Portsmouth Hospitals University NHS Trust

Trust Board Meeting in Public
Held on Wednesday 28th July 2021
Via Microsoft Teams

MINUTES

Present:	Melloney Poole	Chairman
	Roger Burke-Hamilton	Non-Executive Director
	Graham Galbraith	Non-Executive Director
	Gary Hay	Non-Executive Director
	Inga Kennedy	Non-Executive Director
	David Parfitt	Non-Executive Director
	Martin Rolfe	Non-Executive Director
	Christine Slaymaker	Non-Executive Director
	Vivek Srivastava	Non-Executive Director
	Aswinkumar Vasireddy	Non-Executive Director
	Penny Emerit	Chief Executive Officer
	Chris Evans	Chief Operating Officer
	John Knighton	Medical Director
	Mark Orchard	Chief Financial Officer
	Liz Rix	Chief Nurse
In Attendance:	Anoop Chauhan	Director of Research
	Nicole Cornelius	Chief People Officer
	Graham Terry	Director of Strategy and Performance
	Lisa Ward	Director of Communications and Engagement
	Mary Cordova	Staff Nurse (for minute 068.21)
	Clare Jackson	Critical Care Staff Nurse (for minute 068.21)
	Tina Jackson	Family Liaison Officer (for minute 068.21)
	Sean Kerr	Consultant (for minute 068.21)
	Lucy Wiltshire	Associate Director People Development (for minute 068.21)
	Dave Gordon	Committee Clerk (minutes)

Item No	Minute
064.21	**Welcome, apologies and declarations of interest** The Chairman welcomed all to the meeting; no apologies were received. David Parfitt declared an interest regarding his role as a co-opted independent member of the Regulation, Audit and Accounts Committee for West Sussex County Council.
065.21	**Minutes of the last meeting – 26th May 2021** The minutes of the meeting of 26th May 2021 were approved as a true and accurate record.
066.21	**Matters arising / summary of agreed actions** The Board noted the summary of agreed actions.

067.21	**Notification of any other business** No supplementary business was raised.
068.21	**Staff story** The Associate Director People Development introduced four employees who had been redeployed during the pandemic. The Trust had established a centralised staff and manager support function in the preliminary stages of its response to COVID-19. Part of its work had been the identification of core services in this context and the allocation of workforce to support them. Redeployment opportunities were then assessed; some decisions were made based on staff and their need for shielding from the virus. Others had seen their service area suspended, whilst some were needed to support temporary programmes (e.g. the Trust's vaccination hub). In total, 219 staff had seen their roles reassigned in this period. In addition, the changes to the work of employees who remained in their customary roles but had to adapt to the challenges of the pandemic were recognised. Two areas which had been instituted during the pandemic remained in place; the staff support line and Family Liaison Officers. The former facilitated the reporting of staff absence and conducted welfare calls, whilst the Family Liaison Service enabled contact between families and patients whilst visiting restrictions were in place. In Critical Care, the unified response to the pandemic had been essential in providing services whilst experiencing operational pressure. The Consultant referred to the second wave, which had posed particularly significant challenges given its intensity and duration. The actions of junior anaesthetists were commended in this regard, with their assistance in the running of the Intensive Therapy Unit appreciated. However, the issues associated with communications regarding a virus which was not well understood had proved to be problematic. This was particularly applicable to the first wave, whilst the second peak proved to be harder in terms of workload and burn out. The impact on family life was also recognised. The Family Liaison Officer remained with the service and had appreciated the opportunity to provide real support for patients and their relatives. Whilst the nature of some of the video calls had proved challenging, families had commented that without the service such contact at vital stages of care would not have been possible. The team ethos had also been noted. The Staff Nurse had needed to shield and worked on the staff support line. This was a significant shift in skill set and initially proved to be challenging. However, the opportunity to offer advice and comfort to individual employees facing issues outside of the workplace had been rewarding. The unity of purpose within the team had been recognised through the Hidden Heroes award received recently. The Chairman alighted on the comment by the Consultant regarding personal circumstances and the impact on family life. Martin Rolfe noted the conversations held at Quality and Performance Committee regarding the demands arising from the pandemic and the impact this had on the delivery of healthcare. The various experiences discussed in this item had confirmed the theoretical observations which they had made on the likely implications for staff and the requirement for them to operate outside of their standard roles.

