Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Held on 5 December 2019 at 9am
Ground Rehab Floor Seminar Room
Royal Papworth Hospital

UNCONFIRMED M I N U T E S – Part I

Present	Prof J Wallwork	(JW)	Chairman
	Mr M Blastland	(MB)	Non-Executive Director
	Ms C Conquest	(CC)	Non-Executive Director
	Mr D Dean	(DD)	Non-Executive Director
	Dr R Hall	(RH)	Medical Director
	Mrs E Midlane	(EM)	Chief Operating Officer
	Ms O Monkhouse	(OM)	Director of Workforce and OD
	Mr S Posey	(SP)	Chief Executive
	Mr G Robert	(GR)	Non-Executive Director
	Mrs J Rudman	(JR)	Chief Nurse
In Attendance	Mr E Gorman	(EG)	CNIO/Head of Operations ICT Applications
	Mr J Hollidge	(JH)	Deputy Chief Finance Officer
	Mrs A Jarvis	(AJ)	Trust Secretary
	Prof I Wilkinson	(IW)	Non-Executive Director (Designate)
Apologies	Dr J Ahluwalia	(JA)	Non-Executive Director
	Mr R Clarke	(RC)	Chief Finance Officer
	Prof N Morrell	(NM)	Non-Executive Director
	Mr A Raynes	(AR)	Director of IM&T Chief Information Officer
Observer	Mr K Jackson	(RH)	Public Governor
	Mr M Ward	(MW)	Staff Governor

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1.i	**WELCOME, APOLOGIES AND OPENING REMARKS**		
	The Chairman welcomed everyone to the meeting and apologies were noted as above.		
1.ii	**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.		

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	The following standing declarations of Interest were noted: i. John Wallwork, Stephen Posey and Nick Morrell as Directors of Cambridge University Health Partners (CUHP). ii. Roger Hall as a Director and shareholder of Cluroe and Hall Ltd, a company providing specialist medical practice activities. iii. John Wallwork as an Independent Medical Monitor for Transmedics clinical trials. iv. Josie Rudman, Partner Organisation Governor at CUH. v. Stephen Posey in holding an Honorary contract with CUH to enable him to spend time with the clinical teams at CUH. vi. Stephen Posey as Chair of the NHS England (NHSE) Operational Delivery Network Board. vii. Stephen Posey as Trustee of the Intensive Care Society. viii. Stephen Posey, Josie Rudman, Roy Clarke and Roger Hall as Executive Reviewers for CQC Well Led reviews. ix. Andrew Raynes as a Director ADR Health Care Consultancy Solution Ltd x. Nick Morell Acting CEO Morphogenics biotech company from 1 April 2018 xi. David Dean as Chair of ETL, a commercial subsidiary of Guy's and St Thomas' NHS FT. ETL are currently providing advisory services to the Estates team at Cambridge University Hospitals NHS Foundation Trust on Project Management. xii. Stephen Posey as Chair of the East of England Cardiac Network. xiii. Michael Blastland as: 1. Board member of the Winton Centre for Risk and Evidence Communication; 2. Advisor to the Behavioural Change by Design research project; 3. Member of the oversight Panel for the Cholesterol Treatment Trialists' Collaboration; 4. Member of advisory group for Bristol University's Centre for Academic Research Quality and Improvement. xiv. Roy Clarke as a member Cambridge Global Health Partnerships Committee part of ACT. xv. Nick Morell as a member of the Regent House of the University of Cambridge. xvi. Cynthia Conquest as Deputy Director of Finance and Performance at the Norfolk Community Health & Care NHS Trust and Lay member: Audit and Governance, City & Hackney GP Federation. xvii. Stephen Posey as a member of the CQC's coproduction Group. viii. Roy Clarke as a member of the Audit Committee for the RCOG. xix. Jag Ahluwalia as: 1. CUH Employee, seconded to Eastern Academic Health Science Network as Chief Clinical Officer; 2. Programme Director for East of England Chief Resident Training programme, run through CUH; 3. Trustee at Macmillan Cancer Support; 4. Fellow at the Judge Business School - Honorary appointment and am not on the faculty; 5. Co-director and shareholder in Ahluwalia Education and Consulting Limited; 6. Associate at Deloitte; 7. Associate at the Moller Centre.		
1.iii	**MINUTES OF THE PREVIOUS MEETING**		
	Board of Directors Part I: 7 November 2019		

