Minutes of the Strategic Projects Committee

Held on Thursday 24 April 2025 at 11:15am

MS Teams

Group Membership	Initials	Present	Apologies
LEACOCK, DIANE (Chair)	DL	√	
BITHELL, Ellie (Minute-Taker)	EB	√	
GLENN, Tim	TG		x
HARRISON, Sophie	SH	√	
MCENROE, Harvey	HM	√	
MENSA-BONSU, Kwame	KMB	√	
MIDLANE, Eilish	EM	√	
MONKHOUSE, Oonagh	OM		x
PADDISON, Charlotte	CP		x
RAYNES, Andrew	AR	√	
ROBERT, Gavin	GR	√	
SCREATON, Maura	MS	√	
SMITH, Ian	IES	√	
WALKER, Wendy	WW	√	
WILKINSON, Ian	IW		x
Other attendees			
JONES, Dave	DJ	√	
HALSTEAD, Abigail	AH	√	

1. **Welcome, Apologies and Opening Remarks**
   The Chair opened the meeting and welcomed all attendees including DJ who was attending their first official Strategic Projects Committee meeting.

   Apologies were noted as above.

2. **Declarations of Interests**
   There were no new declarations of interest to note.

3. **Minutes of Previous Meeting**
   The minutes from the meeting held on 27 February 2025 were agreed as an accurate record.

4. **Action Checklist and Matters Arising**
   The action checklist was reviewed and updated accordingly.

   It was agreed that actions 89, 90, 92 and 93 could be closed.

5. **Agenda Prioritisation**
   There was no change to the agenda order.

6. **AoB to be added to Agenda**
   There were no other items to be added to the agenda.

7. **Committee Governance: Board Assurance Framework (BAF) Update**
   i. **BAF Risks Assigned to SPC**
      The paper was received and taken as read.

KMB informed that the main update was to BAF Risk 858: Optimisation and Development of Electronic Patient Record System, and that the risk rating has increased from 8-12 due to Dedalus giving notice on the Strategic Partnership Agreement and the likely increased costs associated with this which were highlighted on page 24 of the report.

DL stated that she would like to understand further about the strategic partnership and the impact this will have. AR responded that this relates to the existing contract with Dedalus and that we are in contract until 2027 and there is a +2 in that and alongside the contract there was a signed Strategic Partnership Agreement which they have given notice to. They have expressed an interest to renegotiate the contract until the end of the specific provision of Lorenzo. Due to the uncertainty the risk has gone up. The Strategic Partnership off sets the overall cost and £.0.25m will now be payable.

DL noted that this was disappointing and thanked AR for the clarification.

GR added that it was inevitable that Dedalus would terminate the partnership agreement due to the retendering of the EPR.

Regarding action 92 GR did not believe that this had been completed, DL advised that this would be discussed during the Digital report.

Regarding BAF Risk 3449, DL noted that there had not been any updates since March 2025. IES informed that item 12, Working with Partners, would cross link with this risk.

ii. Review and Note Mitigations
There was nothing to note.

8. Strategy Development Update
The paper was received and taken as read.

WW informed that the paper sets out the outputs of the scoping phase and the approach for engagement phase which takes us through to July 2025. The engagement process design is meant to be as impactful as the end product. We plan to deepen our engagement with patients, staff, our community and stakeholders. There is a big emphasis on engaging staff. There has been positive engagement from staff the scoping phase. Kaleidoscope commented that it was the largest number of people that have been involved at this stage in any of the organisations they have worked with. This is a positive basis to start from. The tests for the process, the outcomes and the key lines of enquiry to be used in the engagement process are set out in the paper. It is planned to focus on three approaches to engagement. There will be a group of 12 staff group to lead an intensive period of engagement with staff, patients and the community. The group will be supported by Kaleidoscope, and it will be running from June to July 2025. The partners outreach will be led by NEDs, Executive Directors and other leaders and influencers that NEDs and Executive Directors will be partnered with. These will be different to the 12 staff in the representative group and the pairs will be reaching out to stakeholders for more detailed engagement. There will be an open survey available for all staff, and we are looking to run virtual fortnightly webinars which will be open to all staff, partners, external stakeholders and communities. This will allow people to check in on progress.

