Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Council of Governors
PART I
Held on Wednesday 16 March 2022 at 10:30am
Via MS Teams
Royal Papworth Hospital

M I N U T E S

Present	John Wallwork	JW	Chair (Trust Chair)
	Michelle Barfoot	MB	Staff Governor
	Stephen Brown	SB	Public Governor
	Susan Bullivant	SAB	Public Governor
	Doug Burns	DB	Public Governor
	Trevor Collins	TC	Public Governor
	Aman Coonar	AC	Staff Governor
	Yvonne Dunham	YD	Public Governor
	Caroline Edmonds	CE	Appointed Governor
	John Fitchew	JF	Public Governor
	Caroline Gerrard	CG	Staff Governor
	Abigail Halstead	AH	Public Governor
	Ian Harvey	IH	Public Governor
	Richard Hodder	RHo	Public Governor (Lead Governor)
	Marlene Hotchkiss	MH	Public Governor
	Christopher McCorquodale	CMc	Staff Governor
	Trevor McLeese	TMc	Public Governor
	Harvey Perkins	HP	Public Governor
	Lorraine Szeremeta	LS	Appointed Governor
	Philippa Slatter	PS	Appointed Governor
	Martin Ward	MW	Staff Governor
In Attendance	Michael Blastland	MBl	NED
	Cynthia Conquest	CC	NED
	Amanda Fadero	AF	NED
	Tim Glenn	TG	Chief Finance Officer
	Eamon Gorman	EG	Deputy Director of Digital
	Ivan Graham	IG	Deputy Chief Nurse
	Anna Jarvis	AJ	Trust Secretary
	Eilish Midlane	EM	Chief Operations Officer
	Oonagh Monkhouse	OM	Director of Workforce
	Stephen Posey	SP	Chief Executive
	Ian Smith	IS	Deputy Medical Director
	Julie Wall	JYW	PA to Chair (Minute Taker)
Apologies	Jag Ahluwalia	JA	NED
	Abi Barhoumi	AB	Staff Governor

	Julia Dunnicliffe	JD	Public Governor
	John Fiddy	JF	Public Governor
	Rhys Hurst	RHu	Staff Governor
	Diane Leacock	DL	Assoc.NED
	Andy Raynes	AR	Director of Digital
	Gavin Robert	GR	NED
	Rodney Scott	RS	Public Governor
	Maura Screaton	MS	Chief Nurse
	Ian Wilkinson	IW	NED

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1	**WELCOME, APOLOGIES AND OPENING REMARKS**		
	JW (Chair) welcomed everyone to the meeting. Apologies were noted as above. JW acknowledged the sad death of David Gibbs, Public Governor in December last year as this was the first Council of Governor meeting since.		
2	**DECLARATIONS OF INTEREST**		
	There is a requirement those attending Committees raise any specific declarations if these arise during discussions. There were no new declarations of interest.		
3	**MINUTES OF THE PREVIOUS MEETING – 17 November 2021**		
	The minutes of the meeting held on Wednesday 17 November 2021 were agreed as a correct record.		
4	**QUALITY PRIORITIES UPDATE - 2022/23**		
	Received: The Council of Governors received copy of the Report. **Reported by Ivan Graham** **IG** introduced himself and explained that he was reporting on behalf of Maura Screaton who is on annual leave. He outlined progress in relation to our quality priorities. **Development of QI Capacity:** This has been severely hampered by the pandemic, sickness absence and long-term vacancies within the team; several of the goals have therefore been on hold. It is hoped that with the commencement of a new Clinical Audit and QI Co-ordinator some of the aims can be re-invigorated in 2022		

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	Making Hospitals Safe for People with Diabetes: This has seen some progress with the planning for a diabetes identifier on Lorenzo and inclusion of diabetes on the e-discharge summary however both are awaiting implementation. With both interventions in place it is expected that specific audits of diabetes patients should be electronically facilitated. A training package for healthcare professionals caring for patients with diabetes has been identified however sources of funding beyond the initial training package remains to be identified. **Compassionate & Collective Leadership:** Value & Behaviours (V&B) framework published. • Pilot V&B training sessions held at end of 2021 with full programme roll out by end June 2022 • Line Management development programme to be launched April 22. • Individual Performance Review (IPR) process under review – this will embed V&B framework, encourage conversations about well-being and career development **Overview for 2022/23** Patient Safety Incident Response Framework: • National requirement from April 2022 To support the NHS to further improve patient safety, a new Patient Safety Incident Response Framework (PSIRF), outlining how providers should respond to patient safety incidents and how and when a patient safety investigation should be conducted. Health Inequalities – increased action on prevention of health inequalities: • National and ICS Priority. For reasons both of fairness and of overall outcomes improvement, the NHS Long Term Plan takes a more concerted and systematic approach to reducing health inequalities and addressing unwarranted variation in care. **Recommendation:** The Council of Governors is asked to note the progress of the current Quality Account priorities and the Quality priorities for 2022/23. **JW** thanked IG and asked if there were any questions No questions were put forward.		
5	**CCG Visit Feedback**		
	Reported: By Ivan Graham **IG** informed the Council of Governors that the visit took place on 25 February 2022 and as regulators they had a responsibility to oversee the care delivered by the organisation was safety and of good quality.		

