Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Held on 4 June 2020 at 10:30am
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)
	Mr T Glenn	(TG)	Chief Finance and Commercial Officer
	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(T)
	Mrs J Rudman	(JR)	Chief Nurse
	Prof I Wilkinson	(IW)	Non-Executive Director (T)
In Attendance	Tony Bottiglieri	(TB)	Freedom To Speak Up Guardian
	Mrs A Jarvis	(AJ)	Trust Secretary
	Mr A Selby	(AS)	Associate Director of Estates and Facilities
Apologies			
(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.		
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).		

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	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, and Roger Hall as Executive Reviewers for CQC Well Led reviews. ix. Andrew Raynes as a Director ADR Health Care Consultancy Solution Ltd x. Stephen Posey as Chair of the East of England Cardiac Network. 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. xii. Cynthia Conquest as Deputy Director of Finance and Performance at the Norfolk Community Health & Care NHS Trust. xiii. Stephen Posey as a member of the CQC's coproduction Group. 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. 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). xvi. Tim Glen's partner is the ICS development lead for NHSE/I in the East of England.		
1.iii	**MINUTES OF THE PREVIOUS MEETING**		
	Board of Directors Part I: 07 May 2020 **Approved**: The Board of Directors approved the Minutes of the Part I meeting held on 07 May 2020 as a true record.		
1.iv	**MATTERS ARISING AND ACTION CHECKLIST**		
	Noted: The Board received and noted the updates on the action checklist.		

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1.v	**Chairman's Report**		
	The Chairman reported that: i. The STP Chairs and NED leads were meeting and looking at arrangements for future decision making at a system level. ii. That Chairs of Risk Committees were to be invited to meet across the system to consider the learning from COVID19 and to how the system should balance risks going forward. iii. That the NHS Charities Together had received a substantial sum from the Captain Tom Moore's fundraising and this was an opportunity to bid for some legacy projects to support our charitable activities. iv. That the Appointments Committee of the Council of Governors had met and had approved recommendations for the Appointment of Cynthia Conquest as Audit Chair and Michael Blastland as Deputy Chair. Ian Wilkinson would also be taking over as Chair of the Charitable Funds Committee from Cynthia Conquest. **Noted:** The Board noted the Chairman's report.		
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: i. That the Trust had continued to face a very busy period since the Board last met. ii. That the COVID19 numbers had reduced but that the Trust remained in ECMO surge. iii. That he wanted to record his thanks to our frontline staff and all our support staff who were working at the hospital, at home and at Royal Papworth House. iv. He wanted to note thanks also to our Estates and Procurement teams who had put in place sterling work to manage the supply of Personal Protective Equipment (PPE). v. He also wanted to record his thanks to the volunteers and donors who had continued to support the hospital at this time. vi. That the Trust was now working on plans to resume activity and that would be brought to the Board. The safety and welfare of our staff and patients was paramount in this process and was the focus of the Executive team. vii. That the Trust had introduced a new online risk assessment service for staff this had been consulted on, and had received feedback from the BAME Network, our Joint Staff Council and our Freedom to Speak Up Guardian. viii. That we had put in place a range of support measures for our staff and were looking to identify more with support from the Charity. ix. That the Trust was to embark on a virtual Staff Awards ceremony on the 17 June following the deferral of the March event. x. That the Regional Director had written to the Trust recognising		

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	the role that RPH had played in the system response to COVID19. xi. SP asked AR to provide an update on Cyber Security. AR noted that this remained a heightened area of risk during the pandemic and that several Trusts and Companies had been hit by a recent malware attack. The Trust continued to remind staff of their role in protecting the Trust and being extra vigilant, maintaining updates and identifying and reporting phishing and spam attempts. The Trust had updated its Acceptable Use Policy and this set out the stringent measures that were in place to support the organisation. **Discussion:** i. The Board noted and welcomed the report and feedback from the regional team. ii. JA asked whether we had evidence of having repelled cyber-attacks with the Advance Threat Protection which was deployed. AR advised that we used surveillance software and that provided horizon scanning and we were notified of reports on a weekly basis. **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: i. Had received an update on the Trust response to COVID19 and he commended the Executive on the content of the COVID report. This had provided an understanding for NEDs around how the situation was being managed and how risks were being mitigated. ii. That there had been a suggestion that the Board could consider whether the Performance and Quality and Risk Committees could meet jointly as this approach had been taken and was working well at other Trusts. **Discussion:** i. JW noted the suggestion around joint meetings of Committees. He guided the Board and advised that there were good reasons for the separation of the Committee Agenda and suggested that these could be discussed further with members outside of the Board meeting. **Noted:** The Board noted the Performance Committee Chair's report.		
2.b	**PAPWORTH INTEGRATED PERFORMANCE REPORT (PIPR)**		
	Received: The summary PIPR report for Month 1 (April 2020) from the Executive Directors (EDs). This report had been considered in at the Performance Committee and was provided to the Board for information.		

