Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Held on 01 December 2022 at 9:00am
Microsoft Teams
HRLI, 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 Smith	(IS)	Medical Director
	Prof I Wilkinson	(IW)	Non-Executive Director
In Attendance	Ms K Bigwood	(KB)	Junior Cardiac Rehab Team Leader
	Dr P Calvert	(PC)	Clinical Director of Research and Development
	Mr S Edwards	(SE)	Head of Communications
	Mrs A Jarvis	(AJ)	Trust Secretary
Apologies	Mr A Selby	(AS)	Director of Estates and Facilities
Observers	Susan Bullivant, Trevor Collins, Richard Hodder, Rhys Hurst, 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: 3 November 2022 The following items were revised to read as follows: **Item 1.v Board Assurance Framework:** Revised to read: Discussion i: "...industrial action for a 6-month period." Discussion ii: "...that was looking at Trust plans to..." **Item 1.vi CEOs update**: Revised to read: v. "Plans were being put in place..." **Item 2.b PIPR:** Revised to read: Discussion i: "The cancelled activity was being rebooked." **Item 3.iii Audit Committee Chair's Report:** Revised to read: Reported ii: "Both reports had been given..." Page 16 - 3.iii Audit Committee Chair's Report: Reported ii: "A concern had been raised in the Audit report about the accuracy of the data feeding into the PIPR report relating to cancer waiting time performance. Whilst this matter was recognised, this did not affect the overall assurance around information received from PIPR due to the triangulation of data." **Item 4.i Workforce Report:** Discussion i: "...asked how that was to be assessed?" **4.ii GMC Survey Results:** Discussion v: "CC felt that we needed to understand whether their experience was..." Discussion v: "IW felt that this may be an issue of team size ". **Item 4.iii Guardian of Safe Working: EPR Update:** Discussion i: "...as staff were often too busy to report issues..." **Approved**: With the above amendments the Board of Directors approved the Minutes of the Part I meeting held on 3 November 2022 as a true record.		
1.iii	**MATTERS ARISING AND ACTION CHECKLIST**		
	Item 3.i Action Checklist: **Ref:** i. CC noted the update on declarations of interest and asked whether the Board should set a standard that should be achieved against this. OM advised that we used a 90% target for mandatory training and that was to allow for turnover and long-term absence. ii. JA noted that he felt some concern about decision makers not having up to date declarations given this related to use of public funds. iii. TG proposed that we should aim for 100% compliance but have specific exemptions in place for leavers, newly arrived staff and staff on long term leave. He noted this was a matter for the audit committee. **Noted:** The Board received and noted the updates on the action checklist.		

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1.iv	**Chairman's Report**		
	The Chairman noted that since the last meeting: i. We had been able to hold our first Council of Governors meeting in person which was very welcome. ii. We had also celebrated the 40th anniversary of one of our transplant patients, Sandra Law, who had been transplanted by Sir Terence English and subsequently by Mr Tsui. It was good to see that she was well and was able to celebrate this event with the Trust. iii. He had attended the meeting of the Cambridge Life Sciences Council with Lord Prior, which was a very useful for the future development plans for the campus. iv. He had also met with John O'Brien the Chair of the Integrated Care Board. v. He reflected on the events in the media relating to both industrial action and the current cost of living pressures for our staff would present significant challenges over the coming weeks. **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: i. That the key risks to highlight to the Board related to industrial action and productivity. These matters would be covered under reports on today's agenda. **Noted:** The Board noted the BAF report for November 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 and the Chairman had attended the funeral of Glenn Edge, who had been a longstanding governor of the Trust, and who had contributed significantly in that role during his term. ii. The RCN had confirmed that industrial action would be taken on the 15th and 20th of December. This was a similar position to other providers in Cambridgeshire and Peterborough. The Unison ballot had not met the threshold for strike action. The Trust had set up an industrial action task force to ensure that we could continue to deliver services safely on strike days. We recognised this was a very difficult time for staff, and that staff felt conflicted about taking such action and we hoped that this situation could be resolved rapidly. iii. Our vaccination rates were 58.1% for the COVID booster and		