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	The CQC had not been able to come on site for a while because of COVID restrictions. On this visit restrictions were adhered to the same as apply to staff and visitors. There were two visitors, one with links to infection control and the other to pharmacy. They were escorted for the morning by our Chief Pharmacist and met with Matrons, Sisters and Charge Nurses. A lot of time was spent in CCU, Cardiology Cath Labs and Pharmacy. This was a good visit, and we were waiting for the full formal response from it. The summary at the end of the visit was shared and it was reported that: • The staff were friendly and welcoming. • Departments were clean and tidy. • There was good infection control. • There was evidence of lessons learnt from previous incidents. • On the day there was an issue with power in the cath labs so there was no activity. • The visitors were impressed that the time was being used for a bespoke teaching session while there were no patients. • They spoke to staff and patients and comments were all positive. **Discussion:** **JW** asked when the report was expected and asked AJ if this could be included in the Well Led Review. AJ advised that it could be provided as evidence when received. **IG** explained that the report was imminent. **RHo** asked if notice had been given before the visit **IG** explained that notice had been given. A draft agenda for the morning was written up. There was opportunity for them to ask where they would like to go during the morning. **IG** added that he was proud of the teams. They had a good approach and were proud to show and share their work. **JW** asked if there were any further questions No further questions were put forward		
6	**Pulse Survey Update**		
	Reported: By Oonagh Monkhouse **OM** explained that the survey was taken in January 2022 at the height of Omicron and it was important to remember this when looking at the		

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	results. The survey had been running for 2 years and was used as a quick temperature check. This was done quarterly and asked a small number of consistent questions. The yearly Staff Survey results will be published at the end of March and will be reported at the June CoG. The Data Trend from the Pulse Survey over the last 2 years is as follows: • There was some improvement shown but a dip was noted in wellbeing considered. There is a theme around staff exhaustion and "feeling overwhelmed" • There are some concerns around the renewal of the lease at the House and the continuation of Admin and Clerical staff being able to carry on working from home. Staff feel this has been beneficial and it is valued. **Positive Feedback:** • There were quite a lot of comments about wellbeing support for staff and the Values and Behaviours Workshops. Staff are feeling hopeful about how this develops and are keen to engage. • Despite pressures on staffing, managers were performing one to ones which are so important so that there is connection and opportunity to talk about your work and how you are feeling. Also regular team meetings were being maintained. **OM** explained that there is now peer benchmarking for this survey and as from last year there is a national requirement to submit some of the data so it can be benchmarked with other providers. The four categories looked at are: 1. Staff Engagement 2. Overall Advocacy 3. Involvement 4. Motivation A number of questions are asked to be submitted that are combined into these areas. This will be interesting as this kind of benchmarking data hasn't been seen before. The survey we had been doing was to track ourselves for an understanding on how our staff are feeling. We were in the top quartile for three of the categories around staff engagement, advocacy and Involvement. **Noted: The Council of Governors noted the Presentation Slides.** **Discussion:** **JW** commented that how we compare to relevant peer groups is helpful to understand if we are performing as well, or better, or have we issues		

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	that we need to focus on and look in to. **PS** asked if the national benchmarking was relatively new and were we asking all the same questions as other people that we are being benchmarked with? **OM** explained the Pulse survey started when we were going through the hospital move and was focused on the move. We carried on after the move to see how staff were feeling and settling in. It has been carried on using core questions, the same as national benchmarking but we also added some questions of our own. Last July collection of the data was asked for nationally. Some of the questions were the same as we were already asking, and we added in the extra that we were asked to do. The yearly staff survey has been running 10 years and is rolled out in November/December of each year. We receive that benchmark data from that at the end of March. **TMcL** asked if non-NHS staff participate in the survey and if not could they in future **OM** explained that it was only used for NHS staff. OCS may use their own survey but as RPH is not their employer it is OCS's responsibility to set up one of their own. RPH have a good working relationship with all networks and have included non-NHS staff with the Joint Staff Council, Freedom to Speak Up initiatives and with vaccinations. Where we can we also try to work together with rewards. We can also learn from their ways of working and work along-side them but they have their own terms and conditions for their employees. **TG** wanted to add that we do encourage a one team ethos at RPH including OCS, Skanska and Estates working collectively. **CMcC** asked if a copy of the OCS survey had been asked for. OM commented that Liz Taylor links with their team and could ask for it as an opportunity for shared learning. **PS** offered to explore help with public transport for staff. **JW** thanked PS as this could help with the burden of the cost of petrol in light of the recent price rise		
7	**Operational Performance (Infographics)**		
	Received: Copy of Infographics **SP** informed the Council of Governors that since the last meeting in November it had been a very busy period for the RPH Team. As a Board and Leadership Team we couldn't be more proud of the efforts		

