Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
held on 09 January 2025 at 09:00 hrs
Heart & Lung Research Institute and on Microsoft Teams
Royal Papworth Hospital

UNCONFIRMED M I N U T E S – Part I

Present	Dr J Ahluwalia	(JA)	Chair
	Mr M Blastland	(MB)	Non-Executive Director/Deputy Chair
	Prof I Wilkinson	(IW)	Non-Executive Director
	Ms D Leacock	(DL)	Non-Executive Director
	Ms C Conquest	(CC)	Non-Executive Director/Senior Independent Director
	Ms A Fadero	(AF)	Non-Executive Director
	Dr C Paddison	(CP)	Associate Non-Executive Director
	Mrs E Midlane	(EM)	Chief Executive Officer
	Mr T Glenn	(TG)	Deputy Chief Executive Officer & Director of Commercial Development, Strategy and Innovation
	Dr I Smith	(IS)	Medical Director
	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
	S Harrison	(SH)	Interim Chief Finance Officer
In Attendance	Mr S Edwards	(SE)	Head of Communications
	Ms Torby Christenssen	(TC)	Team Leader for the CCLI Research Team
	Mr K Mensa-Bonsu	(KMB)	Associate Director of Corporate Governance
Apologies	Mr G Robert	(GR)	Non-Executive Director
Observers	Ms A Halstead - Lead Governor and Public Governor		
	Ms M Hotchkiss - Public Governor		
	Mrs A Atkinson - Public Governor		
	Mr J Davies – Governor		
	Mr T McLeese - Public Governor		
	Cllr P Slatter – Governor		
	Mr T Collins – Governor		
	Mr B Davidson – Governor		

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1	**WELCOME, APOLOGIES AND OPENING REMARKS**		
	JA welcomed everyone to the meeting, and welcomed back CC and CP. TG was also welcomed back to the Trust after a period of secondment to East Kent Hospital, and SH was thanked for delivering so well in the interim role at		

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	RPH in TG's absence. TG conveyed thanks to the Chief Executive, Tracey Fletcher and the Senior Leadership Team at East Kent, who were working hard to the improve the hospital, and wished them well for the future. TG also reflected that on his return, he had noted that RPH was continuing to take all the necessary steps needed to provide the best services for all its patients. TG noted that the infrastructure at RPH was the best in the NHS, and this helped ensure that it had the resources along with the dedicated staff to provide excellent services. TG, in conclusion, stated that the wonderful working environment provided by the Cambridge Biomedical Campus was a significant advantage to RPH.		
1.i	**Patient Story**		

	JA welcomed TC to the meeting to present Patient Story item, which was related to the research journey of a non-modulator eligible Cystic Fibrosis (CF) patient through a clinical trial with the Cambridge Centre Lung Infection Research Team.
	
	TC reported that:
	
	• This was an early phase study, which was now being undertaken at RPH and across the world.
	• There was a new therapy for CF patients – Cystic Fibrosis Transmembrane Conductance Regulator (CFTCR) Modulators, in addition to other new formulations.
	• 7-10% of CF patients were, due to genetics. unfortunately, ineligible for the available therapy. TC noted that with no other treatment for the condition, that cohort of CF patients could only have medications for their symptoms or be eligible for possible lung transplantation.
	• One of the studies delivered at RPH was a commercial phases 1 & 2 trial of an inhaled mRNA therapy for this patient group. The study arrived at RPH after only 9 patients in the world had received just one single dose each of the study drug
	• This patient story concerned a 19-year-old male CF patient, who was not eligible for any treatment options but was eligible to be part of this research study. TC noted that this patient had experienced regular exacerbations due to their health condition but had a very supportive family.
	• The RPH patient was the first patient in the world to have more than one dose, with 28 daily doses planned in total.
	• This was a very intense study with many safety procedures in place, which also required significant commitment from the patient and his family.
	• Logistics were outlined as:
	  ○ Screening visit.
	  ○ Inpatient admission for 5 days for the first 5 doses of the inhaled study drug.
	  ○ Daily morning visits from day 6 to day 29.
	  ○ Day 43 visit.
	  ○ Week 8 visit.
	  ○ Week 16 visit.
	  ○ Week 28 visit.
	• Prior to the commencement of the study, the patient was made aware of the fact he was the first human in the world to have more than one dose, that there were unknown risks, and that extensive time commitment was		

