Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Royal Papworth Hospital NHS Foundation Trust
03 July 2025 at 09:00 am – 10:40 am
Heart and Lung Research Institute
and Microsoft Teams

U N C O N F I R M E D M I N U T E S – Part I

Present	Dr J Ahluwalia	(JA)	Chair
	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 (MS Teams)
	Mr D Jones	(DJ)	Non-Executive Director
	Dr C Paddison	(CP)	Non-Executive Director (Interim)
	Professor I Wilkinson	(IW)	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 (MS Teams)
	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
In Attendance	Mr S Rackley	(SR)	Director of Estates and Facilities
	Mr K Mensa-Bonsu	(KMB)	Associate Director of Corporate Governance
	Mr G Matenga	(GM)	Corporate Governance Lead
Observers	Ms M Hotchkiss (MH) – Public Governor		
	Mr B Davidson (BD) – Public Governor		
	Mr T Collins (TC) – Public Governor		
	Dr C Glazebrook (CG) – Public Governor		
	Ms L Howe (LH) – Public Governor		
	Mrs A Atkinson (AA) – Public Governor		
	Ms L Williams (LW) – Staff Governor		
	Ms J McClean (JMc) – Staff Governor		
	Dr Susan Bullivant (SBu) – Public Governor		
	Ms Noreen Daly – MSc Student, Anglia Ruskin University (ARA)		
	Ms Simone Cooke – MSc Student, ARA		
	Ms Akua Adofo-Kissi – MSc Student, ARA		
	Ms Aprille Robb – MSc Student, ARA		
	Mr James Rycraft – MSc Student, ARA		

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1	**WELCOME, APOLOGIES AND OPENING ITEMS**		
	JA welcomed everyone including SR joining the meeting for the Green Plan 2025 – 2027 (Item 4.i) and 5 Anglian Ruskin students who were observing the meeting as part of their MSc courses. There were no apologies.		
1.i	**Declarations of Interest**		
	There were no new declarations of interest.		
1.ii	**Minutes of Previous Meeting on 05.06.2025**		
	GR commented that the wording of the minutes in respect of the Freedom to Speak item did not reflect the level of challenge that was made during the meeting. The Board agreed to include, as a concluding paragraph, this line: *'GR highlighted his concern that the proportion of people who would speak up again is going down'*. The Board of Directors **approved** the minutes of the Part II Trust Board subject to a change in the wording at the Freedom to Speak section.		
1.iii	**Matters Arising from the Minutes/Action Checklist**		
	17/25 – 01/05/25 – 2.iv Staff Survey Results "On the issue of 'physical violence' to give further consideration of the reasons for the scores on the relevant survey questions (with due regard the different perceptions and interpretations of the term "violence")". OM stated that the Workforce Team had undertaken an exercise, to understand whether there were actual cases of staff inflicting 'physical violence and aggression' on other members of staff as the staff survey results seemed to indicate. The Team, during the exercise, had triangulated information from different data sources, and found behaviour that was described as bullying or emotional abuse or inappropriate emails or inappropriate dealings with each other. The Team had found only one case of physical violence during the exercise, and this case was under investigation. OM advised that the Team was assessing ways of revising the staff survey questions related to intra-staff relations so that respondents could provide responses which reflected reality. To provide assurance, the Workforce Team had not found any evidence of there being more than one case of physical violence occurring between members of staff. To be **CLOSED**. The Board **noted** the Matters Arising and Action List.		
1.iv	**Board Assurance Framework (BAF)**		
	KMB presented the Board Assurance Framework for the month of June 2025. **Report:** KMB reported that the Workforce Committee meeting in May 2025 had agreed to reduce the current risk rating for BAF Risk 1853 (Staff turnover in excess of our target level) from 15 (C5 x L3) to 12 (C4 x L3). The Committee agreed to the		

