Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Held on 6 August 2020 at 9:30am
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
	Dr R Hall	(RH)	Medical Director
	Mrs E Midlane	(EM)	Chief Operating Officer
	Mr S Posey	(SP)	Chief Executive (T)
	Mr G Robert	(GR)	Non-Executive Director (T)
	Mr A Raynes	(AR)	Director of IM&T Chief Information Officer(T)
	Prof I Wilkinson	(IW)	Non-Executive Director (T)
In Attendance	Mr I Graham	(IG)	Deputy Chief Nurse
	Ms P Hales	(PH)	Head of Allied Health Professions
	Ms L Howard-Jones	(LHJ)	Deputy Director of Workforce and OD (T)
	Mrs A Jarvis	(AJ)	Trust Secretary
	Mr A Selby	(AS)	Associate Director of Estates and Facilities
Apologies	Ms O Monkhouse	(OM)	Director of Workforce and OD
	Mrs J Rudman	(JR)	Chief Nurse
(T – joined the meeting via online teleconference)			

Agenda Item		Action by Whom	Date
1.i	**WELCOME, APOLOGIES AND OPENING REMARKS**		
	The Chairman welcomed everyone to the meeting and thanked the Board for joining the additional meeting that was required in the very rapidly changing landscape. 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. EM advised that she had been appointed as an External Assessor for CQC Well Led Reviews.		

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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, Roger Hall and Eilish Midlane 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.iii	**MINUTES OF THE PREVIOUS MEETING**		
	Board of Directors Part I: 2 July 2020 **Item 1.v**: Blank numbering in this section (vii and viii) to be removed. **Approved**: With the above amendment the Board of Directors approved the Minutes of the Part I meeting held on 2 July 2020 as a true record.		

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1.iv	**MATTERS ARISING AND ACTION CHECKLIST**		
	Noted: The Board received and noted the updates on the action checklist.		
1.v	**Chairman's Report**		
	The Chairman noted that he had attended recent meetings with the Regional Director and Chairs; CUHP and the STP. There had been a number of formal and informal meetings. The Campus development group had also met and had been Chaired by the Vice Chancellor of the University. The STP had appointed a new executive lead for Programme Development. The focus of the STP and system discussions was recovery with the twin pressures to get back to delivery of as much as possible of our usual services; and to protect our staff. These issues would both be discussed on today's agenda.		
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: i. The issues faced by the Trust were the same as those face across the NHS: Recovery; looking after our workforce and winter preparedness. ii. The Trust had made very good progress on restoring services and was ahead of other organisations. This was as a result of the work on the dynamic modelling tool developed by TG; the maturity of the approach of the CDC led by RH and JR; and the Living with COVID programme structure and approach led by EM. The Trust had moved at pace to recover services in a way that other organisations had not achieved. This work was also supported by the design and layout of the hospital. iii. That the NHS Phase Three recovery letter had been received. This did not indicate additional funding for the NHS ahead of winter and set out activity standards for Trust recovery plans. iv. RH had circulated the outcome data from ICNARC which identified a mortality rate of 23.7% for patients admitted to Critical Care and 17.7% for all COVID19 patients these outcomes compared favourably with national outcome data and all of our staff should have ownership of the role that they played in this and the lives saved as a result. v. The Trust had also received the results of the national inpatient survey and we had been concerned that this might have deteriorated through the move but the Trust had still achieved positive results. vi. The Executive focus was on recovery post the peak of COVID19, and on our workforce where we were taking forward responses to the WRES and the staff survey themes. vii. The Trust wanted to deliver the best possible environment for its staff and had started two exercises that would support this: a. The staff debrief process for COVID19 b. The staff risk assessment process		

