Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Held on 7 July 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 S Posey	(SP)	Chief Executive
	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
	Mr E Gorman	(EG)	Deputy Chief Information Officer
	Mrs A Jarvis	(AJ)	Trust Secretary
	Mrs A Martin	(AM)	Lead Physiotherapist CCU
	Mr A Selby	(AS)	Director of Estates and Facilities
	Ms L Shacklock	(LS)	Dir of Operations Thoracic & Ambulatory
Apologies	Mr A Raynes	(AR)	Chief Information Officer & SIRO
Observers	Susan Bullivant, Trevor Collins, Richard Hodder, Marlene Hotchkiss		

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

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	standing declarations of interests is appended to these minutes.		
1.ii	**MINUTES OF THE PREVIOUS MEETING**		
	Board of Directors Part I: 09 June 2022 **Attendees present:** Noted that JA should be removed from the list of attendees as his apologies had been provided to the meeting. **Item 1.v CEO's update:** Reported iv: Revised to read: '... especially Cynthia Conquest and...' **Item 2.b PIPR: Responsiveness:** Reported ii: Revised to read '...there was a long tail of these...' **Item 4.ii Guardian of Safer Working Update:** Discussion iii: Revised to read: "AR suggested that it would be helpful for CM and MG to meet with himself and Dr Chris Johnson outside of the meeting as this was a concern.' **Item 4.iii FTSU Guardian's Annual Report:** Discussion ii: Revised to read: 'OM thanked TB for the report and...' **Approved**: With the above amendments the Board of Directors approved the Minutes of the Part I meeting held on 09 June 2022 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 noted that amongst all the national events this would be the last Board meeting for Stephen Posey in his role of Chief Executive and he thanked him for his contribution on behalf of the Board. He advised that the Integrated Care Board had come into being on the 1 July and there were significant national political changes in train. He also noted the death of Professor Marc de Leval, whom he had worked with at the instigation of heart and lung transplant work at Great Ormond St Hospital and he noted his contribution to quality, risk management and patient outcomes.		
1.v	**Board Assurance Framework**		
	Received: From the Trust Secretary the BAF report setting out: i. BAF risks against strategic objectives ii. BAF risks above appetite and target risk rating iii. The Board BAF tracker. **Reported:** By SP: i. That the report gave an overview of the BAF, and had seen an increase in residual risk ratings in: • BAF858: Lorenzo EPR benefits realisation risk following the Daedalus decision on Lorenzo and the position		

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	reported on ORBIS U. • BAF675: Hospital Acquired Infections risk relating to the increase in surgical site infections. • BAF1929: Staff Engagement risk relating to concerns about morale and cost-of-living increases. ii. That the report set out the principal risks to the organisation and these had been discussed at Board Committees. **Discussion:** i. MB noted that none of the target risk ratings had changed for the BAF risks. He felt that we needed to be clear on recovery trajectories for each BAF risk, noting that some would require long term shifts and others were temporary elevations that we would expect to see recover over a shorter time period. OM advised that there had been discussion at the Q&R committee and that the staff engagement risk had been reviewed and its residual risk rating increased and that had been updated again since the committee meeting. ii. JA noted that he had some concerns around the EPR risk, and these would be considered in further detail in the Part II meeting. **Noted:** The Board noted the BAF report for June 2022.	EDs	Sep 22
1.vi	**CEO's UPDATE**		
	Received: The Chief Executive's update setting out key issues for the Board and the progress being made in delivery of the Trusts strategic objectives. The report was taken as read. **Reported:** By SP that: i. He wanted to formally thank and recognise all that staff had done for our patients, and the progress and contribution to the emergency and elective recovery at a time where we had endemic COVID as a background issue. ii. That the Duchess of Gloucester was due to be opening the HLRI on the 11 July and he would be attending this with other members of the Board. iii. His report outlined the progress being made operationally in critical care and across the other divisions. iv. He had joined the inaugural meeting of the ICB which had been held on the 1 July. This saw partners coming together and demonstrated a shared commitment to the people of Cambridgeshire and Peterborough. It was informed by all the organisations that contribute to the system. **Discussion:** i. JW noted the update on the reflection garden and asked if this was the new development in the space next to the blood transfusion unit. SP Confirmed that it was. ii. AF asked about the changes in IPC rules and guidance, given the increase in COVID-19 cases. MS advised that we had seen many hospitals changing the rules. We required staff to continue to wear masks when in direct contact with patients and had guidelines for staff outside of clinical areas where it was a personal choice. We had seen no increase in transmission between staff groups since the change in guidance and this may be because of our requirement that staff stay off work if they		

