Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Held on 2 July 2020 at 10:30am
First Floor Meeting Rooms 3 & 4 and via Teams
Royal Papworth Hospital

UNCONFIRMED M I N U T E S – Part I

Present	Prof J Wallwork	(JW)	Chairman (T)
	Dr J Ahluwalia	(JA)	Non-Executive Director (T)
	Mr M Blastland	(MB)	Non-Executive Director (T)
	Ms C Conquest	(CC)	Non-Executive Director (T)
	Mr T Glenn	(TG)	Chief Finance and Commercial Officer
	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 (T)
	Mr A Raynes	(AR)	Director of IM&T Chief Information Officer(T)
	Mrs J Rudman	(JR)	Chief Nurse
	Prof I Wilkinson	(IW)	Non-Executive Director (T)
In Attendance	Mrs A Jarvis	(AJ)	Trust Secretary
	Mr A Selby	(AS)	Associate Director of Estates and Facilities
	Dr I Smith	(IS)	Deputy Medical Director
Apologies	Dr R Hall	(RH)	Medical Director
Observers			
(T – joined the meeting via online teleconference)			

Agenda Item		Action by Whom	Date
1	**WELCOME, APOLOGIES AND OPENING REMARKS**		
	The Chairman welcomed everyone to the meeting and apologies were noted as above. The Chairman noted that later today he and the CEO would be joining meetings with NHS Providers and the NHS Chief Executive, Sir Simon Stevens; and with CUHP.		
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.		

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	The following standing declarations of Interest were noted: i. John Wallwork and Stephen Posey 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 and Roger Hall as Executive Reviewers for CQC Well Led reviews. ix. Andrew Raynes as a Director ADR Health Care Consultancy Solution Ltd x. Stephen Posey as Chair of the East of England Cardiac Network. xi. 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. xii. Cynthia Conquest as Deputy Director of Finance and Performance at the Norfolk Community Health & Care NHS Trust. xiii. Stephen Posey as a member of the CQC's coproduction Group. xiv. Jag Ahluwalia as: 1. CUHFT 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; 5. Co-director and shareholder in Ahluwalia Education and Consulting Limited; 6. Associate at Deloitte; 7. Associate at the Moller Centre. xv. Ian Wilkinson as: 1. Hon Consultant CUHFT and employee of the University of Cambridge; 2. Director of Cambridge Clinical Trials Unit; 3. Member of Addenbrooke's Charitable Trust Scientific Advisory Board; 4. Senior academic for University of Cambridge Sunway Collaboration; 5. Private health care at the University of Cambridge; 6. University of Cambridge Member of Project Atria Board (HLRI). xvi. Tim Glen's partner is the ICS development lead for NHSE/I in the East of England.		
1.ii	**MINUTES OF THE PREVIOUS MEETING**		
	Board of Directors Part I: 4 June 2020 **Item 4.iii** Discussion point iii: SP noted that whilst the role of the Trust was correct, the minute should also note that there were lessons to be		

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	learned and that these will be captured through the de-brief process that had been put in place. **Approved**: With the above amendment the Board of Directors approved the Minutes of the Part I meeting held on 4 June 2020 as a true record.		
1.iii	**MATTERS ARISING AND ACTION CHECKLIST**		
	Noted: The Board received and noted the updates on the action checklist.		
1.iv	**Chairman's Report**		
	The Chairman noted that this had been an interesting month with the Staff Awards being held virtually, and Hannah Gingell, one of our nurse apprentices, being featured on 'The Choir: Singing For Britain'. There had also been significant media interest in our patients who were recovering from COVID19 and going home. The Chair noted that he and JA had spent some time in the CDC and their discussions were focused on what the organisation could do to recover services. He noted that the Trust was a complex organisation and that we do difficult things well.		
1.v	**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: i. That the Trust was still in ECMO surge but now had fewer COVID patients. ii. That the CDC recovery plan was due for discussion on the Part II agenda. iii. That the priority in planning recovery of the Trust was the safety of staff, patients and volunteers and there was extensive work underway to support this being carried out across the hospital. This included the creation of additional staff rest areas in the Atrium, reconfiguration of desk spaces to provide social distancing. He wanted to note his particular thanks to the Estates team and the CFO for this work which was crucial to keep people safe and to maintain confidence across the organisation. iv. The outcome of risk assessments were being reviewed and focus was on those at greatest risk. v. At the last Board the FTSU guardian's report had highlighted feedback from those staff that had been redeployed and we had now started the de-briefing process to learn lessons from staff feedback. vi. The organisation had received feedback from the Pulse Surveys and WRES data that showed that there was more to do around Black Lives Matter. The BAME network was supporting the Trust in looking at this agenda and the Trust was very happy with their input and contribution to this.		