	Inga Kennedy referred to the importance of teamwork in this context and hoped that the benefits arising from greater co-operation and co-ordination would be maintained once the pandemic had concluded. Vivek Srivastava added that it would be imperative to ensure that staff members who may be struggling but were unwilling to come forward were identified and offered assistance in an appropriate and supportive manner. The Chief People Officer had included details on the health and wellbeing offer available for staff in the Integrated Performance Report presented to this meeting. The Trust had also been developed mental health training for managers which would be used to assist staff through conversations. In addition, the 'Respect and Protect' campaign was being relaunched to ensure that service users were aware of the unacceptability of violence or antagonism towards staff. The Director of Communications and Engagement would be using real life examples as part of this to make sure the message was highlighted to all parties. The Chief Executive Officer thanked all involved for sharing their personal experiences. The importance of providing individualised health and wellbeing offers had been made clear through their stories, with the Trust's provision offering the breadth which reflected the various needs of staff members. The importance of team working had also been a common theme running through this discussion. The roles served by some of the new positions created during the pandemic (e.g. Family Liaison Officers) had also demonstrated their permanent applicability to the provision of healthcare and would enrich the Trust's services.
069.21	**Chairman's opening remarks** The Chairman commented on the current situation faced at the Trust and the resultant pressures on staff. As well as the operational considerations of balancing the pandemic and recovery of other services, this had included a recent heatwave and the telephony issue arising from a power surge. Staff members had also had to self-isolate over recent weeks as a result of family members or other close colleagues testing positive for COVID-19. The situation in relation to the Emergency Department and ambulance conveyances would be discussed under minute 071.21.
070.21	**Chief Executive's Report** The Chief Executive Officer highlighted the following matters: <u>Elective recovery, standard service provision and COVID-19:</u> Queen Alexandra Hospital was experiencing considerable pressure with an ongoing peak in demand for urgent care having a significant impact. This manifested itself through increased admission numbers, high levels of bed occupancy and recent rises in COVID-19 hospitalisations. This was consistent with national trends; the stress points arising from this were being mitigated as far as possible. Discussions with system partners were focusing on root causes to ensure that solutions were sustainable and had a long-term impact, with primary care an area of focus to limit future demand for emergency services. Enhanced command arrangements were in place at the Trust to manage the competing pressures. <u>Maternity Services – Care Quality Commission focused inspection</u>: The report from this inspection had been published by the Care Quality Commission on 28th July 2021. An interim summary of findings had also been considered by Quality and Performance Committee on 21st June 2021. Improvements made in the service had been acknowledged by the Care Quality Commission, as had the impact of the interim team and the subsequent arrival of permanent leadership for the area. An improvement plan had been established prior to the visit and would be revisited in the context of the recommendations

