Item 00

Royal Papworth Hospital
NHS Foundation Trust

MEETING OF THE COUNCIL OF GOVERNORS
Wednesday 12 November 2025 from 10.30am – 1:00pm
Royal Papworth Hospital
Venue: HLRI & MS TEAMS

AGENDA

				Lead	*Timing*
WELCOME, APOLOGIES AND OPENING ITEMS					
1.	**Welcome, apologies and opening remarks**		Verbal	Chair	15 mins
2.	**Declarations of Interest**	For Information	Verbal		
3.	**Minutes of previous meetings and matters arising:** 10 September 2025 – Part I	For Approval	Attached		
ASSURANCE					
4.	**Patient Story by:** Michele-Roberto Rella, Transplant Pharmacist	For Information	Verbal	MS	20 mins
5.	**6 Month Review – 2025/26 Operational Delivery**	For Information	Presentation	TG	10 mins
6.	**Board Committees Chairs' Report** • Workforce Committee (Attached) • Performance Committee (Verbal) • Charitable Funds Committee (Verbal)	Chairs (with optional feedback from Governor Observers)	Attached/ Verbal	Chair	30 mins
7.	**RPH 2026 – 31 Strategy**	For Information	Attached	TG	10 mins
8.	**Private Patients Update**	For Information	Verbal	TG	10 mins
GOVERNORS' UPDATE					
9.	**Lead Governor's Report**	For Discussion	Attached	Lead Governor	35 mins
10.	**RPH Governors Membership Engagement Activity – Progress Update**	For Information	Attached	Lead Governor with Laura Favell-Talbot	
11.	**Reports/Observations from Chairs of Governor Committees**	For Discussion	Verbal	Governor Committee Chairs	

12.	**Reports on other Governor Activities (Including from Appointed Governors)**	For Discussion	Verbal	Governors	
GOVERNANCE					
13.	**Update on Actions (You Asked; The Plan/Progress Update)** • **Governor Induction/Training**	For Discussion Verbal	Attached	Chair /Lead Governor	5 mins
14.	**RPH Governors Handbook**	For Approval	Attached	Chair	5 mins
15.	**Governor Matters:** • Appendix 1: Governor Committees Membership • Appendix 2: Minutes of Governor Committees	For Information	Reference Pack	Lead Governor	
16.	**Questions from Governors and the Public**		Verbal	Chair	
17.	**Any Other Business**				
18.	**Future Meeting Dates**: • 11 March 2026 • 17 June 2026 • 09 September 2026 (Plus Annual Members Meeting) • 09 December 2026				

Please Note: The Council of Governors meeting will be followed by a sandwich lunch.

Please Note: If you would like to attend this meeting/ask a question/seek further information, please contact the Associate Director of Corporate Governance. Email: kwame.mensa-bonsu1@nhs.net

Royal Papworth Hospital
NHS Foundation Trust

Minutes of the Meeting of the Council of Governors
PART I
Held on Wednesday 10 September 2025 10:30 am to 12:30
Venue: HLRI & MS TEAMS
Royal Papworth Hospital

Present	Role	Initials
Jag Ahluwalia	Chair (Trust Chair)	JA
Abi Halstead	Public and Lead Governor	AH
Paul Berry	Public Governor	PB
Susan Bullivant	Public Governor	SBu
Vivienne Bush	Public Governor	VB
Trevor Collins	Public Governor	TC
Deborah Cooper	Public Governor	DC
Bill Davidson	Public Governor	BD
John Fitchew	Public Governor	JF
Clive Glazebrook	Public Governor	CG
Christopher McCorquodale	Staff Governor	CMcC
Joe Pajak	Public Governor	JP
Rhys Hurst	Staff Governor	RH
Andrew Hadley Brown	Staff Governor	AHB
Harvey Perkins	Public Governor	HP
Martin Hardy-Shepherd	Public Governor	MHS
Marlene Hotchkiss	Public Governor	MH
Lesley Howe	Public Governor	LH
Caroline Edmonds	Appointed Governor	CE
Trevor McLeese	Public Governor	TMcL
Ian Harvey	Public Governor	IH
Rachel Mahony	Public Governor	RM
Lynne Williams	Staff Governor	LW
In attendance		
Eilish Midlane	Chief Executive Officer	EM
Diane Leacock	Non-Executive Director	DL
Cynthia Conquest	Non-Executive Director	CC
Harvey McEnroe	Chief Operating Officer	HMcE
Andrew Raynes	Chief Information Officer	AR
Kwame Mensa-Bonsu	Associate Director of Corporate Governance	KMB
Godwin Matenga	Corporate Governance Lead	GM
Oonagh Monkhouse	Director of Workforce	OM
Harvey McEnroe	Chief Operations Officer	HM
Sophy Norman	Public Governor Elect	SN
Louise Palmer	Asst. Director for Quality and Risk	LP
Amanda Fadero	Non-Executive Director	AF
Charlotte Paddison	Non-Executive Director	CP

Liz Sanford	Interim Chief Finance Officer	LS
Priya Saini	External Auditor from KPMG	PS
Ian Smith	Medical Director	IS
Jon Dyer	Public Governor Elect	JD
Dave Jones	Non-Executive Director	DJ
Julie Wall	PA to Chairman	JW
Laura Favell-Talbot	Membership and Engagement Officer	LFT
Apologies		
Angie Atkinson	Public Governor	AA
Justin Davies	Partner Governor CUH	JD
Tim Glenn	Interim Deputy CEO	TG
Josevine McClean	Staff Governor	JMc
Gavin Robert	Non-Executive Director	GR
Maura Screaton	Chief Nurse	MS
Ian Wilkinson	Non-Executive Director	IW

Discussion 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.

Item (minute reference)	WELCOME, APOLOGIES AND OPENING ITEMS	Action by whom	Date
1.	**Welcome, apologies and opening remarks**		
	The Chair welcomed those present to the meeting and noted apologies as above. JA noted that this meeting would be the last Council of Governors meeting Gavin Roberts would attend before stepping down from his post as Non-Executive Director in October. Unfortunately, Gavin was unable to attend today but JA would like to put on record his thanks to Gavin for his brilliant work while being a Non-Executive Director for the past 6 years.		
2.	**Declarations of Interest**		
	There is a requirement that those attending Board Committees raise any specific declarations, if these arise during discussions. There were no new declarations raised.		
3.	**Minutes of the previous meeting – 4 June 2025**		
	The minutes of the Council of Governors (CoG) meeting held on the 4 June 2025 were agreed to be a true and accurate record of the meeting.		
3.1	**Action Checklist:**		

	The Chair referred to the Action Checklist included in the meeting pack and highlighted that all actions were scheduled to be addressed as part of the meeting or were not yet due. Any other actions were invited to be raised. **13/25 Governor Training Sessions**: Discussions with a provider have taken place, but it was felt that what was being offered was generic to the NHS and not sufficiently tailored to RPH. JA suggested that with the support of AH and CMcC they could meet to discuss what exactly is needed, and to include some national and RPH information. **15/25 Private Patient Presentation**: It was agreed that this item would be arranged either at the next meeting in November or a separate meeting online if need be. **16/25 Governors Handbook**: A draft version is ready for review at the next GAC meeting in October. This will be brought to the November Council of Governor meeting for approval. **18/25 PIPR**: Pain Management Review results. This item is scheduled for the November Council of Governor meeting.	**JA/AH/CM** **KMB/AH** **KMB** **KMB/MS**	
4.	**Staff Story: Rebecca Roberts Advanced Clinical Practitioner for Cardiology**		
	RR explained her role at RPH and how she had entered her career. • All patients who have suffered a heart attack are assessed by RR. • RR started her nurse training in Swansea in 2012 and applied to train as a midwife but didn't get a placement, so she began nurse training with an 18-month degree course to be a midwife. • She applied for three jobs, one at RPH, one at The Freeman in Newcastle and one in Swansea. • After attending the interview at RPH she was offered a job and started on Varrier Jones ward when RPH was at the old site and fell in love with Cardiology. During those years she made friends and travelled. • At that time, she realized that her ambition to become a midwife was not going to come to fruition. • She made progress and transferred to CCU where she gained experience including ECMO and ventilation. • After applying for the role as Senior Sister on Varrier Jones ward she was successful, and the role included the recruiting and training of new colleagues.		

	• Her favourite element of her role was teaching, and she became a Clinical Skills Facilitator and was responsible for the implementation of the Care Certificate. This was for all people that were new to this type of role and wanted to join the caring profession. They then went on to become band 2 Healthcare Support Workers. This meant that she was shaping people to be what they wanted to be and to look after patients who were at their lowest ebb, and she could share her knowledge and experience. • She found working with patients was very rewarding. She tried to make the best of the horrible situation, and to be their support. • RR became the sister on Hemingford Ward and Coronary Care. She was very proud of her team. • From there she studied an Advanced Practice module which included assessing and diagnosing patients. • After some time, she realised that she needed to gain credibility and experience somewhere else, so she left RPH and took a role at NWAFT as Cardiac Specialist Nurse. • Having worked at RPH she knew all the patient pathways and could guide the patients and equip them with information before they arrived. • Although she hadn't wanted to leave RPH she did learn how to think autonomously. At RPH there were always consultants available to advise but at NWAFT you didn't have that so you had to use the knowledge you had and think outside of the box. • Following having her twins she applied for a Cardiology ACP vacancy and returned to RPH. She felt like she was home and the welcome back was fantastic. • There are six members in her team who can all prescribe anything from the BNF. They clerk patients and are involved with ACP discharges with the hope that this will increase flow through the wards. The ambition is to have a patient admitted for an angiogram and go home within 24 hours. **Discussion:** JA thanked RR for her interesting story, telling her journey, comparing hospitals and sharing what can be learnt. IH asked, what is the next step for her. RR explained that she is taking strong leadership within her team so the next step-up would-be Team Leader.		

	OM commented that this was a great story about progression. She added that it is often heard via the staff survey that there is a lack of progression at RPH, and people struggle to progress their career. It is also seen during leavers interviews, and she asked if there is anything as a Board, they can do to help staff recognize their potential. RR commented that she is just finishing her level 7 master's in advanced practice and that she has done this through RPH. There are opportunities but you must invest in yourself and make moves. You must be self-driven and not expect things to come to you. There are wellbeing coaches who are useful to help you decide where you want to go and what you would like to do. TMcL asked how she copes with being a busy mum and working. RR commented that she is very fortunate to have an army of people around her to help. Her twins are 5 years old and have just started in Year 1 of school. She finds work very rewarding and works in a supportive team. CG asked RR what her most clinical demanding situation has been. RR explained that she is an advanced life support provider and leads cardiac arrest situations. It is very demanding and when done right it works like a robot but when it is not done well it can descend into chaos. Those are the situations that demand the most physically and mentally from us.		
5.	**Governor Election Results – 2025 - Abi Halstead**		
	AH thanked everyone who stood for Governor Election and read out the list of successful candidates and those governors leaving: **Successful Public Governors:** Suffolk – Angela Atkinson Cambs – Helen Eccles Norfolk – Doug Burns RoE – Jon Dyer, Marlene Hotchkiss and Sophy Norman **Successful Staff Governors:** Philip Webb Annemarie Harris Katie Green Governors who leaving are Susan Bullivant, Harvey Perkins, Paul Berry, Lesley Howe, Andrew Hadley Brown and Sarah Brooks. AH thanked the leaving governors for their hard work and their contributions to committees which has been appreciated. An extra special thanks was given to Harvey Perkins who has come to the end of his second 9 years as a governor (18 years).		

	A round of applause was given for Harvey Perkins. AH welcomed Cllr Karen Young as the new appointed governor from Cambs County Council. IH suggested that perhaps new governors should be given a mentor who is already an established governor. AH agreed that a mentor would be a great idea. There is going to be training but she will be in touch with all new governors individually to talk through a buddy system and joining of the WhatsApp Group. JA wanted to thank, on behalf of the Board of Directors, all governors who have served. Congratulations were given to newly elected governors.		
	ASSURANCE		
6.	**2024/2025 Annual Reports and Accounts**		
	Received: The council of Governors received copy of the final report in the pack.		
6.1	**Annual External Audit Report – Priya Saini** Priya Saini from KPMG attended the meeting. • KPMG have provided their assurance and signed the accounts in June. There were no issues found • ISA 260: There were no major findings in ISA 260 so there were no issues or concerns to be reported. • CC as chair of Audit Committee agreed that the Audit was clean. JA extended his thanks on behalf of the Trust to the External Auditors and to CC and the Audit Committee for all their work on completing the audit on time. He commented that it is no small order to obtain a clean audit. **No questions were raised.**		
7.	**Board Committee Chairs Reports**		
7.1	**Audit Committee – Cynthia Conquest** **Received: The Council of Governors receive a report from the Audit Committee Chair.**		

The Role of The Audit Committee

The Audit Committee plays a pivotal role in supporting the Trust's governing body by meticulously reviewing governance structures and assurance processes. It ensures the robustness of financial, operational, and clinical sustainability through comprehensive audits, detailed reports, and thorough risk assessments.

The Audit Committee's role encompasses the review of external and internal audit reports, annual accounts, financial sustainability, staff concerns processes, and the Board Assurance Framework (BAF). This is to provide assurance to the Board and Governors.

Additionally, the Committee receives presentations from Chairs of key board committees to verify risk management and assurance levels.

Assurance Review – Chairs' Report

- The Audit Committee gives the Board overall assurance that Committees can give a level of assurance about the risks or issues facing the Trust.
- This in turn will give Governor's confidence that the Non-Executive Directors (NEDs) are obtaining and assessing assurance on significant matters.
- After considering three questions that the Audit Committee has posed to itself on how it could get assurance from the Committees, it was decided that as the NEDs participate in multiple Committees and are distributed diversely, this allows NEDs to verify that risks are being rigorously evaluated and that the impacts of solutions or ongoing issues are being addressed.
- This assurance process is enhanced by having the Audit Committee randomly request an in-depth presentation from the Chair of a board committee at its meetings.
- The Audit Committee has received three presentations from Chairs of Board Committees explaining how those Committees obtain assurance on the management of risks on the BAF and issues facing the Trust.
- All the presentations gave substantial assurance to the Audit Committee that the Committees were asking about and monitoring controls, seeking triangulation, reviewing outputs and giving keen scrutiny to be able to report to the Board with confidence the level of assurance they had on the various risks and issues in the Trust.

