Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Held on 03 February 2022 at 9:00am
Microsoft Teams
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
	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
	Mr G Robert	(GR)	Non-Executive Director
	Mrs M Screaton	(MS)	Chief Nurse
	Prof I Wilkinson	(IW)	Non-Executive Director
In Attendance	Ms T Crabtree	(TC)	Head of Communications
	Mrs A Jarvis	(AJ)	Trust Secretary
	Mr A Selby	(AS)	Director of Estates and Facilities
Apologies			
Observers	Susan Bullivant, Trevor Collins, Richard Hodder, Rhys Hurst, Trevor McLeese, Harvey Perkins,		

Agenda Item		Action by Whom	Date
1	**WELCOME, APOLOGIES AND OPENING REMARKS**		
	The 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.		

Agenda Item		Action by Whom	Date
	CC advised that she had a new declaration undertaking work for Great Ormond Street Hospital Private Patient Unit. No specific conflicts 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: 02.12.2021 *Previously circulated to the Board on 16 December 2021.* **Approved**: The Board of Directors approved the Minutes of the Part I meeting held on 2 December 2021 as a true record.		
1.iii	**MATTERS ARISING AND ACTION CHECKLIST**		
	Noted: The Board received and noted the updates on the action checklist.		
1.iv	**Chairman's Report**		
	The Chairman noted that there had been changes in national guidance since the meeting was planned and these matters would be reported later on the agenda. He noted also that the Trust was slowly getting back to how we wanted to be working, delivering the maximum care for the maximum number of people.		
1.v	**CEO's UPDATE**		
	Received: The Chief Executive's update setting out key issues for the Board. The report was taken as read. **Reported:** By SP that: i. George Freeman, Minister for Science and Innovation, had visited the campus on the 20 January 2022. He had a very successful visit to HLRI, and the Trust would be writing to him with further information on some specific topics that he raised. ii. He welcomed the discussion at Committee relating to the BAF and risk appetite noting that we were continually seeking to improve our reporting and that we used the BAF to oversee our principal risks. Committees looked at how risks were mitigated, and risks were considered at ED's each week. He drew the Board's attention to the increase in cyber risk (BAF 1021) which related to the increase in international threat levels; and the increase in our workforce recruitment risk (BAF 1854) which related to labour market conditions and competition on salaries. The system reform risk (BAF 3074) incorporates risks in our ways of working within the new ICS and this would build a picture of the risk associated with this over time. The Executive and Board Committees were content that there were no omissions in the BAF and no new risks that should be recorded, however ED's would be reviewing the impact of changes in capital allocations. The Board would be using its development session in March to review risk appetite and he noted that some of this discussion was set out at section 6 of the BAF report. iii. His CEO's report covered another eventful period in which staff and volunteers had responded to the requirements of the pandemic and had demonstrated the values and behaviours of		