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	Attendees: Noted that Gavin Robert and Jag Ahluwalia should have been recorded as substantive Board members and not as Non-Executive Director (Designate). **Item 1.vii:** MB expressed concern that the wording of the minute on the staff story came across as having received an unsympathetic hearing and had not captured the level of concern expressed by Board members. It was agreed that this would be amended: **Noted:** The Board thanked TB and noted the staff story from wards on L3S and L5. The Board put on record its genuine concern for the safety and wellbeing of its staff, and would ensure that the issues that had been brought to the Board were addressed. Further the Board wanted to assure staff that it recognised the importance of having such channels of communication available and welcomed feedback from staff across the Trust. **Approved**: With the above amendments the Board of Directors approved the Minutes of the Part I meeting held on 7 November 2019 as a true record.		
1.iv	**MATTERS ARISING AND ACTION CHECKLIST**		
	Item 2.b.v: JW noted that he had written to clinical directors inviting them to attend the Board and that two had already confirmed attendance. **Noted:** The Board noted the updates on the action checklist.		
1.v	**Chairman's Report**		
	The Chairman provided an update on current activities to the Board. **Reported:** By JW: i. That he and RH had visited China to see a hospital in Ningbo and it was hoped that there would be future opportunities for collaboration around educational work or for the Trust to work with them in developing services. ii. That he and the CEO had visited the College of Arms, as along with the Royal title the Trust could now have its own coat of arms. It was felt this would be useful in commercial activities and particularly welcome for staff badges, awards and communications. iii. That he had attended a very useful meeting at the Academy of Medical Sciences. iv. That he had attended the Staff Long Service Awards to celebrate and recognise how much we value our staff, particularly those with long service.		
1.vi	**CEO's UPDATE**		
	Received: The Chief Executive's update setting out key issues for the Board across a number of areas reflecting the range and complexity of the challenges currently facing the Trust and the significant progress being made in delivery of the Trust's strategic objectives. The report was taken as read. **Reported:** By SP that:		

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	i. That the focus of his report was Hospital Optimisation. The Trust had opened Theatre 6 on time and whilst that achievement was to be celebrated its impact was being limited by the lack of critical care beds. ii. The issues in critical care highlighted that we had not optimised rosters to support bed availability on a consistent basis. The consequences of this were a theme throughout PIPR. The Board should be assured that the Executive understood the pace that was required to resolve this issue. If the Trust were not able to achieve the right level of flow in critical care then this would have an impact on services across the Trust and the wider region. iii. The Trust had opened 11 beds as planned on ward 4NW and this was the first phase of the transfer of cardiology from CUH. This transfer would support the flow of work from CUH and the wider region and SP wanted to record his particular thanks to EM, JR, Wayne Hurst and Carrie Skelton-Hough. These staff had developed and delivered the transfer. iv. That feedback from the Collective and Compassionate Leadership programme would be received later in the Part II meeting and this would feed into the strategy workshop this afternoon. v. That events had been planned for staff for Christmas including a free lunch for staff who had to work on Christmas Day. vi. That the Digital team were taking forward recommendations from the Topol report. The Trust was well placed in already having the CIO on the Board and there were plans for further specific digital training. **Discussion:** i. DD reported on his recent buddy visit to the Critical Care Unit and asked whether the Trust was dealing adequately with the qualitative aspect of the issues raised as he felt that morale was fairly fragile. SP advised that the challenge was both to support our staff and create the right environment for staff to deliver services and getting this right would need leadership, support and visibility across the organisation. Changes needed to be implemented sensitively, but also at pace because of the impact on patient cancelations. ii. That this work linked to the discussion at Q&R around balancing system risks and risks to the patient in front of us. iii. MB noted that this issue had been escalated to the Board by the Q&R Committee and there was a need for continued discussion of indicators that would help this to be understood such as IHU patients waiting in other hospitals, and harm done to patients waiting for treatment. SP noted the need for this to be considered more widely across the organisation and the invitation to Clinical Directors would improve the organisational understanding of how Board decisions were being made. iv. JR advised that actions were being taken to address some of the qualitative issues that had been raised about being and feeling a part of a team. Critical Care had 300 staff and this was too large to manage as a single team and so was being split into three teams of 100. This would help to address some of the anxieties around the level of support with staff more		

