Item 00

Royal Papworth Hospital
NHS Foundation Trust

MEETING OF THE COUNCIL OF GOVERNORS
Wednesday 19 March 2025 from 10.30am – 1.00pm
Royal Papworth Hospital
Venue: HLRI & MS TEAMS

AGENDA

1	Welcome, apologies and opening remarks	Chair	Verbal	5 mins
2	Declarations of Interest	Chair	Verbal	
3	• Minutes of previous meeting: 13 November 2024 • Action Checklist	Chair	Attached	
ASSURANCE				
4	Patient Story by: Emma Harris Nurse Consultant for Interstitial Lung Disease	CN	Verbal	15 mins
5	Board Committees Chairs Report • Audit Committee (Attached) • Quality and Risk Committee (Verbal) • Strategic Projects Committee (Attached) (Reporting schedule for 2025 attached)	Chairs (with optional feedback from Governor Observers)	Verbal/Attached	30 mins
6	2024 Staff NHS Staff Survey Results – Report	DWOD	Presentation	15 mins
7	**Quality Accounts** • Quantity Accounts Priorities – 2025/26 • 2024/25 Quality Reporting Schedule v 2	CN	Attached	10 mins
GOVERNORS' UPDATE				
8	Lead Governor's Report	Lead Governor	Attached	30 mins
9	Reports/Observations from Chairs of Governor Committees • Governors Assurance Committee (Verbal) • Forward Planning Committee (Verbal) • Patient and Public Involvement Committee (To Follow)	Governor Chairs	Verbal/Attached	
10	Reports on other Governor Activities (Including from Appointed Governors)	Governors	Verbal	

11	Update on Actions (You Asked; The Plan/Progress Update)	Chair/Lead Governor	Attached	
GOVERNANCE				
12	**For Approval** Membership and Engagement Strategy	Ian Harvey	Attached	10 mins
13	**For Approval** External Audit Contract Extension	CFO	Attached	10 mins
14	Governor Matters: • Appendix 1: Governor Committees Membership • Appendix 2: Minutes of Governor Committees • Appendix 3: Trustee Board Minutes	Lead Governor	Reference Pack	5 mins
15	Papworth Integrated Performance Report	*Circulated for Information to the CoG (Reference Pack)*		
16	Questions from Governors and the Public	Chair		5 mins
16	**Future Meeting Dates**: • 04 June 2025 • 10 September 2025 • 12 November 2025			

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

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

Royal Papworth Hospital
NHS Foundation Trust

Minutes of the Meeting of the Council of Governors
Held on Wednesday 13 November 2024 10:30 am to 1:00 pm
Venue: HLRI & MS TEAMS
Royal Papworth Hospital

Present	**Role**	**Initials**
Jag Ahluwalia	Chair (Trust Chair)	JA
Susan Bullivant	Public Governor	SBu
Christopher McCorquodale	Staff Governor	CMc
Joe Pajak	Public Governor	JP
Harvey Perkins	Public Governor	HP
Martin Hardy-Shepherd	Public Governor	MHS
Marlene Hotchkiss	Public Governor	MH
Josevine McClean	Public Governor	JMc
Lesley Howe	Public Governor	LH
Angela Atkinson	Public Governor	AA
Trevor McLeese	Public Governor	TMc
Ian Harvey	Public Governor	IH
In attendance		
Eilish Midlane	Chief Executive Officer	EM
Maura Screaton	Chief Nurse	MS
Sophie Harrison	Interim Chief Finance Officer	SH
Harvey McEnroe	Chief Operating Officer	HMc
Andrew Raynes	Chief Information Officer	AR
Kwame Mensa-Bonsu	Associate Director of Corporate Governance	KMB
Cynthia Conquest	Non-Executive Director	CC
Michael Blastland	Non-Executive Director	MB
Tracey Senycia	Theatre Matron, Surgical, Theatre and Anaesthetic Directorate	TS (item 4)
Gavin Robert	Non-Executive Director	GR (item 5.1)
Amanda Fadero	Non-Executive Director	AF (item 5.2)
Ian Wilkinson	Clinical Pharmacologist & Professor of Therapeutics	IW (item 5.3)
Megan Sandford	Charity Governance and Engagement Manager	MSa (item 5.3
Sam Edwards	Head of Communications	SE
Laura Favell-Talbot	Membership and Engagement Officer	LFT
Apologies		
Caroline Edmonds	Appointed Governor	CE
Philippa Slatter	Appointed Governor	PS
Justin Davies	Partner Governor CUH	JD
Vivienne Bush	Public Governor	VB
John Fitchew	Public Governor	JF
Rachel Mahoney	Public Governor	RM
Andrew Hadley Brown	Staff Governor	AHB
Rhys Hurst	Staff Governor	RH

Discussion did not follow the order of the agenda, however, for ease of recording these have been noted in the order they appeared on the agenda.

Item (minute reference)	WELCOME, APOLOGIES AND OPENING ITEMS	Action by whom	Date
1.	**Welcome, apologies and opening remarks**		
	The Chair welcomed those present to the meeting		
2.	**Declarations of Interest**		
	None was raised.		
3.i	**Minutes of the previous meeting - 18 September 2024**		
	The minutes of 18 September 2024 Council of Governors (CoG) meeting were agreed to be a true and accurate record of the meeting and would be signed as such.		
3.ii	**Action Checklist**		
	The Chair referred to the Action Checklist included in the meeting pack and highlighted that all actions were scheduled to be addressed as part of the meeting or were not yet due. Any other actions were invited to be raised; none were forthcoming.		
ASSURANCE			
4.	**Patient Story**		
	TS presented the Patient Story, noting the following: Annie was a 33-year-old lady who had presented to a hospital in Newcastle on 21 September 2024 with a two-day history of high temperature and productive cough; she had recently come home from a holiday in Saint Lucia with her husband and had a previous medical history of asthma and pneumonia. She developed respiratory failure on 24 September 2024 and was transferred to a cardiac centre in Leicester. She was placed on ECMO and then further transferred to RPH on 25 September 2024. Following Pulmonary Thromboendarterectomy (PTE) surgery on 30 September, Annie spent three weeks in Intensive Care, and was then admitted to 5 North on 21 October 2024, prior to being discharged home on 01 November 2024.		

	Annie described the environment as very restful. She was given all the information required and was clear about what was going to happen to her; she felt she was treated with dignity; she felt safe and highlighted that staff treated her with respect and were sensitive to her needs. She fed back that her environment was clean, she felt that she knew who was looking after her, and every day staff entered, introduced themselves and performed spot checks, in addition to giving her the treatment that she needed. Annie was, however, disturbed at night, having found it hard to sleep, due to her medications being administered through the night, and the fact that she was missing her husband and her mother. She was given a clear treatment plan and felt able and empowered to ask any questions, as did her mother and her husband. She stated that the best thing about her stay in the hospital was that she felt that the PTE specialist nurses and the surgeon, were amazing. The PTE specialist visited her daily, was full of enthusiasm, and was honest about everything, which was much appreciated. Whilst in Critical Care, both Annie's mother and husband were kept updated every step of the way. The nurses and doctors were both professional and compassionate. Annie noted that, on waking up from the ventilator, they showed nothing but care for her. The ward nurses and doctors were "lovely" and yet again explained every step moving forward, leading to feelings of trust; when family were present, any questions were answered. Annie experienced swallowing issues for a while and the specialist nurse gave advice; she was also seen by a dietitian. Although the meal replacement shakes she was prescribed were "disgusting", they advised that this would be the case, and their honesty was valued. The worst thing about the hospital, was noted to be her family being so far away and having to travel a long distance to visit. The single room was lovely but felt isolating at times when family were absent. On a positive note, it was lovely to have privacy when being visited. In addition to this, Annie stated it would have been helpful to have another area in which to be with family, like a day room, but that was not offered due to staff using the day room. There were no reported issues which required improvement, with Annie stating that the surgeons and the entire teams in all three hospitals saved her, with the team at RPH being the most prominent. Annie believed that		

	without the national service provided by RPH, she would not have survived. At age 33, when she wanted to start a family, she was aware she would need to be closely monitored, but without RPH, felt she would not be alive, let alone contemplating having a family. In response to being asked what should happen when a patient came into theatre, Annie responded that being informed of what was happening, in simplified terms, and always giving "the good, the bad and the ugly" information, regardless of the outcome, was key. In addition, families being allowed to stay over normal visiting times, if the travel home was a long distance, was helpful. Annie wished to acknowledge that despite staff being busy, they always took the time to come and chat to her, and monitor not only on her welfare, but the welfare of her mother and husband. She wished to thank all for the care and compassion shown to her and her family whilst in the care of the RPH; she stated she could never repay what has been given to her, being able to continue to be a wife to her husband, a daughter to her mum and hopefully one day a mother herself; without any of this care and treatment, she would not be here today. Snapshots extracted from the above included: • Feelings of isolation in the side room. Whilst this had been turned into a positive by the patient, the issue would be discussed at the next matrons' meeting, to establish whether the day room could be turned back into a room for the relatives of patients. • Although staff were busy, patient care remained high. **Discussion:** The importance of reverting the day room back to normal use was highlighted. In addition, it was considered that day rooms should be inviting, promoting both mobility and socialization. How this could be encouraged would be raised at the matrons' meeting. In response to a question regarding families staying with the patient rather than travelling long distances, it was confirmed that relatives of anxious patients, or those at end of life, would be offered this facility. Accommodation was also available to families of long-stay patients. MS added that exercise equipment was in place in certain day rooms, for transplant patients, which had proved successful over the last few months. CM considered that RH, who was absent at today's meeting, would value a multi-professional approach to the matter, rather than this being the sole responsibility of nursing and therapists. The Chair thanked TS for bringing the patient story to the meeting.		

