Governor Committee/Group membership – Current November 2025

NB: New Governor Committee/Group members highlighted in yellow

Committee	Approved Membership	Current Governor Membership
Appointments [NED Nomination and Remuneration] Committee of the Council of Governors	Minimum of 6 Governor Members Quorum of 3 Members Membership to Include: 4 Public Governors 2 Staff Governors Maximum: N/A	Abi Halstead (Public & Lead Governor - Cambs) Marlene Hotchkiss (Public Governor- RoE) Vivenne Bush (Public Governor -Suffolk) Clive Glazebrook (Public Governor - RoE) Annemarie Harris (Staff Governor – Admin, Clerical and Management) Josevine McLean (Staff Governor – Nurses)
Nominations (Board of Directors) **Selection/interview Panel for NEDs**	Governor Members (In addition to the Chairman, CEO and NED) 1 Governor (usually the Lead Governor) One or more members of the Appointments Committee shall sit on the Nominations Committee of the Board of Directors	To be agreed at time of recruitment
Forward Planning (Council of Governors)	Minimum of 7 Governor Members Quorum of 3 Members Membership to Include: 5 Public Governors 2 Staff Governors Maximum: not more than eight Governors, of whom two shall be staff Governors.	Bill Davidson -Chair (Public Governor - Cambs) Trevor Mc Leese (Public Governor -Suffolk) Clive Glazebrook (Public Governor RoE) Vivienne Bush (Public Governor-Suffolk) Karen Young (App Governor – CCC) Helen Eccles (Public Governor – Cambs) 2 Staff Governors required
Public and Patient Involvement (Council of Governors)	Governor Members and other Members Quorum requires two governors. Membership to include at least seven Governors of the Trust, at least one of whom should be a Staff Governor. Maximum: N/A	Marlene Hotchkiss (Chair - Public Governor – RoE) Trevor Collins (Public Governor – RoE) Martin Hardy-Shepherd (Public Governor – Norfolk) Trevor McLeese (Public Governor – Suffolk) John Fitchew (Public Governor- Norfolk) Ian Harvey (Public Governor- Cambs) Jon Dyer (Public governor – RoE) Abi Halstead (Public governor – Cambs) Sophy Norman (Pub Governor – RoE) Lynne Williams (Staff Governor)
Governors' Assurance Committee (Council of Governors)	Six Governor Members Also present: Audit Committee Chair (NED) Task and Finish group Maximum: N/A	(Chris McCorquodale -Chair Staff Governor) Bill Davidson (Public Governor - Cambs) Trevor McLeese (Public Governor- Suffolk) Abi Halstead (Public Governor - Cambs) Marlene Hotchkiss (Public Governor – RoE) Chris McCorquodale (Staff Governor) Ian Harvey (Public Governor -Cambs)

Access and Facilities Group	**Six Governor members** Quorum: Four Maximum: N/A	Trevor McLeese (Chair - Public Governor - Suffolk) Josevine McLean (Staff Governor– Nurses) Bill Davidson (Public Governor – Cambs) Jon Dyer (Public Governor – RoE) Phil Webb (Staff Governor) 1 vacancy
Board Sub-Committees		
Audit Committee (Board of Directors)	Membership 3 NEDs 2 Governor observers in attendance	Vivienne Bush (Public Governor-Suffolk) Doug Burns (Public Governor – Norfolk)
Performance Committee (Board of Directors)	*Membership 6 Board members including 3 NEDs* 2 Governor observers in attendance	Trevor Collins (Public RoE) Rachel Mahony (Public Governor – Cambs) Helen Eccles (Public Governor – Cambs)
Quality and Risk Committee (Board of Directors)	Membership 3 NEDs, Medical Director, Director of Nursing, Chair of Quality and Risk Management Group, Clinical Lead for Risk Management **2 Governors in attendance (Lead Governor or nominated deputy and Staff Governor)**	Rhys Hurst (Staff Governor - AHP) Deborah Cooper (Public Governor - Norfolk) Marlene Hotchkiss (Public Governor – RoE)
Workforce Committee	Governor observers in attendance: 1 Public Governor 1 Staff Governor	Angie Atkinson (Public Governor-Suffolk) Bill Davidson (Pub Governor – Cambs)
End of Life Care	**Governor representative**	Clive Glazebrook (Public Governor- RoE) Rachel Mahony (Public Governor - Cambs) Sophy Norman (Public Governor - RoE)
Emergency Preparedness Committee	**Governor representative**	Lynne Williams (Staff Governor -Doctors)
Trust's committee for local clinical Excellence Awards (Executive Committee)	**Governor representative**	Appointed Governor – University of Cambridge)
Advisory Appointments Committee on Consultants	-	Rota of non-staff Governors
Digital Strategy Board	**Governor representative**	Annemarie Harris (Staff Governor) Abi Halstead (Pub Gov – Cambs) Karen Young (app Gov CCC)– dependent on when meetings are
Ethics Committee	**Two lay Governors**	Ian Harvey (Public Governor - Cambs) Trevor Collins (Public Governor – RoE)

Charitable Funds Committee	**Membership to be determined**	Governor Observer - Angie Atkinson (Public Governor)
SPC		Abi Halstead – Lead Governor

Please contact the Associate Director of Corporate Governance, Lead Governor or Chair of a Committee for further information or to join/change Committee.