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	made by our staff. The theme within the organisation now was around the spring re-set. This spring re-set needs to be seen within the context of: • A period of endemic COVID with 4.6% staff absence. This was fluctuating between 4% and 6% depending on the number of staff having to isolate or who have COVID. • The NHS which was working very hard to deliver elective activity and to make inroads into the backlog to reduce waiting times. This was all being done against a backdrop of increasing demand through urgent and emergency care pathways, and this adds to some considerable pressure on the organisation operationally and clinically. • The NHS having a "fragile workforce" and of course the pandemic was one of the factors around that, but the Health Service was very busy before the pandemic. • There was now the conflict in Ukraine which was raising anxiety. There was also a significant ongoing commitment and focus on equality, diversity and inclusion and around staff wellbeing. • There was a lot going on within the system with changes to national and regional funding flows. This will be discussed under the ICS update. **Notable Updates:** • The builders have left the HLRI, and it will be handed over to us in April. We will then see the first staff moving in. There will be a formal opening in July of this year. • The Compassionate, Collective Leadership Programme will be relaunched and the training of line managers to equip them with the skills that they need. • There is also some good progress on the Cardiovascular Disease Strategy • Progress is seen in Digital with the Shared Care Record (EG to update) **SP** wanted to mention more specifically about the conflict in Ukraine. We understand the raised anxiety levels that this causes for all of us, and we are signposting very actively the staff health and wellbeing counselling support that is available for all members of staff. The NHS response was being managed nationally and it would be important that we contribute when asked to do so. **SP handed over to EM to run through the Infographics**. **EM** explained that she would present the two slides and summarise the overall performance in January 2022. • Friends and Family scores had remained quite strong both in outpatient and in-patient care pathways and EM wanted to give		

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	a shout out to the out-patient team who had been doing some great work with waiting patients within the waiting area. • Also, a shout out to the Business Support team for construction of a dynamic footfall model for out-patients which allows us to model on an hour-by-hour basis, the number of people within our waiting area so that we can respond if there is a risk. • January was a strong month in terms of compliments. There were two complaints which are being explored and we have a strong reporting culture via Datix **EM** asked TG if he would comment on the finance part of the slide **TG** explained that it had been a strong end of year from a financial perspective although the surplus reflects the fact that COVID impacted our elective position during October, November, December and January. As a result of that we were not spending money on procedures. It would have been preferable to have been doing the work if we had been able to. Sadly, events in relation to COVID meant it wasn't possible, so the headline was bittersweet. . **EM** explained the second slide on which a range of activities have been depicted. • Out-patient recovery using the tools developed during the Meridian productivity. • Although we haven't delivered the number of appointments that we did the previous January, over a month we had 8,411 outpatient appointments which was a considerable achievement particularly as about 40% of those appointments continue to be delivered in a virtual way, reducing footfall to the building but continuing to give a high quality of care without the patient requiring to come to the site. • There was a significant improvement, even though there were significant gaps in staffing due to COVID over the course of January. • Elective admissions, 1784 represents in the region of 75% of normal activity in January. Linking back to TG point the financial position reflects the underachievement on cases because of gaps in staffing which has contributed to that surplus. • Unplanned cases have been pulled together with emergency admissions. In January there was a high level of demand through the emergency pathways. • The MI pathway continued right the way through, but we are currently experiencing a surge of demand not only for primary but also for ACS pathways as we work through March • From a transplant perspective if organs were offered, we delivered the service and we never actually switched this service off. We have not had to decline any organs right the way through the last 6 months. Transplant continues to be very		

