Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Held on 6 October 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
	Mrs E Midlane	(EM)	Chief Executive Officer
	Ms O Monkhouse	(OM)	Director of Workforce and OD
	Mr G Robert	(GR)	Non-Executive Director
	Mrs M Screaton	(MS)	Chief Nurse
	Dr I Smith	(IS)	Medical Director
In Attendance	Mr E Gorman	(EG)	Deputy CIO
	Ms T Crabtree	(TC)	Head of Communications
	Mrs A Jarvis	(AJ)	Trust Secretary
	Mr A Selby	(AS)	Director of Estates and Facilities
Apologies	Mr A Baldwin	(AB)	Interim Chief Operating Officer
	Ms D Leacock	(DL)	Associate Non-Executive Director
	Mr A Raynes	(AR)	Chief Information Officer & SIRO
	Prof I Wilkinson	(IW)	Non-Executive Director
Governors Observers	Doug Burns, Trevor Collins, Angela Atkins, Andrew Hadley Brown, Abi Halstead, Marlene Hotchkiss, Trevor McLeese, Harvey Perkins		

Agenda Item		Action by Whom	Date
1	**WELCOME, APOLOGIES AND OPENING REMARKS**		
	The Chairman welcomed everyone to the meeting and apologies were noted as above. The Chairman noted apologies from Alex Baldwin our new Interim Chief Operating Officer as he was on paternity leave.		
1.i	**DECLARATIONS OF INTEREST**		

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	There is a requirement that Board members raise any specific declarations if these arise during discussions. No specific conflicts were identified in relation to matters on the agenda. A summary of standing declarations of interests is appended to these minutes.		
1.ii	**MINUTES OF THE PREVIOUS MEETING**		
	Board of Directors Part I: 1 September 2022 **Item 1.vi CEO's UPDATE:** Revised to read: Reported viii: revised to read: ".We had also seen concerns…" Discussion iii: revised to read "MB welcomed this discussion …" **Item 1.vi Patient Story:** Renumbered to 1.vii and paragraph three of the minute revised to read: "…advised that this should be manage with a GTN..." "… had a strong family history of cardiac disease ..." **Item 2.b PIPR:** Revised to read: Safe: "...included a focus on Surgical Site Infections (SSIs) to provide assurance..." Discussion i:"...would like a risk adjusted measure of..." Discussion ii: "… any risks arising from system performance and...". **Item 4.ii & 4.iii Workforce Race Equality Data 2022 & Workforce Disability Equality Data 2022:** Revised to read: Discussion xi: "as that would deliver improved ..." **Approved**: With the above amendments the Board of Directors approved the Minutes of the Part I meeting held on 1 September 2022 as a true record.		
1.iii	**MATTERS ARISING AND ACTION CHECKLIST**		
	Item 4.ii WRES Data 2022 CC noted the Board's previous discussions about staff survey results and the challenge faced by our BAME staff and that a question had been raised about whether we should continue with the same plans if these were not delivering change. She requested that an action was added against this and that progress against our plans was regularly reported to the Board. EM noted that the Board had agreed that we should focus on behaviours to ensure these were aligned to the values of the Trust and had agreed that as a key priority. A clear message had been delivered to our staff, with all staff asked to attend training by Christmas. This had been shared in our all staff briefing, team briefings and in NewsBites. Our action plan had remained the same, but this issue was being given greater focus as a key priority for the Board and the organisation and regular updates would be brought to the Board. JW noted that actions such as this should be captured and reported as that was a part of being a Well Led organisation. **Noted:** The Board received and noted the update on the action checklist.	**OM**	Feb 23