Royal Papworth Hospital
NHS Foundation Trust

Governors Assurance Committee Meeting
Royal Papworth Hospital NHS Foundation Trust
16 June 2025 at 11:00 am – 12:30 pm
Microsoft Teams

M I N U T E S

Present	Christopher McCorquodale	(CM)	Staff Governor (Chair)
	Bill Davidson	(BD)	Public Governor
	Marlene Hotchkiss	(MH)	Public Governor
	Trevor Mcleese	(TM)	Public Governor
	Ian Harvey	(IH)	Public Governor
In Attendance	Cynthia Conquest	(CC)	Senior Independent Director
	Oonagh Monkhouse	(OM)	Director of Workforce and OD
	Kwame Mensa-Bonsu	(KMB)	Associate Director of Corporate Governance
	Godwin Matenga	(GM)	Corporate Governance Lead
	Laura Favell	(LF)	Communications & Membership Coordinator
Apologies	Susan Bullivant	(SB)	Public Governor

Agenda item		Action by whom	Date
1	**Welcome & Opening Remarks**		
	The Chair welcomed everyone.		
1.i	**Apologies**		
	Apologies were received from SB**.**		
1.ii	**Declarations of Interest**		
	There were no conflicts of interest to declare.		
2	**Minutes and Action Checklist**		
2.i	**Minutes from the last meeting – 28 March 2025**		
	Minutes from the meeting held on 28 March 2025 **were approved**.		
2.ii	**Action Checklist**		
	a. It was noted that Action 04/25 regarding, "Terms of Reference to be reviewed with reference to ICS functions" would be pushed back to November 2025. b. Action 07/25 that relates to including acronyms in the handbook had been completed and was closed. All other actions were closed. The Committee **noted** the action checklist.		

3	**Governor Developments**		
3.i	**Draft RPH Governors Handbook**		
	KMB provided a verbal update on the progress around the steps being undertaken to develop a Handbook for the Governors. KMB reported that feedback from wider Council of Governors members was that the Governors Handbook should be user friendly, this would be done once the structure was in place. The 2018 RPH Handbook, and two other draft versions of the Handbook which were never completed, were attached to the meeting pack for members to review and make suggestions for improvement. There was a discussion around what form the handbook would take. The advantages of having either a live online document, or a document in pdf format were explored. It was suggested that the format used should: • allow for accessibility to useful information; • avoid disclosure of sensitive information; and • be able to accommodate change. It was noted that for a publicly available Handbook, there would be the need for the document to be refreshed regularly and in a timely manner if there were any changes. LR advised that she would be able to develop either a live online document or a pdf format or both formats once the Handbook had been approved. TM suggested that helplines for matters such as IT support be included in the draft Handbook to improve and complete it. CC and BD suggested appendices should be in alignment with the chapters of the handbook and numbered properly. It was added that items needed to be up to date. IH queried the governor capability section of the handbook and said that the Trust should ensure that governors had the skills and knowledge required for them to undertake their tasks. CM informed the meeting that in respect of the Handbook, governors were interested not only in what their statutory duties were, but also in how to fulfil them. They were also keen that the Handbook had practical information around items such as access to a map of the RPH building and how to claim expenses. A balanced approach would be taken to have these in place. The general consensus was to have an online handbook and have it printed when required. There was a discussion around when the governors' Handbook would be approved. The draft would be amended in line with the suggestions, circulated via email for comments before being put for approval at the next meeting in September. The Committee **noted** the update on the Governors Handbook which was being developed.	**LR/KMB** **KMB** **KMB**	09/25 09/25 09/25
3.ii	**Governor Induction Process**		

	CM reported that feedback from governors who had joined the Council of Governors the previous year was that their induction was inadequate. Policy and procedural information needed to be assessed by the committee prior to the induction of new starters. It was suggested to circulate available information to the committee. The induction process would also be shared outside the meeting. It was added that details of the training material for the new cohort of governors were being processed. This information would be available ahead of their start and would be circulated accordingly. IH suggested that new governor could be twinned with an experienced governor, from same region. The Committee **noted** the verbal update on the Governor Induction process.	**KMB/GM**	09/25
3.iii	**RPH Membership Strategy – Plan for Development**		
	IH noted that there was a new strategy in place that needed to be updated and circulated to governors by LR. This strategy had emerged from the (informal) membership working group. It was agreed that the membership working group would continue to meet and that reports on strategy implementation would be presented at each GAC meeting. LR informed that database cleansing had commenced and there were plans to develop a newsletter. A digital pack with fliers and posters was being developed in alignment with the RPH website. There was a discussion around the 2025 Governor elections, and it was heard that there was more than one candidate for each of the seats which were up for election. The Committee **noted** the verbal update on the approved RPH Membership Strategy.		
4	**Trust Governance Developments**		
4.i	**Special Members Meeting**		
	OM provided a verbal update and informed the Committee that a notice has been sent to public Foundation Trust members for a meeting on the 30 June; 2025. OM stated that there had been significant interest from public, and the meeting was on track to be quorate. The Committee **noted** the verbal update on the 30 July 2025 Special Members Meeting.		
4.ii	**Review of Trust Constitution – Process**		
	KMB provided a verbal update and outlined the process for a review and update the Trust's Constitution. It was explained that he would do a review of the current Constitution from July 2025 and that the draft revised document would be circulated to members of the Committee for review. It would then be		

	circulated to the wider Council of Governors for final review. This process was anticipated to conclude in December 2025. The Committee **noted** that verbal update on the planned steps to review and update the Trust's Constitution.		
5	**ANY OTHER BUSINESS**		
5.i	There was no other business and meeting closed at 11:50am.		
6	**Date of Future Meeting**		
6.1	10 November 2025		

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Signed

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Date

Royal Papworth Hospital NHS Foundation Trust
Board of Directors

Meeting held on 16 June 2

Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Forward Planning Committee
Royal Papworth Hospital NHS Foundation Trust
09 July 2025 at 10:30 am – 12:00 noon
Microsoft Teams

