**Minutes of the St George's University Hospitals NHS Foundation Trust Board Meeting**
**In Public (Part One)**
**Thursday, 26 March 2020**
**Room 52, 1st Floor Grosvenor Wing, St George's Hospital, Tooting**

| Name | Title | Initials |
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| **PRESENT *(* attendees joining the meeting via videoconferencing)*** | | |
| Gillian Norton* | Chairman | Chairman |
| Jacqueline Totterdell* | Chief Executive Officer | CEO |
| Andrew Grimshaw | Deputy Chief Executive Officer | DCEO |
| Ann Beasley* | Non-Executive Director | NED |
| Elizabeth Bishop* | Non-Executive Director | NED |
| Stephen Collier* | Non-Executive Director | NED |
| Prof Jenny Higham* | Non-Executive Director | NED |
| Prof Parveen Kumar* | Non-Executive Director | NED |
| Dr Pui-Ling Li* | Associate Non-Executive Director | ANED |
| Tim Wright* | Non-Executive Director | NED |
| Avey Bhatia | Chief Operating Officer (*for agenda item 2.1 only)* | COO |
| Robert Bleasdale | Acting Chief Nurse and Director of Infection Prevention & Control | ACN/DIPC |
| Dr Richard Jennings | Chief Medical Officer | CMO |
| Tom Shearer* | Acting Chief Finance Officer | ACFO |
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| **IN ATTENDANCE** | | |
| Harbhajan Brar | Chief People Officer (*for agenda item 2.1 only)* | CPO |
| James Friend | Chief Transformation Officer | CTO |
| Stephen Jones | Chief Corporate Affairs Officer | CCAO |
| Suzanne Marsello | Chief Strategy Officer | CSO |
| | | |
| **SECRETARIAT** | | |
| Tamara Croud | Head of Corporate Governance/Board Secretary | HCG |
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| **APOLOGIES** | | |
| Sally Herne | NHSI Quality Improvement Director | NHSI-QID |

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| **1.0** | **OPENING ADMINISTRATION** | |
| **1.1** | **Welcome, Introductions and apologies**<br><br>The Chairman welcomed everyone to the meeting and noted that due to the COVID-19 pandemic non-executive directors were joining the meeting by videoconference. | |

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| **1.2** | **Declarations of Interest**<br><br>The Board noted that Elizabeth Bishop was also a non-executive director (NED) at Epsom and St Helier University Hospitals NHS Trust. The Board noted that the Trust's Constitution, and the provisions of the NHS Act 2006 on which it was based, permitted directors to have conflicts of interest where these were authorised by the Board. The Board recognised that Elizabeth's role across the two Trusts did represent a potential conflict of interest, but agreed that this could exist on the basis that her role across the two Trusts would assist with facilitating closer collaboration between two major hospitals in South West London, with potentially significant benefit to the patients of both organisations. This was subject to Elizabeth Bishop formally declaring any explicit conflicts of interest in matters to be discussed and agreed by the Board or its Committees. | |
| **1.3** | **Minutes of the meetings held on 27 February 2020**<br><br>The minutes of the meeting held on 27 February 2020 were approved as an accurate record. | |
| **1.4** | **Action Log and Matters Arising**<br><br>The Board reviewed and noted the action log and agreed to defer the majority of the actions that were due as a result of the current and anticipated operational demands of managing the impact of the COVID-19 pandemic at the Trust. The Board noted those actions not yet due and the following update:<br><br>• ***Action Item TB30.01.20/03 (Estates Data in the Integrated Quality and Performance Report)***: The CTO reported that the data for estates had not yet been built into the integrated quality and performance report and this was unlikely to be done in the short term given other immediate priorities, Covid-19. | |
| **2.0** | **CARDIAC SURGERY** | |
| | The Trust Chairman reported that NHS England and NHS Improvement had at 4 pm that day (26 March 2020) published two independent reports into cardiac surgery at St George's University Hospitals NHS Foundation Trust. Alongside this, the Trust had published a report setting out the actions it had taken to ensure the safety of and improve the service. The Chairman emphasised that while the Board and Quality and Safety Committee had given considerable attention to the issues affecting cardiac surgery since the Trust had received the first mortality report in May 2017, the independent reports nevertheless made for very sobering reading and it was essential the Board carefully reflected on their findings and recommendations, and ensured it had on-going assurance as to the safety and effective operation of the service. The Chairman expressed regret for the failings in care identified and for the fact that as a result of the social distancing guidance issued by the Government as a result of the COVID-19 pandemic, the Board had been unable to hold this important discussion on cardiac surgery with members of the public present. As a result, a full minute of the Board's discussions would be prepared so that the public could understand the Board's consideration of the reports and the steps being taken to improve the service. | |

