Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Council of Governors
PART I
Held on Wednesday 14 June 2023 at 10:30am
Via MS Teams
Royal Papworth Hospital

M I N U T E S

Present	John Wallwork	JW	Chair (Trust Chair)
	Angela Atkinson	AA	Public Governor
	Michelle Barfoot	MB	Staff Governor
	Paul Berry	PB	Public Governor
	Sarah Brooks	SBr	Staff Governor
	Stephen Brown	SB	Public Governor
	Susan Bullivant	SAB	Public Governor
	Doug Burns	DB	Public Governor
	Trevor Collins	TC	Public Governor
	Aman Coonar	AC	Staff Governor
	Caroline Edmonds	CE	Appointed Governor
	Andrew Hadley-Brown	AHB	Staff Governor
	Abigail Halstead	AH	Public Governor
	Ian Harvey	IH	Public Governor
	Richard Hodder	RHo	Public Governor (Lead Governor)
	Marlene Hotchkiss	MH	Public Governor
	Lesley Howe	LH	Public Governor
	Rhys Hurst	RH	Staff Governor
	Christopher McCorquodale	CMc	Staff Governor
	Trevor McLeese	TMc	Public Governor
	Harvey Perkins	HP	Public Governor
	Philippa Slatter	PS	Appointed Governor
In Attendance			
	Jag Ahluwalia	JA	NED
	Michael Blastland	MBl	NED
	Cynthia Conquest	CC	NED
	Amanda Fadero	AF	NED
	Tim Glenn	TG	CFO
	Anna Jarvis	AJ	Trust Secretary
	Diane Leacock	DL	Associate NED
	Harvey McEnroe	HMc	COO
	Eilish Midlane	EM	CEO
	Oonagh Monkhouse	OM	Director of Workforce
	Andy Raynes	AR	CIO

	Maura Screaton	MS	CN
	Ian Smith	IS	Medical Director
	Julie Wall	JYW	PA to Chair (Minute Taker)
Apologies			
	Yvonne Dunham	YD	Public Governor
	John Fitchew	JF	Public Governor
	Martin Ward	MW	Staff Governor
	Ian Wilkinson	IW	NED

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1	**WELCOME, APOLOGIES AND OPENING REMARKS**		
	JW (Chair) welcomed everyone to the meeting. Apologies were noted as above. ***Discussions did not follow the order of the agenda however for ease of recording these have been noted in the order they appeared on the agenda.*** **JW** informed the governors of the following updates: • The new railway station build has begun on the campus and completion is expected to be in 2025. • The Junior Doctors industrial action commences today and will continue for 72 hours. • There will be celebrations on the green on Wednesday 5 July for the 75th Anniversary of the NHS. The official opening of the new TB Hut, situated between RPH and the HLRI, which is a replica of the TB huts that were at the old hospital site, will take place.		
2	**DECLARATIONS OF INTEREST**		
	There is a requirement those attending Committees raise any specific declarations if these arise during discussions. There were no new declarations of interest.		
3	**MINUTES OF THE PREVIOUS MEETING – 15 March 2023**		
	The minutes of the meeting held on Wednesday 15 March 2023 were agreed as a correct record.		
4	**INTEGRATED CARE SYSTEM DEVELOPMENT**		
	Reported by Eilish Midlane CEO **EM** introduced Harvey McEnroe new COO to the Council of Governors and welcomed him to his first CoG at the Trust. • The ICS have formally been in place for 11 months.		

