

**Meeting of the Board of Directors
Held on 03 March 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
	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 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
	Mr E Gorman	(EG)	Deputy CIO
	Mrs A Jarvis	(AJ)	Trust Secretary
	Ms L Palmer	(LP)	Assistant Director Quality & Risk
	Ms H Rumsby	(HR)	Matron Theatres
	Mr A Selby	(AS)	Director of Estates and Facilities
	Dr S Webb	(SW)	Deputy Medical Director
Apologies	Dr R Hall	(RH)	Medical Director
	Mr A Raynes	(AR)	Chief Information Officer & SIRO
Governor Observers	Abby Barhoumi, Steve Brown, Susan Bullivant, Doug Burns, Trevor Collins, Caroline Gerrard, Abi Halstead, Richard Hodder, Marlene Hotchkiss, Rhys Hurst, Trevor McLeese, Harvey Perkins, Cllr Philippa Slatter		
Observers	Jan Sobieraj	(JS)	Arden & Gem CSU
	Alison Hawley	(AH)	Arden & Gem CSU

Agenda Item		Action by Whom	Date
1	WELCOME, APOLOGIES AND OPENING REMARKS		
	The Chairman welcomed everyone to the meeting including Governors and the Well Led reviewers who were attending to observe the meeting.		

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	Apologies were noted as above.		
1.i	DECLARATIONS OF INTEREST		
	There is a requirement that Board members raise any specific declarations if these arise during discussions. No specific conflicts 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		
	<p>Board of Directors Part I: 03.02.2021</p> <p>Item 1.vi Patient Story Discussion vi: Revised to read: "... process was not straight forward."</p> <p>Item 2.b PIPR xii: revised to read: "That we continued to struggle..."</p> <p>Item 3.v.b Audit Committee Minutes: 20.01.22: Revised to read: "... the minutes of the Audit Committee meeting...."</p> <p>Item 4 Workforce Report ii: Revised to read: "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 with out other staff in sessions that were being delivered."</p> <p>Item 5.i Trust Strategy 2020-2025 i: Revised to read: "EM noted that the strategic development priorities sat across different parts of the organisation where we would still be keen to see development of the strategy overall."</p> <p>Approved: With the above amendments the Board approved the Minutes of the Part I meeting held on 3 February 2022 as a true record.</p>		
1.iii	MATTERS ARISING AND ACTION CHECKLIST		
	<p>Noted: The Board received and noted the updates on the action checklist.</p> <p>Discussion: CC asked for the glossary to be reviewed and updated to reflect the new system partners and structures. AJ agreed to review and update.</p>	AJ	April 22
1.iv	Chairman's Report		
	<p>The Chairman reflected on the international events that had happened over the last week and noted the pressures that this could create for the Trust and for all.</p> <p>He noted also that the PIPR report that we were to discuss covered the January period during which the Trust was managing COVID19 restrictions and workforce absence.</p>		

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1.v	CEO's UPDATE		
	<p>Received: The Chief Executive's update setting out key issues for the Board, the principal risks to delivery as articulated in the Board Assurance Framework (BAF) and the progress being made in delivery of the Trusts strategic objectives. The report was taken as read.</p> <p>Reported: By SP that he would take his report as read. He noted:</p> <ul style="list-style-type: none"> i. That the BAF report enabled the Board to maintain oversight of the principal risks to delivery of our strategic objectives. All BAF risks were allocated to a lead committee and the executive reviewed risks each week considering emerging and changing risks to inform the BAF. No omissions had been identified since the Board last met and our principal risks remained the pandemic, workforce, optimisation of our hospital, financial sustainability, and cyber security. The Board was holding a risk appetite workshop later in the day where the executive would propose some minor changes to the wording of our principal risks, and we would agree our approach to risk appetite and use of target risk ratings. ii. He shared the Trust approach going forward to provide the context for the Board meeting. In summary we had ongoing but reduced COVID19 pressures both in terms of activity and staff absence, with continuing urgent and emergency care demand. The national elective recovery plan and approach had been launched and the Board would be aware of the work already underway on this crucial endeavour. Our system role and contribution remained significant as was the need for us to respond and deliver across all these priorities, whilst investing in the health and well-being of our people. iii. This approach required the right environment and culture, as otherwise a sustainable organisation capable of delivering against this agenda was at risk. He noted the following key issues: <ul style="list-style-type: none"> a. Our work and approach to deliver the 104% elective and planned care target b. Our mutual aid response to partners at CUH relating to Lassa fever, a timely reminder that unexpected events can and will impact on plans materially. c. The critical care support and transformation programme launch which aimed to deliver significant benefit to patients and staff which Jennifer Whisken had been appointed to lead on. d. Our maintenance of green safer staffing and the work underway focused on healthcare support worker recruitment. As whilst we had a healthy position on nurse recruitment, we had significant vacancies in support worker positions. iv. The 2021/22 financial performance and the system working to plan and prepare for 2022/23 which we know to be a far more challenging year, and which is becoming more of a feature of discussions through Committee and systems meetings. v. The pulse survey which OM would speak to later. This had some encouraging indicators but there was always more to do. Also, the Values and Behaviours workshops which all staff would attend over the next nine months. These were 		

