

Meeting of the Board of Directors
Held on 06 November 2025 at 9:30 am – 12:15 pm
Microsoft Teams
HRLI, Royal Papworth Hospital

UNCONFIRMED

MINUTES – Part I

Present	Dr J Ahluwalia	(JA)	Chair
	Ms C Conquest	(CC)	Senior Independent Director/ Non-Executive Director
	Ms A Fadero	(AF)	Non-Executive Director
	Ms D Leacock	(DL)	Non-Executive Director
	Mr D Jones	(DJ)	Non-Executive Director (Teams)
	Dr C Paddison	(CP)	Non-Executive Director (Interim)
	Mr G Martin	(GMA)	Non-Executive Director
	Mrs E Midlane	(EM)	Chief Executive Officer
	Mr T Glenn	(TG)	Deputy Chief Executive Officer
	Ms L Sanford	(SH)	Chief Finance Officer (Interim)
	Mr H McEnroe	(HM)	Chief Operating Officer
	Ms O Monkhouse	(OM)	Director of Workforce and OD
	Mr A Raynes	(AR)	Chief Information Officer & SIRO (Teams)
	Mrs M Scream	(MS)	Chief Nurse
	Dr S Webb	(SW)	Deputy Medical Director (IS proxy)
In Attendance	Ms H Webb	(HW)	Cardiac Rehabilitation Service Lead (For Item 1i – Patient Story)
	Mr K Mensa-Bonsu	(KMB)	Associate Director Corporate Governance
	Mr G Matenga	(GM)	Corporate Governance Lead
	Mr S Edwards	(SE)	Head of Communications
	Mr R Taunt	(RT)	Founder and Director, Kaleidoscope (For Item 2 – Strategic Developments)
	Ms C Armstrong	(CA)	Lead, Research and Evaluation, Kaleidoscope (For Item 2 – Strategic Developments)
	Ms W Walker	(WW)	Director of Strategic Projects (For Item 2 – Strategic Developments)
	Dr S Preston	(SP)	Consultant Histopathologist (For item 3.ii – Guardian Safe Working)
	Ms B Krenek	(BK)	Health Inequalities Specialist (For Item 3.iii – Armed Forces Champion Annual Report)
Apologies	Dr I Smith	(IS)	Medical Director
	Prof I Wilkinson	(IW)	Non-Executive Director
Observers	Ms A Halstead (AH) – Lead Governor Dr C Glazebrook (CG) – Public Governor Mr B Davidson (BD) – Public Governor		

	Ms M Hotchkiss (MH) – Public Governor Mrs H Eccles (HE) – Public Governor Dr J Pajak (JP) – Public Governor Mr J Dyer (JD) – Public Governor Mr P Webb – Staff Governor
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1	WELCOME, APOLOGIES AND OPENING ITEMS		
	<ul style="list-style-type: none"> a. JA welcomed everyone to the meeting and noted apologies as above. b. He also welcomed Phil Webb, a newly elected Staff Governor who had attended in person and congratulated him on his appointment. c. Professor Graham Martin was welcomed as a new Non-Executive Director on the Trust Board. It was noted that he also worked at the Cambridge University Healthcare Improvement Studies Institute, which was dedicated to strengthening the evidence base for improving healthcare quality and safety. His appointment formally commenced on 1 November, and he would serve as Chair of the Quality and Risk Committee from January 2026. He expressed appreciation for joining the Trust, and extended thanks for being a member of the organisation. d. Additionally, gratitude was conveyed to KMB at his final Board meeting, acknowledging his contributions over the past two years and wishing him well in his future endeavours. 		
1.i	Patient Story <p>JA welcomed Helen Webb (HW), Cardiac Rehabilitation Service Lead to present the Patient Story.</p> <p>Patient Story:</p> <ul style="list-style-type: none"> a. MS introduced HW to tell two patients' stories that demonstrated how the Cardiac Rehabilitation Team engaged with patients including the skills possessed and challenges faced by the Team. b. HW advised that the two cases demonstrated the individualised, multidisciplinary approach of cardiac rehabilitation at RPH, addressing complex physical and psychological needs, improving outcomes, and reducing hospital readmissions. <p>Patient I</p> <ul style="list-style-type: none"> c. HW introduced Mrs. M, a 61-year-old patient who had initially been admitted to RPH via Primary Percutaneous Coronary Intervention (PPCI) in May 2023. She had not engaged with cardiac rehabilitation due to personal challenges, notwithstanding national uptake rates of around 50% and RPH typically achieving 80–95%. d. Following elective stenting in May 2025, Mrs. M agreed to participate in cardiac rehabilitation, recognising the need for lifestyle changes. Initial assessment revealed fatigue, low mood, increased weight, smoking, and high anxiety/depression scores. e. A comprehensive plan was implemented, including exercise and education, smoking cessation support, dietitian referral, psychological welfare services, and goal setting. 		

