Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Held on 04 April 2024 at 09:00am
Rooms 88/89 HLRI and via Microsoft Teams
Royal Papworth Hospital

UNCONFIRMED M I N U T E S – Part I

Present	Dr J Ahluwalia	(JA)	Chairman
	Ms C Conquest	(CC)	Non-Executive Director/Senior Independent Director
	Mr G Robert	(GR)	Non-Executive Director
	Mr M Blastland	(MB)	Non-Executive Director
	Ms A Fadero	(AF)	Non-Executive Director
	Ms D Leacock	(DL)	Non-Executive Director
	Prof I Wilkinson	(IW)	Non-Executive Director
	Mrs E Midlane	(EM)	Chief Executive Officer
	Mrs S Harrison	(SH)	Interim Chief Finance Officer
	Mrs W Walker	(WW)	Deputy Chief Operating Officer (For Mr H McEnroe)
	Ms O Monkhouse	(OM)	Director of Workforce and OD
	Mrs M Screaton	(MS)	Chief Nurse
	Dr I Smith	(IS)	Medical Director
In Attendance	Dr C Paddison	(CP)	Associate Non-Executive Director
	Mr A Raynes	(AR)	Chief Information Officer & SIRO
	Dr P. Calvert	(PC)	Clinical Director of Research and Development and Associate Medical Director (For Item 5.i)
	Ms T. Sisman	(TS)	Deputy Sister/Deputy Charge Nurse (For Item 1.iv – Patient Story)
	Ms A. Kitchen-Jarvis	(AKJ)	Healthcare Support Worker (For Item 1.iv – Patient Story)
	Mr K. Mensa-Bonsu	(KMB)	Associate Director of Corporate Governance
	Mrs L. Bush	(LB)	Office Manager and EA to Chief Executive and Medical Director
Apologies	Mr H. McEnroe	(HMc)	Chief Operating Officer
Observers	Dr Clive Glazebrook – Public Governor		
	Mr Bill Davidson – Public Governor		
	Ms Angie Atkinson – Public Governor		
	Mr Trevor McLeese – Public Governor		
	Mr Christopher McCorquodale – Staff Governor		
	Ms Sarah Brooks – Staff Governor		
	Mrs Josevine McClean – Staff Governor		

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1	**WELCOME, APOLOGIES AND OPENING REMARKS**		
	JA welcomed everyone to the meeting and noted HMc's apologies. EM introduced WW who was attending in place of HMc, and TS and AKJ who were presenting the Patient Story item. .		
1.i	**Declarations of interest**		
	There is a requirement that Board members raise any specific declarations if these arose during discussions. No specific conflicts were identified in relation to matters on the agenda. A summary of standing declarations of interests was appended to these minutes.		
1.ii	**Minutes of the previous meeting**		
	Board of Directors Part I: 01.02.24 **Approved**: The Board of Directors **approved** the Minutes of the Part I meeting held on 01 February 2024 as a true record.		
1.iii	**Matters Arising and action checklist**		
	a. **19/23** – Food and Nutrition: The work of the Nutrition Group was progressing, and 'Nutrition and Hydration' was one of the three Quality Priorities for 2024/25. **Closed.** b. **18/23** – IG Training for Board Members: AR to progress with the learning option (Teams or e-learning) which was appropriate for individual members. **Open.** c. **15/23** – Patient deferrals: Trend from DrDoctor review to be brought to Committee and Board: The Board agreed that the action needed to be urgently progressed as it had been on the action checklist since July 2023.It was noted that harm reviews had been progressed and guidance from NHSE had also been received. **Open.** d. **11/23** – NHS Impact development session to be added to the Board development programme: This had been scheduled as a 'Board Workshop' topic for October 2024. **Closed.** **Noted:** The Board received and noted the updates on the action checklist.		
NB: The minutes reflect the order in which the agenda items were discussed.			
1.vii	**Patient Story**		
	Presented: MS provided the background to the patient story, stating that it was about the experience of patients when they go through the patient lounge. MS referred to an initiative which had been implemented to improve patient flow across the hospital and the increased throughput through the Discharge Lounge. MS noted that TS and AKJ had championed the improvements achieved so far in the Lounge and they were attending the meeting to provide an update on those achievements. **Discussion:** a. TS stated that the Discharge Lounge was situated within the active treatment lounge on the Day Ward and was always busy. Due to the		

