Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Held on 02 December 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
	Mr T Glenn	(TG)	Chief Finance and Commercial Officer
	Dr R Hall	(RH)	Medical Director
	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)	Chief Information Officer & SIRO
	Mr G Robert	(GR)	Non-Executive Director
	Mrs M Screaton	(MS)	Chief Nurse
	Prof I Wilkinson	(IW)	Non-Executive Director
In Attendance	Ms T Crabtree	(TC)	Head of Communications
	Mrs A Jarvis	(AJ)	Trust Secretary
	Ms P Martin	(PM)	Head of Safeguarding
	Mr A Selby	(AS)	Director of Estates and Facilities
	Dr I Smith	(IS)	Deputy Medical Director and R&D
Apologies			
Governor Observers	Susan Bullivant, Doug Burns, Trevor Collins, Julia Dunnicliffe, John Fitchew, Caroline Gerrard, Abi Halstead, Richard Hodder, Marlene Hotchkiss, Trevor McLeese, Harvey Perkins,		

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1	**WELCOME, APOLOGIES AND OPENING REMARKS**		
	The Chairman welcomed everyone to the meeting and noted in particular Dr Hall's welcome return to the Board. Apologies were noted as above. He added that it had been an interesting week and that the Board would later hear an update on Omicron, the new COVID19 variant.		

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1.i	**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. A summary of standing declarations of interests is appended to these minutes.		
1.ii	**MINUTES OF THE PREVIOUS MEETING**		
	Board of Directors Part I: 04 November 2021 Item 1.vi: Patient Story: Revised to read: "...welcomed Sultana's story and thanked JF..." Item 2.b: PIPR: First paragraph revised to read: "… had been considered at the Performance Committee ...." Item 2.b: PIPR: Safe: Revised to read: "This was still a very vulnerable staffing position with people feeling under pressure, and we were also dealing with short notice absences resulting from COVID and other viral infections." Item 2.b: PIPR: People Management & Culture: iv: revised to read: "JW noted that delivering good IPR was part of how we should function at the Trust." Item 5.i Clinical Education Strategy 2021-26: Discussion i: Revised to read: "IW noted that post Certificate of Completion of Training credentialing was a major opportunity..." Item 6.i Health Inequalities: Discussion i: Revised to read: "...from C&P as the 7% figure related to the contract funded by C&P ICS but not the overall..." Item 6.i Health Inequalities: Discussion iii: Revised to read: "JW noted that as the metrics improved, we could then ..." **Approved**: The Board of Directors approved the Minutes of the Part I meeting held on 4 November 2021 as a true record.		
1.iii	**MATTERS ARISING AND ACTION CHECKLIST**		
	Noted: The Board received and noted the updates on the action checklist.		
1.iv	**Chairman's Report**		
	The Chairman reported that he had attended the opening of the AstraZeneca building on the Cambridge Biomedical Campus (CBC) and that the day had provided our clinical leads with an opportunity to meet with senior leaders and researchers from AstraZeneca. IW had been involved closely with the programme for this. We had also seen the return of the 'Surgeons: At the Edge of Life' documentary series featuring RPH.		

