Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Held on 1 September 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 Executive Officer
	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)	Medical Director
	Prof I Wilkinson	(IW)	Non-Executive Director
In Attendance	Mr A Baldwin	(AB)	Interim COO (designate)
	Mr R Chapple	(RC)	Principal Pharmacy Technician / Trust Armed Forces Champion
	Ms T Crabtree	(TC)	Head of Communications
	Ms C Ellis	(CE)	Ward Advanced Nurse Practitioner
	Mrs L Howard-Jones	(LHJ)	Deputy Director of Workforce and OD
	Mrs A Jarvis	(AJ)	Trust Secretary
	Ms O Patrick-Redhead	(OPR)	Head of EDI
	Mr A Selby	(AS)	Director of Estates and Facilities
Apologies	Ms O Monkhouse	(OM)	Director of Workforce and OD
Observers	Trevor Collins, Rhys Hurst, Trevor McLeese, Harvey Perkins, Martin Ward		

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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		

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	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. EM advised that there were a number of responsibilities that she was taking on from Stephen Posey and these would be updated within her declaration.		
1.ii	**MINUTES OF THE PREVIOUS MEETING**		
	Board of Directors Part I: 7 July 2022 IS noted that he had been listed as Deputy Medical Director on the attendance list and this should read medical director. **Approved**: With the above amendment the Board of Directors approved the Minutes of the Part I meeting held on 7 July 2022 as a true record.		
1.iii	**MATTERS ARISING AND ACTION CHECKLIST**		
	Item 314: PIPR: It was agreed that the benchmarking report should be reviewed in the first instance through the Performance Committee, rather than Quality & Risk Committee. **Noted:** The Board received and noted the updates on the action checklist.	EM/GR	TBC
1.iv	**Chairman's Report**		
	The Chairman noted that Eilish Midlane was in post as Chief Executive and Accountable Officer of the Trust from today, 1 September 2022. He also advised the Board that Her Royal Highness the Duchess of Gloucester had officially opened the HLRI on Monday 11 July 2022. Larraine Howard-Jones advised the Board that Mike Magowan, the Trust's Training and Development manager had died in August, and this was a very sad loss for his colleagues and family. He welcomed Alex Baldwin who was in attendance and would be joining the Trust as interim Chief Operating Officer from September. The Chairman also noted that he had contracted COVID-19 and was now recovering.		
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 EM that there was a new risk that would be added to the BAF this month as unions, including the RCN, were now to ballot for industrial action and this increased risk to the Trust, and we may be particularly vulnerable within some of our smaller teams. **Noted:** The Board noted the BAF report for August 2022.		

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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 EM that: i. She was delighted to present her first CEO's report and wanted to record her thanks to Stephen Posey for the contribution that he had made over the last six years. ii. She was proud to have been appointed as CEO and she had started with some change in the format of her report. She was keen to represent the current key themes for the Trust and noted that people were at the top of her agenda. iii. On Monday the consultation on the move of Royal Papworth House would start. We had identified a location in Huntingdon shared with CPFT and were starting a consultation on how we could make this work for our staff. This had been well received at the earlier soft launch. iv. The 'Delivering Excellence Together' programme was now underway within theatres. v. Three cohorts off staff had now started our Compassionate and Collective Leadership development programme. vi. We had delivered a thank you event for staff, holding an afternoon tea, which many had enjoyed. vii. We had seen excellence in delivery of care with two transplant operations being undertaken on one evening, as well as emergency Cath lab activity. This was truly fantastic collaborative work by our clinical teams. viii. We continued work on surgical site infections (SSIs) but had reduced the frequency of meetings as we were now seeing progress in our numbers. we had also seen concerns raised around legionella and had undertaken work to address this which would be covered later on the agenda. ix. Performance in July was not as good as we wanted because of a number of challenges, however we had seen strong financial performance and had continued with the implementation of our shared care record. x. We also had some excellent examples all our staff leading their field: Dr Sarah Clarke had been announced as the 122nd president of the Royal College of Physicians, Dr Karl Sylvester had been made an honorary fellow of the Academy for Healthcare Science; and Professor R. Andres Floto had been awarded a mid-career gold medal in NTM from the European Respiratory Society. **Discussion:** i. JW asked about the shared accommodation with CPFT and how the digital infrastructure would be supported. EM advised that we had separate networks and that performance would be improved from the current position at the House. ii. JW noted the recent visit by Simon Kendall to review issues around Surgical Site Infections. He also asked Dr Smith to clarify the position on the legionella case. IS advised that the		

