Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Board of Directors
Held on 08 January 2026 at 9:30 am – 11:45 pm
Microsoft Teams
HRLI, Royal Papworth Hospital

UNCONFIRMED M I N U T E S – 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
	Dr C Paddison	(CP)	Non-Executive Director
	Prof 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
	Mrs M Screaton	(MS)	Chief Nurse
	Dr I Smith	(IS)	Medical Director
In attendance	Mr G Matenga	(GM)	Corporate Governance Lead
	Mr S Edwards	(SE)	Head of Communications
	Mrs L Bush	(LB)	Office Manager & PA to CEO and Medical Director
	Dr T Pieters	(TP)	Consultant Psychiatrist (For item 1.i – Patient Story)
	Dr R Brown	(RB)	Clinical Psychologist (For item 1.i – Patient Story)
	Mr A Bottiglieri	(AB)	Freedom to Speak-up Guardian (For item 2.iii – Freedom to Speak-up Guardian)
	Dr L Williams	(LW)	Surgical Trainee (For item 2.ii – Resident Doctors 10 Point Plan Update)
Apologies	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 (In person) Dr J Pajak (JP) – Public Governor Mr J Dyer (JD) – Public Governor (In person) Mr P Webb – Staff Governor		

	Jane Woollard (JW) – Chief Nurse shortlisted candidate Caroline Julien (CJ) – Director of Workforce and OD shortlisted candidate (In person)

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1	**WELCOME, APOLOGIES AND OPENING ITEMS**		
	a. JA welcomed everyone to the meeting and noted apologies as above. b. He also welcomed Jane Woollard, shortlisted candidate for the Chief Nurse role (Teams) and Caroline Julien, shortlisted candidate for the Director of Workforce and OD role.		
1.i	**Patient Story**		
	JA welcomed Dr Thirza Pieters Consultant Psychiatrist and Dr Rachel Brown Consultant Psychologist to present the Patient Story. **Patient Story:** a. TP and RB presented an overview of the Psychological Medicine service, describing its development at Royal Papworth Hospital since 2009 and its role in embedding mental health support within specialist physical healthcare. It was heard that the service had evolved progressively from a small provision focused on cystic fibrosis into a multidisciplinary team delivering support across inpatient services, transplantation, adult congenital heart disease, cystic fibrosis, and wider multidisciplinary teams (MDTs). This expansion reflected national policy directions, commissioned service expectations, and increasing recognition of the critical role of mental health in improving patient outcomes. b. The meeting heard that the team comprised psychologists, psychiatrists, a clinical nurse specialist and administrative support, working largely part-time but bringing broad expertise in liaison psychiatry, mental health law, safeguarding, risk assessment, prescribing, de-escalation and psychological therapies. A wide range of therapeutic modalities were offered, including solution-focused and family-based interventions. c. Between November 2024 and November 2025, the service received 410 new referrals, predominantly from transplant and inpatient services. Common referral reasons included anxiety, depression, distress and concerns about suicide or self-harm risk. It was noted that a series of case studies illustrated the service's impact in improving engagement with care, treatment readiness, patient flow, recovery, and outcomes, including in complex pre-operative, ICU, transplant and Adults with Congenital Heart Disease (ACHD) pathways. d. The presentation emphasised that mental health support benefited patients, families and staff, improved understanding of disengagement, supported complex decision-making, and mitigated psychological harm associated with advanced treatments and prolonged waiting. TP reinforced that while the service had grown organically and delivered significant value, capacity limitations and variable access across pathways remained, alongside gaps in areas such as long-term follow-up and end-of-life support. e. Board members welcomed the insight into the service, and discussed		

