Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Held on 06 June 2024 at 09:00 am
via Microsoft Teams
Royal Papworth Hospital

UNCONFIRMED M I N U T E S – Part I

Present	Dr J Ahluwalia	(JA)	Chairman
	Mr M Blastland	(MB)	Non-Executive Director/Deputy Chairman
	Ms C Conquest	(CC)	Non-Executive Director/Senior Independent Director
	Mr G Robert	(GR)	Non-Executive Director
	Ms A Fadero	(AF)	Non-Executive Director
	Prof I Wilkinson	(IW)	Non-Executive Director
	Dr C Paddison	(CP)	Associate Non-Executive Director
	Mrs E Midlane	(EM)	Chief Executive Officer
	Dr I Smith	(IS)	Medical Director and Interim Deputy Chief Executive Officer
	S. Harrison	(SH)	Interim Chief Finance Officer
	Mr H McEnroe	(HMc)	Chief Operating Officer
	Ms O Monkhouse	(OM)	Director of Workforce and OD
	Mrs M Screaton	(MS)	Chief Nurse
	Mr A Raynes	(AR)	Chief Information Officer & SIRO
In Attendance	Dr U. Hill	(UH)	Consultant in Respiratory Medicine & Cystic Fibrosis Clinical Lead (For Item 1.i – Staff Story)
	Dr H Barker	(HB)	Consultant in Respiratory and General Internal Medicine (For Item 1.i – Staff Story)
	Mr A Bottiglieri	(AB)	Freedom to Speak Up (FTSU) Guardian ((For Item 2.iii – FTSU Guardian Annual Report)
	Mr S. Edwards	(SE)	Head of Communications
	Mr K Mensa-Bonsu	(KMB)	Associate Director of Corporate Governance
Apologies	Ms D Leacock	(DL)	Non-Executive Director
Observers	Ms A Halstead – Public Governor/Lead Governor		
	Dr C Glazebrook – Public Governor		
	Dr S Bullivant – Public Governor		
	Ms A Atkinson – Public Governor		
	Ms M Hotchkiss – Public Governor		
	Ms L Howe – Public Governor		
	Mr T McLeese – Public Governor		
	Mr T Collins – Public Governor		
	Dr H Perkins – Public Governor		
	Mrs J McClean – Staff Governor		

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1	**WELCOME, APOLOGIES AND OPENING REMARKS**		
	JA welcomed everyone to the meeting and noted DL's apologies. EM introduced UH and HB who were presenting the Patient Story item.		
1.i	**Patient Story**		
	Presented: MS provided the background to the patient story, which was about the benefit of an outreach service to patients with chronic lung infections. **Patient Story:** a. UH introduced herself and HB as Respiratory Consultants based in Royal Papworth Hospital NHS Foundation Trust's (RPH's) Cambridge Centre for Lung Infection. b. The outreach service was created for patients with chronic lung infections in a collaborative effort between RPH and North West Anglia NHS Foundation Trust (NWAFT). c. There were 575k people and 375k people, respectively, in the north and south of the area covered by Cambridge and Peterborough Integrated Care System (C&P ICS). The slide deck showed the health inequalities across C&P ICS, with more deprived areas being in the north than in the south. The percentage of patients with chronic health conditions was also higher in the north than in the south. d. While there were fewer referrals of patients to the Trust from the north than from the south, the differential in health conditions was particularly noticeable after the COVID pandemic. The outreach service for patients with chronic lung infections was created to address the health inequalities in the north by bringing expert care closer to the patients. e. The other aim of the outreach service was to foster closer collaboration between the respiratory teams at RPH and NWAFT. The plan under the collaborative programme, was to enhance the expertise and knowledge of the NWAFT team. f. Under the auspices of the outreach service, a clinic was held, three times per month at NWAFT's Peterborough City Hospital (PCH) and once a month at- NWAFT's Hinchingbrooke Hospital (HH). The clinics were attended by a respiratory consultant from RPH with the support of local specialist nurses and local physiotherapists. g. At these outreach clinics, specialised care was provided to patients with chronic lung infections. The patients who attended the clinics also had access to the ambulatory care service, the intravenous antibiotic service, the specialised tests and the inpatient services available at RPH. h. Another aspect of the outreach service was the creation of a joint respiratory consultant post which would predominantly be based at PCH but would be at RPH for one day a week. This would help ensure that the joint consultant attended multidisciplinary team meetings and helped in the delivery of the respiratory service at RPH. The aim was to ensure the consultant did not lose track of developments around the delivery of specialist respiratory care. i. In September 2022, Dr Peter Bailey was appointed to the joint consultant post and then the outreach clinics were launched in PCH and HH in October 2022 and in May 2023, respectively. Since then,		

