Royal Papworth Hospital
NHS Foundation Trust

Extraordinary Meeting of the Board of Directors
Held on 4 March 2021 at 10:00am
via Teams
Royal Papworth Hospital

UNCONFIRMED M I N U T E S – Part I

Present	Mr M Blastland	(MB)	Non-Executive Director (Deputy Chair)
	Dr J Ahluwalia	(JA)	Non-Executive Director
	Ms C Conquest	(CC)	Non-Executive Director
	Ms A Fadero	(AF)	Non-Executive Director
	Ms D Leacock	(DL)	Associate Non-Executive Director
	Mr T Glenn	(TG)	Chief Finance and Commercial Officer
	Mr I Graham	(IG)	Acting Chief Nurse
	Dr R Hall	(RH)	Medical Director
	Mrs E Midlane	(EM)	Chief Operating Officer
	Ms O Monkhouse	(OM)	Director of Workforce and OD
	Mr S Posey	(SP)	Chief Executive
	Mr A Raynes	(AR)	Director of IM&T Chief Information Officer
	Mr G Robert	(GR)	Non-Executive Director
	Prof I Wilkinson	(IW)	Non-Executive Director
In Attendance	Mrs A Jarvis	(AJ)	Trust Secretary
	Mr A Selby	(AS)	Associate Director of Estates and Facilities
Apologies	Prof J Wallwork	(JW)	Chairman

Agenda Item		Action by Whom	Date
1.i	**WELCOME, APOLOGIES AND OPENING REMARKS**		
	The Deputy Chairman welcomed everyone to the meeting and apologies were noted as above.		
1.ii	**DECLARATIONS OF INTEREST**		
	There is a requirement that Board members raise any specific declarations if these arise during discussions. No specific conflicts were identified in relation to matters on the agenda.		
	The following standing declarations of Interest were noted:		

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	i. John Wallwork and Stephen Posey as Directors of Cambridge University Health Partners (CUHP). ii. Roger Hall as a Director and shareholder of Cluroe and Hall Ltd, a company providing specialist medical practice activities. iii. John Wallwork as an Independent Medical Monitor for Transmedics clinical trials. iv. Stephen Posey in holding an honorary contract with CUH to enable him to spend time with the clinical teams at CUH. v. Stephen Posey as Chair of the NHS England (NHSE) Operational Delivery Network Board. vi. Stephen Posey as Trustee of the Intensive Care Society. vii. Stephen Posey, Josie Rudman and Roger Hall as Executive Reviewers for CQC Well Led reviews. viii. Andrew Raynes as a Director ADR Health Care Consultancy Solution Ltd ix. Stephen Posey as Chair of the East of England Cardiac Network. x. Michael Blastland as: 1. Board member of the Winton Centre for Risk and Evidence Communication; 2. Advisor to the Behavioural Change by Design research project; 3. Member of the oversight Panel for the Cholesterol Treatment Trialists' Collaboration; 4. Member of advisory group for Bristol University's Centre for Academic Research Quality and Improvement. xi. Cynthia Conquest as Deputy Director of Finance and Performance at the Norfolk Community Health & Care NHS Trust. xii. Stephen Posey as a member of the CQC's coproduction Group. xiii. Jag Ahluwalia as: 1. CUHFT Employee, seconded to Eastern Academic Health Science Network as Chief Clinical Officer; 2. Programme Director for East of England Chief Resident Training programme, run through CUH; 3. Trustee at Macmillan Cancer Support; 4. Fellow at the Judge Business School - Honorary appointment; 5. Co-director and shareholder in Ahluwalia Education and Consulting Limited; 6. Associate at Deloitte; 7. Associate at the Moller Centre. xiv. Ian Wilkinson as: 1. Hon Consultant CUHFT and employee of the University of Cambridge; 2. Director of Cambridge Clinical Trials Unit; 3. Member of Addenbrooke's Charitable Trust Scientific Advisory Board; 4. Senior academic for University of Cambridge Sunway Collaboration; 5. Private health care at the University of Cambridge; 6. University of Cambridge Member of Project Atria Board (HLRI). xv. Tim Glen's partner is the ICS development lead for NHSE/I in the East of England. xvi. Amanda Fadero 1.Trustee of Nelson Trust , a charity predominantly supporting recovery from drug and alcohol addiction with expertise in trauma informed care for women; 2. Associate Non-Executive Director at East Sussex NHS Healthcare Trust. i. Diane Leacock: 1. Director – ADO Consulting Ltd; 2. Trustee – Firstsite Gallery (voluntary, unpaid position); 3. Trustee – Benham-Seaman Trust (voluntary, unpaid position).		
2	**PERFORMANCE**		