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	<p>f. Over 12 weeks, Mrs. M achieved significant improvements including weight loss of 6lbs, smoking cessation, improved mood through talking therapies, increased physical activity 5-6 times weekly, and regained confidence with no cardiac symptoms; therefore, reducing her risk of future events.</p> <p>Patient II</p> <p>g. HW introduced Mrs. T, aged 58, who had been admitted to RPH via PPCI in February 2025 and discharged on 29 April with medical management. At an initial rehabilitation assessment in May, she presented with severe symptoms including cyanosed lips and breathlessness, which required administration of Furosemide, consequently delaying her rehabilitation.</p> <p>h. After stabilisation, she began the programme but later deteriorated with fluid retention and worsening symptoms. Despite limited GP support, the Cardiac Rehab team escalated care, liaising with her consultant and arranging urgent admission for IV diuretics.</p> <p>i. Following treatment, Mrs. T resumed rehabilitation, regained functional capacity, and completed the programme successfully. Her case highlighted challenges in community follow-up and medication optimisation, with the Cardiac Rehab team increasingly involved in signposting and advocacy to ensure timely care.</p> <p>Discussion:</p> <p>j. EM noted that she had attended a Cardiac Rehab team meeting and highlighted the exceptional level of support and the collaborative nature of the team, describing it as a model for what RPH aimed to achieve. She also joined an exercise class and observed how team members worked together to support patients, praising the leadership and calling the team "fantastic" and "amazing."</p> <p>k. DL raised a concern about the growing number of patients with complex needs similar to Mrs T and questioned how the team was managing this challenge. HW noted that a significant amount of time was spent signposting patients, not only those treated at RPH but also across the wider region. It was heard that post-COVID, patients had become increasingly complex, and the team was conducting an audit to assess medication titration. There was also recognition that patients were struggling to secure GP appointments and necessary tests, which added pressure to the service; mitigation measures were being established.</p> <p>l. CP asked what measures were being taken to bridge gaps in the patient pathway to recovery and whether joined-up conversations existed at ICB and primary care levels. In response, HW explained that the team was exploring the introduction of prescribers to support medication optimisation and implementing long-term risk mitigation strategies to reduce the likelihood of patient recalls. She emphasised the need for clearer messaging to GP surgeries about the scope of RPH services, particularly clarifying that the hospital did not provide A&E facilities.</p> <p>m. AF queried the team's resourcing and capacity. HW acknowledged that while there was flexibility in patient numbers, staff absences made it challenging to maintain service quality. The Team was actively seeking ways to improve efficiency and optimise performance; this included shortening programme duration and enabling patients to join the programme earlier. She also noted that platforms such as GP Connect had been instrumental in improving visibility of patient engagement and GP interactions.</p> <p>Board noted the patient story.</p>		

