are StEISS reportable. 2 were later submissions relating to nosocomial infections in the previous month and 1 related to a fall. There's been a small rise in patient falls in month. There are 6 Corporate risks at 15+, 1 corporate risk at 20 (digital risk relating to the approved business case for a data centre), 2 risks at 16 and 3 risks at 15. There were no cases of MRSA bacteraemia, 1 case of C.diff, which was not due to a lapse in care. There have been 3 cases of E-Coli post 48 hours and no Covid nosocomial infections 6 new complaints were received in month, 51 PALS contacts, 1 inquest request and 2 new clinical negligence claims. In terms of the waiting time standards; ➢ 18 Weeks is at 99.4% ➢ 62 day performance is 77.5% ➢ 24 day performance is 77.7% - we have had quite a few priority 3 patients in April that waited a bit longer as well as late referrals, this has improved in month 2 ➢ 31 day performance is 97.5% ➢ 104 day waiters has reduced to 5 – these have been referred in to us late in the pathway. There were no cancelled operations in month and referrals have been within the predicted range. Activity is in line with the recovery plan. BD showed graphs relating to month 1 activity – predicting to be at 70% of 2019/20 levels of activity. All activity is above the predicted levels apart from SACT. Sickness is at 3.14% excluding covid and 4.15% including covid. PDR's are at	

	82.1% compliance and essential training compliance is at 88.5%. Finance; ➢ EBITDA surplus £4.034m ➢ I&E surplus £1.291m ➢ Cash balance £141,329k ➢ Debtor days of 12 ➢ Capital expenditure at 98.5% against the revised NHSI plan CO asked about PDR and essential training compliance as this is slightly behind and how confident we are that we can recover this position. BD noted that the divisions are reporting an improvement in this and there is an issue with a delay in the recording that is making the position look worse than it is. EL noted that we are seeing improvement in compliance and the HR business partners are supporting the divisions to improve this in a targeted way. NL asked about the covid cases on ward 12 and 11 and what we learnt. BD noted that the reporting of these cases was delayed as the RCA's and harm reviews were not completed in time. There was learning in terms of staff testing as well as touch points in cleaning. We are also looking at enhancing the use of FFP3 masks where there are positive patients. Ventilation is not as good as it could be due to inability to open windows in some areas due to construction work on site. JY added that we worked very closely with Public Health England who commended our approach and how we contained the outbreak. Learning points have been actioned. NL asked about total Trust income including £25m against the operating cost of £28m. JF responded that this is about the wording, we get a top up on the block contract to cover exclusions such as high cost drugs. KR asked about the voluntary resignations and whether this rate is normal. BD noted that this has been reviewed by division and this is at a normal level. EL noted that we are doing a lot of work on turnover and retention and the exit interview process. AP asked about the block contract arrangements & how over performance is covered. JF responded that we get paid based on 2019/20 levels, covering costs for any over performance above this level is being discussed. There is a national pot to cover this.	
c	**Medical directors report - Education update**	
	CH introduced the regular report from the School of Oncology presented by the Director of the SoO. CH noted that RC has taken the SoO from its inception to now but he will be handing over to a new Director of the School at the appropriate point. The role is out for advert now. RC thanked Cathy Heaven for the report who sends apologies today. RC noted the theme of development of nurses and AHPs as well as academic ambitions. We are working for closer collaboration with Research and MCRC to look at the academic institute at the Christie. The SoO responded well to the challenges of the pandemic and RC acknowledged their role through 2020. The move to the virtual environment has meant that many nurses and AHPs have significantly increased their attendance at CPD sessions. This is a big positive. We want to enable these groups to further their careers – there is immense talent in these groups and we can start to unlock this and improve retention. Clinical academic positions in nurse and AHP roles are being explored	

	alongside medical colleagues. The School are also working to enhance development through apprenticeships and working to exploit this more. This links to the academic ambitions. Further integration of NHS staff into the research environment continues for the benefit of the staff and organisation. We have successfully secured extra training posts for clinical and medical oncology. Regionally we deliver teaching for Liverpool University and University of Manchester. Medical students missed a lot of medical practice experience last year so we have been supporting them to get back into clinical practice. A new virtual course was developed to help these students. HEE has changed the contract to be more transparent around funding. Nationally there's been a transformation to virtual programmes, we have been doing this with PET-CT and Gateway-C. We've had an increased uptake in our offerings. Internationally we look to increase income to enable us to support programmes in other countries. We are working with the Kenyan Government, with Uganda and Chennai as well as other countries. Questions were invited. CO thanked RC for all he has done for the School of Oncology and developing it over the last few years. JM asked about measurement of the impact of educational courses in the areas we serve. What do we mean by an Academic approach to education. RC responded that in terms of the measurement of impact, we have standard measures but part of the academic development is to look at this and the impact on change in practice. Academic approach means more joint projects and more publications. TK asked about the growth area of virtual approaches. RC noted that the medical student cancer education on line programmes developed for our students can also be used for work with Kenya and other areas. JY noted the importance of the clinical academic focus in nursing and AHP's and the need to work towards NIHR fellowships as the gold standard. There's a cohort of these people coming through and we must ensure dovetailing of these roles into clinical practice. The next round of the academic investment plan (AIP) is very important in terms of funding these roles going forward and taking things to the next level. RA noted the opportunity to expand into international markets and asked about competition in terms of courses offered by others. RC noted that in health, the UK is strong compared to other countries. The Christie and UoM brand is very strong and our MDT structure is quite unusual and we are in a strong position and are leading this. CH concluded that interactions with international partners indicate that we are inundated with people who want to find out about opportunities, our reputation puts us in a very strong position. Aspirations for the future are strong and well founded. CO thanked RC and CHv for the report.	
17/21	**Other Reports**	
a	**Development of the Greater Manchester ICS**	
	TT presented the current position with the changing legislative and structural changes.	

	TT outlined the paper from Mike Farrar about the operating model and where we are coming from in GM with devolution and the emergency response position. There is a changing commissioning environment, the accountability situation for FTs is changing and there are capital constraints. Collaboration is central to responsibilities of organisations. The operating model aims to enhance and improve the current set up. TT noted the collaboration arrangement and how this will be embedded with local authorities, primary care, social care, mental health etc. Financial flows and accountability arrangements. Design principles outlined. Next steps – workshops are taking place to decide on the governance structure across GM, the planning arrangement and delivery arrangement and what operates at what level. For cancer there needs to be a GM wide planning and delivery function. Financial flows need to be decided alongside this. TT noted the impact on Christie relating to quality, governance, system engagement etc. we are working with cancer alliance colleagues on behalf of the system to develop the future cancer operating model. NL noted that there is still ambiguity. Who is the ICS Board and how does the partnership board fit in. TT responded that this is still uncertain and under discussion. RS added that the proposal is that there will be an NHS ICS Board where the money flows and another board with other partners involved. The provider collaborative is all acute and mental health trusts and in broader organisational arrangements there are 37 organisations including local authorities. PCNs will come into a provider collaborative function. There's been more work with local authorities in GM for a longer period because of the GM Health & Social Care Partnership. Mike Farrar is doing a lot of facilitation work in GM and other systems in the country. TT noted the cancer planning & delivery function and the new model with commissioning set to one side. There is a piece of work to be done on how we provide assurances outside of the provider / commissioner split and what the developing model is. We will be looking at other aspects of cancer care outside of treatment and care such as prevention / survivorship etc. RS noted that there's an opportunity at the next Board time out to look at this in more detail and its impact on the strategy.	
18/21	**Approvals**	
a	**Annual compliance with the CQC requirements**	
	JY presented the annual report relating to CQC requirements. We were due a routine inspection early last year but we have had regular contacts with the CQC officer that have gone well. There's been a focus through the year on the BAF relating to infection prevention and control. There were no improvement actions relating to this review and we were praised for our approach. There is a transitional monitoring review next week to look at recovery from the pandemic. We are unsure as to how the approach will look going forward for inspections and monitoring. There will be more of a focus on intelligent use of the data they have to use their resources more effectively. There will be a focus on equity and access to care in future. CO thanked JY for the very clear report. Approved.	

b	**NHS Provider License conditions: self-certification declarations**	
	RS presented the self-certifications to NHSEI. We have previously submitted these responses to the regulator but we are no longer required to do this. We now note our own assessment and will provide it to the regulator if we are asked to present it. This will be affected going forward as licence changes are made for Foundation Trusts. RS asked the Board to approve this position. Approved.	
19/21	**Board assurance**	
a	**Board assurance framework 2021/22**	
	RS noted the updated BAF for 2021/22 that reflects the risk to the achievement of corporate objectives. No changes were suggested.	
b	**Audit Committee annual report 2020/21**	
	NL noted the unqualified opinion and thanked everyone for carrying out their duties in difficult circumstances this year. Report noted.	
c	**Quality assurance committee annual report 2020/21**	
	JY noted that the committee was paused for a period and then returned to normal functioning quickly. The report was noted.	
20/21	**Any other business**	
	No items raised.	

The Christie
NHS Foundation Trust

Public meeting of the Board of Directors
Thursday 24th June 2021 at 12.45 pm
By virtual means

Present: Chair: Chris Outram (CO), Chairman
Dr Jane Maher (JM), Non-executive Director
Robert Ainsworth (RA), Non-executive Director
Neil Large (NL), Non-executive Director
Kathryn Riddle (KR), Non-executive Director
Tarun Kapur (TK), Non-executive Director
Roger Spencer (RS), Chief Executive
Bernie Delahoyde (BD), Chief Operating Officer
Eve Lightfoot (EL), Director of Workforce
Prof Chris Harrison (CJH), Executive Medical Director (strategy)
Joanne Fitzpatrick (JF), Executive Director of Finance
Prof Janelle Yorke (JY), Executive Chief Nurse
Dr Neil Bayman (NB), Interim Medical Director

In attendance: Stuart Keen, Director of Capital & Estates
Eileen Jessop, Chief Information Officer
Laura Smoult, HR Engagement Manager
Sarah Hanbridge, CCIO Nursing
Colin Bamford, Public Governor
Jo Darcy, Assistant Company Secretary

Minutes: Louise Westcott (LW), Company Secretary

Clinical presentation: Teenagers and Young Adults (TYA) and Endocrinology, Anna Castleton, Consultant Haematologist TYA and Hanna Simpson, Lead Nurse for TYA

AC introduced herself as one of the consultant haematologists and the TYA lead.

