Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Council of Governors
PART I
Held on Wednesday 13 September 2023 at 10:30am
At the HLRI and 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
	John Fitchew	JF	Public 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	TML	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
	Emma Larcombe	EL	External Auditor
	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
	Gavin Robert	GR	NED
	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. JW acknowledged that: • Jag Ahluwalia has been appointed as incoming Trust Chair starting on the 1st of February 2024 • This is the last Council of Governor meeting that Richard Hodder will be attending as he will be stepping down as Lead Governor today at the AMM. • Abigail Halstead will become the new Lead Governor later today. To be announced at the AMM. • It is a year since Eilish Midlane has been in post as CEO. JW informed everyone that Sam Edwards, from Comms will be taking photographs during the meeting to use for updating the Governor website. ***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.***		
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 – 14 June 2023**		
	The minutes of the meeting held on Wednesday 14 June 2023 were agreed as a correct record.		

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4	**ANNUAL REPORT & ACCOUNTS 2022/23**		
	Reported by Tim Glenn CFO **Received: The Council of Governors received the ISA260 Report and the Annual Audit Report.** TG Introduced Emma Larcombe from KPMG the RPH external auditor and explained that he will give their independent opinion on the quality of the Trusts accounts and the Value for Money that it is providing. **TG** gave an overview for 2022/23 which was another successful financial year for the Trust. • The Trust posted a small surplus which was getting increasingly difficult in the NHS. RPH stands out as a Trust who can keep its head above water in the current circumstances. • The work that has been done over the last 24 months has allowed us to build the foundation for this and this is important because it allows us to invest in strategic initiatives. • There will be a talk about the Thoracic Robot and the partnership with CMR at the AMM. • The quality of accounts that were submitted were very good and as can be seen in the ISA260 the recommendations were limited. The report from the auditors confirmed that our accounts were true and fair and showed Value for Money. **Emma Larcombe** **Received:** Two papers have been shared with the Council of Governors in the pack. • One is the very detailed ISA260 report, and this sets out the detailed level of work done in relation to the audit. • The Annual Audit Report sets out the key findings from their audit. • Two aspects are looked at with an NHS Trust: The checking of the accounts and being comfortable with the numbers. • An unqualified opinion was issued. This means there were no issues with any aspects of the account or the annual report. • The Annual report is checked to make sure the detail is consistent with the numbers and the information disclosed by the management. • There were a couple of minor audit adjustments and control deficiencies. • She confirmed this was a very clean report and is a real testament to the finance team in terms of the quality of controls that are in place around the accounts production. • The other aspect of work looked at is around the Value for Money. A narrative report is issued which is set out in the Annual Auditors Report. This looks at three aspects of the Trusts arrangements under the year of audit. This was 2022/23 12-month period.		

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	• Financial Sustainability: arrangements that monitor and govern financial sustainability. Aspects looked at are how the budget is set and how that is monitored through the year. This includes how any potential issues are flagged and discussed. • Forward Plan: understanding factors that have been considered for the forward budget and whether there were sufficient mitigations for cost pressures. • Within the framework in which the Trust operates the auditors were comfortable that there is a strict planning regime in operation and that the financial sustainability aspect was reasonable. There were no significant risks or weaknesses. • The second aspect looked at governance controls and understanding how key decisions are made. This is to make sure that decisions being taken have been given thought and consideration by the appropriate people. No significant weaknesses or risks were identified in that process. • The third aspect is improving economy, efficiency, and effectiveness. This is how the Trust looks to deliver savings and ensure it is spending money effectively. Making sure that the decisions made are utilising public funds effectively. No issues were identified. • It should also be noted that RPH delivered very well against their cost improvement plan which is something that hasn't been seen across all other Trusts. This is to be commended as there have been a lot of pressures over the last year. **Summary:** There were no significant issues. Assurance has been given in that regard. **Discussion:** **PS** asked if the company Emma works for act as auditor for many Trusts and if there are many other companies similar in the business. **EL** explained that KPMG is the external audit provider for a significant number of Trusts especially across East Anglia, including Norfolk, and some in Essex. They have good local coverage as well as nationally. How other Trusts are operating is seen and that is something that is considered. It is important to note that circumstances at different Trusts will vary significantly. RPH is in a slightly more favourable position than others find themselves. In terms of other firms, the audit market is a challenging one but there are several firms within the public sector space. It is something that is being looked at. There are some instances of hospitals not being able to appoint auditors because of the lack of capacity. KPMG are committed to continuing to work with RPH, so it is not a concern here. It is a broader issue. **TMcL** asked how long KPMG have acted for RPH. **EL** explained that she had been involved for the last 3 years and KPMG had been involved for 3 years before that. They are now in the second		

