Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Held on 3 November 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 A Baldwin	(AB)	Interim COO (designate)
	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
	Ms O Monkhouse	(OM)	Director of Workforce and OD
	Mr A Raynes	(AR)	Chief Information Officer & SIRO
	Mr G Robert	(GR)	Non-Executive Director
	Mrs M Screaton	(MS)	Chief Nurse
	Prof I Wilkinson	(IW)	Non-Executive Director
In Attendance	Mr S Edwards	(SE)	Head of Communications
	Mrs A Jarvis	(AJ)	Trust Secretary
	Mr E Palas	(EP)	Advanced Nurse Practitioner
	Mr A Selby	(AS)	Director of Estates and Facilities
Apologies	Mr A Selby	(AS)	Director of Estates and Facilities
	Dr I Smith	(IS)	Medical Director
Observers	Angela Atkinson, Paul Berry, Susan Bullivant, Trevor Collins, John Fitchew, Abi Halstead, Richard Hodder, Marlene Hotchkiss, Trevor McLeese, Harvey Perkins		

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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: 6 October 2022 **Item 1.vii Patient Story:** Revised to read: Discussion ii: "…centres as the quality of medicine and..." Discussion ii: "…had an MDT with Portsmouth ..." Discussion iv: "… story and asked as we could not do ..." Discussion iv: "… service referrals in local hospitals to ensure…" **Item 2.a.i PERFORMANCE COMMITTEE CHAIR'S REPORT:** Revised to read: Discussion v: "…advised that there was a detailed programme ..." **Item 3.i Q&R Committee Chair's Report:** Revised to read: Discussion vii: "…the question was perhaps what we were not…" **Approved**: With the above amendments the Board of Directors approved the Minutes of the Part I meeting held on 6 October 2022 as a true record.		
1.iii	**MATTERS ARISING AND ACTION CHECKLIST**		
	Item 314: MB asked when the Board would receive the Meridian report. EM advised that this was being considered as an element of the Theatres recovery programme which was on the Part II agenda and so this action could now be closed. **Item 2.a. PIPR:** JW asked for the external report on Surgical Site Infections to be circulated to JW and MB. MS noted that this report had been well received by the surgical group. **Noted:** The Board received and noted the updates on the action checklist.	**MS**	12/22
1.iv	**Chairman's Report**		
	The Chairman advised the Board that in September he had a good meeting at the Cedar Sinai Heart Institute undertaking a visiting Professorship and had met with Dr Pedro Catarino a former RPH surgeon who was doing work with transplantation and robotic surgery. He also noted the death of Prof Peter Morris who was a pioneer in transplant in the UK, founder of the Oxford Transplant Centre and a previous president of the Royal College of surgeons.		
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: i. That the key changes related to staff engagement and in particular the increased risk around industrial action		

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	ii. The report also noted changes in relation to the COVID19 risk and the activity recovery and productivity risk where there was a separate report on the Board agenda. **Discussion:** i. JW asked when the results of ballots on industrial action would be made public. OM advised that results of ballots by the Royal College of Nursing and other unions would be known soon and would cover industrial action for a 6 month. The Trust would be given two weeks' notice of specific actions. National sitreps and assessments were being put in place and unions were balloting at an organisational level and so there may be different actions taken across Trusts and different staff groups. The approach taken by trade unions was not subject to negotiation but there were national discussions underway to identify those services that should not be affected by strike action. ii. EM noted that we were keen to support our staff and we recognised their right to strike. AB advised that he had established a working group that was looking Trust plans to respond to industrial action and that would provide assurance to the Board. **Noted:** The Board noted the BAF report for October 2022.		
1.vi	**CEO's UPDATE**		
	Received: The Chief Executive's update setting out key issues for the Board and progress being made in delivery of the Trusts strategic objectives. The report was taken as read. **Reported:** By EM that: i. She welcomed Alex Baldwin as the interim Chief Operating Officer and recorded her thanks to Tara Crabtree, who had left the Trust since the last meeting and welcomed Sam Edwards as our new Head of Communications. ii. She had attended an NHS leaders conference and Amanda Pritchard, Chief Executive of NHS England, had given a clear steer on leader's roles going into winter. This was to adapt and adopt good practice across organisations and to recognise that small gains help systems and provide support across the NHS. iii. We had run a fantastic recruitment day seeing over 300 people attend. We had also held our long service awards at the HLRI, and our staff had really appreciated this. iv. The consultation on the House move had finished and we were finalising arrangements with CPFT. The date for the move was still to be confirmed. v. Plans that were being put in place to respond to the forthcoming industrial action. vi. Over 1000 staff had now attended their values and behaviours training which was excellent progress. vii. The Clinical Research Facility (CRF) had now been approved by the CQC for the delivery of outpatient trials and that the assessment for the inpatient facility was to be scheduled. viii. The CQC had visited cardiology and the cath labs and there would be further discussion on this at the Part II meeting. ix. The statutory consultation on the provider licence had started		

