Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Held on 01 April 2021 at 9:00am
Meeting Rooms 1&2 and via 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
	Ms D Leacock	(DL)	Associate Non-Executive Director
	Mr T Glenn	(TG)	Chief Finance and Commercial Officer
	Dr R Hall	(RH)	Medical Director
	Mrs E Midlane	(EM)	Chief Operating Officer
	Mr S Posey	(SP)	Chief Executive
	Mr G Robert	(GR)	Non-Executive Director
	Mr A Raynes	(AR)	Director of IM&T Chief Information Officer
	Mrs J Rudman	(JR)	Chief Nurse
	Prof I Wilkinson	(IW)	Non-Executive Director
In Attendance	Mr T Bottiglieri	(TB)	Freedom To Speak Up Guardian
	Mr I Graham	(IG)	Deputy Chief Nurse
	L Howard-Jones	(LH-J)	Deputy Director of Workforce and OD
	Mrs A Jarvis	(AJ)	Trust Secretary
	Ms H Rumsby	(HR)	Theatre Matron
	Mr A Selby	(AS)	Director of Estates and Facilities
Apologies	Ms O Monkhouse	(OM)	Director of Workforce and OD
Governor Observers	Lorena AndreuFaz, Michelle Barfoot, Susan Bullivant, Doug Burns, Trevor Collins, Julia Dunnicliffe, Caroline Gerrard, David Gibbs, Richard Hodder, Trevor McLeese		

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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. No specific conflicts		

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	were identified in relation to matters on the agenda. A summary of standing declarations of interests are appended to these minutes.		
1.ii	**MINUTES OF THE PREVIOUS MEETING**		
	Board of Directors Part I: 04.02.21 and 04.03.21 **Minutes 04 February 2021** Item 1.ii: Declaration of Interests: It was noted that CC had left NCHC on 8 January 2021 and this declaration should have been removed. Item 1.4.v iii: Revised to read "... the East of England, London, and the Midlands and beyond." Item: Patient Story: Revised to read: 1.vi "The local charity had funded a couple of nights of...". Discussion iii: Revised to read: "the Trust was looking at whether illiteracy could be flagged ... ". Item 2.c: COVID19 Performance Report: Discussion ii - "Hospitals had learned to manage L1 patients...". Discussion: ii - "The Trust would also have to do a post hoc illness severity scoring ...". Item 3.i: Revised to read: "where risks had been realised we may also need to...". Item 4.ii: Revised to read: “That the Q&R Committee had received the paper that provided updates on the Equality Diversity and Inclusivity, Wellbeing and Compassionate and Collective Leadership Programmes..” Item 4.i.iv: Revised to read: "..and the Trust was in a good position to assess how the needs of our staff would change in response to the recovery programme." Item 5: Discussion i: Revised to read "...he would invite the Director.." **Minutes 04 March 2021** Item 1.ii Declaration of Interests: It was noted that CC had left NCHC on 8 January 2021 and this declaration should have been removed. **Approved**: With the above amendments the Board of Directors approved the Minutes of the Part I meetings held on 4 February 2021 and 4 March 2021 as a true record.		
1.iii	**MATTERS ARISING AND ACTION CHECKLIST**		
	Noted: The Board received and noted the updates on the action checklist.		

