Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Held on 4 February 2021 at 9:30am
Meeting Rooms 1&2 and via Teams
Royal Papworth Hospital

UNCONFIRMED M I N U T E S – Part I

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 A Raynes	(AR)	Director of IM&T Chief Information Officer(T)
	Mr G Robert	(GR)	Non-Executive Director (T)
	Prof I Wilkinson	(IW)	Non-Executive Director (T)
In Attendance	Mrs A Jarvis	(AJ)	Trust Secretary
	Ms P Martin	(PM)	Safeguarding, Social Work & Discharge Lead
	Mr A Selby	(AS)	Associate Director of Estates and Facilities
Governor Observers	D Burns, L Andreu Faz, G Francis, T Collins, D Gibbs, J Pajak, S Bullivant, A Coonar, R Hodder, A Halstead, J Dunnicliffe, C Gerrard		

Agenda Item		Action by Whom	Date
1.i	**WELCOME, APOLOGIES AND OPENING REMARKS**		
	The Chairman welcomed everyone to the meeting and apologies were noted as above. The Chairman noted that this was the first formal Board of the year and noted that this was still a challenging and difficult year. He had visited the hospital on Wednesday and all seemed calm and well organised.		

Agenda Item		Action by Whom	Date
1.ii	**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: i. John Wallwork and Stephen Posey as Directors of Cambridge University Health Partners (CUHP). ii. Roger Hall as a Director and shareholder of Cluroe and Hall Ltd, a company providing specialist medical practice activities. iii. John Wallwork as an Independent Medical Monitor for Transmedics clinical trials. iv. Stephen Posey in holding an honorary contract with CUH to enable him to spend time with the clinical teams at CUH. v. Stephen Posey as Chair of the NHS England (NHSE) Operational Delivery Network Board. vi. Stephen Posey as Trustee of the Intensive Care Society. vii. Stephen Posey, Josie Rudman and Roger Hall as Executive Reviewers for CQC Well Led reviews. viii. Andrew Raynes as a Director ADR Health Care Consultancy Solution Ltd ix. Stephen Posey as Chair of the East of England Cardiac Network. x. 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. xi. Cynthia Conquest as Deputy Director of Finance and Performance at the Norfolk Community Health & Care NHS Trust. xii. Stephen Posey as a member of the CQC's coproduction Group. xiii. 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. xiv. 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). xv. Tim Glen's partner is the ICS development lead for NHSE/I in the East of England. xvi. Amanda Fadero 1.Trustee of Nelson Trust , a charity predominantly supporting recovery from drug and alcohol		

Agenda Item		Action by Whom	Date
	addiction with expertise in trauma informed care for women; 2. Associate Non-Executive Director at East Sussex NHS Healthcare Trust. xvii. Diane Leacock: 1. Director – ADO Consulting Ltd; 2. Trustee – Firstsite Gallery (voluntary, unpaid position); 3. Trustee – Benham-Seaman Trust (voluntary, unpaid position).		
1.iii	**MINUTES OF THE PREVIOUS MEETING**		
	Board of Directors Part I: 03 December 2020 Attendee list: Josie Rudman was marked as present in the meeting and she was not present. Item 1.ii Declaration of interest: Diane Leacock's interest to be noted (as set out above). **Approved**: With the above amendments the Board of Directors approved the Minutes of the Part I meeting held on 3 December 2020 as a true record.		
1.iv	**MATTERS ARISING AND ACTION CHECKLIST**		
	Noted: The Board received and noted the updates on the action checklist. **Discussion:** i. CC noted that a number of items on the action checklist had been deferred and requested that the dates for actions were updated. SP agreed that EDs would review and provide complete or confirm revised dates as appropriate.	EDs	Feb 20
1.v	**Chairman's Report**		
	The Chairman noted that matters were fully covered within the CEO's report to the Board.		
1.vi	**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. **Reported:** By SP that: i. He wanted to thank and recognise the work of all of our staff for their response to the pandemic. The Trust was approaching the milestone of the pandemic being a year old and there was perhaps a danger that we become accustomed to the pressure that is being faced by our staff and the wider service. The number of our staff redeployed and the length of the incident were not normal and this required extraordinary commitment and hard work from all of our staff. The Chair had mentioned that at his visit that the hospital was calm, and morale was good but people were tired and this was understandably so.		