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	reduction due to the improved ability of the Trust to recruit to fill vacancies that arose, thereby reducing the consequence/impact of turnover. **Discussion:** a. CP, with reference BAF Risk 3536 (Trust's ability to recover from a digital incident), queried whether the issue of 'cultural de-prioritisation of business continuity planning' in the Trust was an intentional or unintentional action. As the issue had been highlighted in his Performance Committee Chair's report, GR responded and advised that the Committee had been assured that the cultural issue had been addressed. GR added that this issue had been identified as the reason for the previous lack of progress in the Trust's emergency preparedness, resilience and response (EPRR) action plan. The Performance Committee could see the progress made in the current EPRR improvement action plan. b. In response to GR's query around the accuracy of the Assurance Map, which was attached to the agenda, CC advised that Audit Committee had a plan to review an updated version of the Map in January 2026. The Assurance Map would be updated when the revision of the BAF was completed. c. EM stated that the Executive Team had undertaken further developmental work on the draft BAF risk since it was last reviewed at the Board. EM stated that the Executives had completed the drafting and the articulation of the new individual risks and had updated the lines of defence for the individual risks which would be used to populate a new Assurance Map. EM noted that steps were being taken to organise a developmental session on BAFs, along with a plan to submit the updated draft BAF for Board review in September 2025. d. JA observed that the progress notes for BAF Risks 678 (Waiting List Management) and 3223 (Activity Recovery and Productivity) were the same. HMc stated that this was because the Operations Team utilised the governance of the Elective Access Recovery Programme to address both risks. HMc added that these two BAF risks would be merged in the updated draft BAF. e. JA noted that the last Internal Audit review of the BAF was undertaken in 2018 and queried if another would be undertaken when the new updated BAF was approved and operational. EM agreed that an audit review of the new BAF needed to be undertaken by the Internal Auditors in 2026/27. The Board **noted** the Board Assurance Framework update.	**HMc** **EM/LS**	**09/25** **12/25**
1.v	**CEO Update**		
	EM presented the CEO update **Report:** a. EM updated the Board about the charity-funded BBQ organised for staff on 02 July 2025. The event was a collaboration between the RPH's Hospital Charity and Addenbrooke's Charitable Trust to celebrate their 30th birthdays and provided evidence of the RPH Charity's commitment to the wellbeing of the Trust's staff. EM thanked the team from the RPH Restaurant and the Events Team for a very well organised event. b. Nationally, the NHS 10-year plan was scheduled to be published in July 2025. The 10-year plan provided a framework which would outline how the funding of the NHS undertaken and how services would be constructed and redesigned around patients. The Board would be provided with a full update on the 10-year plan after its contents had been reviewed and understood.		

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	c. The meeting was advised that the 2025/26 National Oversight Framework was published in August 2025. The Oversight Framework provided a consistent and transparent approach to assessing NHS provider Trusts, ensuring public accountability for performance and providing a foundation for how NHS England worked with providers to support improvement. d. EM stated that in respect of the Trust's performance, • the RTT position had improved; and • the CIP gap was shrinking. e. EM advised that it had been noted that the engagement activities for the Nexus EPR Replacement Project and the 2026 – 2031 Strategy development process were having a very positive impact on conversations within the organisation. f. The first re-launched consultants' forum was held in May 2025, with another scheduled for July 2025. The meeting had been well-attended and welcomed by the doctors. The doctors were pleased as the forum had afforded them with the opportunity to meet and network with colleagues, and they welcomed the opportunity for future face-to-face meetings. EM thanked the Events Team for a job well done. g. Regarding the 2025 Governors' elections, the Board was informed that all constituencies were being contested. It was added that the Governors were pleased with the new Membership Strategy approved at the June 2025 Council of Governors meeting. h. EM stated that a milestone of 250 robotic-assisted thoracic surgical procedures had been achieved since RPH started utilising the Versius surgical robot in 2023. EM advised that the Trust would continue working with CMR Surgical, which had provided the robot to RPH under a strategic partnership arrangement. The Board **noted** the CEO update.		
1.vi	**Non-Executive Directors (NEDs) Update**		
	No update.		
2	**PEOPLE**		
2.i	**Workforce Committee Chair's Report**		
	There was no Workforce Committee Chair's report due for this meeting.		
2.ii	**Annual Nursing Establishment Review 2024/25**		
	MS presented the 20204/25 Annual Nursing Establishment Review report. **Report:** a. MS reported that each year the Trust was required to assess safe staffing in accordance with the National Quality Board's (NQB) guidance. The Trust undertook the annual assessment by utilising the Safer Nursing Care Tool (SNCT) and other similar evidence-based tools and triangulating that with professional judgement as well as with patient outcome measures. The NQB championed the importance of quality and drove system alignment of quality across the health and care sector. b. It was noted that after the assessment, there had been no recommended changes to any of the staffing levels on any of the Trust's inpatient wards.		