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	lounge being busy, the expectation was that patients who came into the Discharge Lounge to be discharged from the hospital would be independent and be able to self-care, self-manage and be able to communicate. b. TS advised that this restriction was required as patients who needed more support may not receive the appropriate support while the usually lengthy discharge processes were being progressed. c. While patients waited for their discharge processes to be completed, the main roles of the Discharge Lounge staff were to communicate and manage expectations. d. There was the need to increase the Discharge Lounge's capacity as the number of patients waiting to be discharged had continued to increase. TS stated that in February 2024, 179 patients went through DL against the 109 patients who had gone through it in January 2024. e. TS stated that, in spite of how busy the Discharge Lounge was, the staff received very good feedback, particularly about the care and support they had received while waiting to be discharged. f. The staff also received feedback on patient concerns particularly around the time spent waiting in the Discharge Lounge, and away from family, while discharge processes were being progressed. TS noted that these delays were usually due to multiple factors, including consultants having to focus on treating the patients who were still on admission. g. TS advised that the patient story was about Patient A, an 80-year-old man who had attended the hospital in March 2024 to undergo a valve procedure. h. Patient A, after his treatment, had come into the Discharge Lounge to be discharged from the hospital. Patient A's wife arrived later to take him home, but remained in the hospital's reception area and could not join him in the Discharge Lounge. i. Patient A was in the Discharge Lounge for three hours on a particularly noisy and busy day with many patients also waiting to be discharged. Patient A had been informed on the ward that he only had to wait for his medication, so he was not ready for the long wait. j. Patient A had noted that if Amazon was run like the Trust's Discharge Loung, only 10 to 15 parcels would be delivered per day. k. Patient A who had opened and run a global agricultural business from his 30s, after having worked as a pilot, provided valuable feedback on how the Discharge Lounge and the discharge process could be significantly improved. l. The Discharge Lounge staff utilised the feedback to update the communications on the wards to set expectations around the discharge process. This had significantly changed the expectations of patients and positively changed their approach to the waiting period in the Discharge Lounge. Overall, the patient experience had been improved. m. Patients appreciated the care provided to them and how the communication provided clarity on the pressures and challenges the consultants were managing. n. TS stated that the staff continued to use the feedback from the Friends and Family Test (FFT) Survey to improve upon communications around the discharge process. **Discussion:** m. In response to CP's query around the proportion of patients discharged after 7.00pm, TS stated that the Discharge Lounge closed		

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	at 6.00pm, and any remaining patient was sent back to the wards. CP also enquired if patients were readmitted back to the wards if their discharge processes had not been completed by 6.00pm. TS advised this was rare and only happened about once a month and noted that sometimes patients waiting to be discharged were transferred back to the wards for readmission if they felt unwell. n. In response to AR's query around the technological improvements which could be utilised to improve the Discharge Lounge, TS stated that there was a prescription tracking system already in place. TS noted that it would be helpful if a screen was installed that provided anonymous updates on when patients' medications would be ready for collection. This would be much better that the current situation where patients relied on the staff to provide update. AR agreed to review whether a screen could be provided so patients waiting in the Discharge Lounge could see updates on when their medications would be ready. o. In response to DL's query on the maximum number of patients the Discharge Lounge could hold at any one time, TS stated that the limit was 12 patients. TS advised that at 12 patients, the Discharge Lounge became very busy and crowded. p. In response to OM's query if the team was utilising any improvement methodology, TS advised that the team utilised data from the FFT survey. The Discharge Lounge team also provided feedback from patients for discussion at the Discharge Lounge Flow Improvement Programme. q. AF noted that, from the patient experience perspective, it would be better if patients were discharged home directly from their ward bed and not have to go through the Discharge Lounge. AF suggested that this more direct discharge process could be improved. r. TS, in response, stated that when this direct discharge process was tried, there had been many issues including last minute medication changes and the lack of the appropriate staff to efficiently implement this. s. TS and AKJ left the meeting. t. JA noted that while managing patients' expectations was good, it was also very important that the discharge process was streamlined so that they did not have to wait for 3 hours to be discharged home. CC suggested that, as was done in factory settings, individuals could be given the task of undertaking individual elements of the discharge process. u. IS noted that to speed up the process, elements such as the preparation of discharge letters could be commenced the day before the actual date of discharge. v. CP added that, one important data aspect which was not being captured was the data on carers. DL stated that if an elderly carer was expected to drive a discharged patient home after 5.00 pm, there was a safety issue which needed to be considered. w. WW stated that one the aims of the Discharge Flow Improvement Programme was to ensure all relevant patients were sent to the Discharge Lounge by 11,00 am. WW added that the target was for all those patients to have been discharged home by 5.00 pm as per national requirements. x. WW advised that the Trust was beginning to track the time of day when all discharges were happening, so that an assessment of the causes of delay could be undertaken. There overall aim was to avoid very late patient discharges.	**AR**	**07/24**

