NHS
Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Held on 5 October 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
	Ms C Conquest	(CC)	Non-Executive Director
	Mr T Glenn	(TG)	Chief Finance and Commercial Officer
	Ms D Leacock	(DL)	Associate Non-Executive Director
	Mr H McEnroe	(HM)	Chief Operating Officer
	Mrs E Midlane	(EM)	Chief Executive Officer
	Ms O Monkhouse	(OM)	Director of Workforce and OD
	Mr G Robert	(GR)	Non-Executive Director
	Mrs M Screaton	(MS)	Chief Nurse
	Prof I Smith	(IS)	Medical Director
In Attendance	Mr D Amps-Woodward	(DA)	Dietician
	Mr E Gorman	(EG)	Deputy Chief Information Officer
	Mrs A Jarvis	(AJ)	Trust Secretary
	Mrs W Walker	(WW)	Deputy COO
Apologies	Mr M Blastland	(MB)	Non-Executive Director
	Ms A Fadero	(AF)	Non-Executive Director
	Mr A Raynes	(AR)	Chief Information Officer & SIRO
	Prof I Wilkinson	(IW)	Non-Executive Director
Observers	Angie Atkinson, Trevor Collins, Clive Glazebrook, Abi Halstead, Marlene Hotchkiss, Josevine McLean, 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**		
	Board of Directors Part I: 07 September 2023 **Approved**: The Board of Directors approved the Minutes of the Part I meeting held on 07 September 2023 as a true record.		
1.iii	**Matters arising and action checklist**		
	Noted: The Board received and noted the updates on the action checklist.		
1.iv	**Chairman's report**		
	The Chairman noted that much would be covered in the Chief Executive's report. He had been on holiday and had met doctors from Italy and the United States and in discussion found that there were common problems in their health systems around staffing and access to appointments and so the pressures we were working with we're not just a UK issue. He had attended the staff long service awards yesterday and this had seen awards given to staff who had over 1700 years of service with the Trust. He had also attended an event at Cambridge Medical Robotics, and this had been a very impressive visit to their new manufacturing facility.		
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 AJ: i. That the key risks related to BAF 3261 where we were seeing the continued impact of industrial action; BAF 675 Hospital Acquired Infections and there was a separate report on the agenda on Surgical Site Infections and BAF 678 Waiting List Management where we had seen the start of the Patient Safety Initiatives in September, and these would run for three months. ii. The Performance Committee had also discussed BAF 1021 Cyber and Data Loss looking at the level of assurance and that had followed the assurance mapping exercise that had been undertaken with Committees. **Noted:** The Board noted the BAF report for September 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. **Reported:** By EM that: i. This month had been a restart at the end of the summer holidays and notwithstanding industrial action we had been incredibly busy.		

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	ii. We had brought together respiratory and cardiology colleagues to develop opportunities in research and innovation. This had been hosted with Professor Charlotte Summers, Director of the HLRI. iii. She welcomed our new governors and saw that some were online and, in the room, to observe the Board and thanked them in advance for their contribution Trust. iv. We had seen 72 hours of industrial action this week involving consultant and junior medical staff. We had managed this well and were preparing for the next strike action. We were able to keep our patients safe and allow staff to feel supported in the decisions that they made around strike action. v. The Recruitment and Education team had received an award from the Chief Nurse of the NHS for their pastoral care. vi. We held a recruitment day which saw 30 people booked to attend and another 70 turn up on the day. Following the visit at CMR, the company had proposed that they could bring a robot to our next recruitment event which may further help with generating interest in joining the Trust. vii. It had been great to see the interest in National Organ Donation Week. There was significant participation and media coverage of this activity. viii. The vaccination programme was now underway in the atrium, and we had seen a steady stream of staff attending to receive their flu and COVID vaccinations. This helped to protect our staff, our patients and their loved ones. ix. Our long service awards had been held as noted by the Chairman, and nominations for our staff awards 2023 were open until the 11 October. We had received 336 nominations so far, and that was great to see. x. The Violence and Aggression policy had been launched and this was a very important measure. We don't have high levels reported, but we wanted to ensure that our staff know that actions would be taken and that they would be supported. xi. We had been named as one of the best 8 Trusts in the country in the NHS Adult Inpatient Survey. This was a measure of the professionalism and compassion of our staff in delivering in the patient care at the Trust. xii. We were concerned to see that our surgical site infection cases continued at a high level, and we continued our work on this every day as the risk profile of our patients was higher than ever. xiii. We launched our Patient Safety Initiative and were in a privileged position to be able to undertake these as colleagues across the system had found this approach very challenging. These would manage some of the risk for those patients who had waited longest, as whilst their clinical care may be in a category P3 or P4, the extended waiting periods were not in their best interests, and we would look to address this. xiv. She wanted to congratulate Andy Raynes our chief information officer who had been included at number 15 in the top 100 chief information officers in the UK. It was great to see RPH recognised on this national stage. xv. That we had a number of events scheduled in October around Freedom To Speak Up which would encourage our staff to have a greater appreciation of what this role was for and to celebrate		