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	c. MS stated that through 2024/25 significant progress had been achieved in terms of fill rates, which was in line with improvements in the recruitment for nurses and healthcare support workers. d. This improvement in fill rates had resulted in a decreased need for the redeployment of staff across different areas. It was added that not redeploying staff, always helped maintain high morale, helped to maintain patient safety standards and improved the staff's well-being. e. The Board was informed that, with improved staffing ratios, progress had been made on reducing agency nurse numbers across all areas. It was added that though the number of agency staff in Theatres remained relatively high, the area was ahead of trajectory in terms of the actions being taken to eliminate agency staffing. f. With reference to the nursing staff numbers being close to establishment or almost at full capacity, MS stated that the Trust continued to work on reducing the need for temporary staffing. g. The Trust would, from 2025/26, be able to take steps to assess the effectiveness of the Ward Sister/Charge Nurse role and determine how the role should be utilised. h. MS highlighted another challenge was related to how the Trust could continue to provide student nurses with employment opportunities in the future. The Workforce Team had developed a talent pipeline so that student nurses could be offered employment as opportunities became available throughout the year. i. Student nurses were graduating into a challenging employment environment, so there was the need to manage the expectations of student nurses in the future. The NHS providers in the East of England were putting mechanisms in place so that they learn from each other on the management of the talent pipelines for student nurses. **Discussion:** a. JA, with reference to the case mix of patients treated at RPH becoming older, frailer and having more co-morbidities, queried why the staffing establishment had not required to be increased to support the increased nursing workload. MS, in response stated that the SNCT tool took into consideration patient acuity and dependence as well as co-morbidities before making the recommendations on nursing establishment for the year. The tool had made no recommendation for an increase in the nursing establishment. b. CC queried the fact that RPH had received a new license for the new SNCT prior to the biannual SNCT data collection in May 2024 and asked for more clarity from MS. The Board **approved** the Annual Nursing Inpatient Establishment Review 2024 to 2025.	**MS**	
3	**QUALITY**		
3.i	**Quality and Risk Committee Chair's Report**		
	IW presented the Quality and Risk Committee Chair's report. **Report:** a. IW reported that the number of patient of falls had increased, particularly on Level 5. The issue was discussed extensively at the meeting, and the		

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	Committee was reassured by the improvement plans that had been implemented. b. Overall, the rate of Surgical Site Infection (SSI) infections was stable. It was, however, disappointing that activities such as decontamination had deteriorated from 'green' to 'amber'. IW noted that there was work to do around how the Trust could ensure compliance with all aspects of the infection prevention and control (IPC) standards so that the rating of 'green' could be maintained. c. IW advised that the Committee received an update on the CT backlog reporting issue. The Committee was assured that the Trust was implementing the appropriate mitigating and corrective measures to both ensure patients were not harmed and to also resolve the backlog problem. **Discussion:** a. JA noted that there had been a longstanding message from MS and IS that staff should always focus on compliance with IPC standards and not be reactive to when actions were being implemented to manage infection outbreaks. b. DJ queried if there was a change in IPC processes which could be implemented to ensure there was no decline in compliance with the IPC standards. MS, in response, stated that the Trust was supporting the leadership of Level 5, in particular, to see how a more sustained approach to compliance with the IPC standards could be established. It was added that, over the last four years, the two periods when SSI rates had been almost at 0% were after the first wave of COVID and when there was a Carbapenemase-producing Enterobacterales (CPE) outbreak in 2024. This was because during those periods there were stringent infection control practises instituted across the hospital. c. IW noted that, as evidenced by those two periods, it was possible for the Trust to achieve very low infection rates. The problem was getting staff to focus on ensuring consistent compliance with the IPC standards. d. JA queried if staff were being distracted from their duty to comply with the IPC standards by other demands on their time, MS stated that there was enough capacity for the divisional leaders to be able to ensure that there was compliance among their teams. , e. DJ advised that it would be important to know why compliance with the IPC standards declined when attention moved on to other issues, so the appropriate corrective action could be undertaken. MS stated that the Surgical, Theatres, and Anaesthetics (STA) division's leadership team had been invited to attend the Quality and Risk Committee's August meeting. The leadership team would provide an update on the SSI rates in the area, the challenges in terms of compliance with the IPC standards and what improvement actions needed to be implemented. f. IW advised that the Committee had been very clear that SSI rates in the Trust should be below the acceptable level, and this was a target which could be achieved. The Board **noted** the Quality and Risk Committee Chair's report.		
3.ii	**Combined Quality Report**		
	MS presented the Combined Quality Report. **Report:** MS reported that the Trust was in Phase 2 of a National Implementation Plan around Martha's Rule, a patient safety initiative. An implementation group had been		