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	had any symptoms of COVID. iii. JA highlighted the award for antimicrobial stewardship noting this was a very welcome news. **Noted:** The Board noted the CEO's update report.		
1.vii	**Patient Story**		
	MS introduced the patient story. This was presented by Annie Martin, Physiotherapy Team Leader on the Critical Care Unit. AM noted that she enjoyed her role in physiotherapy and saw a diverse range of patients including those post-transplant, who had very long stays, and others who were in critical care for much shorter periods. All patients were seen and assessed, and plans developed to improve function and regain independence. This story was from a patient on who had a lung transplant and spent 27 days on the unit. The patient had suffered rapid deterioration in his idiopathic lung disease prior to admission and had talked about his decision to undergo transplant. He was a man with two young children and had no second thoughts about the procedure. Following surgery, he required reintubation and a tracheostomy. On waking on critical care, he found that he had lost significant muscle bulk and had lost his ability to communicate. On waking in critical care he was initially very confused and had no idea why he had been admitted to RPH. He felt that nursing staff were excellent and had pre-empted his needs. He was very dependent on the staff and noted that they met the highest standards for 90% of the time, occasionally being off the mark when dealing with less experienced staff, but he offered this as an observation rather than a complaint and he had found staff were incredibly caring. The transition to the ward was challenging as he moved from one-to-one nursing to being in a side room which was more isolated and one member of staff was required to look after several patients. This meant he had to wait longer for washing, drinking and personal care, but again this was offered as an observation and not a criticism of staff. He had input from physiotherapy and noted that the staff were fair but firm and he felt safe in their hands. With their support he was able to do far more than he had believed. The speech and language therapy team moved him from being able to take a teaspoon of liquid, onto soft food, and then to a normal diet. The transplant team kept him and his wife up to date with the progress that was being made. He found the ward round arrangements in critical care confusing. AM noted that there were two ward rounds in critical care and so this could be confusing for patients. He felt he there had been brilliant attention to detail from the medical team to support his care. The only concern he wanted to raise was around the temperature of the food. He was served lukewarm soup and meals, and this was the key improvement area that he thought important. He had been able to find other healthy snacks at the hospital shop.		

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	He noted finally that he was incredibly grateful to have been afforded more time with his family and to be able to watch his children grow up. **Discussion** i. JW noted that it was good to hear this story and perhaps would be good to hear in a years' time how the patient was feeling. His recollection from the first heart and lung transplant patients was incredible progress, and some early concerns were unrecognisable 12 months on. ii. DL noted the issue of side rooms and asked how this was being progressed. MS noted that this was difficult as when patients were in individual rooms, they did not know where nursing staff were. She felt we were getting this right 90% of the time and that wards were aware of the problem and were working on it. iii. AF agreed noting that from visiting she found the rooms quite isolating and wondered whether we could also engage volunteers to provide some companionship. MS advised that our volunteers were coming back into the service over the next weeks and months, and this was an area where we wanted to use their contribution. AF noted that this story had made her reflect on the gratitude from our patients but also on the impact that such procedures had on their lives. iv. JW noted that COVID-19 also had an impact on the level of isolation experienced by our patients because of restrictions and guidance on infection control. v. MB asked whether it was common for patients to wake up with the sense of confusion. AM noted that it was, some patients wake up and are panicked, and patients often do not remember why they have been admitted to the Trust. MB asked whether we were always aware when patients were waking. AM advised that we were, as weaning was done incredibly carefully so that patients were maintained and supported by nursing staff who took time to explain everything that was going on to orientate them to place and time. vi. JA noted that many transplant patients had psychological support prior to procedure and asked what was in place to support patients after waking. AM advised that we had a psychologist on the critical care unit, and they worked with staff teams to ensure that strategies were developed to help manage any vulnerabilities. There was a section for support for each patient within their notes. JA asked if we also provided psychological input to families and whether that had an impact on the patient? JW noted that was interesting as prior to transplant some patients and families were often considering and preparing for a death, and with transplant a patient returned to a more normal life but with active ongoing medical problems. **Noted:** The Board thanked AM for the patient story.		
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:		

