Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Held on Thursday 4 May 2023 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 M Blastland	(MB)	Non-Executive Director
	Ms C Conquest	(CC)	Non-Executive Director
	Mr T Glenn	(TG)	Chief Finance and Commercial Officer
	Ms D Leacock	(DL)	Associate Non-Executive Director
	Mr H McEnroe	(HM)	Chief Operating Officer
	Mrs E Midlane	(EM)	Chief Executive Officer
	Ms O Monkhouse	(OM)	Director of Workforce and OD
	Mr G Robert	(GR)	Non-Executive Director
	Mrs M Screaton	(MS)	Chief Nurse
	Prof I Smith	(IS)	Medical Director
	Prof I Wilkinson	(IW)	Non-Executive Director
In Attendance	Ms E Bithell	(EB)	Minutes
	Dr P Calvert	(PC)	Director of R&D
	Mr S Edwards	(SE)	Head of Communications
	Mr E Gorman	(EG)	Deputy Director of Digital
	Mrs A Jarvis	(AJ)	Trust Secretary
	Mrs K Rintoul	(KR)	Clinical Nurse Specialist Infection Control
Apologies	Ms A Fadero	(AF)	Non-Executive Director
	Mr A Raynes	(AR)	Chief Information Officer & SIRO
Observers	Angie Atkinson, Paul Berry, Doug Burns, Trevor Collins, Abi Halstead, Richard Hodder, Marlene Hotchkiss, Lesley Howe, 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		

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	were identified in relation to matters on the agenda. A summary of standing declarations of interests is appended to these minutes.		
1.ii	**Minutes of the previous meeting**		
	Board of Directors Part I: 6 April 2023 **Item 1.vii Patient Story:** Revised to read: "She had seen the patient at pre-admission…" "The patient was very anxious and as English was his second language, she took time to ensure…" **Item 2.ii Gender Pay Gap Report & Action Plan:** Revised to read: Discussion i: "The clinical excellence awards and the NHS High Potential Scheme had not been run for the last two years and so targets associated with these..." **Item 3.i Q&R Committee Chair's Report:** Revised to read: Discussion i: "...with practitioners and put in place interventions to ensure..." **Item 4.i Performance Committee Chair's report:** Revised to read: Discussion i: "MS advised that this related to the integration..." **Item 4.ii PIPR:** Revised to read: Discussion i - "He wanted to understand if we were addressing the right question…" **Item 5.i People Strategy 2023-25** Revised to read: Discussion iv: "JW welcomed this approach noting that…" **Approved**: With the above amendments the Board of Directors approved the Minutes of the Part I meeting held on 6 April 2023 as a true record.		
1.iii	**Matters arising and action checklist**		
	Noted: The Board received and noted the updates on the action checklist. It was agreed to start taking items off this list and those items with TBC to have dates identified. No issues noted.		
1.iv	**Chairman's report**		
	The Chairman noted that there had been a lot of interest in the Lead Governor role. Abi Halstead had been elected and would shadow Dr Richard Hodder until September when the role commenced. Steve Brown had been elected as Deputy Lead Governor. He reported that he had also recently attended the International Society of Heart & Lung Transplantation meeting in Denver where they had celebrated Norman Shumway, a pioneer in transplantation.		
1.v	**Board Assurance Framework**		
	Received: From the Trust Secretary the BAF report setting out: i. BAF risks against strategic objectives.		

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	ii. BAF risks above appetite and target risk rating. iii. The Board BAF tracker. iv. The Board Risk Appetite Statements for 2023/24. **Reported:** By AJ that: i. BAF 2532 COVID pandemic risk had been closed and going forward this would be managed through BAF 675 (HCAI risk). ii. The BAF 2904 ICS financial balance had been escalated reflecting the uncertainties in the national financial framework and economic environment. iii. BAF 1853: Staff turnover risk had reduced as performance had now been within KPI for five months. iv. Board Committees had received and approved the revised risk appetite statements, and these were appended to the report. **Discussion:** i. CC commented that there were 4 risks identified as below target that were actually above target. [Post meeting note: the table showing risks below target had been filtered on strategic objectives 3 rather than the rating against target. A corrected report was circulated to the Board and posted to the public website]. ii. JA noted that the EPR risk was discussed in SPC and was to be reviewed as this was felt to be out of context in relation to the financial gap. iii. JW noted that with settlements agreed the industrial action risk should reduce. OM added this would reduce but was not resolved as outstanding dispute with doctors continued. **Noted:** The Board noted the BAF report for May 2023 and approved the revised risk appetite statements.		
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. The report reflected the time spent in preparation for industrial action and quantified the impact of this. She acknowledged the investment of time from the Executive team in managing the Trust response with planning, preparations and daily meetings. ii. She had attended a CEO leadership event in London. This had a different tone to the previous meeting with a feeling of hope as well as the need for planning for the mid to longer term. There was talk around continuous improvement and NHSE had launched a continuous improvement programme which will link to our approach to embrace quality and improvement. iii. She had joined the NCBC 2-day conference where Laudit and Rapid N-Stemi were presented and Alaina Yardley, our Lead Cardiac Physiologist had shared her progress in dealing with the national and local shortage in echo-physiologists. iv. The thoracic surgical robot went live last week, and this had been successful. There would be wider publication once 10 cases have been completed. Feedback received had been		