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	• There are several reviews of the existing governance taking place to make sure this is fit for purpose going forward. • The Integrated Care Board works closely with local authorities through the Health and Wellbeing Board. This month there has been another meeting of that Board. • Recent months have been challenging but the operational plan has been signed off. As a system the operational plan has been submitted and they are now developing the 2 year forward plan which outlines the key objectives for the ICS and translates these into deliverables expected over the next couple of years. • There has been notable improvement from a performance perspective in the last quarter. • Overall system performance has improved. NWAFT have moved from tier 1 to tier 2 and CUH have moved from tier 2 to tier 3 for their A&E and emergency services. This is recognition of a strong system working and utilizing all available pathways for urgent emergency care across Cambridge and Peterborough and reflects the success of the ICB Winter Plan. • It has been announced that the CQC have moved NWAFT maternity services rating to "good" which is a positive recognition to all the work that has gone into this achievement. • Long waiters have decreased noticeably across the system. Over the last 2 months delivery above activity plans has been seen. In the last month an overachievement of elected activity has been delivered and from an outpatient perspective CUH did not quite deliver plan, but NWAFT delivered an extra 2000 and RPH delivered an extra 1000. This is taken as a collective endeavour. • For the next period the key focus is the response to industrial action being taken by the Junior Doctors. This is much more significant for organisations with A&E departments. All industrial actions clearly challenge all Trusts and services. • The second two areas of focus are learning disability assessments which is an area where improvement is needed at a system level and work on faster diagnostics which will support early diagnosis of cancers. **Questions:** **JW** commented that he knows that NEDs and Governors are struggling with how is best to interact with the ICB and the ICS and added there have been a few frustrating meetings recently. He asked RH if he had been to any recent governor meetings. Joint NED meetings had been a challenge and there were ongoing discussions with the ICS, and they are working on relationships and ensuring that the relevant people were included in those meetings. **RH** agreed and noted that a lot was to be answered with "in due course". RH realised it was relatively early days since it was instituted and was		

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	hoping for some improvement. There will be another meeting for the Lead Governors with John O'Brien on the 5 September. **JW** noted that the Chairman of the ICB was coming to one of RPH Board meetings, but this was postponed and asked if this had been rearranged. **AJ** advised that the CEO and Chair from the ICB have arranged to attend the Board on the 7 November 2023. **RH** informed the Governors that there is a meeting on 3 October for all Governors and asked everyone to put the date in their diary. **JW** commented that he will follow this up at the Council of Governors in November. **PS** noted that the framework had been slow but, in the meantime, the integrated care was going on. PS recommended that the Governors look up what their local councillors are involved with and look at the agendas from the Health Committee meetings. There are live reports relevant to RPH. PS also suggested governors contact their local councillor as they are responsible for public health and social services in their area. **SAB** asked how much RPH are dependent on the ICB performance. JW noted that RPH is part of it and not separate from it. **EM** explained that management at a system level is the direction of travel and the CQC was moving to doing its assessments on a system wide basis, and they will also do local assessments. The Executive Team are investing time in the ICS because although 10% of activity comes from Cambridge and Peterborough there are interdependencies and RPH need to be at the table influencing and shaping decisions. RPH contributions are received very well. **TG** noted that it has always been in RPH interest and in the patient's interest to work in the system and use our expertise. TG encouraged everyone not to be obsessed by artificial boundaries and focus more on why RPH is here and what RPH is doing. **AC** commented that RPH position within the ICB is fantastic because there is the resource, vision, and great leadership from EM. He had heard some interactions, at those meetings, and they were very positive. **AC** asked to what extent can Governors help the ICB and the system by facilitating activity closer to where the patient lives that perhaps doesn't need to be done at RPH. A couple of areas are general outpatient activity, can this be done virtually or can we send people out to their local DGH so RPH specialist resources are protected for what can only be done at RPH. Also in terms of the bigger services could some of the primary PCI work be done which means the patients benefit by having that done quickly in our linked district hospitals.	GOVS JW GOVS	