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	i. The key issues facing the Trust relating to productivity, people, and finance. ii. That the effective domain had become amber rated for the first time in two years. iii. The Meridian productivity programme which was now at an end. The Committee noted that this approach would be helpful in addressing pressures in critical care and in theatres, but we were expecting tougher times ahead and these activities needed to be sustained. iv. In relation to people, we had seen a positive change in retention figures. Whilst welcome it was felt this related to normal levels of variation. We continued focus on staff engagement but recognised that we also needed to control agency costs, and temporary staffing, and this activity was being undertaken at a system level. There were challenges across organisations, and we needed to be particularly careful about any upward drift in expenditure given the staffing pressures that we faced. v. Financially we were on target to achieve the 104% performance against baseline, and this was included into our breakeven plans. This meant there was no further contribution to financial recovery as our plans were set on a break-even basis and included the requirement to deliver at these standards. vi. The CIP target had been achieved and it was early in the year to deliver this. vii. We had investigated non pay opportunities and whilst we did not think there were significant gains in this area the Executive were to bring a paper on this to the next meeting. **Discussion:** i. MB noted that the Well Led reviewers had asked about how we balanced our focus between Quality & Risk and Performance Committees in relation to workforce discussions. He asked OM whether she felt this arrangement was working. OM noted that this month there were issues in the areas relevant to the individual committees. The Performance Committee had discussed pay and temporary staffing, and had touched on staff engagement, and this had been a quite different focus from the discussion at the Q&R Committee where we had looked at underlying issues driving the difficulties in staff engagement. She felt that these were discussions that were complimentary, and this was positive in terms of scrutiny. JW noted how the workforce and people agenda was being managed between the two agenda and what he had heard from this discussion was that this was positive and was working. ii. JA asked if there was a correlation between areas where we were doing well in terms of staff engagement, relationships, and morale, and if this linked to positive survey feedback on staff engagement. He also asked whether the challenges presented by the Meridian productivity work had contributed to worsening staff experience. OM noted that there was a relationship between scores and the feedback in these areas. Surgery, transplant, and theatres had the worst scores in our national staff survey across the last couple of years. Thoracic was better than average, and cardiology had seen its scores		

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	move up and down (with poorer performance in the prior year being reflected as improvement in this year's scores). iii. JA asked how we identified gains to ensure that the interventions were leading to a positive benefit. OM noted that these were small benefits, and it was difficult to compare across workforce teams as Theatres, wards, critical care and thoracic were each quite different areas. SP felt this was a good question and a positive challenge from the Board. He noted also the need to draw out that efficient productive working was good for patients and good for staff. If we looked for example at the Critical Care Transformation Programme, it was delivering better outcomes for patients and a better experience for our staff such as bringing rosters out to six weeks. The Meridian programme would see gains being generated and a more holistic approach to the improvement agenda in critical care. Staff would start to see the benefit by way of their lived experience iv. EM reflected on the Meridian intervention in outpatients and diagnostics and noted that the Clinical Administration team had some palpable concerns but through the programme they gained valuable skill sets to support the booking process and had overachieved against what had been set as a plan. The process was disruptive, but it did deliver sustained productivity improvements. v. MB asked whether problems with engagement were identified as a red flag in relation to productivity. SP noted that within the NHS we rely on goodwill from staff and the loss of that would have an impact on throughput and would increase risk. vi. AF felt that the difference between the Meridian approach and the critical care programme was the wrap around support offered. Our staff were feeling under pressure and were not well remunerated, and this leads to the standards outlined in the patient story where perhaps 10% of the time our more junior staff were working without the full training and development. TG felt this was correct and that EDs were conscious of this pressure. The ED team had leant into discussions with divisions about what support was needed and who were the subject matter experts that we needed to be able to draw on. **Noted:** The Board noted the Performance Committee Chair's report.		
2.b	**PAPWORTH INTEGRATED PERFORMANCE REPORT (PIPR)**		
	Received: The PIPR report for Month 02 (May 2022) from the Executive Directors (EDs). This report had been reviewed at the Performance Committee meeting and the Safe and Caring domains were discussed at Q&R Committee. It was provided to the Board for information. **Reported:** By TG: i. That overall, Trust performance was at an amber rating. ii. In the context of elective recovery, the wider NHS was operating at 88% against the 104% target. However, for the Trust, the baseline of 2019/20 was an extremely low bar as this reflected the period of the move. iii. Financially this month's PIPR was written before the		