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	Dr Odiri Eneje had joined the team to support the outreach service. j. HB highlighted the condition of a patient who had attended the bronchitis clinic at PCH for about 8 years but was deteriorating at an increased rate. A CT scan showed that the patient had extensive disease which required immediate transfer to RPH for advanced specialist tests and care. The patient had suffered infection problems since childhood and had been diagnosed as having cystic fibrosis during an admission at RPH. k. HB stated that the patient's genetic profile had made them eligible for the new modulator therapy known as Kaftrio, which was being used to treat patients with a certain type of cystic fibrosis. The patient's health had significantly improved since they were placed on this treatment. Though the patient had not had the opportunity to be diagnosed and treated earlier in life, it was fortunate that they could still recover, and were responding to treatment. Their quality of life had significantly improved, and they were now making plans with their family. l. HB highlighted the condition of another patient, a 74-year-old patient with emphysema who had been attending the PCH's Chronic Obstructive Pulmonary Disease without significant problems with infections until September 2022. m. In September 2022, the patient presented with a really severe cavitating pneumonia and was admitted for treatment with antibiotics for 14 days. The patient recovered and was discharged but fell ill again. The patient was readmitted to PCH in October 2022 but was very unwell and was not responding to treatment. n. The RPH team intervened and determined that the patient needed to be treated with more antibiotics. The patient remained on admission at PCH for just over 4 weeks and was discharged home with a care package. Over the course of 2023, the patient had steadily improved, gained weight, no longer required carers, was able to stop using a wheelchair, was able to exercise to strengthen their legs, and was now able to walk without a walking stick. The patient had recently been able to travel by train to London to go and visit family. o. UH stated that a review of the outreach service from October 2022 to October 2023, indicated that 380 patients had been reviewed in the outreach clinic at PCH, with 60 patients being reviewed at the HH outreach clinic. 57 of the patients required further care and input at RPH but the rest only required further follow up through the outreach clinics. p. There were plans to organise teaching events with the specialist nurses and physiotherapists at PCH and HH to raise awareness and increase understanding of chronic lung infections and the important underlying causes that needed to be investigated and addressed. Other plans included the setting up of local facilities at PCH and HH so that they could undertake the initiation of nebulised treatments. This would reduce the need for some patients to have to travel to RPH for such treatment. q. As RPH did not have the capacity to receive all patients with lung conditions, it was important that the Trust transferred knowledge to other NHS providers. The plan was to disseminate the expertise and knowledge in treating lung conditions to other hospitals, so patient outcomes could significantly improve. r. HB stated that the RPH team could bring improvements to patient care by disseminating knowledge and suggested that specialist care		

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	should be available to all residents of the C&P ICS region. **Discussion:** s. JA thanked UH and HB for the presentation and advised that he also thought the specialist hospitals should take steps to spread services far and wide to make sure patients got actual access to high quality care regardless of where they lived. t. GR enquired if, as was the case during the COVID pandemic, the outreach service wanted to make RPH's specialist consultants available to advise consultants in other hospitals in the C&P ICS region. GR, in reference to the first highlighted patient, advised that treatment for them could have been progressed via a conversation between a PCH consultant and a RPH specialist consultant. u. UH, in response, stated that all hospitals had different needs and this model of making RPH consultants available to provide treatment advice depended on there being interested clinicians. UH added that there also had to be the right treatment infrastructure such as home delivered antibiotics. UH noted that the remote model was challenging to support as the specialist consultant would have to provide advice on the treatment of complex patients through the observations of another clinician. v. HB stated that the outreach service could, however, look at developing different models for extending support to areas such as Ipswich, Kings Lynn or Harlow where there was a degree of deprivation and a lack of service. GR advised that the Trust should not underestimate the capacity constraints as that type of support would involve consultants spending a lot of time on the phone to other hospitals. w. CP enquired if the one joint respiratory consultant post between RPH and NWAFT was enough for the level of work that needed to be undertaken in the deprived areas. CP also enquired about the barriers to patients having access to home-delivered intravenous antibiotics and the steps which needed to be undertaken to make that accessible. x. UH, in response, stated that one joint post was enough for the collaboration with NWAFT's PCH and HH. UH noted, however, that if the collaborative model was extended to Ipswich, Harlow or Kings Lynn there would be the need for new joint posts with those hospitals. y. UH advised that, with regards to home-delivered intravenous antibiotics, that was not available to all RPH's patients even if they could self-administer medication. UH suggested that though there were virtual ward services in other hospitals, it was very expensive and staff intensive to run. The expense had limited many virtual ward systems to commit to either no antibiotic deliveries or only once daily deliveries, which was too limited for RPH's respiratory patients. z. UH stated that due to the limitations on the virtual ward service, RPH relied heavily on patients being able to self-administer antibiotics. Though not every relevant patient could self-administer, the Trust was teaching in excess of 400 patients a year to do so. UH advised that the throughput for virtual ward services would increase if more nurse-delivered intravenous antibiotics could be delivered at home. This was, however, too resource intensive to undertake. aa. In response to CC's query around why the first highlighted patient's cystic fibrosis diagnosis was so late in life, UH stated that most patients were now being diagnosed through newborn screening. UH		