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	and this would realign provider responsibilities reflecting the current thinking around delivery as system partners. x. Our Laudit app was the winner of the New Innovation of the Year at the Health Technology Awards; the Trust's Finance team had been nominated for two Healthcare Financial Management Association (HFMA) awards and our microbiology team were finalists in the HSJ Patient Safety Awards in the Patient Safety Pilot Project of the Year category. xi. We had also seen our balloon pulmonary angioplasty (BPA) service treat its 150th patient and perform its 400th procedure. xii. We recognised these achievements and wanted to encourage all our staff to celebrate excellence. xiii. The results of our Governor elections had been announced at the Annual Members meeting and these were included in her report. **Discussion:** i. JA asked whether there was an equivalent national forum for social care. EM advised that the event was wider than acute Trusts with community CEOs also involved but she was not aware of the full range of participants. The Regional CEO meetings included local authorities and social care leaders. JW noted that social care was represented at the ICB Chairs and CEOs meetings, and OM advised that they were also well integrated in the workforce group, which was focused on resourcing, retention, EDI and pay issues. ii. AF welcomed the integrated approach and asked about the messaging coming out of these groups. EM advised that the national message was to look at good practice and to adapt this but noted that there was not one overarching plan or a prescribed approach. iii. JW noted the change in government leadership and we would need to see what impact that might have on stability. **Noted:** The Board noted the CEO's update report.		
1.vi	**Patient Story**		
	MS introduced Earl Palas, Advanced Nurse Practitioner, who was presenting the patient story. EP advised that the patient had consented for his experience to be recorded and anonymously shared with the Board and wider teams. He explained the patient was a long-term patient under Respiratory Support and Sleep Centre (RSSC). He always comes in for a tracheostomy tube change & review for management of his Obstructive Sleep Apnoea (OSA) as outpatient or day case to 3NW. It was identified that he had a chest infection on his last appointment a week ago after the tracheostomy tube change. It was also noted that he had had recurrent chest infections since March 2022 that resolved with taking oral antibiotics. He was provided with another course of oral antibiotics and the plan for in-patient admission for intravenous antibiotics was discussed with him should he not improve with this treatment. He was admitted a week later to 3NE Ward to proceed with IV		

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	antibiotics. It was explained to him that he could continue his IV antibiotics at home, and he was provided information on how to manage this treatment independently. He went home after 2 days after completing the home IV assessment tool with the provision of the necessary medications to continue the treatment at home. He came back as a day case on 3NW after completion of his IV antibiotics and his IV line was taken out. He said that the doctors and nurses knew the plan and reason for his admission to 3NE. He felt respected as everyone was polite and introduced themselves. He also felt valued as he was involved in decision making on how to manage his own IV antibiotics treatment at home. He felt that the information and training were invaluable in helping him make the right decision. He felt that he was not disturbed at all and able to sleep well. In addition, his reflection on his experience was that his needs were well covered. EP reflected on what had gone well: • Recognition of clinical needs of the patient • Providing a safety netting/ plan should the patient not respond to treatment • The clinical plan was agreed by both clinician and the patient • There was good communication with regards to his reason for admission (from day case to in-patient) • Assessment and involvement of the patient in decision making about his plan of care • Reduction in length of stay and improved patient experience without adverse effects on his care • A responsive and well-versed team (e.g., staff nurses, pharmacy and so on) that was able to facilitate this service Actions and learning that had come out of this story were: • To disseminate this patient's experience to recognise how effective teamwork was an essential tool in building excellent patient experience. • That positive experience also supported staff wellbeing as there was a feeling of emotional reward and satisfaction that the service we provided was up to the patient's expectation. • The need to recognise both clinical and care needs and to promote shared decision making that empowers patient to make decisions about the treatment and care that is right for them at that time. • To acknowledge and praise the culture of the workplace, its impact on team dynamics and functioning that supported this positive impact on patient care. • That RPH should aim to maintain and continue adopting and celebrating the team-based culture in which values and principles are shared and communicated among team members to provide exceptional patient care. **Discussion:** i. JW noted it was interesting to hear the experience of a long-term patient in the respiratory service. We had seen high numbers of staff from this service represented at our long		

