Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Held on 4 November 2021 at 9:00am
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
	Ms D Leacock	(DL)	Associate Non-Executive Director
	Mr T Glenn	(TG)	Chief Finance and Commercial Officer
	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)	Chief Information Officer & SIRO
	Mr G Robert	(GR)	Non-Executive Director
	Mrs M Screaton	(MS)	Chief Nurse
	Dr I Smith	(IS)	Acting Medical Director
	Prof I Wilkinson	(IW)	Non-Executive Director
In Attendance	Ms T Crabtree	(TC)	Head of Communications
	Ms J Fowles	(JF)	Nurse Consultant
	Mrs A Jarvis	(AJ)	Trust Secretary
	Mr A Selby	(AS)	Director of Estates and Facilities
Apologies	Dr R Hall	(RH)	Medical Director
Observers	Susan Bullivant, Trevor Collins, Richard Hodder, Rhys Hurst, Trevor McLeese, Harvey Perkins.		

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1	**WELCOME, APOLOGIES AND OPENING REMARKS**		
	The Chairman welcomed everyone to the meeting and apologies were noted as above.		
1.i	**DECLARATIONS OF INTEREST**		
	There is a requirement that Board members raise any specific declarations if these arise during discussions. No specific conflicts		

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	were identified in relation to matters on the agenda. A summary of standing declarations of interests is appended to these minutes.		
1.ii	**MINUTES OF THE PREVIOUS MEETING**		
	Board of Directors Part I: 7 October 2021 **Noted:** That the following sections were revised to read: **Item 1.v: CEO's update:** '...the Trust had eighteen open BAF...' **Item 2.b: PIPR:** 'GR noted this had been discussed...' **Item 2.b PIPR:** 'People Management and Culture: OM advised that:' and at viii: 'A spotlight report would be provided on leavers…' **Item 3.i Q&R Chair's Report:** 'CC noted that a separate committee had been considered for workforce, but it was decided that it was better to focus on getting the right information to the right committee.' **Item 4.i Workforce Report:** 'The Director of Workforce and OD gave a verbal update' **Item 4.ii FTSU Guardian's Annual Report 2020/21: '**We had seen a year-on-year increase in incidents and 50%...' **Approved**: With the above amendments the Board of Directors approved the Minutes of the Part I meeting held on 7 October 2021 as a true record.		
1.iii	**MATTERS ARISING AND ACTION CHECKLIST**		
	Noted: The Board received and noted the updates on the action checklist. **Matters arising.** JW noted as a part of matters arising this he wanted to respond to a question from Harvey Perkins, one of our governors, about what measures we should take to preserve and protect the funding flows and treatment pathways on which RPH, and its patients depend. He invited SP to provide a response to this question. i. SP thanked HP for the question and noted that the Trust spent much time talking about the establishment of the Integrated Care System (ICS) in Committee and at Board. The statutory changes in the NHS involved all partners in the system and it was important that we did not simply focus on protecting and preserving pathways but that we worked with partners together to improve the health and well-being of the entire population. ii. The new legislation would see a focus on health inequalities and the disparities that exist within populations. We saw ourselves playing very important role in these reforms and this was more than we had done traditionally. Our system contribution included the development the Cambridge and Peterborough (C&P) Cardiovascular Disease Strategy; the Rapid NSTEMI pathway (which was now several years old) and the ICS Shared Care Record programme, which was being led by the RPH Digital Team. iii. The reforms introduced a huge opportunity for the NHS to improve care working with local authority and third sector partners. They would also see changes in historic pathways providing system benefits and improved experience and		

