Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Held on 1 July 2021 at 9:00am
via Microsoft Teams
Royal Papworth Hospital

UNCONFIRMED M I N U T E S – Part I

Present	Prof J Wallwork	(JW)	Chairman
	Dr J Ahluwalia	(JA)	Non-Executive Director
	Mr M Blastland	(MB)	Non-Executive Director
	Ms C Conquest	(CC)	Non-Executive Director
	Ms 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
	Ms O Monkhouse	(OM)	Director of Workforce and OD
	Mr A Raynes	(AR)	Director of IM&T Chief Information Officer
	Mr G Robert	(GR)	Non-Executive Director
	Mrs J Rudman	(JR)	Chief Nurse
In Attendance	Ms J Fowles	(JF)	Nurse Consultant
	Mrs A Jarvis	(AJ)	Trust Secretary
	Mr A Selby	(AS)	Associate Director of Estates and Facilities
Apologies	Ms A Fadero	(AF)	Non-Executive Director
	Mr S Posey	(SP)	Chief Executive
	Prof I Wilkinson	(IW)	Non-Executive Director
Governor Observers	S Bullivant, H Perkins, C Gerrard, A Halstead, J Atkins, T Collins, D Gibbs, D Burns		

Agenda Item		Action by Whom	Date
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**		
	There is a requirement that Board members raise any specific declarations if these arise during discussions. No specific conflicts were identified in relation to matters on the agenda.		

Agenda Item		Action by Whom	Date
	A summary of standing declarations of interests are appended to these minutes. JW asked Board members to ensure that their declarations of interest were completely up to date.	All	Jul 21
1.iii	**MINUTES OF THE PREVIOUS MEETING**		
	Board of Directors Part I: 3 June 2021 **Item 1.vii Junior Doctor's Story:** Revised to read: '… junior doctors had ~~to~~ more work to do and were working under….' **Item 3.iii Board Assurance Framework:** Discussion ii: Revised to read: "incidents and matters ~~effecting~~ affecting patient care where…' **Approved**: With the above amendments the Board of Directors approved the Minutes of the Part I meeting held on 3 June 2021 as a true record.		
1.iv	**MATTERS ARISING AND ACTION CHECKLIST**		
	Noted: The Board received and noted the updates on the action checklist. **Action Checklist:** **Item 233:** JW noted that the Guardian of Safer Working action had been on hold since February 2020. It was agreed that this report would be requested for the September meeting. **Item 267:** JR confirmed that these issues had previously been followed up through Education team and the communications issues were resolved. This item was closed. **Item 3.iii Board Assurance Framework** CC had asked that for audit purposes the previous minutes should record that BAF 2904 would be managed by the Performance Committee. It was noted had not been recorded in the minutes as it had been agreed ahead of the meeting and had been included in the BAF report last month.	RH	Sep 21
1.v	**Chairman's Report**		
	The Chairman noted: i. That this was Josie Rudman's last Board meeting as she moved to her new role in the national new hospital building team. There were two items on the agenda that JR had wanted to bring to the Board before she left, and these had not had full approval through committee and JR would speak to both items. ii. That SP and Mr Tsui were taking part in a national meeting looking at cardiothoracic transplant services. iii. That the Board sent its best wishes to Richard Hodder, Lead Governor, who had not been well over the last couple of weeks.		
1.vi	**CEO's UPDATE**		
	Received: The Chief Executive's update setting out key issues for the Board across several 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:** EM noted key highlights from the CEO's report:		

