

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

UNCONFIRMED

MINUTES – 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
	Mrs E Midlane	(EM)	Chief Executive Officer
	Ms O Monkhouse	(OM)	Director of Workforce and OD
	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	Laura Buckingham	(LB)	Deputy Sister/Deputy Charge Nurse, Surgery
	Mr S Edwards	(SE)	Head of Communications
	Mrs A Jarvis	(AJ)	Trust Secretary
Apologies	Mr H McEnroe	(HM)	Chief Operating Officer
	Mr G Robert	(GR)	Non-Executive Director
Observers	Susan Bullivant, Trevor Collins, Richard Hodder, Rhys Hurst, Trevor McLeese, Harvey Perkins,		

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: 6 July 2023</p> <p>Approved: The Board of Directors approved the Minutes of the Part I meeting held on 6 July 2023 as a true record.</p>		
1.iii	Matters arising and action checklist		
	Noted: The Board received and noted the updates on the action checklist.		
1.iv	Chairman's report		
	<p>The Chairman advised that much had happened in the last two months and as improvements in productivity were starting to be seen we had been hit by industrial action. He noted that we were working to maintain services for our patients throughout this action.</p> <p>He congratulated Dr Jag Ahluwalia who had been appointed as Chair of the Trust and would take over this role on the 1 February 2024.</p> <p>He noted:</p> <ul style="list-style-type: none"> i. That he had attended the CUHP Board meeting in July and had attended the Integrated Care Board meeting. The ICB Strategy Board had also met and was seeing more progress. ii. That Professor Charlotte Summers had been appointed Director of the Heart and Lung Research Institute. iii. That he had joined the Reciprocal Mentoring programme meeting and the site visit by the national new hospital team. iv. This was the last Board meeting for Dr Richard Hodder in his role as lead governor, a position which he had held for six years, and he thanked Richard on behalf of the Board. v. The publication of the NHSE framework on the Fit and Proper Persons Test for board members and noted that this would be covered later on the agenda. 		
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 that the key risks related to industrial action, and the impact that had on productivity and waiting list management. Also, the change in the calculation relating to the safer staffing metric in PIPR had been captured as a change in the BAF. Actions mitigating key risks would be covered in reports on today's agenda.</p> <p>Discussion:</p> <ul style="list-style-type: none"> i. JW noted that we had been looking to do as much as was possible to mitigate the impact of industrial action, but this was having a significant impact on the Trust. <p>Noted: The Board noted the BAF report for August 2023.</p>		
1.vi	CEO's update		

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	<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. That she echoed the Chair's congratulations to Dr Jag Ahluwalia & Prof Charlotte Summers, and his thanks to Dr Richard Hodder for his years of service to the organisation. ii. Her report covered the anniversary of her appointment as Chief Executive Officer and this had been an incredibly productive and challenging 12 months for the Trust and for the NHS. iii. She had attended a national meeting where the pressures facing the NHS were considered. The NHS was challenged by the elective backlog, winter pressures, finances, industrial action, the ramifications of the Lucy Letby case, and the concerns relating to RAAC concrete. The meeting had also noted that the NHS delivers some 1.6 million treatments every day to the UK of some 57 million, and we needed to recognise the good that our staff and our services achieve. iv. Industrial action had a significant impact in July where we had five days of action by our junior doctors and in September and October, we would continue to see industrial action with overlapping dates between our junior and our consultant medical staff. The impact of this would be significant. v. We had a really bright picture on recruitment where teams were working fantastically and where we had 52 band 5 nursing staff in our pipeline and 22 student nurses joining us as temporary workers. We had a showcase in July for healthcare support workers and this had seen excellent collaboration across teams. vi. In August she had spent some considerable time with teams across the Trust and this was a very humbling experience. They had shared their challenges and there was clearly a good grip and understanding of the issues that were raised. vii. Our Annual Members Meeting would be held on the 13 September and our Staff Awards would be launched on the 4 September with a ceremony in December. viii. We were moving in the right direction on SSI's but we are not complacent and had an ongoing range of measures in place to address this. ix. We had launched our EPR engagement initiative and great work had been done on this so far. We now needed to talk to the organisation about the key functionality and support that was needed to support patient care, research and innovation. MS and IS had been leading this and a workshop for non-executives would be held in December. x. We had received a presentation on the Patient Safety Incident Response Framework at the Management Executive meeting, and this was coming together well under the leadership of Louise Palmer, Assistant Director for Quality & Risk. We were now training our staff, and this was focused on themes and learning, and that approach was key. xi. The innovation fund meeting had approved three applications with one from a scientist. This aligned with our long-term ambition to open up research to a wider multi professional group. 		

