Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Held on 05 May 2022 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
	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 A Raynes	(AR)	Chief Information Officer & SIRO
	Mr G Robert	(GR)	Non-Executive Director
	Mrs M Screaton	(MS)	Chief Nurse
	Dr I Smith	(IS)	Deputy Medical Director
	Prof I Wilkinson	(IW)	Non-Executive Director
In Attendance	Ms T Crabtree	(TC)	Head of Communications
	Mrs A Jarvis	(AJ)	Trust Secretary
Apologies	Mr S Posey	(SP)	Chief Executive
	Mr A Selby	(AS)	Director of Estates and Facilities
Observers	Susan Bullivant, Trevor Collins, Richard Hodder, Trevor McLeese, Harvey Perkins,		

Agenda Item		Action by Whom	Date
1	**WELCOME, APOLOGIES AND OPENING REMARKS**		
	The Chairman welcomed everyone to the meeting and apologies were noted as above. He noted that the HLRI building had opened, and the research and development and education teams had moved into the new building. The Chairman noted his disappointment that we were not yet able to hold the Board meeting in the HLRI, but a few matters remained, and these would be addressed ahead of the June meeting. The Chairman noted that Dr Roger Hall had retired, and Dr Ian Smith		

Agenda Item		Action by Whom	Date
	had taken up position as Medical Director. He also noted that this was the first meeting since the announcement that Stephen Posey would be taking up the position of Chief Executive Officer at the University Hospitals of Derby and Burton and there would be a further discussion with non-executive directors at the end of the Part II Board meeting. He advised that he had been in Boston at the International Heart and Lung Transplant Society meeting. A very good session had been held outside of the meeting with the doctors and surgeons involved in the recent porcine heart transplant and he noted it was good that xenotransplantation was being discussed again.		
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: 7 April 2022 **Item 2.b PIPR:** Discussion ix: Revised to read: ".. new site where there was a perception that lack of anaesthetic rooms had an adverse impact which Meridian felt that could be mitigated." **Approved**: The Board of Directors approved the Minutes of the Part I meeting held on 7 April 2022 as a true record.		
1.iii	**MATTERS ARISING AND ACTION CHECKLIST**		
	Item 2.b PIPR: JW noted concern that a lack of anaesthetic rooms was being reported as a barrier to delivery of a three-pump day. This was not substantiated by work done on the old site ahead of the move to RPH. The wording of the minutes was revised to reflect this. **Item 301:** CC asked about the local system analysis for the WRES data which was marked as complete. OM advised that there was limited data which had already been provided in her previous update to the Board. She advised that we had received the detailed WRES report, but she had raised a question with the national team as this used a mix of data from 2020 and 2021. Once clarification had been received, she would share the analysis with the Board. **Noted:** The Board received and noted the updates on the action checklist.	OM	Jun 22
1.iv	**Chairman's Report**		
	The Chairman noted that he had covered key issues in his opening remarks.		
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 Trust's strategic objectives. The report was taken as read. **Reported:** By EM that:		

Agenda Item		Action by Whom	Date
	i. The CEO's report reflected the continued theme of staff absence and patient sickness during March and provided the system context for our performance. The Trust was fortunate in having single rooms as we did not have to close wards because of COVID positive patients. The system was seeing increases in emergency activity and difficulties in facilitating discharge. Our staff had worked flexibly to cover staffing gaps and continued to deliver the best quality of care to the highest numbers of patients. ii. The HLRI building had opened, and the mobilisation day saw our education, workforce, and research and development teams move into the building. This had worked very well, and the teams were working effectively in the new building with only minor issues. iii. The Trust had achieved a £3.2 million surplus at year end. We were however mindful that 2022/23 would be a very challenging year for the Trust and the system. The 2022/23 position was being shared with teams across the Trust through budget setting meetings and the star chamber meetings that review the proposals for cost improvements. iv. It was fantastic to see that three of our staff had been nominated in the national BAME Health and Care Awards 2022. v. The Trust was also continuing to play a substantial part in the flagship developments of the ICS, working with Phillips on the development of plans for the system diagnostic centres and on the development of the ICS cardiovascular disease strategy. **Discussion:** i. JW noted that the ICS were identifying major programmes to implement, and the CVD strategy would be one of those. ii. DL asked about the timeline for the diagnostic centre proposal and whether we knew how many patients would be supported through the service. EM advised that there was detailed modelling underway and that the main hub was planned to provide CT, MRI, ultrasound, respiratory physiology and echocardiography services. The choice of location for the new services was to open up access and there would therefore be an expectation of increased demand. The proposals also considered staffing requirements as that would be a key challenge and we would need to grow the workforce for these modalities across the region. We therefore did not have a definitive plan but did expect that services would be operational within the next 12 months if approved. **Noted:** The Board noted the CEO's update report.		
1.vi	**Patient Story**		
	MS introduced the patient story. She noted that this story focused on a patient's experience where we did not get the basics right. She also told the Board that today was Hand Hygiene Awareness Day and the Infection Prevention and Control team were leading work to ensure that staff were aware of and adhered to basic practice in relation to hand hygiene. This was in part in response to the increase in surgical site infection (SSI) rates. A full report and action plan for SSI would		