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	resource alignment, signposting for relatives, integration with wider services, and the challenge of evidencing system-level impact such as reduced length of stay. It was acknowledged that while quantifying financial or capacity benefits was complex, the service played a critical role in safe, compassionate and effective care, reinforcing the principle that there was no health without mental health. **Discussion:** f. EM thanked the team for illustrating the significant impact of the service on patients and asked how the Trust supported relatives and carers who experienced psychological distress while accompanying patients through complex pathways. TP explained that relatives were often engaged as part of holistic patient assessments and were routinely signposted to community-based support, including primary care and local services. She noted that direct clinical intervention was limited by governance, capacity, and record-keeping constraints, as relatives were not Trust patients. g. GMa asked how well the current resource and workforce model matched the level and complexity of need. TP advised that while the service had grown and was increasingly aligned with demand, significant gaps remained, particularly in areas such as extracorporeal membrane oxygenation (ECMO), end-of-life support within transplant pathways, and long-term follow-up. She highlighted the need for greater organisational understanding of the service's role and boundaries, noting that a proportion of referrals related to normal emotional responses rather than psychological disorder. h. OM queried what happened to patients once they left the Trust and whether care is handed over effectively. TP confirmed that while some outpatient provision existed for cystic fibrosis and transplant patients, most individuals were signposted or referred into community talking therapies or secondary mental health services, supported by the team's expertise in navigating those systems and using appropriate clinical language to facilitate access. i. DJ focused on system impact, asking whether the team had evidence that psychological medicine input reduced length of stay, alleviated pressure on services, or improved flow. TP acknowledged that while there was wider evidence supporting these benefits in liaison psychiatry, local data were difficult to isolate, given the highly integrated nature of the work and its indirect effects (e.g. enabling discharge, reducing observation levels, or improving engagement). She noted that work was underway to explore how outcomes and impact might be better evidenced, while cautioning against framing mental health support solely in terms of cost savings. j. JA asked whether the team met in any forum that would allow Non-Executive Directors or colleagues to observe and better understand the service's work at a thematic level. TP advised that the service held a weekly multidisciplinary meeting, which colleagues were welcome to attend, and noted the value of shared understanding. k. JA further questioned whether the service contributed to assessing psychological harm associated with long waiting times, noting that while physical harm was routinely reviewed, psychological distress was less visible. TP responded that while the team was not formally involved in waiting list harm assessments, significant distress was frequently seen in ICU, ECMO and prolonged inpatient settings. l. In closing, JA members thanked TP and RB for a comprehensive and excellent presentation. The Board **noted** the patient story.		

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1.ii	**Declarations of Interest**		
	a. There were no new interests declared.		
1.iii	**Minutes of the previous meeting**		
	Board of Directors Part I: • **06 November 2025** The Board of Directors **approved** the Minutes of the Part I meeting held on 06 November 2025 as a true record.		
1.iv	**Matters arising and action checklist**		
	a. All actions proposed for closure were closed and the following updates were made. b. **Action:08/25 – Any Other Business – Combined Quality Report – Mortality Data – Report on Gender-based Review** IS reported that the action would be included in the 6 monthly mortality review at Quality and Risk Committee and Performance Committee as well. Action was Closed. c. **Action:25/26 – Workforce Strategy Workplan –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.** The summary was part of item 2.i of this meeting (Director of Workforce & OD – Report). Action was Closed. d. **Action:24/25 – Board Assurance Framework (BAF) – EM/LS to include the refreshed BAF in the Internal Audit Workplan for 2026/27** EM advised that this had been noted. Action was Closed e. **Action:27/25 – Performance Committee Chair's Report – In respect of CIP data relevant to patient experience, HMc to check with CC and provide the relevant data to her.** HMc advised that the 52-week wait data is now provided in the elective care recovery report that is presented to Performance Committee every month. Action was Closed. f. **Action:31/25 – Performance Committee Chair's report – HMc to produce data for the 31 and 62-day pathways in a way similar to that for the 52-week breaches for the cancer waiting list** HMc reported that this data is now included in PIPR as standard Action was Closed. The Board **noted** the Matters Arising and Action Checklist.		
1.v	**Chair's report**		