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	likely to be working with same staff which would promote increased familiarity in the teams. **Noted:** The Board noted the CEO's update report.		
1.vii	**Patient Story**		
	Josie Rudman presented a patient story on behalf of Vicky Carr. This related to a patient who had recently had a second episode in Critical Care. The patient was 56 years old and following a bout of flu when he was 33 had developed cardiomyopathy. This had led to cardiac angioplasty surgery (in Sheffield) which was tried ahead of a transplant procedure. He had a heart transplant at RPH in August this year and had a stay in critical care that he had not remembered. He was recently admitted to Critical Care as he had developed rhinovirus and needed oxygen support and was in isolation. The patient had reported that: i. His treatment was excellent. ii. The food was excellent. iii. That his experience of critical care had been better as he did not have post-operative delirium. iv. That he was concerned that some questions were repeated over and over and the team were looking at how we could use our systems to address this. The patient wanted to share his story as he had seen the flu fighter signs at the hospital and he wanted to encourage staff to take up their flu jabs because of his personal experience. **Discussion:** The Board asked how well the flu programme was progressing and JR advised that we were now at 71% and were aiming to exceed the 80% standard. In the previous year the Trust had achieved 84%. JR advised that she would also be sharing this story with staff through the weekly briefing. **Noted:** The Board noted the patient story.	JR	Dec 19
2	**PERFORMANCE**		
2.a.i	**PERFORMANCE COMMITTEE CHAIR'S REPORT** **Received:** The Chair's report setting out significant issues of interest for the Board. **Reported:** By GR that the Committee had focused on three areas: i. A review of the Thoracic RTT position. Mike Davies and Lisa Shacklock had attended to present remedial plans for the service. The Committee were assured that actions were in place and had invited the team to return in three months' time so that remedial plans could be followed up and a discussion held around further measures if required. ii. Discussion of the issues around temporary staffing and the steps being taken to address the high use of agency. The		

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	Committee had agreed that it would look at targets for people and finance to ensure that it could track the progress that was being made. iii. The issue of optimisation and the impact of rostering on flow across the hospital (especially within critical care). The Committee received a report on the actions being taken and an update would come to the next meeting. **Discussion:** i. SP noted that daily reporting was in place on beds and cancellations in Critical Care and that a spotlight update would be included in PIPR identifying the scale of impact on performance across the Trust. ii. IW asked whether the rate of use of temporary workforce was similar to that in other Trusts. OM advised that the Trust was an outlier for nursing overtime, but that the use of agency as a percentage of pay bill was not out of line with other Trusts. Also that we were a positive outlier for medical agency as we don't use this to any significant extent. **Noted:** The Board noted the Performance Committee Chair's report.	EM	Dec 19
2.b	**PAPWORTH INTEGRATED PERFORMANCE REPORT (PIPR)**		
	Received: The PIPR report for Month 7 from the Executive Directors (EDs). This report had been considered in detail at the Performance Committee. **Noted:** i. That there was an overall improvement in performance but the Trust was at a Red rating. ii. That performance was rated as 'Red' in four domains: Effective, Responsive, Finance and People, Management & Culture. iii. That performance was rated as Amber in two domains: Safe, and Transformation. iv. That performance in the Caring domain was rated as Green. EDs outlined key performance issues for the Board and provided detail on the spotlight reports covering: i. Safer Staffing ii. Friends and Family (Inpatients) iii. Outpatient Productivity iv. In House Urgent v. Mandatory Training vi. Lorenzo Digital Exemplar vii. Directorate Financial Performance		
2.b.i	**Safe** **Reported:** By JR: i. That she wanted to draw the Board's attention to the VTE compliance on the fourth floor and invited EG to present. EG advised that the work on 'Lorenzo on the Wall' had been implemented on the four wards on the fourth floor and this had given visibility to the KPI measures. Following this those areas had achieved a 100% compliance rate for VTE risk		