Agenda Item		Action by Whom	Date
	be brought to the next Quality & Risk Committee. Judith Machiwenyika, Nurse Consultant (ALERT and Surgical ward ANP teams) presented the patient story. The story was from one of our current inpatients that JM had talked to about his experience of care. The patient was happy for his story to be shared with the Board and sadly he had not received the high-quality experience that we and our patients would want and expect. This patient had a history of ischaemic heart disease and a calcified aortic valve with a complex medical and surgical history. He was seen in clinic in October last year was and put on the waiting list. Whilst waiting for surgery, his condition deteriorated, and he was admitted to a district general hospital at the end of January 2022 where he was medically managed. During this time, he was deemed a high-risk patient for surgery. He was transferred to Royal Papworth at the end of March after being in hospital for 64 days. When he was told he was being transferred to Royal Papworth, he was very excited and was looking forward to having surgery in a hospital with a very good reputation. When he got here, the consultant surgeon who came to see me was not the one he had met in the clinic which he didn't mind as he was eventually going to have surgery, and that was the most important thing. His surgery was done the day after being admitted to RPH, and he was transferred to the ward after four days in critical care. Unfortunately, whilst on the ward he developed a wound infection that progressed to sepsis and made him more unwell. The patient reported that after a few days on the ward, he started to feel very unwell and was returned to intensive care. He didn't really understand what had happened and the information from the doctors and nurses appeared to change and was given in dribs and drabs. He advised that sometimes during ward rounds, staff spoke amongst themselves and not to him. He had not yet been given a discharge date to look forward to and didn't think the hospital was living up to its good reputation and this made him very frustrated. As a result of his sepsis, he was readmitted to critical care 11 days after his surgery, staying for one night before being transferred back to the ward. He then needed topical negative pressure wound therapy for his wound, as well as a course of antibiotics. He remained on these treatments and had required additional theatre care for his ongoing wound recovery. The patient reported some clear differences in his experience at the DGH and at Royal Papworth. The patient felt the quality of food was better at the other hospital, that there was less clutter in patient areas, and that their standard of cleanliness was higher. He also noted how staff at both hospitals had engaged with him. He said that at points during his care at RPH, he had been made to feel 'inferior' by some staff. He talked about a specific incident where he had an accident following the use of a bottle in his bed and when told a nurse about what had happened, he felt 'told off' and was then left for a long time in a wet bed, despite the nurse saying she would come back in a minute to change the bed. He felt this was one of the most frustrating things nurses did. They said they would be back in a		

