Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Held on 7 July 2023 at 9:00am
Microsoft Teams
HRLI, Royal Papworth Hospital

UNCONFIRMED M I N U T E S – Part I

Present	Prof J Wallwork	(JW)	Chairman
	Dr J Ahluwalia	(JA)	Non-Executive Director
	Mr M Blastland	(MB)	Non-Executive Director
	Ms C Conquest	(CC)	Non-Executive Director
	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
	Ms O Monkhouse	(OM)	Director of Workforce and OD
	Mr A Raynes	(AR)	Chief Information Officer & SIRO
	Mr G Robert	(GR)	Non-Executive Director
	Mrs M Screaton	(MS)	Chief Nurse
	Prof I Smith	(IS)	Medical Director
	Prof I Wilkinson	(IW)	Non-Executive Director
In Attendance	Mrs A Colling	(AC)	Executive Assistant
	Mr S Edwards	(SE)	Head of Communications
	Mr E Gorman	(EG)	Deputy Director of Digital
	Nicky Ward	(NW)	ICS observer (EM mentoring)
Apologies	Mrs A Jarvis	(AJ)	Trust Secretary
	Mr A Raynes	(AR)	Chief Information Officer & SIRO
Governor Observers	Trevor Collins, Marlene Hotchkiss, Harvey Perkins		

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1	**WELCOME, APOLOGIES AND OPENING REMARKS**		
	The Chairman welcomed everyone to the meeting and apologies were noted as above.		
1.i	**Declarations of interest**		
	There is a requirement that Board members raise any specific declarations if these arise during discussions. No specific conflicts		

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	were identified in relation to matters on the agenda. A summary of standing declarations of interests is appended to these minutes.		
1.ii	**Minutes of the previous meeting**		
	Board of Directors Part I: 01 June 2023 **Approved**: The Board of Directors approved the Minutes of the Part I meeting held on 01 June 2023 as a true record.		
1.iii	**Matters arising and action checklist**		
	Noted: CC noted that a number of the actions on the checklist still had dates 'TBC' and that one of these was now over a year old. **Agreed:** That the outstanding items either needed to have a date confirmed or a reason provided for the delay should be provided to the Board in September.	EDs/AJ	09/23
1.iv	**Chairman's report**		
	The Chairman noted that it had been a busy month and yesterday we had celebrated the 75th anniversary of the NHS and our celebrations had included the unveiling of the replica TB hut outside the hospital. It had also seen the installation of the 347th Vice Chancellor of the University of Cambridge. He had attended the Chair's and CEO's meeting in Newmarket and that had included useful discussions. The Trust had seen it's Windrush celebration and the Race Equality network launch and we had held our Council of Governors meeting in June. He had also visited the of Academy of Urbanism.		
1.v	**Board Assurance Framework**		
	Received: From the Trust Secretary the BAF report setting out: i. BAF risks against strategic objectives ii. BAF risks above appetite and target risk rating iii. The Board BAF tracker. **Reported:** By OM: i. That Industrial Action continued to be an extreme risk. ii. That the continuity of supply risk had increased to RRR12 following discussion at the Performance Committee. iii. That the deterioration in the ICS financial balance risk mirrored the deterioration in position across NHS and would be reviewed at the next meeting. **Discussion:** TG noted he would give an update on the ICS financial position in the Part II meeting, and this was subject to continued review. **Noted:** The Board noted the BAF report for Month 2, May 2023.		
1.vi	**CEO's update**		
	Received: The Chief Executive's update setting out key issues for the Board and progress being made in delivery of the Trusts strategic objectives. The report was taken as read.		

