

**Meeting of the Board of Directors  
held on 06 March 2025 at 09:00 hrs  
Heart & Lung Research Institute and  
on Microsoft Teams - Royal Papworth Hospital**

**U N C O N F I R M E D                      M I N U T E S – P a r t I**

<b>Present</b>	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
	Mr G Robert	(GR)	Non-Executive Director
	Ms A Fadero	(AF)	Non-Executive Director
	Mr D Jones	(DJ)	Non-Executive Director
	Dr C Paddison	(CP)	Non-Executive Director (Interim)
	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
	Ms S Harrison (from 10:14 hrs)	(SH)	Interim Chief Finance Officer
<b>In Attendance</b>	Mr David Jones	(DJ)	Non-Executive Director (Incoming)
	Mr K Mensa-Bonsu	(KMB)	Associate Director of Corporate Governance
	Ms A De Sousa (item 1.i)	(ADS)	Chief Nursing/AHP Informatics Officer
<b>Apologies</b>	None		
<b>Observers</b>	Ms A Halstead (AH) - Lead Governor and Public Governor (from 09:41 hrs)		
	Ms M Hotchkiss (MH) - Public Governor		
	Mrs A Atkinson (AA) - Public Governor		
	Mr J Davies (JD) - Public Governor (from 09:51 hrs)		
	Mr T McLeese (TMc) - Public Governor		
	Mr T Collins (TC) - Public Governor		
	Dr C Glazebrook (CG) - Public Governor		
	Ms L Williams (LW) - Staff Governor		
	Ms J McClean (JMc) - Staff Governor		
	Mr R Hurst (RH) - Staff Governor		
	Dr H Perkins (HP) - Public Governor		
	Mr C McCorquodale (CMc) - Staff Governor		

Agenda Item		Action by Whom	Date
1	<b>WELCOME, APOLOGIES AND OPENING REMARKS</b>		
	<p>JA welcomed everyone to the meeting.</p> <p>There were no apologies.</p> <p>DJ was introduced as an incoming Non-Executive Director (NED). His position as Group Director at the London Stock Exchange Group and his background in IT and Cyber Security was noted. DJ would join the Trust Board from 01 April 2025.</p> <p>MB, who was retiring from the Trust Board on 31 March 2025, was thanked for his significant input and contributions to the Board's operations and to the Trust over the last six years.</p>		
1.i	<b>Patient Story</b>		
	<p>JA welcomed ADS to the meeting. MS provided relevant context to the Board, and ADS presented three examples of the positive impact of the Cambridgeshire and Peterborough Shared Care Record on patient services and patient experience since it went live in December 2024. It was noted that at the present time, there was no patient portal, meaning that RPH staff could view patients' Shared Care Records, but patients could not yet do so.</p> <p>ADS reported that:</p> <p>One example was a Cystic Fibrosis (CF) patient whose email address was not recorded on the Trust's internal patients' records system. The patient asked Trust staff to access their email address from the Shared Care Record, upon which the Trust was able to forward a GP's letter and a leaflet with relevant information to the patient via email. This was an example of patient ownership of the Shared Care Record and its usefulness in such circumstances, should details not be evident on the internal patients' records system.</p> <p>For the second example, information from the social care aspects of the Shared Care Record had provided an opportunity for an appropriate, sensitive and speedy approach to be applied to the transitioning process for a patient who was transitioning from paediatric to the adult dietetic service. The information gleaned from the Shared Care Record was related to the patient's sibling who had undergone a similar transitioning process in the past and came from the same background and had the same challenges. This had saved clinical time and significantly improved the patient's experience of the process.</p> <p>For the third example, the patient had during a virtual clinic with a consultant and clinical staff, enquired about the progress of a speech and language referral made by the Trust. This would normally have been passed to specialist nurses to investigate, via the consultant. Instead, an authorised member of clinical staff was able to access the patient's Shared Care Record and inform the patient that the referral had been progressed, and that a letter from the Cambridgeshire and Peterborough NHS Foundation Trust's Community Service was in the post to them. The ability to access his information had saved some consultant and nurse time and assisted in the joined-up care agenda.</p>		