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1.iv	**Chairman's Report**		
	The Chairman reported: i. That since the last meeting we had seen the death of Her Majesty Queen Elizabeth II and this was perhaps an interesting time to reflect upon her life, noting that we were moving on from the 'post war' generation. ii. In September we had therefore cancelled our staff awards ceremony, the Council of Governors meeting and Annual Members Meeting as these all fell within the period of national mourning. We would be rearranging dates as required. iii. He noted that Ian Smith had attended a meeting of the Yale Research Group, also that the Vice Chancellor of the University had left, and a new appointment had been made Deborah Prentice, currently Provost of Princeton University and she would be joining the UoC at Easter. iv. He had met with Katie Mitchell who was one of his longest surviving transplant patients. This was covered in the national media during national organ transplantation week. **Noted:** The Board noted the Chairman's report.		
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 AJ that the BAF report had been discussed at Committee and discussion had focused on target risk ratings. The key change in risk was the new BAF relating to industrial action which had been opened in response to trade union ballots on strike action. **Discussion:** i. MB noted that the Q&R Committee had considered the disparity between target risk ratings. Discussion had focused on whether targets were achievable. If we were unable to deliver against target the committee felt that we should consider whether these should be reset and we needed to consider whether risks around staff engagement and vacancies and would remain elevated for the foreseeable future. TG noted that we monitored risk to delivery against national frameworks and targets, and alongside these we needed to acknowledge the operating environment of the NHS. This was reflected in the BAF and in PIPR. MB noted that BAF risks were a more subjective assessment of risk and should be subject to further review. ii. GR felt it was reasonable for us to plan to get to 'business-as-usual' activity and noted that we would be discussing theatres and sickness absence levels elsewhere on the agenda. iii. AF noted the issue of prioritisation against areas of risk, and the need for that to be considered alongside preparations for winter. iv. EM noted that we would review winter planning and year end forecasts, and these would come to committee in October. **Noted:** The Board noted the BAF report for September 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. Her report illustrated a very turbulent month. She noted that AB had started in his new role and that there had been other key changes within the Trust. Dr David Meek would take on the chair of the Quality & Risk Management Group, Dr Nicola Jones had been appointed as the Deputy Director of Medical Education, and Dr Charlotte Summers had been appointed as the Interim Director of the Heart and Lung Research Institute. ii. September had also seen the launch of the vaccination hub with 350 vaccinations being delivered on the first day and approximately one third of our staff had been vaccinated. We had also been able to hold vaccination sessions at Royal Papworth House and these were being well utilised. iii. We had held a well-being coffee morning and were looking at plans for support for our staff during the winter. iv. Our governor elections had concluded and the results of these would be announced at the Annual Members Meeting which had been rescheduled for 17 October. v. The reciprocal mentoring programme was underway and was proving to be a very powerful group. TG and his mentor Berin had talked about their experience of the programme at the staff briefing, and that had been well very well received. The recording would be shared with the Board. vi. We had seen very positive responses to the national inpatient survey which were included in the Chief Nurse's report. vii. We were pleased to confirm that the Legionella case previously reported had been confirmed as not being linked to our water. viii. We had established two memorandums of understanding one with the East of England Imaging Network and the second with Cambridge University Hospitals. These were high level and set out broad principles of working and would be overseen by the Strategic Projects Committee. ix. The national UK COVID-19 inquiry had started this week and we were planning the key steps to respond to this to provide evidence around our decision making and all services. Further updates would be brought to the Board in due course. x. The Trust had achieved one of its ambitions on the new site which was to deliver a 3-pump day. This was a proof of concept on the level of productivity that could be achieved. **Discussion:** i. MS advised that the further investigation of the Legionella case indicated that this was a community acquired case. The Legionella that had been identified in the hospital had been from routine water sampling. IS noted that we had Legionella in water sampling previously before the hospital move, and this was a common finding. ii. JW Asked about the reporting to the COVID-19 inquiry and whether our response would go through the Strategic Projects	**TC**	Nov 22

