Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Held on 2 April 2020 at 10:30am
Ground Rehab Floor Seminar Room
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)
	Mr D Dean	(DD)	Non-Executive Director (T)
	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)
	Mr A Raynes	(AR)	Director of IM&T Chief Information Officer
	Mrs J Rudman	(JR)	Chief Nurse
	Prof I Wilkinson	(IW)	Non-Executive Director (T)
In Attendance	Mrs S Harrison	(SH)	Associate CFO
	Mrs A Jarvis	(AJ)	Trust Secretary
	Mr A Selby	(AS)	Associate Director of Estates and Facilities
Apologies			
Observers	Mr T Glenn (T)		Chief Finance and Commercial Officer (14/04/20)
(T – joined the meeting via online teleconference)			

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1.i	**WELCOME, APOLOGIES AND OPENING REMARKS**		
	The Chairman welcomed everyone to the meeting and apologies were noted as above. The Chairman noted his thanks to Roy Clarke whose last meeting had been the Extraordinary Board on the 20 March and welcomed Tim Glen who joined the meeting as designate Chief Finance Officer, joining the Trust on the 14 April, and Andrew Selby, Director of Estates and Facilities. JW noted that he had been impressed by the response to COVID-19 and the way that Trust teams had been functioning. Board members should be receiving the daily staff briefings and these reflected to the		

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	professional approach that was being maintained across the organisation.		
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. Josie Rudman, Partner Organisation Governor at CUH. v. Stephen Posey in holding an Honorary contract with CUH to enable him to spend time with the clinical teams at CUH. vi. Stephen Posey as Chair of the NHS England (NHSE) Operational Delivery Network Board. vii. Stephen Posey as Trustee of the Intensive Care Society. viii. Stephen Posey, Josie Rudman, Roy Clarke and Roger Hall as Executive Reviewers for CQC Well Led reviews. ix. Andrew Raynes as a Director ADR Health Care Consultancy Solution Ltd x. David Dean as Chair of ETL, a commercial subsidiary of Guy's and St Thomas' NHS FT. ETL are currently providing advisory services to the Estates team at Cambridge University Hospitals NHS Foundation Trust on Project Management. xi. Stephen Posey as Chair of the East of England Cardiac Network. xii. 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. xiii. Cynthia Conquest as Deputy Director of Finance and Performance at the Norfolk Community Health & Care NHS Trust. xiv. Stephen Posey as a member of the CQC's coproduction Group. xv. 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. xvi. 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		

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	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).		
1.iii	**MINUTES OF THE PREVIOUS MEETING**		
	Board of Directors Part I: 6 February 2020 **Item 2b:** Page 7 the word "going" should be deleted. **Item 2.b.iv:** Page 8 the word "effected" should be amended to read "affected". **Items 2.b.i and 2.b.iii** CC noted that the recording of the discussion under the Safe and Caring domains should be amended to record that the metrics had been discussed at Performance Committee and the Quality and Risk Committee and that no issues of concern had been noted. **Approved**: With the above amendments the Board of Directors approved the Minutes of the Part I meeting held on 6 February 2020 as a true record.		
1.iv	**MATTERS ARISING AND ACTION CHECKLIST**		
	Noted: The Board received and noted the updates on the action checklist.		
1.v	**Chairman's Report**		
	The Chairman provided an update on current activities to the Board. He noted that in complying with the Government guidance on social distancing he very much missed being present at the Trust.		
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. That the response to COVID19 remained fast moving and dynamic. ii. That in addition to his report he advised that the Trust had now joined the NHS Recovery trial. This trial was to evaluate provision of antiviral treatments to patients and it had seen a good start with patients already recruited at RPH. iii. The management of the national incident required rapid evaluation and consideration of options for service provision. iv. The discussion on system capacity was being led by the Executive to free our clinical and nursing leaders to respond to the pandemic. v. The Critical Care Unit (CCU) was currently open to 39 beds. vi. The Trust had 23 COVID19 patients and 19 of those patients were on the Critical Care Unit. vii. Two thirds of the patients in the Trust were from outside the		