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	active and in the last 24 hours we have had 3 transplants delivered, 2 for patients who were on the 5th floor. • Additional donor runs collecting organs to take to other centres have occurred. • Diagnostic and RTT performance are making a good recovery and cardiology pathway care is up to 4000 patients. **SP** welcomed feedback during or following the meeting regarding the change of format of going through the infographics with PIPR being sent out for information.		
8	**Digital-Shared Care Record Update**		
	Reported: **by Eamon Gorman** **EG** explained that the digital team is working with the ICS and a single source shared portal for ICS to bring in GP data. Work is going ahead to connect the systems together. **JW** commented that this is a great piece of work and asked if it is going to stop the tendency of repeat questioning. **EG** explained that this would be included in the work for staff training **JW** asked if there will be an opportunity to show benefits that it will have for patients in different parts of the ICS system by monitoring it. **EG** replied that there will be opportunity but in terms of metrics we are not sure the plan yet that will give us that information **RHo** informed everyone that he had been attending meetings regarding the Shared Care Record and he wanted to reiterate that the development is impressive, and it was secure.		
9	**ICS System Delivery Update**		
	Reported: by Stephen Posey • ICS were leading work on the Shared Care Record, and we are engaging with the system. • Changes are material and will have an impact upon how RPH as an institution are funded and the role that RPH is required to play within our ICS regionally and nationally • This will not change the Board commitment to staff and to deliver the best possible outcomes and experience for patients. Research and innovation was going to be a huge part of this. • We recognise the importance of investing time as a leadership team, both non-executive and executive in making system contribution and building relationships within the system. • The recruitment to the ICS leadership team had continued. John O'Brien had been appointed as our Independent Chair for Cambridgeshire and Peterborough and was very much in the patch spending time with the services and meeting people.		

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	• Jan Thomas had been appointed as the Designate Chief Executive of ICS. Executive and non-executive appointments were underway. The ICS was expected to be established on the 1 July 2022 having been delayed from 1 April 2022 • Governance structures for the new ICS Board are taking shape. A significant development to report is that it is likely that RPH will be appointed as the NHS Provider voting member on the Cambridgeshire and Peterborough Integrated Care Board. This was quite a significant decision made by our ICS. • We believe that funding flows will remain largely unchanged in terms of the funding we receive as an organisation, but it is anticipated that it is going to be a far tougher year financially than the past two years as we are very much in a position of flat cash. Flat cash means that to invest in something new we need to identify savings from elsewhere in existing budgets. • Looking forward uncertainty remained, and it was anticipated that significant proportions of specialist commissioning funding may well flow through the ICS structures. • There are now 42 ICS's across the Country and we continues to be involved in influencing and shaping national and regional policies and this was evidenced by the support for us having a seat on the ICS Board. We were seen as highly credible and positive system partners. This was a good place for us to be amidst profound change in the NHS. • This continued to develop at a fast pace and we were contributing to the conversation. What was not clear was exactly how all this was going to work in detail. SP was happy to answer any questions. **Questions/Discussion:** **RHo** reported that he and three other Governors were having a meeting on 29 March with John O'Brien and he would feedback from that meeting. **HP** wanted to return to regional referrals and funding and asked if local funding control in our ICS would impact on other ICS's referrals. Was there a risk of losing specialist capability and what was the direction of travel with regional and national referrals? **SP** agreed that there was risk, but the Federation of Specialist Hospitals was aware of this. The funding was devolved to 42 ICS's and then discretion on how that money was spent would sit out of our control. Whilst it was not clear how the money is going to flow or how the framework would go forward, we were receiving assurance that the Specialist Commissioning frameworks and the specifications that have been set up would be maintained.		

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	The scope for an individual ICS setting up cardiac surgery or transplant services would therefore be limited because they do not have the population. They will not therefore be able to have the resources or the staff to be able to commit to delivering the outcomes. The higher end of super specialist work was therefore lower risk than other services. We were influencing, through the Specialist Commissioning provider collaborative but we could not provide full assurance but there were live conversation through committees and Board, and as an executive team with our local regional and national partners. **AC** asked if we would be able to influence the ICS to accelerate discharge of patients who no longer need the level of support post-surgery. It may be that they need a more general rehabilitation. He also asked if there would be an increased turnover from the ICS **SP** explained that there would be more opportunity to look at patient pathways and to optimise them. **EM** agreed and added that across the region acceleration of discharge could be to another provider. She explained that work was going on to prepare for discharge before the patient was admitted. There had been a pressure on beds for a long time but we are fortunate that we do not have an A&E department to take into consideration. **AC** asked what specific opportunities there will be with ICS **SP** explained that there will be far more opportunity for us to look at the patient's entire pathway. In the past there hasn't always been the opportunity to look from the beginning to discharge and their rehabilitation. EM and Paddy Calvert had already been leading the Cardiovascular Disease Strategy for Cambridgeshire and Peterborough. **EM** Went on to explain the Cardiovascular Disease Strategy has been discussed right down to primary care and social care with all the providers across the newly forming ICS. It has identified 17 key priorities to take forward over a period which will help improve overall health and cardiovascular disease. This includes health in the population and equality in access. The final approval process was being considered. Focus was on two areas at the moment and they were progressing well. Following the Cardiovascular Steering Group meeting last week both cardiovascular disease prevention and heart failure pathways were reported to have progressed significantly. Focus was also on engagement with healthcare outside of the organisation. **SP** added that it was important to note that we could not stop the changes in the NHS, and that we needed to be involved and to support the system and look at how we could help with problems elsewhere with the new ICS.		

