Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Held on 2 September 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 A Fadero	(AF)	Non-Executive Director
	Mr T Glenn	(TG)	Chief Finance and Commercial Officer
	Ms D Leacock	(DL)	Associate Non-Executive Director
	Mrs E Midlane	(EM)	Chief Operating Officer
	Ms O Monkhouse	(OM)	Director of Workforce and OD
	Mr S Posey	(SP)	Chief Executive
	Mr A Raynes	(AR)	Director of IM&T Chief Information Officer
	Mr G Robert	(GR)	Non-Executive Director
	Mrs M Screaton	(MS)	Chief Nurse
In Attendance	Ms F Fuller	(FF)	Ambulatory Matron
	Mrs A Jarvis	(AJ)	Trust Secretary
	Mr A Selby	(AS)	Associate Director of Estates and Facilities
Apologies	Dr R Hall	(RH)	Medical Director
	Prof I Wilkinson	(IW)	Non-Executive Director
Governor Observers	Michelle Barfoot, Susan Bullivant, Trevor Collins, Richard Hodder, Rhys Hurst, Trevor McLeese, Harvey Perkins,		
Observers	Ms L Gibbie	(LG)	Deputy Operations Manager

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. The Chair welcomed Maura Screaton to her first Board meeting and Dr Ian Smith who was Acting Medical Director standing in for Roger Hall in his absence. JW also reported the death of Janet Atkins who was one of our Governors and who had a heart and lung transplant at the Trust in		

Agenda Item		Action by Whom	Date
	2000. Janet had played a very active role at the Trust as a volunteer and a Governor over many years. He noted the Board's appreciation for her work and sent condolences to Janet's family.		
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. MS declared that her husband was a Radiologist at RPH and that he that she was a Director of Cambridge Clinical Imaging Limited. A summary of standing declarations of interests are appended to these minutes.		
1.iii	**MINUTES OF THE PREVIOUS MEETING**		
	Board of Directors Part I: 01 July 2021 **Item 1.vi:** CEO's Update Discussion ii: Revised to read 'and would come back to that later in the agenda ...' **Item 2.b PIPR:** Revised to read: **'**This report had been considered at the Performance ..' **Approved**: The Board of Directors approved the Minutes of the Part I meeting held on 1 July 2021 as a true record.		
1.iv	**MATTERS ARISING AND ACTION CHECKLIST**		
	Item 3.iii Combined Quality Report CC highlighted the previous discussion about patient and public access to information and requested that the Board capture its intention to try and ensure that everyone could have access to reports and information without having to do so solely through the website as this excluded those who did not have access to IT and this approach would go towards addressing inequalities. This was noted for the record. **Noted:** The Board received and noted the updates on the action checklist.		
1.v	**Chairman's Report**		
	These matters were covered by the Chairman under Item 1.i.		
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. **Reported:** By SP that: i. He thanked Dr Ian Smith who had taken on the role of Acting Medical Director as Dr Hall was unwell. He also welcomed Maura Screaton to the Trust in her new role as Chief Nurse.		