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1.ii	Declarations of Interest		
	<p>a. EM reported her reappointment as the Cambridgeshire and Peterborough representative on the new ICB cluster Board, a position that would run until March 2026.</p> <p>b. She also confirmed her appointment as a trustee of the East Anglia Air Ambulance Board, a voluntary role that will enable the Trust to strengthen collaborative engagement in relevant areas.</p> <p>c. The Chair invited any other declaration of interests to be declared by 17 November via ESR.</p> <p>The Board noted the Declarations of Interest.</p>		
1.iii	Minutes of the previous meeting		
	<p>Board of Directors Part I:</p> <ul style="list-style-type: none"> • 04 September 2025 • 02 October 2025 <p>The Board of Directors approved the Minutes of the Part I meeting held on 04 September 2025 and 02 October 2025 as a true record.</p>		
1.iv	Matters arising and action checklist		
	<p>a. All actions proposed for closure were closed and the following updates were made:</p> <p>b. 19/25 – Workforce Strategy Workplan <i>To develop a summary of the Workforce Strategy which would show the position of the 2024/25 Workplan and the deliverables in the 2025/26 Workplan.</i> AF stated that this would go to the Workforce Committee in January and presented to Board in February 2026.</p> <p>c. 27/25 – Performance Committee Chair's Report <i>In respect of CIP data relevant to patient experience, HMc to check with CC and provide the relevant data to her.</i> In respect of the 52-week wait data requested, HMc noted that this had been produced and will go to the Performance Committee in November and would be submitted to Board in December.</p> <p>d. 3525 – Medical Revalidation Annual Report <i>Workforce Committee to consider what information was available on the quality of appraisals</i> It was noted that OM would follow up the IS and SW and that the report was expected at the Workforce Committee in January and would be made available to Board at the February meeting</p> <p>The Board noted the Matters Arising and Action Checklist.</p>		
1.v	Chair's report		
	<p>Report:</p> <p>a. The Chair reflected on the recent celebrations held at the Trust, noting that the Diwali festivities were vibrant and enjoyable, as well as the Black History</p>		

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	<p>Month events. The latter featured three outstanding internal speakers with Berin Krenek receiving particular praise for her remarkable contribution.</p> <p>b. It was heard that visits were also made to the OCS team, that is part of the PFI contract, where staff expressed that they felt well supported and considered themselves part of the Trust's family. They reported satisfaction with their terms and conditions, and several team members highlighted their long-standing association with the Trust.</p> <p>c. The Chair and CEO, accompanied by colleagues, participated in a celebration of long service at RPH, recognising staff who had achieved 15 years or more of service, with some individuals reaching an impressive milestone of 40 years.</p> <p>d. Further visits included to the Digital Team, who continued to work diligently, managing their workload and reprioritising tasks as needed, and the Resident Doctors' Mess, which was noted to be highly impressive.</p> <p>e. The Chair reported that in September, the Trust had hosted its Annual Members' Meeting, which attracted approximately 130 online attendees and nearly 25 participants in person. The event featured exceptional RPH speakers, including Robert Rintoul, David Jenkins, and Samer Nashef, alongside a presentation from the Executive team.</p> <p>f. Finally, the Chair concluded with a visit to the Norfolk Zipper Club, where tea and biscuits were shared in recognition of the tremendous work the group has contributed over many years.</p> <p>The Board noted the Chair's report.</p>		
1.vi	<p>Board Assurance Framework</p>		
	<p>EM clarified that this is the existing BAF. KMB presented the Board Assurance Framework for the month of October 2025.</p> <p>Report:</p> <p>a. KMB noted that BAF Risk ID 2829 had increased from 12 to 16 due to an adverse Month 05 variance, primarily driven by PFI accounting, pay overspend, and income recoverability risks.</p> <p>b. Additionally, CC raised concerns regarding BAF Risk ID 3223, where assurance levels were reported as inadequate despite no gaps being indicated. HMc confirmed that the risk register has been updated, and the most current information would be provided to the Board at the next meeting.</p> <p>Discussion</p> <p>c. JA acknowledged recent media reports of widespread delays and missed lung cancer diagnoses across several NHS Trusts and sought assurance on the Trust's position.</p> <p>d. HMc confirmed that while the Trust had experienced some 62-day delays for lung cancer patients, all breaches at 31 and 62 days underwent comprehensive harm reviews, a process validated in collaboration with Dr Chris Johnson (Divisional Director for Thoracic and Ambulatory Care) and Dr David Meek (Consultant Physician in Oncology), ensuring 100% compliance. CP reinforced this assurance following detailed discussions with Dr Meek.</p> <p>e. A formal update on lung cancer performance and harm review compliance would be presented to the Board at the next meeting.</p> <p>f. JA also noted discrepancies in progress note dates regarding CT Backlogs within the agenda pack at page 50, with corrections and further updates to</p>		