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	The Trust recognised the important contract between the Trust and its employees. The Trust had put in place free drinks for staff (with positive feedback on this initiative) and had held a recharge week in which all staff and teams were encouraged to take breaks. This built on survey results from our staff that suggested that psychological wellbeing and support was one of the most important issues for them. The Trustee Board would be considered a number of additional schemes today that would support staff wellbeing, but the most important issue remained the relationship with your line manager. The Trust had relaunched the Compassionate and Collective Leadership Programme and this would help to ensure that staff were appropriately supported by their line managers. viii. SP gave particular thanks to the Recruitment Team noting that through the pandemic response they had introduced innovative measures to support ongoing recruitment and had achieved a reduction in the time to hire from 52 to 42 days. ix. SP invited EM to provide an update for the Board on NHS the Phase Three Recovery letter. EM advised that the Phase Three recovery letter identified key themes for the NHS including: a. Acceleration of the return of non-COVID activity. b. The return of cancer and diagnostics activity to plan. c. A push on elective activity head of winter and any second wave of COVID19. d. Addressing health inequalities including mental health and learning disability. e. Winter planning f. The People Plan g. Financial management There were 60+ specific requirements set out within the letter and the Executive had assessed progress against each of these items and the Trust was at an Amber or Green rating for every item identified. The letter sets out the challenge facing the NHS and the requirement that we use the resources that we have to best effect. The initial system response document had been submitted in June and this was whilst the Trust was still in the height of the pandemic response. The system plan would be revised and resubmitted in September based on actual performance of the Trust and this would reflect well on what had been achieved so far. **Discussion:** i. GR asked whether the staff debrief report would be made available to the Board. SP advised that this would be presented to the Emergency Planning Committee and Q&R and Performance and that key issues would be brought to the Board through that route. ii. JW noted the positive outcomes data; also that he had been impressed by the pace of the recovery which was ahead of expectations. SP advised that all services including transplant were pushing to ensure that every possible patient was being brought forward for treatment. iii. JW was particularly impressed by the function of the CDC through the pandemic and suggested that this should be	**JR**	**Sep 20**

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	written up for publication. RH confirmed that this was being pursued with the BMJ and other journals and that Clinical Directors had been tasked with drawing up a chapter for their areas. SP proposed that publication of learning from COVID19 and the functioning of the CDC should be submitted to HSJ as well as clinical journals. Kate Waters to be approached to support this. IG advised that Pippa Hales had also written a paper on the operation of the essential care teams and that was also to be submitted for publication. iv. CC noted that in the recovery model shared with the Performance Committee there were some services that were performing at 45% of plan and asked whether these services would achieve the 80% requirement? EM advised that RSSC/Day ward and Out patients were undertaking a forward review of bookings and services were running at 100% of plan in August. Progress was being monitored through the weekly access group. For diagnostic services the CT backlog would be addressed in August and the MRI backlog in September. v. JA asked for clarification of the block payment and the 'flex' that was to be applied to this. TG advised that it was expected that if Trusts and systems met the requirements set out in the Phase Three letter then they would receive reimbursement and that this matter would be discussed further on the Part II agenda. **Noted:** The Board noted the CEO's update report.	**RH**	**Sep 20**
1.vii	**Patient Story**		
	Pippa Hales Head of Allied Health Professions presented a patient story to the Board setting out their experience of the Allied Health Professions. PH had selected a heart transplant patient (R) who had been with the Trust for a long period of time. R was 54 years old and he was admitted to ward 5NE on New Year's Eve 2019. He had remained at Royal Papworth Hospital since then awaiting a heart transplant. R had his transplant on 29 July 2020 and returned back to ward 5NE on 1 August following a 2 day post-operative stay on critical care. He hoped to be home in a weeks' time. R came to Royal Papworth knowing he would need to stay overnight and seven and a half months later he was still here. He was grateful for and humbled by the care he had received at Royal Papworth Hospital. He said: "(the staff at RPH) and the donor got me through this, 'thank you' is too small a word, it just isn't enough." R had identified the impact pre-operative 'prehabilitation' on his readiness for surgery and his speed of recovery. R has found that the teams had motivated him and continued to engage him in prehab and rehab and had helped to occupy him during his long stay. The Occupational Therapy team had supported him to make chess pieces and to make model aircraft and buildings. Now they were		

