

Meeting of the Board of Directors
Held on 2 November 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
	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	Mr S Edwards	(SE)	Head of Communications
	Ms J Fowles	(JF)	Nurse Consultant
	Ms S Harrison	(SH)	Deputy Chief Finance Officer
	Mrs A Jarvis	(AJ)	Trust Secretary
	Mr A Magpantay	(AM)	Team Lead Occupational Therapist
Apologies	Mr M Blastland	(MB)	Non-Executive Director
Observers	Angie Atkinson, Paul Berry, Susan Bullivant, Trevor Collins, Clive Glazebrook, Marlene Hotchkiss, Josevine Mclean, Trevor McLeese, 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 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: 5 October 2023		
	Item 1.iv Chair's Report: Revised to read:		

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	<p>Paragraph 1: "...were not just a UK issue." Paragraph 2: "... of combined service..."</p> <p>Item 1.vi CEO's report: Revised to read: Reported iii: "...their contribution to the Trust." Reported vi: "...at Cambridge Medical Robotics..." Reported x: "...We do not..."</p> <p>Item 1.vii Patient Story: Revised to read: Paragraph 2: "...for three years; two as..." Paragraph 6: "...were not, struggled..." Paragraph 7: "...patients did not..." Discussion 3: "...manage mealtime..."</p> <p>Item 2.iii Veteran Aware Review: Revised to read: Discussion i: "DL asked whether..."</p> <p>Item 4.i: Performance Committee Chair's report: Revised to read: Reported i: "...at these presentations..." Reported ii: "...the move of the Caring domain..."</p> <p>Item 4.ii PIPR: Revised to read: Reported ii: "That the national..."</p> <p>Item 4.iii Protecting and Expanding Elective Capacity: Revised to read: Discussion: "...40-week..."</p> <p>Approved: With the above amendments the Board of Directors approved the Minutes of the Part I meeting held on 5 October 2023 as a true record.</p>		
1.iii	Matters arising and action checklist		
	<p>Item 27/23: IS noted that this matter related to an observation on the outcome of the inquest (not an action) and could be closed on that basis. Noted: The Board noted the updates on the action checklist.</p>		
1.iv	Chairman's report		
	<p>The Chairman noted that:</p> <ol style="list-style-type: none"> i. Board members had received the privacy notice relating to the Fit and Proper Persons test as we were implementing the revised guidance in relation to this. ii. He had attended the Harveian Oration at the Royal College of Physicians. This had been delivered by Sir Patrick Vallance who was now chair at the Natural History Museum and was working with health startups. iii. He had attended the CUHP meeting and that would be discussed later on the agenda. iv. Staff from the Queen Elizabeth Hospital Kings Lynn had visited the trust yesterday as they were planning the build of their new hospital and wanted to learn from our experience. v. He was concerned about the issue of smoking on the campus and felt we needed to do more to address this as leaders. vi. The death had been announced of Murray Elder a Scots politician who had a heart transplant and whose sister had been transplanted at Royal Papworth. 		

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1.v	Board Assurance Framework		
	<p>Received: From the Trust Secretary the BAF report setting out:</p> <ol style="list-style-type: none"> i. BAF risks against strategic objectives ii. BAF risks above appetite and target risk rating iii. The Board BAF tracker. <p>Reported: By AJ:</p> <ol style="list-style-type: none"> i. That there had been no change in residual risk ratings. ii. The key issues included: <ul style="list-style-type: none"> • The continued impact of industrial action. • Activity recovery and productivity where we had the STA Continuous Improvement programme in place, and we had seen the opening of the sixth theatre and continued with our Patient Safety Initiatives (PSIs) to reduce harm for our patients waiting over 40 weeks. • The continued high rates of surgical site infections where our governance structure was maintaining a focus on compliance with decolonisation treatment, cleaning, and decontamination audits. • The financial uncertainties relating to our medium-term plan which included risks associated with the delegation of specialised commissioning and the EPR replacement programme. <p>Discussion:</p> <ol style="list-style-type: none"> i. AF asked about the reference to industrial action and whether we had reports that provided detail on where we were seeing strike action. HM advised that after-action reviews (AAR) were undertaken on each occasion, and that we had staff numbers of by professional group. The AAR was scheduled to come to the Performance Committee in November and Board in December. ii. JW noted that certain areas were more problematic because of their impact across services. HM agreed noting that if members of the MDT took strike action in the Cath labs, then we would lose the whole of the caseload, whereas in theatres we could be more flexible in our response. <p>Noted: The Board noted the BAF report for October 2023.</p>		
1.vi	CEO's update		
	<p>Received: The Chief Executive's update setting out key issues for the Board and progress being made in delivery of the Trusts strategic objectives. The report was taken as read.</p> <p>Reported: By EM that:</p> <ol style="list-style-type: none"> i. Her report had been held so that the announcement relating to Tim Glenn's secondment to East Kent Hospitals could be included within it. He was joining the trust on a 12-month secondment to support recovery particularly through the winter period. This request had come through the national team at NHSE, and it was not without its challenges. This was an opportunity for Sophie Harrison, Deputy CFO to step into the CFO role on an interim basis as we had succession plans in place for this circumstance. SH's expertise and contribution to 		

