Royal Papworth Hospital
NHS Foundation Trust

# Meeting of the Board of Directors
# Held on 03 June 2021 at 9:00am
# Meeting Rooms 1&2 and via Teams
# Royal Papworth Hospital

**UNCONFIRMED** **M I N U T E S – Part I**

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| **Present** | Prof J Wallwork | (JW) | Chairman (T) |
| | Dr J Ahluwalia | (JA) | Non-Executive Director (T) |
| | Mr M Blastland | (MB) | Non-Executive Director (T) |
| | Ms C Conquest | (CC) | Non-Executive Director (T) |
| | 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 A Raynes | (AR) | Director of IM&T Chief Information Officer(T) |
| | Mr G Robert | (GR) | Non-Executive Director (T) |
| | Mrs J Rudman | (JR) | Chief Nurse |
| | Prof I Wilkinson | (IW) | Non-Executive Director (T) |
| | | | |
| **In Attendance** | Dr A Cheng | (AC) | Foundation Year Doctor (FY2) |
| | Mrs L Howard-Jones | (LHJ) | Deputy Director of Workforce and OD |
| | Mrs A Jarvis | (AJ) | Trust Secretary |
| | Ms S Sebastian | (SS) | CCL Project Manager |
| | | | |
| **Apologies** | Ms A Fadero | (AF) | Non-Executive Director |
| | Ms O Monkhouse | (OM) | Director of Workforce and OD |
| | Mr A Selby | (AS) | Associate Director of Estates and Facilities |
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| **Governor Observers** | Janet Atkins, Susan Bullivant, Doug Burns, Trevor Collins, Julia Dunnicliffe, Caroline Gerrard, David Gibbs, Richard Hodder, Harvey Perkins | | |

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| **1.i** | **WELCOME, APOLOGIES AND OPENING REMARKS** | | |
| | The Chairman welcomed everyone to the meeting and apologies were noted as above. | | |
| **1.ii** | **DECLARATIONS OF INTEREST** | | |
| | The Chairman noted that declarations of interests were now populated from the reporting system and were appended to the minutes.<br>There is a requirement that Board members raise any new declarations or specific declarations if these arise during the meeting. No specific conflicts were identified in relation to matters on the agenda. | | |

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| | A summary of standing declarations of interests are appended to these minutes. | | |
| **1.iii** | **MINUTES OF THE PREVIOUS MEETING** | | |
| | **Board of Directors Part I: 1 April 2021**<br><br>**Item 3.vi:** Revised to read:<br>'CC noted that the discussions at the Committees she observed had been rigorous. The discussion and assessments undertaken by the Audit Committee..'<br><br>**Approved**: With the above amendments the Board of Directors approved the Minutes of the Part I meeting held on 1 April 2021 as a true record. | | |
| **1.iv** | **MATTERS ARISING AND ACTION CHECKLIST** | | |
| | **Noted:** The Board received and noted the updates on the action checklist. | | |
| **1.v** | **Chairman's Report** | | |
| | The Chairman noted that he had attended the CDC and that Pippa Hales had presented the roles undertaken by therapists and technicians during the response to the pandemic. The Chair felt that it would be helpful for one of the NEDs to taken on a specific buddy role with this staff group. JR noted that all these staff fell within the remit of the CNO and she would be very happy to link with a NED to establish a link to the allied health professionals' staff which also included the pharmacy services. | JR/ NEDs | Jul 21 |
| **1.vi** | **CEO's UPDATE** | | |
| | **Received:** The Chief Executive's update setting out key issues for the Board across a number of areas reflecting the range and complexity of the challenges currently facing the Trust and the significant progress being made in delivery of the Trust's strategic objectives. The report was taken as read.<br><br>**Reported:** By SP that:<br>i. The Trust was working hard to restore services and emergency pathways were now very busy.<br>ii. The Values and Behaviours framework was coming to the Board for approval today and he was pleased that this work had emerged from within the organisation.<br>iii. He and JW had visited critical care and other areas of the Trust this week and all areas were very busy with high numbers of transplants undertaken and increased demand in emergency cardiology pathways.<br>iv. The Board would also hear an update on our networks which were growing in strength and contribution to leadership at the Trust.<br><br>**Discussion**<br>i. MB asked whether the Trust understood the drivers for the increases in the emergency activity; whether these were patients from our waiting lists and if this suggested our prioritisation reviews were not picking up deteriorating patients. SP noted this seemed to be an acceleration of a long-term trend from elective to non-elective pathways. | | |