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	<p>designed by our staff to address the priorities of our Compassionate and Collective Leadership programme and which NED colleagues were invited to join.</p> <p>vi. Finally, a month earlier than usual to allow committees to review and feedback the Corporate Objectives for 2022/23 were brought to the Board. These had been developed by the Executive and our triumvirate leadership teams had provided feedback. The structure of the objectives reflected our Trust strategy and priorities which were approved in 2020 and the objectives were intended to support the setting of individual objectives throughout the Trust. These would be brought for approval to the April Board.</p> <p>Discussion CC thanked SP for his report and noted that he had perhaps overlooked the excellent news from digital that we had connected the Trust to the GP connect system. SP noted that this was of course very welcome, and we were proud of the digital team and this sort of initiative was what we should be doing.</p> <p>Noted: The Board noted the CEO's update report.</p>		
1.vi	Patient Story		
	<p>MS introduced the patient story which was presented by Helen Rumsby.</p> <p>HR noted that taking patient stories was a most enjoyable part of her job. This patient had been admitted to the Trust on an In-House Urgent (IHU) pathway and she had seen the patient after their stay in critical care and they were happy for their story to be collected and shared.</p> <p>The patient was an ordained priest and a monk who was on sabbatical writing books about religion. He spoke highly of his experience at the Trust and had spent time in cardiology before being put on a surgical pathway. He noted that the catering staff had remembered very small details, ensuring that he was provided with a sandwich for supper, and he felt the environment was safe and clean.</p> <p>HR advised that we always asked about what should never happen and for this patient the worst thing was having his surgery cancelled. He had been given a date the following week and that was cancelled at five- or six-days' notice and not knowing the timeline for surgery was unsettling. On the Sunday evening his surgeon visited him and asked if he would be happy to have surgery the following day. He was happy to do so but noted this was a difficult conversation. He had been unable to receive the sacrament of the sick before his surgery and HR felt that staff should not underestimate how meaningful that was as it was a great spiritual and religious support. HR had ensured that this was arranged for the day after her visit. She felt that it was a positive outcome to have been able to arrange this and reflected how we needed to treat the whole person and she would share this learning with the IHU team who were undertaking work on a cross divisional basis reviewing on the IHU pathway to improve the patient experience.</p>		

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	<p>Discussion:</p> <ul style="list-style-type: none"> i. JW noted that the balance was difficult, and this was an unbelievably difficult experience for our patients. ii. DL thanked HR for the story and asked if we could improve how we inform patients and ensure that they have opportunity to talk to their family as it would clearly be a shock to a patient and family where surgery was notified so late. She asked if his experience could have been better, particularly as not everyone has a faith, and we should look to improve and learn from this. HR advised that it was recognised that the IHU pathway was not as robust as it should be with cancellations happening where patients were not fit and because of lack of theatre time or critical care beds. We were addressing these issues with fortnightly deep dive meetings to identify what could be done to improve the pathway. iii. AF noted that this issue was relevant not just for the IHU pathway and asked about how we applied learning to the preparation of care plans for individuals. This was an important part of his journey and should have been part of the pre-operative care plans as individualised assessment was very important. HR noted that we do complete a booklet for each patient but in this group the MDT approach made this more difficult, and the last thing that we wished to do was to lose theatre time as a result. HR noted the Meridian pathway work that was underway would also help. iv. JA noted that the story illustrated the difficulty of emergency and intensive care pathways where there would always be some uncertainty and that there was a need to focus on anticipatory care plans. He noted also that whilst this patient was a catholic there were other faith groups as well and it was possible that others who did not have English as a first language may be even more reticent to identify and express their spiritual needs. v. SP noted that the Clinical Decision Cell was looking at missed opportunities and cancellations to identify what was avoidable so that opportunities could be taken to address these issues. <p>Noted: The Board thanked HR for the presentation and noted the patient story.</p>		
2	PERFORMANCE		
2.a.i	<p>PERFORMANCE COMMITTEE CHAIR'S REPORT</p> <p>Received: The Chair's report setting out significant issues of interest for the Board.</p> <p>Reported: By GR that the Committee had:</p> <ul style="list-style-type: none"> i. Discussed the pressures that the hospital faced during January and that there was some optimism that these may have eased during February. He noted the Meridian work that had started in theatres and cath labs and had discussed with EM and the executive team the reasons for starting this work now rather than earlier or later. We had agreed that this was 		