Agenda Item		Action by Whom	Date
	ii. Since the last Board meeting we had seen continued additional demands on RPH in terms of COVID transfers into critical care as well as respiratory Level 1 and Level 0 patients who had been admitted from across the region. We need to note that this had been appreciated by the wider system; particularly our colleagues in Essex in relation to the respiratory surge beds that have been provided. iii. ECMO cases are operating at four times the level that would usually be seen at this time in the year. The ECMO service is providing support through transfers and advice and guidance across the East of England, London, and the midlands and beyond. iv. Emergency and cancer pathways continued through wave one and have continued throughout the second wave and we have also seen a 24% increase in demand in the cardiology heart attack pathway. This is being investigated but it does put the team under considerable increased pressure. At the beginning of the New Year we also launched our critical care transfer service on behalf of the East of England and this has been very busy supporting the response to the pandemic. v. The Board agenda today will see a focus on the health and wellbeing of our staff. vi. Throughout this incident we have been considering and planning for recovery. Through wave one the focus was around service recovery and what is required now is a plan that balances the recovery needs of our staff alongside recovery in services. We need to learn from our experience in the hospital move as we saw that provided a natural break point for some staff who made decision to change working patterns, or to retire and we may see the same issues on the back of the COVID pandemic. The Trust needs to ensure that we keep this in mind through measures that ensure that staff know that their best interests are of paramount importance to us and so they feel that they can continue to commit to the health service and to their patients, but also have a work life balance. This is a major feature of the Executive discussions and the Trust will bring plans on this through Committee and to Board in the coming weeks. vii. The organisation has had national and international media coverage this week with stories that have promoted the great work of our staff and delivered some public health messages. viii. Also impressive were our research endeavours where we have the highest number of patients recruited to trials where we are close to 40% of patients recruited. This is a testament to the R&D team and to the culture of the Trust and mission to bring tomorrows treatments to today's patients **Discussion** i. CC noted that communications with staff around the vaccine had been very positive and she wished to commend the Trust on this. ii. CC advised that the NEDs had met the prior evening and they had wanted to convey that during the pandemic they felt that the Trust was in a good place noting that NEDs felt that they had been given sufficient assurance that the quality of care		

Agenda Item		Action by Whom	Date
	was of a very high standard and that our patients were being well looked after and were safe. This was evidenced by the low mortality and a low nosocomial infection rates. They also believe that the welfare and wellbeing of staff was of paramount importance to the Executive, and this was evidenced by the staff briefings and the resources available to staff. The NEDs appreciated the ability to get independent assurance by attending meetings such as the staff briefings and the Clinical Decision Cell. However they would like to strive to be better and to get further independent feedback and expect that the Executive would support that. SP noted that the feedback was appreciated and he asked NEDs to continue to push for improvement as the Executive would not think of everything and would always look for ideas for improvement. iii. GR asked for detail on what the critical care transfer services entails and what resources were required to support this. RH outlined that this was a service that was commissioned to operate for 12 hours a day over seven days using our critical care team to undertake patient transfers. The service operated in addition to the ECMO transfer team and was Consultant and Senior Nurse led. It provided the ability to transfers between intensive care units as a part of the load levelling undertaken across the region. The team was also able to provide advice and guidance to what could be a distressed intensive care unit and it had been very well received. Around 200 patients had been moved for load levelling within the East of England Region and about 40% of those transports had been undertaken by the RPH teams. The reach of the transfers had been wide with patients as far away as Bristol and Swindon and it was felt to have saved lives. GR asked about the resource impact on other services. RH advised that the resource requirement was probably equivalent to staffing for one critical care bed but the critical care team were very good at maximising resources. iv. AF thanked SP for the excellent reports and wanted to reiterate the comments made by CC. She also asked whether the wellbeing of staff and whether the discussion around balancing the service and staff recovery was a part of the Integrated Care System discussions and whether the long term impact on staff was being considered as a system. SP noted that this was a part of a national conversation about recovery for services and staff and that the balance between those matters was being discussed as an ICS. The Board should also note that the Trust had a range of measures to frame this discussion within the organisation with the dynamic modelling tool that we used to inform recovery plans, and the Clinical Decision Cell who can determine what resources are required to deliver safe service recovery. We had also been able to quantify in the model the impact of some of the wellbeing initiatives such as encouraging staff to take annual leave and to undertake training and development. The modelling tool and the CDC allows us to get the people and the service requirements right and to deliver safe care to our patients. The Trust would share its disciplined approach with the system, and we had to get this right as we have a duty of		