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	outcomes for patients. iv. SP noted that whilst we were geographically positioned in C&P ICS, we were primarily a national and regional provider of tertiary and specialist services. Approximately 7% of our income was derived from the C&P ICS, with most of it derived from national and regional specialised commissioning budgets servicing the forty-two ICS across the country. v. The reforms could lead to changes in funding flows, and we had identified that risk in our Board Assurance Framework (BAF). This outlines the Trust's strategy in relation to the changes and sets out the mitigating actions that are place to provide assurance to the Board. This risk captured the work that was being taken forward within the C&P ICS and our engagement in national policy discussions. vi. The Trust also worked through the Federation of Specialist Hospitals and Specialist Commissioning collaboratives to influence the implementation of the reforms. RPH had been invited share a variety of operational scenarios to inform national thinking on the future of specialised commissioning. This was a live discussion, and the direction of travel was not yet set with a variety of views held nationally, but we were contributing to and influencing the outcome of that debate. As an organisation our voice was seen as positive and credible. vii. Given the scale of changes across the NHS it was important to be honest and open about the fact that no one organisation could provide assurance that there would be no change to pathways or funding routes, but the change in approach from competition to collaboration was welcome and would require all organisations to be very different, adaptable, and agile. **Discussion** i. JW noted that if Governors and others were interested in the ICS their Board meetings were held in public and all would be welcome to attend to observe at those meetings. **Noted:** The Board noted the matters arising from the minutes of the 7 October and the CEO's update on the ICS.		
1.iv	**Chairman's Report**		
	The Chairman noted that he had joined the series of events organised to celebrate Black History Month and that it had been very interesting to hear the uplifting and heartfelt stories. These discussions were relevant to all of us allowing us to understand the experience of our staff and the issues of discrimination particularly in the NHS. He was very pleased to see that Board members had joined the three events and thanked DL for her individual contribution to this as a speaker. He also noted thanks to OM and to Onika Patrick-Redhead for their work in bringing the events together. JW reported that Dr Mark Toshner had given a very good update for staff on the risks and complications associated with COVID and the benefits of vaccination at all staff briefing on Monday.		

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1.v	**CEO's UPDATE**		
	Received: The Chief Executive's update setting out key issues for the Board, the principle risks to delivery as articulated in the BAF, and the progress being made in delivery of the Trust's strategic objectives. The report was taken as read. **Reported:** By SP that: i. He would start his report by reference to the BAF. The themes running through the BAF reflected the operational pressures across the wider NHS and that we saw as a Trust around workforce, demand for services, the impact of the pandemic and IPC risks. BAF 2904 set out key considerations across the ICS reflecting the profound changes in the structure of the NHS and was where we as a team and as a Board articulated that risk. ii. The BAF report included new risks relating to supplier management and a new risk relating to the ongoing management of M.Abscessus. iii. October had seen the news that one of our staff, Scott Wallace, had died and our thoughts were with his family and with those who knew and worked with him. iv. SP had hosted the Long Service Awards with the Chairman, and these had seen a multigenerational celebration of staff serving at Royal Papworth hospital. v. He wanted to pay tribute to our staff who continued to deliver against significant pressures and was heartened to see the scoring in the NHS Inpatient Survey where we had achieved an impressive rating of 9.7 out of 10. We were still looking to improve in those areas where we had not performed so well. vi. PIPR highlighted progress around current performance and work was underway on operational planning to shape our approach to 2022/23. He noted congratulations to the finance team who had been shortlisted for three national awards in October. vii. In November all staff would receive a £100 payment reflecting our thanks as a part of the wider programme of staff appreciation. viii. The Chief Nurse and IPC leads were constantly reviewing measures to improve Infection Prevention and Control. Key to this was performance in flu vaccinations and the COVID booster program. We were very pleased to see that the uptake in our BAME staff was the best in the region and reflected the effort and work to address vaccine hesitancy. ix. John O'Brien had been appointed as chair designate of the ICS and the CEO appointment would be made in two weeks' time. x. The Board was taking place at the same time as COP26, and this left us in no doubt of the need to address sustainability. The Trust was recognised clinically for its initiatives and innovations and this also needed to be applied to the sustainability agenda. **Discussion** i. JW noted that many people were less fearful about the consequence of flu than COVID19 and that we needed to encourage them to attend for their flu as well as for COVID vaccination.		