M I N U T E S

PRESENT		
Bill Davidson	BD	Public Governor **(Chair)**
Dr Susan Bullivant	SBu	Public Governor
Dr Harvey Perkins	HP	Public Governor
Vivienne Bush	VB	Public Governor
Trevor McLeese	TMc	Public Governor
Christopher McCorquodale	CMc	Staff Governor
IN ATTENDANCE		
Eilish Midlane	EM	Chief Executive Officer
Tim Glenn	TG	Deputy Chief Executive Officer & Director of Commercial Development, Strategy and Innovation
Dr Ian Smith	IS	Medical Director
Diane Leacock	DL	Non-Executive Director/Chair of the Strategic Projects Committee
Raj Vaithamanithi	RV	Deputy Director of Digital
Harvey McEnroe	HMc	Chief Operating Officer
Kwame Mensa-Bonsu	KMB	Associate Director of Corporate Governance
Godwin Matenga	GM	Corporate Governance Lead
APOLOGIES		
Dr Clive Glazebrook	CG	Public Governor

Agenda Item		Action by Whom	Date
1	**Welcome & Opening Remarks**		
	The chair welcomed everybody including Raj Vaithamanithi who was AR's proxy. He advised that this would be the last Forwarding Planning Committee meeting for SB and HP and thanked them for being members of the committee for many years and thanked SB for chairing the committee over the last couple of years.		
1.i	**Apologies**		
	Apologies were received from CG.		
1.ii	**Declarations of Interest**		
	There were no interests to declare.		
1.iii	**Minutes of the meeting held on 9 April 2025**		

Agenda Item		Action by Whom	Date
	The FPC **approved** the minutes of the meeting held on 9 April 2025.		
1.iv	**Matters Arising**		
	03/25 – 9 April 2025 – 2.iii – Progress Update – Workforce Strategy Plan (Recruitment and Retention Activities) – TMc to email OM and AR on an issue relating to a staff member with a disability who was experiencing issues relating to 'Workforce on Wheels' (WoW) for OM to consider, with support from AR. It was noted that this action had been completed. To be **CLOSED.** ***04/25 – 9 April 2025 – 2.iii – Progress Update – Workforce Strategy Plan (Recruitment and Retention Activities) – OM to ask the Chief Nurse to provide CG with the scope of the support service provision for patients with regards to their psychological wellbeing.*** It was noted that OM would give an update on this action at next Committee meeting. The Committee **approved** the minutes from the 9 April 2025 meeting and authorised these for signature by the Chair as a true record.		
2	**Strategic Planning/Developments**		
2.i	**National/Local NHS Updates**		
	TG presented the National/Local NHS Updates TG reported that the publication of the new National Health Service (NHS) 10-year plan had been warmly welcomed by the Trust. It had three themes namely, hospital to community, analogue to digital and sickness to prevention. It provided a framework aimed at putting the NHS on a sustainable footing by adopting a new value-based approach that outlined how the funding of the NHS would be used, and how services would be constructed and redesigned around patients in order to achieve better outcomes. The timing of the publication coincided with the development of the new Trust's strategy and was greatly commended. This new strategy would be based on input from patients, staff and the community. However, progress in its development was being adversely affected by reductions of 50% of staffing in Integrated Care Boards (ICB)s and the dissolution of NHS England. The meeting heard that the NHS had published the National Oversight Framework; this framework provided a consistent and transparent approach to assessing NHS Trust providers, ensuring public accountability for performance and provided a foundation on how NHS England worked with providers in order to support improvement. The Committee **noted** the National and Local NHS updates.		
2.ii	**Trust 5-year Strategy**		
	TG presented an update of Trust 5-year Strategy. It was reported that strategy development had commenced and there had been wider engagement. The streams of engagement included		

Agenda Item		Action by Whom	Date
	• public webinars, held bi-weekly where audience were invited to share suggestions; • a staff and a public survey; • Community Partnership Pairing where each Board member was paired with a senior member of staff and the pair would meet external stakeholders including senior leaders within partner organisations across the NHS and more broadly across the community that the Trust serves in order to discuss their challenges and their expectations for the next five years; and • Team 2031 composed of 12 members of staff representative of the gender split, ethnicity, job role and area of speciality; they were involved in engagement with other staff, patients, the public and communities. The output from this engagement was being used to make recommendations to the Board on what the Trust should be undertaking for the next five years. It was noted that there had been 349 responses from the survey. The themes that had emerged from the staff survey were staff wellbeing, staff retention, inclusivity, staff burnout and IT issues. In addition, colleagues had suggested that the Trust could use the specialist activities that it undertook as a unique selling point. At this meeting, attendees undertook a task in order to give their views and input to strategy development. The Committee noted the Trust 5-year Strategy.		
3	**Operational Plans**		
3.i	**2025/26 Operational Plan – Progress Update**		
	The 2025/26 Operational Plan – Progress Update was taken as read. HMc presented key actions against the 2025/26 Operational Plan. The meeting heard that the national standard for referral to treatment (RTT) waiting times was for 92% of patients to start their first definitive treatment or have a clinical decision made that stops the clock within 18 weeks of the referral date. It was noted that the Trust's first milestone would be to recover the RTT position from baseline to 69.5% by 31 March 2026, a 10% annual improvement from previous service plans. The Trust had set an ambitious target of 80% based on high-level forecasting. An operating plan had been set out in order to achieve this target. It was noted that there had been encouraging signs of a consist decline in the number of people with waiting times of 18 weeks. Since the commencement of the Elective Care Recovery Programme, there had been a 5% improvement in the RTT position. This had been supported and delivered by the divisional clinical directors, divisional directors of operations heads of nursing and other executive colleagues. It was explained that the Trust was concerned about the quality of care for those at the end of the waiting list, as a result the backlog was being cleared whilst delivering compliance for early 18-week intervention. In order to avoid late referrals from breaching long waiting times, there had been more focus on reducing the diagnostics waiting time.		