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	vii. viii. **Discussion:** i. CC noted that in relation to Black Lives Matter whilst the Trust would put in measures, perceptions could be difficult to change. Staff must also see that we were doing all that we should, and addressing issues such as the concerns raised last month that appointments to 'acting up' arrangements and roles undertaken during the pandemic were without a proper process. ii. SP welcomed the fact that this had been raised through the network and whilst he felt there was no malign intent he acknowledged that we needed to learn lessons from this. OM had reviewed this and prepared a report that was to go to the Chair of the BAME Network, the FTSU Guardian and the RCN representative and there was a plan to communicate the learning around this. iii. JA also noted caution that not all constituents of the BAME community were as vocal about concerns. **Noted:** The Board noted the CEO's update report.		
1.vi	**Patient Story**		
	The Chief Nurse provided a story from a patient's wife. This was about the care of a patient with COVID had been transferred to the Trust in May from QEHKL and who had been on ECMO for several weeks, they were de-cannulated on the 4 June and transferred back to QEHKL and were subsequently discharged to home on the 25 June. The feedback had been received by Liz on the Family Liaison Team which had been established to support the relatives throughout the pandemic. The message from the patient's wife expressed how grateful they were and how valuable they had found the support from the family liaison team. They were grateful to RPH and QEH as both hospitals were part of their journey of survival. Some of this had been captured in local media and there were links to this footage on the Trust's website. They said that they were a normal family and the video had sent a very powerful message about how Covid-19 has the capacity to nearly destroy any normal family and should therefore be taken very seriously. In addition, for people who have family members going through ECMO, it sent a very powerful message of hope. The family had been kept in touch using FaceTime calls and the patient's wife had some previous experience of working with patients on intensive care. They noted that whilst this meant they felt prepared in the end when they could visit, they were not fully ready for the devastation of seeing their loved one on the unit but after that and day after day, they had seen a miracle happen in front of my own eyes. The family have told the patient all about their experience of the liaison team and how they helped to support day after day after day, from the beginning, and through the darkest moments.		

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	The patient and the family have subsequently spoken to the liaison team members and thanked them for their support. Discussion: i. JW noted that this was a powerful story and felt that we should not forget that we were doing the same for patients before COVID. This was reflective of the good work done and what might have felt like a miracle to the family was just a part of the work that we do as a Trust. ii. SP advised that the Family Liaison was a completely new team that had come together at short notice and had been running as seven day service over the last four months. The feedback on the team was overwhelmingly positive. It was being run in part by staff who had been displaced from their usual jobs as a result of their own risk factors and had allowed for them to take on a role that was not in the frontline. iii. JW asked if the service would continue as patients were still cut off and he felt that the Trust should have this sort of service available to support patients. iv. JA asked whether this was felt to be adding positive benefits for patients. JR advised that service would continue beyond the COVID pandemic but a lower level of demand was expected and there were plans to reduce the staffing and to join it with the PALs service so that the service could be covered. **Noted:** The Board of Directors noted the patient story.		
2	**PERFORMANCE**		
2.a.i	**Performance Committee Chair's Report 25.06.20** **Received:** The Chair's report setting out significant issues of interest for the Board. **Reported:** By GR that the Committee had focused on: i. The treatment of non-COVID patients and the concern that we don't have the usual benchmarking of effectiveness and efficiency and so the Committee was seeking assurance through other routes. ii. 52 week breaches and had noted that patients were being treated in line with their clinical priority. iii. Staffing and the importance of retention of staff as we come out of the pandemic. iv. The peculiarity of the current financial position and the concern that the ending of the block funding this month would expose the Trust, as expenditure was £2.5m above its normal level and TG was keen to establish prudence around the set-up of new services. **Noted:** The Board noted the Performance Committee Chair's report.		
2.b	**Papworth Integrated Performance Report (PIPR)**		
	Received: The PIPR report for Month 2 (May 2020) from the Executive Directors (EDs). This report had been considered at the		