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	Noted: The Board noted the CEO's update report.		
1.vi	**Patient Story**		
	Jo-anne Fowles, Nurse Consultant, introduced the patient story which related to a 34-year-old patient who came to Royal Papworth not directly under the ECMO service but as part of the load levelling that was coordinated through the Regional Critical Care Network. The patient was transferred to RPH as a deteriorating COVID pneumonia patient. Following transfer despite conventional therapies and approaches her condition continued to deteriorate and a decision was made to support her on ECMO. The patient had been delivered of twins a few days before she was transferred to RPH. She was on ECMO for 20 days and at day 12 she was up and awake. She was decannulated without event and wanted her care to be transferred back to local services so that she could be as close to her family as possible which took place two days after decannulation. She came back to clinic at six months looking very well and back at work, and she kindly agreed to be a part of our publicity drive to get more people, especially pregnant women vaccinated. The Board listened to Sultana's story by a video in which she described her experience and expressed her thanks for the care that she and her family had received from the doctors, nurses and all the staff involved in her stay. She thanked the hospital for the care and for the support that was given to her and her family. Her husband noted his thanks for the compassion and care shown by the Family Liaison Team who supported him daily whilst the family were in such a difficult situation. **Noted:** The Board welcome Sultana's story and noted the thanked JF for presenting 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. **Reported:** By CC (for GR) that: i. PIPR had moved from Red to Amber because of the improved rating of the Finance section. ii. The Trust would deliver the planned surplus of £2.5m at year-end and meet its CIP target. She noted however, that a proportion of the CIP delivery was non-recurrent and that would be reviewed with recurrent schemes brought forward. iii. We maintained strong performance in Safe and Caring. iv. The Corporate Risk Register had improved, and the number of overdue risks had reduced. A target of 10% had been agreed to be achieved over the next few months. **Noted:** The Board noted the Performance Committee Chair's report.		

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2.b	**PAPWORTH INTEGRATED PERFORMANCE REPORT (PIPR)**		
	Received: The PIPR report for Month 6 (September 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 that performance was at an Amber rating and that the operational context previously outlined by SP was important. The hospital was under significant pressure and that could be seen throughout the themes of the report. The improvement in rating reflected the increased certainty in the H2 position and the underlying financial performance of the Trust. **Safe** i. MS noted that we were at an amber rating on Safe and there was an improved position for roster fill rates. This was still a very vulnerable position with staff feeling under pressure, and as we were dealing with short notice absences with COVID and viral infections. We had remained safe on staffing through mitigations that were put in place to manage staffing pressures and this showed the fantastic work our people did. **Caring:** i. The Trust's NHS Inpatient Survey results for 2020 showed the results of the fantastic work that our staff continued to do and was a real credit to them. ii. We continue to see challenges and recognised that it was incredibly hard for our patients at this time, which could play out in some frustrations being expressed to staff. We were working to manage this and support both patients and staff. **Discussion:** iii. JW reminded the Board that the issues over the winter would include flu, and other viruses as well as COVID and so the level of absence amongst staff could well see further increases. iv. AF asked if we were looking at mitigations across the region and nationally. MS advised that staffing pressures were discussed at the Chief Nurse regional meetings and there had been sharing of good practice where we were looking at how organisations were approaching well-being issues. In addition, the national societies such as the Intensive Care Society, the British Association of Critical Care Nurses and Health Education England were providing guidance. This included for example the need to protect the education of staff and ensuring that we were training and supporting our education teams to support the staff that we have got. **Effective:** i. EM advised that admitted patient care and outpatient care had met targets in September, but we needed to recognise that instability in staffing, because of COVID and other sickness absence, was challenging and frustrating. This along with the pressures in emergency pathways resulted in constraints on capacity and fewer patients treated because of inconsistency in staffing. This would continue through the winter months. **Discussion** ii. MB Noted that when he visited the Trust, he had heard the		