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	year of a new contract. **JW** added that the only person on the Board who must have a statutory qualification is the Head of Audit who is Cynthia Conquest. Diane Leacock is also a qualified accountant. **JW** thanked EL for joining the meeting. **EL left the meeting at 10.50am**		
5	**COMMITTEE CHAIR'S REPORT - NEDs**		
	Cynthia Conquest – Chair of Audit Committee **Explained some aspects that the Committee look at:** • The Audit Committee supports the governing body by reviewing and reporting the robustness of governing structures making sure there is an assurance process on which the Trust can place proper reliance. • This includes receiving reports from external auditors, internal auditors, and local counter fraud. • Reports from the Trust charity. • Reviews the financial position and sustainability. • To seek assurance that the Board assurance is robust and constantly reviewed. • Reviews of internal and external audit plans to make sure they are following the right processes so that there is reliance on what they do. • To maintain oversight of auditors' market. There is a tendering process for auditors, so they are not allowed to act for more than 3 years before going through a full tendering process. A risk factor for the Trust is the lack of accountancy firms that want to act for the NHS for various reasons. RPH have been in a good position but there are Trusts within East Anglia that have no auditors and are struggling to find a company. **JW** asked what those Trusts do when they are in that situation. **TG** explained that this is a difficult issue. Big firms like KPMG have seen that they are unable to make money on these audits. They are gradually exiting audit contracts with hospitals. The national audit office has had to become involved to find auditors for several colleagues in our region but are trying out auditors that have never audited in the NHS and are small companies. He added if he was the CFO in those organisations, he would be very worried. He works with a professional group of people as external auditors who will challenge him which gives him confidence that they know what they are doing. These relationships are important and there is a higher risk with inexperienced auditors. **CC** commented that there is no issue regarding the audit report from		

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	KPMG and as Chair of the Audit Committee assured the Council of Governors that the audit was well done and as it should be. • KPMG also carry out the audit for the Charity. The Charity accounts will be discussed tomorrow at the Audit meeting. They are submitted in December and there is no reason to think any concerns will be raised. • Internal Audit: Is in a similar position with difficulty in organisations to get internal audit firms. • There were 7 audits carried out in 22/23 of which five were given the second highest step of assurance. • Moderate assurance means that there are controls and the expectation provides assurance that arrangements should deliver. There may be some risk of failure or non-compliance. • There was one audit which was done on an advisory basis which was asked for by NHS England for all Trusts to do around financial statements and sustainability. RPH came out with a high level of compliance. • The Audit Committee has been able to get assurance that there is control for finance audits. The committee does push back at times to make sure they are being critical and scrutinising and not just accepting whatever the auditors tell us is substantial assurance. • Local Counter Fraud is part of the internal audit and there has been no discovery of fraud within the Trust. Training is ongoing to minimise the risk of fraud. • There was an assessment carried out by the local Counter Fraud Team to determine whether we can give assurance against 13 standards that are set by the government. RPH fulfilled everything as it should, and all standards came back as green. The audit committee questioned some things, but they came back as robust. • The Board Assurance Framework: Focus for 2023/24 is on processes. All committees have been asked to report back any risks rated 20 and over and anything that has limited assurance. A report on the highest rated risks was received in April, and the limited assurance risks were being looked at. • Performance: The last report mentioned that NHS England has asked all Trusts focus on the Better Payment Practice code. We are now sustaining performance above the 95% which is the target. The Performance Committee will continue to monitor that, and it needn't come back to Audit Committee unless we started to see a deterioration. • The second aspect was Financial Structures and procurement processes. This has been monitored and there has been a 90% drop in the number of waiver requests and a 69% drop in overall value of waivers. This demonstrates improvement in terms of control processes and making sure we are doing things better.		