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	assessment. ii. That the safer staffing rating reflected the national measure of staff fill rates but not the Care Hours Per Patient Day that were delivered. IG would be reviewing the staffing metric and presenting a proposal on safer staffing in the KPI review for 2020/21. This would retain the national metric but may move reporting below the line as it was important to ensure that there was no false impression of concern around safety created in the PIPR report. Discussion: i. JW noted the power of measurement and visibility of performance against targets. On his recent visit to China ward dashboards were in use capturing performance against VTE and handwashing compliance, as well as capturing decibel levels in the wards. ii. CC asked how other Trusts dealt with the issues around the safer staffing metric. RH noted that as other hospital were often running at more than 100% capacity then this could be considered a leading indicator but as at RPH we planned and restricted bed capacity because of staffing levels, this was a following indicator.		
2.b.ii	**Effective** **Reported:** By EM that the domain was rated as Red: i. There had been improvements in activity throughput for both outpatients and admitted patient care but activity remained below plan. ii. That Theatre six had opened as planned in October but utilisation was adversely affected by the rostering issues in critical care. iii. That the cath labs had experienced four and a half days of downtime in month because of a breakdown. The service was expecting to achieve 90% utilisation in December 2019. iv. That bed utilisation had improved but was adversely effected by the mitigation for safer staffing. v. That critical care occupancy against open and staffed beds was at 92%. This was running extremely hot and so staff would feel under some pressure. vi. That there was a spotlight on the Meridian work which was now over half way through. The project team was working with services to consider the output of the utilisation reviews with key metrics being captured and use of staff huddles to identify and plan workload. Prior to the move there had been concern that there may have been a shortfall in capacity in the new OPD but the utilisation review had identified room availability that could be released to allow repatriation of work undertaken off site and allow for PP outpatient activity to be moved out of ward areas. The project was iterative and had accelerated the pace of change allowing the Trust to get to the throughput levels that it should be delivering. There would be a detailed report on progress to the next performance committee meeting.	EM	Dec 19
2.b.iii	**Caring**		

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	Reported: By JR that Caring was rated as green: i. The Friends and Family score had recovered in outpatients and there had been an improved position on complaints. ii. That the level of bed closures and cancellations being seen would be likely to increase the level of complaints across the Trust.		
2.b.iv	**Responsive:** **Reported:** by EM: i. That RTT performance had improved and that this was expected to recover Trust wide in December. ii. Cardiology had reduced its overall waiting list size and the number of breaches and had increased the number of patients treated meeting the 92% target iii. Respiratory was above the 92% target but their waiting list size was increasing, reflecting the known underlying problem with flow within the service. iv. Surgery had fallen behind trajectory because of the issues in critical care and once that was recovered it was expected to move back to trajectory. v. Cancer performance remained poor with delays resulting from the difficulties in access to PET CT previously reported to the Board. Work was continuing with Commissioners and with the national contract provider to improve access for our patients. **Discussion:** i. SP noted that there were a significant number of KPIs that were being effected by the capacity issues within critical care and that this was the single most important issue to resolve in order to improve flow and performance across a range of indicators. ii. It was noted that the presence of red indicators was a safety concern as these could each result in patient harm. This arose when patients were cancelled, or has extended periods waiting either on Trust waiting lists, or in beds at other hospitals within the region. iii. It was felt that issues were due in part to staff learning to use the new building. There were some in which staff were making decisions that had an impact on flow and these had the effect of slowing pace across the organisation. iv. RH felt that the Trust needed to be embracing a GIRFT approach and that this mind-set needed to be embedded across the organisation. He noted concern that there was silo working between some services and that decisions were being made to slow or turn down the production line and that had a negative effect across the Trust with staff unable to deliver services and becoming demoralised as a result of this. There were some decisions where safety concerns were being invoked at an inappropriate threshold. v. MB asked whether we would then see pressures emerge in other parts of the services if the issues around flow in critical care were resolved. SP advised that with the opening of theatre six and the additional beds on levels four and five that there was the capacity across the Trust to deliver our plans. It was felt that if the issue of rostering for critical care could be resolved then this would allow the hospital to come to life. He		

