

**Meeting of the Board of Directors  
Held on 2 February 2023 at 9:00am  
Microsoft Teams  
HRLI, Royal Papworth Hospital**

**UNCONFIRMED**

**M I N U T E S – P a r t I**

<b>Present</b>	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
<b>In Attendance</b>	Mrs A Jarvis	(AJ)	Trust Secretary
	Ms C Holmes	(CH)	Lung Cancer Specialist Nurse
<b>Apologies</b>	Mr A Selby	(AS)	Director of Estates and Facilities
<b>Observers</b>	Trevor Collins, Richard Hodder, Marlene Hotchkiss, Christopher McCorquodale, Trevor McLeese, Harvey Perkins,		

Agenda Item		Action by Whom	Date
<b>1</b>	<b>WELCOME, APOLOGIES AND OPENING REMARKS</b>		
	The Chairman welcomed everyone to the meeting and apologies were noted as above.  The Chairman noted that the agenda and order of items had been amended with workforce matters brought further up the agenda.		
<b>1.i</b>	<b>Declarations of interest</b>		
	There is a requirement that Board members raise any specific		

Agenda Item		Action by Whom	Date
	<p>declarations if these arise during discussions. No specific conflicts were identified in relation to matters on the agenda. A summary of standing declarations of interests is appended to these minutes.</p>		
1.ii	<p><b>Minutes of the previous meeting</b></p>		
	<p><b>Board of Directors Part I: 01 December 2022</b></p> <p><b>Item 1.vi: CEO's update:</b> Revised to read: Reported: viii: "The first research participant had attended a study appointment in the HLRI and..." Discussed: iii: "...inquests in the press as there had been some negative connotations about the report against the Trust."</p> <p><b>Item 1.vii: Patient Story:</b> Revised to read: Paragraph 4: "...British Association of Cardiovascular Prevention..."</p> <p><b>Item 3.ii Combined Quality Report:</b> Revised to read Reported ii: "She noted that the report included detail of inquests that had been reported in month."</p> <p><b>Approved:</b> With the above amendments the Board of Directors approved the Minutes of the Part I meeting held on 1 December 2022 as a true record.</p>		
1.iii	<p><b>Matters arising and action checklist</b></p>		
	<p><b>Noted:</b> The Board received and noted the updates on the action checklist.</p>		
1.iv	<p><b>Chairman's report</b></p>		
	<p>The Chairman noted that noted two key events since the last meeting the Staff awards which was held before Christmas and was a particularly good event that had been perhaps enhance by the time of the year that it had been held and he felt that we should consider this for the future. Also, the recruitment drive which he had attended, which had been a very positive event.</p>		
1.v	<p><b>Board Assurance Framework</b></p>		
	<p><b>Received:</b> From the Trust Secretary the BAF report setting out:</p> <ul style="list-style-type: none"> <li>i. BAF risks against strategic objectives</li> <li>ii. BAF risks above appetite and target risk rating</li> <li>iii. The Board BAF tracker.</li> </ul> <p><b>Reported:</b> By AJ that key issues included:</p> <ul style="list-style-type: none"> <li>i. Updates to the risk relating to industrial action where we had seen strike action in December and further action was planned in the next week.</li> <li>ii. The staff engagement risk which would be covered through the workforce section on the agenda.</li> </ul> <p><b>Discussion:</b></p> <ul style="list-style-type: none"> <li>i. MB suggested that it would be helpful for any changes in the target risk rating to be identified in the reports.</li> <li>ii. GR noted that the likelihood rating for BAF3261 (Industrial Action) was at 5 because action was being taken and suggested</li> </ul>	AJ	03/23

