Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Council of Governors
Royal Papworth Hospital
PART I
Held on Wednesday 16 November 2022 at 10:30am
HLRI, Cambridge Biomedical Campus and via MS Teams

M I N U T E S

Present	John Wallwork	JW	Chair (Trust Chair)
	Angela Atkinson	AA	Public Governor
	Michelle Barfoot	MB	Staff Governor
	Paul Berry	PB	Public Governor
	Stephen Brown	SB	Public Governor
	Sarah Brooks	SBr	Staff Governor
	Susan Bullivant	SAB	Public Governor
	Doug Burns	DB	Public Governor
	Trevor Collins	TC	Public Governor
	Aman Coonar	AC	Staff Governor
	Yvonne Dunham	YD	Public Governor
	Caroline Edmonds	CE	Appointed Governor
	Andrew Hadley-Brown	AHB	Staff Governor
	Abigail Halstead	AH	Public Governor
	Ian Harvey	IH	Public Governor
	Richard Hodder	RHo	Public Governor (Lead Governor)
	Marlene Hotchkiss	MH	Public Governor
	Lesley Howe	LH	Public Governor
	Christopher McCorquodale	CMc	Staff Governor
	Trevor McLeese	TMc	Public Governor
	Harvey Perkins	HP	Public Governor
	Philippa Slatter	PS	Appointed Governor
	Martin Ward	MW	Staff Governor
In Attendance	Michael Blastland	MBl	NED
	Liz Bush	LB	EA to CEO & MD
	Cynthia Conquest	CC	NED
	Tim Glenn	TG	Chief Finance Officer
	Anna Jarvis	AJ	Trust Secretary
	Diane Leacock	DL	NED
	Eilish Midlane	EM	CEO
	Oonagh Monkhouse	OM	Director of Workforce
	Maura Screaton	MS	Chief Nurse
	Ian Smith	IES	Medical Director
	Andy Raynes	AR	CIO

Apologies	Jag Ahluwalia	JA	NED
	Alex Baldwin	AB	Interim COO
	Amanda Fadero	AF	NED
	John Fitchew	JF	Public Governor
	Rhys Hurst	RHu	Staff Governor
	Gavin Robert	GR	NED
	Julie Wall	JYW	PA to Chairman (Typed up minutes from the recording post meeting)
	Andrew Witham	AW	Public Governor

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1	**WELCOME, APOLOGIES AND OPENING REMARKS**		
	JW (Chair) welcomed everyone to the meeting. Apologies were noted. **JW** acknowledged the sad death of Glenn Edge, who was a past long serving governor. **RH** wanted to say a few words about Glenn who RH thought of as a great man: RH explained that he and Glenn had first met when they were elected as public governors for Cambridgeshire at the old hospital site in 2014. They both had an RAF background and served in Germany and Falklands. After leaving the RAF Glenn ran a family farm on the Suffolk border. He always gave wise input and was an active member of several committees and interview panels. He was always ready to step forward despite his busy farm role. Glenn was diagnosed with lung cancer and had surgery at the old site for this. In 2020 Glenn became unwell again and decided not to stand for re-election. Sadly, he was diagnosed with a recurrence of lung cancer. He continued in his role as ambassador for local charities and hospice. His great interest remained with RPH and continued with his interests for as long as he was able. RH explained that Glenn was grateful to the whole NHS, the hospice, his GP, and local nurses. A Spitfire flypast was arranged by a friend for him. Glenn died peacefully at home with wife and family at his side. Details of the funeral service are available.		
2	**DECLARATIONS OF INTEREST**		
	There is a requirement those attending Committees raise any specific declarations if these arise during discussions. There were no new declarations of interest.		

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3	**MINUTES OF THE PREVIOUS MEETING – 15 June 2022**		
	The minutes of the meeting held on 15 June 2022 were agreed as a correct record.		
4	**PATIENT STORY – Told by Michelle Barfoot**		
	• The Story is regarding an inpatient from 4S respiratory medicine a month ago. • Consent has been gained from patient for his story to be shared with the wider team and hospital. • Well known patient to CCLI service but had not been admitted for a while. He had Bronchiectasis since he was 14 and whooping cough as a child • Reported how marvellous staff are from cleaners to consultants. RPH best in world and are special employees. Felt truly cared for and safe on ward and had very high praise. • At Outpatient appointment with CCLI consultant, he was given a reserve course of antibiotics and advised to take. After 14 days he was no better and following a telephone consultation was advised he needed to come into hospital but there was then a two week wait for a bed. Once he was given IV antibiotics is started improving. • Patient was asked regarding areas to improve on, and food was mentioned (theme from patients). Being a frequent visitor, he found the menu did not change. • Had not been seen by any chaplaincy team during his stay. Previously a priest came weekly but no-one asked if he wanted a visit at this admission. • Action plan – ward hot topics – nurses were reminded to ask patients about preferences – chaplaincy request. Had not raised food concerns to staff but we did ask if a member of the catering team to visit before he was discharged which they did. Patient was advised to raise concerns earlier. **Discussion:** **AC** commented that it was mentioned in the pre meeting about positive feedback from staff using the restaurant saying the food was very good so there are two sides to this. **MS** agreed it is good to highlight spiritual needs of patients. SLA with chaplaincy – visit regularly. Positive item to take forward. A good remembrance service was experienced last week. **TMC** asked if there was an opportunity for IV to be administered earlier in the community? Ambulatory care unit review day 7 and day 14 – not always an option. Was explored in this care. Patient lives on their own.		