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	<p>xii. Our robotics programme was going very well, and she had joined staff presenting to Cambridge Medical Robotics customers on our experience of working with CMR.</p> <p>xiii. We had been shortlisted in the Health Service Journal Patient Safety Award, and for the IT Industry Awards. She was particularly proud of the collaborative work with Fysicon. During the COVID pandemic the Cardiac Physiologist team, led by Alaina Yardley, had spotted an issue and developed a solution to it with industry partners. She was immensely proud of all the staff involved in these initiatives.</p> <p>Discussion:</p> <p>i. JA asked whether the second- and third-year students who were due to come to work with us temporarily would also come to us at graduation? EM advised this was not necessarily the case. All nurses who graduated through Anglia Ruskin University were guaranteed jobs within the system and students would express an interest in the second year of their course. OM noted that Luke Bage, our Head of Resourcing was a nurse by background and understood very clearly the pipeline issue in relation to band 6 and band 7 recruitment.</p> <p>ii. CC asked about how we recognised staff when they had done a very good job within the Trust. EM noted that we used Laudit and that individual areas such as digital would issue certificates for staff who had delivered excellence. We also had funds in place from the charity to support staff recognition. OM advised that this was through the Recognition and Appreciation scheme. We would be making some changes to this so it could be used more uniformly and more immediately across the Trust. TG noted that positive performance was also recognised through divisional performance meetings.</p> <p>iii. AR noted that he was privileged to be working with a team that were finalists in awards year on year and were always working together to enhance and innovate in our services.</p> <p>iv. JW also noted again the impressive performance of the RPH team in the transplant games.</p> <p>Noted: The Board noted the CEO's update report.</p>		
1.vii	Patient Story		
	<p>MS introduced the patient story.</p> <p>LB presented a story from 5N the Cardiothoracic surgery ward. This related to a patient who had been admitted for transplant optimisation in November 2022. Optimisation looked at how we could improve a patient's status before transplant using medications to improve in cardiac and renal function. This patient was on the urgent transplant list and had waited five months on that list in the hospital.</p> <p>He had a transplant on 16 April and was back on the ward by the 24 April. He had to return to theatre and critical care a further four times because of issues including collections on his sternum and an issue with his central venous catheter in his neck and shoulder. The patient ended up with a perforated bowel and now had a colostomy bag and was concerned about whether this could be reversed. The patient was</p>		

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	<p>not able to bear weight and so was now a hoist transfer case.</p> <p>LB noted that the patient had non-specific learning disabilities and would spend much time at home watching television and playing games. He found it stressful that he did not have access to the same facilities whilst he was in the hospital.</p> <p>He was doing well and making progress and when asked what he was missing on the wards he felt that people got bored on the wards as we did not have access to services such as Netflix and the Disney Channel. He was missing out on programmes that our staff would be watching and that meant he was less able to join in conversations. He was also concerned that food turned up cold and that it was bland. He has had a nasogastric supplement tube for the last four months to help him maintain his weight.</p> <p>His mum visits once a week and he had input from this stoma team at CUH. He had been catheterised since April and so he has got a lot to get over, but he remained very positive and appreciative of his treatment. He felt that the environment was restful, and that he could understand the information that was shared with him, which was very positive given his learning disability. He felt safe and felt that he was treated with dignity and respect. The environment was clean, and he knew who was looking after him. He noted that staff were friendly and made him feel at ease.</p> <p>Noting his concerns about cold food, LB advised that this could not be warmed in the microwave on the ward because there was a risk to transplant patients who are immunosuppressed.</p> <p>Overall, the worst issues have been the stoma and his extended stay, but he also missed the television streaming services and he felt he needed to be given more things that looked like the picture on our food menus.</p> <p>Discussion</p> <ul style="list-style-type: none"> i. DL asked how long the patient would have been in hospital had everything gone to plan and what we might do to help relieve the boredom for our long-term patients? LB advised that many patients had long stays whilst waiting for a transplant and that post surgery a patient would usually stay for two or three weeks. She noted that this patient would likely be institutionalised by his stay and that he needed as positive an experience as possible to support his discharge. MS noted that many people would experience institutionalisation during prolonged admissions. ii. JA asked whether the charitable funds might be sought to support equipment for our patients and that we could do well to develop partnerships with local tech companies. JW felt that we should look at doing this and that this story provided a different perspective on what our long-term patients need particularly at discharge after many months of stay in hospital. iii. AR advised the Board that patient entertainment was in his portfolio and that we provided iPads on the wards, and he would look into whether or not there could be enhancements to our patient entertainment system to support this. 		