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	Discussion: **IH** asked if RPH get many people tendering at the 3-year period end. **CC** replied that there are not many, but the National Audit Office is hoping to expand so that there are more next time. **TG** added there were three companies, one of which had no experience of working in the NHS. Firms are needed to challenge us and not be learning on the job. The other was previous auditors and the decision was made that a fresh pair of eyes was needed. **IH** asked who make the final decision. **TG** explained that it is the Council of Governors who decide the external auditors and the Board make the decision regarding internal auditors. **PS** asked about our workforce and if there were good accountants working in RPH producing material to be audited and asked if there are vacancies? Also, if there are people working from home that may be at a distance and how much local knowledge was needed. **TG** replied that accountants like other professions in the NHS are difficult to recruit. It is acknowledged that people do not join the NHS for a high salary, so it is about what you get out of the job. People join to make sure patients get value for money. The focus is on linking that purpose to everyone's job role. A big piece of work was done by the Finance Team 2 years ago which did that in detail. Alongside there is an accreditation programme and the national team are trying to put this into place. There has been patchy take up across Trusts, but here it was taken up by finance team and is designed to celebrate excellence not only in terms of practice but also recognise shared learning, develop training, good leadership, and consistent working. There are 3 accreditation levels: RPH were the second Trust in the East of England to get to level 3 in 24 months. The Trust is one of 18 nationally that have that status. It is encouraging to see that it is recognised nationally and that helps attract more talent. **HP** commented that he attends Audit Committee meetings as an observer and feels comfortable about how the Team operates and assures everyone that there is a thorough process in place. **DB** concurred with what HP said. **EM** Thanked TG for his leadership which had been phenomenal. **Michael Blastland – Chair of Quality and Risk** **A presentation was shown to the Council of Governors** • This was a brief review on hospital mortality following the Lucy Letby case. • A slide was shown detailing hospital mortality before the move, before covid and the data was from cardiac mortality outcome tool Euroscore. Euroscore was devised by Sam Nashef Consultant Cardiothoracic Surgeon at RPH. • Euroscore predicts outcomes using patient's acuity, how serious		

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	their case is and other important factors that might influence their survival. • This measures how RPH is doing in respect of not how many people die but how many would we expect to die given how serious they are. • The Board Reporting included raw mortality data a simple count of the proportion of people who died. Questions were raised about what the real numbers were once it was adjusted for acuity as perhaps the raw data was misleading. • The Board were not seeing the adjusted mortality data and the question became more pressing because in the last 2 years mortality began to rise significantly. • A slide was shown of the previous 6 months reported to PIPR. This showed a big difference between the position a few years ago and the position now, just over 1% on average. In relative terms it was a 60% increase in mortality. MB was not sure what this equates to in real numbers, but a guess would be about 20 additional deaths per year and that is not a small number for a hospital of our size but maybe this has happened because patients are sicker when they arrive. • To seek assurance that this was the case the Committee asked the Medical Director, Ian Smith to take a closer look. • The next slide shown detailed two periods, 2020-2022 and 2022-2023. This showed the death rates that were not adjusted, and the mortality rate was up significantly. • The acuity in these predicted death rates were then looked at and this had also risen. This showed that the people coming through the door are sicker. • Those numbers were put together to see what happens with the expected mortality. The ratio of deaths to the ones predicted decreased slightly. It clearly hadn't got worse once you consider how sick the patients are. • This means that the hospital is doing well which was as expected and our surgeons are of a high standard. • MB felt a relief, but he still questioned why more people are dying. Why are people so much worse when they come through the door? One possibility is that they are getting sicker because of the longer waiting times. • This is something that Sam Nashef has looked at. How sick do people get while they are on the waiting list? A few years ago, he found that about 11 people per year were dying on the waiting list, almost all from cardiac events and for each death there may be another two or three that had additional adverse cardiac events short of death. His conclusion at that time was that waiting was more dangerous than the operation. • It was felt that a situation such as Lucy Letby was very low on the list. We had been around the hospital, we had talked to people, we had looked at the ways they report their concerns if they have		

