

**Meeting of the Board of Directors
Held on 01 June 2023 at 9:00am
Microsoft Teams
HRLI, Royal Papworth Hospital**

UNCONFIRMED

M I N U T E S – P a r t 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
	Ms A Fadero	(AF)	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
	Mr A Raynes	(AR)	Chief Information Officer & SIRO
	Mrs M Screaton	(MS)	Chief Nurse
	Prof I Smith	(IS)	Medical Director
	Prof I Wilkinson	(IW)	Non-Executive Director
In Attendance	Mr T Bottiglieri	(TB)	Freedom to Speak Up Guardian
	Mr S Edwards	(SE)	Head of Communications
	Mrs L Howard-Jones	(LH)	Deputy Director of Workforce and OD
	Mrs A Jarvis	(AJ)	Trust Secretary
Apologies	Ms O Monkhouse	(OM)	Director of Workforce and OD
	Mr G Robert	(GR)	Non-Executive Director
Governor Observers	Angie Atkinson, Trevor Collins, Aman Coonar, Richard Hodder, Marlene Hotchkiss, Trevor McLeese		

Agenda Item		Action by Whom	Date
1	WELCOME, APOLOGIES AND OPENING REMARKS		
	The Chairman welcomed everyone to the meeting and apologies were noted as above.		
1.i	Declarations of interest		
	There is a requirement that Board members raise any specific declarations if these arise during discussions. No specific conflicts were identified in relation to matters on the agenda. A summary of standing declarations of interests is appended to these minutes.		

Agenda Item		Action by Whom	Date
1.ii	Minutes of the previous meeting		
	<p>Board of Directors Part I: 04 May 2023</p> <p>Item 4.i Performance Committee Chair's Report: Revised to read: Reported: "This seemed to be good news but" Discussion iv: "GR noted the measures being taken around discharge and patient flow and asked what impact these would have?"</p> <p>Item 4.ii PIPR revised to read: Discussion i: "...should be informed by a face to face..."</p> <p>Item 5.i: Research & Development Strategy: Revised to read: Discussion iii: - "PC advised that conversations were taking place with Dr Charlotte Summers, Interim Director of the HLRI...He would touch base with CS again as it ..." Discussion iv: "needed to think about the communities we want to..."</p> <p>Approved: With the above amendments the Board of Directors approved the Minutes of the Part I meeting held on 4 May 2023 as a true record.</p>		
1.iii	Matters arising and action checklist		
	<p>Item 318: R&D Governance delays: CC noted that this item still required a date for completion.</p> <p>Noted: The Board received and noted the updates on the action checklist.</p>		
1.iv	Chairman's report		
	The Chairman noted that he had attended Lord Prior's Life Sciences Council meeting key issues discussed included data and access to funds.		
1.v	Board Assurance Framework		
	<p>Received: From the Trust Secretary the BAF report setting out:</p> <ul style="list-style-type: none"> i. BAF risks against strategic objectives ii. BAF risks above appetite and target risk rating iii. The Board BAF tracker. <p>Reported: By AJ:</p> <ul style="list-style-type: none"> i. That the key issues related to the impact of industrial action where we had continuing risk in relation to action and ballots by the BMA. <p>Discussion:</p> <ul style="list-style-type: none"> i. EM noted that there had been an escalation of supply chain issues relating to cardiac surgery and ECMO. This matter linked to the supply risk on the BAF and had been escalated to the corporate risk register. RPH were represented on the national advisory group who were looking at this issue. <p>Noted: The Board noted the BAF report for May 2023.</p>		

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1.vi	CEO's update		
	<p>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.</p> <p>Reported: By EM that:</p> <ol style="list-style-type: none"> i. The prior month had been affected both by bank holidays and the industrial action which reduced the number of working days. ii. The NHS staff council had recommended implementation of the pay deal for staff on Agenda for Change, but we would still see action from the BMA with the junior doctors strikes and the consultant ballot. iii. An announcement had been made on the Cambridge congestion charge. The Trust had lobbied the Council reflecting the concerns of our staff. There was now to be a period of reflection and review of responses. iv. We were coming to the end of the first cohort of our Transformational Reciprocal Mentoring Programme and the staff involved would move into the implementation phase. We were now recruiting to a second cohort. v. Our staff had secured nearly £400,000 in funding to establish a virtual ward. This will be designed to improve preoperative patient care and community based antibiotic management for wound infections. vi. Operational performance had been challenging with the need to balance several days of industrial action against our work to improve flow, productivity and performance. We had received a letter from NHSE about recovery plans and we were working with them as we recognised that our position on referrals, waiting times and in house urgent transfers was not where we wanted it to be. vii. The first phase of the C&P Shared Care Record project had gone live. AR had led and stewarded this programme through much of its course and we would be joining in phase 2 of the roll out. viii. The 'Sign Live' system had gone live. This innovation had come out of a suggestion from our Disability and Difference network. <p>Discussion:</p> <ol style="list-style-type: none"> i. JA welcomed the virtual ward initiative. ii. AF noted that both staff engagement and our performance were not where we wanted them to be. She asked EM to outline when we expected to see improvement in these areas. EM advised that it was easier to address the performance issues and that the cultural change took longer and was more difficult to measure. She noted that RTT had a trajectory to achieve 80%+ in August 2024 and she recognised that this was a long period. We should see improvement over the next 12-18 months. AF noted that the delivery of the improvement was linked to cultural change and that this needed to be considered. HM advised that the work on continuous improvement in STA picked up the importance of culture, particularly in theatres. This work included timelines for improved performance, including the shift to a three-pump day and this set improvement over the next 		