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	<p>iv. CC wondered if there was an opportunity also to use our volunteers to play Board games as she felt there could be some benefit in keeping this simple and having in person contact. LB noted that the Occupational Therapy team had restarted the transplant patient meetings every week, these had been supported by one transplant patient who had died this year and some of his fellow patients were really missing his contribution. She also noted that many transplant patients were now younger with working parents and that families were not necessarily able to fund the extras that are needed when somebody was a long-term patient.</p> <p>v. IW asked about the restriction on reheating food as he felt this was something that should be reviewed. LB noted that housekeeping staff did not allow nursing staff to use the microwaves in ward kitchens. MS advised that we needed to maintain food safety standards, but she would add this matter to the next meeting with the OCS team.</p> <p>vi. EM noted that if patients were not happy with the food on the menu, they could order from the staff servery. LB advised that this was a cumbersome process as it had to have a dietitian referral. She noted that one of the team on the ward had been 'DATIXED' as they had not followed the correct procedure for doing this.</p> <p>vii. IW asked about whether the collections on the sternum wound were infected. LB advised that one was and that was treated with antibiotics.</p> <p>viii. AF noted that this was a very well-articulated story. She asked about the patient's perforated bowel and whether this had been a result of their surgery and if so whether a duty of candour had been undertaken. LB advised that it was, and that the patient's mum had received the duty of candour letter. AF also asked how many of our patients were discharged within the standard stay of 21 days. LB advised that this year we had around 15 transplant admissions to the ward and perhaps four or five of those stayed over 21 days. All patients had extended stays pre transplant because of the treatment with dopamine as that meant they would need to be escorted at all times.</p> <p>ix. AF noted that during extended stays the hospital was a patient's temporary home and we needed to consider that in relation to food and environment.</p> <p>x. MB asked if we needed to assign responsibility for the long-term institutional care within the Trust. MS advised that this was in the Matron's role and in the Ward Sister's role.</p> <p>xi. JW asked for an update on the issues raised to be brought back for a Board update once the work has been done around this.</p> <p>Agreed: The Board thanked LB and noted the patient story.</p>	MS/AR	TBC
2	PEOPLE		
2.i	<p>Workforce Committee Chair's Report</p> <p>Received: The Workforce Committee Chair's report setting out significant issues of interest for the Board.</p> <p>Reported: By AF that:</p> <p>i. This had been a very interesting meeting and it was clear that</p>		

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	<p>there was very much to cover on the workforce agenda.</p> <ul style="list-style-type: none"> ii. We had seen and heard staff stories on the vital support of education team to our middle managers. iii. We were still working through how we were leveraging change in relation to the workforce agenda in particular around EDI and staff engagement, and how we might achieve change more quickly. The committee had asked the question whether there was more that we could do to achieve this and had asked the executive to look at how we use data, how we achieved engagement, and how well resourced our teams were to deliver support across the organisation. iv. The committee had received a range of good reports from the teams looking at how we add value and provide assurance to the Board. <p>Discussion</p> <ul style="list-style-type: none"> i. JW noted that we had established the Workforce Committee in response to a recommendation from our Well Led review and he welcomed the focus that the committee was able to bring to this agenda. <p>Noted: The Board noted the Workforce Committee Chair's report</p>		
2.ii	<p>Director of Workforce Report</p> <p>Received: The Director of Workforce and OD a paper setting out key workforce issues.</p> <p>Reported: By OM that:</p> <ul style="list-style-type: none"> i. The paper provided an outline of the changes relating to the Fit and Proper Person's Test. We were working through the implications of this and would need to revise our policies and procedures to reflect the new guidance and would be writing to Board members setting out key changes. There would be a substantial resource requirement to support the process of annual checks and reviews. The new requirement around assessment of good character would likely develop over time, but the new framework goes further requiring social media checks to be undertaken on an annual basis as well as extended legal requirements and retention of data. The responsibility for the test sits with the Chair of the Trust and we would be discussing the governance arrangements with JW and JA. <p>Discussion</p> <ul style="list-style-type: none"> i. JW noted that we needed to comply with this legal requirement, but we also needed to consider how this might impact on the health service and the potential adverse impact on applicants for non-executive positions. ii. JA noted that some of this work would not be retrospective and asked if aspects such as social media checks and the extended reviews would be retrospectively applied. JW asked how we would respond in this instance if there was activity in the public domain. OM advised that our current policy would already cover matters such as social media as we already had 		