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| | Statement from the Chief Executive:<br><br>The Chairman invited the Chief Executive to make a statement in response to the publication of the reports on behalf of the Board.<br><br>The CEO stated that: "*When a family member or loved one dies we often have great feelings of distress, loss and pain. However when a loved one has died because of poor care, as 67 patients did at St George's, that pain can only intensify. Whilst we can point to many improvements in the care we give at St George's, we need to give, and do give, those relatives and friends of those that died an unreserved full apology for what has happened".*<br><br>The Chairman thanked the Chief Executive for her statement. **The Board endorsed the unreserved apology on behalf of the Board and the Trust as a whole to the families and loved ones of the patients who had died under the care of the Trust in the period examined by the independent panel.**<br><br>Presentation of the independent reports:<br><br>The Chairman invited the Chief Medical Officer (CMO) to present to the Board the findings and recommendations of the independent reports on cardiac surgery. The CMO explained that the Board had been presented with four documents:<br><br>– The report of the Independent External Mortality Review into Cardiac Surgery at St George's University Hospitals NHS Foundation Trust, which had been chaired by Mr Mike Lewis;<br><br>– The report to NHS England and NHS Improvement and St George's University Hospitals NHS Foundation Trust of the Independent Scrutiny Panel for Cardiac Surgical Services at St George's University Hospitals NHS Foundation Trust, chaired by Sir Andrew Cash;<br><br>– The Trust's response to reports into Cardiac Surgical Services at St George's University Hospitals NHS Foundation Trust (in the form of a letter and appended report from the Trust Chief Executive to Sir David Sloman, London Regional Director, NHS England and NHS Improvement); and<br><br>– A summary of the recommendations of the two independent reports into Cardiac Surgery Services at St George's University Hospitals NHS Foundation Trust against which the Trust's actions and progress in implementing the recommendations had been mapped.<br><br>The CMO started by endorsing the unreserved apology to the bereaved families. The CMO explained that he and colleagues had met in person and spoken directly by telephone to six families of the patients who had died under the care of the cardiac surgery service during the period reviewed by the mortality review panel. The degree of distress these families had been through and the distress this brought back to them in talking about the death of their loved ones had been very striking, powerful and profoundly sad. On hearing the outcomes of the reviews of the care provided to their loved ones, families had responded with a range emotions. Some had expressed anger at the failings in care and at the fact the Trust had previously been unwilling to | |