	made by the Care Quality Commission. Staff would be engaged throughout this process to ensure that any required changes were adopted at all levels. Site situation and financial arrangements: Whilst the current wave of COVID-19 appeared to be leading to fewer hospitalisations, the high bed occupancy levels and demand for urgent care meant that the maintenance of a safe environment within the hospital was complex. A further consideration was the lack of certainty regarding financial arrangements for the second half of 2021 – 22. Whilst the exact nature of the regime to be in place for this period had not been clarified, it was anticipated that it would involve a return towards pre-COVID priorities. As a result, the Trust may well need to introduce greater efficiencies which would need to be balanced with clinical and operational considerations. This would also require the formation of an appropriate response at a system level, with conversations on the matter already underway. Trust Executive Team: The arrival of Alison Fox-St Marthe as Interim Director of Governance and Risk on 2nd August 2021 was welcomed, as cover for Lois Howell whilst she undertook her secondment with Isle of Wight NHS Trust. She would be in attendance at the Trust Board on 29th September 2021. The Board accepted the Chief Executive Officer's report.
071.21	**Operating context** The Chief Operating Officer referred to the previous comments made about operational pressures. As of the time of this meeting, there were 48 COVID positive patients on site, with five of these in Critical Care. These numbers had increased over the past fortnight, as had local prevalence rates (although the latter had recently showed signs of decline). Accident and Emergency attendances were currently above the Trust's upper control limit, with Medicine and Urgent Care operating for several weeks at a level which had constantly exceeded their bed base. This had led to a bed occupancy level which had generally fluctuated between 96% and 98%. Modelling on potential future demand for COVID services was being undertaken, factoring in a range of different variables (e.g. ending of restrictions on 19th July, local vaccination uptake rates). This had led to a forecast that the most likely scenario would see a peak in bed spaces for COVID treatment at 126 in the late summer or early autumn 2021. Escalation plans had been drawn up to manage this, with knowledge taken from the previous waves applied to their formation. The most urgent elective cases were being prioritised, with cancer services aligned accordingly. The Deputy Chief Operating Officer was overseeing the Delivery Framework which sought to provide care in as efficient and effective a manner as possible. As part of this, meetings were currently being held every two hours to assess the position at the hospital. Across the Trust 147 employees were self-isolating, which was an additional pressure in terms of workforce capacity. The Medical Director confirmed that the modelling discussed above was proving relatively accurate thus far. This also reflected the experiences of areas worst affected by the present peak of the pandemic in previous weeks, with any such rise in admissions to the hospital expected to commence within the following three weeks. Whilst community prevalence rates may be dropping, their impact would take some time to be felt at the hospital. Cases of Respiratory Syncytial Virus (RSV) in children were also anticipated to exceed usual levels by 30% in the autumn of 2021 given lower immunity in the population after COVID restrictions. This may also apply in influenza and other respiratory conditions. The Board noted the report.

072.21	**Building Better Emergency Care – Outline Business Case** The Chief Financial Officer presented the case, which had been through a series of assurance processes prior to review by the Finance and Infrastructure Committee on 21st July 2021. This meeting had recommended the proposals to the Trust Board for approval. In addition, members had received a detailed briefing on the plans at a Board Development Day on 30th June 2021. At present, the Emergency Department was housed in a facility that was approximately 40 years old. As a result, this placed limitations on provision of services which had led to the redevelopment being proposed. In December 2018 the Trust had been awarded £58.3 million of national capital investment funding by the Department of Health and Social Care to undertake the project. Subsequently the Strategic Outline Case had been approved by Trust Board on 25th September 2019. Should the Outline Business Case be approved by Trust Board and then the national authorities, it would proceed to the Full Business Case which would confirm the final details of the facility. The completion of the first two elements of formulating proposals had cost £2 million which was already included in the Trust's financial planning. Planning consent had been granted by Portsmouth City Council on 21st July 2021 following a lengthy period of collaboration with their relevant officers. Support from local commissioners and the Integrated Care System had been confirmed by formal correspondence received on 23rd July 2021. An additional capital funding request for £3 million would be necessitated by the proposed Emergency Department; this was to cover work which would ensure that it was fully integrated with the rest of the site and suited future demand. This had increased the total cost to £63.3 million, with £1.5 million (of the additional £3 million) to be allocated to cover this in each of the financial years 2022 – 23 and 2023 – 24. This had also been discussed with NHS England & NHS Improvement as well as the Department of Health & Social Care. Under the present schedule, October 2024 would see the vacation of the present Emergency Department, with the reassigned purpose of the area on C level to be decided. Any costs arising from this would be absorbed by the service involved. There was no direct requirement for additional staffing in relation to the proposals. Should progress be made as intended, the Full Business Case would be presented to Trust Board in May 2022. Construction work would then commence in the autumn of 2022 and last approximately two years. The Chief Operating Officer highlighted the improvements for efficient pathways and patient experience that would arise from the redevelopment of the Emergency Department. Clinicians had been involved at all stages of discussions, with key benefits identified including the treatment of adults & children in single rooms, enhanced resuscitation capacity and easier access to CT scanning. In addition, the learning taken from the pandemic had been applied to the creation of separate patient pathways to minimise the risk of cases of healthcare acquired infection. The improved patient flow which would result should then have concomitant impacts on waiting times, ambulance handovers and areas where bottlenecks had emerged in current provision. Given these clinical considerations, the Chairman requested that Quality and Performance Committee should include Building Better Emergency Care in future agendas as appropriate. **Action: COO**