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	<p>follow</p> <p>The Board noted the Board Assurance Framework update.</p>		
1.vii	<p>CEO's update</p>		
	<p>EM presented the CEO update.</p> <p>Report:</p> <ul style="list-style-type: none"> a. EM highlighted that the Trust had passed the six-month point and continued to focus on elective recovery. The target set during the planning round for the year was to reduce waiting lists, improve cancer waiting times, enhance performance against the RTT standard, and achieve a breakeven financial position. b. It was noted that the Trust was ahead of its RTT trajectory, waiting lists were lower, and RTT performance had significantly improved, currently at 72.1%, with a 17% reduction in the Trust's total waiting list. This positioned RPH as one of the best recovering organisations within the NHS, which was good news for patients. c. Cancer performance was slightly below target, and concerted efforts were underway to address this. d. Financial position at Month 06 reflected the benefits of these efforts. EM expressed confidence that the Trust would achieve breakeven by year-end through recurrent savings and support from the newly established Financial Improvement and Productivity Board. e. It was added that several significant celebrations had taken place during the month, as highlighted earlier by the Chair. f. EM thanked everyone involved in the development phase of the Trust's strategy, noting that there had been significant interactions during this phase. g. Regarding the Doctors' Mess, EM commented that the space had been transformed into a pleasant area for colleagues to relax and work as a team. Thanks were extended to resident doctors, patients, Estates & Facilities teams, and contractor SKANSKA. h. SSIs remained challenging, with rates above the UKHSA benchmark of 2.7%. RPH's quarterly validated rate was 6.1%, and further work was planned to address this. i. The flu vaccination uptake had been strong, outperforming other organisations, with approximately 1,200 vaccinations administered in October and 75 to date in November. j. Engagement with MPs continued, with EM and IS working to support understanding of Mycobacterium Abscessus. k. Inpatient survey feedback indicated high levels of satisfaction with RPH services across all areas, from cleaning teams to clinical teams. l. Partnership working remained a priority. As part of ongoing collaboration with the Federation of Specialist Hospitals, the Deputy Chief Executive attended a meeting with the Secretary of State for Health and Social Care who highlighted the added value specialist hospitals bring. m. EM reinforced that financial sustainability remained critical in order to sustain achievements and deliver further improvements. <p>Discussion:</p> <ul style="list-style-type: none"> a. CC highlighted the significant work that has gone into reducing SSIs was not evident in the CEO's report and emphasised that these efforts should be clearly documented in the report to ensure visibility for the public. 		

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	The Board noted the CEO's Update.		
1.viii	NEDs update		
	No issues requiring an update.		
2	STRATEGIC DEVELOPMENTS		
2.i	Trust 2026 – 2031 Strategy		
	TG presented the Trust 2026 – 2031 Strategy. The Board approved the Trust 2026 – 2031 Strategy.		
2.ii	Trust 2026 – 2031 Strategy – Next Steps		
	<p>TG presented the Trust 2026 – 2031 Strategy – Next Steps.</p> <p>The Chair welcomed everyone who was involved in the development of the strategy including members from Kaleidoscope. He acknowledged all engagement efforts made and that a detailed, accessible document had been developed.</p> <p>Report:</p> <ul style="list-style-type: none"> a. TG noted that the strategy development process had begun early in the year with a strong focus on clarity of direction and inclusive engagement. b. Over 1,000 voices contributed, including 450 staff members and representatives from 35 organisations across the NHS, third sector, and industry. c. A comprehensive survey had captured priorities for the next five years, complemented by Team 2031, a dedicated staff group that has engaged directly with nearly 450 colleagues. d. Feedback from colleagues, governors, and external stakeholders had been synthesised into a document reflecting shared aspirations and future ambitions. e. Many thanks were extended to Richard Taunt and Corrine Armstrong of Kaleidoscope for their facilitation and innovative input throughout the process. f. RT outlined the nature of the draft strategy including: <ul style="list-style-type: none"> • Vision: Become a renowned centre for heart and lung care, recognised for clinical excellence, innovative partnerships, and a culture of empowerment and pride; and • Mission: Transform possibilities for patients with heart and lung conditions through outstanding care and thriving teams. g. The meeting was also briefed of the strategic framework including: <ul style="list-style-type: none"> • Six strategic aims grouped under three pillars: Reputation, Partnerships, and Staff Experience; and • Key themes including a lifecycle approach to services, strong partnership working at all levels, and measuring impact beyond direct patient care. h. It was advised that implementation was the next priority, with integration across all areas targeted for April 2026 in order to ensure alignment and mainstream adoption. i. Flexibility and adaptability would be essential. <p>Discussion:</p> <p>j. TG confirmed that governance arrangements for the strategy document</p>		