HS outlined the challenges TYA with cancer have including emotional fragility, formation of self-identity etc. This is a unique group with a unique spectrum of cancer types, there are also issues with this group presenting with different biology in their cancers and increased heredity cancer issues. There's a focus on research and increasing the number of patients in clinical trials.

Survival rates are not showing improvements as some are in adult groups.

There are complex needs for this group of patients – psychosocial care, a holistic approach, fertility, environment, advocacy, patient and public involvement, survivorship & transition and end of life.

Outreach staff are used across the network so that they can access the same level of support across the North West. Young people can often fall between the paediatric / adult gap – this is particularly relevant in palliative care.

The Christie TYA service focusses on turning fragility into a resource. The bespoke service at The Christie is aligned to national policy to provide optimum clinical care and experience.

HS outlined the geographical spread of the patients across the region and the outreach service that supports those who live in the furthest parts of this region. HS outlined the TYA MDT where all patients are considered and discussed.

HS showed some examples of the environment the young people have when they come in including the rooms, family rooms, music room, common room and kitchen as well as the wide variety of staff that support the service.

AC outlined the issues around establishing a TYA NW Operational Delivery Network. This is hosted by the Christie and brings together 2 TYA PTCs, 15 regional DHs, cancer alliances, commissioners, clinicians, research networks etc.

The network is looking at training, service configurations, arrangements for joint care, access to trials etc.

Patients have access to the ambulatory care service. Innovative ways to deliver care really benefit these patients. This promotes independence and normality, encourages peer support and gives them choice and control.

The ambulatory care model reduces time spent in hospital and improves patient experience significantly. The new 4 bedded unit next to the ambulatory care unit will create more flexibility.

AC outlined the need to provide holistic support to these patients and the implementation of a tool to assess how a patient wants to be treated and supported throughout their cancer journey.

Psychological care is being prioritised to this group of patients but there is a gap for the 16/17 year olds and the neuro patients. Development of a more robust service is very important to our patients. A business case for a TYA psychologist has been approved by CFC.

Peer support interactions are very important for this group and there are online support services that have been put in place during covid. There is also a Young Voices Network that involves the patients in service developments and improvements.

There is a piece of work around transition to adult services and survivorship to support them in these aspects.

AC talked about the barriers to clinical trials recruitment for this group – all patients are now discussed for suitability for a trial here or at Manchester Foundation Trust and wider region. The team are looking to enhance the portfolio of trials for this group. Examples of TYA education events were outlined.

Nursing / Allied Health Professional staff development was outlined and the focus of engaging with national policy & research groups to develop TYA services on a national level. The objectives for the next 5 years were outlined.

CO thanked AC and HS for their presentation and the fantastic service provided.

RA asked about whether patients having psychology support at MFT will be a problem. AC noted that this is an SLA with Royal Manchester Children's Hospital, but the service will be delivered at The Christie.

KR noted that the presentation was inspiring and asked why diagnosis is difficult / delayed. AC noted that GPs don't think of cancer as a first thought in children. We continue to work with GPs in raising awareness of cancer as a diagnosis.

Item		Action
21/21	**Standard business**	
a	**Apologies**	
	Prof Kieran Walshe (KW), Non-executive Director	
b	**Declarations of Interest**	
	No declarations of interest received	
c	**Minutes of the previous meeting – 27th May 2021**	
	Minutes accepted as a correct record.	
d	**Action plan rolling programme, action log & matters arising**	

	All items from the rolling programme are noted as on the agenda.	
22/21	**Reports**	
a	**Chief executive's report**	
	RS drew attention to the following items in his report; The Trust situation report, we remain in Trust escalation level 1 which is normal business with covid adjustments. There is an impact on staff absence, approximately 50 are absent currently due to the increased prevalence of covid in the community. We have a small number of patients on treatment who are affected by covid. In the rest of the acute hospital system there is a lot of pressure from acute work. There have been some developments for the requirement of a TYA network. We've gone through a process of hosting the NW network at The Christie. One of our clinical oncologists, Ganesh Radhakrishna was awarded a COVID-19 Outstanding Contribution Award for contributing huge amounts of time and making rapid decisions allowing the Royal College of Radiologists to provide continued high-quality online CPD support in an uncertain environment. There is also additional information relating to the development of ICS's. CO congratulated those receiving long service awards and to Ganesh.	
b	**Integrated performance, quality & finance report**	
	BD outlined the key points from the report for month 2. There were no SI incidents, no Never Events, 7 moderate incidents, 1 of which was StEISS reportable relating to a patient fall resulting in a fracture. There are 7 Corporate risks at 15+, 1 corporate risk at 20 (digital risk relating to the approved business case for a data centre), 2 risks at 16 and 4 risks at 15. There is a new risk relating to the leavers process and access to information when staff retain their NHS.net email address and a task & finish group has been established to deal with this. There were no cases of MRSA bacteraemia and 4 cases of CDiff, none due to lapses in care. There's a regional increase in CDiff due to increased antibiotic prescribing as a result of the pandemic. There have been 3 cases of E-Coli post 48 hours and no Covid nosocomial infections. 7 new complaints were received in month, 28 PALS contacts, 2 inquest requests and 2 new clinical negligence claims. In terms of the waiting time standards they have improved in month in many cases; ➢ 18 Weeks is at 99.4% ➢ 62 day performance is 85.2% ➢ 24 day performance is 86.8% ➢ 31 day performance is 99% ➢ 104 day waiters has increased to 11 – these have been referred in to us late in the pathway. There were no cancelled operations in month and referrals have been within the predicted range. New appointments are still slightly under 2019/20 levels. Other activity is in line with the recovery plan. BD showed graphs relating to month 1 activity – predicting to be at 70% of	

	2019/20 levels of activity. All activity is above the predicted levels apart from SACT. Sickness is at 3.41% excluding covid and 4.35% including covid. This is a rising trend. PDR's are at 85.5% compliance and essential training compliance is at 89.3%. There is a consistent improvement with these measures. Finance; ➢ Surplus £782k against H1 (months 1-6) plan ➢ EBITDA surplus £8.646m ➢ I&E surplus £3.069m ➢ Cash balance £140,657k ➢ Debtor days of 14 ➢ Capital expenditure at 93.4% against the revised NHSI plan Questions were invited. CO noted the improvement in the waiting standards and thanked the team for these improvements. BD noted this must be sustained. NL noted the great results this month. NL asked about risks. BD noted that staff absence as a result of covid is the risk as we are seeing a rise in staff absence. This is being managed on a daily basis. SACT delivery is on track and activity is being managed. Surgery are confident they can deliver their plan. It's a constant challenge to manage the waiting standards.	
23/21	**Other Reports**	
a	**Workforce quarterly report**	
	EL updated Board on the progress with the Christie People Plan. We are setting a longer-term approach to remote working and policy & guidance have been established and teams are discussing this. This is a voluntary process. This is to balance the service needs and will be a blended approach. Divisional managers have been doing targeted work on wellbeing conversations as part of PDRs. There's an overview of the staff survey comments that are being worked through to enhance the action plan. There are more positive comments than negative. A Grand Round was undertaken around the staff survey and issues in estates to show what we have done in response to the feedback received. EL passed over to LS to talk about the Wellbeing Guardian role. The role of the wellbeing guardian is championed in the NHS People Plan, this is one of the priorities around employee support. The wellbeing guardians have a role to play around the recovery post pandemic as well as culture change. TK has taken on this role. TK noted the great support that LS provides. The Guardian is about caring for those who care for others. It's really important that there's the right information that can be fed through to help champion diversity, inclusion and ensuring the Board take wellbeing seriously. This is about championing this with the Board. An overview of the work was outlined by LS. TK has attended the Healthy Workplace Steering Group, spoken to the FTSU team, a role descriptor has been developed and we are tapping into the national steering group. The 9 board principles were outlined, a diagnostic of these will be undertaken. TK noted that we want to do a few things really well to enable buy in for further development. We are at an early stage and there's lots to do.	