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	<p>3-4 months.</p> <p>iii. CC asked about SSI's and when we expected to see an impact in reducing these. JW noted that this was on the agenda and suggested that it be taken in that discussion.</p> <p>Noted: The Board noted the CEO's update report.</p>		
1.vii	Patient Story		
	<p>MS introduced the patient story. In May we had run a Palliative & Supportive Care stand in the atrium, and this was to encourage our staff, patients and visitors to talk about this. The stand had been well attended and this was very important work.</p> <p>She introduced Dr Sarah Grove, Consultant in Supportive and Palliative care.</p> <p>Dr Grove shared the story of 41-year-old patient that she had met two years ago. He had a complicated medical history and was supported by many teams across the NHS looking after multiple conditions in his blood, gut, liver and respiratory systems, he had also had juvenile arthritis.</p> <p>They had met two years ago as his team had recognised that he was less well and so they met to discuss advanced care. A Respect form had been completed and he was pleased to engage with the team. He had already made his will and had put in place lasting powers of attorney. Advanced care plans gave him a voice in his medical care planning and was used to document his choices.</p> <p>Dr Grove had met the patient again a few weeks ago as he had been admitted. The team were able to support his pain changing his medication and offering non-pharmacological approaches to support pain and breathlessness. He tried using a TENS machine and acupuncture and had found both helpful. The team now included two senior nurses who were trained in acupuncture and one clinical nurse specialist who was trained in reflexology.</p> <p>The patient could see that his condition was worsening, and the team were able to provide emotional support listening to him and helping him to make sense of his losses, his loss of work, the loss of his mum and all of these had a profound impact on him.</p> <p>He had fed back that he found the hospital was exceptional, he was getting used to the single rooms, he didn't like what he thought was wasted space downstairs, he was happy with his clinical team and had found that staff were really caring. He found that the handover between doctors and nurses was not as good as it should be. He also had been concerned that the atmosphere at old hospital would not transfer, but felt that it had. SG felt that he was a very typical patient and had typical levels of support.</p> <p>Discussion:</p> <p>i. JA asked about how we maintained continuity of care outside of the hospital. SG advised that the patient had been referred to the community palliative care team about 18 months ago and the two teams liaise well.</p> <p>ii. JW noted the issue of isolation and asked what was in place to</p>		

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	<p>make patients feel less isolated. MS advised that some of the wards had identified spaces but this was difficult for our more vulnerable patients. We had a process in place to return spaces to planned use where these had been taken as staff spaces during the pandemic. SG noted that this patient was in the position where he probably saw more people during his admission than he would usually and had good walks with the physiotherapy team.</p> <p>iii. AF noted that this was a lovely story showing compassion and asked whether this service was available to all patients that needed it and if we had enough resource to meet demand or if we needed to prioritise. SG advised that the team were a liaison service and that they asked for introductions and were established at RPH as the palliative and supportive care team. Many RPH patients had lifelong and life limiting conditions and for some patients there were implications around referral into the service. The team were now included in transplant assessment clinics and all patients there saw the team routinely, most patients were happy to talk and no-one had turned them away. The team had a lot of referrals from critical care and have developed a patient leaflet for families to explain the service.</p> <p>Noted: The Board thanked SG and noted the patient story.</p>		
2	PEOPLE		
2.i	<p>Workforce Committee Chair's Report Received: The Workforce Committee Chair's report setting out significant issues of interest for the Board.</p> <p>Reported: By AF that:</p> <ul style="list-style-type: none"> i. This had been the third meeting of the Workforce Committee and she felt it was getting into a rhythm and pace of working. The Part I & Part II meetings had allowed for full and frank conversations on turning the dial on culture and engagement. ii. The Part I meeting had received the Director of Workforce Report which included the proposed KPI for the strategy. These had not felt sufficiently challenging, particularly in terms of improving the experience of our BAME staff and so the Committee had asked for stretch targets to be set. iii. The staff story from Amy Chadwick chair of the Women's network had shown the strength of their work. iv. OM had reported on the work on time to hire in cardiology and on the focus on work to address the deterioration in our staff engagement scores. v. The Committee had also received reports on: Freedom to Speak Up, mandatory training to support the new Patient Safety Incident Response Framework (PSIRF), the Education Strategy, the Quality Account priorities and the Health and Safety Annual review. <p>Noted: The Board noted the Workforce Committee Chair's report</p>		
2.ii	<p>Director of Workforce Report Received: From the Director of Workforce and OD a paper setting out</p>		