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	required. There had been much discussion and information provided to the patient in advance of his first visit. • The collaboration across RPH had been amazing and the significant number of teams involved were noted. • Patient impact was highlighted, from signing the informed consent form, through the experiences during the dosing period along with feelings experienced by the patient, which included apprehensiveness, excitement, hope, concern, anxiety and tiredness. • Extensive interactions had ensured that the patient and the clinical team had a better understanding of his clinical needs and the triggers for additional treatment. • Since completing the study, the patient remained well, and additional medications had been prescribed long-term. As a result, he was driven to take part in another study and had consented to the screening part of another early-phase study. • In conclusion, the patient had been amazing in commitment, compliance and trust in RPH. There were some side-effects and attending the hospital early every day had not always been easy. The patient and his family were grateful for the opportunity to be part of the study, along with increased contact with the consultant and support from the research team. • A thank you letter received from the patient was shared with those present. **Discussion:** JA thanked TC for her presentation. DL queried whether, as a result of the trial, the patient had decreased antibiotic need. TC explained that time was required to ascertain if his health had improved and if the treatment worked. The patient however, felt better and, whilst some antibiotics had been prescribed, there had been a longer gap between requirements. CP queried whether the experience of being either being eligible or ineligible for trials, and the instances of patients arriving too late to participate had a negative impact on RPH. TC responded that the study, in the early stages, was very strict and but as the study progressed, it was hoped that the eligible criteria for inclusion would be widened. AF questioned the psychological support provided in preparing the patient prior to and during the process. TC stated that the patients had the facilities of the clinical team throughout the study and were invited to ask as many questions as possible at all stages of the process. Availability was facilitated to physiotherapists, psychologists and other specialists, as required. MB understood why patients might be keen to take part in the trials and queried if there was any indication of advantage being taken of those who might be feeling desperate about their health situation. TC explained that the patient had been thoroughly informed from the outset about what the study comprised of, and that there was potentially no benefit, with the risk that it could do harm. Openness and honesty were paramount to the clinical team. EM queried the steps being taken to increase participants in a diverse way. TC stated that this study had been based on genetics and, of the small pool of patients at RPH, all had been considered, regardless of ethnicity, to assess		

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	at eligibility. A website had been created which invited anyone across the country to take part in studies. JA thanked TC and her team for all work undertaken. The Board **noted** the Patient Story.		
1.ii	**Declarations of Interest**		
	There were no new declarations of interest.		
1.iii	**Minutes of Previous Meeting**		
	Board of Directors: 07.11.24 (Part I) The minutes of the Part I Board meeting held on 7 November 2024 was approved as a true and accurate record of the meeting.		
1.iv	**Matters Arising from the minutes and Action Checklist**		
	01/25 - 7 November 2024 – item 2.i - Update of General Medical Council (Trainees) Survey 2024: IS to check how the gap between the high quality of teaching and supervision, and the relative lack of hands-on experience for the trainees was being bridged. IS had discussed this with Nicola Jones, Lead for Medical Education. It had been identified by the team that 95% of the trainees were very satisfied with clinical supervision, although 20% were disappointed with the hands-on experience. This, compared with 9% rate across the country, was an outlier, concerning, particularly, foundation year and intensive care medicine. Three pieces of work were being implemented directly focused on these groups. In the first instance, a handbook would be issued, illustrating availability for weekly teaching sessions and simulation training. Progress could then be checked against the handbook completion. To be **CLOSED**. *03/25 - 7 November 2024 – item 5.i - Audit Committee Chair's Report – October – Pharmacy write-off: MS to address, with the Chief Pharmacist, the issue of the sharing of smaller quantities of particular medications, with other Trusts.* MS confirmed that, in relation to a high-cost drug, a request had been made via system partners. It had been established through discussion with Jenny Harrison, Chief Pharmacist, that Pharmacy did liaise with system partners to access rarely used and expensive drugs, when appropriate. The drug in question (which was written off) was very specialist and, unfortunately, was not held by other Trusts. To be **CLOSED**. The Board **noted** the Matters Arising and Action List.		
1.v	**Chair's Report**		
	JA conveyed thanks for support received since taking up the position in 2024 and highlighted the following: • The Staff Awards had taken place and had been very positive, with 730 nominations and 45 shortlisted for awards.		