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	noted that some people had mild symptoms which were difficult to diagnose, and added that, for an older person such as the first patient, they would have been born long before diagnosing through newborn screening became available. UH advised that about two or three patients were diagnosed with cystic fibrosis later in life each year. **Noted:** The Board **noted** the Patient Story update.		
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: 04.04.24 **Approved**: The Board of Directors **approved** the Minutes of the Part I meeting held on 04 April 2024 as a true record.		
1.iii	**Matters Arising and action checklist**		
	a. **02/24** – Discharge Lounge: 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. AR advised that this was being progressed and the Board would be updated when the work was completed. **Open.** b. **18/23** – Information Governance (IG) Training for Board Members: The establishment of an e-learning option for the delivery of IG training for Board members had been progressed. **Closed.** c. **15/23** – Patient deferrals: HMc stated that work on harm reviews had been rolled into the work on the overall Patient Initiated Follow-Up risk assessments as part the Trust's review of trends from DrDoctor. JA asked for the Board to be updated on DrDoctor and how it was helping the Trust's operational processes. **Closed.** **Noted:** The Board received and noted the updates on the action checklist.	**HMc**	**09/24**
1.iv	**Chairman's Report**		
	a. JA stated that, earlier in the morning, he and EM had joined other members of staff to mark the 80th anniversary of D-Day. There had been a short flag raising and wreath laying ceremony at the hospital's front entrance to commemorate this very important day in history. b. JA noted that the Thoracic Service had for the first undertaken over 700 surgical cases over the 12 months from May 2023 to April 2024. With due regards to the constraints on productivity, this was a very important landmark. JA highlighted the recognition of Dr Raj Vaithamanithi, Deputy Chief Information Officer, as a rising star at the NextCIO Awards 2024 held in May 2024. JA congratulated AR for recruiting such an able senior member of the team.		

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	c. JA informed the Board of a visit to Radiology as part of a 'visibility round' exercise. d. JA also visited the Enhanced Recovery Unit (ERU) in May 2024. The ERU was for patients who were predicted to be in critical care for fewer than 48 hours following their cardiac surgery, before being discharged to the surgical ward. JA thanked HMc and the staff for working to ensure the new ERU was working as optimally as intended. e. JA visited the wards with MS on International Nurses Day on 12 May 2024. On one of the wards the nurses had celebrated their multicultural backgrounds with a great map of the world identifying where they had originally been trained or had ancestral links. The map was a very visual portrait of what a cosmopolitan place RPH was. f. JA stated that he had visited Pharmacy on a couple of occasions and wanted to highlight the significant vacancy challenge in the area with the pharmacists operating with a 30% vacancy rate. JA noted that this was a national issue, but this challenge was perhaps amplified due to RPH's specialist profile. JA thanked the Chief Pharmacist, Jennfer Harrison and her team, for managing the staffing challenges so well that frontline clinical services had not been impacted. g. JA asked that an agenda item be included so Non-Executive Directors would have the opportunity to provide feedback from any visits or other observations that they may have made during the prior month or two to a Part 1 Board meeting. h. CC stated that while volunteering on the Day Ward in June 2024, she had also visited the Cardio-Thoracic Support Team. CC advised that the visits had been very good, and she had observed the tremendous dedication and friendliness of the staff in the areas. i. CP undertook very positive 'quality round' visits to the Day Unit and Outpatients in May 2024.There areas were scenes of calm, with patients being very well-cared for. CC highlighted the need to provide more support for the staff in new standalone roles so the sense of feeling isolated could be avoided. This need for support was particularly important when there was only one member of staff or a small number of staff within a unit. **Noted:** The Chairman's update was **noted**.	**KMB**	**09/24**
1.v	**Board Assurance Framework (BAF)**		
	Received: The BAF report for June 2024. **Reported**: By KMB that: a. Versions of the report had been reviewed May 2024 meeting of the Performance, Workforce and Quality and Risk Committees. b. BAF 3261: Industrial Action: CRR 16 (C4XL4): The current risk score was reduced from 20 to 16 in May 2024 due to the likelihood of industrial action being reduced due to consultants settling their dispute and junior doctors entering into mediation. c. All other progress updates were also highlighted for review. **Discussion** d. In response to JA's query around the rationale for reducing the risk rating for the Industrial Action risk entry, OM advised that the industrial relations landscape was constantly evolving. Due to this constant evolution, OM kept the industrial action risk entry under constant		