Agenda Item		Action by Whom	Date
	minute, but they didn't come back and he could not understand why that happened. JM advised that during this conversation the patient had become visibly upset. It was challenging for him to speak about his experience, and this showed that we must do better. JM noted that whilst his experience didn't reflect most of the feedback we receive, one experience like this was too many and there was much learning that we could take from it in order to improve. This patient's experience had been shared with the sister team in the relevant ward and was being discussed with all nursing staff on the ward with a request for them to reflect on our Trust values and to understand how our small actions can make such a clear difference to a patient's individual experience. In particular, the ward had been asked to think about how they communicate with patients, how they manage patient expectations in terms of time to do things, how they explain and apologise for any delays, and how the ward environment itself can be improved and decluttered. It was also being taken to the sisters' and matrons' meetings, for the feedback to be shared with nursing teams across the hospital. JM had also shared the feedback with the surgical ward team, for them to consider how and when they talk to patients about their care – so that we ensure every patient understands what is happening to them, why, when, and has the chance to ask questions. A plan was in place to improve continuity of care in terms of senior surgical registrars. Equipment had been ordered to allow a number of ward rounds to be done at the same time, which should mean more patients are looked after by the same doctor. This should improve the communication channels between clinical teams and their patients, improving the patient's experience. JM noted that small acts of kindness really do make a big difference. A positive thing he reflected on was the nursing team taking him outside for some fresh air, which he had loved. He noted that his wife could only visit once a week and that it would be lovely to go home. JM had discussed the patient's low-mood and distress with the ward sister, and a referral had been made for some mental health support to ensure that he was able to get any extra help he might need. At the end of their conversation, JM asked if he wanted her to bring him anything from the shop he laughed noting that "a beer would be nice". JM followed this up with his medical team to see if an alcohol-free beer would be suitable for him and happily his medical team agreed and JM arranged this for him. JM noted that she had wanted to share his story today as a rare, but vitally important, example of when we have not got things right for someone that we care for, and what we were doing to change and learn from it. **Discussion:** i. JW noted that sternal wound infections were complications that were rarer than they used to be, and that hand washing was the single most important thing to reduce infection levels. He noted also that the way we dealt with this matter had not been the best for this patient.		

Agenda Item		Action by Whom	Date
	ii. CC asked if this was a one-off case or whether this represented the culture on this ward. She was particularly concerned about staff talking about and not to the patient and asked whether this was reflective of deeper issues. JM noted that whilst we generally received positive feedback from patients this may not be a one off, but it was difficult to assess in the absence of feedback. This patient may see more issues now because of his experience, and we were working to address this with nursing staff. iii. MS noted that there were changes planned in the process of ward rounds which would see a shift to more dedicated teams and therefore the wards and patients would see the same faces attending and would be able to build up a rapport. In addition, matron rounds were crucial to the delivery of essential care. She noted that side rooms had advantages but where patients were in open wards, they had a better line of sight of nursing staff and so could see if a nurse was attending to a patient elsewhere. We needed to support staff in developing approaches in response to this line-of-sight issue. JM also noted the ward had a high number of nurses off sick because of COVID during this period and that may have contributed to his experience. iv. DL noted that it was disappointing to hear that the patient had felt ignored during the ward round and asked what was being done to improve this, and how it had effected his care. JM advised that the lack of continuity in surgical ward rounds had been discussed and the surgical teams were going back into firms. In this respect the patient was correct as the doctors who were seeing them did not know as much about him and his condition as previously. Once the computers were available these changes would be put in place. v. JA congratulated JM's shortlisting for her award nomination. He noted that this story illustrated the issue of dignity and respect for our patients as much as their care and the importance of the information that patients receive particularly when they had stayed for long periods in other hospitals. He asked if long stay patients were routinely offered referral for psychological support. JM advised that this was not something that we did routinely but was undertaken if a patient had a history of mental illness, she agreed that this was something that we should think of doing for long staying patients. vi. AF noted that the story had been well presented and was difficult to hear. She noted the impact of social isolation and how difficult that was for patients as it was detrimental to their health and recovery. She asked about the impact on ward staff and whether they recognised the behaviour described when this was discussed with the ward sister. She also asked whether there were staffing indicators for the ward which might indicate the level of pressure during this patient's stay. She felt this story was vitally important for our staff to understand and recalled there had been a previous programme of 'no care about me without me'. JM advised that this feedback was received positively and had been used as a hot topic for the week for the ward. vii. OM noted that the Quality & Risk Committee had heard a patient story that was very impactful. That also related to an extended	**MS**	TBC

