Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Held on 05 September 2024 at 11:15 am
In Rooms 88 & 89 HLRI and on Microsoft Teams
Royal Papworth Hospital

UNCONFIRMED M I N U T E S – Part I

Present	Dr J Ahluwalia	(JA)	Chairman
	Mr M Blastland	(MB)	Non-Executive Director/Deputy Chairman
	Prof I Wilkinson	(IW)	Non-Executive Director
	Ms D Leacock	(DL)	Non-Executive Director
	Dr C Paddison	(CP)	Associate Non-Executive Director
	Mrs E Midlane	(EM)	Chief Executive Officer
	Dr I Smith	(IS)	Medical Director and Interim Deputy Chief Executive Officer
	S. Harrison	(SH)	Interim Chief Finance Officer
	Mr H McEnroe	(HMc)	Chief Operating Officer
	Ms O Monkhouse	(OM)	Director of Workforce and OD
	Mrs M Screaton	(MS)	Chief Nurse
	Mr A Raynes	(AR)	Chief Information Officer & SIRO
In Attendance	Mr S. Edwards	(SE)	Head of Communications
	Dr Nik Johnson	(NJ)	Mayor of Cambridgeshire and Peterborough Combined Authority (For Item 1 – Patient Story)
	Dr Donna McShane	(DMcS)	Consultant in Respiratory Paediatric Medicine, Addenbrooke's Hospital (For Item 1 – Patient Story)
	Dr Patrick Calvert	(PC)	Consultant Interventional Cardiologist and Director of Research and Development (For Item 5 – Research and Development Update)
	Professor Charlotte Summers	(CS)	Director of the Victor Phillip Dahdaleh Heart and Lung Research Institute (VPD-HLRI)
	Ms Lisa Steadman	(LS)	Head of Nursing
	Mr K Mensa-Bonsu	(KMB)	Associate Director of Corporate Governance
Apologies	Ms C Conquest	(CC)	Non-Executive Director/Senior Independent Director
	Mr G Robert	(GR)	Non-Executive Director
	Ms A Fadero	(AF)	Non-Executive Director
Observers	Ms A Halstead – Public Governor/Lead Governor		
	Dr C Glazebrook – Public Governor		
	Dr H Perkins – Public Governor		
	Mr J Davies – Partner Governor, Cambridge University Hospital (CUH) NHS FT		
	Mr T Collins – Public Governor		
	Mrs J McClean – Staff Governor		

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1	**WELCOME, APOLOGIES AND OPENING REMARKS**		
	JA welcomed everyone to the meeting and noted the apologies from CC, GR and AF. JA introduced NJ and DMcS.		
1.i	**Patient Story**		
	Presented: JA provided the background to the patient story, which was about the experience of NJ and his family, while he was a patient at RPH. **Patient Story:** a. NJ introduced himself and his wife, DMcS. NJ advised that he and his wife did share a common love for Paediatrics, and both were Consultant Paediatricians. b. NJ stated that he was now the Mayor of Cambridgeshire and Peterborough Combined Authority, but remained a strong advocate for the NHS, and for RPH in particular. c. NJ informed the Board that his time as a patient had been problematic, while his family had been significantly exposed to quite a traumatic experience. d. NJ stated that, as doctors, he and his wife understood that the circumstances in the treatment of patients were not always as they should be. NJ added that they also understood that there was a level of risk involved in the provision of healthcare. e. NJ stated that he would, however, be forever grateful for the care he received before and during the first surgical procedure he underwent. NJ stated that he was also grateful for the care provided during the follow-up procedure undertaken due to complications which arose after the first procedure. f. NJ advised that, as a doctor, he accepted that such complications could happen and was proud to have been a patient who had survived two cardiac surgical procedures. NJ stated that he was now an advocate for healthy living and was living as an example of how one could live well after undergoing serious surgical procedures. g. NJ noted that the events surrounding his treatment which had been problematic and had traumatised his family could be narrated better by DMcS, his wife. h. DMcS stated that NJ had attended RPH with mitral valve failure, which was a life shortening illness, and sufferers had a high risk of sudden death. DMcS noted that NJ had the procedures and been successfully cured of the illness, but there were questions, as to whether things could have been done differently and better managed. i. DMcS advised that during the journey through RPH, she felt that she was being listened to but was not being heard. In this vein, staff listened to her concerns about NJ's treatment, but did not intervene to resolve her concerns which left her disappointed and frustrated. j. As an example, DMcS observed that postoperative pain management for NJ had been poorer than expected. The concerns of DMcS were not accepted by clinical staff who had also noted that the pain threshold of young men was not high. k. DMcS stated that after the second surgical procedure, NJ had become opiate dependent but had no support for the steps which needed to be undertaken to wean him of the dependency. DMcS advised that NJ had endured significant difficulties with withdrawal		

