Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Held on 7 April 2022 at 9:00am
Microsoft Teams
Royal Papworth Hospital

UNCONFIRMED M I N U T E S – Part I

Present	Mr M Blastland	(MB)	Non-Executive Director and Deputy Chair
	Dr J Ahluwalia	(JA)	Non-Executive Director
	Ms C Conquest	(CC)	Non-Executive Director
	Ms A Fadero	(AF)	Non-Executive Director
	Mr T Glenn	(TG)	Chief Finance and Commercial Officer
	Dr R Hall	(RH)	Medical Director
	Ms D Leacock	(DL)	Associate Non-Executive Director
	Mrs E Midlane	(EM)	Chief Operating Officer
	Ms O Monkhouse	(OM)	Director of Workforce and OD
	Mr S Posey	(SP)	Chief Executive
	Mr A Raynes	(AR)	Chief Information Officer & SIRO
	Mrs M Screaton	(MS)	Chief Nurse
	Prof I Wilkinson	(IW)	Non-Executive Director
In Attendance	Mrs A Jarvis	(AJ)	Trust Secretary
	Ms J McDermott	(JM)	Diabetes Specialist Nurse
	Mr A Selby	(AS)	Director of Estates and Facilities
	Dr I Smith	(IS)	Deputy Medical Director
Apologies	Ms T Crabtree	(TC)	Head of Communications
	Prof J Wallwork	(JW)	Chairman
	Mr G Robert	(GR)	Non-Executive Director
	Mr A Selby	(AS)	Director of Estates and Facilities
Observers	Susan Bullivant, Trevor Collins, Richard Hodder, Rhys Hurst, Trevor McLeese, Harvey Perkins,		

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1	**WELCOME, APOLOGIES AND OPENING REMARKS**		
	The Deputy Chairman welcomed everyone to the meeting and apologies were noted as above.		
1.i	**DECLARATIONS OF INTEREST**		
	There is a requirement that Board members raise any specific declarations if these arise during discussions. No specific conflicts		

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	were identified in relation to matters on the agenda. A summary of standing declarations of interests is appended to these minutes.		
1.ii	**MINUTES OF THE PREVIOUS MEETING**		
	Board of Directors Part I: 03.03.2022 **Item 2.b** PIPR: Revised to read: Received: "... considered at the Performance Committee and the Safe and Caring domains were discussed at Q&R Committee..." **Safe:** Revised to read: Discussion ii: "..There was ongoing work to address this and it was a multi professional responsibility." **Responsiveness:** Revised to read: Discussion viii: "..to understand what was the right time for surgery clinically, and what was..." Discussion viii: "…was looking at waiting times and ..." **People management and culture:** Revised to read: Discussion i: "There was also a move to set up a national reservist's force for the NHS which would target retired professionals and those who had been in the NHS or were working work part-time through annualised…" **Finance:** Revised to read: "**Finance:** Reported by TG: That the month eight position had pointed to a forecast £1.8 billion underspend nationally, and performance at the Trust mirrored this with a £6.3 million forecast underspend at the Trust." **Discussion:** iv: Revised to read: "There were up to 25,000 annual deaths reported from VTE in the UK prior to the pandemic and there was increased risk of VTE with COVID19. The NHS needs to consider digital…" **Item 3.i: Q&R Committee Chair's Report:** Revised to read: Discussion i: 2…and he asked EG to provide further detail for the Board." **Approved**: With the above amendments the Board of Directors approved the Minutes of the Part I meeting held on 3 March 2022 as a true record.		
1.iii	**MATTERS ARISING AND ACTION CHECKLIST**		
	Item 1.iii Action Checklist: CC requested that the Executive set dates for those actions that are marked 'To Be Confirmed'. SP agreed that these would be updated ahead of the next Board meeting. **Noted:** The Board received and noted the updates on the action checklist.	**EDs**	May 22
1.iv	**CHAIRMAN's REPORT**		
	MB noted that in JW's absence he would invite SP to present the CEO's report.		

