Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Held on 03 September 2020 at 9:30am
via Microsoft Teams
Royal Papworth Hospital

UNCONFIRMED M I N U T E S – Part I

Present	Prof J Wallwork	(JW)	Chairman
	Dr J Ahluwalia	(JA)	Non-Executive Director
	Mr M Blastland	(MB)	Non-Executive Director
	Ms C Conquest	(CC)	Non-Executive Director
	Mr T Glenn	(TG)	Chief Finance and Commercial Officer
	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
	Prof I Wilkinson	(IW)	Non-Executive Director
In Attendance	Mr E Gorman	(EG)	Deputy Director of Digital
	Mrs A Jarvis	(AJ)	Trust Secretary
	Mr A Selby	(AS)	Associate Director of Estates and Facilities
	Mrs L Shillito	(LS)	Matron, Cardiology
Apologies	Mr A Raynes	(AR)	Director of IM&T Chief Information Officer
Observers	Susan Bullivant		Public Governor
	Pippa Erskine (Kent)		Public Governor
	Caroline Gerrard		Staff Governor
	Richard Hodder		Lead Governor
	Trevor McLeese		Public Governor
	Nadia Shaw		Director Healthwatch
(All members and observers 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 and welcomed observers from the Council of Governors and Healthwatch.		

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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.		
	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.		

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1.ii	**MINUTES OF THE PREVIOUS MEETING**		
	Board of Directors Part I: 6 August 2020 **Item 1.vi** i: revised to read "..faced across the NHS.." **Item 1.vi** vii: revised to read "..with their line manager.." **Item 1.vi** ix - revised to read "..the NHS Phase Three.." **Item 1.vi** ix c - revised to read "..activity ahead of winter.. " **Item 3.iv**: revised to read "..received the Audit Committee Chair's report.." **Approved**: With the above amendments the Board approved the Minutes of the Part I meeting held on 6 August 2020 as a true record.		
1.iii	**MATTERS ARISING AND ACTION CHECKLIST**		
	Item 245: MB noted that the full staff debrief had not yet been presented to the Q&R Committee as there were comments awaited from the FTSU Guardian. **Item 240:** OM advised that the Trust had made a good appointment to the EDI lead post that had been funded through the Charity. **Item 229:** JW asked for a timeline to be set for the write up of learning from the Hospital move and from COVID19. **Noted:** The Board received and noted the updates on the action checklist.	SP	TBC
1.iv	**Chairman's Report**		
	The Chairman noted that in normal circumstances he would not have been able to join the Board as he was due to be at the fiftieth reunion of his graduation and this event had been cancelled because of COVID19.		
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 had made phenomenal progress against the recovery targets and this reflected the remarkable achievements of our staff on a daily basis. The recovery targets were a challenge and EM would set out further detail under the PIPR report. ii. That NHS Providers (NHSP) was working with the Trust to publish an account of how we had responded and recovered through the COVID19 pandemic. This would be the first of a number of articles that NHSP were planning with Trusts. iii. That the safety of our staff continued as a key priority for the Trust and that feedback from the debrief exercise would provide learning for the Trust. SP noted his thanks to OM and JR for the progress on this work and advised that this would		

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	be shared widely once complete. NHSE had also requested that the Trust share its learning from COVID19. iv. That the Trust's five year strategy was on today's agenda for approval. This set out RPH's role within the wider system and reflected and built on our experience of supporting the Region through the first wave of COVID19. **Noted:** The Board noted the CEO's update report.		
1.vi	**Patient Story**		
	Lizzie Shillito presented a story about a 41 year old patient that she had spoken to following a Matron's Board Round. This story related to a patient who had experienced homelessness. He had attended A&E with a leg injury. He had an NSTEMI and was transferred into our critical care service with pulmonary oedema. He had an angiogram at RPH which showed no coronary disease but the patient experienced multiple seizures and was admitted to our cardiology ward. The patient had a complex medical history as he was a previous IV drug user; he had Acute Kidney Injury and was Hep C positive and he had developed cellulitis in his leg. The patient spent 5 days on critical care and had made rapid progress. He was not able to remember the early days of his stay as he had significant pain issues, but as this improved he had remembered the kindness of our nurses, particularly one called Rose, and from then he had made good progress. The patient was subsequently transferred to ward 3S and was referred to the dieticians because of his general poor health. He was put on a high protein diet with snacks which he really welcomed. He reported that everyone on the ward had treated him as a human being and with genuine kindness, and that this was the first time that he had really experienced that within the NHS. LS said that this made her feel very proud of the care that had been delivered to this patient whilst at RPH. She said that the patient had reflected on his former lifestyle and had said that he did not want to go back to it. The patient was repatriated to Peterborough for ongoing treatment of his leg. LS felt that his experience showed what a difference kindness and compassion can make in the care that we deliver. **Discussion:** JW asked if we knew what had happened to the patient subsequently. The patient had returned to his hostel place and had made a number of positive changes. He had approached his family for support and help in managing his medications. He had been feeling better and generally well, and felt that he could see a way in the next few months to move on from the hostel to more permanent accommodation. GR advised that he had heard a moving story at a workshop run by Shelter about a hospital patient who had been made homeless during the course of an admission and asked about the Trust's working relationship with social care services and how much intervention there was for vulnerable patients prior to discharge. LS advised that vulnerable patients were identified through the Matron's Board rounds and that there was very good interaction with social services through Penny Martin (Safeguarding, Discharge and Social Work Lead) both		

