Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Held on 01 October 2020 at 9:30am
Meeting Rooms 1&2 and via 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
	Mr I Graham	(IG)	Acting Chief Nurse
	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
	Mr A Raynes	(AR)	Director of IM&T Chief Information Officer
	Prof I Wilkinson	(IW)	Non-Executive Director
In Attendance	Dr D Begley	(DB)	Clinical Director Cardiology
	Mrs A Jarvis	(AJ)	Trust Secretary
	Lynn Roberts	(LR)	Head of Resourcing
	Mr A Selby	(AS)	Associate Director of Estates and Facilities
	Mrs L Shillito	(LS)	Matron, Cardiology
Apologies			

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1.i	**WELCOME, APOLOGIES AND OPENING REMARKS**		
	The Chairman welcomed everyone to the meeting and apologies were noted as above. He noted that he had wished to attend the hospital but had not thought this was appropriate given the revised national guidance.		
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.		
	The following standing declarations of Interest were noted:		

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	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 and Co-Chair of the NHS EOE Critical Care Strategic Programme 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.iii	**MINUTES OF THE PREVIOUS MEETING**		
	Board of Directors Part I: 3 September 2020 **Item 1.v:** Revised to read "**Reported:** By SP:" **Approved**: With that amendment the Board approved the minutes of the Part I meeting held on 3 September 2020 as a true record.		

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1.iv	**MATTERS ARISING AND ACTION CHECKLIST**		
	SP asked RH to provide an update on the Intensive Care National Audit & Research Centre (ICNARC) report. RH advised that: i. ICNARC were collating mortality data across the country and that to date this had been raw data. They had now created a risk adjusted model with 'expected' mortality figures for two tranches of patients those admitted direct admissions to our Critical Care Unit where the Standardised Mortality Ratio (SMR) was 0.36 with a confidence interval at 95% which was therefore well below 1. ii. Figures were based on very small numbers and we were therefore not an outlier in numerical terms but we did probably have the second lowest SMR. iii. The SMR for the second tranche of patients was at 0.5. This meant that for this cohort of patients around half of the number treated would die whilst in our care. For this cohort the Trust was sitting on the second standard deviation (SD) the Trust was therefore one of the 12 positive outliers in the UK. iv. That these figures were a tribute to the fabric of the Trust and the Trust teams. There was a relationship with Trusts with multiple ICUs and good outcomes and whilst our service was delivered through a single ICU this was on the basis of a sound hospital and critical care service. RH also noted that we had received the NHSBT transplant outcome report and that Trust outcomes in heart and lung transplantation were the best for 30 day; 1 year and 5 year survival. The role of DCD transplant was very important in this and our waiting list had reduced because of the DCD service in the national context of growing transplant lists. **Noted:** The Board received and noted the updates on the action checklist. It was agreed that RH would circulated the ICNARC and NHSBT Transplant outcome reports with the Board.	**RH**	**Nov 20**
1.v	**Chairman's Report**		
	The Chairman noted that there had been five consultant appointments that he wanted to report to the Board: **Anaesthetics:** Dr Thomas Chloros, Dr Laurien van Koppenhagen, Dr Rachel Jooste. **Surgery:** Mr Muhammad Rafiq, Mr Vamsidhar Dronavalli (locum) He welcomed the new appointees to the Trust and welcomed Ivan Graham to the Board as acting Chief Nurse. Ivan had taken on this role as Josie Rudman had been seconded to the national track and trace team and was involved in resource planning for the surge and getting the right resources in place.		
1.vi	**CEO's UPDATE**		
	Received: The Chief Executive's update setting out key issues for the		