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	<p>that risk may need to be redefined as the risk was rather the resulting harm that would be caused to patients as a result of industrial action. OM agreed that she would review the risk to ensure that it reflected the risk of disruption to services and the impact of that on patients and staff.</p> <p>iii. EM asked whether the reference to OT (Occupational Therapy) in relation to mitigating actions for BAF742 should also refer to the wider Allied Health Professional (AHP) team as a part of the response. MS confirmed that it would.</p> <p><b>Noted:</b> The Board noted the BAF report for January 2023.</p>	OM	03/23
<b>1.vi</b>	<b>CEO's update</b>		
	<p><b>Received:</b> 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.</p> <p><b>Reported:</b> By EM that:</p> <ul style="list-style-type: none"> <li>i. One of our ex-members of staff, Julie Quigley, had sadly passed away. Julie had been the instigator of our Alert team and had been an extremely valued colleague for many years. MS had been able to represent the Trust at Julie's funeral and many of the people that knew her had been able to be present virtually.</li> <li>ii. That the recruitment event on the 21 January had been exceptionally positive and it was great to see that we got so many recruits on the day. This event was part of the focused support by the workforce team to STA division.</li> <li>iii. We also had the House move in January. EM had been blown away by the professional, calm and organised approach to the move. There was an awful lot of planning that had gone in beforehand, which was very evident, with staff coming in over the weekend just to make sure everything was running, ready and laid out properly for a great welcome on Monday morning. She had seen that by nine o'clock on the day of the move, everybody was settled working, and receiving calls and that was a fantastic achievement. She felt it had echoes of the 'can do' attitude seen at the time of the move and that was great to see.</li> <li>iv. We had also seen the opening of CUH nested ward and that was working well and had received positive news coverage which was welcome, particularly as winter pressures had meant that there hadn't been a great deal of good news coming out about the NHS.</li> <li>v. We had contributed to system working over the festive period and through January expediting transfers on a daily basis and participating in the system meetings. There was a general feeling that although it had been a tough few weeks for the system, it had managed far better than in previous winters.</li> <li>vi. It had also been a busy month from a research perspective. Dr Dariusz Wozniak had secured significant funding from the MND association, and the NOTACS trial had achieved more than half of its planned participant recruitment which was great.</li> <li>vii. She also wanted to share the finance team's accreditation in the One NHS Finance Towards Excellence accreditation, at Level 3, which was a real feather in our cap. The interview team had taken away many examples of best practice from our finance</li> </ul>		

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	<p>function which extended beyond the account's elements to business support and beyond, as they could see we really could evidence best practice that could be spread and shared elsewhere.</p> <p>viii. Finally, whilst not in her report our retrieval team had received a NORS (National Organ Retrieval Service) award for excellence in tissue and organ and retrieval from NHS Blood and Transplant.</p> <p><b>Discussion:</b></p> <p>i. CC asked TG to explain what level 3 accreditation as this was quite an accolade. TG advised that the NHS finance team at centre had set up an accreditation process running from Level 1 to Level 3. The purpose of the system was to add value and to recognise excellence, but also to push and NHS finance teams to improve and learn from one another, and share best practice. The team had started on this journey back in 2020 and were clear that they wanted to get to Level 3 as quickly as possible. The team felt that the way that the trust operated was outstanding across a number of domains, and that it was appropriate the finance team should also do that. A plan was put in place to chart the way through the accreditation levels and Sophie Harrison and Sarah Brisbane deserve a huge amount of credit within the team. This included evidencing what we already did, but it was also about putting in place new elements of good practice, particularly in relation to the way we interact with clinical teams and the way we share learning and development within the team. This was the top level of award that you can obtain and indicated outstanding practice. It reflects both the shared learning internally and our contribution to the development of finance across the Eastern region and nationally. This had taken a lot of work, but it demonstrated the commitment and the level that the teams were working at.</p> <p>ii. CC asked about the new governance code and noted it's focus on health inequalities and EDI and asked whether EM could provide an update on the ICB. EM advised that the ICB was forming partnerships and December and January had seen the coming together of the Health and Wellbeing Board. The executive leads across the ICB and the local authority executive members would form a new Integrated Care Partnership Board, and that would consider strategies of both local authorities and the ICB. There was a lot of work going on to translate those strategies into key messages in terms of where the priorities were for us as a system and which pieces of work feed into those priorities. This would allow people to see where the ICB was going, and see it move forward in an integrated way. She noted that health inequalities came up as key issue on the agenda across the whole range of system meetings. At its December meeting the ICB had received an insights pack with data analysis in terms of areas of inequality and areas for focus and these were real life conversations going on.</p> <p>iii. JA congratulated TG, Sophie, Sarah and the team and asked whether similar efforts were being made by the rest of the ICB so that best practice could be encouraged. TG noted that we needed to get better at sharing best practice and that CUH and</p>		