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2.i	**COVID19 PERFORMANCE REPORT** **Received:** From the Executive Directors the COVID19 performance report. **Reported:** By SP that: i. The report had been instigated in the first wave of the pandemic and aimed to bring together key data for the Trust and the EoE. ii. That chart 1 showed that we were over the peak of the second wave and as at today we were under the baseline level of critical care as a region. iii. The Trust had a strong role in the second wave reflecting the nature of the critical care and ECMO service, and whilst other units were seeing de-escalation RPH was not. iv. There was a difference in role outside of critical care for RPH between the first and second wave. This had seen us responding in the second wave to take L2 and L1 patients from across the region to support load levelling outside of critical care. **Discussion:** i. MB asked about the recovery expectations a. TG advised that as RPH was not de-escalating and were still in surge it could not practically turn on the recovery period but this was the subject to ongoing review. b. EM advised that each of the services was planning recovery with Cardiology expecting to move to address all P2 patients in March and Respiratory services restoring sleep studies and ambulatory care; Surgery was seeing the greatest challenge because of its dependency on critical care bed. c. EM noted that at 40 critical care beds the Trust was 17 beds above its baseline (and that included 22 respiratory ECMO patients). Staff were therefore still redeployed and there were daily huddles in place to work out the deployment of staffing resource across the organisation. d. That the Trust had allocated one theatre for emergencies but the shape of the second wave was different with increases being seen in Cardiac and Surgical emergency pathways. e. In addition critical care had to manage 'green' and 'purple' pathways and that had the impact of carving out capacity across the three critical care areas and this needed to be managed, and at times switched, to balance capacity and staffing across all areas. ii. GR noted that the Performance Committee had received a presentation from the Cardiology team and had noted the increase in the Cardiology emergency pathways. The team were investigating this increase in demand and how it could be managed on a sustainable basis. He noted that it was helpful to hear the first hand reports from the divisions. iii. AF noted that this was helpful to set out the difficult decisions		

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	being faced. As we were one of five ECMO centres nationally what was the plan to balance resources and return to a new normal? RH advised that we were one of the five ECMO centres and of the 75 patients across the country we had by far the largest share of patients and that was because we had been at the geographical centre of the most significant pressures. ECMO patients take longer to recover and therefore they would have an impact which would restrict our ability to do other things. iv. MB asked whether we should bring data on our P1 and P2 patients backlog into PIPR so that we can see the rate of clearance of the backlog as RTT would be impacted by the risk stratification. EM noted that this was reported on a weekly basis through the national sitrep but this was not a static population as patients come on and off the waiting list and were escalated through the clinical review processes. SP noted that when new guidance was published it was expected to reflect new currencies for monitoring waiting lists including the long waiters and waiters by priority. This reporting would be brought into PIPR as it was developed. **Noted:** The Board thanked the Executive and noted the COVID19 performance report.		
3	**WORKFORCE**		
3.i	**Gender Pay Audit & Action Plan** **Received:** A paper from the Director of Workforce and OD to update the Board on the outputs from the 2020 audit. **Reported:** By OM that: i. The data on the mean and median pay gap sets out the size of the pay gap between male and female members of staff and this would be published by the end of March 2021. ii. That the picture at the Trust was similar to other NHS employers with a gap driven by the gender balance of the consultant body and the application of excellence awards. The gender profile of the Consultant medical workforce is 36% female and 64% male; this compared to an overall gender profile that is 74% female and 26% male. iii. The intake at medical schools now has a balanced gender profile but there were still variations in the make-up of individual specialities. iv. The Trust did not operate a bonus scheme but the national clinical excellence awards did have an impact on the gender pay gap in consultant pay. Despite efforts the Trust had made no progress in this area and would look at this in more detail. v. There had been little focus on this agenda as the biggest equality issue that the Trust faced related to race and disability. vi. Whilst recognising that this area was not prioritised at the moment there were issues that could and had been taken forward through reviews: a. The gender balance of our medical workforce. b. Recruitment practices.		