Agenda Item		Action by Whom	Date
	Discussion BD questioned how the Trust continued to cope with increasing demand. HMc explained that the shortfalls due to increasing demand were overcome by simultaneously assessing demand and capacity being mindful that growth in demand profile over the past five years had been met with increased capacity in the number of services. It was noted that in services, including TAVI and sleep, where there were unmet capacity demand issues, the Trust was deliberately focussing on recovery of these services with additional capacity. This was achieved through using patient safety initiatives (extra capacity evening and weekends to clear the backlog). It was noted that once issues in these services had been resolved, deep dives were conducted in areas including Radiology Cath Labs and Sleep Studies in order to make a clear commitment on future pathways in light of the resources available. SB questioned if there was visibility over which group of staff the initiatives in the pipeline were coming from; HMc advised that there was in place an open initiative, led by Senior Leadership, to encourage full participation across the organisation in developing these initiatives and there had been a varying cohort of submissions. It was added that these initiatives were being generated at weekly briefings and All Staff meetings. The Committee **noted** the 2025-26 Operational Plan – Progress Update.		
3.ii	**Nexus Electronic Patient Record (EPR) Replacement Project – Progress Update**		
	The Nexus EPR Replacement Project – Progress Update was taken as read. HMc outlined key points. It was noted that regional and national support had been received for the EPR project. The Trust's Cabinet Office documentation had been submitted to the Business Case Review Service (BCRS), and the former had confirmed their decision to assure the case and to move it forward to invitation to tender, (ITT). The board had approved the release of the Trust's ITT documentation to the market. The Tender had been completed using the Management Consultancy Framework Three (MCF3) framework provided by Crown Commercial Services. HMc explained that: • there was in place a business case based on affordability and benefit realisation; • an integrated model had been developed since partners across the campus had agreed to work on a campus-wide strategy; and • there had been support from regulators for the Trust to go to the market. It was advised that documents would be released to the market and the next steps would involve bidding by those who had undertaken the Trust's market engagement approval process and the wider marketplace EPR suppliers. HMc explained the supplier scenario evaluation and that plans for evaluating and scoring the potential suppliers had progressed. The testing would involve: • a set of pass fail questions; • clinical scenarios; and • a point scored 450-page document.		

Agenda Item		Action by Whom	Date
	HMc gave assurance that the project had undergone a robust RPH governance process including scrutiny at the Strategic Projects Committee, Programme Board and Steering Group. **Discussion** BD enquired whether funding would be provided by the government. HMc advised that it would be based on a benefit realisation case (how the EPR would pay for itself through clinical pathways, product gains, efficiency as well as financial leverage). In respect of how the EPR programme would link with GPs. It was noted that the new EPR would be linked to the shared care record in a way that allowed GPs to access the relevant content of patients' information stored by the Trust and other secondary providers. The shared records would also allow the Trust to access patients' information from GPs and secondary care providers. The Committee **noted** the Nexus EPR Replacement Project – Progress Update.		
3.iii	**Papworth Integrated Performance Report (PIPR) – M02**		
	The Papworth Integrated Performance Report (PIPR) – M02 was taken as read. EM advised that the PIPR articulated RPH's improving performance position. It was noted that the Cost Improvement Programme (CIP) position had not been at desired levels but was improving; for further CIP recovery, extra external resource had been acquired aimed at enabling delivery of the Project Management Function (PMO) function. Improved traction had resulted in the CIP gap being bridged in one month by £3m worth of extra schemes that were going through validation and quality assessment. **Discussion** BD observed that the meeting packs, particularly for the PIPR were too large. EM advised that in order to redress this, the Executive had challenged the organisation at every level to identify areas of productivity, gains, and the opportunity to remove non-value steps. This was aimed at reducing the amount of duplication across the organisation ultimately reducing the size of the meeting packs. SB enquired on the nature of the information that the Trust would need to submit in order to comply with the National Oversight Framework. EM advised that over the next few years, the Trust would be assessed over a smaller suite of metrics. These would cover areas including patient access, waits for diagnostics, treatment through RTT, staff engagement, quality and mortality rates, patients' experience, CQC and workforce elements. However, some statutory metrics currently contained within the PIPR report would continue being visible, notwithstanding them not being required for compliance with the National Oversight Framework. The Committee **noted** the Papworth Integrated Performance Report (PIPR) – M02.		

Agenda Item		Action by Whom	Date
4	**Assurance**		
4.i	**Abridged Board Assurance Framework - Overview of Underlying Risks**		
5	**Governance**		
5.i	**Terms of Reference**		
	The Terms of Reference were taken as read. KMB advised that the Terms of Reference had been brought to the Committee in order for review and approval and recommend their ratification by the Council of Governors. **Discussion** The meeting was in agreement that the Committee could benefit by having two staff governors. CMc advised that appointment of an extra staff governor could be done after the September Council of Governors meeting when information would be available on the membership of the Committee. It was noted that having two staff governors would give resilience to the Committee particularly in respect of strategy development, delivery of strategic elements and the implementation of the EPR. VB requested clarity around the number of staff governors required for the committee and how this differed across the organisation. It was explained that the Committee together with the Appointments Committee needed to have two staff governors due to their governance arrangements; there were no such requirements for other committees. CMc queried the role titles in the Monitoring Table section of the Terms of Reference on page 6; the meeting was advised these would be amended. The Committee **reviewed** and **approved** the revised Terms of Reference and recommended its ratification by the Council of Governors subject to an amendment to Page-6.	**KMB** **KMB**	
5.ii	**Any Other Business**		
	There was no other business at this meeting.		
5.iii	**Date and time of meetings:**		
	i. 08 October 2025 ii. 14 January 2026 Meeting ended at 11:58am		