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	agreement of the breakeven plan, and this would be updated in the June report. iv. That the Board should not underestimate the workforce and staffing issues facing the Trust. He noted also that the national pay award should be announced next month. **Safe:** Reported by MS that this domain was rated amber and had been reviewed at both the Performance Committee and at the Q&R meeting. **Caring:** Reported by MS that the domain was green and that the spotlight was on our returning volunteers. **Effective:** Reported by EM: i. That the domain was amber driven in month to by stable staffing and low COVID prevalence. This had allowed us to improve our activity, which was supported by the Meridian work in cardiology. This saw improved use of Cath labs and an increase in day case activity and that was in an improvement against baseline. ii. In addition, we had delivered mutual aid to CUH through cardiac CT and patients requiring implantable loop recorder device treatments. This was supporting CUH to reduce their long waiters. iii. Outpatients compared well to the 2019/20 baseline which was more robust as we had moved the Trust over a weekend and so had not lost productivity in outpatients. The Meridian activity had set a target of delivery of seven and a half thousand outpatients per month and that had been achieved consistently over a six-month period. We were therefore reviewing this target and would reset that trajectory to reflect the further opportunity to improve and draw through patients who were waiting. **Responsiveness:** Reported by EM: i. That our metrics were holding up, and we had strong performance, but had seen a dip in the last month. ii. RTT performance was driven by consultant-to-consultant referrals, and we had seen a slight increase in the number of patients waiting over 18 weeks, however she was assured that we were drawing through patients in the order of clinical priority. iii. We had seen a shift from GP to consultant-to-consultant referrals as these were now less restricted by commissioners. She noted however that there was not any great degree of consistency in the behaviour across providers and so there may be some degree of continued return to GPs rather than onward referral to specialist services. IS noted that there were times where the was appropriate for example where a patient needed referral into local services and specialised clinicians at RPH would not know which service to select and so would refer via GPs. **People management and culture:** Reported by OM that sickness absence had reduced but was now increasing and was at a level of		