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	y. IW advised that while the complex elements of a discharge letter could be drafted by the relevant doctor the day before, the rest of the routine information could be quickly drafted on the day of discharge. **Noted:** The Board **noted** the Patient Story update.		
1.iv	**Chairman's Report**		
	a. JA thanked all who attended the Cambridge Festival in March 2024, noting that the staff were very enthusiastic participants. b. JA also thanked MS for being the guide on his night tour of the hospital some weeks ago. JA had noted that the staff was very calm, happy and engaged, and had also noted the high number of ethnic minority staff working the night shift. c. During the visit, JA noted an issue with the Lorenzo EPR system which had been passed on to AR. d. JA also visited the Patient Booking Team at Kingfisher House where he had been informed of the challenges they were managing. The challenges included patient cancellations and rebookings, and impact of those on both the patients and the members of the team. **Noted:** The Chairman's update was **noted**.		
1.v	**Board Assurance Framework (BAF)**		
	Received: The BAF which remained in the process of being updated with actions from March 2024 Board BAF Review. The Board noted that though not all actions had been progressed, there was evidence that the changes and revisions requested for were being undertaken. **Noted**: The Board **noted** the BAF report for March 2024.		
1.vi	**CEO's Update**		
	Received: EM presented the CEO's update. a. EM highlighted a recent high-profile visit in February 2024 from the CEO of NHS England, Amanda Pritchard, to the hospital. Ms Pritchard was very impressed by the hospital and its staff, and the patient care being provided. b. Victoria Atkins, Secretary for State for Health and Social Care, visited the Cambridge Biomedical Campus for International Women's Day on 8 March 2024. Ms Atkins, EM and senior professional women working on the Campus met for a wide-ranging round table discussion on topics including 'improving staff experience' and 'building strong collaborative relationships with life science partners'. c. Cambridge and Peterborough Integrated Care System (C&P ICS) had launched an Above Difference Cultural Transformation programme, which was aligned with the Trust's own cultural transformation journey. d. The vacancy rate in February 2024 was at 6.3%, from 12.7% in February 2023. Registered nursing vacancy rate also improved to 4.8% in February 2024, from 11.9% in February 2023. e. In March 2024, three Staff Survey feedback sessions were held, and they were attended by over 200 members of staff. EM and OM had chaired the three sessions which had harnessed rich, vibrant and engaging conversations.		