Agenda Item		Action by Whom	Date
	length of stay because of a wound infection. She was concerned to understand what more we could do about social isolation whilst patients were on our wards. She was aware that the Patient and Public Involvement committee would consider the impact on patients and felt that our staff might be able to support this perhaps with visiting or reading support as she felt we had a kind set of staff and we should mobilise their efforts. **Noted:** JW noted that we needed to reflect on this case and thanked JM 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. **Reported:** By GR that: i. That the issues relating to the committee BAF risks were covered in the report relating to cyber, and business continuity. ii. That the key issue had been the discussion of activity restoration and how we would best make use of the results of the Meridian productivity work to maximise activity across of the hospital. He noted that those benefits were already factored into the 2022/23 plan and so those gains were already 'baked in'. In order to reduce the deficit, we would need to improve against the trajectories in the plan. If these could be brought forward, then we would realise gains in the financial year. iii. The committee had approved the operational plan submission, but this was reluctantly done as it was a forecast deficit position. The committee understood the importance of doing everything that we could to improve the position in terms of performance and cost improvement and recognised that there needed to be a financial recovery plan put in place. iv. The committee had reviewed the Ernst and Young private patient activity review, and this had identified some areas for improvements in profitability. The committee had agreed that there needed to be broader consideration of a private patient strategy and had recommended that should be taken to the Strategic Projects Committee. This should look at profitability in the context of a strategic review of private patients' activity, whether this should be increased or decreased, whether this reflected best use of public assets, and include a discussion on the ethical issues around delivery of private activity. The committee felt it was right to have this conversation now given the financial pressures that we faced this year. **Discussion:** i. JW asked about the progress with the Meridian report. EM advised that we were halfway through a 16-week programme, and we expected to see activity figures starting to move in April. ii. JW noted the issue on private patients and that a separate discussion about commercialisation and what was being done within the hospital was also being set in train. He had involved DL in this discussion along with SP and the objective of this review would be to ensure that we were maximising opportunity	**TG**	TBC

Agenda Item		Action by Whom	Date
	for service and financial benefit. There would need to be a discussion about committee governance in relation to this. iii. JA asked for clarification about the private practice and the commercial discussion and whether these were planned to be taken together or separately. JW felt that the wider commercial review should not delay the initial consideration of private activity, noting that the commercial discussions were nascent and had been held off because of COVID19. This would involve a stocktake of external opportunities. He noted that TG would be the executive lead for the commercial strategy and that the private patient review would be led by EM. iv. MB noted that he was struck by the scale of the gains identified by Meridian and asked whether we could have identified these opportunities on our own. If these were things that we did not know then was it possible that there were similar opportunities and gains to be found in other areas and these seemed to be low hanging fruit. EM advised that we had known that there was opportunity based on the pre and post COVID19 levels of activity. Meridian were invited in to accelerate our ability to move forward and to increase our productivity through the review process. There were differences in the scale of improvement in case numbers between Cath labs and theatres. In theatre cases were much longer and there was some history of decisions being taken early in to cancel cases because of delays earlier in the day and that had a significant impact on utilisation. In the Cath labs cases were shorter there was a lower opportunity for improvement. EM noted that there was an appetite to manage this more tightly and that would deliver a reduction in the turnaround time between cases. **Noted:** The Board noted the Performance Committee Chair's report.		
2.b	**PAPWORTH INTEGRATED PERFORMANCE REPORT (PIPR)**		
	Received: The PIPR report for Month 12 (March 2022) from the Executive Directors (EDs). This report had been considered at the Performance Committee and the Safe and Caring domains were discussed at Q&R Committee. The report was provided to the Board for information. **Reported:** By TG: i. That overall Trust performance was at a red rating. The report continued to show the impact of COVID-19. We had seen some improvement in April and hoped that this would be reflected in the delivery of our operational plans. He noted that there had been a deterioration in our performance in the safe domain. **Safe:** Reported by MS that: ii. The red rating related to staffing and our inability to provide the normal staffing ratios and was related to short notice absence. We had undertaken a deep dive into harm related to this and had not seen any reported but the patient story that we had heard could be related to our staffing position. iii. The spotlight report was on the nosocomial infections that we had seen in March. We had none since that time. iv. Our staffing position was much improved with shifts now		