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	Committee. EM advised that as a project this would be overseen at SPC and if we were called to provide evidence or to attend and we should all be aware of our responsibilities, and this could have some significant impact. We had a robust process established and detailed logs of decision making and would be bringing together a narrative of our COVID-19 journey. iii. AF noted that she would be very interested in hearing the lessons learned from the COVID-19 pandemic. EM advised that we had collected narrative from our staff through two debrief processes and these would be a part of our evidence base. iv. CC asked about the consultation on the RP House move. OM advised that we had made good progress and that there were few concerns at this point. There were some specific issues around tea and coffee making facilities and the Trust was meeting with CPFT this week. They were on board with some of the issues that had been raised and we had good working relationships with digital and so felt assured on equipment and on arrangements for the increase in hybrid and home working. **Noted:** The Board noted the CEO's update report.		
1.vii	**Patient Story**		
	MS introduced the patient story. Paul Lincoln, Deputy Lead Nurse Transplant shared a story from a current transplant patient. The patient was happy that the Board hear his story. The patient had a history of ischemic heart disease and had developed pulmonary hypertension. He had been told that there was very little that could be added to his treatment and was referred to RPH as we had an opportunity for treatment in this difficult case. The patient was referred in 2018 and at that point he was not suitable for a heart transplant. His treatment was focused on optimising his condition and he was admitted to the ward to see how his hypertension could be improved. He was fitted with a left ventricular assist device (LVAD) which allows a more normal output from the heart and reduces pressure. This meant that he could be listed for a transplant. He had his LVAD device fitted in June 2021 and went home four weeks after the procedure. He was able to be listed for a transplant later that year. The medical and nursing staff had told him that it would be unlikely to be soon because of his size and his blood group, and so he got on with his life as best as he could. This year he deteriorated and developed right sided heart failure. He continued to worsen and was admitted for intravenous support and was listed for an urgent transplant. He knew this was in his best interest but found this scary because of the scale of what was facing him. He was admitted in June this year and he waited 55 days for a transplant offer. When the transplant coordinator came to speak to him they explained that this may be a false alarm, but it transpired that this was positive news for him. He was now eight weeks post-transplant and was recovering at home. He reported that he was 100% better than in June and that every day was important. He noted that he sometimes still thought		

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	that he had his LVAD, but it was not there. PL noted that on the same day as this patient's transplant a second transplant was accepted and whilst there are pressures on theatre staffing, on this occasion both patients were transplanted at the same time, and we were one of the only units in the country to be able to undertake this. The patient had been invited to comment on his treatment and he wanted to thank everyone from his first transfer into the hospital, to the LVAD and to the transplant for the rest of his life. **Discussion:** i. JW noted that patients must go through many steps in their treatment journey with LVADs and waiting for transplant. ii. JA asked about how many patients were perhaps 'given up' on in other centres as not worth a referral as the quality of medicine and medical treatment depended on who you were referred to and their ability to maximise the opportunity for treatment. PL advised that many people did get missed and the transplant team had developed an MDT with other hospitals to address this. They had recently had on MDT with Portsmouth who had presented cases for advice, and he hoped that we would be able to do outreach with many other centres as it was possible to advise remotely. In that case four patients had been discussed and two patients were now coming for full transplant assessment. We hoped to be able to spread this service and share the information about what can be provided for these patients. iii. JW noted that one of the problems is that heart failure is such a common issue. Transplant services were restricted by the number of organs available and so managing the waiting list was complex, as having too big a list could result in unrealisable levels of expectation. iv. AF noted that PL had brought the story to life which was important for the Board to hear. His technical expertise and emotional connection were both great to observe in our staff. v. MS noted the length of time that our transplant patients were supported at home so extensively by the transplant nursing team and what a fantastic record this was. vi. CC thanked PL for the story and whether as we could not do all of the cases because of the shortage of organs whether we were doing more to help local hospitals extend the life of their patients. PL advised that we looked at all heart failure service referrals in local hospitals and ensure that patient care was being optimised. This would help to ensure that patients were getting the best treatments and could delay the need for further interventions. We had good local links but there was high turnover in district general hospitals and so teams needed education to be run regularly. Some hospitals were reluctant to ask others for advice, but the same messages were given to all local colleagues. CC asked if we were enabling teams through education. PL advised that we were and that we had open lines of communications and regular contact with teams. vii. EM noted that the ICS CVD strategy on heart failure was one of the key priorities that we were working on as a system.		