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	Black History Month where events would be taking place on the 13 October. All were encouraged to join these if they were able. **Discussion:** i. DL asked how aware our staff were of the new Violence and Aggression policy? EM advised that it had been launched in the all staff briefing and training sessions were being held for managers. OM noted that we had included this material on our external website and our intranet landing page. In addition, we had put posters geared to staff and to patients in staff rooms and in public areas. We were running master classes with line managers, and this was being raised through performance meetings and communications. We were also involving Sarah Steele who had authored work on violence and aggression, and we are looking at whether she may be able to deliver training for us. This would be included in the pulse survey in January to allow us to see how far the programme had reached. ii. CC noted that the inpatient survey results were very commendable, but she wanted to make sure that we captured feedback from our long stay patients. JW noted that the survey respondents were those who were in-patients on a single day and so this may well not reflect our longer stay patients. MS advised that this had been discussed at the Patient and Public Involvement Committee and this was part of our patient and carer experience strategy. This would include co-production work and improvement in the sophistication of our data collection. We would identify themes so that we could look at how we addressed these and recognise that we needed to capture feedback on care delivery not just at the end of an episode. JW suggested that we should talk to our long-term patients and ask them to share with us what they felt we should be looking at. **Noted:** The Board noted the CEO's update report.	MS	04/24
1.vii	**Patient Story**		
	MS introduced the patient story which was being delivered by Dan Amps-Woodward, Dietitian. Dan thanked the Board for the invitation to present the story. He noted that he had been with the Trust for three years two years as a dietitian working with cystic fibrosis (CF) patients and one year working with surgery and cardiology. He had now been appointed as a band 7 dietitian working in critical care. This story related to a CF patient who had spent much time in hospital. The patient was young and was studying for a degree and at some point, might join the medical industry. They had been an inpatient between January and April 2023. CF patients spent long periods in hospital with exacerbations of their condition, but many patients with CF were now healthier and there were new treatment options such as Kaftrio. This patient however was not eligible for treatment and so was struggling with standard approaches, this meant that they needed		

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	multiple treatments with antibiotics. CF patients often develop drug resistances which had to be carefully managed. The patient had found the hospital environment restful and clean and had found staff respectful and reported that they had explained treatments well. There had however been missed opportunities in dietetic support. The patient had been very disengaged with the service, and DAW felt lucky to have been able to talk to the patient and to engage with them. The patient had a very low BMI and had a gastroscopy tube fitted but had declined to use this for a year. This was a supplementary feed tube and it seemed to be a part of the negative image the patient had of themselves, and this was detrimental to the patient's care. The team took a step back from the clinical approach to consider how different standard approaches might help that were less medicalised and more person centred. They looked at whether the feed tube could be removed. This was a challenge as a CF patient might need twice the standard level of calories over a day because of the additional difficulties with breathing. The physio team were involved with the patient's weight management programme and after one or two months of weight gain it was agreed that the tube could be removed, however the patient self-removed the tube (which they were trained to do) but the team called in the CUH nutrition nurse to come and check the site. The removal of the tube built confidence in the patient and not having it seemed to accelerate improvement in their weight gain. They had now achieved a BMI above 20 and this was the heaviest they had been, and the happiest they had been with their body and self-image. They had maintained this weight since their admission and had increased energy which supported their ability to fight off infection. A key issue for cystic fibrosis patients now was weight management as those who were eligible for new treatments often tended to put on weight whereas those who were not struggled to maintain their weight. The team recognised that there would be a need to familiarise themselves better with the management of eating disorders as this would be useful to support this patient group. DAW noted that the choice of hospital food for our long-stay patients with was extensive. They could order off any menu at the hospital, but they still got menu fatigue and some patients didn't have much brought in from home. We were working with the catering team to introduce QR codes to allow rapid feedback direct to the catering team. We were also looking to address other problems that this patient group face as they tend not to follow the same regular eating patterns as other patients and so may miss protected mealtimes. They also had a lot of intervention from doctors, physios, and nurses, and all of these could disturb eating and we needed to protect this as this was a key to maintain their health. The nutrition steering group was now back up and running within the Trust and he felt that would help with this agenda. **Discussion**		