Agenda Item		Action by Whom	Date
	adequately covered. **Caring:** Reported by MS that: v. This domain remained at a green rating despite the evidence of negative experience that had been seen in the patient story. **Effective & Responsiveness:** Reported by EM that: vi. The referral to treatment target remained a concern. We continued to manage patients in order of clinical priority and ensured that we had a plan for those patients who were approaching or exceeding a 52 week wait. She noted also that the performance in diagnostics had improved in March. **People management and culture:** Reported by OM that: vii. Key issues related to supply and demand in the labour market, and we were seeing increases in staff turnover both nationally and at a system level. viii. We were experiencing loss of staff to the private sector and as an example whilst at Royal Papworth House almost every organisation on the business park were advertising that they were recruiting. ix. We were not so concerned about vacancies in our nursing staff and were still managing to attract staff to both critical care and cardiology. We did see a problem in our healthcare support workers and the spotlight in PIPR focused on the national shortage areas. We needed active and visible recruitment activity, supported by word of mouth recommendations and a good profile on social media. The key issue for the Trust was to be seen as a good employer, to support our staff, and to implement our Compassionate and Collective Leadership programme. **Finance:** Reported by TG that: x. The overall rating was green following a fantastic set of results for the Trust. He thanked the Trust staff for delivering this but noted that the year ahead was one of challenge and pressure. xi. We had under shot our target for capital spend and that was as a result of not being able to deliver commitments relating to the digital aspirant programme. However, we had central agreement that this funding could be rolled forward to the current financial year. xii. We were achieving the better payment practice code targets on volume and value for non-NHS organisations and had hit the target for NHS organisations in terms of value but not volume. We were working with SBS to produce a report to identify invoices sooner before they were to breach. **Discussion:** i. GR asked for confirmation about whether our visitor policy had been changed. MS confirmed that this had been changed in response to guidance received relating to inpatient testing, staff testing and visiting policies. We had reviewed these and had increased visiting at the hospital allowing 2 visitors for longer time periods in the day. We still had a booking system in place to ensure we were able to monitor footfall. Outpatients were		

Agenda Item		Action by Whom	Date
	now able to be accompanied to clinic. All of our policies were now in line with national guidance. ii. CC asked about care hours per patient day. She noted that she had visited level 5 and was concerned that both areas seemed to be reporting staffing issues. She asked if there were particular problems in the area. MS advised that there were not. The areas had staffing ration of 1:5 and these had moved out to 1:8 at some periods but this remained within national staffing standards, albeit that our acuity was higher than average. There was a lot of attention focused on this area to ensure it was adequately staffed. iii. AF asked about the impact of bed days lost due to surgical wound infections, noting that length of stay was red rag rated on PIPR. She felt that patients staying for longer in the hospital had an impact on our quality and productivity and wanted to understand the executive perspective on this as it seemed to be a recurring theme. EM advised that the figures reported in PIPR related to coronary artery bypass grafts and to valves, and that our QLICKVIEW system allowed access to information on all lengths of stay and that was discussed at the Trust Access meeting. The drivers for increased lengths of stay were COVID-19 and the increased acuity of patients. As we saw a reduction in COVID19 cases that factor would be removed from our length of stay data. We now had 8 patients in the hospital with COVID-19 one of whom was on critical care. Increased levels of acuity were being seen as patients were waiting longer for surgery and so were more frail by the time of their admission. We were working to look at preadmission activities to support patients before admission. iv. JA welcomed the initiative on 'prehabilitation'. He asked whether patients who were offered remote consultations had a lower DNA rate. EM advised that they generally had a higher level of compliance and that the Trust was looking at how these patients could be managed, and their pathway aligned to that delivered when seen face to face. Currently virtual clinics were not reviewed by admin staff in advance of the clinical consultation and so by the time a clinician contacts a patient they will have already reviewed the notes and spent time on the case even if a patient did not attend or was unavailable for their appointment. It was proposed that we look to develop a virtual waiting room run by administrative staff to ensure that demographic data was collected, and clinicians were advised ahead of time if a patient was not available for review. Our virtual clinics were initially set up in response to the COVID-19 pandemic and these changes formed part of our living with COVID strategy and would our allow us to embed good practice. v. MB asked whether we were prioritising in response to frailty and whether by leaving other cases we may be increasing costs in the longer term. EM advised that we were not prioritising on frailty and that all patients were prioritised on the basis of their clinical need. The issue relating to frailty was to ensure that patients were as fit as possible ahead of interventions and that we were considering less invasive routes such as TAVI as alternative treatment options. We had discussed this shift with commissioners and were expecting increases with a switch to		

