Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Held on 6 February 2020 at 9am
Ground Rehab Floor Seminar Room
Royal Papworth Hospital

UNCONFIRMED M I N U T E S – Part I

Present	Prof J Wallwork	(JW)	Chairman
	Dr J Ahluwalia	(JA)	Non-Executive Director
	Mr M Blastland	(MB)	Non-Executive Director
	Mr R Clarke	(RC)	Chief Finance Officer
	Ms C Conquest	(CC)	Non-Executive Director
	Mr D Dean	(DD)	Non-Executive Director
	Dr R Hall	(RH)	Medical Director
	Mrs E Midlane	(EM)	Chief Operating Officer
	Ms O Monkhouse	(OM)	Director of Workforce and OD
	Mr S Posey	(SP)	Chief Executive
	Mr G Robert	(GR)	Non-Executive Director
	Mr A Raynes	(AR)	Director of IM&T Chief Information Officer
	Mrs J Rudman	(JR)	Chief Nurse
	Prof I Wilkinson	(IW)	Non-Executive Director
In Attendance	Mr Tony Bottiglieri	(TB)	FTSU Guardian
	Mrs S Harrison	(SH)	Associate CFO
	Mrs A Jarvis	(AJ)	Trust Secretary
	Mrs L Shillito	(LS)	Matron
Apologies			
Observers	Dr D Begley		Clinical Director
	Dr S Bullivant		Public Governor
	Mr T Glenn		Chief Finance and Commercial Officer (14/04/20)

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1.i	**WELCOME, APOLOGIES AND OPENING REMARKS**		
	The Chairman welcomed everyone to the meeting and apologies were noted as above.		
1.ii	**DECLARATIONS OF INTEREST**		
	There is a requirement that Board members raise any specific declarations if these arise during discussions.		

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	Noted: That IW had submitted his declarations for the public record and these would be taken into the minutes. No specific conflicts were identified in relation to matters on the agenda.		
	The following standing declarations of Interest were noted: i. John Wallwork and Stephen Posey as Directors of Cambridge University Health Partners (CUHP). ii. Roger Hall as a Director and shareholder of Cluroe and Hall Ltd, a company providing specialist medical practice activities. iii. John Wallwork as an Independent Medical Monitor for Transmedics clinical trials. iv. Josie Rudman, Partner Organisation Governor at CUH. v. Stephen Posey in holding an Honorary contract with CUH to enable him to spend time with the clinical teams at CUH. vi. Stephen Posey as Chair of the NHS England (NHSE) Operational Delivery Network Board. vii. Stephen Posey as Trustee of the Intensive Care Society. viii. Stephen Posey, Josie Rudman, Roy Clarke and Roger Hall as Executive Reviewers for CQC Well Led reviews. ix. Andrew Raynes as a Director ADR Health Care Consultancy Solution Ltd x. David Dean as Chair of ETL, a commercial subsidiary of Guy's and St Thomas' NHS FT. ETL are currently providing advisory services to the Estates team at Cambridge University Hospitals NHS Foundation Trust on Project Management. xi. Stephen Posey as Chair of the East of England Cardiac Network. xii. 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. xiii. Roy Clarke as a member Cambridge Global Health Partnerships Committee part of ACT. xiv. Cynthia Conquest as Deputy Director of Finance and Performance at the Norfolk Community Health & Care NHS Trust. xv. Stephen Posey as a member of the CQC's coproduction Group. xvi. Roy Clarke as a member of the Audit Committee for the RCOG. xvii. 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. viii. Ian Wilkinson as: 1. Hon Consultant CUHFT and employee of the University of Cambridge; 2. Director of Cambridge Clinical		