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	within the hospital and in supporting longer term care packages. JA noted that there had been work undertaken in the US hospitals that asked patients questions on kindness, respect and dignity and answers to these questions always tracked the quality of clinical care. **Noted:** The Board noted the patient story. JW thanked LS for bringing this very encouraging patient story and hoped that the patient would see further positive outcomes in time.		
1.vii	**Trust Strategy**		
	Received: From the Chief Operating Officer the final draft of the revised Trust Strategy 2020 – 2025. **Reported:** By EM: i. That the paper set out the revised Trust Strategy which had been updated with input from Clinical teams and Non-Executive Directors to address the impact of the COVID-19 pandemic. NEDs had been able to contribute to this through a separate review session last week. ii. That if approved the strategy would be launched in September with Executive Briefings for staff and information used in recruitment, IPRs and leadership training. There were also posters for display and reporting would be established through sub-committees and Board. **Discussion:** i. GR asked whether the commitment to achieve HIMSS level 6/7 pre-empted the Board discussion of the Digital Strategy which was planned. SP noted that the Trust would bid for resources to advance this national agenda and this was something that the Trust wished to achieve, but this would need to be affordable within the overall Trust Strategy. JA advised that the HIMSS standards were in reality consequences of what the Trust must do and a check on the effective adoption of the electronic medical record. In delivering this the Trust would achieve HIMSS standard 6/7. ii. CC asked about references to patient surveys as the Strategy referred to the national cancer survey but not the other surveys that were in place. EM noted that we had not included references to all operational and service elements in the strategy but that she would ensure this was reworded to use a generic reference to patient surveys. **Approved:** The Board approved the updated Trust Five Year Strategy.	**EM**	**Sep 20**
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 restoration of activity and had received substantial assurance on the Trust achievements from the data provided and from the report and		

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	presentation from Mr David Jenkins, Clinical Director for Surgery, Transplant and Anaesthetics. The presentation had focused on what was being delivered by the Division in terms of recovery; how staff had welcomed some of the recent initiatives to support staff; and the experience of our staff and the challenges for the Division at the height of the pandemic, particularly in how they had deployed staff and resources. The Committee had also heard about the system and financial challenges and the approaches that were being taken to manage costs and the opportunities to increase other income. He felt that the right approach was being followed and this would be considered further on the Part II agenda. **Discussion:** i. JW noted that the Trust would need to look at the emerging issues around system and identify what might limit the Trust. He was very pleased that the Trust recovery had exceeded expectations set in the CDC medium term plan and noted that the CDC longer term plan would be finalised in the next week and would be shared with the Board next month. **Noted:** The Board noted the Performance Committee Chair's report.	**RH**	**Oct 20**
2.a.ii	**Restoration of Activity**		
	Received: From the Chief Operating Officer a paper setting out progress on the restoration of activity through the Trust. **Reported:** By EM: i. That there had been very good progress in restarting services. This was in line with the targets set out in the CDC strategy and latterly the targets set out in the NHS Phase 3 recovery letter. The recovery report set out the current performance against CDC targets as at 10 August 2020 and provided a view of future bookings. ii. That Imaging, Cardiac Surgery and Cardiology had all exceeded the expectations set. iii. Imaging was now operating at 100% and this was a significant achievement. It was recognised that imaging capacity was a key constraint in many patient pathways and that other Trusts were facing significant problems in this area. iv. The new focus for recovery was on Thoracic Medicine/RSSC and outpatients. The outpatient forecast for September was for an increase in activity (recognising that August generally had lower activity levels) and the sixth theatre would be operational on a daily basis from the 14 September. v. The improvements in performance had a positive impact on RTT targets across the Trust and this was down to the huge efforts of Trust teams. **Discussion** i. SP noted the strong recovery and invited EM to provide an update on the pressures that were being seen across the wider system. EM noted that other Trusts had seen activity losses of 50/60%. These resulted from challenges in the delivery of diagnostic services; significant reductions in theatre productivity and a loss of beds. On campus CUHFT had taken		