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	sample taken at day 16 of admission was a different strain of legionella to that identified in our routine sampling but actions were appropriate in any event. He noted the significant work undertaken in relation to M.abscessus, and that this further scrutiny had provided more positive learning. iii. MB asked about the reference to recalibration of our clinical risk appetite. EM advised that the CDC had discussed our theatre and workforce constraints and whether it was appropriate to have teams on standby whilst not allowing elective cases to progress. It had been proposed that we should reconsider the current stand by structures when we were unable to achieve activity throughput. MB welcome to this discussion and felt that we should be considering what we could do without given the current constraints. MS advised that there was a quality impact assessment in relation to the actions on theatre staffing and that we would have a safer staffing escalation policy for theatres. **Noted:** The Board noted the CEO's update report.		
1.vi	**Patient Story**		
	MS introduced the patient story presented by Claire Ellis, Advanced Nurse Practitioner. She noted that Claire was to share a story on the consequence of delays for a patient on the In House Urgent (IHU) pathway. CE advised that the story related to a patient who had been admitted to the Trust from his District General Hospital (DGH) as has he had unstable angina. The patient was aware that his story was being shared with the Board. The patient had suffered a deterioration in his angina symptoms and had been frustrated with his GP service who had advised that this should manage with a GTN spray. The patient had as strong family history of cardiac disease and he revisited his GP and requested investigations, which were arranged at his local DGH. The DGH had planned to undertake an angiogram, but their equipment was broken, and the patient was seen and sent home having been fitted with cannulas. He was re-admitted locally and suffered chest pain overnight. His local physicians advised that he should be referred to RPH for an inpatient angiogram as they felt certain that he had a blockage. He was transferred after a wait of three days and had the angiogram the day after admission. The need for surgery was discussed with the patient and he underwent a triple bypass operation. The patient reported that he felt well informed but was very frustrated by the time to diagnosis. He had been given a date for surgery and this was delayed by 8 days. During this time, he felt like a prisoner in his room tethered to monitoring equipment. He was isolated and anxious about whether he would be cancelled and delayed again. He felt that he was at times treated like a child and had not found the doctor's rounds very positive. He was unclear about changes in his medication and felt that the content of the surgical cardiac booklet on preparation for inpatient and outpatient procedures was largely irrelevant to his case and was not very holistic. The impact of delays was exacerbated as he was not able to have visitors, as his wife was unable to drive, and this was		

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	distressing to him and his family. He was retired member of the RAF and felt out of control and angry about the delays in diagnosis and in surgery. CE noted that the patient had now had his surgery. **Discussion** i. DL asked about patient medication, whether we had a checklist for medicines changes and whether that was something we could improve? CE advised that there was more discussion with some patients than others, with some happy to take a 'back seat'. She felt that some aspects of medicines management were more focused around discharge and not the whole inpatient stay. However, ANPs took time to manage and explain medicines as there would be a need to stop some drugs, such as blood thinners, 5 days prior to surgery and so that could add to the perception of delays. She agreed that she would feedback this message through the cardiology nursing team. ii. AF noted that we had heard similar experiences of patients in hospital waiting for procedures and how this had a negative psychological effect. She asked if patients needed to be in hospital and whether there were alternative arrangements such as hospital hotels or other facilities that might be used as these patients were occupying beds, but it seemed we were not meeting their needs. CE advised that every referral had an IHU discussion every day and that there was a minimum data set required in order to allow treatment on this pathway. The daily meetings involved surgery and medicine and the plans had to be agreed jointly between the cardiac and the surgical teams. If patients were in DGHs, then they were also invited to join the case discussions so that they understood the outcomes. These multidisciplinary meetings take the decision around whether a patient should be transferred as an IHU case or whether they could return home and be referred for elective surgery. iii. JW noted that it was good when the pathway worked and observed that if medical treatment stabilised a patient on admission, then the decision around relative risk might also change in relation to remaining in RPH, or in their local DGH. iv. EM asked about the role of ward pharmacists and whether they would have the time and knowledge to undertake such discussions. She also noted the issue of isolation in the individual rooms and that we were now looking at whether we could improve the use of day room areas to help with isolation. v. MS noted the deconditioning effect and advised that there may be more that we could be doing for patients who remained in hospital. These patients were seen on ward rounds but were somewhat overlooked as they were listed as waiting for surgery and so their wider needs were perhaps not considered. vi. CC asked whether volunteers could help with this. MS advised that we had welcomed back our volunteers 10 days ago and were identifying areas where they were going to be undertaking similar roles as they had previously been able to do. vii. JA felt this was an instructive story and that this patient was articulate, intelligent, and able to express their views. He noted that there would be others who were less confident and some for whom English was not their first language and asked what	CE/MS	Oct 22