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Signed

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Date

Royal Papworth Hospital
NHS Foundation Trust

Forward Planning Committee
Action Checklist
Following: 09 July 2025 Meeting
Reporting to: 08 October 2025 Meeting

Ref	FPC mtg	Agenda No.	Action	Action owner	Action Taken	To Agenda/ Action Date
05/25	**09/07/2025**	**5.i**	**Terms of Reference Review** KMB to arrange for the appointment of a second Staff Governor	KMB		28/07/2025
0/525	**09/07/2025**	**5.i**	**Terms of Reference Review** KMB to amend Terms of Reference at Page-6 and remove Commercial Officer.	KMB		

Royal Papworth Hospital
NHS Foundation Trust

Patient and Public Involvement (PPI) Committee
Monday 11 August 2025 at 14:00
via MS Teams

Present:	**Role**	
Bullivant Susan	Public Governor	SAB
Collins Trevor	Public Governor	TC
Green Shelley	Fundraising Manager - Charity	SG
Hardy Shepherd Martin	Public Governor	MHS
Harvey Ian	Public Governor	IH
Hotchkiss Marlene	Public Governor (Chair)	MH
Howe Lesley	Public Governor	LH
Marchington Joanne	Patient Experience Manager	JM
McLeese Trevor	Public Governor	TMc
Mensa Bonsu Kwame (left at 15:35)	Assoc Director of Corporate Governance	KMB
Newby Robson Janine	Healthwatch Manager	JNR
Screaton Maura	CNO	MS
Wall Julie	Personal Asst. to Chairman (minute taker)	JW
In attendance:		
Amaral Almeida Lily	Nurse - BPA	LMM
Apologies:		
Edwards Sam	Head of Communications	SE
Jones Dave	NED	DJ
Williams Lynne	Staff Governor for Doctors	LW

		ACTION
1	**Welcome and Apologies:** The Chair (MH) warmly welcomed everyone to the meeting. Apologies were noted as above. *Discussions did not follow the order of the agenda however for ease of recording these have been noted in the order they appeared on the agenda.*	
2.	**Declarations of Interest:** There were no new Declarations of Interest.	
3.	**Ratification of the previous PPI Minutes** Minutes from the previous meeting held on 12 May 2025 were ratified as a true record of the meeting.	
4.	**Action Log Update and Matters Arising: Maura Screaton** **Action Log Updates:** **Patients on Day ward being mixed, pre and post procedure:** • Conversations have taken place with the Head of Nursing regarding the layout of the Day Ward. The Day Ward Team have found this challenging to address because of space and different functions happening on the Day Ward through the day. The Team was looking at a type of screening, but a	

	concern was raised that patients would not be visible, and staff would be unable to observe them. • Patient experience will continue to be monitored via Friends and Family and complaints procedures to make sure that mitigations in place are adequate. **Action closed** **Parking Space Update:** • There are fluctuations in supply and demand. Currently there does not seem to be an issue in relation to the availability of spaces. • There are regular reviews by SABA and RPH. There are regular utilisation audits to make sure there are the right number of spaces and the utilisation of those spaces. It has been found that generally the number meets the demand. • It was suggested that Steve Rackley Director of Estates and Facilities should be invited to a future meeting to report the findings of a review of the parking spaces. • This action is to be closed but if there is a problem found in the future it can be added to the agenda. **Action closed** **Explanation of Incidents and themes reported on the Infographics:** • The Infographics show number data rather than incident data. • There are multiple ways that the trend data is reported. • PIPR explains and reports events and incidents. Safe: shows the number of falls, pressure ulcers, VTE events etc. • The Annual Report shares themes of incidents and was recently completed. This will be published following the Annual Members meeting on 10 September 2025. **Action closed** MH asked for some information about which incidents are considered as low harm and the difference between those reported as moderate harm. MS explained that there are nationally defined terms: • **Fatal Harm** – Patient died because of an incident • **Serious Harm** – The patient could have died but depends on carer service delivery issues. • **Moderate Harm** – Examples include: if a patient needed an escalation of care, or needed a longer time in hospital, or needed another procedure. If they had to return to theatre and was not necessarily due to a complication of surgery but another reason. • There is a panel of clinical experts who discuss each case and can make a clinical judgement using the definitions that are set nationally. They also use their clinical knowledge and expertise in terms of treatment and outcomes for the patient. **In Patient Survey Results (Embargoed)** **Received: Slides were shared in the pack for the meeting.** CQC is to release the full results on or around the 9 September 2025. MS happy to share with the committee results received so far. **Action closed**	SR to be invited to a future meeting