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	service awards. ii. OM noted the comment on the impact on staff as this was a very positive outcome and she felt it might be good to include Board patient stories in our all staff briefing as this would give good recognition and let staff know what the Board were hearing about our services. iii. AF noted that it was wonderful to see Earl's pride in the service. She asked how many patients were able to return home on IV antibiotics. EP advised that the home IV service was mainly for lung defence patients. He had been at RPH for 22 years and had collaborated with specialists in all areas to support service developments. Patients needed a long line to be able to go home and the healthcare scientists in the critical care service could now accommodate this to allow home care within guidelines that ensured patient safety. iv. JW noted that many of our cystic fibrosis and pulmonary hypertension patients could also have delivery of home care and the Trust had a history of helping patients to manage their care and to develop the confidence in this. GR noted that as a lung defence patient he had received IV antibiotics at home and that as a patient the idea that you could receive IV therapy and not have to have to be in hospital for two weeks was fantastic, although it was quite a scary prospect at first. v. JW asked whether every patient who needed a tracheostomy change needed to come into hospital. EP advised that some patients could change their tracheostomy at home and those who were admitted would usually have a review undertaken at the same time looking at whether treatments were working. vi. MB asked if we reviewed other procedures to identify whether they could also be delivered at home? EM noted that this does come up in team discussions and had done so especially in COVID where teams were looking at other ways of working. RSSC had produced a huge number of ideas in this area and the question for the Trust was how we shared that learning inside and outside the organisation. vii. MB asked how this development had come about. EP advised that staff had had discussions around who could do line insertions and had discussed the idea with the pharmacy team. It also needed patient engagement and it was identified that lung defence patience as a group might be enabled and supported to do this at home. It was not an entirely new innovation, but we needed to be assured that our patients and carers could manage this safely at home. MS noted that this initiative was a clear example of shared decision making with patients and that was one of our CQUIN targets and it was great to see an example of this being shared with the Board. viii. JA asked whether the ICB had an ambition to develop joined up community nursing that could deliver this sort of integrated and coordinated care at home. EM advised that the planned 100 virtual ward beds included delivery of home IV antibiotics but there were issues to be resolved around who owned the service and how those patients could be supported in the community. EP noted that the team were looking at setting up a home-based service for tracheostomy patients who were on long term ventilation and for patients with motor neurone		

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	disease who were very frail. We were looking at a review of non-invasive ventilation for this patient group and were hoping to purchase equipment to support this cohort of patients in the community. These were patients who needed significant support to attend hospital and who often would cancel admissions because they were so weak. **Noted:** The Board thanked Earl for presenting this case 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 establishment of a workforce committee which would be discussed later on the part II agenda. ii. Seasonal planning where we were looking to ensure that everything was done to maximise capacity across the year. The Trust did not see the same winter surge as district general hospitals, but it was good to understand how this was being managed through the Trust's annual planning cycle. iii. Changes in referral patterns from GP's and consultants where there was some evidence of a drop in GP referrals as consultants could now refer directly, but some evidence of reductions from Trusts where there were constraints on local performance. There was to be a review to ensure that referring clinicians were not being deterred by constraints on capacity and the increasing waiting times at the Trust. **Noted:** The Board noted the Performance Committee Chair's report.		
2.b	**PAPWORTH INTEGRATED PERFORMANCE REPORT (PIPR)**		
	Received: The PIPR report for Month 6 (September 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 overall, Trust performance was at an Amber rating. This had improved and that was driven by changes in the rating of the finance domain because of the recovery of the CIP delivery, and the caring domain where the number of complaints had reduced. Those rated red related in a significant part to productivity constraints which was being addressed in the theatres programme which was on the Part II agenda. **Safe/Caring:** Reported by MS: i. Following the earlier challenge and concerns raised by the Board the report included a spotlight on care hours per patient day (CHPPD). In general, the actual and required staffing were closely aligned however there were more significant differences		