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	<p>the right time to look at this and that it would put us in a good position at the hospital to get to the 110% target that had been set (and which would support delivery of the national 104% target).</p> <ul style="list-style-type: none"> ii. Reviewed performance in Referral To Treatment targets and the overall financial position of the Trust. It had been pleasing to note that the Cost Improvement Programme was now looking at 2022/23 and that a significant proportion of the CIP was recurrent. We had also reviewed capital expenditure targets and received assurances that these would be met by year end and represented good value for money. iii. Considered cyber risk which we regarded as significantly escalated especially as a result of what was happening in the Ukraine. The issue of improvements in reporting had been raised at the committee and GR had subsequently met with SP and AR to look at how reports could be tailored to ensure that there was clarity on actions and mitigations to the risks identified. iv. Undertaken its annual self-assessment and had a looked at the sources of assurance and work done over the year with regard to our performance and this has been assessed as strong. <p>Discussion:</p> <ul style="list-style-type: none"> i. JW asked about the number of COVID19 patients and whether we were now back into a more stable state. SW noted that the omicron wave had not had a major impact on the Trust as patients were not so seriously unwell. We currently had five patients in critical care who had COVID19 and that number continued to decrease. The Trust focus was on getting back to business as usual and the delivery of our cardiothoracic services. ii. CC noted that the audit committee had a looked at the cyber risk and there was to be a discussion on the next committee agenda to give more assurance in terms of cyber security, as the Trust needed to be aware and responsive to this issue. iii. SP thanked GR and the committee for their input to the cyber assurances and noted that the conversation at Committee provided detail which was more than would be shared in a public forum but he felt we could improve the reporting around this and would look at the balance around this. <p>Noted: The Board noted the Performance Committee Chair's report.</p>		
2.b	PAPWORTH INTEGRATED PERFORMANCE REPORT (PIPR)		
	<p>Received: The PIPR report for Month 10 (January 2022) from the Executive Directors (EDs). This report had been considered in at the Performance Committee and was provided to the Board for information.</p> <p>Reported: By TG that overall, the Trust was at an amber performance status and the context for this had been outlined by SP and GR. COVID19 numbers had decreased through January and December and we continued to see staff sickness and self-isolation which resulted in a pressure on the flow across the organisation.</p>		

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	<p>Safe: Reported by MS: That surgical site infection rates were higher than national benchmarks and work was underway to understand any gaps in practice and gaps in compliance so that these could be addressed. This had been discussed at the Performance Committee and at Q&R.</p> <p>Discussion:</p> <ul style="list-style-type: none"> i. SP noted that the Trust recognised that PIPR KPIs were largely set at pre-pandemic levels of performance and standards and that future iterations of the report would provide performance and benchmarks against other providers. ii. AF noted the discussion at Q&R committee on the VTE rates which appeared to be stuck. MS noted to the compliance issues and advised that we were assessing patients on admission and were below the national target of 95%. There was ongoing work to address this this was a multi professional responsibility. We had undertaken deep dives relating to harm as a consequence and no moderate or severe harms had been identified. This measure was scrutinised through QRMG and we would continue to provide updates to the Board. iii. CC noted the Performance Committee discussion on VTE had raised the issue of junior doctors as the VTE risk assessment was complete by admitting doctors and the move of junior doctors as a contributing factor. MS noted that this was not an issue that was restricted to junior doctors, but better induction would ensure that items were recorded. We had a medical lead for VTE compliance and have cross professional responsibilities. iv. JA noted that compliance was equally challenging in other organisations and that it was good to have a multidisciplinary approach. He felt that we needed to look at system approaches as this matter had been on the NHS agenda for some 15 years. There had been 25,000 deaths from thrombotic diseases as a part of the COVID19 pandemic and the NHS needed to look at the digital approaches to managing this issue. EG advised that the Trust had escalated this matter and had signed off a design for a Lorenzo system update that includes a reminder to staff which was to be included in the September release. v. SW noted that JA was correct that the solution required a multidisciplinary approach as we had prescribers who were both medical and nursing. He noted that thromboprophylaxis were prescribed, and that VTE rate was low, but we were not good at demonstrating that assessments had taken place. <p>Caring: Reported by MS: That performance was green. There had been two complaints in the month one of which had taken longer than agreed timescales to respond to which generated the red rag rating at 50%. She noted that it was proposed that we could and should look at statistical process control charts to allow more meaningful variations to be reported to the Board.</p>		

