Royal Papworth Hospital
NHS Foundation Trust

# Meeting of the Board of Directors
# Held on 3 December 2020 at 9:30am
# Meeting Rooms 1&2 and via Teams
# Royal Papworth Hospital

## UNCONFIRMED M I N U T E S – Part I

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| **Present** | Prof J Wallwork | (JW) | Chairman (T) |
| | Dr J Ahluwalia | (JA) | Non-Executive Director (T) |
| | Mr M Blastland | (MB) | Non-Executive Director (T) |
| | Ms C Conquest | (CC) | Non-Executive Director (T) |
| | Ms A Fadero | (AF) | Non-Executive Director |
| | Ms D Leacock | (DL) | Associate Non-Executive Director |
| | Mr T Glenn | (TG) | Chief Finance and Commercial Officer |
| | Mr I Graham | (IG) | Acting Chief Nurse |
| | Dr R Hall | (RH) | Medical Director |
| | Mrs E Midlane | (EM) | Chief Operating Officer |
| | Ms O Monkhouse | (OM) | Director of Workforce and OD |
| | Mr S Posey | (SP) | Chief Executive |
| | Mr G Robert | (GR) | Non-Executive Director (T) |
| | Mrs J Rudman | (JR) | Chief Nurse |
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| **In Attendance** | Dr J Chung | (JC) | Respiratory Specialist Registrar (Thoracic Oncology) |
| | Mr E Gorman | (EG) | CNIO Deputy Director of Digital |
| | Mrs A Jarvis | (AJ) | Trust Secretary |
| | Mr A Selby | (AS) | Associate Director of Estates and Facilities |
| | Ms J Southon | (JS) | Specialist Nurse, Supportive and Palliative Care Team. |
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| **Apologies** | Mr A Raynes | (AR) | Director of IM&T Chief Information Officer(T) |
| | Prof I Wilkinson | (IW) | Non-Executive Director (T) |
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| **Observers** | Susan Bullivant | | Public Governor |
| | Doug Burns | | Public Governor |
| | Trevor Collins | | Public Governor |
| | Aman Coonar | | Staff Governor - Doctors |
| | Caroline Gerrard | | Staff Governor - Admin, Clerical & Management |
| | Abigail Halstead | | Public Governor |
| | Richard Hodder | | Lead Governor |
| | Trevor McLeese | | Public Governor |
| | Joe Pajak | | Public Governor |
| | Harvey Perkins | | Public Governor |
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| **1.** | **WELCOME, APOLOGIES AND OPENING REMARKS** | | |
| | The Chairman opened the meeting and welcomed to the Board two new Non-Executive Directors, Amanda Fadero (NED) and Diane Leacock (Associate NED). Amanda and Diane had joined the Board on the 1 December 2020 following their appointment at the CoG meeting in November.<br><br>The Chairman reported to the Board that one of our former Governors, Richard Maddison, had died last week.<br><br>The Chairman invited Amanda and Diane to introduce themselves to the Board and for all Board members to outline their background and key areas of responsibility for the benefit of the new members and Governors. (Further information and biographies of Board members can be found on our website at: https://royalpapworth.nhs.uk/our-hospital/how-we-are-run/our-board-directors )<br><br>Amanda told the Board that she was a clinician with a nursing background and had over 41 years of service in the NHS. Her passion was for caring; for working to address inequality and delivery of compassionate leadership. She was currently an Associate Non-Executive Director at East Sussex NHS Healthcare Trust and was looking forward to her role as NED at RPH.<br><br>Diane advised the Board that she was an accountant by background and a Finance Director, and that she now had a portfolio career. She was currently interim Non-Executive Director at the East Suffolk and North Essex NHSFT. That appointment was due to end in December and she was very much looking forward to working in her new role with RPH.<br><br>The Chairman also welcomed the Governors attending the meeting as observers; noting that this included a number of newly elected Governors attending the Board for the first time.<br><br>Apologies were noted as above. | | |
| **1.i** | **DECLARATIONS OF INTEREST** | | |
| | There is a requirement that Board members raise any specific declarations if these arise during discussions. No specific conflicts were identified in relation to matters on the agenda. | | |
| | The following standing declarations of Interest were noted:<br><br>i. John Wallwork and Stephen Posey as Directors of Cambridge University Health Partners (CUHP).<br>ii. Roger Hall as a Director and shareholder of Cluroe and Hall Ltd, a company providing specialist medical practice activities.<br>iii. John Wallwork as an Independent Medical Monitor for Transmedics clinical trials.<br>iv. Josie Rudman, Partner Organisation Governor at CUH.<br>v. Stephen Posey in holding an Honorary contract with CUH to | | |