Agenda Item		Action by Whom	Date
	care to our staff as well as meeting the demand from patients. v. AF noted and commended the appointment of Emma Warren. SP noted that feedback on the appointment had been very positive with staff accessing the service. vi. JW welcomed the positive report of recruitment through the R&D trials; also the low nosocomial infection rates which he felt must relate to the way that the Trust functioned rather than simply the geography or layout of the building. **Noted:** The Board noted the CEO's update report.		
	Patient Story		
	Penny Martin, Safeguarding, Social Work & Discharge Lead presented a patient story for the Board. This related to a 38 year old man from Bangladesh who had been admitted to his local hospital with a heart attack and who had been transferred to the Trust for emergency valve surgery and a CABG who had a five day stay in critical care. His local hospital subsequently refused to accept repatriation of the patient because of his immigration status. The Trust were aware at the point of transfer that there were problems with the man's status and it was subsequently established that he was homeless, had overstayed his visa and had no recourse to public funds. The team at RPH whilst familiar with and having good pathways for homeless patients were unused to dealing with patients who did not have recourse to public funds. An approach was made to the Home Office but they would intervene only if the patient wished to return to Bangladesh. The local hospital subsequently refused to accept repatriation of the patient. The team found it difficult to get support for this patient and contacted many organisations but some were not in a position to help because he had no recourse to public funds. The team sought to focus discussions on the person at the centre of this matter. Eventually a local charity was found which supported the patient with food, clothing, legal advice and they provided some support with discharge. The patient was discharged to street homelessness and there was nothing that the Trust could do to prevent that. The local charity funded had funded a couple of nights of accommodation and were then able to refer him on to a mosque in Manchester which offered him refuge. The issues faced were that whilst we have good pathways around homeless, where patients have no recourse to public funds it is not something that we can resolve. The next issue that was addressed was cultural competence and our understanding of the cultural awareness of the Bangladeshi community and our lack of links into that community. We came across the organisation that provided significant help after many approaches and we hope to build on that relationship. We looked at the importance of religion and food and made arrangements for provision, however this was made more difficult to access because of the COVID pandemic as many local support services were affected by it. Communication was challenging and required the use of		