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	<p>NWAFT were at Level 1 but there was lots more to be done.</p> <p><b>Noted:</b> The Board noted the CEO's update report.</p>		
1.vii	<b>Patient Story</b>		
	<p>MS introduced the patient story. This was a story about the timeliness of care from a patient who had received great care but who had been impacted by delays in her treatment pathway.</p> <p>Chloe Holmes advised that she was a thoracic oncology specialist nurse and had been in the role for two years. This story would share insights of the impact of delays on patients referred into an oncology pathway.</p> <p>The patient was a 65-year-old who had been found to have early-stage breast cancer following a routine mammogram in June 2022. She had been referred for an MRI and that had identified a lung nodule.</p> <p>She was then referred for further investigation and her breast cancer surgery was put on hold and the patient put on hormonal treatment. She had a staging CT and a chest physician review and was told that this was likely to be an early-stage lung cancer which appeared localised on CT it was very small and appeared localised. The patient was referred to RPH and the team contacted the patient two days after the referral, but we were now at the 22 July.</p> <p>Following review, the patient was advised to proceed with a PET scan as this would give a closer look at the activity in the lymph nodes to ensure we were not missing anything significant and to guide on what diagnostic procedure we might do next.</p> <p>Her PET scan showed she had two nodules but there were both in the same lobe of her lung and so that could still be resected. There was no evidence of lymph node involvement and so the next step was to proceed with a CT guided needle biopsy where the CT scanner is used to direct the biopsy needle. She was contacted two days later, and the biopsy was arranged for the 8 August. This was a Monday, the results from this were not ready for the Thursday MDT and so they went on the following Tuesday.</p> <p>The MDT confirmed that there was no lymph node abnormality and so would not need a further staging at that point, which could have added further time into the pathway if required.</p> <p>The patient was booked into clinic on the 25 August to be seen by the chest physicians and surgeons and to be advised on the treatment plan which was for resection.</p> <p>She received the news on her diagnosis and treatment plan very well. The patient had shared that she had retired in May and had been looking forward to a well-earned retirement planning holidays with her partner. She wasn't expecting to be facing months of tests and procedures and surgery. She did feel that all of the information that had been given to her was shared in a way that she could understand and that all of the information provided by the oncology team was very relevant. This meant she felt safe and was reassured about the liaison with the breast team as that surgery would have to be scheduled six</p>		

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	<p>weeks after lung procedure. She had come away with a clear plan and felt less in limbo.</p> <p>Her surgery was scheduled for the 16 September. On that day, she was admitted to the day ward and prepped for theatre. She'd been up since 3:15am as she had to arrive really early, and she lived quite far away. Unfortunately, the Lorenzo system went down for the whole day, and her surgery was unable to take place so she was sent home, having spent most of the day waiting nil-by-mouth.</p> <p>It was another week before she was given a new surgical date, and that was for 5 October, a further three weeks away. During that time, she was feeling very panicky. Patients build up to their surgical dates and keep really focused on them so if it goes wrong, they do go back into a bit of panic. She felt everything was catching up with her and that this was having a knock-on effect on her breast cancer.</p> <p>This patient was initially told about her breast cancer in June and now she had a lung cancer as well, and although we might feel like we're moving along quickly with things, it had been four months since she was first told, and she'd still not had any treatment.</p> <p>Surgery went ahead on the 5 October, and she felt supported, and that her wishes had been respected. She had adequate rest although found that the single room was somewhat unsocial. The histology was returned after a three weeks and she was seen for follow up at 4 weeks. The whole lung lobe had been removed along with local lymph nodes. The results showed that there was some pleural invasion also that her lymph nodes highlighted lymphoma, another cancer diagnosis, and so she was brought in that day to see the chest physicians and told that she may need medical treatment for the prevention of recurrences. She was referred back to the local oncologists and the haematologists for treatment of what was hoped a low-grade lymphoma and then they would have to then refer her breast team. Lastly, she also had some new uptake of a cervical cancer that she'd had removed many years ago.</p> <p>This was a blow in her post operative results, but again, she took it on with a positive outlook. Taking it one step at a time and she was very thankful for the care she received here. She recovered well from her lung surgery and was now back to walking one and a half miles a day and was really well supported by her family and friends at home.</p> <p>The team had brought this story to highlight, that our oncology patients were very complex and often have a lot of things going on at the same time and sometimes multiple cancer diagnosis, and any delays in care impacts their other treatments and appointments.</p> <p>There was no way to know if the plural invasion wouldn't have happened if the surgery was done sooner as it was at a microscopic level, but her story highlighted how for the patient their story begins before they've even come us. She had a four-month journey and quite a lot of being in limbo during that time.</p> <p><b>Discussion:</b></p> <ul style="list-style-type: none"> <li>i. MB noted it was sobering to hear how many times that sort of experience or something like it was repeated and whether that experience would be captured in harm reviews.</li> <li>ii. OM asked about Lorenzo going down and just how reliant we were on technology in these circumstances. EM advised that</li> </ul>		