	Christine Slaymaker welcomed the report in her role as Chair of Finance and Infrastructure Committee. It had covered the areas of assurance they had raised and resolved their questions in full. The Committee had also covered the future proofing of the project in depth, focusing on engagement with the South Central Ambulance Service and the application of knowledge gained during the pandemic to the evolution of proposals (particularly infection prevention and control). This discussion of matters beyond the financial aspects had allowed for the mature consideration of the project and confirmed the justification for the additional £3 million requested. Procurement procedures and any potential future liabilities (e.g. increased cost of construction materials) had also been covered. Given this, the Committee recommended the case for approval. Graham Galbraith concurred, noting the transformational nature of the new facility for the Trust. The Chairman wished to reflect her thanks to those involved for their work on the matter and their insight in forming the details of the plan. The Board approved the submission of the Outline Business Case to NHS England & NHS Improvement and the Department of Health & Social Care.
073.21	**Integrated Care System – Design Framework** The Director of Strategy and Performance outlined the provisions of recent national documents relating to Integrated Care Systems and their implications for future joint working with partners. The overview of the Integrated Care Systems Design Framework, alongside the revised System Oversight Framework released in June 2021 were the key publications in this regard. These consolidated the four principle purposes of Integrated Care Systems, which were improving outcomes, tackling inequalities, enhancing productivity & value for money and supporting broader social & economic development. The Design Framework had two main component parts; the establishment of an Integrated Care Partnership and an NHS body which would be created for the Integrated Care System. The former was a system-level collaboration between NHS bodies and local authorities, whose main role was the development of a strategy created to meet the needs of the population in the area. This will be led via a Board, with the Chair to be appointed jointly. The NHS body would establish the shared priorities for health services across the footprint and would lead on the integration agenda. Major areas of activity would include the allocation of resources to achieve strategic objectives, embedding collaboration and the establishment of appropriate governance arrangements. It would also be led by a Board which would oversee its activities as a unitary body. Membership of this would include Non-Executive Directors, Executives (including a Chief Executive) and partner members representing an NHS trust, primary care and local government. Private provider collaboratives were also specified in the Design Framework as part of the future landscape. Integrated Care System boards would provide accountability for the performance of the organisation across the region. However, individual organisations' boards would retain their role in being responsible for their performance. This would also be applied through provider licences and Care Quality Commission regulation. The System Oversight Framework would support this through the alignment of priorities between organisations and the identification of areas requiring external support from NHS England or NHS Improvement. The document had also introduced a new theme, namely the achievement of local strategic priorities. It was anticipated that the framework would assign one of four levels of oversight to which the Integrated Care System would be subject. This would

	mirror the arrangements for the Single Oversight Framework and range from light-touch regulation to the provision of input and support where required. The Chairman referred to the progress being made on this, with the Chair and Chief Executive for the Integrated Care System NHS body having been appointed. Guidance and provisions for the area were being published and updated regularly; the Chief Executive Officer would ensure that members were apprised as required and involved in related discussions. The Trust would also take its role in shaping proposals and ensuring benefits were delivered for the local population. Christine Slaymaker sought assurance that funding arrangements and aligned incentive contracts would be managed in a consistent and sustainable fashion. The Director of Strategy and Performance would be working with the Chief Financial Officer to ensure that decisions made did not add unnecessary risk to either the system's position or those of individual providers. The Chief Executive Officer added that collaboration would make it unlikely that different contractual models were in operation within the same Integrated Care System. It was also anticipated that needs-based assessment would remain in place for funding decisions. Graham Galbraith asked how other structures would be realigned to ensure that they worked effectively with these new system-level bodies. The Chief Financial Officer referred to the integration of the eight Clinical Commissioning Groups in the region into one covering Hampshire and the Isle of Wight. This would assist with embedding the different level at which decisions were to be made. David Parfitt inquired as to how duplication or administrative ambiguity would be avoided with the introduction of additional governance structures. The Chairman referenced the work undertaken by the Chief Executive for the Integrated Care System NHS body in this regard, with the issue being acknowledged by all parties. Vivek Srivastava observed the potential imbalance between the responsibility for service delivery held by the organisations within an Integrated Care System and their influence in policy formation. Aswinkumar Vasireddy added that the inclusion of all stakeholders in the process, and the resolution of any potential conflicts within their views or interests, required sensitive management. The Chief Executive Officer stated that the representation of the local community within the unitary boards that would be established should help resolve issues arising from this; however, relationship management would be a central role for these bodies. Resilient pathways across the region would also be imperative in delivering the benefits of system-level collaboration and assist with benefits of scale. The Board noted the report.
074.21	**Quality and Performance Committee feedback** The Committee Chair (Martin Rolfe) summarised the recent meetings, with the themes of COVID-19 and site pressures discussed in a manner which was reflected in much of the content of this Board meeting. The focus on reducing the number of patients who were deemed medically optimised for discharge had been clear, with the role of system co-operation being of crucial importance. The workforce issues arising from self-isolation had also been considered (in particular for Maternity Services), with the risk associated with depleted staffing requiring balancing against infection prevention and control. As a result of this conversation, a new entry had been added to the Risk Register.