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	in the figures reported for critical care, however, these were affected by reporting issues. ii. That our surgical site infection rate was 4.9% which was an improvement from the earlier level of 8.3%, however we were still concerned with the incidence of superficial infections. iii. That the report provided detail on the work on VTE risk assessment, and the key learning was that senior clinical engagement and championing at a consultant level had a significant impact. Focus on this at ward rounds helped to ensure that these reviews were completed for our patients. **Effective/Responsive:** Reported by AB: iv. That we had seen positive news in relation to diagnostic performance in month and that reflected the hard work of our teams. We would see a negative impact in diagnostics in month seven because of the PACS issues. v. Theatres continued to be challenged and were having an adverse effect on our referral to treatment targets. vi. Outpatient activity was below plan and that related to sickness absence, the impact of the royal funeral, and the lower level of follow-ups relating to the constraints on theatre activity. **People management and culture:** Reported by OM: vii. That there was a spotlight report on long term sickness absence and there may be a need to review the key performance indicator to ensure that the longer-term impact of COVID-19 was reflected. viii. At a high level we saw some COVID impact, however across the Trust the biggest issue was mental health. Most staff groups were seeing an improving trend but in nursing we had seen a worsening position with an increase in long term sickness associated with mental health issues. This might be associated with the impact of redeployment, and we needed to understand this and recognise the consequence for our staff. ix. In terms of areas of concern STA were seeing a deterioration and had the highest vacancy rate along with the highest levels of long-term sickness absence. They were the area in which there was also the lowest level of staff engagement and the highest levels of reporting of bullying and harassment, and these indicators were aligned. **Finance:** Reported by TG: x. We had a year-to-date surplus of £2.8m which was £2.7m ahead of plan. xi. We had a positive position on CIP delivery and a better position on BPPC where we had seen disappointing performance earlier in the year, but three of the four metrics were now above plan. **Discussion:** i. MB asked about the reasons for the drop in activity reported in September. AB advised that cancellation of activity related to the funeral of HM the Queen had resulted in a significant and unplanned reduction in activity. This this was being rebooked. ii. JA noted that junior doctor turnover was identified as a risk to compliance in relation to VTE assessment and that was		

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		perhaps unhelpful as we needed a systematic approach that was not disrupted by changes in our junior staff which would always be a feature of our work. He asked also if we could see the impact of this on our patients by having reporting on the number of thrombosis that were occurring. MS agreed to see if reporting could be included on that basis.	**MS**	TBC
	iii.	CC asked MS to provide details of the reporting issue for CHPPD. MS advised that the report was taken as a census over a 24-hour period and that resulted in three eight hourly checks, however for critical care the time period used was 36 hours and so each period was measured against a 12 hour and not an 8-hour staffing requirement. This related to a historic methodology that had been revised as a part of the transformation programme and our reporting would be updated to reflect this.		
	iv.	CC asked how our surgical site infection rate compared with peers. MS noted that we were an outlier and that our peers had rates of around 2.6%.		
	v.	CC noted the worsening compliance with POU filters. MS noted that this reported against a bundle of measures, and she was working with the infection control team to revise this. We were 100% compliant with point of use filters. The area of noncompliance what was the completion of respiratory assessments on Lorenzo, the EPR system. MS took an action to separate the reporting of these two measures.		
	vi.	MB asked about overall capacity and utilisation and whether once the theatre utilisation issues were resolved there would be sufficient capacity in our 36 critical care beds to cope with the level of activity. AB advised that the expected throughput in theatres would not be constrained by critical care capacity.	**MS**	TBC
	vii.	AR noted that it was disappointing to hear about the impact of the downtime on the PACS system and that the supplier had been written to and we expected some compensation in relation to this. GR noted that diagnostics had been one of our successes since the earlier Meridian programme, and it would be a concern and a disappointment to see this performance deteriorating.		
	viii.	JW asked if our workforce scores were worse than our peers regionally and nationally. OM advised that we were upper quartile and had good engagement scores for workforce across most areas and that the trend of increases in mental health related absence was probably consistent with peers. However, every hospital would have particular problem areas.		
	ix.	IW asked about the axis for graphs on long term sickness trends by month. OM advised that these showed each area as a proportion of long-term absence for the Trust and that the narrative referred to trends rather than comparisons between areas. JA noted that it may be helpful to understand the rate for the groups as they made up different proportions of the overall workforce.		
	x.	CC noted that the ICB monitoring showed that the ICB had a lower level of staff absence than RPH. OM agreed to review that metric as she did not recognise that figure. EM agreed that there needed to be a review of the performance reporting for the ICB to ensure that the methodology was understood and that the report data could be triangulated.	**OM/ EDs**	12/22