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| | ii. RH advised that as primary prevention pathways improved then there could be a reduction in the demand and a proportion of patients may not now be visible to secondary care. There was also the issue of patients unknown to the system who then presented as emergencies. Previously these patients may have been worked up at a DGH and then referred who were now coming direct through an emergency pathway. SP noted that this was being looked at in the ICS Cardiovascular strategy.<br>iii. EM confirmed that only one patient from our waiting lists had been admitted as an emergency.<br><br>**Noted:** The Board noted the CEO's update report. | | |
| **1.vii** | **Staff Story** | | |
| | Smitha Sebastian and Dr Ann Cheng presented staff stories to the Board. The stories had been collected through the Compassionate & Collective Leadership programme as a part of the second debrief exercise.<br><br>**Housekeeper's Story**<br>Smitha presented a narrative from a housekeeper (HK) who had been with RPH for a considerable number of years. RPH was HK's first place of work and she had continued to work here because of the supportive work environment. HK found her work purposeful, helping the patients in their road to recovery. She had described how she helped patients, encouraging them to eat and noted that even if that took time that *'at the end of the day they take something, can be soup, even if it is two spoonful, doesn't matter, next time they might eat three.'* HK had added that *'patients are the purpose and to give the hospital a good reputation. If you treat the patients badly they won't come back, would they? And they would not say nice things about the hospital. And the staff as well.'* HK had also noted about the staff that '*the sisters and the nurses have put such hard work and getting the doctors where they are, so it's our turn to just add that finishing touches for the ward.'*<br><br>HK continued to work at her designated unit during both the surges. In the first surge, HK's work modified slightly as she had to work at the rest room in ICU to help with providing food and arranging dinner boxes for members of staff. What HK found challenging was to watch what the nurses had to do during the pandemic; *'… they really worked so, so hard. Wearing those masks for 11- 12 hours a day must be horrendous…yet, you never heard them complain!….Papworth is that kind of hospital, everybody just going out of their way, if you can help anybody out, we do it.'*<br><br>When asked what could be done differently to prepare for any future surges, HK remarked, *'More staff definitely for the nurses because they ran off their feet.'* She noted that *'I just think everybody's put 150% into this surge and they all should be proud of themselves because they really have worked hard. It is just the shame, they could not be rewarded for it, but Papworth knows all that. Papworth staff does step up and even in normal circumstances they work hard. This time definitely, how they have all come together, I think a lot of them could do a good holiday. I think we all could.'*<br><br>**Discussion:**<br>i. SP thanked Smitha for the story and invited TG to feedback on the work that was underway with the housekeeping staff.<br>ii. TG advised that he was really keen to hear the views of the | | |