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	felt this could be delivered through effective rostering and use of our staff. This issue had to be resolved within the next few weeks and staff across the Trust were working to ensure that changes were put in place and that these delivered appropriate solutions. vi. JR noted the previous successes in delivery and advised that a project approach had now been established and staff had been given permission to prioritise resolution of this issue. It was noted that Alain Vuylsteke was leading this project with support from the divisional teams. vii. JW noted the positive improvement in the IHU target. This area had seen a focused project approach in recent months and this was now being seen to have impact in delivery of the IHU targets.		
2.b.v	**People, Management and Culture** **Reported:** By OM that: i. That Turnover in October was rated as green and that position would be the same in November. ii. There had been discussion at Q&R about the forward view of the recruitment pipeline over winter. The vacancy rate had increased but that was a result of increases in the funded establishment. iii. Key workforce indicators were being reviewed to allow an improved view of performance over time and clearer communication of key messages such as the sustained increase in staffing that the Trust had achieved. iv. That the recruitment team had set a target to recruit 25 nurses in November and had recruited 24 and were interviewing a further 20 nurses in December. Recruitment would be likely to slow through January in line with seasonal trends. v. There had been good applications into critical care but recruitment in respiratory services remained a stubborn issue. vi. Sickness absence levels had increased to 4.2%. The most significant increase was in short term absence which followed, but was higher, than the usual seasonal trend. Increases in short term casual absence could be associated with lower levels of staff engagement. **Discussion**: i. There was a query about the level of leavers in critical care. OM advised that there were five leavers in December and it was not clear whether that was higher than had been seen in previous years and some of these staff were moving to other positions within the Trust. ii. NEDs asked where the higher levels of sickness absence were being seen. OM advised that absence levels were particularly high in critical care and that the workforce team were supporting the Matrons to address this as the Sisters on the unit had been working clinically and had been drawn away from core management duties including return to work interviews. Matrons were now taking this on to support the unit in the short term. The level of sickness absence on critical care was at 5.5% against a level of 3% for the Trust as a whole.		
2.b.vi	**Transformation**		

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	Reported: By EM: i. That Transformation was being reported against the new scorecard. ii. CIP delivery remained at a red rating for 2019/20. The position for 2021 was much better with schemes to the value of £3m having already been identified. JH noted that the position for 2019/20 would remain red through the remainder of the year; however this position was hedged and so would not affect the forecast outturn. iii. The spotlight was on the LDE. The LDE programme was at Amber and there were some scheduling issues resulting in the programme being 4% behind plan. EG noted that access to the innovation fund would finish at the end of the year and so there was pressure to deliver against schedule. iv. CTP was rated at Amber. The beds on 4NW had been opened on time but this had been incredibly tight and had a short lead time as a result of some lack of clarity from CUH on the progress of the transfer. No staff had transferred from CUH in the first phase of the move. There was much to be done to ensure that the project was delivered in full by April 2020. **Discussion:** i. The Board asked if there would be letters of thanks from the Board to the individuals who had worked to deliver the successful first phase of the project. It was noted that the Trust had a number of mechanisms to recognise staff success including Laudix which had reached over 500 nominations, and the staff awards (nominations for which were currently open) as well as formal thanks being issued from the Chair and the Board.		
2.b.vii	**Finance** **Reported:** by JH that: i. The October YTD position was a deficit of £2.1m against control total and that was £0.7m ahead of plan. ii. The financial position would be discussed in detail in Part II of the Board meeting.		
	Noted: The Board noted the PIPR report for Month seven (November 2019).		
3	**GOVERNANCE**		
3.i	**Board Assurance Framework** **Received:** From the Trust Secretary the BAF report setting out: i. BAF risks against strategic objectives ii. BAF risks above appetite and target risk rating iii. The Board BAF tracker. **Reported:** By AJ: i. That the BAF report included an executive summary setting out key movements in individual BAF risks. ii. That the principal risks were set out in the report. These were: workforce including recruitment and retention; failure to optimise the hospital to deliver activity and meet demand, and		