	The Council of Governors **noted** the Patient Story.		
5.	**Board Committees Chair's Report**		
5.1	**Performance Committee**		
	GR presented the Performance Committee report, providing relevant background to the Council of the role performed by the Committee. It was noted that divisional presentations were received at every other meeting, which it was considered provided further assurance. Outpatients, Clinical Admin, Oncology, the Sleep Studies Unit and Critical Care had all presented in the recent meetings. In respect of finance, there was focus on elective activity, as funding was geared towards the amount of elective activity conducted. An increase in activity to 104% on the benchmark had been noted by the Committee, against a national target of 108%. The CIP (Cost Improvement Programme) was also scrutinised by the Committee. There was confidence that all was on track to achieve the projected savings, and all relevant teams were commended for this achievement. There had been recent focus on costs incurred for premium pay for agency, bank and overtime staff, with a national suggestion of banning the use of such staff at certain levels, or for certain work. However, due to the effort to improve productivity, there was an ongoing reliance on premium paid staff. OM and SH were working on measures that could be used to limit reliance on these types of staff without negatively impacting on performance. Forward financial planning was a further consideration, in order to plan for budgeting the following year; this was well underway. There was further focus on private patients and increasing margins, as well as overall revenue. There had been a steady increase in margins since the start of the year. In respect of productivity, previous focus had been on utilisation of theatres and activity going through Surgery and there had been significant success in terms of increasing utilisation of theatres. In terms of theatre utilisation, performance was at 90%, against a target of 85%. Cath Lab utilisation had however, been more variable and was currently at 79% versus the target of 85%. The other measures monitored included bed occupancy, particularly in the Critical Care Area (CCA). One innovation in the CCA in 2024 had been the opening of the Enhanced Recovery Unit (ERU). The ERU had ten beds		

	and significantly enabled the increased flow of patients through critical care beds. Referral to Treatment Times (RTT) and waiting lists were an area where it was acknowledged more work was required, with RPH having a large number of 52-week breaches. This being one of the key statutory targets, frequent discussions took place around the steps being taken to address the breaches, as this was an unsatisfactory position. There was assurance that the problems had been recognised, and the right measures were in place to address the same, but improvements needed to be seen, and results delivered. The Committee had also addressed the issue of the Transcatheter Aortic Valve Implantation (TAVI) service, for which numbers had increased, with an associated rise in waiting times. A solution was being sought for the required increase in capacity, which would require financial investment. The other backlog was related to CT reporting, which was being reduced with the procurement of insourcing capacity. A longer-term sustainable solution was being investigated. Cyber security risk was a key concern to the Committee and would be a primary focus for the next meeting. Comment was made that the Committee was well-run and informative. Assurance was sought that long-waits were not being made worse by private patients, together with the question as to whether the proposal to get a new Executive to focus on commercial activities, could also have a negative effect on long-waits. The Chair confirmed that private patients work would not in any way be developed at the cost of compromising NHS patient access. Any capacity created would be a more efficient use of, not instead of, NHS waiting lists. In respect of the new Executive, part of their focus would be on the Private Patients' Strategy, but also on supporting the work on the new Electronic Patient Record (EPR). HMc assured Governors that during core working hours, the hospital's priority would be for the delivery of NHS activity. Private work would sit as an aside to that, in terms of priority and focus. CM referred to language used by GR when noting assurance around RTT and waiting times, when he stated he "believed we were doing the right thing", questioning whether further assurance was needed. GR responded that this was inspecting the language too deeply, noting that focus for HMc and his team was the Patient Flow Programme. This required continual active management to improve flow, plus active management of the waiting list, and prioritisation of the right patients at the right time. GR was assured that where the indicators were going in the wrong direction, there		

	was a transparent acknowledgement of the obstacles and a clear articulation of the way to address those. Should there be no improvement in outcomes in six months, Non-Executive Directors (NEDs) would be wishing to know whether the programmes and processes in place were the right tools. HMc added that the Flow Program had focused on the Enhanced Recovery Unit (ERU), which prioritised elective access without hindrance to emergency flow and demand. Since go-live with ERU, there had been opportunity to increase case-throughput by around 57 cases in month six, year to date. These were the expected measures over nine or ten months. The Chair asked whether the governors would appreciate a private patients debrief at one of their pre-meeting sessions. This was received positively and would be booked for the March 2024 session. The Council of Governors **noted** the Performance Committee update.	**AH/ KMB**	**03/24**
5.2	**Workforce Committee**		
	AF presented the Workforce Committee update, and explained that this was a relatively new committee, established in March 2023. This was due to the need for increased support for, and engagement with, the workforce, and in response to poor annual NHS staff survey results. To aid clarity, initiatives were pulled together into a workforce strategy, now a year old and having had its first annual review. This included six themes, taken from staff feedback, developed to address issues of belonging and inclusion, roles and responsibilities and development of the workforce. In addition, the issue of resource and growing the workforce was considered an important area to pursue. Progress was being observed with the six themes, which were broken down into clear plans of delivery, which had ownership by workforce members, and key milestones for delivery; most of those milestones in the first year of the strategy had seen significant improvement. One area that was not improving at the pace required, related to equality, diversion and inclusion. Discussions at Board had aided clarity around what the issue meant to leaders of the organisation and set the tone, culture and expectations. Trust-wide facilitated sessions ensued and culminated in the creation of a vision for inclusion. Feedback had been impressive, and follow-up Trust-wide facilitated sessions had been booked for early 2025. It was highlighted that the Workforce Committee was a complex committee with many different strands of work, all of which had individual, but also collective, impact.		

	The committee was considering issues of the KPIs around recruitment, retention and appraisal. Improving appraisal rates was an area of particular focus, as this was not progressing positively, despite putting in supernumerary time for ward sisters. It was considered that this was affected by the cycle of reporting and clarity around expectations for appraisal. To try to rectify the situation, consideration was being given to having an annual cycle of appraisals to ensure opportunity to focus on improving performance. A further theme reported to the committee, was the feelings of both resident and locally employed doctors, with growing concern that they did not receive the same experience at RPH as others in the country. As such, a focused paper on those two groups would be put before the next committee. Concerns had been raised within the STA Division, where a struggle with recruitment and retention had become apparent. There were growing concerns and themes about culture in STA and some general worries around both performance and workforce issues. The STA leadership team had developed a comprehensive improvement programme focused on the key themes of culture and leadership in the division. There had since been significant improvements within the division. Health and Safety was highlighted as a pivotal part of the governance of the organisation, including sexual safety. Sexual safety had been raised as concerns due to annual staff survey results and through the women's networks. The committee was very focused on ensuring that steps were taken to improve upon the safety of members of safety. Four Board Assurance Framework risk entries were noted, with BAF184, related to how RPH recruited and retained staff, showing such marked improvement that the risk score for this had been downgraded to 12 from 16. The other BAF risk entries were related to safer staffing and engagement, as well as turnover. Due to the extent of the themes and issues arising at the Workforce Committee, the frequency of the meetings had been considered, including from alternate months to monthly sessions, but keeping the meeting tight and focused was the current way forward. **Discussion:** The complexities of this committee were reiterated, but its order and use of a comprehensive action plan created a robust structure from which to work; MH echoed these comments. JP referred to data relating to staff sickness absence, questioning whether there had been discussion regarding the effects of Covid and long-Covid on staff absence, and what extra initiatives or support were being put in place to identify whether this was indeed the case. If so, how were staff in		

	that situation assisted? AF responded that there was a focus on short-term sickness, and a targeting of the causes. In respect of long-term sickness, there had been emphasis placed on stress-related issues, which had resulted in improvements. OM added that sickness absence had been running at around 1% higher in the last couple of years than in the pre-Covid period. This was an established national trend. OM advised that there was no specific code for long-Covid and added that there had been a significant investment in promoting staff health and wellbeing over the last two years. There was a particular focus on psychological wellbeing, with a fully utilised psychologist providing staff support. Physical and financial well-being support, both of which contributed to mental health, were also offered. In respect of short-term absence, it had been identified that in the Covid period, attention to good absence management processes were considered key. The Covid vaccine had also been offered to staff, which was noted to be positive. The Council of Governors **noted** the Workforce Committee update.		
5.3	**Charitable Funds Committee**		
	IW presented the Charitable Funds Committee (CFC) update, explaining that this committee sat between the Trustees of the Charity and those who ran the Charity on a day-to-day basis. The CFC oversaw the running of charity investments, how funds were raised, and how strategy to raise money in the future was developed and monies spent. Additionally, the CFC oversees requests, decides what to spend money on, and makes recommendations to the Trustees as to where monies should be allocated. It was acknowledged that Covid had resulted in a negative effect on fundraising, but this year, the position had improved to enable significant amounts of money to be raised. Focus was on setting the vision for the future to increase the amount of monies raised to spend, and making sure expenditure aligned with the three areas of importance, namely research, staff and patients. MSa provided the Council of Governors with an overview about the charity, advising of her seven-year tenure as Charity, Governance and Engagement Manager and advising of team members Paul Shelley, Funding Stewardship Manager, Jeanette, Communications Officer, Nigel, administrator of grants and Jude, who assisted on the main hospital reception. The Charity fed into the CFC and then ultimate responsibility for the Charity lay with the Trustee Board.		