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	Reported: By EM that: i. The CEO report had been omitted from the pack and this would be circulated after the meeting. ii. It had been an interesting month and we had spent time teambuilding time as executive team. This was investing in ourselves and in development and modelled the right behaviours for our teams. There had now been two sessions and we were planning to carry this forward on regular basis. iii. Further industrial action was coming up including a five days of action by junior doctors closely followed by industrial action by consultant staff. There was detailed work underway to look at gaps and cover arrangements. This would be challenging, and the lack of consultant cover was a concern across the organisation. HM led the IA task force and was finalising plans. iv. Operational performance was good in month, and we were seeing green shoots of recovery on RTT performance. Less good was IHU, where the disruption of industrial action had placed a constraint on theatre capacity. Delays in diagnostics at referring hospital also added to the constraints and we were looking at how we could move these patients forward. v. We had seen an increase in 52-week breaches, and patients were being managed in order of clinical priority. vi. We had a successful recruitment day on 17 June. She thanked all the staff who had taken part in this and joined in on site to support the day. vii. The NHS 75 celebrations had been a very positive day at the hospital and at the house. She noted in particular Denise Bullocks' efforts at the house, with fantastic coordination from her. The TB hut opening had seen local school children attend the ceremony and both schools were grateful of opportunity to come on site. We would be looking to have further visits from them. viii. On the 22 June we launched our renamed Race Equality Network and a celebration of Windrush day and there was great attendance for both events. ix. We had been sharing our knowledge throughout Europe with Trust staff attending the European Cystic Fibrosis conference in Vienna, the World Sarcoidosis Conference in Stockholm, and in the first-ever UK ECPR summit, held in London, which our critical care team attended discussing the role of ECMO in Cardio Pulmonary Resuscitation. x. For SSI's we were not there yet but were seeing green shoots in the May data. We had welcomed teams from NHSE and ICB for 2 days in June. There were no significant findings from their reviews, and we would receive their formal report in due course. She thanked all who supported the visit. xi. The financial position was a surplus of £0.4m at this time. There were some challenges in ICS, as the position was not as positive across all organisations. xii. We had submitted our Information Governance Toolkit and had pushed hard to reach target and were compliant on all required assurances at the submission date. xiii. We had gone live on our new recruitment system, Oleeo and training was underway for relevant staff. xiv. There has been press coverage of the lung cancer screening	EM	07/23

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	programme which had been launched and she was pleased to support this along with colleagues from Liverpool. **Discussion:** i. AF asked about harm reviews for our 52-week waiters noting that the Board needed assurance on how harm reviews for patients on the waiting list were managed. EM advised that we had a long-standing process and policy on harm reviews and these had been recently revised. HM confirmed that patients waiting more than 45-weeks receive a review and we intervene if a change in priority status is indicated, and this information was shared at 6:4:2 meetings. Patients wating over 52 weeks have a harm review and were reported to ICS. AF asked if there was learning from our internal review processes. HM noted that: • There were delays in referrals from secondary care that were external to us, and we were looking at what we could do in response to these. • We were considering frontloading diagnostic elements of pathways to improve how we managed referrals once received. • We were looking again at the application of our policy on patient choice as this was not aligned to practice. Some of our complex patients faced very major decisions and may defer on several occasions but we would not automatically send these back to a referrer. ii. CC asked why patients would defer. HM noted that we were working with DoctorDr to review and understand trends, but these had included things such as attending weddings and holidays. This was work in progress and he agreed to bring a summary on themes to Performance Committee and Board. iii. JW asked whether the strike action affects our In-House Urgent pathways. EM advised that the next strikes would work to Christmas day operating levels and that would mean there would be on IHU activity on that day. **Noted:** The Board noted the CEO's update report.	HM	09/23
1.vii	**Patient Story**		
	MS introduced the patient story. This was presented by Sharon Loveday, Ward Sister, RSSC, 3 North. SL noted that the patient had agreed to share their story with the Board. The patient was transferred to RPH from a regional DGH on the 15 May 2023. He had been admitted to the DGH having collapsed with a cardiac arrest whilst having a routine outpatient MRI scan for investigations of his prostate cancer. He was successfully resuscitated and transferred to their Critical Care Unit where he had a further cardiac arrest that same evening. It was found that he had had a NSTEMI heart attack. The patient had a history of lung disease and was known to have a stable aortic aneurysm, he reported that he was otherwise well and played golf several times a week although was having to use a golf buggy due to increasing breathlessness. He also loved gardening.		