Summary of Work since the last report in March 2025

	• The 2024/25 Trust annual accounts audit conducted by KPMG concluded without issues, affirming a true and fair financial view. • The Charity's audit by the newly appointed Charity auditors, Ensors is currently underway with no anticipated problems. Their report will be received at the Charitable Funds Committee on the 13 September 2025. The final accounts will be submitted to the Audit Committee in October 2025. This is because the submission dates for the Charity are December rather than June. • BDO gave a "Moderate Assurance" for 2024/25 that there is a sound system of internal controls, designed to meet the Trust's objectives, and that controls are being applied consistently across various services. This was based on the completion of a total of eight reviews (six assurance audits and two advisory reviews). • The Committee was content with the overall assessment. Work is ongoing to ensure that the recommendations from these audits are implemented. • The Trust has had two attempted cyber-attacks in April 2025 as reported by LCFS. One was aimed at the Charity where its website was subject to several spam attempts and the second was aimed at the Trust's public website. Both attempts were thwarted. • The Trust's rating against NHS Counter Fraud Authority standards was rated as an overall green and was submitted by the 31 May 2025 deadline. • Whilst the overall assessment was green there were two amber elements for: New legislation and Failure to Prevent Fraud • The Trust's focus must be on ensuring existing counter fraud measures align with the Economic Crime and Corporate Transparency Act (ECCTA) principles, a robust Fraud Risk Assessment (FRA) is essential to demonstrate an adequate defence. The FRA should identify high-risk areas, highlight control gaps, support Committee and Board assurance, and ensure regulatory compliance. It must embed fraud risk into planning and guidance, assign clear ownership, link to assurance mechanisms, and remain a regularly updated document.		

	• The current Fraud Risk Assessment is being reviewed to make sure everything is covered. If there are any gaps they will be discussed at the next meeting in October • The Executive team have been reviewing the BAF risks with the intent that the Trust will have new BAF risks that reflect our strategy and are relevant to the current issues. This will be reported on in September and October 2025.		
7.2	**Strategic Projects Committee – Diane Leacock** **Received: The Council of Governors received a report from the SPC Chair.** • The SPC meet two monthly entirely in a PART II due to the sensitive nature of some items discussed and are structured around key themes. • The Lead Governor attends as an observer. • SPC has examined progress on the Trust Strategy 2026 – 2031, work in the areas of Digital Technology, including the electronic patient record, Working with our partners, Research & Development, the Sustainability Strategy, and the Estates Strategy. • The SPC purpose is to provide the Board with assurance about strategic projects and if there are any challenges SPC will alert the Board of Directors. • The Committee seeks assurance from several sources. • During late April an internal audit for the NEXUS Project was carried out and the full report was given to the Audit Committee. The summary of the report highlights was sent to SPC. The conclusions were good. It gave SPC added assurance that programmes were being managed on good practice governance and is progressing as planned. During the last two meetings, specific areas of discussion were focused on: **Trust Strategy 2026-2031:** The Committee received papers outlining the activities currently underway as part of the strategy development, noting the enthusiasm and energy created through staff, patient and community engagement. Board led Partner meetings (in pairs) took place throughout July & August 2025 - themes from these activities were reported back to the September 2025 Board. It is progressing as planned. There are no concerns at this stage. It will continue to be checked and challenged.		

	Digital Projects: The Chief Information Officer advised the Committee that following wider engagement from stakeholders around the Trust, there was an exercise to re-prioritize digital projects which has now concluded. A total of 24 projects have been prioritized for the remainder of the financial year, some of which are already in progress. The Committee discussed and noted the progress of the work being done to procure a new integrated EPR for the Trust. This project is on track. **Working With Our Partners:** This continues to progress well, and it will achieve improved outcomes for our patients. The Committee was updated on the good progress achieved through joint working with CUH. **Research & Development Update:** A report on the progress made in Research and Development for Q1 of 2025-26 was discussed. The Committee noted increases in the number of non-medical research grants being applied for through the RPH Innovation Fund. It was also noted that there was a significant reduction in the number of days for approval of research requests.		
7.3	**Quality and Risk Committee – Ian Wilkinson** **Received: The Council of Governors received a report.** Ian Wilkinson was not available to attend the meeting today. JA asked if there were any questions to raise from the report. There were no questions raised. **The Council of Governors is asked to note the report**. *JA commented that the level of governance on committees has increased over the last few years with the addition of two processes. Chairs of committees are attending for discussion through the Audit Committee and the work of the Board Assurance Framework being developed. Each committee is now commenting on the level of assurance being given. There is a consistency of governor observers at the committees.*		

7.4	**Progress Update: RPH 2026-2031 Strategy Development Process** **Reported by Eilish Midlane in the absence of Tim Glenn** **Received: The Council of Governors received copy of slides in the pack.** **Highlights:** **There are two key phases in the Strategy Development:** 1. **The Diverge phase –** This is the listening mode and Team 2031 were released from their day jobs so they could go out and have conversations with individuals and Teams within the organisation. They also went out externally and met with people that RPH would not naturally have a link with and obtained feedback. Live surveys have been running throughout the organisation. Staff have been encouraged to complete those surveys. Members of the Board paired with leaders in the organisation and went out to have conversations with external commercial entities, health partners, local authorities, and community groups. The level of feedback has been astronomical from within the organisation. There have been over 1000 contacts so far. A Governor session is arranged for Friday which will be added to that number. Within the numbers there have been 450 survey responses. There has been comprehensive feedback. Team 2031 is a small group of people, but they have had over 500 contacts. In the process of taking all the feedback and distilling it down. Team 2031 have come to the end of their piece of work and have written a report which has been given to the Board. Kaleidoscope a company who are supporting RPH with the Strategy Development are pulling together all the key themes from the feedback. It is now entering a checking phase by going back to people to check that the feedback has been heard in the right way. 2. **Converge phase –** At the end of September the feedback will be condensed down to key themes. Focus will be on the next phase of drafting the strategy of about 20 pages long, readable and accessible and helps decision making more locally and clinically given which can progress. Historically decisions have been made at the top level, but it is recognised that decisions		

	need to be made more locally which tend to be much more well-informed decisions and give sustainable solutions. Feedback from Kaleidoscope has been that they have never seen this level of engagement in any organisation that they have supported, and they are equally energised about the Strategy. The Board set itself the task of being closely involved and have been attending workshops, the next one is in October. These are key in making some of the decisions about which way RPH will be going and defining what is in the final strategy. **Discussion:** CG asked who Kaleidoscope are EM explained that they are a non-profit making organization who are used to carrying out the engagement part of developing a strategy. They have also been supporting NHS England. JA commented that the governors will meet a representative from Kaleidoscope online at the Governor Strategy meeting on Friday. JA added that one strong theme that has emerged from the updates received from Kaleidoscope was that RPH was not only seen to be keen to collaborate with the wider NHS and organizations, but other organizations were keen to collaborate with RPH.		
7.5	**10-Year Health Plan Overview – Eilish Midlane** • This was launched on 3 July 2025. There has been a high level of contribution to the plan. • A clear direction has been set, with three parallel shifts which will be essential going forward. • There will be a shift from receiving care in a hospital to receiving care more in the Community. • A change of focus from treatment which is the focus in the NHS today to prevention of illness. • Recognition of the digitalisation within the NHS, changing from analogue to digital. Digital solutions begin to unlock opportunities which allow the NHS to do more with resources that are currently being used. • It is recognised that the NHS of today has had as much Exchequer Funding as it is going to get and there is no more money. The biggest resource in the NHS is people. There is a need to make sure that the NHS is making use of time and skills.		

	The high-level plan was shared and eight workstreams were set up to begin collecting detail over the summer which will be taken to the National CEO meeting at the end of September. **The Eight Workstreams are**: • Neighbourhood Health • Innovation and Technology • Financial Foundations and medium-term planning • Quality • Workforce • Oversight Foundation Trust Licencing and Integrated Health Organisations • Prevention • Genomics Life Sciences and Research EM explained that she was invited to join the Technology and Innovation Workstream. In August there was a planning meeting and six workshops. There has been a lot of activity and EM offered to share information with anyone who was interested. It is a good opportunity for RPH to be part of a Planning Group which is going to be pivotal to the agenda going forward. • Beyond the 10-year plan some of the guidance and publications have come out to inform of the next level details outside of these workstreams. • Operational planning guidance came out in August which sets a very clear sense of lifting your eyes from the usual 12-month horizon in planning to a 5-year horizon. This allows for the bigger issues to be addressed. • The intent is to have a 5-year planning cycle rolling each year and the first year will align with RPH 5-year strategy. Rationalisation of the ICB's and NHS England has started to move at pace particularly the Integrated Care Boards: • There are currently 42 ICB's in the UK and these will be reduced to 26. This will mean that Cambridgeshire and Peterborough where RPH sits will be combined with Bedfordshire, Luton, Hertfordshire, and Milton Keynes • The reformed ICB will serve 3.2 million people. This is one of the largest clusters within the Country • Within this there will be six acute providers and an opportunity to work closer with NWAFT, CUH, Hertfordshire, Bedford, Luton and Milton Keynes going forward.		

	• The clustering is moving forward with the appointment of a CEO and chair for that combined cluster. EM was happy to share this information outside of the meeting. • Work is currently underway with the Executive Teams within the existing ICBs. They are at risk as they will be reduced by 50%. Several people will be displaced consequently. • Further work will happen around consultation with everybody currently employed by the ICB. The focus of the Operational Model is population health but fundamentals of strategic commissioning: • They will no longer be involved with performance managing. • Their role will be to understand the population needs and make sure they commission appropriate services to support the needs of those populations. • Work at Regional level is continuing. The role of the regional teams will now shift into providing strategic leadership, performance management oversight and improvement. • There are plans in due course for those functions to be absorbed into the Department of Health and Social care. • There is a clear steer from the Secretary of State that the intent is to bring back the policy decision making around health prevention into the department and under the direction of elected members. • There is no timeline for that yet. There has been a level of duplication seen. • The NHS Oversight Framework was published in the summer. This is used to measure organisations, acute specialist, community mental health and ambulance against a set of metrics. This is underpinning that allows the national league tables to be constructed and published as they were this week. • The key areas that the metric areas sit in are operational performance, quality and safety, workforce and finance. • EM is delighted to note that for the first quarter of this year the published results for the league table referenced that RPH is in fifth position in the national acute sector table. This reflects the hard work put in by people across the organisation, particularly in recent times trying to recover the elective position. This focus will continue as there are still patients that are waiting too long for care. • A Board capability self-assessment has been published.		

- A list built on the document was published before the summer which focuses on what Boards should look like and the level of scrutiny that they should receive.
- Currently there is continuing work on the self-assessment that is needed to be undertaken.
- The assessment will be considered when the organisations are rated in the future quarterly league table. To be submitted to the regional team by the 22 October.

Discussion

BD asked about capital expenditure dipping and if the 5-year financial planning would stop this.
EM commented that this has been recognised and has been part of discussions with the National Team.
Discussions are taking place about the element of not being able to carry capital forward one year to the next and within the digital arena opportunity to modernise and be more sufficient. Digital Finance has been ringfenced. The modern way of spending on technology is through revenue streams. There is an expectation that funding changes will be at the end of September.

JA commented that this is important particularly around the Patient Electronic Record project. It is important that in every assessment opportunity that RPH is completely above the line and not being questioned as it will make difficult discussions around getting further capital much easier.

KY asked what the view is about the destination that has been outlined and how is RPH placed to get there, will there be difficulties

EM commented that she feels it is the right thing to do although the pace of changes could lead to the risk of there not being the opportunity to think through in detail the consequences and communicating with the people who are directly affected. There is also a risk of losing a senior workforce that has a lot of NHS organisation experience.
A significant portion of RPH activity is regionally and nationally commissioned through a specialist commissioner route and historically it has been quite difficult to get close to remote populations. There are opportunities through the Strategy to gain a better understanding of meeting the needs of those patients.
There are opportunities but there are some inherent risks, for example, if RPH ends up doing more activity than the commissioned funding envelope allows, particularly as it has been made clear that the money received is all the money there is, RPH will not get paid for that. Navigating the backlog of patients on the waiting list and funding will be an issue over the coming years.