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	Report: a. The Chair highlighted the recent Staff Awards Ceremony held at Queen's College, Cambridge, describing it as a highly enjoyable occasion marked by a joyful atmosphere, excellent company, and an engaging programme of food, music, and dancing. The Trust had received over 640 nominations, from which 45 colleagues were shortlisted, and 15 award winners were selected across a range of categories. b. Warm thanks were extended to Sam Edwards, Head of Communications, and Laura Favell-Talbot, Communications and Membership Engagement Coordinator, for their outstanding work in organising such a successful event at an excellent venue. c. The Chair and the Chief Executive also attended a Christmas Carol Concert at Ely Cathedral, organised by the Royal Papworth Charity event. This was a very positive day featuring some very moving tributes to organ donors and impressive carols and music in a wonderful setting. The event also raised £10,000 for charity. d. The Chair noted a very welcome and kind Christmas message from our patron, the Duchess of Gloucester, to all at the Trust. The Chair expressed appreciation for the continued support and engagement our patron. e. He acknowledged the Trust's improved elective recovery performance, noting that Royal Papworth Hospital ranked joint second nationally among acute and specialist Trusts. He also recognised teams across RPH for achieving the top position among specialist Trusts based on assessed performance metrics. The Board **noted** the Chair's report.		
1.vi	**Board Assurance Framework**		
	EM presented the Board Assurance Framework (BAF) that was noted as read. **Report:** a. EM expressed her pleasure in presenting the Trust's new BAF risk register to the public meeting for the first time. She explained that the redesign had been prompted by the previous BAF becoming overly complex, with a large number of long-standing risks. The new BAF was aligned with the 2026–31 strategy and intended to provide a more streamlined and meaningful strategic risk oversight tool. b. She thanked the Executive Team and all those involved in developing the new framework, noting that further iteration would follow. Feedback on the presentation format was welcomed in order to support ongoing improvement. c. EM drew attention to changes in residual risk ratings: • BAF 2829 – Failure to achieve financial balance, increased from 12 to 20. • BAF 3725 – Inability to access a sufficient capital envelope, increased from 16 to 20. d. These increases reflected the current position within the 2025/26 financial year (FY) planning cycle. LS added that the risks were expected to reduce as planning progressed, also noting that the current ratings were based on early assumptions and that discussions with the system were continuing.		

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	Discussion: e. DJ noted that, while an increase in risk should trigger consideration of additional mitigation measures, this was not yet evident in the BAF register. He added that despite a strong year of operational performance, no strategic risks had decreased and suggested that the Board should identify which risks could realistically be adjusted in 2026, proactively articulating the actions needed, rather than having another year in which ratings remained static and not correlated to movement in determining factors. f. EM explained that financial risks naturally rose at this stage of the annual planning cycle due to uncertainty and typically reduced as detailed plans were finalised. However, given the significant shifts in NHS financial policy and conditions this FY, she cautioned that normal patterns might not apply and that a heightened level of genuine financial risk remained; there would be a corresponding fall in the Trust's risk capacity. g. Addressing DJ's points, JA suggested that: **Action: The Board needed to reconsider its risk appetite for certain risks, especially where high ratings had been tolerated for an extended period.** The annual planning cycle and associated risk appetite discussions were the appropriate point at which revised targets or mitigations should be presented. h. IS highlighted that many BAF entries were composite risks, where improvements in some areas were offset by emerging issues elsewhere, meaning overall scores could remain unchanged; he added that clearer narrative explanations were needed to reflect this movement. i. OM reinforced the difficulty of rating composite risks within Datix, suggesting more dynamic updating of risk components and noting that some elements should naturally fall away as risks were resolved, with potential future adjustments needed to keep the BAF focused and relevant. j. CP suggested that the Board should revisit its conversations regarding risk capacity and appetite. She sought assurance that the mitigation measures for Risk ID: 3730, "if there are no safe systems and practices in place", were sufficient. She highlighted that the Datix report included issues around near misses and delays in the procurement and implementation of the replacement for the M-IGHTY module and requested an update on the cause of the delay and expected resolution. k. MS confirmed that no patient harm had occurred as a result of the fragility of the M-IGHTY module. She noted that there were no near misses formally recorded in Datix but would check with the team to verify. AR advised that the procurement process was progressing, with the expectation that the contract would be awarded before the end of March. l. CP raised Risk ID: 3873, "the Trust's ability to manage clinical capacity effectively so that patients referred to Royal Papworth received timely access to elective, emergency, cancer and diagnostic services". She asked how the Trust captured data and insight on inequity of access. m. IS reported that available data showed the Trust received fewer referrals from more socially deprived areas, but once patients were referred and within the Trust's system, there was no evidence of inequitable waiting times or delays linked to deprivation. n. Initial service-level analysis indicated that GP knowledge was not lower, and was in some cases higher, in more deprived areas, suggesting that	**ADCG**	