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1.iv	**Chairman's Report**		
	The Chairman noted that the Board Agenda had returned to its more usual format. He advised that the were many changes progressing in particular the establishment of the Integrated Care System for Cambridgeshire & Peterborough which had come into being in shadow form on the 1 April 2021. There was still some uncertainty in the guidance around how the ICS would move forward and the Trust would need to be in a position to respond to ensure this worked for the Trust and the system. JW welcomed Josie Rudman back to her position as Chief Nurse and noted that she had secured a job with the national hospital building programme and so would be leaving the Trust to take up that role in due course. JW noted that he had attended the CDC on a few occasions this month and it was looking to see how the Trust could return to more normal times and undertaking as much of its work as possible.		
1.v	**CEO's UPDATE**		
	Received: The Chief Executive's update setting out key issues for the Board across a number of areas reflecting the range and complexity of the challenges currently facing the Trust and the significant progress being made in delivery of the Trust's strategic objectives. The report was taken as read. **Reported:** By SP that: i. He was delighted to welcome Josie back to the Trust and congratulated her on her new appointment. He also thanked Ivan Graham for serving the Trust as Acting Chief Nurse, and Jennifer Whisken for serving as Acting Deputy Chief Nurse during Josie's secondment. ii. The Trust remained in surge with 18 COVID19 patients, of whom 14 were in critical care with 10 ECMO patients. Staff were still redeployed and this was a position that the Senior Nursing team reviewed daily. iii. The Trust had the largest number of COVID19 patients remaining in critical care and that number would fall more slowly than in other centres because of the complex nature of the patients being managed. iv. He thanked the Trust staff and leadership teams who had worked tirelessly over the past 12 months and who were now preparing for recovery. v. The Trust had received the national planning guidance and our work on the pandemic response would stand us in good stead to deliver the requirements of this. vi. The Cambridge & Peterborough ICS had been approved but would not become a statutory body until April 2022. The Board would start to see what was being delivered through the ICS and this included the ICS Digital programme that we were a part of. vii. Our nosocomial infection rates remained at the lowest level in the country and this was very pleasing to see. This was associated with both the design of the Trust and the staff		

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	adherence to our Infection Prevention and Control standards. viii. Workforce KPIs were seeing the lowest vacancy rates ever seen at the Trust, with reductions in turnover and increases in recruitment supporting this improvement. There were variations within this which had an impact at a departmental level, but this was nevertheless a significant achievement. ix. It was disappointing to see that the Trust was a national outlier in the WRES data and this was a huge area of focus for the organisation. The Chief Nurse advert was currently being reviewed and this would use the diversity by design approach which was one of the ways that we were responding to the WRES survey information. **Discussion:** i. It was proposed that there should be further review of the Corporate Objectives to emphasise the role of RPH in the ICS/wider system and the prominence of the staff wellbeing agenda as a part of our People Plan. ii. JW noted that the 31 March was International Doctors day and felt that the Trust should consider how this was marked in future years. **Noted:** The Board noted the CEO's update report.	SP	Apr 21
1.vi	**Patient Story**		
	Theatre Matron Helen Rumsby presented the Patient Story to the Board. This story related to a 54 year old patient who had spent many months at the Trust following transfer from the John Radcliffe Hospital where he had been admitted in March 2020. This was a very complex case that had included multiple procedures and stays in critical care for the patient who had surgery for an Aortic Valve Replacement and for an ascending aortic aneurysm. The patient had spent a week on their intensive care unit and was readmitted to the Oxford unit in May for a redo following an AV Block and had developed an abscess around the skin graft. This resulted in a prolonged stay in ICU and a readmission to critical care and reintubation in July 2020. The patient was subsequently transferred into critical care at RPH for further redo surgery where many issues were identified. The patient was discharged from critical care to the surgical ward and continued to be very poorly and was dependent on Non Invasive Ventilation (NIV) and high flow Oxygen and was pacing dependent. The patient was taking multiple antibiotic and antifungal medications for his sternal wound and in September he suffered a transient ischaemic attack (TIA) and was transferred to CUH where a left atrial clot was identified. He was returned to RPH for repositioning of his pacemaker and continued to suffer infections. His wound needed further debridement in December and in January 2021 he underwent a further pacemaker and debridement procedure with input from the Plastics team at CUH. He had a further redo procedure in February and was discussed by the MDT with input from microbiology and radiology. He had infected graft material which needed removal and a deep seated infection with fistula. He underwent a further procedure		