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| | enable him to spend time with the clinical teams at CUH.<br>vi. Stephen Posey as Chair of the NHS England (NHSE) Operational Delivery Network Board.<br>vii. Stephen Posey as Trustee of the Intensive Care Society.<br>viii. Stephen Posey, Josie Rudman and Roger Hall as Executive Reviewers for CQC Well Led reviews.<br>ix. Andrew Raynes as a Director ADR Health Care Consultancy Solution Ltd<br>x. Stephen Posey as Chair of the East of England Cardiac Network.<br>xi. Michael Blastland as: 1. Board member of the Winton Centre for Risk and Evidence Communication; 2. Advisor to the Behavioural Change by Design research project; 3. Member of the oversight Panel for the Cholesterol Treatment Trialists' Collaboration; 4. Member of advisory group for Bristol University's Centre for Academic Research Quality and Improvement.<br>xii. Cynthia Conquest as Deputy Director of Finance and Performance at the Norfolk Community Health & Care NHS Trust.<br>xiii. Stephen Posey as a member of the CQC's coproduction Group.<br>xiv. Jag Ahluwalia as: 1. CUHFT Employee, seconded to Eastern Academic Health Science Network as Chief Clinical Officer; 2. Programme Director for East of England Chief Resident Training programme, run through CUH; 3. Trustee at Macmillan Cancer Support; 4. Fellow at the Judge Business School - Honorary appointment; 5. Co-director and shareholder in Ahluwalia Education and Consulting Limited; 6. Associate at Deloitte; 7. Associate at the Moller Centre.<br>xv. Ian Wilkinson as: 1. Hon Consultant CUHFT and employee of the University of Cambridge; 2. Director of Cambridge Clinical Trials Unit; 3. Member of Addenbrooke's Charitable Trust Scientific Advisory Board; 4. Senior academic for University of Cambridge Sunway Collaboration; 5. Private health care at the University of Cambridge; 6. University of Cambridge Member of Project Atria Board (HLRI).<br>xvi. Tim Glen's partner is the ICS development lead for NHSE/I in the East of England.<br>xvii. Amanda Fadero 1.Trustee of Nelson Trust , a charity predominantly supporting recovery from drug and alcohol addiction with expertise in trauma informed care for women; 2. Associate Non-Executive Director at East Sussex NHS Healthcare Trust. | | |
| **1.ii** | **MINUTES OF THE PREVIOUS MEETING** | | |
| | **Board of Directors Part I: 1 October 2020**<br>The following items were revised to read:<br><br>**Item 1.iv:** Matters Arising Noted: " ..It was agreed that RH would circulate~~d~~ the ICNARC and NHSBT Transplant outcome reports to ~~with~~ the Board."<br><br>**Item 1.vi:** Patient Story:<br>Introduction Page 5: ".. that staff and the food were good ~~and~~ but he felt restricted by .." | | |

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| | Reported: ix: "…approach that would be ~~being~~ taken in.."<br><br>**Item 1.vii:** Staff Story: "LR advised that for each ~~of~~ round of adverts."<br><br>It was also noted that there had been a duplication of numbering in the headings for the CEO' Update and the Patient Story.<br><br>**Approved**: With the above amendments the Board of Directors approved the Minutes of the Part I meeting held on 1 October 2020 as a true record. | | |
| **1.iii** | **MATTERS ARISING AND ACTION CHECKLIST** | | |
| | **Noted:** The Board received and noted the updates on the action checklist. | | |
| **1.iv** | **Chairman's Report** | | |
| | The Chairman reported that this week he had visited the HLRI with Lord David Prior, Chair of NHS England. He and SP had also attended the topping out ceremony for the HLRI which had taken place last month.<br><br>The Trust had held its Annual Members meeting in November. This was held as a virtual event and despite some technical challenges it had been generally well received. | | |
| **1.v** | **CEO's UPDATE** | | |
| | **Received:** The Chief Executive's update setting out key issues for the Board across a number of areas reflecting the range and complexity of the challenges currently facing the Trust and the significant progress being made in delivery of the Trust's strategic objectives. The report was taken as read.<br><br>**Reported:** By SP that:<br>i. The organisation was responding to the combined pressures of:<br>• Recovery and restoration of activity<br>• Wave 2 COVID and associated staff redeployment<br>• Winter Planning<br>• EU Exit end of transition period<br>• Staff testing and vaccination<br>• Mass vaccination support<br>• System leadership transition<br><br>ii. He apologised as the Board had received a number of papers later than we would wish. Some of these were subject to timetables of other Boards and others were as a result of internal work pressures.<br>iii. The Trust had 13 COVID patients of whom 11 were on ECMO. This compared with a level of 3 ECMO cases in the prior year. This week had also seen the first transfer of an ECMO patient from a partner hospital. The first of the cohorts of staff to be redeployed in the second wave had been trained and were in Critical Care. A decision would be made on releasing the second cohort of staff next week. | | |