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	<p>she had been on the phone to staff early that day looking to make sure that theatres could go ahead. However, as this case was a same day admission there had not been a previous day review of notes and so the question on whether to proceed would depend on the clinical decision as to whether surgery could wait.</p> <p>iii. JA asked whether the last copy of records would be in the backup system so that surgical teams could access that data. Also, whether patient testing could be done in parallel rather than in sequence. CH advised that for this patient the tests needed to be done sequentially to guide treatment choices.</p> <p>iv. IS noted that we see all patients who get to this point, and some would have widespread cancer identified on CT and so it would not be appropriate to have parallel testing in those cases. There was however a proposal being taken forward to have a total body PET and that could undertake scans far more rapidly and so you were likely to see five times the volume of capacity available. In future this could mean that there would be changes in the sorts of investigations undertaken. He also noted that much surgery had continued on the day that the EPR system had gone down, and this was related to the individual cases and associated risks.</p> <p>v. DL asked whether there were opportunities to smooth the patient pathway as the feedback from the patient was complimentary but she had a very extended treatment journey. She also asked about whether we had back up for same day admissions?</p> <p>vi. AR advised that this was taken very seriously and that we rely on critical technology. If the Lorenzo system went down this would be treated as a priority one incident and our response would link to business continuity and disaster recovery plans. He recognised that no IT solution was infallible and that we needed to ensure staff were confident with continuity plans.</p> <p>vii. AF asked what the impact of the down time was and what we had learned from this incident. EM advised that there was an after-action review and the learning from this had been taken forward with some actions relating to business continuity planning. AB advised that we were in the process of reviewing all business continuity plans across the organisation including those relating to digital downtime. Some lessons on early decision-making on clinical risk had been identified and whilst that may not change the decision made, there were issues to ensure that staff were confident and had access to plans so that there was not a significant amount of time spent discussing the process. We also recognised the need to use planning exercises through the year to support our staff in this area.</p> <p>viii. GR noted that he would like the performance committee to look in closer detail at the issues around business continuity and to ensure we understood how we were able to work and conduct surgery in these circumstances.</p> <p>ix. CH noted that she had been nervous about bringing the story, but the team had wanted this story to be told to the Board to illustrate the impact of cancellations on our oncology patients. These patients are cancelled quite often as emergency</p>	AB	03/23

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	<p>surgery will take priority as the trust does not operate a separate emergency theatre.</p> <p><b>Noted:</b> The Board thanked Chloe and noted the patient story.</p>		
<b>2</b>	<b>PEOPLE</b>		
2.i	<p><b>Workforce Committee Chair's Report</b>  <b>Received:</b> The Workforce Committee Chair's report setting out significant issues of interest for the Board.</p> <p><b>Reported:</b> By AF that:</p> <ul style="list-style-type: none"> <li>i. The inaugural meeting of the workforce committee had been held and she wanted to thank OM and her team for the work done to set this up. The committee had spent some time considering the information that was required to ensure that there was a clear understanding of the various workstreams and the workforce data.</li> <li>ii. The first Workforce Committee report was interesting with narrative and infographics that brought to life the detail of how the people and divisions were working and that had illuminated some interesting areas that the Committee had explored. It had started to look at how it would seek and obtain assurance and she had been really impressed with something that was new and a different representation of our people.</li> <li>iii. The first draft of the workforce strategy had also been received and that was a very comprehensive piece of work and that would come back through committee and Board in the coming months. There was discussion on the depth and breadth of the work programme how we measured the impact of interventions. There were a number of areas where we needed time to articulate our plans clearly, setting out what we need to do and when, and what impact it would have.</li> <li>iv. It had discussed how some indicators were not going in the right direction, and the impact that industrial action was having on all our staff, but there were also many other aspects some of which were within our own control.</li> <li>v. The committee had noted key interdependencies, specifically that the audit committee were providing oversight in the management of overpayments.</li> <li>vi. Overall, we would be learning to work together as a new committee.</li> </ul> <p><b>Discussion</b></p> <ul style="list-style-type: none"> <li>i. CC welcomed the report that had been circulated in the reference pack and asked about the mandatory training uptake for medical staff. IS advised there was a continuous campaign to improve performance and that had been affected by the suspension of appraisal during the COVID pandemic. There was therefore some element of catching up but we would expect compliance to improve. OM noted that there was also an issue relating to junior doctors' compliance because of the different arrangements for their induction and we were looking to see if this could be extended to address some of the service areas. We should see improvement over the next six months if the junior doctor induction can be extended to three days.</li> <li>ii. JA noted that there were other sanctions that were used in</li> </ul>		