Agenda Item		Action by Whom	Date
	the most appropriate form of treatment. vi. JW asked whether we were still taking forward the discussion with Anglia Ruskin university in relation to cardiac physiology. OM noted that had addressed departmental issues and had a cardiac physiology lead in place. She noted that we would need to revisit the issue of training with ARU and she would raise that in the divisional performance review. vii. JW asked about the planned spend on planters for the front of the hospital and whether these would be delivered before the official opening of the HLRI. TG advised that there had been some delays, but he was hopeful of progress within the next 4 to 8 weeks. EM advised that the tables for the outside area had been delivered and that these were all made with recycled plastic which was in line with our sustainability agenda. viii. CC Asked why the total debt figure stood at £7m pounds. TG advised the Board that this related to deferred income. **Noted:** The Board noted the PIPR report for Month 12 (March 2022).	**OM**	TBC
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. i. The committee had heard an update on the critical care transformation programme and whilst there were good signals from the programme the benefit of this had already been reflected in operational plans. ii. We had heard a patient story relating to surgical site infection that highlighted the dramatic consequence on individuals. We are an outlier in this area and the remedial actions play back into basic elements of care. iii. We had a discussion the level of scrutiny applied to serious incident investigations and had concluded that the committee did not have the capacity to go over the detail of reviews but would focus on deep dives and thematic learning. This matter had been considered in response to the discussions around the Ockenden report. iv. That we had considered a question from Chris McCorquodale, one of our staff governors who had asked about the safety aspects in relation to vacancies in staffing areas other than nursing. We had agreed that we had less information available for these areas and whilst we were not sure that we would be able to compare pressures directly, we would look at whether benchmark information would be helpful. **Discussion:** i. JW noted that it was crucial for the Trust to properly define and record information in relation to wound infections so that there could be clear comparisons and noted that it would be useful to understand these. MS noted that she would be bringing a report to the next Quality & Risk Committee and that would include both the definitions and the comparative data.	**OM**	TBC

Agenda Item		Action by Whom	Date
	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 included the changes in relation to COVID-19 guidance that she had already reported to the Board. Also, that she wanted to formally record her thanks to Emily Watts who had been working on secondment to ensure that we were adhering to our policy on safer staffing. This had seen a very good start in supporting team working on rostering. IS advised that SIERP had looked at the cases that were reported to the Board in the CQR report. They had noted one death which was from a recognised complication of a procedure and were to look at the question of the frequency of these events going forward. **Discussion:** i. EM advised that the Trust had an HTA inspection this week and that the team had delivered an excellent presentation. This enabled the inspection team to take away some exemplary practice and there were some learning points for the organisation as a result of the inspection. **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: i. The increases in risks that had been seen across BAF risk covering HCAIs, Lorenzo Optimisation, recruitment, achieving financial balance and safe and secure environment. These had been covered on the agenda, with the last of those items having been noted in the prior month's report. ii. The Performance Committee had questioned the reduction in rating for the cyber security risk following discussions relating to business continuity planning. It had been agreed that this would be subject to further review by EDs. iii. The key supplier risk had reduced following conclusion of contract negotiations following the earlier escalation. iv. The report included the draft Risk Appetite statements for approval. These had been developed following the Board workshop in March and had been reviewed by the Executive and at Committee. After the workshop we had added a slider for each risk to help illustrate our appetite for different aspects of risk, as an example we had a very low appetite for breach of regulatory compliance that needed to be reflected in every risk irrespective of the overall rating that had been set for it. Once agreed these would be shared with staff so that our approach could be disseminated and understood across the organisation.		

Agenda Item		Action by Whom	Date
	Discussion: i. EM noted that that there had been several recent escalations in relation to supply chain which were being mitigated by SBS. She felt that this was a distinct issue from the key supplier risk that had been discussed. AJ advised that but there was a separate supply chain risk on the Board Assurance Framework (BAF3009). TG noted that the issues raised had escalated since the production of the latest report and it was a complicated position. However, we had learned many lessons during the pandemic and had done this by working with colleagues at system and regional levels. He felt we had the experience to respond to the pressures identified and would be working with colleagues to address these. ii. JW asked if this would be raised at an ICS level. TG noted that it would depend on the acuity of the problem and that he would reflect and involve partners so that the approach to managing this risk was tiered appropriately. **Noted:** The Board noted the BAF report for April 2022.		
3.v	**Board Sub Committee Minutes:**		
3.v.a	**Quality & Risk Committee Minutes: 31.03.22** **Received and noted:** The Board of Directors received and noted the minutes of the Quality & Risk Committee meeting held on 31 March 2022.		
3.v.b	**Performance Committee Minutes: 31.03.22** **Received and noted:** The Board of Directors received and noted the minutes of the Performance Committee meeting held on 31 March 2022.		
3.v.c	**Audit Committee Minutes: 10.03.22** **Received and noted:** The Board of Directors received and noted the minutes of the Audit Committee meeting held on 10 March 2022.		
4	**WORKFORCE**		
4.i	**Workforce Report** **Received:** From the Director of Workforce and OD a paper setting out key workforce issues. **Reported:** By OM that: i. The paper set out the Q4 update on the Compassionate and Collective Leadership programme. This had been reviewed at the Quality & Risk Committee and set out the initiatives such as the staff support scheme which was to deliver benefit to our staff following the good financial performance in 2021/22. ii. The programme was planned to support staff with cost-of-living pressures and we were working with staff side looking at areas to apply benefit. This included initiatives to support car parking costs, which were due to be reintroduced in June, bus fares, and food costs in the restaurant and at the house. We were promoting the hardship fund and were looking at a		