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	<p>a test around this and would always make a judgement in relation to any issues that were raised.</p> <p>Agreed: The Board noted the update from the DWOD.</p>		
2.iii	<p>Director of Workforce Report – Equality, Diversity and Inclusion Received: The Director of Workforce and OD a paper setting out an update on our EDI Annual Report and strategies and seeking approval for the:</p> <ul style="list-style-type: none"> • Workforce Race Equality Standard (WRES) report and Action plan 23/24 • Bank WRES report 23. • Workforce Disability Equality Standard (WDES) report and Action plan 23/24 <p>Reported: By OM that:</p> <ol style="list-style-type: none"> i. The paper set out the framework for development of the WRES and WES reports and action plans and these were included in the Board reference pack. ii. The key issue was for Board approval of action plans. She noted that there were some inconsistencies in reporting periods with some data sets as of March 2023 and other data that was 18 months old. This disparity was driven by national data collection cycles. iii. The papers had been approved by the Workforce Committee following review at the EDI steering group. <p>Discussion</p> <ol style="list-style-type: none"> i. AF noted that the workforce committee were very keen not to have multiple action plans and so all plans would feed through the workforce strategy reporting. ii. CC asked about the bank WRES report and whether this related to our own staff only. OM advised it did and that there was no comparative data as this was a new data collection. iii. DL thanked the staff who had been involved in the development of the report and acknowledged what had been done to support engagement and work on EDI. iv. OM advised that October was Black History Month, and the Trust would be welcoming Dame Elizabeth Anionwu who was the United Kingdom's first sickle cell and thalassemia nurse specialist. JW noted that this would be a campus wide event being held on Friday 13 October. <p>Agreed: The Board approved the WRES and WDES and Bank WRES action plans and noted the EDI update from the DWOD.</p>		
2.iv	<p>Guardian of Safe Working Report April 2023</p> <p>Received: from the Medical Director the Guardian of Safe Working report for Quarter 1 2023.</p> <p>Reported: By IS that:</p> <ol style="list-style-type: none"> i. This report was from the Medical Director as the Guardian of Safe Working (GoSW) position was temporarily vacant. A call for applicants had gone out to the consultant body but we had no applicants for the post. This had been advertised with four 		