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	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.		
1.iii	**MINUTES OF THE PREVIOUS MEETING**		
	Board of Directors Part I: 5 December 2019 **Approved**: The Board of Directors approved the Minutes of the Part I meeting held on 5 December 2019 as a true record.		
1.iv	**MATTERS ARISING AND ACTION CHECKLIST**		
	Noted: The Board received and noted the updates on the action checklist.		
1.v	**Chairman's Report**		
	The Chairman provided an update on current activities to the Board. **Reported:** By JW that: i. He had attended the Charity's Carol Concert at Ely Cathedral and this had been very well attended and raised funds for the Charity. The address was given by Dr Sarah Clarke and this had been well received. JW had also attended the Cathedral for the Memorial service for Sir Michael Marshall. ii. He had visited Adcam's new headquarters with SP; Medtronic had visited CUHP and there had been a campus visit from a Chinese delegation. iii. Filming had started for the programme 'Surgeons at the edge of life' iv. Building work had started on the HLRI and education facility. JW also noted that in the week commencing the 16 February there was to be action in Cambridge by Extinction Rebellion and this may cause some disturbance to staff and visitors.		
1.vi	**CEO's UPDATE**		
	Received: The Chief Executive's update setting out key issues for the Board across a number of areas reflecting the range and complexity of the challenges currently facing the Trust and the significant progress being made in delivery of the Trust's strategic objectives. The report was taken as read. **Reported:** By SP that: i. That key to his report were the concerns about the impact of critical care performance on patients, patient flow and the Critical Care unit. This would be covered in detail in PIPR and the Board should be in no doubt that addressing this was how the Executive were spending their time. ii. He welcomed the improvement in the volume of outpatient attendances and expressed thanks to the booking team at Royal Papworth House and to Angie Jackson and the outpatient team for delivering this turnaround in performance. The Trust was now exceeding the volumes being delivered on the old site and this was a real benefit to patient outcomes and patient experience.		

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	iii. The Trust was to sharing its best practice with teams involved in PFI management and hospital builds and rebuilds across the NHS. The Trust had been asked to share expertise and was putting a package together to support other NHS organisations. SP noted that sharing of best practice would be a recurrent theme across the year. iv. The 2019 NHS staff survey highlighted how our staff were feeling and indicated some significant room for improvement. OM would provide a summary in Part II and the Compassionate and Collective Leadership programme was fundamental to improving the working experience of our staff. v. That we had now achieved a level of over 85% in the uptake of Flu vaccination, exceeding the national target. vi. The staff awards shortlist had been included in full in the pack. Over 500 staff had been nominated and each of those had received a congratulatory letter from the CEO. vii. The press coverage of our lung cancer surgery world first had reached over 30 million people worldwide and had recognised the contribution of the whole multidisciplinary team involved in the procedure. **Discussion:** i. CC noted the digital update included in the CEO report and wanted to ensure this was not underplayed. The interoperability achieved with Epic was commendable and she would like a team to visit to learn about this achievement. ii. DD asked if the lessons learned document about the move was to be brought back to the Board. RC noted that this was due for a further update and that the finalised version would be brought to the Board. **Noted:** The Board noted the CEO's update report.	TG	TBC
1.vii	**Patient Story**		
	Lizzie Shillito presented the patient story. This patient had been admitted at Peterborough and transferred to the Trust on the 22 January 2020 and had an angiogram on the 23 January. The staff in the Cath Lab had put the patient at ease and his case was discussed at the MDT on the 24 January and with dates for Echo and MRI being set for the 31 January and 3 February. LS saw the patient on the 31 January. At that point they reported they had not seen anyone from surgical team, although the patient was seen by the Surgical Advanced Nurse Practitioner (ANP) and his surgeon later that day. The patient had been moved to the fifth floor and his surgery had been cancelled due to lack of critical care beds. The patient had been very anxious but the discussion with the surgical ANP had reassured him. The patient had reported that he was a very fussy eater, but that he had enjoyed having his own room. He had fewer visitors as his family lived a long distance away and the delay meant he was away from home for a longer time and he did not feel fully informed about his stay.		

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	The patient reported that monitors were an issue as they were noisy. LS noted that this was being addressed and monitors were being reconfigured on Monday 10 February. There would be fewer alerts and the alert tones were to be changed which would be a benefit for patients and staff. The changes were restricted by monitoring requirements and the team were looking at telemetry solutions. The patient was now due for surgery tomorrow. **Discussion:** LS asked the Board whether there were restrictions on the use of Bank/Agency for staff who were permanently employed at CUH. OM advised that the STP employers had agreed that we would not use staff through agencies if the person was substantively employed elsewhere in the NHS. **Noted:** The Board noted the patient story.		
2	**PERFORMANCE**		
2.a.i	**PERFORMANCE COMMITTEE CHAIR'S REPORT** **Received:** The Chair's report setting out significant issues of interest for the Board. **Reported:** By GR that the Committee had focused on a detailed discussion on critical care and had received assurance that the issue was being managed with short term fixes and long term plans. **Discussion:** A member of the public raised an issue around management of pressures in critical care. The Chairman advised that this matter was on the meeting agenda and that any further specific questions could be taken after the meeting. **Noted:** The Board noted the Performance Committee Chair's report.		
2.b	**PAPWORTH INTEGRATED PERFORMANCE REPORT (PIPR)**		
	Received: The PIPR report for Month 9 from the Executive Directors (EDs). This report had been considered in detail at the Performance Committee. **Noted:** i. That overall Trust performance was at a Red rating. ii. That performance was rated as 'Red' in four domains: Effective, Responsive, Finance, and People, Management & Culture. iii. That performance was rated as Amber in three domains: Safe, Caring and Transformation. **Reported:** By SP that the Trust had established a diagnosis around Critical Care but this was a complex matter and the recovery plan required a range of actions. The focus of recovery plans was the safety of the CCU unit and the hospital, and the impact on staff and patients. The diagnosis had revealed that the unit had higher than average:		