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	commitment of our staff everywhere. He asked whether the Trust undertook regular harm reviews for patients remaining on the waiting list out. EM advised that we undertook harm reviews for patients waiting over 45 weeks and that we reviewed P2 patients. We also looked at patients who moved category from P3/4 to P1/2. There were no verified harms recorded to date, but some churn was observed through priority categorisations. iii. JW asked about the metric of same day admissions as we were not and had not delivered against that KPI. EM advised that the Trust was not keen to change indicators during COVID, and this would be considered the next time we looked at reporting. There were particular issues in thoracic oncology where diagnostic and testing requirements prevented achievement of this target. **Responsive:** i. EM noted that the Red ratings were because we were unable to pull through patients on surgical pathways because of capacity constraints and so the waiting list was growing. We had nine patients who had waited more than 52 weeks. Two of those long waiters had been lost in the migration to Lorenzo. This was a data management issue, and we were undertaking a deep dive in this area looking for patients who may fall into that categorisation. The two patients identified have had treatment events this week that would see their pathway closed and no harm had come to either patient. ii. In cancer services we were continuing to see late referrals and delays continuing in PET CT access. In addition, patients were more complex when referred to the Trust. **Discussion:** iii. JW asked whether if PET CT capacity was a constraint whether we should have our own service? EM advised that the service was very busy at CUH and that there had been difficulties in access to radionucleotides which caused some cancellations. We were in discussion with the national commissioners and were using Colchester services (where there was lower demand). The Trust was also in active dialogue with CUH around bringing a PET CT on site, but this would require radiographers with a specific subspecialisation that was not available currently at RPH. **People Management & Culture:** i. OM noted that turnover had remained above KPI in September but had dropped back in October. The steps that we could take to manage this was to ensure that staff could see career opportunities and development available to them. In August and September, we had seen a high number of returners to education and that linked to the Education Strategy that would be taken later on today's agenda. ii. Sickness remained high but was better than both the East of England and C&P. This reflected the baseline level of COVID absence as well as general winter viruses which had been seen in the last two months. iii. Her key concern related to our IPR compliance levels and this was included in PIPR as a spotlight report. We had remained consistently below our KPI and were putting in place cross divisional meetings between operational and nursing leads to		

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	focus on this as a 'wicked problem' and to consider what might be done to recover performance and to plan a realistic recovery trajectory. IPRs were key to development and were important to staff. OM noted that compliance was measured on a rolling basis. **Discussion:** iv. GR noted that the importance of annual appraisal had been discussed at the performance committee as well as the well-being and career progression discussions. He felt that we needed to use the Compassionate and Collective Leadership programme to ensure that these conversations happened naturally. Annual appraisals could be seen as perfunctory and if not valued were often cancelled and the informal discussions and approaches were just as important. OM noted that we had used a well-being checklist to support discussions during the pandemic and that had been helpful. Also, that there was a risk of a negative cycle developing with staff too busy to undertake IPR and development leading to worsening performance. JW noted that delivering good IPR this was part of how we should function at the Trust. **Finance:** i. TG noted that the Trust was on the plan at month six and that we should expect a £2.5m surplus at year-end. Negotiations on H2 we were progressing to plan. He wanted to draw the Boards attention to the improved performance against the Better Practice Payment Code where we had seen an improvement in the volume of invoices paid from 72% to 84%. We continued to expect improvement in this metric. ii. Overall, we had seen good performance on income and expenditure, the BPPC, and we expected our capital spend to see an upturn in the coming month. **Discussion** iii. JW noted that the ICS performance table was included in PIPR but felt it was too early or too new to have confidence in the metrics set out. The NHS was entering a period of significant regulatory change and the Trust would need to maintain its role lobbying as chair of the Federation of Specialist Hospitals, and once the ICS Board was appointed then it would be likely that reporting would change. **Noted:** The Board noted the PIPR report for Month 6 (September 2021).		
3	**GOVERNANCE**		
3.i	**Q&R Committee Chair's Report** **Received:** The Q&R Committee Chair's report setting out significant issues of interest for the Board. **Reported:** By MB: i. That he commended the paper on inequalities that was later on the agenda. ii. He noted the item on Safe Staffing and the spotlight in PIPR relating to Care Hours Per Patient Day (CHPPD). This was		