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	was being done to support these patients. CE advised that the Trust was generally well provided for and was able to access face to face services to support patients. Interpreters would support and translate for patients and would speak with family members if needed. viii. JW asked that where actions were identified in relation to patient stories that updates were bought back to the Board. **Noted:** The Board noted 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 from the July & August meetings. **Reported:** By GR that the Committee had considered the following key issues: i. A presentation from the Critical Care service which had been similarly presented to the Quality and Risk committee. This had reported substantial progress but acknowledged that we were not testing the service to its limits because of the constraints on theatre activity. ii. An update on the theatre transformation project. This was not an 'overnight fix' and would deliver gradual transformation. iii. The steps being taken to maximise our bed capacity including admission of patients 24 hours earlier in the IHU pathway. This would release capacity at referring hospitals and should help to reduce cancellations for patients identified as unfit following transfer. Steps were also being taken to look at whether there were suitable transfers into critical care to ensure that we were maximising our bed occupancy. iv. That we would now need to begin our winter planning and would need to understand the issues relating to finances, workforce, and productivity. **Discussion:** i. JW noted the work underway on theatre transformation and that progress was being made. He felt the steps being taken demonstrated the system approach that was being developed by the Executive and others who were contributing promising ideas to support the whole system. ii. MB wanted to understand the impact of the change in the day of transfer of patients on this pathway and whether this would simply result in a 'stock transfer' figure or an ongoing benefit. It was agreed that this would be followed up outside of the meeting. iii. EM advised the Board that the theatres project was owned by the division and was a transformational change programme, which was different to the critical care programme which was now being moved into business as usual. The theatre programme would require significant new ways of working to be implemented. iv. JW noted that the Committee had raised a query around the SSI risk. MS advised that SSI was a separate risk on the Corporate Risk Register which was linked to BAF risk 675		

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	(HCAI) which had a residual risk rating of 16 (C4xL4). **Noted:** The Board noted the Performance Committee Chair's report.		
2.b	**PAPWORTH INTEGRATED PERFORMANCE REPORT (PIPR)**		
	Received: The PIPR report for Month 04 (July 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 and was provided to the Board for information. **Reported:** By TG that Trust performance was at an Amber rating with three amber and three red domains including effective and responsive services. This reflected the issues in theatres and productivity. The national context was that the NHS was facing a difficult position with ambulance delays and escalations across systems. There were high levels of delayed transfers of care, high levels of COVID19 when compared with historic levels, and significant workforce stresses. **Safe:** Reported by MS: That there was nothing to report by exception. She had included a focus on SSs to provide assurance around the improvement, however we remained cautious around this metric. The report also provided a spotlight on the hygiene code. She noted that we had received the report from Simon Kendall and that had been shared with Mr Jenkins. The report included a number of recommendations but nothing that we had not already identified. His advice on practice issues was positive. **Caring:** Reported by MS: That we were keeping a close eye on complaints and had seen some level of seasonal variation in these numbers. We were keen to learn and to improve our care through these reports. **Effective:** Reported by EM: That we had already spoken about the challenges being faced in relation to productivity. There were some coding issues to be addressed as a volume of day case workload, which was being delivered in appropriate settings within the outpatient department should be being coded by classification of work and not location, and that adjustment would flow into future reports. **Responsiveness:** Reported by EM: The metrics reflected slow progress in admitted care, but diagnostics had recovered back to the 95% target. We had continued to support CUH with echo activity and had some positive news on recruitment and had attracted some experienced candidates into the service. This would support new ways of working and productivity in echo services across the system. **People management and culture:** Reported by LH-J: The key issue for the Board was that turnover and vacancy rates had increased and were particularly challenging. **Finance:** Reported by TG: That the Trust had a £1.6m surplus year to date and had been advised that the elective recovery fund payments would not be clawed back for quarters one and two. He noted that some other system providers were reported to be struggling		