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	preparing him for his return home. They had also provided weekly relaxation sessions which had been really important to R, providing calm and rest. The Physiotherapists had motivated R to exercise daily to maintain and build his strength and fitness. R cycled the distance from Lands' End to John O'Groats on an exercise bike. R felt that if every room could have a bike in it, it would help patients immensely. R had not needed ongoing input from the Speech and Language Therapy team as his muscle strength had been maintained with prehabilitation. His voice was a little weak post operatively and so he may now need some input. The Dietitians had educated R about his need for a high protein diet for muscle strength and tissue repair. He needed to build his weight up to ensure he was fit enough for surgery and to make a quicker recovery. They measured R's grip strength each week to measure muscle strength and bulk. R had noted that he had been using a hand exerciser and therabands to build up his chest and arm muscles and to maintain strength. All hospital teams had worked and contributed to support R's emotional well-being. R said that "from the cleaners to the nurses to the rehab team, if someone's having a hard time they would sort it out and then your endorphins get going and before you know it you are away and on your bike." R also gave his observations of what did not work so well with the teams and what we could do to improve things. The menu can be repetitive for long stay patients. R had been provided with the restaurant menu which had helped. R did not recall the Operating Department Practitioners involved in his immediate pre op care as he couldn't identify them. R knew the radiographers but didn't build a relationship with them as they were involved only briefly. R observed how busy life was at the hospital for patients and recognised that getting rest was as important as all the other input he had received. R suggested timetables on the doors to allow adequate rest for patients. Time to rest was essential and it could be difficult to turn away people who had helped you on your journey. R had experienced being here through COVID and had not found that masks had negatively affected his ability to communicate with staff. He felt that having a mask could be good as people had to look you in the eye and it made you take notice of other things. R had also been here through the restrictions in the visitor policy. He was IT savvy and had used his own digital equipment to stay in touch with family. One of the Occupational Therapists gave him a stand for his phone to make it less tiring to make calls. R had been allowed 1 visitor a week for three hours as he had been here a long time and the individual rooms really helped with visits. R observed that the hospital design had made his experience of being an inpatient during COVID a positive one. He felt it was brilliant for isolation and brilliant for COVID and that future hospitals should be		

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	like this one. Before the IPC restrictions R did not find that the individual rooms impacted his ability to socialise and connect with other patients. He had not been keen on the lunch clubs but could still make connections and meet people on the ward. R was grateful for the care he had received and was planning on working to fundraise for the charity and for the NHS. He was grateful for the NHS and felt humbled to be part of this community. He was thankful for all the teams involved in his care especially the transplant nurses. He was anxious about going home but looking forward to it. At times he was scared as he was institutionalised and even the idea of going out to the duck pond to help with his rehabilitation was a challenge. PH noted that the key issues that were being taken forward from this patent story were: • Timetabling of protected rest breaks for our long stay patients particularly when post operatively back on the ward. • Consider if it detracts from the patient's experience if they cannot identify ODPs or build a rapport with the radiographers. • Aim to offer prehabilitation to all surgical patients to improve outcomes. • Continue to motivate patients to participate in prehab and rehab. **Discussion:** JA asked whether all long stay inpatients had formal psychological input. PH advised that the transplant service maintained regular contact with patients and there was access to psychological support, but she didn't know if that was used routinely for all patients and would provide feedback on that point. **Noted:** The Board of Directors thanked Pippa for her presentation and noted the patient story.		
2	**PERFORMANCE**		
2.a.i	**PERFORMANCE COMMITTEE CHAIR'S REPORT** **Received:** From CC the Chair's report setting out significant issues of interest for the Board. **Reported:** By CC that the Committee had focused on post pandemic recovery planning and had considered: i. A presentation on Critical Care from Cheryl Riotto, Head of Nursing, which had outlined the good progress and a move back towards 'business as usual'. The Critical Care optimisation project had been reinstated along with its eight supporting workstreams. The unit was now open to 33 beds, with some gaps in workforce numbers, which was improving, and was expected to open to 40 beds by October 2020. ii. The PIPR report which had been reinstated. The Trust was showing some signs of improvement in performance. It was at an overall red rating with two domains at green. The position on the cancer 62 day target was to be kept under close review. iii. The Committee had discussed theatre productivity where		

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	optimisation work had restarted, and an approach similar to the Meridian work in outpatients was to be applied. This work had identified a change in practice in relation to cancellations, where patients were now kept in hospital to be rescheduled. This had reduced waiting times and improved the patient experience but would extend lengths of stay. There had been some initial uncertainty about this approach but it was felt to be a model that prioritised patient experience and restoration of services. iv. Outpatient activity had returned to 70% of planned levels and reporting was to be included in future reports. v. The Corporate Risk Register which was to be discussed with GR outside of Board and brought to Committee in August. **Discussion:** i. GR noted that the reporting on restoration of services would require Board oversight to ensure that there is a means of reporting against the activity targets set out within the Phase Three recovery letter as well as the finance and income position. TG noted that the report that had been provided to the Committee would need to be reviewed in line with the requirements of the NHS Phase Three recovery letter to ensure that it met the reporting requirements. Reporting would reflect the continued financial uncertainties. **Noted:** The Board noted the Performance Committee Chair's report.	**TG**	**Sep 20**
2.b	**PAPWORTH INTEGRATED PERFORMANCE REPORT (PIPR)**		
	Received: The PIPR report for Month 3 (June 2020) from the Executive Directors (EDs). This report had been considered in at the Performance Committee and was provided to the Board for information. **Reported:** By TG that CC had covered the key issues considered by the Committee. He noted that: i. The PIPR report reflected a turnaround position with the Trust coming out of the COVID period and restarting services. ii. The Trust had made further progress in July and this had been seen at Committee in the Clinical Decision Cell report. iii. The Safe and Caring domains were rated as Green. iv. Effective and Responsive domains were rated as Red but this was as expected as a result of COVID19. v. People Management and Culture had seen an improved position especially around recruitment and there was a spotlight report on the COVID19 risk assessment process.		
	Noted: The Board noted the PIPR report for Month 3 (June 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.		