	CO thanked everyone for their support and to TK for taking this role on. She noted that it is the whole Boards responsibility to support staff wellbeing. This is an operational responsibility that is being championed. RS noted that LS and the workforce team have delivered a lot that makes a difference to staff.	
b	**Digital update report**	
	CH introduced the item and welcomed EJ and SH. CH noted that this is an area of challenge in the Trust at the moment, in terms of completing an existing strategy and developing and approving a new one. Historical systems require updating and clinical engagement is particularly important and needs addressing. Lots of good things are happening but the challenges are very real. SH noted that the report provides an update on the current work and development of the strategy. EJ noted the challenges with cyber and digital delivery. SH noted the summary position, it's been a very challenging last 16 months as essential teams have not been on site. Digital enablement projects have been impacted, the report summarises some of the key aspects of work that have been completed. Big projects are underway to update systems including the move to Windows 365, e-Rostering, single sign on etc. Digital strategy – work started in 2019 and was progressed until Covid hit which required things to change rapidly. We are in a very different place post-pandemic and a refresh is now planned for the strategy development over the summer. SH noted the requirement to update the digital health record. EJ noted the worry that cyber threats present and the early alerts we are given around weaknesses in our systems. There is a need to patch systems at pace to ensure systems are secure and safe. Cyber security is everyone's responsibility and staff need to be aware. Electronic health record – looking to shape and change the record to show history and patient pathway. There's great AHP and nursing engagement to shape how this will look going forward. Looking to broaden this to medical teams with the support of Dr Fabio Gomes as outcomes medical lead. Order comms is the focus for the year going forward. This will modernise the Electronic Health Record to enable better use of this resource. This is an area that will require a lot of clinical engagement to develop new systems. There is a lot of continued work around data and data analytics working with NHSx on a number of projects. An Implementation Team has been put in place to help the delivery and training of new forms and system changes to CWP. Show and tells have been successful and digital education is in place for nurses. CNIO regional network has been established. Electronic prescribing and management of content Boards are being formed. Clinical engagement and the shape of the workforce in the future are being looked at. Virtual clinic and MDT reform are being addressed. We must continue to modernise to keep us safe from Cyber-attacks. CO thanked EJ and SH for their presentation. CH stressed the issue of clinical engagement and the challenge in building the confidence of clinical medical staff in the development of digital services. JY echoed this and noted SH's work to engage nurses and provide leadership even	

	though there are still challenges. Senior clinical engagement is really important. TK asked about cyber security and what national support there is. EJ noted that there is some central investment and this is very complex, there is a business continuity plan we can fall back on. We do stop most attacks and are reasonably secure to be ready for most things. EJ noted the importance of training staff to spot malware. We have good patching processes and we do have exercises to test our practice. JM noted the clinical leadership and asked what the plan is around future recruitment of clinicians. EJ noted that we have Fabio but are looking at further appointments. NB noted that the medical side need to do what's been done in nursing to enable clinicians to do their job in an easier way. RS noted the great work and stressed clinical leadership is a recurrent issue that Board will want to see more of going forward with some empirical data on what clinicians want from digital enablement. EJ agreed that this must be done with medical staff and agreed to undertake an engagement exercise for digital services.	**EJ/SH**
24/21	**Approvals**	
a	**Annual report, financial statements and quality accounts**	
	This was approved at the Joint meeting of the Audit & Quality Committees. This is noted by Board and approved.	
b	**Draft Trust Sustainable Development Management Plan 2021 - 2024**	
	JF introduced the draft sustainable management plan 2021-24. This is a requirement as part of the standard NHS contract. This has been through the Management Board and shared with the Governors. We have had feedback asking about how much this will cost. Each business case that comes up will be assessed against the plan. SK presented this and noted that we need the plan to focus on net zero NHS carbon emissions. The CQC require this as part of their well led review. We have already approved the move to the energy centre, approval of the plan does not commit us to any specific costs but means that we will consider future business cases against this plan to ensure we are doing what we can. RA asked if we are ahead of where we need to be with progress against the requirements. The commitments in here require money, pleased that any developments will be based on a business case, and asked if any of these commitments do incur a cost then have business cases been done. SK responded that this updates an existing plan, we are about on the curve but behind some other Trusts. Our Green Travel Plan is ahead of others. SK noted that with asset replacement of vehicles is part of existing budgets. RS stressed that there is a regulatory requirement to have a sustainable development plan. JF noted that this is part of the standard contract and everything will be subject to a business case if it is required. The plan was approved.	
25/21	**Board assurance**	
a	**Board assurance framework 2021/22**	

	RS noted the updated BAF for 2021/22 that reflects the risk to the achievement of corporate objectives. No changes were suggested at month 2.	
b	**Audit Committee report**	
	The report was noted.	
c	**Quality assurance committee report**	
	The report was noted.	
d	**Joint Audit & Quality Assurance Committee report**	
	The report was noted.	
26/21	**Any other business**	
	No items raised.	

NHS
The Christie
NHS Foundation Trust

Public meeting of the Board of Directors
Thursday 30th September 2021 at 12.45 pm
By virtual means

Present: Chair: Chris Outram (CO), Chairman
Dr Jane Maher (JM), Non-executive Director
Robert Ainsworth (RA), Non-executive Director
Neil Large (NL), Non-executive Director
Kathryn Riddle (KR), Non-executive Director
Tarun Kapur (TK), Non-executive Director
Prof Kieran Walshe (KW), Non-executive Director
Grenville Page (GP), Non-executive Director
Roger Spencer (RS), Chief Executive
Bernie Delahoyde (BD), Chief Operating Officer
Eve Lightfoot (EL), Director of Workforce
Prof Chris Harrison (CJH), Executive Medical Director (strategy)
Sally Parkinson (SP), Interim Executive Director of Finance
Prof Janelle Yorke (JY), Executive Chief Nurse
Dr Neil Bayman (NB), Executive Medical Director

In attendance: Matt Bilney (MB), Staff Governor, Nursing
Janet Morley, Public Governor, Manchester
Sam Vickerman, Public Governor, Tameside & Glossop
Trish Murray, Matron Ward 4
Zoe Price, Matron Ward 12
Jo Darcy, Assistant Company Secretary

Minutes: Louise Westcott (LW), Company Secretary

Clinical presentation: Hub & mutual aid at The Christie (collaboration & partnership), Mr Chelliah Selvasekar (CS)

CS introduced the presentation. The 1st case of covid was reported in January 2020. The pandemic was then declared in March 2020. This has been a catalyst for innovation examples being virtual clinics, working from home, less paper etc.

Hub activity – the GM cancer hub was established with 2 'green' sites for surgery to deal with priority patients, these were The Christie and Rochdale. NHSE produced prioritisation. Two surgical leads were appointed, Mr Dominic Slade and Miss Sarah O'Dwyer.

Focus was on patient safety & governance. There was a focus on the whole patient pathway and there has been excellent staff engagement. The Rochdale hub dealt with plastics cases so that The Christie site could do priority cancer work. MCHFT (Leighton) and WWL were the primary users of the Hub.

Success was around collaboration with other providers and the independent sector ensuring equity of care. Challenges included workforce issues, particularly anaesthetic support. We have built this support internally to enable us to be self-sufficient. There has been constant change in guidance, move to virtual meetings, communication has changed and visitors were not allowed on site, instead staff were supporting patients and we have 'virtual' visitors.

The NHS has adapted to change very well and rapidly.

Achievements include the collaboration across GM and the infrastructure of the Christie as an elective specialist hospital with level 3 CCU. Biosecurity measures were very effective including weekly PCR testing of staff, masks, social distancing etc. Day of surgery admissions was very successful as were the virtual clinics. Patient safety has not been compromised. The Hub is a big success in terms of mutual aid, the administrative processes in place and minimal clinician involvement.

Mutual aid fits with the ICS development. Our surgical services were outlined including Pelvic oncology, urology with MFT, gynaecological oncology delivered as a 2 site service, colorectal with The Christie as the largest unit. To deliver this specialist work, we now have 9 surgeons, 2 of whom were appointed during the pandemic. In terms of Plastics a collaboration with the Northern Care Alliance (NCA) and Macclesfield is being looked at.

Mutual aid activity is still limited but continues to be developed. Collaboration and partnership in a Hub & Spoke model will continue to develop.

Questions were invited.

RA asked if the team would have done anything differently if it was done again. CS responded that it would have been great if more hospitals were sending patients to the Hub. We have new theatres which has given us more capacity. Communication could have been better with clinicians. Over we feel we did very well.

NB congratulated the surgical team for the work and noted that the GM Hub is held in very high regard nationally. He asked why CS thinks this has worked in GM. CS noted that the personalities here have enabled it to work as well as the reputation of the Christie regionally. Surgical specialities need to be seen outside of the Christie to increase the reputation and trust.

JM noted that the relationships make it work and asked that in relation to diagnostics and imaging will this be an opportunity. She asked if the surgical teams go with the surgeons to other sites. CS noted that there is opportunity with diagnostics and relationships are being worked on in the new collaborative world. We can provide a leadership role to provide equity of care – a new mindset is needed.

GP asked what the priority areas are for building and areas we haven't yet worked on. CS noted that mutual aid allows opportunity for anything to do with cancer in GM and beyond. We must work with the 13 providers, this isn't new but we need to do more. GM Cancer is there to help us work together as a group.

CO noted that the pandemic has helped with collaboration. CH added that for the first time we are in a position where other Trusts are saying that we are part of the solution, this is a real positive.

Item		Action
27/21	**Standard business**	
a	**Apologies**	
	Apologies were received from Fiona Blackhall. CO welcomed Grenville Page as a new non-executive director. Congratulations to BD and NB in their substantive roles on the Board. Welcome to SP in her role as interim director of finance.	
b	**Declarations of Interest**	
	No declarations of interest received	
c	**Minutes of the previous meeting – 24th June 2021**	
	Minutes accepted as a correct record.	

d	**Action plan rolling programme, action log & matters arising**	
	All items from the rolling programme are noted as on the agenda.	
28/21	**Key Reports**	
a	**Chief executive's report**	
	RS highlighted the following items from his report; Colleagues were reminded about the summary relating to the Covid pandemic situation report. We have some covid positive patients in our care and are continuing with the normal service delivery activities. Activity levels are broadly at normal levels. We have had the approvals from Parliament for the Annual Report & Accounts and the Annual Members Meeting date is now set for 3rd November. The anti-bribery strategy is appended to the report and Board are asked to see and note this as a statutory requirement. RS noted the capital projects that are ongoing, they all continue on plan and within budget. This is very good news in light of the ongoing issues nationally with workforce and supply. ICS activity in GM was noted. Statutory changes will come in at the end of the financial year, the GM ICS has formed in shadow form and will be set up 1st October. We have received guidance on H2 planning today. This comes in to place from tomorrow. CO invited questions. TK asked how staff are coping with the changes to the car parking. RS noted that we haven't had the significant pressures that were anticipated due to the increase in staff working from home and our ability to move our other car parking provision around. Things have gone better than expected. We will get some of the new spaces from the end of December which is much earlier than planned. The neighbourhood forum has been dealing with some concerns.	
b	**Integrated performance, quality & finance report**	
	BD outlined the key points from the report for month 5. **Safe** • There were 7 moderate incidents reported in August (3 StEIS reportable). All 7 moderate incidents are still progressing through to full root cause analysis. No never events or serious incidents were reported in month. • There are 7 Trust level risks scored at 15+. One new corporate risk has been identified from last month relating to finance. The Digital risk around the data centre has reduced from 20 to 16. **Responsive** • The 62 day cancer waiting time standard has not been met in August. Our position subject to validation is 81.8%. Within that performance we also failed to meet the internal 24 day standard with 83.6%. The large majority of the breaches are shared breaches due to missing the internal target of 24 days. All 62 & 24 day breaches are reviewed to ensure delays are understood. The number of patients waiting over 104 days as at the end of the month continues to be low and has remained below pre-covid levels. Performance against the CWT thresholds is constantly monitored. 31 days is 99.7%.	