	Maternity Services had been covered extensively, with the findings of the Care Quality Commission and the Improvement Plan for the area considered in depth. The work being undertaken was commended, as was the involvement of Inga Kennedy as the Non-Executive Director with responsibility for the service. The Chief Nurse referred to the focused inspection of Maternity Services held on 20th May 2021. This visit had been welcomed by staff, with the conclusions in the report published on 28th July reflecting the Trust's internal observations. The improvements made since the previous review had been recognised by the Care Quality Commission, with the understanding and vision of the new leadership team having been notable. However, some staff had commented that they felt unable to raise concerns as they would wish, and this would be a central focus for the future. The final report contained one 'must do' recommendation (regarding the timely review of policies to reflect current guidance) and 11 'should do' areas for improvement which would be addressed through the Maternity Improvement Plan. The Maternity Committee would provide governance and oversight of this, reporting into Quality and Performance Committee. The Chief Nurse wished to record her thanks for those involved in this process and welcomed the imminent arrival of 25 midwives and two obstetricians to support the delivery of the required improvements. Inga Kennedy would continue to work with the Chief Nurse and Director of Maternity Services & Midwifery, with the recent completion of the submission for the Clinical Negligence Scheme for Trusts as an example of this. Assurance had also been received regarding the progress of electronic prescriptions and medicine administration. In addition, the Annual Safeguarding Report 2020 – 21 had been presented; this had demonstrated the problems arising from the pandemic (e.g. domestic abuse whilst movement outside the home was constrained) and the Trust's appropriate response to this which included staff redeployment. The Committee wished to commend the work of those involved with mitigating the present situation. The Chief Nurse introduced the Quality Accounts 2020 – 21, with the content following a national prescribed format in many areas and reporting having been affected by the pandemic. Quality and Performance Committee had commended the document for approval, with its publication on schedule with the required deadlines. The Chairman was satisfied with the content and hoped that the Director of Communications & Engagement would be able to communicate its positive messages in a manner which suited a lay audience. A never event had been reported. It had been noted that the issue had been observed and raised by a junior clinician at a preliminary stage, which was a positive sign regarding the safety culture at the Trust. The Board approved the Board Risk Register, Quality Accounts 2020 – 21 and Safeguarding Annual Report 2020 – 21.
075.21	**Safety, quality and operational performance report analysis** The Medical Director thanked the Quality and Performance Committee for their input and support during the recent period which had been appropriate for the challenges faced by the Trust. The risks to quality and safety associated with the current combination of pressures were acknowledged by all parties, with elective recovery continuing despite the increase demand for urgent care. Given the bed base allocated to elective care at present, any downward pressure on its size would have a significant and direct impact. Therefore, all potential risks being observed at present were being recorded, monitored and mitigated as effectively as possible in a timely fashion. Systemic and human factors involved in this were also being tracked, with civility and respect in communications whilst under pressure