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	PS commented that on her visit last week the food was good and added that it is a focus of attention for patients as is highlight of the day. Chaplaincy was not on PLACE forms to fill in. A greater understanding of what chaplaincy has to offer and the wider spectrum is needed.		
5	**ANNUAL REPORT & ACCOUNTS**		
	Reported byTim Glenn, CFO • Accounts as of end of March 2022. Another extraordinary year in RPH history following coming out of a third wave of COVID. A high-level vaccination programme ran. Now back to operating levels pre-pandemic. Good progress has been made. • Financial perspective – a successful year for the Trust, total income increases by 9% reflects government funds to cope with COVID and vote of confidence. • The ECMO Service has expanded which was backed by the government – doubled in size during pandemic, recurrent investment in the Trust. • Alongside continued focus on keeping cost base under control and delivering efficiency led the Trust to deliver 3.2m surplus in year. Vital as entered this financial year and forward plans. • Inflationary pressures that hospital faces currently, grow revenue and control cost base. Healthy balance sheet increased 61m – been able to reduce the number of days to pay creditors and suppliers – important as Trust Supply chain under economic pressure – support small businesses to survive. Down to 32 days currently. • Quality – audited by external auditors –Trust has received unqualified opinion in financial statements – best rating – no amendments to first draft found to be required – underlines the quality of work from teams. • The Annual report and contents were commended.		
6	**CQC FUNDAMENTALS OF CARE**		
	Reported by Maura Screaton, Chief Nurse **MS ran through the presentation explaining:** The CQC refresh of peer review process fundamental standards. There are 12 Fundamental Standards we must review: 1. Care and treatment must be appropriate 2. Service users must be treated with dignity and respect 3. Care and treatment must only be provided with consent 4. Care and treatment must be provided in a safe way 5. Service users must be protected from abuse and improper treatment 6. Service users' nutrition and hydration must be met 7. Premises and equipment used must be clean, secure, and suitable 8. Complaints must be appropriately investigated, and action taken		

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	in response 9. Systems and processes must be established to ensure compliance with the fundamental standards 10. Sufficient numbers of suitably qualified competent skilled staff must be deployed 11. Persons employed must be of good character and have the necessary skills and qualifications 12. Registered persons must be open and transparent. Duty of Candour **Reasons for taking Internal Peer Reviews:** • To ensure a program of continuous self- assessment providing assurance of safe and effective patient care • To create an open and transparent program of self-reflection and self- assessment. • To celebrate areas of excellent practice • To identify areas for improvement • To evidence areas of good practice and maintenance of improvement for future CQC inspections. • Good opportunity for individual personal and professional development for members of the peer review team • Chance for staff/volunteers/governors to learn about an area that they may not previously have visited, or they have limited knowledge on. • To develop the Trust governance around quality compliance. • To maintain an outstanding rating **How Peer Reviews are undertaken:** • 3-4 peer reviewers are assigned to each fundamental standard • 1 individual will be deemed as a subject matter expert to take the lead. • Each staff member needs to dedicate about 3* working days to the full review process (½ day prep, 1 day review, ½ day post report/review). • Discussion with peer reviewers to agree format of review. • Each FOC- has a senior lead/group for oversight **The visit to our Trust areas:** • Conversations with staff groups across the Trust using an appreciative enquiry approach • Conversations with patient/visitors • Inspecting the area linked to the peer review focus. **Governance paper-based review:** As part of each review there will be a governance paper based as well as		