	JA commented that the 10-year health plan has come up in discussions around the Strategy. A question was raised about the identity of RPH and whether it is a specialist centre in which case how it plays into prevention. Most work is reactive. Where do we want to end up and are we still here for locals. SAB asked who the operational centre is EM explained that currently the Regional Team work out of Fulbourn, but she has not heard any discussion about changes. The Region is not changing but the ICB's are changing. JA commented that we will have to be more collaborative about those functions that can be shared across the bigger ICB. EM commented an important part of being in segment one of the league tables is being in the segment of greatest confidence of the organisations' ability to deliver a quality experience within the envelope. Therefore, that means that our own internal governance needs to be strong. RPH is very fortunate to have a strong Trust Board with NEDs that question, have a high level of scrutiny and challenge. CG asked are the league tables worth the paper they are written on. JA commented that it must be recognised that out of the league tables, within the top 10 there are 6 to 7 specialist hospitals. None of them have an A&E or maternity department which are big factors in the day-to-day challenges of a DGH. RPH does not have the distractions or the uncertainty. Those who are informed will see the tables for what they are. A concern is that there could be anxiety caused if you are waiting for treatment at a Trust which is at the bottom of the league table. EM commented that the Government see the league tables as a mechanism to drive improvement by ranking organisations. There is a big risk to those organisations who have more challenges and often strong leadership is needed to steer out of the muddy waters. There is also a risk that it becomes difficult to recruit good quality staff to those Trusts who already have challenges. CE commented that it is useful that you can pick out criteria and look at that across several organisations rather than looking at individual hospitals. HMcE commented that what he has experienced in the last 24 hours with teams across the Trust while he has been walking around speaking to them is ambition not to be fifth but to be first. It is tapping into the competitive nature of the organisation and drive to be the best,		

	what is best for our patients and how we go further than what we already have. JA commented that if it appears that a certain type of hospital can do very well and some are not doing so well on tight budgets. Could the opportunity arise that some resources could be distributed to the hospital not doing well to level the playing field. This has been mentioned and thought about internally, re distributing to areas that are not doing so well. Nationally it could mean that hospitals that are doing well may not need as much finance compared to others. EM commented that there are a lot of discussions within the finance workstream. A rebalancing at the cost of delivering care because that hasn't been reviewed since before covid. JA Commented with the issue of health inequalities some discussion will be needed at some point. If the budget is finite, then there must be an internal distribution.		
	GOVERNORS' UPDATE		
8.	**Lead Governor's Report – Abi Halstead**		
	Received: The Council of Governors received a report in the Pack. • AH reminded the Governors about the Strategy Development Workshop which has been arranged for governors on Friday 12 September 2025. • AH would have liked to say thank you to Gavin Robert for his contribution to governor committees but unfortunately, he was unable to attend the meeting today. • The next PLACE visit has been arranged, and an email has been sent out inviting governors to attend. The Council of Governors **noted** the Lead Governor's Report		
9.	**Reports/Observations from Chairs of Governor Committees**		
	Patient and Public Involvement Committee – Marlene Hotchkiss **Highlights of Discussions:** • A patient raised a situation while they were on the day ward waiting for their procedure. They found it very off-putting having people around them that were post procedure and were		

	able to eat while they were nil by mouth. The nursing team on the ward were asked if the ward could be segregated into different areas for pre and post procedure patients. • Following discussion, it was felt that because of the different functions of the ward it would not be viable. A suggestion was made about screens, but this was thought to be a risk due to the nursing staff not being able to observe the patient following procedure. Unfortunately, there has not been an option found that would suit all. • A lack of parking spaces for both staff and patients was reported earlier in the year. This is being reviewed on a regular basis by Estates and SABA. Currently, this has been reported as not an issue. • It was raised that there were no seating/stools in patient bathrooms. Review of bathrooms is taking place by Occupational Therapists. Stools are given out after assessment. • Paper towel wastage has been raised. There are ongoing communications with OCS regarding the overfilling of paper towel dispensers which causes a substantial amount to come out at once. • One committee member raised fire safety following an admission on floor 4 as a patient. She felt that there was no clear guidance should a fire break out. There is a review of Policy and Procedures. • Committee members have been asked for their thoughts on how they can engage with patients and to contact MH with any ideas. EM explained that the issue of fire safety had been raised on one of the wards initially during an inspection. It was found that instructions during training were contradictory to signage on the ward areas. She was grateful for governor feedback which gives another level of insight into the issue. This is actively being addressed. Face to face training will be brought back. For reassurance there is a matron on site 24/7 and they are the key coordinator in the event of an incident involving anything flammable. This has been taken to the highest level of priority. A specialist in fire safety has been appointed to support the Trust. **Forward Planning Committee – Chair Bill Davidson** BD chaired his first meeting on 9 July and this was the last meeting that Harvey Perkins and Susan Bullivant attended before they both		

	step down as governors. Susan had chaired the Committee for the last 2 years, and Harvey had been on the Committee for many years. Bill thanked them both for their contributions to the Committee. **Recent discussions included**: • The NHS 10-year plan and welcomed an update from Tim Glenn • An update on the 5-year strategy was given by Tim Glenn • Governors are interested in being more involved in the development of the Strategy. A meeting has been arranged about the Strategy Development on 12 September for Governors. • All governors have been invited to the next Forward Planning Committee meeting on 8 October which will include an update on the Strategy Development. • Harvey McEnroe attended and gave an update on Nexus and the Patient Electronic Record. • It was noted that there should be two staff representatives on the committee but currently there is only one. AH to ask new staff governors if they wish to join. AR explained that there is three and half years of data that has been collected from RPH in the Shared Care Record. Full benefits will be seen when other partners in the system can share their full data for completion. This will be progressed within the RPH Strategy and within the NHS 10-year Plan. In terms of the limited funding which is available RPH have gained some extra funding to connect the patient portal to the NHS App which is driving engagement with patients through that mechanism. JA asked if anyone had signed up to the NHS App and suggested that Governors sign up so they can comment on any challenges of using it for feedback to the current designer. EM added that GPs decide on the functionalities that they wish to use and whether they will engage with it. AR explained that the NHS App is the common denominator and is a simple front door with mechanisms to connecting to multiple functions. Essentially this accepts patient portals which will connect to the App. VB asked how to encourage people who are of the older generation to use the NHS App. For instance, some people do not have any photo ID and cannot access any government services online. How do you capture those people to provide an alternative.		

	EM shared that this was a key theme which was recognized during discussions, encouraging the national team to think about solutions. Discussions are ongoing. The NHS App will be the go-to for everyone in the future to streamline services. **Access and Facilities – Trevor McLeese** TMcL reported that the automatic doors were making a big difference that have been changed and that more will be fitted soon. Hearing loops are available to use now. EM thanked TMcL for championing the issue of changing doors to automatic doors. CCU can now move between areas without having to do complicated maneuvers to hold the door open while pushing a patient through. This has made a big difference to working lives. **Governor Assurance Committee – Chris McCorquodale** • CMcC became Chair of this committee at the last meeting. • Discussions that came up have already been discussed at this meeting. • Membership and moving away from development of the membership strategy to delivering it. IH has agreed to continue to attend GAC with a focus on membership. Laura Favell will be reporting into the committee 6 monthly. • The Governor Handbook was discussed and will be brought to CoG in November for approval. It had been suggested to send this around to governors before November including the new governors. • There is planned work on the Constitution with which KMB will be leading and will go through GAC meeting on its way to CoG. This is overdue for an update. • Further discussion was had around training and induction for governors and there is still work to be done to make sure there is a comprehensive induction in place.		
10.	**Reports on other Governor Activities (including from Appointed Governors)**		
	• IH reported that he had spent half of a day visiting the catheter labs. This was arranged by one of the six form students. • He sat with some of the technicians, observing procedures being performed on the other side of screens. • One procedure was a TAVI – insertion of an aortic valve. • Another procedure was an Ablation – eliminate faulty electrical pathways.		

	• He was able to talk with staff and a patient who was having his pacemaker checked. • He found it very interesting to see behind the scenes.		
11.	**Update on Actions (You Asked; The Plan/Progress Update)**		
	JA reported that these have been completed but will pick up with KMB and AH about training.		
	GOVERNANCE		
12	**Terms of References – Council of Governors Committees**		
	For Approval: • **Appointments Committee ToR** • **Forward Planning Committee ToR** JA asked chairs of the committees if they were happy for these to be approved. A discussion took place about the timescale of minutes being completed following committee meetings. In the ToR it states within 10 days, but it was noted that this time is not being met. JA commented that there needs to be a review of who is doing what and that there is a need to separate action lists from the minutes. AR is exploring multiple levels of AI and commented that a co-pilot is on the radar to explore for minute taking or report writing. CE explained that the University have been exploring automatic minute taking. It saves a lot of time but still needs someone to check it. A decision was not made to change the timing as each committee would need to be the same across the Trust. Further discussion ongoing. **Approval: The Council of Governors formally approved the Appointments Committee and the Forward Planning Committee Terms of Reference.**		
13.	**Governor Matters**		
	• Appendix 1: Governor Committees Membership		

	• Appendix 2: Minutes of Governor Committees No new matters were raised.		
14.	**Papworth Integrated Performance Report (PIPR) – Circulated for Information to the CoG** No questions were raised. JA commented that the PIPR report itself requires review because of the volume of data and is in discussion regarding this.		
15.	**Questions from Governors and the Public** CG raised the issue of no water stations for patients available in the out-patient departments hence no water is available to patients while waiting for their appointments/tests. Some patients have multiple tests performed on one day and are in the department for a long length of time. JA to investigate with infection control colleagues.	**JA/KMB**	
16	**Any Other Business:** **Update on m.abscessus from Dr Ian Smith Medical Director** • IS gave a brief update on M.abscessus following recent media coverage. • There were nine patients under RPH care who took legal representation and brought a claim for damages. • The finding of the legal process was that the hospital was not at fault in anyway. It was an unfortunate problem with the water supply. It was a unique situation in the Country at the time that it was discovered. • RPH have done everything they can to support patients to limit the ongoing risk of exposure. • The nine cases were settled. The payment does not come from the hospital but from NHS Resolution which is an overarching insurance for the NHS. • Because of what was found during the investigations various changes have been made to guidance nationally for the building of new hospitals and the safe management of water. • RPH have shared their learning with other organisations.		

	• There are a couple of cases being taken through different solicitors and they are expected to be resolved later this year. • There is still the challenge of M.abscessus in the water at RPH, and various things that are being done which have to be revisited because of new challenges being found. • It was very disappointing that at the end of last year, beginning of this year there were another couple of cases in transplant patients which were related to the water so there have been further changes in management. • Super safe areas of the hospital have been identified, and this is where the care of patients post lung transplant and some other vulnerable patients who have chronic lung diseases will be focused. • There have been no further cases for several months but there are regular ongoing checks. PB asked if Skanska had taken any responsibility. IS explained that RPH work closely with Skanska. In terms of where the ultimate responsibility lies, it is unknowable. It was discovered in the water some months after taking possession of the building, but it may have been there for some time. Part of the problem was that there was a delay in taking occupancy because of the problems with the cladding and so the water system was not being used which left it vulnerable. It is impossible to know when it happened.		
17.	**Future Meeting Dates** • **12 November 2025** • **11 March 2026** • **17 June 2026** • **9 September 2026 (Followed by the Annual Members Meeting)** • **9 December 2026** **The meeting finished at 12:44**		

Chair …… Date ……..

Royal Papworth Hospital
NHS Foundation Trust

Agenda item 4.2

Council of Governors

Action Checklist
Following: 10 September 2025 Meeting
Reporting to: 12 November 2025 Meeting

Ref	CoG mtg	Agenda Item No.	Issue	Responsible Director	Action Taken	To Agenda/ Action Date
02/25	**11 Nov 24**		**Charitable Funds Committee (Chair's Report)** Training for patients – Megan Sandford to check if funds could be made available for patients to undertake a course, to enhance their experience whilst they were inpatients.	~~**Megan Sandford**~~ **Krystyna Grant**	The Charity will revisit the suggestion once the Trust Strategy and its subsidiary Charity Strategy have been completed. The strategy refresh for both the Hospital and Charity over the next few months will enable the Charity to gather insight into patient requirements and allow them to focus our funding into the areas of most need and positive impact.	~~03/25~~ ~~06/25~~ ~~09/25~~ 03/26
08/25	**19 Mar 25**	**6**	**2024 Staff Survey Results** A Suggestion was made to visit Liverpool Hospital as they are usually the hospital who score highest.	**EM/JA/OM**	Verbal Update	11/25
10/25	**19 Mar 25**	**5**	**Invitation to Charlotte Summers to attend the next CoG meeting**	**KMB/JA**	Verbal Update – Invitation accepted for the November 2025 meeting. Unable to attend – the invitation has been rescheduled and accepted for the 17 June 2026 Council of Governors meeting.	~~06/25~~ ~~11/25~~ 06/26

Ref	CoG mtg	Agenda Item No.	Issue	Responsible Director	Action Taken	To Agenda/ Action Date
11/25	**19 Mar 25**	**4**	**Patient Story:** **Volunteer Support for Patient Pulmonary Fibrosis Support Group Meetings:** A request was made during the patient story by Emma Harris and Susan Hall for volunteers to help with the Pulmonary Fibrosis Support Group meeting set up.	**OM/MS/ PALS**	Action being progressed. **Completed**	~~06/25~~ 11/25
13/25	**19 Mar 25** **10 Sept 25**	**8**	**Lead Governor Report.** **Governor Training Sessions.** Training sessions to be arranged for Governors who started in Sept 2023 and Sept 2024 and Sept 2025	**JA/AH/CMcC /KMB**	Verbal Update – NHS Providers has submitted, for review by the Trust, a proposal for induction and training support for Governors. Further discussions held between JA, AH CMcC and KMB – verbal update.	~~06/25~~ ~~09/25~~ 11/25
15/25	**4 June 25** **10 Sept 25**	**3**	**Private Patient Presentation:** To be added as an agenda item for the meeting on the 10 Sept 2025. Discussion was not had at meeting in Sept. To add this to the agenda for 12 November.	**KMB**	Update to be provided at the November 2025 meeting. **Completed**	~~09/25~~ 11/25
16/25	**4 June 25** **10 Sept 25**	**7**	**Governor's Handbook.** Second Draft sent out to Governors for change or amendment. Timeline: Target set to September CoG Timeline changed to November CoG due to draft version being reviewed at GAC on 16 October.	**KMB**	Attached to the agenda for approval. **Completed**	~~09/25~~ 11/25
17/25	**4 June 25**	**10**	**Membership and Engagement Strategy – Update** KMB to add to the agenda in November. IH and LF to give a verbal update of Action Plan progress	**KMB/IH/LF**	Membership Activity Update included on the agenda as a standing item from November 2025. **Completed**	11/25

Ref	CoG mtg	Agenda Item No.	Issue	Responsible Director	Action Taken	To Agenda/ Action Date
18/25	**4 June 25**	**14**	**PIPR** Pain Management review results to be added to the agenda for CoG once the results of the review have gone through Q&R Committee.	**MS**	Verbal Update	~~09/25~~ 11/25
19/25	**10 Sept 25**	**15**	**Question from Governor** An issue was raised about the lack of water stations for patients in out-patient department. Some patients have multiple appointments and are in the dept for some time with no access to water. JA suggested taking this to Infection Control for investigation.	**MS**	Verbal Update **Completed**	11/25

Workforce Committee Report to the Council of Governors- November 2025.