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	56.5% for flu, and whilst we wanted to improve this position, we were one of the highest performing Trust in the Eastern Region and had been invited to share lessons learned about this. iv. There had been some improvement in uptake of the Values and Behaviours workshops, but this was not as much as we would like to see achieved, and we would continue with workshops in the new year. v. We had celebrated our healthcare support workers with events in the atrium and visits to wards, distributing £10 vouchers and raffle prizes. Staff were very grateful to have their efforts recognised. vi. The CQC had issued their report on IRMER and we were doing an initial review to ensure accuracy and this would then be shared more widely. vii. Two inquests had been held for patients who had M.Abscessus. The Trust had attended the inquests and the coroner had given a fair and balanced view of these deaths. A Prevention of Future Deaths Report was being issued to the Department of Health and Social Care as nationally there was more to do to understand this issue. viii. We had treated our first patient in the HLRI and were continuing to recruit staff for the service. Our inpatient services would be commissioned following the CQC inspection of the facilities. ix. We continued to work with CUH on the development of nested ward facilities and were working to a January timetable. x. We had also had a positive ministerial visit with campus partners and ministers were keen to return to visit Royal Papworth. xi. She had joined the Cambridge Life Sciences Advisory Council meeting which had representation from industry, pharma and technology as well as our CUPH partners. xii. We had celebrated our Advanced Nurse Practitioner team in the Respiratory Support and Sleep Centre who were performing amazingly well. xiii. We had been advised that Mr Aman Coonar had become president-elect of the Society of Cardiothoracic Surgeons and Professor Floto, had been elected as the Secretary of the British Thoracic Society. **Discussion:** i. MS noted that our healthcare support workers were incredibly passionate about their work. ii. JW noted the honour of holding the current president as well as the incoming president of the Society of Cardiothoracic Surgeons. iii. CC asked about the coverage of the two M.Abscessus inquests in the press. EM advised that many of our staff had been involved in this and that Sam Edwards, the Head of Communications, had done some very good work to ensure that coverage was factually correct. This could not address everything that was reported but on the whole the coverage was accurate. The Trust was also refreshing the information published on the website. SE noted that this was a highly complex matter and we had ensured that our briefings were accurate. There was a responsibility on journalists to report		

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	accurately and we had challenged and sought corrections where this was not the case. The Prevention of Future Deaths report was clearly worded and had been issued to the Secretary of State as this was a matter that was about us and every hospital. IS noted that we suspected that other organisations may have similar issues but may not have been aware of these and so may not have addressed them. He hoped the inquest position was clear. **Noted:** The Board noted the CEO's update report.		
1.vii	**Patient Story**		

	MS introduced the patient story. This was presented by Kirstie Bigwood.
	
	KB shared with the Board the statement from the British Association for Cardiovascular Prevention and Rehabilitation:
	
	"Saving someone's life following a heart condition is vital but giving them a fulfilling life that is worth living is equally important. The aims of cardiac rehabilitation and prevention is to provide the patient and family with the skills and knowledge to self-manage, facilitate recovery both physically and psychologically and educate to reduce the risk of further CVD events, as well as achieving an absolute risk reduction in cardiovascular mortality." (BACPR) 2017.
	
	She noted that the British Association of for Cardiovascular Prevention and Rehabilitation had 6 core components:
	
	• Health behaviour change and education
	• Lifestyle risk management:
	  o Physical activity and exercise
	  o Healthy eating and body composition
	  o Tobacco cessation and relapse prevention
	• Psychosocial health
	• Medical risk management
	• Long term strategies
	• Audit and evaluation
	
	This story concerned a lady who experienced chest pains whilst on holiday swimming in the sea with her 2 children and husband. She was taken to hospital where she was diagnosed with an ST elevation myocardial infarction. She underwent an angiogram and attempted intervention to her distal right coronary artery which was unsuccessful.
	