	New staff joining soon included a Charity Managing Director, a Head of Philanthropy and a Community Fundraiser. Income was highlighted as being on track, being just £1000 behind the six-month target for fundraising. The annual fundraising target for 2024/25 year was £1.8m. It was noted that were 12 different income streams, gifts in wills and 240 givers that provided on a regular basis. One of the biggest income streams was noted to be gifts in wills, which understandably could be unreliable and fluctuated throughout the year. There was focus on being more strategic with the way money was spent. Within the Charity Strategy, there were five key aims to deliver against, and reporting had become more strategic to give CFC and the Trustee Board greater clarity. Patient welfare expenditure, related to accommodation, aimed to provide patients' families with a place to stay nearby if they were experiencing financial hardship. A recent grant call for self-education had proved hugely successful, with a significant number of applications, and approval of nearly £200,000 for staff education, which aligned to targets. These extra skills and collaboration opportunities, aided staff retention and translated into better patient care. The next funding call, whether it was related to the environment, health inequalities or community initiatives, would prioritise and directly impact patients in a positive way. There were funds set up for a number of departments across the Trust to enable fundraisers to direct their fundraising to particular areas. General funds were also available for areas of greatest need. **Discussion:** SB asked for Trustee Board Committee minutes to be included in the Council's meeting pack so Governors can be appropriately informed of their activities. SB stated that frequently, patients were in hospital for an extended period which could be isolating. Reference had been made for training for staff, but could funds be made available for patients to undertake a course, to enhance their experience whilst an inpatient? MSa advised that she would take the question back to colleagues. It was questioned whether the RPH participated in the October 2024 will-writing campaign. MSa confirmed that the Charity had participated under the auspices of a partnership with Octopus Legacy, who provided a free will-writing service.	**KMB** **MSa**	**03/25** **03/25**

	It was clarified that donations could be made to a particular area or specialism, if this had been close to the personal journey of the patient or family. It was relayed that on the Charity's website, main campaigns were noted, focused on the five strategic aims, with others that were popular, to assist individuals when donating. The Council of Governors **noted** the Charitable Funds Committee update.		
GOVERNORS' UPDATE			
6.	**Investigation Report – 2024 Governor Elections**		
	The Chair extended an apology for potential confusion caused and any failed communications, both to governors who had stepped down and for incoming governors. The unsettling nature of the discussion at the last Council of Governors' meeting, for incoming governors and the risk of new governors feeling that their validity in being elected was undermined was acknowledged. EM presented the Investigation Report into concerns raised in relation to the 2024 governor elections. Background was provided that concerns had related to low voting turnout, which had raised questions about the circulation list used to email members as part of the election, and whether every member had been contacted. In addition, an outgoing governor had reported that they did not receive communication relating to their end of term, and as a result, had not expressed an intent to stand for re-election. EM had commissioned the Deputy Director for Quality and Risk to undertake an investigation process, with terms of reference which were shared with the Council of Governors within the slide pack. Thanks were extended to all those involved in assisting with the investigation. Summary conclusions in respect of low voting turnout were as follows, noting that there was no way to define (?) minimum voting level: • Minimal engagement with members was recognised, with limited opportunity for them to update their details. • The public membership database had been held by the Charity team and this was used to inform the election services provider. • Civica administered both the nomination and voting parts of the election process and had done so for many years. In relation to the notification of candidates for re-election:		

	• It was clear that a single outgoing governor only was affected by an issue related to their contact information.
	• The core issue was that, historically, the Trust Secretary had held a second spreadsheet with contact details for elected governors and that changes made to this database, when email details changed, did not appear to have been communicated to the Charity Team, to ensure the main database was updated with the new details.
	• The issue was deemed to be human error but would have meant that the governor concerned would have continued to receive governor-related emails, to their new email. The absence of member emails would have essentially gone unnoticed as they were so few in number.
	• In respect of the election itself, there was confidence that this had been run appropriately by Civica in all aspects. There was, however, recognition that although it met the minimum requirement for the election to be valid, there was more that could, and would, be done in future to raise awareness and publicise the same.
	• Due to the email details for the affected governor on the database used being incorrectly, they did not receive emails from Civica, however, there were a number of mitigations:
	  ○ Both in 2022 and 2023, the then Trust Secretary had emailed with a full list of governors and re-election dates attached.
	  ○ The Lead Governor had communicated the election process and timeline in a Council of Governors' pre-meet.
	  ○ Communication had gone out through 'Newsbites' on a weekly basis in advance, and during, the election process.
	  ○ The Lead Governor had sent a 'WhatsApp' message to the governor group by way of a reminder to put themselves forward, should they wish to be re-elected.
	
	It was therefore considered that the outcome of the investigation stood, notwithstanding that there were lessons to learn and opportunities to improve the process going forward.
	
	Several recommendations had been suggested, to strengthen the processes and communication, to ensure that all were aware that elections were running and would be encouraged to come forward.
	
	EM offered a personal apology that the process was not as robust as it might have been.
	
	In advance of this meeting, EM, the Chair and AH had met with the affected governor, to discuss the outcomes of the report and to have any questions answered. All was understood, but feedback had been received that engagement with NHS email had proved difficult, which was a reflection of		

	the security arrangements around this system. The individual had enjoyed their time as a governor and wished to continue in the capacity of volunteer, which was much appreciated, and encouragement was extended to stand as governor in a future election. AH confirmed that she had been interviewed as part of the investigation. The Chair apologised that the formal document had not been circulated prior to today's meeting and highlighted the commitment to ensuring correct process in the future. CM questioned whether the Information Governance Team had any oversight over the membership list and was this on the Information Asset Register? EM confirmed this to be the case. Discrepancies here were noted to have been historical. SB asked AH whether she had felt pressured as governor representative and whether there would have been some benefit in having a colleague present at the interviews. AH replied that whilst she had felt nervous, the interviews had proceeded without issue, and no pressure had been felt. It was queried whether the membership list was available to view, but this was not permitted due to issues of data confidentiality. The Chair committed to providing, when possible, demographics and groupings, once there had been a cleanse of the database. EM and the Chair confirmed that the Investigation Report – 2024 Governor Elections would be circulated to Council members after the meeting. The Council of Governors **noted** the Investigation Report – 2024 Governor Elections.	**KMB**	**03/25**
7.	**Lead Governor's Report**		
	AH presented the Lead Governor's Report, and stated that at the pre-meet in morning, it had been agreed that there would be another meeting on Wednesday 28 November, at 09:30, due to the extent of issues to be discussed. A staff governor volunteer was sought to attend the Finance and Performance Committee (FPC) and members had been encouraged to put themselves forward. The Council of Governors **noted** the Lead Governor's Report.		

8.	**Reports/Observations from Chairs of Governor Committees**		
8.1	**Forward Planning Committee**		
	SB reported that: • As Doug Burns and Stephen Brown had retired from the Committee, this had left the meeting with two public, and one staff governor, short. SB had agreed to liaise with AH to find potential members to propose to the Council of Governors. Existing staff governors had a full agenda, so another individual was required in order to fulfil the terms of reference. • During the meeting, EM had outlined the plan for the Five-Year Strategy. There was a plan for, as the strategy development process progressed, a session with Governors to be arranged. • It had been requested that Committee members had sight of a copy of the Operational Plan, to ensure that all actions being undertaken, aligned with that plan. • It was highlighted that at every Committee meeting, there was now an item regarding review of risks. It had been decided that an abridged BAF would be received. • As RPH had a national, and international presence, it had been felt that when considering how to evolve the Foundation Trust membership, Wes Streeting MP could perhaps be invited to come along and give a talk or presentation. Members could be invited to the event, and hopefully more people could get involved. • It was felt that a 'heads up' could have been given that there was going to be a new Non-Executive Director and Executive Director, and potential changes to the Constitution, by way of awareness that this was something that was going to affect the hospital in the future.		
8.2	**Patient and Public Involvement Committee:**		
	MH was not available to provide an update, the paper for which would be circulated after the meeting.		