Agenda Item		Action by Whom	Date
	i. The numbers of COVID patients in critical care and in hospital remained relatively low across the East of England, but it had been a busy month for the Trust and the system. The region had seen pressure in the acute Trusts and in primary care with increased demand on GP services. The system was very tight on capacity for the time of the year. ii. RPH had seen another good month in terms of its activity recovery and financial position. It was operating under the national financial framework and was ahead of plan at the end of month two with a year-to-date surplus of just under £1m without any drawdown on the Elective Recovery Fund. This was a positive position. iii. The National Inpatient Survey had been published in June and 95% of our patients had scored their overall experience as 7/10 or above, which was very good especially given the pressure on services over the year. iv. That the Trust had had a never event relating to a misplaced Nasogastric Tube. Discussions regionally had recognised the impact of fatigue in the workforce and providers had seen increases in incidents and never events. The Trust was supporting staff and going 'back to basics' to promote the focus on safety. v. On Monday the Trust would launch its Behaviours Framework under the Collective and Compassionate Leadership programme with the revised values of: **Compassion, Excellence and Collaboration.** This was a fantastic piece of work with many staff involved in its development and it was great to see the work being taken forward. vi. We had seen improvement in our Freedom To Speak Up index, where we'd increased to 82% and were comparing well against other organisations. vii. We had seen the closure of our vaccination hub, having vaccinated over 1500 health and social care staff which was a fantastic achievement. The team had been phenomenal in the way that they'd stood that up and delivered this service against the backdrop of constant change. viii. We also had governor elections coming up in July and there were vacancies in all of the public constituencies. ix. Next week the Trust would be holding the Papworth Big Tea event. This would be done in a socially distanced way, but it was very important thank you for our staff. Finally, EM echoed JWs thanks to Josie Rudman Chief Nurse who had been an incredible colleague to work with and would be missed. EM thanked JR for everything that she'd done in supporting the hospital. **Discussion:** i. JW noted that the transplant service was incredibly busy and that the team should be congratulated. This was notable performance in the context of the national position. EM advised that the service had undertaken one transplant today had transplanted on four days in succession over the weekend and into Monday. JW noted that our new surgeons had stepped up and were working incredibly hard. ii. JW noted that the Trust needed to be mindful of fatigue issues and would come back to that later the agenda and it was important to note that this was happening to everybody, and not just the clinical staff, but also the admin staff and others across the Trust. As the pressure of response to COVID was lessening staff were now faced		

Agenda Item		Action by Whom	Date
	with recovery of business as usual and that was hard work across the organisation. iii. JW also noted discussions about the ICS developments where there was still a lot of uncertainty. The White Paper had not been taken through parliament and so there could be further delays in plans for the year ahead and the Board should note that the system was working against a background of increased stress. **Noted:** The Board noted the CEO's update report.		
1.vii	**Patient Story**		
	JF presented a patient story of an ECMO patient. This story related to a 54-year-old man who had spent 113 days supported on ECMO. The Trust had been one of the centres who stepped up to support an extraordinary number of ECMO patients during the COVID pandemic. It had cared for 140 patients last year compared with about 90 in previous years. For the first 55 days of his stay with us the patient was completely sedated. But from day 55 he was alert, restless and engaged in what the team were doing. He knew where he was and knew what was happening to him. He had a tracheostomy which was decannulated on day 117. JF had caught up with the patient just before he was discharged. He had not found intensive care a very restful environment but felt that the nurses and doctors were very knowledgeable about his condition and had answered his questions. He thought it was a clean environment. He knew who was looking after him each day as staff made a point of telling him. He had woken up into a world where he only saw people's eyes and he sometimes couldn't understand them very well with their face masks on. He didn't like critical care at night. It was very noisy, and he couldn't sleep very much. JF noted that problem had been taken on board by the team who were working to emphasise a day and a night routine in critical care to allow patients some rest. This would look at filtering noise and whether alarms could be set quieter at night. One of the things he was enthusiastic about was when he was taken outside for short periods of time. The air in the hospital was very dry and the best thing about going outside was the fact that the air was moist. He felt that if we could do that every day for every patient it would be good. JF noted that this happened when staffing allowed but it couldn't always be supported. JF talked to him about what the ECMO was like, and interestingly, it was a bit of a non-event for him. What he didn't like was the ventilator. He felt that was worse than ECMO. The team were looking at how that feedback was worked into pathways; how we manage patients working towards getting them off the ventilator earlier and thinking differently about how we approach their management. His only concern with ECMO with was weaning. This was done by stopping the gas supply into the ECMO system and so patients can start to feel breathless. Weaning was started at about day 90 and he was very frightened and that was when trust with the staff was really needed. He noted that most staff would say when they were going to turn the gas back on, and he really disliked it when some staff would push him and say let's		