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| | iv. The Trust had achieved uptake greater than 86% for flu vaccination and this was the highest level ever.<br>v. The Trust was working on plans for vaccination of staff and for mass vaccination in the community.<br>vi. The Board would receive a paper on the STP System Leadership and Integrated Care System (ICS) proposal on the Part II agenda as despite the operational pressures the Trust was finding time to shape, and be fully involved, in the development of system plans.<br>vii. The recurrent theme throughout the Board would be our people. The Board had received a wonderful patient story and he noted that this care had been delivered at a time of great pressure. The demands on Trust workforce were huge and the Board's priority was to recognise and to support that.<br>viii. That there were two other items that he would like to bring to the Board's attention:<br>• The completion of the exchange on 26 November for the sale of the old site. He wanted to record the Trust's gratitude to the residents of Papworth Everard for their long standing support to the hospital.<br>• The M.abscessus meeting that had been held with Public Health England (PHE), and he invited RH to provide a verbal update on this matter.<br><br>**M.abscessus**<br><br>**Reported:** By RH that there was a paper coming to the Part II meeting which would set out this matter in detail for the Board. In addition he advised that:<br><br>i. M.abscessus was a non-tuberculous mycobacterium (NTM). This organism was similar but distantly related to M. Tuberculosis the organism responsible for causing TB in humans. M.abscessus was an environmental organism and as a consequence it has evolved defences against many antibiotics and other therapies in use clinically.<br>ii. Colonisation by, and in some cases and infection with the organism in patients with Cystic Fibrosis and those patients who have chronic lung infection such as bronchiectasis has long been recognised internationally.<br>iii. Research at RPH aiming to further our understanding of the mechanism of infection and colonisation had guided our approach to Infection Prevention and Control (IPC) and informed the design of the air handling in our new hospital. Because of our active research efforts and our heightened awareness of the significance of the impact on patients' lives we deliberately take additional steps to actively look for M. abscessus.<br>iv. In September 2019 M.abscessus was grown from two patients who had undergone lung transplantation during the first few months of our occupation of the new hospital. The Trust has become concerned that there has been a further case of a lung transplant patient acquiring the organism following implementation of all of our mitigations in the water supply and our enhanced IPC measures.<br>v. This concern has led to a request from RPH to Public Health | | |