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	any and we are satisfied that we have a good system in place and there are multiple layers of analysis of deaths by different routes. • MB is confident that although we are unable to stop anybody with malicious intent doing something bad, they would be caught quickly. • This concern was the fact that we are struggling like everyone else in the NHS with increased waiting lists and waiting times. There was an enormous amount of effort from the Executive Team going on to try to improve the flow of patients through the hospital especially during strikes or other constraints the most pressing health and safety issue was the speed of treatment. **IS** commented that he had come to the same conclusions. There are more people dying and the top priority for the Trust is Patient Safety Initiatives to cut down waiting lists. **JW** commented that this had been discussed at Board and it was noted that we are beginning to see an increase in productivity and activity, but it is hampered by Industrial Action taking place. The Board is as concerned as MB about patients that we see here and about the ones that are sitting outside waiting to be seen here that may never get to see us. **Discussion:** **CMcC** asked MB if he was assured that if someone did have concerns about a Lucy Letby type situation that it would make its way to the Committee from wherever in the organisation that those concerns would be raised. **MB** commented it was a difficult judgement to know what level of concern should make its way to the Committee. He wouldn't want everybody's anxiety to come through. He suspected that the conversation about things that could have been done differently was going on every day in every area of the hospital. He is satisfied that concerns on a "low level" are discussed routinely and intensely in all areas. He was assured that if there was something more serious, that all staff know that the Medical Director's or any of his Team's door is always open. They will get a good reception, be listened to sensitively and concerns would be taken seriously.		
6	**WORKFORCE STRATEGY**		
	Reported by Oonagh Monkhouse DWOD **The Workforce Strategy 2023-2025: Prioritisation for 2023/24 and NHS Long Term Workforce Plan presentation was shared with the Council of Governors.**		

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	Points discussed: The Workforce Strategy is based around 6 key themes: 1. **Compassionate and Collective Culture**: creating a positive, engaging working environment, developing skilled and compassionate leaders, and keeping colleagues safe, healthy and well. 2. **Belonging and Inclusion for all:** ensuring we are an organisation where everyone is welcome, everyone is respected, everyone can grow, and everyone feels their voice is heard. 3. **Developing the Workforce:** helping people to realise their true potential for the benefit of patients, protecting us from national skill shortages and helping us to be more effective and efficient. 4. **Growing the Workforce:** being a place where people want to work, where they can develop their roles and careers. 5. **Efficient and Effective Workforce Processes:** ensuring that guidance and support for colleagues and line managers is accessible and high quality. That our policies, processes, and practices align with our values and principles of a just culture. 6. **Working with Partners:** collaborating and learning from partner organisations both in our system but also regionally and nationally. This is a 2-year strategy which is aligned to the timeframe for the Trust Strategy which will start to be reviewed next year. **Annual Goals: Monitoring of the Delivery of the Strategy** Implementation of the strategy will be monitored by the Workforce Committee with bi-annual updates being provided directly to the Board. The following groups will oversee delivery of key work areas to enable the strategy to be delivered: • Compassionate and Collective Leadership Programme Steering Group • EDI Steering Committee • Resource and Retention Improvement Programme Steering Group • Management Executive **Focus for 2023/24** **Theme 1- Compassionate and Collective Culture** • Line Managers Programme • Support and Develop succession across all services. • Staff health and wellbeing – covering mental and physical health and financial wellbeing support. • Provide safe working environment. **Theme 2- Belonging and Inclusion for All**		