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	financially. Our performance against the better payment practice code had declined in quarter one and improvements would be implemented before Christmas. Non-NHS providers had met the standard, but NHS invoicing had deteriorated, and the further actions would address this. **Discussion:** i. MB asked about the measurement of cardiac surgical mortality and noted that he had reviewed our mortality rates from the period when he had originally joined the Trust and had seen that there had been a very small increase over that period. He felt that this was an interesting measure and was keen to understand whether this was as a consequence of long waits and so would like to a measure of risk adjusted cardiac mortality. JW noted that this data was scrutinised at an individual consultant level and was published on an annual basis. The rate of mortality in cardiac surgical cases was now so low that there was a shift in emphasis towards morbidity and the surrogate indicators for this were length of stay in intensive care and in hospital, and these would have a different risk ratio to mortality. MB felt this was something worth looking at to identify if performance was now "in the pack" and whether this would trigger further discussion. He asked if IS could speak to Mr Jenkins and see if the data could be distilled into a format that could be plotted. JW noted that the data was there and was available as a percentage of expected mortality within standard deviation limits. IW agreed that it would be good to have the data but felt this might show a regression to the mean and we would need to look at the time frame and numbers involved. ii. JW asked about how we recorded the support that we provided to the wider system. EM advised that the system highlight report was included within PIPR and we should probably articulate the elements and the plans that we were delivering as part of the narrative update. This was not really visible within activity figures as numbers were low, and for RTT patients would be added and removed from the list within month as that was measured on a census basis. CC noted also that any risks arising system performance and how these might impact on RPH should be reflected in our monitoring. iii. IW asked about plans to train echo technicians and whether this was a national issue. EM advised that it was, and a regional programme had been launched to support echo trainees. We were looking at whether it would be appropriate for us to take on the burden of training for the whole system and were meeting with system leads to consider whether this could be delivered as a part of the educational element of the RPH school. iv. AF felt this demonstrated that we were a strong system player and compared this to our response and to delivery during COVID, which had been stronger than it was at present. She asked how we balanced this extension of role against the pressures that we were seeing in intensive care and in theatres. There was a significant question around the balance of resources to address internal pressures and the external initiatives. EM advised that we did not have a clear plan as yet and the current position was different to earlier recovery phases, however there was a need to ensure that we recreated	IS	TBC

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	the 'can-do' spirit that had been seen historically at RPH. Executives were working with their teams and one another to get us back to that position and we would be considering mitigations that were required but also looking at opportunities to be less risk averse. MS felt that there was support needed in this area and that particular attention needed to be paid to the language that was used. We are supposed to be busy and that was not unsafe; the key issue was to ensure that we supported people so that we could be busy. We provided health and well-being support through our programmes and needed to provide effective rostering and recovery times. This would require leadership at all levels, and we needed to look at how we worked with our teams to deliver this. We were aware that there was a need to balance the narrative between staff feeling exhausted and staff feeling frustrated that they were unable to deliver or get on with their work, both resulted in disengaged staff, and we needed to work with them. v. JA asked whether we needed a formal psychological approach to be taken across the hospital. The Trust has moved a hospital, it has responded to the pandemic, nationally we were facing a recession and staff were exhausted. There would be a collective impact of all of these drivers, and it was important to understand what RPH could do and can do to address this. He was also concerned that we recognise that architecture of the new hospital may have an impact on staff. JW agreed that this would lead need leadership at all levels. EM noted that there were discussions about opportunities as well as the issues of flux in the local system. vi. MS noted that we needed to recognise what our staff could offer and where they could each add value to ensure that we were not hindering progress. IS agreed that we needed to engage those staff groups where there were difficulties. Some staff were not happy, and felt their supporting structures were not working, whereas other areas were achieving more than 200 percent of their pre-move activity and workload. There were teams where some structures or middle layers had the perception that it was all 'too difficult' and we needed to change the microclimate in those areas. vii. AF asked about the deterioration in the clinical supplies position. TG advised that this was more of an issue of phasing as the plan reflected the 2019/20 activity during which time we moved the Trust and so we had more planned activity than had been undertaken historically. **Noted:** The Board noted the PIPR report for Month 04 (July 2022).		
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 from the July & August meetings. **Reported:** By MB that: i. The committee had received an update on digital clinical safety reporting that had been developed had progressed a long way.		