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	review and would be reviewing it soon in the light of current developments around mediation talks with Doctors in Training. e. CC advised that considering the developments around cyber security, the risk rating for the Cyber Security risk rating probably needed to be increased. This would better reflect the heightened risk to the Trust's cyber security arrangements. **Noted**: The Board **noted** the BAF report for June 2024.		
1.vi	**CEO's Update**		
	Received: EM presented the CEO's update. a. As part of the increased activity around the Cambridge developmental agenda, she had represented the Cambridge University Health Partners at a Cambridge Ahead hosted event with Michael Gove, the Secretary of State for Levelling Up, Housing and Communities. EM stated that she and attendees from other sectors had provided some key cohesive messages in relation to the actions which needed to be undertaken to support the developmental agenda. b. EM stated that the expectation was the agenda to develop Cambridge into the science capital of Europe would be maintained by the next Government after the July 2024 General Election. c. EM attended a Lifesciences Advisory Council in May 2024, which received updates on the development of a new Children's Hospital on the Cambridge Biomedical Campus. The new hospital would provide a holistic approach of addressing both the mind and body of children and young people and their families. It would also provide a hub for the integration of research and the design of integrated datasets which could be used to create tools for early disease prediction and intervention. d. An 'EPR month' would be held from 10 June to 05 July 2024 to provide staff with the opportunity to engage in the Trust's EPR selection process. There was significant interest in the EPR replacement programme, which the Trust continued to nurture and grow. e. EM noted that there had been a spike of surgical site infections in March 2024, and highlighted the extensive improvement actions which were being implemented in the hospital. f. The energy, and enthusiasm and commitment of the newly formed ERU team was palpable, and it was a joy to visit the area. EM encouraged Board members to visit the ERU to experience the atmosphere for themselves. g. EM highlighted several awards won by Trust staff in May 2024: - i) Radiographers - for producing outstanding high-quality images produced during cardiac CT scans. In 2023, 97% of cardiac CT scans at Royal Papworth were of the best quality, compared to a national average of 92%; ii) Respiratory Physiologists – the Trust's Respiratory Physiologists showcased their research excellence on the national stage at their recent national conference. One of the Trust's Respiratory Physiologists won the prize for the best respiratory research poster; iii) Estates collaboration award – the Estates and Facilities team won the 'best operational – healthcare' category at the 2024 Partnership Awards, which recognised excellent partnerships across the world. They won the award alongside Skanska, OCS Facilities Services Group, and Project& Co for their collaborative approach to building and running the new hospital.		

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	Discussion: h. CC queried how the team continued to have a CT backlog but was able win prizes for the quality of their work. EM, in response, stated that from an image acquisition perspective, the position was over 95% compliant against NHSE's 6-week referral to image acquisition standard. EM stated that she was confident that the Radiology Department had recovered the position on 'access' and was working on reducing the backlog in reporting. i. IS added that it was an award for the Image Acquisition team, who were outstripping the capacity of the Reporting team. IS stated that the locum consultants recruited to help reduce the backlog, had not been able to report at the same rate as the Trust's consultants. IS noted that while steps continued to be taken to reduce the backlog, the reporting rate of the Trust's consultants needed to be highlighted for praise. j. AF, in reference to the increased activity in the hospital, enquired if the Trust had any expectation of when all patients who had waited for more than 40 weeks would be treated with no long waiters remaining. HMc, in response, stated that treating all long waiters was an important objective for the Trust to be achieved by October 2024. HMC added that the steps to achieve this objective were being undertaken by utilising standard capacity. k. HMc advised that the decision to utilise standard capacity carried some risk as it assumed that there would be no more industrial actions and that referrals from other NHS providers would stop being late. . **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. **Reported:** AF reported that: a. The Chief Pharmacist provided a presentation to the Committee in May 2024 which stated that despite recent investment and support the Pharmacy department was still struggling with high vacancy rates. This was having an impact on the staff's health and wellbeing, and on the Trust, with the need to prioritise some areas over others. The Committee asked for further focus on the challenges in the department and for an improvement action plan to be submitted to the Committee in the next quarter. b. The Committee received a comprehensive action plan after the review of the Workforce Strategy was undertaken. c. The Committee noted with concern, the experience of the Trust's locally employed doctors (LEDs), who were usually employed to non-permanent posts on local terms and conditions. The Trust employed about 70 LEDs, most of whom are from BAME backgrounds and whose experience of working at RPH was far from positive. Steps were being undertaken to ensure that the appropriate training, appraisal processes and accommodation were in place for the LEDs. The Committee asked for a further update on the progress of the		