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1.v	**CEO's UPDATE**		
	Received: The Chief Executive's update setting out key issues for the Board, the principal risks to delivery as articulated in the Board Assurance Framework (BAF) and the progress being made in delivery of the Trusts strategic objectives. The report was taken as read. **Reported:** By SP that: i. The Trust had updated its principal risks following the workshop on the 3 March with four principal risks relating to: workforce, productivity, finance, and cyber security. Also, that the Cost Improvement Programme risk would be closed and restated for the new financial year as the 2021/22 CIP had been delivered. The Research and Development risk had increased following discussion of R&D resourcing levels at Committee, and he noted the change in rating of the secure environment risk. The key supplier risk remained elevated relating to various issues including the Ukraine. ii. He would set out the context of current performance for the Board. There was high COVID19 prevalence in the community and increased absence was being seen across the NHS. High emergency demand was being sustained and this had an impact on elective recovery plans. RPH was working hard to address its performance. iii. The Board would see we had funded staff support schemes in 2022/23 and he thanked the finance and workforce teams for developing these. These schemes were being set up to mitigate some of the economic pressures that were being seen. iv. The Executive were leading the Trust in a 'spring reset' which would increase our ability to treat patients identifying ways of working smarter and not harder. Key to this was the Meridian programme which would support the operational plan requirement to deliver 104% against our 2019 baseline. v. We had seen six nosocomial COVID19 infections in March. This reflected increased prevalence in the community, and we were reinforcing our infection prevention and control measures. vi. We had welcomed Dr Art Baker, from Duke University, USA who had shared learning from their experience of M.abscessus. vii. He thanked TG's team and the whole organisation for the achievement of the financial outcome position for the Trust. This was hugely important for the Trust and for the NHS. viii. He noted that TG had circulated a briefing note on the Operational Plan for 2022/23 setting out matters relating to risks that had now been realised. ix. The 2021 NHS Staff Survey results had been published and the Trust was extremely pleased with the response rate achieved which adds to the value of the feedback. We had performed well against national benchmarks, although less well against our specialist peer group. We had seen through the survey results the evidence of fragility, tiredness and burnout which featured heavily from our staff and this reinforced our approach to staff wellbeing. x. We remained an outlier in our WRES scores and were		

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	disappointed not to have seen an improvement in the experience of our staff from a Black, Asian and minority ethnic background. There were a range of initiatives underway which were in the early stages and the BAME network was also looking at how we could address these issues. xi. The report included the announcement by Daedalus of the move to OrbisU which would have a consequence for the Trust. **Discussion:** i. MB asked about infection prevention and control and whether there had been discussion on the relaxation of measures to address our productivity pressures. He asked if we had the leeway to implement changes yet? SP advised that this had been considered and it was felt the wrong time to relax measures as we had seen increases in nosocomial infections and sickness absence across the system. The Trust sickness absence rate was at 5% and we would need to see the community prevalence drop before we agreed relaxation of IPC measures. ii. AR noted that he would be reviewing the implications of the Dedalus announcement on OrbisU and what our strategic approach/response should be. This would be reported through the Strategic Projects Committee and to Board. iii. AF asked about the implementation of the latest guidance on lateral flow testing and whether this would have an impact on staff absence. SP advised that this had been discussed at length and the focus on symptoms was expected to drive an increase in absence levels, even where staff had a negative lateral flow test. This impact was being seen across the whole of the NHS. MS advised that the Trust had received the new guidance and we now had 13 symptoms to consider for COVID19. There was some level of discretion, but the six nosocomial infections reported were in part related to staff coming to work who were symptomatic. She advised that the Health and Safety Executive expected us to identify the risk of harm early and we had a very guarded approach that protected staff and patients. She noted that we had seen no further nosocomial infections since the stricter rules on symptoms had been implemented. She expected that over the next three or four weeks we would be able to take more of a judgement around this noting that once staff start to feel better, they could return to work with a negative lateral flow result. iv. DL asked about visiting arrangements if we worked on the symptom basis only then we may inadvertently be causing harm. MS advised that we were continuing with visiting restrictions and that we had a visitor checklist encouraging visitors to wear facemasks and focus on hand hygiene. We also encouraged visitors to purchase lateral flow tests prior to visiting to keep patients safe. v. JA noted the WRES data and acknowledged the open response to the scores. He encouraged colleagues to continue this journey as these results would not change quickly. He noted that as our staff had some freedom to move in the region and the ICS it might be helpful for us to look at		