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	JW reiterated that EM does not only represent RPH on the ICB Board, but she represents the Providers, so it is important to make clear that she is not just there representing RPH. However, the movement of patient care has changed over time. Years ago, all pacemaker patients came to RPH, and no one would have thought that one day pacemakers would be fitted in a DGH setting which was now in place in some DGHs. **EM** noted that this was the direction of travel in the system. The strategy for work in the community includes as priorities, heart failure, disease prevention and diagnostics being done closer to home for example, echocardiograms. The Community Diagnostic Centre is one of the key steps in the strategy. This includes not just imaging but also physiology, respiratory, cardiology echo and getting these delivered closer to the patient is a key driver. Further conversations are needed about where RPH are positioning themselves and some of that will be related to the changes and specialist commissioning we talk about which gives opportunities but also some threats. We need to look at where we want to be and whether we are at the very specialist end or whether dipping into the wider patient pathway would be better for RPH. **JW** added that this information should go out to the population via Comms but can also go through the Governors.		
5	**COMMITTEE CHAIR'S REPORT**		
	I. Jag Ahluwalia NED – Strategic Project Committee (SPC) **Overview of SPC area of focus and structure**: • SPC meets entirely in Part II of Board activity and not in public due to the sensitive nature of some of the programmes of work. • The Membership comprises of three other NEDs, Gavin Robert, Diane Leacock, and Ian Wilkinson. The full Executive are in attendance and Wendy Walker from Strategy, Anna Jarvis, and Ellie Bethel secretary to the Committee. • There is good engagement and attendance. The meetings are every two months, lasting 2 hours. • There are six strategic objectives in the Trust Strategy. SPC focus is on four: sustainability, growing pathways with partnerships, research and innovation and sharing education. • The risks linked to the committee are now down to two from five. Three have been moved to the corporate risk register or have been closed. • The Estate Plan has moved to the corporate risk register – clear resolution has been reached regarding outstanding issues with contractors. • The Clinical Research Facility (CRF) was a Board risk, and has now returned to business as usual as funding is secured. • The Committee had combined the risk around working with		

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	Partners into the 5-year strategy as this was now business as usual. **The two risks still assigned to the committee are**: • The patient electronic record and optimising its use and its future. • The delivery of the 5-year strategy plan. To make sure they are in full alignment with those of the ICB in which RPH sit. **Specific areas of discussion**: • In recent months the Electronic Patient Record around fifty percent of time had been spent looking into issues regarding digital and EPR. The end of the contract for this will be in 2027 and the supplier had announced a new product direction. SPC is duty bound to look at the plans for replacement or continuation. • Key factors for reviewing and discussing are supported by Andy Raynes, Chris Johnson and Eamon Gorman. This included cost, alignment with systems and interoperability with partners within the ICB and research partners, as well as patients' quality of service. This is all vital to seamless care provision. Products must have suitable functionality and be supplied within RPH timelines. • A key factor is what the system provides by way of patient access to portals to RPH records and staff ease of use. • The committee has sought assurance from due diligence visits undertaken by the CIO and his team to various sites of different suppliers. • It was important to have staff engagement including a broad range of staff, junior doctors and nurses, allied health professionals and nursing staff. • External reviews have been commissioned from professional assessors and meetings have been arranged with current providers. • Further information of products and the timeliness of their delivery lines are pending. The current contract ends in 2027 but these systems take 9-18 months to install so a decision is needed well before that date. **Discussion:** **AR** thanked JA and everyone that has been involved with this work. He reiterated that it was a significantly important decision as a huge investment has been made in the Electronic Patient Records and digitising the hospital. People's input was valued. **JW** commented that it was a matter of balancing what we can get and what we can afford. This is a complex issue, and the Board will have to make a decision within the next 6-9 months. **AR** commented that digitisation has moved on significantly in the last		