Agenda Item		Action by Whom	Date
	ii. He extended his thanks to all Trust staff and noted that it was because of the effort of the Trust's many teams including OCS and Skanska that the Trust was able to deliver such outstanding performance. He noted that the Trust had celebrated Estates and Facilities day with the teams since the last meeting and this had included colleagues from our partners. iii. We were continuing manage competing priorities and the CDC were helping to prioritise Trust resources in the light of the sustained pressures. The Trust was working with in line with national and regional requirements and was managing its urgent and emergency care demand. We were also developing our winter plans. Cardiology had been exceptionally busy, and we had seen exemplary behaviour under substantial pressures on the service. iv. We had 12 COVID ECMO patients (and would usually have only 4 ECMO patients at this time) and the majority of these were unvaccinated patients. We would continue to promote the uptake of vaccines within and beyond the Trust. v. Staff were being encouraged to take time for respite and we had set a target for staff to take half of their leave entitlement by the 30 September. Managers were having health and wellbeing discussions with staff to support this. vi. We were making progress on the Equality, Diversity and Inclusion (EDI) agenda and this was key to improving the experience of our staff. We continued to promote the reciprocal mentoring programme and were seeing more applications to join this scheme. vii. We were proud to have been shortlisted for the Health Service Journal Trust of the Year award. viii. There was to be a visit from the Organ Utilisation Group on the 17 September to showcase and share best practice. ix. The ICS Chair and Accountable Officer roles were progressing, and the development of the ICS would see implications for the system and RPH. x. In the Autumn we would see the launch of the NHS Staff Survey. This would help to inform the Trust on what it had done well and where there were areas for improvement. xi. We would also be holding our Annual Members Meeting on the 15 September and so this would be a busy month for the Trust. **Discussion:** i. Would the Trust continue to take ECMO patients at the same level as was being seen currently? SP noted that there had been discussion at CDC about the position of the 5 ECMO centres across the country. Two centres were under similar levels of pressure and pressures were skewed towards London and the South East. Given the pressures nationally we would look to see if this could be managed to a level of 10 cases. **Noted:** The Board noted the CEO's update report.		
1.vii	**Patient Story**		
	MS introduced the patient story. She noted that this story related to the delivery of cardiac rehabilitation which was very important to successful recovery and outcomes. Since the pandemic this had been delivered		

Agenda Item		Action by Whom	Date
	virtually and the story showed how staff had to use their judgment and curiosity for the benefit of patient outcomes and experience. The story was presented by Felicity Fuller, Ambulatory Matron. The story was from a patient who had Mitral Valve Replacement surgery in December 2020. Following this he participated in the cardiac virtual rehabilitation programme. He was initially progressing well despite Covid-19 restrictions (which prevented face to face contact). He was due to have his final telephone assessment in April 2021. On speaking to the patient, he advised that he had been suffering from shortness of breath (SOB) and fatigue which was preventing him from being active and he was concerned about his symptoms. He was keen to regain his normal life back as he had been progressing so well. On assessment he was booked in for an appointment to see the Cardiac Rehabilitation team face to face. He felt the appointment in the rehabilitation gym was very thorough and safe, and he was grateful to have 2 hours' time for this. During the appointment he had a long discussion about his symptoms and an ECG was performed. He was found to be in atrial flutter with numerous ectopics. A decision was made to contact the EP consultant who agreed to review the patient in the gym. He was given a clear treatment plan, the first being a cardioversion and if that was not successful, they would look at an ablation. The patient was overwhelmed with the outcome from the assessment and felt more relaxed knowing that things were being addressed. His appointment came through for one week's time and he was contacted by telephone by Cardiac Rehab team to see how he was and to inform him about the appointment which he found very reassuring. During the phone call the Rehab team arranged to see him on Day ward on the day of his procedure, which turned out to be very successful. The patient expressed how grateful he was for the extra time, care and effort that had gone into his treatment here at RPH, as the face-to-face appointment had given him the time to discuss matters properly with a healthcare professional. The examinations and tests had led to him having life changing treatment and he couldn't be more thankful for that. He had since received a phone call to follow up how he was doing post procedure and he felt fantastic. He was happy with his recovery and could now build up his exercise again. His only disappointment was that due to COVID restrictions he was not able to have more face-to-face communication and sessions with the cardiac rehabilitation team, but he felt that he had been offered the best service under the circumstances. This story highlighted that communication with patients was vital to their recovery, outcome and experience of services, especially with the added stress and difficulties of the pandemic. It showed that staff felt empowered to tailor services to meet individual needs and had the autonomy to change to face to face appointments where that was needed. It showed a highly professional service where the staff went above and beyond, thinking 'outside the box' and making a difference to Royal Papworth patients. The story highlighted the positive impact of virtual appointments during COVID, but also the need to have a		