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	local benchmarks for this data as that could provide a good comparison and would be sensitive to where our staff might choose to work. SP confirmed that we could provide this analysis. He noted that one or two providers in the region had bettered us in the 'recommend to work' score with a difference of around 0.4% and 0.8%. Also, that for 'recommend to treat' we were the best in the region we were therefore performing very well. He noted that the Trusts who had outperformed RPH were community and mental health Trusts, and the level of variation was not statistically significant. OM noted that she had joined the system EDI meeting and on the four questions in the staff survey related to WRES the movement in scores was as follows: a. RPH had improved in two and deteriorated in two b. NWAFT had deteriorated in all four scores c. CCS deteriorated in three scores and improved in one d. CUH improved in two and deteriorated in two scores e. CPFT had improved in three scores and deteriorated in one. This was not a great picture across the system and CPFT had seen the best improvement over time but had a longer standing programme with an experienced lead. JA noted that it would be helpful to see the local rankings for the WRES performance. **Noted:** The Board noted the CEO's update report.	**OM**	TBC
1.vi	**Patient Story**		
	MS introduced Jackie McDermott, Diabetes Specialist Nurse, who provided the patient story. JM advised that the story was from a 61-year-old gentleman admitted early December for a single lung transplant for treatment of hypersensitivity pneumonitis. Prior to becoming ill, he was a self-employed plumber and noted that the mould that he was exposed to during his career was felt to have caused his lung condition. He was listed for transplant during COVID19 and was advised that there were fewer offers of transplant due to the reduced availability of critical care beds. He was also made aware that when he got the call for transplant, he would have to attend alone due to COVID19 rules. Following transplant, he spent five days in critical care where he experienced delirium and he heard voices talking to him which continued on transfer to the ward. He told nursing staff about the voices and some of them dismissed him, but some went with him to his room to check for people, which was reassuring as he felt as if he was being believed and supported. He was troubled by several episodes of confusion during his stay, including visual and auditory hallucinations which were thought to be due to the high dose steroids. He continues to have nightmares and is still having input from the psychiatric team. The diabetes team see all patients undergoing transplant due to transplant medications causing high blood glucose (BG) levels. This gentleman also had type 2 diabetes treated with tablets. He was seen regularly by the diabetes team because of the elevated BG, and the need to stop oral treatment and start insulin.		

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	His 'New to insulin' education was delayed due to his confusion, and eventually the team involved his wife with the teaching to ensure important aspects of the education were not forgotten. His wife was very involved with supporting him with his transplant treatment. Since discharge he had continued to need Diabetes Specialist Nurse follow up via clinic and telephone calls to optimise his diabetes management. JM spoke to the patient about his experience at RPH and the downsides he reported were limited visiting, which he understood was due to COVID19, but because of the one visitor rule his daughter was upset as she could never visit. Also, he spent 6 weeks in hospital over the Christmas period, and there were several disappointments when he thought he was going home but it was cancelled due to acute rejection, and on three occasions pneumothorax requiring chest drains. He felt that his hopes were raised, and then dashed when test results returned, but understood it was best to sort problems whilst he was here. He told JM that the menu was very repetitive with only a few meals that he liked, and so he had sausage and mash every other day. He finished the conversation saying that he felt he had received brilliant care, and liked the hospital from day one, when he was referred from Glenfield hospital in Leicester. He reported great service from nice people across the multidisciplinary team. **Discussion:** i. MB noted that support for patients who were worried or concerned provided huge value and reassurance and he thanked JM for the story. ii. CC asked whether we were able to take professional advice on caring for a patient with delirium and whether our ward nurses knew how to cope with patients with mental health issues. MS advised that we had a lot of training on delirium and had a delirium group in critical care and we had access to psychological medicine services with a mental health trained nurse. JM noted that as a general nurse she did not have critical care training or experience and whilst she was aware of the huge wealth and knowledge of those staff, the general ward staff learned as they went along, and she felt that there needed to be very clear handover of what was needed for each patient. This patient had been referred to and had been seen by the mental health team, but it was in his general nursing care where staff needed to be more aware of the support that was needed. iii. MS noted that feedback would be provided to the critical care team and she thanked JM again for her story to the Board. **Noted:** The Board thanked JM and noted the patient story.	**MS**	May 22
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 DL that after a brief pause the divisional presentation programme had restarted and that Thoracic Services had made a		