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	<p><b>Discussion:</b> JA thanked ADS for her presentation.</p> <p>DL queried why postal letters were still being sent to patients. ADS explained that some patients did not have email addresses and had stipulated they wished to receive hard-copy letters. ADS noted that arrangements needed to be tailored to patients' needs and circumstances but with sustainability in mind.</p> <p>AR commended ADS for the work being undertaken and highlighted the change in the organisation due to the Shared Care Record, which would improve going forward as the system developed further.</p> <p>AF queried how the benefits of the Shared Care Record could be relayed to other staff groups. ADS explained that briefings had been held, as well as the joining of trolley rounds to relay the benefits of the system, which had yielded positive results. ADS stated that, when the Shared Care Record went live in CUH, the accrued benefit would even be more significant.</p> <p>CP referred to data privacy and safeguarding and questioned, firstly, whether access to the patient care record was restricted so staff members, who were not part of the care team for a particular patient, could not access the patient's information. Secondly, CP wished to know if there was provision for a digital fingerprint to evidence which part of the record had been accessed, and by whom. ADS responded that there had been delays in releasing data between December 2024 and January 2025 due to the extent of the checks being undertaken to ensure that information being released was appropriate. In respect of role profiling, there were both clinical and administrative roles, with the necessary level of access. In addition, should any breach of access become evident, full details of that access could be established, reported upon and investigated by the Informatics Team. A digital footprint linked the information that had been accessed, when and by whom.</p> <p>CC queried how the Shared Care Record system worked for patients outside the Cambridge area. AR advised that discussions were underway at the regional level around steps to develop the system further.</p> <p>JA noted the reliance on digital fingerprints, highlighting that there was no option for this in relation to the use of paper records. The Shared Care Record system offered greater opportunity for monitoring such issues.</p> <p>The Board <b>noted</b> the Patient Story.</p>		
1.ii	<b>Declarations of Interest</b>		
	There was a requirement that Board members raise any specific declarations if these arose during discussions. None were raised.		
1.iii	<b>Minutes of Previous Meetings</b>		
	The Board of Directors <b>approved</b> the minutes of the Part I of the Board meeting held on 09 January 2025 as a true and accurate record of the meeting, subject to the revisions below being completed:		

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	<p>Paragraph 3.i – The paragraph, “The Committee noted while the Trust previously had outstanding results in this area, that was <b>probably</b> 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”, should be revised to:</p> <p>“The Committee noted while the Trust previously had outstanding results in this area, that was <b>possibly</b> 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 <b>if there is found to be any</b> slippage.</p> <p>Paragraph 4.ii, line 4: “MB added that with the current level pressures from patient referrals, the RTT position could not be improved in spite 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”, should be revised to:</p> <p>“MB <b>asked if</b>, with the current level <b>of</b> pressure from patient referrals, the RTT position could be <b>sufficiently improved</b>, even by the impressive Patient Flow Programme and productivity improvement measures <b>now</b> being implemented. MB wondered how the hospital, given the limits on its capacity, could successfully manage the pressures from the increasing referrals”.</p>		
1.iv	<b>Matters Arising from the Minutes/Action Checklist</b>		
	<p><b>02/25 – 7/11/24 – 2.ii Guardian of Safe Working Report Quarterly Report - June to September 2024.</b>  “MS/IS to liaise further regarding exception reports related to patient safety, to ensure these are being captured and fed through normal investigative channels”.</p> <p>IS provided background to the action, noting improvements in reporting as a result of the new Guardian of Safe Working and his interaction with the resident doctors. IS noted that no patient safety related events had been reported in the last two quarters, adding that the level of interaction with the resident doctors provided the Trust with the assurance that no such incident had occurred.</p> <p>MS had been involved in a triangulation exercise from which it had been evident that the Datix system was being used for all patient safety issues, irrespective of their reason. To be <b>CLOSED</b>.</p> <p><b>04/25 – 09/01/25 – 1.vi Board Assurance Framework</b>  “BAF 1021: Potential for Major Organisational Disruption due to Cyber Breach – Re 6 Incomplete Business Continuity Disaster Recovery Plans. Report on the EPRR programme to test 6 areas of the hospital site in January and February 2025, on their ‘timeliness of standing back up and responsiveness’ in case of an incident”.</p> <p>This action had been completed. To be <b>CLOSED</b>.</p> <p><b>06/25 – 09/01/25 – 1.vi Board Assurance Framework</b>  “BAF 1021: Potential for Major Organisational Disruption due to Cyber Breach. To arrange a Workshop session around the Trust’s cyber security arrangements”.</p> <p>EM advised that preventative work continued, but stress-testing of response was</p>		