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	xi. DL asked how we might move the dial on the level of engagement in the STA division. OM advised that levels of staff engagement were influenced by a wide range of factors including staff morale, behaviours, feeling valued and a sense of belonging as well as EDI measures. This could not be taken as a whole, and we had seen the impact of the focused transformation work in both the theatres and critical care programmes. The surgical areas had been affected by redeployment and we needed to see the overarching plans from the division. The division had put in place a dedicated HR manager which perhaps indicated an understanding of the pressures, and this was being picked up in performance meetings. What was key was the need for transformation, not just to achieve an increase in the available beds, but to deliver a change in the level of staff engagement which was equally important for the long term. TG noted that the issue was for our staff to want to achieve this sort of transformation and we were investing in both areas to support this work in the theatres and the critical care programmes. xii. CC asked about triangulation of the figures for BPPC and the debt over 90 days as we were at 92% for the latter and that seemed out of kilter with the BPPC reporting. TG noted that this related to a few specific agreements particularly around medical staffing recharges. **Noted:** The Board noted the PIPR report for Month 6 (September 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 Committee had discussed: i. Safe staffing issues that had been considered in the PIPR. ii. The establishment of the workforce committee which was to be covered later on the agenda. iii. Staff engagement and in particular the concern about redeployment and the stress that could result from this, as these arrangements would need to continue in the medium term. The committee had considered what we might do to provide support for staff to enable them to adapt to these requests in the face of changes in demand. It was proposed that we should share practice from those areas where people were doing well. Also, that we are looking to support ward sisters and matrons to take a more planned approach to redeployment. **Discussion** i. JW noted that as a specialist heart and lung hospital, we were probably less diverse in terms of specialties than district general hospitals and he felt there could be an opportunity to work with staff to manage their expectations and make them feel more comfortable in these roles.		

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	Noted: The Board noted the Q&R Committee Chair's report		
3.ii	**Combined Quality Report** **Received**: A report from the Chief Nurse and Medical Director which highlighted information in addition to the PIPR. **Reported:** By MS that the report provided an update on: i. Items that we were celebrating this month which included the Allied Health Professional's week. ii. The refreshed focus of the Fundamentals of Care Board which included a systematic review of the key standards. **Discussion:** i. JW noted that he had asked for further information on the inquest that was reported in September. MS agreed that she would provide further details to the Chair after the meeting. **Noted:** The Board noted the Combined Quality Report.	**MS**	12/22
3.iii	**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 the Committee had: i. Received the update on compliance with declarations of interest which had seen only a small improvement (as the denominator figure had changed) and were still disappointed that we had not achieved 100% compliance with this standard. The committee was concerned that staff were not completing declaration forms and the recommendation from the audit committee was that there should be a sanction considered in these cases. ii. Received two final internal audit reports one on data quality and PIPR, and a second on M. Abscessus. Both reports had being given moderate assurance and that position was endorsed by the committee. A concern had been raised about the accuracy of data feeding into the PIPR report relating to cancer waiting time performance. This matter was recognised and was flagged in the PIPR. iii. Had received two benchmarking reports which reflected well on Trust performance. iv. Had approved the charity annual report and accounts which would be brought to the Trustee Board in December. **Discussion** i. GR asked whether there was an internal audit of compliance around declarations of interests. TG advised that reviews were cross referenced against the Association of the British Pharmaceutical Industry (ABPI) register and Companies House register of directors to identify any transactions with the Trust and those checks were undertaken annually. ii. JA noted that professional regulators took a very dim view of failures to disclose and that would include sanctions on individuals. He was concerned that the Trust should ensure that where staff had not declared an interest that this was considered in any committees that were decision-making		