The Workforce Committee, oversees the implementation of the Trust's workforce strategy and the operation of workforce policies and procedure, ensuring that key risks, controls, and mitigations are presented and thoroughly discussed.

This report summarizes the key discussions, assurances, and decisions made during the Workforce Committee meeting in July and September 2025. The workforce committee chair presented to the Audit Committee on July 17th. The chair of the committee provided assurance to the Audit committee on key workforce risks, including staff turnover, recruitment and retention, staff engagement, and industrial relations. The committee chair described that through the strategic oversight, data monitoring, and initiatives like the Compassionate and Collective Leadership Programme, revised values frameworks, and staff support schemes, the committee ensures alignment between workforce strategies and staff well-being. Regular reviews of key performance indicators, staff feedback, and internal audits support a comprehensive understanding of workforce challenges and progress, enabling informed decision-making and risk mitigation by the committee and Board.

The key issues addressed at the committees are detailed below.

Board Assurance Framework (BAF) and Key Workforce Risks:

The Workforce Committee reviewed the BAF at both committees and determined that no changes to the risk ratings were necessary. The current focus remains on the following key risks:

- **BAF Risk 1: Staff Turnover (ID 1853)** - Residual risk rating of 4x3=12.
- **BAF Risk 2: Inability to Attract and Recruit Staff (ID 1854)**
- **BAF Risk 3: Low Levels of Staff Engagement (ID 1929)**
- **BAF Risk 4: Negative Impact on Industrial Relations/Potential for Industrial Action (ID 3261)** - Risk rating remains at 20, to be reviewed in 3 months.

Temporary Staffing, Vacancies, and Sickness Absence:

At the request of the Performance Committee, the Workforce Director highlighted the work undertaken regarding temporary staffing, vacancies, and sickness absence. While there is a slow improving trend in sickness absence, it remains above the target of 3.5%. Maternity leave absence is stable, but other absences have increased, potentially due to a change in the reporting process. The total temporary staffing use has been slowly improving, but the reduction in temporary staffing is not commensurate with the reduction in the overall workforce shortfall. Further analysis is needed to implement appropriate mitigations and controls at departmental and organizational levels.

Positive Developments:

The committee noted the following positive developments:

- Mandatory training compliance has reached 90.55%, the highest in approximately 7 years.
- A smooth transition of resident doctors occurred in August 2025.
- Operational HR is almost fully established.
- Manager self-service has been successfully implemented.

Disparity in Appointment Likelihood Ratios (LR):

Recruitment data reveals a growing disparity in appointment LR between BAME and White colleagues. The LR of White colleagues being appointed compared to BAME colleagues increased from 1.19x in 2023/24 to 1.8x in 2024/25. This trend raises concerns regarding equity and alignment with the Trust's EDI commitments. Following initial exploration and identification of statistical anomalies, cardiology was selected for a deep dive. The comprehensive review uncovered opportunities for improvement. Next steps include:

- Using the nurse recruitment team in moderating short listing and interviews.
- Meeting with candidates who submitted multiple job applications to understand their experience.
- Auditing a random selection of 30 jobs to review compliance regarding interview feedback and managers' use of OLEEO.

Fairer Recruitment Audit:

The committee reviewed a summary of the audit of recruitment practices for Band 7 and above, using a model piloted at Imperial College London. The audit highlights important risks for the Trust due to disparities in appointment outcomes for BAME candidates, which contradict WRES, the NHS People Plan, and the Trust's EDI commitments. Recommended next steps focus on:

- Training and capability
- Audit development
- Compliance and accountability
- Systems integration
- Candidate support

Sexual Safety in the Workplace Update:

The Director of Workforce and OD provided an update on the progress of the sexual safety charter, which the Board signed up to in 2023. A revisedNHSE sexual safety framework was published in August 2025, outlining best practices to support the delivery of the seven commitments in the Charter. A self-assessment against the framework is required and will be presented to the committee in November and subsequently to the Board. The committee discussed encouraging all staff to

participate in e-learning on sexual misconduct and suggested that Board members "road test" the e-learning package. Including the work on Sexual Safety in the Workplace in a future Board development session was recommended.

Other Reports and Updates:

The committee received and commended the following reports:

- Annual report from the Trust Armed Forces Network: The committee supported the Trust's progression from Silver to Gold Defence Employer Recognition Scheme status.
- Annual Medical Revalidation Report (presented by Dr. Stephen Webb): Recommended to the Board for approval. The committee sought assurance on the quality of appraisals, progress since last year, and the testing of mandatory training.
- Graduation Guarantee for Newly Qualified Nurses: The committee received a paper detailing the approach to delivering against NHS England's graduation guarantee for newly qualified nurses and midwives. RPH has demonstrated strong alignment with the principles outlined by NHS England and is identifying opportunities to enhance predictive workforce planning, optimize bank staffing, and improve visibility of support mechanisms such as relocation policies.
- Next Steps from embedding our Vision for Inclusive Leadership: A report from the Director of Workforce and OD updated the committee on progress following the March 2025 event where divisions and directorates shared their work to share the vision and embed it into practice. Progress was presented in line managers/ leaders development programme, the commissioning of EDI anti racism training for managers, commissioning a development programme for staff from a BAME background and the leader's workshop on bullying. More details and progress will form part of the board development workshop later this year.
- Guardian of Safe Working Hours Report April to July 2025 and the Annual Report (presented by Dr. Steven Preston): Recommended to the Board for approval.
- Improving the working lives of doctors in training: The committee noted the report and the work ongoing to improve the working lives of doctors in training. A baseline against a 10 point plan exposed there were a number of areas where the trust is fully compliant with best practise or plans are in place. In some areas compliance was lacking including ensuring that resident doctors have protected breaks. Another area for improvement is to reduce payroll errors which result in doctor overpayments.

Conclusion:

The Workforce Committee continues to actively seek assurance regarding the Trust's workforce. The committee closely monitors workforce strategies, their impact on staff well-being and organizational performance, and works to mitigate identified risks. The Committee will continue to review and adapt its approach to ensure that workforce risks are effectively managed and mitigated.

At the centre of heart and lung care

Royal Papworth Hospital, strategy 2026-2031

About this document

This document tells the story of where we are now in 2025, and where we want to be by 2031. It sets out -

- **what matters to us most**: our mission as an organisation;
- **where we would like to be**: our six aims for the next five years; and
- **how we're going to get there**: our actions and next steps.

It is the result of hundreds of conversations with our people, our patients, our partners and our community. We are incredibly grateful to all of them for their contribution so far, and we look forward to working together to make these words a reality.

Summary

- Royal Papworth Hospital has been transforming what is possible for patients with heart and lung conditions for more than 100 years. As patients' needs change and new treatments and ways of working emerge, this strategy sets out how we will build on that proud history.
- By 2031 we want to be a centre for heart and lung care which is renowned for clinical excellence, innovative partnerships, and where every member of staff is valued, empowered, and proud to work here.
- Our strategy is shaped by the voices of hundreds of staff, patients, and partners who told us what makes Papworth special - exceptional care, world-leading expertise, and a deep sense of compassion - as well as where we must improve: tackling cultural challenges, reducing bureaucracy, empowering staff, and clarifying our role locally and nationally.
- We will focus on six aims: focusing on clinical excellence in our services, building our culture of innovation, team-working and learning, partnering locally and regionally to extend our impact, leading nationally and internationally in heart and lung care, ensuring all staff are valued and empowered, and getting the basics right.
- This is a strategy for action, built on what we've heard, and to be delivered together by building thriving teams that deliver outstanding care.

Where we are now

Our organisation was set up over 100 years ago in order to give the best care we could for some of the most unwell people in the country.

Much has changed since 1918, and our beginnings as a colony for people with tuberculosis. But throughout we've kept our focus on finding new ways to provide excellent care, caring for hundreds of thousands of patients and performing a number of treatments for the first time in the UK, or even the world.

As we look to our next five years, we will change again - and all to ensure we can provide and support *even better* care in the East of England, and across the UK.

The last decade has been one of the most momentous in our history. We have a new hospital, we continued through the Covid-19 pandemic, and we are now treating more people than ever before.

We are proud of successes - such as our CQC 'Outstanding' rating and being recognised as one of the top 100 hospitals in the world. We particularly value the feedback we receive from those we care for. But we also know that many of our staff don't feel valued, our purpose has not always been clear, and that we have opportunities to do even better. As part of the wider NHS, we also have a part to play in supporting *Fit for the Future: 10 Year Health Plan for England* which was published in 2025 with a focus on three 'shifts' in how care is provided : hospital to community, sickness to prevention, and analogue to digital.

Infographic to be designed for final print version

How we've got here - our process to engage, listen and inspire

Creating this strategy involved engaging with hundreds of people between April and August 2025. We used a range of different ways to ensure we heard from staff, patients, communities, and partners across our health and care system.

Team 2031

Team 2031 was a diverse group of 12 staff members selected through an open expression of interest process. The group included representatives from a broad range of staff - from medical education fellows to healthcare scientists, critical care nurses to estates staff.

During eight weeks, Team 2031 had more than 500 interactions with people about the strategy. They worked through three subgroups: internal staff engagement (using one-to-one discussions, focus groups, team meetings, and conversations around the hospital), patient and community engagement (with patients in hospital, patient support groups, and community activities), and learning from external organisations (meeting stakeholders from various industries and sectors).

Wider engagement

We ran a comprehensive online survey that received 467 responses from staff (273), patients and community (185), and partners (9). We used a "Pairs Discussions" approach where Board members and staff leaders met together with 29 partner organisations. Five fortnightly strategy webinars provided updates and gathered ongoing feedback. Targeted workshops with groups like our Consultants' Forum ensured we heard from specific stakeholder groups.

What we heard

Across these hundreds of conversations, a clear picture emerged. Despite the diversity of voices - from patients recovering from heart transplants to healthcare scientists developing new treatments, from community partners to administrative staff - there was striking alignment on both our greatest strengths and most urgent challenges.

Our golden thread

Two themes emerged consistently across every conversation as Royal Papworth's core identity:

- Excellent quality of care and patient satisfaction. Patients consistently described their experience in terms that went beyond satisfaction - "everything is perfect," "1st class service," "true holistic care." What made this more significant was hearing staff across every department, from medical to administration, talk about patient care with the same pride and commitment. Patients said they felt "genuinely cared for" and wanted us to "share the expertise with other authorities."

- Specialist excellence and innovation leadership as the UK's leading heart and lung hospital. Staff spoke with pride about "saving lives that have previously not been treatable" and giving "hope to many." Community members recognised us as "the leading heart and lung hospital" with distinctive specialist skills that other hospitals cannot provide.

Key challenges

While our clinical excellence provides a strong foundation, our engagement revealed significant challenges that need urgent attention:

- **Culture is the key.** Across every theme - clinical excellence, staff experience, innovation, community engagement - organisational culture emerged as what will determine our success. We heard about areas of exceptional collaborative culture existing alongside reports of incivility, discrimination, and leadership disconnect.
- **Staff experience requires improvement**. Despite almost universal pride in working here, we heard about practical frustrations and areas of disconnect between staff and senior leaders. We heard staff say "we're good at talking the talk but lack action to back up." Some departments had seen no response to previously raised concerns, whilst others celebrated tangible changes when they felt heard.
- **Innovation barriers are holding us back.** Though we aspire to be research-strong and innovative, staff described bureaucratic processes that separate those with good ideas from those with power to implement them. Staff feel that innovation gets stuck in committees whilst frontline improvements that could help both patients and staff struggle to reach decision-makers who can make them happen.
- **Questions about our role.** We heard different views about our ideal reach and role. Staff want to focus on specialist expertise, whilst community groups see opportunities for us to expand our local role through prevention programmes and health education.

Our mission and vision

Our mission is to transform what is possible for patients with heart and lung conditions. We deliver outstanding care by building thriving teams.

Our vision is to be a centre for heart and lung care which is renowned for clinical excellence, innovative partnerships, and where every member of staff is valued, empowered, and proud to work here.

Our hospital primarily serves the East of England. Providing specialist services for our region, along with our remarkable research, education and innovation, will always be at the core of what we do as an organisation. Yet we have additional roles locally in Cambridgeshire, nationally across the UK, and internationally.

We are already making a difference to so many lives. Our challenge now is to make an even greater difference. We will do this by being much clearer as to the importance of *all* of these roles - providing care in our hospital, undertaking research, being a leader in education and sharing of knowledge, and working with others elsewhere.

As such, we see a future where -

Our hospital retains and builds on its world-class reputation for specialist clinical excellence and patient experience

- We build on this by becoming renowned not just for the care we give, but the way we enable our staff to thrive, further enabling us to recruit and retain the very best staff and deliver the very best care.
- We seek to grow our role as a provider of specialist education, providing training and sharing our learning with our specialist and non-specialist partners. We value research, teaching, education and leadership as fundamental to our identity as a specialist centre.

We remain committed to cutting-edge research and pioneering treatments

- We build on this through exceptional team-working that connects teams inside and outside the hospital, enabling us to innovate rapidly and bring new treatments to patients faster.
- We develop a new ‘life-cycle’ model for our services whereby we always seek to use our facilities at Royal Papworth for what is needed to provide the cutting-edge treatments of tomorrow, seeking to be an early adopter of new treatments. At the same time we work with and support other providers to take on the treatments of today.
- Focusing on how we best use our specialist expertise, and working with our partners, we review all of our clinical services as to whether they need to happen on the Royal Papworth site, or whether there are alternative clinical models which can enhance patient outcomes and experience.

We transform how we work in collaboration with partners

- We maximise the local impact we can have through a wide range of partnerships on our Campus and across the East of England, where we listen, engage and work

together in a new way. We will use our specialist expertise and role in the local economy to support the communities who live closest to us.
- Our role in working with and supporting care with fellow partners in the East of England is greatly strengthened, with a greatly increased model of access for others to bring in our specialist experience where needed, and for us to learn from them.
- We work with partners across the UK and beyond, including industry and academic partners, contributing to national and international debates and developments in heart and lung care and health.