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	<p>Discussion:</p> <ul style="list-style-type: none"> i. AF thanked MS for the impressive dashboard and noted how this was key to how care was delivered at Royal Papworth, it demonstrated how we were maintaining standards particularly around the friends and family reporting. <p>Effective: Reported by EM: The Trust expected this domain to be red for some time noting that January had been one of the most frustrating months at the Trust. SP and SW had noted that the COVID19 cases had reduced, and the numbers of patients supported by ECMO/mechanical support on critical care unit had reduced but staff absence had an impact across the organisation this had resulted in short notice cancellations of outpatients, and in cath labs and theatres. This reflected high levels of infection in the community and was a combination of staff testing positive or having household members testing positive and therefore activity had to be reduced.</p> <p>We had commenced the outpatient ‘restart’ programme in January building on the Meridian work from 2019 and that was seeing us turn the dial on activity and we expected to achieve more throughput in February. Across Cambridgeshire and Peterborough January activity was at 73% of the elective plan and our rate was lower but reflected the pressures felt across the system.</p> <p>As a system we were at 113% of first outpatients delivered and 101% follow-up attendances delivered. All these measures would contribute to the system target of 104%.</p> <p>Responsiveness: Reported by EM: That the system performance for diagnostic was at 55% and that the Trust performance was at 93%. Overall waiting lists had increased across the system and at the Trust. The number of patients waiting over 52 weeks was static, but this was made up of a changing cohort of patients. As a system there were c.7,500 patients waiting over fifty-two weeks.</p> <p>Discussion:</p> <ul style="list-style-type: none"> i. JW noted that these were crude measures as they did not reflect the severity or urgency of the patients waiting. ii. MB noted that the target for activity restoration to 2019/20 levels was the benchmark set in the first Meridian work where it was recognised that the Trust had productivity issues. He noted that optimisation was a key activity for the organisation and felt that 104% target should reflect the minimum level that we would work to and asked whether this was challenging enough given the current circumstances. EM agreed and noted that our target had been set at 110% operationally and that still may not be the correct level. The Trust had secured Meridian to undertake work on productivity in cath labs and theatres and we were confident that we had outpatient recovery tools in place. We were now applying the same scrutiny to theatres and cath labs and in the first week Meridian had identified the opportunities that would get us to the 110% level. 		

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	<p>iii. DL asked about diagnostic performance and whether MRI and other scanning had caught up in the system. EM noted that there was a 20% vacancy rate amongst radiographers which was a national problem with similar levels in the system and whilst we were doing further work to recruit from overseas some of the staff who we had recruited pre-pandemic were now returning home. Cardiac physiology echocardiogram trained staff were an acute shortage area and there was no quick fix to this problem. EM noted the CT performance was good and that we had managed to secure some agency echo support. Also, some of our clinicians were taking on higher level echocardiogram activity to ensure activity was managed.</p> <p>iv. GR noted that the target of the 104% or 110% was the subject of discussion at the Performance Committee and given the uncertainty on the system financial planning it was right to aim high. However, system finances might affect this, and we needed to use our resources to help others as there were risks in relation to overshooting our targets as well as undershooting by other providers.</p> <p>v. SP noted that it was right to be ambitious for the Trust to do more and that we aimed for 110%. The experience of the last two years would mean that delivery of the 104% target would be extremely challenging, but the Board and the Trust had the ambition to do more than this. The Trust would be looking to work smarter to balance the issues of pressures on our staff versus demand. We were working through the triumvirate teams with Meridian and making sure that we were walking the tightrope and that we would always do the trade-offs that were required.</p> <p>vi. JW noted the issue about the baseline noting that we needed to rethink our baseline and to rethink our language we needed to achieve as much as we could do sensibly.</p> <p>vii. TG advised that guidance on the financial flows was not yet published but there were discussions between the centre and providers to ensure that this was clear. This would see an integration of performance assessment at a system level that would result in our financial position being intertwined with the system performance. The Trust would need to ensure that we supported system decision-making and delivery as this would drive the financial success of the system.</p> <p>viii. JA noted that the Trust needed to understand what the right time for surgery clinically, and what was the sustainable workload that staff could deliver, as finances must be practical and real. He also asked whether the system was looking at time waiting times and whether if we worked harder would we get remunerated for this, noting that what was important was the delivery of care. He felt what mattered was that our philosophy was informed by what was important for our patients and sustainable for our staff. SP noted that this was accepted in principle (at system) but was work in progress and would inform the discussion on the use of assets and mutual support, but not all waits were equal clinically and there would be a role for clinical leadership here. There was also a need to understand the capacity and capability of the system workforce and to ensure that we were working smarter and not</p>		