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	He noted that the Charity team had joined the Zipper Club for their Christmas lunch, and he welcomed the changes in the atrium which had seen the removal of the temporary screens and the installation of two Christmas trees.		
1.v	**CEO's UPDATE**		
	Received: The Chief Executive's update setting out key issues for the Board, the principal risks to delivery as articulated in the Board Assurance Framework (BAF) and the progress being made in delivery of the Trusts strategic objectives. The report was taken as read. **Reported:** By SP that: i. The AstraZeneca event showed the significant future opportunity for campus partners to work together to generate new ideas and collaborations. ii. We had seen the international reports on the new COVID variant and there was still much that we did not know. It was one week since the World Health Organisation had notified the new variant and it was gaining dominance in South Africa. It would be two or three weeks until we could access data to understand disease severity. He invited RH to provide an update on the new COVID variant. RH advised that it was difficult to compare the experience of South Africa and the UK as our vaccination rates were much higher and in South Africa 40% of the population was immunocompromised as a result of HIV. Porton Down were looking at invitro analysis of the virus and would assess how effective antibodies would be. There was some speculation that the virus had reverted towards the original Wuhan strain but there were no answers yet and it was too early to understand transmissibility in the UK setting. The key issue was whether this would cause more or less severe illness. iii. We expected to see an increase in staff absence linked to the changes in travel requirements and requirements for self-isolation. The Trust had policies in place to manage this and the impact on staffing was being monitored. Sickness absence levels were high relative to the pre-pandemic period (but not relative to others in the system) and discussion at the Clinical Decision Cell was focused on the likely impact of staff absence on capacity. iv. The BAF included a new risk relating to the change in funding and patient flows as a result of the national reforms in the NHS. This linked to BAF 2904 (Achieving financial balance at ICS level) and BAF2854 (Engagement with the ICS) which were distinct but linked risks. The scoring of residual risks above risk appetite reflected Trust and system pressures arising from the pandemic including the increased IPC requirements, the impact on performance standards, and associated workforce pressures. He noted that the Executive were to hold a review of risk appetite and target risk ratings in the next week to ensure consistency of assessment and this would be brought back to the Board. v. There was further progress on recovery, and he reiterated his thanks to staff across the organisation which had seen significant numbers of staff from level 5 again volunteering to	EDs/AJ	Feb 22

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	be redeployed to the Critical Care Unit. We currently had eight patients on ECMO, and the focus of activity was on urgent and emergency demand, the elective backlog and the impact of the new COVID variant. vi. The emergence of the Omicron variant was driving some concern through a workforce who were already tired. We were facing capacity constraints and seeing a high level of emergency demand and balancing these was a golden thread throughout PIPR. We needed to pay tribute to the work of the CDC and recognise that this was one of the best developments in the pandemic with these difficult choices being debated. vii. We had seen our first nosocomial COVID infection since April 2020; it was however remarkable that we had not seen cases over that period, and we were using this case to promote the importance of IPC. viii. The Secretary of State had announced mandatory vaccination for health workers, and we were undertaking extensive work to look at how we supported staff with bespoke conversations with leaders around vaccine hesitancy and were encouraging managers to start those conversations now. ix. The Women's Network had launched with fantastic speakers and he thanked OM and AF for their contribution to this. x. We had received our Trust performance rating assessment and were in SOF1 reflecting the excellent outcomes that we continued to deliver. xi. The ICS had seen the appointment of Jan Thomas as the Chief Executive designate, Jan had been the Chief Executive of the Clinical Commissioning Group and this was very positive news for the system. The remaining ICS appointments would continue through the local process. The Trust was engaged in extensive joint working across the system and the region and was leading ICS programmes including the development of the Shared Care Record, the diagnostics hub, the Cardiovascular Strategy. **Discussion:** i. CC asked about the impact of the segment assessment of the ICS as RPH was in SOF1 and the ICS was in SOF4. SP advised that this was unclear, but actions taken against the system would be visited on all organisations within the system regardless of individual SOF rating, an example of this was the enhanced performance regime under the C&P Improvement Director, which would see increased oversight reporting through to the regional and national teams. It was understood that whilst RPH was within the ICS we were part of a much wider system reflecting our role in delivery of regional and national services. CC requested that a summary of organisations and their segment rating was provided to the Board. ii. AF asked whether other specialised hospitals were also in segment one. SP advised that only 19% of specialist providers	TG	Feb 22