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	Performance Committee and was provided to the Board for information. **Noted:** The Chairman requested that the Executive identify any exceptional items that should be brought to the attention of the Board. **Caring:** JR advised that there were no other matters to be brought to be brought to the attention of the Board. **Effectiveness and Responsive:** i. EM advised the Board that there would be deterioration in Cancer performance in the next month's figures. The Trust had very small volumes of cancer patients and had a received a number of late referrals. There had also been a number of clinical decisions not to treat during the pandemic which would come into the figures next month. ii. TG noted that the bed occupancy of 29% highlighted the challenge and the very limited activity that was going through the Trust in May. iii. JW noted that the Board needed to look at the plans to open up capacity at the Trust. **People, Management and Culture:** i. OM noted that the reduction in the vacancy rate was positive and that recruitment was very strong and was running at a level of 20 Band 5 nurses per month. ii. The first of the virtual recruitment events was planned for the 21 July and the focus of this would be Critical Care and it was to be run as a learning and recruitment event. iii. OM noted that the Trust had been able to maintain the multiple induction programmes and had moved to expand the virtual learning environment to support this. iv. SP commended the work of the recruitment teams during the pandemic as this had maintained a very healthy pipeline for the Trust. **Transformation:** i. TG advised that Transformation activities had been stepped down during the pandemic response but focus would now be brought back onto this programme.		
	Noted: The Board noted the PIPR report for Month 2 (May 2020).		
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 that the BAF had been reviewed at Committee and the key movements related to the reduction in those risks that related to the Pandemic including PPE and Surge capacity.		

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	Noted: The Board noted the BAF report for June 2020.		
3.ii	**Q&R Committee Chair's Report 25.06.20** **Received:** The Q&R Committee Chair's report setting out significant issues of interest for the Board. **Reported:** By MB that: i. The Committee had seen a good illustration of benchmarking data that showed we were right at the lowest end of the comparators for complaints. ii. The Committee had received a report on the mortality alert from Dr Foster that thoroughly rebutted the issues raised. iii. He felt that the Committee were on top of issues. **Discussion:** i. JW noted some challenge as a very low level of complaints might be an indicator that we were not pushing hard enough at an organisational level. ii. JA noted that the Committee had also received the external audit of the PALs service and this had received strong assurance noting that an efficient and fully responsive service was provided. JW invited MB to provide an update on the system Quality & Risk Chair's meeting. MB reported that: i. That the meeting had discussed the experience of organisations during the pandemic and this was worse in some areas than others. ii. There were concerns raised about the pressures that would emerge in community and mental health services in the wake of the pandemic. Providers of those services had felt this would require a shift of focus, and resources, in order to respond to those pressures and this would form part of future discussions on resource allocation. iii. The group were to continue to meet and one of the issues to be considered was the development of system wide risk and quality metrics. MB felt that this it would be difficult to discuss balancing of risks across a whole system. **Discussion:** i. SP noted that the resource and risk discussions would form a part of the third phase of recovery and the system would be challenged to consider risk across the whole of the STP. He felt that this may become an embedded way of working that might also be extended to other committees. ii. JW noted that the system would morph into an Integrated Care System by the 1 April 2021 and that would have a new and independent Chair. The system Quality and Risk and other Committees would form a part of the infrastructure that supported the ICS Board. If this Committee was functioning then it would be worthwhile to maintain this for a period ahead of integration. **Noted:** The Board noted the Q&R Committee Chair's report.		