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	6% (including 2.5% COVID-19 absence). This had an impact on capacity and on the stress levels of staff across the organisation who were working to cover absences. **Finance:** Reported by TG that as a part of the additional funding approved by Julian Kelly there was an emphasis on application of agency caps nationally and it was expected that this would be enforced across systems. **Discussion:** i. GR Noted that the 104% target was an interesting measure as each organisation benchmarked against its own baseline for 2019/20. TG acknowledged that but advised that was not the only issue. If no providers or systems were able to deliver against this target nationally, then there would be an argument that this needed to be considered with some degree of flexibility. ii. JA suggested that given the difficulties of comparisons in PIPR whether we could focus on what was within our control. TG agreed noting that we needed to compare to our own baseline, but also needed to know what it was possible to deliver. iii. MB noted the commitment to review the baseline benchmark for the full optimisation of the hospital looking further back to 2018/19, following conclusion of the Meridian work. EM advised that we already tracked activity against that measure. There were complexities with this as we had seen higher emergency activity since the move in 2019 and so needed to look at some shifts in baseline. MB welcomed the creation of the bridge that would set out the extra burden of the new therapies and services delivered, noting this should include the shift to emergency pathways, as well as the shift in elective cases to less invasive therapies delivered through cardiology. JW advised that this work needed detailed consideration and proposed that this should be taken forward through the Q&R committee. iv. GR asked about the mutual aid provided to CUH and whether this would have an impact on Trust performance or if it related to a small number of long waiters. EM advised that this related to about seventy patients so far and was not significant in the context of our overall waiting lists. This was being accommodated through additional lists. We had no patients waiting over 52 weeks and were picking up patients from CUH who were waiting over 78 weeks. JW noted that this was the right thing to do but felt we should capture the impact on our performance. EM advised that these were our patients once they had transferred, and she would attempt to reflect them in RTT monitoring but they would not have a material impact and the way forward would be to have a single system wide priority treatment list for each specialty. v. SP noted that this was important and that the ICB had discussed differentials in diagnostic waiting times and would be looking at how resources were applied for patients across the whole geography of the ICB. This would include consideration of the financial flows to those organisations who were doing the right thing, however there wasn't a national rule book, and this would therefore be a significant matter between partners in the ICB. It	**EM/MB** **EM**	TBC Sep 22

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	was good to have this discussion at Board and this reflected the priorities and discussions at the ICB meeting. vi. MB noted the temporary staffing spotlight and asked for clarification of the calculation of the shortfall in staffing. OM advised that the figures indicated that we needed four hundred staff and had been able to secure resource to cover one hundred of that requirement. This figure included all gaps across sickness, vacancies and the increase in establishment that followed budget setting. MB asked whether there was an increased burden on our remaining staff and how that related to vacancy rates and short-term unpredictable absence. OM advised that we had pressures in cardiology which related to rostering issues and demand, however, demand did not always match what was needed. In areas where we had an increase in vacancies and increase in absences, then temporary staffing was not going to be able to meet that demand. MB returned to the issue of remaining staff picking up the increased burden and whether this was a feature of feedback. OM noted that this was being seen to a greater extent across admin and clerical roles and in Allied Health Professional roles where we were unable to recruit on a temporary basis for staff who in prior years would have been able to support and to fill gaps. This would have a widespread impact across departments and across the Trust. vii. JA asked about the basis of payment for agency and NHS pay rates, the impact on ability to recruit and whether it contributed to tensions within departments between staff. OM noted that we had national caps and rules that applied to agency staffing and had a framework agreement in place relating to nursing and admin and clerical roles. This included a cap but also had a 'break glass' provision which required executive approval. We had a good temporary staffing manager who worked well to secure appropriate rates and contracts. We had areas where we paid over cap such as cardiac physiology and theatre staffing, but we also looked to see if requests could be managed with an alternative approach. We had an agreed regional approach for medical staffing and at a system level had a procurement hub to support the framework agreement. We also shared information on bank and agency data. We had local rules that applied such that staff employed in the local system would not be engaged as agency in partner Trusts, but this restriction only operated within our local system. OM advised that Trust bank staff were paid at Agenda for Change rates. viii. JW asked whether the ICS summary in PIPR should now refer to the ICB. TG agreed that it should and that would be updated. **Noted:** The Board noted the PIPR report for Month 02 (May 2022).	**TG**	Sep 22
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 the Committee had: i. Received reports on theatres and the QI improvement programme which required a sustained change in culture to		