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	to achieve a sustainable financial position. iii. Following the earlier discussions at Board and Committees around the staff engagement the rating of workforce risks had been reviewed again. The recruitment risk was rated at 20 and the staff engagement risk was maintained at a rating of 16. These were felt to reflect the current levels of risk within the Trust. **Discussion:** i. DD asked about the assessment of risk surrounding EU exit. It was noted that EU exit was included in the BAF and that the Trust had plans in place for this in line with the national process. **Noted:** The Board noted the BAF report for November 2019.		
3.iia	**Q&R Committee Chair's Report** **Received:** The Q&R Committee Chair's report setting out significant issues of interest for the Board. **Reported:** By MB that: i. That there had been a drop in compliance for IG training. This raised some concern given the outcome of the phishing exercise. There had been a discussion around tailoring the training that the Trust offered in order to ensure that we could supplement the national training provision. This was to be considered by the Executive team. ii. The Committee had considered the issues around rostering in critical care iii. That RH and MB were continuing the discussion around the measurement of risk for those patients who were not in our care so that decision making could be seen in the wider context of system risk. **Discussion:** i. It was suggested risk measures might include deaths of patients waiting, and the impact of delays on our Euroscore rating. RH noted that these indicators may be based on very small numbers of patients and that there may be merit instead in looking at the area under the PTL curve as changes in this could give a view of the number of patients exposed to an increased level of risk. ii. GR noted that risk assessment of safeguarding in schools might provide a useful system model. That looked at not only at the risks internal to an individual school but also a measure of pressure in the local authority, and so if an LA was in special measures this would increase the assessed risk at a school level because of the wider system context. iii. There was discussion of other metrics that might be useful to review including: treatment times and waiting list size for particular therapeutic areas, and specific indicators that could be considered in diabetes, hypertension and heart failure. **Noted:** The Board noted the Q&R Committee Chair's report. It was	AR	Dec 19

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	agreed that consideration of metrics to support the wider understanding of system risk should be kept on the agenda for Q&R and the Board to ensure that EDs and NEDs had clear visibility of safety issues.		
3.v	**Quality and Risk Committee Minutes 15 October 2019**		
	Received and noted: The Board of Directors received and noted the minutes of the Quality and Risk Committee meeting held on 15 October 2019.		
3.iib	**Combined Quality Report** **Received**: A report from the Chief Nurse and Medical Director which highlighted information in addition to the PIPR. **Reported:** By JR that: i. That the uptake of flu vaccinations had now exceeded 70% which was a significant increase from the figure included in the report (54% as at the 22 November 2019). This had been supported by positive uptake from A&C staff who were now included with the release of the third tranche of vaccines. **Noted:** The Board noted the Combined Quality Report.		
3.v	**Performance Committee Minutes 31 October 2019**		
	Received and noted: The Board of Directors received and noted the minutes of the Performance Committee meeting held on 31 October 2019.		
4	**WORKFORCE**		
4.i	**Workforce Report** **Received:** From the Director of Workforce and OD a paper setting out key workforce issues. **Reported** by OM: i. That the Trust had achieved a response rate in excess of 60% in the national staff survey and this was the highest level ever achieved by the Trust. The analysis of the survey would be released early in the new year and this would be brought to the Board. ii. That the Rainbow badge scheme had been launched at the Trust this month. This is to promote an open and inclusive culture within the organisation and had been supported by staff volunteers following an article in NewsBites. Twelve staff came forward to help with the launch of the scheme and over 150 staff had signed up to the scheme. They had each shared their personal statement about why they wanted to support the scheme and to wear a rainbow badge. iii. The Trust was now setting up an LGBT+ network and initial activities included taking part in Cambridge Pride 2020. This was expected to be positive for the Trust and for recruitment. iv. The Trust was keen to ensure that the scheme helped to provide a positive experience for patients, relatives and staff across the Trust. v. That nationally work was being done on the NHS People Plan		