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	<p>including a statutory governance page for reference, detailing the meetings and structures involved in implementation would progress to the Board via the Strategic Planning Committee (SPC).</p> <p>k. He reported that high-level discussions had taken place, and the ICB had expressed confidence in RPH's strategy. CC queried whether the ICB could leverage positive influence should there be adverse NHS policy change. TG stressed that RPH's operating principles and collaborative approach during strategy development demonstrated its commitment to delivering best value for the population, which positioned the Trust strongly within the ICB.</p> <p>l. In addition, JA highlighted that while priorities might be adjusted over time to reflect external changes, the hospital's core purpose, delivering high-quality healthcare, remained constant and embedded in the strategy. By maintaining these principles, RPH reinforced its influence and credibility within system-level decision-making.</p> <p>m. GMa recommended strengthening the implementation phase with clear performance metrics, timelines, and intuitive lifecycle elements. This was also echoed by CP and AF who further emphasised the need for explicit measures of success, prioritising harm-free care and "getting the basics right." JA reiterated that the strategy should define expected behaviours and non-negotiable standards, with any deviation deemed unacceptable.</p> <p>n. It was suggested to broaden the strategy beyond KPIs to include system influence, workforce implications, and education, noting the education team's role in capability building.</p> <p>o. TG confirmed that success measures in the draft included sustained excellence in clinical outcomes, improved patient experience, streamlined pathways, increased capacity for advanced treatments, and compliance with national standards. He added that investment in education and training was embedded within the strategy and would be refined. OM added that cultural and inclusion initiatives should continue as part of the transformation journey.</p> <p>The Board approved the Trust 2026 – 2031 Strategy – Next Steps. Subject to the amendments.</p>		
3	PEOPLE		
3.i	Workforce Committee Chair's Report		
	<p>AF presented the Workforce Committee Chair's Report which was taken as read.</p> <p>The Board noted the Workforce Committee Chair's report.</p>		
3.ii	Guardian Safe Working – Report		
	<p>Dr. Stephen Preston presented the Guardian Safe Working – Report.</p> <p>Report:</p> <p>a. The quarterly exceptional reporting and annual report were noted, with SP confirming that resident doctor employment and locum usage had decreased for Quarter 4 ending July 2025. Changes to exceptional reporting were scheduled to commence by 4 February 2026.</p> <p>b. It was observed that exceptional reporting did not fully capture areas of greatest challenge, such as critical care, which experienced periods of high-intensity work, significant out-of-hours and weekend activity,</p>		

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	<p>recruitment pressures, and changes in skill mix. This was in part because rota gaps were filled with short term staffing.</p> <ul style="list-style-type: none"> c. It was noted that despite a full establishment, locum shift usage remained prevalent across departments. Recruitment efforts had been generally proactive, with gaps filled quickly. d. Cardiology continued to face workload pressures, prompting discussions about establishment levels and sustainability of twilight shifts. e. Broader reviews were underway to ensure workforce alignment and to understand drivers of temporary staffing. These did not appear to be linked to sickness rates but seemed to relate to short-term training gaps or rotational patterns. f. Overall, staffing stability had improved compared to prior years, with low vacancy and sickness rates, however, OM highlighted the need for clarity on the Board's appetite for responsiveness. <p>Discussion:</p> <ul style="list-style-type: none"> g. SP noted that, despite current staffing issues, the Trust could improve its position by taking a highly proactive approach. h. OM provided an update on the 10-point plan following discussions at the Resident Doctors Forum, noting the requirement for a peer representative to act as a feedback conduit. Interest had been limited due to the challenging NHS role profile. i. Progress around practical issues was noted, including water safety and improvement on evening food availability. <p>The Board noted the Guardian Safe Working report.</p>		
3.iii	Armed Forces Champion Annual Report		
	<p>BK presented the Armed Forces Champion Annual report that was taken as read</p> <p>Report:</p> <p>BK noted that the Trust continued upholding the Armed Forces covenant. The Trust's one-year accreditation had just been reviewed and all the standards required had been met. BK went through the standards that included:</p> <ul style="list-style-type: none"> a. Understanding and compliance noted as met in light of the accreditation. b. Appointment of Veteran and Armed Forces Champions: Different champions had been recently appointed, HMc had been appointed as one of the executive sponsors. BK had also been appointed and was serving as an Air Force reservist. Luke Bage continued as deputy champion and was also head of resourcing. c. Identification of veterans and armed forces community status patients: It was heard that in the last two months, work had been undertaken in partnership with Business Intelligence in order to create a dashboard that enabled the identification of veterans who had been admitted to the hospital. d. Training and education needs of the veterans and armed forces community: The meeting heard that there was a national programme commencing that day that provided various modules for staff on specific content relating to military personnel and their needs. e. Established links to appropriate nearby forces support services: It was noted that RPH had good links with the Royal British Legion who had supplied poppies. There were also excellent links with the Cambridge Veterans Club; three of the veterans would be joining RPH remembrance service the following week. 		