	PPI Committee ToR Query: There was a query about membership of the committee and whether the Medical Director should be a member. MS explained that she attends meetings from a clinical executive level and covers this role. Capacity was discussed and it was felt that while MS is in attendance there was no need for the Medical Director to attend. MH asked if MS was away for a length of time would the Medical Director need to attend and would it be possible for the ToR wording to be changed to invite the Medical Director if required. MS commented that Jennifer Whisken could attend as her Deputy. The Medical Director could be invited to attend if there was a specific item on the agenda. **KMB to amend the PPI Committee ToR. To be taken to the next CoG for approval.** IH commented that he is not sure what the specific roles of people are and asked what the Medical Director's role is. MS explained that the Medical Director along with herself are responsible for the quality and safety of the hospital. The Medical Director provides professional and medical leadership across the medical workforce. Within his portfolio he has a specific area of responsibility around research and development and other areas of responsibility individual to his portfolio. IH asked if it was possible for governors to have a profile, including responsibilities for each person that governors are likely to meet especially those who are involved with committees. KMB commented that there is a portfolio in the Annual Report and suggested sending this out to the committee. He suggested that this could also be added to the Governor Handbook. **Action closed** It was noted that it is the duty of the PPI Committee to add the PCEG Strategy to the agenda. It was agreed that the PPI Committee should oversee the process. MS to request the Strategy from the PCEG committee. **Action ongoing** It was noted that on some wards the wardrobe hangers were missing. On investigation some wards keep aside hangers for long term patients as hangers keep going missing even though a lot of money has been invested buying them in the past. It was noted that there were no stools in patient bathrooms. On investigation occupational therapists give these to patients on an individual basis following assessment. There is a review into bathroom safety on going.	KMB to amend ToR wording KMB to circulate MS to request Strategy

	A concern was raised about the difficulty that patients have while showering with IV lines. It was found that arm coverings are expensive but are given out on an individual basis. A concern was raised about the amount of paper towels that are being wasted due to over filling of the towel dispensers. This causes a lot of towels to be pulled out together when trying to pull one or two to dry your hands. There are ongoing communications with OCS to stop the over filling of the dispensers. **Action closed** **There were no new matters arising.**	
5.	**Current Issues:**	
5.1	**Patient Story: Lily Amaral Almeida** **Specialist Nurse in Hypertension Service, specifically in Balloon Pulmonary Angioplasty Service (BPA)** • Patients that have a specific type of pulmonary hypertension are treated at RPH with this procedure. The patient has high blood pressure in their lungs, and this can affect the heart. The pressures can be caused by a chronic blood clot. • The procedure is only performed at RPH and has been performed for the last 10 years. • A catheter is introduced through the vein in the groin and is fed up to and through the heart and lungs. The catheter has a tiny balloon attached which the doctors then inflate to push aside obstructions allowing the blood to flow better and reduce the pressures in the lungs allowing the patients' breathing to improve and reduce strain on the heart. • This is a planned procedure, the patient is referred, information is collected, and a meeting is held to discuss treatment. The patient comes to talk about the procedure, and a date is planned. • The patient story being told today is about a patient who came into RPH to have this procedure performed as an emergency which is the first time that this has happened. • The patient was referred in January 2025 after being at her local DGH since early December. • At this time the patient was very poorly needing high levels of oxygen. Her heart was weak, and her kidneys had deteriorated. She was taking a lot of medication to help support her. • Her case was discussed, and the Team was very concerned about how poorly she was and if the procedure would be the best way to treat her due to complications that the procedure could cause and could be potentially fatal to her. • Ultimately the decision was made to transfer the patient to RPH intensive care unit. She was very breathless and was unable to lie down, she was only comfortable when sitting up and had to sleep in a chair. • The doctors were very concerned about the risk of the procedure and was scored at 50% which is much higher than usual patients when the risk is maybe 1-2% of something serious happening.	

	• The patient understood the risk and said that her quality of life was so poor that any help at any risk would be worth taking. • Thankfully following four procedures over a four-week period, she did very well. There were some complications but none that were not overcome. She was moved out of intensive care and admitted on to the ward on the fourth floor. • The patient was very weak and could not walk so the nursing team, the physiotherapists, and the occupational therapist did a lot of work with her and eventually got her back on her feet. She was discharged home mid-April. • She came back in July for follow up. She is still unwell with pulmonary hypertension, but she said that the procedure changed her life. She is now able to do things that she could not do before. • When asked about her experience she was very positive on her feedback and very complimentary about the care that she received. She commented that she felt very safe and well looked after. The most important thing for her was that she was given information that she could understand about her treatment. • Her family were present, and they commented that the patient is now enjoying life. • This was important to the Team to know as this was a first in terms of a patient being admitted for this treatment as an emergency. The biggest learning point is that sometimes you need to look at things in a different way and think about different options, different strategies and the patient's choice to decide whether to go ahead with what is offered. **Discussion:** IH thanked LAA and commented that it was good to hear that communication, and explanation was found to be good as it is a concern that some patients are not told enough. SAB asked how the experience of the Team is disseminated nationally or internationally for others to learn from it. LAA commented that nationally RPH is the only centre in the country that does this procedure so there isn't the opportunity to do this, but the pulmonary hypertension community is well structured in terms of how it communicates. There are quarterly meetings where pulmonary hypertension professionals meet. The next meeting is in October which she is hoping to attend and share experiences with the Team. There has not been an opportunity to share internationally yet.	
5.2	**Infographics for June: Maura Screaton** **This was circulated to the Committee and was shared on screen.** MS commented on some highlights of the report: • There is a lot of information in terms of activity numbers and patients being treated. • Focus has been on waiting lists and progress has been made across pathways and referral to treatment. The number of patients on our waiting list has reduced. • The number of transplants is shown and the number of compliments and complaints that have been received.	