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	an approximate measure that was difficult to measure as acuity changed so quickly especially in critical care. He noted that the 'red flag' system in critical care also provided indications of staffing pressures and that we had seen instances where there were high numbers of red flags but at the same time we could be assessed as green on CHPPD. The question that the committee were therefore looking at was how best we measured safe staffing. We had always tried to triangulate data, but this also required judgement. **Discussion:** iii. MS agreed that CHPPD had limitations and was one of the measures that we needed to consider when looking at safer staffing. We needed to combine evidence with outcomes and with nurse sensitive indicators such as pressure ulcers, falls and infection rates. She had reflected a great deal on this not wishing to add papers but to bring a more comprehensive staffing report to the Board rather than relying on one metric. JA noted that he welcomed the use of outcomes, he noted that the red flag system was helpful, there were occasions when staffing would not mitigate a particular patient outcome. iv. DL noted that the governance reporting for digital clinical safety was noted as under review in the report. MB advised that he expected this would be completed in month. AR advised that he was supported by Chief Information Officers with medical, nursing, pharmacy and AHP backgrounds. This provided a level of input and oversight with clinical safety cases written and approved before implementations and this was report through the Q&R on a regular basis. v. JW asked if our staffing ratios were correct given the acuity of patients as historically in critical care standard staffing recommendations did not reflect the variation in level of care between patients. MS advised that these were linked to national policies and included professional judgement. We had evidence-based tools and used all of these to respond to staffing pressures with measures being put in place to respond to the issues identified. **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: i. That our visiting policy had been reviewed as we needed to recognise the impact of restrictions on our patients and our focus was on Compassionate IPC as we were living with COVID. Visitors supported patients who had to remain in hospital for a long time and supported patients at outpatient reviews. We had agreed changes to our policy that would see an additional visitor being able to attend with outpatients and an increase in access for identified visitors for inpatients. This was being managed very carefully as we had seen no nosocomial infections for a long period, and we needed to ensure that we continued to comply with national guidance. ii. The report included for information the full NHS Inpatient Survey results for 2020 which had been discussed previously.		

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	Discussion: iii. CC asked about inquest patient B. She noted that as a layperson the note that a blood test that had been ordered but not completed in a timely manner was a concern and asked if this patient would have died in any event and whether the Trust had done all that it could. IS advised that when you scrutinise cases you do pick up omissions that may not have influenced the outcome for the patient. CC requested that such context be added to the reports in future. IS noted that these were reports from the coroner and so whilst we were able to comment we would not change the substance of any report. iv. DL asked about actions to prepare patients for discharge. MS advised that we were reviewing preparation for discharge across the hospital to ensure that we had a robust approach and that we improve communications with social care. This included how we used the discharge lounge and the Chief AHP was taking a lead responsibility for moving patients into their home setting. As a part of this we would be looking at developing KPIs and ways to improve performance in this area. These would be reported to CPAC on a quarterly basis. v. JW welcomed the changes to visiting as this recognised need for patients to be supported at the hospital. AF noted also her delight in the reference to compassionate IPC. IS reminded the Board that this was not without risk as other Trusts had seen infections and deaths arising from visitors. vi. AF noted that there were very good conversations at the Q&R Committee about changes in case-mix and the Trust response in terms of staffing changes and how these impacted patient safety and outcomes, and how this matter would be reported to the Board. MS noted that this linked back to the issue of triangulation of all relevant metrics. **Noted:** The Board noted the Combined Quality Report.		
3.iii	**Audit Committee Chair's Report** **Reported:** By CC that the main items of business were: i. The Charity Annual Report and Accounts which would be brought to the Trustee Board on the 2 December. She commended the audit and finance teams for their work on the delivery of a clean audit. ii. The Committee were pleased that the internal audit and counter fraud programs were making satisfactory progress. A Risk Maturity audit had been completed and an action plan was being developed from this. The Committee would be advised of progress against this in future months. vii. Reporting of conflict of interests was now at 70% of decision-making staff and the Trust were taking steps to ensure that compliance against this metric improved. viii. The committee had also reviewed the governance around the external audit tender and that had been reported to the Board for information. **Received and noted:** The Board received and noted the Audit Committee Chair's report setting out significant issues of interest for the Board.		