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	• Strong commitment to and leadership from Board level • Embedded fair and inclusive recruitment processes. • Provide comprehensive induction, onboarding, and development programmes for internationally recruited staff. • Revision of our policy framework for addressing abuse, violence, and aggression against staff • Continue to support, promote, and value the contribution of staff networks. • Develop and support Cultural Ambassadors • Transformational Reciprocal Mentoring Programme • Ensure there is accessible, well-known and flexile routes for staff to raise concerns. **Theme 3 - Developing the Workforce** • Procure and implement a learning management system • Grow own workforce. • Provide high quality training experience/placement and supervision, mentoring and support. • Adress recruitment and retention hot spots • Support managers to think differently to address their workforce supply challenges. • Learn from errors, improvement methodology and helping staff to report or raise concerns. **Theme 4 – Growing the Workforce** • Reduce turnover. • Reduction in time to hire. • Improve the experience of applicants. • Embed our values and behaviours. • Recruitment processes that are free from bias • Provide a high-quality induction programme. • Focus on a flexible working process. • Provide a high-quality annual appraisal for all staff. **Theme 5 – Efficient and Effective Workforce Processes** • Procure and implement a new electronic recruitment system - There has been an unacceptably high time to hire for a long time for several reasons, but one was that the system was inadequate. A national system has been procured and the implementation phase is nearing the end. • On going leadership development • Implement talent management and succession planning. • Procure and implement a learning management system. • Act on staff feedback to improve the working life experience. • Provide up to date policies and procedures. **Theme 6 – Working with Partners**		

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	• Develop our ICS partnership working: Learning from working with other organisations and partners. • Engage effectively with our Campus neighbours. • Develop and implement workforce strategies with local staff partners. OM shared a slide to give assurance of the tracking and measuring of progress. This looked at scores from the previous year and sets goals for the next year. **OM noted that this linked to the NHS Long-Term Workforce Plan and the key elements of this were:** • There is a comprehensive plan for the NHS. • It is a 15-year plan. • There is a £2.4 billion training budget attached to this. • This will be reviewed bi-annually and updated if necessary. • The plan is divided into 3 main areas: 1. Training 2. Retaining 3. Reforming • This does not address: ○ Pay and conditions – because this is a long-term plan. ○ Elective recovery pressures ○ Interim period before proposals begins to impact. ○ Funding of expanded workforce **Discussion**: **AH** asked about growing the workforce through training pathways and if there would be a job at the end of it in the area they are expecting. OM advised that there are apprentices and nurses coming out of training and there are jobs for all those who wish to work at RPH. The government approach is to get us from a deficit into a position where there is a surplus of people. Currently some jobs are guaranteed but this depends on what specialty and on team sizes. RPH also train people for the wider system and wider community because of the facilities and specialties here. They often then leave to go to work nearer to where they live. **MS** commented that RPH is committed to training and there are opportunities for experience and training particularly in CCU. **SAB** raised the issue of bullying and asked what is specifically being seen. **OM** advised that the staff survey had shown that there is high levels of bullying but it is not confined to one group of staff. The common incidences reported are conflict between colleagues and line management. People report that the way they are being managed or		

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	being asked to do things is unfair or report colleagues being disrespectful with each other. The Freedom to Speak Up Guardian gives a 6-month report to the Board and provides examples and case studies. **SAB** commented that it is a matter of how you find it at a lower level before it becomes an issue and affects the culture of a whole group. **OM** replied that there is a lot of work going on around line management and the common understanding of what is expected in terms of behaviour. The Values and Behaviour Framework sets out what is expected across the organisation including inclusion and belonging. There is good resolution at a low level but sometimes staff want to take a formal route. Work has started with union partners to look at how we might give people more confidence to engage in mediation to resolve issues. **SAB** noted that it depended on circumstances as to how wary you may be to say anything. It could be because you are worried about losing your job as you depend on that money or because of power of more senior staff. **OM** agreed that there are different levels within the NHS with different relationships and dynamics. **PS** commented that the key is how people affect other people, **OM** commented that about 70% of staff had attended the Values and Behaviour sessions. This looked at listening skills and how you are perceived. The Freedom to Speak Up Guardian was running sessions on civility and microaggression and looking at self-awareness. **PS** asked why there was not a slide shown on exit interviews and retention within the strategy and if housing and the journey to work were issues. **OM** explained the main reasons given in an exit interview are relocation or a lack of opportunities and that work life balance was a consideration. They are not relationship or behaviour issues. There is a question mark against this as it is thought that people may not be willing to say. **MH** asked at each level who conducts the exit interviews. **OM** explained that this is something that is being investigated. It is not something that is specified. Some people do them with their line manager or with HR. This is being looked at to maybe have a fixed process, but the problem is once you gather the information it then also needs to be analysed. **MH** asked to what extent are the reasons not being given specifically are related to the person doing the exit interview. **OM** commented that exit interviews are useful but are only one part of the picture. **MH** asked at what stage are “stay interviews” held and again with who. **MS** explained that they are trying to turn it around to ask what would make someone stay rather than why someone wants to leave. This was started with one ward, and we were getting an understanding from a survey and the answer is predominantly around career progression and experience. There is work going on around addressing		