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	improvement steps being undertaken in the next quarter. d. The Committee noted, with concern, the risk to the Trust's education budget due to the undue delays in the allocation of funds by NHS England. **Discussion:** e. JA noted that the poor experience for LEDs was widespread and long standing among NHS providers, adding that it was very helpful for the Committee to make it an area of focus for improvement. **Noted:** The Board **noted** the Workforce Committee Chair's report		
2.ii (a)	**Director of Workforce & Organisational Development (DWOD) Report**		
	Received: OM presented the DWOD report for review and the 2024/25 Workforce Strategy Workplan for approval. **Reported:** OM stated that: a. The results of the Q1 2024/25 Pulse Survey, undertaken in May 2024, was perplexing so no hypothesis could be deduced. The score for 'the recommender as a place to work' question was substantially reduced, though the scores for the other components of engagement were quite good. OM noted that the 'recommender' score' for the Pulse Survey, which was conducted on a quarterly basis, had fluctuated over the last 4 years. b. The May 2024 meeting of the Workforce Committee received a report of the progress achieved against the Trust's three-year Workforce Strategy. The Strategy was published in June 2023, with the overarching objective of making RPH a great place to work for all its employees. c. The report highlighted all the appropriate support and governance framework being placed around the Freedom To Speak Up Guardian role so it was as effective as it was intended to be. d. In April 2024 NHSE wrote to employers emphasising the need to enhance the working lives of NHS staff. Specifically, due to the pay discussions with the junior doctors, the UK government was now focussed on steps to improve the junior doctor working arrangements. An improvement in the arrangements would help engender better engagement and a better sense of being valued in the junior doctors and doctors in training. A report on any gaps in the working arrangements for junior doctors at RPH would be submitted to the Workforce Committee in July 2024. e. The NHSE letter also asked for employers to focus on ensuring that staff were being paid appropriately. The report provided the Board with the assurance that RPH had all the appropriate payroll processes in place to ensure payroll errors did not occur. **Discussion:** f. MB advised that the fluctuations in the 'recommender' score may be down to the sampling of each survey. MB suggested that OM should take and work with those, as despite the fluctuations, there was some evidence of underlying improvement. OM highlighted the scores about 'line managers' and teams' and 'raising concerns', as being very consistent, which provided evidence of the progress being achieved.		

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	g. JA enquired if the Workforce Directorate had the capacity to progress with all the workstreams and actions underpinning the Workforce Strategy and Workplan. AF, in response, stated that the Workforce Committee had reviewed the Strategy and Workplan and had agreed that, all things being equal, achieving all the objectives would be quite a stretch. AF advised that there were many demands, which pulled in different directions, and required the attention of the HR Directorate. AF stated the Workforce Committee, and the Board needed to keep all the workstreams and action plans under review but also needed to be realistic in terms of their progression. h. OM stated that there was another requirement for the Trust and other NHS providers to conduct job evaluations on nursing roles to assess whether the roles were banded at the right level and were being paid the appropriate remuneration. This would be a significant project which would require the full attention of the Directorate and could derail the progression of some of the workstreams and actions in the Strategy's Workplan. OM stated that there had been a discussion at the May 2024 Workforce Committee around whether some short-term resource could be recruited to support the Directorate. i. JA, in agreement, advised that it would be ideal for some short-term additional resource to be procured to help deal with the backlog of work being undertaken. JA stated that a lot of work needed to be undertaken before the situation in the Directorate could return to a business-as-usual position. j. AF stated that managing all the differing priorities, in addition to the regular workforce activity, would be very challenging. AF added that the need for the procurement of the short-term resource, should be viewed in the context of a Directorate being asked to implement many differing actions and workstreams. **Noted:** The Board **noted** the DWOD report. **Approved:** The Board **approved** the 2024/25 Workforce Strategy Workplan.		
2.ii (b)	**The 24/25 Gender Pay Audit Action Plan**		
	Presented: OM presented the Gender Pay Audit Action Plan to the Board for approval. **Report:** OM reported that: a. The action plan had been developed to address the gaps highlighted in the Gender Pay Audit Report discussed at the April 2024 Part 1 Board meeting. b. The action plan was developed in very close collaboration with the Trust's Women's Network and IS, as the Medical Director, for his perspective on the Clinical Excellence Awards (CEAs). c. This was a focused action plan, and very much aligned to the Equality, Diversity and Inclusion improvement action plan and Workforce Strategy action plan already being implemented. d. The particular focus of the Gender Pay Audit action plan was around aligning recruitment processes with the Trust's flexible working policy and relevant national regulations. The objective of the action was to ensure that people, especially women, would be able to be recruited to or promoted to senior roles even if they worked part-time.		