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	symptoms which also impacted negatively on her as a working mother of three children. l. DMcS also highlighted a very traumatic incident after the first surgery, when NJ was getting ready to be discharged. NJ started to deteriorate, and this was because his heart had begun to bleed into its cavity. If this form of bleeding continued, it would cause the heart to progressively get compressed, leading to NJ's death. m. DMcS stated that for about an hour she contacted 3 different nurses who all correctly identified that NJ's heart was probably bleeding into its cavity but then failed to make the necessary escalation for expert intervention to be sought. DMcS noted that in that period, she didn't want to make a scene so did not ring the 'cardiac arrest bell' for expert help to be summoned. n. DMcS reiterated that throughout the episode when NJ's heart was bleeding , she felt she was being listened to but was not being heard. DMcS stated that the nurses had not undertaken any of the safety checks to confirm the cause of NJ's deteriorating condition and suggested that this may have been because NJ was considered to have been discharged. o. DMcS stated that the Trust had not provided any opportunity for a review of the events surrounding the period when NJ developed complications and deteriorated. The family was not concerned about the complications but were concerned about the fact that no steps were taken to intervene quickly enough. p. NJ, noted that he had limited memory of his deterioration, but was also concerned by the comments from clinical staff that young men had a low pain threshold. NJ stated that these comments were expressed at a point when he was in serious pain and dying. q. NJ stated that the consulting surgeon had conducted an outstanding procedure to repair his heart but there was an underlying cultural belief that nothing went wrong at RPH which needed to be tackled. Tackling such a belief would help ensure that problems were more quickly recognised and corrected. **Discussion:** r. JA thanked NJ and DMcS for attending the Board meeting to narrate their story. JA stated that it was a sobering series of events and concerns for the Board to absorb and seriously reflect on. s. MS thanked DMcS and NJ for their honesty and clarity, and their willingness to share. MS stated that RPH was committed to reviewing the experiences of patients and their families, learning from those and taking the necessary corrective measures. t. DL thanked NJ and DMcS for sharing their story and wondered if the outcome would have been significantly different had the couple been lay people and not medical doctors. DL stated that a lay person in DMcS's place may not have noticed the deterioration in NJ and would not have persisted in seeking expert medical help. DL thanked DMcS for her persistence and expressed the hope that the appropriate lessons would be drawn by the hospital. u. In response to MB's query on how this case which had no harmful outcome would be graded, MS stated that any event after a surgical procedure such as a cardiac arrest was thoroughly investigated and the lessons shared as appropriate. MS added that the event would then be graded after all the circumstances surrounding it had been fully investigated.		

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	v. MB observed that the patient story showed how much information could be gleaned from thoroughly interrogating a patient about their experience. This visit had provided significantly more information about the patient experience than the standard patient experience survey was able to. w. With reference to the practice of grading of serious 'no harm' incidents as 'near misses', JA advised that there needed to be a better way of categorising those type of incidents. JA stated that the question which needed to be answered was 'how close the patient came to a disastrous outcome'. x. JA stated that another issue which needed to be addressed was about how the hospital accommodated and allowed for psychological harms for patients and families, even when the physical harm had not been crystallised. JA advised that this was an area which the hospital needed to give some thought to. y. JA, in agreement with MS, stated that the hospital was committed to learning from such incidents and continuously seeking to improve. z. JA thanked NJ and DMcS for attending the Board to share their experience. **Noted:** The Board **noted** the Patient Story update.		
1.ii	**Declarations of interest**		
	There is a requirement that Board members raise any specific declarations if these arose during discussions. No specific conflicts were identified in relation to matters on the agenda. A summary of standing declarations of interests was appended to these minutes.		
1.iii	**Minutes of the previous meeting**		
	Board of Directors Part I: 06.06.24 **Approved**: The Board of Directors **approved** the Minutes of the Part I meeting held on 06 June 2024 as a true record.		
1.iv	**Matters Arising and action checklist**		
	a. **07/24** – Chairman's Report Agenda slot for Non-Executive Directors to provide feedback from any visits or other observations that they may have made during the prior month or two to a Part 1 Board meeting. **Closed.** b. **06/24** – Quality and Risk (Q&R) Committee Chair's Report Redesign Board Committees Chair report template so their reports could reflect the level of assurance received on items discussed or reviewed at the Committee meetings. **Closed**. c. **05/24** – End of Life Care Biannual Report - To provide the 'Learning from Deaths Annual Report' to the Board. **Closed.** d. **04/24** – Papworth Integrated Performance Report (PIPR) - To update the Board on how the 52-week breach allocations worked in terms of which provider was negatively impacted. **Closed.** e. **02/24** – Patient Story – Discharge Lounge: To review whether a screen could be provided so patients waiting in the Discharge Lounge could see updates on when their medications would be ready. A screen providing updates had been installed. **Closed.**		