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	on the 25 February 2021 and some improvement was achieved but he had poor cardiac function and required veno-arterial ECMO for 7 days before weaning was attempted. The patient underwent further surgery for a change of pack and he experienced liver dysfunction and rising CO_2 levels. He was taken back to surgery on the 08 March following CT. The patient died on the 12 March 2021. HR had been to see this patient to collect his patient story in December 2020 after the patient had been at RPH for 156 days. The patient had written his own story. HR read this out to the Board and it is set out for the record below: "156 days at Royal Papworth hospital Cambridge (so far!). No matter who I meet at Papworth when asked what My problem was, they all commented "well you're in the right place Papworth is the best". They all believed it as well. After spending a great deal of time at Papworth I agree too. It is like one large family all working towards the same goal. The nurses that look after me always have bags of empathy and importantly a good sense of humour! To have a good sense of humour and remain immensely professional was incredibly appreciated. They even went as far as making a centenary card for my hundredth day when it came. Whilst it might seem a small thing, it was an extremely helpful to my state of mind and hugely appreciated! The level of medical expertise is evident everywhere. My surgeon Ravi De Silva comes to see me on an almost daily basis. Given his hectic schedule and the huge emotional pressures that his job generates, I hugely appreciated him taking the time off to talk to me both as a human being and as a patient. I always know what the plan is and have the options clearly explained - as a result, I have immense faith in him. Specialist care from the TVNs Rob and Philippa are helping my wounds to heal quicker - they involve me in the process and I am very grateful for their input. Dr Rasoel is a constant - every day on the ward round checking my progress and updating me. He is always reassuring. The porters that take me to x-ray, CT scans et cetera remember my name and ask how I am when they pass - their kindness doesn't go unnoticed. One of the evenings I had a stroke in the middle of the night. Very quickly my room was full of nurses and doctors helping me out when I was aware of very little and had very little control over what I said and did. I spent a week on Addenbrooke's hospital Stroke Ward as a result. Out of the three hospitals that I have stayed in since March, Royal Papworth is the hospital where I feel completely safe. This is due to excellent communication, the efficiency of departments and having faith in the doctors, nurses and allied health care workers who		

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	demonstrate skill and professionalism at all times. Some examples.... It goes without saying I owe Ravi my life and my words cannot do this man justice. After my surgery I was seen by a Speech and Language Therapist for trial by yogurt! They were lovely. I had a Fibre endoscopic evaluation of the swallow (FEES). I was quickly onto a normal menu. I am a bass guitar player. After my stroke I was deeply concerned that the connection between my brain and my fingers might be effected. When I explained this to the occupational therapist Emile, he came back with a guitar and amplifier and we played together in the room on the ward. Not only that, he left his bass guitar and amplifier for me to practice during my stay. This had a profound effect on my state of mind. Instruments are very personal, and it was hugely generous for him to lend me his instrument. I will not forget this. I enjoyed my chats with all members of staff - the cleaners told me of East Timor and although my Portuguese is not good we found common ground with a love of travel. It was great to see Connor first as a cleaner, then training to be a HCSW - health care support worker. He epitomised what caring is all about. When you have the misfortune to be a long stay patient, especially under the extra lock down restrictions that COVID brings, the days are long and slow, and the care you receive quickly becomes your world. I was surprised, just how much of my recovery was mental, particularly managing my expectations. With so many people having positive attitudes, confidence, obvious clinical skill, it instantly puts me at ease. In a department with so many stars, it would be wrong and divisive for me to point out too many individuals names as they all shone so brightly. One particular trait, that as a patient I thought was of paramount importance, is empathy. All who cared for me had it in spades! Although there will never be enough words to express my gratitude for the superb care I have received. I will simply say thank you to all on the 5 North for giving me a second chance in life. There are so many in critical care I should mention - but alas with the drugs I was on my memory fails me apart from Brian from the Philippines. Apologies to all those I did not mention by name, but thank you for putting me back together again. Best wishes, ” HR noted that the patient had found out at the age of 54 that he had a bicuspid rather than a tricuspid valve and so had surgery at the JRO. Whilst he was a patient at RPH he had witnessed the birth of his daughter and the death of his father. HR felt that he had been the		