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	<p>required. A tabletop exercise was planned for 12 March 2025, at which this would be explored; it was acknowledged that further work would be required as a result. A Workshop would be organised after all relevant actions related to the tabletop exercise had been developed. <b>OPEN</b></p> <p><b>07/25 – 09/01/25 – 1.vii CEO Update</b>  “Shared Care Record – To arrange a Patient Story which would illustrate the utilisation of the system since its launch in December 2024”.</p> <p>The Shared Care Record had been the subject of the Patient Story at today’s Board. To be <b>CLOSED</b>.</p> <p>The Board <b>noted</b> the Matters Arising and Action List.</p>		
<b>1.v</b>	<b>Chair’s Report</b>		
	<p>JA reported the following:</p> <ul style="list-style-type: none"> <li>• The Nexus team was congratulated for the Electronic Patient Record (EPR) Investment Board (EPRIB) approval of the EPR Outline Business Case (OBC), for which high-quality feedback had been received.</li> <li>• JA, EM, and TG had met with the Thoracic Lung Transplantation Team to consider the latest pioneering lung perfusion technology, which had proved immensely helpful. It had been noted that the median wait time for a lung transplant at RPH was circa.240 days, compared to 580 days at other hospitals.</li> <li>• EM added that the Transplant Team’s ambition was to establish how this technology could assist in making donor lungs more available in other areas, which would assist in addressing health inequalities.</li> </ul> <p><b>Discussion:</b>  IS noted that when charity funding had been sought to support the Transplant Team’s activities, the issue of the collection of outcomes data had also been raised. This was to ensure that there was adequate evidence of no harm being done to transplant patients.</p> <p>EM advised that the Transplant Team collated up-to-date outcomes data. EM added that outcomes data from all transplant centres were also collated by NHS Blood and Transplant (NHSBT) and information to validate internal data or assess performance was received from that organisation.</p> <p>The Board <b>noted</b> the Chair’s report.</p>		
<b>1.vi</b>	<b>Board Assurance Framework (BAF)</b>		
	<p>JA noted that the Executive Team had begun a comprehensive review of the BAF and added that the Non-Executive Directors (NEDs) had met on 02 March 2025 to discuss how best to use the BAF to focus on items of concern. JA stated that the main suggestion from the NEDs had been to consider the BAF less frequently, potentially every three months, but in more detail.</p> <p>EM stated that Executive development time had been spent on a deep dive into the BAF, for which a whole-scale refresh had been proposed. Colleagues were advised it</p>		

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	<p>may take up to two months to complete this task and NED colleagues were requested to contribute.</p> <p>The Board <b>noted</b> the Board Assurance Framework (BAF).</p>		
<b>1.vii</b>	<b>CEO Update</b>		
	<p>EM presented the CEO Update:</p> <ul style="list-style-type: none"> <li>• Gratitude was extended to MB for his valuable input to the Board over the last six years.</li> <li>• Key leadership changes were noted to be: <ul style="list-style-type: none"> <li>○ Dr Penny Dash had been announced as the government's preferred candidate to become Chair of NHS England (NHSE).</li> <li>○ Amanda Pritchard, CEO of NHSE, had announced plans to step down from the role at the end of March 2025. This would be covered by Sir Jim Mackey whilst a permanent replacement was sought.</li> <li>○ Sir Mike Richards had been selected as the preferred candidate to Chair the Care Quality Commission.</li> </ul> </li> <li>• The NHS had been focusing on completing the current round of operational planning, following the publication of 2025/26 Operational Planning Guidance at the end of January 2025. This was proving to be one of the most challenging planning rounds, not least because of the exceptionally tight timeline to complete it. EM stated that there were difficulties because NHS providers were also being challenged to reduce patient waiting times and lists by treating more patients within the limited resources they currently had.</li> <li>• EM advised that based on the challenge to improve patient waiting times, there had been candid conversations with the leadership team at RPH both to manage expectation in terms of the available resources for 2025/26 and to make the need for improvements very clear. EM stated that the target was to improve the Referral To Treatment (RTT) rate back to 80%, and ultimately to achieve the NHSE standard of 92%.</li> <li>• EM advised that all stakeholders had engaged positively with the various aspects of the corporate Strategy development process.</li> <li>• The Trust's latest recruitment event, held at the start of February 2025, had been another success, with 38 interviews held and 18 offers made.</li> <li>• On 13 February 2025, teams from the School of Medicine at the University of Cambridge, and the East of England NHS Deanery, had been welcomed for separate quality assurance visits. The visiting teams had fed back on how impressed they were with the quality and experience of teaching provided to undergraduate medical students and resident doctors at RPH. EM extended thanks to the Clinical Education team involved in preparing for both visits and to everyone who contributed to the experience of RPH's learners.</li> <li>• A visit from the Eastern Physiological Science Network on 29 January 2025 was highlighted as having been both productive and successful.</li> </ul>		