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	• JA noted that RPH was relatively protected from the traumas of the typical NHS winter, which was proving particularly difficult elsewhere, and this protection was partly due to the fact that RPH did not have maternity or A&E departments. • There was thus a responsibility to make particularly good use of the hospital's environment. Thanks were conveyed to the Operations Team for the continuing successful flow of operations across the Trust. • With the recent directive for all Trusts to offer flu and Covid vaccinations to all staff, the Chair highlighted and was grateful for the positive decision taken by RPH to undertake this earlier in the season, and prior to the directive. • To enhance collaboration in various areas including research and education, steps had been taken to develop positive relationships between JA and EM and the Chair and CEO of North West Anglia Foundation Trust (NWAFT). The Board **noted** the Chair's Report.		
1.vi	**Board Assurance Framework (BAF)**		
	KMB presented the BAF. <u>BAF 2829</u>: Achieving Financial Balance - this rating had been increased from 8 to 12 to reflect soft intelligence emerging around the financial framework for 2025/26 which suggested no growth in funding and potential changes to the elective funding mechanism. <u>BAF 3649</u>: Failure to Embed Sustainability into the Culture and Operations of the Trust – this was a new risk entry and reflected the goal of fully adopting sustainable development approaches into the Trust's culture and all aspects of its operations. <u>BAF 858</u>: Optimisation and Development of the Electronic Patient Record (EPR) – the "risk" description had been revised to reflect the Outline Business Case (OBC) approval and the progress to procurement and to Full Business Case (FBC) delivery. **Discussion:** CC queried BAF 3536 – Trust's Ability to Recover from a Digital Incident - and stated that discussion at Performance Committee had concluded that this risk rating of 9 was too low and required to be increased. The review of the risk rating was required given what was known about recovery from cyber security, being deemed one of the most serious risks for the Trust. JA requested that this be addressed offline. BAF 1021: Potential for Major Organisational Disruption due to Cyber Breach – It was noted that 6 Business Continuity Disaster Recovery Plans remained under development, and it was questioned when these would be completed for review by the Board. AR stated that the Plans were expected to be completed by the end of March 2025. EM stated that as part of a recent Emergency Preparedness Resilience and Recovery review, there had been a deep dive on site security, with a number of areas having been identified that required addressing. HMc noted that the audit identified six areas of failure across the Trust concerned with	**AR/ KMB/JA**	**03/25**