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	established to oversee the implementation of the initiative in the Trust, with the support of Health Innovation East. The Board **noted** the Combined Quality report.		
3.iii	**End of Life Care Annual Report 2024/25**		
	MS presented the End-of-Life Care Annual Report 2024/25. **Report:** a. MS reported that the Trust had undertaken a gap analysis against the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) report called 'Planning for the End' which was published in November 2024. b. The key recommendation in the NCEPOD report that was relevant to the Trust was around the need to consider the provision of a mandatory training module for basic end of life care for the Trust's patient-facing staff. It was noted that, considering the number of different training sessions staff already undertook, this would be challenging to implement. Steps would be taken to understand how this recommendation could feasibly be progressed. c. There had been an increase in the on-site chaplaincy support, including on the wards, throughout the year. This support had been well received. d. The medical examiner role became a statutory requirement from September 2024. e. MS informed the Board that the Committee had also discussed how support for Dr Sarah Grove, the Lead Consultant for Palliative Medicine, could be enhanced so she could have the capacity to think about how the area could be further developed. MS noted that the challenges associated with Parliamentary approval of the Terminally Ill Adults Bill in June 2025 were yet to be assessed and understood. To manage the challenges may require the need for the recruitment of more support staff to help with the provision of the End-of-Life Care Service in the Trust. **Discussion:** a. CP noted that the NCEPOD report included a recommendation for a parallel planning approach to be adopted in hospitals. This would ensure that patients with advanced chronic diseases had access to palliative care alongside disease modifying treatments to improve symptom control and quality of life. CP advised that this was an approach that the Board could consider adopting in terms of the 2026 – 2031 Strategy. b. CP queried if the Trust had a handle on the experience of different types of patients in terms of the inequalities associated with the process of dying and access to palliative care. MS agreed to check with Dr Grove for an answer to the query. c. AF stated that the parallel planning approach had been discussed thoroughly at the End-of-Life Care Steering Group meeting. AF agreed that the Board needed to consider the adoption of the approach in the Trust, with due consideration given to the fact that though the Palliative Care team had grown, consultant capacity remained limited. d. JA queried the accuracy of this line in the report, the Palliative Care Service "may be without a specialist trainee from Sept 2025 for at least a year". MS, in response, stated that the section had been clarified at the June 2025 Quality and Risk Committee. MS stated that a new specialist trainee for the End-of-Life	**MS**	**09/25**