Agenda Item		Action by Whom	Date
	interpreters it was also established at discharge that the patient was illiterate and so translated materials were not helpful in this circumstance and this presented another barrier to providing support. On discharge the patient needed to have warfarin management and counselling. The team found support for this in Cambridge and then in Manchester. The lessons learnt were around the financial consequences of treating patients without recourse to public funds. There were ethical considerations for the Trust given the financial costs as well as the costs of other patients not treated. The team had now seen two other cases and there was a need to focus on the human rights of the patient at the centre of these matters. The team have undertaken training on homelessness and the Human Rights Act and were looking to improve their cultural competence. The Trust was also now a part of the 'no recourse to public funds' network. JW thanked PM for the story and noted that whilst there were costs associated with this he felt that the focus should be always on the patient at the centre of this. **Discussion:** i. IG thanked PM for presenting this story to the Board, he was aware of the time that PM had worked to support this patient and the way that the team had engaged positively with the patient with public and voluntary agencies and noted the positive outcome that had been achieved. ii. MB asked how this patient had been picked up. PM noted that the patient had presented with a heart attack and we were therefore under an obligation to provide lifesaving treatment. iii. JA asked about the general matter of illiteracy and whether in general we spoke to patients to identify this this and whether there were opportunities for new technology to be used to record conversations and advice so that patients could play back and access instructions. PM noted that in this case it was not picked up until we were providing written information to the patient and that patients were often good at masking illiteracy and the Trust was looking at whether illiteracy this could be flagged on the records system. **Noted:** The Board thanked PM for presenting the patient story.		
2	**PERFORMANCE**		
2.a.i	**PERFORMANCE COMMITTEE CHAIR'S REPORT** **Received:** The Chair's report setting out significant issues of interest for the Board. **Reported:** By GR that: i. Emma Warren had attended the Committee to present the work that was being undertaken on wellbeing. Listening to		

Agenda Item		Action by Whom	Date
	Emma had allowed the Committee to triangulate the assurances provided on wellbeing initiatives. ii. That in the PIPR report Safe had moved back to Green from Amber and that the numbers of falls and pressures ulcers had reduced to more normal levels which was pleasing to see. There had been increases reported in levels of bacterial infections and RH had advised that these were principally associated with the high volume of critically ill patients being managed at RPH. This assurance would be considered over the coming months and each instance of infection was monitored very closely. iii. That it was difficult to have a clear view of performance at this time as for example we had reported high theatre utilisation but this was as a result of a number of theatres being closed. It did show that the Trust was using its assets well but the Board needed to be mindful of reporting at this point in time when the hospital and system were effectively in shock. iv. The Trust was in a strong position financially because of the lower costs of COVID19 than our standard cases and as some ECMO costs being incurred had been funded earlier in the year. This position was allowing the Trust to reach out to offer support to other partners in the local system. **Discussion:** i. JW noted that it was difficult to interpret PIPR data in the current context and good to highlight that caring had also moved to a green rating. **Noted:** The Board noted the Performance Committee Chair's report.		
2.b	**PAPWORTH INTEGRATED PERFORMANCE REPORT (PIPR)**		
	Received: The PIPR report for Month 09 (December 2020) from the Executive Directors (EDs). This report had been considered in at the Performance Committee and was provided to the Board for information. **Noted:** i. That overall Trust performance was at a Red rating. ii. That the summary version of the PIPR for December 2020 included the latest dashboard KPI and additional KPI metric information but excluded elements of routine reporting on key challenges and spotlight narratives. **Discussion** i. JW proposed that the report PIPIR should be taken as read unless there were specific queries as this had already been scrutinised at Committee. ii. RH noted that he wanted to clarify that the issue of increase infections was not as a result of overcrowding at RPH but more to do with patients recovered from other critical care units that had been working in exceptional circumstances and this may be driving some of the increase but this would be monitored and reviewed over time.		
	Noted: The Board noted the PIPR report for Month 9 (December		