A working group has been established to manage the process, and the group will monitor the engagement process to ensure they are working and that we are reaching all those we want to reach and synthesising the outputs. This approach can be adapted and changed if we are not reaching the groups required. The plan is to launch in the first week of May 2025 and the team are thinking of a name for the group of 12 and working with Sam Edwards, Head of Communications, and the team regarding branding.

DL thanked WW for the comprehensive update and noted that good progress was being made. EM commented that it would be helpful to understand whether the engagement, which was not in the original plan, has an impact on the overall delivery timescale for having the strategy ready as we want to ensure that the operational planning for next year, is informed by the strategy and are we still aligned. WW responded that we are aligned and that we want to have the engagement phase finished by July 2025, and that by September/October 2025 we will have clear outputs. This will feed into operational planning and look at the development of enabling strategies.

MS noted it was fantastic to see the numbers who have been reached along with the plans for engagement and asked how we can ensure that this is as representative as it can be as it may not be possible to capture all voices such as night staff. WW informed that there is stakeholder mapping taking place to pick out the hard-to-reach groups to bring them into the process. The working group are aware of those groups that are difficult to reach. The team are using networks and regular meetings and will hold regular 'come to you' approach. The team can pick up those who may be hard to reach as long as they are made aware of them.

GR informed that he had been sceptical initially but was impressed with the first output and liked the brutal facts, the tensions and approach being taken.

DL was pleased to see that there will be protected time for the group of 12 to engage with this piece of work but asked how we can be assured that time is protected for staff. WW responded that the team are in the process of identifying the 12, and part of the application process is having line manager support to free up time. This would need to be looked at on an individual basis to support the group of 12 and their line management team and escalate where necessary. The day a week can be flexible, and this will need to be worked through.

DL noted it was a great start and looked forward to more updates in due course.

9. Strategic Digital Projects

9.1 Chair's Report from Digital Strategy Board:

i. Digital Reprioritisation Process

The paper was received and taken as read.

AR informed the committee that the paper was a work in progress that will be developed over time to showcase where the team are in terms of delivery against the new Digital strategy. In particular it looks at these things - progress against the strategic initiatives and how we are delivering on last year; the plan to review our projects, in the context of the NHS presently, and checking there is a process to review projects. Included is also a review of the highlights from the Digital Strategy Board from 10 March 2025.

Regarding the progress against the strategy, there are six delivery points including Cyber Safe environment, Recording IT, Using IT, Sharing IT and Innovating IT. The aim is to drive value out of our existing digital solutions and new ones to ensure care is seamless, as well as advancing our aspirations relating to research and innovation. Progress is currently on track.

Multiple projects were delivered last year including a new Laboratory Information Management System (LIMS), printer replacement programme, WoWs across the estate, the new Shared Care Record and artificial intelligence in the imaging space called Brainomix. There was a lot of work being undertaken that the team delivered on. Additionally, there was a focus on professionalism and the team achieved BCS Silver accreditation which means 44 of 52 digital staff are registered with the British Computer Society. The team won national

awards through BloodTrack and Haemonetics for reducing waste and are meeting CIP year on year. There is also a partnership with the Alan Turin Institute which sets out the governance framework.

There were certain things that needed to be done when the strategy was devised. But since then NHSE has been abolished and there is a focus on waiting lists. We need to ensure that we are still doing the right things, and the process is described in the paper. Initiatives will be checked against the £1.6m capital plans for the year and this will begin at ME next week and it is hoped a full review will take place.

Highlighted in the Digital Strategy Chair's report is the launch of the Patient Referral Information System (PRIS) initiative which went live from Monday 28 April 2025. This was an inhouse development and gives a referral access pathway to 11 District General Hospitals (DGHs).

AR apologised as the risks cited for cyber were due to be the risks that prevent the Trust from achieving the strategy and not cyber risks.

GR stated that it would be helpful to have a risk section that related directly to the points in the report. It was mentioned that the report showcases what has been happening but that it would be useful to expose in greater detail where we have fallen short and we need to understand the risks and why we didn't achieve what was planned. We need to see both sides in order to be able to challenge and scrutinise. It would be helpful, for transparency, to have a more detailed report which shows what we have said we will achieve and what has not been achieved.