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	Care Service would rather be starting in the Trust in September 2025. JA asked for the section to be amended to reflect the correct position. e. CC queried whether the Trust's partner organisation, the Arthur Rank Hospice, could play a bigger role in the provision of the End-of-Life Care Service. IW, in response, advised that the role of the Arthur Rank Hospice had been discussed at the June 2025 Quality and Risk Committee and added that, though the importance of that facility was very much appreciated, it did not have the capacity to accept every patient recommended to it. f. AF expressed the hope that the NHS's new 10-year plan would help in refocusing attention on palliative and end of life care along with the acceptance that the pathways for palliative care needed to be recommissioned. There was the need to ensure that there was the opportunity for more patients to experience world class care in hospices. g. JA and AF agreed on the need to broaden both community palliative care and 'hospice at home' services. JA advised that this was an underserved area as an increasing number of patients expressed a preference to die at home. The Board, subject to the completion of the requested amendment, **approved** the End-of-Life Care Annual Report 2024/25.	**MS**	**09/25**
4	**PERFORMANCE**		
4.i	**Performance Committee Chair's Report**		
	GR presented the Performance Committee Chair's Report. **Report:** a. GR advised that the key area to highlight was CIP performance, adding that the Committee had been concerned for several months about the gap between the 2025/26 CIP target and current delivery trajectory. The Committee was informed of a recent tightening of validation processes and the governance framework around CIP schemes, as well the procurement of some extra resource to support with the delivery of those CIP schemes. GR stated that the Committee considered the assurance around CIP performance to be inadequate. b. EM informed that Board that there had been a sizeable gap the previous month, but since the extra resource was procured as support, the gap between the delivery trajectory and the target had been reduced by £3.2m. As such significant progress had been achieved within this short period, with the appetite to close the rest of the CIP gap (£2m) and achieve all of the targets for the year. c. GR noted that the CIP risk was on the Corporate Risk Register (CRR) but was incorporated within the Financial Sustainability BAF risk. GR advised that this was an issue which should be reviewed. GR stated that the CIP risk was elevated on the CRR but that had not impacted on the Financial Sustainability BAF risk rating. The BAF was the document the Board regularly reviewed and not the CRR. d. The Committee noted the significant progress that was being achieved in reducing the number of patients on waiting lists, particular those who had breached the 18-week RTT standard. e. GR informed the Board that the Committee had been worried for some time over the elective patients who had breached the 52-week RTT standard. The Committee was updated on actions to be implemented over the next two months focusing on the elective patients who had waited from 40 weeks to over 52		

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	weeks. The expectation was that, for the next two months, lots of elective patients would breach the 18-week RTT standard, but this was seen as a necessary step in order to then make more progress in the autumn of 2025. **Discussion:** a. DL expressed concern that the resource which had been procured to support the CIP delivery process was going to cost money and queried whether there was a chance of a return on investment. b. Concern was also expressed that while waiting list numbers were improving, Radiology had emerged as a key concern. It was noted that it felt as if as problems in one area was being solved, problems in another area would be exposed. c. HMc, in response, stated that the Trust had only identified Radiology as having issues which were obstacles to further improvement. The actions being implemented were aimed at removing the obstacles so that the Trust could continue to improve. The overall aim of the actions was to improve upon the Radiology pathways so that early intervention on the 18-week pathway could be maximised. The target was to ensure that, for all modalities, patients referred to RPH would be on their diagnostic access pathways within the first 6 weeks of their referral pathway to RPH. d. HMc stated that for some modalities, 99% of patients were placed on their diagnostic pathways within 6 weeks of their referral, and the aim was to ensure that this target was achieved for patients in all modalities. HMc stated that these were known issues, but as part of the improvement actions being undertaken under the Elective Recovery Programme, improving the diagnostic pathway had become one of the key priorities. e. It was heard that the focused support recently procured for the CIP programme had helped to close the pipeline gap value by about £3.2 million. There was now a shortfall of £2m of CIP schemes yet to be identified and validated. HMc advised that there were opportunities within the Trust's spend that would help in mitigating the £2m CIP shortfall. f. The meeting was advised that the remit for the provider of the procured support for the CIP programme, was to make ten times return on the value of the cost of this service. g. In response to JA's query on the current position with the regards to the RTT metric, HMc advised the meeting that the patient backlog size had gone from 7380 in February 2025 to 6722 as of 02 July 2025. This represented patients who had been treated and had either returned home or been sent back to secondary care for continued care. It was added that the number of referred patients who were being treated within 18 weeks of referral had improved from 61.5% in February 2025 to 65.5% as of 02 July 2025. h. JA noted the continuing challenges of very late cancer referrals from secondary care and enquired if treatment for this cohort of patients were being expedited in any way. HMc, in response, stated that a key intervention within the Cancer Improvement Programme was to ensure that patients referred after 31 to 62 days of diagnosis were prioritised for treatment. The aim of the intervention was to mitigate the risk of their treatment being further delayed, and steps were actively undertaken to ensure that they did not breach the 62-day wait for treatment standard. i. CC expressed her unhappiness with the performance trajectory of the Trust and stated that though HMc provided regular updates on the improvement actions being implemented, she could not see any evidence of the promised progress.		