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	e. GR enquired if any action was specifically being implemented to encourage female doctors to apply for consultant posts and to mentor them to support their promotion into more senior positions. IS, in response, stated that he was mentoring all consultants who had not applied for CEAs to begin taking the steps which would make them eligible. IS noted that the evidence for the CEA application was over a 3-to-5-year window, and winners of the CEA had usually undertaken non-hospital roles with a national impact. The only part a hospital such as RPH could play was to support a clinician who put themselves up for external roles. f. IS stated that in terms of encouraging female doctors to apply for consultant posts and other senior positions, there was a very limited pool. IS noted that most doctors were only interested in performing clinical jobs, which they would have to limit or sacrifice if they took on senior positions. IS advised that the senior positions were mainly about committee work and most doctors, whether male or female, were not interested in that. g. OM stated that there was a recruitment issue as well, which was being addressed by the action plan's focus on 'flexible working'. The objective was to make becoming a doctor in a specialist hospital an easier career choice for more people but especially for women. h. JA advised that data on the current intake for British medical schools indicated the proportion was about 70% female in a lot of the schools. With due consideration to the fact that the lead time required to achieve eligibility for senior medical roles was substantial, the hope was that in about a decade's time the number of female doctors in senior roles would significantly increase. **Approved:** The Board **approved** the 24/25 Gender Pay Audit Action Plan		
2.iii	**Freedom To Speak Up Guardian (FTSUG) 2023/24 Annual Report**		
	Presented: AB presented the FTSUG Annual Report for 2023-2024. **Report:** AB reported that: a. The number cases reported under the bullying, harassment and intimidation categories increased in 2023/24. b. Members of the medical profession and scientists were becoming more open in speaking up about their experiences and concerns. c. Staff would rather speak to the FTSUG than Executives about very deep-rooted concerns regarding how they were being treated by their managers. These included managers' lack of response to reported concerns or unwillingness to seriously tackle those concerns. This was a theme which was reflected in previous annual reports. d. Overall, the FTSU Champions were busy, and the trend of cases being reported continued to increase year on year, from 84 in 2020/21 to 137 in 2023/24. e. The FTSU function ran workshops on microaggressions and incivilities. As not all staff could attend the Trust-wide workshops, the number of requests from clinical areas for bespoke workshops had continued to grow. **Discussion:** f. JA, on behalf of the Board and the Trust, thanked AB for the work done over the last 6 years to develop and establish the FTSU function		

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	at RPH. AB's work to establish the FTSU function, and the increasing activity of the function, had resulted in the Trust agreeing to expand the weekly working hours of the FTSUG from 24 hours to 37.5 hours (full time). g. CC noted that a lot of the cases being reported were HR-related but very few cases were reported in relation to patient safety and quality, and queried whether that was a true reflection. CC also enquired whether complaints about patient safety and quality were being made through other channels/bodies in the Trust. h. AB advised that he always referred the patient quality and safety cases to relevant clinical leads and was always reassured by the seriousness with which the issues were managed and resolved. AB added that, nationally, FTSUGs were dealing mostly with HR-related issues instead of patient safety and quality issues. AB noted that, considering the FTSU function was set up as consequence of the avoidable patient deaths scandal at Mid-Staffordshire, this was an ironic development. i. CP referred to the 2024/25 Pulse Survey and noted that the score for the 'opinions listened to by senior leaders' had declined from 53% in Q4 2023/24 to 45% in Q1 2024/25. CP also noted that the number of staff who declared to the FTSUG that they 'would not speak up again increased from 6 in 2023/24 to 16 in 2024/25. CP enquired about what needed to be done differently to improve confidence and whether an action plan had been developed to improve the position. j. AB, in response, stated this was a result of some cultural dissonance, due to there being the encouragement of staff to speak up but there being no consistency in the responses to staff concerns. The response depended on the manager who received the report of the concern, which did not engender confidence in the process for raising concerns. k. AB added that staff were also worried about being seen speaking to the FTSUG, so there was the need for there to be a way of ensuring that interactions and conversations were private and secure. l. GR advised that the data on the staff who were prepared to speak up again was in decline year on year and was not on a positive trend. GR stated that staff being prepared to speak again to the FTSUG was central to the effectiveness of the role and advised that urgent steps needed to be undertaken to improve upon that issue. AB, in response, agreed and stated that a plan of work was to be arranged from 2024 aimed at improving on the 'speaking up again' score. m. JA advised that AB shared responsibility for the work to improve upon the confidence of staff in the 'raising concerns process' with the whole Trust Board. The improvement work needed to be a collective effort. n. MS stated that the new Patient Safety Incident Response Framework (PSIRF) would help the Trust track trends better, as it focused more on systems and team dynamics rather than on individuals. o. In response to CC's query around the capacity of the FTSU function and the plans to enhance confidentiality, AB stated that there were 34 FTSU Champions and added that steps were being undertaken to procure an app which enabled anonymous reporting. p. CC informed the Board that she had set up a WhatsApp group with other FTSU Non-Executive Champions around the country so that they could start learning from good behaviour and good practice. q. JA thanked AB for his sustained and ongoing work in the FTSU area.		