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	<ul style="list-style-type: none"> <li>• Congratulations were extended to Zoe Robinson who has been appointed as the Trust's new Deputy Chief Operating Officer (DCOO), working with HMc as COO. Zoe was currently the Divisional Director of Operations - Thoracic and Ambulatory Care</li> <li>• As referred previously to by JA, on 26 February 2025, RPH's outline business case (OBC) for the new EPR had been fully endorsed and approved by NHS England's EPR Investment Board (EPRIB); thanks were extended to all involved for what was noted to be an exemplary application.</li> <li>• In early March 2025, RPH teams had successfully discharged home their first patient on the same day as their transcatheter aortic valve implant (TAVI) procedure was undertaken. With due consideration to the complexity and frailty of the patients who have to undergo this procedure, this was noted to be an outstanding achievement.</li> <li>• The Transplant Team had also recently undertaken 36 hours of continuous retrieval work including support for a transplant for a paediatric patient at Great Ormond St hospital in London. The Team had been able to call on people who were not supposed to be at work in order to deliver on the work.</li> </ul> <p><b>Discussion:</b></p> <p>JA advised that Professor Aiden Fowler, the National Director of Patient Safety at NHSE, had been seconded to the role of Interim Chief Inspector of Healthcare covering Secondary and Specialist Care and Primary and Community Care. Professor Ramani Moonesinghe would act up as National Director of Patient Safety for a period of six months in his stead.</p> <p>MB referred to communication around productivity and the extent of the task to be undertaken in this regard, noting widespread misconceptions as what the term productivity meant within the organisation. MB continued that there was a need for the concept of 'humane productivity' to be established in the Trust, and Trust-wide engagement was required in order to make the necessary progress.</p> <p>EM considered that the term productivity required to be translated into what it would mean to RPH, which would be different in different contexts. The Line Managers' briefing had been used as a forum at which to explain the challenges, and the All-Staff Briefing on 10 March 2025 would be led by EM, to raise the issue on a broader scale.</p> <p>AF echoed MB's sentiments and asked EM whether the Secretary of State for Health and Social Care's new Delivery Unit could be explained in terms of how this might assist the Trust. EM relayed her understanding to be a reduction in the gap between the Department of Health and Social Care, and local delivery. This had been evident through the oversight frameworks and in the recent announcement around the role of integrated care systems being involved in the strategic commissioning. EM noted that it would be necessary to understand new ways of working, engage with these and adapt, adding the discussions around productivity had been underway for some time and progression was now required.</p> <p>The Board <b>noted</b> the CEO's report.</p>		