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	the visit, which can include looking at: • Policies • Processes & procedures • Patient information leaflets • Care plans • Staff surveys • Inpatient surveys • Audit outcomes • Incidents/complaints **Quality & Risk** • Schedule of peer reviews are set out for whole year. We have individual identified to lead on it and request for volunteers from staff to undertake reviews. • How can you help? Everyone can become part of the process. Best reviews carried out with diverse perspective. • If you would like to get involved, please get in contact. • Nutritional needs peer review – recently carried out – good identification of good practice and improvements to service. • Email JW if interested in joining peer review. **Questions:** • **CMc** – medical input still to be agreed – IES and MS to discuss. Some medical engagement but need to include in forward plan.		
7	**COMMITTEE CHAIR'S REPORTS**		
	Presentations to Committees – Chair of Committees from Board to present to Governors **Cynthia Conquest – Chair of Audit Committee** CC explained that she has been Chair of Audit for the past 18 months. There is a formal requirement for NHS FT to have an Audit Committee. Her key role is to support and gain assurance for the Trust Board on the robustness and relevance of governance structures we have in the organisation. It also obtains assurance around controls and the reliability of data. This takes form in several ways, internal and external audits, benchmarking, and risk assessment identifications and other forms. • The Committee is made up of three NEDs, Michael Blastland, Diane Leacock, and herself. Two Governors, Doug Burns and Harvey Perkins as observers. There are at least five meetings held annually and are centred around the timing of the Annual Report and Accounts and submission for national deadlines. • Internal and external auditors have been impressed with the quality of reports and ongoing financial rigor. The Trust is doing what it needs to be doing to protect its governance and money. • Significant work has been looked at since January 2022 in addition to the annual work and approval of documentation such		

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	as Scheme of delegations, approval of policies, annual account sign off for Trust and Charity. • Assurance has been sought over salary over payment which was recognised as a deficit, there is now an understanding of issues and regular report to committee and process undertaken to recover the money. • M.abscessus – we commissioned an internal audit report in July to seek assurance that everything was being done that was needed. A positive coroner's report was received. • Cyber – we need to ensure that data and assets are protected. The national audit office requested evidence that we were asking the right questions. This was discussed at the Committee meeting, and we were satisfied that we were getting sufficient answers to the questions from our IT team and got significant assurance around that. • Standing financial instructions – making sure that correct procurement processes are completed • The aim is always to improve. • We do not work in isolation we work with our Q&R committee members. The National Quality Audit processes reviewed and were assured that they are completed appropriately. We can rely on the Clinical Audits that we do. • CC attends other committees as an observer to gain further assurance across the Board. **CC** was happy to answer any questions. None were put forward at this time. **Gavin Robert – Performance** GR explained that he last presented to the Council of Governors back in June. Since then, the same work has continued but several issues have come to the fore: • The most important of those issues is the recovery of activity in theatres. This has resulted in a significant downturn of work that we can do for patients and bed occupancy as well. Given that we have now improved bed availability in critical care because of The Critical Care Transformation project, it is disappointing that activity is still on the downturn in theatres. • We have started to look at the impact of the productivity work that was done by Meridian which identified a real opportunity to increase activity in theatres and in the cath labs. We seek to understand the reasons for the drop and assurance as to the program to recover our activity in theatres and cath labs. • We have looked at workforce issues and have been concerned by the increase in staff turnover that we have seen steadily in		

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	recent months but saw a spike in September of around 28% and we can see some of the reasons for this are a lack of career opportunities at Papworth. • There are high levels of vacancies in some areas. We have probed for the reasons for this. Tight labour markets in the surrounding area is an important part of the general contacts that we are seeing. High vacancies and high turnover are being seen regionally. • We have been discussing and looking to create a new Workforce Committee which will give us more time to investigate these workforce issues in greater detail. Another issue we focus on is procurement. Scrutiny and challenge that we are receiving value for money when entering major purchasing contracts, for example, earlier this year was a contract to procure cardiology devices and seeing the inflationary context we are in we have turned our attention to how the Trust is controlling costs that are in our control and it is worth mentioning that a lot of costs are not within our control, and what processes are within the Trust and within management. • Finance is a key part of our work and ensuring financial health and sustainability. • We keep a close eye on the CIP framework, and I am pleased to say that this has been steadily on track for the year and attention is beginning to turn to the pipeline for cost improvements in future years. Most CIP gains have been recurrent gains which is what we want to see year on year. • We also look at better payments and the important role that the Trust plays in local economy and ensuring it pays its bills on time is important and we continue to track that. Our ability to meet our target of 95% of payments within 30 days and significant progress has been made. • Some of those processes are beginning to be automated and should improve things further. • One of the other forms of assurance that we have is through the Divisional presentations that we introduced two or three years ago. • We have had presentations from Critical Care and Pharmacy and crucially at the next Performance Committee meeting this month, a presentation from Surgery and Transplant. Given the issue around recovery in theatres that is particularly a good form of assurance for us to receive. **Questions:** **RH** thanked Gavin for his report and mentioned that he was pleased to have attend the Performance Committee recently. He asked if Gavin could explain, as there is no glossary of acronyms, what CIP stands for		