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	• Maternity leave (7 WTE over forecast) • Sickness absence (4 WTE over forecast) • Levels of supernumerary staff reflecting the increased recruitment levels (Equivalent to 5/6 WTE) • Registered/Associate Nurses vacancies (21 WTE) • Use of Bank/Agency/overtime (27/28 WTE) This resulted in a gap of 11 WTE vacancies. This level of vacancy did not match the level of closures on the unit. Other Issues included beds that were expected to operate at Level 2 (a lower staffing ratio) which were working with higher levels of acuity and complexity. For example yesterday there were no Level 2 patients all were at Level 3 and so required higher nursing ratios. Actions were being taken: i. To improve rostering and make better use of substantive staff. The roster for March was showing improved utilisation and the Trust had commissioned work from Allocate who had expertise in deploying rosters and training. ii. To maintain recruitment activities and close down issues around retention. The workforce team were actively working with CCU Matrons and Cheryl Riotto, Head of Nursing. iii. To finalise the recovery trajectory which would come to ED's on Tuesday and would include plans for daily monitoring. The recovery plan would be brought to the Performance Committee in February and this would provide actions in context. **Discussion:** i. JR advised Q&R had discussed the approach to staffing and she and RH were to review the model for the winter period. The Trust addressed pressures by moving and flexing staff on a daily basis but did not plan to cover all potential peaks in demand which might require more staffing overall in winter than in the summer months. RH noted that small variations in demand from ECMO; routine and emergency activity and transplantation could have a large impact on workload. ii. RC advised that Trust plans were created and modelled on a level of capacity that was set on a consistent basis and that was reviewed each year. iii. It was recognised that our staff were an incredibly valuable resource and that the review was about setting staffing at an appropriate level. There were opportunities through flexible working, staff bank and additional hours to give a degree of flexibility in the establishment. iv. JA sought assurance around whether staffing to the average was right and whether it would be better to move closer to peak requirement as the Trust could otherwise spend reactively to address issues. He also noted that he had joined the mock CQC inspection on Monday and that despite the pressures on staff, the unit itself appeared calm and serene. v. MB noted caution as we had seen some optimism bias around the staffing pipeline and so the wider assumptions around improvement may also carry a degree of risk.		

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	vi. OM advised that we had planned to get to a full establishment and would not turn off recruitment at that point or apply an artificial on cap recruitment. The next recruitment day was on the 15 February. vii. SP advised that EDs would review the recovery trajectory and it there was not confidence in plan he would look outside the organisation for external support. He noted also that there was merit in going asking the organisation to review and "'kick the tyres" on the proposal. viii. DD asked about how staff were now finding the changes. JR advised that the CCU were on a journey in terms of how they and the unit worked. Staff were working with more open doors, the unit had been segmented to support staffing deployment and there were additional Health Care Support Workers deployed whose numbers had doubled. ix. SP noted that many of the Red and Amber ratings in PIPR were linked to critical care performance. GR noted that these had been explored in committee and whilst there had been good conversations about CCU he did not want that to obscure other issues of underperformance. x. JA asked whether there was need for collection and monitoring of mood and morale on the CCU. JR would take this as an action for the CCU working group. JR reported that the Trust was putting in place resources around mindfulness on shifts in the Unit and was also undertaking the Pulse staff survey. xi. MB noted that the discussion on relative risk, and risk to patients waiting to come in was ongoing. He felt that we were short of information on the balance of risk and the harm to patients waiting. The waiting list graphs in PIPR showed a substantial drop in patients having treatment within 7 days but we were unable to see patient harm that occurred as a result of this and needed to balance this against staff distress. xii. RH noted that harm reviews were crude and not necessarily meaningful but there may be an opportunity to look for an index or RAG rating for patients waiting and consider additional events in that period expected outcomes. xiii. JW felt that there may be cohorts of patients with coronary disease where there would be some increase in infarcts; admissions; deaths and other events that could be measured. xiv. SP asked for RH to take a proposal to the Q&R Committee on the review of the consequence of waiting on patient outcomes and wellbeing. EDs outlined key performance issues for the Board and provided detail on the spotlight reports covering: i. Safer Staffing ii. Friends and Family iii. Critical Care iv. Referral Trends v. Band 5 Registered Nurse Supply and Demand Modelling vi. CIP Planning 2020/21 vii. Directorate Financial Performance	JR RH	Apr 20 TBC