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	He had spent several weeks in critical care with his stay being complicated with an osteomyelitis of the sternum, as a result of the resuscitation, as well as episodes of delirium. The DGH had attempted to take him off the ventilator on several occasions but this failed. At this point he was referred to the RSSC for weaning. The RSSC receives referrals from critical care units around the region for our expertise and skills in weaning patients from invasive ventilation. The majority of patients referred are those with lung disease or neuromuscular problems. He was referred as having a diagnosis of COPD, but there was no significant reference to his on-going heart failure which would have been a contraindication for acceptance for weaning. On arrival he was transferred onto a ventilator and investigations showed he had signs of heart failure which needed further treatment before weaning could be attempted. He was referred to RPH cardiology colleagues for review and was found to be in heart block so underwent the insertion of a pacemaker. Over the next few weeks, he gradually improved, although whilst trying to wean, he still required high flow oxygen to maintain his oxygen saturation levels. On the 1 June he experienced acute chest pain and was transferred to CCA where an angiogram showed severe triple vessel disease. Unfortunately, he was deemed not suitable for surgical intervention and transferred back to the RSSC. Over the next 3 weeks he was gradually weaned and eventually he was able to have his tracheostomy removed. He was still receiving high flow oxygen, but this was gradually being reduced and we were in the process of discharge planning. SL met with the patient and his wife to ask him about his time at RPH and to hear what he thought were the positives and negatives of his experience. Both he and his wife praised the RSSC team saying how they felt safe, as all the staff, without exception, were knowledgeable and gave them confidence in what we were doing. He noted that 'you work as team a good team, everyone is always happy and smiling'. His wife noted she was always kept informed and that she appreciated staff calling her on the day he was transferred to reassure her that he had arrived and had settled on the ward. The worst thing was when he first arrived. He could not communicate and felt that staff were not listening to him, although he shared that 'they were trying to set me up on the breathing machine, but they reassured me once it was working'. He said all the staff kept him informed and always explained things to him in a language he could understand. He was always treated with dignity, and knew which nurse was looking after him most of the time. He said he didn't know if the ward was a restful environment, but he was in the 'best room'; next to the nurses station, so there was always lots of activity which he liked and that 'everyone, without exception, would come in and say hello to me which was great as I like company'. He didn't sleep well but that was nothing to do with the		

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	environment as he was a poor sleeper. He praised the food, although was not complementary about the pureed diet the Speech and Language Therapy team had instructed him to have when he first started eating. He noted it wasn't the taste, but the consistency of the pureed food. Once on a normal diet he loved the cooked breakfasts. He noted that the ward was kept clean. He ended the conversation saying he had never been in hospital before and that 'it has been a life changing experience and a world where you are out of your comfort zone'. He said he could not have had better care and felt secure in a team that knew what they were doing and were sympathetic to what he and his wife were experiencing. He was looking forward to going home but at the same time anxious about leaving the safety of the hospital. When asked what he was looking forward to most he noted it was, 'checking that the person who has been mowing his lawn has kept up with the stripes!!' This patient was possibly not an appropriate referral for weaning as his main problem was oxygenation rather than ventilation due to his heart failure, but working in collaboration with our Cardiology colleagues, he had a successful outcome, and we felt privileged to have provided his care and to be discharging him home to his family. SL had noted his concerns about not being listened to when he was first admitted, and SL would discuss these with the team. When patients who are on life support, arrive on the ward our priority is to transfer them safely from the portable transfer ventilator to the ward ventilator and she acknowledge that during this period we may not always communicate or listen to patients as effectively as we should. The best way to approach this would be to ensure one nurse was with them and listening to the patient during the transfer period as that would offer them the reassurance needed. Another point of note was that he did not always know which nurse was looking after him. He said everyone always introduced themselves, but his nurse did not always write their name on the board in his room. This was shared with the team and would be monitored. SL explained the specialised area where he was being cared for. This had three HDU beds and was where we managed critical care patients who were not able to come off life support. They were referred into the RSSC team to try and get them off ventilator. They also support patients who need help with breathing at night. The term 'weaning' referred to a patient coming off the life support ventilator. **Discussion:** i. JA asked about the appropriateness of the referral and the system for feeding back to referring hospital about the quality of triage/referrals. SL advised that RPH consultants speak to the consultants at referring Trusts and although it had not been an appropriate weaning patient, he was successfully managed and had a good outcome. IS noted that diagnoses were often uncertain with some 80% of patients being referred with COPD and 40% leaving us with a COPD diagnosis. In DGHs they		