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	<p>key workforce issues.</p> <p>Reported: By LH-J that:</p> <ul style="list-style-type: none"> i. The report focussed on engagement with both the Pulse and the staff survey and acknowledged that these were not where we would want them to be. These reflected how staff felt as they came to work each day and that was influenced by team cohesion, line management and the level of absence that you were having to cover. ii. The line manager development training was now oversubscribed, and this was important to support staff and to make them feel that there was a job that was doable. Divisions and their recruitment managers were presenting plans to the executive the following week. iii. She felt that we were moving the dial but staff needed to feel that we were not so stretched with colleagues not off sick so often. iv. She felt that the work of the programmes on Compassionate and Collective Leadership, Recruitment and Retention and Employee Relations set out in the strategy were the right ones to address the challenges. v. The Health & Wellbeing agenda had a strong offering. Having access to this could improve our ability to fill roles and that would improve sickness absence rates. <p>Discussion</p> <ul style="list-style-type: none"> i. MB asked about recruitment and whether the change was because of overseas staff and if that programme was sustainable? LHJ noted that would have a big impact, but we had seen high turnover in Q3 and had experienced some administrative problems. Work was improving in relation to overseas recruitment, and we would be dependent on this in the short term as there was a national issue around training numbers, however each department had a strategy for recruitment and we were implementing a new system that would add to efficiencies. ii. DL welcomed the news that the line management development programme was on track but noted that some staff had missed modules. LHJ advised that there were some issues around release from service, also that some staff felt that they could pick modules undertaken. There had been work to refocus and communicate the need to complete the whole programme. The programme had executive support and that would help to drive attendance. The new lead for the programme was following up with managers to ensure there was commitment to release staff for every module. iii. AF noted that the Workforce committee had recognised the phenomenal work that was being done, noting that it might be more impactful if there were additional capacity in the workforce team to support OM/LHJ. JW noted that he had raised the issue of support for OM because of her external commitments and the stretch that put on our staff. LHJ noted that we had the funding for a new senior role within the workforce team and that would provide additional capacity. 		

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	<p>iv. IW asked about the issue of training numbers nationally and asked if this was in terms of the places available or the uptake. LHJ noted that there were posts available at the Trust but there was not enough supply to fill these and so we were looking at talent management and succession planning. In hard to recruit areas we were looking to redesign roles through our workforce planning agenda. MS advised that for nursing the uptake of training spaces at ARU was 20% down on the position two years ago and that both nursing and AHP training spaces were not being filled.</p> <p>v. MS noted the fantastic training and support that was in place and that we needed to recognise the importance of management and leadership. We focused on the academic, but all professionals also needed management skills.</p> <p>vi. JA asked about bursaries and whether there were opportunities for sponsorship and whether we saw learners dropping out of programmes. MS advised that we worked with ARU and UEA and that provided a good matrix with the apprenticeship routes, nursing assistant roles providing step on/step off opportunities and direct entry. Working with ARU, learners were guaranteed a nursing position within the local system. There was a process in the second year of training for staff to express an interest on particular areas. Very few of these staff subsequently dropped out of roles and this was fewer still in the apprenticeship route.</p> <p>vii. LHJ noted that the DWOD paper had asked for approval of the Workforce Strategy metrics and asked whether these could be approved by the Board. AF advised that these were to be reviewed and revised around the BAME/disability targets and that she was happy that these could be approved with the caveats as discussed at WFC and that the revised targets would be brought back to the Board for those areas.</p> <p>Agreed: The Board thanked LHJ and noted the report from the DWOD. The Board approved the updated Workforce Strategy metrics with the caveat as above.</p>		
2.iii	<p>Freedom to Speak Up Guardians Annual Report 2022/23</p> <p>Received: From the FTSU Guardian his Annual Report for 2022/23.</p> <p>Reported: By TB that:</p> <p>i. This report was a requirement in the FTSU recommendations.</p> <p>ii. This had been a busy year as illustrated by the increased trend in reporting.</p> <p>iii. The areas identified in reports reflected the themes around bullying and harassment that had been seen in the national staff survey and in WRES data. He felt that he had also seen a positive year in terms of the Trust addressing the issues raised and noted the information in table 1 summarised reports in 2022/23.</p> <p>iv. Staff were advised that when they spoke up that this was confidential. He had not included examples of concerns raised in this year, noting that maintaining confidentiality reflected something of the current atmosphere and concerns.</p>		