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	CC advised that she was very pessimistic about the performance trajectory over the next few months. j. In relation to the position of the RTT standard, CC stated that she accepted that the trajectory would worsen before it improved, however, believed that the Trust was in serious problems and she was not sure if there was an effective plan on how to reverse the downward trajectory. CC, in conclusion stated that she wanted to place it on record that as a member of the Performance Committee she was not happy. k. In response to JA's query around what evidence she wanted to see of any progress achieved, CC stated that the Performance Committee had received a lot of data about 52-week patient waiters. She had however, asked for similar data received for cancer patients for the 52-week waits on what the Trust was doing to ensure that patients' waits for RPH services were reasonable, but the information received was incomplete. l. CC added that in relation to CIP performance, she was not convinced that the Trust could achieve its target for 2025/26 and advised that the steps being taken to bridge the gap with newly identified CIP schemes would likely negatively impact on CIP performance in future years. m. She reiterated that these issues were the cause of her unhappiness with the performance of the Trust. n. In response to JA's query on the availability of the data CC was asking for, HMc agreed to check with CC and provide the relevant data to her. In response to another query from JA, GR advised that assurance for CIP performance was currently deemed to be inadequate by the Performance Committee. o. TG, in terms of the CIP performance, reiterated that support had been procured to help with the delivery of the 2025/26 CIP target. TG accepted that the only way CC and the Performance Committee could be assured on CIP performance was when the 2025/26 target was achieved. It emphasised that progress toward achieving the 2025/26 CIP target was being made. p. TG stated that in relation to elective care recovery the Trust's RTT position was currently the best of any NHS provider in the East of England. TG added that, whilst the Trust held itself to a high standard and needed to keep progressing, there was the need to acknowledge that the hospital was operating in a very difficult context and performing reasonably well in that context. q. DJ enquired about the impact of failing to achieve the CIP targets for 2025/26. EM stated that if the under delivery could not be mitigated, then the Trust would not be able to deliver on its projected break-even position for 2025/26 and emphasised that, if that were to occur, there would be significant negative implications for the Trust. As a result, active steps were being taken to quickly identify, validate and deliver on CIP schemes. r. TG added the Trust was working hard to outperform the NHS England-mandated RTT target of 69.5% for elective care and stated that the work to outperform the national RTT elective care standard was being undertaken at a cost to the Trust. It was advised that if the Trust was unable to generate the savings needed to allow the work to outperform the national RTT standard to happen, the Board would be asked to consider ending the quest to outperform that standard. s. TG reiterated that he could not let the Board walk into a deficit position without giving the Board a choice as to how it could avoid that position. It was emphasised that the choice before the Board at that point would be whether to continue spending money to outperform the national elective care RTT standard or save money. t. TG stated that, in order not to be in that position where such a choice would	**HMc**	**09/25**

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	have to be made, the CIP gap would have to be closed. That would enable the Trust to be able to outperform the elective care RTT standard and deliver the projected breakeven position for 2025/26. u. CP enquired whether it would be right to proactively start thinking of the mitigations for under delivery against the CIP target. This would help the Board to review the choices available to it at an early stage. v. HMc stated that it was the Trust's intent to cover all the items within its delivery plan. HMc added the Trust was also assessing the risks of under delivery and the potential ways of mitigating those risks. Th Board **noted** the Performance Committee Chair's report.		
4.ii	**Papworth Integrated Performance Report (PIPR) Month 02 – May 2025**		
	TG presented the May 2025 (M02) PIPR. **Report:** TG noted that the comprehensive Performance Committee Chair's report had highlighted all the important areas in relation to the Trust's performance data for May 2025. **Discussion:** a. DL enquired whether, with the return of Langley Clark Insourcing (LCI) as external providers of the CT scanning service in May 2025, there had been any improvements or any reduction in the patient backlog numbers. HMc, in response, stated that the Trust was two and half weeks behind the trajectory. It was emphasised that the Trust was on track to achieve the turnaround times of four-week responses by the end of August 2025. b. MS highlighted that the April 2025 (M01) PIPR had been included in the July 20205 Part 1 Board meeting pack instead of the May 2025 (M02) PIPR. KMB would circulate the correct version of the PIPR to Board members after the meeting. The M02 PIPR had been reviewed at 3 Board Committee meetings in June 2025. The Board, subject to the M02 PIPR being circulated, **noted** the report.	**KMB**	**07/25**
4.iii	**Green Plan 2025 – 2027**		
	SR presented the Trust's 2025 – 2027 Green Plan for Board approval. **Report:** a. SR reported that, in accordance with national requirement, this iteration of the Green Plan covering 2025 – 2027 required approval by 31 July 2025. It was noted that the Trust operated to a 3-year rolling Green Plan, the last of which was approved in January 2022. The Green Plan was the core tool by which a Sustainability Programme could be undertaken to implement the aims of the Trust's 2021 – 2026 Sustainability Strategy. b. It was stated that to make the Green Plan accessible to all stakeholders there would be two versions of the document – a published version with about 86 high level actions and a detailed version which provided over 765 clear definable actions. c. The meeting was advised that the Green Plan was scheduled to be ratified at a meeting of Trust's Sustainability Board on 16 July 2025, prior to its publication		