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	<p>harder. All organisations were looking at how they could deliver this, and as we would be expecting Meridian teams to develop material ideas to support delivery at RPH the system challenge would be to look these sorts of initiatives and opportunities across the six providers and multiple specialties.</p> <p>People management and culture: Reported by OM: That staff absence had been a key theme in January with higher rates related to winter bugs and COVID19 resulting in short-term unplanned absence.</p> <p>Staff turnover had seen an increase in healthcare support workers linked to changes in the labour market and pay but there was work that we could do on career development and pathways to ensure that we were in a good position. NHS organisations were generally less competitive on salary. We were trying to identify trends but given the last three years it was hard to fix on a good national or local benchmark.</p> <p>Discussion:</p> <ul style="list-style-type: none"> i. AF asked whether given that we were struggling with recruitment whether any of the volunteers who had been identified as wanting to join the NHS during the COVID19 pandemic had come to fruition in any way. OM noted that there were particular features of COVID such as the national furlough scheme that had promoted roles during the pandemic, but the labour market had shifted quickly post COVID19 and we were in a position where we had very low unemployment and were seeing increases in pay in the market. There were new apprenticeships launched on the back of COVID19 and this work was being followed up. There was also a move to set up a national reservist's force for the NHS which would target retired professionals and patients working through annualised and bank hours and all systems had been given funding to set this up. There had been increases in uptake in nursing places at universities but the market for healthcare support workers had reduced. OM was working with MS to articulate our recruitment pipeline looking what proportion should be grown through apprenticeship opportunities, what proportion should we expect from UK recruitment given we are a specialist hospital, and what proportion could be from overseas recruitment. We would also see the use of a new banding for nursing associate roles. ii. JW noted the time lag from university to employment pipeline. SP noted that Anglia Ruskin University wanted to join the CUHP and to bring their apprenticeship programmes forward as a focus area. This included programmes looking at perfusionists and estates and facilities which could be taken forward in partnership with Skanska. <p>Finance: Reported by TG: TG noted that the month eight position pointed to the £1.8 billion underspent nationally and performance at the Trust mirrored this with a £6.3 million underspend at the Trust. The ICS was forecast to deliver an £18m surplus by year-end. This was driven by activity</p>		

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	<p>levels not being delivered as planned and so this was not strong financial performance and was not good news for our patients. He noted that the ICS was still in shadow form and noted EM's comments on how difficult it would be for the ICS to get to 104% of baseline activity across all providers.</p> <p>Discussion:</p> <ul style="list-style-type: none"> i. JW noted the fine balance between financial and performance delivery. <p>Noted: The Board noted the PIPR report for Month 10 (January 2022).</p>		
3	GOVERNANCE		
3.i	<p>Q&R Committee Chair's Report</p> <p>Received: The Q&R Committee Chair's report setting out significant issues of interest for the Board.</p> <p>Reported: By MB that. That the committee had a heavy agenda, and the tone of the meeting was to move as far and fast as we could from 'emergency' mode back to the detailed work of running the tightest possible ship. The committee had received a report on surgical site infection and noted that some of the increase required attention to matters that may have been deferred because of the pressures and processes of work, but the intention was to recover performance in these areas.</p> <p>Discussion:</p> <ul style="list-style-type: none"> i. CC asked about the issue of interoperability between Metavision and Lorenzo. MB noted the focus followed a small number of prescription errors relating to the two systems not talking to one another which was a problem across the NHS. The Committee were interested in those risks that were low or no harm but that could have been significant, and this was one area where there could be high risk involved and so may provide a and asked for executive colleagues to provide further summary. EG noted that Metavision included a drugs list that was a locally defined list. The Lorenzo drugs list was a nationally defined list and so this was noted as a fractured pathway and therefore required transcribing across two systems. This was a recognised risk at the point of transfer and was not unique in the NHS. Trust staff managed this clinically on an ongoing basis. ii. JW asked for clarification that there was not a technical solution available to resolve this matter. EG advised that the roadmap for a technical solution was several years away and so this would need to be managed. iii. MB asked whether or not we would be able to resolve this using a flag on systems but EG advised that we could not link the two up as the two systems used different languages and so the only option and way to do this would be re-implementation from scratch of the Metavision system. JW noted that the Board may need a review of the options available around this. iv. JA advised that this had been picked on the Q&R agenda and 		