	On return home she had not been referred for any cardiology follow up so arranged to be seen at the Trust privately in August. At this appointment it was concluded that her presentation was consistent with spontaneous coronary artery dissection (SCAD). When seen she was physically well, however clearly psychologically affected by the event. This anxiety was exacerbated by the fact that her father had previously died suddenly, but the cause was unknown as there had not been a post mortem. Her doctor explained the diagnosis and referred her to the cardiac rehab team at RPH.
	
	On initial assessment it was evident that she was suffering psychologically and had lost confidence. Prior to her cardiac event she had been cycling regularly and playing tennis, however at		

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	assessment she had been doing minimal activities as she was very anxious of overdoing things and damaging her heart further. She reported that on discharge from the hospital in Belgium she was told to avoid getting out of breath. She didn't know how much she could or should be doing. She was not playing with her children and had lost all confidence in socialising with her family or friends. She had also not yet returned to work as she did not know how long she should take off. During her assessment her lifestyle risk factors for cardiovascular disease were addressed. These include diet, exercise, stress and anxiety. As part of our MDT, we have access to a psychological wellbeing service for our patients and with her consent she was referred into this for specialist counselling. The BACPR state that every patient taking part in cardiac rehab should be screened for psychological, psychosocial and sexual health and wellbeing as ineffective management can lead to poor health outcomes (BACPR 2017). She underwent an exercise tolerance test to assess her baseline level of physical fitness. Cardiac rehab uses a range of functional capacity tests to give valuable information on risk assessment and to enable appropriate exercise prescription and to aid goal setting (BACPR 2017). She achieved 13 minutes on the Naughton protocol on the treadmill which was the most exercise she had achieved since her cardiac event. Throughout the test her heart rate, heart rhythm and blood pressure were constantly monitored as were her exertion levels. With this information her target heart rates were calculated. Target heart rates are safe working heart rates which achieve cardiovascular exercise that can be maintained for a prolonged period of time and which increased as she progressed through the programme. These gave her confidence to increase her exercise and activity as she had achieved a heart rate of 151 when on the treadmill with no ill effects, so her target heart rates gave her a safety net to work towards. She was also loaned a heart rate monitor to use at home. She chose to attend the weekly exercise classes at the hospital for 6 weeks. During the programme she increased her exercise levels and confidence week on week, and she was now nearing the end of the programme. She had returned to work which she cycles to, and was enjoying family time and has started socialising again. Where could this experience have been improved? This patient would have benefited from receiving cardiac rehab much earlier in her journey. Best practice is that eligible patients are referred either during inpatient stay or within 24-72 hours of discharge and that they are contacted within 72 hours of receipt of the referral. Post stent or myocardial infarction eligible patients can attend for assessment 10 days post discharge from hospital. She was not referred until 30 August which was 49 days post her event. Earlier referral and participation in the programme may have massively reduced her anxiety and lack of confidence. This may have resulted in her not requiring a PWS referral and returning to exercise, work and normal activities sooner. She could have been referred into the programme directly from her GP once they had received her discharge paperwork from Bruges.		