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	ii. It had heard the story of Victor, one of our staff nurses on Critical Care outlining how treatment including oversight for promotion and insensitivity in feedback had a negative impact on his experience and working life at RPH. iii. That we had looked at quality standards and the indicators associated with current stresses being experienced by the organisation and had not seen significant variations as a result. **Discussion:** JW noted that there had been a change agreed in relation to the 'nursing message of the week' which was now promoted as the 'message of the week' as these messages were relevant to all staff. **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 key issues had already been covered in earlier discussions around the water issues. **Noted:** The Board noted the Combined Quality Report.		
3.iii	**Infection Prevention Control Annual Report** **Received**: From the Chief Nurse the Director of Infection Prevention Control Annual Report. **Reported:** By MS: That the IPCC report had been through the Quality and Risk meeting and was the activity report for 2021/22. There were other issues that would have more prominence in the current years report (2022/23) and she highlighted the summary of key issues for the forthcoming year, setting out the governance, management of ventilation and the report from the Estates team. She thanked all who had contributed to the preparation of the report. **Discussion:** i. DL asked about the issue of sharps injuries and what was being done to reduce these. MS advised that we were working with occupational health who owned the sharps policy. Much work was being undertaken on elimination of items that were not 'sharps friendly' in order to reduce the risk of injury. Heads of Nursing were reporting on this matter through CPAC to Quality and Risk. **Agreed:** The Board approved the Infection Prevention Control Annual Report 2021/22.		
3.iv	**Audit Committee Chair's Report** **Received:** The Board received the Audit Committee Chair's report setting out significant issues of interest for the Board. **Reported:** by CC: That there were two issues to draw the Board's attention to the first of these was the EPR audit and we had assurance that this would be taken to the Quality and Risk committee via QRMG. The second was		

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	the issue of salary overpayments which have not historically been reported to committee and that would be happening from October. **Discussion:** i. AR advised the Board that the review of the EPR system was being established through a formal project and would report via SPC. We were also setting up a data quality group to feed in to the steering group for the EPR system. **Noted:** The Board noted the Audit Committee Chair's report.		
3.v	**Health Education England Self-Assessment** **Received:** From the Chief Nurse and the Assistant Director for Education the Health Education England (HEE) Provider Self-Assessment summary report. **Reported:** By MS: That Health Education England was the statutory body that delivers education for health and there was an assessment process that we were required to undertake to ensure that quality standards were maintained. We had undertaken the self-assessment against the contract application for 2022/24. She thanked Jon Lonsdale and the education team for their contribution to the report. **Discussion:** i. DL noted the lack of protected training spaces and asked about the risk associated with this and whether that would mean that training would not happen or if we would have to repurpose clinical areas? MS advised that these activities were undertaken in unoccupied areas and going forward if we needed that capacity for patient activities then we would need to take a creative approach or strategy to resolve this. ii. JW noted that on campus there was no postgraduate education centre and whilst there was discussion about this with campus partners we were not seeing any progress. JA advised that Dr Aaron Gupta had led some CUHP discussions and may be asked to consider this issue. **Agreed:** The Board approved the provider self-assessment for submission to Health Education England.		
3.vi	**Board Sub Committee Minutes:**		
3.vi.a	**Quality and Risk Committee Minutes: 30.06.22 & 28.07.22** **Received and noted:** The Board of Directors received and noted the minutes of the Quality and Risk Committee meetings held on the 30 June and 28 July 2022.		
3.vi.b	**Performance Committee Minutes: 30.06.22 & 28.07.22** **Received and noted:** The Board of Directors received and noted the minutes of the Performance Committee meeting held on 30 June and 28 July 2022.		
3.vi.c	**Audit Committee Minutes: 21.07.22** **Received and noted:** The Board of Directors received and noted the minutes of the Audit Committee meeting held on 21 July 2022.		