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	<p>with the lens of external assessment, and whilst we had been able to locate and manage this risk it may only take one significant harm incident to result in retrospective criticism and the Trust may need to think and talk to other centres to look at whether this could be resolved.</p> <p>v. SP noted that based on the conversation on medicines management we would take this to the QRMG and then bring this back through the Q&R Committee for review to identify what we could do ahead of any system solution.</p> <p>vi. AF noticed that the last item on MB's report was the annual review. She felt that the focus on workforce had been embedded in the Q&R agenda and this was really making a difference and wanted to make sure that the Board were aware of this.</p> <p>Noted: The Board noted the Q&R Committee Chair's report</p>	MS	Apr 22
3.ii	<p>Combined Quality Report</p> <p>Received: A report from the Chief Nurse and Medical Director which highlighted information in addition to the PIPR.</p> <p>Reported: By MS that there was a correction at 1.2 in the paper as the letter referred to was from UKHSA and not NHSIE. She noted that her report covered the new guidance that had been issued to the public on living with COVID19, but that restrictions and infection and prevention and control measures remained in place within the Trust.</p> <p>Discussion:</p> <p>i. DL welcomed the critical care improvement programme and asked when we would be assessing progress and whether key performance indicators had been set. CC also asked whether success factors had been agreed and whether these would be monitored at the Q&R committee. MS noted that the key performance indicators were clear and were part of the programme these included the number of critical care beds available, the improvement in rostering practice, improvement in EDI practices and assessment of engagement. She would bring regular updates to Q&R on the progress of the programme.</p> <p>Noted: The Board noted the Combined Quality Report.</p>		
3.iii	<p>National Patient Safety Strategy: Patient Safety Specialists</p> <p>Received: The Board received a presentation on the National Patient Safety Strategy from Louise Palmer, Assistant Director for Quality & Risk.</p> <p>LP advised that the new national patient safety strategy had been published in 2019 and that this had three elements insight, involvement, and improvement. The programme would see the inclusion of patients and staff as safety partners.</p> <p>The requirements around insight would ensure that we change the way we reported incidents and how we used medical examiner</p>		

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	<p>systems to better understand how safe care was. The involvement agenda would ensure that patients and family and carers were more involved and would establish two patient safety specialists to lead safety improvement. The improvement agenda saw the Trust working as an early adopter site and we would be looking at how we escalated risk and provided support across the Trust using the framework as an effective platform for learning.</p> <p>We had two named patient safety specialists (Louise Palmer and Sarah Powell, Clinical Governance Manager) and they had attended national webinars as a part of the early adopter programme. We had undertaken a baseline review and the governance structure and the duty of candour process and the new dedicated roles were key to delivery.</p> <p>The programme launch had been delayed because of the pandemic and whilst our patient safety specialists were preparing, the output of the early adopter work had again been put on hold. The national team were working on what had gone well and looking at how the full rollout of the programme would be supported. This would include training for staff, the development of the patient safety partner role and the patient specialist roles which would all be helpful. It had taken longer to evaluate but it was felt this would be very useful for the coroner services as it made it possible to identify clusters and themes through this work. There would be regular updates provided at points to the Board over the next 6 to 8 months.</p> <p>Discussion</p> <ul style="list-style-type: none"> i. JW asked whether there was an expectation that this framework would make this better and how this would be measured. LP noted that this was one of the things had come from the early adopter sites. It was seen as a good programme and reliant on big cultural change, but key was to share the learning and that was still being worked on. ii. MB thanked LP for the presentation and noted the number of TAVI patients who had that procedure because of frailty and asked whether that would be seen as a patient safety incident. LP noted that all complications of TAVI were reported as were complications of surgery and investigated those and that would identify themes and trends allowing us to apply learning across the Trust. SW noted that TAVI outcomes were looked at closely and that every patient was considered for TAVI or surgery and the best option for the individual patient was selected rather than an inferior treatment being offered. iii. SW noted that terms of the new framework, he saw this as bringing together what we already do at RPH. Key would be to see what the outputs of this work were. When patient safety incidents occurred, we would need to decide what channel we would use to examine this through either the coronial process, the medical examiner process, the mortality and morbidity process or the serious incident process all of which were well established at the Trust and we would want to use and build on this model to become an exemplar and share with others. iv. MS noted that the involvement of our patients was very important as a part of this improvement and that was learning 		

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	<p>from other sectors such as mental health services where this was already common practice.</p> <p>v. SP noted that we were one of two Trusts rated as outstanding in safe and he felt that we have a responsibility to take this approach further to make it work for us and our patients and share learning. On the issue of patients waiting, we might consider how this linked to health inequalities which would require a degree of sophistication and would need further consideration within the framework.</p> <p>Noted: The Board thanked LP for the presentation and noted the update on the National Patient Safety Strategy.</p>		
3.iv	<p>Board Assurance Framework</p> <p>Received: From the Trust Secretary the BAF report setting out:</p> <ul style="list-style-type: none"> i. BAF risks against strategic objectives ii. BAF risks above appetite and target risk rating iii. The Board BAF tracker. <p>Reported: By AJ that the key risks in the BAF had been outlined through the discussions under the CEO and Chair's reports and PIPR. The key areas highlighted in the report relate to cyber security and key supplier risk. The Board would be undertaking its review of principal risks and considering its risk appetite at the workshop this afternoon and we would also be look at some minor revisions to the tracker report.</p> <p>Noted: The Board noted the BAF report for February 2022.</p>		
3.v	<p>Annual Reviews</p> <p>Received: For review and approval:</p> <ul style="list-style-type: none"> a. DN142 Standing Orders b. DN140 Standing Financial Instructions c. DN137 Scheme of Delegation d. Committee Terms of Reference <ul style="list-style-type: none"> i. TOR001 Audit Committee ii. TOR002 Quality & Risk Committee iii. TOR007 Performance Committee iv. TOR18 Strategic Projects Committee <p>Reported: By AJ that these had been reviewed at Committee and were recommended for approval. A summary of amendments had been included in the reference pack.</p> <p>Agreed: The Board approved the revised documents and Committee terms of reference as set out.</p>		
3.vi	Board Sub Committee Minutes:		
3.vi.a	<p>Quality and Risk Committee Minutes: 27.01.22</p> <p>Received and noted: The Board of Directors received and noted the minutes of the Quality and Risk Committee meetings held on 27 January 2022.</p>		
3.vi.b	<p>Performance Committee Minutes: 27.01.22</p> <p>Received and noted: The Board of Directors received and noted the</p>		