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	presentation. They had highlighted delays in the availability of PET CT scans and in pathology turnaround times. It had been agreed that these areas needed a deep dive which was to be referred to the SPC. Also, the change in the Daedalus system was identified as a concern and an analysis of the impact of this was also referred to SPC. In terms of performance the committee had noted the increase in staff absence and in patients testing positive for COVID19 and recognised that we were not yet at the peak of the surge and so these constraints on activity would continue. **Noted:** The Board noted the Performance Committee Chair's report.		
2.b	**PAPWORTH INTEGRATED PERFORMANCE REPORT (PIPR)**		
	Received: The PIPR report for Month 11 (February 2022) from the Executive Directors (EDs). This report had been considered at the Performance Committee and the Safe and Caring domains were discussed at Q&R Committee and was provided to the Board for information. **Reported:** By SP that the Executive would set out the current position in relation to delivery of the 104% target and the gap to delivery and how that would be filled. The key interventions that related to this included the Meridian work in theatres and cath labs and the implementation of the outpatient optimisation programme. Also, the work being undertaken on transformation in relation to critical care capacity and the work led by the CDC to identify opportunities to increase productivity. The April committees would receive a plan which would quantify this position and set out a roadmap for improvement and this would be brought back to the Board in May. **Reported:** By TG that the assessment of performance against the 104% target was a weighted on both the financial value and the volume of activity undertaken. From a financial perspective elective inpatient activity and day case activity had a higher weighting than outpatient workload as it had a lower resource use. The run rate charts were below the 104% target on two key metrics (at 60% for inpatients and 90% for day cases), but that belied the increase in emergency activity and the case-mix change that was being seen. The initial assessment by his team gave an 87% figure for case-mix adjusted performance which was below the 104% target. We were now working through how we could recover this position over time managing staff absence and patient cancellations due to COVID19. Overall performance was at an amber rating and staff absence and cancellations were the key drivers of performance. **Safe:** Reported by MS: i. That whilst care hours per patient day were flagging as red and amber our performance against benchmark was good and we were delivering safe staffing. ii. The one red area reflected the increased activity throughput in cardiology. We were maintaining good staffing levels in that area and applying mitigations to address any staffing shortfalls. iii. We had a good discussion at the Q&R committe on the fractured pathway issue relating to medications and a spotlight		

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	report was included in PIPR. **Caring:** Reported by MS: iv. A balancing measure of our safe staffing was our performance in relation to patient experience and this remained very good. MB noted that this was reassuring and was a tribute to the Trust. **Effective and Responsive:** Reported by EM: v. Staffing issues had played into the effective and responsive scorecards. vi. The number of patients admitted had been reduced because of patient cancellations and gaps in some teams where we had seen some surgeon absence related to COVID19. vii. The outpatient productivity programme was paying dividends and the challenge in month had been lack of diagnostics, patient non-attendance and cancellations because of COVID19. viii. The 104% target was managed as a system and whilst we had not met the 104% our metrics compared well with others and reflected overall pressures in urgent and emergency care. **People management and culture:** Reported by OM: ix. The impact of sickness absence was showing in the report and we had seen a further uptick reaching a level of 6% absence in the last two weeks. x. We were making good progress with recruitment where we had high vacancy rates in our healthcare support workers and where we and other employers were struggling to recruit locally. We had received investment from Health Education England and had hosted a recruitment event which had resulted in 17 healthcare support worker offers being made. xi. We had been doing work to improve rostering and the report gave an overview of that. We had seen a level of 50% compliance with the last roster period which was an improvement and had some further clinical areas to review. **Finance:** Reported by TG: xii. That we had seen another strong performance in month and had a £5m surplus. The £6.9m forecast included in the report had been revised following the Board's agreement to further interventions that would see the forecast outturn reduce to around a c.£4m surplus figure. **Discussion:** i. JA asked for clarification on the application of the 104% target and how that would be assessed in year. TG advised that the guidance on this had not yet been published but this year it had been set up on a month-by-month basis and so Trusts were not able to 'catch up' on their position over the course of the year. He noted that it would be useful to pick up that discussion in the part two meeting as it was to receive the draft operational plan. This issue reflected the challenge facing the centre as the prevalence of COVID19 was different to the planning assumptions. JA noted that this was a serious issue.		