	being emphasised. This allowed staff in areas such as the Emergency Department to operate in a manner which reflected the evolving position as closely as possible. The Chief Nurse reflected many of these points, with safe services relying on proven solutions which were effective when placed under stress. As a result, the learning taken from previous periods of high demand had seen the reintroduction of measures to increase mitigation (e.g. daily safe staffing meetings had a greater patient safety focus, use of military support where appropriate for service provision). Infection prevention and control was a further area of activity given the recent gradual rise in COVID hospitalisations. The Chief Operating Officer noted the importance of both the volume of demand arriving at the Trust and referring patients to more appropriate care settings where suitable. The resilience of the teams delivering services would also be crucial and require evaluation should the current scenario remain in place for a protracted period. Christine Slaymaker sought guidance as to how Finance and Infrastructure Committee could support the work of Quality and Performance Committee; the review of committee effectiveness had highlighted clinical engagement at meetings as a key strength of the body. This was with reference to a discussion the latter had held on cleaning standards, which her committee had previously considered from an infrastructure perspective. The Chief Nurse was working with the Estates and Facilities Team on this matter, with progress reported to the Infection Prevention and Control Transformation Group. A detailed review of the cleaning standards was underway and would be fed into Trust policy once the work had concluded. The Board noted the report.
076.21	**Finance and Infrastructure Committee feedback** The Committee chaired by Christine Slaymaker had reviewed the recent telephony issues mentioned under minute 069.21. The replacement of the switchboard concerned had been the subject of a business case presented to Finance and Infrastructure Committee on 23rd September 2020 which had been agreed. Aspects of this were being accelerated to resolve the issues arising from the incident; however, it had been noted that the root cause (a power surge) was not connected with the equipment itself. The financials risks that had arisen recently were also considered. While the Trust's position remained relatively stable, planning for the second half of 2021 – 22 was becoming more complex in the absence of national guidelines. This particularly applied to the Elective Recovery Fund (where targets require to receive grants may become higher), fluctuating costs associated with staffing and the need to recommence the Cost Improvement Programme whilst demand remained at an elevated level. The outpatient pharmacy project had experienced a delay, although the new timetable appeared to be robust. The Board noted the report.
077.21	**Financial performance report analysis** The Chief Financial Officer referred to the conclusion of the present financial framework at the end of September 2021. This included additional funding available to accelerate elective recovery; however, the nature of its replacement from October 2021 onwards was not yet clear. At present, the Trust was reporting a broadly balanced position, with a deficit of £26,000 for the year to date. However, receipts from the Elective Recovery Fund had

	exceeded original estimates by approximately £4.6 million. This had been counterbalanced by increased workforce spend, resulting from increased activity. Planning for the second half of 2021 – 21 would have to be cognisant of the non-recurrent nature of Elective Recovery Fund payments. It was expected that the regime for the remainder of the financial year would only be clarified in September 2021. However, it was apparent that the efficiencies required to be delivered would increase; cost savings in the region of 3% savings may be required. Meanwhile, allocations were expected to continue on a block basis as was the case for the first half of 2021 – 22. Any pay settlement would be backdated to 1st April 2021 and nationally funded based on the Trust's workforce establishment. As a result, the only expected costs arising were associated with new appointments made since the start of the financial year. The capital expenditure profile for 2021 – 22 was front loaded, with 32% of the annual budget having been spent in quarter one. The chief contributor to this was the construction of the modular wards on the site of the North car park. The Trust's cash position remained healthy, with £5 million of the £15 million of liquidity related to undertaken annual leave carried forward from 2020 – 21. Rapid payment of non-NHS business suppliers was being prioritised given the wider economic position and potential importance of income for their sustainability. The Board noted the update.
078.21	**Workforce and organisational development performance report analysis** The Chief People Officer focused primarily on workforce, in terms of capacity and wellbeing. The establishment had been increased slightly due to business cases; however, temporary staff had been engaged to provide cover for those self-isolating or otherwise unable to attend. Whilst this had essentially used bank staff rather than agency workers, the fact that this led to an employee base in excess of the funded establishment placed pressure on Trust finances. However, the number of staff who were self-isolating had recently reduced and a system for the management of such situations had also been introduced. Turnover had increased; this had been anticipated given the fact that very few people had changed jobs during the height of the pandemic and was at a reasonable level (10.4%). The vacancy rate had also risen, but from a very low base and mainly as a result of the increase in the establishment mentioned previously. Wellbeing support and staff development were areas of activity, with coaching and mentoring being expanded. An additional 15 staff members would be able to take on such roles in a fully accredited capacity by 2022. Affina team coaching had been launched and would work on developing the sense of shared purpose within staff cohorts as well as across different services. The action learning set model had been applied to nursing having been well received by the Senior Leadership Team when trialled there. React mental health training would support managers in identifying potential moral injury in staff, with 15 Trust staff able to deliver this internally as well as including this within the Passport to Manage system. Gary Hay added that the Workforce and Organisational Development Committee would monitor the return of standard whistleblowing arrangements after the Freedom to Speak Up team had amended their activities in response to COVID-19. Christine Slaymaker returned to the theme of family life raised under minute 068.21 and the importance of the home for staff experiencing heightened workplace demands. As a result, it may be important to consider this theme throughout meetings in coming months