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	support the programme. ii. Had received a proposal around analysis of low harm and no harm incidents which, whilst small scale, was something that had been identified for some time and was a good contribution to the quality improvement agenda with a constructive conclusion. iii. Had discussed our response to the elevated levels of surgical site infections. He noted that MS had been prompt when joining the organisation to highlight concerns and to react to this information, however it had been a feature of reports for some time, and the Committee wanted to understand whether the information we received was well calibrated, and whether we were taking too much by way of reassurance from the Executive. We had agreed that there was a willingness to consider the position and our reaction, and to look at how we dealt with the issue in front of us. **Discussion:** i. CC noted this linked to the issues raised around Ockendon, principally understanding whether we were asking the right questions. JW noted that whilst we could not fully understand what we didn't know, we needed to ensure that concerns were listened to, and that reporting was sufficiently sensitive to identify serious issues. ii. JA returned to acceleration of the use of SPC charts which would help the Board to assess whether what was being looked at was normal variation or a proper signal in relation to performance. He felt that we should also accept that where there was a need to demonstrate more assurance or evidence that it was not disrespectful to set that expectation as this would make securing quality improvement more certain. iii. SP welcomed the discussion noting that there was value in having the SPC charts and tripwires and value in fresh eyes coming to an agenda. JA noted that this might suggest we look in future at how we also refresh committee membership. iv. MS advised that it was for the Board to have confidence in the systems and processes that alert us to problems at an early stage. The improvement framework needed to be set in that context and reflect our compassionate and collective leadership programme. The Board needed to have confidence that data provided early warning when things were going wrong. v. OM noted that this was not just about the Board it was about our governance and accountability framework. This was an aspect of divisional development which had been delayed by the pandemic and we were now developing our divisional structures and would be building a programme to support them in the autumn. This would ensure the framework was working. vi. AF noted the key issues were system, process, and governance, and that our staff remain curious and use their professional judgement and intuition. MS noted that good judgement could be developed by working through scenarios in development programmes. **Noted:** The Board noted the Q&R Committee Chair's report	**EDs**	Nov 22

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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: i. There had been a good discussion on surgical site infections at the Q&R meeting ii. The report highlighted the work on the critical care transformation programme. The work streams associated with this programme were now coming into their own and were focused on values and behaviours. We were now seeing thirty-five beds open on the critical care unit on a consistent basis. iii. We had responded to updated guidance in relation to COVID-19 and had put in place further steps on face masks and protecting our patients. iv. She wanted also to record her thanks to Ivan Graham the Deputy Chief Nurse who was leaving the Trust to take up a new post at North West Anglia NHSFT. She thanked him for his contribution and leadership over the last four years. **Discussion:** i. JW echoed his thanks for Ivan's contribution to the hospital, in particular the establishment of the command-and-control centre to support the hospital move. ii. IS applauded the work in critical care and the team that had supported this. He felt this model should be used across all our services to ensure that a Quality Improvement culture and approach was established across the Trust. iii. GR welcomed the news that critical care was open to thirty-five beds and asked how far the project had progressed. MS advised that we were twenty weeks into the programme and were about halfway through at this point. What was left was the embedding and sustainability and that would need us to resolve several challenging issues. The bed target had been achieved but this needed to be embedded and monitored. IS noted that all staff needed to understand their role to ensure that this change could be sustained. MS advised that the requirement for additional support was being discussed to ensure that there was divisional ownership. GR felt this recognised the importance of sustaining change. iv. DL asked about the transformation and how we managed capacity where patient numbers exceeded the number of beds available. She also noted that we were still not producing rosters six weeks in advance. MS advised that the unit was not always full and so staff would be redeployed towards to cover gaps, however that had a negative impact on morale. Work on roster management was continuing but rosters were built around 10 weeks ahead of time and so there were still issues that were being worked through and resolved. The team were now setting deadlines and key dates as smart targets to ensure that rosters were delivered in a more timely fashion. v. AF noted this was a complex programme and sustainability was crucial. She felt the time and energy that Jennifer Whisken and Katie Morrish had put in would be difficult to		