Agenda Item		Action by Whom	Date
	flexible approach to care. The Rehab team had now bought face-to-face assessments back to the hospital and were re-opening the Cambourne service to further enhance patient care. **Discussion:** i. JW noted the wide geographical area served by the Trust and asked how that was managed. FF advised that rehab services were delivered across a wide area and that some patients were referred into local services. The Trust were looking at options to extend services into the St Ives/Huntingdon area. ii. AF asked whether GPs were using referral schemes into gyms in the area. It was noted that this was a different service as we provided post-surgical rehabilitation and the GP referral schemes related more to preventative care. However, it was some patients found peer support and continued to use the gym facilities beyond the rehab programme. iii. The Board were keen to hear about metrics relating to the service and whether these would evidence the outcomes in terms of reduced use of other services, improved confidence and in Quality Adjusted Life Years (QALYs). IS noted that Dr Len Shapiro was looking at how we could compare outcomes in RPH services against alternative services in terms of outcomes achieved but this was very early research. FF advised that the rehab service was accredited to a gold standard and that during COVID it was seen as a lifeline by some patients who had limited access to primary care. **Noted:** The Board noted the patient story and thanked FF for bringing this 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. These were presented by CC and DL. **Reported:** By DL that the Committee on the 29 August had received: i. A presentation from the Surgery, Transplant and Anaesthetics Division and it had been pleasing to see the high level of collaboration underway to optimise Trust services. ii. An update on cyber security with assurances being received around the patching and testing programme and other updates which were to be considered under the Part II agenda. **Noted:** The Board noted the Performance Committee Chair's reports.		
2.b	**PAPWORTH INTEGRATED PERFORMANCE REPORT (PIPR)**		
	Received: The PIPR report for Month 4 (July 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:** By TG: i. That overall Trust performance was at an Amber rating. ii. That PIPR was still evolving following the second wave of		

Agenda Item		Action by Whom	Date
	COVID19. It included the latest dashboard information and additional KPIs and included more narrative on key challenges. iii. That the key thread running through the report was the balance between the delivery of recovery in terms of staff wellbeing and increasing elective workload, at the same time as maintaining high volumes of critical care and ECMO workload. iv. In Safe the review of rosters and delivery of safe staffing was ongoing work, and this was reflected in the report. v. In Caring and Effective the Trust was unable to return to its usual performance at the current time because of the need to balance the recovery. **Discussion:** i. GR asked about the use of theatre 6 and whether this had continued. EM advised that the Trust continued to schedule activity into theatres 1-5 and used the sixth theatre for one scheduled IHU case and for emergency workload. The Trust had continued to see pressure from the emergency pathways for cardiology. ii. GR noted the increase in cancellations. EM advised that these related to the constraints in capacity in critical care arising from staff sickness and covid contact isolation. Elective activity had been titrated down to minimise cancellations. This had been discussed at the CDC who were trying to ensure that there was a balance between cancellations and missing opportunities to deliver additional workload. iii. GR asked whether patients were contacted before they had travelled to the site. EM advised that lists were considered ahead of time and patients were cancelled with notice where that was deemed necessary. The KPI was to report patients cancelled within 24 hours of surgery and the report would include any patient who had been cancelled within that timeframe. iv. SP noted that the level of cancellations was indicative of the pressures that were being managed across elective, emergency and transplant workload. To bring this figure down further would reduce the number of patients booked and so that approach needed to be balanced. Cancellations were a disappointment to those patients but meant we were bringing in patients who would otherwise remain untreated and it was a balanced approach that was being taken. **Noted:** The Board noted the PIPR report for Month 4 (July2021).		
3	**GOVERNANCE**		
3.i	**Q&R Committee Chair's Report** **Received:** The Q&R Committee Chair's report setting out issues of interest for the Board. **Reported:** By MB that whilst there was nothing significant to draw to the Board's attention to the Committee had heard feedback from some staff on critical care who were convinced that the unit was under-staffed. The Committee were seeking to understand this. The Committee's instinct was to trust the data on staffing but they were		