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| | England and the regional team IPC team at NHSE for a review of our actions since this problem was first identified. An Incident Management Team (IMT) meeting was convened by RPH; this meeting was held on 25/11/20. There was attendance from a broad PHE team with experts in NTM epidemiology and Public Health Protection. The Trust had given three presentations to the meeting covering:<br>a. The history of the RPH management of the outbreak.<br>b. The governance steps taken by RPH.<br>c. A detailed presentation around the water supply mitigations.<br>vi. PHE were then given the opportunity to comment on what had been done. The view of the IMT was that the Trust had taken extensive steps to understand and prevent the disease but was unable to offer any advice about additional steps to take. It was agreed that neither PHE nor the Trust were able to fully understand the mechanism of transmission and acquisition of M.abscessus.<br>vii. The Trust was continuing to seek further mitigations and is employing the precautionary principle as a basis for instituting them rather than waiting for a fully evidenced based approach; this was thought to be prudent given the many months between potential acquisition of the organism and a subsequent positive culture. Additionally, there had been and there would continue to be engagement with the team at Duke University in North Carolina where there had been a similar outbreak.<br><br>SP noted that this matter had been discussed at Q&R and that there was a paper going to the Part II Board.<br><br>JW noted the importance of this matter to the Trust and its patients.<br><br>**Noted:** The Board noted the CEO's update report. | | |
| **1.vi** | **PATIENT STORY** | | |
| | **Patient Story**<br><br>The Board welcomed Dr Jonathan Chung, Respiratory Specialist Registrar (Thoracic Oncology), and Julie Southon, Specialist Nurse, Supportive and Palliative Care Team.<br><br>**Reported:** By Dr Chung that the case that was being brought to the Board was an important case that highlighted the impact of COVID in cancer care and related to a patient who presented on the lung cancer pathway.<br><br>This was of an 81 year old patient referred into the lung cancer pathway for a specialist EBUS (Endobronchial ultrasound) investigation at RPH.<br><br>The patient had developed common respiratory symptoms and had experienced rapid deteriorations; there had been a delay in GP appointments due to COVID19 whereby she ultimately presented to her local hospital with worsening symptoms. The imaging had shown a large mass and this was indicative of advanced lung cancer. The | | |

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| | patient was referred to RPH for an elective EBUS procedure. The patient arrived at RPH on a Friday and was poorly on admission. Immediate medical treatment was provided and a decision made that we should not proceed with the EBUS procedure. There was discussion of this decision with the patient, their partner and the specialist nurse. They were informed of the speed of deterioration, and it was explained as to why they would not proceed with the EBUS investigation. There was discussion with the patient and the family about the RESPECT form and involving the supportive and palliative care team. The discussions included preferred place of death. The patient felt safe and supported at RPH and was admitted to the respiratory ward. The patient's family were allowed controlled visits within the COVID visiting restrictions and the patient's partner stayed with the patient overnight.<br><br>The patient deteriorated the next day and the patient was seen with the palliative team and discussed with the lung cancer and palliative care consultants. There were round the clock communications with the teams, and the family, and the patient died peacefully on Saturday night. This patient story highlighted the importance of role of palliative care and the specialised nursing services at the Trust.<br><br>Dr Chung noted that lung cancer management needed to adapt to COVID19 as it was the number one killer in cancer. The Trust was seeing late stage referrals because of the public concerns about COVID19 and that the thoracic oncology service was fully running and functioning. The Trust was continuing to highlight this matter to the public.<br><br>Julie Southon noted that it was very helpful that the referral, having been made on a Friday afternoon, allowed the clinical nurse specialist to assess the patient's holistic care needs and ensure that medicines were prescribed for pain and breathlessness for the overnight period. This highlighted the collaborative working to involve the supportive and palliative team and the ability to be more supportive particularly with the development of weekend working since April 2020. This case enabled the first occasion where a newly developed Personalised Care Plan for Last Days of Life (PCPLDL), to improve the quality of individualised care. A clinical audit of end of life care at RPH showed a lack of documented evidence about the quality of care and especially with regard to nutrition and hydration and this had provided the rationale to improve communication, care and documentation.<br><br>The patient's partner had subsequently written to RPH to say that this had been a very positive outcome for a very sad event, and that they had appreciated the way that their partner had been cared for, the communications and the compassion that had been displayed. JS felt immensely proud to be able to present this story.<br><br>**Discussion:**<br><br>i. JW felt that this was a good patient story. It showed a patient being treated exceptionally well and their quality of death was incredibly important in this.<br><br>ii. SP noted that he was proud of the end of life care that had been provided to the patient by the Trust teams. He noted that end of life care was one of the services that had not been | | |