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	200 beds out of use. In this context our progress on recovery was very positive. ii. SP noted that schemes to support recovery at a system level had been called for and RPH had put in bids to deliver endoscopy services that should provide some support to CUHFT and NWAFT. The Trust was also engaged with the bid for additional MRI/CT imaging capacity on site. iii. IW noted that the achievement in relation to Imaging was amazing and asked how this had been achieved. EM advised that this was being delivered within the funded establishment with some switches having been seen from agency to substantive staffing and changes to rosters and shifts that had allowed an extension of opening hours. iv. IW asked whether the outpatient performance and reduction in volumes was as a result of problems in getting patients to attend face to face clinics. EM noted that the technology for our virtual and telephone clinics was working well, and that the Trust was carefully managing the footfall in the outpatient department. This had been supported by a new footfall tool that allowed us to see patients waiting in the outpatient area. However patients were reluctant to attend in person. There was a lot of work being undertaken to explain to patients about how safe our services were and to encourage them to attend. There had also been changes to pathways and new Advice and Guidance clinics that had seen around 900 patients removed from the Cardiology waiting list without the need for an appointment as they had been directed to appropriate services. v. MB noted that he was pleased to see the recovery report and asked for clarification of the figures used in the occupancy adjustments on page five of the report. TG advised that the unadjusted figure was based on the number of patients in beds and the occupancy rate adjustment brought in an assessment relating to the staffing headroom required to support this level, it was then adjusted to the target level. vi. MB asked whether the baseline figures used in the model reflected where we should have been in terms of activity delivery, or what we had actually delivered (which was underperforming against plans). RH advised that the purist view on business as usual targets (BAU) was to set these at the busiest four months of the prior year's activity. The Trust had recognised in the CDC long term strategy that the Trust needed to go beyond that level and to maximise the use of the hospital capacity. On this basis BAU was only a part of this assessment and not where the Trust wanted to be. vii. TG advised that this was the way the centre was looking at activity and cost. The Trust would need to articulate its aspirations and describe the changes that were needed and how these would influence reductions in the wider NHS cost base. However given that the current funding mechanisms were based on the historic workload this could be difficult to achieve. viii. MB felt that it would be helpful for reporting to be provided on the basis of our performance against our aspirational targets. ix. CC asked why we had not included assessment against		

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	targets relating to system performance. These were currently greyed out in the performance summary. EM advised that we were engaged with and contributing to delivery of system targets but it was difficult to assess and rate the overall progress against these targets. EM agreed that an assessment of our contribution to system performance targets would be reflected in future iterations of the report. x. SP noted that the recovery letter was sent to both individual organisations and to system partners and that the Trust would push as hard as was possible whilst delivering a safe recovery of services for our staff and our patients. He also noted that the remarkable achievements had been delivered by the strain and hard work of our staff. xi. JW noted that plans needed to be sustainable and to be embedded within the longer term plans of the Trust. These would need to have a long term view of the impact on our staff. **Noted:** The Board noted the update on restoration of activity.	**EM**	**Oct 20**
2.b	**PAPWORTH INTEGRATED PERFORMANCE REPORT (PIPR)**		
	Received: The PIPR report for Month 4 (July 2020) from the Executive Directors (EDs). This report had been considered at the Performance Committee on the 27 August and was provided to the Board for information. **Noted:** i. That overall Trust performance was at a red rating with five domains rated red rating and two at a green rating. ii. That the Safe and Caring domains were rated as green and that this reflected the positive performance in Care Hours Per Patient Day; Friends and Family scores and the number of compliments received. iii. That the five red ratings were areas affected by the pandemic. The Effective and Responsive domains reflected the challenges faced by the Trust were assessed against the original targets. The Trust needed to continue to assess against its the previous aspirations and the Board were aware of the recovery that was underway. iv. The People domain was affected by low levels of compliance with IPR which had been put on hold, but a renewed focus on this was starting in August. v. Finance and Transformation were also affected with the uncertainty of the future system architecture around finances, and the limited progress on CIP as a result of COVID19. **Discussion:** i. Safe: JR wanted the Board to note that there had been no nosocomial COVID19 infections in May, June and July. She advised that this was important information to share with our patients and that there had been no nosocomial infections since visiting was stopped. The Trust was now looking at reopening to visitors and establishing a 'Living with COVID' visiting policy but it would take the appropriate time to do this to ensure that we keep our patients and our staff as safe as possible.		