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	and this was being led by Prerana Issar, Chief People Officer for the NHS. This would set out a framework for workforce priorities over the next five years and this was welcomed. vi. The framework would form a part of the Board agenda for Trusts. This would focus on standardisation and collaboration across the NHS and would include developing the core offer for NHS staff and a shared approach across workforce planning and core roles. It would include plans for Digital transformation and training for the workforce. Work on this programme was to be held over during purdah and OM would be looking at this in the context of the Trust's workforce strategy and the output of the Trusts' Collective and Compassionate leadership project. **Agreed:** The Board noted the Workforce report.		
5	**Research & Education** No report was due on this item. **Discussion:** i. JW noted that building of the HLRI had now started on site. ii. GR asked whether there were plans to educate our own Respiratory specialist nursing staff to address pressures in this area. OM advised that this was a part of the solution for staff in this service. We were recruiting band 5 nurses would provide the specialist skills and training that was required for these staff. The Trust had previously sent staff away to undertake a Respiratory module and the establishment of the virtual school would support this but there was further work to be done. iii. CC noted that the Charity had supported the educational agenda and invested in staff development. JR advised that there was a budget for training and that a Training Needs Analysis was being undertaken for 2020/21 to agree how this budget would be applied. iv. There was recognition that Respiratory services needed to take a different approach to differentiate their offer to staff. In Critical Care recruitment was supported by offering a Masters level module and whilst there had been some reluctance in staff applying to Respiratory services a similar model might improve this situation. There were also steps being taken to demystify nursing in the Respiratory service at RPH. The service was different to that delivered in DGHs with a more mixed patient group and disease profile. The Ward Sister for Respiratory had taken over the Trust Twitter account as a part of the work promoting greater understanding of the service.		
6	**Digital** – *no report due*		
7	**BOARD FORWARD AGENDA**		
7.i	**Board Forward Planner** **Received and Noted:** The Board Forward Planner.		
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 5 December 2019

Glossary of terms

CIP	Cost Improvement Programme
CTP	Cambridgeshire Transition Programme
CUFHT	Cambridge University Hospitals NHS Foundation Trust
DGH	District General Hospital
GIRFT	'Getting It Right First Time'
IHU	In House Urgent
IPPC	Infection Protection, Prevention and Control Committee
IPR	Individual Performance Review
KPIs	Key Performance Indicators
LDE	Lorenzo Digital Exemplar
NED	Non-Executive Director
NHSI	NHS Improvement
NSTEMI	Non-ST elevation MIs
PET CT	Positron emission tomography–computed tomography - a type of scanning of organs and tissue
PIPR	Papworth Integrated Performance Report
PPCI	Primary Percutaneous Coronary Intervention
PROM	**P**atient **R**eported **O**utcome **M**easure: assesses the quality of care delivered to NHS patients from the patient perspective.
RCA	**R**oot **C**ause **A**nalysis is a structured approach to identify the factors that have resulted in an accident, incident or near-miss in order to examine what behaviours, actions, inactions, or conditions need to change, if any, to prevent a recurrence of a similar outcome. Action plans following RCAs are disseminated to the relevant managers.
RTT	Referral to Treatment Target
SIs	Serious Incidents
SIP	Service Improvement Programme
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