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	decade. The ICB have commissioned an £8 million Shared Care Record. The Shared Care Records and EPR use standards to create interoperability and share records in context with those systems being compatible. **AC** thanked JA and the digital team for all their hard work. AC wanted to clarify that when we talk about EPR are we talking about multiple software programs or one. **JA** replied that we are talking about integrated electronic patient records, so it was a single unified electronic record. **AC** asked if that would include radiology, pathology, and all medical records. **JA** replied that it is the intention to make sure it is a single source of unified truth, and that access was unified. The experience staff have needs to be as seamless as possible. **AR** agreed that the user experience is key as is the safety. Single source data is more powerful. We will be looking at what we can include with the core EPR offering, as different contracts end at different times. **JW** commented that we need to make sure that users are included with the evaluation. **CMc** asked what additional actions and assurances are needed. **JA** explained there are a certain number of decisions to be made. Further external assessments and reviews, site visits and user acceptability feedback. The biggest issue related to risk is affordability and knowing what support there might be from the ICB for affording change. Uncertainty is leading to the risk issue at this stage. **SB** asked for clarification on whether this is about systems within RPH talking to each other or talking to partners/other organisations outside the Trust. **JA** advised that there are components to varying degrees. We want an integrated electronic patient record system for use by our staff and patient access portal for our patients integrated within it. It is recognised that patients move between different hospitals for different conditions. We need to be mindful about what the options are for joining our electronic patient record for certain groups of patients or certain situations with other records. This will mean that the physician or nurse looking after that patient at that moment in time has as much access as possible and the shared care record is a good example of how various providers within the Integrated Care Board in Cambridge and Peterborough system can contribute to a shared care record so there is one view of the patient record at the point of care. This is a function we need to be mindful of in anything procured going forwards. There is a broader set of connectivity required with collaborators further afield, both in the field of research and use of data. We want to make sure that the appropriate consents and confidentiality being observed and allows our research community here to collaborate with peer groups further afield and not just the ICB in this region.		

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	PB asked if the record at the point of care would include social care as well as healthcare. **AR** explained that this includes local authorities. There has been a lot of communication with patients and public involvement sharing. Consent is a huge issue and maintaining patients trust is important. **JA** added that RPH starts from a position of being digitised and many of the partners start from a position of paper so although the journey is the same direction the point at which some milestones are reached will be different. **5 Year Strategy:** • The SPC focuses on the 5-year strategy on a regular basis. • This was initially approved in December of 2019. Due to launch in Spring of 2020 but was unfortunately delayed due to the pandemic until September 2020. • The first 2-year progress reports have just been received. There has been a lot of good progress. All the enabling strategies have either been renewed, revised, or developed. • Areas of the Strategy where good progress relate to the six objectives including remote consulting and monitoring, CPAP Outreach, reducing delays in the diagnosis of atrial fibrillation, staff retention and partnership working. • Focus has also been on research and development and that has culminated in the commissioning of the clinical research facility within the HLRI. Assurance has been gained through Tim Glenn that the finance has been agreed for the clinical research stability and the next phase. The facility is now open, and participants are being received. There are very positive indicators with trial numbers. There is good engagement with the new CRF Director Mark Toshner, RPH consultant and from the HLRI Director Professor Charlotte Summers who is a Professor in Intensive Care Medicine at the University of Cambridge and CUH. • Both are fully engaged and that marries well with the Research and Development Strategy which the Committee endorsed for approval by the Board. Dr Paddy Calvert the Director of Research and Development is the lead for this work. The first update has been received on the Strategy which is going to focus beyond the work of the CRF in terms of new trials. It will be focusing on improving the ability to attract grants, increase the number of trials, publications, and equity in research participation. It is important to have non-medical researchers lead research programs. The Charity have provided a significant amount of money for Innovation Funds to encourage non-medical researchers. Other research imperatives include how data is used to inform research and deliver research. • Importantly from a patient perspective focusing on digital remote monitoring and new medicines and what the RPH role is in		