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	bodies at the Trust. It was proposed that this could be considered alongside appraisal as a part of a mandatory review for decision making staff. iii. TG advised that the current reporting against cancer standards was reliant on manual handling of data and that the Trust had now purchased the Somerset system which would automate more of the reporting. **Noted:** The Board noted the Audit Committee Chair's report.	**OM/AJ**	TBC
3.iv	**EPRR Core Standards** **Received:** From the interim Chief Operating Officer a copy of the Trusts annual assessment of compliance against the Emergency preparedness, resilience, and response (EPRR) Core Standards. **Reported:** By AB that the Trust had achieved substantial compliance against the 10 domains. These included 64 standards of which we were fully compliant in 50, partially compliant in three and 11 which were not applicable to the Trust. This was a very positive position to be reporting. The self-assessment had been reviewed by system leads and he wanted to record his thanks to Achanda Neale for her hard work on the self-assessment. He recommended the self-assessment for approval. **Discussion:** i. DL noted that we had assessed exercise Sheldon as success and asked whether we had plans to re-run it as external partners had not been able to join it? AB advised that this was a part of the annual plan for exercises across the year and that he would add a note to that effect as a part of the submission. ii. JA asked whether we knew how well the rest of the system were performing, in particular campus partners as we would be reliant on system partners and reports such as that on the Manchester Arena bombing showed how this impacted across partners. EM advised that the ICB Audit & Risk Committee had received the compliance reports from acute providers and both CUH and NWAFT had reported substantial assurance against standards through the self-assessment. However, that did not address how partners responded in practice and that system response would build and be assessed over time. iii. CC noted the deep dive relating to health inequalities where the Trust was declaring non-compliance. EM advised that this related to staff where we were not yet assured in relation to personalised evacuation plans as these were not collated and were reliant on buddying systems that needed to be tested to ensure there were suitable arrangements if for example a buddy was sick or on annual leave. This was an action that had been identified through the operation Sheldon exercise. **Agreed:** The Board noted the self-assessment against the EPRR core standards and approved the assessment for submission.	**AB**	12/22
3.v	**Board Sub Committee Minutes:**		
3.v.a	**Quality and Risk Committee Minutes: 29.09.22** **Received and noted:** The Board of Directors received and noted the		

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	minutes of the Quality and Risk Committee meeting held on 29 September 2022.		
3.v.b	**Performance Committee Minutes: 29.09.22** **Received and noted:** The Board of Directors received and noted the minutes of the Performance Committee meeting held on 29 September 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 the report had been discussed in detail at the Q&R meeting. **Discussion:** i. GR noted that it was difficult to measure the benefit of training such as delivered in our Values & Behaviours programme and asked how the that was to be assessed? Also, whether we were targeting attendance and whether staff from challenging areas were joining the development sessions. OM advised that the V&B workshop was part of the wider Compassionate & Collective Leadership programme and provided an opportunity for discussion and learning. This CCL programme was also supported through: • Line manager development programme • Line manager induction • Framework for managing employee relations • The relaunching of the appraisal with review against the Trust V&B framework • Divisional development which included the work with Theatres and Critical Care. The latter had been supported with a tailored workshop delivered by Dr Chris Turner on 'Civility Saves Lives' this had been supported by Onika Patrick-Redhead and Tony Bottiglieri and had seen good attendance across all staff groups in critical care and the follow up work would look at tools and how issues could be addressed. The next area of focus would be on teams. Some areas were not as strong as others, and we would look at how we could support and develop teams so that all our staff were well supported. We had also identified those areas where there was less engagement with Trust programmes and had set up a more specific tailored. This included facilities management staff and our junior doctors where there was concern this was not such a good focus for their educational programme which was already set within an educational framework. ii. GR asked about the level of training compliance in the nursing workforce. OM advised that there were often difficulties in releasing staff to enable them to be involved. iii. DL asked if there was an updated figure for the vaccination uptake which was below target. OM advised that this was now around 57% (and that compared to a national rate c.33%). We		

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	were not seeing the same energy from some staff groups and uptake was lower. We also no longer had access to the COVID-19 vaccine and so staff would now need to access that through their GP services. JW noted that the focus on delivery of the flu vaccination would continue. JA noted that he had been vaccinated in the Trust clinic which was a great experience with excellent staff. iv. JA asked about the consultant staff engagement in development programmes as there were some reports of incivility in the GMC survey results. OM advised that we had seen engagement from our medical staff and IS had led the way in this where had been previously low uptake. Eight surgeons had attended the civility saves lives session delivered by Dr Turner and she felt that our consultant staff did understand more about this agenda and were becoming more involved and engaged with the programme. JA noted that with our medical leadership value setting and messaging was especially important. **Agreed:** The Board noted the update from the DWOD.		
4.ii	**GMC Survey Results** **Received:** From the Director of Medical Education on behalf of the Medical Director a paper setting out the results of the GMC national training survey 2022. **Reported:** By OM that: i. The report set out the results of the GMC survey that had been undertaken between late summer and early autumn. This had been prepared by our new director of medical education Dr Nicola Jones. ii. This was a complex report and Dr Jones had identified areas where we were an outlier, and these had been discussed with the education team. We had a recurrent issue relating to facilities for our junior doctors which related to decisions taken at the time of the new hospital build where it was envisaged that there would be use of shared spaces and multidisciplinary working and that plan imposed restrictions on our facilities. New junior doctors joining the Trust always express concern at the lack of a dedicated mess facility. The Trust had put in place rest rooms for on call and on shift staff, and had upgraded those facilities and the junior doctors had an area that was shared with the advanced nurse practitioner team, but this was not what they expected. **Discussion** i. JW noted that there had been discussions around campus improvements which might provide some shared facilities. Also, that the move away from clinical firms now resulted in less of a team identity and these changes would have a knock-on effect on our junior staff. ii. OM acknowledged that she could see why junior doctors needed different facilities as they were on different contractual arrangements. This had been discussed at the junior doctor's		