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	local system with patients being admitted from across the East of England and from north London. SP invited the Executive Leads to provide updates across the Trust activities in response to the COVID-19 pandemic. **Research and Development** i. JW noted that IW had supported the establishment of research trials in response to COVID19. IW thanked the Trust team for their response and noted that whilst this was a difficult time to engage with research local Trusts had prioritised this and were engaging with three national trials covering: a. The NHS Recovery trial. b. An ITU trial c. A Primary Care trial ii. Campus teams were developing complementary studies and had received funding to develop a trial on healthcare worker prophylaxis and another trial similar to the current Recovery study and all of these would provide opportunity to build understanding. **Clinical Decision Cell** i. RH advised that the Trust was in a period of rapid manoeuvres and this was being support by the Clinical Decision Cell that had been established in the first instance to support internal decision making and which had evolved to provide advice to the CCG and the Region. ii. The Trust had been able to support the transport arrangements as it had put in place a contract for four ambulances to support transfers but required referring Trusts to staff the transfer team. The priority for transfer were those patients who were suitable for escalation based on assessment of frailty and comorbidities, and who wished to receive intensive care measures. iii. It was hoped that a significant number of patients could be supported through Non Invasive Ventilation (NIV) and Continuous Positive Airway Pressure (CPAP) and the Trust was ready to manage deteriorating patients through invasive ventilation. iv. The Trust was progressively expanding critical care capacity and was now using surge area two which included the cardiology holding bay. It would next move into using the third floor which was phase three in the surge plan. **Critical Care Surge** v. JR advised that the Trust was in surge and this would provide a legacy of heightened ICU training for our nursing staff. Three hundred staff have been through a basic awareness course for Critical Care and were now able to provide bedside care under appropriate supervision. vi. The surge had moved into zone two and there were some small reconfigurations underway and these were going to plan. vii. The oxygen supply to the bedside was secure as the building was designed to allow for a supply of 6L per bed space at full capacity and so would be able to maintain a supply of 15L per		

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	bed space throughout the surge. viii. There were many staff who were now not fulfilling their usual roles and the Trust had launched its Task Teams. These had been put into practice with great success by the Allied Health Professionals team in preparation for the full response to the surge plan. ix. The Trust currently had 39 patients in Critical Care and whilst these were not all at Level three the staffing and delivery of care on the unit was working well. **Urgent and Emergency and non COVID19 Activity** x. EM advised that all non-urgent elective activity had been stepped down. Clinicians had identified urgent cases on waiting lists and these were reviewed through the CDC. The Trust had also completed a review of patients waiting for admission and had attached a clinical priority identifying those who may be at risk of harm if their care was delayed by 16 weeks. The Trust was also continuing to deliver its emergency pathways for heart attack. **Discussion:** i. DD asked about supply of Personal Protective Equipment (PPE). JR advised that the Trust had safe working practices for PPE and that Command and Control had a dashboard and had a count of availability of all PPE equipment in each category. The Trust was monitoring availability and predicting availability in number of days. This gave assurance on the forecast availability of PPE. ii. JR noted that the Trust had safe systems in place for where there was no satisfactory PPE mask fit, and had put in place a secure management system for the issue and return of 'tornado hoods' which was operational from 6am to 10pm and all teams were contributing to management of PPE in a positive way. iii. JW and SP both noted that the guidance that the Trust was working to was clear and in line with PHE guidelines. Also that confusion had arisen where individual colleges and institutions had deviated from national guidance and developed different protocols. SP noted that this had generated a degree of anxiety amongst staff and the public that variations in guidance between Trusts was another cause of concern. Updated national guidance was expected to be issued imminently. **Noted:** The Board noted the CEO's update report.		
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 the Committee had focused on the role of the		

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	Committee during the response to the COVID-19 outbreak as the implementation of the surge plan would require the Committee to focus on: i. The effectiveness of residual service provision. ii. Monitoring of key risks. iii. Overseeing financial sustainability and governance. This issue was to be discussed with the Executive team to agree how best the Committee could discharge these responsibilities without interfering with the operational management of the pandemic response. **Discussion:** i. JW noted that the Trust had guidance on what reporting was required to continue during the pandemic response and that the Executive would consider this with GR and the Committee Chairs. There was a need to continue to collect standard data on an ongoing basis. ii. SP noted that in principle data collection would continue where it was sensible to do so. National guidance would be reviewed by the Executive and there was ongoing live discussion around requirements for Cancer and IHU data. Continuing to collect data would allow the Trust to understand the impact of the pandemic, and provide an understanding of risks relating to future recovery of services. iii. CC noted that the data on performance and assessment of recovery trajectories would be critical information and would be required by Commissioners and the DHSC when consideration moved to recovery plans. EM noted that the operational teams had started to consider how that might be managed and some staff who were required to self-isolate were taking a lead role in the review of data quality and information and the Trust was running a dual track approach on this. iv. EM noted that the Trust had identified those patients that could be managed remotely and was keeping more patients out of hospital as a result of this. The Trust was currently running at 60% occupancy and had 97 empty beds. v. SP noted that there would be a need for the Trust to start planning for recovery although this was challenging as the pandemic was unprecedented in scale, and indeterminate in nature. There was also a risk that there could be a second surge which could peak over the winter period at a time when there was a need to manage the longer term impact of the pandemic in terms of staff illness and absence, and managing the consequences of working at surge levels. This context would inform thinking about recovery plans. **Noted:** The Board noted the Performance Committee Chair's report and JW invited any further questions to be directed through him outside of the meeting.	**EDs/ Chairs**	**Apr 20**
2.b	**PAPWORTH INTEGRATED PERFORMANCE REPORT (PIPR)**		
	Received: The PIPR report for Month 11 (February 2020) from the Executive Directors (EDs). This report had been considered in at the Performance Committee and was provided to the Board for		