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	most influential patient in her 30 year career as a nurse and felt that in the context of discussion of micro aggressions she had wanted to highlight the celebration of the positive micro actions that we all took for granted in how we supported our patients which saw transplant patients enabled to hold their weddings and our critical care patients being taken to the duck pond. HW noted the patient had written a poem and had given staff a video of his experiences which could be shared with the Board. **Discussion:** i. Board members thanked HR and noted that there were some patients who were interesting and amazing people and who were able to light up the Trust. This was a genuine and heartfelt story and HR had relayed this well. HR was thanked for her care and compassion which was evident in the presentation and represented all at RPH. ii. The Board asked about the learning from this story and how this was being put to use. HR noted that this had been captured and that she felt that the Trust should celebrate how safe the patient had felt during his stay at RPH. **Noted:** The Board thanked HR for presenting this story to the Board.		
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 events were moving rapidly and that he would focus on the most recent Committee report. The Committee had received an update from the Respiratory team and they had provided assurance on the services that had been delivered and the innovation that had continued throughout the pandemic response. The focus was now on recovery and staff wellbeing and the Committee were assured on progress around this. The service had also noted that setting up the Acute Respiratory Care Service during the second wave response had taught them a number of lessons. The Committee had also considered the PACS procurement and a paper on this was being brought to Part II meeting. The main change in PIPR was the movement to a red rating for People, Management and Culture and this was not felt to capture the extraordinary position that had been achieved in relation to vacancies, and recruitment and retention. The rating reflected the drop in compliance in IPR, although it was seen as an achievement to have maintained it at its current level given the pandemic response. The Committee had queried the fluctuation in the number of compliments and IG had assured that this was because of system changes and backlogs rather than any real variation. The number of 52 week breaches was higher and the Committee was		

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	assured that each breach was reviewed very carefully. Two cases were as a result of patient choice because of concerns over COVID19. The Committee had also received the Estates project plan and considered the PFI buildings issues. The Estates plan incorporated a pathway for each item and would be a useful device to keep track on all items but would not limit or change the way that these items were monitored and so issues would be managed by the relevant Board Committee. **Discussion:** i. The increase in emergency Cardiology activity was not fully understood and the Trust experience was at odds to other areas. This may be associated with the prevalence of COVID19 in the community, as it was a cardiac as well as a respiratory disease. It could also reflect patients being pushed out of elective pathways because of pathway access issues. ii. That the Trust was to review metrics in PIPR as these were set pre COVID19. PIPR would have input from a wider range of measures including the ICS agenda. Changes in reporting would need to reflect: • how system contribution would be captured; • the balance between the requirements of recovery and the needs of staff wellbeing; • Trust performance in relation to WRES data. iii. There was some concern about the timing of changes as requirements would be difficult to assess until the Trust was in steady state. TG noted that the planning guidance had been published and that had included some performance metrics. These would need to be reviewed at an organisational level and monitoring agreed. iv. SP noted that it was likely that there would be a narrative in relation to the STP/ICS to bring key systems issues into Board papers. There were risks that the whilst RPH performance might be 'green' there could still be a consequence for RPH if the was poor performance as a system with financial risk and risk from increased regulatory oversight. The Executive would ensure that there was narrative within PIPR that highlighted any relevant system issues. v. There would need to be careful communication to staff as this could be a difficult message. There had been discussion of the system issues at ME and this had included input from Clinical Directors and Triumvirate leads. The key messages from this were the need to keep on with delivery, but also to consider where services could focus their expertise in supporting the system through networks, training and building relationships. The Trust was well placed to respond to this need, with its specialised expertise but it represented only 10% of the ICS spend and so we should not underestimate how difficult it would be to respond to this. vi. There was discussion on how the Trust would understand what a good partner would look like in the ICS and how it could focus the narrative around those matters. One area would be through taking on leadership roles in the ICS and the		