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	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: v. The outcome information shared in the NHSBT and ICNARC reports would be shared in future reporting. vi. Teams were working hard to support recovery at RPH and across the system and that he wanted to record his thanks for these efforts. vii. There was a level of anxiety and concern being felt by staff relating to the second surge and they were worried about the impact on them. The Trust was doing all that it could to support staff and reflecting learnings from the debrief project in how we mobilise and respond to any second surge. viii. The Board had approved its five year strategy in September and this was to be launched on the 5 October 2020. ix. He would be having discussion later today on the Integrated Care System model and the approach that would be being taken in Cambridgeshire & Peterborough. x. The 2020 flu campaign had started. The Trust had achieved an uptake rate of 86% in 2019 and this year was aiming at achievement well above 90%. SP thanked the nursing and workforce teams who were working together to manage the plan for 2020. xi. The national DCD organ retrieval service had been launched by RPH and this was a credit to the transplant team. xii. EU Exit transition planning had been restarted and this needed to be managed and balanced whilst the Trust was continuing to respond to COVID19. **Discussion:** i. CC asked about the development of community based respiratory diagnostics services and whether the Trust was working with the Community Trust to deliver this. SP advised that this was a system based initiative and it would be delivered outside the hospital. The respiratory team had identified areas with the worst health outcomes in areas of greatest deprivation. Karl Sylvester was the Respiratory Physiology lead for RPH and the Trust had partnered with NWAFT to deliver the proposed mobile spirometry service in the community. As a part of the joint initiative NWAFT would be offering a drive through respiratory service delivered at existing test centres. **Noted:** The Board noted the CEO's update report.		
1.vi	**Patient Story**		
	Lizzie Shillito, Matron, Cardiology presented a patient story to the Board. This was a recent story from a 91 year old man who had been transferred to the Trust from Hinchingbrooke Hospital. The patient was admitted with chest pain and aortic stenosis and was assessed		

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	for TAVI and was progressing well. The patient had a reduced urine output and increased U&E's and his care was therefore escalated and he was admitted to the Critical Care Unit. Lizzie had caught up with him about his experience when he was moved from the CCU to the ward. He had fed back that staff and the food were good and but he felt restricted by monitoring equipment when accessing the bathroom. His daughter had also noted the exceptionally kind care that he had received. He had advised that the Junior doctors had looked at both his health and his mental well-being. He had spent four weeks away from his wife and this had been felt to have a detrimental effect on him and this had been escalated to critical care (which was a part of the usual process). The patient was subsequently discharged to his daughter in Yorkshire. The actions being taken from this story were: The Trust was looking at options for telemetry to address the limited mobility caused by the monitoring equipment. This would require modules to be converted to Wi-Fi and this had previously been rejected by the Medical Devices Committee and not supported but an Authority To Invest Request (ATIR) was being completed to reconsider this proposal. **Discussion:** i. The Board asked about the escalation of care in this circumstance. LS advised that all moderate harm incidents would be escalated as a part of the usual governance processes. This incident happened at a weekend and the issue of medical cover had been discussed at the Divisional Meeting and Dr Stephen Webb was involved in this. It was noted that the NEWS2 assessment process did not pick up urine output and this had previously been highlighted and so the Trust was looking at a separate scoring system to use alongside NEWS2. The department had also identified urine output as a part of the 'buzzword of the week' initiative at handover. ii. LS advised that the SBAR (Situation-Background-Assessment-Recommendation) escalation framework was included in nursing notes and captured the timely documentation ensuring clarity of communications within clinical teams. There was discussion ongoing with the Communications team to review how this could be further promoted with staff. **Noted:** The Board thanked LS for presenting today's patient story.		
1.vii	**Staff Story**		
	Lynn Roberts presented a staff story to the Board. This story related to a new member of our staff, Joyce, who had joined the Trust from Nigeria. She had been recruited in May 2020 but had not been able to join the Trust at that time because of the COVID19 pandemic. The Trust recruitment programme was being undertaken in the context of the national shortage of Radiographers and LR advised that for each of round of adverts we placed that we received approximately 100 applications from overseas candidates. The Radiology team had now		

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	made four or five appointments and they had six new recruits in the pipeline to fill vacancies after January 2020 and so the recruitment process had now been paused. Joyce had been ready to join the Trust in May but was unable to progress this until visas were obtained and flights were available which was in August 2020. Joyce booked to come to the UK on the first available flight and the recruitment team worked quickly to ensure that all arrangements were put in place. The team had engaged with radiology management and had put a buddy arrangement in place for Joyce with another recruit from Nigeria, and was living at the Waterbeach accommodation. LR advised that the buddy greets the new member of staff, buys food for them during their quarantine period and acts as a link to the recruitment team. Sue Boniface, the Estates Accommodation Manager organises the quarantine arrangements at Waterbeach and there is regular contact with our new staff through Lynn and the recruitment team; their buddy; the accommodation team and with staff in their new department. LR noted that all had seemed well until the day after Joyce completed her quarantine when LR received a call. Joyce was very distressed and LR arranged to meet Joyce in the park to discuss her concerns. She told LR that the quarantine period had made things seem worse and she shared her story with LR. Joyce was 30 years old and had always wanted to come and live and work in Cambridge. She had three young children in Nigeria and in leaving Nigeria she had left behind her family, her culture and her friends. She was worried by this but had been able to visualise herself and her husband and her children in Cambridge and saw this as her future. LR spoke to Joyce about her concerns and how grateful she was for her care and recognised the sacrifices that she had made in moving to the UK. Practically she also took Joyce to get her biometric visa sorted out and to get shopping sorted. She later received an e-mail from Joyce saying that she was grateful for the kind words and that these had helped her to feel strong. She also felt that she was happy that she had made the right choice for her and her family. Joyce started work and her story was included in social media and this had so far received 7.5k views. This week she was asked if we could also share this with the Board. **Discussion:** SP noted that LR had worked to deliver an excellent recruitment experience and had redesigned how we manage this process. This was an example of the output of that of that work. He thanked LR and the recruitment team for their superb work in this area.		
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: i. That the main issue to draw to the Board attention was how		