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	information. **Noted:** i. That overall Trust performance was at a Red rating. ii. That a summary version of the PIPR had been produced for February 2020 which included the latest dashboard KPI and additional KPI metric information but excluded elements of routine reporting on key challenges and spotlight narratives. iii. That the maintenance of clinical, operational and financial control and stewardship of the Trust remained critical during the NHS response to COVID-19 and that routine reporting to Committees was currently constrained by the requirement to devote maximum operational effort and resources to the COVID-19 readiness and operational response. The reporting flexibilities agreed by the Board on the 20 March had been exercised at by the Trust Executive but data collection and reporting would continue where it was sensible to do so and in line with national reporting requirements.		
	Noted: The Board noted the PIPR report for Month eleven (February 2020).		
3	**GOVERNANCE**		
3.i	**Board Assurance Framework** **Received:** From the Trust Secretary the BAF report setting out: i. BAF risks against strategic objectives ii. BAF risks above appetite and target risk rating iii. The Board BAF tracker. **Reported:** By AJ: i. That the Executive team had discussed how we look at the risks associated with COVID-19. The BAF Pandemic Risk (BAF 2532) had been escalated to a residual rating of 25. It was expected that this rating may reduce once the outcome of all measures that have been put in place to respond to the COVID-19 outbreak were assessed. ii. The BAF report was also being brought to the Board ahead of publication on this occasion as it was felt that there needed to be some reflection on the language that was used to describe the increase in our risk appetite as this would need to be heightened during our response to the pandemic. **Discussion:** i. That the BAF report included a summary of the COVID-19 actions that were in place and that these would allow the Trust to reduce the level of residual risk to staff and patients. ii. That there was a tension between the inherent risk of responding to the pandemic and the adverse impact on delivery of the usual activity of the Trust. This would have an adverse impact on many of our patients with delays to treatment that would need to be assessed and managed. iii. That a significant mitigation of the operational response was the training of our staff to deal with the COVID-19 surge and the development and implementation of treatment protocols to		

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	support staff and patients. iv. RH noted that the Trust would be undertaking treatments with some increased risk where that was the right thing to do for our patients. The Trust had to take measured and appropriate additional risks in order to respond to the pandemic. All mitigating steps carry risk and the prevailing level of risk had increased as a result of the COVID outbreak. v. MB advised that he felt that RH's analysis was right and that every action to mitigate one risk had countervailing impacts, for example a heightened focus on safety might reduce our ability to undertake treatment and so increase risks to patients that we cannot therefore support. The response to the pandemic outbreak therefore would require us to review and to reassess our risk appetite across a number of areas. **Noted:** The Board noted: i. That the COVID-19 pandemic was a major risk to our staff and our patients. ii. That failure to delivery optimal capacity was a significant risk and the Trust needed to focus efforts on how we perform and respond to the COVID-19 threat. iii. That in some measures our usual quality standards would be impacted in order to respond to and support the increased demand arising from the pandemic and this would need to be reflected through increases in the risk appetite across many of our BAF risks. This would be a necessary action taken in response to the operational facts of the pandemic outbreak. iv. That the Trust was following national guidance and doing all that it could to prepare for and manage the pandemic response and to keep our patients and staff safe throughout. v. That the issue of communicating the issue of change in risk appetite would be considered further outside the meeting. vi. The BAF report for March 2020.		
3.ii	**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 one issue that would be kept under close review was the issue of risk around staff confidence in PPE guidance and the adverse impact on staff engagement that had been seen as a result of the variation in opinions across institutions that had been noted previously on the agenda. **Noted:** The Board noted the Q&R Committee Chair's report		
3.iii	**Combined Quality Report** **Received**: A report from the Chief Nurse and Medical Director which highlighted information in addition to the PIPR. **Reported:** By JR that the report provided the headline actions taken in response to the pending surge from the COVID-19 Pandemic.		