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	ii. JW felt the Board should also now explore the possibilities of face to face meetings and this would be discussed in the later meeting. iii. JW asked why safer staffing was rated as red when it was at 90% overall. JR advised that the RAG rating required staffing to be above 90% on both days and nights and for days it was currently at 84.4% and so this triggered a red rating. iv. JW noted the information on Surgical Site Infection rates that had been reported through Q&R and asked for further information on these. JR advised that these related to a mix of infection sites and that this included some deep wound and organ space infections. There had been further investigation of the strains of infections and these were predominantly Staphylococcus A. There were some issues identified relating to the timing of prophylactic antibiotics and pre-operative washing since the move to the new site, and there was now a focus on getting these matters put right. v. JW noted the spotlight report on cancer services performance and the reduction in referrals since COVID19. vi. EM advised on the actions being taken to manage long waiters. Long waiters were reported over 52 weeks and the Trust had tracking processes in place with weekly reviews for all patients waiting above 30 weeks. The Trust had five 52 week breaches. Four of these patients had declined earlier dates to be seen and were scheduled for September and October. Two patients were in Cardiac Surgery and three were in the Sleep Study service and had come through the previous GP Community Sleep Study pathway all three of these patients had now had diagnostics undertaken. vii. MB asked about the reporting of Cardiac Surgery mortality rates in PIPR. He had asked for this to be confirmed at the Q&R meeting. These were now reported as being crude mortality figures rather than the Euroscore adjusted data. If PIPR was using crude data he wanted to know if we could obtain adjusted mortality data. The Trust was now rated as amber on the crude data and that may be a factor of more complex cases being undertaken. JW noted that nationally mortality data is monitored at an individual surgeon level and that intervention is undertaken where a surgeon is more than 2 standard deviations (SD) from the average. Within the Trust there is an intervention where a surgeon moves outside 1SD of the expected mortality rate. RH advised that the figures in PIPR were crude mortality rates and that he had presented a paper to the Board three years ago that set out the crude vs. Euroscore adjusted figures and that he would be happy to repeat this report. He assured the Board that there were remediation actions put in place internally if a surgeon breach the confidence limits that were in place. MB asked that a measure of this was included in the reporting to the Board. It was agreed that RH would bring an updated report to the Board and see whether this information could be added to the PIPR report. viii. GR felt that the assessment against Finance and Transformation was somewhat conservative in approach and resulted in a harsh assessment. TG advised that the lack of	**RH**	**TBC**

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	progress and delivery in relation to CIP had been identified through both the CQC and Internal Audit and so was not an issue that could be set aside, even with current circumstances. ix. JA noted that there was a need for the assessment of performance over a longer time period and to take in the whole of the last year as there had been a lot of elements that were red rated pre COVID and we needed to reflect those in a balanced way.		
	Noted: The Board noted the PIPR report for Month 4 (July 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 i. That the Performance Committee had asked the Board to consider a new BAF risk relating to the potential consequence of the new system financial architecture. The Executive team would consider the terms of this and it would be added to future reports. ii. That whilst reporting had been suspended against some risks as a result of COVID19 some of these would now be rescheduled or revised such as EU-Exit and the CTP programme risks. **Discussion:** i. That it would be helpful if the suspended risks could be highlighted on the tracker report. **Noted:** The Board noted the BAF report for August 2020.	**TG** **AJ**	**Oct 20** **Oct 20**
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 issues of SSI and Mortality reporting were as previously discussed and that the other issue for the Board was a concern about Health Inequality. He felt that the Trust needed to understand if it was more difficult for some of the population to access the high end services that we provide. He was concerned in particular by the social deprivation indicators for patients who had accessed our services during COVID and felt the Board ought to be concerned if the patients referred were selected in a way that increased inequalities – all patients should have access to specialised services and this should be an area of interest for the Board and for the STP. He proposed that the Board consider the Committee and Executive leadership of this area of work.		