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	inequity was not due to GP awareness. Instead, barriers appeared to occur earlier in the patient pathway, potentially relating to patient understanding, awareness of treatment options, help-seeking behaviours, or access to GP services, with further work required to address these upstream factors. o. AF raised concerns about the distinction and management of Risk ID: 2904 (ICS failing to achieve financial balance) and Risk ID: 2829 (the Trust failing to achieve financial balance). She stressed the importance of being clear about what was within the Trust's control versus what relates to wider ICS-level regulatory and financial issues, noting that having both risks presented similarly could be confusing. It was added that the current risk targets of 8 and 12 did not feel appropriate and supported the view that risk scoring should be dynamic, reflecting real-time changes in risk, controls, and mitigation effectiveness. p. LS agreed and noted that Risk ID: 2904 would require review as the financial framework changed from beginning April, which would alter what was within the Trust's ability to influence. This update would be incorporated as part of planning for the new financial year. q. TG emphasised the importance of distinguishing between factors within the Trust's control, such as productivity improvements, and external influences, including the macroeconomic environment; these external factors not only impacted financial performance but also shaped the level of performance it was reasonable for the Trust to achieve. He underscored the importance of clearly articulating both elements while acknowledging their respective impact. r. JA commended the quality of the discussion and confirmed that the current BAF format would be retained for the next three reporting cycles. He noted that a formal review of the framework would take place at the Part II Board meeting in April, with preparatory discussions progressed through the relevant Committees. The Board **noted** the Board Assurance Framework update.		
1.vii	**CEO's update**		
	EM presented the CEO update that was taken as read. **Report:** a. EM highlighted the significant positive impact of the Royal Papworth Charity, noting that under its new leadership the charity had grown substantially, delivered strong support to patients and staff, organised successful fundraising events, and continued to foster innovation across the Trust. b. She announced with sadness the passing of Sir Terence English, aged 93, in November, recognising his profound contribution to transplantation in the UK and his long-standing support for the Trust. c. EM confirmed that the Trust's strategy had moved fully into the implementation phase, with a strong emphasis on continued engagement across the organisation. She also praised the recent staff awards, noting the sense of celebration and recognition of colleagues' achievements, and thanked Board members for their involvement. d. She commended the progress made on the 10-point plan for improving the experience of resident doctors, thanking IS for his leadership. e. In respect of surgical site infections (SSIs), EM reported that the new clinical leadership had strengthened the approach to developing actions, improving data collection and insight. Work with the infection team was		

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	enabling a more comprehensive review of the infection pathway, and she expressed confidence that the emerging plan, being overseen by the SSI Oversight Group, would identify the right priority mitigation measures. f. EM also noted ongoing collaboration with Skanska on reviewing the hospital's ventilation systems, with oversight through the Ventilation Committee. g. She congratulated three colleagues, Tina Bryan, Allaina Eden and Ellen O'Brien, for securing places on the prestigious NIHR Health and Care Professional Internship (East of England) 2025/26, supporting the development of research skills and capability within the Trust. The Board **noted** the CEO's Update.		
1.viii	**NEDs update**		
	a. DJ reflected on the NEDs' earlier discussion about how they engaged with the hospital more broadly and invited the Executives to suggest areas within the organisation that would be worthwhile for NEDs to visit in order to gain deeper insight into issues affecting services within the Trust. b. JA also asked NED colleagues to outline where they had engaged within the hospital over the past six months, in order to help identify and map any gaps in their exposure. The Board **noted** the NEDs update.		
2	**PEOPLE**		
2.i	**Director of Workforce & OD – Report**		
	OM presented the Director of Workforce & OD – Report that was taken as read. Report: a. OM noted that the report provided an update on progress against the workforce plan and confirmed that the staff survey results would be discussed in Part II. **Discussion:** b. DL queried the absence of RAG ratings in certain areas, including AI and the Learning Management System (LMS), and sought clarification on progress. OM advised that the LMS had been procured, and work was underway with Clinical Education on the implementation plan. She added that work on AI continued, with a focus on developing policies while managing potential risks. c. AF reiterated that the Workforce Committee had commended the Workforce team's overall progress but highlighted areas where progress had been slow and required prioritisation. She noted concerns about the team's capacity and the need to revisit discussions on priorities, workload, and resourcing at a future Part II meeting. d. JA noted that progress against the Workforce Strategy appeared more evident than progress on the Equality, Diversity and Inclusion (EDI) agenda, particularly in relation to milestone delivery, and queried whether this was an unfair comparison. e. OM advised that the assessment depended on how progress was measured. She highlighted that while there had been a period of reduced capacity within the EDI team, which had slowed progress, cultural		