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	the timeliness of standing back up and responsiveness. There was a programme to test the identified areas in January and February 2025. JA requested that an item be included on a future Board agenda to review the outcome of the test of the identified areas of failure, along with a Workshop session around the Trust's cybersecurity arrangements, which would provide information and assurance. The Workshop session was felt to be particularly useful for the new incoming NEDs to participate in and contribute to. JA noted the cover page of the BAF and queried the assurance evidence being up to date; assurance evidence dates required to be reviewed on all cover sheets. EM stated that an internal audit deep dive required to be implemented. In relation to BAF 678 (Waiting List Management), HMc noted that the implementation of the mitigation actions would be considered in the context of newly published documents received from the Department of Health and NHSE. This review of the Department's documents on waiting list management would be undertaken during January 2025. The Board **reviewed** and **noted** the Board Assurance Framework updates.	**HMc** **KMB**	**03/25** **03/25**
1.vii	**CEO Update**		
	The report was presented by EM, with highlights as follows: • EM welcomed TG back to the Trust and thanked SH for all her work. • The quiet period during the Christmas holidays had provided space to reflect on the positive support that the Board and colleagues within the organisation provided, for which EM was grateful. • The Staff Awards had been beautifully orchestrated, and thanks were extended to the Comms Team. • The first results of the 2024 NHS staff survey had been received, with a more detailed discussion to take place in the Part 2 Board meeting. Indications were that all was moving in the right direction, which was encouraging. • The Recruitment Team were thanked for their work around weekend recruitment events which had resulted in 31 interviews being held, with 19 offers made. 35 new starters had recently been welcomed to the organisation. • It was pleasing to note that the rates of Surgical Site Infections were moving in a positive direction, although there was still much work to do. • Financially, there had been much discussion across the NHS leadership in the past weeks, which had been noted in the report. This year's Operational Guidance was yet to be received but was understood to be imminent. Financial balance and elective recovery were being requested, without further investment, and to be achieved via productivity gains. • The Shared Care Record system had gone live, and it included primary care data, local authority data, community data, secondary care data and tertiary care data. This was developing positively, and conversations were in progress as to how to use this to maximum benefit. • Looking forward, there were significant opportunities around commercial and innovation, which were to be reflected in the development of the new strategy. • Thanks were extended to all staff throughout the organisation.		

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	Discussion: In response to CC's query around how the Shared Care Record system was being utilised, JA suggested User Case Studies would be advantageous to demonstrate how the system was being utilised. JA advised that an appropriate Patient Story would be helpful in illustrating the utilisation of the system. AR stated that demonstrations were available and noted that, for context, over 1000 users were taking advantage of the Shared Care Record which was only launched prior to Christmas. In response to AF's query around planning for 2025/26 while the Trust awaited the release of NHSE's 2025/26 Operational Planning Guidance, EM stated that the Trust's 2025/26 Corporate Objectives were already being drafted and local operational planning for next year were at an advanced stage. The Board **noted** the CEO Update.	**MS/AR**	**03/25**
1.viii	**NEDs Update**		
	Nothing was raised.		
2	**PEOPLE**		
2.i.	**Workforce Committee Chair's Report**		
	AF presented the Workforce Committee Chair's Report, with highlights as follows: The BAF was considered, and on the safer staffing BAF transfer from Quality and Safety Committee to Workforce Committee, whilst this was accepted, it was noted as "odd" to have the transfer and de-escalation undertaken simultaneously. There had been an amazing Staff Story, which concerned the Reciprocal Mentoring Programme and the associated partnerships; this had been incredibly impactful. OM provided a comprehensive Workforce Report: there was concern as to the ongoing static/deteriorating position of appraisals in some areas. A more comprehensive plan to address the deteriorating positions was ready to be implemented. High sickness rates were a concern, which remained disappointing in some areas. Education report: non-consultant doctors and how they were feeling along with their experience at RPH, was raised. A single action plan with respect to doctors was requested to be produced in lieu of the multiple numbers in existence. **Discussion:** JA noted that the highlighted areas of concern with regards the working lives and training experience of Resident Doctors, was a significant issue across the country.		