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	were in segment one. It was agreed that a summary would be provided at a regional level in the first instance. **Noted:** The Board noted the CEO's update report.		
1.vi	**Patient Story**		
	PM shared a patient story on the theme of safeguarding and the drive to create a safe environment for patients with learning difficulties. i. PM noted that the story was heavily reliant on observation. It related to a 38-year-old patient who was admitted in June having had a lengthy wait for cardiac surgery because of the COVID pandemic. The patient lived in supported accommodation for people with Learning Disability. She had no next of kin and her primary support was provided by the carers on site. None of the patient's regular care staff were able to stay with the patient during admission. ii. The patient was seen in outpatients in 2019. The outpatient consultation recorded the question of her mental capacity, but no capacity assessment was undertaken, and this had contributed to a delay in the patient's pathway. When PM became involved in the case, she instructed an Independent Mental Capacity Advisor (IMCA). iii. PM undertook a virtual capacity assessment using a range of sources with three video consultations, review of hospital notes, and evidence of higher-level functional skills from the care home. During the assessment PM was able to gain information on the patient's likes and dislikes and she provided a virtual tour to establish more of a relationship with the patient before her admission. This allowed her to become familiar with the hospital and with one member of staff on the ward. iv. When the patient was admitted PM was able to take her to her room and to introduce her to staff who were very welcoming. The patient was used to a very specific way of introduction to reassure her and had advised that she was more comfortable with female staff and that request was accommodated on the ward. It was planned that her operation would be first on the theatre list but that was delayed because of the deterioration of another patient. PM stayed with the patient to reassure her and PM and the patient remained nil by mouth until 3pm. The theatre porter had excellent communication skills, this was a male member of staff, but he had personal experience that he used to support this patient. The patient stayed longer on Critical Care than planned and the support on Critical Care was very good. Staff needed to concentrate and to talk about one item at a time so that the patient could understand clearly. The patient struggled with some of the housekeeping staff when they entered and left her room as at times, they did not say hello or goodbye to her, and this was distressing. This provided some learning that staff needed to consider the patient in the room and understand their needs. v. The patient subsequently deteriorated on the ward and was readmitted to Critical Care. Her care was subject to reporting through Datix and reviewed at SIERP. There was no evidence of the patient coming to harm. The patient then developed a		

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	right sided effusion and needed review in radiology. She was met in radiology by a male member of staff who asked her to sign a consent form and that resulted in the patient becoming very distressed. There was excellent support from Nursing Apprentice who accompanied her and from the Consultant Radiologist who seeing the distress caused asked for a proper plan to be put in place for the treatment to be undertaken. The patient was discharged after 28 days in hospital. PM had spoken to her carers before presenting the case to the Board. Her carers felt that she had benefited from the support that she had received in the hospital, they recognised that it had been a long stay and that she was ready to go home at point of discharge. PM felt there were several areas of learning in relation to our staff and their understanding and knowledge of the Mental Capacity Act, as the absence of the mental capacity assessment at pre-admission had contributed to the delay experienced by this patient. There was also positive feedback with the virtual tour using the laptop being an example of good practice and some excellent work from a range of staff with an awareness of special needs in emergency situations. Key to this was the skill of staff rather than their gender. **Discussion:** vi. MB thanked PM for the patient's story and shared with the Board his own experience with his son Joe, who was profoundly autistic. He thanked PM for the care and attention provided for this patient. He noted that a part of his experience with Joe was that out of ordinary experiences created significant distress and could result in challenging and violent behaviour. He asked if we had designated staff who had experience of autism and who were alert to these sensitivities who could respond quickly. He felt that the time and effort taken in getting a patient comfortable and happy was extremely valuable, as otherwise the result would be cancelled procedures. He felt if we had a team to support this approach and got this right for our most vulnerable patients then we would get this right for everyone. vii. MS thanked PM for the story. She noted the context for this was that we had a 'creating safer culture' week in November. We were fortunate that we were aware of patients admitted with autism and learning disability as planning for these patients was a key issue. We did not have many patients with learning disabilities but had the opportunity to plan their care to ensure that we were making proper adjustments and that we get it right for these patients as that would bring benefits to the wider patient population. viii. JA thanked PM for the story and noted that her action in remaining nil by mouth with the patient was a fantastic way to show support being delivered, responding at a personal level to the needs of the very vulnerable. He noted that for other patient populations there was emerging use of virtual reality to help patients get used to the hospital and he offered to provide contacts to take this discussion forward. PM noted that she was working with Ivan Graham to include a flag on the		