Agenda Item		Action by Whom	Date
	do 10 more minutes. This experience was being incorporated into training to ensure that where trying periods off gas if a patient wants to go back on that is a trigger regardless of what the blood gases and other results look like. This is because trust is probably the most important element of care. From a personal point of view, he had enjoyed his physical rehab. He liked getting out of bed and liked having a framework to work to. He felt the staff were brilliant, very attentive, friendly and had made an extra effort to make him feel safe. He noted that the clinical psychologist (who had recently been employed in critical care) had given him meditation techniques which were put onto laminated cards and shared with his nurses, physiotherapists and doctors. He felt this input was the thing that got him off ECMO as he was able to relax and use those techniques. JF noted this was now a part of team practice and was showing huge benefits in patient care. He noted that when he was lonely the use of FaceTime worked well. JF advised that thanks to the RPH Charity, the service had access to iPads and were able facilitate calls and FaceTime for families. This had been invaluable for patients and relatives during COVID19. JF noted a new scheme that could help patients who were feeling lonely, the Read Aloud project. This was funded by the RPH Charity and run by the librarians and one of the Sisters. Every week patients had a story, or a book read aloud. Two weeks ago, this had been about traveling through Cornwall and the feedback from patients was excellent. JF felt that understanding the overall impact of the psychological and social care support provided was important. For this gentleman whilst it was the complex care that saved his life, what he valued was the support that went on around that. The patient had now gone home, and the team looked forward to seeing him in clinic. He was fit and well prior to COVID and they were hoping that he would return to as near normal as possible. **Discussion:** i. JW noted the story highlighted the difficult issues patients faced when they had extended stays on critical care and it was good to hear about the supportive measures that were in place. ii. JR noted that ECMO turnover was usually relatively quick, and this story allowed for further learning as it provided the opportunity to look after the patient for a longer term. iii. GR asked how the issues raised through stories were used? JF advised that issues raised from patient stories and debriefs were taken to the critical care MDT which was held each week and the ECMO MDT or M&M meeting which was held every month. Feedback was disseminated through teams and captured in meeting action lists with progress monitored until matters were resolved. iv. JA welcomed the story noting that it helped staff to understand the experience of being a patient in critical care. He felt the reading aloud project was a great idea and asked if it was available in multiple languages for people who perhaps don't speak English, as they are often very alone because they couldn't understand the conversations around them from nursing colleagues and others. JF agreed to take that suggestion back to the team delivering the service as it was an excellent point. **Noted:** The Board thanked JF for presenting a very well articulated patient		

Agenda Item		Action by Whom	Date
	story.		
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: i. The Committee had received a presentation from the pharmacy team and had learned about the critical support they had provided during the pandemic. This had highlighted that the low vacancy figure for the Trust masked variations across departments which contributed to feelings of low morale. The pharmacy team were addressing this through career and professional development opportunities, but this was limited by the small size of the team at RPH, and challenges faced in the wider profession. ii. Performance was generally strong in terms of finance and restoration of activity. The key change in PIPR was the change in the Safe rating from Green to Amber as a result of the never event that EM had reported. iii. The drop in GP referrals to RPH was more pronounced than other centres and we were looking into the reasons for that. It was important for patients to be referred and added to waiting lists as they would get prioritised in line with their clinical need. However, as the Trust was busy, it may not treat more patients overall. iv. The Committee had also received an update on the recall of Philips CPAP devices. This was a significant issue and may impact on performance over coming months whilst the situation was resolved. **Discussion:** i. EM provided further background on the CPAP recall. She advised that in the USA some patients had used cleaning agents on CPAP devices that caused degradation of PU foam in the equipment. This had not been linked to any direct harm to patients but had been linked to the potential development of cancer in tests in animals. The FDA in America had put in place a full recall and in the UK the MHRA had set a deadline of 17 December for Phillips to undertake a full recall, replace, and repair program. The MRHA advice was that it was safer for people to continue to use the devices than to stop using them. The Trust team had mobilised fantastically well and quickly and had put a link on our website as a landing page for patients that might need to ask questions. This had clear advice and an excellent video by Dr Ian Smith which explained to patients what this issue meant and what the advice was. The Trust had also set up a call centre and had used the call centre to contact patients who didn't have mobile devices. The use of our messaging service meant that all affected patients had been contacted very rapidly. We had been able to give proactive advice making sure patients understood that we knew about the recall and that we were setting up processes to deal with the situation. Consultants would see the patients that they had concerns about in virtual clinics and those went live yesterday. Our Consultants were		