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	i. JW asked about the age of the patient at transition into the Trust services, noting that it could be difficult moving from paediatric to adult services. DAW noted that the patient was in their early 20s and so had been with us for a little while. ii. JA asked if patients were able to cook their own food. DAW advised that we had a blast chill and reheat catering system and so did not have cooking facilities available to patients. There were microwaves that could be used by the healthcare support workers and staff nurses, but we needed to be mindful of issues with cross infection between some of our CF patients. Some patients had tried to bring in equipment to prepare food, but this had needed risk assessment and PAT testing of devices and so the answer was not straightforward. Patients could also order from food delivery services. JW noted that this was an important issue as there was a correlation between weight and the longevity of CF patients. iii. DL asked what we could do to manage meal time disturbances and whether we could reschedule treatments. DAW advised that we provided patient centred care which was planned each day with the most intensive elements being planned in so that patients could rest around these. These patients would stay with us for a long time, and it was important for the team members to build a rapport with them. iv. MS noted that dietitians taking on specialised courses on eating disorders was amazing. The courses were truly multi professional and build skills to address a range of eating problems and this was very useful for us to support our patients. This was a commitment of time for staff with two days off site, and we should support this. JW noted that this may be more important because of the very limited services that CPFT were able to offer in this area at the moment. DAW summarised what he had taken from the story which was the importance of patient centred care, of collaboration between professions, and the need to develop links between our catering and dietetics teams, which we were now working on with a joint post. We had seen national standards for food and drink launched in November 2022 and needed to work to implement these. We had also appointed a Dietetic apprentice which was a new pathway and was designed to improve recruitment. This was the first to be implemented in the ICS. He also noted that the national AHP Day was being celebrated on the 14 October and there would be stands in the atrium on Friday 13 October. **Agreed:** The Board thanked Dan Amps-Woodward and noted the patient story.		
2	**PEOPLE**		
2.i	**Workforce Committee Chair's Report** **Received:** The Workforce Committee Chair's report setting out significant issues of interest for the Board. **Reported:** By JA that the committee: i. Had a good discussion around BAF risks in particular the staff engagement risk which had a residual rating of 20. There were some positive signals including the positive patient feedback,		

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	but this was felt to perhaps reflect significant pressure and effort on our staff to deliver this. It had been agreed keep the risk rating at 20. ii. We had heard an excellent staff story from Gerrie Powell the co-chair of the Disability and Difference network. She had shared with the committee the sort of activity and effort put into the role, and the committee noted that network chairs were putting in many more hours than allocated to the role. iii. Had noted the workforce report and the improvements seen in the time to hire, as well as mandatory training and appraisal rates. However, sickness absence rates remained high and that needed further attention. We welcomed initiatives to improve employee relations focused on early intervention and conflict resolution. iv. We had endorsed the EDI improvement plan which set goals for progression for our BAME staff which were recommended to the Board for approval. v. The NHSE Education self-assessment had also been reviewed and was brought to the Board for approval. vi. We had also welcomed the report on nurse validation noting that there were no concerns in relation to it. **Discussion** i. GR asked whether we had access to comparative sickness data as he would like to understand whether ours was higher than others within the ICS. He noted that comparators were important as these provided a good signal of staff morale. OM advised that we had access to national data through the data warehouse, but she had not seen regional data more recently. Our trend tracks the national and regional figures, and she would see if this could be brought together for the ICB. We were not an outlier for sickness absence, but she would take an action to bring the comparative data to the Workforce Committee. **Noted:** The Board noted the Workforce Committee Chair's report	OM	12/23
2.ii	**Director of Workforce Report** **Received:** The Director of Workforce and OD a paper setting out key workforce issues. **Reported:** By OM that: i. Her report brought forward the recommendations approved by the Workforce Committee on the goals for progression through the pay bands for staff from a BAME background. This was something that we could measure and was a proxy for progression and visible leadership. ii. The goals were set separately for clinical and non-clinical workforce which matched to the data collection within WRES that informed the disparity ratio and so gave us a good marker. iii. 30% of our staff were from a BAME background and this was the goal that had been set. This was a simple measure that we could review across the next three years. The change in more senior bands was more difficult as we had very few posts at		