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| | acknowledge these failings or to listen to their concerns. Some expressed the view that, while difficult to hear, it was reassuring that their longstanding concerns had belatedly been taken seriously. The CMO added that the Board should also be cognisant of the fact that this sadness was no less profound for those families where the independent panel had not identified failings in care. For almost a year, the families had known that a review was being conducted into the death of their loved ones and this was inherently challenging and stressful for them.<br><br>The CMO provided an overview of the key findings and recommendations of the reports and highlighted he following points:<br><br>• The Independent External Mortality Review had been led by Mr Mike Lewis and supported by a panel of independent medical and surgical experts. The panel had examined the deaths (most of which were post-operative) of 202 patients who were looked after by the cardiac surgery service at the Trust between April 2013 and December 2018. The review had concluded that there were failings in the care provided to 102 of those patients and in 67 cases those failings either definitely, most likely or probably contributed to their deaths. The review identified a number of themes around pre-operative care, operative care, post-operative care, and professionalism. The Trust fully accepted the findings of the report. While the review did find examples of good care, it concluded that there were "many cases in which the evidence observed in the case note review suggested that the death of patients was avoidable, or that care was of a poorer standard than would have been expected". The CMO explained that the Trust had written to the families of those who had died under the care of the Trust during the period under review to set out the findings of the panel in relation to the care provided to their loved one. In so doing, the Trust had been committed to being open and doing the right thing by the families, and had also thereby discharged its responsibilities in relation to duty of candour.<br><br>• The Independent Scrutiny Panel, led by Sir Andrew Cash, had been established to act as a 'critical friend' to the Trust in October 2018 to support the improvements to safety, leadership, governance and culture of the service. The report made a total of 19 recommendations, which the Trust again had accepted in full. A number of the recommendations had already been implemented by the Trust including the appointment of a new, externally-appointed clinical lead for the cardiac surgery service, the establishment of new protocols for overseeing the safety of the service, and enhancing governance processes around the operation of multidisciplinary team meetings and morbidity and mortality meetings.<br><br>The CMO explained that although the Trust only recently received the final reports, the Trust had been taking a range of actions to improve the safety and governance of the service since it had received the first cardiac surgery mortality alerts in May 2017. In addition, both reviews had ensured the Trust was sighted on any areas of concern in real time so that any further improvements could be made ahead of the completion of the reviews. The Trust had strengthened the day-to-day operational processes, the oversight of the service and the visibility of what happens within it, internal safety governance mechanisms and leadership. The CMO concluded by saying that the Board could take assurance as to the safety of the service from external sources as well as the Trust's own internal measures. These included the | |

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| | improvements documented by the CQC in its inspection report published in December 2019 and by the fact that the National Institute for Cardiovascular Outcomes Research (NICOR) had found that the latest data demonstrated the Trust was no longer an outlier for mortality.<br><br>The Chairman thanked the CMO for the overview of the reports and of the actions taken by the Trust to ensure safety and oversight of the service, and invited questions from Board members.<br><br>Professor Dame Parveen Kumar, Chair of the Trust's Quality and Safety Committee, asked why the issues identified in the review had not been identified by the Trust at the time and escalated through its governance structures and processes. The CMO responded that the current Board and Executive team had been in place largely since Spring 2017 and it was clear that the problems affecting cardiac surgery were longstanding and dated back at least a decade. The Wallwork report of April 2010 had highlighted a number of concerns regarding culture and behaviours within the service and a lack of effective governance, and the potential impact of this on safety. The first mortality alert regarding cardiac surgery had been received from NICOR in May 2017 and related to deaths in the service between 1 April 2013 and 31 March 2016. Following the receipt of the first NICOR alert, the Trust had undertaken a proactive and comprehensive programme of actions, overseen by a Cardiac Surgery Task Force, the Trust Executive Committee, Quality & Safety Committee and the Board, to improve the safety, leadership and governance of the service. New and robust governance structures and processes had been introduced to ensure more effective oversight of the service and the service was now led by a well-respected and externally-appointed cardiac surgeon who had been appointed as Care Group Lead and Associate Medical Director for cardiac surgery. Multi-disciplinary team meetings had been strengthened and all deaths in the service were reviewed by the Trust's Serious Incident Decision Making Group (SIDM). The details of these improvement actions were set out in detail in the Chief Executive's letter to letter to Sir David Sloman as well as being referenced in the independent reports themselves. The CMO acknowledged that it was undoubtedly the case that, historically, there were weaknesses in the Trust's clinical and corporate governance and this had been documented by the CQC in November 2016 when it had placed the Trust in quality special measures. With better governance systems and processes, the issues should have been escalated and addressed at an earlier stage.<br><br>Professor Kumar asked what assurances the Board could take that the cardiac surgery service was genuinely safe, particularly given that the composition of the surgical team had not changed. The CMO reported that there was a range of both internal and external assurance around the safety of the service. The key pieces of evidence on which the Board could rely as assurance that the service was safe were presented to the Board in December 2019. Externally, the key sources of assurance were the findings of the Care Quality Commission inspection report, published in December 2019, which had noted significant improvements in the service and the latest data from NICOR which demonstrated that cardiac surgery at the Trust was no longer an outlier for mortality. Since September 2018, there had been robust external scrutiny of the service with NHS England and NHS Improvement holding regular Quality Summits with the Trust, CQC, and the General Medical Council and neighbouring Trusts to oversee the safety of the service. | |