Agenda Item		Action by Whom	Date
	involved in regional and national meetings and colleagues were keen that we shared the tools that we've developed, which we will do with other centres that are affected. ii. JW noted that the CPAP issue was being well managed by the Trust but would continue to cause additional work. The approach to the CPAP recall was noted to be a classic example of balancing risk: the immediate risk of taking patients off a device balanced against a very small risk of keeping them on a device where there was a possibility of future harm. The exercise had been very professional led and Dr Mike Davies had worked to ensure that region had a sensible strategy to manage this. iii. JW noted that the Board should congratulate all those involved in getting this response put in place. iv. JA noted his thanks for the update and advised that Dr Ian Smith had asked the clinical Ethics Committee to look over the proposals and they had met to review these. A report had been sent back and the response had moved on since the referral was made as the service had already addressed some of the recommendations on helplines and engagement with patients and support groups. There were also some consequences for people who drive for a living that would need to be considered. He noted that Ian and colleagues have done a fantastic job in taking very broad perspective on this. v. There was some encouraging discussion through the STP/ICS about allowing consultant to consultant referral pathways rather than referrals going back via GPs as there was some inevitable delay in this as we provided a tertiary service. **Noted:** The Board noted the Performance Committee Chair's report.		
2.b	**PAPWORTH INTEGRATED PERFORMANCE REPORT (PIPR)**		
	Received: The PIPR report for Month 2 (May 2021) from the Executive Directors (EDs). This report had been considered in at the Performance Committee and was provided to the Board for information. **Reported:** TG noted that the never event was the key driver of the overall change in rating and the movement of the safe domain from green to amber. **Discussion:** i. JW noted that whilst never events were serious issues there were lessons to be learned from them. In this case the incident had been benign, and no harm had come to the patient. ii. MB wanted to understand the limits of Trust capacity and whether there was room for further increases in activity. EM advised that much of the capacity was governed by staffing and so although we have physical space within the building, capacity was limited by staffing constraints. This year there was a need for staff to take annual leave that had been carried forward and to undertake CPD as that had been paused. A higher level of headroom had been built into staffing rosters to allow for this (increasing from 22% to 30%) which was a constraint on capacity, but the Trust remained universally committed to using its capacity effectively in terms of getting patients treated. All Cath labs and theatres were fully open and staffed and the sixth theatre was being run as a hot theatre as		

Agenda Item		Action by Whom	Date
	emergency work was at running at higher levels. The only way that we could extend use would be to extend into the evening sessions, which would require more staff. The bed base was also a constraint as we would struggle to have more than 75 beds open for surgery. iii. DL noted that voluntary turnover was above the KPI and asked if exit interviews provided any themes. OM advised that a spotlight report in PIPR last month had identified opportunity for development as a reason for leaving. We had seen some staff leaving after around three years of service and acting on career plans that had been delayed because of COVID. This was an issue for us as a specialist provider and relatively small hospital. We had quite flat structures in a lot of departments with small numbers of senior posts. This Compassionate and Collective Leadership programme included work to support managers promoting use of career conversations with staff and thinking about talent management. The education team were also looking at developing career pathways maps. This feedback fitted with a pattern of staff joining the Trust to gain experience and then seeing opportunities that they could move into. iv. JR noted that during the pandemic staff had held off retiring as well as moving on to other posts. We had now seen several senior nurses moving on which was great for their career progression where we didn't have senior posts available for them. She felt that we contributed to the development of staff and that helped the whole system. JW noted that was a golden thread that flowed through everything that we did and had been so for many years. **Noted:** The Board noted the PIPR report for Month 2 (May 2021).		
3	**GOVERNANCE**		
3.i	**Board Assurance Framework** **Received:** From the Trust Secretary the BAF report setting out: i. BAF risks against strategic objectives ii. BAF risks above appetite and target risk rating iii. The Board BAF tracker. **Reported:** By AJ that the report had been reviewed at Committee and could be taken as read unless there were questions from the Board. **Discussion:** i. JW noted that committees were now taking the BAF early on their agenda and linking this to the committee activities which had come through in the in the committee Chair's reports. ii. CC welcomed the changes that had been implemented in the BAF report and congratulated AJ on how the report now looked. She also noted the table mapping risks to strategic objectives which she felt was very helpful. **Noted:** The Board noted the BAF report for June 2021.		
3.ii	**Q&R Committee Chair's Report** **Received:** The Q&R Committee Chair's report setting out significant issues of interest for the Board.		