Agenda Item		Action by Whom	Date
	unwilling to dismiss concerns and comments from our staff who were feeling under pressure. EM and OM were working to identify how the Trust could rapidly identify where there were staffing issues and how we could use data to describe the pressures to get to an objective story in relation to it. **Discussion:** i. SP noted that the Trust was open to fewer beds in Critical Care and that was driven by fewer staff as well as the impact on staff of working in full PPE. Safer staffing was being monitored but the Trust understood that staff would not feel reassurance if they were overwhelmed by a sense of tiredness and fatigue. ii. AF noted that this issue was being seen across the country. **Noted:** The Board noted the Q&R Committee Chair's report		
3.ii	**Combined Quality Report** **Received**: A report from the Chief Nurse and Medical Director which highlighted information in addition to the PIPR. **Reported:** By MS that the report provided a brief overview across: i. Infection Prevention and Control and M.Abscessus. ii. The End of Life (EoL) Strategy which highlighted how in addition to the lifesaving care delivered by RPH teams also provided a high level of care to patients who had life limiting and life-threatening conditions. iii. An update on patient experience which was all very positive. **Discussion:** i. JW noted that the Trust figures for nosocomial infections were low when compared to the rest of the country. ii. CC asked about the care relating to patient D and whether there were any areas of concern arising from this inquest. IS advised that most patients going forward for TAVI would be turned down for elective surgery and these were the cohort of patients most at risk of complications associated with the procedure. The Trust reported all complications, and these were well within the envelope of what we would predict. iii. DL asked how staff across the Trust had contributed to the EoL strategy. MS noted that there was an EoL steering group that had representation from across the hospital and included patient experience representatives. The strategy had also been presented to the Clinical Professional Advisory Committee (CPAC). GR noted assurance through the steering group that he attended as the NED lead for EoL care. He commended the amazing team led by Dr Sarah Grove and he had confidence in the way that the strategy had been brought together with a clear focus on a small number of key issues. iv. AF welcomed the strategy document, noting that feedback and comments from bereaved relatives had been used in its development. She noted that EoL care was the most important part of this pathway for individuals and relatives and that was often constrained by out of hours care. She asked whether there was more that the Board needed to consider in relation to out of hours care. MS advised that this was discussed on a regular basis and that the palliative care		

Agenda Item		Action by Whom	Date
	nurses had advised that improvements in cover had been seen with seven-day services that were able to liaise with the hospice team and this delivered significant support. MS agreed that she would confirm the scope of the hospice provision that was available to support our patients. v. SP noted that the EoL service was not included in the 2019 CQC inspection. He echoed all that had been said about the improvements that had been made in the service. The team had worked incredibly closely with the hospice team and that had come through in the strategy. vi. JA noted that when he joined the mock CQC inspection he had the opportunity to listen to feedback first-hand and those observations noted how effectively Dr Grove and the team listened as well as communicated. Also, that the focus of work at RPH was wider than EoL care with the service providing supportive and palliative care to a much larger cohort of patients with compromised cardiac and respiratory systems. **Noted:** The Board noted the Combined Quality Report.	MS	Oct 21
3.iii	**Audit Committee Chair's Report** **Received:** The Board received the Audit Committee Chair's report setting out significant issues of interest for the Board. CC took the report as read and reported that the Committee had approved the BDO internal audit plan. **Discussion:** JA noted the support for the increase in hours for the Freedom to Speak Up Guardian and welcomed that decision. **Noted:** The Board noted the Audit Committee Chair's Report.		
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 that the key issues discussed at Committee had included: i. BAF 841: CIP which had a reduced rating as the CIP programme for 2021/22 had been identified. ii. BAF 675: HCAI where the risk had increased following the change in national guidance on contact isolation. Local risk assessment processes had been put in place to address this. iii. That the SPC had asked that risks were reviewed against our objective around research capabilities to ensure that the impact of this was reflected fully across BAF risks. **Discussion:** i. SP noted that Committees had taken a revised approach to how they used the BAF on their agendas and asked for feedback from the Board on how this was now working. ii. CC and GR welcomed the changes and noted the positive change in the use of the BAF report at the Performance		