This new role goes beyond being a hospital - a single building in one place. When we describe Royal Papworth as a *centre* for heart and lung care, we mean acting as a hub of expertise, partnership, and learning that reaches far beyond our walls.

Being a centre means:

- **For patients,** access to world-leading care, whether delivered here in Cambridge or closer to home through our partners.
- **For staff,** being part of a thriving community of clinicians, scientists, educators, and innovators who shape national and international standards in heart and lung care.
- **For partners,** a trusted collaborator that shares knowledge, supports service improvement, and helps strengthen specialist care across the East of England and beyond.
- **For learners and researchers**, a place where discovery and education sit alongside care - turning new ideas into better outcomes for patients everywhere.

Our vision for 2026–2031 is to measure our success not only by what happens inside our hospital, but by the wider difference we make - to the communities in better health, the professionals we support, and the future treatments we help create.

Introduction to strategic aims

Getting to our vision - to be a centre for heart and lung care renowned for clinical excellence, innovative partnerships and staff experience - will require changes across everything we do as an organisation. This includes work on six specific areas, each led by a member of our executive team.

By 2031 we want to be a centre for heart and lung care which is renowned for…	
	Strategic aims
Clinical excellence	1. Focusing on clinical excellence in our services – Maura Screaton, Chief Nurse 2. Creating a culture of innovation, team-working and learning – Tim Glenn, Deputy Chief Executive and Executive Director of Commercial Development, Strategy and Innovation
Innovative partnerships	3. Partnering locally and regionally to extend our impact – Liz Sanford, Chief Finance Officer (Interim) 4. Leading nationally and internationally in heart and lung care – Ian Smith, Medical Director
Where every member of staff is valued, empowered, and proud to work here	5. Ensuring all staff are valued and empowered – Oonagh Monkhouse, Director of Workforce and Organisational Development 6. Getting the basics right – Harvey McEnroe, Chief Operating Officer

Strategic aim 1: Focusing on clinical excellence in our services

By 2031, we want to be recognised as a leading centre for heart and lung care, always ensuring our facilities enable us to deliver the cutting-edge treatments of tomorrow whilst helping others provide the treatments of today. We will be a centre where patients know they will receive world-class specialist care, and where other health providers come to learn and collaborate with us.

Why do we need to focus on this?

Clinical excellence in specialist heart and lung care is our golden thread - what staff, patients, and partners consistently identify as our greatest strength and essential foundation for everything else we do. Staff expressed profound pride in our specialist capabilities and our position as a national and international referral centre.

Patients consistently described their experience as going beyond excellent care - they spoke about feeling genuinely cared for and receiving first-class service that transforms and saves lives. Partners recognise us as a specialist centre of international renown, with some saying we provide world-class transplant services which give hope to many people.

However, we face important choices about which services we provide directly and which we support others to deliver. Staff emphasised the importance of not becoming a jack of all trades, whilst patients want the same outstanding skill without long waits. We heard about capacity challenges and questions about whether all our current services need to happen on our site. We know that, while some of our services are as good as any in the world, this is not true for everything we do. Even for those areas where we do lead the world, we need to be continuously pushing to improve what we do.

This means we will develop a new 'life-cycle' model for our services whereby we always seek to use our facilities at Royal Papworth for what is needed to provide the cutting-edge treatments of tomorrow, while supporting other providers to take on the treatments of today. This supports the approach set out in the NHS 10 Year Health Plan to move more services from hospitals into the community, while also focusing on prevention and digital innovation.

Working with our partners, we will regularly review all of our clinical services as to whether they need to happen on the Royal Papworth site, or whether there are alternative clinical models which can enhance patient outcomes whilst freeing our capacity for the most advanced specialist treatments. If this requires us to stop providing some services directly at Royal Papworth when partners can deliver them more effectively for patients, we will do so with utmost compassion and care both for our patients and our staff.

How will we measure our success?	What will we start by doing?

● Sustained excellence in clinical outcome measures (mortality, morbidity, harm reduction) ● Patient experience scores, including use of patient-reported experience measures (PREMs) ● Quicker, smoother care pathways and fewer differences in outcomes between communities ● Increased capacity for cutting-edge treatments, supported by successful implementation of service "life-cycle" reviews ● Independent reviews and national standards confirm the quality of our care and the strength of our teams	● Initiate service-by-service reviews using the "life-cycle" model to determine optimal delivery location and model ● Establish continuous improvement processes in every clinical area with staff ownership and clear learning mechanisms, celebrating QI work undertaken in the last year and setting plans for the year ahead ● Invest in education and training infrastructure to formalise role as specialist training centre ● Optimise use of technology to enhance clinical care delivery and patient monitoring ● Add questions to Friends and Family feedback to capture patient-reported experience measures ● Baseline current accreditations, celebrate existing achievements, and plan for growth in recognition standards

Strategic aim 2: Building our culture of innovation, team-working and learning

By 2031, we want to be recognised for exceptional team-working where innovation happens at every level. Teams are empowered and trusted to make improvements themselves, with the autonomy to experiment, learn, and drive change. We are a learning organisation where knowledge is shared openly and everyone contributes to continuous improvement.

Why do we need to focus on this?

Our engagement revealed both areas of exceptional collaborative culture, and significant barriers to innovation and team-working across the organisation. Staff described good ideas struggling to reach decision-makers who can act on them, with many feeling their ideas are blocked by bureaucratic processes. However, the solution isn't creating better pathways to approval committees – it's trusting and empowering teams to innovate themselves.

Exceptional team-working requires trust, an ability to work through conflict, commitment to find solutions to the problems our communities face, ownership of accountability, and collective ownership of the results of our actions from which we learn. Building a culture of innovation means fundamentally shifting power and decision-making closer to frontline teams. Staff want genuine autonomy to make improvements in their areas without needing multiple approvals. They want to be trusted to understand the problems they see daily and to design solutions.

We saw examples of this working well – teams that felt empowered to make changes celebrated tangible improvements, showing what's possible when hierarchical barriers are removed and teams are trusted to lead. We want to replicate this across the organisation, enabling high-performing teams that work across boundaries – both within Royal Papworth and with our partners – to directly impact patient care. Staff particularly want to focus innovation efforts on digital transformation and AI integration, research-to-practice translation (turning "bench to bedside" research into improved patient pathways), and technology-driven operational improvements that enhance both patient care and staff experience.

Teams need the tools to rapidly assess the changes they make and their impact, and psychological safety where they can experiment, learn from both successes and failures, and share knowledge openly without fear of blame. We will build this by ensuring our teams have access to the information they need to understand the problems our communities face, supporting them to manage conflict in ways that are in line with our values, and providing clear accountability frameworks that support decision-making closer to the frontline.

To support this transformation, we will bring together a single improvement support team who will provide the practical tools teams need to drive change and clarify decision-making responsibilities. Where governance is genuinely needed, decision-making must be streamlined with clear boundaries about what teams can decide themselves.

Creating this culture of team-working, innovation, and learning makes work more fulfilling and gives everyone genuine agency to improve how we deliver care. As a major provider of

specialist education and as a research institution, building a strong learning culture internally also strengthens our ability to teach and inspire others externally.

How will we measure our success?	What will we start by doing?
● Increase in number of staff-generated innovations successfully implemented, with reduced time from idea to implementation ● Staff reporting increased autonomy and empowerment to make improvements in their areas	● Establish clear pathways for staff ideas to reach decision-makers, with transparent tracking and defined approval timelines ● Collect baseline data on committee returns and resource-neutral proposal blockages to identify and address bureaucratic bottlenecks ● Review and streamline decision-making governance to increase team autonomy within clear boundaries ● Formalise and resource education delivery as core strategic function, not supplementary activity

Strategic aim 3: Partnering locally and regionally to extend our impact

By 2031, we will work in partnership to extend the reach of specialist heart and lung expertise across the East of England. Through collaboration with community organisations, GPs, and local hospitals, learning from each other, more people will benefit from prevention, earlier diagnosis, and better access to specialist knowledge closer to home.

Why do we need to focus on this?

Our primary role is to directly deliver healthcare to our patients, typically in the East of England region. However this is not the only way we can have impact; over the next 5 years we want to expand the difference we can make to patients' lives, reaching from the local communities who live close to our hospital, through to patients across the world who can benefit from our research and innovations.

This requires different ways of working to those we are used to. We will not be directly leading many of these partnerships, nor do we expect to be establishing new sites to provide care badged as Royal Papworth Hospital. Instead, we want to do this in partnership, supporting others to deliver for their populations and patients.

For example, while our core expertise is treating illness, we recognise that preventing heart and lung disease is just as important as treating it. Many conditions can be prevented or managed better in the community by organisations already embedded and trusted in their local areas. Our role is not to lead this work directly - that's not where our specialist expertise lies - but to support and strengthen what others are already doing well whilst learning from their expertise about what approaches work best locally.

We also recognise that access to specialist care is not equal across our region. Patients living further from Cambridge, those in more deprived communities, and those from certain ethnic backgrounds face greater barriers to accessing our services. Through our partnerships, we want to address these inequalities by bringing specialist expertise closer to where people live, improving pathways for timely referral, and ensuring our services are accessible to all who need them.

Local hospitals and GPs care for many more patients with heart and lung conditions than we are able to see. We want to make it easier for GPs managing patients with heart and lung conditions to draw on our specialist expertise when helpful. We will explore establishing educational forums with primary care, sharing best practice, and developing clearer pathways for seeking advice and support. This partnership approach directly supports the NHS 10 Year Health Plan's shift from hospital to community and from sickness to prevention.

The impact we can have goes beyond health and healthcare. As one of the area's largest employers and a key part of the Cambridge Biomedical Campus, we have responsibilities as an 'anchor institution' - using our economic presence to support local communities through training opportunities, local supply chains, and inspiring the next generation of healthcare professionals.

How will we measure our success?	What will we start by doing?
● Number and quality of active partnerships with measurable impact on community health outcomes and patient pathway improvements ● Reach metrics showing expanded access to RPH expertise across the region through remote consultation, training, and shared pathways ● Community health indicators (smoking rates, cardiac rehabilitation participation, earlier diagnosis) in partnership areas ● Anchor institution impact metrics (local employment, training opportunities, supply chain investment)	● Map existing partnerships and identify gaps, with clear definition of what "true partnership" means for RPH ● Establish mechanisms for partners to easily access RPH specialist expertise (consultation, training, pathways) ● Develop community health education programmes in collaboration with local organisations, leveraging RPH's trusted voice ● Create formal anchor institution strategy addressing employment, procurement, and community investment

Strategic aim 4: Leading nationally and internationally in heart and lung care

By 2031, we want to be a leading voice in heart and lung care nationally and internationally. Through innovative partnerships with NHS organisations, research institutions, industry, charities and beyond, we will help raise standards everywhere. We will grow our impact through education, contributing to national guidelines and policy, and translating our research into improvements that benefit patients far beyond the East of England.

Why do we need to focus on this?

Transforming what is possible for patients with heart and lung conditions means helping raise standards everywhere, not just in the East of England. Staff expressed pride in our position as a national and international referral centre, recognising that we have a duty to treat the sickest people who lack access to specialist care elsewhere. System partners told us they want organisations like us to help address health inequalities, including inequalities in access based on geography, deprivation, and ethnicity, through shared knowledge, technology, and remote support rather than expecting all patients to travel to Cambridge.

Research is fundamental to achieving national and international impact, yet our engagement revealed that our research capacity needs strengthening to match our ambitions. We need to strengthen our research output, translate discoveries into practice faster, and ensure our research contributes to national guidelines and international standards. When we do this well, we multiply our impact far beyond the patients we treat directly.

As a specialist centre, we can contribute to national conversations about heart and lung health alongside other leading organisations. By sharing our research, participating in guideline development, and supporting policy discussions, we can help ensure the latest evidence and innovations reach frontline care.

Beyond research, we can lead through education and knowledge-sharing. Royal Papworth is already a major provider of specialist education and training. Staff, partners, and patients all emphasised that education should be central to our identity as a specialist centre. We train medical students, nurses, allied health professionals, and specialists from across the UK and internationally. Our education role connects directly to our partnership ambitions - by training others, we multiply our impact far beyond the patients we treat directly. We will grow our role as a provider of specialist education, sharing our expertise through formal education programmes, exploring innovative models like shared consultant posts with acute hospitals, and ensuring education is properly recognised.

How will we measure our success?	What will we start by doing?
● Growth in national and international education delivery, training programmes, and knowledge-sharing activities	● Map current national contributions and identify strategic opportunities to increase impact

● Contributions to national guidelines, standards, and policy development tracked and measured ● Research output and translation metrics showing impact beyond direct patient care ● Recognition through national benchmarking, peer review, and invitations to lead national initiatives ● Growth in formal education and training delivery (number of trainees, programmes, external partnerships)	● Explore shared consultant posts with acute hospitals to support recruitment and spread expertise ● Maximise Cambridge Biomedical Campus partnerships for pioneering research and innovation ● Establish clear pathways for translating research findings into improved national practice standards ● Ensure workforce planning supports the full range of activities required to be a national centre of excellence

Strategic aim 5: Ensuring all staff are valued and empowered

By 2031, we want to be known as an exemplary employer in specialist healthcare. Staff across all roles and levels feel genuinely valued, heard, and supported to do their best work. Our culture consistently extends the same compassion we show patients to our colleagues, creating an environment where everyone feels a sense of belonging and can thrive.

Why do we need to focus on this?

Our engagement revealed a paradox: almost universal staff pride in Royal Papworth alongside significant frustrations about working here. We heard about exceptional collaborative culture and family-like teamwork, with staff demonstrating genuine care for each other and shared commitment to excellent patient care. However, this isn't consistent across all areas.