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3.iv	**Corporate Objectives 2021/22** **Received:** From the CEO a paper setting out progress against the Corporate Objectives for 2021-22. **Reported:** By EM that AJ had coordinated a review of our Corporate Objectives for 2021-22. The paper summarised progress and was provided to the Board for information. The Trust was happy that progress was broadly on track and where there had been variations in response as a result of the COVID response this was identified. **Discussion:** i. DL welcomed the comprehensive report and asked for further information on the development of the RPH School business model. She asked whether this would be delivered this year or next. MS advised that the skill set to build the business model was not available within the Trust and so we were looking to bring in external support in year to help up to set this up. The Trust team had a lot of ideas but needed to help work these into a model. **Noted:** The Board noted the update on the Trust Corporate Objectives 2021/22.		
3.v	**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:** AJ noted that the report had been comprehensively covered in SPs summary at the beginning of the meeting. **Noted:** The Board noted the BAF report for October 2021.		
3.vi	**Board Sub Committee Minutes:**		
3.vi.a	**Quality and Risk Committee Minutes: 30.09.21** **Received and noted:** The Board of Directors received and noted the minutes of the Quality and Risk Committee meetings held on 30 September 2021.		
3.vi.b	**Performance Committee Minutes: 30.09.21** **Received and noted:** The Board of Directors received and noted the minutes of the Performance Committee meeting held on 30 September 2021.		
4	**WORKFORCE**		
4.i	**Workforce Report** **Received:** The Director of Workforce and OD a verbal update on key workforce issues. **Reported:** By OM that: i. The report set out a summary of the activities delivered in Black History Month. She thanked all the Board members who had attended and contributed to the events and noted that we		

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	sometimes underestimate the contribution that this makes. The visibility of Board members gives a strong message that Board members were active allies, and our staff felt heard. ii. The Women's Network was being launched in November and we had fantastic speakers lined up including Rt Hon Patricia Hewitt, Chair, Norfolk and Waveney Health and Care Partnership; Samantha Allen, Chief Executive, Sussex Partnership NHSFT; Harprit Hockley, Head of Equality and Inclusion, NHSEI, EoE; and Edward Morris MD PRCOG, President RCOG as well as speakers from across the Trust. iii. That she had also included a report an update in the workforce responsibilities of the ICS/ICB. **Agreed:** The Board noted the update from the DWOD.		
5	**STRATEGIC UPDATES**		
5.i	**Clinical Education Strategy 2021-26** MS introduced the strategy which she felt was a challenging and realistic plan for the next five years. She noted that it was important to link the strategy to the contribution to improvement in patient care and that it set ambitions relating to: • Professional and personal development for our staff which was key to retention. • The need to protect education and training as a part of the strategy, particularly given discussions on service pressures. • The vision for development of technology and online training platforms to deliver education and training. • The support for leadership and development and the links to appraisal, Compassionate and Collective Leadership and development needs. This was created as a standalone strategy, but it also needed to link closely with the finance and workforce agenda. **Discussion** i. IW asked about overseas fellows and visitors. MS noted that this was an important element of the strategy and areas such as ECMO supported international training, but this had been more challenging during COVID. IS felt that there would be opportunities to improve this as some placements were undertaken on an ad hoc basis. However, we recruited very able people from around the world and we were each able to gain from the opportunities that were put in place. This was an area where it would be very helpful to explore with input from the Royal Colleges who may also able have access to funding streams to support in this area. IW noted that post CCT credentialing was a major opportunity and should be a unique selling point of Royal Papworth Hospital. ii. JA noted and liked the principal objectives of the strategy. He asked if the strategies could also set out the 'must dos' and identify long list priorities so that the Board could better understand what had been considered and what had matters prioritised and not, also how we would leverage the unique experience offered by RPH. He noted that education and training could be a soft target and felt that we needed to look		