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	<p>f. For standards six and seven, handover and continuity of care, it was heard that RPH continued to collaborate with champions from other hospitals in order to ensure seamless patient support. When patients required ongoing care or were repatriated to their district general hospitals, contact was made with those hospitals or relevant community charities to maintain continuity of support.</p> <p>g. Supporting the Armed Forces as an employer: It was noted that training was being provided on various tools designed to support candidates in preparing for NHS interviews.</p> <p>h. There was ongoing collaboration involving individuals visiting RPH to shadow colleagues and vice versa. BK emphasised the importance of completing the required training and encouraged attendance at any available Armed Forces training sessions.</p> <p>DJ commended the work done by BK and Luke Bage.</p> <p>The Board noted the Armed Forces Champion Annual report</p>		
4	QUALITY		
4.i	<p>Quality and Risk Committee Chair's Report</p> <p>The Quality and Risk Committee Chair's report was taken as read.</p> <p>The board noted the Quality and Risk Committee Chair's report</p>		
4.ii	<p>Combined Quality Report</p> <p>MS presented the Combined Quality report.</p> <p>Report:</p> <p>a. The paper was taken as read. It was noted that the report primarily focused on inquest activity from the previous month.</p> <p>Discussion:</p> <p>b. CC queried whether the backlog of Coroner's investigations and inquests was improving. MS confirmed progress, noting 82 outstanding cases currently with the coroner's office. A dedicated liaison officer for RPH within the Coroner's office was highlighted as a key factor in accelerating processes through effective pre-inquest reviews.</p> <p>The board noted the Combined Quality report.</p>		
4.iii	<p>Health & Safety Annual Report</p> <p>MS presented the Health & Safety Annual report.</p> <p>Report:</p> <p>a. MS noted that the report provided a detailed overview of health and safety (H&S) management across the Trust during the 2024/25 financial year.</p> <p>b. The report outlined RPH's responsibilities under H&S legislation and confirmed a reduction in the number of incidents.</p> <p>c. A positive correlation was observed between compliance and training, with increased uptake of training, including manual handling.</p> <p>d. It was noted that Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) reports remained comparable</p>		