Agenda Item		Action by Whom	Date
	charity scheme that could provide financial support with uniform costs for staff on low incomes. We were also looking to establish a credit union so that staff had an opportunity to access low-cost loans. This was important work that tied into our being a good employer. iii. The other area of the report was on system workforce priorities. She was keen to see the system engage broadly involving COO's and finance leads as there was evidence of some silo working and a lot of flux in the system and it needed to set a realistic plan in its first year. There were plans to develop a resource at an ICB level to support system working and the key challenge to that would be resourcing. iv. The system EDI subgroup was looking to develop its work plan around violence, progression, and training. v. The ICS had appointed to their Chief People Officer, and OM felt they would be a great asset to the ICB. They had a non-NHS background having worked in industry in IT systems and EDI roles. **Discussion:** i. JW noted that the flu vaccination programme for 2022 would start planning again in August. OM advised that was correct and that we were still waiting to hear about plans for COVID-19 booster vaccinations for this year. ii. DL asked about how the staff who had volunteered to become cultural ambassadors would be deployed and what their area of focus would be. OM advised that she had met with the first of our cultural ambassadors to receive their training. They would support work in employee relations cases, and she was keen to see them involved in dignity at work and grievance procedures as well as in disciplinary matters. She hoped that we would be able to use them in our recruitment work but was conscious that we should not overstretch this resource. It was expected that this training would have an impact and support our focus on EDI. She was impressed that the engagement from staff was broad and included a medic, she noted also that we had a doctor joining the line manager development programme. This group would provide a good resource and act as a reference group. We would start to work with these staff as soon as they were trained. iii. JA proposed that in due course we should invite our cultural ambassadors to share a staff story as this would ensure that they know they have an audience at the Board. OM agreed that this would be helpful and would schedule this for the end of the summer or early autumn. She noted that training for these roles had been joint across the ICS and so these staff also had some external support. It was also envisaged that in future this might offer the opportunity to provide cross organisational support where appropriate. **Agreed:** The Board noted the update from the DWOD.	**OM**	Sep 22
5	**BOARD FORWARD AGENDA**		
5.i	**Board Forward Planner**		

Agenda Item		Action by Whom	Date
	Received and Noted: The Board Forward Planner.		
5.ii	**Items for escalation or referral to Committee**		
6	**ANY OTHER BUSINESS** The chairman noted that the next meeting of the Board would be held on the 9 June because of the additional bank holiday for the Queen's Platinum Jubilee.		

……
Signed

……
Date

Royal Papworth Hospital NHS Foundation Trust
Board of Directors
Meeting held on 5 May 2022

Glossary of terms

CIP	Cost Improvement Programme
C&P ICS	Cambridge & Peterborough ICS
CUFHT	Cambridge University Hospitals NHS Foundation Trust
CUHP	Cambridge University Health Partners
DGH	District General Hospital
GIRFT	'Getting It Right First Time'
ICB	Integrated Care Board (of the ICS)
ICS	Integrated Care System
IHU	In House Urgent
IPPC	Infection Protection, Prevention and Control
IPR	Individual Performance Review
KPIs	Key Performance Indicators
LDE	Lorenzo Digital Exemplar
NED	Non-Executive Director
NHSE/I	NHS England/Improvement
NSTEMI	Non-ST elevation MIs
NWAFT	North West Anglia NHS Foundation Trust
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
SOF	NHS **S**ystem **O**versight **F**ramework (Graded 1-4)
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