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	<p>v. 64% of staff reported that they would use the service again.</p> <p>vi. The biggest category of concerns was bullying and harassment which accounted for around 50% of the issues raised, and which featured in 63 of the cases reported.</p> <p>vii. The most significant number of reports came from patient facing areas. Those arising in other areas had levelled at around 30/40 cases per year. This was felt to represent an improvement as issues had been addressed.</p> <p>viii. There had been a positive trend toward facilitated outcomes with issues raised through line managers (unless they were the subject of a report). Staff were also benefitting from the work with the line manager programme where staff were being encouraged to explore and to report matters and this was having a positive benefit.</p> <p>ix. The key actions were outlined in the report. Staff were still interested in becoming champions, but this was a challenging aspect as these were all volunteers. TB attended induction and spoke to staff networks and all staff wanted their voice to be heard. There were areas where we could promote the role further and that included our medical staff.</p> <p>x. In terms of the role, he had undertaken recruitment of FTSU champions and provided refresher training. He had worked through a reflection tool with OM and CC and that identified strategies that we could use. He had regular 1:1 meetings with Executive Directors and non-Executives as well as other senior leaders across the organisation to share themes and issues that they should be aware of. He noted that his links with Divisional Boards were not as strong, and he felt there was perhaps some challenge there around a lack of curiosity. He would like to contribute more to staff briefings. We had met the Q4 reporting timetable both to the Board and the National Office. The FTSU policy had been updated and was awaiting approval.</p> <p>xi. He noted that there was some variation in response when matters were handed over to divisions and heads of nursing. It seemed that actions were put in place more readily to address issues in relation to lower banded staff, and he felt this was unfair, and that there should be a consistent approach with steps taken to address the issues raised so that there was confidence in our approach and values.</p> <p>Discussion:</p> <p>i. DL asked if there was more that the Board could do to support TB in the FTSU role. TB noted that networking and support in addressing inconsistencies in approach. There were handover forms and whilst there was discretion around management approaches to the issues raised, there should be a record of conversations that had taken place so that these issues were documented. There was concern that line managers still interpreted values and how these applied to different staff.</p> <p>ii. CC noted that inconsistency was an issue both at RPH and in the wider NHS and that some staff were able to get away with poor behaviour and we could not accept that. The Board needed assurance from the Executive that we would treat everyone equally. EM welcomed this invitation and reported that</p>		

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	<p>she had seen our staff and leaders calling out unacceptable behaviour and we required the same values and behaviours from all our staff.</p> <p>iii. MB asked if we had a breakdown of results by area and whether this identified patterns and outcomes. TB noted that the authority to resolve matters was through our management structures and he could point to areas that were not responding as well as others, but this was complicated as some staff wished to remain anonymous. We do report if we know individuals and departments have recurrent issues raised, for example staff not wishing to work with others on a particular rota.</p> <p>iv. MS thanked TB for his candid approach and noted that we were responsible and accountable for our behaviours and we needed to hold our teams to account for their behaviours and their professional standards. She agreed this needed consistency of approach and we needed to address this across the board.</p> <p>v. AF invited TB to meet with her and suggested that he could bring soft intelligence to help inform the Board on what it needed to do next. She asked about whether the issues that had been identified in our theatres had been evident through earlier reports and soft intelligence. TB noted that they had and that we were sighted on these early on and had developed work streams and action plans and staff also fed back on what was working in relation to these. There had been some issues within critical care and that had allowed discussion with staff prior to action plans being put in place. He felt that we needed to be better at identifying and acting on signals and implementing change. This could be seen by staff in different areas as either an opportunity or a threat.</p> <p>vi. IS noted the challenge of anonymity in relation to reports, as issues of confidentiality meant that there was no right of reply from the subject of the concern and assumptions at times that there were no interventions happening in response to issues raised. As these were not issues that were formalised this could hamper how they could be addressed.</p> <p>vii. CC asked if there were anything that could be done to support TB's work which she felt was fabulous. TB advised that he would appreciate administrative support for the role.</p> <p>viii. JW felt that given the increased role of our champions which was not recognised financially that we should look at a celebration event or gift to reward them for undertaking this role.</p> <p>Noted: The Board noted the FTSU Guardian's Annual Report for 2022/23.</p>	<p>AF/TB</p> <p>OM</p> <p>EM/TB</p>	<p>TBC</p> <p>TBC</p> <p>EM/TB</p>
3	GOVERNANCE		
3.i	<p>Q&R Committee Chair's Report Received: The Q&R Committee Chair's report setting out significant issues of interest for the Board.</p> <p>Reported: By MB that:</p> <p>i. He had raised the issue of how the Board were assured about surgical mortality soon after he joined the Trust, noting that the crude mortality reported in PIPR had worsened over time and that IS had presented a paper to the Committee looking at the predicted and actual mortality, using the Euroscore tool. This</p>		