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2.b.i	**Safe** **Reported:** By JR that the metrics in the Safe domain had been discussed at Performance Committee and Q&R.		
2.b.ii	**Effective** **Reported:** By EM that the domain was rated as Red: i. The throughput of activity in month had been adversely affected by issues in critical care. ii. That Cath Lab utilisation was reduced as one machine was out of commission in month however scheduling work was now showing dividends. iii. That there were a variety of bedding in issues in Radiology which had an impact on throughput. RC noted that the issue this month related to fixings that were safe, but remedial works were being undertaken as a precautionary measure.		
2.b.iii	**Caring** **Reported:** By JR that the metrics in the Caring domain had been discussed at Performance Committee and Q&R.		
2.b.iv	**Responsive:** **Reported:** by EM that: i. RTT performance in surgery was effected by critical care. ii. Respiratory medicine had seen an increase of 60 referrals per month and this had increased patient numbers on the waiting list and the number of breaches. The service was taking actions to adjust capacity to deal with surge in referrals and was monitoring those actions. iii. The cancer position was driven by a very small number of patients and performance was worse at M9. Key issues identified through root cause analysis (RCA) related to delays in PET CT and the Trust was working with commissioners and providers to address this. **Discussion:** JW asked whether we had sufficient work to have our own PET CT. EM advised that we had very small numbers and would be unlikely to recruit, mirroring the issues faced by current providers. The resolution of this matter was a strategic and national issue.		
2.b.v	**People, Management and Culture** **Reported:** By OM that: i. Turnover had increased in December and was expected to remain at the same level in January ii. Sickness levels had increased but this followed seasonal trends. The highest absence category was for anxiety, stress, and depression. The Compassionate and Collective Leadership programme would pick up this issue and the Trust was introducing an Employee Assistance programme with a helpline and counselling service. The Trust was also promoting the CPFT self-referral access to talking therapies. iii. It was 'Time to talk day' and that there would be a stand in the atrium that Board Members could visit. **Discussion**: i. MB asked whether the increase in reports of stress and		

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	anxiety were worse than the seasonal trends. OM advised that these were not and this was similar to rates reported across the NHS. The overall increase in sickness absence was affected by increases in colds and flu. ii. GR asked about the report from CUH that their nurse vacancy rate was now at 6% and whether we had a view on why our rate was higher? OM advised that over the period of the move we had fewer people joining the Trust because of the level of uncertainty around the move and in addition we had increases in establishment. CUH had also made a significant investment in overseas recruitment. iii. GR queried the KPI for vacancies. OM advised that this was 5% and noted that we had moved towards target consistently since the move. OM advised that the Trust actively responded to recruitment pressures and could recruit. It was an attractive employer and the focus to achieve step change must be through the Compassionate and Collective Leadership programme.		
2.b.vi	**Transformation** **Reported:** i. By EM that the next significant CTP transfer was Cardiology and the Trust was working with CUH on a single service solution and were aligning messaging around this. ii. By RC that the HLRI had started construction the Estates team were working to ensure that the site works did not cause disruption to patients. They were reviewing noise and dust pollution and would halt work if problems were identified to agree solutions. The build was scheduled to take two years to complete.		
2.b.vii	**Finance** **Reported:** by RC that: i. The M9 position was a £2m deficit YTD on a control total basis. The Trust forecast was a £2.6m surplus at year-end however the net position would be adverse to plan because of the land sale. ii. Income was £2.3m below plan (£4m excluding the GIC). iii. Pay was £1.9m above plan reflecting increases in temporary staffing associated with critical care and pump priming of ward transfers. iv. Non-pay was adverse to plan reflecting the impact of the new rateable value which had increased by £780k following the move. This had been challenged but it may take more than a year to resolve this matter. v. Reserves were being deployed to mitigate the CIP gap. vi. The capital programme was behind plan but would be fully utilised in year. vii. We would be in receipt of NHSX capital funds for cyber and digital security improvements. viii. That focus was on the achievement of the run rate from the 1 April 2020. **Discussion:**		