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| | In relation to the appointment of Mr Steve Livesey as Care Group Lead for cardiac surgery, Professor Kumar asked whether his leadership in improving the service was evident and what succession planning was in place to ensure that the improvements made would be sustained in the event he was to leave the Trust. The CMO explained that Mr Livesey's influence was clearly evident and he had had a profound effect on the safety, governance and operation of the service since his appointment in December 2018. At present, the CMO acknowledged that there was no one in the cardiac surgery service who could take over the role of Care Group Lead in the event that Mr Livesey were to leave. However, succession planning was inherently linked to the emerging plans to develop a cardiac surgery network across South London.<br><br>Professor Kumar asked about how the Trust managed complex cardiac surgery cases. The CMO explained that, in consultation with the regulator, since September 2018 the Trust had decided that complex and high risk cardiac surgery should be performed by neighbouring Trusts to allow the service at St George's the space required to make improvements to the service. Initially, cardiac surgery with a EUROCORE of higher than 2 (in effect, a risk of death greater than 2%) should be performed elsewhere. This was subsequently raised to surgery with a EUROSCORE of greater than 5. The exception to this was Mr Livesey who was the only cardiac surgeon permitted to perform complex surgery above this risk rating. The Trust had recently contacted the Chief Medical Officer at Spire, where most of the cardiac surgeons conducted their private cases, to advise of the limitations set on the complexity of cases that could be undertaken by the Trust's cardiac surgery service, and he had agreed that similar limitations to the complexity of procedures should be implemented in private practice.<br><br>Ann Beasley, Vice Chair of the Trust and Senior Independent Director, asked what assurance the Board could have that other services at the Trust were not affected by similar issues that had been evident within the cardiac surgery service, and in addition asked how the Board would know and be informed should any other services develop mortality or other safety concerns.<br><br>The CMO explained that there had been very significant weaknesses in the governance and oversight of cardiac surgery over many years. These would have been more clearly evident had the Trust reviewed the internal governance of the service at an earlier stage. In light of this, the current Board and Executive team had commissioned an independent review of clinical governance across the Trust, to look at how effective service level governance was operating, including the effectiveness of multi-disciplinary team meetings and morbidity and mortality meetings, and the arrangements and resource available to support effective clinical governance at service level. The Trust had also reviewed corporate level support to Trust-wide clinical governance. The Board had received these reviews, which demonstrated that there was good practice in many areas but had also highlighted areas for improvement and steps were being taken in response to strengthen this. The Board could note recent examples of where behavioural challenges within teams had led to timely escalation to the Board and to the commissioning of external reviews where this was appropriate. This demonstrated that issues were spotted early and that they were escalated from the ward to the Board.<br><br>Jenny Higham asked what external measures the Trust had to ensure the | |