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	Lorenzo system as it did not currently allow for this. AR welcomed the use of technology to improve the experience of our patients. He noted that the right discussions were underway with IG but cautioned that we needed also to be mindful of alert fatigue and adopt a balanced approach. ix. AF felt this was an incredibly powerful story setting out the journey taken by the patient. She also thanked MB for sharing his experience and illuminating the impact on patients. AF asked whether the story had been shared widely with staff as it communicated the importance of connection and compassion in how we worked with our patients. PM advised that it had been shared with the Joint Safeguarding Committee as we wanted to hear the voice of our patients with learning disability and with autism, as we had a few admissions and so opportunities for us to learn were quite limited. AF encouraged PM to share this widely with our clinical teams. x. JW felt that the use of virtual reality might have benefit beyond our most vulnerable patients as there would be a wider patient population who could benefit from this. PM agreed that video and virtual opportunities were important as a part of communications with all our patients. **Noted:** The Board thanked PM for her contribution and for presenting this story on behalf of the patient.	MS/TC	Feb 22
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 the Committee had considered the following key issues: i. How the Trust had stepped down elective activity to ensure that we had safe staffing, and how staffing pressures informed operational decisions at the Trust. The Committee had asked MS to present further information on this to the Quality & Risk Committee. ii. The high sickness absence levels for admin & clerical staff which we were looking into. iii. The resolution of the 52-week breaches which had not been related to implementation of Lorenzo but were errors in pathway management. Further reviews had been undertaken to ensure that other patients had not been lost from follow up in the same way. iv. Business continuity plans and protocols which were to be brought to the Committee to provide assurance and so it could understand the arrangements that were in place. v. The EPR contract which would be discussed on the Part II agenda. vi. The rostering review which the Committee were looking forward to seeing the outcome of and the impact on the efficient use of our capacity.		

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	GR noted that the Board should not think that the Committee was 'second guessing' operational management decisions, but it was thought appropriate for the staffing review to be used as an example to review how decisions were made and so the Committee had referred this on to Q&R. This would show how decisions were taken and how the overall performance of the hospital was affected by this. It was acknowledged that this was not a question of a scientific thresholds as decisions were multifactorial, and that these all involved professional judgement. **Discussion:** i. JW reminded members that whilst we were a 'unitary' Board, the Executive were those charged with decision-making on a day-to-day basis. ii. MB welcomed the referral to the Quality & Risk Committee as he felt we should understand how we articulated decision-making through Committees and how the themes were set out for the whole Board. MS noted that it was important to understand that this was a shared decision-making process, and she was keen that we use evidence and data and that was subject to professional judgement. The Clinical Decision Cell was then used to provide a 'temperature check' and this included senior leaders across the organisation. The nursing escalation framework would provide assurance around our approach to planning staffing over the winter period and set out the impact assessment and that helped with shared decision-making operationally. This would be brought to the Q&R Committee, but it was a responsibility of the whole Board to endorse the approach taken. **Noted:** The Board noted the Performance Committee Chair's report.		
2.b	**PAPWORTH INTEGRATED PERFORMANCE REPORT (PIPR)**		
	Received: The PIPR report for Month 07 (October 2021) from the Executive Directors (EDs). This report had been considered at the Performance Committee and was provided to the Board for information. **Reported:** By TG that the Trust was at an amber rating overall and the themes associated with this were set out in the PIPR narrative and metrics. This included increases in levels of sickness and self-isolation, a reduction in bed availability, and increase in the requirement to treat COVID patients within our capacity. JW noted that even if the new variant did not produce more patients on ECMO the process of prevention would have a significant impact on our workforce and a consequent impact on activity. **Safe:** Reported by MS: i. We had achieved a safe staffing position despite the challenges faced by the Trust and all wards were safely staffed. ii. The number of patients assessed for VTE on admission had been discussed at the Performance Committee and that would be taken forward through Q&R.		