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	on 31 July 2025. EM, in her capacity as the Trust Board's Lead on Sustainability, was the Chair of the Sustainability Board. **Discussion:** a. EM stated that the Sustainability Team had done very well to transform the previous version of the Green Plan, which was quite cumbersome and not very detailed, into this version with actions which could be tracked and measured. It was added that a dashboard had also been developed which helped any interested stakeholder to, at a glance, be able to track the significant level of activity that was being undertaken in the Trust b. It was stated that, with regards to RPH's allocated contribution to the overall net zero target for the NHS, the fact that the Trust was a new build with new and efficient systems was not taken into consideration. This was considered an unfortunate drawback. c. The Board heard that, since the Sustainability Board was reconvened, the level of engagement with it had been significant. It was noted that, for example, the clinical attendance at Sustainability Board meetings had been significant. This would help provide the opportunity for the Trust to genuinely make movements in sustainable clinical practise. d. GR advised that, at the June 2025 Performance Committee meeting, the discussion had focused on the need for objectively justifiable metrics to be utilised to track outputs. The Green Plan's metrics only tracked the inputs, but the Committee believed that having metrics which tracked both inputs and outputs would help provide assurance that the right actions had been chosen. e. GR also advised that there was a clear acknowledgement that there had not been as much progress previously as was expected. The best course of action was for the Trust to acknowledge the lack of progress, and to clearly build on the lessons learned from that failure to improve in the future. f. JA noted that only 9 of 91 actions contained in the 2022 – 2024 Green Plan had been completed and enquired if that pointed to a lack of resources or a lack of clarity on what needed to be achieved. SR stated that this was because the actions had been so large that progress had been difficult to measure and advised that for the 2025 – 2027 Green Plan, the actions had been broken down into more manageable bite size chunks which could be tracked and measured much better. The Board **approved** the Green Plan 2025 – 2027.		
5	**AUDIT**		
5.i	**Audit Committee Chair's Report**		
	There was no Audit Committee Chair's report for this meeting.		
6	**GOVERNANCE & ASSURANCE**		
6.i	Board Committee Part I Approved Minutes: a. Audit Committee – 28.05.25 b. Quality and Risk Committee – 29.05.25 c. Performance Committee – 29.05.25 d. Strategic Projects Committee: 24.04.25		
7	**Board Forward Plan**		

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7.i	**Board Forward Plan**		
	The Board **noted** the Board Annual Plan.		
7.ii	**Review of actions and items identified for referral to committee/escalation**		
	None was available		
8	**ANY OTHER BUSINESS**		
	JA informed the Board that a Special Members Meeting (SMM) had been held on Monday, 30 June 2025. This was a part of the steps being undertaken to make the role of Deputy Chief Executive a permanent role along with an increase in the number of Non-Executive Directors by one. No concerns had been raised at the SMM to the permanent change being made to the composition of the Trust Board with the appointment of an extra Executive Director. OM stated that the next steps would be a meeting of the Remuneration Committee in July 2025 to commence the process of recruiting a permanent Deputy Chief Executive. A Non-Executive Directors (NED) Appointments Committee would be convened in August 2025 to commence the recruitment process for a new NED. A new NED was required to be recruited in this instance so that the Trust Board would remain compliant with Code of Governors of NHS Providers, which mandated that NEDs be the majority on NHS Trust Boards of Directors.		
9	**CLOSE**		
	JA concluded the meeting at 10:31 am.		

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Signed

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Date

Royal Papworth Hospital NHS Foundation Trust
Board of Directors

Meeting held on 03 July 2025