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| | Trust and the Board had oversight of key performance areas and in addition asked what systems were in place so that the Trust could track and act on early warning or soft signals that there could be fundamental issues within a service.<br><br>The CMO acknowledged that the Trust did not always have robust sources of external data to rely upon. NICOR data relating to cardiac surgery was a key source of intelligence regarding mortality and receipt of a NICOR alert had prompted the Trust to take action to improve the service. However, not all services had sources of externally validated data of this kind. Some care groups regularly submitted clinical data externally but this was not routinely done across the Trust. It was recognised that there needed to be stronger systems in place to ensure governance leads across all services and care groups were able to provide the correct data and correlate early soft signals of underlying issues. With implementation of the recommendations from the clinical governance review the Trust had begun moving in the right direction. It would be important to ensure that key sources of soft intelligence could be brought together to identify any emerging issues within a service.<br><br>Asked whether the Board and the Trust management looking at the right sources of information, the CMO explained that the Trust now more effectively triangulated key data from Patient Advice and Liaison services, complaints and freedom to speak up with performance data. It may be possible to have a look back at these data sets at the time that the cardiac issues first arose to ascertain whether these would have yielded information that may have enabled earlier intervention. Culture was a key issue in cardiac surgery and it was essential that staff felt empowered to speak up where they had concerns and were able to escalate issues and concerns effectively.<br><br>Stephen Collier asked about the support being provided both to the staff working in and with the cardiac surgery service and other staff not directly implicated in the findings of the independent review. The CMO explained that support was available to all staff, and particularly those affected by the review. Pastoral support was available to staff in cardiac surgery and the broader members of the care group team including nurses, allied health professionals, and anaesthesiologists. The Trust had held engagement events with affected staff prior to the publication of the report and these had been well attended. Work had been undertaken to strengthen and reinforce the freedom to speak up processes within the Trust and to encourage staff to escalate issues.<br><br>In response to a question regarding the Coroner's engagement with the Trust on the review, the CMO stated that he had met with the Coroner on a number of occasions during the development of the report. At no point had the Coroner expressed a lack of confidence in the current systems and outcomes now in place. The Coroner had received the report and all of the Structured Judgement Reviews compiled by the independent panel and would decide which cases warranted a further review.<br><br>The Chairman thanked Board members for their questions and the CMO for his detailed responses. The Chairman reiterated that the mortality review made for very difficult reading and it was clear there had been significant failings in care that must not happen again. Significant work had been undertaken since the Trust had received the first NICOR alert in May 2017 and the Board could take assurance from the external sources of assurance | |

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| | regarding the safety of the service. The external clinical governance reviews commissioned by the Trust in 2019 and the actions being taken as a result provided further assurance that similar issues would be identified early and would be reported to the Board. She thanked the executive for the work they had done to date and the Board for its ongoing scrutiny of the safety, governance and operation of the service, which would continue.<br><br>**The Board:**<br>• **Received the reports of the Independent External Mortality Review and the Independent Scrutiny Panel into cardiac surgery at St George's and accepted their findings and recommendations in full;**<br><br>• **Recognised the serious failings in care identified in the reports and endorsed the unreserved apology by the Trust to the families of patients who died under the Trust's care; and**<br><br>• **Noted the actions that had been taken by the Trust to improve the safety, leadership, governance and culture of the cardiac surgery service at St George's since the first NICOR mortality alert was received in May 2017;**<br><br>• **Noted that the cardiac surgery service was safe, and in particular noted the independent external assurance on this provided by both the Care Quality Commission's inspection report of December 2019 and the latest data from NICOR which demonstrated that the Trust was no longer an outlier for mortality in cardiac surgery; and**<br><br>• **Agreed that it would require ongoing assurance as to the safety of the service, the implementation of the recommendations of the reviews, and the wider improvements to cardiac surgery at the Trust. The Board agreed it would continue to receive regular reports on the safety and performance of the cardiac surgery service.** | |
| **3.0** | **NOVEL CORONAVIRUS (Covid-19)** | |
| **3.1** | **Update on Novel Coronavirus (Covid-19)**<br><br>The Board was provided with a comprehensive report on the Trust's preparations, operations, governance and wider system issues in light of the developing COVID-19 pandemic.<br><br>The CEO reported that the NHS had not experienced such a crisis in peace time. Modelling conducted by the system had predicted that, on current estimates, around 7,000 people across London may require ventilation during the pandemic, which was way in excess of the number of ICU beds available in the region. The new field hospital at the Excel Centre in East London, the NHS Nightingale Hospital, was designed to provide additional ICU capacity and was being developed to have up to 4,000 ICU beds. The Trust could expect the number of cases to rise dramatically up in the coming days and weeks, though it was hard at present to know when the peak of infections and hospital admissions may come. Given these pressures, Trusts across London were having to look across the range of their operations, consider what additional ICU capacity could be created, and what activity could be postponed or stopped to free up that additional capacity. These pressures applied equally to staffing; as ICU capacity was scaled-up so the pressures | |