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1.viii	<b>NED Update</b>		
	JA had met with John O'Brien, Chair of NHS Cambridgeshire and Peterborough ICB by way of regular catch-up. JA highlighted the importance of such engagements with external stakeholders.		
2	<b>STRATEGIC DEVELOPMENTS</b>		
2.i	<b>2025/26 Corporate Objectives</b>		
	<p>EM presented the 2025/26 Corporate Objectives:</p> <ul style="list-style-type: none"> <li>This was noted to be the final version of the document and reflected the feedback received from stakeholders. The objectives had been themed into three groups as follows: <ul style="list-style-type: none"> <li>Develop our culture so that it is inclusive with our people feeling a strong sense of belonging.</li> <li>Get the basics right and deliver our commitments to the Operating Plan Guidance 2025-26.</li> <li>Optimise our added value through progression of our strategic objectives.</li> </ul> </li> </ul> <p><b>Discussion:</b></p> <p>CC considered that how success was measured could be written to be more specific. EM responded that she had not wanted to replicate the milestones detailed in the Workforce Plan. JA highlighted that the column on how progress would be measured had noted that these relevant improvements had been agreed in the Workforce Plan.</p> <p>DL referred to objective 3 regarding 'added value' and noted that one of the measures of success around research and innovation was the achievement of a Clinical Research Facility (CRF) delivery plan in year 2. DL was of the view that this was a multi-year plan and reference to year 2 should be removed. EM considered that this was a specific ask for the coming year within the CRF plan but would look at re-wording.</p> <p>In response to AF's query around whether the Corporate Objectives were linked to the Trust's Strategic Objectives, EM confirmed that this was the case, references to the linkage were woven through the document. AF highlighted the need for this to be made explicit and suggested a statement be included that these were enablers to the delivery of the Trust's Strategic Objectives.</p> <p>JA concluded that this could be reflected under 'Purpose' on the front-sheet, to state that the "The purpose of this paper is to present a final draft of proposed Corporate Objectives for 2025/26 for the Board to review and approve. This will be the delivery vehicle for the Trust's Strategic Objectives".</p> <p>Subject to the above amendments, the Board <b>ratified</b> and <b>agreed</b> the 2025/26 Corporate Objectives.</p>	<p><b>EM</b></p> <p><b>EM</b></p>	<p><b>05/25</b></p> <p><b>05/25</b></p>



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<b>3</b>	<b>PEOPLE</b>		
<b>3.i</b>	<b>Workforce Committee Chair's Report</b>		
	<p>AF presented the Workforce Committee Chair's Report.</p> <p>AF reported that:</p> <ul style="list-style-type: none"> <li>• A new stage in the staff appraisal process, the pre-appraisal assessment, had been developed. The new stage was introduced to the Committee, receiving overwhelming support. It provided an approach which would benefit both the individual being appraised and the manager appraising the individual and would help them to prepare for a meaningful conversation at appraisal.</li> <li>• The Committee considered the Modern Slavery Statement and discussed assurance that supply chains were compliant. The Director of Finance had commented that this was complex and that because most of RPH's supplies came through the NHS supply chain, this was more likely to be a source of assurance. The Statement was recommended for approval to the Board.</li> <li>• The Workforce Committee Self-assessment was received by the Committee and was reviewed for areas of improvement and development.</li> </ul> <p>The Board <b>noted</b> the Workforce Committee Chair's Report.</p>		
<b>4</b>	<b>QUALITY</b>		
<b>4.i</b>	<b>Quality and Risk Committee (Q&amp;R) Chair's Report</b>		
	<p>MB presented the Quality and Risk Committee Chair's Report.</p> <p>MB noted that:</p> <ul style="list-style-type: none"> <li>• There had been a recent shift in the thinking of how the risk of harm to patients on waiting lists could be managed. MB noted that previously the focus had been on individual patients and the harm that came to them because of their being on a waiting list. This required the utilisation of resources to follow up on individual patients by phone calls to ascertain any developments related to their conditions while they waited for treatment to be undertaken on them.</li> <li>• The shift in thinking related to how harm could be assessed across whole categories of patients, or whole patient pathways, in order to identify those for whom the risks of waiting appeared to be greatest because of their particular conditions. rather than trying to assess individuals. MB advised that to progress with this shift in thinking would require a significant shift in resources.</li> </ul> <p><b>Discussion:</b></p> <p>MS advised that, 'post event', the hospitals always picked up any issues in terms of whether any harm came to a patient whilst on the waiting list. The hospital had the appropriate systems and processes to collate the information on any harm to all the patients who had been on the waiting list for a while.</p> <p>MB advised that, if the shift to focusing on higher risk patient categories was implemented, it would be important to utilise all tools to safeguard against other less</p>		