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	Reported: By AJ that the key changes included the agreed closure of the BAF 2249 Hospital Optimisation as this programme had been superseded by the Living With COVID programme and this would be reflected in future reports. **Noted:** The Board noted the BAF report for July 2020.		
3.ii	**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 the Committee had been advised about the increase in surgical site infection rates and the NWAFT concern raised through the coroner's office which was noted in the Combined Quality Report. The Committee would keep oversight of these matters and ensure that any issues identified were triangulated. **Discussion:** i. IG noted that Carole Buckley, Assistant Director for Quality and Risk had written to the doctor involved at NWAFT and that no further information had been provided and this was being followed up again by letter. ii. JA noted the discussion at Q&R and suggested that an informal clinician to clinician approach may also be helpful. iii. SP was concerned to ensure that this matter was addressed and that assurances were brought back to the Board. **Agreed:** That the Medical Examiner at NWAFT should be approached to ensure that information was provided to allow review of the concerns through the Q&R Committee. **Noted:** The Board noted the Q&R Committee Chair's report.	**RH**	**Sep 20**
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 RH and IG that the report had covered matters outlined above in the Q&R Chair's report and in addition it presented: i. The Infection Prevention and Control Board Assurance Report and the report of the CQC Engagement Assessment ii. The Supportive and Palliative Care Team Annual Report iii. The Trust's IPC Annual Report **Discussion:** i. GR asked for further detail on the areas that had been identified for improvement in the Supportive and Palliative Care Team Annual Report and whether these were significant issues. IG advised that many areas of care were carried out to a very high standard but there were two areas that had been assessed as requiring improvement relating to assessment of hydration needs for patients and preferred place of care and anticipatory prescribing. The team were working to improve these areas and address documentation issues to evidence how needs were being met. He noted also that work on Preferred Place of Care (and at end of life, preferred place of		

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	death) was in place with many of our patients being supported with chronic lifelong conditions. The roll out of the RESPECT programme was helping with this agenda across the Trust. ii. CC noted that some of the coroner's cases included in the report dated back a number of years. IG advised that the delay in coroner's cases was not within our control and had been further adversely affected by COVID19. Carole Buckley liaised closely with the coroner on these investigations. **Noted:** The Board noted the Combined Quality Report.		
3.iv	**Audit Committee Chair's Report** **Received:** The Board received and the Audit Committee Chair's report of the meeting held on the 16 July 2020 setting out significant issues of interest for the Board. **Reported:** By CC: i. That the focus of the meeting had been on the PricewaterhouseCoopers (PwC) report on the bridging loan and the land disposal. It had been important that the Committee had the opportunity to review the PwC report in great detail, and that good financial governance had been followed. It was acknowledged that no governance rules had been broken and the Trust had followed due process, but there should have been greater documentation of discussion at Board level. Further that whilst a different decision could have been made, the disposal strategy was sensible given the Trust had received an offer of £15m for the site. PwC had made a number of recommendations to the Trust and these would be followed up and documented at Committee and Board. ii. That the Committee had received the Local Counter Fraud Annual Report and this was rated at an Amber status. This was based on an Amber assessment of two indicators where the Trust did not have the opportunity to demonstrate compliance and CC had requested that this matter be challenged nationally on that basis. The Trust was assessed as demonstrating a strong antifraud culture and a robust management approach. The recommendations of the report had been accepted by the Trust. iii. The Committee had also agreed the reallocation of internal audit days from private patient invoicing and consultant job planning to financial governance reviews including the procedures surrounding the use of high cost drugs. **Noted:** The Board noted the Audit Committee Chair's Report.		
3.v	**Board Sub Committee Minutes:**		
3.v.a	**Quality and Risk Committee Minutes: 25 June 2020** **Received and noted:** The Board of Directors received and noted the minutes of the Quality and Risk Committee meeting held on 25 June 2020.		
3.v.b	**Performance Committee Minutes: 25 June 2020** **Received and noted:** The Board of Directors received and noted the		