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	This would have led to earlier intervention by the cardiac rehab team. However, due to a lack of follow up she arranged her own private follow up through a tertiary centre. **Discussion:** i. JW asked about the age of the patient and whether patients were able to support one another by talking through their experiences. KB noted that the patient was in her 40s and that she had a high level of anxiety. Patients met in their rehab groups each week, and these provided a level of support, but patient led support groups had lapsed and the service was looking again at how these could be supported. ii. CC asked about the pathways and how and when we moved patients into community rehab services. KB advised that patients with heart attacks would be referred at 10 days and those having surgery would be referred after six weeks. The pathway was for an assessment at RPH which would be followed up with weekly rehab sessions for a 12-week period either at the hospital or at the RPH service at Cambourne. We would then offer referral into phase four services that were delivered in community settings such as gyms. These were specialist cardiac rehab gym programmes and classes. Around 50% of our patients would seek to maintain follow up with the Trust. This was delivered through exercise DVD's and YouTube links. iii. JW asked whether this could be offered to other people in a similar position who had not accessed services at RPH. KB advised that this was a system wide service, and we would see heart attack patients wherever these arose. She noted that Peterborough and Cambridge had their own service, and we would see referrals from our historic catchment. She noted that QEH were losing their cardiac rehab programme and we were trying to work with them to offer support. iv. DL asked whether this was available for patients who had cardiac events outside of centres. KB noted that we would not be aware of patients unless the GP or the patient self-referred. The service had recently seen a new patient who was two years post heart attack, they were still monitoring their blood pressure three times daily and had not progressed through rehabilitation as they should have. She advised that all patients on the rehab programme had been contacted during COVID and about 80% had wanted to continue to follow their programme. v. JW asked whether this could be delivered more universally through social media. KB noted that we still needed to assess all patients within our service and so would have constraints on overall numbers because of staffing but we were looking at whether we could hold virtual classes. vi. JA asked whether we were looking at cardiac rehab as a part of the ICB strategy so that this service could be delivered across the whole of the system and if we knew the detail of those who did not attend whether that was higher in groups such as women or those from ethnic minorities. KB advised that this was an area that we had looked at and that whereas nationally there was an uptake level for rehab around 50% we		

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	had an uptake level of 90% and so were in a very different position to other services. This may be because we were a tertiary centre, and we establish a link with patients before discharge as we see patients on the ward and we then ring to follow up but we were massively ahead of the national benchmark. vii. CC asked whether we would be in a position to 'level up' services across the ICB as the experience of this patient had illustrated the psychological impact that could be lifelong for many patients. KB advised that all patients were different. We had started the service with the input of a psychological practitioner for one day a week, and now referred many patients into this service and so that capacity needed to increase. These events were hugely triggering for some patients, but for others there were not similar issues. viii. MB noted that he was one of the patients in this type of service. He had not been a patient of RPH but suspected that there was an enormous amount of unmet need. He felt that he still did not fully understand what he could safely do and that his consultant was not fully able to advise as his heart was remodelling and so this generated a persistent psychological niggle that was quite oppressive. KB noted that the team at RPH had good discussions with medical staff and this helped in decision-making for individual patients. She noted that many patients called the service directly for advice and there were a number that would automatically be diverted to a 999 route. ix. JW felt that we should to consider how we could use social media to support patients in this circumstance more broadly and ensure that rehabilitation formed a part of the cardiovascular disease strategy for the Integrated Care Board. **Noted:** The Board noted the patient story and thanked KB for sharing this with the Board.		
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 divisional presentation from the STA team. ii. Recruitment, and particularly lead times and onboarding for candidates and the KPIs associated with this as this was felt to be something that was under our control and was not externally dependent on labour market factors. Delays had been caused by turnover in the HR team and the complexity of the pre-employment checking process and we were looking at a risk assessed process in relation to this. iii. The Trust's industrial action plans and these were coming to the board in Part II. iv. The current staffing pressures on level 5 where we had seen issues around bed occupancy and the impact of redeployment, and it would be looking at this in further detail. v. The operational planning framework process which was a		

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	comprehensive and robust process and that was looking positive. vi. The soft FM contract review and the theatres recovery programme. **Discussion:** i. JW noted that the ICB people lead had presented to the Trust chairs meeting. Workforce had been identified as a significant issue and the discussion focused on how we would get the whole system back on target. They had raised the issue of the disjointed process between partners that was seen to inhibit the recruitment process. OM advised that a part of this issue was the digital system which we were about to reprocure. She agreed that we needed to improve what was within our control, and this would be supported by the move to the new system which would be implemented in April 2023. There was other work being undertaken at a national level looking at pre-employment checks and the minimum standards that must be delivered through recruitment processes. However, these needed to sit within the regulatory requirements. JW felt it was important to lever change at a system level where checks were felt inappropriate. OM noted that this was a part of the national programme, and we had a voice in that process. ii. AF noted that the workforce committee had been established and its first meeting would be on the 26 January 2023. She would review the membership and confirm that with JW. All Board members had been asked to hold this time in their diary and membership would be confirmed. **Noted:** The Board noted the Performance Committee Chair's report.	**AF/JW**	01/23
2.b	**PAPWORTH INTEGRATED PERFORMANCE REPORT (PIPR)**		
	Received: The PIPR report for Month 7(October 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. JW noted that he was concerned to see the deterioration that was apparent in our safer staffing reporting in PIPR. EM advised that the reporting reflected the organisation being under stress in terms of staffing and the monitoring had been revised to clarify how we presented our data. We had changed the safer staffing metric to present fill rate for areas rather than the care hours per patient day. This perhaps meant that trends were more obvious that had not been as evident in the previous metrics. Notwithstanding this the information was showing the impact of recent changes and a degree of catch up in relation to audits. **Safe:** Reported by MS: i. That we had reviewed how we undertook our High Impact Interventions. There were areas where these were not undertaken during the pandemic and areas where they had not been restarted. We had identified where improvement was needed, and areas where interventions were taking place		