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	f. **01/24** – Quality and Risk Committee Chair's Reports For Meetings On 21 December 2023 and 25 January 2024: Potential Patient Claims in relation to historic cases of M. Abscessus. Scheduled to be provided on a 6-monthly basis to the Part 2 Quality and Risk Committee meeting beginning from September 2024. **Closed.** **Noted:** The Board received and **noted** the updates on the action checklist.		
1.v	**Chairman's Report**		
	Received: The Chairman's report. **Reported**: By JA that: a. He, together with EM, OM, KMB and the Chairs of Council of Governor Committees, had meetings in August 2024 to review and revise the terms of references of the Council of Governor Committees. The Governance Assurance Committee had been resuscitated, while steps were being taken to develop a terms of reference for the Council of Governors. b. The Surgical Site Infection (SSI) Summit held in August 2024 was well-attended by the clinical staff. The staff was also very engaged with the issues that were discussed during the Summit. JA thanked IS and MS for arranging the Summit and noted that follow-up summits had been planned. c. JA undertook another evening visit in August 2024. JA advised that much of the visit was spent directing visitors to the right wards so they could visit their relatives and friends. JA stated that the reception desk was not manned after about 5:30pm but visitors were arriving throughout the night. JA stated this was an area which could be improved. d. The enhanced recovery unit (ERU) had staff who were enthusiastic, positive and motivated and were looking forward to expanding the number of beds in the area. The ERU had expanded for 5 to 10 beds since its establishment in May 2024 and had since contributed significantly to improving the patient flow in the hospital. JA thanked HMc and everyone else who had been involved in initiating and establishing the ERU. e. The ERU was a new dedicated space which had been opened within the Trust's Critical Care Unit for the enhanced recovery of some patients after cardiac surgery. The ERU was intended for people who were predicted to be in critical care for fewer than 48 hours following their cardiac surgery, before being discharged to the surgical ward. f. The South Asian History Month in August 2024 was well organised and well attended. The different types of South Asian foods had also been heavily patronised, and motivating and inspirational stories were shared by staff who had travelled far from their countries of origin to work at RPH. g. JA together with IS and, in the past with EM, had been attending induction events for new staff. JA complimented the Trust's recruitment staff for their ability to recruit staff from all over the world. h. JA advised that he had met recently with Professor Steve Barnett, Chair of North West Anglia NHS Foundation Trust's Board of Directors and Ms Mary Elford, Chair of Cambridgeshire Community Services NHS Trust's Board of Directors. The purpose of these meetings was		

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	to increase the dialogue as well as to see where those organisations and RPH could work together. i. It was announced at the end of August 2024 that the 500th balloon pulmonary angioplasty (BPA) had been carried out in the Trust. The BPA was a pioneering procedure for patients with a rare form of pulmonary hypertension, and RPH was the only hospital in the UK that performed the procedure. j. JA had attended an Innovation Session in September 2024. JA advised that the output from the session emphasized the key role that genomics will have in the future. JA stated that RPH needed to think about its approach to genomics and its genomic strategy, including as part of the new 5-year strategy. **Noted:** The Board noted the Chairman's Report.		
1.vi	**Board Assurance Framework (BAF)**		
	Received: The BAF report for September 2024. **Reported**: By KMB that: a. Versions of the report had been reviewed at meetings of the Performance Committee, the Workforce Committee, the Special Projects Committee (SPC) and the Quality and Risk Committee in July and August 2024. b. BAF 2901: Emerging ICB Strategy may not be aligned to the RPH Five Year Strategy. The entry was de-escalated from the BAF in July 2024 because all mitigations had been implemented and the target risk rating had been achieved for a number of months. c. BAF 3536: The Trust's ability to recover from a digital incident: A new risk entry was included on the BAF in July 2024 to provide assurance on the measures and actions being taken to help the Trust to recover from a digital incident d. BAF 3261: Industrial Relations – Industrial Actions. KMB highlighted a request from the Workforce Committee for the monitoring of BAF 3261 to be transferred from the Performance Committee to the Workforce Committee. This was because, as NHS staff salaries had been enhanced, the risk of industrial action impacting on activity and performance had significantly declined. On the other hand, industrial relations had declined due to developments around banding issues for nursing staff and other non-pay workforce related matters. e. All other progress updates were also highlighted for review. **Discussion:** f. DL advised that there was an outstanding action at the SPC for a decision to be made around whether BAF 858 would be split into different risk entries or not. BAF 858 was the risk entry related to the progress of the Electronic Patient Record System procurement project. The project was in business-as-usual mode and the suggestion was for the related BAF risk entry to be reviewed. g. JA advised that at a meeting in September 2024 between himself, EM, IS and Karen Panesar, Head of Medical Staffing, it was learnt the CT backlog (BAF 3433) position had continued to improve. It was also noted that staffing levels for CT Reporting and Radiology remained at 2018/19 levels while activity had increased. In response to JA's		