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	<p>other settings that could impact on wider medical workforce including revalidation, excellent awards and ability to bid for investment funds. Also, that there were regional discussions around passporting for junior staff that might help to deal with some of that issue.</p> <ul style="list-style-type: none"> <li>iii. JW noted that whilst there had greater been tolerance over the last two years, we perhaps needed clearer communication with staff that these requirements were the 'must do's'.</li> <li>iv. DL noted that this was a good summary of what it was a huge area of work that was being brought together.</li> <li>v. JW noted the importance of having a very clear focus on priorities as we needed to choose and focus on specific areas within the strategy.</li> <li>vi. IW asked what percentage of the Consultant workforce had been appraised in the last year. OM advised that it was 78%.</li> </ul> <p><b>Noted:</b> The Board noted the Workforce Committee Chair's report</p>		
2.ii	<p><b>Director of Workforce Report</b>  <b>Received:</b> From the Director of Workforce and OD a paper setting out key workforce issues.</p> <p><b>Reported:</b> By OM that:</p> <ul style="list-style-type: none"> <li>i. The resourcing and retention improvement programme (R&amp;R) had been set up and was co-chaired by OM and MS. It looked to bring the same kind of approach that we had adopted in the compassionate collectively leadership programme to this area as it had become an increasing priority over the last year.</li> <li>ii. This was a complex area as matters were so interconnected and we needed to be able to manage these without being overwhelmed. We would also learn from other programmes such as the critical care improvement and try to build a way of working that used improvement methodologies.</li> <li>iii. The R&amp;R programme was made-up of a diverse group of staff from across the organisation and there was much enthusiasm for collaborative working and we had identified leads for each of the programmes of work. These were not just from the workforce team but staff from across the organisation.</li> <li>iv. The R&amp;R programme was still in the diagnostic phase and had commissioned a report that had a number of areas to focus on. These included turnover in our healthcare support workers who had been in post less than 12 months. This was running at a rate of 25% and we needed to understand if that rate was appropriate in that staff group, or whether there were opportunities to reduce this and deliver improvement based on career progression.</li> <li>v. We had appointed Jutta Nedden as the new lead for the compassionate and collective leadership programme and part of her work would be to track the impact of the programme.</li> <li>vi. We had also seen over 70% of our staff attend our values and behaviours workshops and needed to understand how we could measure the impact of this.</li> </ul>		

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	<p><b>Discussion</b></p> <ul style="list-style-type: none"> <li>i. JW noted that it was important to focus on what we could deliver through each of the programmes of work. OM noted that the programmes would have a layered impact alongside the implementation of the new recruitment system. Staff were excited to be able to move forward with this and it would be a building block that would help to improve our recruitment process.</li> </ul> <p><b>Agreed:</b> The Board noted the update from the DWOD.</p>		
<b>3</b>	<b>GOVERNANCE</b>		
3.i	<p><b>Q&amp;R Committee Chair's Report</b></p> <p><b>Received:</b> The Q&amp;R Committee Chair's report setting out significant issues of interest for the Board.</p> <p><b>Reported:</b> By MB that:</p> <ul style="list-style-type: none"> <li>i. His report covered the January and December meetings of the committee and matters that had raised concern included surgical site infections and patient harm.</li> <li>ii. In December, the Committee had looked at health inequalities and saw evidence that we could have a constructive effect on this agenda through review of our own services.</li> <li>iii. The committee looked at outputs and trends relating to patient harm and Louise Palmer had produced a report that provided good assurance on what was happening to patients at the end of the process rather than the input measures, which were often red rated in PIPR.</li> <li>iv. There were areas where we were seeing stresses such as in fill rates, but these were not translating into poor outcomes. It was recognised that this may be a precarious position as stresses were very evident, but these needed to be measured against other indicators. He felt that the Trust was doing well in adverse circumstances, and this review had provided assurance in relation to patient harm.</li> <li>v. There were indicators which were of greater concern and the number of red flags as an indicator of stress was one of those.</li> <li>vi. The Committee had looked at the measures of harm related to SSIs and supported the significant programme of work that continued to mitigate this problem. We had seen that where infection prevention control measures and audits were being undertaken routinely, we were seeing positive results and when these reduced then we saw an increase in rates return but that gave some evidence that we could achieve improvements.</li> <li>vii. The Committee had also received the long list of priorities for the Quality Account and needed to identify the key priorities from this to take forward into 2023/24.</li> </ul> <p><b>Discussion</b></p> <ul style="list-style-type: none"> <li>i. CC asked about the measurement of outcomes as she continued to see red RAG ratings in PIPR and that was a concern. She asked for outcome measures to be included where these were able to provide evidence of good</li> </ul>		