AR understood the points and noted that this is a work in progress and the feedback had been taken on board.

DJ commented that it was great that things are being delivered. It would be interesting to see some demonstrations if possible and asked if there were sessions available to see these things in more detail. AR acknowledged that the team do like to showcase their work and was happy to take suggestions including a potential presentation or workshop. DJ felt it would be good for people to know how to get value out of what has been done.

DL asked when the digital reprioritisation process would be completed, and AR was hoping that this would be completed soon and would begin at Management Executive (ME) next week. There is a roadmap of what is being done now along with the must dos. After ME there will be a follow up with a you said, we did and then implementation will begin. This will go back to the Digital Strategy Board for governance.

ii. Update on Progress on Implementation of Digital Strategy

Discussed under item 9i.

iii. EPR Replacement Update

The paper was received and taken as read.

HMc informed that a lot of work has taken place since the last meeting and that the key area of focus was the premarket engagement (PME). This is a formal phase that allows providers the opportunity to engage with us ahead of a formal tender. Meetings have taken place with five suppliers. Meaningful conversations have taken place, and steps have been taken on ensure that responses to interested parties follow a standard process. There will be no individual provision of feedback at this stage. The meetings were quite informal with the exception of the incumbent provider where both legal teams were present.

Key query from a supplier during PME included whether or not an English reference site was a necessity. It has been previously agreed that the Board would not include this in the pass or fail criteria. Other areas of challenge included interoperability with EPIC. We are clear that campus and working together with our partners is critical to our long-term objectives and this was fed back at all PME engaged parties. The read write into EPIC has not remained, but we have said we want interoperability and the ability to see EPIC content.

There is a huge amount of work for the next stage of the procurement process. We submitted our ITT to the Cabinet Office and the quickest response known is 9 days and the slowest, 56 days. We are eager to see that we move at pace. The view of NHSE is that this will move quickly. There is a summary of scoring that has gone into the ITT and timescales have been summarised in the paper along with detail regarding areas that carry risk. The final piece of work is to work up the scenarios and scenario overview. This speaks to 15 pathway scenarios. Each one will be criteria assessed and given the opportunity to test in real life what the product will look like. Each scenario takes 14 hours of assessment, and the same people are needed each time to ensure universal feedback. 63 people have shown interest in being involved.

DJ asked if we are validating any feedback that has been collected on the current system to ensure that it is not an issue going forward. HMc informed that known provision pathway and existing provision issues have been built into the criteria questions and scenarios. This has been built into the specification for the tender and into the ITT. In the ITT is a detailed level of 'must haves' and 'should haves'. All feedback has been built into how we will market, analyse and assess through the next phase.

DJ asked if there was a general expectation that the new system will replace a number of incumbent processes and systems and that different solutions may replace a different number of those applications. It would be good to see how the assessment criteria works in the selection process and how we are dealing with integration with other systems to ensure we get the most effective solution possible.

HMc informed that there could be more detail at the next update and there will be a review of each of the specific products, and this has been put through our benefit realisation assessment to reduce and sunset those systems/applications. It will be a criteria that provision of our existing 64 applications will be assessed against all providers. Each provider will say how many they can do from day one of deployment. This is assumed in our impact of the new service and what the benefits will be.

GR commented on the integration of EPIC at CUH and wanted confirmation that the tender does not require a single campus wide EPR. It will say that there needs to be a significant degree of integration and to be able to operate as a campus wide EPR even if separate solutions. So a non-EPIC provider could meet the specification if they are able to demonstrate sufficient integration with EPIC at CUH. We want to be able to integrate the system direct. This will come out of the scenario testing and parts of this will be a degree of integration with CUH.

HMc shared that through all PME discussions, all providers, with the exception of EPIC, had raised concerns specifications built to EPIC only standards. EPIC is a closed loop EPR system and does not read out as other EPR systems. EPIC only speaks to EPIC systems. EPIC systems can be seen in other systems but not edited. All four PME organisations raised concerns and this has been tested with our lawyers.

We have not stated read/write in our criteria as this provision does not exist. We have stated that it must be connected with the ability to read and then obtain information our end, which can then be in a file that can go into the EPIC system. This is in the OBC and not pass/fail.