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	helpful it was for the Committee to have Divisional Directors attending as that allowed for a richness in reports from teams, seeing what they had done in response to COVID19, and what was being delivered in recovery. ii. That the Thoracic team had presented to the meeting. They were a little behind their targets and they set out the challenges that they had faced and which accounted for that. Further information on recovery would be reported in the Part II agenda. iii. That he was to speak to JA on the reporting against CIP delivery and monitoring. **Noted:** The Board noted the Performance Committee Chair's report.		
2.a.ii	**Restoration of activity**		
	Received: From EM a paper setting out progress to restore activity through the Trust. **Reported:** By EM that: i. The report included the weekly monitoring of activity recovery and she noted that the Respiratory recovery had been slower than plan; however they served some of the clinically most vulnerable patients across a mix of subspecialties and these patients had been unwilling to come in to the Trust and so this was therefore a complex recovery plan. ii. The RSSC day cases were now at 77% against an 80% target for September 2020. iii. There was continuing concern about the reduction in the number of GP referrals. The system advice was that GP services were in place but these were not happening on a face to face basis and referrals remained low. This position was the same across the system and was driving an underperformance in first outpatient referrals. The Trust had worked through all patients waiting for first outpatients and had converted a number of slots to follow up slots to serve those patients who were waiting. It was also writing to all referrers encouraging them to refer, and advising that the Trust's services were open for referrals and had good throughput. iv. The data at a sub speciality level was included within the report. **Discussion:** i. CC noted the performance for month 6 was at 38% against a target of 100% and she understood this, but noted this was a very big drop. EM advised that this was for first outpatients, and as patients referred had been seen there were very few coming through. There were 12 new outpatient surgical referrals waiting for a first outpatient and we were usually getting patients to an outpatient appointment within two weeks of referral. The Trust was hoping that the flow of patients through the system would encourage referrals and that would see numbers increase. ii. MB asked whether if the referral bottleneck was to disappear would the Trust had the capacity to treat the patients referred? EM advised that Theatres/Day Cases and Cath Labs were		

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	seeing steady increases in capacity despite PPE and cleaning requirements. The cath lab was now at 88% utilisation of capacity and had been at 85% pre COVID-19. The Trust had also had a successful recovery in diagnostics with cross sectional imaging seeing recovery, and ECHO and Respiratory Physiology seeing slower recovery as more staff in those services had been redeployed. In future plans the Trust would not want to take staff from diagnostic areas in the same way if we were to go back in to surge. EM felt that the cath labs would not go under if referrals were turned back on and that the Trust expected Cardiology to be at 92% of capacity from October 2020. iii. MB noted that at the system quality group it was felt that GPs were holding significant risk. He asked if that reflected discussion across the region. EM noted that the Trust would be keen for GPs to see patients on a face to face basis and for them to refer patients into the Trust. The Trust had not pushed out routine requests and tests into primary care (as had been reported in other systems) and was ready to support GPs in managing the risk. iv. JW noted that the Trust philosophy was to keep as much as possible running and that whilst GPs were not our remit those on the STP were feeling that there was some disconnect between the perceptions and reality of provision where they were not always able to refer on and were seeing a significant rise in mental health issues. SP note that the STP had had conversations about learning from the first wave of COVID19 and would want to maintain services to a much greater extent. For the Trust this would mean that we needed to have a focus on seeing as many patients as possible and for us to be nimble in response and supporting our staff and learning from our previous response. v. JA asked whether there was a wider forum in place for discussions with GPs. EM advised that the Trust did not have a GP liaison forum and had used mailings from clinical leads. The Trust had GP referrers from beyond our local CCG but had joined the Clinical Commissioning Group GP Liaison meetings to support communications with local GPs. **Noted:** The Board noted the update on restoration of activity.		
2.b	**PAPWORTH INTEGRATED PERFORMANCE REPORT (PIPR)**		
	Received: The PIPR report for Month 5 (August 2020) from the Executive Directors (EDs). This report had been considered in at the Performance Committee and was provided to the Board for information. **Noted:** i. That overall Trust performance was at a Red rating. ii. That the Trust was seeing continued strong performance in Safe and Caring and this was reflective of the performance in Care Hours Per Patient Day and the Friends and Family test. iii. That Effective and Responsive were providing good indicators on recovery but the Trust was not delivering the NHS Constitution standards.		