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	<p>risky patients or patient categories on waiting lists being missed out. MB stated that a shift to thinking of patients in categories instead of as individuals was the right way to go, in his view.</p> <p>JA expressed concern around disadvantaging certain groups using this method. MB considered it to be more a matter of being aware of enhanced risks to a particular group. HMc noted that, though the reduction of waiting list numbers was the key reason for this mooted initiative, there was a potential risk that the access of patients could be negatively impacted.</p> <p>TG highlighted the challenges of the number of the patients requiring to be moved through the system, and the need for Quality Impact Assessment (QIA) assessments to be undertaken. TG stated that a conscious decision would need to be made regarding how the two relative risks of reducing the waiting lists versus prioritisation of categories could be safely balanced and managed.</p> <p>AF stated that the effective management of the risk of harm to patients on waiting lists was an important area of concern for the Quality Committee and suggested that there was the urgent need for a methodology to progress with this complex issue.</p> <p>JA questioned how the decision around the prioritisation of categories would be undertaken and queried how comprehensive the assessment of harm would be. HMc advised that the current process for contacting patients on waiting lists required significant resources. HMc stated that was not just a matter of bandwidth of how this harm was determined clinically, but also the practical feasibility of contacting 7,500 patients every 12 weeks.</p> <p>DL questioned whether psychological harm to patients was being increased by the regular telephone calls which may be anticipated by patients as progress up the waiting list, rather than an enquiry around whether treatment was still required. HMc could not comment on individual impact, but as patients were contacted, the provision of the needed treatment was being progressed.</p> <p>JA referred to a meeting he had attended with IS, at which an innovation created by a physiotherapist had been based on identification of a 'red flag' symptoms approach. JA questioned the extent to which patients should be contacting the Trust, should they experience such events. HMc responded that this was an area of work which required further scrutiny and noted that there were strategic choices which could be made, which would require quality and safety assessment to be undertaken, but which could reduce the risk of harm to the patients on waiting lists.</p> <p>AR highlighted available solutions such as going live with an information system known as Performance of Routine Information System Management or PRISM, which was under discussion at the Digital Strategy Board. In addition, the Patient Portal rollout would assist with the validation elements of the prioritisation initiative under discussion. AR also referred to current collaboration with a company who could develop tools to integrate with RPH's digital infrastructure. AR advised that these different digital elements could assist with resolving the waiting list issues referred to and should be considered in the discussions being undertaken.</p> <p>In response to JA's query around how the category prioritisation process would be undertaken, MS stated that 'waiting lists and reducing harm for those waiting' was a Quality Priority for 2025/26. In view of this, there would be work to scope the waiting</p>		

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	<p>lists and to develop the methodologies for determining how patients could be safely categorised. JA was of the view that the discussions of the prioritisation issue should return to Board for review rather than being the responsibility of one Board Committee.</p> <p>JA enquired of MB whether the Committee had been content with the assurances in respect of the BAF. MB explained that there had only been one significant risk, regarding infections, with a risk of 16 and a target of 8, which it was suggested should perhaps be trended down as progress trended down. The Committee had, however, been content with the assurances in relation to the BAF.</p> <p>EM relayed that at the Executive Team's review of the BAF in February 2025, the agreed view was that the current focus on quality in the infection control area alone was too narrow. As such the new version of the BAF would have a broader quality risk which would include other feeder risks as well as infection control, which would result in the overall BAF risk score being less sensitive to the movements of the individual components.</p> <p>The Board <b>noted</b> the Quality and Risk Committee (Q&amp;R) Chair's Report.</p>		
<b>4.ii</b>	<b>Combined Quality Report</b>		
	<p>MS introduced the Combined Quality Report.</p> <p>The Board <b>noted</b> the Combined Quality Report.</p>		
<b>5</b>	<b>PERFORMANCE</b>		
<b>5.i</b>	<b>Performance Committee Chair's Reports</b>		
	<p>GR presented the Performance Committee Chair's Reports and highlighted the following:</p> <ul style="list-style-type: none"> <li>• It had been recognised that there were signs that the status of day-to-day activity, effectiveness and productivity was positive, but backlog remained a concern.</li> <li>• A presentation on the new programme around elective care priorities had been well received and extensive discussion had ensued further to its delivery.</li> <li>• In respect of CT reporting, this had suffered a deterioration due to a fall in performance by RPH's insource supplier. The Committee was therefore pleased to see a medium-term plan to achieve sustainable improvement not dependent on a single insource supplier. This would involve improving digital capacity to make images available outside RPH, enabling the Trust to take advantage of the much wider pool of external capacity.</li> </ul> <p><b>Discussion:</b></p> <p>MB, in reference to the Patient Safety Initiatives being implemented to improve on the RTT position, enquired if any improvements would be sustainable. HMc advised that though the assurance on sustainability was currently unclear, there was the need for different approaches to be applied to help clear the backlog. HMc stated that while some services would be able to sustain improvements post-intervention, some were unknown, and others could not sustain any improvements. HMc stated that where there was a chance of improvement regressing, there was the need for consideration</p>		