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	The Board **noted** the Workforce Committee Chair's Report.		
3	**QUALITY**		
3.i	**Quality and Risk Committee Chair's Report**		
	MB presented the Q&R Committee Chair's Report, with the highlights as follows: Surgical mortality – Increasing patient mortality was explained to be a result of rising acuity in patients. The Committee noted while the Trust previously had outstanding results in this area, that was probably no longer the case. Though there was no significant concern and no question relating to the quality of the Trust's surgeons, the Committee would take steps to identify any possible reasons for the slippage. **Discussion:** Nothing was raised. The Board **noted** the Quality and Risk Committee Chair's Report.		
3.ii	**Combined Quality Report**		
	MS and IS presented the Combined Quality Report: AF observed that there was a reflective piece of work concerning lessons learned, that would be useful to implement to understand why mortality issues had not been spotted at Board level in other hospital Trusts. Those hospitals were now undertaking deep dives as a result. The Board **noted** the Combined Quality Report.		
4	**PERFORMANCE**		
4.i	**Performance Committee Chair's Report**		
	CC presented the report on behalf of GR. • The spend on premium temporary staffing remained a concern. The Committee comprehensively reviewed the relevant metrics and have asked for details of the specific actions being implemented to improve the high level of expenditure. • CT reporting: There had been improvements in the performance of the insource supplier, after an intervention after concerns were raised about their performance. **Discussion:** In response JA's query around a decline in the occupancy rate at the Enhanced Recovery Unit (ERU), HMc stated that much work had been undertaken in December 2024 to understand the impediments to the full utilisation of the ERU's capacity. It was found that the ERU's capacity had been used to support ICU demand, so steps would be taken to ringfence ERU staff, so they were not deployed to the ICU in time of high demand. This had been viewed as a learning curve, and corrective action had been put in place.		

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	IS noted much work had been undertaken to establish the ERU's purpose and recruiting undertaken accordingly. The fact that there were less critical care beds had not been fully absorbed, and further messaging was required and would be the focus of the CDC meeting tomorrow (10 January 2025). CT Reporting: EM noted that, since the Performance Committee meeting in December 2024, the most recent information demonstrated that there had not been the fill-level over the Christmas period expected by the insourcing company. This was being escalated and possible interventions considered. The Board **noted** the Performance Committee Chair's Report.		
4.ii	**Papworth Integrated Performance Report (PIPR) – Month 08 – November 2024**		
	SH noted November's PIPR which reflected the context of winter pressures. This also reflected the high standards held at RPH. **Discussion:** MB highlighted the significant improvement in theatre capacity and performance as a result of the implementation of the Patient Flow Programme and other improvement measure. MB, however, considered prospect of a similar improvement on the number of patients on the waiting list and indications for RTT to be "bleak". This was inspite of improvements in the use of resources and an increase in the hospital's capacity. MB advised that, from the available information, the hospital could not generate the extra capacity required to move the waiting list numbers in a positive direction. MB, in reference to previous Board discussions, advised that there was the need for the Trust to use its own 'aspirational full capacity' as the benchmark for performance instead of the 2019/20 (pre-Covid) performance data which was being utilised for benchmarking purposes currently. With the 'aspirational full capacity' as the benchmark, the hospital could then more adequately assess how its patient base could be managed. MB added that with the current level pressures from patient referrals, the RTT position could not be improved inspite of the impressive Patient Flow Programme and productivity improvement measures being implemented. MB wondered how the hospital, given the limits on its capacity, could successfully manage the pressures from the increasing referrals. EM posed the question of what operations used capacity at RPH that could be undertaken elsewhere. There may be benefits to delivering some treatments originally undertaken at RPH, which had now become mainstream, closer to the patients' homes. HMc welcomed the opportunity to address MB's comments more extensively at the Performance Committee, but noted the set of external factors which made some difference in the way service was delivered. The reform in delivery at RPH and delivery of diagnostic pathway and outpatient care, among other factors, provided an opportunity for improvement. Capacity and best use was work underway at present. HMc suggested that the right questions were being asked. It was acknowledged that there was		