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| | housekeepers and had put in place measures to enable staff to provide their views into the Trust. This had included providing I-pads so that staff could fill out survey returns on-line. A new manager had been appointed in the area and was working with staff looking at vision and purpose. We needed to understand what worked well and what didn't to try and make the working experience very positive. A workshop had been held to work through the problems and improve the experience of coming to work for this team.<br>iii. AR welcomed the story and noted how good it was to hear a story from a team that we do not often hear from.<br><br>**Junior Doctor's Story**<br>Ann Cheng was a Foundation Year (FY2) Junior Doctor who started on rotation at RPH in August 2020 and works within the cardiothoracic speciality at RPH. She was approached by the CCL team to share her story in the second debrief.<br><br>Ann didn't get redeployed during the last surge. For her, one of the personal challenges was that all the surgical Advanced Nurse Practitioners (ANP) were redeployed because of staffing pressures within the critical care. As the ANPs shared similar responsibilities as the junior doctors in the cardiothoracic speciality, their redeployment meant that the junior doctors had to more work to do and were working under increased pressure as there were fewer people to share the tasks with. This pressure was later offset in part by the reduced number of patients going for elective operations.<br><br>The pandemic had also forced the specialities to think about introducing emergency rotas as a backup to prepare for any more severe wave of the pandemic. She noted that before the pandemic, junior doctors had flagged up concerns for patient safety due to the specialities being not as well staffed as they felt appropriate and were concerned that there had not been a lot of steps taken to resolve those issues. Trying to introduce an emergency rota also meant that during the daytime there would have been even fewer junior doctors available to staff the different specialties. Fortunately, the Trust did not need to implement the emergency rota, but the pandemic had highlighted the issues which exist in the current rota and she felt these needed to be addressed. Despite the concerns raised around the emergency rota she had witnessed junior doctors stepping up, with some volunteering to work in ICU.<br><br>AC noted that there were aspects of communication that could have worked better, and the Trust could improve its information sharing strategy. She noted that a lot of the junior doctors were not on the 'all staff communication' list, and that needed to be addressed. Also, there were gaps in communication through the chain of command. It felt like information wasn't necessarily fed back to juniors as soon as possible and a lot of the communication came from second-hand information received by one junior doctor, who would then communicate through messaging apps.<br><br>Throughout the pandemic she felt juniors had been well supported by the BMA, Health Education, England and Royal Papworth Hospital and several of the juniors had gone on to accept training positions at the Trust. She noted that pandemic had disrupted the rotation program (the duration spent in their chosen speciality) for all the junior doctors. Still, this had not dampened their aspirations. They had all signed up to medicine because | | |

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| | they wanted to do good, and in the pandemic they had accepted the challenges and did the job that was needed.<br><br>**Discussion:**<br>i. RH noted that the Trust did have a lot to learn about communications and that the Trust had been reliant on the good will of its junior doctors and he offered heartfelt thanks for their contribution during the pandemic where they had stepped up in ways that no one had expected. They had acted up into roles, been bedside carers; he noted also that the juniors had not been able to experience what they would usually do in their placements and so some had their CCT (certificate of completion of training) delayed and this would result in some backlogs in the training pipeline.<br>ii. JR echoed RH thanks to the junior medical staff. She noted that she was the supervisor for the ANP roles and advised that she would like to offer to pick up the issues around patient safety that had been identified by junior medical staff so that these could be addressed and suggested that communications issues could be discussed with Zilley Khan, Clinical Fellow Medical Education.<br>iii. AR thanked AC for the presentation and noted the need highlighted for effective communication. He was the SIRO at the Trust and had a particular concern to ensure that all staff had effective means of communication that were securely encrypted and he would look at this to make sure that the juniors were able to communicate in secure and effective way.<br>iv. GR offered thanks and noted that as a Non-Executive Director he was grateful to hear stories direct from staff and felt that our junior doctors did tend to get a little overlooked. They made a huge contribution to the Trust and he would welcome hearing from them more frequently. He welcomed the follow up that had been offered by JR and looked forward to hearing how that progressed.<br><br>**Noted:** The Board thanked Smitha and Ann for their contributions and noted the staff stories. | | |
| **2** | **PERFORMANCE** | | |
| **2.a.i** | **Performance Committee Chair's Report**<br>**Received:** The Chair's report setting out significant issues of interest for the Board.<br><br>**Reported:** By GR that:<br>i. They had reviewed the updated BAF report and how this was used in the committee and this had seemed to give more focus.<br>ii. They had received a presentation from the critical care and theatres division setting out how in the second wave activity had been maintained at a level that allowed the Trust to continue to reduce the number of patients waiting, and how the service had continued with the optimisation work.<br>iii. The Committee noted the approach to management of waiting lists across the ICS and that the Trust would be looking at whether it could support other providers once Trust backlogs were cleared.<br>iv. That the key risks discussed related to staff wellbeing and managing this alongside the restoration of activity.<br>v. PIPR had been revised and the narrative and spotlight reports had been restored. | | |