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	f. A Matron Development Programme was launched in March 2024 aimed at providing matrons and aspiring matrons with an opportunity to review, practise and enhance their skills, confidence, and capability whilst having an opportunity to network and share experiences. g. Surgical Site Infection (SSI) rates for patients who had undergone coronary artery bypass graft surgery had continued to decline. In February 2024, the infection rate was at 1.3%, from 5,3% in January 2024. The SSI stakeholder group continued to oversee the improvement work relating to reducing our SSI rates. h. In February 2024, the Trust reported a surplus of £1.3m, after the re-distribution of system funds in support of a breakeven position by organisations across the ICS. The Trust was on track to deliver a breakeven or better position at the financial year end. i. There had been noticeable increase in reports of cyber incidents in recent months, affecting organisations in healthcare, industry and academia, with the University of Cambridge among a number of universities hit by a malicious cyber-attack in February 2024. The Trust's Cyber team was continuously reviewing and improving the Trust's systems while increasing staff awareness, training and education. j. There was a significant and sustained reduction in the CT scan reporting backlog in January and February 2024, which had allowed patients to receive results in a timelier manner. EM thanked all the teams involved, who were working hard to reduce the backlog. k. Work to finalise the Trust's 2024/25 Financial and Operational Plan had progressed after the publication of the national planning guidance in March 2024. Given the late publication of the planning guidance and ongoing discussions around several key funding contracts with commissioners, there remained some uncertainty in the Trust's draft financial plans. Good progress had however, been achieved by the Trust on the development of activity, capacity and financial plans, with a focus on establishment plans at divisional level. A review of proposed investments and early work on identification of efficiencies had also been undertaken. l. The Trust had 13 stands at the Cambridge Festival including a mini operating theatre and a Teddy Bear Clinic, with dozens of staff giving up their Sunday to speak to the public and the families of colleagues. More than 300 people attended across five hours, with positive feedback across the board. **Discussion:** m. In response to AF's query around how the improving CT backlog position would be sustained, EM confirmed that steps were being undertaken to recruit and fill the consultant vacancies. EM noted that the work to improve the backlog position had so far been undertaken by Trust staff with support from insourced reporting capacity. The Trust had also undertaken a demand/capacity exercise to understand the requirements necessary for sustaining a non-backlog position. n. In response to CC's query on the aims of the C&P ICS's Cultural Transformation Programme, OM stated that it was progressing on elements of the East of England Anti Racism Strategy. OM added that it was one of the areas which NHS organisations in the East of England had agreed to work together on. o. OM advised that the programme would be providing training for managers at different levels across the system and have facilitators trained in methodology to support the programme. OM stated that the		

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	intent of the programme was to raise the capability and skills of senior and middle leaders at all levels of the system so that they had a common language on the issue of racism. OM also noted that the next steps of the programme was yet to be decided. p. JA advised that the facilitator for the C&P ICS's Cultural Transformation Programme had been outstanding, and their focus on inclusion and diversity had been refreshing. IS stated that it had been a participatory and informative session where attendees had been challenged on their action plans and outcomes and commitment to making a difference. q. EM stated that the 3 cohorts of individuals in the Trust being trained as facilitators would be combined so that the hospital could fully benefit from their training. r. OM stated that the one advantage was that the ICS's programme was aligned with the Trust's work on transformation reciprocal mentoring. OM also noted that with so many Trust staff being trained as facilitators by the ICS, the Trust's own cultural improvement work could only be reinforced. **Noted:** The Board **noted** the CEO's update report.		
2	**PEOPLE**		
2.i	**Workforce Committee Chair's Report**		
	Received: The Workforce Committee Chair's report setting out significant issues of interest for the Board. **Noted:** The Board **noted** the Workforce Committee Chair's report		
2.ii	**2023 Staff Survey Results**		
	Received: OM presented the 2023 Staff Survey Results for review. **Reported:** OM stated that: a. This report was a snapshot of the 100 questions and answers included in the main Survey report. b. The Board report focused on the areas that had either been the topic of discussion at the Board or with staff over the last year as requiring significant improvement. The report was also focused on highlighting the newer survey questions. c. After reviewing the Survey results the Executive Team had identified three key areas for focus in 2024/24: 1. Appraisal: To Improve the appraisal process and its role in talent management/career progression and staff feeling valued. 2. Staff feeling confident to raise concerns: Although the Trust's results were close to its peer average, the scores had not returned to the levels reported in the 2021 Staff Survey results. The Trust would continue to work with the Freedom to Speak up Guardian (FTSUG) to improve staff confidence in this area, and to ensure the hospital was a psychologically safe working environment. 3. Bullying and discrimination: The continuing high levels of staff reporting bullying and discrimination, from colleagues and line managers was particularly concerning. Another concern was related to staff experiencing unwanted behaviour of a sexual		