Agenda Item		Action by Whom	Date
	Committee. It considered BAF risks at the start of the agenda and at the close of the meeting to confirm that the Committee had considered and received assurance on Committee BAF risks. GR felt this approach might also be a useful for the Board. iii. JW asked whether the approach applied to the BAF might be considered in Committee's and Board's use of the PIPR report as this contained all the performance data needed to provide a strategic overview of performance. SP agreed that the executive would explore how this could be used. iv. MB noted some anxiety in how the BAF demonstrated how risks were balanced but acknowledged that short-term trade-offs were managed and monitored through other routes such as the CDC which maintained oversight of pressures on the Trust and provided a source of assurance that these issues were being well managed. v. IS raised the issue of grading of risks associated with R&D and whether risks should be graded in a way that was more aligned or whether R&D was more risk averse. SP noted that this would be considered through the regular discussions on emerging risks on the EDs agenda. vi. JW noted the risks around the HLRI and the delivery of the research agenda. JA felt that research was a golden thread as if not successful it could have a significant impact across the Trust with knock on issues ranging from recruitment to attracting resources and maintaining its position leading systems and service development. It was agreed that this should be considered in the across BAF risks and any changes would be brought back to the Board. **Noted:** The Board noted the BAF report for August 2021.	EDs EDs	Oct 21 Nov 21
3.v	**Guardian of Safe Working Report** **Received:** From the Guardian of Safe Working the yearly Report on Safe Working Hours: Doctors and Dentists in Training (August 2020 – April 2021). **Reported:** By IS that: i. The role of the Guardian was to monitor and bring forward issues to the Board arising from exception reporting from our Junior Doctors. Reporting had initially been suspended during the pandemic and was subsequently re-introduced. This report covered the period where the Trust was looking to move back to 'business as usual' and reflected some of the stresses being seen across departments. ii. Overall, the Trust was one of the best performing Trusts within the region (and nationally) with positive outlier scores in seven areas and negative in three. Nationally we were rated in the top ten programmes for respiratory services and were the top-rated programme for cardiac surgery. iii. The key concern raised by Juniors was the lack of a dedicated mess facility. A dedicated area had been shared with members of the Alert Team but that had subsequently been used as a doffing area during the pandemic. The Trust did provide all the requisite elements of support for Juniors in terms of suitable facilities for rest and refreshments, but these were not provided in a dedicated area.		

Agenda Item		Action by Whom	Date
	Discussion: i. GR felt it would be helpful if further context could be provided to enable him to interpret the report and to understand what the Trust was trying to achieve in relation to the report. SP advised that nationally the Guardian role had been put in place to allow concerns about working practices to be raised by Junior medical staff and there was a statutory requirement for a report to be made to the Board to ensure that our staff had a voice within the organisation. ii. OM advised that the requirement arose from the Junior Doctors contract and was not specific to RPH. All Junior staff reported to their Trust's where rotas were not complied with and there was a formal mechanism for concerns to be reported to the Board through the Guardian role. The Trust had been working with the Junior Doctors Forum to address the standards that need to be delivered and the Trust was compliant in term of provision of working areas, rest areas and catering facilities. It was difficult to provide a dedicated area due to the layout of the building and that was a source of concern for Junior staff. These additional provisions for Junior doctors were driven by the need to ensure they were supported as they moved between organisations more frequently than other staff. iii. GR asked about the context in terms of the number of exceptions reported whether this was an improvement or a decline in performance. OM noted that if we saw no exceptions that would suggest that there was a problem with reporting and that we were probably at the lower end of the range for the numbers of exceptions logged. We wanted our staff to feel able to report but also expected there to be a degree of reality around working in a multi professional way in an acute setting. OM & IS would take feedback to the Guardian to ensure that trend information was included in future reporting. iv. DL asked if unresolved exceptions could be removed if they were incomplete reports to make the report more informative. She noted that other Trusts provided dedicated areas for rest and nourishment and given that there were funds asked what could be done now or in the medium term to build their sense of belonging whilst with us. OM reassured the Board that a rest area was in place on one of the day areas with two sleep pods and reclining chairs. There were also kitchen facilities available for staff and we had extended the opening hours of the restaurant. v. JA noted that this was an important subject and that recurrent themes should be considered by the Board. He suggested that it could be helpful if the report were presented at the same time that the Board received feedback from Juniors in order to provide some triangulation of responses. SP agreed that this feedback would be considered as this was an important issue but reminded the Board that the report was one of the best seen in the region. **Noted:** The Board noted the Guardian of Safe Working Report.		
3.vi	**Medical Revalidation Annual Report** **Received:** From the Acting Medical Director the Medical Revalidation		