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	minutes of the Performance Committee meeting held on 27 January 2022.		
4	WORKFORCE		
4.i	<p>Workforce Report Received: The Director of Workforce and OD a paper setting out key workforce issues.</p> <p>Reported: By OM:</p> <ul style="list-style-type: none"> i. That her report focused on the Pulse survey for Q4 and we would look at some of the embargoed staff survey results in the part two session. She noted that the 14% response rate was average for the survey at this time of the year and that the report looked at trends emerging from it. ii. It was encouraging to see that despite pressures there had been improvement in the recommender score and in the one-to-one meetings being undertaken, communications were also positive. The free text feedback provided positive reports on well-being and identified some themes in concerns around stress among staff and the availability of rest areas and facilities. There was also a lot of positive feedback on the values and behaviours framework which was welcome. iii. The issues of workload, staffing levels and high absence rates for registered nurses were reported as having an impact although we were better than KPI for our nurse vacancy rate. She noted that this could still result in challenges in particular specialist areas. iv. Some external assurance was now being established as we were required to report nationally for some questions on our quarterly survey. The Trust was within the top quartile for three questions, and it was a helpful tool that was being developed. v. We had seen celebration of the LGBTQ+ History month in February and had run several events which were well run and professionally prepared by our network with Onika's support. There had been some difficult stories, but the events were also good fun they were very well received and would continue to build across the system. <p>Discussion</p> <ul style="list-style-type: none"> i. CC thanked OM and whilst not wanting to reflect on the negative she felt disappointed that some of the figures relating to the health and well-being of our staff had worsened. OM noted that we would look at the national staff survey and that provided some assessment against our peers. The responses were intertwined with the pandemic stress and the ongoing high workload at the organisation, and this was complex to assess. She noted that the work of Professor Michael West on workforce facing stress and burnout was encouraging and that the activities that we were focusing on in terms of compassionate and collective leadership and the need to work smarter and not harder, were all aspects that were seen as positive. Health and well-being was one part of these pressures but a new aspect playing in was impact of cost-of-living increases and we were seeing concerns around financial 		

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	<p>well-being. There would be a greater focus on this next year as there was action that we could take to support our staff. The key message from Professor West was to build on our programmes and to keep on with their delivery.</p> <p>ii. DL asked whether there was anything that the Board could do ahead of the launch of the line management programme. OM advised that staff felt more supported and that the values and behaviours workshops and line managers development sessions were planned and that currently these were full, and we were adding in more capacity. She noted that all of the Board and others attending would be invited to these attend events. OM also noted the work set out in the Freedom To Speak Up Guardian’s report which demonstrated that we were seeing and addressing poor behaviours and giving feedback at an early stage. There was a time element and a conversation with managers if their approach did not fit within our values and behaviours, but there was an important element that was needed and that was a compassionate and caring culture.</p> <p>iii. SP noted that our ability to deliver stemmed from getting this right and that there was much that we needed to do more on. He noted a relative position on matters of well-being and that there was pressure around that. He advised that issues raised in staff surveys were addressed as soon as the survey closed the Trust did not wait for months to address concerns as there was a need to lower anxiety. He noted that he would welcome any feedback from other organisations where there were successful approaches to this issue.</p> <p>iv. JA noted that there were good things happening on this agenda and we need to take this report in the round as this was not a linear process. The survey was undertaken at a point in time. We needed to take assurance from data that one in seven people had reported and not over interpret either the good or the bad. This gave a quick consensus of what people were thinking and the question was always could we do more. We needed to treat this with caution, but it would be helpful to increase the uptake in feedback.</p> <p>v. SP noted that the national survey demonstrated that we were the best in terms of number of staff who completed this and it would therefore give greater confidence as 7 out of 10 staff had completed it. OM noted that pulse survey provided triangulation, and this was supported by visits from the leadership team to all areas across the Trust. She noted that concerns and worries would present, but there was a balance of good experience here also.</p> <p>vi. JA suggested that it would be helpful for a thematic feedback to be collected from individual performance reviews as he was aware that other organisations were looking at this. OM noted that we were re-drafting appraisals to incorporate the values and behaviours framework and that we would also capture gaps through training needs analysis. She noted that the new process would in time be developed through the national electronic staff record and that might be something that could form part of that brief. Colleagues at CUH would be looking at the development of the electronic system.</p>		