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	the level of 8D and there may not be movement of staff in those posts during this period. iv. The workforce committee had supported the goals set out and this was brought to the Board for approval. v. The second part of her report had focused on the staff networks. She and Onika had met with the EDI steering group, and they were quite blown away by the range of work being undertaken and she wanted to highlight the topics that were being covered. Our networks were taking a holistic approach looking at the needs of staff and patients. They were supported through our CCL compliance role that had been funded by the charity. The networks had celebrated inclusion week raising money for the charity through cake sales which had been very well received. She also wanted to note their role in the development of the Violence and Aggression policy. **Discussion** i. JW asked how our goals compared to those in other organisations. OM advised that there had been national goals set within the WRES and this would bring us back to those national data. ii. CC noted that the report was very welcome and that she supported the goals set out. She asked why our very senior management figures were not included within the report. OM noted that this was an omission and that we could add these to the plan. She noted also that we had excluded medical staff because of the different profile and career pathway. iii. JW asked for the Board to be given advanced notice of the events that were being organised across the Trust and suggested it would be helpful to have a calendar of these on the intranet with invitations being shared with all non-executive directors. **Agreed:** The Board noted the update from the DWOD.	OM SE/AJ	12/24 12/24
2.iii	**Veteran Aware Review: Armed Forces Champion update** **Received:** From the Armed Forces Champion the annual Veteran Aware review for the Board setting out key activities that had taken place across the year. **Reported:** By OM that the paper set out the review of the year. She had been impressed by the range and thoughtfulness of the activity undertaken over the last year. **Discussion** i. GR asked whether we tracked the number of patients treated who were armed services veterans. EG advised that there was not a specific field on Lorenzo to capture this data and so it could be haphazard. ii. JW noted that not all staff who had been veterans would necessarily participate in work-based activities and we also needed to respect that. **Noted:** The Board noted the annual report from the Trust Armed Services champion.		

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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 JA that: i. The committee had looked at surgical site infections and there were some signals of improvement but felt that we needed to keep a close eye on this matter. There was ongoing poor compliance with MRSA decolonisation and there were two actions that had been identified to be taken forward to the next committee. ii. We had seen three new cases of M.Abscessus and the relatedness testing for these was awaited. iii. IS had provided updates on the coronial cases and these had been included in the report to the Board. iv. We had agreed that we would receive quarterly statistics on mortality from all areas across the Trust. v. We had also ratified a number of policies and had approved the DIPC annual report which was elsewhere on the agenda. **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. An update on the continuing work on surgical site infections and the areas of concern identified. This included the decolonisation for Staphylococcus A, and the preoperative optimisation of our diabetic patients. We were also evaluating endoscopic vein harvesting in the clinical practice group. ii. The theatre ventilation project was underway and reporting through the environment group. This would be using sensors to monitor the effectiveness of ventilation during operations. iii. We were also working on culture to ensure that we are working with the building and its environment. **Discussion:** i. JW asked about the work on optimisation of diabetic patients. MS advised that we do HbA1c tests prior to admission and feed results back to GP practices. At the Liverpool Heart and Chest Hospital (LHCH) these patients were seen by a diabetic specialist nurse. They were doing similar assessments at pre-admission for patients with a high BMI. This approach could link to our work on the setup of a virtual ward. LHCH also follow up patients in a different way after discharge. We take pictures at discharge, and they use an app to allow patients to submit photos of their wound on a weekly basis so that infection is picked up earlier. DL asked if we would implement these measures. MS advised that we were planning to implement use of the photos and the app and the nurse consultant for surgical site infections was looking at this		