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	those issues with firm actions.		
7	**ICS UPDATE**		
	Reported by Eilish Midlane CEO • The ICS had enjoyed its first birthday as it came into being on the 1 July 2022 • This led to a review of governance structures and effectiveness of meeting structures within committees. Overall, this was a positive review but some structures within the ICS are being stood down. The Management Executive, which was a bi-monthly meeting had been stood down in lieu of setting up a Delivery Board. • There are several performance improvements that have been seen over the last year. Patient access to emergency care has improved across the system particularly for acute providers. There has been a noticeable improvement in cancer performance in relation to faster diagnosis standards and access to diagnostics. • There now is a focus on Winter Planning. The ICB received the first draft of the Winter Plan last week. This is pulling together those additional initiatives that will be stepped up going into November, December and into the early part of 2024. RPH have a contribution towards this. Last year RPH opened the Nested Ward and there are internal discussions are taking place led by Harvey McEnroe in terms of what can be done to support system partners going through winter. • Industrial Action is a challenge that everyone faces going forward. Staff are being supported to do what they feel is right but waiting lists and patients potentially coming to harm is to the fore in the ICB collective mind. • The conversation has been had as to the impact and tensions appearing between different groups of staff and frustrations about wanting to get patients through is beginning to present. • There is a recognition of morale more generally being lower because of reports, the Lucy Letby case, and some other elements. • It has been decided to change the shape of the industrial action BAF risk into something that reflects not only the waiting list impact but the impact on staff morale. • The RAAC issue that has been in the press is in the forefront for Cambridge and Peterborough. There are four areas that have RAAC within our system. This affects Hinchingbrooke Hospital, and it has a case for a rebuild of some of its facilities under the new hospitals programme. There is RAAC at Stamford and at Wisbech where there is a diagnostic centre and there is some RAAC in primary care facilities. This is challenging because primary care is a collective of individual businesses and money		

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	does not flow in the same way. It is recognised that we cannot afford to lose any of our primary care access as this is key to the flow of patients coming through. • On the back of the National Workforce Plan the system developed a local workforce plan for Cambridge and Peterborough. This will focus on some hard to recruit staff groups and how they are grown working in collaboration with educational providers. • A programme was introduced at the ICB last week to address equality, diversity, and inclusivity (EDI) items. This is core across Cambridge and Peterborough regardless of where you are in the system. The ICB have committed to a programme which will be externally facilitated, and this is called the Above Difference Programme. This requires considerable commitment and engagement. The EDI group who has developed this programme is led by Oonagh Monkhouse. EM wanted to thank OM for all the work that she has done. **Discussion:** **RH** reminded the Council of Governors that there is a meeting on the 3 October 2023 that John O'Brien Chair of the ICB had organised for all governors in the system which included CUH and NWAFT. **SB** asked if the Nested Ward that was organised last year would be repeated this year. **EM** replied that there may be some potential. There has been discussion with CUH about developing a model of how we can work more closely together, improve the integration and seamless movement of clinical staff between organisations. The Nested Ward focused on discharge, but should it be done again it should be done in an area which brings that collaboration into reality. **HMcE** added that a meeting was underway as part of the support package. **PS** commented that the role of local councils is vital but largely ignored by central government. There are different counties represented and different versions of ICS. Public Health is a local government responsibility. She noted that RPH had status and carried weight to encourage and help with public education. PS wanted to encourage RPH to help local counties with public education because of this. **EM** noted that one of her reflections having sat on the Board was the value of local government being represented in all developments and events to enable those types of conversations. EM agreed with the idea around RPH helping with health messaging and RPH is leading the Cardiovascular Disease Strategy for the whole system because RPH have the knowledge and experience. Work has been		