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	nature and the percentage of staff reporting this type of behaviour, both from patients/relatives and colleagues was higher than the Trust's peers and the national results. It was be noted that the question on unwanted sexual behaviour was one of the new survey questions. d. OM stated that the very helpful information from the three Staff Survey feedback sessions would be reflected in finalising the workforce strategy work plan which would be submitted to the May 2024 Workforce Committee for approval. e. OM, in response to the Lead Governor Abi Halstead's question on how the Trust was working on resolving its persistent bullying problem, stated that this had been a focus of the Board of Directors for some years. OM noted that while for example there had been an improvement in the experience of staff from a Black and ethnic minority ethnic background, the statistics on bullying and harassment remained poor. f. OM suggested that it was a multifaceted issue and the questions being discussed at the Board and in the Trust included this – what was it about the culture of the organisation that had created the environment for bullying and harassment to remain embedded'? g. OM stated that was also an area focus for the FTSUG and had been a major issue at the Staff Survey feedback sessions. OM noted that there was this dichotomy in the organisation where patients had a good experience, while staff had a bad experience. h. OM advised that several practical actions had been implemented so far. These actions included the Trust's values and behaviour framework to underpin the kind of behaviour that was expected from staff in their interactions with each other. The themes of expected behaviour were also reflected in the Trust's policies and procedures framework. i. OM stated that there was also the recognition that, in the most part, relations would have broken down completely by the time issues between staff were escalated through the appropriate processes for resolution. Steps were being taken to determine how the Trust could intervene much earlier by giving staff and their immediate managers the tools, skills and training to resolve issues much earlier. The Trust had worked with the trade unions and the staff who had utilised the current resolution process for feedback on how this can be improved. j. The other tool being utilised was the 'second messenger approach', which was promoted by the 'Civility Saves Lives' programme or the 'coffee conversation approach'. This involved a third party, who had not witnessed the alleged bullying behaviour, approaching the 'perpetrator to have an informal discussion about the impact of their behaviour. The issue was then escalated if the feedback on the impact of their behaviour was not accepted. k. OM stated that in all staff communications there was constant messaging about expectations about behaviour, with the Trust ensuring that staff see that the incidents of bully and harassment were addressed fully. l. OM highlighted the following: i) Workforce Race Equality Standard (WRES) data improved from last year and this needed to be maintained. ii) The Workforce Disability Equality Standard (WDES) data, compared to last year, deteriorated in some areas. Steps being undertaken to understand why there had been a deterioration.		