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	comment that the Medical Workforce Plan needed to be reviewed, OM stated that the review was in progress. **Approved:** The Board **approved** the transfer of BAF 3261 from the Performance Committee to the Workforce Committee. **Noted**: The Board **noted** the BAF report for September 2024.		
1.vii	**CEO's Update**		
	Received: EM presented the CEO's update. **Reported**: By EM that: a. Due to challenging public finances, it was unlikely that the new UK government would increase NHS funding. EM stated that the focus of the Trust should, going forward, be around living within its means and continuing to address the organisation's performance and productivity issues. b. Though the widespread incidents of civil unrest and overt racism across the country in the summer did not occur in Cambridgeshire, some of the Trust's staff felt anxious and scared for the safety of themselves or loved ones. The Trust's approach to supporting staff with enhanced leadership visibility, the promotion of active allyship and the deployment of appropriate flexible working arrangements on an individual basis had been very well appreciated. c. Two valued members of staff, Nisha Abraham and Malcolm Thatcher, had passed away since the last meeting. EM stated that both deceased members of staff would be missed and noted that members of staff had provided significant levels of support to both the bereaved families and to each other. d. Dr Hema Nair and Dr Lilian Sandu were appointed to the posts of consultant in anaesthesia and consultant in cardiothoracic radiology respectively in September 2024. e. The 2024 Annual Members Meeting would be held on 18 September 2024. f. The outbreak of the carbapenemase-producing enterbacterales (CPE) infection in July 2024 was quickly brought under control by the enhanced infection control measures implemented to prevent the spread of infection. In total, thirty-two patients were infected, and none of them were harmed. g. The Trust had progressed in July 2024 with the introduction of an AI technology known as Brainomix in Radiology. This technology helped to make faster treatment and transfer decisions for stroke patients by reducing the time for the transfer of images to the Trust's two stroke hub centres at CUH and the Royal London Hospital. h. Phase two of the Shared Care Record Project was close to going live. The aim of the project was to provide a platform for the health and social care data of RPH, CUH, North West Anglia Foundation Trust (NWAFT), Cambridgeshire Community Services NHS Trust (CCS) and adult social care services to be shared. Phase 1 of the project, which had been live since March 2023 provided RPH staff with a summary view of GP records and records held by Cambridgeshire and Peterborough Foundation Trust. **Noted:** The Board **noted** the CEO's update report.		

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1.viii	**NEDs Update**		
	Non-Executive members provided updates of their activities since the last meeting in July 2024: a. MB commented that there was usually a lack of adequate evidence which underpinned a lot of the presentations at meetings of the Trust's Clinical Practice Committee (CPC), of which he was a lay member. b. IS, in response, stated that this had been recognised and steps had been taken to redraft the forum's terms of reference. IS noted that this redraft exercise provided an opportunity for the position to be made very clear that the CPC meetings should be focused on transparently and comprehensively evaluating evidence. The CPC was not a forum for arguing the case for a particular new process or procedure without fully providing evidence of their benefit to patients. IS added that the goal was to encourage clinicians to 'push the boundaries' but to also be fully transparent about any risks associated with their proposals for new or updated processes or procedures. c. JA highlighted the ongoing debate around the Lucy Letby case and advised that any related decisions be deferred till all relevant issues had been fully explored. **Noted**: The NED updates were **noted**.		
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:** OM reported that: a. A Staff Story was presented by Jackie Pettitt, Co-Chair of the Trust's Women's Network. The Story was focused on the impact of participating in a staff network and being able to have the capacity to contribute positively to the organisation while developing themselves. Jackie also indicated how lessons drawn from her personal life were being utilised in the service of the Network. b. In terms of the vacancy rates, there was a very healthy recruitment pipeline through the winter season till the end of 2024/25. OM noted that, for instance, there were currently 72 nurses in the recruitment pipeline against vacancies of about 60 nursing positions. c. The Committee was also fully assured by the output of the Nurse Safer Staffing report. **Noted:** The Board **noted** the Workforce Committee Chair's report.		