Agenda Item		Action by Whom	Date
	the Trust. We had established the public vaccination hub; had seen high demand in cardiology services and experienced staff shortages due to the omicron COVID-19 variant, which had seen staff absence reach a high of 7%. Our winter planning and pandemic planning had stood us in good stead to respond to these pressures and in January we were able to shift the focus onto our elective patients. Along with the establishment of the vaccination hub we had continued to work with partners to support the system response to COVID-19. iv. He noted the importance of the well-being of staff but also that there was also an appetite from staff to see improved delivery of clinical services and the Clinical Decision Cell (CDC) had focused on this area of work. Throughout the period we had maintained safer staffing across the organisation. This was delivered by hard work and the willingness of our staff and he commended Trust teams for their response to these demands. v. We had also undertaken significant work relating to the statutory requirement for Vaccination as a Condition of Deployment (VCOD). The Trust had approached this with compassion and had focused on individual conversations with members of staff. It had achieved some of the highest rates of vaccine compliance rates in the East of England and prior to the government decision to review the requirement only eight staff had chosen not to be vaccinated. This was a testament to all our staff and the teams working on implementation, but the Board should not underestimate the work, and the anxiety that had been caused. vi. Research news was positive and included the handing over of the HLRI and we had been delighted to showcase this to the minister. The HLRI was a key element of delivery of the Trust Strategy, and this would provide support on a system basis with educational offerings that extended beyond the Trust. vii. He noted that the establishment of the ICS and ICB had been slipped to the 1 July and that a summary paper would be brought to the next meeting. **Noted:** The Board noted the CEO's update report.	**SP**	Mar 22
1.vi	**Patient Story**		
	MS introduced the patient story. LS Shillito presented the patient story. This related to a patient that had a good outcome but was a story that highlighted several matters that she wanted to share with the Board. This patient was admitted on Christmas Eve on the ACS pathway. The patient had an angiogram the same day and was referred for consideration by the In-House Urgent (IHU) MDT. The case was discussed at the MDT on the 29 December at which two surgeons and two cardiologists were present and it was agreed that the patient would benefit from a surgical bypass graft. The patient required a dental review which took place on the 4 January 2022. The patient was seen by the Surgical Advanced Nurse Practitioner on the 7 January and was told that she would also need surgery on other valves. This was new information to the patient, and she was concerned by this. She was subsequently reviewed by the surgical		

Agenda Item		Action by Whom	Date
	registrar who deemed that she was unfit for surgery and so was considered for a TAVI procedure. The patient was relieved by this, her case was discussed at the TAVI MDT the next day, and she was seen by the TAVI specialist nurse. It was agreed that she would go ahead for an angiogram the following Monday. The PCI was successful however the TAVI procedure was subsequently cancelled on the 12 January and rebooked for the 19 January. This meant that the patient had spent over three weeks in hospital over the Christmas period and a further minor delay meant that she went home on the 23 January 2022, thirty-three days after admission. The patient reported that: • she had enjoyed her stay and she had liked the food and the private rooms • she had been frustrated by being woken for observations overnight • the input of the TAVI nurses allowed her to feel empowered and to continue her own diabetes management whilst an inpatient. The patient had a good outcome from her procedure, but LS raised the question of whether her experience of care be improved and whether we could have involved her earlier in decisions on care. We use TAVI for the most frail patients and the question was whether we could select and prepare our patients more effectively. We had seen a 180% increase in the use of TAVI since April 2019, which was thought in part an effect of COVID-19, with patients more frail when presenting resulting in extended lengths of stay and this was being discussed by the teams. We had seen increases in the emergency pathway with 40% of ACS transfers now on the IHU pathway and so it was felt that we needed to review how this pathway was working. **Discussion** i. AF and JW asked about the service response and opportunity for reflection on the decision-making process at the MDT, also whether frailty issues could be better identified if the patient was seen. LS advised that the MDT had representatives from surgery and cardiology, and it was the clinical judgement of those in the room, however they did not see the patient, they saw the angiogram and the echocardiogram results. The service was looking at what else could be done and there was collaborative work going on in cardiology and surgery to review this pathway. ii. CC asked whether TAVI was a less invasive procedure and why TAVI was not used for all frail patients. LS advised that it was less invasive using femoral catheter access and the recovery time was significantly less. Where a surgical discharge might typically take 6 to 10 days a TAVI discharge could be achieved within 24 hours (and we were benchmarking with centres who were seeing discharge within 12 hours of TAVI). RH noted that there were other clinical elements to be considered in the decision and that we needed to offer selective pathways to minimise delays. He noted that the cost of the TAVI valve was higher when compared to a surgical valve and that longer term outcome data was less established. A surgical valve had a mortality rate approaching 0% for an AVR but that needed to be		