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	Discussion: i. JW noted that this was a timely issue and SP advised that there was much time spent on health inequalities at the STP. One of the areas of focus was on GIRFT recommendations which would drive more equal access to services and outcomes for the population. The STP was collating all recommendations from GIRFT reports across Cambridge and Peterborough and there was a role for RPH in responding to these and in setting standards for COVID services. This work would ensure that patients across the system were able to access specialised pathways of care. RH noted that the Trust was taking a full part in these discussions and would report progress on the GIRFT recommendations through Q&R. ii. RH noted that our COVID response had demonstrated superb outcomes for those patients that had been referred into our services but noted these arose through unorganised referral pathways. In order to address this there was a need to look at how the Trust could distribute its model of services across the region in the form of a 'Papworth Way' – we are limited in the number of patients that we can admit but we can lead and guide medical and nursing interventions elsewhere. **Noted:** The Board noted the Q&R Committee Chair's report		
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 that the report covered the plans for visiting that had been discussed and noted that Executive Led Patient Environment rounds were being planned and NEDs would be invited to join these. She advised that the highlights from the COVID19 project debrief had been shared with the Q&R Committee, this was as the feedback from the FTSU guardian was not yet available and this would be circulated once complete. Task and finish groups had been established to address the key programme areas and these had been asked to complete their reports by the end of September so that we would be able to provide confidence for our staff in any second surge response. **Noted:** The Board noted the Combined Quality Report.		
3.iv	**Board Sub Committee Minutes:**		
3.iv.a	**Quality and Risk Committee Minutes: Q&R Committee: 30.07.20** **Received and noted:** The Board of Directors received and noted the minutes of the Quality and Risk Committee meetings held on 30 July 2020.		
3.iv.b	**Performance Committee Minutes: 30.07.20** **Received and noted:** The Board of Directors received and noted the minutes of the Performance Committee meeting held on 30 July 2020.		

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3.iv	**Sustainability Update: #ThinkPlastic Pledge**		
	Received: From Andrew Selby, Director of Estate and Facilities an update on the sustainability and the #ThinkPlastic pledge. **Reported:** By AS: i. That the sustainability strategy launch had been planned for the 25 March and that had been deferred as a result of the pandemic. The update covered the progress that had been made in relation to the 'Papworth Green Plan' which included targets that the Trust wished to achieve. ii. The plan had a much wider remit than waste and lights and was rated as excellent under the BREEAM sustainability standards. iii. The Trust has appointed a Sustainability Officer who was a Post Graduate and brought knowledge and experience to role. It had been agreed that this would be the sole focus of their role. iv. The Trust had launched a Sustainability Board with EM as Executive Sponsor **Noted:** The Board of Directors noted the update on sustainability.		
3.vi	**Medical Revalidation Annual Report**		
	Received: From the Medical Director a summary of revalidation activity undertaken during the period 1April 2019 – 31 March 2020. **Reported:** By RH that he would usually be presenting the annual revalidation report to the meeting, but the review process had been suspended nationally and so reporting was not required this year. However he wished to advise the Board that the process would be restarting in March and that the appraisal process would restart ahead of this date. Some medical staff had already been revalidated although this was not a formal requirement in this year. **Noted:** The Board of Directors noted the update on medical revalidation.		
4	**WORKFORCE**		
4.i	**Workforce Report** **Received:** The Director of Workforce and OD a verbal update on key workforce issues that were not covered in the COVID Report and PIPR. **Reported:** By OM: i. That the report focused on two areas the People Plan which had been published earlier in the summer and the Compassionate and Collective Leadership Programme ii. The Board had received an interim report on the NHS People Plan which was being published in two parts, with the second part including financial assessments expected after the public spending review is published. iii. The key elements of this part of the plan included actions on staff health and wellbeing and the equality and diversity agenda. There was a requirement to have a wellbeing lead NED and for all recruitment processes to be overhauled by		

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	October 2020. iv. The Trust had already included wellbeing in its appraisal processes and we have comprehensive recruitment processes that address the issues raised. v. The Compassionate and Collective Leadership Programme was progressing and we were now out to advert for two posts funded by the Charity that would support the programme and deliver line manager training. vi. That there had been much work undertaken on the CCL programme over the last two months and that the Trust was looking at how it listened to staff and demonstrated that it was providing support and feedback to staff. **Discussion:** i. JA noted that the national plan did not appear to address the needed for staff development and training to deliver new models of care and he was happy to see that RPH had included these matters. OM advised that she expected that these matters would be addressed in the second part of the national publication. SP noted that this reflected and was linked to the development of the Royal Papworth School and that this was a key part of our strategy for the next five years. ii. JW noted that recruitment requirements were changing and hoped that this would not have an adverse effect on the improvement in time to hire that had been achieved by the trust. OM advised that it would not and that this should expand our opportunity to recruit into roles with careful consideration of role requirements and improvement in the quality of decision making in the recruitment process. **Agreed:** The Board noted the update from the DWOD.		
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**		
6	**Any other business** The Chairman thanked those Governors and Healthwatch members who had joined the Board meeting as observers.		

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Signed

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Date

Royal Papworth Hospital NHS Foundation Trust
Board of Directors
Meeting held on 3 September 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