Agenda Item		Action by Whom	Date
	2020).		
2.c	**COVID19 PERFORMANCE REPORT**		
	Reported: By TG that: i. The Trust was producing a COVID19 performance report as in phase one of the pandemic. ii. He would draw the Board's attention to page 2 which showed the pressure that the pandemic had placed on the EoE critical care units which were working at twice their baseline capacity. iii. The summary showed how RPH and CUHFT had stepped up to load levelling to support Trusts across the region and that for critical care patients we were now back at the level of wave one numbers for COVID19. In addition the graphs showed that whilst the total numbers in critical care were the same as in wave one the Trust was also providing L1 and L0 respiratory care. When increases in cardiology emergency activity and transport service were overlaid onto this picture it illustrated just how the hospital was responding in wave two in quite an extraordinary way. Discussion i. RH noted that accepting the L1/L0 admissions was a deliberate strategy not because they were more straight forward. The vast majority of these patients were like L2 patients and some of these patients had ended up on ECMO. The Trust had selected patients who were eligible for escalation and the respiratory physicians had performed extremely well managing these complex patients in a ward environment using O+ therapies and had delivered great outcomes for those patients. ii. JW asked what outcomes were being seen for patients in wave two. RH noted that critical care outcomes were thought to be likely to be worse than in wave one for a number of reasons. Hospitals had learned to managed to L1 patients with respiratory failure in the ward environment; also that the survival benefits of research, particularly the Recovery trial had highlighted the benefits of drug therapies (including use of using arthritic medications to dampen the immune response) and so what was being seen in the critical care units were patients who had not responded to these approaches and so this number represented a smaller proportion of the total COVID19 patient population. The Trust would need to take these things into consideration when analysing outcome data. RH expected good and excellent outcomes, but as these patients had very long lengths of stay it would not be in a position to assess these for some time. The Trust would also to do a post hoc illness severity scoring for COVID19 patients to ensure that there were like for like comparisons being undertaken. RH also reminded the Board that COVID19 was a new disease and that whilst we were seeking to deliver evidence based medicine there was a weak evidence base. iii. EM noted that the key demand issues were as had been set out and that in addition to critical care, the demands in respiratory and cardiology services were very different to the		

Agenda Item		Action by Whom	Date
	first wave of the pandemic. iv. IW asked about the calculation of 'safe surge' capacity and how far this reflected the burden of ECMO cases and the volume of level 0/1 level patients that were being managed by the Trust. RH advised that the safe surge figure was calculated after discussion with the critical care network. It was therefore a network assessment of the surge capacity. Levels had been assessed in response to some unrealistic plans that had been seen across Trusts in wave one. RH noted that the network was looking at level 2 patients (oxygen+ therapy and ventilated patients) being included in the surge capacity. During wave two the mix of patients and demand had changed and the Trust was able to manage ECMO patients with broadly the same resource a ventilated patient. v. EM added that whilst the safe surge figures had come from the centre the Trust had done extensive modelling using its dynamic tool to work through the level of services that could be delivered. The learning from the first wave had improved the regional understanding of the competing demands and commitments on the organisation particularly around staffed safe care rather than bed capacity. The Trust was therefore comfortable with 54 critical care beds being a deliverable, along with 20 respiratory beds and 20-25 ECMO beds within those figures. vi. DL asked about the graph showing the increase in clinical staff off sick. OM advised that this represented a mix of seasonal increases (which were at lower than normal levels); COVID absence for those who are symptomatic and those identified through test and trace. In addition there were numbers included for those staff who were shielding either for themselves or as a result of household shielding. This was a very complicated position for managers to support because it was so fluid. A significant spike had been seen around Christmas associated with community rates of infection. Within the region Cambridge & Peterborough (C&P) had one of the lowest rates of sickness absence, with much higher levels of absence being seen in Suffolk and Essex and within C&P the Trust was at the lower end of the absence rates. All Trusts were managing absence well but all were being impacted by the volume of cases arising in the community. TG noted that the sickness levels reported were within the parameters of the modelling that had been undertaken. vii. MB asked about assessment of acuity that RH had mentioned as if the Trust was taking the most complex cases this would have an impact and should inform who we would seek to learn from and the way that we were recognised nationally. RH noted that in wave one the Trust was one of the top five for critical care outcomes after severity of illness weighting. The weighting assessment was undertaken by ICNARC and they would do this analysis in the second wave. RH noted that the Trust would need to understand the impact of bias as it took a differentiated approach to admissions meaning that the Trust would not accept patients who were unsuitable for further escalation. There would also be a further bias towards		