Agenda Item		Action by Whom	Date
	balanced against the frailty issues which could only be done by seeing the patient. He noted that we were not always able to see the patient in the decision-making process, but all procedures were carefully considered, with the pros and cons of doing nothing versus doing something, and what that procedure should be. iii. CC asked about observation overnight and whether anything could be done to address this. LS noted that this was always a fine balance. This patient had significant three-vessel disease and small changes, if not picked up, could result in our missing an opportunity to manage deteriorations. This would have influenced the decision on four hourly observations. iv. MB asked whether patients might be allowed to attend an MDT meeting if they wish to do so, as he felt that we perhaps underestimated whether patients might wish to be more involved in their care. He also asked whether we had data on the number of patients who were judged to be unfit for surgery at a late stage. LS advised that this was looked at in the surgical division and that late-stage decisions were recorded on DATIX, especially where a patient had been in for a long period prior to surgery and had then been cancelled as this induced significant anxiety for patients. Communication with the patients was key. v. MS noted that whilst mindful of the changing landscape over the last 18 months, we should not underestimate the deconditioning that would be associated with a thirty-three day stay in hospital. Whilst a patient may become unsuitable for an open heart procedure a thirty-three day stay was very long for a TAVI procedure. MS felt that we should be looking at surgical reviews and key to that would be a proper conversation with the patient. vi. JW asked whether patients needed to be kept in hospital and if they could be managed at home with an appropriate emergency contact. RH noted that the decision-making process was note straight forward. vii. IW noted that where a patient was at a referring hospital waiting for an IHU transfer their clinical teams had very little information, and the decisions made by Trust teams had a significant impact on partners. viii. JA agreed that these were complex decisions, and that this was not linear data and asked what were the factors that would switch a decision. He also asked whether it was worth looking at whether part of the delays was due to the Christmas holiday period and to COVID-19. LS advised that services would have been affected by the Christmas period as the MDT meetings operated on a Monday to Friday basis and not seven days, and there were fewer staff available at weekends. **Noted:** The Board thanked LS for the presentation and noted that they would look forward to the development work in relation to the IHU pathway.		
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 considered the following		

Agenda Item		Action by Whom	Date
	key issues: i. The BAF issues which were as noted by SP and that would we come back to some of those matters on the agenda. ii. The impact of current pressures on performance and activity, with high demand from emergency cases in cardiology and the IHU pathway which had an impact on elective activity in surgery. We had also heard about the delays in thoracic relating to the delay in rollout of the CPAP pumps replacement programme. iii. The choices that were being made in how we allocate resources and the operational decisions taken on a regular basis and felt that they needed to understand how these decisions were taken. iv. That it had been disappointing to see that the increase in turnover (which was at an annualised rate of 19%) was in part related to lack of opportunity within the Trust. This would be a focus for the Compassionate and Collective Leadership programme. v. The BAF risk for CIP had increased as a result of the shift in focus into the 2022-23 pipeline, as whilst we would hit our targets for current year, we were now looking further forward. vi. Finally, the Committee had looked at the operational planning for 2022-23 and that would have significant implications for our future financial sustainability. **Discussion:** i. MB noted request for the Q&R meeting to look at the decision-making process and advised that this was in train and he and GR would meet to discuss this outside of the Board meeting. GR felt this appropriately sat within the Q&R agenda but would have wider implications for the Board. MS noted that Ivan Graham and EM had been looking at this work and a summary would go to the Q&R meeting in February 2022, their work had brought operations and nursing teams together and would describe the processes and the risks that were considered in balancing these decisions. ii. SP welcomed that discussion noting that there were many variables to be taken into account, also that this work once developed could be shared with others across the system. AF advised that in another role she had seen a very good process and was happy to share that with MS and EM. **Noted:** The Board noted the Performance Committee Chair's report.	**MS**	Mar 22
2.b	**PAPWORTH INTEGRATED PERFORMANCE REPORT (PIPR)**		
	Received: The PIPR report for Month 9 (December 2022) from the Executive Directors (EDs). This report had been considered in at the Performance Committee and was provided to the Board for information. **Reported:** By TG that overall Trust performance was at an Amber rating. **Safe:** Reported by MS: i. That the indicators on safe staffing looked not as good as they should be, but this was because not all beds were occupied		