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3.iii	**Combined Quality Report** **Received**: A report from the Chief Nurse and Medical Director which highlighted information in addition to the PIPR. **Reported:** By JR: i. That for completeness and following the Q&R Chair's report she wanted to advise the Board that the Trust had identified 16 cases of M Abscessus. The Trust has a usual rate of acquisition in Cystic Fibrosis and Lung Defence patients and the Trust had asked Public Health England to sequence all cases. Four cases had been linked to the outbreak period. ii. The report also included reporting on Covid-19 nosocomial infections (those acquired within health care). There had been much discussion of these across the system and higher levels of infections had been seen at other Trusts and so we had put in place measures for patients who were transferred into the Trust to protect our staff and patients. The Trust was now required to attend weekly and monthly IPC meetings to manage this as a system response. iii. That the report had appended to it the Annual Reports covering: • Learning from Deaths • Q4 and Annual Quality & Risk • Safeguarding • Antimicrobial Stewardship These had been reviewed by the Quality and Risk Committee and were brought to the Board for information. **Discussion:** i. JW noted his concern that many patients were reluctant to attend hospital because of the risk of transmission of COVID but we had a very low rate of transmission to staff and to patients because we had an effective building and had good access to PPE. This anxiety is preventing us from expanding our general work and we must consider if we could do more non-COVID work in the hospital. ii. JW noted that the Board would hear later about the outcomes for our COVID patients in Critical Care in the Part II meeting. iii. JA noted that in the exchanges at the CDC the proportionality of IPC measures was an active and live discussion. JR noted that she was content that the approach to IPC was balanced. iv. GR asked how safeguarding was managed within the hospital. JR advised that she was the Board Level lead for safeguarding and that she and SP had specialist training to support that role. Ivan Graham the Deputy Chief Nurse was the operational lead for safeguarding and Penny Martin was the Trust lead Social Worker and had a proportion of her time spent on this role, she was supported by the Social Work team and the Trust had adequate cover. Penny Martin had extensive safeguarding training. v. GR asked whether the format of the safeguarding report was mandated. JR advised that it was not but there were a number of mandatory items that had to be reported on. These were all included within the report and the Trust then added reports on other areas as appropriate.		

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	vi. GR asked above whether information was available on the benchmarking of safeguarding incidents over time. JR advised that this was difficult as we had very few incidents as an organisation and that the majority of issues managed were patients' declarations of matters outside of the hospital. There was benchmarking available at a system level that was shared in by the County Council and JR would be happy to share the minutes of the multiagency meetings with GR. vii. GR asked whether the Trust was on top of safeguarding reporting and record keeping. JR confirmed that there was robust record keeping; incidents were reported and that patients and relatives were supported. **Noted:** The Board noted the Combined Quality Report and the Annual reports as presented to the Board.	JR	Aug 20
3.iv	**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.		
3.v	**Board Sub Committee Minutes:**		
3.v.a	**Quality and Risk Committee Minutes: 28 May 2020** **Received and noted:** The Board of Directors received and noted the minutes of the Quality and Risk Committee meetings held on 28 May 2020.		
3.v.b	**Performance Committee Minutes: 28 May 2020** **Received and noted:** The Board of Directors received and noted the minutes of the Performance Committee meeting held on 28 May 2020.		
3.v.c	**Audit Committee Minutes: 4 June 2020 and 17 June 2020** **Received and noted:** The Board of Directors received and noted the minutes of the Audit Committee meetings held on 4 June 2020 and 17 June 2020.		
4	**WORKFORCE**		
4.i	**Workforce Report** **Received:** The Director of Workforce and OD a report setting out on key workforce issues for the Board. **Reported:** By OM on COVID19 Risk Assessments: i. That 71% of staff had returned their individual risk assessments and that bank staff made up 10% or the remaining shortfall. The Trust was looking at how it worked with those staff and may require completion of the assessments before any further shifts were allocated. There were other groups where there was low compliance including medical staff and we were looking at how we engage with those groups. The Trust had also included staff on sick leave and maternity leave within its baseline figures. ii. That the medical staff figure included the count of juniors who would be moving on from the Trust at the end of July. An overarching approach to managing these doctors had been		