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	<p>the system had also been noted by the regional team.</p> <ul style="list-style-type: none"> ii. We had a visit from West Hertfordshire as a part of their hospital rebuilding programme as they were planning redevelopment on an existing site, and they were keen to learn lessons in the design and transfer to a new facility. iii. We had seen the continued impact of industrial action as had been discussed. iv. Our PSIs had now been in place for four weeks and we had seen over 300 patients benefiting from this approach. Staff were volunteering to help us address the safety issues in relation to our longest waiting patients. This was an example of how our staff supported patients in a compassionate way. v. We had received 512 nominations for our staff awards and she had the pleasure of being on the judging panel. This had given her some immense pride and reflected our Trust values. It was wonderful to see so many colleagues being nominated. vi. The national staff survey continued, and we were encouraging our staff to respond to this. vii. In October we had Black History Month events and our staff and Executive had attended these celebrations. We had also held events for national Allied Health Professional day and had run Freedom To Speak Up events throughout the month of October. viii. We had seen a slight improvement in relation to surgical site infections and continued to focus this area through our governance oversight group. This included implementation of actions from the peer review and our visit to the Liverpool Heart and Chest Hospital. ix. The Cardiac Rehabilitation team had regained their national accreditation, and we had seen a world first and commercial first in research led by Professor Andrew Klein. This was in line with our research strategy which was gaining momentum. x. AR had represented the trust in Brazil, and we had been shortlisted in the Health Technology News awards for our collaborative work with DrDoctor which was delivering real patient benefits. <p>Discussion:</p> <ul style="list-style-type: none"> i. JW noted that Mr Giuseppe Aresu Thoracic Consultant Surgeon had returned to the Trust following time abroad where he had spent time working with transplant surgery teams and we hoped to emulate this approach at RPH. ii. TG thanked the Board for their support and kind words noting that the Trust had a fantastic team. He would be away for a 12-month period and was looking forward to his return. He also noted that SH was ready to take on this role. JW noted that there would be further discussions on the support that might be needed for executive staff for the duration of this secondment. <p>Noted: The Board noted the CEO's update report.</p>	EM/OM	12/23
1.vii	Patient Story		
	MS introduced the patient story. She welcomed Sandra and Jonathan Pang with Jo-anne Fowles, Nurse Consultant ECMO and Amil Magpantay, Team Lead Occupational Therapist. She noted her thanks for their attendance.		