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2.ii (a)	**Director of Workforce & Organisational Development (DWOD) Report**		
	Received: OM presented the DWOD report for review. **Reported:** OM reported: a. On the progress following on from the Culture/Equality, Diversity and Inclusion (EDI) Board Development session in June 2024. Steps were being taken to develop the structure of the whole day Culture/EDI event for leaders and managers of the Trust on 17 September 2024. b. That some steps had been taken to progress the Culture/EDI deliberations, so more visible leadership could be provided across the organisation on the issue. A smaller group of the Trust Board, including OM, MB, HMc, SH, SE, EM and JA, had been meeting weekly to shape the leadership vision on the Culture/EDI agenda and the associated leadership behaviour framework. c. OM stated that there had been engagements with focus groups drawn from a wide variety of stakeholders in the Trust to review and test the efficacy of the draft vision and leadership behaviour framework. **Discussion:** d. JA thanked all who had supported the work to progress the Culture/EDI programme. e. Dr Davies invited the Board, and the Trust in general, to a Consultant Forum on 16 September 2024 at CUH. The organisers of the Forum had arranged for Lord Simon Woolley to speak to the attendees on the importance of EDI from a staff and from a patient perspective. Lord Woolley was the Principal of Homerton College, University of Cambridge and a major voice on EDI issues in the UK. **Noted:** The Board **noted** the DWOD report.		
2.ii (b)	**Improving the lives of Doctors-in-Training – Gap Analysis**		
	Received: OM presented the report, 'Improving the lives of doctors-in-training - gap analysis'. **Reported:** OM reported that: a. This was linked to the national discussions that were undertaken during the remuneration-related industrial actions called by the resident doctors. The national discussions had highlighted other issues of concern for the resident doctors including their training conditions, terms and conditions and the structure of their contracts. b. That NHSE, during the negotiations with the resident doctors issued two letters to NHS employers setting out the areas that they wished NHS providers to pay attention to. c. Teams in Workforce and Clinical Education had jointly undertaken a review of the areas highlighted in the NHSE letters, and the findings had been discussed at Executive Committee and Workforce Committee meetings. d. The findings included a mix of issues which were either within the Trust's domain or the national NHS domain to resolve. OM stated that the discussions in the Committees' meetings had been related to the provision of rest facilities by the Trust. Other issues including the		

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	structure of training for junior doctors and training could only be resolved nationally e. The report provided an honest assessment of where further action could be warranted from the Trust. The Workforce Committee was partially assured by the report and asked for an update on the progress against the gap analysis's findings in six months. f. IS stated that NHSE had also set out their central concerns and requested responses from NHS Trusts detailing their compliance with the relevant criteria. The central concerns were mainly related to rota management for resident doctors, the criteria for which RPH was 100% compliant with. g. IS stated that steps had been undertaken to resolve priority issues local to the Trust, such as participation in the annual General Medical Council (GMC) survey so it matched that of other staff areas. The results from the 2024 GMC survey had been published and a report on it would be submitted to the September 2024 Workforce Committee. **Discussion** h. In response to DL's comment that the report was passive on the actions which needed to be undertaken to achieve compliance the NHSE's concerns, OM noted that the Trust was fully compliant with the criteria underpinning those concerns. OM stated that the Trust was, however, prioritising the resolution of issues local to the Trust, which were the contracts of locally employed doctors and rest facilities. Reports on the two issues had been reviewed at the Workforce Committee, and progress on the issues would be reviewed by the Committee in six months' time. **Noted:** The Board **noted** the 'Improving the lives of doctors-in-training - gap analysis' report.		
2.iii	**2023/24 Annual Nursing Inpatient Establishment Review**		
	Presented: MS presented the 2023/24 Annual Nursing Inpatient Establishment Review to the Board for approval. **Report:** MS reported that: a. The report described the Trust's approach to the setting of nursing establishments on the wards, the review of establishments, and how that was triangulated with professional judgement and patient safety and patient outcomes. b. Through the year there was an improvement in fill rates, which ensured that there was a significant decline in the redeployment of nurses. It was noted that this was a positive development, as the redeployment of nurses to wards or clinical areas which were not their usual places of work was the cause of some stress. c. The areas which needed to be improved included relieving the pressure on the sister-in-charge's supervisory time, which was key to maintaining the staffing levels and maintaining quality and safety. **Approved:** The Board **approved** the 2023/24 Annual Nursing Inpatient Establishment Review.		