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	iv. People Management and Culture reflected the low performance in delivery of Individual Performance Review and there was a plan in place to improve this and mandatory training. v. Finance and transformation were Red rated and this reflected the delayed delivery of CIP because of the pandemic response. We were not where we wished to be and there was continued uncertainty around the year-end financial position. **Discussion:** **Caring:** i. MB noted that the number of complaints were assessed against the number of WTEs and not activity and was concerned that this was not a proportionate measure and therefore the best way of keeping this at a low level. IG advised that this measure was not new to the NHS, but was new for this year in PIPR. In addition PIPR captured the number of complaints in each month, and as a 12 month rolling average. PIPR also included the written complaints measure from the model hospital data and this therefore gave a national benchmark measure which provided more timely information through NHSI. The F&F test also provided an overview of patient experience. ii. GR welcomed the benchmarked information as that allowed the Trust to look at performance against other Trusts and agreed that we should try to use established data sources. iii. JA felt that the rolling average data was helpful and noted the reduction seen since the start of the COVID19 pandemic and suggested this could be picked up at Q&R. **Effective/Responsive** i. EM noted the current performance and the caveats that TG had highlighted. **People Management and Culture** i. OM noted the challenge in relation to nurse recruitment particularly in surgery and that there was some optimism that the current media coverage and stories would have a positive impact on the position.		
	Noted: The Board noted the PIPR report for Month 5 (August 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. **Discussion:** i. CC asked about BAF 858 Electronic Patient Record System benefits and the extreme risk rating. AJ advised that the RRR had reduced but it remained an extreme risk because of the		

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	identified funding gap in the digital plan. ii. MB asked about the reduction that had been applied to the BAF 1929 Low levels of Staff Engagement as this had been reduced to a rating of 8. OM agreed to undertake a further review of this risk. **Noted:** The Board noted the BAF report for September 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: i. The Committee had considered the first draft Quality Accounts and had agreed that some priorities would be slimmed down as it was unclear about the capacity for delivery of the targets that had been set. ii. The Committee had heard concerns raised through a patient safety round about staffing levels on wards, and this was not consistent with the data being reported and the Committee. He was concerned that this could lead to morale issues and staff feeling hard done by. This was an area that the Committee felt needed to be resolved rapidly. **Discussion:** i. SP noted that the issues raised around staffing were an area of focus and that staff survey responses relating to having the right resources to carry out the job were low. ii. IG noted that on the measure of CHPPD the Trust was ranked third in the country and he reported the same experience when speaking to staff. The data gathered on this is triangulated and the focus in PIPR this month was on staffing data. iii. IG was concerned that the internal messaging and communication on this needed to be addressed and was working with Communications to promote the positive patient and staff stories and to link to the staffing forum. He noted that 128 staff had been trained on Health Roster and Safe Care Live and that this issue was very important to our staff. The CHPPD was based on a monthly matron's audit which included an assessment of acuity of patients and the output from this formed a part of the messaging about our safe staffing levels. The audit is undertaken with ward staff to ensure that there is good understanding about acuity and dependency levels and teaching in the use of the tool and use of audit data in national audits and workshops. iv. IG wanted to reassure the Board that this was being approached at a number of levels and that there were staff returning to RPH realising that our staffing levels were impressive. Patients were sicker on the wards at RPH and we cared for patients in ward settings that in other Trusts would be cared for in Critical Care Units but returners to the Trust had cited missing the 'RPH family' as well as our staffing levels as reasons for returning to RPH. v. JA noted that it was helpful to have multisource feedback on		