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	Agreed: The Board noted the update from the DWOD.		
4.ii	<p>Freedom To Speak Up Guardian’s Report Received: The FTSU Guardian’s report for Q3.</p> <p>Reported: OM noted that the Board had received the quarter three report from the Guardian who was on leave and that he would attend in June to present the annual report. The stories reflected the experience that the Board had discussed relating to attitude and values.</p> <p>Discussion:</p> <ul style="list-style-type: none"> i. CC noted that concern that bullying and harassment reports appeared higher and that whilst we may be better than our peers, we did not want to lose sight of the fact that 11 people including team leaders felt that they were working very hard but this was not recognised by managers. She felt we needed to focus on what we could do about how are staff were feeling and what we could do about this matter. She also noted the concerns raised around sexism and felt like this needed to be dealt with very rapidly. JW agreed that some matters were weighted more heavily than others and this should be one such case, recognising that we would never be perfect. OM noted that these concerns were entirely personal for the individual and that we tried to have a positive process and approach. She felt benchmarking was positive but support to the individual was very important to us. She noted that line managers were in many respects the ‘squeezed middle’ with pressures from above and below in relating to the service delivery. She too was surprised by the reports of sexism had felt these may be being surfaced because of the work of the women’s network and the focus on speaking up. It may be that people feel that we are listening and so there was now an opportunity to address matters that are raised. ii. GR asked if it would be possible for comments to be sent with data that included trend information. OM advised that this would be included in the annual report. He asked also where there were issues of quality or patient safety how those matters were fed into incident reporting to ensure that there were links to any other potential issues and wanted clarification on the extent to which we made sure that these matters were fed back to management. OM advised that she would feedback to Tony Bottiglieri on the Freedom To Speak Up report. She noted where there were safety concerns we did close the loop talking to clinical and governance leads as well as involving HR and freedom to speak up leads. GR felt it would be helpful if that could be reflected in the reporting of feedback and timelines for resolution. iii. SP noted CC’s concern about the relevance of performance and benchmarking and noted that these were not offered as an excuse for inaction it was to provide context to the Board and the organisation was not complacent. It would however be helpful to see how we fared against our peers. iv. AF thanked OM for the helpful conversation and noted the individual experiences described. She felt we had a wealth of 		

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	<p>opportunity through the networks and through freedom to speak up guardians and asked whether we could target and give a voice in the organisation by having a network for non-professional staff. OM felt that a lot of the measures and issues raised were about empathy and understanding of the impact of managers in their role. We have reciprocal mentoring and reverse mentoring in some areas and these might be helpful where there is a power differential. OM advised that she would feedback through the Q&R committee as this thinking was further developed. It was noted that the balance of complaints or concerns raised was skewed towards registered nursing staff who had 16 concerns and nursing assistants where there was one concern raised.</p> <p>v. JA congratulated OM on the case reports and noted that the rich content was worth a lot. He felt that in case two there were some concerns raised not only because of the sexism of the approach but also perhaps the attitude to the staff such as cleaners and healthcare support workers who need our respect for their role and contribution, and this may need a further focus. OM agreed to feedback that observation.</p> <p>Agreed: The Board noted the FTSU Guardian's report for Q3.</p>	OM	April 22
6	RESEARCH & DEVELOPMENT		
	<i>No report due.</i>		
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 3 March 2022

Glossary of terms

CIP	Cost Improvement Programme
C&P ICS	Cambridge & Peterborough ICS
CUFHT	Cambridge University Hospitals NHS Foundation Trust
CUHP	Cambridge University Health Partners
DGH	District General Hospital
GIRFT	'Getting It Right First Time'
ICB	Integrated Care Board (of the ICS)
ICS	Integrated Care System
IHU	In House Urgent
IPPC	Infection Protection, Prevention and Control
IPR	Individual Performance Review
KPIs	Key Performance Indicators
LDE	Lorenzo Digital Exemplar
NED	Non-Executive Director
NHSE/I	NHS England/Improvement
NSTEMI	Non-ST elevation MIs
NWAFT	North West Anglia NHS Foundation Trust
PET CT	Positron emission tomography–computed tomography - a type of scanning of organs and tissue
PIPR	Papworth Integrated Performance Report
PPCI	Primary Percutaneous Coronary Intervention
PROM	Patient Reported Outcome Measure: assesses the quality of care delivered to NHS patients from the patient perspective.
RCA	Root Cause Analysis 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 Sustainability & Transformation Partnership
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