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10	**Governor Matters**		
	Reported: by Richard Hodder **RHo** welcomed Lorraine Szeremeta and Ian Smith to the meeting and mentioned about Roger Hall's imminent retirement 1) **Committee Memberships** **AJ** informed the Council of Governors that the Appointments Committee are two members short due to the sad death of two of the Governors. 2) **Minutes from Committee Meetings.** **Received:** Forward Planning Committee – 12 January 2022 Patient and Public Involvement Committee – 8 November 2021 3) **ToRs**: ToR004 Forward Planning Committee ToR005 Appointments Committee The CoG is asked to review and approve the terms of reference which were recommended for approval by the Committees held on the 12 January 2022 (FPC) and the 2 March 2022 (Appointments Committee) **Approved: The Council of Governors approved the recommendations.**		
11	**PIPR**		
	Received: The Council of Governors received copy of PIPR for information. **JW** asked if there were any questions regarding PIPR No questions were put forward		
12	**Questions from Governors**		
	1) **Governors Visiting on Site** • **IG** explained that RPH had made the right decisions over the last two years and informed the Governors that there was a meeting on the 8 March on the National Guidance update. • It has been recognised that reduced visiting has caused some difficulty. • The risk of patients having two visitors instead of one was being looked into. Also, consideration of out-patients having a friend or relative to accompany them. • It was important anyone feeling unwell should not visit the		

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	hospital and that mask wearing and distancing was adhered to. • In Summary: there was not a lot of change, but he would keep the Patient and Public Involvement Committee informed. **2) Patient Visiting Policy Including Children** • **IG** explained that there had not been any changes in guidance regarding children visiting but each case was reviewed separately and having single rooms had given more flexibility. • **JW** commented that there is a risk but it was a sensible not to have a blanket approach. • **CMcC** commented that it was important, looking at the views of in patients, for their well-being especially when they are long term stay patients. • **IG** agreed and explained that adjustments had been made for CF patients and patients in CCU. Internal feedback was reviewed regularly and then fed back to PPI Committee. Going forward IG suggested that he could also take this to the Patient Experience Group meeting. • **IH** asked about arrangements for end of life care patients • **IG** explained that adjustments had been made for these patients all the way through the pandemic. Flexibility even to letting loved ones stay by their side overnight. • **MH** agreed whole heartedly that she found the balance was correct. She had recently been visiting her father who was an in-patient and felt that the measures in place protected both patient and visitor. **3) Volunteer Services Return on Site** **IG** explained that this is being reviewed, risk assessments were being looked at and reinstatement would be in line with the national guidance. **4) Values and Behaviours Programme for Governors** **OM** advised that this programme was being rolled out to all staff and that it would be good for Governors to attend as it was an important topic within the Trust. The programme is being run face to face and online sessions were being developed. Details would follow. Sessions will be running up to the Autumn so there was time for everyone to attend. **5) NHS ECMO update on RPH role** **TG** explained that commissioning of an increase in beds was needed. Pre pandemic there was use of three beds and now there is a continued of use of six beds. A request had been put forward to the National Team and specialist commissioners for another three beds. ECMO was an expensive therapy and a bid for £3,000,000 had been granted for the six beds which was good news as we were now in a position to solidify ECMO provision. He reiterated that he		

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	was proud of the Service and what everyone had done over the pandemic. This has been recognised nationally. **JW** explained that this was recurring funding as it was not only for COVID patients but also patients with other forms of diseases whose lungs don't work properly and sometimes need support. **EM** informed everyone that the levels of patients on ECMO was now at a more manageable level regionally. Our numbers had reduced and at the moment critical care was had many transplant patients rather than ECMO patients.		
13	**Any other business**		
	No other business was put forward		
14	**Date of Next Meeting – 15 June 2022**		

The meeting finished at 12:00

Signed: 

Professor John Wallwork Chairman

Date: 15 June 2022