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	would not necessarily know exactly what was wrong with a patient as these were rare events, and he felt that the referral had been helpful in that circumstance. ii. JA and JW noted the importance of feedback and education across systems. IS advised that we worked with referring Trust's and would provide feedback, but we needed to recognise that their clinical staff might see these cases very infrequently and at RPH we see many rare episodes as we were a specialist hospital and so there were limitations on the opportunity to upskill staff across all settings. SL noted that this was also an opportunity to look at a patient with fresh eyes where they had been in another CCA for many months. iii. IS noted that this patient was also fairly deaf and so the fact that our staff could communicate with him was a huge benefit. iv. AF asked if SL took patient stories regularly or if she had taken this story as she was presenting at Board. SL noted that as a Ward Sister she did not generally take patient stories, our Matrons took these once a month and there were set questions to ask patients. She did see and talk to all patients on her ward once a week, but these were not structured patient stories. v. IW asked why we do not take HF patients into RSSC, as this would be the majority and asked if this should this be re-considered. IS noted that we take patients with ventilatory failure as a specialised service and that was valued by referring providers. In general, management of cardiac failure and low oxygenation would be undertaken in intensive care units. The patients that we accept were complex ventricular cases and would have other co-morbidities. This was a cardiac cause as weaning was triggering angina and how this patient was dealt with was appropriate. **Noted:** The Board thanked SL and noted the patient story.		
2	**PEOPLE**		
2.i	**Director of Workforce Report** **Received:** The Director of Workforce and OD a paper setting out key workforce issues. **Reported:** By OM that: i. The Windrush event had been inspiring linking the past to the present, and to our future and our Race Equality network had met yesterday which was well attended and she thanked Onika Patrick-Redhead for organising that. ii. Nationally there had been an update on NHS national Futures Programmes. This had been in progress for 2 years and was now reaching outputs. This would improve standards in HR practice and processes driven by digitisation, standardisation, and the development of future roles and services by ICBs. The funding for this needed to be considered nationally. This would provide the building blocks for progressing HR through digital services. We would bring further information on this as the programme progressed and this will be reported through the Workforce Committee. iii. The Chair's appointment process was in progress and CC would be chairing the appointment panel. Shortlisting was taking place today and interviews were to be held on 18 July.		

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	The process was working to time, and we were working with the Council of Governors on the appointment. **Discussion** i. DL noted that the Futures Programme sounded interesting and was curious that it was optional to engage with this. She was keen for us to see how this could be used within RPH. OM noted that we would look to implement the best from the programme and there were discussions progressing at system level around this. ii. CC asked if we could identify and prioritise the different initiatives in the Futures Programme and report against these. She also wanted to understand how we could ensure that our values as an organisation were included at the top of ICS requirements. OM advised that we were active participants in ICS discussions and there would be good points to draw on from this work programme. We wanted to achieve good practice and expertise. iii. JA noted that if the programme were optional, then we also need to make sure we delivered on our plans and could engage with this as required. AF agreed that it was helpful for us to learn from others, but we needed to stay true to our plan. iv. AF had watched the Windrush event and felt it was very good. She noted that OM was an excellent speaker and had shared her learning and experience of bringing about change. CC agreed noting that she was very proud of what the Trust had achieved and that she congratulated OM and OPR. CC asked if we could share the second part of the programme on line. v. CC asked about the Chair's appointment and how that process had gone so far? OM advised that the early stages of planning were challenging as we had not done this for many years. NHSE guidance was opaque and not entirely joined up across the historic and new code of governance. Our Governors and the Board had worked through this to stay true to guidance. Odgers had been helpful and had provided advice to the Trust and their expertise had been welcomed. OM noted that the role had interest from diverse range of backgrounds. The designate lead and lead governor were happy with process and engagement, and our Governors were aware of the responsibility to deliver a good and fair process. CC felt that the support provided to the process had been good. **Agreed:** The Board noted the update from the DWOD.	OM	09/23
3	**GOVERNANCE**		
3.i	**Q&R Committee Chair's Report** **Received:** The Q&R Committee Chair's report setting out significant issues of interest for the Board. **Reported:** By MB that: i. SSIs numbers were sharply down but there was no complacency about this position, and we continued to work on the areas identified through the whole process of review. Some aspects of behaviours would be discussed further on the Part II agenda. ii. We had received a paper on cardiac surgical mortality. This		