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	GR explained that CIP is Cost Improvement Programme. This is an obligation for providers to constantly find ways of cost savings, and there is a percentage target set by each Centre and we are obliged to meet this. **AC** thanked GR for focussing on theatres and asked if he had any further insights to share **GR** handed over to TG as SRO on the Theatre Project. **TG** explained that it is important to add a little bit of context. Some of the main narratives of the NHS have been seen in the press recently, there was headlines about more money in and less activity coming out and RPH is not immune to that. We have increased staffing, and we have increased money coming into the Trust and we are dealing with more patients from an unelected perspective than we did pre pandemic, but we are not dealing with our elective in patient levels at the same level as we were pre pandemic. We are currently running at 70% inpatient elective flow coming through theatres, nationally that compares to 80-83%. It is a sector wide problem, but we are slightly worse than other. The reason for that is quite complex. There are a lot of issues and there is not a silver bullet that will fix it and indeed from a national context that is recognised. We are working gradually working through those and as a Performance Committee and an executive with that diagnosis we are starting to enact changes that will help to alleviate pressures, but it will not be a quick fix. **AC** asked if TG could be more specific **TG** replied that he could not be more specific because there is a lot of work underway, and he thinks it would be inappropriate to talk about it at this time. **CMc** commented that he could understand why TG was not happy to share here but can he just check with Gavin and the NEDs and the executive that they have gone into the reasons for it, and they are happy. **GR** explained that the job of NEDs is to obtain assurance and the Executive Team are doing the absolute maximum that they can to solve the issues and manage the risks that the hospital faces. I would say on this issue we have assurance that the problem has been correctly diagnosed and we have assurance that there is a plan to deal with the problem. At this stage I would say we have limited assurance as to the speed with which the plan is able to deal with the problem and the success in implementing. We hope we will gain more assurance over the		

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	coming weeks, and we have various measures in place to try to achieve that in terms of the plan for meetings and the reporting from management back to the NEDs. I can assure you that we have been looking at this in great detail and I have seen some detailed plans from Tim and we will be hearing from the surgical team itself at our next Performance Committee meeting. **JW** reminded Governors that they are welcome to attend Part 1 of the Board meeting. **JW** commented about the issue in the water with M.abscessus which had been widely reported due to the two inquests held last week. **TG** had circulated a report to the Governors the day before the meeting. **JW** asked if anyone has any questions about that process. **IES** attended the inquest and went on to explain that this was regarding two lung transplant patient's deaths who obtained M.abscessus which is a difficult organism to treat. The purpose of the inquest was to establish who had died, where, when and how they died and the conclusion was that they had died in part because of infection with M.abscessus. As part of the process the coroner investigates whether there was any care issues in which they were provided or if there was any other reason why, if there was anything that should have been done that wasn't done and the conclusion on both cases was that they both died of natural causes and that this was an unavoidable infection given the state of knowledge when we opened the hospital and the care that was provided. Everything that should have been done by the staff was done. The outcome was a notice sent to the Government to the Secretary of Health to say guidance particularly in the design and opening and testing of new hospitals should be updated to include this new problem which is being increasingly identified over the last 10 years or so. As assurance we continue to have regular meetings of a clinical groups and of estates groups and we meet with external experts. We keep various bodies informed. The number of cases has come down year on year. It is disappointing that it has been a gradual process that the number of cases has come down. It is difficult to tell when a patient has become infected because it can take months or years before it can become apparent so the fact that we are still seeing patients present with M.abscessus we can't tell when they contracted it and we can't be absolutely sure that it isn't recent but the likelihood is that some of these patients are legacy cases who contracted it before we put in all of the mitigations in place.		

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	JW commented that Quality and Risk have been well informed over the last two years and as a result other hospitals around the country are finding this and have been in touch with us about how we are dealing with it. **RH** asked if this was a national or international problem? **IES** explained that it had been identified in the Duke Hospital in the US and they published their experience which was much worse than ours in that they had over 100 transplant patients infected, and it has been sporadically reported in other parts of the world. In South America there was a case which had a slightly different aetiology it was related to contaminated surgical instruments and cases have been reported in Italy. It is likely that it depends on how water is treated centrally. Different Countries have different water standards, but it also seems to be something to do with new hospitals. It may be treating hard for other bugs that leaves the only thing you cannot get rid of and then that expands, and you get this very difficult to treat bacteria. In our experience the biggest cohort who were affected were people with cystic fibrosis. We have seen historically about 10 cases per year of people with cystic fibrosis or bronchiectasis in our clinics who have contracted the condition in the community because they are always vulnerable to it. It has been seen in lung transplant patients but not heart transplant patients so far. This is not just to do with immunosuppressant conditions it is to do with the vulnerability of the lungs. **SB** asked what people thought if they had seen the write up in the Cambridge news, if this was good publicity or was it badly presented? The coroners summing up of the report was fair. **IES** replied that the point of a reporter is to make a story and things that were reported, potentially out of 5 days of evidence, they picked on a couple of things where what was said might not have reflected what was in the records but that was what they pounced on. In terms of the overall impact, I think the fact that it wasn't picked up wider than the local newspaper and the hospital did a good job dealing with this it wasn't a big story that the national press picked up on. Local press picked up on contradictions and not the robust process, but it didn't run to a long story. **TMcL** commented about the filters on the taps and asked if this is something that the NHS should be doing nationally? **IES** explained that the filters are very effective but also very expensive. Behind the filter you reduce the flow but one of the things you want to do to keep the water clean is to keep high flow through the system. We have been trying very hard to get to a point where we can take them off and that is still the ambition. It would not be the best thing for every hospital to do for those reasons. Certainly, testing and responding to any positives is the right thing to do.		