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	<p>other educational posts relating to junior doctors and had coincided with summer holidays and so would be readvertised.</p> <ul style="list-style-type: none"> ii. There had been some improvement reported and we had now opened the junior doctors mess facility. iii. He had asked about the limited number of issues raised and that would be a focus for the new incumbent. <p>Discussion</p> <ul style="list-style-type: none"> i. JW noted the issue on provision of a fridge in the new doctor's mess area and asked why these sorts of blocks were arising across the organisation. TG advised that this was being worked through with the team. ii. CC asked about the equity of access to training and development for non-Deanery medical staff. IS advised that the Deanery had set standards for supervision and there was no funding allocation for non-Deanery medical staff. One of our new appointments was a tutor for this group and was a Locally Employed Doctor (LED) and so knew the system that these staff would come through. Many LED staff were new to the UK and new to the NHS and so needed significant input, but others joined at a consultant level and so their support needs would be lower. iii. JA asked how we felt this reconciled with the GMC report from trainees where there were many concerns raised. IS noted that in general, exception reports related to patient safety, staffing levels, and working hours. He agreed that the GMC survey gave a signal across all of those areas. We did not have enough of our juniors reporting and this was a gap, and we were looking at this with the local training organisers as we needed more of that information to be shared by our staff. iv. DL asked what targets we expected to see achieved by the end of the year and whether reports would come back through workforce or an education group. IS advised that we would bring reports back through the WFC. <p>Noted: The Board noted the GoSW report</p>		
2.v	<p>Workforce: Update on GMC (General Medical Council) Survey 2023</p> <p>Received: From the Medical Director the report of the GMC Survey for 2023.</p> <p>Reported: By IS that:</p> <ul style="list-style-type: none"> i. He was concerned that we do not have a return from the surgical trainees. Data returns were suppressed where there were fewer than three reports and this was the second year where we had seen this. We were looking at how this could be addressed as blank returns would have the potential to damage the reputation of the Trust. ii. That the Foundation Year 2 doctors were very early trainees and were looking for general experience undertaking drug charts, bloods and some procedures that we do not do here and so Dr Nicola Jones was focusing on how we could offer that more generic element of their training. iii. Anaesthetics was showing a lot of red ratings. This reflected a 		

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	<p>known mismatch between expectations of staff who joined the Trust from overseas to learn anaesthesia and who were being given experience in critical care rather than in theatres. We needed to review the advertising process to ensure that we were recruiting the right staff into these posts.</p> <p>iv. Thoracic services had performed well in the survey.</p> <p>Discussion</p> <p>i. JW noted concern about the responses in anaesthesia and trainees being pushed into the critical care unit.</p> <p>ii. IW asked about the issue relating to rest facilities and was concerned that provision might be seen as ‘cobbled together’. IS advised that there was limited access to on call rooms, many of which were pre-booked for non-medical staff. Staff had access to reclining chairs but there were some problems locating these. These were originally placed in set rooms, but many had been subsequently moved around the Trust. We were looking again at the optimisation of facilities and during the periods of industrial action we had been able to open the day ward on the third floor overnight and that had worked well and not disrupted other services, and so we would be looking at that as a potential longer-term solution.</p> <p>iii. IW noted the F2 issue of small numbers of reports and asked if had a view of information over time. He also felt the issue was perhaps more around the breadth of opportunity for example in attending outpatients and to be taught. IS advised that this would be considered in the recovery plan that was being brought together by Dr Nicola Jones and it may be simpler to deliver in some areas than others where there was easier access to clinic facilities.</p> <p>iv. JA asked about trainers and whether they had also expressed concerns about inadequate time or resources to undertake the role. IS noted that he was struck by the number of people who were allocated and paid time to undertake the role and we would be exploring what we were able to deliver.</p> <p>Noted: The Board noted the update on the GMC (General Medical Council) Survey 2023.</p>		
2.vi	<p>Medical Revalidation Annual Report</p> <p>Received: From the Medical Director the Medical Revalidation Annual Report for 2023.</p> <p>Reported: By IS that:</p> <p>i. The report presented the historic position that we were working to improve. Currently 78% of our consultant staff had a revalidation appraisal every year. The end point of the process was revalidation and all consultant staff who were ready had revalidated.</p> <p>ii. He noted that our consultant staff were engaged with the annual appraisal process, but revalidation was managed across a five-year cycle and a number of staff would be likely to drop one appraisal within that period.</p> <p>iii. The Board were asked to approve the Statement of Compliance.</p>		