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4	**WORKFORCE**		
4.i	**Director of Workforce Report** Larraine Howard-Jones, Deputy Director of Workforce and Organisational Development provided an update on behalf of OM. **Reported:** By LH-J: i. That the many of the key issues for the Trust had been noted in the meeting in particular: • The Royal Papworth House consultation • The Critical care and Theatres programmes • Progress with the CCL programme and our Values and Behaviours training ii. The challenges being faced at RPH mirrored the national workforce position relating to fatigue, vacancy levels and the national narrative on health staff being underpaid. iii. In addition, unions were now balloting on strike action and that was feeding into messaging that times were not good. iv. On a rolling basis turnover was at 17%. We had good numbers of staff in the pipeline including 73 band 6 nurses and 50 unregistered nurses and were progressing with overseas recruitment. v. We needed to think more broadly about recruitment and were establishing a recruitment and retention programme Board that would look closely at what we could do across the organisation to support workforce planning. This would all play into the recruitment and retention agenda. vi. The pressure on cost of living was important but it was not the main reason behind people leaving the Trust, this was a national issue but not the key issue locally. vii. She noted that the Board were receiving papers on WRES and WDES plans which had been scrutinised at the Q&R Committee. **Discussion:** i. JW noted that the Board needed to consider whether the Trust was as effective as it could be in relation to time to appointment and time taken for in house training. ii. GR noted that the Performance Committee had requested a deep dive into the recruitment process to ensure that we were maximising the opportunity and process. He hoped the report to Committee would provide insight into whether we were in a similar position as others in the system and nationally. He had also met with the PC Chair at CUHFT and was keen to understand whether a joint approach to overseas recruitment could provide additional leverage in the process. LH-J advised that the comparative information would be provided in the October Committee report and that we were actively involved with the ICS on workforce deployment and planning. International recruitment was a collaborative effort, and we were looking jointly at the future community pipeline. The Trust had overhauled the recruitment process and were keen to focus and improve the time from resignation to recruitment. The issue of training would go to the planned recruitment and retention programme Board for review.		

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	iii. AF noted that we had a fantastic workforce team including OM, LH-J and OP-R, but she questioned the overall capacity that was available as it seemed that we had a significant dependence on the team to work across a broad range of projects and she wanted to be assured that we had capacity to continue to make progress whilst we were continuing to support business as usual. TG advised that he was in discussion with OM and that this would be considered through the usual process of review as this was not a decision for the Board at this point and would be dealt with through the existing Trust processes. **Agreed:** The Board noted the update from the DDWOD.		
4.ii & 4.iii	**Workforce Race Equality Data 2022 & Workforce Disability Equality Data 2022** **Received:** From the Director of Workforce and OD and the Head of Equality, Diversity and Inclusion, the WRES and WDES data submissions and action plans for 2023/2023. The Chairman welcomed Onika Patrick-Redhead Head of EDI to the meeting. **Reported:** By LH-J: i. That the Trust was required to put its WRES and WDES data and action plans into the public domain and to provide these to NHSE/I by 31 August 2022. ii. The papers and action plans had been through the Q&R Committee and had been approved and they were being brought to the Board for ratification. **Discussion:** i. JW noted that the WRES and WDES were an integral part of the same issue. He felt the reports set out the progress made but did not fully answer the question what should we be doing. He noted the issues that had come out of the staff survey and what we cared about was career progression. Here we were seeing reports that staff with the same qualifications and experience were not achieving the same level of progression and we were failing to make progress into senior posts, and this should be an area of focus. ii. TG asked what it would take to allow the Trust to make progress more quickly on this agenda and whether we should have specific targets to achieve a percentage level of representation in an agreed time frame? iii. MB noted that the Q&R Committee had asked for the analysis of data on career progression, by staff group looking at the time taken to progress at a divisional level. He felt that given that the Trust only had some 30 staff in higher bands then it should be within our capacity to address what appeared to be a long-standing issue. iv. JW noted that we needed to identify issues and ensure that career progression was not held up. MS advised that we would need to look at both appointments and the applications		