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	i. DD asked whether the additional cost of temporary staffing in CCU was offset in other areas and whether if we had not used the staffing we would have been in a worse position in relation to performance. EM noted that there was a direct impact of CCU performance on surgical cancellations and theatre utilisation. One area under review was the utilisation of work across six theatres with consideration of whether moving to five theatres might unlock resources. ii. OM noted that the Trust had not capped temporary staffing; however increased of temporary staff puts also pressure on leaders in those areas. iii. IW asked about how Trust income had been affected by the CCU performance. RC advised that surgery income was significantly below plan as a result of CCU performance. Separately cardiology income was below plan and OPD was £1m below plan as a result of slower optimisation and ramp up following the move. For 2020/21 there would be no ramp down of activity and we should see improvement in outpatient performance in the next financial year. The Trust would be seeking a GIC agreement next year to manage risk and income.		
	Noted: The Board noted the PIPR report for Month nine (December 2019).		
3	**GOVERNANCE**		
3.i	**Board Assurance Framework** **Received:** From the Trust Secretary the BAF report setting out: i. BAF risks against strategic objectives ii. BAF risks above appetite and target risk rating iii. The Board BAF tracker. **Reported:** By AJ: i. That the BAF report included an executive summary setting out key movements in individual BAF risks. ii. That the principal risks were set out in the report. These were: workforce including recruitment and retention; failure to optimise the hospital to deliver activity and meet demand, and to achieve a sustainable financial position. **Discussion:** i. CC raised the assessment of Cyber Risk in relation to the principal risks. This had been discussed previously at Board as this featured as a principal risk for other organisations and the issue of staff response to cyber threats and had been escalated through Q&R. SP noted that the cyber risk score was high risk but this was mitigated. It was agreed that this would be explored by the Executive Team and a recommendation brought back to the Board. ii. DD asked about the risk review and trigger processes as he was concerned that some risks were static across significant periods. RC noted that all BAF risks were reviewed on a monthly basis by Board Committees and Executive Directors	SP/AJ	Apr 20

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	and were reported to the Audit Committee. It was noted that there had been change and challenge to ratings as a result of reviews. **Noted:** The Board noted the BAF report for January 2020.		
3.ii	**Q&R Committee Chair's Report** **Received:** The Q&R Committee Chair's report setting out significant issues of interest for the Board. **Reported:** By MB that CCU had been the main issue of discussion for the Committee as well as the issues around the Clinical Audit Plan which was not on track but it was expected to show improvement over time. **Noted:** The Board noted the Q&R Committee Chair's report		
3.iii	**Combined Quality Report** **Received**: A report from the Chief Nurse and Medical Director which highlighted information in addition to the PIPR. **Reported:** By JR that: i. The uptake of flu vaccinations had now exceeded 85%. CC noted that the level of 85% was a very good rate when compared to other providers across the region. ii. The briefing had been used to share flu updates and a survey had been undertaken to understand the detail of why staff declined vaccination. This would be used to inform the vaccination campaign next year. iii. The report noted the increase in the Surgical Site Infection Rates and the planned review process. The outcome of the review would be taken to Q&R in February. iv. The Trust had limited bed closures due to infection prevention and control (IPC) and was a positive outlier as an organisation. **Discussion:** i. GR asked whether there was guidance around the Corona virus. JR advised the IPC teams had been fully briefed and information screens had appropriate messages for patients and staff. JR and RH had reviewed pandemic planning arrangements and EM had joined the national teleconference. Guidance had been issued to staff. ii. A query was raised as to whether ECMO would have therapeutic use in Corona virus. RH advised that if we did have an outbreak its role would depend on disease behaviour. iii. JW noted that the Trust must be able to respond as and when the need arises. iv. JA noted that the lack of closure of beds as a result of IPC was a positive aspect of the building design and had clinical and financial benefits. Historically other Trusts had been subject to beds being closed for many weeks as a result of norovirus and flu and the absence of closure was a significant return on investment. RC advised that the financial impact of the last flu closure on the old site was assessed at £480k.		