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	Caring: Reported by MS: iii. The key issue was the results of the NHS inpatient survey which had been excellent and the focus on areas where we could make further improvements. **Effective:** Reported by EM: iv. The PIPR dashboard KPIs illustrated the pressures that had already been outlined. v. We were working through the CPAP response and we are ready to embark on our plan, but Phillips had faced delays in implementation. This would reduce the window to deliver remedial actions. This presented a time constraint as this programme must be completed by September 2022. **Responsiveness:** Reported by EM: vi. That we had seen a strong diagnostic recovery with performance at 97%. This was being driven in October by the recovery seen in Radiology. **People management and culture:** Reported by OM: vii. That sickness absence and COVID absence which we had seen reduce earlier in the year was now increasing. Today we had 25 staff self-isolating because of COVID contact. This would feature through the winter and was dependent on COVID rates in the community. viii. That we had issued guidance for staff this week on the new travel requirements. **Finance:** Reported by TG: ix. That we were on track year-to-date for our financial performance and for CIP. He wanted to explain the performance on the Better Payment Practice Code as we had achieved only 74% against the target of 95% in month. He advised that this was because of a change in supplier in our outsourced payments system. He noted that the position affected NHS providers and that non-NHS suppliers were at a level of 94% against the 95% standard which he felt was appropriate. This would continue to be monitored closely in coming months. **Discussion:** i. AF noted the deterioration in the Friends and Family Test and asked whether this was a concern. MS advised that given the triangulation of data she felt we had assurance on this metric, but she would review this in month. ii. MB noted that he had expected the activity analysis spotlight to include both source and ethnicity data. EM advised that we needed to undertake improvements in data capture so that the improved information could be provided. The initial analysis indicated that we were providing services disproportionately as historically the capture of ethnicity data had not been an area of focus. She had therefore not included this data as she had not wished to mislead the Board in the analysis. MB asked whether social class or analysis based on postcode data could serve to provide some analysis. EM noted that there were		

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		challenges in using specific geography data. IS advised that this was a part of a bigger project and that data could be misleading, for example in Cambridge we had very high numbers of students who in statistical analysis appeared in very low-income groups but in reality, were generally supported by affluent families. He noted also that the Trust needed to resolve issues in how it ran its virtual clinics as patients were not presenting to receptionists who had traditionally undertaken the checks of registration, address and demographic data and doctors undertaking clinics were not collecting this data. This process would need to be built back into our systems.	IS/EM	TBC
	iii.	JW asked about progress on the national proposals for developments of community diagnostic hubs. EM advised that ICS diagnostics workstream was to address that issue. We were currently reviewing capacity and potential locations for hubs across the system. This was work was being undertaken in partnership with Philips.		
	iv.	SP noted the conversation and debate about PIPR and its limitations, however it gave the shape and the sense of our priorities and it felt that the care and wellbeing of our patients was core to this. He felt that the ratings in Safe and Caring demonstrated the considerate and respectful approach that we were taking. Ratings in the Effective and Responsive domains reflected the pressures that the system and the Trust were working under, but the reality of balancing operational pressures meant delivery of less activity and increases in cancellations in response to these. This also provided a mechanism to reduce pressures on staff. SP asked whether the Board were satisfied that the Executive were getting the balance right as was reflected by the ratings in PIPR. He asked if this gave the Board the shape of the pressures being managed and whether there was a sense that this was appropriate given the operating context.		
	v.	MB noted that we had two PIPR segments rated Green and three segments rated Amber and that could suggest an imbalance. He noted that the question was whether we could rebalance the hospital to address this and whether we should consider different kinds of trade-offs. He felt the question around balance was right because of the strain on staff. Overall, he supported the decisions being made and advised that he got great reassurance from watching the Clinical Decision Cell wrestle with these issues.		
	vi.	AF felt that PIPR was useful but was not the only tool. The leadership team brought the report to life and presented the feel of the 'here & now' of the organisation and the context it was operating in. This was more than the numbers and the narrative presented and she felt that the team did an extraordinary job of balancing the risks with patient safety and care, and the well-being of our staff at the heart of it.		
	vii.	SP noted that the shape of PIPR was helpful as it spoke to what we were prioritising at a Board level and allowed for drill down, challenge and review of the choices made within limited resources.		