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	<p>Discussion</p> <ul style="list-style-type: none"> i. JW asked if there were any staff who had not revalidated. IS advised that we had a few staff who were delayed by three months but had never had anyone who had not revalidated. ii. JA noted that if a medic did not revalidate there was a process followed by the GMC ahead of removal from the register. iii. CC was concerned that this was a lengthy report, that needed review and asked if the submission had been reviewed by the Workforce Committee. AF advised that it had not but that it would in future. AJ noted that the report had historically come directly to the Board for approval. JA noted that the form of the report had been cut down in recent years and that there was not anything controversial within the report. All the doctors that did not get appraised were agreed by exception and the numbers reconciled. The only question that he would raise was whether we were we confident that we got feedback for our doctors working in private practice from those organisations where we were their designated body for revalidation as that was not referenced in the report. IS advised that this feedback was obtained but not recorded separately. iv. IW asked about the number of doctors having annual appraisal as he would expect this to be above 90%. IS advised that this had been the ambition, however historically this had been limited by the number of appraisers within the Trust. We had now doubled the number of appraisers. IW asked how our rates compared with those at other organisations. JA noted that these would probably have been higher pre-COVID and there would always be a proportion off staff who were on long term sick or maternity leave but the level of non-compliance at 25% seemed significant. The 35 staff who did not get an appraisal did each have an exception agreed. v. JW suggested that staff who had not completed an annual revalidation appraisal should not be put forward for merit awards. <p>Noted: The Board of Directors approved the Medical Revalidation Annual Report.</p>		
3	GOVERNANCE		
3.i	<p>Q&R Committee Chair's Report</p> <p>Received: The Q&R Committee Chair's report setting out significant issues of interest for the Board.</p> <p>Reported: By MB that the committee had considered:</p> <ul style="list-style-type: none"> i. The Patient Safety Incident Response Framework (PSIRF) and the updated policy and plan were included in the reference pack. He encouraged all Board members to read these as they touched on the issues that we want to be discussed through the Q&R Committee. This programme had got off to a tremendous start and he was excited about the policy and commended this to the Board for approval. ii. The harm review process at RPH as we had considered the requirement for the reviews and asked for proposals to come 		

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	<p>back to Q&R. These would need to answer a fundamental question as to whether we were assessing the overall level of harm or the need for an escalation and that needed a balanced view on productivity.</p> <p>iii. Surgical Site Infections which looked as if they were moving in the right direction, but we were not complacent.</p> <p>Discussion</p> <p>i. MS noted that the PSIRF framework established a change in oversight as a Board and as an Executive and that there would be choices to be made on what we investigated, how we undertook this, and how we justified decisions on those matters we take forward for investigation and those we do not. We would need to understand the resource implications and put in place risk management training with a focus around risk tolerance and the question of mitigations. She had attended an oversight training development session yesterday and would recommend that we have a Board member development session on this so that the framework was understood at every level.</p> <p>ii. JW noted that we should approve the policy and plan and then review implementation and oversight and the work that was required to support that. AF suggested that this approach should be brought into the next discussion that the Board has on risk appetite.</p> <p>Noted: The Board noted the Q&R Committee Chair's report and approved the Patient Safety Incident Response Framework policy and plan.</p>	MS/AJ	Mar 24
3.ii	<p>Combined Quality Report</p> <p>Received: A report from the Chief Nurse and Medical Director which highlighted information in addition to the PIPR.</p> <p>Reported: By MS that:</p> <p>i. The Trust had an MRSA bacteraemia in July and there was learning for the Trust from that.</p> <p>ii. IS had provided further information that was highlighted in the report on Coroners Inquests.</p> <p>Discussion:</p> <p>i. CC noted that the additional information added to the inquest data was helpful.</p> <p>Noted: The Board noted the Combined Quality Report.</p>		
3.iii	<p>Safeguarding Committee Annual Report 2022/23</p> <p>Received: From the Chief Nurse the Safeguarding Committee Annual Report 2022/23.</p> <p>Reported: By MS that:</p> <p>i. The report had been approved by the Q&R Committee and was recommended for approval by the Board.</p> <p>ii. The report set out the key activities of the team. The main focus and areas of escalation included self-neglect, financial abuse and domestic abuse, and the increase in the requests relating to Child Death Overview Panels (CDOP) as all</p>		