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	<p>We had held the National Allied Health Professionals Day in October where she had heard this story and it recognised the collaboration between our AHP, nursing and medical teams as well as the patient and her husband. It outlined a collaborative approach to care and recovery. Sandra had spent 113 days on ECMO and 130 days in the critical care unit in total. Sandra had led her recovery with determination and support. Jo and Amil were a part of the team that had supported Sandra over the last year.</p> <p>Sandra thanked everyone at RPH for the care that had been provided to her and shared her thanks to God that she was here today sharing her story. She was a very busy 47-year-old mother working as a manager in a domiciliary care company. She had started her working career at Meldreth Manor school and had a busy home life with her three children. Out of the blue she was diagnosed with a rare autoimmune disease in early December 2022.</p> <p>On the 28 February last year, she was admitted to CUH following an appointment with her GP. She was moved to RPH on the 15 March as her lungs were giving way and she was very poorly. Her doctors advised that she had little chance of recovery. She was put on ECMO on the 28 March. She understood that many people were considered for this service, and that following assessment and acceptance the team had moved very quickly to put a plan in place for her care. She needed significant support and as she progressed, she was hoisted to be sitting up and started to engage in therapy, in the first instance standing up for perhaps 10 seconds. This was a very long journey but with the help of the team she managed to progress.</p> <p>Her husband Jonathan worked at RPH came to visit her every day during her stay.</p> <p>She shared a short video of how staff had worked with her. She told that how Board staff pushed her to walk, noting they were very pushy, and she was very slow, but with persistence her walking became better. There were major logistical concerns as she needed five staff to turn her or to exercise with her, and she was aware of the problems with staffing levels across the trust. A friend had visited her from the United States and was very surprised at the number of staff that were there to support her noting that would not be provided to the same level in her home country. She said that the staff were fantastic and that she was incredibly pleased with the care given to every patient.</p> <p>She shared a video of Amil the occupational therapist who had worked with her whilst on the Critical Care unit. He played his guitar whilst getting her to exercise to improve her hand coordination. They used handheld shakers which she had to play in time to the music. This was a brilliant session and a wonderful approach to rehabilitation.</p> <p>Nursing staff had pampered her during her stay providing a foot spa, washing her hair, and applying face masks and she really appreciated the time the team gave to her. She also saw how they worked together. A visit outside needed a doctor, a perfusionist, a critical care nurse and a care assistant, but it meant that she could see the sunshine which she felt was therapy and allowed for a whole village of visitors to come to see her for a few minutes.</p> <p>After she had been on ECMO for 116 days she was decannulated. She was very glad to come off ECMO, but it was a very difficult</p>		

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	<p>process, and was a roller coaster with some days better than others. She had a pneumothorax that meant she was not able to engage with rehabilitation and walking for a few days which was very frustrating. She was not really able to comprehend the process, but she progressed increasing the reduction in oxygen support for periods from two hours to 24 hours. She needed to relearn how to eat, to use a commode, and how to live without the ECMO machine. Jo had been up-front on her last day on ECMO, and her strategy was that you can do this, as the oxygen support was now very low. That supported her for a final 40-hour period, and she was then taken off ECMO.</p> <p>She wanted to express her thanks to all staff on the ward. They had helped her and Jonathan celebrate their 19th wedding anniversary whilst on the ward and she was very glad to share the story of ECMO that had saved her life.</p> <p>Jo noted that everyone in the team had worked hard but that Sandra had worked the hardest.</p> <p>Jonathan talked to the Board about the reasons for RPH moving to the biomedical campus and said he could see how the close collaboration between CUH and RPH had supported swift decision making and had allowed medical staff from CUH to attend here to collaborate in his wife's care.</p> <p>Amil noted that critical care was not usually a place for occupational therapy interventions but there was now a drive for this to happen. For our ECMO patients we were looking at how we could increase the level of intervention offering treatments and going back to the roots of care at RPH. He needed to factor in the likes and dislikes of patients, whether they might like activities such as art perhaps decorating pebbles, or whether like Sandra they enjoyed music. The RPH charity had supported the opportunity to bring music into critical care and respiratory services and this showed just how this could be used.</p> <p>Discussion</p> <ol style="list-style-type: none"> i. JW agreed that it was very important for our long-term patients to be able to get outside. JF noted that the next project for the unit was how we could allow patients to be taken outside and not have to use the car park for this. ii. AF was overwhelmed by the story, humbled to see what we did and amazed by Sandra's determination and ambition. iii. DL thanked Sandra for the story and asked what care she would need going forward. Sandra said she would need reviews by the ECMO team and would be seen by Rheumatology and the Interstitial Lung Disease specialist nurses who would review her on a six-monthly basis. iv. GR asked if anything could have gone better in her stay. Sandra noted that it would be better if there were an exit that could accommodate beds other than the ambulance bay so that patients could be taken outside to see the duck pond. She also noted that there was miscommunication at times and at times she was confused by the different advice and plans received. JW noted that this could be difficult and challenging especially with such a big team involved in her care. v. EM told the Board that she had spent time with Amil on an 'in your shoes' walk and was incredibly impressed by the range of 		