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	JW commented that we have assurance that the right things were done, and it is important not to overreact to the press reports.		
8	**INTEGRATED CARE SYSTEM DEVELOPMENT**		
	Reported by Eilish Midlane **EM** apologised for not being on site for the meeting as she is on leave and did not want to miss the meeting this morning. **EM** explained that an overview report, of what has been going on within the ICB, had been added to the pack of papers that was sent out before the meeting. **Points from the Report:** • ICS was formally formed on the 1 July 2022, so still in the storming and forming stages and securing our governance routes and making sure we have the development sessions running so everyone comes together to work collectively. • Working alongside the ICB is the Health and Wellbeing Board which is chaired by the local authority and one of the first pieces of work that has been undertaken has been to have a clear read across the two groups, so they are working from the same agenda. • EM was confirmed as a voting member of the ICB and represent Partner and NHS Trusts on that Board of a wider view of health. • The key elements through the first 3 cycles of sub committees and boards have been confirmation of the governance system, authorisation of approval of the People and Community strategy and the Voluntary Community and Social Enterprise Strategy and a sign off on the winter surge plan. We are expecting as a system to be iterative as we go through winter, and we add further elements. • At the last ICB there was a very good presentation of an insights pack into population growth within our system and a focus on health inequalities which is a key agenda item as we go forward. It is recognised that there is a huge disparity across the geography of Cambridge and Peterborough. • On a positive note, we received a primary care road map and our primary care access within Cambridge and Peterborough is better than many other systems in the Country but none the less there is still work to do. • There was an update on where we are in terms of the SOF4 which is the measures of financial category and overall performance. We were SOF4 because we are in a position as an ICB that we are financially challenged, and the good news is that we are beginning to get very strong indications that we will be coming out		

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	of SOF4 into a more assured position financially as we go forward. That is a response to some really strong work that has been done across the system and we have been able to give solid assurance that we have a good grip on our financial positions. **Questions:** **PB** commented that he was conscious that RPH covers a region and asked if there is a link with adjoining ICB's i.e., Norfolk or Suffolk etc? **EM** confirmed that there are going to be changes to the Specialist Commissioner Services. There is discussion around whether one of the systems withing the region is likely to take the responsibility for doing the specialist commissioning. It looks like BLMK (Bedford linked with Milton Keynes) will be that system. There is a recognition of the Specialist commissioning service transformation anticipated in April 2023 will now be delayed because it is recognised that the pace of change is going to be too rapid. The intention with these reforms is to make the financial resources follow the patient rather than the traditional approach of the money follows where the centres are. This is good news for the local population within the region because many patients would have had to travel into London for some services. It is less good news for areas like London where there is a high density of specialist providers. **JW** added that as we are a highly specialist centre and we must be sat on the ICB but there are external issues. **TG** added that he has been actively involved with colleagues at the CUH and set up a specialist provider collaborative and what has been done is identify big service providers in each of the ICB's. We got together to start to talk about how access for patients is improved across the region. **PS** reiterated that local authorities have not sat back either. She is pleased that RPH has a wider remit and there is a lot of specialist advice coming from RPH making it a splendid contribution. PS explained that Social Care is complex with no quick fix but thanked RPH for being in the thick of it. **AC** asked to what extent we will be able to work with providers and local communities to facilitate discharges? Discussion so far has been about access and pathways coming in but discharge being part of the flow needs to be focused on **EM** explained that there is a daily system resilience meeting that happens, and we are an active component to that meeting. We feed in our status, but we are also able to escalate through that forum any delays on discharges. This is for Cambridge and Peterborough, and we have delay discharges that are wider than within our own patch. There is an escalation process in terms of a bronze, silver, gold escalation which		