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3	**QUALITY & GOVERNANCE**		
3.i	**Quality and Risk Committee Chair's Reports – July, August and September 2024**		
	Received: The Q&R Committee Chair's report setting out significant issues of interest for the Board. **Noted:** The Board **noted** the Q&R Committee Chair's reports.		
3.ii	**Combined Quality Report**		
	Received: A report from the Chief Nurse and Medical Director which highlighted information in addition to the PIPR.		
3.ii.a	**Surgical Site Infection (SSI) Summit Report**		
	Received: An update on the CPE outbreak and a report from the Chief Nurse on the SSI Summit held in August 2024. **Discussion:** a. MS noted that the control measures implemented to stop the spread of the CPE infection had been effective and well-supported. There was no infection from 22 July 2024 until 31 August 2024 when there was a report of one infection caused by indirect transmission. Overall, 32 patients had by infected by CPE, with none being harmed. b. MS stated that the recent indirect transmission showed that the CPE bacteria was still present in the hospital's environment. Though it was very difficult to clear the bacteria from the environment, the fact that there had been no infections until recently showed that the control measures had been effective. c. The Trust retained the support of the UK Health Security Agency (UKHSA). It was noted that the UKHSA had scheduled the Trust to attend and share the learning from the CPE outbreak at their annual conference in March 2025. d. IS stated that the fact that 32 people were cross infected with one bug meant that there was something intrinsically wrong, and that needed to be resolved. IS noted that the next step was to assess which of the new control measures had been most effective, and not a burden on the patients, so the Trust could maintain those. e. MS informed the Board that 140 staff had attended the Surgical Site Infection Summit on 08 August 2024. Elective activity in Theatres was stood down in the morning of 08 August to allow as many people as possible to attend. The purpose of the Summit was to take stock of the improvement actions already implemented, acknowledge the improvements made and then think about next steps. f. MS advised that the Summit was also utilised to successfully deal with some misconceptions about why the Trust had high SSI rates. MS highlighted the four areas of particular focus for the Summit as being: air monitoring and ventilation, diabetes, how to ensure the Trust's theatre environments and estates were utilised as they were designed for, and whether endoscopic vein harvesting had any impact on SSIs or not.		

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	g. Engagement by the attendees with the expert presentations at the Summit was vigorous, and at the end, there was some consensus on the areas the Trust needed to focus on in the effort to reduce SSI rates. MS advised that steps were being taken to agree and develop the structures for monitoring the effectiveness of any SSI control measures in the future. h. IS stated that the control measures implemented to manage the CPE outbreak had prompted the sense that, to further improve upon SSI rates, the Trust may also need to focus on ward behaviour as well. i. JA, who attended the SSI Summit, advised that the lasting impact for him was the opportunity to dispel some myths around, for example, laminar flow theatres. JA agreed that the Summit had provided a very good opportunity for such a discussion to be undertaken in the open. j. JA stated that holding the Summit had been a very good investment of time and suggested that more of such summits may need to be organised to progress with the SSI improvement work. k. MB advised that there was, however, some doubt about whether the focus on theatre footfall would completely resolve the SSI issue. MB suggested that though there was a consensus at the Summit on the level of accepted footfall, the expectation had been for much less footfall to be agreed on. l. MB also noted that there was no consensus on whether audio visual links to the HLRI must be implemented or not. MB suggested that, in his view, it was an overwhelmingly human factors problem, and this was probably reflected in the significant decline in SSI rates during the CPE outbreak. MB stated that the question that needed to be explored further was whether actions on the wards contributed to the SSI rates. m. MB advised that lots of work still needed to be implemented, noting that there was no assurance that the current actions being implemented would provide the required answers on the SSI rates. The Board's Quality and Risk Committee would monitor progress on the improvement actions and seek the necessary assurance that all options were being explored. n. JA advised that the work to control infection-causing bacteria was never ending and added that the nature of hospitals made achieving this an impossible target. The goal should be to implement effective infection control measures as infection causing bacteria would always be present in the environment. **Noted:** The Board **note**d the SSI Summit Report.		
3.ii.b	**2023 Adult Inpatient Survey Results**		
	Received: A report from the Chief Nurse on the Adult Inpatient Survey 2023 Results. **Report:** MS reported that: a. The report on the results of the 2023 Survey was published by the CQC on 21 August 2024. The report summarised the experiences of patients who had used NHS adult inpatient services for at least one night during November 2023. b. Each NHS Trust was assigned one of five bands according to their overall performance across the survey: 'much better than expected', 'better than expected', 'about the same', 'worse than expected', 'much		