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	at how we could safeguard against that going forward. MS advised that the 'must do' elements included compliance areas including induction and mandatory training and that the business model was required to move forward qualification and specialism courses for all staff. In terms of priority areas, she noted areas where there was little succession planning as a system, such as Infection Prevention and Control where the recent pandemic had seen the need to deploy large numbers of practitioners. She noted that she would distil the document further, matching priorities to the business strategy and was very keen that a multi-professional approach was followed. iii. MB supported the proposal that the Board should receive long list priorities and see the choices that had been made and how these had been evaluated up to this point, as that helped to ensure that what was being undertaken was addressing the most urgent matters and would reassure the Board that the strategy had been considered against a range of options. The consideration of 'what if' scenarios could also support evaluation of whether the strategy would deliver benefit in the way that we hoped. If we were unable to deliver this model what would that mean in practical terms so that we were able to see both sides of the discussion and the options that had been considered. iv. JW noted that the strategy needed to fit with the established training programs and that it might be helpful to have conversations with the Homerton College as we could be looking at operating in spaces in which they could provide accreditation, standardisation, and governance. MS agreed and noted that was her priority as accreditation was core to successful programmes as our staff needed to be able to progress to master's level and that needed to be evidenced. The plan was to go out to tender for a partner to establish courses, much of the preparations would be in house as we had the expertise to deliver successful course but these must have links to the University. v. GR had struggled with the document and wanted to understand what we were doing now and how this would change and the difference that the RPH school would make. He felt it lacked some clarity on how we would do things differently and better. JW noted that we do much formal education at the present with Colleges and the Nursing & Midwifery Council including degrees and higher education and that this strategy was to plug a gap. vi. JA felt that if we could add some commentary on the strengths, weaknesses and opportunities in relation to the School then this could help to inform the Board as to what good, great, or good enough would look like after a five-year period. vii. MS noted that she welcomed all the comments from the Board and proposed that she would bring a further report to the Quality and Risk committee in three months' time to address the issues raised and relate these to the strategy. An action plan could then be put in place and tracked to ensure that this saw delivery within agreed timescales.		

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	Agreed: The Board approved the Clinical Education Strategy 2021 – 2026.		
5.ii	**ICS Accountable Officer Board Report** EM noted that the ICS report was shared for information. The recruitment process for the accountable officer had been held and the decision on this was subject to approval by the Secretary of State. Following appointment, they would build their team to take forward the governance and function developments moving into next year.		
6	**Research & Development**		
6.i	**Health Inequalities** **Received:** A paper from the Acting medical Director and the Chief Nurse setting the concept of health inequality(HI), its current priority in the NHS, and plans for how RPH would contribute to this agenda. **Reported:** By IS that: i. The Board had asked the Trust to start talking about this agenda. Locally and nationally, this was a key issue and the Trust needed to play its role within it. The paper provided a stock take of what we had done as a Trust, and where there may be opportunity for review in the future. ii. A meeting of the ICS Health Inequalities leads had taken place and there was a lot of discussion about how this agenda should affect funding. Cambridge was a relatively advantaged area but represented only 7% of RPH income. Within the region there were pockets of rural and coastal deprivation and these were in areas that we served. iii. The ICS work looked at barriers to referral and had provided a breakdown of staffing in GP surgeries. This identified the proportion of people seen by GP and non-GP services in areas of higher and lower deprivation. In areas of deprivation people were more likely to see a nurse and that linked to the lack of GP provision in those areas. This raised concerns about whether there was a hesitancy to refer by these practitioners, particularly into specialised services such as RPH. IS felt that there was a need for us to be active and to talk to the surgeries to spread the message about our referral pathways. iv. Another key issue was the silo around information as GP practices could share data, but we could not see this and as a provider in the ICS we would be interested in the patients who were not referred to us. **Discussion:** i. CC asked for further information to be provided on the proportion of activity that is from C&P as the 7% figure related to the of the contract funded by C&P ICS but not the overall proportion of patients treated from C&P as this could also be funded through regional and national commissioning. She expected that if we looked at ethnicity this should demonstrate how different populations accessed services at a local, regional and national level. EM agreed to do a more detailed report and would bring that back to the Board.	EM	Dec 21