Agenda Item		Action by Whom	Date
	and so not all staff were required. ii. We were undertaking a focus on compliance with VTE risk assessment and had looked for harm associated with the reduced level of compliance that was reported. None had been identified. **Caring:** Reported by MS: iii. That we were seeing good experience reported and good response levels in our Friends and Family ratings and we were now looking at the experience and response rate in relation to virtual clinics. **Effective:** Reported by EM: iv. That this domain was Red rated and TG and GR had described key issues relating to the operational pressures where we had seen our critical care capacity being used to deliver ECMO and devices in one third of our beds in December, and in half of our beds in January. v. In addition to staff absences there had been significant patient sickness levels which had resulted in cancellation of inpatient and outpatient slots and so we were unable to use all of our capacity. vi. In outpatients we had stood down activity in December to support the establishment of the vaccination hub and had expected to see an impact of 10 or 15% associated with this. However, when compared with the three prior years this was one of the highest outpatient levels on record. Activity had continued because of the use of virtual appointments which followed the investment in remote monitoring to support our activity through the pandemic. The outpatient teams were now building on the productivity work undertaken with Meridian before the pandemic and this would contribute to service recovery. **Responsiveness:** Reported by EM: vii. That the waiting-list backlog was increasing and that all patients were being managed in order of clinical priority. We had however seen some frustration from surgical colleagues who felt they were being required to review but unable to operate on their patients. viii. That we were not seeing all priority 2 patients when needed and had seen some deterioration in our position which we were looking to recover in January. ix. Another key area of operational performance was cancer where we had seen poor performance relating to late referrals, complex patients, and restricted access to PET CT services. Where possible we had used capacity in Colchester for our patients and we were continuing to work with the Cancer Alliance to maximise patient flows. x. In cardiology we had been incredibly busy with 131 ACS pathways and 97 primary PCI activations and 25% of these needed critical care on arrival. It was felt that we were seeing a shift in the urgency of our patients and that delays in accessing services during the pandemic may have contributed to the deterioration in presenting conditions.		

Agenda Item		Action by Whom	Date
	People management and culture: Reported by OM: xi. That staff leavers continued to be above the KPI. This was not in a particular department or staff group but was across the board and to some extent this was outside our control, with changes in the local labour market and pay inflation in other sectors having an impact. There were other factors that were significant such as career pathways and the use of IPR and development plans. However, she felt it was difficult to understand what a normal level would look like for the Trust given the significant change associated with the move, and the subsequent COVID-19 pandemic. We would look at whether we should set our turnover KPIs at the same level as District General Hospitals or at a higher level as there were some drivers such as the more limited development opportunities associated with being in a smaller organisation. xii. Tat we continued to struggle on delivery of in-depth individual performance review and that this would be difficult to recover during the continued COVID-19 absence. **Finance:** Reported by TG: xiii. Year-to-date performance was strong and overall NHS finances were forecast to be better than budget allocation at a regional and at an ICS level, however some organisations were struggling and in that context our results were positive and we should be proud of them. xiv. He noted that the better payment practice standards where we had seen poor performance in the summer had continued to improve in terms of volume of and value of invoices. In December we have achieved targets for non-NHS Providers and had 98% by volume but only 94% by value of bills paid for NHS Providers. We were looking to achieve against all these metrics in this year. xv. The financial position for 2022/23 looked more challenging and we were now looking at our financial envelope with our partners. xvi. The ICS role would increase with the appointment of the Chair and Chief Executive Officer but this would remain in shadow form ahead of the formal structures being established, however we should expect to see further change. **Discussion:** i. AF noted EM's presentation and felt that her level of grip was assuring. Following the issues around length of stay raised in patient story she asked whether or not this was being seen in activity changes and whether this warranted a deeper dive into the length of stay experienced by our patients. She asked also whether COVID-19 was impacting on our internal patient flows resulting in us being less efficient. EM advised that this was a complex picture and that we were seeing blockages in referring hospitals and systems. EM and MB noted that length of stay and mortality provided some assurance that these levels were being maintained despite the fact that we were only undertaking priority one and priority two patients and would be expecting to see extension in the length of stay. EM felt that it would be possible to look at aspects of the care and see whether these		