Staff told us excellent patient care depends on supported, engaged staff. We heard concerns about feeling disconnected from senior leadership and frustrated when escalated issues don't result in change – with some departments reporting that previously raised concerns had seen no response, whilst others celebrated tangible improvements when they felt heard and supported. Equally important, staff told us about their desire for fulfilling careers with clear development pathways, opportunities to grow their skills, and the ability to progress professionally while continuing to do work they find meaningful.

Staff reported burnout affecting patient care due to excessive workloads and limited wellbeing support. We heard staff say "we're good at talking the talk but lack action to back up" and concerns that colleagues are considering leaving because issues raised with senior leadership are not being addressed. Staff want to feel that their voices matter and that feedback leads to meaningful change, not just acknowledgment.

This means we must address the cultural issues around leadership response to feedback and creating consistent experiences of respect and inclusion across all departments and levels of the organisation.

Our vision for leadership is that inclusion and belonging is felt by every staff member, no matter their background or race, in an organisation where everyone contributes, everyone matters, and everyone deserves and receives respect. Leadership and personal conduct which nurtures inclusion and belonging *is* clinical excellence.

This requires leaders and managers at every level to model the behaviours we expect, have difficult conversations when needed, and follow through on commitments. It also requires personal accountability from everyone for how we 'show up' to work – how we treat colleagues and contribute to our team culture under both personal and professional codes of conduct. Importantly, this is not about creating new programmes or initiatives, but about fundamentally changing how we all engage with each other and how we respond to the feedback we receive.

How will we measure our success?	What will we start by doing?
● Significant improvement in NHS Staff Survey scores on staff engagement, feeling valued, and psychological safety, with specific focus on reducing the gap between best and worst performing areas ● Increased staff satisfaction with career development opportunities and progression pathways, with particular focus on ensuring equitable access across all staff groups and roles ● Measurable increase in staff reporting that their concerns are acted upon and feedback leads to tangible change ● Improved equity metrics showing consistent positive experiences across all staff groups, roles, and sites	● Improve the mechanisms for staff to raise concerns so that they are transparent and streamlined with clear timelines for response and visible action tracking (addressing the "we're good at talking but lack action" feedback) ● Create ways to recognise, celebrate and build team excellence and collaborative behaviour, not just individual clinical achievements ● Implement inclusive leadership development focused on creating psychological safety and responding effectively to staff feedback ● Review and strengthen career development pathways across all staff groups, ensuring clear opportunities for progression and professional growth

Strategic aim 6: Getting the basics right

By 2031, our facilities, digital systems, and processes work reliably and efficiently. Staff have experience of systems that support rather than hinder their work, freeing their time and energy for excellent patient care and innovation. Getting the fundamentals right creates the foundation for everything else we want to achieve.

Why do we need to focus on this?

Excellence in specialist care and pioneering innovation can only rest on brilliant basics. During our engagement, staff were clear that ambitious aspirations for the future must be grounded in fixing fundamental operational issues that affect their daily work. Getting the basics right means both the interpersonal fundamentals - listening, caring for colleagues, treating each other with respect - and the operational fundamentals: facilities, digital systems, and processes that work reliably. This aim focuses on the operational basics.

We heard about facilities where basic amenities and working conditions aren't consistently met. While we have made progress in our digital maturity, staff described frustration when systems don't work reliably or when digital literacy gaps create workarounds that add administrative burden. Staff described spending excessive time on workarounds when systems don't function reliably, innovation being hampered by lack of investment in digital basics, and time taken away from patient care by inefficient processes.

Addressing this requires both reliable infrastructure and investment in enabling all staff to use digital systems effectively through training, support, and sustained commitment to continuous improvement.

The impact of poor basics extends beyond daily frustrations. When systems don't work reliably, staff experience unnecessary stress and burnout. When digital infrastructure is inadequate, we cannot innovate effectively or work seamlessly with partners. When facilities don't meet basic needs, it affects staff wellbeing and our ability to recruit and retain the best people. In a financially constrained NHS, operational inefficiency also means wasted resources that could be invested in patient care or staff development.

Getting the basics right directly enables every other strategic aim. Staff cannot thrive when basic systems don't work. Innovation cannot flourish when infrastructure is inadequate. Clinical excellence requires reliable operational foundations. And we cannot credibly lead nationally if our own operations aren't exemplary. This isn't about lowering ambition - it's about building the foundation that makes excellence sustainable.

How will we measure our success?	What will we start by doing?
● Reduction in time staff spend on system workarounds and administrative burden through efficiency metrics	● Conduct rapid assessment of highest-impact basic failures (IT systems, facilities, processes) and create a prioritised action plan

● Measurable improvements in facilities standards (meeting spaces, amenities, working conditions) tracked through regular audits ● Staff satisfaction scores specifically on digital systems, IT reliability, and operational processes ● Quantified reduction in complaints about basic operational issues	● Invest in digital infrastructure basics before pursuing advanced innovation projects ● Establish clear service standards for facilities and IT with visible accountability when standards aren't met ● Systematically resource dedicated operational improvement capacity to address inefficiencies systematically ● Fix basic infrastructure issues that signal neglect of staff needs (meeting spaces, drinking water access, working conditions)

Implications for specific functions

Delivering our strategic aims will require coordinated action across all our organisational functions. While each aim has its specific focus, success depends on how well our core enabling functions work together to support our transformation. In addition, we will work with all of our divisions to translate this strategy into specific clinical visions for their services.

Workforce

Our people are central to delivering every strategic aim. Building on our significant work in this area, we will ensure we have comprehensive plans that support clinical excellence, create the conditions for staff to feel valued and heard, enable innovation and collaboration, build partnership capabilities, and establish us as an employer of choice that attracts national talent to our specialist services. We will explore how our planning and recognition systems can best support the breadth of work required to deliver these strategic aims.

Financial sustainability

Our aims rest on our ability to be financially sustainable. In today's financially constrained NHS, we will ensure that our strategic aims are affordable and enable us to increase efficiency both as an organisation and across our system. Where we can, we will work to ensure that our funding models enable us to invest in clinical excellence and staff experience, support innovation and partnership development, demonstrate value from community engagement, and maintain resources needed to sustain our position as a national centre of excellence.

We will direct resources where the return for patients and staff is clearest - investing in actions that improve care quality, safety, and experience while reducing waste and duplication. Every pound we spend should strengthen our people, our partnerships, or our ability to deliver outstanding outcomes. We will be transparent about costs and benefits, prioritise value over volume, and work collaboratively with system partners to make the best use of collective resources.

Digital

Digital transformation is fundamental to achieving our strategic aims, guided by our current "Beyond Value" digital and data strategy. We are committed to becoming a digital and data first organisation, moving from analogue to digital while ensuring resilience and security. This includes responsible AI adoption, NHS App integration, and building interoperable systems that connect seamlessly with our partners. Our digital infrastructure, including our new electronic patient record, will support team-working and innovation by giving frontline teams the tools, data, and autonomy they need to make decisions and drive improvements themselves. We will always use technology as a way to solve real problems and support continuous improvement rather than as an end in itself.

Research

Research, along with teaching and clinical leadership, are integral to everything we do and will connect our clinical work with our innovation ambitions. Our engagement revealed that

our research capacity needs strengthening to match our ambitions. We will ensure research infrastructure that enhances patient outcomes, creates fulfilling career opportunities for staff, drives continuous improvement, supports evidence-based community health initiatives, and strengthens our reputation for advancing heart and lung care knowledge.

Communications and engagement

Effective communication will sustain the cultural transformation required for our strategy. We will continue the transparent and honest conversations with staff about progress and challenges, build strong relationships with community and regional partners, establish our national profile and influence, and ensure all stakeholders understand their role in our transformation journey.

Estates and facilities

While we are lucky to have a world-class estate, there is work for us to do to ensure it works for everyone. We will ensure facilities that support excellent clinical care and provide staff with the basic amenities and working conditions they deserve. We will explore whether we could offer flexible spaces for innovation and collaboration, welcome community partners, and project our reputation as a national centre. In addition, we are committed to lowering the carbon footprint of our estate, and will ensure alignment of this strategy with our environmental sustainability goals.

From ambition to impact

This is where the hard work begins. Making this strategy work will take more than good intentions or a glossy document. Delivering on these ambitions will require clear leadership, investment, and courage, but also trust, teamwork, and humility.

At the start of this process, we asked staff “When we have achieved really successful change, how has this happened?” We heard that real change has always worked best when “it starts from staff upwards, not top down,” when there is “clear leadership and shared direction,” and when “frontline teams feel they own it.” The move to the Biomedical Campus was successful because it was “planned with thorough engagement, driven internally,” and “everyone pulled together under a common goal.” They also warned that change fails when “everything is already decided by top management” or “buried under bureaucracy.” This strategy will only succeed if we listen to those lessons: involve people early, cut red tape, and make staff ownership real.

Our approach will focus on:

- **Clear accountability and responsibility.** Every strategic aim will have a named executive lead, a delivery team, and clear milestones. We will share progress openly, celebrating success while being honest about where we are falling behind. Leaders will be expected to create the conditions for success and will be held accountable for results.
- **Prioritising skills and infrastructure.** We will prioritise leadership development at every level, data and analytics to track progress, and project management expertise to turn ambition into action. We will focus resources where they make the biggest difference.
- **Integration into daily operations.** We will weave this strategy into how we run the organisation. It will shape budgets, workforce planning, and everyday decisions. We will stop activities that do not align with our vision, freeing time and energy for innovation and high-value work.
- **Addressing cultural barriers.** Staff feedback made it clear that collaboration, psychological safety, and feeling valued are the foundations of success. We will challenge behaviours that undermine trust but do so with compassion and support.
- **Systems for sustainability.** We will create systems that make this strategy last, including a clear performance dashboard, regular reviews to adapt plans, and networks of change leaders across the organisation who can keep momentum going even as leaders change.

This transformation will not happen overnight and requires sustained effort from all of us. We have learned that change works best when it starts from the ground up, when people feel ownership of the solutions, and when leaders create conditions for success rather than trying to control every detail.

Next steps

This strategy marks a turning point for Royal Papworth. It draws on the voices of hundreds of staff, patients, and partners who told us what makes this organisation special - world-class clinical care, compassionate culture, and expertise that changes lives - as well as where we must improve: removing barriers to innovation, making staff feel valued, and being clearer about our role locally and nationally.

Over the next five years, we will build on our reputation as a centre of heart and lung excellence, while strengthening our partnerships to deliver care closer to home, lead national debates, and bring innovation to patients faster. We will invest in our people, adapt our facilities, and create a culture where everyone feels heard and proud to work here.

This document sets direction but does not pretend every answer is here. We know that some aims will need detailed plans, resources, and further engagement. The coming months will focus on early wins that show change is happening, while we put in place the systems, leadership, and skills to deliver sustained progress.

Our ambition is bold but rooted in who we are: a hospital with a century-long history of saving lives and a unique spirit of teamwork. By 2031, success will be measured not just by national recognition but by the experiences of every patient we care for, every colleague we support, and every community we serve.

Lead Governor's Report November 2025

On 30th September I attended the Regional Network of Lead Governors (LG) Meeting. This is an annual meeting of the LGs from across the Eastern region including Milton Keynes, Kettering General, North West Anglia, Queen Elizabeth Hospital, West Suffolk, James Padgett, Cambridge University Hospitals and Norfolk and Norwich University Hospitals. We discussed the 10-year plan and how this may affect the role of the governor. We shared our experiences of how different CoGs challenge their Boards and interact with NEDs. Not all Trusts allow Governors to attend Board Assurance Committees or ask questions at CoG which have not been submitted in advance. On the other hand, some Trusts have Governor/NED meetings before and after every CoG to allow open discussion. An overarching theme of concern from all Trusts was a decline in membership and a lack of ability to engage with members. We are hoping to meet again sooner than next September but a date is yet to be decided.

I was able to attend Liverpool Heart and Chest Hospital's Annual Members Meeting online in September. Like ourselves the meeting was online only for members with the Board of Directors and the Governors in the room at LHCH. The meeting lasted 50 minutes with 9 attendees online and featured 2 interesting presentations.

Governors Rhys Hurst, Marlene Hotchkiss, Angie Atkinson and I took part in judging the staff awards. Thank you to for giving your time on the day and in advance to read all the nominations!

On 23rd October Governors had a Q+A session with the CEO and Chair. This was very informative and gave Governors opportunity to bring any concerns from the members to the attention of Jag and Eilish.

Themes from conversations with members include lack of water in outpatients (now resolved), difficulties with ordering certain items from inpatient menus and confusion around pre transplant patient support groups. These queries have been taken to the appropriate committees.

As usual I have met alternate weeks with the Chair, CEO and ADCG to share any concerns from the Governors and hear any news about the Trust.

On 7th November 4 members of the appointments committee (AH, MH, CMc and CG) will be on the interview panel for a new NED following the decision to increase the size of the Board. On a related note I was a part of the interview panel for the new Deputy CEO position.

Abigail Halstead

5/11/2025

NHS
Royal Papworth Hospital
NHS Foundation Trust

Council of Governors

Comms and engagement report

12 November 2025

Compassion
Excellence
Collaboration

Key priority 1

Royal Papworth Hospital NHS Foundation Trust

Membership recruitment

Aim: increase number of members and ensure they are representative

- Membership database cleanse through three separate postal mails
  - Annual Members' Meeting
  - Special Members' Meeting
  - Governor elections
- We have begun capturing equality, diversity and inclusion information – increased % of members supplying this data.
  - Now have about 22% of members sharing ethnicity, sexual orientation or religion
- We are continuing to see an increased number of members supplying email addresses
  - Up 87 since June (handover point)
  - 737 out of 3,883 members (19%) can now be contacted via email

Compassion Excellence Collaboration

Key priority 1 cont.