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	happens daily as well. Over recent months the position of many acutes have been equivalent to what we would have seen pre pandemic in the depths of winters and it can be really difficult to push for patients to return to a local hospital when they are articulating with that they are, in order to de risk A&E departments, they have had to move patients up to wards where they don't actually have beds available yet. **RH** commented along with other lead Governors in Peterborough and Cambridge there have been meetings with the Chair of the ICB John O'Brien and there was an open meeting on the 26 October when some governors attended. There will be another open meeting scheduled next spring. Date to be circulated when available **PS** wanted to bring up a point about the discharge to assess process and this clearly varies across the region. Does RPH send out any OT specific advice which will enable RPH patients with their particular issues to enable them to be back home or where they want to be? **EM** explained that we have a very small discharge team, and they work actively with the community and other organisations in order to do the right thing and get people returned home wherever possible. **PS** asked if the 6-week period scheme working. **EM** commented that it was a bit variable and reflects the fact that we are interacting with such several different locations, but we have got a good handle on it within our own patch. **HP** informed everyone that he had attended the open meeting, and many governors were there from different Trusts within the ICB. A lot of issues came up and at the end of it all when it came to distilling the essence of the meeting several headings came up in a particular order: 1. Why are we doing this? Why are we putting ourselves through another serious upheaval when there is so much pressure on the NHS at a time of year when it is particularly difficult. It was impossible for any of the Board members present to give any clarity or reassurance on that point. It is important to recognise that Governors from other Trusts as well as RPH also have concerns about the reason for doing this. 2. The second issue was public accountability, Governors were concerned that while hospitals must have public accountability apparently the ICB does not need public scrutiny and surveillance. This is a concern very high on the list. 3. Cross border issues came up as a serious concern particularly in the Northeast of our region. Resources are stretched in many directions for Stamford and Rutland and there were conflicts. 4. Specialist commissioning was frowned upon and there is no provision for it in the set up.		

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	5. The Primary Care was said to be leaking away at an alarming rate in our region. This includes GP's retiring, GP practices closing or merging. Work is being undone as to the merging of practices by these actions and social care seems to be a blind spot. No one understood where the ICB stands on remedying the huge hole we have in social care. This is the order these concerns came up and just wanted to let you know that Governors widely are concerned. **EM** thanked HP and agreed it was a good summary of concerns. **EM** wanted to pick up on why now? This is not something that the system has chosen for itself, this has been mandated through government as part of the Health and Social Care Act. The intention is to bring local authorities and health closer together. We should be investing in keeping people well and keeping people at home. That is the underlying principle. **TG** wanted to pick up on the governance point, the ICS has got a joint arm with the Integrated Care System (ICP) who cover the health side and there is a link to the Integrated Care Partnership which is joining with the health wellbeing board. That is the way that the population has an oversight of governance. It is a different way of working but that is for the very reasons that have been highlighted and these reforms are intended to help with areas of concern. **AC** commented that as a clinician he really welcomes this. The patient pathway was and is a mess and we need a new look at it to improve it. It will bring health and financial benefits. We need a healthy society for a healthy economy. NHS England is restructuring with Clinical Leads for all the different areas for specialised commissioning to work with other clinical leads and partners to help redesign those pathways.		
9	**DIGITAL UPDATE**		
	Reported by Andy Raynes, CIO • Review AV systems in the room. Improvements need to be made. • Shared Care record – partnership across our system with Orion Health. Exchange data between different systems across our community and presents back the data in that system. CUH or RPH or local authority you will be able to see information from systems based on a consent model. • Last couple of months working on an Information Campaign, My Care Record leaflets have been posted out through letterboxes to explain what we are doing. Hoping to reach first stage before the end of year which is to connect our GP practices to the Shared Care record. • Lorenzo is our EPR and we know from Dedalus that they are stopping any further development in that so exploration is taking		

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	place of the patient record journey once again. We are in a process of evaluating computer systems. A visit to Germany is coming up in December to review the latest product from Dedalus Orbis U and comparing this like by like with other popular systems including, Epic, Cerner and other market leaders that are available. • We are looking at our Cyber posture as an ICS and continuing on an individual organisation level. We are starting a poster campaign to help with communications about what staff can do to help prevent or what to do in the event of attack. There is a rise of this from Wannacry 2017 which cost the NHS around £100 million in damages and waiting list lost opportunities to the more recent attack on NHS 111 and GP practices. • We have relaunched our patient entertainment system, on TVs in patient rooms including a menu format similar to a hotel with food and drinks. • Attended on behalf of the Trust the IT Industry Awards in recognition of a fantastic innovation from Dr Will Davies and the work from RPH Charity on the Laudit App which recognises staff performance and was nominated for an award. **JW** commented that the Shared Care Record will be the main focus for our development next year.		
10	**OPERATIONAL PERFORMANCE SUMMARY (Infographic)**		
	JW explained that this is a new way of reporting statistics from month to month and is a great way to look at key figures and data: **TG reported:** • Keen to get feedback on the infographics as want to improve reporting and are aware that PIPR is quite heavy so want to pull out key figures and data that are relevant and interesting to the Governors. • **AH** commented that she could not see anything on Thoracic data. There is cardiology, transplant but no information at all regarding thoracic. • **JW** commented that there was thoracic medicine under mandatory training. • **AH** added that she would like to see about the service generally. • **TG** thanked AH and added that if anyone thought of anything after the meeting to please feedback • **CMc** asked about mandatory training. The data is written to a high degree of precision but there is not a measure of how many people we are talking about in each one so more context is needed. • **AJ** explained that this looks at the percentage of the whole mandatory training requirement.		