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	change, especially tackling racism, was inherently more challenging and less straightforward to evidence than transactional workforce activities; workforce strategy actions, which were often easier to track and complete. f. JA acknowledged this distinction but questioned whether the organisation was allocating proportionate time and resources to the area that was harder to address. g. OM outlined the recent restructuring within the Workforce department, noting increased Organisational Development (OD) resource in recent years and the introduction of a new structure designed to improve support to divisions. She explained that Business Partners were now positioned to focus more on planning and OD rather than casework, with transactional HR functions managed elsewhere. This shift was intended to strengthen the organisation's capacity to support both workforce processes and longer-term cultural development. h. AF highlighted that this was an important conversation needed to support delivery of the strategy and to ensure alignment between organisational development and cultural work. The Board **noted** the Director of Workforce & OD – Report.		
2.ii	**Resident Doctors 10 Point Plan Update**		
	IS and LW presented the Resident Doctors 10 Point Plan Update. **Report:** a. IS introduced Dr Luke Williams as the Trust's new resident doctor representative under the NHS England 10-point plan. b. LW reported that a baseline assessment and early survey findings showed meaningful progress, particularly in facilities, study leave, and amenities, but significant challenges remained, including protected breaks, payroll errors, induction and communication, mandatory training burden, and inadequate rest facilities after long on-call shifts. c. While early engagement had been strong and improvements were underway, further evidence from the ongoing survey would inform priorities aimed at delivering sustained improvement in resident doctors' experience **Discussion**: d. GMa expressed concern that baseline ratings for mandatory training and rest facilities were marked as "green," yet early survey responses from junior doctors suggested a different lived experience. He highlighted the risk of a mismatch between what the Trust believed it was providing and what staff were actually experiencing, particularly with only ten survey responses so far. e. IS noted that the accuracy of the findings depended heavily on how the survey questions were framed, whether they referred to historic issues, or they referred to experiences since the programme began. He added that if issues were still occurring 2½ months into the programme, they required immediate attention. f. OM explained that baseline assessments relied on information recorded in Trust systems. For example, mandatory training compliance was drawn from system records, but if documentation had not been uploaded or processed, the system would incorrectly flag it as incomplete. HR workload and administrative delays could contribute to these gaps, meaning that the systems might not always reflect real activity. g. MS welcomed progress but urged recognition of how other staff groups, such as nurses working night shifts, also faced challenges with breaks		