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	approach. We would consider other elements through the virtual ward project, which may be further down the line, but we were clear that it would need increased levels of diabetic nurse support. There was not a clear timeline for the virtual world project, but we would expect to see some changes early next year. If the decision were not to go ahead with the virtual ward these elements should be taken forward. ii. CC was very pleased to see the learning from Liverpool but asked about the consequence for our staff where they were failing to comply with basic standards. MS noted that the approach to audit had changed and this was now being done on a peer review basis. Historically there had been some element of 'marking your own homework' and that had resulted in compliance levels at 100% that she did not find assuring. This meant that although compliance had dropped it was more likely a realistic assessment of performance and we were now focused on improvement work with staff. It also reflected the assessment of a very broad range of staff, some ward based and others visiting ward areas from different professional groups. CC was concerned that this was not being addressed by our clinical staff and asked if we understood why this was not being done. MS noted that this came back to culture and behaviours and was something that needed continuous work to improve. iii. JW asked the medical director to look at the information provided in relation to patient D. This reported a perforated bowel some years after the procedure, and this seemed odd. **Noted:** The Board noted the Combined Quality Report.	IS	11/24
3.iii	**Director of Infection Prevention and Control (DIPC) Annual Report 2022/23** **Received**: From the Director of Infection Prevention and Control (Chief Nurse) the DIPC Annual Report 2022/23. **Reported:** By MS that: i. The report had been reviewed by the Quality and Risk committee and was recommended to the Board for approval. ii. The IPC team had been impacted by the level of surgical site infections in this year. iii. We had reviewed the hygiene code requirements and overseen the development of improvements in relation to this. iv. We continued to take part in all mandated surveillance and had scrutiny and oversight with the involvement of the ICB. v. M.Abscessus continued to be a priority with external stakeholders involved in our oversight group. vi. The report was written to link with the requirements of the hygiene code and the nine key areas if set out. **Discussion:** i. JW noted that the DH New Hospital Group had visited the hospital and were very interested in this area. The team had included microbiologists and one of their recommendations was around not having hand wash basins in patients' rooms as there were concerns around the opportunity for these to cause		

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	contamination. They envisaged most of the hand hygiene in rooms being managed through gels but there was some concern that this would also have contamination issues. MS noted there were several infections where hand washing was the gold standard. We would be looking at how we could reduce the number of water outlets as a part of our overall programme. JW noted that it would be good to see the evidence but noted concern with the optics of removing hand washing stations given the current issues around surgical site infections. ii. DL asked how patients accessed facilities for hand washing and teeth brushing in their rooms. MS noted that these were provided in the en-suite bathrooms and that the sinks in patient bedrooms were purely for the purpose of hand washing. Used inappropriately, for example for brushing teeth, could create significant IPC risks. iii. EM noted that we also needed to empower our patients to ensure that they felt able to challenge staff to wash their hands. **Noted:** The Board approved the Director of Infection Prevention and Control (DIPC) Annual Report 2022/23.		
3.iv	**Board Sub Committee Minutes:**		
	Received and noted: The Board of Directors received and noted the minutes of Board sub-committees held on: 3.iv.a. Quality & Risk: 31.08.23 3.iv.b Performance: 31.08.23		
4	**PERFORMANCE**		
4.i	**Performance Committee Chair's report** **Received:** The Chair's report setting out significant issues of interest for the Board. **Reported:** By GR that the Committee had considered the following key issues: i. The divisional report from the Thoracic and Ambulatory Division. He noted that non-executive director attendance at this presentations seemed to have had dropped in recent times. It was particularly good to hear from divisional leadership as this was a level in the organisation on which we depend. It was clear that they had a good grip and understanding of the issues within the division and whilst there were no silver bullets, they outlined a series of actions that were being taken to improve performance. This was all encouraging and they also demonstrated a level of innovation in the area. ii. We noted the move of caring from a green to an amber rating and this was because of one complaint that had a delayed response and was felt to be a rather harsh standard. iii. We recognised the continuing impact of industrial action on activity and performance standards, and noted the shift in the measure of utilisation and occupancy which we felt provided a clearer view of productivity. This looked at the overall goal of		

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	5/5.5 theatres as the measure against which we looked at utilisation and occupancy. We had struggled with how productivity gains and measures could be seen through our metrics and how these were being adversely affected by industrial action. iv. He noted the discussion on the patient safety initiative at a cost of £660k and had asked how well sighted the Board had been on the plans for this activity as he was not sure it had been communicated clearly. v. The STA improvement programme had shown some clear signs of improvement in the metrics, and we must now turn to the sustainability of this position. vi. We had also received and discussed the expanding elective care capacity letter which was on the agenda and was recommended to the Board for approval. This would also be discussed further on the Part II agenda. **Discussion:** i. EM advised that the first patient safety initiative weekend lists had been run in September and we wanted to get into this rhythm of delivery going forward. ii. TG noted that this had not been undertaken as a standalone measure and that RPH had embarked on this in discussion with the ICS and the national team who were aware of the proposal and that this would get us to a position of having no long waiters over 40 weeks. iii. HM advised that he had alluded to this opportunity in the BAF risk and earlier reports and could now articulate the impact over the three months of the programme. The activity was not above contract and reporting against this would go into PIPR. The income would be within assumptions, but the additional costs would be outside of this. GR noted it would be interesting to see the impact of this specific measure as that would allow us to see how this might be used in the future. **Noted:** The Board noted the Performance Committee Chair's report.		
4.ii	**Papworth Integrated Performance Report (PIPR)**		
	Received: The PIPR report for Month 5 (August 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. This was provided to the Board for information. **Reported:** By TG that: i. Overall, Trust performance was at a red rating. ii. GR had covered most matters but he felt it important to acknowledge the continued impact of industrial action and that managing to hit the recovery plan that we had set as a Trust in December 2022 was a significant achievement. iii. That te national financial position for the NHS was a £1.6BN deficit and the £700k surplus that the Trust was able to report needed to be seen in that context. The ICB had a £12M deficit but we were continuing to show positive performance indicators, although there would be some offset against that		