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	Discussion: m. CC highlighted the issue of unwanted sexual behaviours from patients/relatives and staff towards female members of staff and expressed surprise that it was not a survey question before 2023. CC enquired if there were any actions being implemented to resolve this issue. n. OM noted that element of power dynamics was a common denominator between the bullying and harassment and unwanted sexual behaviours issues. OM added that feedback from other NHS providers on the survey question suggested this had been significantly underreported for many years. Though reports of unwanted behaviours from patients had been reported over the last year, no NHS Trust could have predicted the overall response to the question. o. OM stated that the Trust's staff in the Therapy Unit had been raising a lot of concerns over the last year about the unwanted behaviours of patients. The Trust had been working with the Women's Network to develop the measures which could be implemented to support staff, including a review of the security arrangements in the Trust. The Estates Department was committed to helping find a solution. p. The Trust was also supporting the staff with some training to provide them with the tools and techniques to be able handle unwanted behaviours from patients and their relatives. q. In response to CC's query on the continuing lack of BAME representation on the Executive Team, OM suggested that may be because the pool of qualified BAME candidates was not large enough. OM stated that vacancies were widely advertised, with the advertisements clearly asking all to apply but the pool of relevant applicants was never deep enough. r. On the continuing issue of bullying and harassment GR queried whether the Executive Team worked in close collaboration with the FTSUG. GR advised that staff would only be confident in the Trust's processes if issues they speak up about were swiftly dealt with and that they were not discriminated against. s. OM, in response, stated that the Executives worked closely with the Guardian and a lot of the materials around the issue of bullying and harassment were co-produced with the FTSUG. The FTSUG was independent of the Executives but was involved in developing the approaches to resolving the issues impacting on the staff. t. CP highlighted the Survey data and enquired whether any steps were being taken to improve the long-term sickness and the low appraisal compliance rates among the staff in Estates and Facilities. u. SH stated that quite a large programme of engagement had been undertaken for the Estates and Facilities team since she came into her role. SH advised that the engagement exercises were based on information received both from the Staff Survey and the FTSU function which clearly indicated that were problems to be resolved in the area. v. SH stated that engagement exercises had included externally facilitated listening exercises involving all staff from the housekeeping teams on the ground to the teams working at the senior management level. w. SH stated that the plan was to have some externally facilitated feedback sessions with the senior team and the wider team to share the feedback from the earlier sessions. SH added that action plans would then be developed to improve the situation in the Estates and		

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	Facilities team. The action plan would cover a wide span of issues including the quality of appraisals, and the provision of specific training and coaching opportunities to individual members. x. JA noted that the Trust's performance, against other specialist NHS providers in the 'recommender' section was in the bottom quartile for the last 5 years. IS stated that unlike NHS providers in its peer group, the Trust had over that period been involved in a move to a new site and been completely transformed in response to the pandemic. IS suggested that as the Trust continued to recover from those events, the 'recommender' data were likely to change. **Noted:** The Board **noted** the 2023 Staff Survey Results.		
2.iii	**Gender Pay Audit Report**		
	Presented: OM presented the Gender Pay Audit Report to the Board **Reported:** OM reported that: a. The report was to provide assurance and information on the progress around the gender pay gap in the Trust to the Board, before it was published on the Trust website. b. An action plan was being developed with the support of the Women's Network. c. The focus of actions would continue to be around flexible working, maternity leave and pregnancy, and career progression. d. In relation to the medical staff, it would take a little while for the change in the demographics to reflect a narrowing of the gender pay gap, as both national and local Clinical Excellence (CE) awards were the factors in determining the level of remuneration. e. IS stated that two female consultants currently held national CE awards. 40% of the applicants for the national CE awards were female, with two of them being among the very best. **Discussion:** f. GR also advised that it would be ideal if the gender pay improvement action plan was submitted to the Board after review at the May 2024 Workforce Committee meeting. g. OM agreed that the action plan would be submitted to the next Board meeting after the May 2024 Workforce Committee meeting. **Noted:** The Board **noted** the Gender Gap Audit Report.	**OM**	**06/24**
NB: The minutes reflect the order in which the agenda items were discussed.			
5	**RESEARCH AND DEVELOPMENT**		
5.i	**Research and Development Update**		
	Presented: PC presented the R&D Report. **Reported:** By PC that: a. The R&D Strategy was approved in 2023, and the business plan to support the appointment of a number of infrastructure posts was signed off in July 2023. The majority of these posts had been recruited to and this was having a positive impact on governance and throughput in R&D.		