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	<p>performance. MB noted that the use of statistical process control charts may allow information to be included for the Board on a rolling basis.</p> <ul style="list-style-type: none"> <li>ii. DL noted her concern about SSI rates, despite the level of effort being put into the management of the problem and asked whether this was controlled as we were still an outlier in terms of performance, and she would like to see more evidence of the output of this work.</li> <li>iii. JA agreed that the decline that had been seen in relation to the lack of traction on the audit process may be helpful to drive improvement in performance. He noted the enormous effort required how and asked how we could focus on a small number of actions that might support improvement and how could we ensure that these were embedded? MS noted that what we were talking about was basic practice, “the way we do things around here”. This was related to manging human behaviours, looking at how we came to work and undertook our jobs to ensure that the right standards were delivered. This needed ongoing oversight and audit but was a part of our fundamental standards of care.</li> <li>iv. IS noted the levels of unhappiness reported in our staff surveys and how it would be important to change team dynamics and take that change into all areas so that any member of the team was able and confident to challenge. We could identify problems on a top-down basis, but our teams needed to develop their own their actions so that this became second nature.</li> <li>v. AF felt we had previously not been able to assure ourselves and that in January the harm review and deep dive into SSIs had been a turning point. She now had increased confidence in the oversight process and noted that the level of detail seen at Q&amp;R was helpful.</li> <li>vi. JW noted that the VTE compliance needed a similar approach to ensure that staff were doing the right thing.</li> <li>vii. JA noted this was core work of the Trust and what we were meant to deliver.</li> </ul> <p><b>Noted:</b> The Board noted the Q&amp;R Committee Chair’s report</p>		
3.ii	<p><b>Combined Quality Report</b>  <b>Received:</b> A report from the Chief Nurse and Medical Director which highlighted information in addition to the PIPR.</p> <p><b>Reported:</b> By MS that:</p> <ul style="list-style-type: none"> <li>i. Most of the matters covered had already been discussed on the agenda.</li> <li>ii. That we had submitted our IR(ME)R improvement plan to the CQC. They had some queries on this and we would be responding to the points raised within the timelines set.</li> <li>iii. She also wanted to note her appreciation of her friend and colleague Julie Quigley, who had died.</li> </ul> <p><b>Noted:</b> The Board noted the Combined Quality Report.</p>		

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3.iii	<p><b>Audit Committee Chair's Report</b></p> <p><b>Received and noted:</b> The Board received and noted the Audit Committee Chair's report setting out significant issues of interest for the Board.</p> <p><b>Reported:</b> By CC that:</p> <ol style="list-style-type: none"> <li>i. The committee had received two finalised internal audit reports. One was on infection prevention and control which had been referred to the Quality and Risk committee. That had received moderate assurance, which was not a bad report, and any questions would be taken through that committee.</li> <li>ii. We also received the HFMA financial sustainability audit which validated the earlier discussion about the Level 3 assessment. This had been undertaken as a self-assessment that the audit team then validated. The Trust's assessment was supported and this was a very good outcome.</li> <li>iii. She noted that the bad debt write-off of £28,437 should be ratified by the Board.</li> <li>iv. The Committee had received and approve the revised Standing Orders, Standing Financial Instructions, and Scheme of Delegation and these would be brought to Board in due course.</li> </ol> <p><b>Discussion:</b></p> <ol style="list-style-type: none"> <li>i. TG noted that the bad debt arose from an overseas patient and the Trust had gone through all the recovery processes and it was now in situation where it would cost more to continue to seek to recover the debt.</li> <li>ii. JA asked about the impairment of £360k relating to the four VADs, and whether there were early warning systems that identified where stock was going to become out of date as these were expensive and there may be opportunity for their use elsewhere. TG advised that these would usually be picked up and managed, but this related to the reduced use in relation to COVID and should have been written off in the prior year. There was a process in place to manage this on an ongoing basis.</li> <li>iii. JW noted that there were 235 salary overpayments that were open and that seemed to be a level that was higher than sensible and asked how this would be managed. TG agreed and advised that there was work underway looking at this with payroll and there was a plan in place with oversight at the Committee. There would be an element of training required for line managers to ensure that the relevant forms were completed as staff left the Trust.</li> </ol> <p><b>Noted:</b> The Board noted the Audit Committee Chair's Report and ratified the write off of bad debt of £28,437.</p>		
3.iv	<b>7 Day Services - Board Assurance Framework</b>		
	<b>Received:</b> From the Medical Director setting out performance in relation to the Seven Day Hospital Services (7DS) Clinical Standards BAF.		