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	improvement in efficiency to some services at the front of the pathway and associated waiting times. CP queried observations that a significant proportion of issues with waiting concerned team delays; for example, 61% of delays in surgeries were due to internal factors. Insight was requested into these internal factors; HMc noted that these particular delays were not entirely indicative of the internal/external balance. Many of the patients at the top end of the waiting list were inherently delayed in their referrals to RPH. Whilst received at week 36, for example, these patients were never going to be compliant at 18 weeks. Access to diagnostics was another key focus for RPH going into next year. AF noted that RPH was in significant control of many issues and a trajectory of improvement had been requested previously. There was concern that patient risk and safety related to delays, although system pressures required the approach to be realistic. HMc noted that trajectory-setting was in progress. CP queried whether it would be appropriate to consider, from a strategic perspective, how unintended consequences were planned for and tracked. Snippets were being picked up intermittently at meetings, but it was felt that a more strategic oversight of unintended consequences was required. MS stated that this created a reactive situation in terms of actions required. The attitude of "just because we can, we do", was often adopted. This required consideration when looking at Critical Care. Whilst it was positive to be the one and only provider of some services, it was queried if this was the right thing and whether planning for services development in the future was being given adequate consideration. JA noted the positive vacancy rates included in the report and acknowledged the efforts of the Workforce Team. The Board **noted** the Papworth Integrated Performance Report (PIPR) Month 08 – November 2024.		
5	**RESEARCH**		
5.i	**Research & Development Q2 Update (July to September 2024/25)**		
	This item was omitted from the meeting.		
6	**GOVERNANCE & ASSURANCE**		
6.i	**Constitutional Review and Update**		
	KMB presented the update for approval, with the following highlighted: For a period of 6 months from December 2024, the following amendments were required to reflect the changes to the make-up of the Trust Board. 12.1 The Board of Directors is to include: 12.1.1.2 not more than ~~six~~ seven other Non-executive Directors who are to be appointed (and removed) by the Council of Governors in a General		

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	Meeting; 12.1.2 the ……Executive Directors (to include) 12.1.2.2 a Finance Director, a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984), a registered nurse or registered midwife, and not more than ~~two~~ three other Executive Directors, all of whom are to be appointed (and removed) by a committee consisting of the Chairman, the Chief Executive and the other Non-executive Directors **Discussion:** JA queried the wording "not more than" and suggested that clarity was required that there should always be one more NED than Executive. A caveating line was requested to be included. KMB noted that there was further work to undertake on the constitution during the coming year. The Board **approved** the Constitutional Review and Update, subject to the addition of the caveat around NED and Executive numbers discussed.		
6.ii	**Board Committee Part I Approved Minutes**		
	6.ii.a. Quality & Risk: 31.10.24, 28.11.24. **6.ii.b. Performance: 31.10.24, 28.11.24.** **6.ii.c. Workforce: 26.09.24.** The Board **noted** the Board Committee approved Part 1 minutes.		
7	**BOARD FORWARD AGENDA**		
7.i	**Board Annual Plan**		
	The Board received and **noted** the Annual Plan.		
7.ii	**Review of Actions and Items Identified for Referral to Committee/ Escalation**		
	There were no items for escalation.		
8	**ANY OTHER BUSINESS**		
	Combined Medical Director and Chief Nursing Officer report: mortality and death of a patient was raised by JA along with the observation that women with cardiovascular diseases fared less well than men with the same conditions. When looking at mortality data, it was queried whether this was broken down by gender and if different signals were being seen from what might be expected. A counter example around obstructive sleep apnoea was provided and described as "a man's disease". IS noted that because women presented with slightly different symptoms, historically there were not being diagnosed. This was reflected in the ratio of women to men referred for treatment at RPH being		

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	at 1:8. IS stated that after relevant population and mortality data was reviewed, it was understood that the ratio was about 1:2 in terms women to men who suffered from the disease. After some outreach work with the GPs, currently 55% of referrals to the hospitals were women and this was considered a significant improvement. IS stated that overall, there was a commitment to review mortality data by gender, with the hope that viable information would be gleaned for improvement actions to be undertaken. JA advised that in taking steps to be 'inclusive' in its service provision, there was the need for the focus of the hospital to be on the gender issue as well.	**IS**	**05/25**
	As there was no other business to discuss, JA closed the meeting at 10:55 hrs.		

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Signed

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Date

Royal Papworth Hospital NHS Foundation Trust
Board of Directors

Meeting held on 09 January 2025