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	replicate but this was required to achieve sustainability and that pastoral care was an essential element of the plan. vi. JA welcomed the work and noted that the stress test for this would be the winter period rather than the summer months which were relatively calm. He noted also the difference between sustained quality improvement and continuous improvement where every day we review what we did and do things differently and better. **Noted:** The Board noted the Combined Quality Report.		
3.iii	**Board Sub Committee Minutes:**		
3.iii.a	**Quality and Risk Committee Minutes: 26.05.22** **Received and noted:** The Board of Directors received and noted the minutes of the Quality and Risk Committee meetings held on 26 May 2022.		
3.iii.b	**Performance Committee Minutes: 26.05.22** **Received and noted:** The Board of Directors received and noted the minutes of the Performance Committee meeting held on 26 May 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 she would take her report as read. It summarised the quarter one pulse survey results and set out progress on the reciprocal mentoring programme which had seen a great start and had given a boost to the networks. **Discussion** i. JA noted the update on reciprocal mentoring and the appointment of the twelve cultural ambassadors and asked when they would be invited to present to the Board. OM noted that this was planned for September or October once they had started to gain experience in their roles. It was planned to invite them to speak at a staff briefing and this could perhaps be as part of a talking heads conversation between some of the pairs. ii. DL asked whether Laudit was still in use and was as successful as it had been originally. OM noted that Laudit figures were included in PIPR, and that it was working well. iii. DL asked about the ODP vacancy rate in theatres and what we were doing to recruit into this role. MS advised that the department recruited nurses who subsequently trained to be anaesthetic practitioners. This was a one-year course, and we had four trainees in each year to keep the flow of practitioners/ODPs in place. We were also looking at roster coordination, but this still left a gap in terms of vacancies. OM advised that there were some improvements to be made in recruitment activity which were being pursued and we would be doing some overseas recruitment for scrub nurses.		

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	iv. CC asked about the staff survey and the feedback around inconsistencies in granting home working. OM advised that this was already a part of flexible working arrangements if it worked for the organisation and the role. This was an issue in clinical administration where there was a perception that we were not being as flexible as we could be. This feedback was emerging from surveys and was a theme we were aware of. CC asked if this generated tension between clinical and administrative teams who may not have the same opportunity to work from home. OM noted that many clinicians were able to organise working one day a week at home and clinical and nonclinical staff recognised the different requirements. This was a different matter from managers who had negative views on flexible working; however, legislation and guidance had changed, and our flexible working policy was being revised to reflect this. OM acknowledged that this would need line managers to be engaged and to improve how this was managed and that some managers felt vulnerable where they were not able to grant flexible working requests. CC asked whether there was a system discussion on the approach to this. OM advised that there were system discussions, but this was an individual employer matter. We needed to work with line managers as we could not always compete on pay but we could compete by enabling flexible working. **Agreed:** The Board noted the update from the DWOD.		
5	**STRATEGIC**		
	No report due.		
6	**RESEARCH & DEVELOPMENT**		
	Research & Development Directorate Strategy Update **Received:** From the Medical Director a presentation to inform the Board of recent updates in the Research & Development Directorate. **Reported:** By IS that: i. That Dr Paddy Calvert and Dr Vikki Hughes had put together the R&D presentation and Dr Calvert was working on the strategy for the R&D department which would come to the Board in October. ii. Portfolio studies were used to assess and inform financial support for research within the region. These studies were logged and recognised nationally by the National Institute for Health and Care Research (NIHR) and to qualify, studies must have either been established with commercial funding through open competition or be funded by a recognised research charity. They support quality research and attract extra income, but funding was not straight forward as there was a significant lag between changes in volumes and changes in funding flows. The Trust had done well in growing this area of business but had hit a block in terms of governance processes. This was being reviewed to ensure that there were enough staff to undertake due diligence checks in a timely fashion.		