Agenda Item		Action by Whom	Date
	measures had moved. SP noted that it was right to push ourselves but given the pressures on the NHS he felt we also need to consider our relative position. He felt this should be provided to the Board in our written and verbal updates to ensure that the Board understood how Trust performance sat in the context of the system and the wider NHS. ii. EM noted that she saw the regional reports on waiting times each week and that our deterioration was less marked than others. We managed 52-week waiters very carefully. Currently we had five patients waiting over 52 weeks and had been at eight, but we had no patients waiting over 104 weeks and that was at odds with the rest of the NHS in the local system. iii. Our diagnostic performance was strong even though we had significant workforce challenges and whilst colleagues were proud of what had been achieved, this was not where we wanted to be. JW noted that in time COVID-19 would become an endemic issue and we would need to consider the wider impact of this in reporting. He also felt that the assessment of performance against the diagnostic waits was not reasonable as performance below the 99% target was classified as Red. EM advised that we had not changed targets since the pandemic and that the team were proud of the services and their success in what was being delivered. She noted also that we had also been able to deliver mutual aid to CUH in CT and bronchoscopy services. She recognised the phenomenal performance of the team and noted their ambition to achieve Amber and Green ratings. **Noted:** The Board noted the PIPR report for Month 9 (December 2021).		
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. **Reported:** By MB that we had seen no increases in serious incidents and other indicators were consistent with the overall experience in the NHS. Cardiac mortality would be expected to increase in line with acuity and we were monitoring the levels and were assured that we were maintaining safety at the highest levels. He welcomed the change that would be seen in reporting of cardiac mortality in the PIPR report in May. **Discussion:** i. DL asked about the processes that were slowing patient flow through the organisation and whether we needed to re-examine these. MB/JW noted that this had been the focus of discussion at the CDC over recent weeks. This had focused on the 'barnacles' that had accumulated on our pathways. Our clinicians had seen this happening and felt that now was a good time to review processes and consider whether they added value and to have the difficult discussions about trade-offs. MB was pleased to see that this discussion was happening across the organisation.		

Agenda Item		Action by Whom	Date
	ii. RH noted that during any period of crisis there would be opportunity to use learning as a time to reset and redesign our processes. This could be done in parallel with the work to look at restoring activity. If we looked at the patient story presented to Board what was described was a series of small hold-ups in the system which had resulted in sluggish progress. There were more difficult challenges but we should always look and embark on this process of review and the Trust should be working to deliver a continuous process of improvement. SP agreed that continuous improvement was a key factor. The Trust had achieved ratings of outstanding in five domains at the last CQC review not because it was perfect, but because we knew the issues and were seeking improvements. He had been encouraged by the CDC discussion and was hopeful that the Board would see that we were moving in the right direction. MB noted that it would be helpful for the Board and the Q&R Committee to receive briefings on progress. **Noted:** The Board noted the Q&R Committee Chair's report	**RH**	Mar 22
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 report included a celebration of the work of our volunteering services. The Trust had secured funding to support recruitment of volunteers and that had helped with establishment of our vaccination hub as well as being deployed in other areas of the Trust. We were using some volunteers in pharmacy but were not yet able to use volunteers in clinical areas because of the restrictions on visiting. This was being kept under review and we would build back the recruitment and deployment of volunteers. **Noted:** The Board noted the Combined Quality Report.		
3.iii	**Audit Committee Chair's Report** **Received:** The Board received and noted the Audit Committee Chair's report setting out significant issues of interest for the Board. **Reported:** By CC that the January audit Committee had seen a significant number of policies along with the Standing Financial Instructions. This had been a weighty meeting but had been fruitful. One of the themes through the meeting was the Board Assurance Framework. The Committee had considered the policy for this and it had subsequently had feedback from other Committees and the final version would be brought to the Board in March. Other documents reviewed included the Standing Orders, Scheme of Delegation and the Audit Committee self-assessment and Terms of Reference. She noted that the external auditors had advised of the national submission date of the 22 June and had advised that they would have difficulties meeting the earlier deadline requested by the Trust. In view of this some of the approval meetings had been rescheduled to fit with external audit timelines. The audit Committee had also undertaken its self-assessment and whilst suitably critical in its assessment, it felt that the		