- Referrals in August are back at levels consistent with 2019/20.
- Activity levels in most aspects are above GM recovery plans and in some areas back to 2019/20 levels. New attendances are behind 2019/20. Outpatient follow ups are above 2019/20 levels whilst surgical operations and radiotherapy fractions remain behind 2019/20 levels. Plastics referrals are under plan.
- Length of stay has increased a little in month.

Effective

- There have been no cases of MRSA bacteraemia. There have been 5 C-Difficile cases attributable to the trust in month with no lapses in care identified.
- There was 1 hospital acquired nosocomial Covid-19 infection in month. There was an outbreak in month on ward 12.
- Sickness has increased in August. 3.76% excluding covid, 6.51% with covid.
- PDR compliance is at 80.1%, essential training is at 88.2%. lots of work going on to improve these areas.

Well – Led

- The trust position as at month 5 is a surplus of £1.302m against an agreed nil balance control total for H1 which reflects the new GM financial arrangements in place for M1-6.
- The month 5 I&E surplus is £7.587m, prior to adjusting for donated depreciation, charitably funded capital donations and impairments.
- The cash balance is £158,327k
- The trust is showing a Capital underspend at month 5 of £3,378K, which equates to 8.5% underperformance against the NHSEI plan. This underspend is driven mainly by underspends on the Paterson project and Macclesfield and is expected to be recovered to a breakeven position in the coming months.
- CIP has been achieved non-recurrently.

Questions were invited.

RA asked about the PDR compliance and what the plans are. BD responded that the service areas are focusing on this as this is also an opportunity to have wellbeing conversations with staff. There is a focus and we are seeing an improvement in the figures.

NL asked about the headcount and establishment and why there was a big increase. EL noted that this was around us adding in budget to cover posts at risk that were added to the funded posts.

JY noted that PDRs have been spoken about with ward sisters and matrons and they are having regular wellbeing conversations with staff, these conversations need to be identified in the recording of the PDRs on the system. There is a more flexible approach and ongoing wellbeing conversations. EL noted that the HR partners are supporting the areas with low compliance.

GP asked about the number of falls being above acceptable levels. BD noted that these are all reviewed, there is no clear connection with these. There have been thematic reviews undertaken, there is no common thread, many are unwitnessed when patients get out of bed. MB added that these are monitored per 1000 bed days to take out any impact of activity. Our levels are very low comparatively. We have many safeguards in place.

29/21	**Other Reports**	
a	**Strategic Planning**	
	SP and NB presented a set of slides. Strategic planning approach described. NB outlined the headlines of the major clinical strategies broken down into their service development, R&I and partnerships. Radiotherapy was outlined, a steering group has been implemented, new planning, funding of DIBH, level 3 SABR roll out. SACT strategy was outlined including an increase in capacity, further development of care closer to home, outreach research at other sites. Partnership with Bolton (20+ chairs). Surgical strategy includes new theatres, change in scheduling, expanded workforce, mutual aid work. SP outlined the GM approach – our strategies sit within the GM system. The GM Cancer Alliance (hosted by The Christie), the GM Provider Collaborative infrastructure with groups for the executive directors across GM. GM new pathway boards have aspirations to increase their responsibilities considerably. Disease groups and pathways – we have to align our strategies with the new GM structure. We need to think strategically about how we plan our strategy across the full patient pathway. We need to have a view across the whole patient journey. The process of engagement was described including a period to review proposals. Board will be updated at the away days in November and February. Strategic financial planning was described. In H1 we had a block contract with an efficiency factor. There was a breakeven expectation. Elective Recovery Fund revenue funding is available for restoration/recovery work. Capital limit for GM ICS has significantly limited capital plans to ‘contractually committed’ and backlog only. Accelerated capital – each NHS Trust in GM identified projects to create more capacity. We have put forward 3 proposals. We expect the planning guidance for H2 to be similar to H1. SP outlined the challenges beyond 2022/23. We expect to continue with a block contract and a continued requirement for efficiency improvements and for the capital limit to continue on an ICS basis. Mitigating action includes a review of the group structure. CO noted the complex situation we are in. Questions were invited. RS added that the efficiency requirement in H1 was delivered through non-recurrent means due to vacancies. There has not been an active approach to keep vacancies in order to deliver efficiency. We have been actively trying to recruit in H1. KW asked whether block contracts are volume related – does this mean the national tariff doesn’t exist anymore. SP responded that the block contract will be fixed to cover fixed costs and there is also a variable element to cover risk and over performance – this is a blended approach. Tariff is redundant but we haven’t completely moved away from this, we are still working out tariff. KW asked how ICS capital limits are set. SP responded that they come down from treasury, there was a lot of adjustment in year. There is consultation about how these limits get moved about in the ICS. SP confirmed that we can’t make a capital to revenue transfer although there are some grey areas in the Trust.	

	Treasury make these transfers. GP asked what the timeframe is around exploring models for the group structure and expert advice. SP responded that we must look at this now as a matter of urgency. CO noted that we will look at this more when we meet in November.	
30/21	**Approvals**	
a	**Compliance with NICE Safe Staffing Guidelines**	
	JY presented the report. This is the 6 monthly report, our reporting continued throughout the pandemic but wasn't required to be centrally submitted. The key messages include challenges with provision of services but we continue to provide safe staffing across the Trust in this period. Staffing is constantly monitored across the whole Trust to ensure safe staffing by moving staff around. There is lots of innovation including the recruitment of Healthcare Assistants that are employed to work flexibly across the wards, some have now joined particular wards. The nursing establishments have been increased across the Trust, this also increases our vacancies. We must train and skill our new staff and allow time for this. There is a focus on nurturing new starters and appointing senior staff. There is an increase in practice nurse educators to support orientation of the new staff. Questions were invited. KR noted 'fatigue', 'anxiety' and 'challenge' are recurrent themes. JY agreed that we continue to focus on supporting our staff and this reflects some really difficult shifts. We are looking at different ways of working to take some of the pressure off our nurses. JM asked if we feel we are doing enough to retain senior staff. JY noted that we have amazing senior sisters, some of which are looking to start MSC's. We aren't losing senior staff, we are seeing some being promoted. We are focusing on improving things. EL noted that we have a lot of wellbeing support and focus on recruitment and retention. We also focus on turnover. More detail will come to the next Board in the workforce report. MB noted that the feelings expressed around fatigue and anxiety is not unique to The Christie and is much worse in some other Trusts. He noted that it is amazing to know that we can recruit more staff, this is really good for the nurses' morale. Additional nurse educators to deliver training to new staff is excellent. CO noted that the more we introduce new areas to the site the more there is a contrast with the older buildings. We must look at our estates' strategy and the capital limits and consider the ward areas in this.	
b	**Emergency Preparedness, Resilience and Response assurance process**	
	BD presented the report that shows the self-assessment against the requirements. This is an annual requirement. There are 35 standards, we are partially compliant for 3 standards. There has been a deep dive on oxygen this year, we were compliant against 4 and partially compliant against 3 standards relating to oxygen. BD outlined the work that's needed to become compliant and noted that this report will go through assurance committees in future. The Board is requested to confirm that the Accountable Emergency Officer may declare **substantial** compliance with the EPRR core standards. Confirmed.	

31/21	**Board assurance**	
a	**Audit Committee report**	
	NL noted the assurance received around digital and IG.	
b	**Quality assurance committee report**	
	KW noted the report. EL noted that the QAC signed of the WRES and WDES for submission onto the national system and our website. Report noted.	
c	**Board assurance framework 2021/22**	
	RS noted the updated BAF for 2021/22 that reflects the risk to the achievement of corporate objectives. Updates were noted and the changes were highlighted. No changes were suggested at month 5. GP commented that most of the risk scores have target risk scores that are much lower than the current risk score. RS noted that this is the target score for year end.	
32/21	**Any other business**	
	No items raised.	