Royal Papworth Hospital NHS Foundation Trust

Membership recruitment

Aim: increase number of members and ensure they are representative

- First of our quarterly membership e-newsletters sent to 736
  - 424 opened the email (57.6% open rate – this is very good)
  - 100% of people who responded (28) rated it excellent, very good or good
- Membership sign-up page improved
- Any new or updated patient information leaflets now advertise FT membership on the back page
- Further promotion through pull-up banners in the hospital, digital signage in the atrium and outpatients and regular social media pushes

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Key priority 2

Enhance engagement

Aim: improve engagement and retention of members

- Every seat in Council of Governor elections (both staff and public) was contested for first time in many years

- Successful Annual Members' Meeting in September
  - 142 signed up to watch online
  - 93 people joined online plus about 35 in the room – best attendance certainly since 2019
  - 13 responses to feedback form – overall rating 4.54 out of 5
  - Positive experience with audio visual equipment for people joining online

Royal Papworth Hospital NHS Foundation Trust

Compassion Excellence Collaboration

Key priority 3

Royal Papworth Hospital
NHS Foundation Trust

Support for engagement

Aim: improve and provide suitable training and tools to support engagement

- Digital mailing platform now being used to hold membership database (same platform we use to send out the e-newsletter)
- Emailed all governors asking them to identify opportunities for public engagement event in their constituency
- Printed materials designed and delivered to support atrium stands when promoting governor elections (including the true vs false cards)

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Starting point

A reminder that we said our initial qualitative success measures would be:

- **To see a growth of <u>new</u> members**
  - 39 new members since July* – previously would have had 1 every few months
- **To see an increase in existing members providing email addresses**
  - +87 since June
- **To see an increase in existing members updating their EDI info**
  - +411 for religion since June
  - +179 for disability
  - +400 for sexual orientation
  - +393 for ethnicity
- **To increase engagement through a variety of avenues**
  - Having highly contested governor elections can be a positive marker of increased engagement
  - Higher attendance at Annual Members' Meeting
- **To increase governor interactions with public and staff**
  - Atrium stands to promote governor elections
  - Big Biology Day – first event to advertise FTM

What next?

- **Further cleansing of the database**
  - Deceased screening
- **Increase governor interaction and engagement with public and staff**
  - Governors to identify public events to attend and promote membership and also to engage with their constituents
  - Staff governor clinics
  - ‘Marketing’ pack to be designed and ordered: ie. posters, default text, imagery
  - Contact page to be built for public to access their governors
  - Constituency emails – meet your governors
- **Organise first exclusive event**
  - Heritage talk
- **Continue with newsletter**
  - Next edition in December 2025 – suggestions most welcome!
  - Rasing profiles of each gov (spotlight pieces)
- **Improve the membership portal on the website**
  - Further work on automated responses needed
- **Further collaboration with the charity**

FTM stats as of 5 November 2025

Comparisons against June 2025 (data handover) and October 2025

NHS
Royal Papworth Hospital
NHS Foundation Trust

Members

3,883

-313 members since handover

+7 NEW members this month

Email addresses

737

+87 since handover

Reason for leaving Running total

Died	54
Illness/age	34
Not stated	105
Moved away	136
Other	8
Unsubscribed from mailout	10

Compassion Excellence Collaboration

EDI details

	# of completed records	% of completed records	Since handover	Since previous month
Ethnicity	884	22.77%	+393	+4
Disability	208	5.36%	+179	+5
Sexual orientation	841	21.66%	+400	+4
Religion	824	21.22%	+411	+4

Members by constituency

	Total	%	Since handover	Since previous month
Cambs	1,502	38.68%	-110	+1
Norfolk	565	14.55%	-45	-/+0
Suffolk	497	12.80%	-45	-/+0
RoE&W	1,311	33.76%	-121	+4
None	8	0.21%	+8	+1

Top five counties in Rest of England and Wales

Comparisons against handover

Bedfordshire

397 -31

Hertfordshire

174 -12

Essex

164 -9

Lincolnshire

144 -13

Northamptonshire

68 -7

Royal Papworth Hospital
NHS Foundation Trust

Item 13

Report to:	Council of Governors	**Date:** 12 November 2025
Report from:	Chairman/Lead Governor	
Principal Objective/ Strategy and Title:	Update on Actions (You Asked; The Plan)	
Board Assurance Framework Entries:	N/A	
Regulatory Requirement:	Well Led	
Equality Considerations:	Equality has been considered but none believed to apply	
Key Risks:	Governors are not able to effectively discharge their responsibilities. Inadequate governance processes and oversight.	
For:	Review and comment.	

1. Purpose

1.1 This paper provides the progress achieved against the overview of the outputs of discussions between the Chairman and the Lead Governor, following a meeting between some of the governors and Non-Executive Directors, on how the Council of Governor (CoG) meetings, the nature and range of interaction between governors and Non-Executive Directors (NEDs) and the general support to governors can be developed further.

1.2 The areas of improvement set out below are intended to enable governors to discharge more readily their obligations whilst also continuing to respect the complementary but discretely different obligations expected of NEDs. It is hoped that by addressing the key issues described in this paper we are able to make greater use still of the wealth and breadth of experience governors bring to the Trust.

2. Areas for Improvement

2.1 Training and development for governors.
There is an induction programme for new Governors, and this will be reviewed to ensure it is meeting the needs of new appointees. A programme of refresher/ongoing development will be developed. It was also agreed that the governor handbook would be refreshed.

Update: The final version of the RPH Governors' Handbook has been circulated to Governors and is attached to the agenda for ratification by the Council of Governors.

Update: Verbal update on an Induction process for new Governors and refresher support for the Council's members to be provided by the Council Chair and the Lead Governor.

The Council is requested to:

- Review and comment on the contents of the paper

NHS
Royal Papworth Hospital
NHS Foundation Trust

Governors' handbook

Version 1
12 November 2025

Contents

Introduction

The purpose of this publication is to ensure that governors are aware of their statutory and other duties and the means by which those duties are undertaken at Royal Papworth Hospital NHS Foundation Trust (the Trust). The document is produced and updated by Royal Papworth Hospital's management under the direction of the Governors' Assurance Committee.

1. Statutory roles, responsibilities and powers

1.1 The Foundation Trust (FT) corporate structure

The governance structure laid down in legislation for NHS FTs consists of:

- The membership
- A Council of Governors composed of constituency governors elected by the membership, elected staff governors, and appointed representatives from local government, the health sector and academic institutions in the area
- The Board of Directors consisting of the executive directors who are responsible for the management of the trust, and non-executive directors (NEDs) selected and appointed by the Council of Governors to provide overview and scrutiny.

Meetings of the Board of Directors and the Council of Governors are held in public but commercially sensitive matters are dealt with in the absence of the public under a Part II meeting. The Chair of the Board of Directors (Chair) is a NED who additionally chairs the Council of Governors unless the Chair is not available in which case the NED designated as Deputy Chair takes the chair. The Lead Governor chairs the Council of Governors on matters relating to NED remuneration and the appraisal or (re-) appointment of the Chair/NEDs.

The lead governor is elected by the Council of Governors as a contact point for NHS England, the sector regulator for health services in England, in the event that normal communications with the Chair or the Board of Directors are deemed inappropriate. The Council of Governors takes decisions as a body but conducts its work through a series of governor committees aligned to its various statutory and other duties. The current governance structure of the trust is attached as Appendix 1.

The trust's constitution sits out in detail the functioning of trust's structure. Up-to-date copies of the constitution are available on both the trust's websites and on request from the associate director of corporate governance. The outline of executive director portfolios is attached as Appendix 2.

1.2 The statutory duties and powers of the Council of Governors

The National Health Service Act 2006 gave the Council of Governors various statutory roles and responsibilities. The amendments to it, contained within the, Health and Social Care Act 2012, expand, clarify and add to original statutory roles and responsibilities.

For completeness please also see the updated 'Your statutory duties - A reference guide for NHS foundation trust governors', published in November 2013 and the 'Addendum to Your statutory duties – reference guide to NHS foundation trust governors' published in October 2022.

1.2.1 Summary of key duties and obligations for governors

Please see below for a summary of the key duties and obligations for Governors as approved at the November 2024 Council of Governors meeting:

Purpose

The establishment of, and the role of, the Council of Governors is derived from Schedule 7 and other sections of the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 (the Act). This document should be read in conjunction with the Act and with the Code of Governance for NHS Provider Trusts (2022) and other guidance from the NHS England (NHSE) or the Department of Health and Social Care or any successor regulatory department body or function to NHSE.

General duties

The statutory general duties of the Council of Governors are:

- to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors, and
- to represent the interests of the members of the corporation as a whole and the interests of the public.

Membership

The composition of the Council of Governors is set out in the Royal Papworth Hospital NHS Foundation Trust Constitution. The Chair of the Board of Directors is the Chair of the Council of Governors and presides over the meetings of the Council of Governors. In the absence of the Chair, the Deputy Chair will preside. In the absence of this individual, the senior independent director (if they are not the same person) or another non-executive director or another person as defined in the constitution or trrust standing orders will preside.

Quorum

The quorum for meetings of the Council of Governors is twelve Governors as set out in the trust constitution.

Council of Governors committees

The Council of Governors has established the following committees:

- Appointments (NED Nomination and Remuneration) Committee
- Governors Assurance Committee
- Forward Planning Committee
- Patient and Public Involvement Committee
- Access and Facilities Group

Statutory roles of the Council of Governors

- Hold the non-executive directors individually and collectively to account for the performance of the Board of Directors.
- Approve the policies and procedures for the appointment and where necessary for the removal of the Chair of the Board of Directors and Non-Executive Directors.
- Approve the appointment (or removal) of the Chair of the Board of Directors.
- Approve the appointment (or removal) of a non-executive director.
- Approve the policies and procedures for the appraisal of the Chair of the Board of Directors and Non-Executive Directors.
- Approve changes to the remuneration, allowances and other terms of office for the Chair and other non-executive directors.
- Consider and if considered appropriate approve the appointment of a proposed candidate as chief executive recommended by the Chair and the non-executive directors.
- Approve the criteria for appointing, re-appointing or removing the external auditor.

- Approve the appointment or re-appointment and the terms of engagement of the external auditor.
- Elect a lead governor who will be a contact point for NHS England, the sector regulator for health servics in England, in the event that normal communications with the Chair or the Board of Directors are deemed inappropriate

Constitution and compliance

- Following consultation with the Board of Directors, approve amendments to the constitution. Any changes in respect of the powers, duties or role of the Council of Governors being considered, need to be approved at the next general meeting of members.
- Notify NHSE if the Council of Governors is concerned that the trust has breached, or is at risk of breaching, its licence conditions if these concerns cannot be resolved through engagement with the Board of Directors.

Strategy, planning and reorganisations

- In response to requests from the Board of Directors, provide feedback on the development of the annual plan and the strategic direction of the foundation trust.
- Contribute to the development of stakeholder strategies, including Foundation Trust membership engagement strategies.
- Where the forward plan contains a proposal that the foundation trust will carry on an activity other than the provision of goods and services for the purposes of the NHS in England, determine whether the Council of Governors is satisfied that such activity will not interfere in the fulfilment by the trust of its principal purpose (the provision of goods and services for the purposes of the health service in England). Notify the Board of its determination.
- Consider and if appropriate approve proposed increases to the amount of income derived from the provision of goods and services other than for the purpose of the NHS in England where such an increase is greater than 5% of the total income of the Trust in the relevant financial year.
- Consider and if appropriate approve proposals from the Board of Directors for mergers, acquisitions, separations and dissolutions. Any such proposals may only be approved if more than half of the total number of governors agree with them.
- Consider, and if appropriate, approve proposals for significant transactions where defined in the constitution or such other transactions as the Board may submit for the approval of governors from time to time. Any proposals for significant transactions (as defined in the constitution) may only be approved if more than half of governors voting at a quorate meeting of the Council of Governors agree with them.

Representing members and the public

- Represent the interests of the members of the trust as a whole and of the public.
- Consider and if appropriate approve the membership engagement strategy.
- Contribute to members' and other stakeholders' understanding of the work of the trust in line with engagement and communications strategies. Seek the views of stakeholders, including members and the public and feedback relevant information to the Board of Directors or to individual managers within the trust as appropriate.
- Promote membership of the foundation trust and contribute to opportunities to recruit members in accordance with the membership strategy.
- Report to members each year on the performance of the Council of Governors. Some of the following may support this process and dialogue:
    - Receive the agenda of the meetings of the Board of Directors before the meeting takes place.
    - Receive the minutes of the meeting of the Board of Directors as soon as is practicable after the meeting.

- Equipped by the trust with the skills and knowledge they require in their capacity as governors.
- Receive the Annual Report of the External Auditor which provides a summary of the findings and key issues arising from their most recent audit of the trust's accounts.
- Receive the Annual Report and Accounts (including Quality Accounts).
- Receive the quarterly report of the Board of Directors on the performance of the trust against agreed key financial, operational, quality and regulatory compliance indicators and stated objectives.
- Participate in opportunities to review services and environments such as 'visibility rounds' or '15 Steps Challenge'/quality reviews/local activities and evaluation of user/carer experience.
- Receive and review quarterly assurance reports.
- Receive reports from the Board on important sector-wide or strategic issues.
- Use information obtained through the above sources to monitor performance and progress against the key milestones in the strategic and annual plans and to hold the non-executive directors to account for the performance of the Board of Directors.
- If considered necessary (as a last resort), in the fulfilment of this duty, obtain information about the foundation trust's performance or the directors' performance by requiring one or more directors to attend a Council of Governors meeting.

Other/non-statutory duties of governors

- Approve the appointment of governors to any committees or working groups of the Council of Governors or the Board of Directors.
- Receive reports from the Chairs of any committees or working groups of the Council of Governors on the discharge of the committees' duties.
- Approve the removal from office of any governor in accordance with procedure set out in the constitution.
- Approve jointly with the Board of Directors the procedure for the resolution of disputes and concerns between the Board of Directors and the Council of Governors.
- Governor observers, appointed to Board Committees, are encouraged to contribute to the meetings of those committees with their questions and suggestions, as appropriate.
- Governors can contribute to the annual appraisal process for non-executive directors with their observations and views, as appropriate.