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| | inspected at our CQC inspection last year and this would be an area that would be due for inspection in the future.<br>iii. IG advised that he had met with CQC colleagues about the work that we had done in relation to RESPECT and collaborative working. He noted that the staff and Trust teams had made a massive impact on the lives of this patient and their family and wanted to pass his thanks onto all the Team.<br>**Noted:** Board members expressed their thanks to Dr Chung and Ms Southon for the care provided, and for bringing this story to the Board. | | |
| **2** | **PERFORMANCE** | | |
| **2.a.i** | **PERFORMANCE COMMITTEE CHAIR'S REPORT**<br>**Received:** The Chair's report setting out significant issues of interest for the Board.<br>**Reported:** By GR that:<br>i. In October the Committee had seen some degree of normality with improvement in recovery trajectories; but the Board needed to bear in mind that the first three weeks of October had seen progress in restoration of activity ahead of the second wave, and we would not see further progress on this as a result.<br>ii. The improvement in recruitment and retention and the reduction in the vacancy rate at the Trust was a significant achievement by the workforce team which should be noted.<br>iii. The resilience of our staff going forward was essential and that he had suggested that a deep dive into the efforts around wellbeing should be received at the Board or one of the Board Committees.<br>iv. That the Committee had approved the approach to operational planning for 2021/22 and whilst this would usually be a bottom up approach it had been agreed exceptionally that a more central approach would be taken with the exception of the review of Corporate Services and Critical Care.<br>**Discussion:**<br>i. JW noted that looking at PIPR the Trust was performing better than it had in 2019 in many areas. This demonstrated that the Trust was able to rapidly get back to normal and would hope to return to the position of performance after the current surge.<br>ii. DL noted the commendable performance in relation to workforce. She noted with concern that the deep dive report into temporary staffing had been paused and asked about the measures in place to monitor this expenditure. GR advised that the Committee was conscious of this and understood that grip was required in order for progress to be made, but it had felt that given the other burdens on the Trust, especially around redeployment, that the team were not in a position to take this forward although this measure was regularly reported through PIPR. OM advised that the routine monitoring and reporting measures were all still in place and all that was | | |

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| | paused was the deep dive report. The pause was partially related to time requirements but also because this measure would be distorted because of the movement of staff, and it was felt that it would be more appropriate to look at this in Q4.<br><br>**Noted:** The Board noted the Performance Committee Chair's report. | | |
| **2.b** | **PAPWORTH INTEGRATED PERFORMANCE REPORT (PIPR)** | | |
| | **Received:** The PIPR report for Month 7 (October 2020) from the Executive Directors (EDs). This report had been considered in at the Performance Committee and at Q&R and was provided to the Board for information.<br><br>**Reported:** By TG that:<br>i. The Chair's report had covered matters comprehensively and that the October PIPR was the last point before the impact of the second surge would be seen in terms of activity and financial recovery.<br>ii. The COVID position would necessitate moving to lighter reporting through PIPR and COVID reporting would be reinstated from next month setting out the hospitals' response within the regional system.<br><br>**Discussion:**<br>i. JW noted that the PIPR report had been thoroughly reviewed at Committee. He noted also that the account from the supportive and palliative care team demonstrated the high quality of care that was being delivered.<br>ii. AF noted that she had really enjoyed the PIPR particularly the reports on workforce, safer staffing and BAME.<br>iii. DL asked what the Trust was doing to close the CIP gap. TG advised that there were meetings with divisional and corporate areas to consider the remaining CIP gap. The position was better than had been reported in the papers and the Trust was pushing hard to keep focus on this through both this year and next. GR advised that the CIP delivery report introduced at the Committee provided a very good level of detail. | | |
| | **Noted:** The Board noted the PIPR report for Month 7 (October 2020). | | |
| **3** | **GOVERNANCE** | | |
| **3.i** | **Board Assurance Framework**<br>**Received:** From the Trust Secretary the BAF report setting out:<br><br>i. BAF risks against strategic objectives<br>ii. BAF risks above appetite and target risk rating<br>iii. The Board BAF tracker.<br><br>**Discussion:**<br>i. SP noted that whilst it might seem that EU Exit had been overshadowed by the response to COVID19 the Trust had considered the impact and associated risks and a paper on this matter was being brought to the Board in Part II which set out plans as part of the national and regional response. The | | |