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	discussed with the Deanery but this was not thought to be feasible. iii. The return rate for our BAME staff was only at 65% compare to a 75% return rate from other staff. iv. In feedback from staff in Bands 2-4 (where there was a low return rate) some staff had not completed the form as they had already had COVID19 and this was being addressed through line managers and the Communications team. v. The current focus of work was on the 6% of staff who were either shielding or assessed as having a Red risk rating. vi. There were 88 clinical staff that were assessed as having a red risk rating and there was concern around how we could redeploy those staff to allow them to return to work. The Trust had started the discussions with staff to bring them back into work and around 45 staff were being supported through this route with some clinical advice from within the hospital. Discussion: i. JW noted that the Region were expecting the Board to ensure that the process of risk assessment was undertaken and to ensure it had effective oversight of the outcomes and the actions that were being put in place to manage risks. ii. SP asked about our confidence in achieving a stepped increase in the compliance as other organisations were achieving 100% compliance figures. OM noted that the Trust had included all staff in its assessments and was focusing on the quality of the assessment process. iii. JW asked whether the approach taken was just for COVID as this was one of a number of diseases that our staff were at risk of contracting and he questioned whether it was being given a different weighting to other disease. OM advised that the risk assessment process was COVID specific but that it was recognised that this activity needed to be moved into the normal pre-employment health screening that was undertaken along with diseases such as HIV and TB. iv. JW asked to clarify how screening viewed conditions and personal characteristics that might make someone unsuitable for a role. OM noted that the process was to ensure that the Trust had undertaken its duties in relation to Health and Safety legislation. This was to ensure that we provided advice to staff and set out the precautions and mitigations we had in place to provide safe working practices including the built environment factors such as the air exchange system and the wearing of appropriate PPE. v. SP noted that we must acknowledge the fear and concerns expressed and provide reassurance to our staff. The concerns here mirror those raised around PPE earlier in the pandemic response which were managed through 1:1 and small group discussions and that had provided assurance for our staff. The same approach was to be taken with staff assessed at higher risk. JW felt that this approach should be used for our staff in all situations. vi. MB noted that the communication around the risk assessment was key as it was easy to feel that COVID19 was a unique problem and it was important to contextualise the factors that		