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	b. Progress was being made around the sourcing of funding for the appointment of 50/50 research and leadership posts. The hope was that the first post in Cardiology would be appointed in Q3. c. There had been a reduction overall in the mean number of days for the approval of trials and an increase in the number of trials being approved. d. Compared to CUH NHS FT, the set-up time for commercial and non-commercial research studies had been approximately 20 days longer for the Trust in 2022/23. In 2023/24, the Trust set-up time for both types of study were approximately 60 days quicker than that for CUH NHS FT. e. An event was planned on 29 April 2024 to update Community Leaders on how the R&D team was working to embed health equality and culturally inclusive practices into the research they undertake. Funding had been secured from the local Clinical Research Network to host the event. **Noted:** The Board **noted** the R&D update.		
3	**QUALITY & GOVERNANCE**		
3.i	**Quality and Risk Committee Chair's Reports for Meetings on 29 February 2024 and 28 March 2024**		
	Received: The Q&R Committee Chair's reports setting out significant issues of interest for the Board. **Reported:** MB reported that: a. Progress had been achieved around the Surgical Site Infection (SSI) rates, with some encouraging actions being undertaken. b. Safer staffing had steadily improved, which had resulted in less need for mitigation actions to be implemented. This would ensure that there was improved working conditions and enhanced assurance on safety. **Discussion:** c. CC queried whether the SSI improvement actions would be further embedded in the theatres. MS confirmed that the actions were being embedded as required. The actions included an increase in theatre staffing numbers and enhanced training and educations on infection control, d. In response to CP's query on the reported increase in complaints of a serious nature, EM stated that most complaints had previously centred around communication issues, but this had shifted to issues of a more clinical and care nature. EM added that she was working with MS and IS to understand why this shift was occurring, and this would involve a comprehensive review of not just formal complaints, but also of informal complaints as well. EM advised that this comprehensive review was necessary because due to the low rate of formal complaints, the sample size available was too small to provide a viable insight. **Noted:** The Board noted the Q&R Committee Chair's reports.		
3.ii	**Combined Quality Report**		
	Received: A report from the Chief Nurse and Medical Director which		

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	highlighted information in addition to the PIPR. **Noted:** The Board **note**d the Combined Quality Report.		
3.iii	**Audit Committee Chair's Report**		
	Received: The Board received the Audit Committee Chair's report setting out significant issues of interest for the Board. **Reported:** By CC that: a. The work to implement the actions from the Board Assurance Framework review in March 2024 was continuing. It was acknowledged that more work is still required to get the BAF to the state where the Board is satisfied with its effectiveness. b. A very well written 'Green Plan 2022 – 2024 – Current Progress' Report was submitted from review by the Committee. The Committee recommended that the Green Plan governance architecture, which stipulated that the Sustainability Board must report into the Performance Committee, must be urgently implemented. **Noted:** The Board **noted** the Audit Committee Chair's Report.		
3.iv	**Board Committee Minutes**		
	Received and noted: The Board of Directors received and noted the minutes of Board Committees held on: a. Quality & Risk: 25.01.24 & 29.02.24 b. Performance: 25.01.24 & 29.02.24 c. Audit: 18.01.24 d. Workforce 25.01.24		
3.v	**Board Self-Certifications**		
	Received for review and approval: a. General Condition 6 and Continuity of Services Condition 7 of the NHS Provider licence b. Corporate Governance Statement c. Training of Governors **Approved:** The Board Self-Certifications were **approved.**		
4	**PERFORMANCE**		
4.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 considered the following key issues: a. Critical Care Area (CCA) Presentation – The Committee received a presentation on the steps being taken to sustainably increase the bed base of the CCA. The presentation included information on the		