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	Discussion: i. GR asked for an update on the Clinical Decision Cell (CDC) that had been established and asked for clarification around the governance of the CDC. RH advised that the cell had terms of reference and that it reported to Command and Control. The CDC formed an ethical committee to guide the Trust decisions and resource allocation. It was a co-ordinating body operating 24/7 and could convene up to date research and provide a digest of this for use within the Trust. ii. The approach of the CDC would be to follow national guidance when considering PPE, drug therapies, research and ethics and that all of its recommendations would be reviewed to maintain the highest of standards and to avoid discrimination. The CDC was minuted and had external ethical advice from the Psychological Medicines team at CPFT. There had been no difficult decisions so far and the CDC allowed the Trust to ensure that it was doing the right thing for patients. iii. JA noted that RH had captured the activity of the cell and that the principles that it worked to might be something that the Board would want to see. There would not be a 'right answer' in the context of responding to pandemic but there was a need to assure the Board that the decisions taken were within the bounds of reasonableness. All discussions would be amplified and the Trust needed the CDC to capture how it considered decisions and to evidence its decision making. iv. GR supported the approach set out noting that the Board did not need to be privy to the decisions taken but needed to be assured that the principles and governance were in place. v. RH noted that the approach being taken was a whole population view and that the CDC had been able to contribute to other Trusts and the wider system. vi. JA felt that there did need to be consideration of the non-clinical voice in this agenda to ensure that there was not scope for a perception of clinical group think to be attributed to the group in any future review of its work. vii. RH noted that MB had been included in the prototype ethics review committee that had been established previously and that there would be a need for the CDC to consider the public view and how this was expressed through the decision making process. The CDC decisions used national frameworks that included frailty scores and clinical comorbidities to inform decisions on where it was appropriate to offer higher levels of care. He also noted that in the context of transplantation the Trust was well versed in making choices on the best use of scarce resources and in that respect the role of the CDC was not very different. **Noted:** The Board noted the Combined Quality Report.		
3.iv	**Audit Committee Chair's Report** **Received and noted:** The Board received and noted the Audit Committee Chair's report setting out significant issues of interest for the Board.		

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3.v	**Board Sub Committee Minutes:**		
3.v.a	**Quality and Risk Committee Minutes: 30.01.20, 27.02.20 (draft), 26.03.20 (draft)** **Received and noted:** The Board of Directors received and noted the minutes of the Quality and Risk Committee meetings held on 30 January 2020, and the draft minutes for the 27 February and 26 March 2020 meetings.		
3.v.b	**Performance Committee Minutes 30.01.20 and 27.02.20** **Received and noted:** The Board of Directors received and noted the minutes of the Performance Committee meeting held on 30 January 2020 and 27 February 2020.		
3.vi	**Annual Review of Standing Orders, Standing Financial instructions and Schedule of Decisions reserved for the Board** **Received:** From the Chief Finance Officer and Trust Secretary the updated documents for approval on the recommendation of the Audit Committee: a. Standing Orders of the Board of Directors (DN142) b. Standing Financial Instructions (DN140) c. Schedule of Decisions Reserved for the Board of Directors and Scheme of Delegation (DN137) **Approved:** The Board of Directors approved the updated Trust documents.		
3.vii	**Board Committee Self-Assessments** **Received:** From the Trust Secretary a paper setting out the feedback from the Committee self-assessment process. **Reported:** By AJ that the risk assessments had been completed by Committees in January and had been reviewed by the Board at the development workshop held in March. **Noted:** The Board noted the output of the Committee self-assessments.		
3.viii	**Terms of reference.** **Received:** From the Trust Secretary the updated Terms of Reference for the Audit Committee. **Approved:** The Board of Directors approved TOR 001 Audit Committee Terms of Reference.		
4	**WORKFORCE**		
4.i	**Workforce Report** **Received:** The Director of Workforce and OD a verbal update on key workforce issues. **Reported:** i. SP advised that the Trust was running with a level of circa		

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	20% absence of staff that were either sick or self-isolating and this had a very significant impact on the work of the Trust. ii. OM advised the Board that the Trust would be moving to put in place restrictions on annual leave to support the response to the pandemic. The Trust would be moving managed leave arrangements to ensure that all staff had access to annual leave over the coming weeks but a limitation on blocks of leave being taken would be applied over the next three months. The Trust would have a process in place to manage exceptional requests. iii. That there were full HR services running across the Trust and that all staff rostering would continue as normal. **Agreed:** The Board noted the update from the DWOD.		
5	**BOARD FORWARD AGENDA**		
5.i	**Board Forward Planner** **Received and Noted:** The Board Forward Planner.		
5.ii	**Items for escalation or referral to Committee** It was agreed that the review of Risk Appetite in relation to COVID-19 would be taken forward outside of the meeting.	**EDs/AJ**	**May 20**

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Signed

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Date

Royal Papworth Hospital NHS Foundation Trust
Board of Directors
Meeting held on 02 April 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) Level Four: L4S and L4N Level Five: L5S and L5N CCU Critical Care Unit
WTE	Whole Time Equivalent