Agenda Item		Action by Whom	Date
	accepting patients who had a higher than normal probability of being accepted on to ECMO and there will be a signal of this approach in outcomes. RH noted other issues in the understanding of the impact of intensive care as a therapy. This would buy time but much of the outcome was determined by the relationship between the virus and the host, and how the host responds. Many patients had perfect intensive care management but if the virus had destroyed their lungs they would not survive. The core of the service was related to how well the unit worked; how well the team worked and how well they were able to standardise the treatment and decision making which each delivered incremental gains related to the organisation and delivery of the service rather than the impact of, for example, individual drugs. viii. JA asked if we could look at how populations have fared in the management of COVID19 across the system because of the selection bias. Which patients had been managed in primary care, which had accessed hospital services and which had been referred between hospitals as the population level outcomes would reflect how the system over all coped, rather than individual organisations. Secondly as well as counting outcomes based on survival or death would we look at the quality of survival and the impact of long COVID which would need to be assessed and which would take a much longer period of time to be determined. JW noted that the issue here was that clarity and relevance would come with time. The analysis of outcomes would take time and delivery of treatments to our COVID patient cohort also would take time. **Noted:** The Board noted the COVID19 Performance Report.		
3	**GOVERNANCE**		
3.i	**Q&R Committee Chair's Report** **Received:** The Q&R Committee Chair's report setting out significant issues of interest for the Board. **Reported:** By MB that the Committee recognised that there was a need to formalise the Trust's system for identifying emerging risks to improve horizon scanning and that in relation to consequences where risks had been realise we may also need to maintain an issues log. The Assistant Director of Quality and Risk would be taking those matters forward on behalf of the Committee. **Discussion:** i. JW noted the complexity of this process and asked about how this would be considered as it was very dependent on the horizon that was being considered. MB felt that the horizon could be quite short but he wanted to see the process extending to cover the identification of emerging risks and assessment of the opportunity for mitigation once known using a more standardised approach in how risks were added to risk registers. ii. JW suggested that it might be useful to look at emerging risk in the context of the five year strategy and identify potential		

Agenda Item		Action by Whom	Date
	risks to the Trust plans. COVID would be one risk to delivery and would require us to reassess strategy against potential risks. MB noted also that a strategy such as the Royal Papworth School and whether this had been considered against the associated risks of non-cooperation from academic institutions for example and the risks associated with the costs and the organisation of this plan. SP welcomed the idea to review risks against our strategic objectives and suggested that this could be taken forward through the Board development process. iii. JW noted the need to look at the immediate and longer term position and noted this was analogous to how one would consider differently the immediate risk of adverse weather events and the long term risk around climate change. MB agreed that he would take this discussion forward through the Q&R Committee. iv. DL asked about the Quality review that had been undertaken. IG advised that this had been completed and circulated after the Q&R meeting and it formally documented the impact on staffing of the increased staffing ratios. This was documented formally as a Quality Impact Assessment linked ot the pandemic risk. **Noted:** The Board noted the Q&R Committee Chair's report.		
3.ii	**Audit Committee Chair's Report**		
	Audit Committee Chair's Report **Received:** The Audit Committee Chair's report setting out significant issues of interest for the Board. **Reported:** By CC that the two issues that she wished to bring to the Board's attention: i. That the Committee had reviewed the Internal Control Framework relating to COVID19 and was satisfied with the operation of this in relation to the COVID19 surge. This would be reviewed again by the Committee after March 2021. ii. That the deadline for the Annual Accounts had been extended to the 15 June 2021 and no quality accounts would be expected to be submitted as a part of the Annual Report. **Discussion:** i. GR asked for further information on the single tender waivers that had been noted in the Chair's report and whether this was reviewed by internal audit and whether the reasons were valid and substantiated. CC advised that waivers were reviewed by the Committee at every meeting and were subject to audit. The Trust had received benchmarking that had evidenced that we had relatively low numbers of waivers and were not an outlier. CC felt assured that the Trust undertook due diligence on the waivers and the reasons provided was robust and numbers had reduced as expected following the move. TG noted that every waiver was reported to the Committee with the reasons set out. Internal audit had undertaken work on that list and had provided assurance that		