Agenda Item		Action by Whom	Date
	Annual Report. **Reported:** By IS that: i. The Trust was required by NHSE/I to submit an annual report to the Board to provide assurance that patient care was being supported and that we were fulfilling the statutory obligations of the Responsible Officer for the Trust ensuring that all doctors had effective appraisal, and that revalidation was undertaken every five years. ii. Nationally the process of consultant appraisal was suspended from March 2020 until January 2021. iii. The Trust had seen around 25% of appraisal and revalidations undertaken during the year and there were now plans in place to recover the performance standards by the end of the year. The 36 staff who were approaching revalidation would be prioritised and the appraisee and appraiser hours required to deliver this recovery needed to be recognised. **Noted:** The Board noted the Medical Revalidation Annual Report.		
3.vii	**Board Sub Committee Minutes:**		
3.vii.a	**Quality and Risk Committee Minutes: 24.06.21 & 29.07.21** **Received and noted:** The Board of Directors received and noted the minutes of the Quality and Risk Committee meetings held on 24 June and 29 July 2021.		
3.vii.b	**Performance Committee Minutes: 24.06.21 & 29.07.21** **Received and noted:** The Board of Directors received and noted the minutes of the Performance Committee meeting held on on 24 June and 29 July 2021.		
3.vii.c	**Audit Committee Minutes: 15.07.21** **Received and noted:** The Board of Directors received and noted the minutes of the Performance Committee meeting held on 15 July 2021.		
4	**WORKFORCE**		
4.i & 4.ii	**Received:** From the Director of Workforce and OD the WRES Data submission and Action Plan 2021 and the WDES Data submission and Action Plan 2021/2022. **Reported:** By OM: i. That the Trust was required to put its WRES and WDES data and action plans into the public domain and to provide these to NHSE/I by the end of August 2021. ii. The papers and action plans had been through the Q&R Committee and these had been approved and they were being brought to Board for ratification. **Discussion:** i. CC asked for an amendment relating to the presentation of information on BAME staff entering a disciplinary process as she felt this could be misleading. OM agreed that this was not a helpful presentation of the data and noted that this did not		

Agenda Item		Action by Whom	Date
	form a part of the published action plans. She confirmed that this would be amended. ii. MB noted that many people had an unknown status and that could make a very large difference to the data. Also, that scores for both white and BAME staff had seen a decline in relation to fairness in prospects for promotion. That perception could be susceptible to isolated incidents which rapidly erode trust which was extremely difficult to rebuild. OM noted the work in the action plan on fair recruitment and the report that the East of England HRDs had commissioned from Roger Kline that focused on recruitment practice. That report highlighted that transparency, accountability and explaining decision making was required to build trust. This was needed across all roles including acting up arrangements and project opportunities which all had a positive impact on career development and where a small number of anecdotes could spread the perception of poor recruitment practice. iii. DL noted that the WDES the numbers were also very skewed as staff had not disclosed their status. OM advised that the disability and difference network had discussed how we give people the confidence to disclose this information and how we communicate why this was an important question. The network was looking at a communications campaign to help staff understand why this mattered. The response in the national staff survey (which was anonymous) probably gave a more realistic indication of the burden of disease. iv. To support this, and to set an example, CC asked that all Board members review their record and ensure that they had declared their status in terms of disability. She also welcomed the inclusion of the disparity ratio as that showed the Trust the level of work that was needed in this area. OM agreed that it gave us a more granular feedback in terms of ranking against other organisations and gave us the opportunity to identify organisations that were doing well. v. AF asked how all the strands of work could be brought together into a single overarching plan to improve the experience of our staff so that the Board could have a regular 'drum beat' on what we were doing to improve our current position on WRES/WDES as we had articulated that as a priority. OM noted that there was intersectionality across all areas of the agenda around EDI and improving H&WB for all our staff. The overarching structure for this work was the Compassionate and Collective Leadership Programme and there was a steering group that provided links across EDI, H&WB, recruitment practice and policy & procedures. Within the CCL programme our Values and Behaviours Framework underpinned all of those areas of work. The progress in WRES and WDES was reliant on the work on policies and procedures, as well as the V&BF. AF welcomed the advice on how this agenda was to be managed. vi. JW also noted that this linked to the wider conversation at the Board around management of the Workforce agenda. **Agreed:** The Board noted the update from the DWOD and ratified the WRES and WDES reports and action plans.		