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	Noted: The Board thanked PL for attending and 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. **Reported:** By GR that the Committee had considered the following key issues: i. The pharmacy presentation from Jenny Harrison, Chief Pharmacist, and the main issues from that were the structural challenges around lack of staff in the profession. However, the committee had received considerable assurance that a creative approach was being adopted and we were looking at long term solutions with partners in the system. ii. The committee had considered theatres in detail and were under no illusion of the scale and seriousness of the problem and the impact this had on productivity and patient welfare. The committee had not yet received assurance on how and when this problem would be resolved and that was required in order to build confidence in plans. **Discussion:** i. JW asked about pharmacy staffing within the health service as this area had workforce problems historically and asked which university system they trained under and whether we talked to people in training? OM advised that nationally there had been a lack of planning in relation to training numbers, as well as competition with private sector and industry posts. We were very engaged with partners and with education providers, and were working jointly to attract and train more pharmacists. ii. JA noted that the establishment of pharmacists varied greatly between hospitals and therefore needed a major reset in some areas. Also, that there may be opportunity in partnership with the commercial sector as offering opportunities for their staff to undertake one or two days a week based in NHS service could build credibility for pharmacists working outside the NHS. iii. TG noted that we had complex issues in theatres, with issues relating to staff welfare and cultural issues, as well as the pressures from ballots on industrial action. We had set up four workstreams in response: a. Resourcing: to ensure we had the right numbers of staff for the service b. Culture: to focus on our values and behaviours c. Productivity: ensuring that we have optimum number of theatres working with efficient throughput d. Quality & Safety: to ensure that the right standards were being delivered for example in relation to SSI's. We had made some progress since the project was set up in June and had put in place additional resource to support the team. This was improving week on week, but we were not moving quickly enough. iv. GR asked if the matter were not resolved then how could the		

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	Board understand more about the programme to ensure that the Board could discharge its duties. He asked whether a Board level steering group was required as he felt quite distant and therefore wanted to understand what more we needed to do as a Board. v. AF echoed GR's concern as she had felt well sighted on the critical care transformation programme but did not have this assurance on the theatres programme. EM advised that that there was a detailed programme of work ongoing that was being supported by the business support team. We would share the detail of actions and noted that activity on this programme would increase rapidly. EM advised that we had released staff resources to focus on this work and whereas the critical care programme had been delivered with ED scrutiny on this occasion the division had asked for support to resolve this and so we were not directly managing this in the same way and were supporting the division. We recognised that development was needed to support divisions and it had always been intended that we run a development programme for the divisions, and we were reviewing how that would be delivered. We were also bringing in additional theatre support and they would be reporting to the STA division but would have a line of accountability direct to EDs. vi. GR noted this was good to hear and that what was needed was some greater involvement and a clear understanding of the programme. TG advised that he would welcome further inquiry and scrutiny in the Part II meeting. vii. CC noted that the committee had made one escalation to Q&R which was around the presentation of care hours per patient day. She was concerned that we reported performance that appeared to be non-compliant with national standards and whilst MS provided assurance that staffing levels were safe, she was concerned that we may not know or see a deterioration in reporting. She felt that we needed to be clear about the metrics that were used to generate this measure and it had been escalated to the Quality and Risk committee and she would like the response to this recorded in the minutes of the Board. If this was a national measure, then we should be looking to get this to a green rag rating or formally note that the metric was wrong. JW noted that this was a matter of balancing risk and that we may have what were seen as 'gold plated' staffing service standards but agreed that we needed clarity in reporting. viii. GR noted that a second escalation had been made in relation to the objectivity of our complaints handling and this had also been referred to the Quality and Risk committee. **Noted:** The Board noted the Performance Committee Chair's report.	**TG**	Nov 22
2.b	**PAPWORTH INTEGRATED PERFORMANCE REPORT (PIPR)**		
	Received: The PIPR report for Month 5 (August 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.		