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	national GIRFT leads would be able to contribute to work on equality of access in terms of outcomes. The Trust would need to look at how its clinicians contributed to those groups and influence these as priority areas for the ICS. vii. JW noted that this came back to the challenge of system change that was all around the Trust, and noted that as an organisation the Trust needed to stay healthy and to do what it did well. **Noted:** The Board noted the Performance Committee Chair's report.		
2.b	**PAPWORTH INTEGRATED PERFORMANCE REPORT (PIPR)**		
	Received: The PIPR report for Month 11 (February 2021) from the Executive Directors (EDs). This report had been considered in at the Performance Committee and was provided to the Board for information. **Discussion:** i. JW asked whether it would be helpful for PIPR to be brought to the next Board or if we needed to reflect further on what should be prepared for the next meeting. TG advised that the Trust did need to reiterate PIPR and change this to reflect revised circumstances. He would work with Directors between Board meetings to pull this together. JW proposed that the next meeting should receive a proposal on the framework of future report reflecting what was known from the new guidance. ii. SP noted that the Region had seen the number of over 52 week waiters increase from 400 to 42,000 and the Trust needed to see its position in relation to this. It had worked hard to manage this position and it would be helpful for this and current reporting to continue until the new version of PIPR was agreed. iii. IG noted that there had been discussion of key metrics at the ICS Quality Leads Group and that it was clear that there would be mandatory reporting requirements but it was too early to know the detail of these at present.	TG	Jun 21
	Noted: The Board noted the PIPR report for Month 11 (March 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 the report set out key issues considered by the Committee. He drew the Board's attention to: i. The thematic review of SI's where the Committee had taken action to ensure that learning was embedded and it was agreed that the learning from SIs would be considered as a part of the clinical audit process. There was no question that reviews were extremely well conducted and this was to improve the process to extract learning from reviews. ii. Discussion at the CDC on service redesign where there had		

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	been enormous enthusiasm from our staff. It was pleasing to see the adaptive mind-set that was demonstrated and the Committee we were keen to encourage a research based approach in both clinical and operational systems. **Discussion** i. JW felt that it was important for the Executive to work with the CDC to translate this discussion into one or two proposals that could be delivered and that would produce results. SP noted that there was a positive conversation on this at ME. It was clear that staff wanted to do this and with many of our staff being national authors on GIRFT they had roles inside and outside the organisation, as well as inputting through CDC discussion. ii. RH agreed with the comments from the Board members and agreed that these were necessary but were not easy changes. The Trust used the precautionary principle to drive down the risk in outcomes associated with staffing. It would need to consider at what point we would change our risk appetite and not use the precautionary principle and understand how this would translate into the real world such as in staffing ratios. The Trust would need to consider how it influenced the national guidelines covering the deployment of all staff including AHPs/Nursing and Medical staff. COVID had provided an opportunity to run experiments on how we deliver care within the hospital and we needed to recognise this and not fall back into the pre-COVID models. The Trust could not continue with 'business as usual' models going forward. iii. JW noted that the Board had considered its risk appetite in the context of the response to the pandemic and that this had been done with a degree of 'air cover' provided through the NHSE/I and support from the Royal Colleges, as well as waivers from the GMC and NMC. RPH had a history of innovation by design and we would need to capture the spirit of this whilst recognising that we had been working in very different circumstances. A number of initiatives had been published and we would need to look at how all of this work could be captured and stratified for agreement to be reached on what could be continued. iv. JR supported the conversation and had discussed this with SP and others. The work in this area had started pre-pandemic and there was already some pressure around this. The Trust were not as good at capturing what had already been delivered in terms of AHP and Nursing roles and there were questions raised from staff about whether we should implement change - because we could, as well as questions about why this was being taken forward at RPH. Our response to staff needed to be balanced and address these concerns but we had seen examples of how this had been taken forward. We would need to build the team's ability to capture every contribution that was being made to the 'Care Hours Per Patient Day' from AHPs, nursing and all staff and have a structure that allowed us to measure this. v. DL asked for clarification on how the Trust would establish a 'helicopter view' in relation to the serious incident reviews. MB		