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	increased risk in relation to COVID19 would also have an impact on other indications and the aim should be to reassure our staff and not to cause alarm. vii. JA agreed and noted that the NHS had previously had to deal with other issues such as H1N1 and circumstances where we could not assure that we had the right PPE at the right time. In this case we were faced with a different situation which was dynamic and in which we needed to ensure that individuals took responsibility. We would also need to ensure that if we were to move back into surge that we were able to have a sustainable level of PPE for our staff. **Reported:** By OM on the BAME Network: i. That the network was operating very well with a mature approach and constructive challenge and a confidence in asking questions. The network meetings had addressed difficult subjects and that she had seen increased levels of confidence as the network raised issues and saw that these were being addressed (such as the issue of critical care staffing). ii. That she was looking at how this agenda could be speeded up as it was not progressing as fast as it should and so she was seeking support for the network to help it turn plans into reality. **Discussion:** i. JW noted that there were vacancies coming up in the elections to the Council of Governors and suggested that the network should be encouraged to make a nomination to these roles. ii. CC asked if the programme of reverse mentoring could be pursued as she had seen this working effectively in other settings. OM to consider how this could be taken forward. **Agreed:** The Board noted the report from the DWOD.	OM/AJ OM	Sep 20 Sep 20
5	**Research & Education**		
5.i	**Research update** **Received:** IS provided a verbal update on research matters. **Reported:** By IS: i. That most non-COVID research had been suspended in March and staff re-deployed to support the operational response to COVID19. IS wished to note his thanks to all the R&D staff who had been redeployed supporting areas including: Command and Control; the Clinical Decision Cell; COVID19 Data Reporting; R&D Nursing who had been redeployed to critical Care; and clinical leads who had taken the Chair of campus wide meetings making essential contacts and taking forward research initiatives. ii. That over 50% of our COVID patients had been recruited to the 'Recovery' study. iii. That all COVID patients were logged on the registry studies and in bio resources. iv. In PVDU Dr Mark Toshner had set up a study on a 50/50 basis with the University of Cambridge working in the vaccine field.		

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	He had also taken on a Campus role as Lead Principal Investigator in the Oxford international vaccine study. Cambridge had been the last of the centres to go live but had progressed well with recruitment to the trial. This Campus role would be good for commercial vaccine studies in the future. v. The Trust was also looking to secure a national role in follow up of COVID patients through a national bid for a £12m grant and it was the national lead for vascular complications. vi. That Helen Baxendale from the immunology team had provided daily updates on the evidence base during the pandemic through a 'sound bites' summary that was provided to clinical staff. This had provided a constant refresh of evidence for our clinical staff. Dr Baxter had also had a paper published in the Lancet on primary immunodeficiency. vii. The Trust had today agreed a collaboration with the University of Cambridge Vet School looking at zoonotic disease. viii. The Trust had also received a £1.4m grant looking at whether the COVID immune response was protective. This was recognised as a very impressive bid and could be accepted into the SIREN study. The study centre for that trial will analyse information in Cambridge and nationally the study would involve repeat testing for 10k staff. ix. The R&D department were now looking at which of the non COVID studies could reopen. Studies continuing would include the High Flow Nasal Oxygen Study led by Dr Andy Klein. x. The Trust was also looking at the strategy around new devices and was looking at the new Morgan device to transport organs to support the transplant push. This was aligned to the NHS Blood and Transplant (NHSBT) programme and was funded by NHSBT and the Trust had signed the contract for this work. **Discussion** i. IW echoed the feedback provided on R&D by IS and noted that the work on COVID19 had brought all partners together. The approach that had been forged would be a good foundation for the HLRI going forward, and this progress had been achieved against some level of resistance at a high level. ii. IW noted that there was a need to publish the outcomes data four our patients to ensure that there was wider understanding of what had been achieved. IS advised that Helen Baxendale was working on papers for publication. **Noted:** The Board thanked IS for the update on research activities and welcomed the very positive outcomes of these activities.		
5	**BOARD FORWARD AGENDA**		
5.i	**Board Forward Planner** **Received and Noted:** The Board Forward Planner.		
5.ii	**Items for escalation or referral to Committee** It was agreed that the review of Risk Appetite in relation to COVID-19 would be taken forward outside of the meeting.		

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6	**Any other Business**		
6.i	**Board meeting frequency** SP asked whether the Board would continue to schedule meetings on a monthly basis. It was agreed that this would be driven by events and in the short term the monthly meetings would be retained.		

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Signed

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Date

Royal Papworth Hospital NHS Foundation Trust
Board of Directors
Meeting held on 2 July 2020

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/IPC	Infection Protection, Prevention and Control Committee/ Infection Prevention and Control
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