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	<p>approaches that he used to help patients with rehabilitation. OM noted that Amil had many nominations in our staff awards and JA noted his contribution to the Ethics Committee.</p> <p>vi. CC noted the number of people needed to take patients outside and asked whether this was something that could be supported by volunteers. JW advised that each member of staff had different responsibilities in relation to moving ECMO patients and it was not like mobilising other patients.</p> <p>Agreed: The Board noted the patient story and thanked Sandra, Jonathon, Jo and Amil.</p>		
2	PEOPLE		
2.i	<p>Director of Workforce Report Received: The Director of Workforce provided an update on key workforce issues.</p> <p>Reported: By OM that there were a number of issues that would be being taken through the Workforce Committee before coming to the Board next month. She noted:</p> <ul style="list-style-type: none"> i. The progress being made on the WRES report. ii. That the staff survey was open until the end of November, and we currently had a 40% participation rate and were at 27% for our bank staff. We normally led participation rates for specialised hospitals, and we were currently just below average. We had been doing more communications and had asked managers to allow time for staff to complete this. We had focused this discussion with matrons and had been helped by the digital team providing iPads for use. We were looking at ways to encourage staff and would continue to work on this over the next month. <p>Discussion</p> <ul style="list-style-type: none"> i. JW asked whether we might be seeing survey fatigue as there always seemed to be a lot undertaken. OM said that this was also a marker of staff engagement. We had three more weeks to work with our clinical areas to see if we could improve this level and were talking with our staff to support this. <p>Agreed: The Board noted the update from the DWOD.</p>		
2.ii	<p>Freedom to Speak Up Guardian's Report Received: From the Freedom to Speak Up (FTSU) Guardian his report for Q1 and Q2 2023/24.</p> <p>Reported: By TB that:</p> <ul style="list-style-type: none"> i. This report covered Q1 and Q2 for 2023-24 and that activities had continued as planned. He had engaged in networks, in 1:1 sessions and events held in Freedom To Speak Up month and c.40 people had attended these, and we had many new volunteers to act as champions. He felt this gave some indication of the reach of the FTSU service. ii. The work of champions was done on a voluntary basis, and he felt they needed to remain as volunteers as they were able to sign post our staff across many areas of the Trust. iii. The Executive supported the FTSU role, and he had 1:1 		

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	<p>meetings where he was able to speak candidly. He felt the Executive wanted to know and to learn about issues. He also noted thanks to CC for her support to the role.</p> <p>iv. His report referenced the Countess of Chester Inquiry and the question to be considered was whether this could happen here. He noted that the FTSU guardians at the Countess of Chester had been Trust Board members, and there was some discussion around use of independent guardians.</p> <p>v. There were still some issues around the responsiveness of managers and leaders to the concerns raised and whilst curiosity had improved there were still differences in the response when concerns were raised.</p> <p>vi. The data trends were interesting. We had received 67 bullying and harassment cases in Q1 and Q2, compared to 73 in the prior year. Reports of detriment had also increased over time. This might be related to staff perceptions around workload, but it was difficult to define a reasonable workload and unfair treatment could cover a range of areas such as lack of access to CPD and concerns around career progression. There needed to be fairness in our processes and outcomes. Examples had included how we used 'essential' and 'desirable' criteria in appointments and that specifications were written to favour particular internal candidates. Other concerns related to re-employment and staff returning to areas where they were perhaps not so comfortable.</p> <p>vii. We had seen a plateau in relation to confidence in speaking up with 40% reporting that they were not confident to do so in our staff survey in 2022.</p> <p>viii. It was the role of our leaders to promote good behaviour across all staff.</p> <p>ix. We had received reports of racial discrimination and there were questions about the definition for this, and the intention of staff as this could relate to poor levels of access, or poor communications with individuals who had been excluded from CPD and study leave.</p> <p>x. Reports of incivility included unkindness, offensive banter and staff being shouted at across corridors. There was a sense that some of these were not being taken seriously by managers and staff were made to feel small. There was good empirical data relating to incivility and the impact that had on staff across the NHS, and it was a concern about the delayed timescales in response to this.</p> <p>xi. In terms of cases, one involved a staff member whose car had broken down on their way in and so they were late into work. A taxi was sent to collect them before the recovery service had arrived and they were asked to stay and make up the 2.5 hours that evening. This incident had been discussed with the individuals involved and with the team. Another case related to Christmas shift patterns and the unfair allocation of leave with some staff being seen to have their applications approved more than others. There is a need to ensure that we have staffing in place to provide essential services and ensure that staff are treated fairly. There were two further cases noted one relating to recruitment and the adjustment of person specifications and the second relating to sexual harassment</p>		