NHS
The Christie
NHS Foundation Trust

Public meeting of the Board of Directors
Thursday 28th October 2021 at 12.45 pm
By virtual means

Present: Chair: Chris Outram (CO), Chairman
Dr Jane Maher (JM), Non-executive Director
Robert Ainsworth (RA), Non-executive Director
Neil Large (NL), Non-executive Director
Tarun Kapur (TK), Non-executive Director
Prof Kieran Walshe (KW), Non-executive Director
Grenville Page (GP), Non-executive Director
Alveena Malik (AM), Non-executive Director
Roger Spencer (RS), Chief Executive
Bernie Delahoyde (BD), Chief Operating Officer
Eve Lightfoot (EL), Director of Workforce
Prof Chris Harrison (CJH), Medical Director and Deputy CEO
Prof Janelle Yorke (JY), Executive Chief Nurse
Dr Neil Bayman (NB), Executive Medical Director
Fiona Blackhall (FB), Director of Research
Karen Holdship (KH), Assistant Director of Finance – Costing & Efficiency
Sue Mahjoob (SM), Freedom to Speak Up Guardian

In attendance: Matt Bilney (MB), Staff Governor, Deputy Divisional Head of Nursing
Janet Morley (JM), Public Governor, Manchester
Sam Vickerman (SV), Public Governor, Tameside and Glossop

Minutes: Jo D'Arcy (JD), Assistant Company Secretary

Clinical presentation: Visit to inpatient wards, Matt Bilney (MB), Deputy Divisional Head of Nursing

CO welcomed MB to the meeting and congratulated MB and the team on the recent CQC inpatient survey and the fantastic results achieved.

MB introduced himself to the Board and began the presentation from Ward 2. There have been some recent changes made to bed numbers, wards have been repurposed and social distancing remains on wards. Ward 2 was repurposed 12 months ago. MB introduced a colleague, Linda, to the Board who has worked at the Trust for a number of years. CO thanked Linda and the team on the excellent results from the recent CQC survey. Linda commented that the patients are the main priority and it was fantastic to get the results.

CO asked Linda what it is like at the moment on the ward. Linda stated they try to normalise as much as possible for the patients. The team all work together and any concerns are raised straight away. Some patients are apprehensive, and they are well looked after.

The Sister in charge, Charlotte, joined the call. CO welcomed Charlotte to the meeting. Charlotte informed the Board that patients may stay overnight on the ward and some stay for up to a week, patients are naturally nervous but once they get to know the staff they are more reassured. Extra training is currently ongoing on the ward. The recent changes have been really good for everyone.

CO asked how it is for patients with not being allowed to bring visitors. Charlotte confirmed that people are understanding of the situation, the medical wards have struggled but they have got iPads on the wards so patients can communicate remotely.

Charlotte confirmed that she had mentioned the visit to some of the patients and has a patient who would be happy to share some comments with the Board. The patient shared his experience of Ward 2, and stated he only had positive comments to give especially compared to other hospital wards in his home town, there is a lot more space, it is safer to walk around and the staff are extremely knowledgeable, overall it is a very nice experience.

CO asked in relation to not being able to have any visitors or bring people with you to the Trust, how did the patient find that. The patient stated that he feels safer knowing the wards are not going to be packed with visitors, and he is able to make phone calls while at the Trust and has quickly built up a rapport with the staff so now looks forward to coming in. It is difficult being away from the family but the visit is made pleasant and you don't feel lonely. He also thinks that other patients feel the same. He commented that Ward 2 is very specialised compared to other wards.

CO asked if there was any message that the Trust need to think about that it could do better at. The patient said he genuinely couldn't think of anything, it is nice having access to a Doctor all the time although may not always be the same one so this maybe something for more consistency but the experience is always so positive there is no constructive feedback to give. CO thanked the patient for the feedback and wished him good luck.

Passed back to MB who moved on to present from Ward 4.
MB stated that there are challenges regarding staffing but these are being met with additional budget to support new roles. The CODE accreditation is still continuing for all ward areas, which is a programme of 14 quality standards with hundreds of things measured within the standards. There is a strict criteria and differing levels of accreditation.

MB introduced Becky, who is a Clinical Practice Facilitator. Becky gave an overview of her role; it is a supportive role for new starters and current nurses. We have recently had an influx of new starters and she is there to make them feel supported in their role. She gets in touch with them with details of the induction programme before they start, the induction is an 8 week supported package including pre-planned study days, clinical skills training and the provision of enough time on the ward to settle in. We also support in the practicing of clinical skills to enable them to achieve their competencies. Where any gaps are identified or training needs adapting, Becky would also do this. We are looking to get more CPFs across the wards. Becky introduced Jess, who is a new starter to share her experience. Jess informed the meeting that she started in post 2 weeks ago, spoke to Becky beforehand and was able to understand the role and expectation before starting, she gained an understanding as to how the role would work and has had great support from Becky. This is her first job as a newly qualified nurse. CO asked what Jess would do if Becky wasn't there. Jess confirmed there are always others around to provide support.

Another member of staff confirmed that they started on Ward 4 6 years ago as a HCA and since then has done a diploma and qualified as a TNA nurse associate. CO asked if the role was different. The staff member confirmed the role is massively different with a change in responsibility and that she is thoroughly enjoying the difference.

TK asked whether they had completed this training as part of an apprenticeship programme. The staff member confirmed that they had. CO asked whether they would recommend the apprenticeship programme. The staff member confirmed they would, stating that you learn better being on the job and the support from colleagues is invaluable. You also learn so much from the patients. It is a great route to go through even if not academically minded. You learn everything about the whole structure of the Trust.

MB stated that one challenge they have been faced with has been the transport of patients and introduced Zoe who has been working with St John's Ambulance since August to improve the process. Zoe confirmed that there is now dedicated St John's Ambulance transport for the Trust

on Wednesdays, Thursdays, & Fridays, the vast majority are end of life transfers and the change has been really successful. This also significantly increased patient flow and reduces costs. CO asked JY for any closing comments.

JY commented that the patients are so lucky to have such amazing staff and she can't thank the staff enough, especially over the last 18 months which have been really challenging. She noted that she feels very fortunate to have such fantastic staff, there is a great foundation with training and she thanked MB for all his dedicated work.

NB echoed JY's comments and picked up on the comments from the patient on ward 2 and confirmed that this has been recognised as an issue that the Trust are challenged with on the continuity when seeing a Doctor. This is currently being worked on as an area to improve on and is being led by Mike Leahy.

CO thanked MB and all the members of staff who participated.

Item		Action
33/21	**Standard business**	
a	**Apologies**	
	Apologies were received from Kathryn Riddle, non-executive director, Sally Parkinson, Interim Director of Finance & Louise Westcott, Company Secretary	
b	**Declarations of Interest**	
	No declarations of interest noted.	
c	**Minutes of the previous meeting – 30th September 2021**	
	Minutes accepted as a correct record.	
d	**Action plan rolling programme, action log & matters arising**	
	All items from the rolling programme are noted as on the agenda.	
34/21	**Key Reports**	
a	**Chief executive's report**	
	RS highlighted the following items from his report; The Trust remains at escalation level 2 and the situation is the same as reported in previous months. The number of patients affected with covid is stable as are the staff numbers. The Trust continues to implement plans for the sustained delivery of its services going forward as well as supporting the full recovery of cancer services together with other care providers in the Greater Manchester (GM) system. The GM system is under significant pressure with acute activity with covid as one of the contributing factors. Winter planning is being escalated across the system, an example of the pressure is the delays occurring within the North West Ambulance service. The Trust has once again received excellent results from the CQC inpatient survey, which is undertaken independently by the CQC. The results have just been released. More detail is provided in the paper and the results are outstanding, which have come directly from our patients. This is testament to the incredible hard work and excellence of our staff, particularly our ward nurse	

	leaders. Item 6 of the report relates to a CQC visit made on the 19th October to the Trust laboratories. The CQC clarified that the inspection is part of their new methodology and medical laboratory framework and was not triggered by any concerns. Sections 9 and 10 provide detail about some awards recently won by staff groups. Colleagues from radiotherapy education, the PBT service and the digital team have won the Creative Provision of Practice Placements award. Christie staff were also amongst more than 115 people nationally to have won the 'cancer team of the year" at the BMJ awards. RS invited questions. NL asked if the CQC visit was an announced or unannounced visit. RS confirmed it was an unannounced visit. We have regular catch up meetings with the liaison person at the CQC who confirmed the visits were done unannounced to see what they could learn from that approach. JY added it was a planned inspection but an unannounced visit. We don't have any red flags for concerns with the CQC that would warrant an unannounced inspection, which has been confirmed by the CQC. No further comments or questions raised. CO thanked RS.	
b	**Integrated performance, quality & finance report**	
	BD outlined the key points from the report for month 5. **Safe** 1 SI incident, 0 Never Events, 9 moderate incidents (2 StEISS reportable). All incidents are going through the ERG process. 8 Corporate risk 15+, 1 new risk at 15, 5 risks at 16, 2 risks at 15 Further details in relation to the risks are provided in the Board papers. There is a need to improve on accessibility information standards and ensure patient requirements are recorded in the PAS system, there is a piece of work to do in relation to this. The staffing gaps are being worked through and the risk associated with this will be reduced to a 12 next month. The financial risk links to the required H2 planning. Stress assessments need to be reviewed and assessed on a regular basis, there is a need to enhance the Trust processes following an audit. **Effective** 0 cases MRSA bacteraemia, 1 case C.diff with no lapse in care, 1 case E-Coli post 48 hours, 4 Covid nosocomial infections. Full reviews following IPC investigation processes, the nosocomial infections related to an outbreak on Wards 11 and 12. **Responsive** 12 new complaints received in month, up slightly on last month. 55 PALS contacts, 5 Inquest requests and 2 new clinical negligence claims. Length of stay has improved to 6.79 days **Access** 18 Weeks 99.2%, 62 day performance 83.6%, 24 day performance 85.2%, 31 day performance 99.8%. We have 22 104 day waiters.	