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	ii. AF asked about the two aspects of productivity and financial controls, as she could not see from PIPR how we could mitigate over and above what was already in place given absence due to COVID19 and emergency pressures both of which were unprecedented. She asked whether there was more that the Board could do to support improved delivery. She had felt very assured by the presentation but understood that we were not in the place we would like to be. SP advised that we had identified opportunities to do more regardless of the constraints that we were working within and that we needed to get the balance right. Staff were tired and burnt out and we needed to ensure that workload was sustainable and so were looking at opportunities to work smarter not harder. The Executive would present the bridge from the current performance of 87% to achievement of the 104% target. This would set out assumptions around what would be delivered from the Meridian work and from the activity being undertaken to improve the effective use of resources. This work was not quite ready but would be brought to the committees and Board in April and May. He invited EM to provide further detail on the work being undertaken by Meridian and noted that MS would provide an update from the critical care work and these would both feed into the modelling by TG's team. iii. MB noted that this was a very helpful conversation and felt that we should devote more time on this matter on the next agenda. He noted that whilst levels of sickness were high our pipeline of staff had grown, and he asked whether if we stripped out the illness data our staffing position was still better than the 2018/19 baseline position, and if so, were are we able to improve against the productivity gap as in 2018/19 we were delivering more with fewer people. This would allow the Trust to establish and consider its true productivity gap and assess whether we were getting as much as we should be in terms of performance as we needed to understand the magnitude of that gap. SP advised that this would form a part of the plan. iv. EM provided an overview of the work on productivity that was being undertaken by point of delivery. In outpatients she had every confidence that we would get to the 104% target and were likely to achieve the 110% target in the first quarter of the year. The outpatient team had rigour and were applying the tools developed in 2019. They were meeting weekly and the barriers to delivery were predominantly arising from patient cancellations. Beyond the current COVID19 surge (which was expected to peak at Easter) we should be able to address the patient availability issues. v. Day case activity was driven by cardiology elective workload and RSSC, and we were confident that we would get beyond the 104% target in those areas. vi. The Meridian work undertaken in the cath labs had identified a 7% gain from improved scheduling which would get back the pace and reduce downtime in schedules. This was based on planning for the 80% rather than around the 20% of cases that might see overruns. vii. In February we had seen that the income associated with elective cardiology was down by £4.5m but this was offset by a		

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	year-to-date increase of £13.4m in emergency workload which was seen in Cardiology and the ECMO service. We would not see the higher use of ECMO continuing for COVID19 cases that had been seen in earlier surges, but the change in cardiology pathways had been 'baked in' and so we had agreed an increase to the cardiology bed base and two additional CCU beds to support this. viii. The position in cardiac surgery was complex. The initial review by Meridian had seen opportunity for a 20% gain in productivity using the 80/20 rule and aligning the availability of staff across all theatres. There was evidence that current working patterns had eroded or set patterns that enhanced national guidance and so we were not getting the best in terms of utilisation and that resulted in increased costs in bank staff and in overtime. The review was being undertaken over a 12-week period and she was working with MS on the critical care transformation programme that would run alongside this. ix. JA asked whether the 20% productivity gain was in time or in case throughput as that would have a significant impact in terms of patient numbers managed through theatres. He noted also that the reasons for cancellations included patient being unfit, insufficient work up, and equipment not being available and some of these matters would be within our own control. EM advised that the equipment issue related to the electrical supply issues and was very unusual. Patients being unfit for surgery included those who tested positive for COVID-19 on arrival or whose medication management had caused issues. Our surgical team felt that this was in part because of the pressures on referring teams and MDTs. Patients admitted on the IHU pathway were brought in the night before surgery and so there was only a small window to ensure that patients were fully worked up and ready for surgery. She advised that the gain identified was a 20% increase in case throughput and that on the old site we had a standard of working to a three-pump day, which had not yet been achieved on the new site because of the lack of anaesthetic rooms and Meridian felt that this could be mitigated. x. MS noted that there was real and positive work being undertaken with the theatre and critical care teams and the Meridian work and these were working alongside one another. The first five weeks of the critical care programme had focused on 'hearts and minds' and it was now moving into the action phase. This would look at how we could support teams and would establish clear actions and monitoring to allow us to increase the bed base in critical care and to align ourselves to the increases in productivity in theatres. A progress report would be brought to the next Q&R Committee and to Board. The level of engagement with staff was so that they could see that they were protected and supported through these changes. xi. SP noted that the work on productivity would be a part of discussions at the next committee meetings and that the bridge chart would reflect the output in terms of analysis of additional staffing numbers, the impact of emergency workload in cardiology, and would set out the actions that were required		