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	<p>and supporting staff in reporting this. The message was reinforced that this behaviour was unacceptable and that this should be reported.</p> <p>Discussion</p> <ul style="list-style-type: none"> i. OM thanked TB for the work that had been done in freedom to speak up month. She noted that he went above and beyond his role for the Trust and demonstrated the Trust values. ii. GR agreed we were lucky to have TB. He asked about the process of escalation and the reaction from divisions and managers and whether that had changed over time? TB said that it had but there were continuing difficulties and defensiveness in some areas, which OM was aware. There was a willingness to know more and a better level of curiosity. All staff were encouraged to speak to their line managers as that was where issues could be addressed. There were areas that were more defensive and less open at their meetings, and he continued to push in these as his role was to serve the organisation and he needed to make staff aware of the right of access to the FTSU Guardian. iii. His academic background drove a particular area of interest in training, and we had leadership development programmes that were being delivered and had civility and microaggression workshops in place for our staff. He felt there was progress in this area and that more people were more willing to hear and to understand why this was important. iv. DL was concerned about the increase in bullying and harassment numbers and asked if this was happening across the Trust and how we could support colleagues. TB noted we had discussed with the leadership team and where staff were perhaps not complaining through dignity at work processes, but they were willing to engage with FTSU. There had always been some fear in other speaking up processes and the potential impact on team dynamics, but this could be about staff wanting others to know that issues had been raised. v. OM noted that that it was entirely normal to feedback about someone behaving badly and we supported staff to talk in this way but addressing patterns of behaviour was difficult and needed skill. One department were looking at how to deal with emerging issues, and this approach was seen in other trusts and in Royal College reports. We were focused on the individual and issues around right to reply but it was perhaps more appropriate to look at patterns of behaviour. vi. CC thanked TB for his report and noted she had monthly meetings which were open honest and patient with her. She asked about the implications from the Letby case in relation to independent guardians and whether he supported that approach. TB noted that he mentors independent guardians who work at the Queen Elizabeth Hospital in King's Lynn. There had always been a question around the level of independence, but he felt it must be a balance. There could be tensions for example if you worked in the same area as a staff member raising concerns, but organisational knowledge was also important and there was no real benchmark on the grade of staff undertaking the role. vii. AF thanked TB and noted his skills, ability, and approach to 		

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	<p>this role. She felt we may be missing a trick by not focusing on core hygiene factors as these were intrinsic in terms of time for CPD and appraisal rates, as what was required of our staff was not just the contribution through their clinical role. This matter would be picked up in the workforce discussions.</p> <p>Noted: The Board noted the report from the FTSU Guardian.</p>		
3	GOVERNANCE		
3.i	<p>Q&R Committee Chair's Report Received: The Q&R Committee Chair's report setting out significant issues of interest for the Board.</p> <p>Reported: By JA that:</p> <ul style="list-style-type: none"> i. AF had challenged the committee to consider the areas of focus and whether the papers and issues considered were appropriate. The committee agreed that these were and were mindful of the lengths that our staff go to deliver good results and the pressure this could result in. ii. The number of surgical site infections had reduced but the rate was higher than the level we experienced on the old site. The NHSE recommendations all had plans in place which was reassuring. iii. The IR(ME)R recommendations from the previous CQC inspection and improvement notice had all been completed. iv. We heard a very positive story from the pulmonary hypertension team on how they were able to support patients to self-manage and therefore reduce the frequency of visits to the hospital. v. We also focused on the issue of supervisory time for our nurse leaders. <p>Discussion</p> <ul style="list-style-type: none"> i. JW noted the tension for our staff in managing competing risks and time pressures. <p>Noted: The Board noted the Q&R Committee Chair's report</p>		
3.ii	<p>Combined Quality Report Received: A report from the Chief Nurse and Medical Director which highlighted information in addition to the PIPR.</p> <p>Reported: By MS that:</p> <ul style="list-style-type: none"> i. We had a quality assurance visit from the ICB and that had focused on surgical referral pathways and the movement of patients through the system. It had also looked at our Surgical Site Infections with a focus on the lessons learned and the plans that we had in place to address these. The visit was from the governance and quality teams at the ICB who had nursing backgrounds and were informed and competent. <p>Discussion:</p> <ul style="list-style-type: none"> i. CC asked what the acronym NEWS stood for. MS advised that this was the National Early Warning Score. This included regular monitoring of measures such as blood pressure and 		