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	<p>provided assurance as we had achieved better outcomes than were predicted for our patients. Whilst providing assurance he was concerned about the length of time taken to get to this view of mortality data.</p> <p>ii. The SSI dashboard had been discussed at length. The Trust had been on this programme for a year and had not seen any impact on SSI rates and had reported the highest ever rate in Q4. Much of the actions that had been taken would not have an impact until the culture behaviours and accountability framework were aligned. This work was all interlinked and so we would not know when this might turn the dial in relation to performance but this was needed and would be supported by the revised governance structure. The biggest area of focus was behavioural change and how we achieved this. He noted that we had an external visit scheduled and they would look at basic issues.</p> <p>Discussion Surgical Mortality:</p> <p>i. JW questioned some of MB's language in relation to his concerns noting that the Trust had developed and used Euroscore tool that was used internationally, and that Mr Nashef had presented on this to the Quality & Risk Committee. The tool provided data on comparative outcomes, and he noted that the UK had some of the best reporting systems for cardiac outcomes. RPH surgeons used this data and set much stricter boundaries for intervention than used in national reporting. MB acknowledged this but felt that the Trust could have done this analysis sooner. He noted that this also raised questions, as the Board did not have clear sight of whether the changes in mortality over time were as a result of a change in acuity or because patients had suffered deterioration in their clinical status as a result of the waiting times, which we knew had been extended. He felt that this presented a challenge and felt that this was an area that had taken too long to provide adequate assurance to the Board.</p> <p>ii. IS noted that his report had been a worthwhile piece of work as it did provide a measure but noted that the model itself was now out of date and that the Trust were sponsoring the process to update this. There was data available through the national teams, but that excluded some groups, such as emergencies and intubated patients and so also only provided a partial view of the data. He noted that our outcomes were worse than two years prior and he hoped that this approach would be instructive so that we could see if this was as a result of sicker patients now being admitted from the waiting list. This approach needed a reasonable time period for comparisons to the drawn and he planned to undertake this again in six months' time. MB noted that this was an area that he wanted to look into as the change in the crude rate from 1.7 to 3 was a serious deterioration in outcomes and needed to be understood.</p> <p>iii. JA noted the discussion at Q&R and noted that this did provide a greater degree of assurance, he felt that the move to SPC run charts which would bring in more data points would allow</p>		

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	<p>us to consider the outcomes over time. IW agreed noting that this should probably be taken over a 10-year time period.</p> <p>Surgical Site Infections:</p> <p>iv. JW asked if we were making assumptions in relation to the elevated rate of surgical site infections. He noted the earlier concerns that had been raised around the air flow within the theatres and asked if that had been discounted, he also noted operating times which were extended for some surgeons. MS advised that all of the work and testing and assessment of the air flow system indicated that it was acceptable. One area being reviewed was the level of disturbance within theatres and whether there was clear evidence that an increase in disturbance resulted in an increase in distribution of microorganisms that was affected by door openings. The visit from NHSE included an expert in IPC and ventilation. Testing on this was protocol driven and was undertaken when theatres were empty.</p> <p>v. CC asked if there was a point at which we consider that alternative measures should be taken if we could not improve the infection rates and how long the board should wait to see improvements delivered. MS noted that the issue of whether we should be operating had been discussed with IS and with Mr Jenkins and had been reported to the Q&R Committee. Our outcomes were good and if we weigh up the risks, we were doing more good operating than not. MS noted that there was a question around how long we accept these standards and the consequences of these and that was a question around a hard stop for the surgical group in terms of accountability. This was a question that needed to be posed continually and if we were not improving in terms of infections then the further question to be asked was what was the consequence of this.</p> <p>vi. JA felt that this raised two issues, firstly the ventilation which may or may not be an issue, and the other was the focus on basic practise as with a 52% decolonisation rate for MRSA was not an acceptable standard, this was mirrored in VTE and in administration of prophylactic antibiotics. We needed to get the basics right and then look at other causes and he felt this should be addressed within the next two months. MS noted that she had discussed the position with the microbiologists and that we had seen a similar spike 10 years ago and it improved but it also was not addressed by a single approach, but the accumulation of all of the improvements in practice. JA noted that our staff had professional responsibilities to each undertake their role, but this was a culture that spread, and we needed to address that.</p> <p>Noted: The Board noted the Q&R Committee Chair's report. The key issues arising from this were the planned repeat of the review of surgical mortality audit which the Medical Director would be undertaking on a six-monthly basis reporting to Q&R, and the action to manage the elevated rates of SSI's where there was an action plan in place led by the Chief Nurse and which was reported to Q&R and Board on a monthly basis.</p>		