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| | vi. The Trust had changed the use of theatre 6 to an emergency only theatre to minimise the risk of cancellations. This also supported the ambition to manage staff welfare.<br>vii. We had seen a drop in GP referrals which was common to other providers but consultant to consultant referral were robust<br>viii. We had assurance around CIP plans for the first half of the year, but this was expected to be more challenging in the second half of the year.<br><br>**Discussion:**<br>i. JW noted that he had visited the critical care unit and had seen that it was open to 36 beds which was welcome. He noted also that the Trust was delivering in its role and supporting partners in the ICS. It was currently seeing and taking patients from Hinchingbrooke Hospital as a part of this effort.<br>ii. JW welcomed the progress reported in use of the BAF. CC & MB noted that the BAF reports had been revised to bring in further detail on the assurance relating to each risk and that the additional information was very useful.<br>iii. JA asked whether the ICS would be moving to single waiting lists across the system. EM advised that the ICS were working on specialty waiting lists at an ICS level and that those would include diagnostic waits. There was work underway to establish and combine waiting lists using P codes (priority) and D codes (diagnostics).<br><br>**Noted:** The Board noted the Performance Committee Chair's report and JW invited any further questions to be directed through GR outside of the meeting. | | |
| **2.b** | **PAPWORTH INTEGRATED PERFORMANCE REPORT (PIPR)** | | |
| | **Received:** The PIPR report for Month 01 (April 2021) from the Executive Directors (EDs). This report had been considered in at the Performance Committee and was provided to the Board for information.<br><br>**Noted:**<br>i. That the key changes in PIPR were to bring in a system perspective reflecting the changes in regulation and setting out the overall financial position for the ICS. The report would be developed iteratively and so the Board would see improvement in reporting over time.<br><br>**Discussion:**<br>i. JW asked if the report would distinguish between what were system and Trust metrics and those that the Trust was able to affect. SP advised that the system metrics were not yet fully defined but they would be reassessed and used to provide relevant context for RPH.<br>ii. DL asked whether there was a correlation between the low level of rosters published on time and the level of agency and bank usage. JR advised that this would have an impact because of the late notice and that use of agency was costly. Matrons had been asked to review this and one concern was around the rate of payment for bank where this was not the same as at other providers.<br>iii. JA asked about work life balance in the reasons for staff leaving | | |

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| | the Trust. It was noted that as a small Trust with lower turnover in more senior grades then there may be some lack of opportunity internally but the training and development offered was to a high standard and so staff may look for opportunities in other parts of the NHS. JA asked if staff were aware of the opportunities that were available within the organisation and suggested that career development was looked at as a part of discussions at appraisal.<br>iv. MB asked for clarification on the new metrics and progress in treating patients within their priority rating. EM advised that all P1 patients were treated within timescale. For P2 (treatment within one month) there were some challenges in respiratory services, although that may be related to 'over' coding of cases and in surgery the focus was on dealing with the P1 and P2 cases as this resulted in backlogs of P3 cases. MB noted that it would be helpful for future reporting to reflect the disaggregated position.<br>**Noted:** The Board noted the PIPR report for Month 1 (April 2021). | EM | TBC |
| **3** | **GOVERNANCE** | | |
| **3.i** | **Q&R Committee Chair's Report**<br>**Received:** The Q&R Committee Chair's report setting out significant issues of interest for the Board.<br><br>**Reported:** By MB that:<br>i. The April report was missing from the Board pack and this would be circulated after the meeting.<br>ii. The Committee had received an interesting presentation on operational research and the new ways of system working. This would be as important as clinical innovation looking at how we consider access; regulation and changes in ways of working which all have impact on patient pathways and can result in unintended consequences. An example of this had been the sleep apnoea service which had seen disparity in referrals and uptake across social class.<br><br>**Discussion**<br>i. GR noted the focus of discussion on a smaller number of matters at each meeting. There were similar agenda pressures at the Performance Committee and he and TG had reviewed forward plans to add a rolling programme of in-depth reviews to address this. SP noted that this could also be addressed using spotlight reports in PIPR. MB noted that whilst focus on particular areas was effective there was a difficulty in missing some of the significant routine issues and Committees needed to be mindful of that issue.<br>ii. DL asked why the people and workforce issues did not have their own Committee given the scale of the issues around EDI and the size of the workforce agenda. JW noted that Workforce was a standing item on the Board agenda but this may be considered in the future.<br>iii. JA noted his support for the Q&R Chair's approach of checking what was worrying members at each meeting. This allowed for consideration of matters arising outside of routine reporting and extended discussion beyond strict compliance issues. SP noted that each week Executive Directors were also considering whether there were items arising that were emerging risks and considering | AJ<br><br>TG/GR | Jun 21<br><br>Jun 21 |