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	Reported: By TG that overall, Trust performance was at a Red rating. **Safe/Caring:** Reported by MS: That these metrics had been scrutinised at committee and the key matter that she would highlight was venous thromboembolism (VTE) screening compliance. The Clinical Decision Cell was supporting this as a priority to improve performance and ownership of this standard across the Trust. **Effective/Responsive:** Reported by EM: i. That in July and August we had seen the impact of increasing levels of sickness absence, vacancies, and annual leave. We were working with the divisions to review the process of approval of annual leave as this had resulted in an impact on the number of patients being seen in the outpatient department. This area was impacted first when there was a shortage of consultant staff. ii. We had seen lower throughput in theatres and that had resulted in an increase in the size of the waiting list. This impacted on our performance in the responsive domain where our referral to treatment indicators were increasing. iii. We had good performance in relation to CT and MRI and were seeing a good recovery in diagnostic services. EM was leading the system work on mutual aid for cardiac CT and we were working across the region on solutions to manage this service. This would provide particular support to CUH to manage their backlog **People management and culture:** Reported by OM: iv. That the key focus was high vacancy levels and remedial actions to address these. The context around this had been discussed at both Performance Committee and at Q&R. v. Also, in industrial relations we had received confirmation that ballots for industrial action would be undertaken by Unison, and the Society of Radiographers, and the BMA was to ballot junior doctors in January. **Finance:** Reported by TG: That whilst the finance domain was Red, that would be only temporary as it related to the change in our CIP forecast and we expected it to come back on track at month 6. **Discussion:** i. JA asked how we were assured that patients who were on a patient initiated follow up plans (PIFU) were enabled to make the right decisions about when to access care. He was a supporter of this initiative but felt that we needed to seek assurance around those patients who might not seek timely healthcare advice. EM advised that this had been introduced as a national programme and to aid recovery following the COVID-19 pandemic. We had not expected that many of our patients would use this route but had established a 'super PIFU' route through our SOS clinics. In the PIFU model patients were discharged with contact information. In the SOS model patients were provided with information having been assessed that this was an appropriate model of care and were		

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	able to speak directly to a specialist nurse. We were therefore confident that patients were safe and would come back into the service when needed. ii. JA asked whether we triangulated deteriorations or emergency admissions and whether we used that feedback loop in triaging patients into the service. IS noted that the group that was chosen were the safest. These were CPAP patients, and they were usually symptomatic. If their management was not working, then they would feel worse and they were patients who would observe a deterioration. Many patients also required DVLA review for their driving licences and that supported compliance. However, he agreed that we would need to audit compliance with treatment protocols. JW noted that this was about empowering patients with long term conditions such as cystic fibrosis and transplant patients and formalising processes that were already in place for patients with chronic conditions. This was an excellent development, and we should prioritise resources to support this. **Noted:** The Board noted the PIPR report for Month 5 (August 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. **Reported:** By MB that the key issues discussed were: i. Workforce governance where the new programme focused on Resourcing and Retention looks a very sensible structure and we needed to consider how this programme should report. ii. The Committee had considered having a bi-monthly workforce meeting. It had been proposed that this could meet on alternate months with the Q&R committee and that it should be composed of different NEDs to the current membership to bring together members from the performance and Q&R committees with the ability for both committees to escalate matters directly to the Board if required. iii. The escalation of CHPPD and he noted that the committee would review this. The Committee had previously looked at the shift-by-shift balance of staffing supply and the level of demand. This provided assurance that we were in our judgment safe, and this was a well calibrated measure. This looked at quality standards and was a measure that was conditional on the level of demand. It did depend on an accurate measure of need, and there were regular reviews of establishment, and this looked to have sufficient attention. **Discussion** i. JW noted that the Well Led review had raised the issue of whether we needed a workforce committee to manage the workforce agenda. He recognised that whilst we might not want to add another committee if we wished to address the representation of NEDs which had been noted in relation to this agenda, it might be a welcome move.		