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	Reported: By TG: i. That overall Trust performance was at a Red rating. One domain was rated as Green (Caring), two domains were rated as Amber (Safe and Transformation) and four domains rated as Red performance (Effective, Responsive and People, Management & Culture and Finance). ii. That the Trust was seeing the impact of COVID19 in its performance in the Effective and Responsive domains as its theatres and bed base were not able to be used as effectively. iii. That the increase in RTT waits that had been identified had been discussed at Committee and they remained a concern. iv. That People Management and Culture was being adversely affected by vacancy and sickness absence rates. v. That the rating of the financial position reflected the underlying position of the Trust and the future challenges that would be faced. Discussion: i. JW asked whether the Trust could continue to rely upon the same metrics given the understanding that we would not be able to return to our normal levels of activity as he felt uncomfortable that this would always result in red ratings. ii. SP advised that we would retain the metrics to support and inform commissioning discussions and that a number of these were a part of the NHS constitutional standards and that we needed to hold ourselves to account in relation to our performance against these. Any consideration of returning to 'normal' levels of activity and performance would also form a part of the national political discussion. iii. JW noted the need to review this matter once the Trust was in a more stable state and that this needed to be considered through the national response to COVID19. He felt that the Board would need to consider how it used the BAF to reflect the changing state and risks over the next few months. iv. MB supported the use of the BAF to survey the shifting pattern of risks. JW noted that this would also be picked up on a system basis in the planned meeting of NED risk leads. v. The Board reflected on how targets were set and the issues previously raised about how our internal standards were at amber and red ratings, where we were assessed externally as outstanding but acknowledged that any change to these would need to be for a sensible and evidenced reason. vi. JA noted that he was in favour of stability and that any review should be on the basis of what delivered the best possible care for our patients and our staff and that targets should be framed in the context of our new strategy. vii. SP noted that this was a test of our five year strategy and that he and EM had set up a small group to review this given the context of COVID19. It was expected that some aspects of the strategy would need to be refocused and that some deliverables would change. However the Trust was not starting from scratch and in some areas this had accelerated change. It was planned that this would be reviewed through Committee in July and then brought to Board for approval. This could then be communicated to the whole Trust. JW		

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	welcomed the work that was underway on the Trust Strategy.		
	Noted: The Board noted the PIPR report for Month 1 (April 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 PPE risk had been escalated onto the BAF. ii. That the report had been reviewed at Committee and that EDs had been asked to review the rating of the BAF 2532 Pandemic and BAF 2572 Super surge. **Noted:** The Board noted the BAF report for May 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 from the meeting on 28 May 2020. **Reported:** By MB that. i. That the Chair's report focused on the difficult question of indeterminate risk and the impact of future changes on how we could assess this. The Trust could face very large problems in managing patient expectations in the face of increasing risks and difficult ethical choices, which could become painfully apparent over the coming months. **Discussion:** i. JW noted that the STP recognised this difficult discussion and that we would need to do what was appropriate and sensible. There would be a need to prioritise what was done or not done, and this was not fixed in stone. It was also likely that within the next few months some hospitals may have no COVID patients and so may reassess the extreme levels of risk associated with COVID19. MB noted that we would need to consider how we prepare people for these ethical dilemmas and that we must be as prepared as we can be to face this. ii. RH advised that he felt that the Executive were very aware of the complexity of the task, and pace of decision making that needed to be maintained. There would be difficult decisions to be made, and whilst the initial pressures of the pandemic had been well navigated the issue would be how the Trust emerged from it and the Clinical Decision Cell (CDC) provided one of the routes through this. JW and JA had been involved in the CDC and the group was now settling on the second phase of the response to COID19. This was to get back to doing what we could within our current resources in terms of space, staffing and infection control requirements. Phase three would focus on the recovery plans and Tim Glen and		