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	noted that there was not an obvious answer to this. The review had not identified any lack of professionalism and all staff were doing their jobs. QRMG had been asked to think about how this might be delivered on a day to day basis. He reminded the Board that this related to a small number of cases and we would try and make progress with the professionalism of the QRMG. vi. GR noted that the End of Life Care mock inspection was referred to in the February Chair's report. He noted that he had not seen the outcome of this although he was a member of the EoL Care Steering Group. IG noted this may have been an issue of timing. Also that he was taking over as Chair of the EoL Steering Group from the next meeting and this was to support engagement and raise the profile of EoL care. **Noted:** The Board noted the Q&R Committee Chair's report.		
3.ii	**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 Committee had devoted some time to the annual reviews of documents that were included on the Board agenda today as well as the indicative plan for External Audit and the report on bad debt write offs which she would raise in the Part II meeting. **Noted:** The Board noted the Audit Committee Chair's report.		
3.iii	**Combined Quality Report** **Received**: A report from the Chief Nurse and Medical Director which highlighted information in addition to the PIPR. **Reported:** By JR that the key issues to highlight from the report were: i. That the last nosocomial infection at the Trust was in April 2020. The HSE had written to every Trust CEO following a review across a number of Trusts providing summary findings. The Trust had reviewed these and there were no actions arising for the Trust. ii. That the Trust was continuing to focus on IPC with regular monitoring and spot checks. The Trust had also updated its assessment against the IPC BAF and was compliant against those measures. iii. The position on inquests and investigations had been discussed with the Clinical Governance Team. There were a number of pending cases and some were now listed for hearings or pre-hearings but there were no outstanding actions for RPH. The senior Coroner had requested support through provision of Assistant Coroners and this was expected to increase the pace of progress through the backlog. **Noted:** The Board noted the Combined Quality Report.		

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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: i. That the Board had undertaken its annual review of risk appetite at the development session held in March and it had been agreed that the principal risks should be reframed going into 2021/22 and these would be brought to the Board. ii. That the report included a summary of risks that had been closed or moved to the Corporate Risk Register as there had been a significant number of changes following Committee and Board discussion. **Noted:** The Board noted the BAF report for March 2021.	AJ/EDs	Jun 21
3.v	**Annual Reviews of:** **Standing Orders of the Board of Directors (DN142);** **Standing Financial Instructions (DN140);** **Schedule of Decisions Reserved for the Board of Directors and Scheme of Delegation (DN137)** **Received:** From the CFCO and the Trust Secretary the above Trust documents for review and approval. **Noted:** That the updated documents had been considered at the Audit Committee on the 18 February 2021 and were recommended to the Board for approval. **Agreed:** The Board of Directors approved: • Standing Orders of the Board of Directors (DN142) • Standing Financial Instructions (DN140) • Schedule of Decisions Reserved for the Board of Directors and Scheme of Delegation (DN137)		
3.vi	**Board Committee Self-Assessments 2020/21** **Received:** From the Trust Secretary the outcomes of the Board Committee self-assessments for 2020/21. **Discussion:** JW noted that all Committees had undertaken a self-assessment and that all Committees had rated themselves as 'strong'. He asked about whether Board members were happy that this process had been undertaken with sufficient rigor. CC noted that the discussion at Committee had been rigorous. The discussion and assessments undertaken of the Audit Committee were stringent and challenging and were not complacent and had resulted in a strong rating against performance. **Agreed:** The Board noted and approved the output of the 2020/21 Board Committee self-assessment process.		

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3.vii	**Board Committee Terms of Reference** **Agreed:** The Board of Directors received and approved the updated terms of reference for: • TOR 001 Audit Committee • TOR 002 Quality & Risk Committee • TOR 007 Performance Committee • TOR018 Strategic Projects Committee		
3.viii	**Board Sub Committee Minutes:**		
3.viii.a	**Quality and Risk Committee Minutes: 28.01.21** **Received and noted:** The Board of Directors received and noted the minutes of the Quality and Risk Committee meeting held on 28 January 2021.		
3.viii.b	**Performance Committee Minutes: 28.01.21 & 25.02.21** **Received and noted:** The Board of Directors received and noted the minutes of the Performance Committee meetings held on 28 January and the 25 February 2021.		
3.viii.c	**Audit Committee Minutes: 21.01.21 & 18.02.21** **Received and noted:** The Board of Directors received and noted the minutes of the Audit Committee meetings held on 21 January and the 18 February 2021.		
4	**WORKFORCE**		
4.i	**Workforce Report** **Received:** The Deputy Director of Workforce and OD gave an update on key workforce issues. **Reported:** By LH-J that: i. The key focus in the report was the NHS Staff Survey; the WRES results and the Compassionate and Collective Leadership programme. ii. Whilst we do need to focus on those areas where we are a negative outlier we should also recognise those areas where there had been a statistically significant improvement in performance and it was encouraging to see this level of improvement in half of the themes in the survey including staff health and wellbeing; staff morale and staff engagement. iii. The results in relation to Equality Diversion and Inclusion were disappointing, but we knew that this would be an area of focus and were progressing with this agenda. We were having frank discussions around behaviours and values and we want to provide a better service to our staff as this translates into our patient care. iv. We have put in place staff to lead our work on EDI and Health and Wellbeing but we recognise that change needs to come from our managers and one of our areas of focus will be around leadership and line management development.		