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	process in order to ensure that applicants had the confidence to apply for promotion in the first instance. v. EM noted the use of reciprocal mentoring and noted this would contribute to this agenda. We needed also to provide better information than a candidate 'not being the best on the day' and provide a feedback process that was developmental and added value. MB noted that this reflected Victor's feedback to the Quality and Risk committee. vi. JA noted that the report had been discussed at the Quality and Risk Committee and that OP-R had provided reassurance and he thanked her for her hard work on the report. He felt our ambition should be to send signals that change historic perceptions around difference being a potential risk to being a positive attribute in a candidate. vii. OP-R thanked the Board for their input. She felt that as a Trust we needed to hold people to account and that there should be consequences if people did not change their ways. We were developing our people through a process and if we saw that leaders were returning to the same way of working then there should be feedback and there should be an expectation of change. There also needed to be an understanding of the blocks in the system their impact, and how these should be addressed. She agreed that there was a need to change messaging in how managers assessed risk in relation to appointments. In our overseas recruitment decisions, we were very happy to bring in staff at Bands 2, 3 and 5 without seeing such risks but these staff then reported that they did not see any internal progression. viii. GR noted that we had been looking at data that had not improved for some time and asked whether some more fundamental change was required or if the things that we were doing were right and would simply take time to translate into our staffing structures. OP-R noted that we were doing some things right, but we were not holding leaders to account, and we were not undertaking training to comprehensively address issues such as micro aggression and address policy loopholes in our recruitment process. We needed people to be up front and perhaps more blunt in communicating such messages. We had to ensure that behaviours were aligned to the values of the organisation. ix. JW asked how we measured whether people were taking on board these messages and developing their thinking as that word deliver improved outcomes. OP-R felt that we didn't have all the answers to this at present and we would continue to work on those. x. GR noted the willingness to make changes and set targets and that we needed to be less soft and more radical. OP-R noted the need for those from different backgrounds to be supported and prepared to step into the next post. If the Board demonstrated its support for this agenda this would contribute to change. Board members supported this and felt that we needed to ensure that we had outcome measures for the Trust so that we could consider what success looked like. MS noted that we needed to apply critical thinking to ourselves, to our own behaviour, looking at what we could each do to achieve this.		

Agenda Item		Action by Whom	Date
	xi. LH-J noted that we were doing the right things but there was further room to grow. We had action plans in place to bring in career conversations and talent management looking at where we have got staff now and where they aspired to be in the future. This would build on the process of holding to account through line management and we needed to agree the next steps working with them to ensure that they were considering career pathway conversations with staff and reflecting on their contribution to development pathways. xii. JA noted that the use of targets had been positive in university settings when the promotion of the role of female academics had been linked more explicitly to grant funding and role development, this had ensured that there were meaningful consequences associated with any lack of action. **Agreed:** The Board noted the update from the DDWOD and ratified the WRES and WDES reports and action plans.		
4.iv	**Medical Revalidation Annual Report** **Received:** From the Medical Director the Medical Revalidation Annual Report. **Reported:** By IS that: i. Following a dip in performance where we had only 25% of appraisals in date during the COVID pandemic the Trust had made progress and now had around 75% of appraisal and revalidations undertaken and in date at the end of last year. The target for revalidations was 90% and the Trust expected to deliver this in year. ii. That the role of Responsible Officer had been separated from the role of Medical Director and would be undertaken by Dr S Webb, Deputy Medical Director. Dr David Meeks had been appointed to take over Dr Webb's former role as Chair of the Quality and Risk Management Group. iii. Appraisal provided opportunity for feedback on the quality of the process and whether they were well used and Dr Webb would be undertaking a review of that aspect of the process. **Discussion:** i. EM asked whether the tolerance of 10% generated any risk in terms of staff falling outside the terms of revalidation. IS advised that revalidation was established across a 5-year cycle and that required completion of four appraisals during that period. If staff did not come forward, there were processes to address this. ii. JA noted that the quality and effectiveness of appraisal were key to engaging people, however the risk to an individual's licence to practice was also a major driver. **Noted:** The Board noted the Medical Revalidation Annual Report.		
4.v	**Armed Forces Champion Annual Board Update** **Received:** From the DDWOD on behalf of the Armed Services Champion the annual report from the Armed Forces Champion and Veteran Aware workstream for 2022.		