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| | Trust had reviewed its business continuity plans (BCPs) and with mitigation these were rated as green.<br>ii. EM advised that a table top exercise to inform escalation and to test plans had been set for tomorrow afternoon. This would support the reviews of BCPs and would do the job of ensuring that all plans were tested the RAG ratings and were sound.<br><br>**Noted:** The Board noted the BAF report for November 2020. | | |
| **3.ii** | **Q&R Committee Chair's Report**<br><br>**Received:** The Q&R Committee Chair's report setting out significant issues of interest for the Board.<br>**Reported:** By MB that.<br>i. That the Committee was very pleased to receive a report on inequalities. This had focused on outcomes for patients who were treated at RPH. The Committee had asked the Trust to look at how we could understand and report on inequality in how patients were able to access services at RPH. He noted that the social gradient of our COVID patients was sharp and whilst this may reflect the gradient that exists in our area this needed to be understood and the Committee wanted to persevere with this work.<br>ii. That the Committee had received a report on how the Trust records and monitor surgical mortality data, which was very good in terms of analysis and outcomes. The team had been asked how we could best represent this to the Board. The Board sees raw mortality data in PIPR and it was felt that there needed to be some sort of risk adjusted monthly figure. He was in touch with Sam Nashef (Consultant Surgeon) and Craig Salmon (Head of Business Intelligence and Analytics) and would bring a report and recommendations back to the Board.<br>iii. The Committee had identified that it would like to receive themed information arising from SIs, incidents and near misses to identify key areas of focus. For example we had a seen a number of incidents relating to the deteriorating patient, and having previously implemented a QI programme in this area the Committee would like to understand the particular issues involved. Carole Buckley (Assistant Director for Quality and Risk) had been asked to bring together a report on the emerging themes.<br><br>**Discussion**<br>i. JW was pleased that MB was in touch with Sam Nashef. He noted that at present we had no COVID admissions from Cambridge and Peterborough, and in that respect it was difficult to assess the matter of equality. He asked whether the STP Q&R leads meetings were considering how care pathways would be addressed across the STP patch. MB noted that he would like the STP to look at issues across the system but there was limited progress as the system focus was on organisational pressures being faced, such as the universal concern around staff wellbeing. However that independent scrutiny and governance may provide suggestions around how this could be approached.<br>ii. SP noted that it was important to drill down into the work on | | |

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| | inequalities and that the ICS would be looking at funding flows and population health management; however there would need to be a more sophisticated approach in the discussion on how RPH meets the health needs of the different 'populations' that it serves. MB felt that this might need to us to look at system demographics viewing the regional and RPH patient populations as a first step.<br>iii. IG noted that the Trust's Nurse Consultant lead for the Alert Team had led great work to improve the hospital at night and some of this learning was now being transferred into the daytime cover within the Trust, and this was a good example of the impact of the QI programme.<br>iv. JA noted that the issue of improving the integrity of our dataset in relation to the collection of ethnicity was important as otherwise we would not know the extent of any issues, and where we were in addressing these. There needed to be work with other provider partners and our deprived populations should be over represented in this work. This would need a whole population approach and would require a comprehensive data set to support this work. JW noted that the populations that serve for Pulmonary Endarterectomy services and for Acute Heart Attack would be very different and suggested that we consider this issue in relation to one or two of the high volume pathways that we deliver.<br>v. MB noted that one of the most important things was for the issue of data completeness to be address at a system level, and that we improve the capture of ethnicity data for our own patients in order to properly assess our performance.<br><br>**Noted:** The Board noted the Q&R Committee Chair's report | | |
| **3.iii** | **Combined Quality Report**<br>**Received**: A report from the Acting Chief Nurse and Medical Director which highlighted information in addition to the PIPR.<br><br>**Reported:** By IG that:<br>i. the report provided detail on nosocomial infections. There had been a great deal of focus on this matter and IG was in contact with the CCG and regional teams in relation to the Trust actions. The two appendices set out the 10 key actions for Infection Prevention and Control (IPC) and the IPC testing regimes.<br>ii. The action plan at Appendix 2 was essentially green. The two amber rated actions were controversial:<br>a. Point 4 - The requirement of not moving patients until 2 negative test results were obtained was not in place but we do not have an issue arising from this because of the use of single rooms. NHSE had indicated that they were happy with the Trust's pathway and testing regime.<br>b. Point 8c – The Trust was to implement testing on day three from Monday 7 December. This approach had not been used because of the swabbing regime, single room layout and the IPC measures that were in place. | | |