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	Discussion: i. CC thanked LHJ for the report and welcomed the alignment of these issues to our Trust values. She asked for clarification on whether long term funding for the EDI and H&WB posts was being addressed. TG advised that the funding for these positions had been secured for 2021/22 and that the Trust was working through how these posts could be supported on a substantive basis. ii. AF asked that given the focus on values and behaviours, were we learning from what had worked well elsewhere and would really make a difference to the diversity agenda, and what could we do differently as Board members? LHJ advised that there was a lot of learning coming out of the regular STP meetings on EDI. The first element of this was to ensure that we had good data and that we were open about the problems that we had. This was being discussed in an open and frank way. Our FTSU guardians also reported on matters and staff were able to raise issues that provided detail on the real and lived experience of our staff. We needed to be open to this and to have a plan to address the differences in particular recruiting for behaviours and to understand the gap in our management cohort. iii. SP welcomed the discussion and considered what the Trust had done in this area: • Put in place resources and expertise to support staff. • Equipped our leaders with the skills to address these issues. • Formed strong and effective networks to support our staff (but recognised that our networks were only two years old). • "You said/We did" which provided an incredible focus on acknowledging where we have got things wrong, for example in the matter of temporary promotions in critical care. This was not a good experience for our staff from ethnic minorities and was not an equal experience. This issue mattered to the Trust, its staff and its patients. iv. SP noted also the NHSP response to the Sewell report and felt that we would endorse this position and would share this with our staff. v. CC noted that it was sometimes the little things that made an experience good and she felt that it would be helpful for the Board to receive presentations from staff from an ethnic minority background. vi. JW noted that there could be some level of worsening results because of the promotion and openness in relation to this agenda. It was noted that this could reflect an element of case finding in an open culture. In many ways we were reaching for examples of how we could improve and what we could do was to have conversations and to recognise these issues. vii. MB noted a concern that he felt that we may see very little difference until we see a change in who is in the room where decisions were made. He agreed with the recognition of the impact of the softer issues but felt that this should not distract from the 'bottom line' which was to start to see staff from		

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	ethnic minorities moving into positions of authority. CC cautioned about underestimating the impact of the soft issues as attending to these issues was also a part of getting recognition and being a part of the system. viii. IG noted that there were changes within the Trust and that Onika Patrick Redhead had joined the Charge Nurses meeting yesterday to speak on being an 'Active Ally' and it was fantastic to have the discussion with our Sisters and Charge Nurses. **Noted:** The Board noted the update from the Deputy DWOD.		
4.ii	**Freedom to Speak Up Guardians Report** **Received:** From the FTSU Guardian an update on key issues raised in reports through the service. **Reported:** By TB that he was glad to be back at the Trust. The report provided the Board with an update on issues raised during Q1-Q3 2020/21. He noted that this work had continued in his absence through the 16 FTSU Champions across the Trust who had done a sterling job in maintaining the service. TB advised that: i. A variety of drop in activities had continued as well as FTSU stalls and meetings and attendance at the Joint Staff Consultative Forum; EDI leads and the hardship fund awards panel. ii. This had been a very challenging year for our staff and a range of approaches were needed to ensure that staff felt safe to raise their concerns. iii. There was still a lot of scepticism around the culture of the organisation and about the reporting process. The Trust had to address the concerns in how it responded to matters raised and address the fear of consequence or repercussions from reporting. iv. In October the Trust had celebrated FTSU month and that helped to strengthen and promote the role using Communication briefings. v. There was an error in the report in the table at point 5. The number of concerns relating to management and leadership style should read 19 and not 28. vi. The concerns raised covered: • work expectations of the staff and the organisation; • bullying and harassment; • management and leadership style • patient safety vii. Concerns reflected a lack of compassion in leadership style; poor understanding of the disciplinary process and interpretation of behaviours construed as bullying and harassment; racial discrimination and discrimination based on gender. viii. The report set out three cases as examples for the Board: • The first related to an agency employee working for OCS who reported that their reputation as a worker had been sullied and that they had no right of reply; • One was from housekeeping team members who		