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| | whether these needed to be reflected in the BAF.<br><br>**Noted:** The Board noted the Q&R Committee Chair's report | | |
| **3.ii** | **Combined Quality Report**<br>**Received**: A report from the Chief Nurse and Medical Director which highlighted information in addition to the PIPR.<br><br>**Reported:** By JR that:<br>i. The Trust had reported a Never Event where a patient had a misplaced nasogastric tube. This would be investigated and the outcome reported to Q&R following review. JR noted that there had been an increase in adverse events reported across the region and it may be associated with the return to normal practice following the COVID19 surge.<br>ii. The DIPC report included the Infection Control RCA and Alert Organism Report and the peak in organisms reflected the COVID19 peak. This position was similar across the country.<br>iii. She had shared the 2020 Inpatient Survey results with the Board. The timing of these was later than usual but she wanted the Board to have sight of these. The Trust had performed better in 14 areas and 9 had declined. There was no previous comparator for 18 questions and two had remained about the same. The very few negative comments related to assistance for patients who needed help with meals and divisions and teams were working to develop their action plans to respond to this feedback.<br>**Discussion:**<br>i. JW noted that NG tube 'never event' had not resulted in harm to the patient.<br>ii. SP was very pleased with the results of the inpatient survey and felt this reflected the hard work of our staff. This was one of the key pieces of information used by regulators to assure them about the quality of our services.<br><br>**Noted:** The Board noted the Combined Quality Report. | | |
| **3.iii** | **Board Assurance Framework**<br>**Received:** From the Trust Secretary the BAF report setting out:<br><br>i. BAF risks against strategic objectives<br>ii. BAF risks above appetite and target risk rating<br>iii. The Board BAF tracker.<br>**Reported:** By AJ that she had met with the subgroup of NEDs and EDs to consider the scope of the reporting to Board and the paper provided the Board with an update on the outcome of those discussions and the actions for improvement which had been put in place.<br><br>**Discussion:**<br>i. MB thanked AJ/SP and the Executive for the review that had been undertaken. He outlined one area that he felt remained a problem in how we express the choices that are made in balancing risk. This was seen in the priorities of the ICS vs. delivery of specialist services; the balance needed to address issues of recovery vs. staff wellbeing. He remained concerned that such trade-offs were not clearly articulated in the BAF report and it could not therefore capture how these matter had been explored and justified within | | |