GR is worried that if we prefer EPIC because integration is important and no other system integrates to the extent we need, we could be exposing ourselves to challenge as we have not made it clear in the tender documents.

HMc responded that it remains crucial to the delivery of our shared clinical patient services that we have connectivity and integration. In this context it means that we expect potential bidders to have the ability through shared software to include a shared care record observation, through Orion, the PACS integrated system and through Mindray to be able to read into and update EPIC solutions. All 3rd generation EPRs should be able to do that. We have stated that we have an ambition to have an integration system in the context of our future working as a campus. We have not stated that this needs to be seamless and we have taken legal advice on the terminology. We have been clear that as a clinician you should not have to access multiple systems to gain information. It should look as one. All parties are being given the opportunity to prove that they can do this and it does not exclude any provision at this stage.

GR would like assurance that this still gives us sufficient flexibility in the end and to not score lower those providers who do not offer the same level of integration. GR agreed to speak to HMc regarding this offline.

10. Working with our Partners Update

IES informed that there had been an appointment at the University of Cambridge of a new Professor for Radiology. His expertise is in Cardiac imaging and he is keen to have some sessions at our Trust and this will build our academic status in radiology.

We have been planning joint appointments with the University as there is funding for five posts. The first post will be an interventional cardiology and there is a business case with the medical school for final approval and it is hoped this will be advertised in the autumn.

There is a three-way collaboration between the CRF with the University, RPH, and CUH CRF and there was not a manager in post for some time. There is a joint funding position with CUH CRF and a manager has been successfully seconded to us for the past three months. An interview for the permanent post will take place shortly.

The NIHR brain injury health technology centre is a partnership with the University and CUH has been up and running for a year and the contact has been signed today by IES for the provisional statistics and health economics to the group. Good progress was noted at the first annual review.

There is a collaboration with GSK regarding a major investment in respiratory research on the campus. This is partly in COPD but a large proportion is in interstitial lung disease and this is getting close to launching.

DL commented that the update was comprehensive and it was good to hear about the collaboration with GSK and asked when this would begin. EM responded that we were in the last phases of planning and will then be into mobilisation.

11. Integrated Care System Update

The report was received and taken as read.

The Integrated Care Board (ICB) meeting took place on 14 March 2025 and this was a routine meeting. There was an update on the joint forward plan and this was a light refresh, and there as a paper on the digital enablers programme and the plan for developing a digital front door.

On the 24 March there was an extraordinary board meeting and this discussed the operational planning templates for the system for sign off prior to upload to NHS England. Through a lot of work, an agreed operational plan was submitted plan of a breakeven position, not only on aggregate but for every provider and saw delivery on the recovery asks in the planning guidance for cancer and elective care specifically. There was no assurance that we will be able to provide recovery on the urgent emergency pathway, but as a ICB it was felt that significant progress had been made and they were happy to submit the operational plan for this year. In providing a breakeven position they are carrying considerably more risk than in previous years. Our Trust plan sees no intention to reduce head count but a number of providers within the patch have submitted break even plans which are dependent on the reduction of head count. CPFT and CUH are looking at redundancies. There is uncertainty in the system for everybody. A lot of work has taken place with executive colleagues internally to make sure that our operational planning principles are understood that the staff at our Trust do not feel anxious knowing others are talking about redundancies.

The signed off plan did not include the provision for the 50% reduction in NHSE and ICS costs which have been announced recently by the government as part of the abolition of NHSE. The plan was well developed by the time of the announcement and there was uncertainty as to what that meant to individual systems. Now we have some clarity as to what the announcement means for the ICS. NHSE per capita cost on all ICS's and this should be no greater than £18.76 per head of the population they serve and that is just over 1m people for Cambridge and Peterborough.

There is now a need to deliver a reduction of the ICS infrastructure by 44% and strip back the ICS so the functionality it could deliver would be medicines management and the continuing health care agenda. This is not viable in terms of the new way forward where they are intended to be strategic commissioners and that is driving conversations with other ICS's in the region regarding mergers.