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	<p>to previous years.</p> <p>e. The meeting heard that there had been three incidents reported to the CQC under the Ionising Radiation (Medical Exposure) Regulations (IRMER) in 2024/25, an increase of one from the previous year.</p> <p>f. 42 staff were referred to Occupational Health for reported sharps injuries, consistent with the previous year.</p> <p>g. Special recognition was given to Terri-Louise Smith, the Trust's Health and Safety Risk Manager, for increasing staff training and leading health and safety assessments across key areas.</p> <p>Discussion:</p> <p>h. DL raised concerns about the difficulty in reducing the incidence of sharps injuries, noting recent moderate harm incidents. MS confirmed that a task group with representation from Infection Prevention Control, Occupational Health, and Theatres had been established to develop an improvement plan. She had no visibility of specific mitigation measures and explained that the task group reported regularly to the Health and Safety Committee and Infection Prevention Control, with added focus on theatres where most injuries occurred.</p> <p>i. DL also questioned whether gaps identified in the March 2023 Health and Safety Annual Report would recur in the 2024/25 report. MS assured that these gaps had been addressed through improved reporting and oversight, supported by the Health & Safety team and other groups, including the Radiation Protection Committee, which met more frequently with Q&R.</p> <p>j. All policies and procedures were reviewed by this group with Medical Physics experts, providing an additional layer of assurance.</p> <p>The approved the Health & Safety Annual report</p>		
5	PERFORMANCE		
5.i	Performance Committee Chair's report		
	<p>The Performance Committee (PC) Chair's report was taken as read.</p> <p>Report:</p> <p>DJ presented his first Performance Committee report, highlighting key areas:</p> <p>a. In respect of Elective Recovery, significant improvement was noted, with 52-week breaches at their lowest level in 18 months. Work continued in order to reduce waiting lists, though some challenges remained.</p> <p>b. With regard to finance, concerns persisted regarding meeting CIP targets by year-end, but improvements were underway. It was noted that EPR underspend posed a capital risk, and this was being actively managed. The Committee and Trust Board were advised to remain alert to emerging financial risks as the year closed.</p> <p>c. In respect of forward planning, the Committee had discussed the approach for planning over the next three years and that the annual operational planning approach had been approved.</p> <p>d. EPRR Core Standards had also been endorsed by the Committee.</p> <p>e. Inconsistencies in BAF reporting were acknowledged. A new reporting format that had been developed was expected to reduce mismatches and improve risk oversight.</p> <p>The Board noted the Performance Committee Chair's report.</p>		

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5.ii	Papworth Integrated Performance Report (PIPR)		
	<p>MS presented the PIPR report for Month 06 – September 2025.</p> <p>Report:</p> <ol style="list-style-type: none"> a. MS reported that complaint rates remained higher than benchmarked levels, largely due to the complexity of cases. b. HMc provided an update on CT Scan outsourcing risks. He noted that initially, there had been concern about a two-week delay in transitioning from Langley Clark's in-source model to a new outsourced provider. This had been resolved through collaboration with Finance and Digital teams; the contract had been signed, and deployment remained on track for 8 December. He assured the Board that delays were no longer material. c. In respect of clinical impact that the outsourced model would have, HMc confirmed that reporting after imaging would return to within 28 days, with compliance expected to reach 95% by mid-to-end December. This trajectory was considered sustainable and would be closely monitored by the Executive Oversight Group and the Performance Tracking Group three times weekly. d. Further work was underway with clinical teams, the Divisional Director of STA, and the Clinical Lead for Radiology to shape future interventions. EM highlighted emerging MRI issues that were prompting deeper analysis. <p>Discussion:</p> <ol style="list-style-type: none"> e. In respect of CT backlogs, CP queried if the Trust was taking a proactive approach. HMc confirmed a strategic approach involving internal reviews of radiology operations, waiting times, access standards, and workforce challenges. Mitigation plans were in design phase, expected within three weeks, with a Board briefing scheduled for January. f. Recruitment and retention challenges, including consultant vacancies and MDT considerations, would also be addressed in a plan for the Board in January via the December Workforce Committee. g. AF raised concerns about RAG ratings in the report noting that they did not provide assurance to the Board since they hardly moved to the green category. EM clarified that while national standards were met, they did not fully reflect RPH's true performance. Alignment of planned delivery with in-year targets was intended for the next planning round in order to provide a fairer reflection. h. JA queried the 51,673 patients on non-RTT open pathways and whether they were in onward care. HMc explained that most were in onward care, with elective and follow-up delays and added that follow-up intervals extended to 2-3 years, double pre-pandemic levels. He noted that this cohort included: <ul style="list-style-type: none"> • 30,000 patients on standard monitoring with open access pathways; and • 20,000 in active follow-up, some beyond expected dates. i. HMc added that these patients remained clinically important. Pivot interventions included virtual services and use of technology, but assurance on their effectiveness was pending. j. JA requested that the statistics for onward care patients be disaggregated in order to provide greater visibility of this group, as these were the patients where issues most frequently arose. HMc agreed, noting ongoing work with Chief Nurse and Medical Director and that a breakdown of active clocks and monitored patients would be provided in the next financial year. 	HMc	02/26