Agenda Item		Action by Whom	Date
	Reported: By MB that: i. Mr Sam Nashef had provided an illuminating history around the measurement of surgical mortality and the Committee had been reassured to see the rigor with which the system was designed and monitored at RPH. ii. In terms of metrics, the interesting developmental question was how we could get further than looking at crude mortality and to equally assess impact on quality of life and treatment benefit. iii. Practically a question for the Board was how we should report surgical mortality in PIPR where we currently measure crude mortality. The recommendation from the Q&R discussion was that ideally, we should express mortality as a ratio between expected mortality and actual outcome using Euroscore. It was appreciated that we have very good scrutiny of this at several different levels within the organisation, but it felt important for this to be included in external reporting, and for the Board to assure itself that things were not moving in any untoward direction. **Discussion:** i. JW noted that information on surgical outcomes was published down to individual organisation and surgeon and that included funnel plots that consistently showed the Trust was performing well. MB noted that this had been to a previous Q&R and that it may be useful to review this information on an annual basis. ii. RH supported the use of a mortality ratio as changes in raw mortality were down to circumstance as had been seen during the pandemic. Internally the surgical group measure themselves against a target of 50% of Euroscore and he felt it would be sensible to use the same approach and include this below the line on PIPR with agreed confidence intervals set. iii. CC asked for clarification on funding for the AHP lead post. JR advised that this had now been agreed as a permanent position. The AHP team was looking at working differently and were being supported by the strategic projects team as there had been significant shifts in service. It was hoped that this would allow them to identify funding to support this. TG noted this was part of a wider package where several posts were being removed from establishments and would not layer in additional costs. iv. JW thanked MB for the report and noted that we would implement the change in reporting in PIPR. **Noted:** The Board noted the Q&R Committee Chair's report.	RH/TG	TBC
3.iii	**Combined Quality Report** **Received**: A report from the Chief Nurse and Medical Director which highlighted information in addition to the PIPR. **Reported:** JR thanked JW for accepting two additional reports as this was her last meeting with the Board. She noted that: i. The Infection Prevention & Control (IPC) Annual Report had not yet been to Q&R, but she had wanted to present it to the Board before she left the Trust. ii. The AHP strategy had been to Q&R and detailed annual objectives were to be agreed and monitored through the Q&R Committee.		

Agenda Item		Action by Whom	Date
	iii. That the NHS cadets project was a collaborative piece of work with St John's Ambulance and would help us bring in young volunteers (16 to 18-year olds in the first instance) into the Trust to experience NHS life. They could work in any department (corporate or clinical) and this was an exciting initiative. The risk was managed by NHSE/I and St John's Ambulance, and we would provide support and placements. **Discussion:** iv. MB welcomed the IPC report and noted that overall, the performance in the hospital had been outstanding. He had a question about the impact of the antibiotic ward rounds as reductions in antibiotic use may also be driven by other factors. He understood that this may be a very good innovation but was keen to ensure that we applied the same rigorous research standards where we introduced operational change. JR advised that this was part of the antimicrobial stewardship programme and that there was rigor within this. The ward round helped in the choice of antibiotics and in when to start and stop them and this was where savings arose. There was a 0.6WTE pharmacist who worked on the project, which was not a heavy burden in terms of cost, and savings outweighed the cost of delivery. It was also better for patients if we use the right antibiotics first time and know when to stop. The correct use of antibiotics saved money and prevented the development of resistance to antibiotics. It was agreed that this would be considered on the Q&R Agenda. v. CC asked how patients and the public were able to access this information. JR advised that the report was published on the Trust website. CC was concerned about those who did not have access to the website. JR agreed to talk to the team about that matter. vi. JA noted that the numbers for inoculation injuries looked low, but there was no way of comparing to historical or benchmark figures. He asked whether there was any long-term harm from any of those inoculation injuries? JR advised that staff were managed through a very rapid process and that there were no incidents with any significant harm. vii. GR asked about lab turnaround times and whether there were any issues with diagnostic turnaround times. JR advised that if infections were suspected we would always take the IPC precautions, and the doctor or prescriber would prescribe what they thought to be an appropriate antibiotic. The antibiotic stewardship role was in helping them choose the right antibiotic. EM advised that the microbiology service was under a contract with Public Health England which was the laboratory run out of CUH. The contract included key performance indicators which included the expected turnaround times and that was monitored on a monthly basis. viii. DL welcomed the papers. She had hoped to see key milestones for delivery within the AHP strategy and asked whether there were plans for our AHPs to develop non-medical consultant roles to provide more structure within the team. JR advised that this work was planned and the team were now setting objectives for this year and next and would revisit these through an annual refresh. ix. To complete the picture about programs for young people OM advised that the Trust had joined the national initiative called Kickstart which offered opportunities to people who had been unemployed. Unfortunately, it was not going as planned nationally		