Agenda Item *(minute reference)*		Action by Whom	Date
	• **CMc** commented on a piece of the content reading 2.8 million surplus so far and asked is that good or bad. It is good that we are not in debt, but we know that we are not meeting RTT and we would like to be doing more activity so why is that? • **TG** explained that the figure reflects where we are at and this good news. Contract arrangements are not activity linked and exactly what you are saying if you do not do the work, you see a surplus. • **JW** agreed this is a complex issue. This will be refined but is a useful way to review figures and report up to date progress. Something that could be added stating that this is progress or a pre indication of the month to gage it to. • **TMc** asked about staff welfare and if money is put aside to help support staff. • **TG** explained that they had put some money aside to enable them to act with the cost-of-living crisis interventions and are able to offer free travel on the park and ride bus, restaurant discounts, and all staff will receive £100 in their November pay. We are in discussion regarding extending further		
11	**PIPR**		
	Received: The Council of Governors received copy of PIPR for information. **JW** asked if there were any questions regarding PIPR No questions were put forward		
12	**GOVERNOR MATTERS**		
	Reported by Richard Hodder – Lead Governor **i. Appendix 1: Governor Committee Membership** • RH commented that all the Governors would have received appendix 1 showing Governor Committees that we can sit on and chair. Asked new governors to come along and observe any meetings that may be of any particular interest. • RH explained that a hospital induction was being set up for the new governors staring in December with a further three sessions after that and we are rerunning the NHS Providers Induction for Governors program. • **JW** commented that the hospital is much more open now and would like to encourage NEDs and Governors to visit. • **RH** commented that there was a very good PLACE inspection last week on level 4 which had a positive outcome. • **Appendix 2: Minutes of Governor Committees**		

Agenda Item *(minute reference)*		Action by Whom	Date
	RH asked if there were any comments on the minutes **SAB** wanted to ask on a general point, she had noted there is a new issue added, that each committee will now have emerging risks added to the agenda. **AJ** explained that this was a recommendation to the Board from our internal auditors to remind members to identify any risks and to escalate any emerging risks identified on a committee agenda. **SAB** added that in May under this item she had seen no risks but there was M.abscessus and asked if she had misinterpreted what that is all about. **AJ** explained that item is the capture any new emerging risks that are not already on the risk register so M.abscessus would already have had a risk entry on it. It depends what is on the agenda at the particular meeting. **SAB** commented that on PIPR it records issues with staff shortages and would like to raise the issue of staff morale. It has come to some of our attentions that senior management think people are ok and they are not. She suggested that managers are more visible and showing concern for their welfare. This appears to not be happening. **OM** replied that she did not recognise that management think that staff are ok. There is a lot of time spent in our formal Board, Committee meetings, Executive and Divisional meetings discussing the pressures on staff in the NHS at present. There are many of those and a lot of external pressures. You hear on the news the national picture with the economy and labour market with people not working because of ill health which shrinks our labour force. Within the NHS, all hospitals are under pressure and that means that staff often feel that they are working in a way that is outside the way they would like to be working. In terms of they do not have enough time with their patients, and they are being asked to cover in other areas to balance safe staffing levels. We are aware of that and we try to do a lot to help including staff benefits, the welfare scheme, the staff hardship fund to try to help giving support but it is agreed that of is fine and line managers should be keeping in touch and talking to their staff and I am sure that all of them try to do their best to do that. The pressure is that they will get pulled into clinical work as well because they are covering. At every level it is important to keep in touch and we recognise pressures on all staff and understand pressures on all managers. **AH** asked if senior managers go up to wander around the wards. **OM** replied that she could answer for the Executives and Divisional Levels that they do.		