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	required staffing level for the proposed bed numbers 35 beds by May 2024 and 36 beds by September 2024. b. The Committee reviewed the draft 2024/25 Operational Plan 2024-25 which forecasted a £1.5m budget deficit. The Committee also noted the key assumptions, including the 2% net growth in activity once the impact of tariff changes and unwinding of Industrial Action were factored out; and the 28% workforce headroom – this was the current rate required to take into account sickness cover, compared to the standard measure of 22%. c. The draft Operational Plan would return to the Committee in April 2024 for recommendation to the Board for approval in April 2024 following further work with Divisions and Commissioners. d. PIPR moved from an overall RAG rating of 'red' to amber' because of the Safe, Effective and People measurement domains moving from red to amber in March 2024. The reflected, among other factors, improvements in safer staffing fill rates, higher theatre and Cath lab utilisation, and reduced vacancy and sickness rates. **Noted:** The Board **noted** the Performance Committee Chair's report.		
4.ii	**Papworth Integrated Performance Report (PIPR)**		
	Received: The PIPR report for Month 11 (February 2024) from the Executive Directors (EDs). **Reported:** SH reported that: a. The overall performance remained RAG rated at 'amber', with the impact of 5 days of in-month Industrial Action a significant factor. **Discussion:** b. As every initiative implemented impacted on waiting patients, MB enquired if steps could be taken to review and monitor the impact of delayed treatment on outcomes. MB advised that the there was a significant amount of data available to be able to review, assess and monitor outcomes. c. MS stated that Quality Impact Assessments were undertaken on all relevant initiatives implemented in the Trust, adding that reports on impact assessment could be reviewed on an exceptional basis at the Quality and Risk Committee. d. In response to JA's query around the effectiveness of quality impact assessments, MS emphasised that they were very helpful and informative, and the reports could be utilised formally as had been done in the past. e. CC, in reference to the cancer treatment breaches, enquired if the C&P ICS was working to resolve the blockages in and outside the local system which caused patients to be late in attending the Trust for treatment. MB also enquired if the Trust was able to ensure that cancer patients from the C&P ICS areas received treatment on time. f. EM stated that the due to delays in pathways, the Trust was regularly starting from a negative position as referred patients were either about breach or already in breach positions. g. EM noted that the Trust's Cancer Recovery Board had been revived, and they were implementing actions in the Trust after completing a recent deep dive of the issues in the Trust. h. EM advised that the C&P ICS's Planned Care Board had made the recovery of cancer service a focus of their attention. EM stated that a		

Agenda Item		Action by Whom	Date
	key limiting factor for people on cancer pathways in the ICS area was access to diagnostics. The Planned Care Board's was focused on working with NHS providers to improve access to diagnostics, while also working them to resolve other internal issues. i. IW advised that he chaired a group working to remove the blockages in the referral system. The aim of the group was to make the referral process as seamless as possible. The next step was to ensure the flow of information from referring hospitals to specialist tertiary hospitals was unimpeded. j. WW stated that the plan was to submit a report, from the Cancer Improvement Programme to the May 2024 Performance Committee, detailing the achievements and improvements made so far. k. AF suggested that, after several discussions by the Board around the issue of cancer breaches, a deep dive and an improvement programme around the Trust's cancer waits would be ideal. l. AF advised that though the number of cancer breaches were small, and the Trust was working on improving the issues it had control over, the Board needed to be updated fully on the positive actions being implemented. m. GR advised that an update would be provided to the Board after the report on actions around cancer recovery had been reviewed at the May 2024 Performance Committee. **Noted:** The Board **noted** the PIPR report for Month 11 (February 2024).		
6	**BOARD FORWARD AGENDA**		
6.i	**Board Forward Planner** The Planner was under review to reflect the changes in Board Operations. **Received and Noted.**		
6.ii	**Items for escalation or referral to Committees** None		
7	**ANY OTHER BUSINESS**		
	None		

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Signed

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Date

Royal Papworth Hospital NHS Foundation Trust
Board of Directors
Meeting held on 4 April 2024

Glossary of terms

CIP	Cost Improvement Programme
C&P ICS	Cambridge & Peterborough ICS
CUFHT	Cambridge University Hospitals NHS Foundation Trust
CRF	Clinical Research Facility
CRN	Clinical Research Network
CUHP	Cambridge University Health Partners
DGH	District General Hospital
GIRFT	'Getting It Right First Time'
H2	Half 2 – this refers to the second half of the financial year
HLRI	Heart and Lung Research Institute
ICB	Integrated Care Board(of the ICS)
ICS	Integrated Care System
IHU	In House Urgent
IPPC	Infection Protection, Prevention and Control
IPR	Individual Performance Review
KPIs	Key Performance Indicators
LDE	Lorenzo Digital Exemplar
NED	Non-Executive Director
NIHR	National Institute for Health and Care Research
NHSE/I	NHS England/Improvement
NSTEMI	Non-ST elevation MIs
NWAFT	North West Anglia NHS Foundation Trust
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
SOF	NHS **S**ystem **O**versight **F**ramework (Graded 1-4)
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