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	was a useful exercise and was reassuring to a point . He noted that after adjusting for acuity, at points mortality had increased by 50% following the move. This could be an effect of COVID, and the same pattern was seen across the wider NHS. This still represented an increase towards a 3% mortality rate and whatever the reason, we needed to do our best to understand it. Given this pattern was being seen at a national level it may be to do with delays in treatment. He felt it would be a useful exercise for mortality data to form part of harm reviews as we needed to understand the numbers as a statistical exercise. He was pleased that IS had commissioned this work and was keen to see this data reported in PIPR. **Discussion** i. JW noted that mortality as measure of outcome was difficult in the area of high-risk surgery and our mortality rate would be below what was expected at other Trusts, but it would be useful to compare results. MB noted that our surgeons were performing better than predicted by the risk scores and that we were reassured that our surgeons were doing their job well. JW noted that Mr Nashef had written an earlier report on the number of deaths on the waiting list which identified that historically these were greater than deaths following surgery. ii. DL asked about local audits and whether there was more information on how these were working and whether follow up audits were planned and what the process was to know we were improving. MB noted that this was discussed at Committee, and we would be having a follow up report to Q&R to keep this under review. MS noted that we had re-established our audit schedule post COVID, and this was overseen by the Quality & Risk Management Group. iii. JA echoed MB's thanks to IS. He noted that mortality represented a small fraction of the overall burden on our patients and asked if we routinely looked at longer term outcomes on transplant patients following surgery, informed by how long they had waited for surgery. IS noted that this extended beyond transplant, and that Mr Nashef was working on this through the QUACS study (Quality of life After Cardiac Surgery). This would be enormously valuable in deciding who should be operated on. This would look at how people were impacted by the wait for surgery. Euroscore helped with this looking at risks and how a patient had deteriorated whilst on the waiting list and deterioration in comorbidities. The virtual ward process would also see if we could intervene more actively with waiting patients to help with management of their diabetes and other conditions to improve their overall health status whilst waiting. iv. JA asked if given the ageing patient population whether we had gerontology or other assessment process for assessing these older patients? JW noted that this was work in progress and that we would progress with further analysis in this area. v. CC asked if a patient was deferring an appointment, did we explain that by deferring could cause them deteriorating health issue. HM advised that this was outlined to patients. Our access policy currently suggested that we refer patients back		

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	where they had initiated two cancellations, but this was not necessarily appropriate for our patients. He reminded the Board that we needed to remember the whole pathway and the total length of wait before they reached RPH. **Noted:** The Board noted the Q&R Committee Chair's report		
3.ii	**Combined Quality Report** **Received**: A report from the Chief Nurse and Medical Director which highlighted information in addition to the PIPR. **Reported:** By MS that the report provided. i. The data on Surgical Site Infection where we had seen some green shoots in the May data with reduced numbers and superficial infections. We were awaiting June data and that was also looking positive. The quarterly update would be provided to the next Q&R Committee. The formal report from the NHSE and ICB visit was due early next week. ii. We had celebrated Learning Disability Awareness Week which was reported along with key learnings. iii. We had also confirmed our Head of Nursing appointments with Lisa Steadman taking up the post in Thoracic Medicine and Judith Machiwenyika taking up the role in Surgery, Transplant and Anaesthetics. **Discussion:** i. CC asked if there were posters up in theatres providing basic guidance and reminders on SSIs. MS advised that we would not use posters but were using education in practice in theatres. There were clear demarcation lines on the theatre floor and work was ongoing to review footfall in theatres which had seen an improvement, but there was still work to do. ii. DL asked about the dashboard information on surgical instruments and whether the figure of 11 was good, as there was no comparative data. She also asked for an update on the decontamination sub group. MS noted we had started monitoring this 6-8 months ago and this identified a number of issues in different areas and MS explained these. There were fortnightly meetings to review progress and good improvements were being seen. **Noted:** The Board noted the Combined Quality Report.		
3.iii	**Board Sub Committee Minutes:**		
	Received and noted: The Board of Directors received and noted the minutes of Board sub-committees held on: a. Quality & Risk: 25.05.23 b. Performance: 25.05.23 c. Audit:.23.05.23 **Noted:** The Board noted the Board sub-committee minutes.		
4	**PERFORMANCE**		
4.i	**Performance Committee Chair's report** **Received:** The Chair's report setting out significant issues of interest		