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	<p>hospitals were now contacted about these. Of the 10 CDOP requests received this year we had input to one case.</p> <p>iii. Level 3 training had increased over the last three months. We would be delivering the Oliver McGowan training and were undertaking succession planning for the safeguarding team. We had also agreed the domestic abuse policy.</p> <p>iv. CQC regulation 13 (safeguarding) which had been self-assessed as red, was rated amber in the forward plan.</p> <p>Discussion:</p> <p>i. DL asked about the staffing shortfall and whether we had enough staff to undertake these responsibilities. MS noted that we had enough staff, but it was a small team. We were training up the social workers in the team to take on the hospital safeguarding lead and were linking with CUH to support focus on learning disability as support was planned for our patients, but it was fragile and so the link was positive.</p> <p>ii. OM noted that NHSE had published requirements around a sexual violence and aggression policy and that had included domestic abuse against staff. OM was the executive lead for this and it had been developed with significant input from the Women's Network. This would sit alongside our safeguarding activities and needed to ensure that there was support in place for staff and work was ongoing to improve support in this area. JW asked about why this sort of social concern was sitting with the Trust and where our responsibility lay as a specialised heart and lung hospital. OM advised that we do have complicated instances where our staff need protection at work, and we wanted to ensure that teams know how best to support staff. AF noted that this was being picked by the Women's Network and this was an important issue in terms of the well-being and taking care of our staff, but it would be best discharged through networks and links with other providers.</p> <p>iii. AF asked whether we had children's safeguarding within our remit. MS advised that we had named doctors and named nurses for children's safeguarding, and we linked to the ICB work on this and completed a section 11 return on a biannual basis. We also had a transitions group as children would usually be referred into services at RPH between 15 and 17 years. We did see some younger children in our sleep labs, and they were covered by a separate policy.</p> <p>Noted: The Board approved the Safeguarding Committee Annual Report 2022/23.</p>		
3.iv	<p>Audit Committee Chair's Report</p> <p>Received: The Board received the Audit Committee Chair's report setting out significant issues of interest for the Board.</p> <p>Reported: By CC that the committee had considered:</p> <p>i. BAF reporting and had asked all Committees to review their risks rated 20 and above to ensure that these were being actively discussed, assessed, and managed, and the committee were comfortable with the outcome of those reviews.</p> <p>ii. The waiting list audit had a moderate assessment and two</p>		

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	<p>recommendations one of which was review of the process of harm reviews that MB had outlined, and the other related to the need to improve the system used to book follow-ups for patients on the non-RTT pathway. The committee felt that the management response was adequate on that.</p> <p>iii. The waivers of Standing Financial Instructions, which was a good news story as since 2018/19 there had been a 90% drop in the number of waiver request and 79% drop in overall value of waivers. This was to be commended and she thanked TG and his team for that improvement.</p> <p>iv. The improved performance on the Better Payment Practice Code and that this would no longer be reported to the Audit Committee but remain with the Performance Committee</p> <p>Noted: The Board noted the Audit Committee Chair's Report.</p>		
3.v	<p>TOR006: Executive Remuneration and Nominations Committee of the Board of Directors: Terms of Reference</p> <p>Received: From the Trust Secretary the terms of reference for the Remuneration Committee (TOR 006) for approval.</p> <p>Reported: By AJ that:</p> <ul style="list-style-type: none"> i. TOR006 had been reviewed and recommended for approval at the last Remuneration Committee meeting and were being brought to the Board for approval. ii. The updates reflected changes in the Code of governance for NHS provider trusts which was published in October 2022 and come into effect from 1 April 2023. <p>Agreed: The Board approved TOR006: Executive Remuneration and Nominations Committee of the Board of Directors.</p>		
3.vi	<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: 29.06.23 & 27.07.23 b. Performance: 29.06.23 & 27.07.23 c. Workforce: 25.05.23 & 10.08.23 (draft) d. Audit: 17.07.23 		
4	<p>PERFORMANCE</p>		
4.i	<p>Performance Committee Chair's report</p> <p>Received: From GR the Chair's report setting out significant issues of interest for the Board.</p> <p>Reported: By DL that:</p> <ul style="list-style-type: none"> i. The July meeting had received a presentation from cardiology where there were encouraging metrics and had received a paper on health inequalities but noted that there was more work to be done in that area. ii. In August, the committee had received the review of materials management and considered the Trust plans for improvement in this area. 		