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| | **Discussion:**<br>i. JW noted that the Region had written to Board to request that they were sighted on the matter of nosocomial infections. It was pleasing to see that there were still none being reported and he felt this was a function of the layout and function of the Trust, but recognised that this was a complicated picture.<br>ii. IG confirmed that this was a significant issue across the region and that this information was included in the PIPR summary to allow for floor to Board assurance on nosocomial infection rates.<br>iii. CC asked for clarification on whether the nosocomial rate reflected transmission from staff to patients. IG advised that this was all hospital acquired cases and so would include patient to patient, as well as staff to patient transmission. Infections were monitored and classified at 2-3 days; <7 days; <15 days and >15days to map acquisition and spread. He noted that the staff to staff infection rates were very low and that if there was an infection we would follow the standard track and trace approach. IG was aware that one member of staff had been identified through track and trace and that no other members of staff had been required to self-isolate as a result of this. We had however seen incidents where staff had to go into isolation as a result of track and trace as a result of increasing incidence in the community, and as a result had moved to the use of face masks (instead of face coverings) in all areas of the hospital. An audit was being undertaken on a weekly basis by the IPC team on social distancing. Any staff who were required to self-isolate were followed up by the Keeping In Touch (KIT) team.<br>iv. RH noted that the Trust had received a visit from the Regional IPC team and that at that they had identified some concerns with the open plan office areas and that in response to this the Trust had increased the focus on social distancing; moved to the use of face masks in open plan areas and increased the frequency of air changes in those areas. IG noted that when the guidance came out on COVID secure areas we were compliant with it, but we had taken additional measures following the discussions with NHSE.<br>v. AF thanked IG and RH for the clear explanations relating to the report and asked IG about the three SIs that had been reported in October and September and whether there were any particular causes for concern arising from these. IG advised that the position in November was better and that he reviewed all SIs and felt these reflected an open reporting culture. SIs were reviewed through the Quality & Risk Management Group (QRMG) and the through Serious Incident Executive Review Panel (SIERP). Issues arising from this were reported and reviewed at the Q&R meetings. IG advised that he would be happy to provide further information on the specific incidents. RH reminded the Board that the threshold for reporting at RPH was quite low and that there were a number of matters that were considered as SIs that were subsequently downgraded. The Trust always ensured that a 'just culture' approach was adopted which considered the spectrum of issues from what system failures there might be | | |

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| | through to issues of performance.<br><br>**Noted:** The Board noted the Combined Quality Report. | | |
| **3.iv** | **Quality Accounts**<br><br>**Received:** From the Chief Nurse and Trust Secretary a copy of the Quality Accounts for 2019/20.<br><br>**Reported:** By IG:<br>i. That the Quality Accounts were a national requirement. He thanked the Committee members for their scrutiny of the report.<br>ii. That progress against the Trust priorities had been summarised and presented to the Annual Members Meeting and that progress against the 2020/21 priorities was already well underway in this year.<br>iii. He noted his thanks to AJ for her work in bringing together the Trust Quality Accounts for 2019/20.<br><br>**Discussion:**<br>i. CC noted that Quality Accounts had been discussed at length and that an extraordinary Audit Committee meeting had been held jointly with the Q&R Committee to review the final draft. She advised that in usual times there would be external audit of the Quality Accounts but that requirement had been removed in this year and so the Committee had sought to ensure that appropriate Governance had been followed and she was assured that it had.<br>ii. DL asked about the absence of comment from the CCG and whether that was a concern? AJ advised that this was perhaps a matter of timing. SP noted that that we have a very good relationship with the CCG but they were not the largest commissioner of Trust services and so were not our major stakeholder.<br>iii. AF noted the response received from the Cambridgeshire County Council's Health Committee and felt that this was a huge accolade and a wonderful statement on the Trust Quality Accounts.<br><br>**Approved:** The Board approved the Trust Quality Accounts for 2019/20. | | |
| **3.v** | **Board Sub Committee Minutes:** | | |
| **3.v.a** | **Quality and Risk Committee Minutes: 24.09.20 & 29.10.20**<br><br>**Received and noted:** The Board of Directors received and noted the minutes of the Quality and Risk Committee meetings held on 24 September and 29 October 2020. | | |
| **3.v.b** | **Performance Committee Minutes: 24.09.20 & 29.10.20**<br><br>**Received and noted:** The Board of Directors received and noted the minutes of the Performance Committee meetings held on 24 September and 29 October 2020. | | |