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	started out in the Community with Heart Failure and this will be built on going forward.		
8	**GOVERNOR MATTERS**		
	Reported by Richard Hodder Lead Governor • Announced the new Chair of the PPI Committee is Marlene Hotchkiss**.** MH will commence this role at the next meeting on the 6 November 2023. • The appointment of the new Trust Chair has taken place and is Dr Jag Ahluwalia • The Governor Committee Membership was shown as a slide to highlight vacancies on Committees and was also sent out in the pack. RH urged governors who had been observing meetings to become members if they wish to join. • He had been to the Regional Lead Governor meetings and reported that repeated on all agendas was Membership Strategy. • There have been two local meetings with John O'Brien through the year including CUH and NWAFT. • RH encouraged people to take part in 15 steps and PLACE Audits when they are organised. • RH thanked AJ and JYW for supporting him and noted that it had been a privilege to be a Governor/Lead Governor for the last 9 years. He added that he would not be disappearing as he was going back to volunteering. RH wanted to thank everyone for their support and wished them well for the future. **IH** noted that there was a vacancy on the Ethics Committee and would like it recorded that he would join that Committee. **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** The Committee minutes were noted by the Council of Governors **Appendix 3: CG010 Policy for the Composition of Non-Executive Directors on the Board of Directors** **For Approval:** The Policy CG010 was ratified by the Council of Governors **8.1 Election Results 2023** **Received:** The Election results were shared in the pack received by the		

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	Council of Governors and will be shared at the Annual Members Meeting later today.		
9	**Papworth Integrated Performance Report (PIPR)**		
	Received: Circulated for Information **No questions were put forward.**		
10	**Questions from Governors or the Public**		
	SAB commented that she and AH were observers at the Performance Committee meeting and there was a presentation shown. Within that was an audit of stock and it was shown that an amount of stock had gone out of date and asked why this had happened. **TG** explained that the stockholdings and materials management is managed by three separate areas. Theatres, manage the equipment for theatres and cath labs. Goods In, is currently managed by an outsourced company called Shared Business Services (SBS). SBS have indicated that they want to stop this arrangement, not just at RPH but nationally and so discussion is taking place regarding what to do and whether to keep this in-house to manage ourselves or team up with someone else. The PwC report was there to aid our thinking. To see if it was working well or not the report had identified that clinical engagement within the theatre area in terms of products that are being purchased and used by the surgeons is second to none and had been useful when there have been supply chain challenges over the last five years. Their expertise has allowed a rapid switch of supplier to get products to the Trust to prevent cancellations and make sure operations go ahead. It had highlighted that stock holding levels were on the high side and the reason why that happened related to the pandemic and Brexit which put massive pressures on the supply chain. There was therefore a conscious decision to stock up to manage risk but in doing that there was more wastage. In conclusion, the implications of the report were being worked through. Firstly, the SBS exit needs to be resolved quickly and the broader processes around stockholding will then be investigated. **SAB** asked if there was a relationship with CUH and RPH where they could support each other if there were shortages. **TG** explained that during the pandemic they were the first point of call if RPH were running close to the wire for PPE and similarly at different points, RPH may have had a particular item they needed. This is known as mutual aid between the hospitals. **SB** asked what the situation is with the robot as at the last meeting it was in training mode. **IS** replied that the robot is up and running and is portable so it can be moved between theatres. There is a programme for training, this is being done cautiously as each operator must become experienced and skilled		

Agenda Item *(minute reference)*		Action by Whom	Date
	before moving on to mentoring others, but it had been going very well.		
11	**Any other Business**		
	The HLRI AV QR code for feedback was added to the pack sent out before the meeting. **The QR code was noted by the Council of Governors**		
12	**Future Meeting Dates**		
	• **15 November 2023** • **20 March 2024** • **12 June 2024** • **18 September 2024 (Followed by the AMM)** • **13 November 2024**		

The meeting finished at 12.25.

Signed: Professor John Wallwork- Trust Chair

Date: 15 November 2023