A paper was presented with options including the least unpalatable merger with Bedford and Milton Keynes and Hertfordshire. This would provide a much larger population than the ICS serves currently. There are some commonalities and priorities in the population groups but this could be potentially sustainable going forward. There is a lot of uncertainty within the ICS regarding both personnel resources and what a new merged future might mean. Things are moving quickly, and some information will be brought directly to Board due to the timing of this meeting, but this committee will be updated.

EM gave an update on the work of the Federation of Specialist Hospitals and informed that TG is co-chair of the Federation along with Tim Briggs, National Director of Clinical Improvement and Elective Recovery. On 2 April 2025, following a lot of work, a report launched at the Houses of Parliament on the value of members of the Federation of Specialist Hospitals. This was intended to bring the unique aspects and added value that the specialist hospitals bring to the attention of parliamentarians and others so our voice and the specific things that specialist hospitals need are reflected and not lost. This was well received and there were good conversations with Parliament being engaged.

IW asked if the £18.76 was for the running costs of the ICS and not providing patient care. EM confirmed that it was for running and project costs. IW asked if we get to influence what is going to be done with the money and suggested reducing medicine management as we have NICE and there is no need to reinvent the wheel at considerable cost. EM informed that we have

influence through the ICS Board and the committees that EM sits on. There is also a CEO and Chairs meeting for the system, and we have some influence there too. With potential mergers, individual voices are diluted because there are more people at the table. EM does not know what the table of the new ICB would look like should it be merged and whether we would still have a place at that table. There is a lot of uncertainty. It is important to try and influence the choices of who we do merge with and if we do merge, what can be done at scale. Our ICS has often gone after niche elements rather than the big wins and delivering things at scale. That is where there is the opportunity with a larger population to serve. There are a lot of unknowns presently. Also, there is a proposal with BLMK & Hertfordshire as the only merger option, as we meet the baseline of 1m population for an ICS in the new world. There is concern about this position as we will not have enough resources to deliver all that is needed with the 44% reduction. There are not too many other systems that do not come with significant challenges. EM has proposed the question why are we sticking with the geography of the region? There could be benefits in looking at Lincolnshire or Leicestershire but there is no appetite to go beyond regional patches presently.

DL noted that things will move quickly and would appreciate updates whenever possible.

SH advised that the narrative that has been going round is that the ICB roles as commissioners will be the main constant. There is detail that needs to be worked through and it is important to assess new partners as that will have a bearing on what ICBs continue to retain. There is some narrative regarding scale cuts and the functions left which doesn't do the job. There is a lot of detail to work through. There are not clear allocations and wider funding flows outside of running costs allocation but the core allocation element and that needs to be at the front of our mind when looking at who we might merge with as there are very different financial baselines and different ICBs around us and in the midlands as well. It is very up in the air at the moment.

EM added that as the five-year strategy is developed there may be a need to make adaptations in the latter part as information is shared. There is a national and leadership meeting next week and EM agreed to update specific new developments via email following this.

OM commented from an organisational change perspective the system is working together and looking to the region to look at how we can minimise redundancies. They are working through a list of posts to be advertised internally first only and then with system partners before going externally to give people the opportunity to find alternative employment. The region are not replacing posts as they lose people. Of concern is the degree and lack of clarity / targeting of the cuts which could undermine the working of key functions. There is a real growing concern across a lot or organisations as there are cuts happening everywhere. They are thinking about resignation schemes and redundancy schemes without clear thinking about what roles to retain.

EM added that since we submitted the plan that was signed off as an organisation, we have been asked to review corporate staffing resources and the growth over recent years. We have not needed to do this to breakeven but from a strategic position it would be good to be seen to be doing something although we plan to stay under the radar by delivering on our operational plan. We are undertaking a piece of work reviewing changes where the workforce has grown. There is good assurance that all growth has been aligned to deliberate decisions made via correct processes. It has been very tactical and evidenced along the way. We are doing a review in case we need to at a later stage.

12. Research and Development Update

The paper was received and taken as read.

IES informed of a couple of highlights including the funding of a research fellow with Abbot and funding for a fellow from NHS BT. There has been a report from the European Cystic Fibrosis

Society and there has been a major collaboration across Europe of centres recruiting patients into trials of novel treatments and we are in the top third of recruiters and are having year on year success which is a solid basis for our success.