Agenda Item		Action by Whom	Date
	and between ourselves and CUH we had filled only 38% of placements offered out of seven roles across the campus. We had offered two roles at RPH one of which was declined. We will continue to engage with this programme, but there would probably need to be a rethink nationally about buy in and marketing. x. JA noted that the EAHSN had some experience with Kickstart and had seen very limited results from it. He welcomed the Cadet programme and the focus on inequalities that was included in its recruitment targets. He applauded this as it recognised that many volunteers may be from a disadvantaged background and the programme could benefit them individually. **Noted:** The Board noted the IPC Annual report and the AHP Strategy. It was agreed that the IPC Annual Report would be considered by the Q&R meeting in July. **Noted:** The Board noted the Combined Quality Report.		
3.iv	**Quality Accounts**		
	Received: The Board noted that Quality Report had been published to the website on 30 June 2021. This was available online at: https://royalpapworth.nhs.uk/our-hospital/information-we-publish/annual-reports **Noted:** JR noted the enormous amount of work that had gone into the production of the Quality Report for 2020/21 and thanked AJ and Chris Seaman (Quality Compliance Officer) for their work to ensure that the report was complete and published in line with the national timetable despite the challenges and changes in national guidance.		
3.v	**Audit Committee Chair's Report** **Received and noted:** The Board received and noted the Audit Committee Chair's report setting out significant issues of interest for the Board. **Reported:** By CC that: i. The Committee had met on the 3 June and had approved the Annual Reports and Accounts and recommended those to the Board for approval. ii. That RPH had decided to go for the earlier deadline of submission of the 15 June whereas most organisations had worked to the 30 June submission deadline. CC felt it was very commendable for the finance team to have worked to the earlier deadline. Ultimately the deadline was exceeded by one day as KPMG had a technical issue and so were unable to submit their accounts until the 16 June. She felt that we really did need to thank the RPH and KPMG teams for the work they'd done to meet that deadline. iii. The other elements of the meeting were to agree the internal audit annual plan and counter fraud strategies. The Trust had new auditors, BDO, and the Committee had seen their audit plan for the first time. There were some challenges as the plan was several days over budget and the Committee would work through that during the year. BDO had mapped the plan to the Trust BAF risks and so it covered the key risks that were important to the organisation. **Discussion** i. TG welcomed CC's comments and agreed that the year had been		