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	worse than expected'. c. RPH, along with eight other NHS Trusts, was placed in the top band of 'much better than expected' and, on average, patients rated the overall experience at the Trust as 9.2 out of 10. This was the fifth year in a row that the Trust had been named in the top category. d. The survey response rate for the Trust in 2023 was 65%, compared to 62% in 2022. e. MS cautioned that the Trust was in an enviable position where it did not have the bed pressures of acute trusts but had single bed rooms which preserved the dignity and privacy of patients. f. MS stated that the Trust could improve its discharge processes, and the managers of the Discharge Workstream part of the Patient Flow Programme were taking steps to implement the feedback from the survey. g. JA thanked the entire staff for the positive survey results and noted that was the result of collective effort. **Noted:** The Board **noted** the report on the 2023 Adult Inpatient Survey Results.		
3.iii	**Learning from Deaths Annual Report – 2023/24**		
	Received: The Board received the 2023/24 Learning from Deaths Annual Report for review and approval. **Report:** IS reported that: a. From 01 April 2023 to 31 March 2024, there were 194 inpatient deaths at RPH. All the inpatient deaths (100%) were reviewed by the Medical Examiner (ME) Scrutiny Review. IS advised that the ME Scrutiny Review process was being nationally launched later in September 2024 and noted that the process was fully embedded at RPH. **Noted:** The Board **noted** the 2023/24 Learning from Deaths Annual Report.		
3.iv	**2023/24 Annual Safeguarding Report**		
	Received: The Board received the 2023/24 Annual Safeguarding Report for review and approval. **Reported:** MS reported that: a. Two children under 18 years of age had died at RPH in February 2024. The Child Death Overview Panel (CDOP) was notified as appropriate. It was noted that as the last child death at the Trust was 6 years ago, this was an unusual occurrence for RPH. b. The Trust fully engaged with the Integrated Care Board (ICB) in developing the Oliver McGowan Mandatory training for learning disability and autism. Level 1 of the training programme was introduced in November 2023 as an e-Learning package. Level 2 of the training programme was under development. c. A new statutory duty for NHS Trusts, the Serious Violence Duty, commenced in January 2023. The Duty was a statutory requirement that was being implemented to strengthen referral pathways and to strengthen the partnerships between NHS Trusts and other public sector agencies to prevent and reduce serious violence.		

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	d. The Trust received a visit from NHSE in March 2024 for a spotlight check on Safeguarding, and the feedback received was positive. In line with the CQC's Regulation 13: 'Safeguarding Service Users from Abuse, and Improper Treatment', the Trust also undertook an internal inspection of its Safeguarding structures and processes in March 2023. The improvement action plan, developed after the internal inspection, had been completed. e. Penny Martin retired as Safeguarding Operational Lead in September 2024 and had been replaced by Afua Tobigah. MS thanked Ms Martin for her many years of excellent service in the role and wished her well for the future. MS also commended the Deputy Chief Nurse, Jennifer Whisken, for her strategic leadership of the Safeguarding function. **Discussion:** f. OM informed the Board that the Trust's Women's Network had begun working with the Safeguarding Team on issues around sexual violence and domestic abuse against staff. OM stated that future reports would highlight this collaboration and the progress which had been achieved. g. EM queried how, in view of the relatively small amount of safeguarding activity and the small Safeguarding team, there was assurance that all vulnerable patients were being tracked and supported. MS, in response, stated that through the daily safety huddles for the senior nursing team, there was always a very clear indication of where the vulnerable patients were at any time. h. MS stated that among the different mechanisms used to collect data on patient vulnerabilities, one other mechanism utilised was the matron quality rounds. The matrons would take patient stories and make determinations if reasonable adjustments needed to be implemented for them or not. MS noted that the fact that very few Safeguarding incidents were reported was also reassuring. i. JA advised that there should be a high intolerance of staff not engaging in training. It was important that staff not only recognised and reported the Safeguarding issues impacting on vulnerable patients, but also the safeguarding issues in their (patients')families as well. **Approved:** The Board **approved** the 2023/24 Annual Safeguarding Report.		
4	**PERFORMANCE**		
4.i	**Performance Committee Chair's Reports – June, July and August 2024**		
	Received: The Chair's report setting out significant issues of interest for the Board. **Reported:** By SH (on behalf of GR) that: a. The Committee received a very detailed report on the Trust's cybersecurity arrangements. The report covered the work that was being undertaken to strengthen the cybersecurity arrangements and provide the Trust with the tools to recover in case of a cyber-attack.		

Agenda Item		Action by Whom	Date
	The cybersecurity risk continued to be one of the major risks that the Committee was monitoring. b. The Committee reviewed and was assured by the actions around the insourcing work being undertaken to improve the CT reporting backlog position. The Committee was updated on the work being undertaken around the sustainability of the CT reporting performance and how that could be progressed. **Discussion:** c. AR stated that the discussion on the Trust's cybersecurity arrangements had been very constructive at the last Performance Committee. AR advised the current BAF score of 20 for the cybersecurity risk correctly represented the cybersecurity environment within which the Trust existed in. d. HMc informed the Board of a meeting he had held with the Chief Operating Officers of the referral providers whose patients persistently arrived late at RPH and already close to breaching the referral to treatment standards. The discussion at the meeting was around how to mitigate some of these breaches by, as much as possible, speeding up these patients up the referral pathway. e. HMc stated that a deep dive into the causes of the delays was being undertaken. HMc added that there was assurance from the East of England regional and ICB teams that they would support the provider Trusts to make earlier referrals and support a review of the referral pathways. **Noted:** The Board **noted** the Performance Committee Chair's report.		
4.ii	**Papworth Integrated Performance Report (PIPR)**		
	Received: The PIPR report for Month 04 (August 2024) from the Executive Directors (EDs). **Noted:** The Board **noted** the PIPR report for Month 04 (August 2024).		
5	**RESEARCH**		
5.i	**Research and Development (R&D) Q1 Update (Apr – June 2024/25)**		
	Received: The R&D Q1 update. **Reported:** By PC that: a. The delivery of the R&D Strategy was being supported by the VPD-HLRI. PC acknowledged the presence of CS, who was observing the Board meeting. b. As part of steps to progress delivery against the R&D Strategy, almost all the candidates for research infrastructure roles were either in post or being processed by Recruitment before taking up their roles. PC noted that those in post were already delivering on their objectives. c. The infrastructure roles included 50:50 research posts in clinical areas at RPH, and those posts had the objective of increasing research in the areas they were based in as clinicians. PC stated that he had worked closely with CS to develop these 50:50 posts as establishing them involved significant investments by both the Trust		