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	viii. JA felt this was a good question and he echoed the sentiments of AF and MB. He noted that many of the domains were not entirely within our control but where they were then our staff and the Executive were demonstrating control and these sectors were importantly Green. A part of the importance of this was also to ensure that the institution and its staff were supported in sustainable ways to ensure its long-term survival and recovery plans. ix. CC noted that the PIPR document was not only about metrics. It also provided good reports from the Executive including analysis and forecasts of future performance. As an example, in previous reports, we had forward trends reported in the narrative, which had been demonstrated to be thorough and realistic assessments in subsequent reports. This suggested that we had an appropriate narrative and controls in place through the Executive. x. DL noted some constraints primarily relating to staffing as we were looking at historic data and so contextual information was needed, and this was provided by the Executive narrative. She also valued the detail that was provided in Spotlight reports. JW noted that the spotlight reports had been brought in to enhance the narrative provided to the Board. xi. It was noted that at this stage there was little to report on the ICS and so the metrics on this were still in shadow form. **Noted:** The Board noted the PIPR report for Month 7 (October 2021).		
3	**GOVERNANCE**		
3.i	**Q&R Committee Chair's Report** **Received:** The Q&R Committee Chair's report setting out significant issues of interest for the Board. **Reported:** By MB that he had nothing specific to add and that the report illustrated the balance and tensions across PIPR and the sense of triangulation around these pressures. **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 new guidance had been published relating to Infection Prevention and Control and that we had reviewed our pathways and were placing emphasis not only on COVID but on all respiratory viruses as we approached winter and would use a respiratory risk assessment approach to inform decisions on patient pathways. We were to remove the green and purple pathways as there were risks with all patients, and, going forward, we would embed the new standards which would help with patient flow. This would ensure that all patients had correct isolation and PPE in place. We had seen a positive response to the changes from the clinical teams.		

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	We were also risk assessing staff who were categorised as 'red risk' and offering them support through the Chief Nurse's team. **Discussion** i. JW thought this was a useful move and hoped this would see more people treated safely. ii. DL was pleased to note the nurses seconded to the Critical Care Unit and asked with the likely winter pressures what the plan was for review at the end of the period of secondment for this cohort. MS advised that secondments had been secured because of bed closures in surgery. We were not putting through the volume of surgery and so it was possible to release staff to move. This would be reviewed at six weeks and the forward plan considered ahead of time. iii. GR asked about the dismantling of the separate pathways and whether we understood the cause of the nosocomial infection. MS noted that this had occurred on a green pathway and following review it looked as if this had been contracted from a member of staff. This went back to the need to remind, encourage, and support our staff to comply with infection control processes. It was felt that having one standard would be easier to communicate and monitor compliance against and this case reinforced need to take this approach. **Noted:** The Board noted the Combined Quality Report.		
3.iii	**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 it had been proposed that BAF 3074 would be monitored through the Performance Committee rather than jointly with the Strategic Projects Committee. **Agreed:** It was agreed that BAF 3074 would be monitored at Performance Committee. **Noted:** The Board noted the BAF report for December 2021.		
3.v	**Board Sub Committee Minutes:**		
3.v.a	**Quality and Risk Committee Minutes: 28.10.21** **Received and noted:** The Board of Directors received and noted the minutes of the Quality and Risk Committee meetings held on 28 October 2021.		
3.v.b	**Performance Committee Minutes: 28.10.21** **Received and noted:** The Board of Directors received and noted the minutes of the Performance Committee meeting held on 28 October 2021.		