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	promoting these. • A key issue for research colleagues within RPH is the operational performance of the research itself to make sure we are agile, responsive, and competitive for the possibility of new research applications, permissions to approve studies and to support studies. **II. Amanda Fadero NED – Workforce** **AF** explained that she is the newly appointed Workforce Committee Chair. The Workforce Committee was created in January 2023 Prior to this Workforce issues had been part of the Quality and Risk Committee chaired by Michael Blastland. • It had become clear that people are the Trusts greatest assets, and that more attention was needed. • Three meetings have taken place. They are arranged every other month. The 26th May was the last meeting held. • The agenda is significant covering three of the risks on the BAF, day to day workforce issues and strategic requirements. • In January the first workforce strategy was developed. This has six key strands which covers: 1. Compassion 2. Culture 3. Inclusivity 4. Developing the workforce 5. Partnerships 6. Key areas of how we care and allow our staff to be the best that they can possibly be. • The Strategy has been seen and Approved at Board and the Workforce Committee required key metrics to be developed. There are twenty-one in total and this was a huge amount to oversee and look at. We are looking at how we drill down into those metrics to have key deliverables to gain traction for staff. • Oonagh Monkhouse Executive Lead has been asked to look at those metrics and to be more challenging in some areas, particularly around the BAME Groups and generally inclusivity. This is expected to be seen at the next Committee meeting. • The three risks that the Committee are overseeing and how they are looked at: OM does a bi-monthly report for the Committee which covers about twenty indicators of measuring what staff feel like through staff engagement scores and general scores on turnover, recruitment, retention, time to hire, appraisal rates, and mandatory training. • The report is very detailed and looks at the overall ratings, also specific to divisions and specialties. This is helpful to understand		

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	where the pinch points are. It also celebrates the areas that are doing well and focuses time and attention on areas that need some support. This development has been welcomed and is improving all the time. • The next task is to align the Strategic metrics with the day-to-day operational metrics which is quite a challenge. The 3 BAF risks are worrying: 1. Turnover – rated 15 2. Recruitment and Retention – rated 16 3. Staff Engagement – rated 20 • Staff engagement has been a real focus over the last two committees about how staff are being engaged with and what people feel would be helpful. While the committee and the Board recognise that a comprehensive suite of interventions, opportunities, and support for staff are in place it is important to make sure that actions are having the right impact. • The Executive Team have been asked to respond to the question, are we doing the right thing at pace in some areas. There is a concern that there is not enough traction and so the focus will be on this at the next committee meeting. • As mentioned, the agenda is huge. It ranges from Workforce Strategy to health and safety, employee relations and statutory management training and development needs. **Discussion:** **JW** noted that the metrics that measure workforce issues are complex. **OM** advised that as the Committee gets into the rhythm of review it would see the value of the dedicated time to focus on specific measures. **PS** commented that there must be a lot to be learnt from "Exit Interviews" and asked how much you can harvest once the dust has settled as this must be a key place to understand the things that have come together, have been the last straw and someone has gone. It maybe that they are leaving for promotion or another job but if it is a lack in the hospital or the environment was there anything that the Governors could help with. **OM** agreed that exit interviews were an important source of information, but they are not straight forward. The reasons given for leaving are related to relocation which is linked to the nature of the organisation and the way people come for a period to gain expertise and then move on. There is also movement because of promotion. The biggest reason seen from feedback is related to how we work, career development opportunities and flexible working which echoes what is seen in the staff survey. To look at data behind exit interviews needed to be done in a proportionate way and it was not an easy process to collect data. The Recruitment and Retention Improvement Group have this as one of their projects and were looking at more detail and information from local		

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	managers and departments and collating that feedback. **AF** Agreed that exit interviews shouldn't be the surprise information point. There should be regular conversations and concerns should be known, recorded, and dealt with if appropriate so that exit interviews are not so relied upon. The committee is focusing on the whole pathway for staff, and how line managers can be supported to have regular conversations that are searching, thoughtful and supportive. **AC** thanked AF for her summary and commented that he hears from all staff groups that key factors included opportunities for leadership and turnover of leadership. AC would like to encourage ways whereby there is regular turnover of leadership to allow people to develop. **AF** agreed that every individual should be given the opportunity to reach their full potential. The Workforce committee are looking at where they should put their time and energy to make sure the Trust is realizing these talents as leadership was important. **AF** suggested that she meets with AC to discuss this further. **AC** agreed. **OM** commented that the Collective Leadership part of the Strategy is about giving people skills, confidence, competency, and the environment to lead in their area of work. This includes an essential element of staff engagement and accountability. **SAB** commented that people come to RPH to gain experience and move on and perhaps this could provide a marketing opportunity for why people might champion RPH as the place to come and get that experience. **OM** noted that several departments are looking into why people come to RPH and why people stay rather than the exit interviews. This is providing a lot of helpful information about their departments that makes it an attractive option for current staff and attracting new staff. **JA** commented that he had heard staff stories from international recruitments, and they were very positive about all experiences RPH offered and the warm welcome they get from staff and support from HR. **AF** noted that there had been a great presentation by the Women's network. The connection with staff networks was important for the Workforce Group as it allows understanding of staff stories.	**AC/AF**	
6	**QUALITY ACCOUNTS PRIORITIES 2023/24 UPDATE**		
	Reported by Maura Screaton – CN **The Council of Governors were shown slides explaining the Quality Priorities for 2023/24 and MS ran through the priorities.**		