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	but not being captured. There was a lot of work being undertaken in this area by the IPC committee and there was increased monthly monitoring in place. Audits were now being signed off by Matrons and action plans were being followed up. This looked as if it were a downward trend, but we were now able to follow this up more systematically. ii. That the change in reporting of staffing had been undertaken in response to the Board questions about care hours per patient day. That measure was a derived figure and could be subjective depending on the information put into the system. We still reported that figure nationally based on the midnight bad state, but the provision of information on fill rates was a more accurate description of staff availability. Those figures were taken from rosters worked and took into account sickness, annual leave and vacancies and were an actual number, so if we required 100 shifts to be filled per month and we ended up with 80 then the fill rate for that would be 80%. This was measured against planned shifts and so the rating assumed that all beds were open. **Discussion:** i. JW asked whether patients were being harmed as a result of the staffing fill rates. EM noted that this constraint linked to activity which was mitigated on a daily basis as our beds were not fully occupied. Ideally, we would like all beds and shifts to be filled but this was always a balance. JW proposed that the rating should be amended to reflect this. IS noted that the calculation was green four months ago and so this metric was reversable. This data told us about capacity and throughput as well as safety, but it also told us of the measure of pressure on staff as we saw staff working outside their areas. JW noted however that this was not a direct measure of safe staffing as a shortfall against a very low activity base would still flag red. MS noted the detail in the spotlight report which triangulated the fill rate, the mitigations in place, and the CHPPD and across these areas and that we were able to benchmark our performance against peers and we remained above the bar on these comparisons. However, in terms of redeployment there were pressures where staff were not working in their teams. She noted that staff reported 'red flags' in relation to staffing but there was not a uniform approach to reporting, and these would be seen in areas where staff were feeling stressed and overwhelmed such as critical care, level 5 and in cardiology. The spotlight include the nurse sensitive indicators where we would identify if staffing levels were leading to harm These demonstrated that incidents were stable and that harm levels remained low. We had seen an increase in falls and were reviewing the significance of these. MB noted that he understood the account provided by MS and agreed that the fill rate was not a measure of patient safety he felt that the measure and narrative provided a more dependable assessment, along with the information around incidents and patient harm. ii. JW asked whether we would ever move away from a red rating in relation to staffing. IS advised that this measure was		