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	for the Board. **Reported:** By GR that the Committee had considered the following key issues: i. The BAF risk relating to consumables and the longer terms solutions which PWC had been commissioned to review and we would look at in August. ii. Productivity where we had seen an uptick in May's data and expected the June position to be even stronger. May had seen targets artificially deflated as these were based on 2019/20 activity which was at the time of the hospital move but there was an underlying improvement in activity which seemed to be direct result of actions taken in STA and more broadly. iii. How reports into committee, such as PIPR, elective activity, data quality might be rationalised to provide one consistent set of reports and he would be working with HM on this. This should improve how we were able to scrutinise matters. iv. 52-week breaches and cancer waiting times and how these may be attributed to delays in referrals, but also how we could shorten turnaround time when patients arrive. We were also meeting our diagnostic targets. v. Looked at the letter on elective care priorities and our response and the tracking of priorities. vi. We reviewed the medium-term financial plan and that was on the Part II agenda for discussion. **Discussion:** **i.** JW asked about the cancer waiting time breaches and how many patients that involved? HM advised that four patients had waited greater than 62 days. We would always strive to reduce these waits and were keen to make the most of the facilities we have to help these patients to get through diagnostics quicker. **Noted:** The Board noted the Performance Committee Chair's report.		
4.ii	**Papworth Integrated Performance Report (PIPR)**		
	Received: The PIPR report for Month 02 (May 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 and was provided to the Board for information. **Reported:** By TG that: i. Overall, Trust performance was at a Red rating. ii. The following amendments had been made to the report on the public website: • The Finance tracking wheel on page four should be red not amber in the prior month. • The RRR on BAF3009 should be at 12 • The narrative on RTT breaches, should read that 3 breaches were as a result of internal delays and MDT review. • The header slide on page 23 should read Sickness Absence Trends		

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	• The total debt position should read £3.98m and the percentage over 90 days 22.9%. He apologised that these updates had not been included in the circulated pack. iii. Some areas had seen green shoots and it was important to consider that in the national context. Industrial action had affected activity levels across NHS with many trusts seeing reductions in activity whereas we had seen an increase, albeit against the lower 2019/20 targets as mentioned by GR. iv. The improvement in SSI rates had been discussed and VTE compliance was the highest it had been in some time. v. Finance had moved from red to amber in month and we were posting a small surplus. vi. We were a positive outlier in the ICS and nationally and were continually pushing to improve performance in all areas. **Discussion:** i. JW asked if there were any matters that had not been covered in the report. GR noted that industrial action would extend into July and so we expected a downturn in activity. ii. JW asked if we should consider reporting 3 monthly or monthly. TG advised that monthly reporting was best practice and should continue. iii. GR noted that our performance was strong despite strikes and asked if this was due to better management of activity during IA or whether, IA affects us less acutely or was the result of all the good work and focus we'd had on productivity. HM advised it was a blend of all three. He explained how we differ as a specialist trust than acute trusts on emergency activity and elective pathways. We had also seen fewer colleagues taking IA action than other trusts. July would be difficult as we would see 8 days of IA and Consultants could not be backfilled. IS observed that from a medic's point of view, the backfill cover had been excellent and had allowed activity to continue; outpatients had also performed well during IA. iv. AF reflected on our learning from COVID and now from IA and asked how when looking back at performance and activity, we could capture learning and activity during this time as this would have an impact on practice going forward. HM advised that a part of the EPRR responsibilities was a formal write up of all actions and learning. We would need to take time to reflect and review this as a Board as was done with COVID. Working through COVID had set us up to deal well with IA issues. OM advised that some of our managers were doing MBA dissertations on the impact of IA on staff and on decision making and these would be interesting to see. v. GR asked if we had we reached the moment to look back at Covid learnings? EM noted that this had been done at two points during pandemic. These exercises had taken feedback from staff on how they were managed, as well as reflections on decision making and we should do similar exercise with IA. vi. HM noted that the learning we take from these event is vital and that it would be useful to trend the current data into the future. JA observed that the answer may not always be in data and trend, and that conversations with staff were important also.	HM	10/23