	Referrals are within the predicted range and activity is in line with the recovery plan. The increase in waiters relates to patients coming to the Trust late in the pathway (after day 90). **Activity** New attendances are behind plan and we are doing some work on this which includes looking at some system coding issues and virtual appointments not pulling through. This will be updated for next month and backdated. SACT and radiotherapy are in line with the plan. Surgical electives are also behind plan, mainly due to plastics. Mutual aid arrangements are being stepped up to provide 10 theatre sessions for GM, which have started this month. We will be taking additional plastics referrals. PDR compliance is continuing to fall, this has been raised at service & operational reviews and weekly reporting on PDRs is now taking place. All PDRs are required to be reported through ESR which has been identified as an issue, putting in additional administration support to help with improving on this. Recruitment plans are in place to support wards and getting staff skilled up. Departments are presenting improvement plans at service & operational reviews. **Finance** Good financial position at the end of month 6: Surplus £1.476m against H1 plan, EBITDA surplus is £25.458m, I&E surplus is £8.8m, Cash balance is £161,878k and debtor days of 12. Capital expenditure is at 89.1% against the revised NHSI plan. CIP is achieved non recurrently due to underspends. BD invited questions. RA asked about the CIPs which are being funded non recurrently at the moment through staff savings which is not what we want to do and mentioned a couple of months ago that would be seeing the progress on recurrent CIPs in second part of the year, he asked for confirmation of this progress. BD confirmed have been working on this with operational groups and that this will be confirmed through next month's report. RA commented that in relation to the finance executive summary year to date (page 61) that it would also be useful to show year to date against budget. Referring to page 45 of the report and the 4 graphs, he asked why the graph relating to transfers length of stay is consistently higher than other length of stays. BD confirmed if transferring to another Trust and that Trust has bed pressures or patients are transferring with a package of care this can cause longer delays. GP asked about safe staffing; some wards are not achieving the 90% fill rate, such as the Acute Assessment Unit (AAU) at 62%, he asked what the triggers are when staffing levels aren't being met. BD confirmed that daily staffing meetings take place to discuss how to fill gaps, which involves looking at the dependencies on all units. JY added assurance by confirming that a formal bed meeting takes place every morning and one more time in the day to review discharges, shortages and surpluses. Sometimes these meetings happen 3 times a day to ensure safe staffing. GP referred back to the AAU figure and asked if there is any particular issue and if staff would be called in to cover.	

	JY stated that this could be related to sickness, staffing would be reviewed and moved on a shift by shift basis to ensure there is appropriate cover. CH added that this is a 7 day activity and Execs are also involved in the review. NL commented on the underlying position for the future, the Trust has invested heavily in the last 12 months on service. The workforce numbers have had an increase in establishment. He expressed concern that staff budgets increases have not been matched by spend. He would like to see CIP split as to how much has come from staff vacancies. CIP target will be quite significant next time. RS confirmed that the Trust is on the cusp of the H2 part of the planning, and that these are really important points raised by NL. In the H1 budgets the Trust were keen to put staffing costs in there although not all have been recruited to yet. We are doing a lot of work to be able to measure this through the H2 planning. NL commented that he is not concerned as to where we are, but that we must be clear on the underlying position for next year. EL added assurance on the recruitment of posts, 80 nurses have accepted offers and ae waiting to get into the system, will give further information in due course. No further comments or questions raised. Report **noted.**	
c	**Medical directors report - Research & Innovation update**	
	CH introduced the agenda item and gave an overview to new Board members and introduced FB. FB highlighted the following areas from the report: Time has been heavily focussed on funding renewals for major grants, circa £15m. These are significant pieces of work for demonstrating future innovation. The ECME grant has been deferred to next year. Many of the NHS facing clinical trials activity are commercially funded, internationally delivered and sponsored by a pharmaceutical company. Despite covid, these have performed extremely well and the Trust has been ranked in 6th position nationally on a number of studies set up during that period. We want to achieve better than national standards met to attract more pharma trials. Following on from an MoU signed with the Kenyan High Commission, The Christie and University of Manchester submitted an NIHR Global Health Research application with Kenyatta University Teaching, Referral & Research Hospital (KUTRRH). The partnership will be centred around education and scoping research opportunities. The University of Manchester submitted its Research Excellence Framework in March 2021, which included eight cancer specific research impact case studies. Of those 8, 6 were directly attributable to Christie academic researchers. An overview of the ground-breaking research examples from the report were provided to the Board. Dr Sarah Valpione is very creative and highly skilled. She has led a research team that made a ground-breaking discovery that is expected to have a significant impact on how personalised medicine is used to treat cancer patients in the future. They discovered that patterns of behaviour in the immune cells (T cells that help the body fight infections and diseases) can not only more accurately determine the patient's prognosis, but also which	

	immunotherapy drugs are likely to be most effective. In effect this means that by analysing a patient's T cells, clinicians can work out the chances of a patient responding to an immunotherapy treatment. We have recently identified pump priming funding to start the research. We are supporting Sarah locally and hoping to secure national funding in due course. The UK's first lung cancer patient was treated using the MR-Linac as part of the MOMENTUM trial in August 2021. This followed the first patient treated for cervical cancer in Feb 2021. Treatment via this method is not currently an NHS routed way of funding. Have research funding streams which will continue to support as there is real value for patients. There has been a lot of opportunities to reward staff through accolades; members of the Christie R&I Division and wider research community have been shortlisted for the NIHR CRN Greater Manchester's Evening of Excellence Awards. The pandemic has affected organisational structures across many cancer research organisations. CRUK is in the process of a 25% reduction in overhead, and this is common for many charity funders. Equally, funds available for the CRUK Major Centre, NIHR BRC and CRF will be challenging. While positive outcomes are expected from the applications, there is expected to be a pressure on a number of posts across R&I and the UoM as a result. Wes Dale and Prof Fiona Blackhall have been working with research teams across the trust to scenario plan and identify specific posts at risk in order to put in place mitigations. Staffing vacancies and pressures have led to a temporary reduction in the Clinical Trials Pharmacy workforce. Studies are being prioritised for set-up and opening, and staff recruitment and new staff training is underway, with additional posts agreed to provide more resilience in the coming year. Once the new Director of Pharmacy, Damian Childs is in post, R&I will work with pharmacy to future proof the service. FB opened out for any questions. JM asked in relation to real world evidence and if the Board has seen the final statement of intent. Also asked on risks noting the 2 urgent risks in relation to CRF and asked for further detail as they sound like they are significant. A further question in relation to the Manchester Clinical Trials Unit centre closing and whether this will have a significant impact. FB responded with regards to real world evidence that this is one research area with a future focus to increase and expand. There are grant renewals which include real world research as part of the strategy for the next 5 years. The data statement of intent is a statement of reassurance to patients on the use of data. Referencing to the CRF risks, related to the funding that will be secured from the bid, we have put in a bid that they are comfortable with. We have been awarded a good share compared to other sites and are just awaiting confirmation of the final award. The Manchester Clinical Trials Unit will close in 2 years, we have a plan to ensure current activities with the trials will be completed. Many trials are not delivered through the Manchester CTU, and where they are we will develop a strategy for an alternative. RS noted that it is really important to understand that where FB is explaining about the unit closing, it is not a clinical trial facility where patients attend as part of their treatment. RS reminded colleagues of the cancer revolution exhibition at the science museum, the details for which are in item 6 of the CEO report, the work of FB	

	and her colleagues feature in that exhibition. KW noted the report as being helpful, between now and Spring 22 he would like to know how things will be developed and how the Board will be cited. He didn't realise that the academic investment plan (AIP) is coming to an end, it would be good to do a review to realise the benefits and look at a potential round 2. FB thanked KW and noted that the strategy will be presented in draft early next year (end of January 2022) with the final strategy to be presented at the end of the financial year. We will be reflecting on the AIP and what it has led to, this is key. CH added on the AIP, the piece of work identified by KW is already underway. It is now important to move on and think differently. In terms of Board engagement, there is a need to take forward with clinicians and move forward with the clinical strategy. FB and NB are aware of the requirements. This will form part of a future Board Away Day. No further comments or questions raised. CO thanked FB. Report **noted.**	
35/21	**Other Reports**	
a	**Workforce quarterly report**	
	EL presented the paper with the quarterly update on the Christie People Plan and other key strategic workforce developments highlighting the following points: The first item raised was the review of the Trust workforce risk. Prior to the review, the workforce risk around staffing gaps was a 12. There has been a deterioration in workforce supply in particular within nursing and turnover has slightly increased. Added to increased sickness absence both covid and non covid related, the Workforce Committee has increased the risk score to a 16. It is anticipated that gaps will reduce as there is a healthy pipeline of new recruits coming through the recruitment process. There is also a number of work streams which are documented in the paper to improve recruitment and retention. In addition to this, a bid was submitted for some ERF funding for two new 6 month posts, one will focus on staff wellbeing to support the existing team and the other will support the recruitment team to help speed up the recruitment process. Both bids have been successful and recruitment has commenced. Appendix 2 provides a detailed report focusing on turnover. The paper shows that turnover has remained at around 14% throughout the year. The Trust are slightly higher than the average for specialist hospitals which sits at 12% and colleagues at the Clatterbridge and Marsden also sit at 12%. The highest leavers group are those in the Admin and Clerical staff group and the highest percentage of leavers have less than 1 years service and work at a band 5 level. Promotion indicates the main reason for staff leaving. TK asked what the percentage was on turnover, prior to the pandemic and Brexit. EL confirmed that it was about 12% and usually runs at this. In terms of exit interviews, the current response rate sits at 28% which is an improvement on last year, although this indicates a need to put some focused effort into the exit interview process to understand fully the reasons why staff are leaving. The feedback shows that staff feel happy with their work life balance and would be likely to work at The Christie again. Noted as an area of concern is that staff feel they are treated unequally by their manager and not offered	