8.3	**Access and Facilities Group**		
	TMc presented the Access and Facilities Group update, noting that: • Estates had tagged further wheelchairs in the Atrium. Estates had advised there would be training for Volunteers to use the wheelchair tagging retrievable system. The training provider had scheduled a date for Monday 25 November, for a duration of two hours. Estates had been advised to contact the Volunteer Department to obtain a team that could join the training, along with arranging for volunteers/staff to be involved with training, for future use. • Three new coffee machines had been installed in the restaurant. • In respect of automatic doors, SH advised that some elements of the variation were awaited, after which this would go through the Investment Group for prioritising. The Council of Governors **noted** the Reports/Observations from Chairs of Governor Committees.		
9.	**Reports on other Governor Activities (including from Appointed Governors)**		
	There were no reports on other Governor Activities.		
10.	**Update on Actions (You Asked; The Plan/Progress Update)**		
	The Chair presented the report: Some aspects of the plan had been progressed, whilst other items were still awaited, such as central NHS guidance on appraisals. The Governor Handbook remained work-in-progress, and this would form part of the extra meeting scheduled for Wednesday, 13 November 2024. KMB had provided an extract of key duties and roles of governors, which would be added to, as necessary, and linked to the handbook and training requirements. HP offered a message of support for the work being undertaken. **• Outline Framework for the draft RPH Membership Strategy (For Approval)** IH considered that once the meeting prior to Christmas had taken place, with a formal agenda, the governors would be able to establish targets to be tested against the draft Membership Strategy.		

	The Chair highlighted the appointment of LFT, as the Trust's Membership and Engagement Officer, as providing a clear indication of the Trust's commitment to progressing in the area of Foundation Trust membership engagement. EM clarified that this was a new full-time role, half of which would be dedicated to the engagement and support of governors. The position would report to the Communications Team, with a strong link to KMB in terms of the Membership Strategy and delivery element. The report noted that establishing administrative support for the Governors remained a work-in-progress. The Council of Governors **noted** the Update on Actions (You Asked; The Plan/Progress Update) and **approved** the Outline Framework for the draft RPH Membership Strategy.		
GOVERNANCE			
11.	**Governors' Assurance Committee of the Council of Governors - Terms of Reference** The Chair advised that both CMc and HP had challenged elements of the Terms of Reference previously, and these had been revised accordingly. Membership had been increased to include governors who were not chairs of Council of Governor committees, and it had also been suggested that the Chair of this committee should not be the existing Chair of another committee, to further aid independence. The scope of the Governors' Assurance Committee was noted to have changed, but a key remit remained keeping horizon scanning, constitutional changes and duties of governors, at high level. HP noted that one of the main roles of the Governance Committee when it was first set up had been to review the changes in the statute, the recommendations and guidance from the Department of Health and the regulator. However, responsibility of this Committee to oversee the accuracy and completeness of the handbook was not evident in the final draft of the Terms of Reference. The Chair noted the same and advised that relevant adjustments could be made to reflect this. CC questioned who would be undertaking horizon scanning. AH advised that this would be the Chair of the Governors' Assurance Committee as part of that remit, but this role was currently to be filled. CC continued that training would be essential, and EM advised that KMB's role would support that delivery. The committee would provide the oversight and assurance function on what was presented, handbook writing would be subject to discussion at Wednesday's meeting but would be supported by the Trust to pull content together. The Chair highlighted that the volunteer nature of Governor time required to be respected.	**KMB**	**03/25**

	The Council of Governors, subject to the suggested revisions, **approved** the Governors Assurance Committee's Terms of Reference. **• Summary of key duties and obligations for Governors'** The Chair determined that this item had been covered in the above discussions.		
11.1	**For Noting - Membership and Engagement Officer Appointment**		
	The appointment of a Membership and Engagement Officer was **noted**.		
12.	**Governor Matters**		
	• Appendix 1: Governor Committees Membership **• Appendix 2: Minutes of Governor Committees** The Council of Governors **noted** the Governor Committee Membership and Minutes of the Governor Committees.		
13.	**Papworth Integrated Performance Report (PIPR) – M06**		
	The Chair introduced the M06 PIPR: SB sought clarity on the number of theatre cancellations noted within the document. The Chair responded that there were a range of issues with theatre cancellations, which might include availability of staff, theatres and equipment, or prior overruns in the event of emergency activities. There was also the issue of sickness and patient suitability on the day. EM added that historically, the number of patients who underwent surgical procedures in the theatres had been optimised. This was because there had always been a recognition that surgical procedures at RPH were always quite complex and lengthy. Theatres were therefore booked to maximise utilisation, and should a patient not be suitable or ready due medication reasons, or if there were issues relating to a transplant patient, cases may have to be stood down. Unpredictable emergency activity was also a factor to take into account. HMc stated that steps had been taken by the operational team to improve upon theatre utilisation in support of improvement actions being undertaken under the auspices of the Patient Flow Programme. HMc advised that as activity had been running at 90% for a few consecutive months, this had put pressure on the theatres in the case of emergencies or transplant issues. HMc stated that for the month 06, the three factors which put pressure on the theatres were increased staff sickness, staff vacancies, and primarily,		

	the acuity of the patients being treated. To reduce the number of patients on the waiting list, priority was given to the sickest and longest waiters at the front end of that list. The extended length of time required to treat such patients usually resulted in the loss of some of the surgical cases scheduled for the latter part of the working day. SB further queried whether there were physician assistants at RPH. EM advised that whilst there were no physician assistants, there were anaesthetic associates, which was a similar role. The Chair considered this to be an umbrella term for a number of different roles. MS reiterated the above and noted recent activity in relation to the regulation of such roles and how they were perceived by the public, and their scope of practice. A significant review had been undertaken on anaesthetic associates, and governance around these roles had been strengthened, adding levels of assurance to the function and scope of practice within the theatre environment. JP questioned if it was possible to be more explicit under the KPIs, which were healthcare acquired infections, and whether these were tracked. MS responded that consideration could be given to this being more explicit, but there was robust tracking in place, with regular reporting to the Board on MRSA bacteremias and C.difficile, as well as any bacteremias which were healthcare associated. These were reported via the PIPR every month. MB added that discussions at Quality and Risk (Q&R) Committee meetings had been dominated recently by improvement actions related to surgical site infections and by M. Abscessus infections. Infection Control actions had been a major area of focus for the Q&R Committee over the past year. M.Abscessus management was viewed as more of a 'business as usual' case now, and the governance was in place to make sure the Trust's water system was properly regulated. External assistance had been sought to understand the best management of the M. Abscessus infections. Surgical site infections remained a serious concern. There had been a drop in numbers during a recent Carbapenemase-producing Enterobacterales (CPE) infection outbreak. The speculation was that this was because the implementation and compliance with infections controls measures had been optimal. MB advised that clearly, changing the cultural behaviours of members of staff was key but would take time The Council of Governors **noted** the M06 PIPR.		
14.	**Questions from Governors and the Public**		
	There were no questions from governors or the public.		

15.	**Future Meeting Dates**		
	• 19 March 2025 • 04 June 2025 • 10 September 2025 • 12 November 2025		

Chair …… Date ……

Royal Papworth Hospital
NHS Foundation Trust

Agenda item 3.ii

Council of Governors
Action Checklist
Following: 13 November 2024 Meeting
Reporting to: 19 March 2025 Meeting

Ref	CoG mtg	Agenda No.	Issue	Responsible Director	Action Taken	To Agenda/ Action Date
01/25	**11 Nov 24**	**5.1**	**Performance Committee (Chair's Report)** To arrange a 'private patients' debrief at one of the Council of Governors pre-meeting sessions.	**AH/KMB**		06/25
02/25	**11 Nov 24**	**5.3**	**Charitable Funds Committee (Chair's Report)** To include Trustee Board Committee minutes in the Council of the Governors meeting pack.	**KMB**	**Completed**	03/25
03/25	**11 Nov 24**	**5.3**	**Charitable Funds Committee (Chair's Report)** Training for patients – Megan Sandford to check if funds could be made available for patients to undertake a course, to enhance their experience whilst they were inpatients.	**Megan Sandford**	The Charity will revisit the suggestion once the Trust Strategy and its subsidiary Charity Strategy have been completed. The strategy refresh for both the Hospital and Charity over the next few months will enable the Charity to gather insight into patient requirements and allow them to focus our funding into the areas of most need and positive impact.	03/25
04/25	**11 Nov 24**	**6**	**Investigation Report – 2024 Governor Elections** To circulate the 'Investigation Report – 2024 Governor Elections' to Council members after the meeting.	**KMB**	**Completed**	03/25