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	The Board noted the Papworth Integrated Performance Report Month 06 – 2025.		
5.iii	Annual Assessment Against NHSE EPRR Core Standards		
	<p>The Annual Assessment of Trust Compliance against Emergency preparedness, resilience and response (EPRR) Core Standards paper was taken as read.</p> <p>Report:</p> <ul style="list-style-type: none"> a. HMc advised that the Annual Assessment Against NHSE EPRR Core Standards was submitted to the Board twice yearly. b. The September submission was presented for the Board's information and did not require formal approval, whereas the March 2026 submission would require the Board's approval. c. It was noted that the assurance process covered 10 core EPRR domains, and the latest submission recorded overall substantial compliance. d. It was noted that there were three domains that had partial compliance with an ongoing action plan with key stakeholders; these areas were: <ul style="list-style-type: none"> • Domain 1 Governance – EPRR Resource; • Domain 7 Warning and Informing – Communication with partners; and • Domain 7 Warning and Informing – Media Strategy. e. It was noted that a clear plan was in place to maintain progress and strengthen resilience over the coming year. <p>The Board noted the Annual Assessment against NHSE EPRR Core Standards.</p>		
6	AUDIT		
6.i	Audit Committee Chair's Report		
	<p>CC presented the Audit Committee Chair's Report.</p> <p>Report:</p> <ul style="list-style-type: none"> a. CC noted that reports from various Royal Papworth Hospital sub-committees had been presented, providing assurance to the Trust Board. CC said that the Chair of the Charitable Funds Committee (CFC) would be invited to Audit Committee to present how that Committee gets assurance. b. In respect of the Consultant Job Planning review, the Audit Committee had received a report from BDO in July on their review across ten NHS Trusts, including RPH. BDO's findings provided significant benchmarking opportunities. c. The Medical Director had presented a report outlining the Trust's benchmarking position and the proposed actions in order to address areas requiring improvement. RPH was found to have performed well against the benchmarking, and the Committee had requested that future oversight of such reports would sit with the Workforce Committee. d. The Committee also considered progress on recommendation follow-ups. Concerns had been raised at the July Audit Committee meeting regarding several recommendations remaining unresolved for extended periods, with completion dates frequently revised. The Executive had since undertaken work to address this, and BDO confirmed that 90% of recommendations had been completed. Outstanding improvements were noted in outpatient 		

Agenda Item		Action by Whom	Date
	<p>work, the CT scanning audit, and benchmarking on health and safety.</p> <p>e. The Royal Papworth Charity audit for 2024/25 was reported as ongoing. Auditors had queried the timing of legacy income recognition, which they considered too early, requiring prior-year adjustments. LS confirmed these adjustments had been completed and that the Trust's accounts would be updated accordingly. These changes would be disclosed at the CFC meeting the following week, followed by an update at an Extraordinary Audit Committee meeting and final approval at the Trustees Board.</p> <p>Discussion:</p> <p>f. JA observed that RPH had a high number of job plans exceeding 12 and 15 programmed activities and expressed concern that, while this might be clinically and cost-effective, it could have an impact on consultant performance. SW explained that he, the Medical Director, and other members from his team were reviewing various factors influencing job planning and considering a suitable limit. He noted that some job plans were long-established among senior colleagues and might not be attractive to new applicants. OM added that job planning remained an active discussion, and work was underway to amend the guidance framework and include a ceiling for the first time.</p> <p>The Board noted the Audit Committee Chair's report.</p>		
7	GOVERNANCE & ASSURANCE		
7.i	Review of Remuneration Committee Terms of Reference		
	<p>The Remuneration Committee Terms of Reference were taken as read.</p> <p>The Board approved the review of the Remuneration Committee Terms of Reference.</p>		
7.i	Board Committee approved Part 1 Minutes		
	<p>a. Quality and Risk Committee – 28.09.25</p> <p>b. Performance Committee – 28.09.25</p> <p>c. Strategic Projects Committee 28.08.25</p> <p>d. Audit Committee: 17.07.25</p> <p>The Board noted the Board Committee Part I Approved Minutes.</p>		
8	BOARD FORWARD PLAN		
8.i	Board Forward Plan		
	<p>The Board noted the Board Forward Plan.</p>		
8.ii	Review of actions and items identified for referral to committee/escalation		
9	ANY OTHER BUSINESS		
	<p>EM advised that there would be 5-day resident doctors' strike commencing on 14 November.</p>		

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Signed

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Date

Royal Papworth Hospital NHS Foundation Trust
Board of Directors Part I
Meeting held on 06 November 2025