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	Sophie Harrison were contributing to that programme of work. This work was not too aspirational and neither would it re-set the Trust to a 'comfortable' level of work. This programme needed constant attention as the experience of COVID19 was different across the Trust with some areas seeing very little change and others craving a return to 'normality'. iii. RH noted that the Trust was close to clinical consensus on the first elements of the programme and had clarity on what needed to be done to achieve its longer term goals. **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: i. That there was an Emergency Preparedness meeting today and that was to debrief to this point. JR noted that we had not as yet entered the recovery phase of the incident. ii. That she had provided the Board with a timeline of events and this illustrated how quickly events had arisen and the pace at which this had been managed. iii. That the report included the Infection prevention and control board assurance framework. JR noted that the template had been revised subsequently and so an updated report would be taken back through Q&R and the Board but the indicators were looking positive at this point and the IPC team were confident that they would be able to resource model to the new standards. **Discussion:** i. JW noted that the CDC seemed to have changed to a different function and that whilst it was positive, its focus needed to be on how to do the best for the most people. ii. JA noted that RH and JR had done a good job in bringing together clinicians to work out what worked best for the whole organisation and that this was more than a zero sum game. He felt it was very positive to see the clinicians respectfully challenging one another in the CDC. iii. JW noted that focus would need to shift to the future strategy and felt that the output in terms of immediate and longer term plans would need to come back to the Board. RH advised that the CDC were finalising a paper setting out the first short phase of recovery and that would be recommended to the Executive through the Living With COVID Steering Group. A part of the goal of this process was to achieve an accelerated cycle of decision making and execution of plans. iv. SP noted that the CDC short term strategy paper would be brought to the Board in July and that there was an item on the supporting modelling that was on the Part II agenda. **Noted:** The Board noted the Combined Quality Report.	JR SP	Jul 20 Jul 20

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3.iv	**Board Sub Committee Minutes:**		
3.iv.a	**Quality and Risk Committee Minutes: 30.04.20** **Received and noted:** The Board of Directors received and noted the minutes of the Quality and Risk Committee meetings held on 30 April 2020.		
3.iv.b	**Performance Committee Minutes: 30.04.20** **Received and noted:** The Board of Directors received and noted the minutes of the Performance Committee meeting held on 30 April 2020.		
4	**WORKFORCE**		
4.i	**2021 Q1 Pulse Survey Results** **Received:** The Director of Workforce and OD a verbal update on key themes from the Q1 Pulse Survey. **Reported:** By OM: i. That the survey results had been to Q&R and this survey was undertaken as we wanted a baseline for staff feedback. The results presented a mixed picture with improvement in some areas and deterioration in others. There were key issues identified around the redeployment of staff to critical care and this would be an area of focus going forward. **Discussion:** i. JW noted that staff had behaved incredibly well throughout the pandemic but he felt that they were still fragile. SP advised that this had been the subject of discussion at the Monday briefing and the Trust recognised that there was still much work to do. The feedback reflected themes in the national staff survey and there were areas that we needed to improve such as our staff recommender score which we would like to see at 85% or 90% and we were not close to that level. One of the key issues identified was the relationship with line managers where a lot of staff did not feel that their contribution was acknowledged or recognised as they should be. The Trust planned to stoke a conversation around how to support people and to lead creating the best environment for our staff and there was still a lot of work to do on this. ii. JA thanked OM for the report and noted that it was good to see. He observed that sometimes the fragility of staff after a crisis was over could intensify and so the Trust may see this increase over time. **Agreed:** The Board noted the update from the DWOD.		
4.ii	**Freedom To Speak Up Guardian's Report**		
	Tony Bottiglieri attended for this item. **Reported:** by TB: i. That that FTSU annual return had been submitted on the 11 May and a summary report would be brought to the Board in the summer. ii. That he was attending today to provide feedback from the		