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	The priorities have been discussed in several forums and has had Patient and Public Involvement and Quality and Review support. **The following 5 priorities were agreed**: 1. Implement the Patient Safety Incident Response Framework 2. Increase action on prevention of health inequalities. 3. Harm free care: VTE, PU and Falls 4. Reduce Surgical Site Infections 5. Improve Resourcing and Retention		
7	**OPERATIONAL PERFORMANCE SUMMARY (April Infographics)**		
	Received: The Council of Governors received copy of Infographics in the pack before the meeting. **Reported by Harvey McEnroe COO** **HMcE reported some of the operational key figures:** • Diagnostic Investigations completed: 98.5% of patients waiting were seen within 6 weeks for a diagnostic procedure with an improvement from the previous month which was 91% • RTT status - patients treated within 18 weeks of referral was at 70.8% and while this remains below national standard this still puts us the fourth best company in the Country. We are seeing recovery and improvement each month. • There are 6009 patients on open RTT pathways and 43,088 on open non RTT pathways. There has been an audit on this group to make sure no one is waiting there that should not be. • Activity - A huge amount of work had been done across the elective care program. ITU occupancy use has increased, and theatres had increased from 4.8 to 5. The projections to move to 5.5 and to 6 theatres were on track to be delivered. • Workforce – Challenges had around industrial action continued. We had lost of 8 days of elective and diagnostic capacity. Several patients were able to be re-scheduled and were offered appointments within a month. Some cases were within a week of cancellation. **MS reported Quality Feedback:** • Family and Friends scores: Inpatients – 98.8% Outpatients – 96.5% Both above target • Feedback is always encouraged, and any concerns raised are seen as an opportunity for learning. • Incident reporting – Important to understand incidents with harm and we had seen no increase in that measure.		

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	Discussion: **IH** asked what 41 on the day theatre cancellations and lack of critical care capacity means. He asked what was the lack. Was it people? **MS** explained that it can be a lack of people and lack of beds. Sometimes CCU is full so there is bed unavailability. There have been a couple of unprecedented times when there has been short notice staff absence so it would have been unsafe to admit to the critical care area. HMcE commented that the data is slightly skewed on this, but the narrative is important. There were 27 patients that were unable to be operated on, on the day of the strike and were rescheduled on the day or the day prior to, due to industrial action impact. The data is pulled so they were aware of the risk for cancellation, but they are kept scheduled. The patients were engaged with and given priority when the risk was known. **IH** commented on the Mandatory Training compliance. He asked who makes it mandatory. Does this come from within RPH or is this an expectation from outside that the training should happen? **OM** explained that Mandatory Training is set out for the NHS as part of the CQC Framework and nationally developed competencies. There are several different competencies within this depending on your role and level. Most of the training is now online for the first level. There are modules where you are required to have face to face training because of more complex practical skills. There is also a set of training that is linked to the policies and procedures within the Trust. **IH** asked if this could be a problem if there was an inspection. **OM** explained that this is a key part of CQC inspections and the Well Led Inspections. The Well Led Inspections are set at 90% compliance. There are several groups who have responsibility for overseeing implementation. This is addressed through performance meetings with departments. The monthly compliance data is published so that departments can see. There is constant review on how more complex types of training is provided. It is a subject which receives a significant amount of attention. Everyone knows that they are required to do their mandatory training. The CQC look at the compliance data. They look at the trend and they will want to see if there is a gap in it and if we have areas that are not compliant, what are the reasons for it and what is the plan to improve this. **IH** asked if the figures could get better. **OM** replied that there are elements to that: • During the COVID period mandatory training was suspended. The levels now in terms of improvement are good and have not dipped as far as they could have during those big periods of time where people were not required to undertake the training. • There are several pressure points: Capacity for training. Clinical education is looking into resolving this. As much as possible has		