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	<p>pulse and it generated an alert if patient data was outside set parameters.</p> <ul style="list-style-type: none"> ii. DL asked about the frequency of the ICB visits. MS advised that we had regular quarterly visits and the ICB would work with us to select an area for focus and these matters were picked up through our regular meetings with them. We also picked up actions outside of our usual processes. iii. JA noted that it was good to see the positive preliminary report for the Surgery Transplant and Anaesthetics division. <p>Noted: The Board noted the Combined Quality Report.</p>		
3.iii	<p>Audit Committee Chair's Report Received and noted: The Board received and noted the Audit Committee Chair's report setting out significant issues of interest for the Board.</p> <p>Reported: By CC that:</p> <ul style="list-style-type: none"> i. In an update to her report, an error had been found in the charity accounts that needed to be corrected before these would be brought to the Trustee Board for approval. ii. The committee had received the outcome of three audits two of which were rated as limited effectiveness. One of these would be going to Quality and Risk for oversight and the second relating to appraisal would be looked at through the Audit Committee. She felt that we had more confidence in the reports coming through from BDO given the challenge that was included in these. <p>Discussion:</p> <ul style="list-style-type: none"> i. TG advised that the final review of the Charity accounts had identified a movement on the pay line. This was because we had not journalled two months of pay for charity staff and this was a material figure for the charity. We were in the process of amending the accounts to correct this error. We would also review the controls that were in place to deal with this going forward. ii. TG noted that it was a testament to the Trust that we were not picking safe areas as the subject of audits and were using this resource to address concerns and difficult issues, and this was a part of a healthy learning process. iii. JW noted that he was keen for us to use reports such as audit and inquests to understand the questions of what happened and why so that we were able to learn from our experience. <p>Noted: The Board noted the Audit Committee Chair's Report.</p>		
3.iv	<p>Board Sub Committee Minutes 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: 28.09.23 b. Performance: 28.09.23 c. Workforce: 28.09.23 		

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4	PERFORMANCE		
4.i	<p>Performance Committee Chair’s report</p> <p>Received: The Chair’s report setting out significant issues of interest for the Board.</p> <p>Reported: By GR that the Committee had considered the following key issues:</p> <ul style="list-style-type: none"> i. A deep dive into productivity. It would turn its attention to the financial position of the Trust at its next meeting. ii. The improving signs in relation to our resource optimisation and productivity, but these were being offset by the impact of industrial action. The committee wanted assurance that what we were seeing were real improvements in our processes so that we would see benefits delivered once industrial action was concluded. iii. In terms of areas of concern the Trust was already undertaking deep dives in relation to RSSC and Referral To Treatment times and our cancer targets, and were due to receive reports on those areas next month. iv. The flow improvement programme was central to delivery, and we were re-initiating that but were concerned that we may face initiative overload. The committee were assured that much of this programme was bringing together disparate initiatives that were already underway within the trust and this was good for our staff and patients. v. In positive news, despite the low occupancy in critical care we were still managing to maintain our theatre throughput and that had been delivered by optimising our bed capacity and managing the theatre capacity and flow more effectively. vi. The committee noted however that if we did not have ongoing industrial action, we still would not be opening to 36 critical care beds because of the issues relating to staffing levels, rostering and sickness. vii. The STA productivity work was going well but there was a concern on sustainability if cultural issues were not addressed. viii. We noted the recovery on capital expenditure in relation to our financial position and would hit planned levels by the end of the year. We were looking understand delivery of plans around our strategic initiatives funding as this had been underspent and would return to this topic at the next meeting. <p>Discussion:</p> <ul style="list-style-type: none"> i. JW asked whether areas had asked for too great a level of investment rather than having under spent against plan. TG advised that this may be an issue of phasing for example the research and development team were not yet recruiting principal investigators and it would likely be these sorts of issues that had affected spend. <p>Noted: The Board noted the Performance Committee Chair’s report.</p>		
4.ii	Papworth Integrated Performance Report (PIPR)		
	Received: The PIPR report for Month 6 (September 2023) from the Executive Directors (EDs). This report had been considered at the Performance Committee and the Safe and Caring domains were		