Agenda Item		Action by Whom	Date
	and the University of Cambridge. PC had also worked with IS, so clinical directors at RPH would fully buy into hosting these 50:50 posts in their clinical areas. d. In terms of R&D Department performance, the mean time for the approval of trials had improved to an average of 80 days in 2023/24, from 202 days in 2022/23. The number of trials receiving approval had also increased significantly. e. Wendy Walker, Deputy Chief Operating Officer, and the Operations Team had helped to resolve a significant number of problems with clinical departments. PC thanked Ms Walker and her team for helping progress research work in the Trust. f. In relation to the recruitment of patients, the number of commercial studies had increased, while the number of non-commercial studies had declined slightly. PC noted that the complexity of non-commercial studies had, however, increased. g. While funding from charities had either stagnated or declined, grants for both commercial and non-commercial work had increased significantly. h. Steps were being taken to understand how the barriers to diversity in research could be removed. A workshop was being arranged to progress with the work on diversification, and this was being supported by the Trust's EDI Team. **Discussion:** i. JA stated that it was very good to see such progress in some key performance areas. j. In response to DL's query on the timeline for improvement around the EDI agenda, PC stated that it was really challenging to get people to engage in research. PC advised that the causes for the lack or reluctance to engage were trust, finances and busy lives. PC stated that the R&D Team was talking to Trust staff to get them to influence people in the hard-to-reach communities, so they understood the relevance of research. PC assured DL that the EDI work would continue but improvements would not be realised in the short term. k. JA noted the increased number of patient recruits into research studies and stated that there was no clarity around the recruitment targets for the R&D Team. JA advised that would be important to know if the R&D Team had achieved its recruitment targets. PC, in response, stated that the targets would be included in the next update to the Board, especially as the National Institute for Health and Care Research (NIHR) was also now focused on clarity around trial recruitment targets. **Noted:** The Board **noted** the Q1 R&D Update.		
6	**Audit**		
6.i	**Audit Committee Chair's Report – July 2024**		
	Received: The Chair's report setting out significant issues of interest for the Board. **Reported:** By SH (on behalf of CC) that: a. The Audit Committee received an annual review on 'Raising Issues of Concerns'.		

Agenda Item		Action by Whom	Date
	b. The Committee received an update on salary over-payments, which was a particular area of focus for the Trust to improve on. The progress achieved was significant but there were some questions around the sustainability of the improvement actions which were being implemented. c. There was a good discussion around how the Audit Committee could play a role in supporting other Board Committee chairs in articulating levels of assurance in a more consistent way, and the value of that consistency. d. EPR governance was a key topic of discussion at the Committee, with some focus on the risk of delay in seeking Board approval. The risk of delay was due to external factors, the level of detail required on the benefits markup and a delay in getting an indicative idea of the procurement cost from the suppliers that the Trust had been engaging with. **Noted:** The Board **noted** the Audit Committee Chair's report.		
7	**GOVERNANCE & ASSURANCE**		
7.i	The revised Terms of Reference for the Strategic Projects Committee was withdrawn for further consultation and review.		
7.ii	**Received and noted:** The Board of Directors received and noted the minutes of Board Committees held on: a. Quality & Risk: 30.05.24, 27.06.24 & 25.07.24 b. Performance: 30.05.24, 27.06.24 & 25.07.24 c. Workforce: 30.05.24 d. Audit: 23.05.24 & 20.06.24		
8	**BOARD FORWARD AGENDA**		
8.i	**Board Forward Planner**		
	Received and noted.		
8.ii	**Review of actions and items identified for referral to committee/escalation.**		
	None.		
9	**ANY OTHER BUSINESS**		
	None		

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Signed

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Date

Royal Papworth Hospital NHS Foundation Trust Board of Directors
Meeting held on 05 September 2024