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3.v.b	**Audit Committee Minutes: 14.10.21** **Received and noted:** The Board of Directors received and noted the draft minutes of the Audit Committee meeting held on 14 October 2021.		
4	**WORKFORCE**		
4.i	**Workforce Report** **Received:** The Director of Workforce and OD a paper setting out key workforce issues. **Reported:** By OM that: i. We were awaiting guidance on mandatory vaccination. This would provide information on which roles were in and outside scope, how medical exemptions would be managed and the requirements on proof of vaccination for staff joining the Trust. This had been discussed at ED's and managers were being encouraged to start conversations with staff. We were in the first instance cleansing data to ensure that we had an accurate view of staff who were not vaccinated. Some staff had found that their details were not updated on the national system and we needed to understand what evidence would be required for those staff with vaccinations administered overseas. Where staff had indicated that they were not willing to undergo vaccination then managers would be undertaking conversations about the reasons for this. The national timeline would require the Trust to give notice to staff by the end of December to comply with a first of April implementation date. The Trust did not want to move to this timeframe, and it was hoped that we would be able to complete this work and identify all affected staff in January and by that time would have further information to support individual conversations. ii. As noted by SP the Women's Network had held its launch event with a number of excellent speakers. iii. The reciprocal mentoring programme was now making real progress and we were finalising feedback to applicants. There were some staff where this was not quite the right programme and that was being fed back. The national team had not yet finalised their work and we were waiting for workshop dates. The programme had however attracted significant interest from a range of staff, and it was felt that this would help us to attract recruits in the future. iv. The future of the NHS Human Resources and Organisational Development (HROD) was a very significant piece of work undertaken over the last year. This looked at how the NHS would improve its workforce capability and capacity and set out long-term plans extending to 2030. This work was aligned to the NHS People Plan and identified areas that would require resources such as the digitisation of HR function, workforce planning and resourcing. There was a lot of detail on system and regional roles, but it did not look at the impact on individual organisations and that would take time to plan and develop at a Trust level. There had been discussion at director level within the ICS and the region and we would be agreeing areas of focus and looking for early wins. We were being		

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	encouraged to review and engage and to ensure that this was reflected in our People Plan. **Discussion:** i. GR asked whether we had a sense of the best- and worst-case scenarios in relation to mandatory vaccination. OM advised that we did not as we were still waiting for detail on the proof of vaccination required. The best guide was feedback from community staff in Essex and Suffolk where once data cleansing had been completed there were very small numbers of staff who were unvaccinated (single figures). The issue facing the Trust was that as we had some very small teams if one or two members were unvaccinated then that could still result in a significant operational problem. ii. IW asked whether we would redeploy staff who could not be vaccinated. OM advised that we had considered this and our scope to do this will be limited as all staff at the hospital and the HLRI would be classed as interacting with patients. IW asked whether changes in the way that we used telephone and video consultations might offer some further appropriate opportunities. JW noted that this assessment would form a part of the review and further reports would be brought to the Board. iii. JW noted that there were many actions included in the HROD report and felt that the Board should be guiding the Trust and its partners to look at those actions that could be taken in the first instance so that a clear plan could be set and delivered. **Agreed:** The Board noted the update from the DWOD.		
4.ii	**Your Behaviour Matters – Disciplinary Procedure DN117** **Received:** From the DWOD a copy of the revised disciplinary policy for approval. **Reported:** by OM that: i. The policy ' Your Behaviour Matters' was being brought to the Board for approval. ii. The policy had been developed with engagement of staff networks and the Joint Staff Consultative Committee. The policy had also been reviewed in the light of the Trusts revised Values and Behaviours Framework. **Discussion:** iii. AF noted that this document had a thorough discussion at the Q&R Committee and that the changes were applauded. **Agreed:** The Board approved the Trust disciplinary policy, Your Behaviour Matters (DN117).		
5	**STRATEGIC**		
5.i	**Trust Strategy 2020-2025 Year 1 Update** EM advised that the Strategic Projects Team had planned that this should come to the next Board and so it would be taken in February.		

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6	**Research & Development**		
6.i	JW noted that we would soon be seeing the handover of the HLRI building and he hoped that the Board would be able to visit and to see the building itself. He noted that the development of the HLRI, and more importantly the people who work within it, was one of the most important issues that the Board would take forward in the coming years.		
5	**BOARD FORWARD AGENDA**		
5.i	**Board Forward Planner** **Received and Noted:** The Board Forward Planner.		
5.ii	**Items for escalation or referral to Committee**		

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Signed

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Date

Royal Papworth Hospital NHS Foundation Trust
Board of Directors
Meeting held on 02 December 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