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	green four months ago and the position was related to changes in our staffing levels. This measure informs us about our capacity iii. JW noted the performance pressures and the catch up that was being undertaken in relation to High Impact Intervention audits as we were restarting our routine monitoring methodologies. iv. JW asked about the impact of the multiple reports against fill rate and the CHPPD reporting and whether this skewed reporting in the domain. TG agreed that the weighting of the metric needed further review. v. DL noted concern about the level of redeployment as she was concerned about the sustainability of this position given the fragility of the workforce. MS noted that we would need to recruit to get to a green rating as our nursing vacancy rate had risen from 5% to 13%. We also needed to reduce sickness absence as the rosters worked were running at 30% headroom and were written with 21% headroom. In relation to redeployment we aimed not to have staff working outside of their areas and were tracking and supporting staff to address this. We needed to get our ward sister to manage and support staff in their supervisory roles and were looking to reduce movements and increase plans to buddy. vi. AF noted that safer staffing was set within a national framework and that she felt that MS's reporting brought this to life for RPH. She felt that the spotlight was very helpful. She also noted in terms of assurance that she had joined the senior nurse's forum with OM and MS and they had looked at redeployment and impact and what we wanted to do to address this, and this was very helpful to understand. vii. CC noted that there had been a good explanation of the position to the meeting but returned to the concern posed by Ockenden that the Board needed to have a report that provided this assurance at each meeting. JA noted that the Q&R Committee had proposed that we could schedule a deep dive on Safer Staffing for NEDs and suggested that this might be undertaken as a part of a Board development session. MS suggested that we kept the spotlight report in PIPR going forward so that the explanation of the metrics was included in reporting each month especially over the winter period so that the Board could see the progress and mitigations that were in place. MB asked that we look at reporting in both nursing capacity and safer staffing. MS advised caution in this as the metric was aligned to national reporting that we needed to maintain. **Noted:** The Board noted the PIPR report for Month 07 (Oct 2022).	**MS**	01/23
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 JA that: i. The key items related to workforce as had previously been discussed and a further briefing had been proposed. ii. The Quarter 2 Quality and Risk report highlighted that performance against the WHO checklist and VTE risk		

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	assessment remained low but there were signs of improvement where this had a medical champion to support implementation. iii. SSI remained a concern and whilst we had seen reductions in deep wound infections there were increases in superficial infections and this was an area of ongoing focus. **Discussion** i. GR noted that the performance in relation to the point of use (PoU) water filters was at 100%. This followed the separation of a bundle of measures in relation to M.Abscessus. He asked for assurance that Q&R were happy with the change. IW noted that this proposal had been considered at Q&R previously. MS advised that reporting had been revised in line with the earlier Board discussions. ii. JW asked about the wider impact of PoU filters. EM noted that there had been detailed discussions at the water safety group and there were consequences from their use for example the reduce flow could adversely affect legionella growth. TG advised that the Water Safety Group had the Authorising Engineers from the Trust and from Skanska and we needed to listen to their expert recommendations. He did however welcome the report's 100% compliance. **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. i. Detail on the two improvement notices received in relation to IR(ME)R Regulations. ii. She noted also that M.Abscessus inquests were being held this month. **Discussion:** i. JW asked about the inquest findings relation to patient C as this did not look to have an understandable timeline and he asked if the patient had further surgery. MS advised that this was a very delayed inquest going back to 2016. This related to a complex case. The patient's surgery had been delayed three times and these delays had been investigated as serious incidents. The patient's family had lots of questions about the care provided, and some of the meetings with the family had been delayed through the pandemic. The coroner had also requested expert opinion on the case and this all meant that the family had waited a long time for the inquest and for closure. The patient had a choice of procedure (which we no longer undertake) and they had recovered well. They were discharged six days post operatively but suffered a collapse two weeks later and they were admitted to the Trust (through CUH) and they did not recover from the collapse. JW noted that there were also significant delays in the coronial system. **Noted:** The Board noted the Combined Quality Report.		