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	series of drop in sessions held during April and May. These had been successful with sessions available across the day and around 30 staff had attended some in groups and some on an individual basis. iii. There were some key themes relating to redeployment including: a. The preparation for staff that were being redeployed and a concern that the induction period was too short. b. Some staff felt ill prepared to support some of the specialist services such as ECMO as they had not worked in critical care for a many of years. c. The level of anxiety experienced in the move to other clinical areas and staff reported feeling unclear as to how to express those concerns and reports of a lack of compassion when staff had expressed concerns. d. A concern as to why the Trust had put itself in the position of accepting such increases in the numbers of patients when neighbouring Trusts were dealing with fewer patients. e. That there were insufficient breaks when on critical care (however this was noted to have been in the early stages of the pandemic and this had been supported on a more orderly basis with the introduction of the ECT teams). f. Wearing PPE as this had been difficult to wear for long periods and had reduced the ability to keep hydrated leading to some urinary tract infections and incontinence issues. g. That the selection process for staff to return to their original work areas seemed to have little guidance and to have been subjective and so seemed inconsistent in application. h. That some admin and clerical staff had reported feeling underutilised and left feeling that they had to fight to get accepted in undertaking new roles. They also reported feeling criticised for not being busy. They had been encouraged to take annual leave and felt that they were being penalised for not being fully utilised through redeployment. i. There were some issues reported by BAME staff around PPE and these were shared with the BAME network and a process was in place to assess risk factors for staff on wards in relation to PPE. j. There were issues also from BAME staff around the allocation of acting up and promotions which had been reported to the FTSU Guardian as well as to Unions and the Chair of the BAME network. k. There were requests for the tone of messaging to acknowledge some of the pressures felt by staff rather than the focus on the extent of the role being undertaken as this had increased levels of anxiety. **Discussion:** i. JW noted that it was difficult to hear that our staff had not felt valued but he hoped that they would understand that the		

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	reason that the Trust had admitted more and sicker patients than other centres would be explained when staff saw the results of the care that was being delivered which was better patient outcomes than at other centres. ii. SP acknowledged the feedback and the work done on this. He noted that the impact on individuals was significant and this was being considered at the BAME Network and with the Joint Staff Council. iii. SP noted that as an Executive he did not feel that we would have done things differently in the time of a national pandemic and under significant time pressures. He acknowledged the need to have clear communications and messaging and that these were not intended to be heroic; but the Trust was the last point of escalation for many patients and one of only five ECMO centres in the country. iv. SP noted in relation to redeployment that the Trust would be looking at the lessons learned and would reflect on what could be done differently to ensure that there was fair and equitable treatment of all staff. v. SP also wanted staff to hear the feedback that 85% of our COVID19 patients had survived and this was down to the care that they had delivered. He noted that there would be opportunities to look at this with staff and to consider how things could be done differently in the future. vi. JR noted the feedback given by SP and added that the pace and the principles that had been applied during the pandemic had been to do what was best with our resources in order to respond to the regional and national requirements. The training that had been provided to staff was short and focused but was based on the national competency framework. Nationally during the Surge there was an expectation that there would be staffing of one critical care nurse to four registered nurses and we had managed to achieve a higher rate of critical care nurses to registered nurses every day. This had been captured in the classification of Category A and Category B nurses and every day there were more critical care trained than redeployed staff. vii. The plans around redeployment had included input from the Clinical Professional Advisory Committee, Heads of Nursing, Matrons and Ward Sisters and the care hours per patient day measures demonstrated that we had staffing levels above that standard in all areas on a daily basis. This may not necessarily help how a bedside practitioner felt in critical care but having spent time on the unit JR was confident that the Heads of Nursing and Matrons were seeking out redeployed staff to ensure that they were provided with support. viii. JR also noted that there were many positive things to have come out of the response to the pandemic. On the whole staff were feeling supported when redeployed and in circumstances where there were particular issues they were moved back to their existing role. ix. There were plans in place and agreed through CDC for the review of arrangements for every staff member who was redeployed to Critical Care as we remained in ECMO Surge and to identify priorities for staff to be released back to ward		

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	areas. x. The Emergency Preparedness committee would also be picking up feedback on this issue through the debriefing process ahead of de-escalation. **Noted:** OM thanked TB for this work and noted that this was a draining process to undertake. The Trust would want to learn lessons from this and JR and OM would be writing to all redeployed staff this afternoon as this remained a live issue that needed clear communications. **Noted:** The Board thanked TB for his work on this matter and noted the FTSU update.		
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.		

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Signed

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Date

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