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	to close the gap in productivity and when this would be achieved. The Executive would bring forward a balanced position for the Board to review. **Noted:** The Board noted the PIPR report for Month 11 (February 2022).		
3	**GOVERNANCE**		
3.i	**Q&R Committee Chair's Report** **Received:** The Q&R Committee Chair's report setting out significant issues of interest for the Board. The report was taken as read. **Discussion:** DL asked for clarification on whether the question relating to serious incident investigation into the fall would be addressed by the new patient safety framework. MB noted that the investigation process did not currently tell us the number of falls where there was learning that was relevant from previous incidents that had not been applied. This was a part of the new patient safety framework and so would be introduced through that process. MS advised that implementation of the new framework had been delayed because of the pandemic and it was expected to be launched in June. Organisations were ready with local implementation plans and we were undertaking work as a system so that a community of practice would be developed to take forward learning which would contribute to our quality improvement plans. There would be a positive system working approach around the new framework. **Noted:** The Board noted the Q&R Committee Chair's report		
3.ii	**Combined Quality Report** **Received**: A report from the Chief Nurse and Medical Director which highlighted information in addition to the PIPR. **Reported:** By MS that that most of the issues set out in the report had been discussed in terms of critical care project, the CCG visit and COVID19. In addition to her report, she advised that the Ockenden report had been released on the 30 March and whilst that included much learning for maternity units there were also lessons for organisations across the wider NHS. All organisations were required to review the report in detail and to consider the recommendations in relation to safer staffing, listening to patients and families, listening to staff, and learning from incidents and governance. She noted that the governance team were looking at the recommendations and we would have a gap analysis to understand our level of assurance and that report would be taken to the QRMG. The Q&R Committee would be updated in coming months. **Discussion:** i. CC noted her concern that the NHS received repeated reports and asked whether there was more that we should be doing as the NHS to address this as it felt that we had seen many reports with many recommendations of the same nature. ii. AF echoed CC's concerns noting that many reports pointed to the same underlying issues: the importance of listening to our patients and staff and the management of risk as a 'tick box'		

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	exercise rather than addressing the cultural change that was needed to mitigate risks in the right way. iii. JA noted that the Medway report on maternity was yet to be published which would bring further recommendations. He had been pleased that the ICS had indicated that they should focus on a small number of actions that could be undertaken successfully and felt that we needed to apply the same rigour to these recommendations and as a Board we needed to focus on what we could deliver. He noted that the national funding for this agenda was limited and given the rising litigation bills facing the NHS felt this warranted action but was not resourced properly to address this at a national level. iv. SP noted that whilst we did not have comprehensive answers, he agreed with the concerns expressed by the Board particularly around responsibilities placed on overwhelmed services. He felt that there was a key issue of mindset when things went wrong. There were always warning signs from patients and from staff. We did not have the same quality issues, but we needed to look at how we responded to difficult issues. He noted the example of M.abscessus where our approach had been to ensure that we had appropriate candour; that we had engaged with our regulators and with patients; that we had to sought out the best approaches that any organisation could take; and that we had responded in as open, honest, and engaging way as possible. He also noted that the current staffing position with the NHS having 100,000 vacancies would be likely to drive issues of quality. v. MB felt that the Trust had a good approach to managing risk, it was proud but not defensive and it looked at problems in detail. **Noted:** The Board noted the Combined Quality Report.		
3.iii	**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 SP had highlighted the key movements reported in the tracker. The secure environment risk (BAF 2833) had been reduced in the prior month but was to be re-escalated following the issues relating to the electrical supply. ii. That the principal risks had been restated for 2022/23 and these, along with the mitigations would be included in the annual report. **Discussion:** i. MB noted that this was the first time that the Board had seen the final version of the principal risks following the Board workshop. AJ advised that two risks had been brought together with the focus on productivity as agreed at the workshop. MB felt that these captured the risks that had been considered by the Board.		