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| | on staffing increased. This would mean revising staffing ratios in ICU, for example. NHS England and NHS Improvement had agreed that the nurse-patient ratio in ICU would be changed from 1:1 to 1:6 with additional supporting staff assisting.<br><br>The DCEO reported that in order to manage the challenges facing the Trust in the current crisis and to ensure that there were robust systems for when the Trust returned to 'a new normal', several workstreams had been established to work through the scaling up of ICU and other resources to care for patients infected with COVID-19, the safe stepping down of other activity, the workforce implications for the Trust, the estates, procurement and IT aspects, and the ethical dimensions of managing a surge in very ill patients with limited ICU capacity. Additional workstreams had been established to oversee the management of gifts and offers of help from the community and to begin the planning for the 'new normal'. An executive director had been appointed to lead each workstream. There were daily staff communications across the Trust as well as daily operational meetings.<br><br>The ACN/DIPC reported that there were robust systems in place for the isolation and care of patients who had tested positive for COVID-19. The Trust had created a system for streamlining patients that required screening at the emergency department. The Trust had been reporting tests within 24 hours by completing three-to-four runs each day. More patients were being cohorted and the Trust was using its influenza business continuity plan to manage operationally. The Trust had identified cohort wards and surge ICU capacity. There was understandable anxiety among the Trust's intensive care team regarding personal protective equipment, but the Trust was adhering to national guidance on PPE from the Department of Health. The Trust was currently working to identify staff who could be deployed to support the critical care units and other areas of the Trust, as well as identifying staff to support NHS Nightingale. There was also an improved clinical rota to ensure that there was sufficient senior leadership support and guidance available seven days a week. The Trust was now contemplating how it could provide up to 575 intensive care beds to support the wider system however this would be predicated on the system being able to provide respirators and equipment. To date, there had been a total of 38 deaths from COVID-19 at the Trust and 33 patients had been admitted to its level three critical care function.<br><br>The following key points were raised and noted by the Board in discussion:<br><br>• Jenny Higham noted that St George's University of London, which shared the site with the Trust, had closed and was now conducting its curriculum online. The research laboratories remained open with clinicians focusing on supporting the work around COVID-19. Other clinicians had been released to support the NHS frontline. Students in their final year had also been released into the workforce to support the NHS. The University had also produced a number of guidance and information resources.<br><br>• The DCEO explained that, at present, the Trust had 110 critical care beds. Any empty beds were available to support neighbouring trusts and some Trusts had already transferred patients requiring ICU support to St George's.<br><br>• In response to Ann Beasley's query about how mental health patients could safely attend the emergency department, it was reported that the | |

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| | Trust had redesigned the emergency department pathway so that patients were cohorted into 'green' and 'red' zones. The red zone was for those patients who may have COVID-19. The rooms for mental health patients were located within the red zone footprint but were in separate side rooms. These beds were specifically designed with reduced ligature risks. There were also robust protocols in place to support mental health patients and ensure they were not at risk. In addition, the Chief Executive Officer of South West London & St Georges Mental Health Trust had visited the psychiatric liaison team and was assured by the protocols in place which included faster response from the liaison team when a mental health patient attended the emergency department.<br><br>• NHS England and NHS Improvement (NHSE&I) had asked the Trust to identify staff who could support the new NHS Nightingale Hospital. The Trust had emailed all clinical staff to gauge which staff would like to volunteer. The CPO and COO were considering how the Trust could release staff to the Nightingale while ensuring that the Trust could manage the demand on site.<br><br>• Elizabeth Bishop enquired what the Trust was doing with regards to step down facilities for patients who were medically fit for discharge. It was reported that the Trust had been working with social care and community organisations to ensure that medically fit patients were discharged into appropriate care settings.<br><br>• In response to a question from Stephen Collier, the CMO reported that the Trust was working with the wider NHS system to ensure that there were robust systems for ethical decision making should demand for respirators outstrip capacity. These ethical decisions would be based on rigorous protocols and any assessments would be made on a case by case basis. It was also recognised the impact such decisions would have on clinicians and there would be mechanisms put in place to support staff. Tim Wright added that the Clinical Ethics Committee, of which he was a member, was engaged in this work.<br><br>• The Chairman enquired about the resilience of staff and plans to ensure that there would be continued executive leadership for the duration of the pandemic. It was reported that at present there were no firm resilience plans for executive directors and the executive team had been working hard to ensure that there was senior support on site seven days per week and ensure that staff on the frontline feel supported. At a basic level the plan would be for the next level of senior manager to step up in the event that an executive director gets COVID-19. **The Chairman asked that a resilience plan for the Executive team be developed and shared with the Board.**<br><br>• Pui-Ling Li asked about the extent to which the Trust was able to track the number of staff infected by COVID-19 and who were self-isolating either due to being infected themselves or as a result of a family member displaying symptoms. It was reported that the Trust had started testing certain staff for COVID-19. The Trust had also organised local hotel accommodation for staff who had members of their household in the 'shielding' category as defined by the Government. Occupational Health had been keeping in contact with staff who were self-isolating. The Trust was also considering which staff could be redeployed into other functions | **CEO/ DCEO** |