	• Complaints are seen as a positive thing and although these are not a good experience for the patient it gives the opportunity to learn from them which is important. • The response rates for Friends and Family scores are good • There is a high level of incident reports seen but a low level of harm. • Mandatory training: teams are being supported for staff to find the time to complete. There has been improvement across the board. **Discussion**: IH commented about the Medical Director directorate being shown as red and asked who is responsible overall. MS explained that this directorate has a small number of people within it and that this could be one person who has not completed their training. IH asked who would raise this with the Medical Director MS agreed to discuss this with the Medical Director SAB commented about the 274 transfers from other hospitals and asked if it was known which hospitals frequently transfer at the last minute. MS was unable to answer the question but explained that each team scrutinise their own data in relation to this. There is a work plan that is used to minimise any delay in transferring patients. The ACS pathway is monitored and tracked using compliance with their standards. Each service has its own monitoring. SAB commented that it would be interesting to see an overall figure to monitor whether there is one hospital who consistently transfers patients at the last minute. MS explained that this is picked up by the Operational Team at ICB level. JNR asked about the new stat regarding virtual wards and asked how this was progressing. MS commented that in general it is very successful. The service has been limited to patients from the Peterborough and Cambridgeshire areas and was started by admitting patients who needed close observation in relation to their wound. It then expanded to patients who needed some ongoing treatment for example antibiotics. It has enabled patients to be discharged earlier. Patients can sleep in their own beds but still have a safety net of someone checking in with them. RPH have paid for the service which is provided through Addenbrookes. It is not a stand-alone service for RPH, so it is a combined model which has received good feedback.	
5.3	**Healthwatch Update: Janine Newby Robson** **Received:** The Committee received updates from Janine Newby Robson in the pack for the meeting • JNR shared with the Committee that the proposed closure of Healthwatch has now been confirmed. There will be a formal process taking place and it is thought that the closure will happen in October 2026.	

	• The 10-year NHS plan includes several independent patient voice organisations to close, and the funding will be redirected to local authorities in the case of adult social care services and the Integrated Care Board for health services. • The main concern, as an organisation, is that if patient voices are going through the Integrated Care Board it will not be a truly independent process for the patient voice. • One suggestion has been that the NHS App will be more utilised as a digital framework in a lot of areas for health and social care feedback. Questions have been asked about what will happen to the information and who will be analysing it, and who will be communicating back to the patient to explain things or signpost them to other services. • The funding for Healthwatch comes through from Cambridge County Council so they may not be given any more funding from March 2026. • Some projects are still ongoing, for example, Patient Participation Groups which are becoming more important for the patient voice. Training is being provided to the groups. • The aim is for patients to be able to go to their local group to say what is good, what is working well and if things could be better. • Interim View visits are taking place locally to community diagnostic centres, in Ely and Wisbech. They have multiple diagnostic services. • There is going to be a Diagnostic Centre opening in Peterborough which is being built, date of opening not known. • The Healthwatch summit this year is Mental Health in Young People transitioning from child into adulthood and the situations that can happen around that. • This is arranged to take place on 8 October 2025 and will be held at the Marriot Hotel in Huntingdon. Everyone is welcome to attend if they are interested. MS commented that she was sad to read the news of closure and added that the Healthcare work has been valuable and important and thanked JNR for her support at RPH. IH commented that speaking as a teacher, work on mental health with young people is important. He has witnessed the death of several students when they may have been able to receive help and reiterated that work needs to continue. **Recommendation:** The Committee is asked to note the contents of the updates.	
6.	**Quality: Maura Screaton**	
6.1	**PIPR Safe and Caring – M03** **Received**: PIPR was circulated for information prior to the meeting. **<u>Safe reported overall Amber</u>** **<u>Caring reported overall Green</u>**	

	MS commented that PIPR has a lot of scrutiny through Board sub-committees. Focus and attention are also given to PIPR at the Board meetings. MS is happy to answer questions. IH commented that there has been an improvement with safer staffing. MS agreed and added that this reflects the vacancy levels being the lowest they have been at less than 2% across a lot of areas. There is a healthy recruitment pipeline for theatres. A talent pool has been made for students that have been on placement at RPH and would like to apply to stay if a role is available. There are opportunities for them to be able to have a job as posts come up. IH asked if RPH offer degree apprenticeships MS commented that RPH does offer degree apprenticeships, but this is dependent on how many can be supported by the apprenticeship levy, which does not support the educational part of their training. IH asked how C.Diff is detected and if every patient is tested or only when symptoms are seen. MS commented that not every patient is tested. There are specific symptoms which have guidelines around treatment. There are nationally dictated criteria and protocols.	
6.2	**Quality Priorities: Q1 Progress - Maura Screaton.** **Received: Quarter 1 Progress Report was included in the pack** • The report describes how the waiting times will be decreased and what areas are being focused on. • The Working Group have made progress with discharge summaries which are sent to GPs. A new e-discharge summary was launched last week. These have previously been complicated and long to read but they have been streamlined so that key areas can be seen instantly. • Health inequalities – a panel has been set up who meet once per quarter. A self-assessment has been done, in terms of health inequalities and a workshop took place at Board recently. A health plan has been written, and the focus is on treating back to independency. Work is continuing. The treatment of obesity is also being considered. **The committee is asked to note to contents of the report**	
7.	**Charity Update: Shelley Green Fundraising Manager** **Received: The Charity Report** **Highlights:** • It has been a strong start to the year. New and experienced staff have been recruited and an increase in income has been seen in their areas**.** • The charity generated £833k in quarter one of the financial year; £300k higher than anticipated, largely due to a significant legacy gift of £531k	