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	positive and a lot of time and energy had been invested in the training by our staff. v. Industrial action was the key feature of the last few weeks, and it was hoped this would come to an end. vi. There was a fantastic recruitment event held in April. Staff gave their time freely to help address gaps in our workforce. Also, clinical staff that were in for the event had responded to 'on the day' pressures and went to the wards to allow colleagues to take breaks which she felt reflected our Trust values. vii. SSI's were still a major focus and external support was coming in to undertake peer review to see if there were any further actions that could be taken. viii. Laudit had reached 1000 sign ups. This was great to see, and other organisations wished to implement this. **Discussion:** i. CC queried who the SSI external support was? MS advised that the Brompton and Harefield surgical site surveillance team would support how we audit and looked at human factors. NHSI would be supporting with peer review and a table top exercise would be taking place this afternoon. In addition, the infection control team would be visiting other sites. The review of the theatre air flow was also part of the NHSI work. ii. GR asked if the first patient operated on by the robot knew this. EM said they did and they had consented, and it was a positive experience as this had shortened their length of stay. The ambition was to be able to have day case thoracic surgery. **Noted:** The Board noted the CEO's update report.		
1.vii	**Patient Story**		
	MS introduced the patient story. Katy Rintoul told the story which related to a patient with a complex medical and infection history. The patient had consented to their story being told. The patient had ischemic heart disease, hypertension, type 1 diabetes and end stage renal failure; she had peripheral vascular disease and had a below knee amputation in March 2021. She was initially admitted to RPH on 1 December last year for a CABG. She was a known carrier of MRSA and so the IPC team had already built up a relationship with the patient and they had arranged decolonisation and post treatment swabbing prior to her admission. She had a 6 day stay on critical care post CABG procedure and was then moved to the ward. She was discharged on the 5 January and the wound was described as 'oozy' and to be cleaned and redressed by the district nurses. Later in January she presented to Broomfield Hospital with a deep sternal wound infection. She was transferred to Papworth for treatment. She was diagnosed with CPE in February which is resistant to powerful antibiotics. She was barrier nursed and was taken back to theatre 8 times for wound debridement. The patient had answered a range of questions about her care. Her privacy had been maintained and her plan of care had been clearly		

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	explained by the tissue viability nurses. She reported messages were not so clear from the doctors and there had been some mixed messages received as to location of the infection. She had good communications from the Registrar, but she would like her Consultant to explain further and that had been communicated to the medical staff. Staff had introduced themselves. The room was clean, and the patient was able to sleep well, however they attended Addenbrookes for dialysis three times a week in the evening because of her CPE status. She left the ward at 6pm and did not get back until 1am and then needed her IV antibiotics and this meant she doesn't get to sleep until 6am and this was leaving her permanently tired. The Trust had been in touch with the team at CUH to discuss this position. She felt the food was good although felt there were a lot of multi-cultural choices. Visiting hours were fine and her experience of staff was positive, and they were caring. She had been in a room facing into the inner courtyard and had been moved to a lighter room and that was positive. She now wanted to know the plan going forward and how long a stay was expected as this was having a significant impact on her mental health and she missed being with her family. **Discussion:** i. DL asked how the patient could be better informed due to mixed messaging and the repeated theatre experiences. KR noted that her clinical and infection problems were complex. KR had contacted the consultant to raise the issue and noted the patient had seen a lot of different doctors also as she was sleeping during the day due to the timing of dialysis. The patient could not see a clear end to treatment presently and it was a very tough situation. ii. JW asked given the complications of this patient whether there were non-invasive options that could have been considered through the MDT review. IS did not know the individual patient but advised that these would have been considered in review. iii. MB asked if we knew where the infection came from and whether colonisation was outside the Trust? KR advised that it was not known, but as she was discharged with an 'oozy' wound then it was likely this was already present in the hospital. JW advised that these patients were vulnerable to infection, and we did not know how the issue of MRSA colonisation affected their biome. He agreed that the needs of longer staying patients should be considered and they should have a room with a better view. iv. JA asked when more than one consultant involved was there one who takes an overview? MS noted that one consultant from surgery would take a lead, but they did also work in teams. **Noted:** The Board thanked KR and noted the patient story.		
2	**PEOPLE**		
2.i	**Received:** The Director of Workforce and OD a paper setting out key workforce issues. **Reported:** By OM that: i. The focus of her report was on staff networks and that an annual review had taken place with herself the EDI lead and		