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	Noted: The Board noted the BAF report for March 2022 and approved the summary of principal risks for 2022/23.		
3.iv	**Audit Committee Chair's Report** **Received:** The Audit Committee Chair's report setting out significant issues of interest for the Board. **Reported:** by CC: i. That the committee had looked at the cyber risk and cyber recommendations and the questions that we should be asking in relation to this risk. The committee was assured that these questions were being addressed by the organisation. ii. The committee had also received the draft head of internal audit opinion and at this time that was an overall moderate assurance opinion. iii. The committee had received papers from TG and from KPMG that provided assurance that all the technical issues relating to the annual audit and accounts were being addressed. **Received and noted:** The Board noted the Audit Committee Chair's report.		
3.v	**Corporate Objectives 2022/23** **Received:** From the CEO the Trust's Corporate Objectives for 2022/23. The Board had seen the draft objectives at its meeting in March meeting and they were being brought for approval. **Reported:** By SP that once approved the objectives would form the basis of the CEO and ED objectives and these would be reported through the Remuneration Committee and would be cascaded to be used for objective setting for staff across the Trust. **Agreed:** The Board approved the Corporate Objectives for 2022/23.		
3.vi	**Annual Reviews:**		
	a. Board Certifications **Received:** From the Trust Secretary the annual Board self-certifications for approval. **Reported:** By AJ that the Board was required to review its certifications on an annual basis ahead of publication on the Trust website and these included: • The Corporate Governance Statement • The annual certification of Licence compliance (General Condition 6) and Continuity of Services (Condition 7) of the NHS Provider licence. • The self-certification for Training of Governors **Discussion:** CC asked whether the Governor training certification had been considered by the CoG. AJ advised that the final documentation would be on the agenda for the next CoG meeting but that training matters were included under the Governor Matters item at every CoG meeting. **Agreed:** The Board approved the self-certifications for publication.		
	Annual Reviews: **b. Board Self-Assessment**		

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	Reported: By AJ: i. That the Board self-assessment summarised the reviews that had been undertaken by Committees during the period from January to March 2022 and the outcome of assessments would feed into the annual report. ii. That the self-assessment of performance was strong across all committees. **Discussion:** JA asked how the external well led review process would feed into the Board self-assessments. AJ noted that the feedback would be brought to the Board in May and that any recommendations would be included within the Annual Report as evidence of assurance beyond the self-assessment process. **Noted:** The Board noted the Board committee self-assessments.		
3.v	**Board Sub Committee Minutes:**		
3.v.a	**Quality and Risk Committee Minutes: 24.02.22** **Received and noted:** The Board of Directors received and noted the minutes of the Quality and Risk Committee meetings held on 24 February 2022.		
3.v.b	**Performance Committee Minutes: 24.02.22** **Received and noted:** The Board of Directors received and noted the minutes of the Performance Committee meeting held on 24 February 2022.		
4	**WORKFORCE**		
4.i	**Workforce Report** **Received:** The Director of Workforce and OD a paper setting out key workforce issues. **Reported:** By OM that the focus of the report was on the NHS Staff Survey 2021 which had been discussed at the part II meeting in March as the information had been provided to the Trust under embargo. Her report set out an overview of our results. These showed: i. That we had a 70% response rate which was one of the highest in the NHS. This was an indicator of the level of engagement of our staff and it gave us a good degree of confidence in the results in terms of how they represented the experience of staff working for the Trust. The survey results were included in full in the Board reference pack. Overall performance across the NHS was very much worse than had been seen in prior years. ii. Our performance had improved from the bottom quartile to average performance within our peer group and there were two specific areas of concern that SP had noted, our scores for staff burn out and our WRES scores. iii. For the questions on burnout, we were the worst in our peer group and were in line with the national average scores for burnout and exhaustion. These were questions that were not asked last year. iv. In our WRES data we had areas where we had improved, but		