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	<p>discussed at Q&R Committee and was provided to the Board for information.</p> <p>Reported: By TG that:</p> <ol style="list-style-type: none"> i. Overall, Trust performance was at an Amber rating. He noted it was fantastic to see the improvement in rating and this was because of improvement in the effective domain. ii. The safe domain was rated red because of staffing elements. iii. People management and culture and Responsive were both seeing continued difficulties related to industrial action and culture and engagement. This was impacting on sickness absence and therefore we remained at a Red RAG rating. iv. The financial position was also at an amber rating because of the impact of industrial action. We expected further announcements in relation to this after the Autumn Statement. <p>Noted: The Board noted the PIPR report for Month 6 (September 2023).</p>		
4.iii	<p>Annual Assessment Against NHSE EPRR Core Standards</p> <p>Received: From the COO an update on the annual assessment of Trust Compliance against the Emergency preparedness, resilience, and response (EPRR) Core Standards.</p> <p>Reported: By HM:</p> <ol style="list-style-type: none"> i. That the report had been discussed at the Performance committee who had seen the two versions. ii. The change from the first report was to a level of substantial assurance and that had been approved by our ICB system partners. iii. The initial submission was done prior to the audit process, and the submissions formed the annual report to the Board. <p>Discussion:</p> <ol style="list-style-type: none"> i. DL asked about the assessment of these seven domains where we were not fully compliant. HM advised that under the act all measures were important and required assessment but a number of these would not be relevant to RPH and so we would never be compliant with some as we were not asked to undertake these services. There were others that were relevant and where we were not compliant such as the requirement of 100% compliance in relation to training and we would strive to improve that position and expected to achieve that in year. <p>Noted: The Board noted the outcome of the self-assessment against the EPRR core standards.</p>		
5	RESEARCH & EDUCATION		
5.i	<p>Research & Development Update</p> <p>Received: From the Director of R&D an overview of the Research & Development Directorate activities.</p> <p>Reported: By PC that:</p> <ol style="list-style-type: none"> i. The report set out an update on the research and development strategy the cornerstones of which were: <ul style="list-style-type: none"> • The investment in people and diversity 		

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	<ul style="list-style-type: none"> • The support for the 0.5WTE leadership posts to drive research at a variety of levels and support the development of non-medical research which was a part of the plan along with a non-medical research committee. • The research skills course which was to be re implemented this month. • The agreement on the tissue bank to relocate to the HLRI. He was grateful for the support that had been received in this area and noted that we had ethics approval for the renewal of the five-year licence for the tissue bank. <p>ii. We had strategies within our five-year plan which addressed:</p> <ul style="list-style-type: none"> • Research appointments • Study approval times being reduced by 25% • The establishment of the AHP and Nursing steering group • The 25% increase in the trial activity • The digital strategy and that would provide a more streamlined approach. <p>iii. The Gantt chart within the pack summarised where we wanted people to come online in the different phases of the strategy. These appointments were approved and would increase research capability within departments.</p> <p>iv. We went out to advert for the governance support post and had a locum cover in that which had helped us through recent months. We had a clinical project manager in place along with a QA manager and research posts. The projections for research leaders included in the graphic demonstrated progress in line with plan.</p> <p>v. The governance process for getting trials through was very different for each trial and we needed to manage and improve the performance in this area. There was some variability in the time for approvals the national average being 90 days. In this quarter we were at 83 days. Previously this had been worse, and we recognised the need to reduce the time taken for approvals.</p> <p>vi. The future actions included: the appointment to the governance post, which was due in December; securing additional support from the local NHS; obtaining additional pharmacy support and considering throughput against those measures.</p> <p>vii. We had looked at the approvals process and it is a long one particularly when you have collaborations with material transfer agreements and with the UoC and this could be improved. In terms of directorate approvals some were good, others were slower. We had an element of non-standard contracting, and we were trying to encourage use of standard documentation across all industries and Trusts through the NIHR. Our staffing capacity also meant that we needed to have measures in place to address the NIHR benchmark. The Liverpool Heart and Chest hospital was similar and if we compared relative positions their recruitment, we were lower, but number of trials was higher. That may be associated with them having a greater number of observational trials with very</p>		