Agenda Item		Action by Whom	Date
	The Chairman welcomed Richie Chapel the Armed Forces Champion to the meeting. **Reported:** by RC: i. The Trust was required to renew its Veterans Covenant Healthcare Alliance accreditation for 2022 and that included reporting to the Board on an annual basis. ii. The report summarised the activities across the year. It set out what we do to support and educate our people and how we interact with veterans as patients and staff within our Trust community. iii. He noted that we had received reaccreditation within the general scheme at a silver level. **Discussion:** i. JW asked how many veterans we had in the Trust overall. RC advised that we had around 15 included within the current informal group and these were individuals who were veterans or reservists or working in roles such as cadet service volunteers. RC noted that we produced a newsletter for veteran staff to encourage their involvement. ii. JW asked if we were able to identify patients as well as staff members. RC noted that we were able to include this information on the Lorenzo EPR. The team were also looking at whether we might identify this by a symbol applied to individual bed spaces that could highlight whether additional assistance was required. We had also established links into services such as the Defence Medical Welfare Services and SSAFA, the Armed Services Charity, that could provide enhanced support packages for veterans. We also linked to teams within CUH and across the system. iii. TC noted that we would like to do more work to promote this agenda to help staff understand requirements through communications that explain the veteran aware signage as where patients did identify themselves as veterans then staff did not always know what arrangements were in place to support such patients answer and it was felt that more work could be done to promote this. iv. AR noted that capturing and acting on this information this was a good use of Lorenzo. **Noted:** The Board noted the report from the Trust Armed Forces Champion.		
5	**STRATEGIC**		
5.i	**Quality Strategy 2019-2022** **Reported:** By MS it had been agreed earlier in the year that the review of the Quality Strategy 2019-22 would be paused for a six-month period, and this was now due. However, this needed to be linked with the wider review and development of the Trust approach to QI and the Board development session later in the day would form a part of the development of this approach. The review of the Quality Strategy would therefore be deferred and re-aligned to that programme of work which was due to conclude in February 2023.		

Agenda Item		Action by Whom	Date
	Noted: The Board noted the update on the Quality Strategy 2019-2022. This would be re-scheduled to the March 2023 meeting.		
5.ii	**Sustainability Strategy 2021-26 (review)** **Received:** From the Director of Estates and Facilities the annual review of the Sustainability Strategy 2021 – 2026. **Reported:** By AS: i. That all NHS organisations were required to have a Board approved strategy which outlined the organisation's aims, objectives and delivery plans for sustainable development. In addition, each NHS organisation must have a Green Plan to set out how its vision, strategy, and targets for delivering sustainable healthcare to the communities that it serves would be met. The Trust strategy was approved in August 2021 and this paper provided an overview of the progress in the first year since approval. ii. The key issues and progress against the plan were set out at section 3 of the report and there were some notable positives to report, including use of re-useable PPE gowns where the national team was visiting to see how we had rolled this out across the Trust. iii. The Trust was making effective progress and was achieving ahead or on plan and he asked the Board to re-affirm their commitment to the Sustainability Strategy. **Discussion:** i. JW asked whether we were supporting the ICS and sharing learning as a system and Region. AS advised that we did and that there was an ICS working group in place. ii. EM noted that the strategy had been driven by AS and his team particularly Hannah Greensill and Kirsty Mainds and she wanted to pass on her thanks for their work on this programme. She also noted the wider benefits associated with the programme such as the nature walks lead by Dr Webb which encouraged people to look at their environment and contributed to the health & wellbeing agenda and supported our staff. **Agreed:** The Board noted the update and reaffirmed its commitment to the Sustainability Strategy.		
5.iii	**New Papworth Hospital: Lessons Learnt & Benefits Realisation** **Received:** From the Director of Estates and Facilities a paper setting out our learning from the hospital move. **Reported:** By AS that: i. The report summarised our experience of the building journey and the various elements involved from the business case development through to mobilisation. ii. The Trust had been looking to develop greater analysis around benefits realisation, but this had been hampered by the absence of a stable baseline during the pandemic.		

Agenda Item		Action by Whom	Date
	iii. A key learning was the need to 'live & breath' in the building before being fully able to appreciate the impact of the change. **Discussion** i. JW asked how this learning would be disseminated for those planning moves and the wider system and community. AS advised that we were engaged with the national New Hospital programme team and had other direct approaches from other new build projects. ii. CC asked about whether this would be developed as a booklet to be shared and whether there were any opportunities to commercialise this? TG advised that we the Trust was looking at how this and other initiatives might be commercialised with third parties. **Noted:** The Board noted the report on Lessons Learnt & Benefits Realisation following the hospital move.		
6	**BOARD FORWARD AGENDA**		
6.i	**Board Forward Planner** **Received and Noted:** The Board Forward Planner.		
6.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 1 September 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