Agenda Item		Action by Whom	Date
	<p><b>Reported:</b> By IS:</p> <ul style="list-style-type: none"> <li>i. That these standards were NHS wide directions which the Trust had reviewed and whilst some were not relevant to us the paper set out our self-assessment for the four standards that were national priorities.</li> <li>ii. We had processes in place for each of these. We did not have 24-hour MRI but could undertake Cardiac MRI within our establishment and would transfer to the CUH service if required.</li> <li>iii. It was planned to undertake an audit of the services in February and the results of this would be brought to the Board in April.</li> </ul> <p><b>Noted:</b> The Board the Seven Day Hospital Services (7DS) Clinical Standards BAF.</p>		
<b>3.v</b>	<b>Board Sub Committee Minutes:</b>		
	<p><b>Received and noted:</b> The Board of Directors received and noted the minutes of Board sub-committees held on:</p> <p><b>3.v.a.</b> Quality &amp; Risk: 24.11.22 &amp; 22.12.22  <b>3.v.b.</b> Performance: 24.11.22 &amp; 22.12.22  <b>3.v.c.</b> Audit Committee 13.10.22</p>		
<b>4</b>	<b>PERFORMANCE</b>		
<b>4.i</b>	<p><b>Performance Committee Chair's report</b></p> <p><b>Received:</b> The Chair's report setting out significant issues of interest for the Board.</p> <p><b>Reported:</b> By GR that the Committee had considered the following key issues:</p> <ul style="list-style-type: none"> <li>i. The presentation from the STA division and there would be some further discussion of that in the Part II meeting.</li> <li>ii. PIPR which reflected that the system was under stress during December and January. The Trust had prioritised inhouse urgent transfers during that period to relieve the pressure on district general hospitals and that had impacted on elective activity, waiting list size and our RTT performance.</li> <li>iii. We did not have assurance that we were maximising activity flows across the hospital and had asked to see further assurance especially looking at the impact of staff vacancies and sickness absence. As an example, Cath lab activity had seen high utilisation which reduced in January and this variability in performance needed to be understood and managed.</li> <li>iv. The financial position was positive, with good progress on the better payments practice standards and the cost improvement pipeline which were both on track. The CIP had been an area of success over the last three years and was an area where we had considerable assurance.</li> <li>v. We had looked at the operational plan and had agreed to organise another session for NEDs to focus on that area.</li> <li>vi. The Committee had recommended that the proposed research</li> </ul>		

Agenda Item		Action by Whom	Date
	<p>grant to the University of Cambridge and employee benefits proposal be approved by the Board.</p> <p>vii. The Committee had also received the paper on soft FM services and that was on the agenda for the Part II meeting.</p> <p><b>Discussion:</b></p> <p>i. TG noted that the recommendation on the UoC grant, and the employee benefit proposal would come to the Board in Part II.</p> <p><b>Noted:</b> The Board noted the Performance Committee Chair's report.</p>		
<b>4.ii</b>	<b>Papworth Integrated Performance Report (PIPR)</b>		
	<p><b>Received:</b> The PIPR report for Month 9 (December 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&amp;R Committee and was provided to the Board for information.</p> <p><b>Reported:</b> By TG that overall, Trust performance was at a Red rating. Also, that the report showed the hospital was under stress in line with some of the key issues that had been highlighted by GR, and in earlier Board discussions.</p> <p><b>Discussion:</b></p> <p>i. GR noted that virtually every NED had expressed concern on the dashboard on Safe and that although we had received assurance from the Q&amp;R Committee, he felt that this should be captured in the Board minutes. JW acknowledged this, noting that there had been thorough discussion at committee and Board, but he did not want the Board to feel that this was being disregarded.</p> <p>ii. AF raised the issue of elective performance, noting the powerful patient story and the good financial position and asked whether the Board were missing any opportunity for recovery as she felt we needed some assurance in this area. EM advised that this was a key focus for the executive and operational teams as the new planning guidance saw a return to a payment by results system and so the number of patients treated and the focus on managing our waiting patients was very important and a significant area of risk.</p> <p>iii. AB advised that our focus was absolutely on recovery and restoration of activity and that whilst that had been considered in greatest detail in relation to theatres, he had commissioned work to look at outpatients and day case procedures where he believed we had further opportunity to improve productivity and that would support our overall recovery. We were also focusing on areas where there were long waiters as the number of patients waiting over 40 weeks had been increasing and we were putting in place a clear action plan to address this. However, it was not solely a capacity constraint, there were other processes that we could review which would improve our performance.</p> <p>iv. AF Asked whether the 104% target would be achieved at year end. AB advised that it would be difficult to assess each</p>		