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	<p>to be made in respect of further support for the relevant teams.</p> <p>AF stressed that assurance was needed to ensure this work aligned to job, workforce and operational planning. Any choices needed to take into account ideas identified by the various Divisions, and the consequences of not pursuing those.</p> <p>In response to a question from CP raising concern about the work being taken forward and sustained in the longer-term, HMc was able to offer assurance that a continuous improvement methodology would be utilised throughout, to ensure any embedded changes became how work was undertaken going forward. Digital input into that would include current thinking in relation to work on referral management and 'new to follow-up ratio management.'</p> <p>The Board <b>noted</b> the Performance Committee Chair's Report.</p>		
<b>5.ii</b>	<b>Papworth Integrated Performance Report (PIPR) – Month 10 – January 2025</b>		
	<p>SH presented the PIPR (Month 10 – January 2025). It was noted that:</p> <ul style="list-style-type: none"> <li>• An overall Trust rating of amber was a positive shift from December's rating.</li> <li>• Within safe and caring domains, thought was being given to the sensitivities around the metrics to ensure these depicted a genuine reflection of patient experience in these domains.</li> <li>• The effective and responsive sections were noted to have been affected by winter issues with increase in non-elective pathways, and the resulting effect on aspects of flow.</li> </ul> <p><b>Discussion:</b></p> <p>IS referred to CT reporting, noting an improved position but expressing concern at high numbers of waiting patients, which were still evident.</p> <p>JA also wished to question, of those patients waiting longer, what grip there was in respect of harm as a result of the delay. IS advised that there were reports on unexpected findings, but these had been few in number. IS noted that the CT scanning system had worked very well for patients until the current crisis with the external service provision. IS added that the aim was resolve the problem with the service provision and return to that position where patients were not waiting for long periods for scans to be undertaken on them.</p> <p>HMc advised that as part of the new specification for the outsourcing work and long-term commitment to the CT Department's recruitment and retention, the service specification would be set to reflect the previous timescales. Work was ongoing and updates would be provided at different forums, but it was confirmed that four weeks for return of diagnostic reports would not be the timeline going forward.</p> <p>EM confirmed that via her role as Chair of the System Diagnostic Board, there had been recognition that cardiac imaging constituted a particular problem that providers could not address. Imaging reporting and image acquisition activity had therefore been taken from Northwest Anglia NHS Foundation Trust (NWAFT) for the last three to four months by way of support. Specific workstreams had been commissioned to look at cross-system approaches to address issues of cardiac imaging, echocardiogram, and</p>		

Agenda Item		Action by Whom	Date
	<p>audiology.</p> <p>JA acknowledged and extended thanks to all for the positive elements of the PIPR, including Supervisory Sister time, the management of venous thromboembolism (VTE), a reduction in the workforce vacancy rate and turnover figures and the appointment of a consultant in diabetes</p> <p>The Board <b>noted</b> the Papworth Integrated Performance Report (PIPR) – Month 10 – January 2025.</p>		
<b>6</b>	<b>AUDIT</b>		
<b>6.i</b>	<b>Audit Committee Chair's Report</b>		
	<p>CC presented the Audit Committee Chair's Report:</p> <p>CC noted the following:</p> <ul style="list-style-type: none"> <li>• DPST and Role of Audit Committee: This year, NHS England had introduced a new approach that aligned the Data Security and Protection Toolkit with the Cyber Assessment Framework (CAF). The new CAF-aligned DSPT approach required increased scrutiny by Audit Committees and senior management on cyber risk management. Regular reporting and a clear understanding of cyber risks would be essential. The Audit Committee's role included: <ul style="list-style-type: none"> <li>○ receipt of regular updates from management on DSPT compliance;</li> <li>○ review of periodic reports on cyber security risk assessments and mitigation strategies;</li> <li>○ oversight of the allocation of resources for cyber security and to ensure that there was adequate funding for compliance.</li> <li>○ to encourage ongoing staff training and awareness programmes to enhance the organisation's security culture; and</li> <li>○ to recommend a formal review of the organisation's cyber security policies to ensure alignment with the CAF-aligned DSPT approach.</li> </ul> </li> <li>• As a result, DPST would be a standing agenda item for the committee.</li> </ul> <p><b>Discussion:</b></p> <p>GR questioned how it was possible to ensure the way cyber security was reviewed was consistent. CC advised that the DSPT fell under the ambit of the Audit Committee, and this would receive primary monitoring. Everything under cyber security coming to the Performance Committee should enable the DSPT to become more positive.</p> <p>AF queried waivers, how many were received and any concerns around volume. CC responded that a significant number had been received historically, but this number had reduced in the recent past. CC note that though the numbers had increased slightly, but this was not considered to be a cause for concern. A report received by the Audit Committee noting the detail of all waivers received, offered broad assurance in this regard.</p> <p>The Board <b>noted</b> the Audit Committee Chair's Report.</p>		