	opportunity for promotion or development. A plan has been developed in line with one of the objectives of the Christie People Plan. The plan will focus on quality and quantity of exit interviews undertaken; it will also look at how the Trust engages with newly appointed staff in the first few months of their employment. JY has already started to do this with the new nursing recruits. There is a plan to look at career pathways and development opportunities which are currently in place but there may be a need to re-focus communications on this. This also aligns with the importance of staff PDRs which is known as a current issue. As administrative are the largest percentage of leavers, there also needs to be focus applied here as they are as integral to our service as our clinical teams. Section 5 of the paper provides an update on the Trusts Leadership Plan and whilst the pandemic did impact on the delivery of some of the plans we have still made significant progress. The Christie Leadership framework has been developed and is aligned to the new assessment tool used to recruit senior roles into the organisation. We have also continued to run the in-house leadership programme for bands 4-7 including taking some positive action to support development of the ethnically diverse workforce and have launched a bespoke Christie coaching programme to equip participants with a formal accreditation with a view to developing an in-house set of coaches to support the wider workforce. Appendix 4 provides a full review of our progress against the plan. The wellbeing of staff is a huge focus and EL noted the summary evaluation of the last quarter wellbeing support across the Trust. The Trust has signed the North West pledge for the wellbeing of NHS people and is planning to tailor the pledges to staff at The Christie. The Gender Pay gap report is a mandatory report. The average hourly pay difference between men and women has reduced to 13 pence per hour and is the smallest gap recorded. Focus remains around bonus payments with the gap between male and female being the highest. Bonus payments refer to Clinical Excellence Awards. An action plan is in place that has been approved by the EDI programme board to address the findings. EL passed over to SM to present the 6 monthly Freedom to Speak Up update. SM confirmed the number of contacts by quarter highlighting activity during the pandemic. Patterns appear to be reverting back to previous activity. 39% of cases relate to attitudes and behaviours and 22% related to policies, procedures and processes. One staff member reported detriment and will decide how to proceed following the outcome of a HR process and other review. We must be doing what we can as a Trust to encourage good working relationships. The Trust is focussing attention on attitudes and behaviours. October is FTSU month and the National Guardian's Office have asked all guardians to promote the national FTSU training. The Trust has decided to make module 1 of the training mandatory training for all staff. The further modules will be aimed at managers and senior managers. It will be difficult to quantify how much difference the training makes but is important in setting the culture and thanked the Executive team for their support with this. SM has recently presented at Management Board on FTSU and found it encouraging to hear the conversations it raises and shows the level of support within the Trust. SM is promoting all the routes that can be used for staff to speak up and developing a poster for display in departments. FTSU have been introduced, the listen to learn project is underway and we are collecting feedback which will go back through the EDI programme board.	

	Support for staff and managers involved in a FTSU concern will be enhanced, this is in its early stages. Triangulation of information with other metrics to identify action required early is being developed using a flow chart showing how the FTSU guardian, the union and workforce will all work together. The staff survey is currently being run, this will give an understanding of staff thinking in relation to FTSU. The FTSU index won't be published next year so won't be able to quantify the improvement made on the previous survey scores. SM opened out for any questions. RS added that SM came to Management Board, where there was the longest debate on the fantastic work being done by SM. Exemplary work, thanked SM. No further comments or questions raised. CO thanked SM and EL. Report **noted.**	
b	**Digital Service update**	
	CH presented the report noting that the purpose of the paper is to confirm formally to the Board the interim arrangements in place following the move of the previous CIO Eileen Jessop. The paper deals with internal management issues and is not the regular update to the Board, this will be presented in January. Executive level responsibility sits with CH who advised that there is a need to take stock before next appointing to the CIO role to ensure this is correct for the future. Digital enablement will become more crucial so there is a need to ensure robust leadership is in place. A process of engagement is currently being run and is being led by Mike Leahy and Wes Dale looking at the issues and how the role of the CIO will need to be positioned to link with clinical and operational divisions. CH added that it would be helpful if there is any NED who could contribute to support the engagement process. CH invited questions. CO thanked CH and agreed it is greatly important to take the time to source the right replacement. JM commented that it would be helpful to have an organisational chart of the people involved as it is a complex area. Also need to ensure PPI, ethical and consent processes are very clear early on with regards to use of data. CH agreed that this needs setting out and clarifying and that this will be done. RA stated that it would be helpful to understand the risks and specific problems and the mitigations in place in Digital Services. CH agreed and noted that this will be appropriately documented through the risk register. KW asked if the review will lead to a new plan, structure and leadership for the Digital team. CH responded that it will and that it is now time it is looked at again as things have moved on digitally since it last reviewed. No further comments or questions raised. CO thanked CH. Report **noted.**	

36/21	**Approvals**	
a	**Review of corporate objectives and Board assurance framework 2021/22**	
	RS updated about where the Trust are up to in terms of the corporate objectives and that there are scheduled dates to review further through the Board Time Outs. Updates to the BAF reflect discussions during the course of the last month. RS invited questions. GP asked about the current target scores for some risks but there are no gaps identified in the controls and would like to understand this more. It is not clear which risk scores are above the risk appetite. RS commented that the BAF relates to the delivery of the corporate objectives to the end of the current year. Arrangements will be made to discuss this further with GP to assist with understanding. Update and progress **noted.**	**LW**
b	**Audit Committee report**	
	NL commented on his leaving as Chair of the Audit Committee and as a NED and that this year there has been 6 pieces of work already completed with no irregularities reported. The letter of concern raised to the Board also resulted in no irregularities being identified. There are areas where improvements can be made but there is no substance to any allegations made. There is one outstanding piece of work relating to a procurement review. As Chair, there are no concerns to raise and he would be happy to return at any point in the future to support the Trust on that statement. No comments or questions raised. Report **noted.** CO expressed her gratitude to NL for the last 7 years, giving an overview from when he started at the Trust on an interim basis for 6 months. She thanked him for his dedication to the role as Audit Chair, a Non-Executive Director to the Board and as a personal support. RS added that NL has been a great support and expressed his personal thanks to him. NL thanked CO and RS for their comments and noted that he has enjoyed every moment.	
37/21	**Any other business**	
	No items raised.	

NHS
The Christie
NHS Foundation Trust

Public meeting of the Board of Directors
Thursday 25th November 2021 at 12.45 pm
By virtual means

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

In attendance: Cathy Heaven (CHv), Associate Director of Education
Jo D'Arcy, Assistant Company Secretary
Janet Morley, Public Governor, Manchester
Scott Davis, Public Governor, Salford
Mike Norcross, Public Governor, Cheshire
Patrick Flynn, Senior Clinical Scientist MUFT

Minutes: Louise Westcott (LW), Company Secretary

Clinical presentation: The Christie @ Macclesfield Cancer Centre

Bernie Delahoyde (BD), Chief Operating Officer
Stuart Keen (SK), Director of Capital & Estates
Catherine Fensom (CF), Operational Management Lead, The Christie @ Macclesfield
James McGovern (JMG), radiographer The Christie @ Macclesfield
Hannah Davenport (HD), Lead Chemotherapy Nurse / Unit manager
Aileen Gasco (AG), Chemotherapy Sister
Janet Parkinson (JP), Information and Support Manager
Dr Faye Sharple (FS), Consultant Haematologist

SK gave a tour of the external parts of the Christie @ Macclesfield cancer centre development. The project was costed at £26.5m and it remains within budget and was handed over in the specified timeframes. He outlined some of the challenges caused by the pandemic in terms of delays, especially in the early stages. He noted that there are solar panels that produce considerable amounts of power on the roof of the building. Vinci have been an excellent contractor and have contributed to the local area in a positive way whilst on the project.

BD introduced Catherine Fensom (CF) and noted that the unit has been designed around the patient requirements. CF noted that the design is a direct result of patient feedback, particularly in the waiting area where it has been kept light and spacious but with some semi open screens to break up the open area and provide some privacy.

JMG showed the cancer information centre and the radiotherapy facilities with the prep rooms, cannulation room, CT sim and changing areas etc. The office areas and clinic rooms were also

shown. Both linear accelerators at the centre are the same, images were shared with the meeting of the bunkers.

CF showed the Systemic Anti-Cancer Therapy (SACT) treatment area. There are 16 treatment chairs in bays of 4, each bay has artwork on the walls and there is the ability to create privacy around each chair.

BD and CF introduced some of the staff that will be running the centre. Introductions were made with HD, AG, JP and FS. Each member of the team introduced themselves and outlined their role in the centre. HD commented that it is an amazing space, very light and loads of privacy for chemotherapy patients.

CF noted that this will be a comprehensive cancer centre and will offer a range of cancer care including haematology.

CO noted the size and quality of the centre. KR noted that it really looks like The Christie and is fantastic. She asked if the corridors are wide enough for wheelchairs. CF responded that they have been made wide enough for hospital beds. JM noted that it a lovely building and asked if there is some space for staff to have downtime. BD responded that there is, this will be shown as the tour continues.

TK asked if there is a full induction planned. CF noted that this is being finished off at the moment, the staff have started to visit to familiarise themselves with the centre and there is a full induction planned.

CH linked the new facility with the health inequalities issues across GM & Cheshire, the unit provides excellent care to the Christie standard for the patients in this area in the same way that we do this in Oldham and Salford.

GP asked about local businesses and community interest. FS noted that there are GP teaching sessions planned linking treatment in local communities.

EL noted that different teams are being integrated from different organisations and this is supported by the HR team, efforts are being made to ensure the staff are connected.

CF noted that staff can link into training at the main site in the seminar room to get access to everything virtually, this has got better in the pandemic.

There is also a feel that the Macclesfield staff are a part of The Christie, they already have the Quality Mark and feel that connection with the Trust. The team also link in with the clinical skills team at The Christie.

JP added that they are looking at how the centre links with the main site, the staff do feel like they are part of The Christie, it’s a development and continuation of the existing links.

AM asked if there have been challenges in engaging the local community. CF responded that there have been some issues raised about parking and that there is a dedicated car park for radiotherapy and additional spaces at the centre. The local community have got behind this development very enthusiastically and there has been excellent support.