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	this, and that we were in a good position relative to others, but asked about our productivity and where the absolute line was in relation to that? He felt it would be helpful to ask staff to give feedback on what they could not do for their patients on any given day because of staffing levels. IG supported this approach and linked this to an example on the previous week's Matron's round which had focused staff on the question of why staffing was not great on that day. This had promoted interesting discussion on the ward and this was starting to see that approach being adopted. vi. JW noted that the Committee were looking at Board assurance around the reporting of Cardiac Surgery Mortality data. He suggested that RH should invite Sam Nashef to the Q&R meeting to present the Trust data. **Noted:** The Board noted the Q&R Committee Chair's report	RH	TBC
3.iii	**Combined Quality Report** **Received**: A report from the Acting Chief Nurse and Medical Director which highlighted information in addition to the PIPR. **Reported:** By IG that the report should be taken as read and that he wanted to advise the Board: i. That there had been no nosocomial infections since the 5 cases reported in March and April. ii. That the Living With COVID Steering Group (LWCSG) had considered the visiting policy and had decided not to go back to open visiting given the increase in the R rate and the absence of infections since the COVID visiting restrictions had been applied. The Trust would maintain its current processes which were working well. iii. The LWCSG had also had feedback on the COVID19 debrief project and that was also working well. iv. The surge plan that had been circulated had some further updates which reflected the discussion about the movement into 3 North as the next surge area as there may be a need to move RSSC and Respiratory Medicine into that area and so the empty beds in the fourth floor quadrant would be identified as the next surge area to protect RSSC and Respiratory Medicine. The Trust may also need to titrate the activity coming into the Trust and this option would be identified and managed through the Clinical Decision Cell (CDC) and LWCSG. **Discussion:** i. JW noted effective working and planning through the CDC which had good membership but noted that events and the burden of disease may dictate our response. ii. CC asked about the additional resources needed and whether the costings and financial risks of the second surge were understood. TG advised that the Trust had undertaken that work and had discussed this with the regional team. This would be picked up in the Part II discussion on financial forecasts. iii. JW noted also that whilst we could make plans to surge the		

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	Trust would also need the resources to deliver these. iv. GR asked about the staff debrief which had been to Q&R but had not yet been circulated to the Board. He would be interested in seeing the summary of learning from the first phase and to understand what was being planned to be done differently. EM advised on some of the initial learnings: a. The cath lab holding area that had been used as a part of the surge plan in the first wave was very uncomfortable and was not intended for this purpose and so had been removed from the surge plan. This was also the case for the Theatre recovery area. b. Staff had fed back concern around the communications when pulling from and stepping back into ward roles. There was a plan to address this by advising staff where and when moves would take place and whether these would be for a fixed period of time. This would give staff the duration of a move so they would know ahead for a period of four or six weeks and would know when or whether they would then be returning to their wards after this period. c. There was also a plan to keep more service running during any second surge. The initial modelling for 54 critical care beds required a major reduction in other activity and there were discussions with the Region on opening sections of the hospital. The CDC discussions needed to remain nimble and to respond to allow utilisation of capacity and to cohort COVID activity across different floors. v. IW asked who at a Regional level would be making decisions on this. RH advised that this would be a sub group of Regional Incident Control, the Critical Care Cell and that he and Dr Stephen Webb were members of this cell. The decisions would be driven by circumstances but RPH were represented at the table. vi. SP noted that the East of England Region had a steering group to address the question around deployment and the Trust was clear that there were resource and workforce implications that would need to be addressed. vii. RH noted that the CDC longer term strategy would be subject to change and expressed an ambition around recovery. Largely the CDC strategy was being met but the second wave of COVID19 was now upon us. **Noted:** The Board noted the Combined Quality Report.		
3.iv	**Board Sub Committee Minutes:**		
3.v.a	**Quality and Risk Committee Minutes: 27.08.20** **Received and noted:** The Board of Directors received and noted the minutes of the Quality and Risk Committee meetings held on 27 August 2020.		
3.v.b	**Performance Committee Minutes: 27.08.20**		