Agenda Item		Action by Whom	Date
	very challenging and he was aware that locally and nationally some organisations had still not submitted accounts. **Noted:** The Board noted the Audit Committee Chair's report.		
3.vi	**Board Sub Committee Minutes:**		
3.vi.a	**Quality and Risk Committee Minutes: 27 May 2021** **Received and noted:** The Board of Directors received and noted the minutes of the Quality and Risk Committee meeting held on 27.05.2021.		
3.vi.b	**Performance Committee Minutes: 27 May 2021** **Received and noted:** The Board of Directors received and noted the minutes of the Performance Committee meeting held on 27.05.2021.		
3.vi.c	**Audit Committee Draft Minutes: 03 June 2021** **Received and noted:** The Board of Directors received and noted the draft minutes of the Audit Committee meeting held on 03.06.2021.		
4	**WORKFORCE**		
4.i	**Workforce Report** **Received:** From the Director of Workforce and OD a paper setting out key workforce issues. **Reported:** By OM: i. That there was a national requirement to undertake a review of disciplinary procedures which was overdue. The Trust had started this review looking at best practice and was having discussions with the trade unions. An update had been provided to NHSI, and they had not raised any concerns around progress. This would be brought back to the Board in September. ii. The Pulse Survey had seen a relatively low uptake with only 10% of staff responding but it did indicate some improvement in areas that we had been focusing on around communication and health and well-being and was steady in other areas. The narrative returns echoed previous surveys with themes around workload pressures, either currently felt or anticipated, and themes around development opportunities. Staff were worried about the pressure in terms of recovery and that was being picked up in discussions with staff through the Compassionate and Collective Leadership programme. iii. That the debrief survey had again been a good exercise with positive feedback around the improvements that we'd made between the first and the second COVID19 surges. This had been shared with the divisions and we had broken it down so they could look at it for their individual areas. This was also linked into the CCL programme. **Discussion:** i. CC noted that the table of responses for the four areas. She was concerned that the responses appeared not to align positively to where staff were having regular 1:1s and team meetings. OM was wary of drawing any kind of conclusion as the numbers were very low. The trends relating to communication and well-being had improved over the last few quarters and this correlated to the narrative feedback received. The next survey was due at the end of the summer. These surveys were quick temperature checks and		

Agenda Item		Action by Whom	Date
	would have some normal level of variation. If we saw this continue or return to where it had been for a couple of quarters (60%) then we would have cause to worry. ii. MB asked whether the survey should be undertaken less frequently. OM advised that we'd been doing the survey since before the move and there was a good rhythm to it and much of the narrative feedback correlated to the annual staff survey findings. It was a helpful indicator of the level of staff engagement, which was more positive now than it had been after the move and it provided a regular indicator of morale but would not be used in isolation. This was one data point in the picture and looked at against the debrief survey, there was some correlation between matters raised by staff. iii. GR noted that one of the things that was most disappointing matters in the first debrief was the sense of unfairness and discrimination around the redeployment process. It was good to hear that staff thought we had learned lessons and that the redeployment had been better handled, but he noted that the issue of unfairness had emerged again. OM advised that the Trust had been very open in this. The number of people that had raised issues was small and these seemed to be more about inconsistency. Staff were working in different departments during the redeployment and when they saw how things were done in other areas they reflected on their own teams. For example, there were overtime payments in critical care that weren't paid in other areas. We had reviewed this arrangement, and there were good reasons for it, but that would not change the fact that people may think it was unfair. There was also variation in leave arrangements where the number of staff that could be off the rota varied across areas. Again there would be good reasons for this, but it could still contribute to the view that there was inconsistency across the Trust. There was not inequity reported in the same way as the first wave, it was more subtle and a lot of it came down to people feeling that perhaps another area had a more compassionate a style of leadership than another. GR felt these issues were helpful to hear and asked how they would be addressed. OM advised that the CCLP included management development and would introduce a consistent set of values and a behaviour framework across the organisation and that would help to address these issues. iv. CC noted that the Trust had already started to do work on the disciplinary procedures and reporting had started into the Board last month and regular reporting was included on the Board forward plan. **Agreed:** The Board noted the update from the DWOD.		
5	**BOARD FORWARD AGENDA**		
5.i	**Board Forward Planner** **Received and Noted:** The Board Forward Planner. **Discussion:** CC noted that the Audit Committee had agreed to revise the Forward Planner to present this as a rolling forward plan from the current month so that members could see what was happening for the subsequent meeting and suggested that this could be considered for the Board Forward. It was agreed that AJ would pick up the discussion outside of the meeting.	AJ	Jul 21

Agenda Item		Action by Whom	Date
	JW noted that whilst we had reverted to monthly meetings traditionally, the Board did not meet in August. JW was also very aware of the fatigue around the Trust and the need for staff to take leave, and that included the executive staff as well as everybody else. He proposed that the Board should not meet in August unless there was an exceptional need to do so. This would allow some respite ahead of the autumn period where there would be significant workload in terms of recovery and the ICS developments.		
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 1 July 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