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3.ii	<p>Combined Quality Report Received: A report from the Chief Nurse and Medical Director which highlighted information in addition to the PIPR.</p> <p>Reported: By MS that in addition to the position highlighted on SSI's the report provided a note on the celebration for international nurses' day and information on 'dying matters' week activities.</p> <p>Noted: The Board noted the Combined Quality Report.</p>		
3.iii	<p>Health & Safety Annual Report 2022/23 Received: From the Chief Nurse the Health & Safety Annual Report 2022/23 and the key priorities for the Health and Safety Committee and its subcommittees for 2023/24.</p> <p>Reported: By MS that:</p> <ol style="list-style-type: none"> i. the report detailed the activities as required by Health & Safety at Work Act and that the key areas for improvement. It was recognised that the Trust needed to develop a better line of sight from Ward to Board. ii. That Health & Safety representatives had been trained and needed time to do this part of their role. iii. That the Health and Safety committee had reported into QRMG and it was felt that this should instead be on a par with QRMG reporting into a board subcommittee either Workforce or Quality and Risk. The report indicated key areas for improvement for all of the areas covered and these needed detailed action plans and would be overseen at the Health and Safety committee. This would need action across different areas and whilst we are compliant we needed to strengthen the governance around this. <p>Discussion</p> <ol style="list-style-type: none"> i. AF noted that this had been looked at the Workforce committee and commended MS and her team for the report. She agreed that assurance could be improved and that the proposed changes in governance were important next steps. ii. EM noted that as health and safety was wider than workforce matters her personal preference would be for this to report into the Q&R committee. iii. DL asked about the steps being taken to reduce sharps injuries and patient incidents against staff. MS noted that sharps incidents were reported through Occupational Health and IPC. Needlestick injuries were overseen more closely and this was one of the areas looked at as a risk in each department. We were developing more robust action plans in relation to this. It was also raised in environment rounds and matrons' quality rounds. The plan in relation to patient incidents on staff related mainly to STA and patients who had delirium, but there was also an issue of some unacceptable behaviours. We were reviewing the processes and policy on violence and aggression, but we needed to be mindful of what might lie behind this. There was a greater level of concern around how we addressed staff on staff incidents. iv. JA asked whether we used technology to reduce and design out of practice sharps incidents. MS noted that we did and that 		

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	<p>that approach needed some further oversight.</p> <p>Noted: The Board noted the Health & Safety Annual Report 2022/23.</p>		
3.iv	<p>Audit Committee Chair's Report</p> <p>Received and noted: The Board received and noted the Audit Committee Chair's report setting out significant issues of interest for the Board.</p> <p>Reported: By CC that the report provided a summary of the meeting held on the 23 May. This had:</p> <ul style="list-style-type: none"> i. Considered the approval of the accounts but the External Audit had not yet been completed on these. External and Internal Audit had both advised that they expected to issue a clean audit report. ii. Received the annual counter fraud report and she was pleased that all standards had been met. <p>Discussion:</p> <ul style="list-style-type: none"> i. JA noted the substantial assurance provided by the governance report in STA. CC advised that the committee had discussed this and there were issues in relation to the specification. Internal Audit had been asked to review the recommendations in relation to the report. TG advised that the terms of reference for this perhaps focused on the structure that was in place rather than the performance against this. <p>Noted: The Board noted the Audit Committee Chair's Report.</p>		
3.v	<p>Board Sub Committee Minutes:</p>		
	<p>Received and noted: The Board of Directors received and noted the minutes of Board sub-committees held on:</p> <ul style="list-style-type: none"> a. Quality & Risk: 27.04.23 b. Performance: 27.04.23 c. Workforce: 30.03.23 d. Audit: 09.03.23 <p>Noted: The Board noted the Board sub-committee minutes.</p>		
4	<p>PERFORMANCE</p>		
4.i	<p>Performance Committee Chair's report</p> <p>Received: The Chair's report setting out significant issues of interest for the Board.</p> <p>Reported: By DL that the Committee had considered the following key issues:</p> <ul style="list-style-type: none"> i. Activity recovery, and HM had given a comprehensive overview and assured the committee that there was a good structure in place to oversee this work. ii. PIPR, where the financial performance was red RAG rated, and TG had advised that the targets related to the new variable income mechanisms had not been met, and that the cash position had been impacted by the purchase of the thoracic robot. TG was looking at how we reported variances 		