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	we continued to be significantly below the national and our peer averages. Our response to this would be to keep going with the schemes that were in place which included reciprocal mentoring, which was starting in June, our cultural ambassadors training, where the next cohort were starting in May, and the line manager development programme which was due to start with the first cohort of 50 staff in April and next year would see more staff being brought through this programme and supported to become compassionate and collective leaders. v. We had not yet seen the full WRES data and needed to access this to get the breakdown at a directorate level. We were aware of variations in performance across departments and so needed to use this information to provide focus. **Discussion:** i. DL asked if the WRES data could be shared once available. OM advised that it would be shared but that there were no surprises and the summary data received showed that our poor scoring areas were in STA and in critical care. We had the transformation programme in place which would address two components of change one of which was to improve the culture and experience for our staff. She noted that one unexpected area had been within clinical administration and we would need to drill down into the data for that area. ii. CC noted that the Board should be hopeful, as we had a plan and we had seen improvements. We did have poor results, but we needed to give time for this to improve and to take our staff with us. iii. SP noted his thanks for everyone's contribution, he noted the disappointments in the survey results, but also that we should not overreact, and that what was needed was sustained commitment over time and we should take confidence that the actions being taken were the right ones. **Noted:** The Board noted the update from the DWOD.	**OM**	May 22
4.ii	**Gender Pay Audit**		
	Reported: By OM that the gender pay audit had been discussed at the Women's Network and at the Q&R Committee. It was being brought to the Board for approval prior to publication. Key issues for the public sector reflected national pay scales and structures, which were seen to drive a proportion of the differentials in pay. The network discussion had focused on career opportunities for those with caring responsibilities who were working part time as that was felt to be a barrier to development and promotion. Review of the differential in pay for medical staff demonstrated that these were driven by the national clinical excellence awards, as our local awards were proportionate to the composition of our workforce. Our focus in this area would be on supporting women to apply for national awards. **Discussion** i. JA asked whether we could re-examine the information and exclude the doctors from the analysis. OM advised that the first three quartiles would provide a proxy for that measure and that the gender differential at this level was more		

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	proportionate. JA noted that he had been involved in regional review committees and that any change in the national awards system would take a long time. JA advised that he had been on review committees for a number of years and that women applying for awards needed to be less modest. He noted that he would be happy to support work in this area. OM thanked JA for the offer of support. ii. RH noted that whilst JA's offer was helpful this area was fraught with factors that were inherently unfair, and consultants generally had worked with this. There were changes coming forward and a new structure that would see awards being set at lower values and judged in different ways and we would need to encourage more women to apply. This should reduce some of the cliff edges in the current system and it would be interesting to see the impact of this over time. iii. DL wanted to understand better how we could encourage our female consultants to apply for awards at a national level and whether our staff who had awards were able to mentor staff applying. RH advised that the Board should feel comfortable that there was an extensive programme of mentoring and that applications for national awards were closely scrutinised, also whilst we did have a significant male/female disparity the mentoring process accounted in part for the higher level of success from applications submitted from RPH as the Trust had five times the national level of award holders than other centres. DL noted that irrespective of this in the context of the gender pay gap we were not getting enough women across the line. RH noted that the key metric for success should be in proportion of awards again in relation to the gender make up of the consultant body. iv. JA suggested that it would be good to know the number of women applying and whether the percentage of applications that were successful was better than thought, as then the key issue was that they must apply. He also noted that the national scheme was still dependent on evidence of participation in regional and national committees and other platforms and that we should promote the engagement of our female staff through those opportunities. v. MB felt that we also needed to discuss the data in the report and whether they were selection effects that could allow us to understand more, and we would see what could be found out about those bottlenecks. **Agreed:** The gender pay audit and action plan were approved for publication.		
5	**RESEARCH & DEVELOPMENT** *(report deferred)*		
6	**BOARD FORWARD AGENDA**		
6.i	**Board Forward Planner** **Received and Noted:** The Board Forward Planner.		
6.ii	**Items for escalation or referral to Committee** None		

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7	**ANY OTHER BUSINESS**		
	MB noted that this was RH's last meeting of the Board and he expressed thanks on behalf of the Board and the Council of Governors, and he felt that we had been indebted to RH's wisdom and guidance and expertise whilst on the Board of the Trust. RH thanked MB for his appreciation and noted that he had been proud and had enjoyed being a member of a great team.		

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Signed

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Date
Royal Papworth Hospital NHS Foundation Trust
Board of Directors
Meeting held on 07 April 2022

Glossary of terms

CDC	Clinical Decision Cell
CIP	Cost Improvement Programme
C&P ICS	Cambridge & Peterborough ICS
CUFHT	Cambridge University Hospitals NHS Foundation Trust
CUHP	Cambridge University Health Partners
DGH	District General Hospital
GIRFT	'Getting It Right First Time'
ICB	Integrated Care Board (of the ICS)
ICS	Integrated Care System
IHU	In House Urgent
IPPC	Infection Protection, Prevention and Control
IPR	Individual Performance Review
KPIs	Key Performance Indicators
LDE	Lorenzo Digital Exemplar
NED	Non-Executive Director
NHSE/I	NHS England/Improvement
NSTEMI	Non-ST elevation MIs
NWAFT	North West Anglia NHS Foundation Trust
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
SOF	NHS **S**ystem **O**versight **F**ramework (Graded 1-4)
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