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3.iii	**Board Sub Committee Minutes:**		
3.iii.a	**Quality and Risk Committee Minutes: 27.10.22** **Received and noted:** The Board of Directors received and noted the minutes of the Quality and Risk Committee meetings held on 24 November 2022.		
3.iii.b	**Performance Committee Minutes: 27.10.22** **Received and noted:** The Board of Directors received and noted the minutes of the Performance Committee meeting held on 24 November 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 paper set out the key issues around recruitment and the relaunch of the appraisal policy reflecting the Trust's Values & Behaviours Framework. The new procedure strengthened the support provided to staff. **Discussion** i. JA noted that this was very welcome and thanked OM and her team for their work to bring this together. **Agreed:** The Board noted the update from the DWOD.		
4.ii	**Guardian of Safe Working** The Board noted that IS would provide an update in the Part II meeting.		
5	**STRATEGIC**		
5.i	**Research & Development Strategy** **Received:** From the Clinical Director of Research and Development the Research & Development Strategy 2023 - 2028. **Reported:** By Dr Calvert: i. That Board members had seen the earlier versions of the strategy and that it had been well liked and he thanked the Board for the opportunity to present it today. ii. It had been developed with the input of stakeholders across the Trust, the University and industry partners. iii. It set out our priorities and how we make best use of the opportunities that arise that arise from our colocation on the CBC, and our investment in the HLRI. iv. It also set out how we would achieve sustainable development identifying investment, work required and enablers. v. That the section on the HLRI was a co-strategy with the UoC supported by charitable funding (including from the RPH Charity) and a key focus for the Trust was the delivering the full potential of the Clinical Research Facility. vi. The strategy was a significant investment in people and diversity. It included plans for five research leaders whose posts would be funded through Trust and research funds, who		

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	would be catalysts in departments across the Trust. A key metric for these posts would be the acquisition of grant funding support. vii. The strategy looked at the barriers to delivery in R&D, and the governance arrangements and research delivery. There was a job to be done to in relation to cultural change and rewarding the delivery of research and this would need some institutional change and that was expected to increase job satisfaction. viii. There was an ambition to promote research with Nurses, AHPs and Clinical Scientists, and to recruit to lead roles from these staff groups as well as medics. ix. The strategy planned to expand our research active clinicians and expand the portfolio of trials by 25%, aligned to our industry partners. x. That he had worked with Dr Chris Johnson to align to our digital priorities and that included patient involvement in research and the use of research to reflect and to benefit the whole population. xi. It sought management support for resolution of the permanent location of the tissue bank. xii. It saw the establishment of an innovation committee to ensure that we were delivering our ambitions. **Discussion** i. JW thanked PC for the work in bringing the strategy together. He asked about the future of the tissue bank. PC noted that this needed a permanent solution as this was currently being run as a hybrid arrangement off site and that was not satisfactory. IS advised that there was some complexity around the allocation of space in the HLRI relating to the lease and that the space was not lab grade and so we needed to work with the UoC to find a mutually acceptable solution. ii. CC was pleased to see the reference to inclusivity to address the needs of the wider population and asked how that would be delivered and monitored. PC advised that it was planned to have a performance dashboard to track the metrics included in the strategy so that we know how we are performing. Research UK does not do well in the area of population data and we would need to look at a novel solution to deliver this and were looking at the increased use of de-identified data where patients did not object to this. iii. IW noted that the heading on P28 needed to be revised to refer to 'medical devices'. iv. DL noted the ambition to implement a research data solution by 2023 and asked how far we were expecting this to progress. PC noted that this programme was being led by Chris Johnson and AR. AR advised that a number of pilot areas were going ahead and the self service analytics tool that was being developed with Dedalus was a part of this, alongside the discussions on the EPR replacement, T4C, and the shared care record as these would each provide some opportunity for R&D. v. AF asked how the document could be condensed to share with colleagues across the Trust. EM advised that once		

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	approved the intention was to provide an easy read guide in the new year. vi. JA asked about the next steps for the strategy noting that that the Trust was a very research orientated organisation, and that the strategy should be brought through SPC for reporting. He noted the plan to develop the reporting dashboard and felt it would be helpful for the SPC to see and approve that. vii. MB liked the set of ambitions outlined and asked about the Trust's commitment to the open science framework to make research data and coding publicly available. TG and JW noted that there was some history of the NHS failing to benefit from intellectual property created through research and that was also a consideration. MB felt that there needed to be a clear commitment to the publication of sufficient data and coding in order to satisfy the requirement of others to scrutinise the healthcare outcome of research. IW noted that data and summary trial information would be published and that non-reported trial outcomes should be published so that others could scrutinise but done correctly this could protect IP. It was agreed that MB and IS should discuss the approach to this. **Agreed:** The Board approved the Research & Development Strategy 2023 – 2028.	IS/PC MB/IS	TBC 03/23
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 December 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