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	ii. GR asked if the proposal was for this committee to subsume the whole of the workforce agenda and for other committees look at workforce matters as a part of their day-to-day scrutiny in the round. Also, that he had had previously questioned whether monthly committees were too frequent as this could lead to too operational a focus. MB noted that this would bring in the whole workforce agenda but would not fully remove the overlap between committees because of the cross-cutting issues. iii. JW noted that the move to a bi-monthly Board that had proved difficult, as this increased the time taken for some matters to be brought to the Board, but at a committee level and with use of teams it might allow for additional meetings on single issues if that were required to manage urgent business. He felt that the Executive and NEDs should discuss and bring back a proposal on how committee scheduling could operate. iv. JA noted that one safety net was that the Board would continue to meet monthly so that urgent matters required to be brought to the attention of the Board could be escalated where required. Also, that there was no expectation that operational decisions would be subject to months of delay to wait for decisions as the role of the Committees was a reporting in and not a decision-making function in this context. The Executive would continue to respond in the moment to operational matters. This would also be an important signal and message for our staff. v. OM noted that we would need to consider the Board function on signing off and approving workforce matters and agreed that OM/MS and AJ could look at the scheduling of the workforce agenda. JW agreed that we work up this recommendation. vi. GR noted that the discussion on CHPPD was welcome as this matter was raised at every committee meeting. MB noted that if we were able to identify beds that were both unstaffed and unused then that could be helpful. vii. JA noted that the metrics were a challenge and asked if our assurance should be based on output rather than input measures as we needed to understand the impact of our staffing on delivery of safe patient care. Measures such as incidents and adverse events were required to help to prioritise and could give more nuanced reporting. AF agree that we needed to ensure that we had the right targets and that risks was balanced and understood, as we were not yet back to a 'business as usual'. MB noted that we did have output measures such as incidents and falls, and that the question in was perhaps what we were not capturing in relation to outcomes. AF noted that the staffing measures were balanced with redeployment but that also had a cost on staff and patient experience. **Noted:** The Board noted the Q&R Committee Chair's report.	**OM/MS/ AJ**	Dec 22
3.ii	**Combined Quality Report** **Received**: A report from the Chief Nurse and Medical Director which highlighted information in addition to the PIPR.		

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	Discussion: i. JW asked about the inquest report for Patient B and how long post-transplant this patient had died. MS noted that these related to older inquest reports. JW was concerned that the information included in the reports needed to make sense clinically. ii. CC noted that the outcome of the national inpatient survey was very positive, but she wanted to understand those areas where we had lower scores. The score in relation to dignity when examined or treated was one of our worst scores and she could not understand how that could be the case as we had single rooms. MS advised that this was one of our worst scores, but the score was 9.9 out of 10. Board members noted that this needed to be considered in context. MS advised that some areas the issue was rather how questions were put to patients. She agreed that she would see if we could get a narrative report in which patients are asked about their care as this was not reflected in the current scoring. **Noted:** The Board noted the Combined Quality Report.	**MS**	TBC
3.iii	**Board Sub Committee Minutes:**		
3.iii.a	**Quality and Risk Committee Minutes: 25.08.22** **Received and noted:** The Board of Directors received and noted the minutes of the Quality and Risk Committee meetings held on 25 August 2022.		
3.iii.b	**Performance Committee Minutes: 25.08.22** **Received and noted:** The Board of Directors received and noted the minutes of the Performance Committee meeting held on 25 August 2022.		
4	**WORKFORCE**		
4.i	**Workforce Report** **Received:** The Director of Workforce and OD a paper setting out key workforce issues. **Reported:** By OM that: i. The flu and COVID vaccination campaigns were going well and that one third of staff had received their COVID vaccination in the last two weeks. ii. The proposal for the Resourcing and Retention programme was set out in the paper and this would support a coordinated strategic approach in what was a very difficult environment. iii. The staff support scheme had been updated and she had discussed proposals for how this could be supported going into 2023/24 so that we did not have a 'cliff edge' of support being withdrawn. **Agreed:** The Board noted the update from the DWOD.		
5	**RESEARCH & EDUCATION**		
5.i	JW noted that there had been a very good presentation to NEDs by Dr Calvert the on the R&D strategy the previous week and that would be		

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	coming through to the Board for approval in due course. He also noted that good discussions with Prof. Charlotte Summers, Interim Director of the HLRI and it was important that she had strong working relationships and felt a part of the hospital and an honorary TG advised that there was progress being made on the Clinical Research Facility that he had held a very positive meeting with Prof Summers and Dr Toshner.		
6	**BOARD FORWARD PLAN**		
6.i	**Board Annual Business Plan** **Reported:** By EM: That there were several strategies that had been delayed or deferred and these were shown in red on the plan. Scheduling of these items was reviewed with EDs. **Received and Noted:** The Board Forward Planner.	**EM/AJ**	Nov 22
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 6 October 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)
SSI's	Surgical Site Infections
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