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	<p>and the tolerance around the Trust's cash position.</p> <p>Discussion:</p> <ul style="list-style-type: none"> i. TG noted that the cash position would recover as indicated by DL, but the income position was directly related to activity recovery. <p>Noted: The Board noted the Performance Committee Chair's report.</p>		
4.ii	<p>Papworth Integrated Performance Report (PIPR)</p>		
	<p>Received: The PIPR report for Month 01 (April 2023) from the Executive Directors (EDs). This report had been considered at the Performance Committee and the Safe and Caring domains were discussed at Q&R Committee. The report was provided to the Board for information.</p> <p>Reported: By TG that overall Trust performance was at a Red rating. The report included changes in reporting in the effective and responsive domains introducing Statistical Process Control (SPC) charts, which had been a recommendation from the Well Led review undertaken in 2022. This was considered best practice and allowed the Board to look at trends in data over time, identifying statistically significant changes and those processes that were within control limits, and therefore expected to maintain their target. It had been agreed that these would be introduced in the effective and responsive domains in the first instance and this highlighted areas such as variation in cardiac mortality, which was under target and so historically would not have been flagged through RAG ratings. It was recognised that there would be a need for training, and this was being put in place for NEDs and Governors.</p> <p>Effective and Responsive: Reported by HM:</p> <ul style="list-style-type: none"> i. That the Trust was above plan in thoracic and ambulatory admitted care and below plan for non-admitted care. This primarily driven by the strike action which had affected 4 days within the month. We expected to be back on track in May. ii. The occupancy levels reflected high demand in April and we had seen a spike in acuity in mid-April indicated by the high levels of patients with longer length of stay and increases in occupancy of critical care beds. iii. We planned to optimise the in-house urgent pathway and our theatre utilisation had improved delivering 197 cases against a plan of 190. This had been delivered primarily by improvement in turnaround times. Of the 31 cancelled, 29 had been rescheduled in month and we had achieved an 88% utilisation rate against the 85% target. iv. Industrial action had also impacted on the Cath lab which had resulted in a loss of capacity. v. Cancer performance for the 31-day target was at 96% and our 62-day target was at 62%. We had 6 breaches of the 104-day which had been referred beyond the 62-day target. vi. We had 15 patients waiting more than 52 weeks and nine of these patients had not been rescheduled because of patient choice. vii. We were focused on the reduction in the IHU delays where we 		

Agenda Item		Action by Whom	Date
	<p>had reduced the number waiting from 48 to 36 and around 62% of these were treated within 10 days of referral. We were doing a lot of work to manage this with partners to improve the quality of referrals and this had a benefit across our system.</p> <p>Discussion:</p> <ul style="list-style-type: none"> i. MB thanked TG for the introduction of SPC charts noting that these were very welcome and gave a much quicker view of common cause variations. He noted that there were some issues with their use, noting that if the surgical mortality data capture had been extended for the prior six months then it would have captured the earlier lower rate of 1.7% rather than the elevated baseline of around 2.4%. He felt that this could therefore miss some special case variation as the baseline was set in a period of elevated mortality. HM noted that this had been used as an example at committee and that he would review the baseline to ensure that we did not use a negative special cause variation as the baseline. JA noted that this should also be referred to as a ceiling rather than a target mortality rate. <p>Noted: The Board noted the PIPR report for Month 01 (April 2023).</p>	HM	09/23
5	STRATEGIC DEVELOPMENTS		
5.i	<p>Clinical Education Strategy 2021-2026 (review)</p> <p>Received: From the Chief Nurse an update on the Clinical Education Strategy.</p> <p>Reported: By MS that the update was brought to the Board for information and it set out the work being undertaken. There was a workshop being held on the development strategy for the Royal Papworth School and the output from this would be taken to the SPC in June.</p> <p>Discussion</p> <ul style="list-style-type: none"> i. IW asked about the delivery of the RPH school strategy. MS advertised that the workshop would look at ambitions and options which had been under discussion for some time. ii. IW asked if this was a discussion around places to enable the trust to grow its own staff and offer out places in areas such as Cardiac Physiology and also to increase the supply side in shortage areas such as perfusionists. JW noted this was to allow a review of the concept around the school and noted that we already had interactions with ARU in relation to the national discussions on cardiology and perfusionists. We would not be able to affect that individually as a hospital but would help and contribute as a part of the wider training systems. iii. MS noted that we realised that whilst we could deliver the operational education function, we do not have the capacity to undertake the whole strategic assessment as we were not set up to deliver this. We do engage with ARU and worked with them on specialised courses, but there was a huge requirement to write and develop content with these courses. IW asked if this work fell on MS and her education team and whether this was a significant burden and whether we should 		