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	been put online which has helped. • Another aspect is that there have been some changes around the rules of pay progression. For someone to move through their pay points they will have had to have an appraisal and be compliant with their mandatory training. This hasn't been applied over the last few years, partly due to the move and partly due to the pandemic but this has been reintroduced from April of this year. This is another driver to make sure that staff understand that connection. The workforce team have been supporting people with accessing the online training. **SBr** asked what the current situation is with outpatient remote consultations. Is it part of the plan for this to carry on in the organisation. **HMcE** explained that virtual clinics work for both the patient and the provider. This will be part of our outpatient ambulatory care improvement programme which will focus on how we digitalise and virtualise as much of the capacity that is safe to do. Some care must be done in front of the clinician, but some follow up can be done through wearable tech and monitoring tech that can be given to a patient should be part of the design of our operating plan. Between now and September the digital team and the operations team will be designing a programme to grow this using some national benchmarking that advises which services are right for virtual care and which services are being tested. Looking particularly at patients with long term conditions.		
8	**DIGITAL UPDATE**		
	Reported by Andy Raynes • The hot topic now in digital is information governance and the data security toolkit. • This is about being compliant with information governance and having a good positioning around cyber security. • There is a compliance target for the end of the month that is submitted as part of the toolkit. There must be 95% of staff trained up. There is work going on to achieve this and we are on track to deliver. • Cyber-attacks in healthcare are up by 94% and RPH experienced an attempted ransomware attack last month. The attack was isolated before it landed. It is important to be vigilant and alert to emails that look suspicious. • Multifactorial authentication has been introduced on devices. If staff are going overseas, they must have two factor authentication enabled. • A product called Zivver has just been introduced which is supporting email correspondence. If there is anything that looks like there is patient identifiable information, it will alert the user. This is a step to make sure correspondence is secure and safe. • The number of new Workstations on wheels that have been put		

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	out around the site has been increased to 60. • AR wanted to give a shout out to the Team and commented that all the technology infrastructure is supported by a team of less than 40 staff and added that he is very proud of those individuals and the work that they do. AR informed the CoG that half of the Team are now signed up with the British Computer Society.		
9	**PIPR**		
	Received: Council of Governors received PIPR for information. **Reported by Tim Glenn** • That putting things into context the NHS nationally has been going through challenging times with industrial action. RPH has not been immune to the struggle of getting elective activity back to the point before this. • Despite the challenges RPH continuing performance is strong. Performance in caring, friends and family continues to be strong in theatre following the Improvement Programme. • We needed to acknowledge impact of strikes and note that staff turnover has been high. There was continuing concern regarding sickness levels. • Finance was reporting as red but was expected to bounce back next month. • The impact of strikes was expected to continue. **CMcC** asked if the balance scorecard was reported looking at 3 months or 3 years as it is difficult to judge. **TG** advised that it was 3 months but the Trust was moving to **Statistical Process Control (SPC).** He outlined: • This is a new reporting format. • There was a presentation given recently for Governors and TG thanked those who had attended. • Within the Effective and Responsive domains, the data was being presentation had been changed and this was deliberate. • This had been introduced following a Well Led Review, where it was suggested that we make this change. It was supported by NHS England and various other Trusts had adopted this approach. • The reason for adopting this approach was that it gives better information on statistically significant changes and the assessment of data was more reliable. • It also gives information looking over time which allows you to reliably see if targets will be hit. **Discussion:** **TG** commented that if anyone was interested in more details, he would be delighted to take a call or an email.		