Ref	**CoG mtg**	Agenda No.	Issue	Responsible Director	Action Taken	To Agenda/ Action Date
05/25	**11 Nov 24**	**11**	**Governors' Assurance Committee (GAC) of the Council of Governors - Terms of Reference (ToR)** To further revise the GAC's ToR so that it's responsibility to oversee the accuracy and completeness of the proposed Governors' handbook was more evident and clearer.	**KMB**	The revision was undertaken. The GAC at its first meeting in January 2025, however, requested further revisions to be undertaken.	~~03/25~~ 06/25

Royal Papworth Hospital
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Agenda item 05.1

Report to:	**Council of Governors**	**Date: 19 March 2025**
Report from:	**Chair of the Audit Committee**	
Principal Objective/ Strategy and Title	**GOVERNANCE: To update the Council of Governors on the work of the Audit Committee**	
Board Assurance Framework Entries	**FSRA BAF (Unable to maintain financial, operational, and clinical sustainability)**	
Regulatory Requirement	**Regulator licensing and Regulator requirements**	
Equality Considerations	**Equality has been considered but none believed to apply**	
Key Risks	**Adequate assurance not being received to ensure that the organisation is being adequately run.**	
For:	**Information**	

1. Introduction

Role of Audit Committee
Is to support the governing body by critically reviewing and reporting on the robustness of the governance structures and assurance processes on which the Trust places reliance.

This will include:

- Receiving reports from External Auditors and Internal Auditors including Local Counter Fraud,
- Review of Annual Reports and Accounts for the Trust and the Charity,
- Review of financial position and it sustainability,
- Review of the effectiveness of arrangements in place for staff to raise concerns about possible improprieties.
- Getting assurance that the process for the Board Assurance Framework is robust and constantly reviewed.
- Reviewing the findings of other significant assurance functions which includes getting reports from Committee Chairs on their level of assurance for areas dealt with in their Committees.

In the September 2025 meeting I will present a report on the year end annual reports for 2024/25. However, for this meeting, I will concentrate on the two last bullet points to demonstrate how the Audit Committee ensures that assurance and not reassurance is received on the known risks for the Trust.

2. Assurance Review – BAF

Board Assurance Framework (BAF)

The Board Assurance Framework (BAF) is a focus for the Audit Committee and regular reviews and assessments of risks 20 or higher or have limited assurance on the BAF are made and reported to the Audit Committee.

The Executive lead on the BAF risk is expected to give a report to the Audit Committee on what are the action plans to reduce the risk, the trajectory to getting the to the targeted risk level and what are the barriers, if any.

It was agreed at Board that the BAF risks need an in-depth review by the Executives, and this should be discussed at the Audit Committee meeting in May. The Annual BAF Assurance Map will also be updated after this review.

The BAF Assurance Map is a toolkit that shows where assurance is gained on how the risk is being managed and assessed. It usually shows the three lines of defence that is required to test assurances.

The three lines of defence are:

First line	Reports from management on the operation of controls
Second line	Internal reporting such as quality assurance, performance reporting, KPIs, etc.
Third line	Independent assurance such as external assessments which will include internal audit reports, regulators, inspectors, etc.

The BAF risks are assigned to the Committee for in-depth review and is reported on by the Committee Chairs to the Audit Committee and Board.

3. Assurance Review – Chairs' Reports

The Audit Committee is the forum to give the Board overall assurance that Committees can give a level of assurance of any risks or issues facing the Trust. This in turn will give Governors confidence that the Non-Executive Directors (NEDs) are obtaining and assessing their assurance on significant matters.

There are three questions that the Audit Committee has posed to itself:

- What role should/could the Committee play in shaping how assurance levels are assessed by Committees and how this is reported back through Board?
- Should we be seeking a common language on assurance from Committees and if so, what should this look like?
- Recognising Committees work together across domains (e.g. quality, finance, people, performance etc), how are assurances being triangulated and what role can the Audit Committee play in supporting this?

Assessment of Assurance Levels

Discussion have been held at Audit Committee and with the NEDs and it was felt that the process of including in the Committee Chair's report, the level of assurance received on the BAF risk or issue discussed works quite well. The reports from the Chairs give sufficient detail of the discussion and highlights the issues of concern.

Common Language

It is important that the Chairs are given the flexibility on how they assess the level of assurance, so it has been decided not to prescribe the format of the reporting. Also, it was felt that the NEDs are aligned with what is required to assign into the four levels of assurance of "Substantial", "Moderate", "Limited" or "No".

Triangulation

NEDs participate in multiple Committees and are distributed diversely. This setup allows NEDs to verify that risks are being rigorously evaluated and that the impacts of solutions or ongoing issues are being addressed.

The NEDs have decided to enhance the assurance process by having the Audit Committee randomly request an in-depth presentation from the Chair of a Committee at its meetings.

During the Audit Committee meeting on 13th March, Michael Blastland, Chair of the Quality & Risk Committee, delivered such a presentation. He gave us a review on BAF Risk 675 "Failure to protect patient from harm from hospital acquired infections". Using Surgical Site Infections as an example, Michael effectively demonstrated the defensive strategies that were employed to get assurance.

4. Conclusion

It is hoped that Governors are content with the way NEDs are constantly seeking assurance that the risks facing the Trust are being dealt with appropriately and in a timely manner.

Agenda item 5.3

Report to:	**Council of Governors**	**Date: 19 March 2025**
Report from:	**Chair of the Strategic Projects Committee**	
Principal Objective/Strategy/Title	**GOVERNANCE:** **To update the Council of Governors on the work of the Strategic Projects Committee**	
Board Assurance Framework Entries	858, 3449	
Regulatory Requirements	Well Led/Code of Governance	
Equality Considerations	To have clear and effective processes for assurance of Committee risks	
Key Risks	None believed to apply	
For	Assurance to the Council of Governors	

Overview

The Strategic Projects Committee (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.

Since the last Council of Governors meeting in November 2024, SPC met twice – in December 2024 and in February 2025.

The committee has examined work done in the area of Digital technology, including the electronic patient record, working with our partners, and research & development.

There are two BAF risks assigned to the committee:

1. Electronic patient record, optimising its use and its future
2. Working with our campus partners, in particular industry and the university.

These risks are scrutinised each meeting and the mitigations examined and challenged where appropriate.

Specific areas of discussion focused on the following:

Digital – The committee was informed that the new Shared Care Record had successfully gone live in December 2024.This system enables sharing of patient records from the community, GPs, NWAFT, the local authority and mental health.

Electronic Patient Record – The committee has sought assurance around the work being done to prepare an Outline Business Case (OBC) to detail the need for investment in a new fully integrated electronic patient record (EPR) for the Trust. The committee has been monitoring the progress of the OBC which has recently been approved by the EPR Investment Board (EPRIB). The OBC will next progress through to Cabinet Office approvals.

Working with our campus partners is progressing and will achieve improved outcomes for our patients through research, innovation and joint working. The recent planned joint meeting with CUH was postponed. The plan is to explore further areas where joint working would be beneficial for our patients.

Research and Development – The committee received a report which gave an overview of the work done by the Research & Development Directorate in the quarter, October – December 2024. The committee noted collaboration with Campus partners and further work around championing diversity in health research through a successful workshop held in October, followed by attendance at a Health & Wellbeing event at Cambridge Central Mosque.

Trust's 5 year Strategy – Work has begun on scoping the Trust's 5 year strategy and the committee was given an update on progress to date.

The Council of Governors is asked to note the contents of this report.

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Schedule for Board Committee Chairs Reporting to the Council of Governors

Date of Meeting	
04 June 2025	• Performance Committee • Workforce Committee
10 September 2025	• Audit Committee • Quality and Risk Committee • Strategic Projects Committee
12 November 2025	• Performance Committee * • Workforce Committee • Charitable Funds Committee

* New Chair in October 2025

Agenda Item 7

Report to:	Council of Governors	**Date: 19/03/2025**
Report from:	Maura Screaton, Chief Nurse Louise Palmer, Deputy Director for Quality and Risk Jacqui Renwick, Head of Quality Improvement and Transformation Ian Smith, Medical Director	
Principal Objective/ Strategy and Title:	Quality Accounts Priorities – 2025/26	
For:	Discussion and Consideration	

1. Purpose

The purpose of this report is to provide the Council of Governors with the three Quality Priorities which are being taken forward to the 2025/26 Quality Accounts.

The January 2025 Quality & Risk Committee (Q&R) meeting was presented with a long list of scoped proposals for the 2025/26 Trust Quality Account Priorities. The Committee was asked to review the scoping exercise and to discuss and agree the three priorities to take forward to the 2025/26 Quality Accounts.