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	vii. JA asked about the number of juniors and fellows at RPH and whether we had fewer here than compared to other hospitals and if so whether we needed to think about this in the context of job planning conversations and how these consider IA. viii. JA noted the SPC charts for 52-week breaches had not hit target line since Feb 20 and indicated concern, yet the forecast says we might achieve this. HM advised that it was difficult as the target on 52-week breaches was zero. He would take this away to see how this could be better demonstrated. EM advised that we had not had an issue on 52-week breaches historically. HM noted the national context around 52-week breaches and that we were receiving patients much later in the pathway. **Noted:** The Board noted the PIPR report for Month 02 (May 2023).	HM	09/23
4.iii	**Elective Care 2023/24 Priorities**		
	Received: From the Chief Operating Officer a summary of the plans to deliver elective and cancer recovery to address the Elective Care 2023/24 Priorities set out in the letter from NHSE. **Reported:** By HM that: i. A deep dive had been undertaken and an assurance statement had been prepared for noting by the Board. ii. Reporting against the priorities and plans would be worked in to PIPR reporting structure going forward. **Noted:** The Board noted the Trust's response to the letter and checklist from NHSE setting out the Elective Care 2023/24 Priorities.		
5	**RESEARCH & EDUCATION**		
5.i	**Research & Education Update** **Received:** A verbal update from the Medical Director setting out key issues. **Reported:** By IS that: i. The Trust had secured a £550k grant for a Xeon polariser. He explained to the Board how this was used in imaging. We had also secured £145k funding for other equipment for the Clinical Research Facility. ii. The bid for the total body PET scanner was continuing. We were still in the running, but no final decision had been made. iii. We were in the middle of the process to appoint the Director of the HLRI. We had four applications and there was a strong field. Interviews were being scheduled and he would keep the Board updated. **Discussion** i. CC asked IS to provide the feedback on governance that was included in the action checklist. IS advised this would be brough to the Board in September. ii. JW noted that patients were now moving through CRF, and one room was being used for robot training**.** **Agreed:** The Board noted the update from on Research & Education.	IS	09/23

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6	**BOARD FORWARD AGENDA**		
6.i	**Board Forward Planner** JW noted that the August Board date had been kept on hold in diaries, but we did not expect to meet again formally until September 2023. It was noted that the IG training session would be rearranged. **Received and Noted:** The Board Forward Planner.	AR/AJ	09/23
6.ii	**Items for escalation or referral to Committee**		

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Signed

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Date

Royal Papworth Hospital NHS Foundation Trust
Board of Directors
Meeting held on 06 July 2023

Glossary of terms

CIP	Cost Improvement Programme
C&P ICS	Cambridge & Peterborough ICS
CUFHT	Cambridge University Hospitals NHS Foundation Trust
CRF	Clinical Research Facility
CRN	Clinical Research Network
CUHP	Cambridge University Health Partners
DGH	District General Hospital
GIRFT	'Getting It Right First Time'
HLRI	Heart and Lung Research Institute
ICB	Integrated Care Board(of the ICS)
ICS	Integrated Care System
IHU	In House Urgent
IPPC	Infection Protection, Prevention and Control
IPR	Individual Performance Review
KPIs	Key Performance Indicators
LDE	Lorenzo Digital Exemplar
NED	Non-Executive Director
NIHR	National Institute for Health and Care Research
NHSE/I	NHS England/Improvement
NSTEMI	Non-ST elevation MIs
NWAFT	North West Anglia NHS Foundation Trust
PET CT	Positron emission tomography–computed tomography - a type of scanning of organs and tissue
PIPR	Papworth Integrated Performance Report
PPCI	Primary Percutaneous Coronary Intervention
PROM	**P**atient **R**eported **O**utcome **M**easure: assesses the quality of care delivered to NHS patients from the patient perspective.
RCA	**R**oot **C**ause **A**nalysis is a structured approach to identify the factors that have resulted in an accident, incident or near-miss in order to examine what behaviours, actions, inactions, or conditions need to change, if any, to prevent a recurrence of a similar outcome. Action plans following RCAs are disseminated to the relevant managers.
RTT	Referral to Treatment Target
SIs	Serious Incidents
SIP	Service Improvement Programme
SOF	NHS **S**ystem **O**versight **F**ramework (Graded 1-4)
STP	Cambridgeshire and Peterborough **S**ustainability & **T**ransformation **P**artnership
VTE	Venous thromboembolism
Wards	Level Three: L3S (South) and L3N (North) Level Four: L4S and L4N Level Five: L5S and L5N CCU Critical Care Unit
WTE	Whole Time Equivalent