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	figure relating to the whole of the NHS group. **Discussion:** i. JA asked for clarification about the national figure and whether that was a year-to-date position. TG confirmed that this was the year-to-date deficit at month 4. ii. JW asked whether it was possible to understand what of this was due to issues around cover for industrial action. TG advised that this would be a significant proportion of the national and local system deficit. **Noted:** The Board noted the PIPR report for Month 5 (August 2023).		
4.iii	**Protecting and Expanding Elective Capacity** **Received:** From HM the self-assessment on protecting and expanding elective capacity. **Reported:** By HM that: i. The Trust self-assessment had been discussed in detail at the Performance Committee and had been signed and submitted by the Chair and Chief Executive following that review. ii. The standard in question 1B relating to 90% of our patients who had waited more than 12 weeks being validated by the end of 31 October would be a challenge that we would not be able to deliver. We were at 27% and were using the DrDoctor system to achieve this level of validation. The volume of patients subject to PIDMAS (Patient Initiated Digital Mutual Aid System) at RPH was a much lower proportion than other organisations and we expected to achieve the standard required in November or December. **Discussion** i. JA noted the Trust's position but felt this was an almost impossible task across the NHS. HM agreed noting that we needed to contact 90% of six and a half thousand patients waiting on our lists. The challenge for one larger NHS Trusts was some 196,000 patients of whom only 12% had been contacted. That was also a significant issue in that patients may be offered places for treatment with multiple providers and may appear on more than one waiting list. This requirement applied to only 25% of our activity as it would not apply to specialist and tertiary care referrals. However, our response was to look to treat all patients within the 40 week wait and we had a plan to get down to that with our Patient Safety Initiatives. ii. CC raised a concern as Audit Chair that the Board had been asked to consider the assurance being provided by the Trust after submission and that in future, she felt matters of this nature should be circulated to the whole Board ahead of submissions. EM agreed that that approach would be followed in future. **Agreed:** The Board ratified the Trust's self-assessment against the requirements of the NHSE letter on Protecting and Expanding Elective Capacity.		
5	**RESEARCH & EDUCATION**		

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5.i	**NHS England (previously Health Education England) Provider Self-Assessment** **Received:** A paper from the Assistant Director of Education on behalf of the chief nurse setting out the summary education self-assessment for NHSE. **Discussion** i. GR noted the reference to the continued development of the RPH school and asked if there were any issue in relation to the ongoing review of this. MS advised that we had a paper coming to the next Strategic Performance Committee and she did not think this would change the position in relation to the RAG rating of the submission. We would still have the governance structures in place that supported it. JW suggested that we should add a comment to the submission to note that this was subject to review. **Agreed:** The Board approved the education self-assessment for submission to NHSE.	MS	11/23
6	**BOARD FORWARD AGENDA**		
6.i	**Board Forward Planner** **Received:** The Board Forward Planner. **Discussion:** i. CC noted that there were no items listed for discussion on the January schedule and this meeting was now to be held. AJ confirmed that it been agreed and that the focus for this meeting would be the discussion on the EPR replacement. GR was concerned that he would not be able to attend the January date and would like to be fully involved in the EPR review. JA advised that a full Board workshop was being held in December and that should allow for contribution to the review process. ii. JW noted that the Board-to-Board meeting with CUH had also been confirmed and would be held on the 6 November 2023.		
6.ii	**Items for escalation or referral to Committee:** None		
7	**ANY OTHER BUSINESS**		
7.i	**Appointment of Associate Director of Corporate Governance** **Reported:** By OM that we had made an appointment to succeed AJ, and that Kwame Mensa-Bonsu would be joining the Trust on the 2 January 2024. He was currently Trust Secretary at Milton Keynes University Hospital NHS Foundation Trust and had been an excellent candidate for the role. AJ had agreed to provide cover in the role until December.		

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Signed

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Date

Royal Papworth Hospital NHS Foundation Trust
Board of Directors
Meeting held on 5 October 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