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	Noted: The Board **noted** the Freedom To Speak Up Guardian (FTSUG) 2023/24 Annual Report		
3	**QUALITY & GOVERNANCE**		
3.i	**Quality and Risk (Q&R) Committee Chair's Report for Meetings on 25 April 2024 and 30 May 2024**		
	Received: The Q&R Committee Chair's report setting out significant issues of interest for the Board. **Discussion:** a. JA highlighted positively the focus on the level of assurance on matters discussed and reviewed at the Q & R Committee meetings. The Committees Chair report template needed to be redesigned so their reports could reflect the level of assurance received on items discussed or reviewed at the Committee meetings. **Noted:** The Board **noted** the Q&R Committee Chair's reports.	**KMB**	**09/24**
3.ii	**Combined Quality Report**		
	Received: A report from the Chief Nurse and Medical Director which highlighted information in addition to the PIPR. **Discussion:** a. MS congratulated Judy Machiwenyika on her appointment to the substantive role of Head of Nursing in the STA Division. Judy had been in an 'acting up' position for the past 10 months. **Noted:** The Board **note**d the Combined Quality Report.		
3.iii	**End of Life Care Biannual Report**		
	Received: The Board received the two-year report on End-of-Life Care at RPH, covering 2022 to 2024. **Report:** MS reported that: a. The report was extensively discussed and reviewed at the May 2004 Q&R Committee meeting. **Discussion:** b. JA queried the discrepancies between the Royal College of Physicians' recommended staffing numbers and actual staffing numbers for the Palliative Care team. MS, in response stated that a one whole time equivalent specialist nurse role for palliative care had recently been confirmed by the Trust's AITR Investment Group. MS advised that the Palliative Care team was very satisfied with the new role in terms of providing support, but the Trust would continue to monitor and assess whether a new consultant was required. c. In response to CC's request for assurance around the monitoring of mortality data on the palliative care pathway, MB stated that there were multiple levels of scrutiny for all deaths at RPH, and that provided a lot of assurance. MB added that this was an area which was reviewed by the Q&R Committee every month.		

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	d. CP queried the occurrences of a lack of communication with carers and patients about the risks of death or the impending deaths of those patients, MS stated that because of the nature of the Trust's services most patient deaths occurred in Critical Care, where some deaths could be quite sudden, while others were unexpected. MS noted however, that the Trust needed to improve on a few areas including the expectations for families and carers, and how messages should be delivered in terms of risk of death and outcomes for patients. e. AF advised that she had attended an End-of-Life Steering Group meeting where there had been a discussion on the kind of communication and personal skills required to undertake the very important task of communicating that somebody was dying. AF stated that this was an ongoing discussion which needed further work by the End-of-Life Steering Group. f. CC, with reference to the Quality Committee Chair's report, noted that the 'Learning from Deaths Report' was not attached to the meeting pack as it should have been. The report would be submitted for review and approval to the September 2024 Part 1 Board meeting. **Approved:** The Board **approved** the End-of-Life Care Biannual Report.	**KMB**	**09/24**
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: a. Finance – The Committee did not yet have assurance on the success of recent steps undertaken to implement temporary staffing controls. GR noted that this was because the work being undertaken was in its early stages. b. Finance – The Committee had assurance particularly around the process to achieve CIP our targets. c. Effective – The Committee found the current level of 52-week breaches to be very concerning. The Committee was also updated on steps being implemented to treat all of 40 weeks plus waiters by October 2024. There was no assurance yet on whether the steps being implemented to reduce the number of long waiters would be successful. d. CT reporting – Due to the recent resignations of radiology consultants and a discontinuation of the in-sourcing project, there had been an increase in the backlog of patients. The Committee did not have the assurance that the improvement actions being planned for implementation would be effective. **Discussion:** e. JA highlighted steps to recruit consultants in Radiology, with the aim of improving the capacity of Radiology. IS, in response, advised that there were applicants for the advertised consultant roles IS stated that steps were being undertaken to restore the insourcing capacity, with the plan for it to be in place for up to a year while the substantive consultant posts were recruited into. The objective was to stabilise the backlog position with the insourcing resource, then work to remove		