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	<p>high numbers of patients recruited. The time taken to move to trial, compared reasonably.</p> <p>viii. Our non-commercial work was down and that related to an increase in the complexity of studies being undertaken. This was led by our researchers and the facility provided in the HLRI to run more complex studies.</p> <p>ix. Income from research was projected to increase and this would be derived from both charitable and commercial funders. One of our strategies was to support our researchers to increase the level of successful applications for grants.</p> <p>x. We were also looking at diversity and work was underway to increase the diversity of research using patient ambassador panels. We would look to use indices of deprivation to compare the number of patients in services at RPH with the number of patients in research trials. It was clear that the less deprived patients were more likely to participate in research.</p> <p>xi. The number of grant applications had dropped off but was now starting to recover. Grant income had been lower but was now recovering.</p> <p>xii. The library provided a list of research publications that was updated each month.</p> <p>Discussion</p> <p>i. GR asked about the governance around trials. PC noted that these were subject to legal agreements and there was an administrative process in place to ensure that we could legally and safely run trials.</p> <p>ii. JW noted that the clinical research facility doors were often closed, and beds were not occupied, and asked how we could get this working. PC noted that we met regularly with the clinical research facility leadership group, and he was assured that we were running trials to the capacity of the staff that we had. TG noted that we had something of a dichotomy as compared to what was done in start-up versus other units, we were performing well but there was frustration around the pace of interventions.</p> <p>iii. JA shared those concerns and asked about the size of the team and whether we took on all types of studies and trials or had a more focused approach on what we did well. PC advised that we had a clear area of focus and turned down studies that were not suitable for the HLRI or the Trust.</p> <p>iv. JA asked about research governance and the reach of the information provided and whether our directorates provided assurance on the conduct of trials and adherence to protocols. IS advised that there was regular audit of compliance with protocol and suggested that a slide could be added to reflect the outcome of this. There were no untoward conduct findings or data fraud findings. Dr Vicki Hughes would run the audit processes and we were awaiting an MHRA inspection, but he expected that everything would be up to standard in this area.</p> <p>v. JA noted that the focus on EDI in trial recruitment and the commentary on being underrepresented in terms of referrals would not allow us to shift the dial in terms of participation from underrepresented groups and this would need to be addressed. MS noted that patient experience was considered</p>	PC/IS	02/24

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	<p>in each individual study. IS advised that this was part of the design of audit process and that further questions could be added to explore this.</p> <p>vi. IW noted the delays following receipt of valid applications and he found these worryingly. He noted that this approach was taken in other centres, and we needed to ensure that we did not reinvent the wheel an approval time of 100 or 200 days from receipt of a valid application was a very extended process and we needed to consider how this could be addressed.</p> <p>Agreed: The Board noted the update from Director of R&D.</p>	<p>PC/IS</p> <p>PC/IS</p>	<p>02/24</p> <p>02/24</p>
6	STRATEGIC DEVELOPMENTS		
6.i	<p>Trust Five Year Strategy – Year Three Review</p> <p>Received: A paper setting out an update on the delivery of the Trust Strategy 2020 - 2025, on the third anniversary of its launch.</p> <p>Reported: By HM that:</p> <ul style="list-style-type: none"> i. The report could be taken as read and had been discussed at the Strategic Projects Committee. ii. That there may be some changes to strategy documents in relation to both workforce and the RPH school and these changes would feed into our operational planning processes. iii. That we had reviewed this system plan and aligned our activities and priorities, and these were set out in the summary document. <p>Agreed: The Board noted the update from the Chief Operating Officer.</p>		
7	BOARD FORWARD AGENDA		
7.i	<p>Board Forward Planner</p> <p>Received and Noted: The Board Forward Planner.</p>		
7.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 2 November 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