	• Four supporters sky-dived in May, raising £2,000 and a corporate team of 12 raised a fantastic £14,000. • The campus 10k was a huge success again this year, 25 people including Chief Nurse, Maura Screaton took part for RPH and raised nearly £9,000. • The team have been busy supporting events in the community including a music event in London, several golf days as part of Charity of the Year partnerships and a charity night at a restaurant hosted by a former RPH patient. A team of runners from Howden Aviation took part in their local 10k and raised an amazing £15k in memory of a colleague who was treated at the hospital. • The Cambridge Half Marathon earlier this year raised £25,000 • Philanthropy has had a strong start to the year, securing a £120,000 gift to the hospital. • Amending and updating the Privacy Statement to enable the proactive research and outreach of potential donors is in progress, a critical step in delivering philanthropy income. • The charity celebrated its 30th Anniversary in July and marked the occasion with a staff BBQ, a cake cutting ceremony and gifting a commemorative pin badge to all staff. **Grant giving activity** • Three grants totalling £107,000 were approved by the Charitable Funds Committee in June. • £46,000 was granted to fund the refurbishment of a staff rest room which was Identified in a recent survey as an area for improvement whereby an upgrade would have a positive impact on staff wellbeing. • £29,000 approved to fund a finance undergraduate who will work within the Financial Management Team to support several areas. • A request in response to the recent 'Investing in Innovation' grant call provoked an application for actigraphy devices which are a method of assessing sleep and wake patterns by using a wearable device. The device enables the Royal Papworth Sleep Medicine Service, which is the largest in the UK to make more accurate diagnosis and treatment plans. **Discussion:** SAB asked if legacies are part of philanthropy SG explained that they are separate. There have been legacies that they have been promised but are going through the probate process after a death. Philanthropy income is from people who would like to give funding while they are alive. IH commented that he is working with SG writing quizzes and producing a quiz pack as a Fundraiser. SG commented that she is going to launch this as part of the Charity 30th Anniversary Celebrations.	
8.	**Patient Carer Experience Group (PCEG) Maura Screaton** **Minutes from the March and June PCEG meetings were received in the pack.**	
8.1	**The PCEG Highlight Report written by Jennifer Whisken was received in the pack**	

	• This includes areas of focus for the group which were concerns raised by the group and the response. • Charity bids have been sent for dayrooms to be updated for patient use, so they are able socialise. • It has been reported that single rooms are good for dignity and privacy, but some patients feel isolated and lonely. • Patient visiting – the group recently reviewed the policy around patient visiting to make sure that all patients can have someone with them at any time. This is also a CQC requirement regulation.	
8.2	**Adult In-Patient Survey 2024 (Embargoed) The Committee received the report with the pack.** • This used comparisons with other organisations that also used Picker as a provider of delivering the In-Patient Survey. • The other organisations who used Picker are not known to RPH. • The release of the results will be in September. True comparisons will be made with similar organisations and similar specialities. • From what has already been seen the outcome is positive in terms of overall scores. • There was a good response of 65% of patients. • RPH is in the top three for an overall positive experience. • RPH is above average in five scores. Areas of improvement have been seen, and they were in areas which were focused on from the previous year. • More information is to follow. IH asked if ear plugs are offered to patients at RPH. MS commented that they are available but as patients are in single rooms there is not a routine need for them.	
9.	**Board Meeting Feedback:** **KMB left the meeting before this item. No feedback was given today.** • Board papers can be seen on the hospital website for information. • The PART I Public meeting agenda is sent out to all the Governors with the link for the meeting, so they can observe.	
10.	**Patient Experience – Complaints & PALS: Joanne Marchington** **A report was received by the Committee.** JM explained that PALS staff are available from 09:00 – 16:00 The office closes at 13:00 to people walking in so that staff can catch up with emails and phone calls which has had a beneficial effect. No negative effects have been noted. Monitoring is ongoing. **Summary from the last quarter**: o A total of 19 new formal complaints were received o A total of 43 informal complaints were received o A total of 363 PALS enquiries were received o Volunteers' Week	

	○ PAT dogs started to visit wards from May 2025 – positive feedback. There are 5-6 dogs with their handlers on the books. A concern was raised about the main reception in the atrium not being staffed on a Saturday morning and, therefore whether a visitor arriving would know where to go. MS explained that there is a sign is on the desk giving information of where to go and what number to phone. In the last few months helpful information for patients and relatives has been added to the information screens in the atrium. This continues to be developed.	
11.	**Terms of Reference (ToR)** **N/A for this meeting** **Governance:** None	
12.	**Risk**	
	It is recommended to the Committee that this item has been added to all agendas. • Emerging Risks – None raised.	
13.	**Governor Requested Items:** No items were requested.	
14.	**Any Other Business:** • TMcL reported that a complaint had been communicated through the DaD network following an email being received from a patient who had a problem with the Sign Live System for people who are hard of hearing and the patient was unable obtain a Sign Live Translator. • The patient had been asked to use the system on their phone but could not hold the phone and watch the demonstration on how to use a CPAP machine. • New guidance is to be circulated to booking office and outpatients department. • Each patient is to be assessed individually and face to face appointments should be given to patients who need demonstration of machines. The team are working with the Interpreter Service which has been recently commissioned to make sure it is made clear at the booking of the appointment. • RPH will be using iPads for the Sign Live System. A Guide has been issued for the hearing loops to be added. Information screens will inform patients that they are available. MH asked the Committee if they had any thoughts on how PPI could improve patient engagement to please contact her. MH announced that sadly this is LH and SAB's last meeting before they step down as Governors. She thanked them both for their commitment, active participation and interest at PPI Committee meetings.	

	Future Dates	
	• **The next Council of Governors meeting will be held on Wednesday 10 September at 10.30am** • **The next PPI Committee Meeting will be Monday 3 November 2025 at 14:00** **Future Meeting Dates - 2026:** **Monday 9 February** **Monday 11 May** **Monday 10 August** **Monday 9 November** **The Chair thanked everyone for their participation and the meeting finished at 16:05**	