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| | across the Trust to support work on COVID-19 either directly or indirectly.<br><br>The Board noted the update and recorded thanks to all Trust staff for everything they were doing during the Covid-19 pandemic.<br><br>The Board also considered proposals for managing Board and Committee, and other Governance meetings, during the pandemic. Due to the operational demands of COVID-19, it was essential that the Trust focused on dealing with the pandemic and providing safe and effective care to patients. The Board would continue to play an essential role during this period, both in terms of providing oversight of the Trust's response to COVID-19 and in providing support and challenge to the Executive team. At the same time, usual Board business during this period needed to be reconsidered to ensure that staff were freed up to deal with and respond to these pressures. Although the Board had planned to move to bi-monthly meetings from April 2020, the Board would now meet monthly by videoconference focusing on key matters of business. The Quality and Safety Committee (QSC) and Finance and Investment Committee (FIC) would continue to meet each month albeit with shorter and more focused agendas. The Workforce and Education Committee would be suspended for the time being with key workforce business escalated to the Board or to FIC and QSC. The Audit Committee would meet to consider key year-end and urgent business, although it was anticipated that the year-end deadlines would be extended and therefore the scheduled meeting of the Committee on 14 April may well be postponed. Provisions would be made to ensure that attendees could join the meetings virtually. In lieu of meetings being held in public, a summary of the key matters discussed and decisions made by the Board would be published on the Trust's website and be made available to Governors. Public Board papers would also be published in advance of meetings and Governors and members of the public would have an opportunity to ask questions in advance. It was also noted that meetings of the Council of Governors had been paused for the time being and that the May Council meeting had been cancelled.<br><br>The Board:<br>• **Approved the proposed arrangements for Board and Committee meetings during the period of intense operational pressure during the pandemic.**<br><br>• **Noted the arrangements put in place to ensure continued transparency and public accountability of the Board during this period.**<br><br>• **Noted the arrangements put in place regarding the Council of Governors and membership engagement.**<br><br>• **Delegated authority to the Chairman, on the advice of the Chief Executive and in consultation with the Chairs of the relevant Board Committees, to approve temporary amendments to the Trust's Standing Orders and Standing Financial Instructions where these are required, in order that the Trust could respond rapidly and in an agile way to a rapidly changing situation.** | |