At a previous meeting it was asked to see the impact that our research has had. The library was asked to assist and to look back over the past five years. The broad output was the number of applications, but IES requested to know the impact of those applications including whether they were quoted in guidelines in government policy etc. The library found a tool for doing this which gives some of the information but not all but as the tool free trial is due to end we will be looking at funding this. There have been a number of publications that have had an impact and quoted in such guidelines.

In the last five years there have been 14,142 papers. The numbers have gone down year on year in the last five years and the five years prior to that were going up year on year. This is partly to do with Covid as that was impactful and there were a lot of publications. We are on level with 2018/19. We have talked about joint appointments with the University for five years as that was the next step change in our productivity and them not being in post is why we are static with our papers.

Looking at the impact of the papers, there have been 940 citation guidelines and 44 in NICE guidance. Our research is being impactful but we do not have a comparator. Last year we had the least number of publications over the past five years. We need to ask ourselves if we are doing research that matters. We do need to check the tool to see how it works and where year ends fall. We now need to look at what we would expect from an outfit of our size.

DL noted that it was an interesting paper and that it would be good to keep the volume of papers up and a good point was raised about whether the research we are doing is relevant.

IW was not worried about the guideline citations in the last year as it takes time to get those into the guidelines. You could expect a lag of a few years. More worrying is the decline in publications. It would have been good to benchmark prior to Covid. It is important to get a peer group comparison of where we are. IES assumed the tool can do that and agreed to find out if benchmarking was possible.

DJ commented that there were a lot of positives and asked if some of the data points were used when recruiting, advertising, or presenting the Trust as these were good soundbites. How can this be leveraged further? IES responded that when recruitment takes place research does feature on job descriptions and role profiles. A couple of lines about this real-world impact of our research would be valuable. We have a moral obligation to improve care and demonstrate what we are doing is part of that.

SH reflected that it was really challenging to articulate what happens over time. Is it the right research for the value of impact, given our specialist expertise and our cohort of patients? It is unclear how we measure that and having metrics as mentioned is a really helpful starting point. The number of publications is the most helpful leading indicator.

13. Morgan Update

IES gave an update on the Morgan device which is being developed inhouse. We are now on version 3 of the design and a prototype with part funding. There as been some work to find out if this is commercially viable. This is at the early stages presently.

DJ asked how the IP could be protected and IES informed this had been protected as the project has gone along. There are some additional things that need to be patented following a conversation with a commercial body. DJ stated that commercially we could licence some of

the ideas and not just the product.

GR agreed with DJ. Thought should be given to commercialising at the start of the project. Agreements need to be in place so that the Trust gets the value.

EM commented that we are in a privileged position to be able to develop something like this and we need to think how this can be of value more generally to the rest of the NHS. Leveraging the reduced cost so it becomes affordable for the NHS is worth considering.

IES noted that the view is that the UK market is small and we ought to be able to get concessions, if we get a commercial partner, there could be a deal that means that the NHS does well.

DL agreed that this was exciting work.

14. Committee Governance

i. BAF – BAF risks assigned to SPC

DL commented on the two risks assigned to SPC and asked if anything needed to change. We are aware of the EPR and Working with Partners risks. EM responded that when the proposals for the new BAF are presented, conversations will be had as to where they sit.

ii. Forward planner

There was nothing to note on the forward planner.

HMc commented on the Nexus work and that sequencing needed to be worked out once the ITT tender process has been concluded that it reports back to this committee in terms of a tender review. We will need to consider how the committee members at Board have assurance. HMc agreed to come back with recommendations but suggested this will need a sizable amount of time at SPC in the future. DL thanked HMc for flagging this.

15. Meeting Review

DL informed that good discussions had taken place and thanked all for their contributions.

16. Any Other Business

EM was delighted to share that DCD hearts has been commissioned, and this was supported by our own charity. This is now in mainstream commissioning. This has taken 10 years.

DL thanked all attendees for their time.

Date of Next Meeting – *Thursday 26 June 2025 – 11.15am*
Signed

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Date
Royal Papworth Hospital NHS Foundation Trust
Strategic Projects Committee
Meeting held 24 April 2025