Collective evaluation of performance

The Council of Governors will commission an annual review of its effectiveness and efficiency in the discharge of its responsibilities and achievement of objectives.

Frequency of meetings

The Council of Governors meets four times a year.

Minutes

Minutes of the meetings will be circulated promptly to all members of the Council of Governors as soon as reasonably practical. The target date for issue is 10 working days from the date of the meeting.

Differing roles of executive directors, non-executive director and governors

Within the corporate governance architecture of the trust, there are clearly differing roles for the executive directors, non-executive directors and governors. In a summary, the differences are:

- The Board of Directors, made up of executive directors and non-executive directors, is responsible for setting the strategy and objectives of the trust.

- Executive directors are responsible for delivering on the strategy and objectives of the trust, and the performance of the trust.
- Non-executive directors hold the executive directors to account for the delivery of the strategy and objectives, and performance of the trust.
- The governors, with due regard to their statutory and non-statutory duties, are responsible for holding the non-executive directors to account for the performance of the trust Board.

1.3 Governor capability

The trust must take steps to ensure that governors have the skills and knowledge they require to undertake their role.

1.4 What are governors not allowed to do?

With reference to the 'Summary of key duties and obligations for governors' (Section 1.2.1 above) it is instructive to note what governors are not allowed to do:

- To act in any executive capacity
- To run the foundation trust; this responsibility lies with the Board of Directors
- To be responsible or accountable for the performance of the foundation trust
- To be responsible for trust decisions or the operational detail behind decisions
- To be involved in the operational planning of each initiative developed by the trust
- To use the powers of the Council of Governors to veto the decisions of the Board of Directors or otherwise obstruct the implementation of agreed actions and strategies
- To approach individual members of staff for additional information. Contact should be made through the associate director of corporate governance.

2. The code of conduct for governors

2.1 Introduction

The purpose of this code is to provide clear guidance on the standards of conduct and behaviour expected of all governors and addresses both the requirements of office and their personal behaviour.

This code forms part of the framework designed to promote the highest possible standards of conduct and behaviour within the trust. The code is intended to operate in conjunction with the trust constitution, standing orders and The Code of Governance for NHS Provider Trusts. The code applies at all times when governors are carrying out the business of the trust or representing the trust.

2.2 Principles of public life

The principles underpinning this code of conduct are drawn from the 'Seven Principles of Public Life' and are as follows:

- **Selflessness**
  Holders of public office should act solely in terms of the public interest: they should not do so in order to gain financial or other benefits for themselves, their family or their friends.
- **Integrity:**
  Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
- **Objectivity:**
  In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

- **Accountability:**
  Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
- **Openness:**
  Holders of public office should be as open as possible about all the decisions and actions they take they should give reasons for their decisions and restrict information only when the wider public interest clearly demands.
- **Honesty:**
  Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
- **Leadership:**
  Holders of public office should promote and support these principles by leadership and example.

2.3 Confidentiality

Governors must comply with the trust's confidentiality policies and procedures. Governors must not disclose any confidential information, except in specified lawful circumstances, and must not seek to prevent a person from gaining access to information to which they are legally entitled. Information received through attendance at trust meetings and official duties should be treated as confidential.

Nothing said in this code precludes governors from making a protected disclosure within the meaning of the Public Disclosure Act 1998. The associate director of corporate Ggvernance should be consulted for guidance.

2.4 Meetings

Governors have a responsibility to attend Council of Governors meetings. If this is not possible apologies should be submitted to the associate director of corporate governance in advance of the meeting. Persistent absence from Council of Governors meetings without good reason may be grounds for removal from the Council of Governors.

2.5 Personal conduct

Governors are expected to conduct themselves in a manner that reflects positively on the trust and not to conduct themselves in a manner that could reasonably be regarded as bringing their office or the trust into disrepute. Specifically, governors must treat each other, directors and trust staff with respect; not breach the equality enactments and not bully any person. Governors must not seek to use their position improperly to confer an advantage or disadvantage on any person and must comply with the trust's rules on the use of its resources. Finally, governors must have regard to advice provided by the Chair and the associate director of corporate governance pursuant to their statutory duties.

2.6 Training and development

The trust is committed to providing appropriate training and development opportunities for governors to enable them to carry out their role effectively. Governors are expected to participate in training and development opportunities that have been identified as appropriate for them. To that end governors will participate in any appraisal process/skills audit that may be carried out by the trust.

2.7 Undertaking and compliance

Governors are required to give an undertaking that they will comply with the provisions of this code. Failure to comply with the code may result in disciplinary action in accordance with the agreed procedure.

2.8 Interpretation and concerns

Questions and concerns about the application of the code should be raised with the associate director of corporate governance. At meetings the Chair will be the final arbiter of interpretation of the code.

2.9 Review and revision of the code of conduct

This code of conduct has been agreed by the Council of Governors. The Governance Assurance Committee will review this governors' handbook (and the code of conduct). The Council of Governors would need to review and approve any amendments or revisions to the governors' handbook (and the code of conduct).

2.10 Breach of code of conduct

Non-compliance of this code of conduct may result in action being taken as follows:

- Where a clear case of misconduct occurs, the Chair of the Council of Governors is authorised to take such action as may be immediately required, including the exclusion of the governor from a meeting.
- Where misconduct is alleged, it will be open to the Council of Governors to determine by simple majority decision at its meeting, to lay a formal charge of misconduct, whereupon it will be the responsibility of the Council to take the following actions:
    - Notify the governor in writing of the charges, detailing the nature of the alleged misconduct and inviting and considering their response within a prescribed timescale
    - Inviting the Governor to meet with the Chair and lead governor if the matter cannot be resolved in a satisfactory manner through correspondence.
    - Deciding by simply majority of those present and voting, whether to uphold the charge of conduct detrimental to the trust.
    - Impose such sanctions as shall be deemed appropriate. Sanctions will range from, but not be limited to, the issuing of a written warning as to the Governor's future conduct and consequences, and / or the removal of the Governor from office.
    - To aid participation of all parties, it is imperative that all Governors observe the points of view of others and conduct likely to give offence will not be permitted. The Chair will reserve the right to ask any member of the Council of Governors who, fails to observe the code, to leave the meeting.
- This code of conduct does not limit or invalidate the right of the governors or the trust to act under the constitution.

Personal declaration

The following declaration must be signed as a requirement of an individual's election or appointment to the Council of Governors.

Failure to do so will preclude a prospective Governor from taking office.

Declaration:
I.....(full name)
have read, understood, and agree to abide by this Code of Conduct for the Council of Governors of Royal Papworth Hospital NHS Foundation Trust.

Signature: .....

Date: .....

Important contacts

Julie Wall, Personal Assistant to Dr Jag Ahluwalia, Chair
julie.wall@nhs.net
01223 639833

Laura Favell-Talbot, Communications and Membership Engagement Co-ordinator
laura.favell@nhs.net
01223 639834

Digital (IT) Helpdesk
01223 638241
or through julie.wall@nhs.net

Dr Jag Ahluwalia, Chair of the Trust Board of Directors and the Council of Governors
jag.ahluwalia@nhs.net

Corporate services
papworth.corporateservices@nhs.net

Additional information:
New governors should please note the following

1. Governors are generally expected to become members of two Council of Governors Committees, and to be regular attendees and contributors to those committees' meetings.

2. All Council of Governors meetings (as well as Annual Members' Meetings) are hybrid (face to face plus online an option on Microsoft Teams for attendees).

3. Where governors receive and accept invitations to visit the hospital to help in assessing the effectiveness/efficiency of patient services or healthcare settings, specific information will be provided around where to go and how the assessment would be undertaken.

4. For information on or help with parking, please contact **julie.wall@nhs.net**

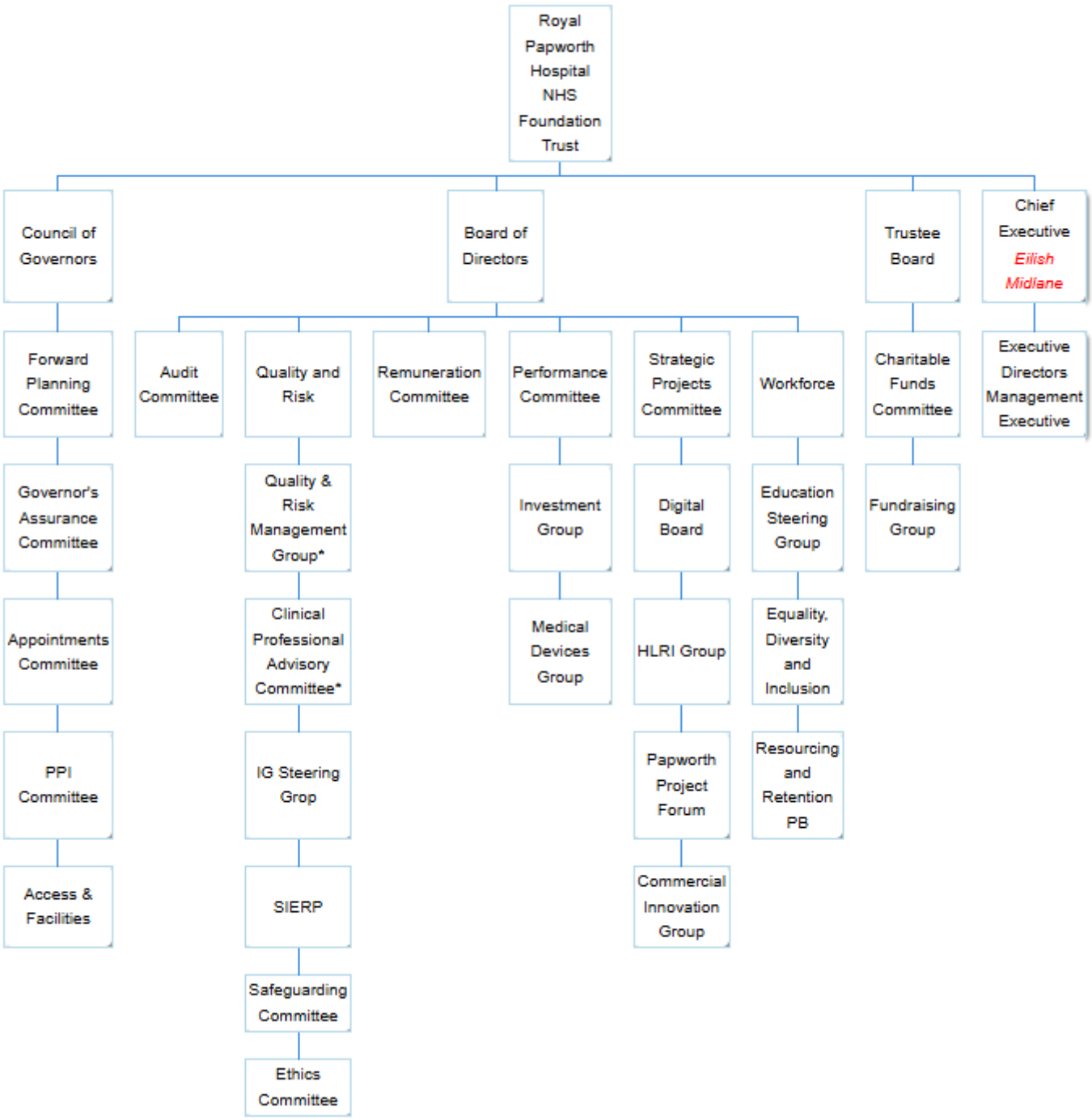
5. During your induction, you will be provided with a nhs.net email account with the support of Julie Wall and the digital team.

6. New governors are invited to join to the governors WhatsApp group, which helps facilitate the exchange of information between governors.

7. Governors are able to contact non-executive directors directly via their nhs.net email accounts. Where necessary, please contact – **julie.wall@nhs.net** – for the non-executive directors' email addresses.

8. For information on foundation trust membership or for support with regards to engagement with the foundation trust members or members of the public, please contact – **laura.favell@nhs.net / 01223 639834**

Appendix 1
Governance structure



Appendix 2

Outline of executive portfolios

Medical Director	Chief Nurse	Chief Information Officer	Chief Operating Officer	Director of Workforce and OD	Chief Finance Officer	Deputy CEO and Chief Commercial Officer	CEO
Dr Ian Smith	Maura Screaton	Andrew Raynes	Harvey McEnroe	Oonagh Monkhouse	Liz Sanford (Interim)	Tim Glenn	Eilish Midlane
Clinical Effectiveness	Clinical Education and Training	Information Management and Technology	Operational Management/ Delivery of Access Standards	Human Resources Management	Financial Management	Deputy CEO responsibilities	Accountable Officer
Research	Patient Safety & Quality/CQC compliance	Information Governance	Demand and Capacity Planning and Management	Corporate Administration and Governance	Procurement	Commercial & Business Development	Implementation of goals, targets and strategic objectives as determined by the Board of Directors
Consultant Job Planning	Medicines Management/ CD Accountable Officer	Health Records	Emergency Planning and Prepared-ness	Leadership and Non-Clinical Training	Clinical Coding	Collaboration and partnership	Voting member of the Integrated Care Board (ICB)

INVOICE

NHS
Royal Papworth Hospital
NHS Foundation Trust

RGM Payables F665
PO Box 312
Leeds
LS11 1HP

Expenses claim form for Governors And Volunteers

Name: .....

Address....., ...

(Current mileage rate is 0.45p per mile)

Date: .....

Invoice Number:.....

Date	Particulars of journey and nature of business	Receipt number	Car mileage Miles	£	Fares £	Subsistence £	Other £	Total £
							Net Amount	
							Vat	0 .00
		Total					Invoice Total	

I declare that the travelling and other expenses claimed above were actually and necessarily incurred whilst engaged on the business stated and are in accordance with the expenses procedure relating to Governors.

Signed: .....Date: ..... Approved: ..... Date: .....

Appendix 3
Expense claim form

Appendix 4

Cambridge Biomedical Campus site map