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	reported concerns about management and leadership style noting a lack of team meetings; a concern about the method of scrutiny of start and finish times and late responses to requests for leave. These staff who, were some of the lowest paid staff in the Trust, had initially struggled to bring this matter forward but had submitted a letter as a group. • The third related to an individual in a capability process where it had taken six months to get request for flexible working to be considered (and agreed) where her personal circumstances should have been considered much earlier in the process. This was a member of staff from a BAME background. ix. He was also working with Martin Goddard on medical staff representation. **Discussion:** i. JW noted the need for the Trust to be responsiveness to its staff and to ensure that mechanisms such as the review and approval processes were speeded up. ii. CC found the third case very disappointing in terms of equality and was concerned that requests relating to flexible working were not being responded to. TB advised that whilst flexible working was seen to be working well in more senior roles this was not the experience for other staff and in this case it had taken a long time for it to be accepted. This highlighted issues around autonomy and whether people felt empowered in their jobs; as well as how more junior staff were directed to manage their workload. iii. SP welcomed the report and noted that there was more for the Trust to do. He asked for further information on the increase in cases and whether this was being seen across peer organisations. He also asked that in future reports could we see outcomes, learning and progress from older cases. iv. TG advised the Board that in the first case TB and AS were in touch and they would ensure that this matter was treated in the fairest way possible. In the second case we had apologised to our housekeeping staff as this was not our usual standard. We were making changes and there was a new patient catering manager in post and three additional team leaders. The issues had arisen in a period of extraordinary stress on the services during the pandemic and this had contributed to the issues. AS would be working with the teams and would continue to monitor this. v. DL asked whether it was possible to understand more about staff reluctance in coming forward and whether we could triangulate increases in cases to the introduction of the EDI and HWB roles. Also about the ability of the FTSU role to respond to concerns raised. TB noted that it was the FTSU role to respond to staff and that could be difficult when the inbox was full. However with the increase in time since his initial appointment he was better able to respond and coordinate with colleagues managing issues jointly to ensure that there was not a 'them' and 'us' culture. vi. GR asked about the overall function of FTSU rather than the		

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	individual cases and whether we felt that staff could speak up as this was a very important safety valve for the organisation. We needed to understand that issues of substance were being dealt with as effectively as possible and have an indication of how matters were resolved. It was important for the report to demonstrate that the function was working properly and that we were maximising the number of staff who were able to speak up. vii. MB asked whether approaches such as setting a timeline for responses would bring leverage to the role. TB advised that the role did have leverage and could access information to respond to queries, as well as having recourse to the CQC and NHSI if required. The latter had not been required so far. He noted that whatever the rights and wrongs, all concerns had an impact on the lives of our staff and at times that could be protracted through lack of action. viii. SP also noted that TB had a direct route of escalation to SP/OM and LHJ and met regularly with CC. **Noted:** The Chairman felt that this had prompted a good discussion and thanked TB for his presentation. The Board noted the FTSU Guardian's report.		
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** It was agreed that the review of Risk Appetite in relation to COVID-19 would be taken forward outside of the meeting.		

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Signed

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Date

Royal Papworth Hospital NHS Foundation Trust
Board of Directors
Meeting held on 1 April 2021

Glossary of terms

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