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	and rest. She emphasised the importance of ensuring communication reflected inclusivity across all staff groups. h. JA emphasised that enhancements introduced for resident doctors should be extended more broadly across staff groups, so that benefits were not limited to a single cohort. i. OM linked the discussion to the wider Trust strategy, noting that improvements should balance competing organisational priorities. Many 10-point plan elements related to staff facilities, an area the Trust recognised required significant improvement. Efforts should remain aligned with broader strategic goals while meeting the diverse needs of different staff groups. j. JA asked about coordination with neighbouring hospitals. IS reported that regional monthly meetings were taking place within the system, while OM noted that the regional office was expected to share best practice, although this had not yet fully materialised. k. JA also asked about the best method for communicating with residents. LW advised that email and WhatsApp were the most effective channels of communication, alongside the newly established physical space. l. The Board agreed that: **Action: the next update will be presented at the May meeting.** The Board **noted** the Resident Doctors 10 Point Plan Update.	**GM**	**02/26**
2.iii	**Freedom to Speak-up Guardian**		
	AB presented the Freedom to Speak-up Guardian that was taken as read. **Report:** a. AB reported that over the past six months, activity levels had been high, with a continued increase in reported incidents compared to the previous year. This trend mirrored patterns seen across the NHS, indicating growing willingness among staff to raise concerns. b. It was highlighted that the introduction of anonymous reporting in June 2025 had generated a steady flow of four to five reports per month, in line with similar trusts. c. Anonymous reporting had broadened the dialogue around emerging issues, enabling conversations with project managers on topics such as the impact of recent Supreme Court rulings on sex and gender. d. Some reports also reflected frustrations with inconsistent handling of concerns across departments. While over 2,000 staff had activated their accounts on the reporting platform, this engagement had not yet translated into proportional communication directly with AB's office. e. AB noted an ongoing challenge around definitions, particularly in relation to racism, sexism, and inappropriate behaviours. It was noted that variability in how managers interpreted and applied definitions could sometimes obscure the seriousness of staff experiences. f. The meeting noted that over 150 culture-related cases had been reported in the past year. It was further noted that increased collaboration with the Workforce team had enabled better triangulation of intelligence from sources such as DATIX, supporting the development of a clearer organisational view of emerging trends and concerns. g. AB advised that promoting anonymous reporting remained a priority, particularly as some staff groups, especially within the medical workforce, remained reluctant to speak up. h. It was reported that increasing confidence and accessibility was seen as		

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	essential to uncovering deeper issues. i. On a positive note, the network of Speak Up Champions continued to grow, exceeding 40 members. AB expressed a long-term ambition to reach 100 champions to ensure strong, visible support across the Trust. **Discussion:** j. DL raised concerns about the high number of inappropriate-behaviour cases, which did not align with organisational values, and asked how feedback was provided to anonymous reporters. AB confirmed that although identities remained unknown, the team responded through the anonymous reporting platform and ensured all issues, minor or significant, were passed to the appropriate managers. k. AB noted that reports of inappropriate behaviour had increased, often involving condescending remarks, offensive 'banter', and culturally normalised behaviours. These were addressed through established processes, including mediation, Dignity at Work procedures, disciplinary action, or Maintaining High Professional Standards (MHPS) for medical staff. It was heard that when reports were anonymous, AB's team still provided guidance and encouraged further engagement where possible. l. GMa observed that anonymous reporting seemed valuable and queried low "would speak up again" rates. AB confirmed this reflected a national decline in confidence, with staff often linking willingness to speak up with whether they felt actions taken matched their expectations. GMa also asked about Speak Up Champion diversity; AB noted the group of 44 champions was not as diverse as desired, particularly regarding medical staff representation. m. AF highlighted inconsistencies in how management had responded to concerns; this had been a key driver behind the establishment of the new Leading for Inclusion Programme, which aimed to improve consistency and leadership capability across the organisation. The Board **noted** the Freedom to Speak-up Guardian		
3	**QUALITY**		
3.i	**Quality and Risk Committee Chair's Report**		
	GMA presented the The Quality and Risk Committee Chair's report that was taken as read. **Report:** a. GMa highlighted that the Committee had previously discussed SSIs at both the November and December meetings. Enhanced executive governance arrangements for SSIs had since been established, including the introduction of fortnightly executive-level meetings. It was noted that a full review of all aspects of the care pathway was underway. b. It was confirmed that there had been no evidence linking recent cases to the Mycobacterium Abscessus outbreak strain. GMa proposed that, at a future meeting, the Committee should undertake a focused discussion on Transcatheter Aortic Valve Implantation (TAVI), including case mix and the associated consequences, particularly in relation to inpatient activity. **Discussion:** c. DL asked what measures had been implemented in order to prevent recurrence of recent issues. MS explained that two Patient Safety		