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	c. Promotion practice. d. Support for applicants for clinical excellence awards (which is anonymised and ranking is therefore undertaken blind). e. Mentoring and development for those consultants who have not put themselves forward for excellence awards. f. Trust policies where whilst there has been progress that has seen new ideas and changes in practice such as support for carers, which had a benefit in terms of being good practice, and a benefit in terms of both gender and race inequalities. Onika, our EDI lead was also keen to look at issues associated with race and gender as women from a BAME background have the lowest wages and opportunity for career progression. **Discussion:** i. DL welcomed the initiatives outlined and noted concern about staff capacity to deliver this. She asked if it would be possible to focus on one or two areas in the first instance and to measure our progress against these? OM agreed that these matters had not been addressed because of prioritisation but felt there was an opportunity of intersectionality with the race and WRES work that was underway through the EDI programme and noted that there was an opportunity to focus on the data and to look at recruitment metrics and so there were a number of ways of assessing this. ii. JA asked about the position if we were to exclude Consultants, noting also that whilst we should not give up on the Consultant gap, the position at medical schools was now a 55% female intake which would deliver change over time. This approach could eliminate a lot of the variation but he noted that this would not have any impact at other bands such as 8a and 8b where he was aware of pay gaps at other organisations. OM advised that Trust had not undertaken that analysis but felt that there would be issues such as working patterns; caring responsibilities and work life balance that should be considered in how we are addressing this matter. iii. GR noted that in his sector there had been significant improvement over the last 20 year in the balance of male and female staff taking up senior roles and he found it difficult that we should accept limited progress if we did not want to waste resources. He felt there was a great deal that could be done to encourage progression of women and to see that as a priority. OM noted that this was a priority and that she was surprised to see that the profile of our trainees was not balanced. However when looking at priorities the issue of race stands out and we have applied our limited resources to that agenda. iv. RH felt that the issue of work life balance was also a factor and that this was increasingly an issue for both genders. Those jobs that required immediate recall to the Trust on a seven-day basis were not compatible with family life and this would have an impact on the jobs that medical staff chose to undertake.		

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	Agreed: The Board noted the update from the DWOD.		

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Signed

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Date

Royal Papworth Hospital NHS Foundation Trust
Board of Directors
Meeting held on 4 March 2021

Glossary of terms

CIP	Cost Improvement Programme
CTP	Cambridgeshire Transition Programme
CUFHT	Cambridge University Hospitals NHS Foundation Trust
DGH	District General Hospital
GIRFT	'Getting It Right First Time'
IHU	In House Urgent
IPPC	Infection Protection, Prevention and Control Committee
IPR	Individual Performance Review
KPIs	Key Performance Indicators
LDE	Lorenzo Digital Exemplar
NED	Non-Executive Director
NHSI	NHS Improvement
NSTEMI	Non-ST elevation MIs
PET CT	Positron emission tomography–computed tomography - a type of scanning of organs and tissue
PIPR	Papworth Integrated Performance Report
PPCI	Primary Percutaneous Coronary Intervention
PROM	**P**atient **R**eported **O**utcome **M**easure: assesses the quality of care delivered to NHS patients from the patient perspective.
RCA	**R**oot **C**ause **A**nalysis is a structured approach to identify the factors that have resulted in an accident, incident or near-miss in order to examine what behaviours, actions, inactions, or conditions need to change, if any, to prevent a recurrence of a similar outcome. Action plans following RCAs are disseminated to the relevant managers.
RTT	Referral to Treatment Target
SIs	Serious Incidents
SIP	Service Improvement Programme
STP	Cambridgeshire and Peterborough **S**ustainability & **T**ransformation **P**artnership
VTE	Venous thromboembolism
Wards	Level Three: L3S (South) and L3N (North) Level Four: L4S and L4N Level Five: L5S and L5N CCU Critical Care Unit
WTE	Whole Time Equivalent