Agenda Item		Action by Whom	Date
5	**RPH Sustainability Strategy 2021-26**		
	Received: From the Director of Estates and Facilities the Sustainability Strategy 2021-2026 which outlined the Trust's aims, objectives, and delivery plans for sustainable development. **Reported:** By AS that the report had been to the SPC and through the sustainability Board. The strategy brought together our plans around sustainability and would be backed up by the Trust's Green Plan. The paper sought approval to: • Delegate authority to the Executive to approve and submit the Green Plan which was due in January 2022. The Green Plan was an action plan for change and would support the commitment to the principles and timescales of the strategy. There would not be scope for the plan to be brought through Committee for approval ahead of submission. • To confirm EM as the Executive Sponsor for the programme. **Discussion:** i. SP noted that the Trust were the only BREEAM excellent rated organisation in the East of England (BREEAM rated developments were more sustainable environments that enhance the well-being of the people who live and work in them and help protect natural resources). The HLRI would also be classified as BREEAM excellent. He welcomed what was a great strategy and noted that the Trust had very engaged and positive staff who wanted to do more on this agenda which was increasingly important. ii. MB welcomed the report and noted that the strategy was a model of clarity. **Agreed:** The Board of Directors: i. Affirmed the Trust's commitment to the principles and timescales of achieving NHS Net Zero. ii. Approved the Sustainability Strategy 2021-2026 and formally adopted this as Trust strategy. iii. Affirmed the Chief Operating Officer as the Executive Director with responsibility for the Trust's net zero targets and for the production and delivery of the Trust's Green Plan. iv. Delegated to the Executive Committee powers to conclude and submit the Trust's Green Plan 2022-2025 to the ICS.		
5.ii	**Integrated Care System Update**		
	Received: The ICS Joint Accountable Officer Update for System Partnership Board. **Reported:** By SP that the ICS Joint Accountable Officer's report was welcome and was being taken to all Trust Boards to ensure common oversight of the ICS agenda. It was anticipated that in future the substance of the report would become more of a feature in reports that come to Committee and Board. **Discussion:** i. JW noted that the content of the report would change in focus over time with key appointments being made to the ICS		

Agenda Item		Action by Whom	Date
	Executive and Non-Executive roles. ICS plans would inevitably be wider that the Trust agenda and it was important that the Trust sensibly took a role in discussions and guided where appropriate. This would be considered further under the part II agenda. ii. AF welcomed the report on the public section of the Board and noted the progress on the System Oversight and Performance Framework. She asked for clarification on how the rankings would be applied. SP advised that this process was iterative and that there were four levels of intervention (with 1=good and 4=bad). All ICS were to self-regulate and each would have their own oversight and performance framework. There were four or five systems nationally that had been placed in level 4 and that included the C&P system because of the financial problems that it faced. C&P had its first System Oversight and Assurance Group (SOAG) meeting this week. This had a part B section that would consider support for those system providers who had significant delivery challenges. The ICS would hold to account all providers within it, and this would extend to national and regulatory input where performance was at level 4. **Noted:** The Board noted the ICS Joint Accountable Officer Update.		
6	**BOARD FORWARD AGENDA**		
6.i	**Board Forward Planner** **Received and Noted:** The Board Forward Planner.		
6.ii	**Items for escalation or referral to Committee** None		

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Signed

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Date

Royal Papworth Hospital NHS Foundation Trust
Board of Directors
Meeting held on 2 September 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