The February 2025 Patient and Public Involvement Committee (PPI) meeting also had opportunity to input into the final selection of three priorities.

2. Summary

The list below is the initial draft long list of possible Quality priorities reviewed at the Q&R Committee and PPI Committee meetings, with the recommended Quality Priorities highlighted.

Quality Priorities Proposals	Trust/National/Regional Strategy, etc
Waiting Lists and reducing harm for those waiting.	**Background:** Research has shown that '*People waiting more than 18 weeks for NHS treatments used more healthcare resources than others, research found. Healthcare resource use differed depending on what treatment people were waiting for'.* In March 2020, almost 4 million people were waiting for NHS treatment; by June 2024, this had risen to almost 8 million. Before the pandemic, the NHS met its target of treating people within 18 weeks of referral for 86% people. By March 2022, fewer people (62%) were treated in this time (NIHR Dec 2024). **Proposal:** To review and scope how we can embed further the requirement of DN807 Referral to Treatment (RTT) Clinical Harm Review Quality Assurance Procedure. To ensure we have robust processes in place to be able to carry out for all patients who have been waiting for treatment on the RTT pathway to have a completed harm review and to assess if any associated harm has occurred due to a delay in treatment. This will enable wider learning from these reviews to continue to plan and enhance our current processes to reduce harm for patients on the RTT waiting lists. **Trust position**: Limited assurance proposal to take this forward as a priority for 25/26.
Health Inequalities and Equality and Diversity of our Patients and families/carers.	**Background:** Within the NHS Long term plan - there is recognition that for reasons both of fairness and of overall outcomes improvement, the NHS should take a more concerted and systematic approach to reducing health inequalities and addressing unwarranted variation in care (NHS Long Term plan 2019). When assessing high - quality, person-centred care, under the Single Assessment Framework (CQC 2023) CQC considers the experience of people with protected equality characteristics and those most likely to have a poorer experience of care or experience inequalities.

	Proposal: To further embed our work on health inequalities and focus on our commitment to equality and diversity, the review and development of services to enhance accessibility for all patient populations. This would include improving the recording of patient demographics within our EPR and how this is embedded into the Nexus project. Further, ensuring all patient feedback and Friends and Family Test evaluation include the ability to filter patients with protected characteristics for analysis of their experience. To launch the new Translation and Interpretation service from April 2025 and new ways of working, using technology (Video Translation) and ensuring that the new services are accessible to all. Another area to review are the Did Not Attend (DNA) by patient groups to ensure disadvantaged groups are able to access our services. **Trust Position**: Health inequalities resource in place and work has begun to focus on this area of work. EDS annual review has been completed for 23/24 with identified actions for improvement underway. This area of work will be added to the new 3-year Quality & Risk Strategy to go live from April 2025. Which will set out the further detail of how we will work further to embed this work over the next 3 years.
Discharge Assurance.	**Background:** The Department of Health and Social care have updated their Statutory guidance on Hospital discharge and community support guidance (updated 2024) which now outlines that NHS bodies and local authorities should agree the discharge models that best meet local needs and are effective and affordable. Additionally, following on from the wider learning from an inquest into a death at RPH in 2021, linked to other district general hospitals, the Department of Health and NHS England have issued a report in relation to discharge summaries nationally and the ability of medical staff to have the most pertinent and up to date patient information easily accessible on transfer. **Proposal:** We need to ensure safe and effective discharge, ensuring discharge forms and paperwork are correct, issued in a timely way and aid future care for the patient. Enhancing safe discharges alongside increasing patient flow, to be able to treat more patients. **Trust position**: This work has started with our Discharge Assurance group, with several workstreams developing, that will feed into this group. However, this is a key area of focus, to ensure we can embed a safe and effective discharge process with discharge summaries being a key part to this. Following on from the Learning from Deaths learning, we need to build further assurance, and it is recommended this is taken forward as a priority for 25/26.
Patient experience and Engagement and learning from patient/carer feedback and involvement.	**Background:** Within the NHS long term plan (2019) and in the new CQC Quality statements is the clear recognition of listening and involving patients and their carers in our services and the care we offer. Ensuring services and providers need to work together to plan and deliver high quality care (CQC 2023). **Proposal:** to increase the Trusts patient participation and co-production capacity. Continue the scoping for resource required for further Patient Experience, engagement and co-production of our services and future services. This would include benchmarking of activity against other Trusts. Embedding of complaints actions/improvement within our services using themes for learning process followed. To be able to undertake audit of patient feedback and resulting improvements. Furthermore, working from engagement to co-production where we would have increased capacity for the involvement of patients, families and Next of Kin, in the co-production of our services. **Trust position**: The Trust has feedback process (FFT) and some involvement underway. This work is underway to look at resource and will be linked to the newly published 3-year Quality and Risk Strategy due to be launch from April 2025.
In House Urgent and utilisation of virtual ward.	**Background:** It is recognised in the NHS that we need to continue to develop and work smarter with the resources that our available. Virtual wards allow patients to get hospital-level care at home safely and in familiar surroundings, helping speed up their recovery while freeing up hospital beds for patients that need them most. Virtual wards also increase flow of patents to enable to reduce waiting list (NHS England-Accessed online Jan 2025)

	Proposal: to continue to develop our virtual ward space and how we remote monitoring to enhance care. Alongside maximising the use of Attend Anywhere, for more virtual clinic appointment. With the overall aim being to help with capacity and flow. Scoping and benchmarking against other organisations. **Trust Position**: The Virtual ward is live and working well, scoping is underway to extend the capacity within other specialities within STA division to be able to use this virtual ward. Governance in place between the two Trusts.
CQC Compliance Assurance and Readiness.	**Background:** CQC launched in 2019 the new quality statements, linked to the 'I statements', and future inspections and trust reviews will be done through the 5 domains with a focus on the newly formed 'We statements'. **Proposal:** newly launched in November 2024 was the Implementation through the Fundamentals of Care Board the two new stepped approach to Trust quality of care assurance via: • Self-assessment - Divisional and team CQC self-assessments • Quality Accreditation Assessment - peer review of wards/departments. **Trust position**: As this is a new process, and a Trust wide change in relation to CQC readiness alongside embedded clinical quality improvement process, is that proposal is taken this forward as a priority for 25/26.

Recommendation: The Council of Governors is requested to note the Quality Account Priorities for 25/26.

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2024/25 Quality Accounts Timeline

DATE	ACTION	BY WHOM	STATUS
30/01/25	Q&R Committee consider proposals for 2025/26 Quality Priorities Draft Quality Account Timelines for 2024/25 completion of report.	MS KMB	
10/02/25	PPI Committee membership to receive an update on: i. Progress of 2024/25 Quality Priorities. ii. Also proposed 2025/26 Quality Priorities.	MS	
27/02/25	Quality and Risk Committee to receive: i. Updated timetable and any National requirement changes for 2024/25 Quality Accounts for review.	KMB	
19/03/25	Council of Governors (CoG) to receive: i. Update on progress of the 2024/25 Quality Priorities plus request to review and support the Quality Priorities for 2025/26. ii. Summary of any changes to reporting timetable and requirements for the 2024/25 Quality Accounts.	MS KMB	
18/04/25 21/04/25	**EASTER BANK HOLIDAYS**		
24/04/25	Quality & Risk Committee to receive for review: • Draft 2024/25 Quality Accounts Report – which will include 2024/25 Quality Priorities Performance Report and Quality Priorities for 2025/26 • Draft Annual Governance Statement	KMB KMB	
25/04/25	Circulate draft Quality Accounts 2024/25 to stakeholders (30 days statutory period required to review and return their comments for inclusion in the final report). *Stakeholders:* (If more than 50% of your services are commissioned by NHS England, you should send your Quality Account to england.qualityaccounts@nhs.net for comments) NHS Specialised Commissioning East of England Hub, Cambridge and Peterborough ICS, Healthwatch, Cambridgeshire Adults & Health Committee Welsh Health Specialised Services	KMB	
25/04/25	PPI Committee to receive draft Quality Accounts and agree Governor comment for inclusion in the report.	KMB	

05/05/25	**EARLY MAY BANK HOLIDAY**		
26/05/25	**SPRING BANK HOLIDAY**		
29/05/25	Quality and Risk Committee Meeting to receive: 'Final' draft Quality Accounts	MS	
30/05/25	Deadline for the receipt of comments from the ICS, PPI Committee and other stakeholders on Quality Accounts for inclusion in final report.	KMB	
12/06/25 (TBC)	Audit Committee Meeting to receive: Final draft Quality Accounts	MS	NB: No requirement for the Quality Accounts to be submitted for an External Audit Process
19/06/25 (TBC)	**09:00 am – 09:30 am Extraordinary Trust Board** meeting to consider the draft Quality Accounts and consider recommendation for approval. Accounts to be signed by CEO and Trust Board Chair.	MS KMB	
20/06/25-27/06/25	Design work on Quality Accounts, Annual Report and Accounts to be undertaken by Communications Team & Associate Director of Corporate Governance. Production of pdf and bound copies if required.	KMB/ Comms	
30/06/25	Deadline for publication of the 2024/25 Quality Accounts on the Trust website. Forward the link of the webpage to the following email address: NHS providers – quality-accounts@nhs.net	KMB/ Comms	

Lead Governor's Report March 2025

Since last our last CoG in November Governors have taken part in the following:

We appointed two new NEDS to replace our NED colleagues Michael Blastland and Gavin Robert when they step down in March and December respectively. Thank you to Michael for all your hard work, the Governors have valued your thought provoking questions and challenges. We are sorry to see you go and wish you all the best for the future.