Agenda Item		Action by Whom	Date
	<p>individual area but there were clear opportunities and actions that were being put in place and it would be delivered in some. GR noted this had been raised at the last two Performance Committee and asked for the diagnosis and the plan to come to the Committee in February. EM noted a caveat that as there were two days of industrial action planned and that would have a significant level of disruption and impact on the Trust.</p> <p>v. MB noted on effective that in four years at a NED this patient story was one of the only patient stories that reflected the experience of patient waiting and that was not simply related to Lorenzo but to all aspects of waiting and we needed to understand the impact of these delays. JW advised that pathways were very different depending on the urgency of the condition. Some patients would not see harm from a lengthy wait and others needed immediate treatment, but he agreed that this needed to be understood. He asked if thoracic had a relatively high level of cancellations? EM advised that she thought there was an even spread and that cases were considered in the priority of emergencies, cancers and then elective procedures. IS noted that the CDC had considered this when theatres were most constrained, and that the direction of travel was for thoracic lists to be expanded first as theatre capacity increased. They were also more likely to be subject to cancellation as they had shorter cases and so would see cancellations once a surgery had been completed.</p> <p><b>Noted:</b> The Board noted the PIPR report for Month 9 (December 2022).</p>	AB	02/23
<b>5</b>	<b>RESEARCH &amp; EDUCATION</b>		
	<p><b>Reported:</b> By IS that there was no significant update, but he was expecting that Dr Calvert would be come back to the Board to update on the R&amp;D Strategy in due course.</p> <p><b>Discussion:</b></p> <ul style="list-style-type: none"> <li>i. JW was concerned for the Board to understand how the strategy would now be taken forward.</li> <li>ii. EM noted that there was an outstanding action on the checklist for Dr Calvert to bring together the metrics that should be used to assess our progress against delivery. IS would follow up this action.</li> </ul> <p><b>Noted:</b> The Board noted the update from the Medical Director.</p>		
<b>6</b>	<b>BOARD FORWARD AGENDA</b>		
<b>6.i</b>	<p><b>Board Annual Business Plan</b></p> <p><b>Discussion:</b> EM asked about the scheduling of the two items that were deferred from the Board agenda:</p> <p><b>Freedom to Speak Up Guardian’s Report:</b> AJ advised that this report had been deferred and was to be brought to the May meeting and would be combined with the Q4 report. This would still be in line with the national requirement for Board reporting.</p>		

Agenda Item		Action by Whom	Date
	<p><b>Digital Strategy 2020-2025 (review):</b> AJ advised that it had been agreed at SPC in December that that the review paper would be deferred and brought to the next meeting. JA noted that this was the progress review against the first year of the strategy as the overarching review should be paused until there was greater clarity on the next steps on the EPR system.</p> <p><b>Noted:</b> The Board noted the Forward Planner.</p>		
6.ii	<p><b>Items for escalation or referral to Committee</b> None</p>		
7	<p><b>Any Other Business</b></p> <p><b>Health &amp; Safety:</b> MS advised that the output of the Health and Safety review that had been planned for March would need to be rescheduled.</p>		

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Signed

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Date

**Royal Papworth Hospital NHS Foundation Trust**  
**Board of Directors**  
Meeting held on 02 February 2023



## 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	<b>Patient Reported Outcome Measure:</b> assesses the quality of care delivered to NHS patients from the patient perspective.
RCA	<b>Root Cause Analysis</b> 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 <b>S</b> ystem <b>O</b> versight <b>F</b> ramework (Graded 1-4)
STP	Cambridgeshire and Peterborough <b>S</b> ustainability & <b>T</b> ransformation <b>P</b> 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