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	ii. JA noted that he sat on the C&P Ethics Committee and that it was a struggle to recruit GPs to more deprived areas. They therefore had fewer partners per practice and so more of their patients would be seen by non-doctors. The amount of time available to support primary and secondary prevention was more limited for patients in these areas and so this approach was welcome. iii. MB was keen to develop a sense of excitement and responsibility around this and thanked IS and MS for the work that had been undertaken. The Trust may not have the power of intervention, but we did have data and that would be a significant lever in this conversation. If we looked at patients with learning disabilities, we could see that these were only 0.2% of the Trust population but represented 2% of the national population. We were therefore seeing only one tenth of the number expected and needed to understand why that was. We couldn't change referrals, but we could identify the numbers and we could look at how we make our services more accessible and link to the community and to referrers. JW noted that as the metrics improved, and we could then look at the wider system impacts. iv. DL asked whether we had an alternative plan for the data requests if a response from GPs was not forthcoming. IS noted that we were also working with a researcher with a company who collected information from GP practices. They had offered to provide information from five practices to see if this might meet our needs. If we are unable to access data through the ICS this could give us information on outcomes and would allow us to find a way to undertake the analysis. v. IW noted RPH's role should be leading healthcare professional education. He asked who would look at the main causes of death such as lung cancer, cardiovascular disease and stroke and develop options that would impact on mortality and delivering healthy years. IS noted that we would go through each of our areas of core business to see if we were getting a similar referral base. He noted however that people in deprived areas already had a different life experience, as well as different experience of health services and they may not be coming to see their GP. The key priorities for the Trust were to ensure that: • we were not disadvantaging anyone referred to us. • we were able to understand referral patterns from GPs and across the region. • That we were able to look at national comparators and national campaigns in education. This was like the approach taken in sleep apnoea where we had gone out to the community to communicate in different ways. vi. JA noted on the issue of learning disability that it was good to understand the referral rate. He felt it was important also that the Trust should feedback on the outcomes achieved as this could inform the judgements of those conditions for those who refer into services and provide evidence of the beneficial outcomes. IS noted some caution as there were other barriers and there may also be missing data in the same way was seen		

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	in ethnicity data. To capture a classification of learning disability a clinician needed to identify the degree of intellectual impairment through an IQ test. This requirement put off clinicians from recording that diagnosis as this required several steps to establish the threshold. **Noted:** The Board noted the update on Health Inequalities. JW added that he looked forward to future reports and to seeing what the ICS would do in this area.		
7	**BOARD FORWARD AGENDA**		
7.i	**Board Forward Planner** **Received and Noted:** The Board Forward Planner.		
7.ii	**Items for escalation or referral to Committee** None		
8	**Any other Business**		
8.i	**Board Assurance Mortuary Standards**		
	EM noted that the mortuary standards had recently been published and there was an expectation these would be presented to Trust Boards. EM confirmed that we did not have a mortuary as we access this service from CUH. We therefore did not require assessment against these standards.		
8.ii	**NHS Inpatient survey results 2020.**		
	The Board noted again the NHS Inpatient Survey Results for 2020 (received under Item 3) which had been excellent. They noted all the areas where we had done so well and recorded their thanks to our staff and all our teams for all their hard work in delivering these outstanding results.		

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Signed

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Date

Royal Papworth Hospital NHS Foundation Trust
Board of Directors
Meeting held on 4 November 2021

Glossary of terms

CIP	Cost Improvement Programme
CTP	Cambridgeshire Transition Programme
CUH	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