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	network leads and co-leads. This looked at learning from successes and what they want to focus on in future and was a useful exercise. The networks were each making a difference, and all had a different character. They were led by staff who had chosen to step up and who wanted to make a difference and make the organisation a better place. Good work had been delivered for both patients and staff. They included a mix of patient views as well as staff views and discussions were on-going. We had Discussed the potential of hosting a men's network but there had been no real interest in carrying this forward although there was a lot of interest in men's mental health, and we were looking to build this in to the Disability and Difference network. ii. The networks had worked together to produce a draft strategy and that would be reviewed by the Workforce Committee before coming to Board. This was indicative of their commitment and the professionalism of their approach as well as the support from Onika and Chanel. iii. The BAME network had been renamed to the Race Equality network and the network lead would be changing. The Chair and co-chair of the network were clinical which could make the time commitment difficult. Discussions were continuing and she had spoken to other Trusts about their experiences as it was good to refresh and reenergise Networks when chairs change. iv. Network chairs were supported with some paid time for the role, but it was not always possible to carry out the work in these hours. There was no clear sense of another arrangement from the chair's, but we would look to see how others had managed this. v. She noted that our networks were run by an amazing group of people. **Discussion** i. DL noted it was good to see what has been done and the plan for the coming year. She noted that the plan referred to the Disability Network holding the Trust to account regarding the WDES action plan but the BAME network states to oversee implementation of the WRES action plan. OM advised that they should read the same and she would revise the wording. ii. GR asked if we should invite the Network Chairs to present at Board. OM welcomed that proposal and noted that they would contribute regularly to the WFC and come to Board on occasion and that would support and recognise their contribution. CC noted that this should be seen as best practice to come and present at Board rather than recognition. iii. JA asked about embedding men's mental health in the disability & difference network as there could be a risk it limits the issues raised. OM noted that we would establish a men's network if there was sufficient support for this, but it had seen limited interest and we were responding a request for a particular forum for men's mental health to have a forum to talk with other men. iv. JA asked how we represented other people's views that we don't hear about through the networks? OM noted that	OM	07/23

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	invitations to give staff stores were widely advertised and there were other opportunities with FTSU guardians, Trade union representatives and other management routes. There were opportunities and we did not exclusively focus on networks. JA noted the need to be thoughtful and inclusive in every conversation. v. GR asked about staff recruitment and how that was measured over time. He wanted to see this to understand if we were recruiting more and doing well in context of similar times of year. What is our reputation in the market place? OM noted that the focus PIPR on recruitment has the two year data on recruitment and that the PIPR spotlight for next month would be on recruitment in different roles looking at starters and leavers and that would provide a net position for the staffing numbers gained. We will look at recruitment at workforce committee. MS advised that there were periods of the year where we saw more recruitment and we were prepared for that. People generally made decisions as the New Year and in the summer especially. vi. HM noted that he had met Onika and that she was an asset to the Trust. This was an area that he would focus on he wanted to ensure that her contribution was recognised. vii. EM also thanked OM for her commitment to support the Networks as there were none when OM joined the Trust five years ago. The Board agreed to formally send their thanks to the networks. **Noted:** The Board noted the update from the DWOD.	OM	06/23
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 MB that: i. SSI's had dominated discussions and the Trust was focussed on practical responses to address these. We had discussed in particular the need for informed patient consent so that this was considered thoroughly and as early as possible. There would be a further discussion of this on the part II agenda. **Discussion** **i.** JW noted seeing staff and visitors not wearing masks properly. MS advised that there was a proposal coming to CDC to change our policy on mask wearing. If we were managing vulnerable patients they would be worn, but otherwise it was felt that the risks of masks not being worn correctly was a higher risk than not wearing them. **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.		