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	the backlog when the permanent consultants were recruited. f. IS stated that, to resolve the CT backlog issue, the Executive team had agreed that the Trust needed to incur some cost and procure some insourcing capacity. IS accepted that while the Committee could not have the necessary assurance, he was confident that when the insourcing capacity was in place, the patient backlog issue would be stabilised. **Noted:** The Board **noted** the Performance Committee Chair's report.		
4.ii	**Papworth Integrated Performance Report (PIPR)**		
	Received: The PIPR report for Month 01 (April 2024) from the Executive Directors (EDs). **Reported:** SH reported that: a. There had been a number of changes to metrics and to targets in the PIPR report which reflected the Trust's Operational Plan for 2024/25. The changes in the PIPR also reflected some of the changes in the national targets stipulated by NHSE's 2024/25 Planning Guidance. b. The overall Trust performance was RAG rated at 'amber' **Discussion:** c. MS informed the Board that the May 2024 Quality and Risk Committee had reviewed the progress of the Surgical Site Infection (SSI) improvement actions. The Committee noted that a lot of progress had been achieved in the areas of compliance with the fundamentals of infection prevention and control. MS stated that the rate of infections, however, continued to be higher than expected. d. MS highlighted the significant rate of infections in March 2024, which really concerned the Trust. A deep dive was conducted, and the finding was that no specific area of practise was causing the spike in infections. The Trust was organising a summit of all teams to get that wider engagement on the SSI improvement agenda. A date for the summit was being arranged with the support of the Q&R Committee. e. JA stated that, despite improvements from time to time, the SSI issue remained one of the most troubling aspects of the Trust's performance. In response to JA's query around how all members of staff would engage in the improvement process, EM stated that the Trust was planning to stand down some activity to enable all relevant staff to attend the summit. f. HMc informed the Board that in terms of the position on the high number of 52-week patient waiters, an over 40-week oversight structure, which he chaired, had been set up. Weekly meetings were being held with each of the respective divisions, to review the number of patients who had waited over 40 weeks and 52 weeks. The objective of these weekly meetings was to schedule appointments for these patients and maintain that schedule plan with no change. g. HMc stated that since these weekly meetings commenced the 40-week waiting list position had improved. HMc advised, however, that 18 patients referred in May 2024 to RPH had all waited for more than 70 weeks. HMc advised that these late referrals were happening more frequently, and the recently referred patients would unfortunately impact negatively on the Trust's 52-week waiting list position.		

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	h. HMc stated that he was working with system partners to address the issue of frequent very late referrals. HMc assured the Board that the Trust was absolutely focused on treating the patients who were already on the waiting list and was working closely with IS to ensure that those patients did not breach the 52-week target. i. In response to JA's query on the stakeholders in the system partners he was engaging with, HMc stated that he and IS were liaising directly with the chief medical officers and chief operating officers. JA advised that he had discussed with EM that there may be the need to write to chief executive colleagues if that was deemed necessary. j. In response to AF's query around the sustainability of improvements in theatre activity, HMc assured the Board that this would be sustained due to the return of the Critical Care Unit to full bed capacity. k. In response AF's query of the sustainability of the improvements to the CT scan underreporting issue, HMc stated that the CT data management process had recently been reviewed and significantly improved. IS added that the Trust was also recruiting four more consultants while procuring insource capacity. IS stated that the plan was to have a higher capacity than was required, which was where the CT service capacity should have been six months ago. IS advised that, one of the disappointments with the insource capacity originally procured was that the individuals were not as efficient as the Trust staff. Lessons had been learnt and were being implemented. l. In response to CP's query around the reasons for very late referrals by NHS providers to RPH, IS advised that he had engaged on this issue with system partners and proffered some solutions. IS stated that when all factors were considered, including the fact that many did not have referral data, it was quite clear that the providers had no grip on their waiting lists. m. JA asked for HMc to update the Board on how the 52-week breach allocations worked in terms of which provider was negatively impacted. JA noted that it was not in proportion to who had caused the delay and that was an important disincentive for changing behaviours. **Noted:** The Board **noted** the PIPR report for Month 01 (April 2024).	**HMc**	**09/24**
5	**Audit Committee**		
5.i	**Audit Committee Chair's report**		
	The report was not included in the Part 1 Board meeting pack in error and would be reviewed in the Part 2 Board meeting.		
6	**GOVERNANCE & ASSURANCE**		
	Received and noted: The Board of Directors received and noted the minutes of Board Committees held on: a. Quality & Risk: 28.03.24 & 25.04.24 b. Performance: 28.03.24 & 25.04.24 c. Workforce: 28.03.24		

Agenda Item		Action by Whom	Date
7	**BOARD FORWARD AGENDA**		
7.i	**Board Forward Planner**		
	Received and noted.		
7.ii	**Items for escalation or referral to Committees**		
	None.		
8	**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 06 June 2024