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| **4.0** | **QUALITY AND PERFORMANCE** | |
| **4.1** | **Quality and Safety Committee Report**<br><br>Professor Parveen Kumar, Chair of the Committee, presented the report of the meeting held on 19 March 2020, which set out the key matters raised and discussed. The Board endorsed the Committee's concerns about COVID-19 risks and the need to ensure it was adequately reflected as a key risk for the Board and, as such, should be reflected on the Board Assurance Framework. Due consideration should be given not only to the short-term implications but the long-term impact of COVID-19 and the risks to the Trust, its patients and the delivery of its strategy. It was noted that given the scale of the pandemic and its impact COVID -19 inevitably impacted across all aspects of the Board Assurance Framework risks to varying degrees but it was accepted that this should be clearly articulated in the Board Assurance Framework.<br><br>It was also reported that the Committee had considered a deep dive on maternity services and was encouraged by the progress made but intended to closely monitor this over the coming months. The Committee had observed that the Trust was close to its full year threshold for cases of clostridium difficile and had had a case of MRSA. The Committee had considered a paper on serious incidents and was assured that there was were no particular themes from the incidents that were closed which signalled underlying performance issues. Ongoing SI investigations were also discussed and the Board noted that these would be reported formally once the investigations had been completed.<br><br>**The Board noted the report and agreed that a risk related to COVID-19 should be reflected in the Board Assurance Framework.**<br><br>**The Board agreed that executive team should ensure that both the short and long term risks associated with COVID-19 and its impact and implications for other service provision should be considered by the relevant executive workstreams responsible for managing the Trust's response to the pandemic.** | **CCAO**<br><br>**DCEO** |
| **4.2** | **Integrated Quality and Performance Report (IQPR)**<br><br>The Board received and noted the IQPR at Month 11 (February 2020), which had been scrutinised at both the Finance and Investment and the Quality and Safety Committees. Outside the matters raised in the Board Committee reports and the issues discussed elsewhere on the agenda there were no other key performance issues to highlight.<br><br>The Board received and noted the report. | |
| **5.0** | **FINANCE** | |
| **5.1** | **Finance and Investment Committee Report**<br><br>Ann Beasley, Chair of the Committee, provided an update on the meeting held on 19 March 2020. The Trust's financial performance was in line with revised forecast of £9m deficit. Cash remained well managed based on current requirements, but COIVID-19 was expected to have an impact here which would need to be carefully monitored. The decision of NHS England | |

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| | and NHS Improvement to provide block contract funding for months one and two of 2020/21 in April 2020 was welcome. The Committee recognised the challenges COVID-19 posed to the current planning round and it noted the suspension of this by NHS England and NHS Improvement. Effective forward planning for 2020/21also presented a challenge in the current climate.<br><br>The Board noted the report. | |
| **5.2** | **Finance and Investment Committee (Estates) Report (FIC(E))**<br><br>Tim Wright, NED Estates Lead, provided an update on the meeting held on 19 March 2020. The estates team had made significant improvements and there was now greater transparency and scrutiny of estate issues. There were also robust governance systems in place. As such, it was agreed that the group, which had been set up on a temporary basis to oversee enhanced assurance on estates, should be disestablished and estates matters be reincorporated into the core FIC meetings with an estates dashboard presented each month.<br><br>The Board noted the report, acknowledge the good work of the estates team, and agreed that estates issues would be re-integrated within the core Finance and Investment Committee meetings. | |
| **5.3** | **Month 11 Finance Report**<br><br>The Board noted the Month 11 finance report. The ACFO reported that the Trust was £7.5m off plan and expected to end the year with a £9m deficit in line with the reforecast position. The COVID-19 pandemic was impacting on the Trust's ability to manage its finances with decisions focused on ensuring that the Trust could continue to care for patients effectively. NHS England and NHS Improvement (NHSE&I) had indicated that Trusts would be reimbursed for COVID-19 related expenditure. A key consideration for the Trust was cash and as Ann Beasley had reported NHSE&I had confirmed that the Trust would be provided with the months one and two 2020/21 block contract payments in April 2020.<br><br>The Board noted the report. | |
| **6.0** | **CLOSING ADMINISTRATION** | |
| **6.1** | **Questions from the public**<br><br>The Board also addressed a question from Sandhya Drew, Public Governor in the Rest of England constituency, about the sufficiency of the Trust's personal protection equipment (PPE). It was noted that the Trust continues to operate within the guidance and instructions set out by Public Health England and the Department of Health in relation to the use of PPE. The Trust currently had sufficient stocks of PPE and had put in place a regime whereby staff were proactively topping up stocks in each clinical area of the Trust. It was also noted that NHS England and NHS Improvement was providing all Trusts with supplies of PPE and these were being procured at a national level. | |
| **6.2** | **Any other risks or issues identified** | |

| | | Action |
|---|---|---|
| | There were no other risks or issues identified. | |
| **6.3** | **Any Other Business**<br><br>There were no matters of any other business raised for discussion. | |
| | **Date of next meeting: Thursday, 30 April 2020, Room 52 and videoconference** | |