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| | the business. He noted the assurance he gained from joining meetings such as the CDC where he felt there was a clear demonstration of the risks and trade-offs being considered. He noted overall that the choices made sense and that groups did explore and articulate the issues, but he did not feel that this was quite seen at Board level.<br>ii. JW felt it might be helpful to look at how particular issues had been managed and balanced by the Board. The Board were fully involved in the consideration of the balance of risks in relation to the hospital move where the issues relating to the cladding meant that the Board took the decision to postpone the hospital move from September 2018 to May 2019. In that decision the Board had weighed up the impact of the delay on staff and patient care; the risks and consequences associated with remaining on the old site and potential risks on the new site. All had been articulated and discussed. There were other examples of incidents and matters effecting patient care where there were trade-offs to be considered the example here could be around achieving 'gold standards' and whether we should be looking to treat 100 patients at a 100% standard or 1000 patients at a 90% standard. This was a matter that would be explored further by the Board.<br>iii. JA noted that the documentation needed to provide an audit trail to evidence that mitigations were acts of commission prior to implementation. This could include the range of risks for the mitigations considered and why we had decided on any particular course of action.<br>iv. SP felt that the discussion on balance of risk was excellent practice. The issues had been explored in the conversation between NEDs and EDs but there were not models for this from elsewhere and we would continue to explore these. The Executive and the Board regularly made decisions that balanced risks, such as those around restoration of services and the resilience of our staff. The CDC was one forum in which this was explored and tested using the Trust's capacity model which allowed us to consider the impact of a range of variables including staffing. TG noted that this approach of balancing trade-offs had informed the Trust's operational planning. The issues of annual leave vs. recovery vs. the Trust's financial envelope were all considered in the plan that had been adopted and he felt this had been done well. JA noted the response on the operational plan and agreed that where this was reflected in detail then this may address the risks around silo working, but these needed to be apparent in the plan.<br>v. CC asked for the Board to consider the proposal that had been made on those risks that were mapped to the Board and to multiple Committees. She noted her support for the proposal that each risk should be linked to a single Committee for oversight. AJ advised that this was generally the approach but there were occasions where the risk had been referred across committees.<br><br>**Noted:** The Board noted the BAF report for May 2021 and agreed:<br>i. That BAF 2338 EU Exit was expected to close following the final project review meeting and so would remain mapped to the Board.<br>ii. That BAF 2532 COVID19 Pandemic risk would now be overseen by the Q&R Committee. | | |

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| **3.iv.**<br><br>**3.iv.a** | **Board Committee Terms of Reference**<br><br>**Received and approved:** TOR 006 Remuneration Committee | | |
| **3.v** | **Board Sub Committee Minutes:** | | |
| **3.v.a** | **Quality and Risk Committee Minutes: 25.02.21, 25.03.21 & 29.04.21**<br><br>**Received and noted:** The Board of Directors received and noted the minutes of the Quality and Risk Committee meetings held on 25.02.21, 25.03.21 & 29.04.21**.** | | |
| **3.v.b** | **Performance Committee Minutes: 25.03.21 & 29.04.21**<br><br>**Received and noted:** The Board of Directors received and noted the minutes of the Performance Committee meeting held on 25.03.21 & 29.04.21. | | |
| **4** | **WORKFORCE** | | |
| **4.i** | **Trust Values and Behaviours Framework**<br>**Received:** From the Director of Workforce and OD a presentation on the draft Trust Values and Behaviours Framework which had been circulated for approval.<br><br>**Reported:** By LH-J, Deputy Director of Workforce and OD:<br>i. That review of our Values and Behaviours Framework was a central ambition of the Compassionate and Collective Leadership Programme and the report set out the proposed three core values of Compassion, Excellence and Collaboration.<br>ii. That the programme was ready to be launched having had a long development journey. The development of values and behaviours framework had been delivered by the Trust team with the involvement of engaged, motivated and enthusiastic staff.<br>iii. That the need for common values and behaviours had been underpinned by the work of Prof Michael West which demonstrated that compassionate leadership mattered and resulted in better engaged staff.<br>iv. That there was evidence that bullying and harassment costs the NHS £2.3bn each year and that 50% of staff in the NHS report debilitating levels of stress which was higher than other sectors. Our staff had told us that they experienced bullying and harassment from their managers in the staff survey.<br>v. The CCL programme identified eight key priority areas and the focus of the Trust would be on development of managers, empowering staff and valuing difference.<br>vi. Communications with staff would focus on how we work together to do things differently and each of the values were supported by examples of the behaviours that we expected to see and not see associated with it.<br>vii. The communications team were involved in the preparation for the launch which was scheduled for the 5 July and this would include videos delivered by the Executive and a contribution from Professor West. Screensavers and new auto signatures would also be used to promote our Values and Behaviours. The CCL Programme Board would oversee the main workstreams and they would be used in recruitment and induction; management development; our EDI work programme and would help our staff to | | |