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	iii. The spike in the number of participants enrolled in studies related to our staff volunteering to participate in COVID-19 trials. We were now back to a more static picture of recruitment, and number of studies. iv. Income had grown from competitive grant funded awards. This provided some independence and financial stability as these were generally awarded for periods of three to five years. v. We had undertaken benchmarking against Liverpool Heart and Chest Hospital and the Royal Brompton and whereas 10 years ago the Brompton funds were five times the volume of RPH this differential had reduced, but this was in part due to a worsening of their position over time. vi. The research capability fund was a central government funding stream matched to partner grants. This was an area of opportunity as our clinical researchers could now be recognised by the UoC as academics. In principle researchers appointed to affiliate professorships would be able to apply for research capability funding. This funding was on top of other funding streams and was to support infrastructure so that in the subsequent years we could do more. vii. He noted that it took a long time to get studies through governance processes and whilst there had been a focus on this it had slipped again and so we were losing studies as they expired before approval. We had no overall problems with recruitment and time to target once studies were approved. viii. He felt this was a good area for QI as there had been growth in staffing and we needed to consider if we had staff in the right places to increase productivity and optimise the budget that supports this work. **Discussion** i. GR asked about other income and how profitable this was. IS advised that CRN (Clinical Research Network) income for high profile studies was static but was an area of potential growth. This was NIHR national funding and was complex and was related to participant values which could be at a rating of 1, 3, or 13. Many studies at RPH were rated at the high end of this range, but funds were limited because of the low volume of participants with some having as few as one or two participants in a trial for complex studies. Commercial income had reduced, and we needed to rebuild that income linked to the clinical research facility in the HLRI. ii. IW noted that the governance check delay was a serious matter and asked if this had an impact on commercial income. IS advised that it did as these were studies that expire if we did not get them off the ground. This was top of the agenda for the R&D directorate with temporary backfill in place, but it needed a sustainable plan. iii. IW asked about the latest information from NIHR on Research Design Service (RDS) Clinical Trial Unit (CTU) competitions and whether there was opportunity to leverage monies that had gone outside area. IS advised that much of the financial flow was into London and whilst this was a priority for R&D, we did not have a plan to take this forward at this point.		

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	iv. GR asked about the business model and whether central funding covered fixed costs or whether we had to recoup fixed costs from individual studies. TG advised that this was something that we were reviewing closely. The Trust investment in R&D pre-COVID was around £150k per year as a net contribution. The discussions around the opening of the CRF and the R&D budget included consideration of how we take on Principal Investigators to ensure this would not become unstainable. IS noted that ideally income streams should increase along with the non-financial benefits of being a research led organisation in attracting and retaining staff. This would be part of our being a centre of excellence and an attractive place to work. This should also help us to achieve a break-even financial position. v. JA noted that it was good to see this data and asked about the percentage of patients enrolled in trials from our eligible patient population as this could help to provide focus. He also noted the agenda on widening diversity of participation in research and suggested that it may be helpful to have measure of EDI participation in trials reporting as this was an untapped population. There were also drives to increase funding for this work which might be particularly relevant around genomic data linking with external partners such as the British Heart Foundation as the reference data for black and minority ethnic populations was minimal. IS advised that this area of work was led by Dr Calvert and was an iterative process. One thing that had been achieved was more an improved search function in Lorenzo so that researchers were able to pinpoint patients eligible to be enrolled in trials. This would give better information about the number of patients not recruited and provide real time information to clinicians. In general, we were recruiting to time and to target numbers for the trials that were operational. vi. IS noted that the collection of data on ethnicity was a particular problem in the hospital as 40% of our patients do not have this data collected and that needed to be resolved at a hospital level. JA noted discussion at the NHS confederation on rare diseases the chance of getting a genetic signature was 30% for those affecting white babies and only 1.5% for those effecting non-white babies and this position was mirrored across other disciplines. vii. JW noted that the ambition at the Trust should be that every patient was enrolled in a research and development study. viii. DL asked about the recruitment time and targets, how that linked to the delays in the governance process and whether this resulted in loss of income another opportunity costs. IS advised that we were still performing well against our targets but there may be lost opportunities because of delays. IS agreed that we should bring this back in the next R&D report advised that there would be some further discussion in Part II meeting which would focus on some of the required changes in working practices. **Noted:** The Board noted the Research & Development strategy update	**IS**	Oct 22

Agenda Item		Action by Whom	Date
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 7 July 2022

Glossary of terms

CIP	Cost Improvement Programme
C&P ICS	Cambridge & Peterborough ICS
CUFHT	Cambridge University Hospitals NHS Foundation Trust
CRF	Clinical Research Facility
CRN	Clinical Research Network
CUHP	Cambridge University Health Partners
DGH	District General Hospital
GIRFT	'Getting It Right First Time'
HLRI	Heart and Lung Research Institute
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
NIHR	National Institute for Health and Care Research
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