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	i. An update on the work to address the elevated level of SSI's ii. An update to keep Q&R and Board up to date with the Patient Safety Incident Response Framework (PSIRF). Louise Palmer was the Trust representative on the ICS group looking at its implementation. iii. Jacqui Wynn was our new Head of Quality Improvement and Transformation, and she would be focusing on continuous improvement programmes across the Trust. She joined us from CCS and came with a wealth of experience and expertise. **Discussion:** i. CC asked about coroner inquests and if the backlog was managed in chronological order. IS advised it was not manged in date order. We did not have sight of the prioritisation, but we were aware that some cases were pushed back which may be related to complexity. ii. IW asked about how the number of cases waiting (111) compared to earlier periods. IS advised that this was significantly greater, as this used to run at 20 or 30 cases pending inquest. JW noted that we asked for a lot of inquests including every transplant death and that was a good approach to have. IW acknowledged their benefit but noted this was not a good situation for bereaved families. iii. MB noted that the new appointments and the PSIRF framework, would support change in how we thought about incidents and how we learned from them. He felt that the QI agenda had suffered during Covid, and this would support our focus on continuous improvement. iv. JW asked about how we planned to measure quality improvement. MS noted that this was key. We had many projects and audits and wanted to identify specific changes and ideas to test out. v. JA asked how PSIRF would be different to current practice. MS noted this was what it delivered in terms of how we do things around here, with people taking ownership and having confidence to change and improve practice. This needed support and training and was a whole culture piece not a scattered approach. We needed to identify key areas of priority and test these with thorough evaluation and KPIs. vi. MB noted the key issue was the structure to support this and that we needed to listen, support and challenge in relation to both clinical and non-clinical practice and KPIs. vii. EM noted that at the launch of NHS Impact there was a commitment for every member trained in improvement and she proposed to invite them to facilitate a Board development session on continuous improvement. HM noted he had undertaken the NHSE training, and this was an important part of how to take the change forward. **Noted:** The Board noted the Combined Quality Report.	EM/AJ	TBC
3.iii	**Board Sub Committee Minutes:** **Received and noted:** The Board of Directors received and noted the minutes of Board sub-committees held on:		

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	a. Quality & Risk: 30.03.23 b. Performance: 30.03.23 c. Audit: 09.03.23 **Noted:** The Board noted the Board sub-committee minutes.		
4	**PERFORMANCE**		
4.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 productivity improvements. It had been some time since the critical care transformation project was completed which had moved us to 36 beds but had not been tested in practice. It was good to see this was now being delivered and we were able to keep these open. We had also seen the green shoots of recovery across the hospital including out patients. This seemed to be good neds but there was some caution around STA. We had opened 5.5 theatres ahead of trajectory as the target for that was 5 June and had been delivered largely as a result of meeting recruitment targets. However, we need to get culture right or could be in similar position in 6 months' time and so there was still some way to go with this work. **Discussion:** i. MB asked about the reaction of staff to the increase in pace of working. MS advised that in general staff were pleased to do this and were thinking of different ways of working in relation to acuity and dependency to allow this achievement. These are the same staff and at times they are stretched and so we do set a limit at 34 beds on occasion but there was greater ownership of decision making. This was a stressful environment and with urgent and emergency admissions. ii. MB asked if the staff responded well to the efficient running of the service. JW noted that as we had seen in Covid a lot of staff liked the buzz of effective working. iii. JA noted the need for caution. We were seeing greater throughput, but we still needed to understand this in terms of the changes in resource and utilisation of our estate. HM felt that we were seeing green shoots with the reduced waiting list size and reduced tails of long waiters but agreed we were not necessarily seeing any efficiency gain yet. We were working with 36 beds and 5.5 theatres and would require more efficiencies to maintain that. iv. GR noted the on discharge and patient flow and asked what impact that would have. HM advised that he would provide further detail at the next Performance committee. **Noted:** The Board noted the Performance Committee Chair's report.	HM	06/23
4.ii	**Papworth Integrated Performance Report (PIPR)**		
	Received: The PIPR report for Month 1 (April 2023) from the Executive Directors (EDs). This report had been considered at the Performance Committee and the Safe and Caring domains were		