Agenda Item		Action by Whom	Date
	<p>take on a new person to drive this forward with the appropriate capacity and resources. MS noted this was a part of the strategic discussion that would be brought back to the Board.</p> <p>iv. JA noted that this was a part of the discussion planned within SPC as the Trust needed to understand the resources, the direction of travel and it wanted to have outlined the ambitions and associated challenges with delivery of the school. This was a strategic issue and needed a strategic solution to be identified. MS noted that we also needed to consider collaboration with CUH, she had worked well with them previously and they had employed staff to develop and write programmes and then worked with ARU to deliver the courses.</p> <p>Noted: The Board noted the update on the Clinical Education Strategy.</p>		
5.ii	<p>ICB Forward Plan Received: The ICB Forward Plan</p> <p>Reported: By HM that:</p> <ul style="list-style-type: none"> i. The ICB Forward Plan was being shared with colleagues to ensure that they were sighted on the key system priorities. RPH was well aligned to system in terms of plans, outcomes, experience, and the link to wider social care. ii. RPH held an important role as an anchor organisation within the system. iii. That the plan was 'work in progress' and figure 1 was the system priority wall and we would review this against our own priorities. The key areas for the Trust would be the focus on the basics – improving performance against core standards which included the 62-day target and RTT performance and would be supported by our programmes in planned care and theatre productivity and optimisation of day case activity. <p>Discussion</p> <ul style="list-style-type: none"> i. DL Asked about the key deliverables and the dates that were associated with these. EM advised that this was a forward plan looking over the next 2/3 year period and about the associated dates had been reflected in the operational plan. A separate piece of work would be undertaken around the timeline for other metrics to be met. ii. AF asked about the governance of the plan and how we should challenge and assure ourselves that the effort that we make is being reciprocated and that there were shared responsibilities and that partners were as responsive as we needed them to be. EM advertised that this was exercised through the members of the ICB and she and other providers had fed in concern and challenge to their discussions. She noted that she was on the ICB board as a representative of provider trusts, but this meant that she was able to influence at this level. iii. AF welcomed all presence on the ICB Board but felt we needed assurance around transparency and accountability and had some concerns that we were not yet seeing the impact in the first year of their operation. iv. JA noted that the transparency issue had been raised with TG in relation to the sharing of data on financial submissions, and 		

Agenda Item		Action by Whom	Date
	<p>that if data was not shared then we would be continuing to work in silos. He also asked if there was a plan for the ICB to identify and work on three key issues. EM advised that this was a discussion at the ICB as they had a raft of metrics, and it was difficult to see how these would each be delivered. The ICB board development that was planned would focus on key priority areas and local delivery plans were being developed around the North and South places.</p> <p>v. JW noted his concern that the wording ‘reducing inequalities deaths in the under 75’s’ had not been addressed as he felt this should apply to all ages.</p> <p>vi. IW noted the differential in performance between the North & South places and that we would not address these differentials unless we were ‘leaning in’ as a whole system.</p> <p>Agreed: The Board agreed to support the ICB Forward Plan and associated Delivery Plans</p>		
6	BOARD FORWARD AGENDA		
6.i	<p>Board Forward Planner</p> <p>Received and Noted: The Board Forward Planner.</p>		
6.ii	Items for escalation or referral to Committee		
7	Any other business		

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Signed

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Date

Royal Papworth Hospital NHS Foundation Trust
Board of Directors
Meeting held on 1 June 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	Patient Reported Outcome Measure : assesses the quality of care delivered to NHS patients from the patient perspective.
RCA	Root Cause Analysis 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