	and also consider how support can be offered to the families themselves. Vivek Srivastava related his experience that, traditionally, redeployment had been followed by a period of normalisation and recovery once the individual concerned returned to their standard duties. The fact that this had not been possible since the start of the pandemic was a further factor which required inclusion in planning. The Chief People Officer acknowledged this, with the establishment of a wellbeing day and the distribution of letters to the children of staff explaining their parent's role during the recent period being well received. The expansion of such responses was being considered at present. The military had signalled their ability and willingness to support such efforts. The Chief Executive Officer would also ensure that this was included in any flexible working policy. The Board noted the report.
079.21	**Audit Committee feedback** The Committee Chair (David Parfitt) noted that the external auditors have given an unqualified opinion on the Trust's Annual Report and Accounts 2020 – 21, with the value for money conclusion having been signed subsequently. This delay had been caused by the new form of a report specified by the National Audit Office and had not had any material impact on the auditor's view. The meeting of the Committee on 12th July 2021 had undertaken a detailed review of the internal audit on medical staff leave. Given the "limited assurance" opinion by the internal auditors, the Audit Committee had referred it to both the Quality and Performance Committee and the Workforce and Organisational Development Committee for follow up. A counter fraud strategy had been presented to the Committee in line with the new standards for the area and was commended. The Board noted the report.
080.21	**Record of attendance** The record of attendance was noted.
081.21	**Any other business** The Director of Research was asked to identify key areas of work being undertaken in his directorate. A Research and Innovation Sub-Group had been established and would report to Quality and Performance Committee. This body would consider the large bank of information which had been gathered during the pandemic, as well as building on the Trust's University hospital status which was celebrating its first anniversary. Major fields of study included diagnostics & genetic sequencing for coronavirus, nosocomial infection & policies on infection prevention & control and technological support for the trust (working alongside local businesses to assess the potential benefits of their services). In addition, relationships with faculties besides medicine at the University of Portsmouth (e.g. law, business) were being cultivated. The cosmology department offered some high calibre scientists, whose expertise on data analysis may well prove to be applicable to the Trust's research work and clinical delivery. Graham Galbraith referred to the co-operation between the hospital and the University during COVID-19, with the next logical step being the appointment of the academic chairs which have been under consideration in recent months.

	The Chairman requested that an item on research should be added to future agendas. This was agreed by the Director of Research. **Action: DR**
082.21	**Opportunity for the public to ask questions relating to today's Board meeting** No questions were raised by the public.
083.21	**Conclusions on key messages from the meeting** The Chairman anticipated a return to Board meetings in persons once circumstances allowed.
084.21	**Additions to Board Assurance Framework and Risk Register** This had been considered in depth under minute 049.21 and would be raised with the Interim Director of Governance and Risk upon her arrival in August 2021. **Action: CEO**
	Date of Next Meeting: Wednesday 29th September 2021 9.30am at Royal Maritime Club, Queen Street, Portsea, Portsmouth PO1 3HS