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	Incident Investigations (PSIIs) had been commissioned using the Trust's cluster-based review methodology. d. One PSII related to a cluster of incidents involving the monitoring of ventilated patients. These cases are being reviewed collectively to identify common themes and any wider systemic improvement requirements. e. A second PSII concerned a discharge medication error following a recent case, alongside a similar incident approximately 18 months earlier, in which a patient did not receive dual antiplatelet therapy. A review would be undertaken in order to explore whether there were recurring risks or process failures that could inform further improvements. f. Further clarification was sought regarding whether the issue related to prescribing, administration, or downstream safety checks. MS confirmed the incident occurred at the point of discharge, and that the error was due to human error, where the incorrect medication was crossed off rather than the intended one. It was acknowledged that, while there are existing checks and balances, such as discharge counselling and medication reconciliation, these may not have functioned optimally in this scenario. g. JA emphasised the importance of ensuring that learning from these and other critical incidents was embedded into the development of the new Electronic Patient Record (EPR), particularly in relation to workflows and safety controls. h. MS agreed, noting that involving clinicians and staff with direct experience of the care pathways was critical in shaping EPR clinical scenarios and identifying areas where systems need to better support safe practice. i. JA further highlighted the value of ensuring that intelligence from Trust-wide incident reporting, such as those summarised in quarterly safety reports, was fully shared with the EPR supplier in order to influence design and functionality. j. GMa added that Jenny Harrison, the Chief Pharmacist had recently echoed similar concerns, particularly around human factors and medication visibility within the current system. While not specific to the incident discussed, she recognised limitations in how discontinued medications were displayed and viewed the forthcoming EPR as a key opportunity to address these weaknesses. The board **noted** the Quality and Risk Committee Chair's report		
3.ii	**Combined Quality Report**		
	MS presented the Combined Quality report that was taken as read. **Discussion:** a. In respect of the patient who died while waiting for surgical intervention on the Royal Papworth Hospital elective surgical pathway, JA asked whether the Board was assured that the waiting times had been appropriate, given the patient's condition at the time. b. IS explained that the patient had been under clinical surveillance and had not been identified as requiring urgent intervention during that period. The patient had been reviewed by an anaesthetist approximately three to four weeks prior to admission and was reportedly asymptomatic at that time. It was reiterated to the patient that they should contact the Trust should their condition change.		

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	c. He further noted that, on the day of admission, the patient's condition had deteriorated significantly and rapidly, representing a marked change from previous assessments. IS confirmed that the patient had undergone a pre-admission assessment. The board **noted** the Combined Quality report.		
4	**PERFORMANCE**		
4.i	**Performance Committee Chair's report**		
	DJ presented the Performance Committee (PC) Chair's report was taken as read. **Report:** a. DL reflected that the Trust had entered the year with strong performance against Key Performance Indicators (KPIs) across all areas of the hospital. b. In respect of financial performance, DL highlighted that the Trust was on track to deliver a breakeven position. A number of mitigating measures had been implemented in order to manage and reduce risks to delivery of this position. It was noted that overspends in some areas had been offset by financial returns in others, and he emphasised the importance of closely monitoring this position as the Trust moved into the next FY, in order to mitigate the risk of future overspending. c. DJ highlighted that additional operational areas would continue to be monitored through the remainder of the FY, including CT reporting. He advised that actions had been taken to deliver an outsourced CT reporting model, and that these actions would continue to be tracked as delivery concluded towards the end of the financial year. An assessment would be undertaken to determine whether the actions had achieved the desired outcomes and enhanced performance. d. DJ reflected on the BAF and the Papworth Integrated Performance Report (PIPR), noting that it was difficult to gain a high-level view of how the Trust was tracking and trending performance over time. While national recognition and targets were clearly articulated, it was felt that internal reporting made it challenging to understand performance trajectories across the organisation. e. He advised that measures had been put in place to improve this and that there were open actions relating to the further development of PIPR, which would be discussed. The Board **noted** the Performance Committee Chair's report.		
4.ii	**Papworth Integrated Performance Report (PIPR)**		
	LS presented the PIPR report for Month 08 – November 2025. **Report:** a. LS took the report as read and invited questions from the meeting. **Discussion:** b. CP acknowledged the processes in place for the collection and recording data relating to patient and care experience. She asked what formal mechanisms existed to integrate patient and care experience into quality improvement initiatives.		