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	forum, which was an active body, and we were open to new ideas about how this might be made to work iii. DL noted that we had the third lowest score of any Trust in the UK and asked if that was all related to the lack of a dedicated space for our junior staff? OM advised that this was one of the most significant learnings from the design of the new build and we were considering how we could improve the sense of belonging and deliver facilities. We had sectioned off a part of the shared room and had installed sleep pods and created a quiet area. We had also installed a coffee machine and there were workstations available for juniors in the shared facility with ANPs. However, these facilities did not meet the expectations of junior staff. We were also not able to put in a portacabin because of planning restrictions. iv. JA suggested that we should focus on those areas that were possible to improve if we were not able to fix the physical facilities for our junior staff. He noted that the scores on experience and scores on incivility had both reduced and these were within our control, and he felt that we should focus on these areas. He asked if we were seeing increases in sickness absence across junior staff and whether there were vacancies. OM noted that the monitoring of sickness absence for medical staff was being recentralised and we would be identifying trends in sickness absence, but we did not have issues with vacancies in junior roles. v. CC felt that we needed to understand whether experience was bad in relation to facilities, or if this was not what was expected. IW felt that this may be an issue of team, he noted that the Trust teams were small and that they could feel lonely and felt we should revisit how we could deliver a mess facility. OM noted that in the pandemic we had managed to fix the facilities issue but that was not on a sustainable basis. vi. It was agreed that this issue should be considered by the workforce committee and an increased focus should be given to look for solutions to this. **Noted:** The Board noted the feedback and the action plan in response to the GMC training survey 2022.	**OM/IS**	05/23
4.iii	**Guardian of Safe Working: EPR Update** **Received:** From Dr Chris Johnson, Chief Medical Information Officer a paper outlining the response to the issues raised in the GSW report to the Board in June 2022. **Reported:** By AR that: i. The report set out the work undertaken by Dr Johnson who had attended the junior doctor's forum to discuss the issues raised. IW had joined Dr Johnson on a visit to explore the issues around usability and the frustrations that had been expressed around the system. ii. We had a high performing infrastructure but recognised that we needed to routinely refresh WOW's (workstations on wheels) and PC's, and these were to be managed as a part of a rolling replacement programme.		

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	iii. We were looking at how we could improve sign in processes using profiles rather than a role-based access. iv. The paper outlined limitations in how we might be able to tailor services in Lorenzo, but the view of our digital clinical safety officers was that the system was clinically safe. **Discussion** i. IW reported that he had been to the ward areas and had interacted with staff on how well the system worked. Pre-emptive maintenance rounds were found to be helpful and provided proactive checking on hardware as staff work often too busy to report issues and so problems were left unaddressed. He had been told that notes were being pasted into Lorenzo from separate systems and that was dangerous practice in a number of ways and was being revisited by the team. The practice on ward rounds was that as the system was slow then notes were being taken and added to Lorenzo after reviews had taken place. ii. JW noted that there would be a much deeper look at this in the process of review of our EPR system. He noted that the consultant view was perhaps this was a slow system. iii. JA noted that it was good to see IW's feedback that the system was safe if used as designed, but if we were seeing work arounds being put in place then we did introduce fragmentation in our systems. iv. DL noted that the paper stated that the system was safe but had issues with stability and usability which were real and a serious concern. She asked how the Board could get assurance data around these performance issues as it needed to understand the concerns and the impact on our patient records. AR noted that he agreed with everything that had been said and that as Chief Information Officer his role was to improve systems to the optimum and to look to put in proactive measures to respond to system pressures. The team had provided a review to back up their assessment of the system but there were issues that were recognised including asset management and refresh, he noted also that training was incredibly important to address the creation of 'work arounds' and the impact that these could have on our systems. He was happy to talk further outside of the meeting and will feedback into our EPR systems procurement process. He acknowledged that no system was perfect, and that we needed to work to address the challenges of each. v. CC noted that one option was to increase our Wi-Fi capacity and she asked whether this cost might be undertaken as a part of our financial flexibilities. TG advised that this was a valid issue and could be raised under the Part II agenda. **Noted:** The Board noted the update on Junior Doctor feedback made through the Guardian of Safe Working report.		
4.iv	**FTSU Guardian's Report** **Received:** From the Freedom to Speak Up Guardian a summary of the FTSU activity in Q1 and Q2 to inform the Board of progress and key issues.		