Agenda Item		Action by Whom	Date
<b>7</b>	<b>GOVERNANCE &amp; ASSURANCE</b>		
<b>7.i</b>	<b>Corporate Governance Documents:</b> <b>a. DN142 Standing Orders</b> <b>b. DN140 Standing Financial Instructions</b> <b>c. DN137 Scheme of Delegation</b>		
	<p>SH introduced the Corporate Governance Documents which were presented for approval.</p> <p>JA referred to page 5 of DN137 where this stated “The CFO is authorised to delegate <b>his</b> approval levels” and suggested this be changed to reflect <b>his/her</b> approval levels.</p> <p>The Board <b>ratified</b> and <b>approved</b> the Corporate Governance Documents.</p>	<b>SH</b>	<b>05/25</b>
<b>7.ii</b>	<b>Board Self-Assessment</b>		
	<p>JA introduced the Board Self-Assessment.</p> <p>JA observed issues relating to committee composition, workload and membership and suggested that to formalise discussion around these points a deliberate Part 2 item be scheduled every six months to ensure all were addressed.</p> <p>Prior to the next iteration of the document, JA was of the view that the questions within the self-assessment should be reconsidered, to ensure all were useful and relevant.</p> <p>TG and JA suggested that the question be asked “over the course of the last year, were there any issues you would have addressed sooner?” Themes could then be considered. AF suggested that this also featured as part of the Board review.</p> <p>The Board <b>approved</b> the Board Self-Assessment.</p>	<b>KMB</b>	<b>05/25</b>
<b>7.iii</b>	<b>Board Committee Self-Assessment Reports</b> <b>a. Audit Committee</b> <b>b. Quality and Risk Committee</b> <b>c. Performance Committee</b> <b>d. Strategic Projects Committee</b> <b>e. Workforce Committee</b>		
	The Board <b>was assured by</b> the Board Committee Self-Assessment Reports.		
<b>7.iv</b>	<b>Board Committee Approval Part 1 Minutes</b>		
	<b>a. Audit Committee: 17.10.24; 26.11.24</b> <b>b. Quality &amp; Risk: 19.12.24; 30.01.25</b> <b>c. Performance: 19.12.24; 30.01.25</b> <b>d. Workforce: 28.11.24</b>		
	The Board <b>noted</b> the Board Committee Approval Part 1 minutes.		

Agenda Item		Action by Whom	Date
<b>7.v</b>	<b>Guardian of Safe Working Hours – October to December 2024 - (Reviewed at the January 2025 Private/Part 2 Board Meeting)</b>		
	The Board <b>noted</b> the Guardian of Safe Working Hours – October to December 2024.		
<b>8</b>	<b>BOARD FORWARD PLAN</b>		
<b>8.i</b>	<b>Board Forward Plan</b>		
	CC noted an Audit Committee meeting in May 2025, which required to be added to the Forward Plan.  The Board <b>noted</b> the Forward Plan.	<b>KMB</b>	<b>05/25</b>
<b>8.ii</b>	<b>Review of Actions and Items Identified for Referral to Committee/Escalation</b>		
	MS/HMc would take forward the proposal around categorisation of pathways in respect of harm. This would be brought back to Board from the Quality Committee.	<b>HMc/MS</b>	<b>07/25</b>
<b>9</b>	<b>ANY OTHER BUSINESS</b>		
	EM highlighted that a section for questions from the public should feature on the agenda, and this would be added, going forward.  OM advised that National Staff Survey data would be published on 13 March 2025.  There was no other business, and the meeting closed at 11.01 hrs.	<b>KMB</b>	<b>05/25</b>

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Signed

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Date

**Royal Papworth Hospital NHS Foundation Trust  
Board of Directors**

Meeting held on 06 March 2025