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	c. MS explained that patient experience measures were primarily based on the Friends and Family Test (FFT) recommendation score, which was actively monitored and managed across the Trust. d. It was advised that care experience intelligence was largely drawn from complaints data. While complaints were shared effectively at a local level, this intelligence was not yet consistently or robustly shared across services or the wider organisation, limiting the potential for cross-Trust learning. It was acknowledged that this was an area requiring improvement. e. MS emphasised the importance of improving patient experience through early, local resolution of concerns within teams, citing examples of strong divisional practice where issues were addressed proactively before escalation into formal complaints. She added that work was underway to simplify and improve FFT reporting to make it more accessible and support learning. f. MS also highlighted the positive contribution of Patient Safety Partners to quality improvement and outlined current work to scope enhanced co-production with patients and carers, including leadership and resource considerations, with next steps to be defined by the end of February. g. JA asked about plans for changes to the PIPR. EM advised that it was reviewed annually as part of the Trust's operational and financial planning cycle and that significant changes would not be made mid-year. Learning from the current year would inform metric setting and reporting for the next FY. h. In discussion, JA highlighted both the annual refresh of operational metrics and a broader concern about whether the current data and reporting approach provided the most effective signals for Board assurance and decision-making. i. CC also raised concerns regarding the accuracy and credibility of SPC data within PIPR and suggested the report be reviewed in its entirety to ensure effective governance and appropriate focus across Committees. She proposed that Committees identified issues relevant to their remit, with Executive Directors retaining oversight of any redevelopment. EM welcomed Committees raising their key considerations. j. EM acknowledged that while the Board had historically prioritised statutory KPIs, some targets were not achievable within-year, despite agreed delivery plans. She emphasised that PIPR should better reflect progress against in-year plans, while continuing to acknowledge longer-term strategic ambitions. k. JA asked how Committee feedback would be coordinated and over what timeframe. EM advised that feedback would be aligned with the operational and financial planning timetable and Committees to provide prompt input. It was agreed that any changes would be finalised ahead of the new financial year, with February Committee meetings identified as potential review points. l. AF stressed the importance of consistency across Committees. EM outlined key principles for future PIPR development, including simplifying the core data pack, supporting priority issues through deep-dive papers, reflecting both national targets and in-year plans, and allowing Committees flexibility to focus on areas most relevant to their remit. m. JA stated that, consistent with the BAF process, he would welcome an opportunity for the Board to review a draft version of PIPR. DJ supported this, noting it would enhance transparency, strengthen discussion, and inform the development of more effective dashboards. It was agreed that: **Action: Performance to draft PIPR would be developed and shared for Board consideration.**	**HMc**	

Agenda Item		Action by Whom	Date
	n. DL raised concerns regarding the CT backlog and consultant recruitment, expressing disappointment that recent starters had not taken up posts; she sought assurance on retention. o. IS explained that candidates increasingly judged organisations on the digital working environment and remote working capability, which the Trust was actively improving. Recruitment remained challenging, though a potential 0.5 whole time equivalent (WTE) academic appointment was being progressed. p. It was noted that readiness of systems would be critical for new starters, with further detail to be covered in Part 2. q. JA reiterated that while system upgrades in radiology were welcome, digital environment issues persisted, and improving factors within the Trust's control remained essential. r. JA acknowledged and positively noted that cardiac surgical mortality rates were lower than expected, given the complexity and multi-morbidities of the Trust's patient population. He noted, however, a concern that only 88.6% of patients had a completed the World Health Organisation (WHO) surgical safety checklist, highlighting this as a potential risk area that was subject to external scrutiny. The Board **noted** the Papworth Integrated Performance Report Month 08 – 2025.		
5	**GOVERNANCE & ASSURANCE**		
5.i	**Board Committee approved Part 1 Minutes**		
	a. Workforce Committee: 27.11.25 b. Quality and Risk Committee – 27.11.25 c. Performance Committee – 27.11.25 The Board **noted** the Board Committee Part I Approved Minutes.		
6	**BOARD FORWARD PLAN**		
6.i	**Board Forward Plan**		
	The Board **noted** the Board Forward Plan.		
6.ii	**Review of actions and items identified for referral to committee/escalation**		
7	**ANY OTHER BUSINESS**		
	Meeting ended 12:01.		

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Signed

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Date