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	Reported: By TB: i. That he continued to encourage staff to speak up and had seen an improvement in the numbers of issues raised across the period. ii. We continued to see an increase in reports of bullying and harassment and most reports arose in our clinical services covering medical, nursing and healthcare support workers. A smaller proportion of reports were from non-clinical areas. iii. He noted that the key issue was around the response to the issues raised. Where matters took time to resolve or were not responded to positively then staff might consider an alternative approach through grievance or dignity at work procedures. He noted that positive outcomes were facilitated through good discussions with line managers. iv. We had an increasing number of champions across the Trust who were all volunteers in the role. They met as a group on a quarterly basis and had bimonthly catch ups with the guardian. These staff were in place to signpost and guide colleagues. We had thirty-two in post and four in training and they were all doing well. Maintaining a supportive network would bring new champions to the role. v. He was involved with workshops targeted at areas with particular challenges and worked with all parts of the Trust. **Discussion** i. JW noted that it might be helpful to look at the proportion of reports for each staff group given the difference in number of employees at the Trust. ii. CC noted that the number of staff who would not use the service again had increased and whilst a small number she felt it might be helpful to explore why that might be the case. TB advised that it was for individuals to decide based on their experience of the service and noted that some staff may be frustrated with the outcome if it was not what they had been seeking. iii. DL noted the concern about lack of engagement in some forums and asked how the Board could support this? TB advised that he attempted to meet regularly with forums across the Trust and there were some issues where agendas were very busy rather than this being related to a negative view of engagement. iv. AF thanked TB for a good report. She asked if given the range of feedback there were any key messages that TB had for line managers that might be disseminated. TB highlighted the issue of responsiveness and that in some areas senior staff did not see themselves as a part of 'management' and felt that a move into roles that included performance management did not fit with their rationale for being in the NHS. This had been discussed as a part of the civility workshops and the focus there was on how we each needed to work together to get this right. He also felt it was important that staff could see data that was being relied upon at briefings matched their experience of staffing on a day-to-day basis. v. JA noted that staff who indicated they would not speak up again and staff feeling subject to detriment because of the		

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	process may result in underreporting which meant that we could not take full assurance from the numbers that we were seeing. TB advised that in discussions with staff individually there were sometimes concerns shared on impact on their career, their relationship with their line manager, and other colleagues in their team, and these were all areas that could be seen as having a detrimental effect and this formed a part of the national reporting. vi. GR asked whether we also captured speaking up through other routes such as line managers. OM advised that this data was a subset of reporting that could arise through many routes including the chaplaincy, the workforce team as well as line managers. This was not data that could be aggregated into a report, but this was a metric in the national staff survey. vii. JW asked if there was other support needed by the guardian's service. TB suggested that administrative support would be very welcome. **Noted:** The Board noted the FTSU Guardian's report for Q1 and Q2.	**OM**	02/23
5	**STRATEGIC**		
5.i	**AHP strategy 2021-26: Update** **Received:** From the Chief Allied Health Professional on behalf of the Chief Nurse a copy of the update on the AHP Strategy 2021-26. **Reported:** By MS that the report had been reviewed at the Quality & Risk committee and was being brought to the Board for information. **Noted:** The Board noted the update on the AHP Strategy 2021-26.		
6	**BOARD FORWARD PLAN**		
6.i	**Board Annual Business Plan** **Received and Noted:** The Board Annual Business Plan. **Discussion:** EM noted that Board committees had struggled with their planned agenda this month and had overrun. She was also concerned that the February meeting of the Board may be quite a heavy agenda and so the scheduling around this would be reviewed.	**EM/AJ**	12/22
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 3 November 2022

Glossary of terms

ARU	Anglia Ruskin University
CIP	Cost Improvement Programme
C&P ICS	Cambridge & Peterborough ICS
CPFT	Cambridge & Peterborough NHS Foundation Trust
CRF	Clinical Research Facility
CRN	Clinical Research Network
CUH/CUHFT	Cambridge University Hospitals NHS Foundation Trust
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
MoU	Memorandum of understanding
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
UoC	University of Cambridge
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