Agenda Item		Action by Whom	Date
	overall outcome was strong performance. **Noted:** The Board noted the Audit Committee Chair's Report.		
3.iv	**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 that key issues had been summarised in the CEO's report. **Noted:** The Board noted the BAF report for January 2022.		
3.v	**Board Sub Committee Minutes:**		
3.v.a	**Quality and Risk Committee Minutes: 25.11.21** **Received and noted:** The Board of Directors received and noted the minutes of the Quality and Risk Committee meetings held on 25 November 2021.		
3.v.b	**Performance Committee Minutes: 25.11.21** **Received and noted:** The Board of Directors received and noted the minutes of the Performance Committee meeting held on 25 November 2021.		
3.v.b	**Audit Committee Minutes: 20.01.22** **Received and noted:** The Board of Directors received and noted the minutes of the Performance Committee meeting held on 20 January 2022.		
4	**WORKFORCE**		
4.i	**Workforce Report** **Received:** The Director of Workforce and OD a paper setting out key workforce issues. **Reported:** By OM: i. That between writing her report and it being presented there had been a national change in the arrangements for VCOD. Trusts had been instructed not to issue notice to staff, although the VCOD remained a statutory requirement at this point. This left questions around our future recruitment processes which would not be resolved until after the consultation process concluded. We were continuing communications with staff and meeting with those staff who were not vaccinated. She felt that the Board should not underestimate either the work that had been generated by this requirement in recent months or the impact on the staff. The Trust was in a good position, but she felt that time and opportunity had been lost because of this exercise. The Trust		

Agenda Item		Action by Whom	Date
	would continue to work with all staff and wait for new guidance to be finalised nationally. ii. More positively teams were now picking up with plans to restart our values and behaviours work in February and that continued through the Compassionate and Collective Leadership programme. There had been very good engagement around the Trust values which had been developed with staff and this was being positively received. She wanted like the Board to consider how they would engage with the values and behaviours programme as this could be approached either by a session for the Board as a whole or for individual Board members to join without other staff in sessions that were being delivered. **Discussion** i. JW felt that the VCOD work was not wasted time as this was required work, and staff who were affected by this may now be happy and able to continue their work with the Trust. OM noted that two staff had resigned over this matter, one of whom had not yet served their notice, and the Trust was trying to get back in touch with the other member of staff. JA supported JWs comment, noting that work undertaken demonstrated what a small and dedicated team could achieve building trust with staff and using our relationship with them. This had minimised the number of unvaccinated staff and that was a testament to the organisation. ii. JW welcomed the restart of the values and behaviours work and felt that the whole Board should in the sessions and asked whether it might be possible for this to be delivered on a face-to-face basis once the whole Board were able to meet again. iii. GR thanked OM and noted that it was very valuable to see all the good work that was being undertaken through the Compassionate and Collective Leadership programme. He asked how we measured the success and the outputs from the programme. He noted that we had feedback in our staff surveys but wondered whether there were other outcome measures that we could use. OM advised that the key indicators for this were the results of the annual and quarterly staff surveys. In addition, we should look at WRES indicators and our turnover and absence figures, as if our staff felt that they were being well supported and offered development we should see an impact on those measures. In addition, the Board sees the FTSU index and receives soft intelligence through the reports from the FTSU Guardian. She advised that the work of Professor West indicated that our culture and values contributed significantly to the delivery of better outcomes for patients. She noted that in this respect not all of our metrics aligned as our outcomes were generally excellent, whereas we continued to see some degree of negative feedback in survey responses, and we continued to address these matters through staff briefings and by listening to our staff. JW and JA noted that this relationship and the approach was perhaps not quite scientific or straightforward, and that changes in reporting may be related to the programme promoting case finding, with staff feeling more able to provide	**OM/AJ**	TBC