In January the Governors met on Teams. We discussed the need for Governors to have more training to better understand the role and duties. This is essential for new Governors, but we felt everyone could benefit from a refresher course.

In February Lead Governors from across the ICS met with John O'Brien and Martin Wheeler. There was no formal agenda. We heard about the challenges facing each trust, with most time spent on those with an A and E department. It has been suggested we have a formal agenda for the next meeting, although a date for the meeting has not yet been set.

At the end of Feb and start of March governors were given the opportunity to provide feedback on the NEDs as part of the appraisals process. Thank you to Oonagh for producing a helpful questions template and thank you to my colleagues for both your patience whilst I was away and your quick responses on my return.

At the last CoG we heard from Ian Wilkinson and Megan Sandford about the work of the Charitable Funds Committee. We have since agreed to have a Governor observer join the committee.

Abi Halstead

13th March 2025

Royal Papworth Hospital
NHS Foundation Trust

Item 11

Report to:	Council of Governors	**Date:** 19 March 2025
Report from:	Chairman/Lead Governor	
Principal Objective/ Strategy and Title:	Update on Actions (You Asked; The Plan)	
Board Assurance Framework Entries:	N/A	
Regulatory Requirement:	Well Led	
Equality Considerations:	Equality has been considered but none believed to apply	
Key Risks:	Governors are not able to effectively discharge their responsibilities. Inadequate governance processes and oversight.	
For:	Review and comment.	

1. Purpose

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

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

2. Areas for Improvement

2.1 *NED Appraisal Process:*
The Chairperson is accountable for undertaking NED appraisals and the Senior Independent Director (SID) for the Chairperson's appraisal. It is acknowledged that for the appraisal process to be comprehensive and of sufficient rigour the process needs to ensure that governors feedback and observations are systematically gathered. This is in addition to the role of the Appointments Committee in reviewing the performance of Non-executive Directors.

In Autumn 2024 NHSE will publish new appraisal documentation for Non-Executive Directors and Executive Directors to align with the new national Board Leadership Competency Framework. We will integrate this into our process when it is published and use it for the 24/25 cycle.

Update: NHSE is yet to publish the new appraisal documentation. We have refreshed the Trust's documentation to reflect the Board Leaders Competency Framework. **Completed.**

2.2 General support for governors.

There was a specific request for organograms for the key committees/ for the governor, NED and key Trust committees.

The support for governors will also be reviewed to consider how, within the resources available, this can be improved.

Update: Trust Governance Structure is attached to the agenda for information. **Completed**

2.3 Training and development for governors.

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

Update: Implemented – Draft Governors Handbook is ready for review at the 28 March 2025 Governors Assurance Committee meeting. **Completed**

2.4 Membership.

It was acknowledged that in order for Governors to be actively engaging with members to represent their views at the CoG we need to both increase the membership, which has been falling for some time, and to put in place channels of communication between Governors and members. There has not been the capacity over the last couple of years to support this but in the 24/25 planning round an additional post was approved which will provide capacity for this.

Update: Implemented – Draft Membership Strategy is attached to the agenda for approval. **Completed**

The Council is requested to:

- Review and comment on the contents of the paper

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Trust Governance Structure: Trust Committees

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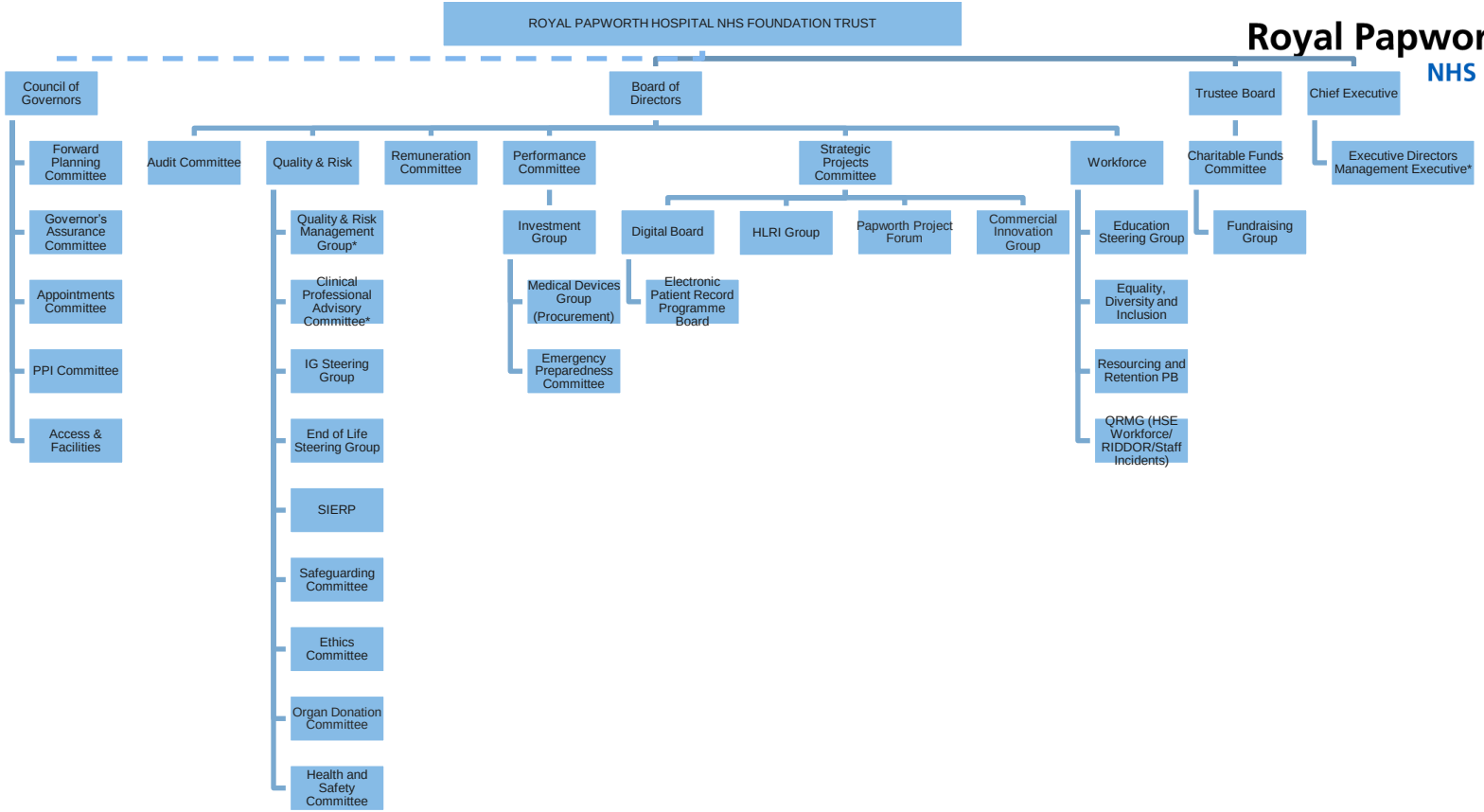

Royal Papworth Hospital
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Membership and Engagement Strategy

2025-2028

Content

This document should be read in conjunction with the Trust's Annual Report and Accounts particularly the sections entitled *Foundation Trust Membership* and *Council of Governors* which includes information on the following:

- Definition of the membership constituencies;
- Annual membership analysis;
- Membership activity during the year;
- Involving Governors and Members.

Names of the members of the Council of Governors can be found at https://royalpapworth.nhs.uk/our-hospital/how-we-are-run/our-council-governors

Further details of the hospital can be found at:
https://www.royalpapworth.nhs.uk/

1. Introduction

Royal Papworth Hospital NHS Foundation Trust ("the Trust") is the UK's largest specialist cardiothoracic hospital and the country's main heart and lung transplant centre. While the Trust is a regional centre for the diagnosis and treatment of cardiothoracic disease in Cambridgeshire and Peterborough, it is also a national centre for a range of specialist services, including heart and lung transplantation, pulmonary endarterectomy (PEA) and Extra Corporeal Membrane Oxygenation (ECMO). Additionally, the Trust has the largest respiratory support and sleep centre (RSSC) in the UK.