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	minutes of the Performance Committee meeting held on 25 June 2020.		
3.v.c	**Audit Committee Minutes: 16 July 2020** **Received and noted:** The Board of Directors received and noted the minutes of the Audit Committee meeting held on 16 July 2020.		
3.vi	**Performance Committee Terms of Reference** **Received and approved:** The Board of Directors received and approved TOR007 Performance Committee. The terms of reference had been reviewed by Committee in February 2020 and recommended to the Board for approval.		
4	**WORKFORCE**		
4.i	**Workforce Report** **Received:** The Deputy Director of Workforce and OD provided a verbal update on key workforce issues. **Reported:** By Larraine Howard-Jones that: i. The recruitment team had been doing phenomenal work and had achieved the lowest vacancy rate in three years. ii. The Trust had 95 Band 5 nurses in its recruitment pipeline. iii. Time to hire had reduced from 52 to 42 days. This had been achieved by streamlining processes and having a nurse specialist working every day to support onboarding of staff. iv. The Trust had done well with the risk assessment process when compared to peers and had responded very rapidly to updated guidance. The Trust was confident in the data that it had gathered and had completed risk assessments for 86% of staff in the Red/Orange and Yellow categories and had plans in place for all staff. Six hundred and fifty conversations had been held with staff in the higher risk groups and the Trust was working with staff and managers to ensure that there was a safe environment for staff to return to work. On the whole the Trust was managing to return staff to existing roles and with small number moving to alternative roles. v. 85% of our BAME staff had returned their risk assessment forms and 42% of those staff were in the Red/Orange/Yellow categories. vi. There was support in place for staff returning to the workplace and managers were helping to address staff concerns. vii. The Trust had set up an advisory panel to support the assessment for staff in the Red risk category and around 65% of staff assessed had been able to return to work. viii. Progress was also being made on the lessons learned from the response to COVID19. This would consider what we wanted to continue and what was needed to step up in the the event of a future surge. ix. The Trust was now putting focus back on business as usual and this included completion of IPRs for staff and restarting work with our LGBTQ+ and disability networks. The Trust was also planning for the 2020 flu programme and the staff survey. x. The National People Plan had also been published and the Trust would be promoting this and developing the local plan in response to it. The plan did not contain any surprises but the		

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	issues set out would need a continued focus on staff health and wellbeing and challenging inequality. **Discussion:** i. GR thanked LH-J for the update and asked about the sustainability of the vacancy rate. He felt that whilst the work on recruitment was excellent the vacancy position could be being driven by a lower attrition rate as a result of COVID19 rather than increased recruitment. LH-J agreed that could be a factor and advised that focus was being maintained on recruitment and retaining our staff through improved staff engagement, and restarting our compassionate and collective leadership programme. ii. CC noted that the Performance Committee had heard about the innovative recruitment approaches being developed in Critical Care. LH-J advised that the service had run very successful online events and the approach had been well received by the workforce coming through this system. This formed part of ongoing recruitment plans. iii. JW asked whether we had plans in place to respond to any second surge in cases. EM advised that we had plans and had taken lessons from the first surge which would change the order of opening of some critical care surge areas. There would also be a different approach to the management of elective activity along with a critical care surge. iv. RH advised that the regional system would need to ensure that there was a sufficient response to the transfer of critical care nursing staff in the event of a second wave. Members of the Executive Team were seeking to influence matters in regional meetings to gain support for the surge plan. In the initial response the Chief Nurse had to approach other Trusts directly to discuss transfers of staff and given the outcomes for patients transferred the system must have effective workforce plans in place. **Agreed:** The Board noted the update from the DDWOD and it was agreed that the Trust response to a COVID19 second wave would be taken through Q&R and the Performance Committee.		
5	**BOARD FORWARD AGENDA**		
5.i	**Board Forward Planner** **Received and Noted:** The Board Forward Planner. **Discussion:** CC noted that she did not find the Forward Plan very useful and requested that this was reviewed.	**AJ/JW**	**Oct 20**
5.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 6 August 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	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