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| | feel safe.<br>viii. A responsible officer had been assigned to the work and the deliverables were being presented to the Programme Board. This should deliver benefits for our staff and contribute to patient outcomes.<br><br>**Discussion**<br>i. SP noted that this had been an excellent piece of work and that the Board should acknowledge the progress made throughout the pandemic response. This represented a significant investment of time and resources. Our staff had the right to feel valued and rewarded and this programme would deliver this along with patient benefits. This programme had been designed by our staff and provided the opportunity to equip our staff to display these values and SP wanted to thank the team for their efforts in developing the programme.<br>ii. CC raised the issue of the team behaviour and how that was different from the requirements on individuals. LH-J noted that this was to support teams working together and would be supported by the development of our line managers. It was noted that this would support staff in holding their peers to account.<br>iii. It was agreed that the descriptions of behaviours on slide 7 would be amended so that these were all stated in a consistent manner. There was also a request to ensure that all the communications used clear language so that the guidance was easy for staff to understand.<br><br>**Agreed:** The Board approved the Values and Behaviours Framework and asked LH-J to pass on their thanks to all of the team for the work that had been undertaken to develop the framework. | LHJ | Jun 21 |
| **6** | **STRATEGIC DEVELOPMENTS** | | |
| **6.i** | **Estate Strategy – 2020-2025**<br>**Received:** From the Director of Estates and Facilities the Estate Strategy 2020-2025 which had been circulated for approval.<br><br>**Reported:** By AS:<br>i. Prior to 2020 the focus of the Trust had been on the hospital move and the maintenance of services on the old site. It was now time to pause and to refresh the Trust's Estates Strategy.<br>ii. Following the move to the biomedical campus the Trust's strategic aims were:<br>• Creation of the HLRI<br>• Maximising utilisation of the whole site<br>• Consolidation<br>• Building capacity to support innovation and collaboration<br>• Ensuring that the site was right sized, maintained high standards and was energy efficient.<br>iii. This approach was being supported by robust contract management.<br>iv. The strategy had been reviewed by the ED's and the SPC and set out a detailed mapping of key issues to the Trust's strategic objectives. It was being brought to the Board for final approval.<br><br>**Discussion**<br>i. The Board welcomed the strategy and noted this was a | | |

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| | comprehensive and well written document that was easy to understand.<br>ii. MB asked whether there was a role for the ICS in the view of the Trust assets and whether and how this would link into their operational agenda. TG advised that this was a Trust strategy and that is aligned to the Trust Strategic Objectives. A risk could emerge if the Trust Strategy was not aligned to the ICS but he felt this was a theoretical risk and not a practical one as the Trust and ICS were aligned. The risk around strategic alignment to the ICS was included within the BAF and was a broader strategic matter for the Trust rather than a risk relating to estate.<br>iii. DL asked about the review of soft FM costs where the Trust seemed to be an outlier. TG advised that PFI control period ends in 2023 and that the Trust would be benchmarking costs at that point to reduce costs whilst continuing to deliver safe and high quality services.<br><br>**Agreed:** The Board approved the Estate Strategy 2020-2025 and thanked AS and his team for their work on the development of the strategy. | | |
| **6.ii** | **Review of Quality Strategy (2019-2022)**<br><br>**Received:** From the Chief Nurse an update on the Review of Quality Strategy.<br><br>**Reported:** By JR that the Assistant Director for Quality and Risk had retired and so the Trust had taken the opportunity to undertake a review ahead of the full review and relaunch of the Quality Strategy which would take place in 2022.<br><br>**Noted:** The Board noted Review of Quality Strategy (2019-2022). | | |
| **5** | **BOARD FORWARD AGENDA** | | |
| **5.i** | **Board Forward Planner**<br><br>**Received and Noted:** The Board Forward Planner.<br><br>**Discussion:** JW noted that the Trust was looking at how it would introduce face to face Board meetings but was looking to continue to support remote access as this had proved invaluable in promoting access to the Board for our Governors so that they could see the Non-Executive Directors in action. He thanked the Governors for joining the Board meetings. | | |
| **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 June 2021

Glossary of terms

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| 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)<br>Level Four: L4S and L4N<br>Level Five: L5S and L5N<br>CCU Critical Care Unit |
| WTE | Whole Time Equivalent |