Agenda Item		Action by Whom	Date
	<p>iii. It was pleasing to see that PIPR had moved from red to amber reflecting the improvement in effective from red to amber.</p> <p>iv. We had received a report from HM on the work so far on STA and had spoken about the need to consolidate the reporting of that data. This was still work in progress.</p> <p>Discussion:</p> <p>i. TG added that these two meetings covered a very difficult period for the NHS with periods of industrial action having an impact on performance. The movement of PIPR from red to amber reflected the fact that the Trust was performing well outside of the periods of industrial action and based on the theatres that were open, we managed to perform well in that space. But that did not detract from the fact that if we were measuring utilisation as a measure of physical capacity, we would have seen a deterioration in those months because of industrial action. We were managing what was in our control but there were still significant factors outside of our control and it was important for the Board to understand that context.</p> <p>ii. CC noted that IS's health inequalities paper was welcome and had prompted her review of the paper published nationally. This paper identified chronic respiratory disease as an area of disparity, and she asked whether we should be looking at this area and what our role and the ICB role was in relation to addressing this. EM advised that the respiratory disease analysis covered in the NHS Core20 report was much more aligned to primary and secondary care, but there would be a role for RPH in terms of leadership of the cardiovascular disease strategy. This linked to the ICB forward plan. She noted this was not included on the wall diagram in the ICB strategy document and she would raise that with the ICB. IS noted that he had been reflecting on the impact of ethnicity on chronic lung disease. The biggest disease in this area was COPD and that was almost always caused by smoking. We also knew that people from a BAME background are much less likely to smoke than the white population. The significant disparity in this area related to affluence with smoking rates in affluent areas having dropped to around 8% and in economically challenged areas this was at around 25% of the population. There was a significant programme of work being undertaking in the ICB relating to smoking cessation and this was one of the best ways to address this issue. This work was one of the best news stories in health in the last 30 years. Historically smoking had been at a level of 70% of adult men and the UK now stood out within Europe as having one of the lowest rates of smoking in the adult population at a level of about 14%. This was comparable to Sweden and significantly better than France and Germany. This had been achieved through UK health policy and this would see a significant health dividend in coming years as this was linked to both chronic lung disease and ischaemic heart disease. IS noted that this position was exacerbated by the economic pressure as in low-income households the proportion of disposable income spent on smoking was much higher. They were also affected by the economic impact of the disease once</p>	EM	10/23

Agenda Item		Action by Whom	Date
	<p>manifested, and often were unable to take time off work when they were unwell.</p> <ul style="list-style-type: none"> iii. DL asked if we were now collecting data on the impact of vaping. IS noted that we did not have full data, but the evidence so far was that this was much less harmful than smoking. EM noted concern that we were seeing increases in the level of vaping in younger people who had not previously smoked and who had developing lungs and there may be some lag in understanding the full impact in this group. iv. MB asked for the Board to agree which committee would deal with health inequalities as this would help to define the agenda for RPH in terms of issues such as the proportionate access to specialised services. It was agreed that this would be managed on the Q&R agenda. v. JA welcomed the report and noted that 75% was a good start in terms of data collection and asked what the ambition was to improve the level of data capture. IS noted that we needed to understand more about how we could support data collection in telephone consultations and if we could put in a process to collect those missing data and he would look at how that an improved data standard could be achieved. <p>Noted: The Board noted the Performance Committee Chair's report.</p>		
4.ii	Papworth Integrated Performance Report (PIPR)		
	<p>Received and noted: The PIPR report for Month 4 (July 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.</p>		
5	STRATEGIC DEVELOPMENTS		
5.i 5.ii	<p>Estates Strategy 2021-25 Sustainability Strategy 2021-26</p> <p>Received: From the CFCO two updates strategy on the Trust strategies.</p> <p>Reported: By TG that:</p> <ul style="list-style-type: none"> i. The two updates referred to the strategies that we signed off as a Board last year and the year prior and they had been taken to SPC for their annual review. Both reports had shown that good progress had been made in the last 12 months. ii. The Estate Strategy had seen progress with the closing of the Flexible, Adaptable and Resilient (FAR) Action Plan which was an excellent piece of work. iii. There was a huge amount of work being taken forward by Trust teams on the Sustainability Strategy. <p>Discussion</p> <ul style="list-style-type: none"> i. JW noted that he had joined the tour undertaken by the New Hospital Group visit and he recommended that we set up some tours for our staff so that they can appreciate the building management across the organisation. 		

Agenda Item		Action by Whom	Date
	Agreed: The Board noted the updates on the RPH Estates Strategy 2021-25 and the RPH Sustainability Strategy 2021-26.		
6	BOARD FORWARD AGENDA		
6.i	Board Forward Planner Received and Noted: The Board Forward Planner.		
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 7 September 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