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	Received and noted: The Board of Directors received and noted the minutes of the Performance Committee meeting held on 27 August 2020.		
4	**WORKFORCE**		
4.i	**Workforce Report** **Received:** The Director of Workforce and OD a verbal update on key workforce issues. **Reported:** By OM: i. That her report focused on the WRES data and action plan and included details of the flu campaign for information. ii. That following publication of the WRES data she had met with the BAME network and had produced an action plan which was presented for comment and feedback. iii. That she was disappointed by the results of the survey but this was an issue that required a long term commitment from the organisation and the Charity appointment that would be made within the next two weeks and would provide resource that we had not previously been able to deliver. iv. That the BAME network and the FTSU guardian roles were providing a space for staff to speak up on issues of race and macroaggressions. These were not felt to need formal escalation but this was a matter that needed to change. v. There had been small improvements seen in clinical leadership. There was system and regional working and STP leads were helping to pull together work at partner trusts. There was a group looking at micro aggression, career progression as well as mentoring and stretch assignments for our BAME staff. vi. There had also been some steps made such as using pre-disciplinary hearing to address the disproportionate number of BAME staff facing disciplinary action. vii. That the dignity at work agenda could seem like a blunt approach and at a service level there were issues around incivility at work that needed to be addressed. **Discussion:** i. JW noted the good ideas from the region but felt that micro aggressions were very difficult to deal with. OM noted that the Trust approach had been discussed at the Monday staff briefing. ii. SP shared OM's disappointment in the outcome data but he felt that the issues raised felt different and that bringing information into the public domain was to demonstrate to staff that we are taking these matters seriously. There was further work to be shared with the leadership teams across the organisation and the Trust would continue to redouble efforts on this matter. iii. CC asked for OM for a discussion on the calculation of WRES data outside of the Board meeting. iv. IW thanked OM for the presentation and asked for the numbers of staff making up the target figures and whether the representation of BAME staff in lower bands was higher. OM advised that we had a trajectory that we were expected to	OM	Dec 20

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	meet in the more senior staff bands and that a statistical analysis would be refreshed at the end of each period of review. OM noted that in 2019/20 there had been some progress at levels 8a and 8b and there would be further improvement in 2019/20 where we were aware of appointments at 8b and 8c levels. v. On flu one member noted their experience of receiving the flu jab in a car park (in primary care). That had not been positive and asked if this might be an issue for Trust staff who had to work from home. It was agreed this issue could be considered in staff communications. JW encouraged all Board members to get their flu vaccination. **Agreed:** The Board noted the update from the DWOD.		
4.ii	**Freedom to Speak Up Guardian's Report**		
	Received: From the Freedom to Speak Up Guardian a report informing the board of progress on the Speaking Up Service. **Reported:** By TB: i. That the National FTSU Index report was an informative and detailed report. This identified an improvement in index position from 78% to 80.7%. The median figure for England was 70% and the report demonstrated that the Trust was doing relatively well in culture and attitudes in relation to speaking up. ii. Activities to raise the profile of the FTSU Guardian and Champions had been slowed by COVID19 work with fewer taking place, but drop in sessions had been provided for redeployed staff. iii. There had been an increase in reporting of 50% year on year. Most reports related to bullying and harassment and this indicated that staff were not reporting low level issues. In 2021 it was planned to improve feedback to staff on the range of issues that could be raised through this route to promote action at a lower level. iv. The impact of racism. People needed to be helped to understand the impact of their behaviour on others especially those from other cultures and backgrounds. This included activity to support fair redeployment processes in the event of a second wave of COVID19. v. That today was the start of 'Speaking Up' month and there would be a stall in the atrium to promote this. **Discussion:** i. JA and the wider Board considered the use of the term racism and considered that this was correct and that this needed to be addressed. ii. Whether we were assured that the issues arising from Case 4 (relating to reports of unfair promotions within the COVID19 pandemic) had been resolved. OM advised that the investigation had been completed and the addendum to the		

Agenda Item		Action by Whom	Date
	recruitment policy had been put in place. The issue had been fully discussed with Matrons and the Trust was now going out for 'acting up' roles that would be taken forward if there was a need to go into surge. JA noted that whilst these were the right inputs they may not fully resolve matters raised. iii. CC asked about the FTSU Champions and whether these roles had worked and improved and expanded the ability to speak up. TB advised that they had; most of the 16 Champions were from clinical backgrounds and were responding to queries. They met quarterly and had received great support from SP and OM. iv. OM thanked TB for the report. She noted that the way that he worked with Judy Machiwenyika (BAME Network Chair) was extremely helpful on the issue of racism. This was not an easy or straightforward matter and they had been very helpful in navigating and tackling improvements and this had resulted in Trust plans for: a. Line manager development and training b. The appointment of the new EDI lead c. The EDI development programme and the next twelve month period would be key to address this matter. **Noted:** The Board noted the update from the FTSUG.		
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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Signed

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Date

Royal Papworth Hospital NHS Foundation Trust
Board of Directors
Meeting held on 1 October 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