Agenda Item *(minute reference)*		Action by Whom	Date
	MS commented that there are visibility rounds every Friday and other times during the week in clinical areas to try to give a bit more flexibility. There is the opportunity for anyone to join these rounds, students or healthcare workers so there is a wider perspective. There are communications regarding this. Cynthia Conquest NED and Diane Leacock NED come to those. It is generally the senior nurses that lead this. That is definitively every week, and we have other sporadic ones feeding in. We are trying to look how our Matrons are working because they are key clinical leaders in clinical areas. Now they tend to work longer days and do duty Matron roles. We are trying to get them back into their clinical areas to provide leadership and are visible to staff and patients. MS agreed that is would be nice to be out more, but it is difficult balancing with other responsibilities and work pressures. She and TG have been out recently to theatres to support staff and take impromptu moments if we are free to do that. The visibility rounds are varied, it might be a Step in your Shoes one week, or Patient safety or focus on medications so there are different themes, so we have different perspectives. **SBr** commented that she is out and about daily. These visits are not regimented but certainly we are on the wards to give our support. We are trying our best to be visible. **IH** commented that he understands that the staff survey is being conducted now and asked what happens next and when will the findings be shared with the governors for example. That survey will shed some interesting light on some of the things that have been spoken about. For example, staff turnover. **OM** explained that is the staff survey that happens every year and it closes at the end of November. Generally, the results are embargoed and then publishes in February/March. Governors will receive a presentation on the results. A quarterly staff survey is undertaken in between. It has been static over the last year. It is hard to gage the whole NHS. The results were down over the last couple of years, high levels of burn out and staff engagement. It is difficult to say that we will not see that again this year. We are in the middle of potential industrial action and there is an underlying sense of NHS/Public Sector staff not feeling valued at present. Then you add on the normal stresses and strains of the organisation. **IH** asked if some questions do raise concerns do you then feedback to the staff in general about how those concerns are being addressed. **OM** replied that there is a constant cycle at our weekly managers meeting and staff briefing. We provide feedback whenever a survey has been done. We also think about things that we are doing because of the		

Agenda Item *(minute reference)*		Action by Whom	Date
	feedback from staff and there is the opportunity for staff to put comments in the chat box at the briefing. We often get emails after the meetings with suggestions. **IH** commented that there is nothing more frustrating for people, if you have completed a survey, and it does not bring about change. **TG** informed everyone that the Staff Survey results for last year is available now and were also included in the Annual Report. Key points that we were far out on was the treatment of our BAME staff. Oonagh with Onika have implemented the C&C Leadership Programme to instigate a high level of improvement for our BAME staff and that is a direct result that came from last year's survey. **RH** asked about the Pulse Survey? **OM** advised that this will not be done this quarter as the Annual Survey is being conducted this month. She will give feedback at the next meeting in March for both surveys. **CMc** commented that there is quite a gap from doing the survey to when the results are reported. **OM** replied that it is to do with the National Protocol around it. **CMc** asked if we could run the Pulse survey alongside the Annual Survey. **OM** replied that we only manage 15-20% on the Pulse survey so we need to focus on the Annual Survey. At the moment, only 50% of staff have completed so we get a good response if we focus hard. Last year we had a 70% response rate which was one of the highest in the NHS. **CMc** commented that the fundamental issue that people are struggling with is that they would like to provide better care and there are not enough people to do it. **JW** commented that we are aware there are issues, and we can always do better which is the reason for setting up the new Workforce Committee to address these current issues which are not only regional but national. **ii. NHS Code of Governance: Anna Jarvis** This is to bring to the Council of Governors an update on our constitution. We normally look at the constitution every 3 years but this year it has been flagged that there will be consultations on a new code of governance which will reflect the national changes in systems. The new code was published on 27 October 2022, so we need to review		

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	our constitution to see whether we need to make any changes in terms of membership and how we work with ICB's. The proposal is that the code comes into effect on the 1st April 2023. I propose that we set up a Governor Assurance Committee meeting to review the constitution. We are also in touch with NHS Providers because they want to do some collaborative work with us. We will bring that back to the March Council of Governors meeting. **Recommendation:** The Council of Governors is requested agree the revised timeline for review of the Trust constitution which be brought to Council of Governors meeting in March 2023. **iii. Election Results 2022** **All unopposed for a 3-year term** **Cambridgeshire:** Susan Bullivant **Norfolk:** Paul Berry **Rest of England and Wales:** Marlene Hotchkiss Lesley Howe Harvey Perkins **Suffolk** Angela Atkinson **Staff:** Andrew Hadley Brown – Nurses Sarah Brooks – Admin, Clerical and Managers		
13	**QUESTIONS FROM GOVERNORS AND THE PUBLIC**		
	No further questions were put forward		
14	**ANY OTHER BUSINESS**		
	No other business put forward		
15	**FUTURE MEETING DATES**		
	• **15 March 2023** • **14 June 2023** • **13 September 2023 (Followed by AMM)** • **15 November 2023**		

The meeting finished at 12:34

Royal Papworth Hospital
NHS Foundation Trust

Signed: 

Date: 15 March 2023

Royal Papworth Hospital NHS Foundation Trust
Council of Governors Meeting
Meeting held on 16 November 2022