The Trust's vision is, "to bring tomorrow's treatments to today's patients", and its mission is "to provide excellent, specialist care to patients suffering from heart and lung disease".

2. Membership Constituencies

The Trust's Constituencies are:

- Public Constituencies: Cambridgeshire; Norfolk; Suffolk; and The Rest of England and Wales
- Staff constituencies, which reflect different professional groupings: Doctors, Nurses, Allied Health Professionals, Scientific and Technical, Administrative, Clerical and Managers, Ancillary, Estates and Others.

3. Membership and Engagement Strategy – Key Aims/Objectives

The Membership and Engagement Strategy has been developed on behalf of the Council of Governors (the Council) with the overall aims/objectives of:

- Providing Governors with an effective model/tool for representing and engaging with their electorates (Trust members) and the public;
- Increasing the membership numbers;
- Improving upon the diversity of the membership, to make sure the makeup of membership is representative of the communities the Trust serves;
- Keeping the membership informed of developments in the Trust;
- Supporting the improvement of population health, by building awareness of key health topics and advocating for the importance of both members and the general public taking ownership of their own health

4. Key Drivers for Membership and Public Engagement Activity

It is a statutory requirement for Governors, and the Trust, engage with the members, patients and the public. The statutory documents which support engagement activity include:

- The 'Addendum to Your statutory duties - reference guide for NHS foundation trust governors – System working and collaboration: role of foundation trust councils of governors' was published in October 2022. It provides guidance for

how Councils of Governors should operate in support of the NHS's 'co-design and collaboration' agenda after the establishment of Integrated Care Systems (ICSs). Councils of Governors are required to support their organisations in their collaborative efforts, and to form a rounded view of the interests of the 'public at large'. The 'public at large' includes the population which live within the boundaries of the ICS of which the relevant NHS Foundation Trust is a part of, and not just the members of the Trust.

- The Code of Governance for NHS Provider Trusts, published in October 2022, also requires Councils of Governors 'to take account of the interests of the public at large'.

5. Delivering the Strategy

The Council's Governors Assurance Committee (GAC) will have responsibility for ensuring the objectives of this Strategy are implemented, supported by the Trust Executive.

To achieve the Strategy's objectives, three key priority areas have been identified together with actions to be implemented:

Key Priority Area 1: *Membership Recruitment – To increase numbers and to ensure that they are representative of the communities the Trust serves.*

Actions to achieve this include:

- Cleanse the membership database
- Improve membership portal on the website and welcome message. In the long-term, utilise all forms of communication including appointment letters, LinkedIn, Facebook etc. as a recruitment tool.
- Develop the relationships with the 'avenues' through which members will be recruited – For example: Research and Development Team, Medical Charities; County and Borough Councils, GP Practices, Medical and Nursing leaders, Hospital Charity (the Charity), etc
- Develop a 'Contact Strategy' – which would focus on the frequency of newsletters to the members, which events to target and attend, the materials event attendees will distribute, etc.
- Create regular 'membership recruitment days', with Governors in support

Key Priority 2: Support for Governor/Members/Public engagement

Actions to achieve this include:

- Procure a standalone customer relationship management system to use alongside the Trust's mailing platform (NewZapp)
- Develop, through the engagement with the councils, the Charity, etc. a communities events calendar which Governors can utilise and know what events to attend – staff can either attend to support or provide material for the attending Governor (s) to distribute or speak to

- Create a point (s) of contact for Governors – generic email or contact person which Trust members and members of the public can either email or write a letter to
- Support Public Governors to hold events in their constituencies. Staff Governors should also be supported to raise their profile with regular blogs, stands in the Atrium, etc.
- Provide Governors with the relevant training support so they can excellent Trust ambassadors

Key Priority 3: Enhance Member/Public Engagement with the Trust

Actions to achieve this include:

- Publicise meetings and events of the Governors, Board or the Trust so there was awareness
- Based on feedback from the public and members or other avenues, organise events with themes which will attract audiences
- Invest in or utilise audio visual equipment which will ensure public attendees of events or meetings have a good experience.

6. Evaluating the Strategy

The GAC will consider all aspects of the Membership Strategy's implementation and recommend any updates or revisions to the Council. In monitoring the effectiveness of the strategy, the GAC will ensure that it is delivered and remains meaningful and relevant.

An annual progress report will be submitted to the Council.

7. Comments and Questions

For membership queries contact the Communications and Membership Engagement Co-ordinator on 01223 639834 or email papworth.corporateservices@nhs.net

Royal Papworth Hospital
NHS Foundation Trust

Agenda Item 13

Report to:	Council of Governors	Date: 19 March 2025
Report from:	Chief Finance Officer	
Title:	External Audit contract	
Board Assurance Framework Entries:	Not applicable	
Regulatory Requirement:	National Health Service Act 2006	
Equality Considerations:	None believed to apply	
Key Risks:	**Failure to submit Annual Report and Accounts to required statutory deadline**	
For:	**Approval**	

1. Purpose

1.1. The purpose of this paper is to provide options for the continuation of the contract for External Audit Services with KPMG LLP or to tender for a replacement.

2. Background

2.1. The Trusts current provider for External Audit Services is KPMG LLP. The contract commenced on the 1 January 2022 with the initial contract period expiring on 31 December 2024. This contract was awarded after completing a competition exercise under the NHS SBS framework for Internal and External Audit, Counter Fraud and Financial Assurance Services. Of the 7 companies invited to participate in the competition exercise, only KMPG LLP prepared an offer.

2.2. The current contract can be extended in 2 separate 12 month periods by giving the supplier no less than 3 months' notice. The Trust has exercised the first of these 12 month extensions with the current contract therefore running until 31 December 2025, covering the 2024/25 year end.

2.3. The contract is subject to an annual inflationary uplift of 3% and expenses are capped at 5% of the total fee each year.

3. Context

3.1. The market for internal audit and external audit services is significantly different to what it was 5+ years ago. Regulatory requirements have changed and there are an increasing number of suppliers exiting the audit market to re-focus on consultancy offerings and a number of the big 4 have already exited.

3.2. Cambridgeshire and Peterborough is viewed as a high profile consultancy target and this has impacted many of our in-system peers who have been unable to readily secure internal audit or external audit services, leading to one of our peers submitting Trust accounts almost three months after the national deadline. This also played out in the Trust's last competitive market tender where KPMG LLP were the only bidders.

3.3. External audit providers are now advising NHS organisations to put out tenders for external audits services at least a year in advance to ensure due diligence and consideration can be provided.

3.4. In recognition of the market context, the Financial Reporting Council has published an NHS audit market study report. HFMA's response to this is available here: https://www.hfma.org.uk/system/files/2025-02/HFMA%20response%20to%20the%20FRC%27s%20NHS%20audit%20market%20study%20emerging%20findings%206-2-25.pdf

3.5. The HFMA has published various briefings and comment pieces on the NHS audit market over recent years, exploring the issues such as the tendering process, audit interest, risk, capacity and fees. As set out in the FRC's emerging findings report, issues were raised about the future resilience in the market. In particular, concerns were raised regarding constraints on market capacity, limited auditor choice and issues with the procurement processes used for external audit within the NHS.

4. Proposal

4.1. Audit Committee previously discussed the option of extending the current contract or going out for a replacement via procurement. The conclusion of members was that given the context of the external audit market, the fact that KPMG were the only bidders in the previous competitive exercise and considering the high level of service provided by KPMG, the +1 year extension to the KPMG contract should be exercised to cover the 2025/26 year end.

4.2. The Trust would need to notify KPMG of their intention to extend the agreement by September 2025. We have had informal discussions with KPMG who have confirmed they would be pleased to extend the contract. This would extend the contract to 31 December 2026 and cover the 2025/26 audit year end. The anticipated costs would £149k including £137.5k (a 2.1% increase on 2024/25) for the core audit fee plus a further £11.7k technology fee reflecting a 8.5% of base fee applied to all KPMG fees moving forward to cover the costs storing and protecting data given their heavy reliance on data. Any additional accounting review on EPR or any further work required would be on top of this.

4.3. This would be the final extension. The Trust will then need to run a competitive process via a framework that includes a wide range of suitable providers such as the NHS SBS framework and appoint an external auditor for the 2026/27 year end onwards. It is recommended that we start this process at least 18 months prior to 2026/27 year end to give us time to re-run any process should we be unable to attract sufficient calibre bids. This would mean starting the process around July/August 2025.

4.4. We would propose inviting one or both Governor observers at Audit Committee to be part of this process. The panel would also consist of the Audit Committee Chair, the CFO, the Head of Procurement and the Associate Director of Corporate Governance.

5. Recommendation

Following approval by the Audit Committee, the Council of Governors is asked to approve an extension to the existing External Audit Contract with KPMG LLP to cover the 2025/26 year end (taking the contract to December 2026).

Further, the Council of Governors is asked to approve the commencement of a procurement process for the 2026/27 year end onwards.