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	discussed at Q&R Committee and was provided to the Board for information. **Reported:** By TG that overall, Trust performance was at a red rating. The caring domain remained green. Theatre utilisation had improved, and we were ahead of recovery trajectory. Cath lab utilisation had increased as well as outpatient capacity. Areas that were rated red included SSIs and safer staffing. **Discussion:** i. JA welcomed the detail on harm reviews which was good to see, but noted that STA were not doing many of these. He also asked if these were focused on physical health or do they bring in mental and psychological health? MS noted that the process varied and should be informed by a be face to face consultation with the patient, however many were done as a desktop review. She noted that the clinicians were engaged with the reviews and do try to take a more holistic approach. ii. MB noted that it seemed that length of stay had increased and asked if we understood why this was the case and if it was due to increased complexity associated with the length of time that patients had waited for admission. He asked if we were fully capturing harms as a result of wating as we needed to understand the impact of changes in waiting times. HM noted that it was important to recognise that the length of stay was associated with pre operative and not post operative days and this could also be associated with patients being admitted early to secure bed capacity. He would work with MS and IES to explore this area. **Noted:** The Board noted the PIPR report for Month 1 (April 2023).		
5	**RESEARCH & EDUCATION**		
5.i/5.ii	**Research & Development Strategy** **Received:** A paper from the Clinical Director of Research and Development setting out the progress and planned reporting to support the R&D strategy. **Reported:** By PC that: i. The R&D Strategy had been agreed by the Board in December and had received comprehensive review. This paper was to bring the proposed monitoring dashboard to the Board. ii. He reminded the Board that there were five key areas for strategy improvement. iii. The investment in people and diversity strategy would see the research leaders appointed and a 25% reduction in approval times. iv. The paper set out the metrics re grant applications and had a target of doubling average number of grants applied for from 6 to 12. v. In terms of NHIR profile we planned an increase in RPH studies with a 25% increase in number of trials through RPH. vi. Slide 7 set out detailed metrics and when each of these came on line and this approach ran through the course of the		

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	strategy to ensure that we were able to monitor how we were performing. The number of patients recruited was also important as were approval times and that was an area where we needed to do better, and targets had been set for this. vii. The Business Intelligence team had developed a dashboard to support monitoring of diversity metrics. viii. There were some benchmarking slides in the pack to show how the Trust performed in comparison to provider across the country. **Discussion** i. JW thanked PC for the comprehensive report and asked where the updated strategy would be published and how this would be shared with partners such as the UoC and campus partners? PC felt that we needed to ensure we were performing which was the intention of the dashboard. He noted that the relationship between us, the UoC and industries and partners on campus was going well and they met regularly and discussed collaboration. There was a challenge in coordinating meetings to ensure they were efficient and useful. Industry wanted clear ideas and clear outputs would achieve that. ii. JA was grateful to see additional slides and noted that progress would be presented quarterly at SPC. iii. JW asked about progress on the tissue bank which was and issue for some time. PC advised that conversations were taking place with Charlotte Summers. The primary aim was to locate this at the HLRI, and they would try and overcome any obstacles. He would touch base CS again as it was key for there to be a permanent home for the tissue bank on campus. TG noted that it seemed this was getting closer. iv. JA noted that there was not one single audience for the R&D strategy and therefore not one document for all. He felt that different versions needed and that we needed to think about the communities want to recruit from. v. IW noted the planned reduction in approval time line in the short term and asked how much of that was due to MRHA? PC noted that there were significant issues but we could do better for elements that were within our control. vi. IW asked about the 50/50 research posts and whether these were new people or internal appointments. PC noted that the target was to get successful people in and that we may not attract someone from elsewhere for a single post. There were external adverts out but we also needed to look at local talent also to get the best people that can be attracted. **Noted:** The Board noted the update on the Research and Development Strategy.		
6	**STRATEGIC DEVELOPMENTS**		
	No report due.		
7	**BOARD FORWARD AGENDA**		
7.i	**Board Forward Planner**		

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	Received and Noted: The Board Forward Planner.		
7.ii	**Items for escalation or referral to Committee**		
8 **8.i** **8.ii**	**AOB** **Gender Pay Gay** IES noted the Board's previous discussions on the gender pay gap, noting that the deadline for clinical excellence higher awards was on Friday. He advised that 4% of award holders were women and that women represent some 27% of the consultant workforce. For the submission 20% of the applications were from women (2/10) and that this was a start. He had spoken to 5 members of staff to encourage their application. **52 Week Waits** HM advised that the number of patients waiting between 40-52 had increased and that a daily review was taking place to address this. We had rescheduled 9 out of the 11 patient and they had been rescheduled and booked in within one month of the breach. This was in part due to patient choice but we needed to ensure this was managed and we had rigour in our internal monitoring processed. Meeting closed 10.30am		

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Signed

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Date

Royal Papworth Hospital NHS Foundation Trust
Board of Directors
Meeting held on 4 May 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	**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