RS noted the strong historic link with Christie teams working on the Macclesfield site. This builds on a well-developed partnership that’s very successful. It also builds on our experience in Oldham and Salford. He also noted the importance of having Haematology services on this site.

RS added that there are car parking issues everywhere but one of the advantages to having this centre is around the miles saved on patient travel in having the care closer to home.

There has been incredible support from charity supporters in Macclesfield, including business partners and local people as well as support from local politicians and health commissioners who have supported the project.

KW asked how this feels for the East Cheshire Trust. CF responded that those employed by the Trust tend to live in the area and have had family & friends treated at The Christie and feel very strongly that this is a fantastic development for local people. It’s been very positive and really well received by the staff at East Cheshire.

KW asked whether there will be an opportunity for those who have donated to be part of the opening of the centre. RS responded that there is a plan to do this within the current restrictions.

BD noted that there will be an opportunity to provide detail on the benefits for patients through patient experience surveys etc. BD noted that this is in the business case requirements.

RF noted that the School of Oncology would be interested in the centre leading education sessions and that this will be explored.

Further facilities were shown including the research room, the physics room for planning, office space and the seminar room. This room will be used for health & wellbeing events, physiotherapy as well as staff training.

CO noted that it is great to see education and research codesigned into the centre.

CO thanked BD & SK and all the members of staff who participated for the tour and opportunity to see the fantastic new centre.

Item		Action
38/21	**Standard business**	
a	**Apologies**	
	Apologies were received from Fiona Blackhall (FB), Director of Research	
b	**Declarations of Interest**	
	No declarations of interest noted.	
c	**Minutes of the previous meeting – 28th October 2021**	
	The minutes were accepted as a correct record.	
d	**Action plan rolling programme, action log & matters arising**	
	All items from the rolling programme are noted on the agenda.	
39/21	**Key Reports**	
a	**Chief executive's report**	
	RS outlined the current situation report on site. We are in level 2 escalation, operating as business as usual but with a prevalence of covid as well as delivering cancer treatments. We continue to deliver treatments for patients who used to be treated elsewhere in Greater Manchester. RS noted the patient safety specialist role that is now in place in the trust and pointed to the details in the report. We are implementing a dedicated patient safety role in line with national requirements, more information will come to future meetings. RS noted the update on our developments in his report. No further comments or questions were raised. CO thanked RS.	
b	**Integrated performance, quality & finance report**	
	BD outlined the key points from the report for month 5. **Safe** • Two serious incidents and eight moderate incidents were reported in October. All the incidents are still progressing through to full root cause analysis. No never events were reported in month. • There are seven Trust level risks scored at 15+. **Responsive / Access**	

	• The 62 day cancer waiting time standard has not been met in October. Our position subject to validation is 83.8%. Within that performance we did achieve the internal 24 day standard with 87.7%. The large majority of breaches are shared breaches due to missing the internal target of 24 days. All 62 and 24 day breaches are reviewed to ensure delays are understood and harm is assessed. The number of patients waiting over 104 days as at the end of the month decreased. The large majority of these patients are referred to the Trust over day 100. All 31 day targets and 18 week referral to treatment standards have been achieved in October. Performance against the cancer waiting time thresholds is constantly monitored. Details were discussed at the Quality Assurance Committee in November. • There were 8 cancelled operations on the day due to a full critical care unit • Referrals in October are back at levels consistent with 2019/20. • Activity levels in most aspects are above GM recovery plans and in some areas back to 2019/20 levels. New attendances are behind 2019/20 due to a data classification problem. This issue has been resolved for September & October and a full year refresh will be reflected in the December report. Outpatient follow ups are above 2019/20 levels whilst surgical operations and radiotherapy fractions remain behind 2019/20 levels. • There were some coding issues relating to how virtual appointments were showing in the figures. This is being addressed. • The personal development review (PDR) position is under target but starting to recover • Sickness was up in month but managed without an impact on service. **Effective** • There have been no cases of MRSA bacteraemia and no cases of C-Difficile that were attributable to the trust in month with no lapses in care identified. • There were no cases of hospital acquired nosocomial Covid-19 infection in month. **Well – Led** • The trust position as at month 7 is a surplus of £1.558m against an agreed nil balance control total for the year which reflects the new GM financial arrangements in place for M1-12. • The month 7 I&E surplus is £12.509m, prior to adjusting for donated depreciation, charitably funded capital donations, donated grant income and impairments. • The cash balance is £162,776k • The Trust is showing a Capital underspend at Month 7 of £1,862k, which equates to 3.2% underperformance against the NHSEI plan and £3,733k (-6.3%) underperformance underspend is driven mainly by underspends on the Paterson project, Macclesfield, the tiered car park and the Carbon Energy Fund and is expected to be recovered to a breakeven position in the coming months. BD invited questions. RA asked about CIP and the savings made through establishment underspend. This is non-recurrent. SP responded that we are looking at recurrent CIP and working with divisions to address CIP from 1st April as we can manage in this year.	

	SP noted that to deliver the required level of mutual aid we asked what staff we would need, this is what is in the budget. For budget setting for next year we will review all of this and may take some of these out. GP asked about high patient satisfaction but asked what we do with any poor responses. BD noted that we pick these up through incidents, complaints etc and work closely with the Quality & Standards team to respond. GP asked about the underspends and if we will have a surplus what do we do. SP noted that money is coming in with little notice so it is difficult to plan, we can reallocate at year end across the system. GP asked about the higher sickness rates in estates & facilities and whether this gets additional attention. EL noted that we know what the hotspots are and we are working with these areas with higher levels and this is managed closely with the HR team. JY noted that all patient experience and safety data is well scrutinised at Quality Assurance Committee. CO congratulated the team on the improving position on waiting times that is a massive effort. No further comments or questions raised. Report **noted.**	
c	**Medical directors report – School of Oncology update**	
	CH introduced RF as the new Director of Education and CHv as Associate Director of Education. RF introduced himself, he is from an academic education background. RF thanked Richard Cowan for his work so far and noted the success of the team over the pandemic. CHv noted the student placements activities. There is a push to increase the number we train due to shortages going forward. We have done this through a virtual radiotherapy placement for protons which has been well evaluated and award winning. We have been funded by Health Education England to allow a 1 or 2 week virtual placement for therapy radiography students in protons and radiotherapy. This will be broadened to over 1500 students. We have introduced a new practice educator in SACT delivery. We have specialist leads on this work alongside the University of Manchester and the School of Oncology on a SACT module to teach others how to effectively deliver chemotherapy, this will be opened up nationally and then internationally. Our education offerings relating to the PET-CT and Gateway-C training have been very successful virtually, the numbers of people using these are very impressive. The events team have converted over 80% of our education to purely virtual, the remaining 20% is highbred. They have doubled the numbers that are accessing the courses & events offered. Internationally we are supporting work in Kenya, China and Nigeria and this work is now funding a Fellow post to come and learn here. RF reflected that there's a huge amount of energy to develop education. This is mainly about education for Christie colleagues to deliver excellent care, it is about the GM ICS and how education is supported across the system. We are also looking at education for all staff including non-clinical. Patient and public involvement (PPI) and patient education is also included. The School is recognising academic achievement but looking at outputs and	

	impact is key to the future. Questions invited. AM noted that this is very exciting and there is a lot of potential. AM noted the virtual direction is excellent. She asked about the demographics and who can be reached to come into oncology, particularly a pipeline through schools. RF responded that it is a balance, we must keep technology simple to ensure there is easier access for all. It is about simplicity and easier access, reaching out to schools in a positive way, we will be looking at getting links with schools and would appreciate input. We are looking to use existing tools to support learning e.g. Microsoft Office. CHv noted the kickstart programme, we have 12 recruits and have another 16 coming, we have a target of 60. AM noted how good this is. JM asked about the challenges between online, face to face and telephone and asked if there is enough focus on making this work. She also asked about the measures of the impact of Gateway-C and GP engagement. CHv noted that there is a questionnaire to assess impact that shows positive feedback. There is GM focused work to connect with the referrers in GM and with pathway leads so they know who they are referring to. KW noted the main purpose is to train staff, the other area is revenue driven. He also asked about apprenticeship funding and making full use of the contribution. CHv noted there is focus on both training Cristie staff and generating revenue. In terms of the apprenticeship levy we are doing OK, there's a clinical trial coordinator apprenticeship and we are using this as well as others, we are using as much as we can currently. RF noted that education must be accessible and relevant and we want to see how it can lead to change. We could do better with certain staff groups so we must start well and get it good here in order to then offer it out. CO noted the report.	
40/21	**Board Assurance**	
a	**Board assurance framework 2021/22**	
	RS noted the BAF. There are no suggested changes in month. No questions.	
b	**Staff engagement activities**	
	BD noted the paper that outlines some of the operational engagement sessions that have been put on. The Board are asked to note this, a more comprehensive report will be brought back in a future meeting. RS noted that previously the Board could look at activities relating to executive walk rounds etc, this is an opportunity to demonstrate the alternative activities that are taking place across the organisation. A broader set of activities will be presented in a future meeting. GP noted that this is very impressive. He asked if there's been any feeling that some of the engagement has been disproportionate in certain groups. RS responded that this hasn't been tested but that we endeavour to reach all groups of staff including the Equality, Diversity & Inclusion groups. The network groups are very engaged and we seek their feedback more, the pandemic has made this stronger. JY noted that feedback from staff is that they find virtual sessions more inclusive.	

	Its more flexible and attendance has improved. CO thanked the team for the report, noted.	
c	**Quality Assurance Committee report**	
	KW noted the report of the last committee meeting. There was extensive discussion around complaints and cancer waiting times. Noted.	
41/21	**Any other business**	
	No items raised.	
	Date and time of the next meeting	
	Thursday 27th January 2022 at 12:45pm	