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	Noted: The Board noted the Combined Quality Report.		
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 DD that the Committee had approved the internal and external audit plans and had discussed the issues identified in relation to oversight of the Clinical Audit programme and the plan to improve joint working around this. **Noted:** The Board noted the Audit Committee Chair's report		
3.v	**Board Sub Committee Minutes:**		
	Quality and Risk Committee Minutes 26.11.19 and 16.12.19 **Received and noted:** The Board of Directors received and noted the minutes of the Quality and Risk Committee meeting held on 26 November and 16 December 2019.		
	Performance Committee Minutes 28.11.19 and 19.12.19 **Received and noted:** The Board of Directors received and noted the minutes of the Performance Committee meeting held on 28 November and 19 December 2019.		
3.vi	**Terms of reference.** **Received:** Updated Terms of Reference: a. TOR 001 Audit Committee b. TOR 002 Q&R Committee c. TOR 018 Strategic Projects Committee **Noted:** That a further amendment had been requested for the Audit Committee and these would be brought back to the next Board with the remaining Committee TOR. **Approved:** The Board of Directors approved: b. TOR 002 Q&R Committee c. TOR 018 Strategic Projects Committee		
4	**Trust Strategy 2020-25**		
4.i	**Received:** From the CEO the final draft of the Trust Strategy 2020 – 2025 for approval. **Reported:** By SP that: i. The Trust Strategy reflected the culmination of a year's work and would stand the Trust in good stead alongside regional plans and the development of ICS at a regional level. ii. He wanted to record his thanks for the contribution from teams across the organisation, in particular the Heads of Nursing and		

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	the Divisional Triumvirates. iii. The key issues going forward were: a. Making the strategy live: this was to be addressed through communications plans for staff and patients. b. The timeline for enabling strategies: which were to be set and included in the Board forward plans. c. How the strategy informed organisational objectives: JW and SP had met to discuss drafts objectives for 2020/21 and these would be cascaded across the organisation. **Discussion:** i. JW raised a concern that the document was not written in plain English and requested that there was a public version for publication. SP advised that was being addressed with input from the Communications team. ii. GR raised a query about sustainability as there did not appear to be a plan in relation to environmental sustainability. RC advised that one of the supporting strategies was the Estates and Sustainability Strategy and this was due to come to the Board in June. This would include key issues and targets for becoming carbon neutral with a focus on sustainability within the supply chain. iii. DD welcomed the reference to reputation and how we income generate as a Trust, but was concerned to understand how this would be achieved and the actions associated with this. EM advised that further detail would be included in supporting service strategies. SP noted that Tim Glenn had been appointed as Chief Finance and Commercial Officer and that this was a deliberate refocus of the role. This revised commercial focus would be captured in the strategy. **Approved:** The Board Approved the Trust Strategy 2020-2025		
5	**WORKFORCE**		
5.i	**Workforce Report** **Received:** From the Director of Workforce and OD a paper setting out key workforce issues. **Reported:** by OM that: i. The report provided an update on the Compassionate and Collective Leadership programme (CCLP) which team members had presented to the Board in December. A pictogram summarising the eight priorities identified by staff for improving culture and leadership at the Trust was set out at Appendix 1 of the paper. This would be used to communicate with staff with a 'you said we did' approach. ii. Trust values and behaviours were the building blocks of the CCLP and the team were now developing its third phase. A bid had been submitted to the Charitable Funds Committee to allow the programme to move ahead at pace and this would be considered by the Committee next week. Other supporting programmes were progressing including the employee assistance programme; the BAME network; the NHS Rainbow badge scheme and the LBTQ+ network.		