Agenda Item		Action by Whom	Date
	the reasons provided were valid. ii. JA asked about the number of waiver requests that were turned down as that could provide triangulation of assurance. CC noted that this information had been added to reporting at the request of the Audit Committee and that the Committee saw that a number of waivers were turned down each month. **Noted:** The Board noted the Audit Committee Chair's report		
3.iii	**Combined Quality Report** **Received**: A report from the Acting Chief Nurse and Medical Director which highlighted information in addition to the PIPR. **Reported:** By IG that the report provided an update on the coroners inquests and the current position on nosocomial infections. **Discussion:** i. AF asked about the number of coroner's inquests that were pending as this appeared high at 68. IG noted that this number was high but advised that this was not within our gift. Carole Buckley, the Assistant Director for Quality & Risk liaised closely with the coroner's office but there was a backlog in their system that had been exacerbated by the COVID19 pandemic. RH noted that the Trust had a very robust system to capture concerns before these get to Coroner. This included the work of the Medical Examiner and the structured judgement review of case notes. We also have a very low threshold for reporting incidents to the SIERP. RH reassured the Board that there was no cause for concern. ii. JW noted the background of a culture that looked for and reported issues to the coroner as it wanted to have an investigation of death. iii. IG advised that the Trust wanted to see closure through the full governance process and invited AF to join the weekly SIERP meeting. **Noted:** The Board noted the Combined Quality Report.	IG/AF	
3.ii	**Board Assurance Framework** **Received:** From the Trust Secretary the BAF report setting out: iii. BAF risks against strategic objectives iv. BAF risks above appetite and target risk rating v. The Board BAF tracker. **Discussion:** i. JW noted the earlier discussion and the need for the Board to review principal risks against its strategic objectives. The Trust's principal risks had been reviewed early in 2020 and the Board had added Cyber Security and the COVID19 Pandemic risk and these would be need to be considered on a regular basis. ii. AR noted that the Cyber Security remained a prevailing risk which had seen some level of escalation through the COVID 19 pandemic and it continued to be closely monitored.		

Agenda Item		Action by Whom	Date
	iii. GR asked why the change in rating for the pandemic risk was not captured on tracker report. AJ advised that the tracker was produced at a point in time in the month and that any subsequent changes in rating were captured within the narrative update that was provided to the Board. iv. A number of Board members felt that it would be helpful for the Board to undertake a more comprehensive review of the BAF looking at how risks were identified and the assessment of consequence and likelihood but this should be scheduled for a later point following the easing of pandemic. **Noted:** The Board noted the BAF report for January 2021.		
3.v	**Board Sub Committee Minutes:**		
3.v.a	**Quality and Risk Committee Minutes: 26.11.20 & 17.12.20** **Received and noted:** The Board of Directors received and noted the minutes of the Quality and Risk Committee meetings held on 26 November and the 17 December 2020.		
3.v.b	**Performance Committee Minutes: 26.11.20 & 17.12.20** **Received and noted:** The Board of Directors received and noted the minutes of the Performance Committee meetings held on 26 November and the 17 December 2020.		
3.v.c	**Audit Committee Minutes: 08.10.20** **Received and noted:** The Board of Directors received and noted the minutes of the Performance Committee meeting held on 8 October 2020.		
4	**WORKFORCE**		
4.i	**Workforce Report** **Received:** The Director of Workforce and OD a verbal update on key workforce issues. **Reported:** By OM: i. That the Q&R Committee had received the paper on providing and update on the EDI, Wellbeing and CCL Programme and she wanted to ensure that the full Board were aware of the key areas of progress. ii. That a lot of work had continued on CCL programme and this was aligned to the recovery discussion for our workforce. iii. That recovery required a balance between service and staff and these needed to be balanced in terms of impact and how these elements interact. iv. That there was an aspiration to speed up the progress and assess the constraints and the Trust was in a good position in assess in the how the needs of our staff would change in response to the recovery programme. v. The EDI agenda was being progressed through the national and local initiatives and the Committee had received an update on the work on values and behaviours from Smitha Sebastian, the Compassionate and Collective Leadership		