| Agenda Item | | Action by Whom | Date |
|---|---|---|---|
| | | | |
| **3.vi** | **Audit Committee Chair's Report 08.10.20 & 29.10.20**<br><br>**Received and noted:** The Board received and noted the Audit Committee Chair's report setting out significant issues of interest for the Board. | | |
| **4** | **WORKFORCE** | | |
| **4.i** | **Workforce Report**<br>**Received:** The Director of Workforce and OD a paper setting out key workforce issues.<br>**Reported:** By OM:<br>i. That she wanted to highlight three issues to the Board:<br>a. The regional surge workforce planning which was focussed on discussion with other providers on release of staff to support the surge response. The Trust had started its surge response with the release and redeployment of the first tranche of staff from wards to Critical Care.<br>b. The COVID19 vaccination programme which was had seen changes in requirement on an almost daily basis and the Trust was working with the Region to respond to the staffing requirement to support this.<br>c. COVID19 Staff Testing Programme which had been launched on Monday and had received a good response from staff. Staff had collected over 1,000 testing kits already and that was a c.60% uptake. Staff had also started submitting their results through the online system and as of the 2 December there had been no positive tests returned. This was really welcome progress and reflected the fact that our staff were very engaged with this programme.<br>ii. That all strands of the Trust response were being supported through the brilliant team working that was taking place across the Trust.<br><br>**Discussion:**<br>i. JW asked for further information on the plans for vaccination. OM advised that at present the plan is for delivery of the Pfizer vaccine and that would be delivered through the two hub sites in Cambridge and Peterborough based at CUHFT and NWAFT. The Trust was collaborating with these programmes and was supplying vaccinators, and there was a booking system now in place. The prioritisation for accessing the vaccine was still not fixed. SP noted that the frequent change in requirements was contributing to the overall uncertainty and pressure on staff.<br><br>**Agreed:** The Board noted the update from the DWOD. | | |
| **5** | **REASEARCH & EDUCATION** | | |
| | No report. | | |

| Agenda Item | | Action by Whom | Date |
|---|---|---|---|
| **6** | **BOARD FORWARD AGENDA** | | |
| **6.i** | **Board Forward Planner**<br><br>**Received and Noted:** The Board Forward Planner.<br><br>**Discussion:** JW noted that with the appointment of the new Non-Executive Directors to the Board there may be some changes in Committee membership going forward. | | |
| **6.ii** | **Items for escalation or referral to Committee**<br><br>None | | |
| **7** | **CLOSING REMARKS** | | |
| | The Chairman thanked the Governors and members of the public who had attended the meeting and reminded them that the Board would now move into the Part II meeting. | | |

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Signed

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Date

**Royal Papworth Hospital NHS Foundation Trust**
**Board of Directors**
Meeting held on 3 December 2020

Glossary of terms

| | |
|---|---|
| CIP | Cost Improvement Programme |
| CTP | Cambridgeshire Transition Programme |
| CUFHT | Cambridge University Hospitals NHS Foundation Trust |
| DGH | District General Hospital |
| GIRFT | 'Getting It Right First Time' |
| IHU | In House Urgent |
| IPPC | Infection Protection, Prevention and Control Committee |
| IPR | Individual Performance Review |
| KPIs | Key Performance Indicators |
| LDE | Lorenzo Digital Exemplar |
| NED | Non-Executive Director |
| NHSI | NHS Improvement |
| NSTEMI | Non-ST elevation MIs |
| PET CT | Positron emission tomography–computed tomography - a type of scanning of organs and tissue |
| PIPR | Papworth Integrated Performance Report |
| PPCI | Primary Percutaneous Coronary Intervention |
| PROM | **P**atient **R**eported **O**utcome **M**easure: assesses the quality of care delivered to NHS patients from the patient perspective. |
| RCA | **R**oot **C**ause **A**nalysis is a structured approach to identify the factors that have resulted in an accident, incident or near-miss in order to examine what behaviours, actions, inactions, or conditions need to change, if any, to prevent a recurrence of a similar outcome. Action plans following RCAs are disseminated to the relevant managers. |
| RTT | Referral to Treatment Target |
| SIs | Serious Incidents |
| SIP | Service Improvement Programme |
| STP | Cambridgeshire and Peterborough **S**ustainability & **T**ransformation **P**artnership |
| VTE | Venous thromboembolism |
| Wards | Level Three: L3S (South) and L3N (North)<br>Level Four: L4S and L4N<br>Level Five: L5S and L5N<br>CCU Critical Care Unit |
| WTE | Whole Time Equivalent |