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	iii. That the Trust had taken part in the national 'Recruiting for Difference' trial. The programme had been interesting and learning would be shared. The approach had been used for the Head of Nursing position with the job description and advert signalling the importance of the individual's leadership style and their work on diversity; as well as their role in supporting organisational change. iv. The interview process had included assessment of skills with candidates being set a task around ward staffing, operational and RTT pressures with observation by a wider team. The feedback was very positive, although it was a more resource intensive recruitment process. The Trust would be using the process for another post as a part of the national pilot and recommendations would be fed back nationally. **Agreed:** The Board noted the Workforce report.		
5.ii	**Guardian of Safer Working** **Received:** The yearly report on safe working hours From Dr Martin Goddard, Guardian of Safe Working (GSW). **Reported:** By RH: i. That the report was a statutory requirement and provided assurance to the Board around adherence to Junior Doctors' rota requirements. ii. That the GSW had noted concerns around the rota compliance and whilst no exception reports had been received the report alerted the Board to the issue for the Cardiac Surgery trainees who were likely to breach rota requirements. iii. That the options for rota management were being developed by the supervisory group these would be taken to the Education Steering Group and reported to Q&R Committee. **Discussion:** i. That there was a balance to be achieved around assessment of the rota; rota rules and a demanding surgical career path. ii. That the Trust needed to provide the opportunity to learn. It had been rated as the best cardiac training programme in the last year, and the best surgical training programme in the prior year and balancing the learning opportunity against the rota compliance required a process of careful balance. iii. CC welcomed the report and understood the pressures that needed to be balanced. It was noted that decisions made would be developed with views obtained from the Junior Doctors Forum and input from the British Medical Association. This would support the Training Programme Director. It was recognised that the way forward was through conversation with trainees and not immediately moving to steps that could result in lengthening training programme requirements. iv. MB asked about the consequences of non-compliance in relation to sanction and enforcement. RH advised that if formal concerns were raised that would trigger reports and an escalation and review process would be followed. It was unclear as to whether junior surgeons wanted this to be raised as the Trust programme produced good and successful	RH	TBC

Agenda Item		Action by Whom	Date
	surgeons. OM noted that compliance was ultimately a contractual matter which would need to be addressed. v. JA noted some caution as whilst recognising rota rules were challenging, and that they did not work in every specialty, the Trust should ensure that rotas whilst potentially stressful should not cause distress. **Noted:** The Board noted the report of the Guardian of Safe Working.		
5.iii	**Freedom to Speak Up Guardian's Report** **Received:** From Tony Bottiglieri the Freedom to Speak Up Guardian's Report for Q2 and Q3 2019/20. **Reported:** by TB that: i. There was increasing use of the service including the new FTSU Champions and this provided confidence and reassurance about the overall level of provision. ii. That the report included the numbers for Q2 and Q3 that had been submitted to the national office and these would build into a profile of incidents and trends over time. iii. The Trust had 27 incidences reported and these covered: • 15 bullying and harassment or leadership concerns • 4 concerns relating to patient care or safety iv. The report included three case studies one of which was from a clinical area and presented concerns about empowerment and staffing levels. TB had met with the team with the Matrons and the Head of Nursing and had worked through the communications breakdown. v. The second case study around consent had been followed up with their supervisor and resolved. vi. The third study related to a staff member on a temporary contract and the outcome was worked through with HR. vii. The FTSU role profile was extending and was promoted through induction and briefing. TB had also talked about the role to Year 5&6 Medical Students. **Discussion:** i. SP noted his thanks to Tony. He was conscious that staff hear about the role at induction but might not appreciate the scope of the work undertaken and the case studies provide assurance around the role. It was also important to promote to staff through briefings so that they felt able to speak out. ii. TB advised that he received good support from OM and felt that the organisation had recognised the importance of the role. CC welcomed this feedback given the issues around time commitment previously reported. iii. CC asked about the FTSU Champions and how they were working in their new roles. TB advised that the 16 Champions were becoming embedded and getting known as FTSU ambassadors. The Champions were new in role and he didn't want to expose them to significant issues but they had set up a WhatsApp group, Action Learning Sets and had set up bi-monthly meetings for Champions. iv. DD asked about the case related to challenging inappropriate		

Agenda Item		Action by Whom	Date
	behaviour. TB noted that the staff member had been correct to confront inappropriate behaviour but there were concerns on how this was approached. The Board welcomed the fact that staff were being encouraged to challenge respectfully. iv. The Trust had received 32 concerns last year and 42 in the first three quarters of the year. The number of concerns was included in national reporting and the trend figures were likely to grow. These would be included in future reports. v. OM noted that key themes identified would be addressed through the Compassionate and Collective leadership programme. **Noted:** The Board noted the report of the Freedom To Speak Up Guardian.		
5	**Research & Education** – *no report due*		
6	**Digital** – *no report due*		
7	**BOARD FORWARD AGENDA**		
7.i	**Board Forward Planner** **Received and Noted:** The Board Forward Planner.		
7.ii	**Items for escalation or referral to Committee**		

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Signed

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Date

Royal Papworth Hospital NHS Foundation Trust
Board of Directors
Meeting held on 6 February 2020

Glossary of terms

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