Agenda Item		Action by Whom	Date
	Project Manager. Smitha had been looking at working in different ways and was starting to look at models and test these with individual departments and there had been significant interest from the areas. OM advised that a further paper would be brought to the Board in June and there was work to be undertaken on this to widen the participation in this programme. Discussion: i. DL thanked OM for the report and noted the huge amount of work that was underway and asked about the specific priorities for EDI for the next 6-12 months. OM noted that the current focus was on vaccination rates where we had seen differential uptake between white and BAME staff groups. Also the launch of the reciprocal monitoring programme where the Trust had joined the national programme and would see 20 pairs invited to join the programme over the next 18 months, and Onika Patrick-Redhead, the EDI Manager, was currently undertaking work with managers on level five looking at issues around cultural competency and allyship. ii. SP noted his thanks for this work. He noted that the Trust spent time focusing on areas where we were strong and must recognise that it had more to do in this area and the impact of this would be seen in our staff survey results. He had attended the national launch of the of the reciprocal mentoring programme and had seen that this could deliver terrific benefits in terms of co-creation of initiatives and this would provide an opportunity find solutions to some long standing issues. iii. AF noted that Onika had attended Q&R and had presented the work that was underway and that she had felt reassured about the approach, the scope of the work, and the progress that was being made. **Agreed:** The Board noted the update from the DWOD.		
5	**Research & Education**		
5.i	**GMC Survey Results 2020** **Received:** From Medical Director the report setting out the 2020 GMC survey results. **Reported:** By RH: i. That the survey was undertaken during the period of the pandemic and so responses would reflect the impact and consequence of redeployment for trainees. The Trust should not minimise the impact of this as it would have had an impact on individuals with some facing delays in their training. RH also noted that he wanted the Board to thank its trainees for the their flexibility and their support in response to the COVID19 pandemic. **Discussion:** i. CC asked whether there was anything that the Trust could learn from Liverpool Heart & Chest as they seemed to have		

Agenda Item		Action by Whom	Date
	done very well in their survey. RH agreed that he would invited the Director of Medical Education to get in touch with the Trust to ask about their approach. ii. JA noted that this was a snapshot in time and asked what the Trust did to measure the feedback from juniors over the course of the year. RH advised that we had a Junior Doctors Forum which provided opportunity for feedback and that juniors were encouraged to feedback through their Education supervisors. A junior trainee was also on the Joint Local Negotiating group but much of the reporting would be directed through the Dean and Deputies. iii. JW noted that there had been a very good report on the surgical training programme last year which had indicated that the training opportunities were excellent. RH noted that the core medical and surgical training was not as balanced a programme as would be delivered in other settings because of the specialised nature of the Trust and so in some areas there were fewer opportunities to learn. iv. IG advised that there was a dedicated Medical Education Manager and that they used GMC survey feedback along with feedback from the HEE and Deanery surveys to feed into the multi-professional Education steering group. He felt this agenda would be at the heart of the Royal Papworth School. v. The Board asked for a further update in year on how we use feedback from our Junior Doctors. **Noted:** The Board noted the GMC Survey Results for 2020.		
6	**BOARD FORWARD AGENDA**		
6.i	**Board Forward Planner** **Received and Noted:** The Board Forward Planner.		
6.ii	**Items for escalation or referral to Committee** It was agreed that EDs would review parked items and the Board Action Checklist to plan how these matters would be brought forward to the Board.		

……
Signed

……
Date

Royal Papworth Hospital NHS Foundation Trust
Board of Directors
Meeting held on 4 February 2021

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) Level Four: L4S and L4N Level Five: L5S and L5N CCU Critical Care Unit
WTE	Whole Time Equivalent