Agenda Item		Action by Whom	Date
	open feedback through our reporting structures and this would be driven by how our staff talked to one another about their experience at the Trust. GR noted that the programme was a bundle of many activities and if we could identify measures that would help us understand what was working well that may provide opportunities to refocus resources across the different areas of the programme. He did however appreciate that this was a complex issue and that not all the elements were tangible in a way that could be easily measured **Agreed:** The Board noted the update from the DWOD.	**OM**	TBC
5	**STRATEGIC**		
5.i	**Trust Strategy 2020-2025** **Received:** The Trust Strategy 2020-2025 Year 1 Update. **Reported:** By EM that in 2019 we had developed our five-year strategy. The strategy launch had been delayed to September 2020 because of the need for review in response to the COVID-19 pandemic and this paper brought a summary of where we were one year on. She was pleased to report that good progress had been made and that the enabling strategies were now largely complete. Also, that we would report on areas where we had seen development beyond the scope the strategy. There were six areas that had been delayed because of the context we were working in and six areas that had been prioritised for progress. There were challenges arising from future financial flows, but we had confidence that our strategy would stand us in good stead. **Discussion** i. JW welcomed the summary and noted that it provided detail on those areas delayed or put back. He asked about the mechanisms that we would use to stratify actions to ensure that we could identify those that were most important in relation to effort required to deliver. EM noted that the strategic development priorities sat across different parts of the organisation we would still been keen to see development of the strategy overall. One example was the Papworth school where we were working up a case to support this and it clearly aligned to the priority of the HLRI. The Trust had also set up a project forum that reported into the Strategic Projects Committee to support the management of initiatives across the Trust relating to recovery, strategy, and digital development. The project forum would help to coordinate the competing demands across the Trust. JW asked for reports to be provided in a succinct fashion with clear timelines, with updates being provided on one side of A4. EM noted that the reporting line would be through the Strategic Projects Committee and the Committee would agree the reporting requirement. JA confirmed that the paper had been discussed by the Committee in October and the key challenge was to consider whether we needed to drop or catch up with different priorities. The Strategic Projects Committee would hold the Executive to account for delivery. He agreed it would be helpful to have short summaries on those priorities that were delayed, and he would discuss this further with EM.	**EM/JA**	Mar 22

Agenda Item		Action by Whom	Date
	Noted: The Board noted the year 1 update on the Trust Strategy 2020-2025.		
6	**RESEARCH & DEVELOPMENT**		
	RH advised the Board of the appointment of the new Director of Research and Development, Dr Paddy Calvert. This appointment followed his upcoming retirement which would happen in the spring, and the appointment of Dr Ian Smith as Medical Director. He noted that the HLRI was on the point of opening and we had a specific interest in the operation of the Clinical Research Facility and had made an appointment to the post of Clinical Director of the CRF, Dr Mark Toshner. Dr Toshner was known to the Trust and would bring energy and enthusiasm to the CRF to ensure that this was a success. He noted that this was dependent on national funding decisions which we were expecting to hear about soon relating to the National Institute for Health Research and Biomedical Research Centres funding bid. IW noted that the current clinical research facility based at CUH had been moving forward with the development of standard operating procedures and he welcomed the progress that was being made. JW noted that this would help to trigger discussions with partners and with industry and there were many great opportunities that would be brought about with the opening of the CRF and the HLRI.		
5	**BOARD FORWARD AGENDA**		
5.i	**Board Forward Planner** **Received and Noted:** The Board Forward Planner.		
5.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 03 February 2022

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