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	AH thanked TG on behalf of the Governors for the presentation which was very helpful. **JW** commented that the recording and presentation if available could be sent out to the Governors that did not attend. **AJ** noted that the presentation was asked to be set up by the Executive Directors for Governor Observers of Committee meetings to share learning between committee members in the first instance and then share with other Governors either by another session or sharing the recording of the presentation.		
10	**GOVERNOR MATTERS**		
	Governor Committee Updates: **Anna Jarvis Trust Secretary reported in RH absence.** • The key item discussed at the Forward Planning Committee was the new Chair for the Committee. It was agreed that Steve Brown would carry on as Chair. • PPI Committee had met and have agreed that Marlene Hotchkiss will be the new Chair. • The minutes for both the Forward Planning Committee and PPI Committee meetings were in the pack sent out. • There will be spaces on Committees coming up. Richard and Abi to investigate filling those gaps. **Appendix 1: Governor Committee Membership** **Recommendation:** The Council of Governors is asked to note the current Governor Committee membership **Appendix 2: Minutes of Governor Committees** I. Patient and Public Involvement Committee– 15 May 2023 II. Forward Planning Committee – 12 April 2023 **The Appointments Committee minutes will be discussed in Part II Council of Governors.** **Appendix 3: TOR008 Patient and Public Involvement (PPI) Committee** **For Approval: Approved and Ratified by the Council of Governors** **Extend Approval Date:** • The Access and Facilities Group as they have not met so the approval could not be agreed. To bring back in September meeting. • Terms of Reference from Governors Assurance planned to be		

Agenda Item *(minute reference)*		Action by Whom	Date
	brought back in November for Approval. **Extended Dates - Approved**		
11	**LEAD GOVERNOR AND DEPUTY LEAD GOVERNOR ELECTION RESULTS**		
	Anna Jarvis Trust Secretary reported: • Abigail Halstead – has been elected as the new Lead Governor and is acting designate – Abi will be working closely with Richard Hodder current Lead Governor until he steps down in September. • Stephen Brown had been appointed as Deputy Lead Governor.		
12	**QUESTIONS FROM GOVERNORS OR PUBLIC**		
	No questions have been put forward.		
13	**ANY OTHER BUSINESS**		
	CMcC commented at the Governors pre- meeting there was a lot of time spent discussing Governor's engagement with Members of the Foundation Trust and whether a Governor led working group would be able to support this. **AJ** noted that this links into the review of the Membership Strategy this year. **JW** commented that we need make sure that our membership numbers are properly recorded, and access made easier to gain. JW felt it important that AJ and CMcC meet to discuss as this is a good suggestion. **CMcC** suggested engagement by letter and other methods on site also. **AC** thanked CMcC for raising this issue and AJ for her enthusiasm. **PS** added that the Governors would be self-sufficient and exploit their own talents. **JW** suggested bringing this forward at the next meeting in September. **IH** commented that this links in with public engagement and raising RPH profile. RH and IH to discuss with Sam Edwards, Comms how to move that forward. **JW** commented that Governors represent constituencies and are there in the community to engage. **IH** commented that RPH has got a very good profile but feels that people would like to know more about what happens at RPH and to hear from people like AC. **SAB** noted the link with fundraising and commented that it was important not to step on toes. **AH** asked if a meet and greet could be set up between NEDs and Governors, outside of Council of Governors. **JW** suggested talking to AH about this after the meeting. He commented that over the last two years there has been more interaction between NEDs and Governors than there has ever been before. At the Board meetings there may have been none or only one Governor observing previously. Since we have been		

Agenda Item *(minute reference)*		Action by Whom	Date
	interacting on Teams an increased number of Governors are observing. There are opportunities for interaction. JW suggested working out where the gaps need to be filled in the existing system. We don't want to set up separate systems if there is no need.		
14	**FUTURE MEETING DATES: 2023**		
	13 September – Followed by the Annual Members Meeting **15 November**		

The meeting finished at 12:13

Signed: John Wallwork

Date: 13 September 2023