Royal Papworth Hospital
NHS Foundation Trust

Meeting of the Council of Governors
PART I
Held on Wednesday 15 November 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
	Paul Berry	PB	Public Governor
	Sarah Brooks	SBr	Staff Governor
	Stephen Brown	SB	Public Governor
	Susan Bullivant	SAB	Public Governor
	Roger Burnay	RB	Public Governor
	Doug Burns	DB	Public Governor
	Trevor Collins	TC	Public Governor
	Bill Davidson	BD	Public Governor
	Yvonne Dunham	YD	Public Governor
	Caroline Edmonds	CE	Appointed Governor
	John Fitchew	JF	Public Governor
	Clive Glazebrook	CG	Public Governor
	Andrew Hadley-Brown	AHB	Staff Governor
	Abigail Halstead	AH	Public and Lead Governor
	Ian Harvey	IH	Public Governor
	Marlene Hotchkiss	MH	Public Governor
	Lesley Howe	LH	Public Governor
	Rhys Hurst	RH	Staff Governor
	Josevine McClean	JMc	Staff Governor
	Christopher McCorquodale	CMc	Staff Governor
	Trevor McLeese	TMc	Public Governor
	Joe Pajak	JP	Public Governor
	Harvey Perkins	HP	Public Governor
	Philippa Slatter	PS	Appointed Governor
	Martin Ward	MW	Staff Governor
	Lynne Williams	LW	Staff Governor
In Attendance			
	Jag Ahluwalia	JA	NED
	Cynthia Conquest	CC	NED
	Amanda Fadero	AF	NED
	Sophie Harrison	SH	Interim CFO
	Anna Jarvis	AJ	Trust Secretary

	Diane Leacock	DL	Associate NED
	Harvey McEnroe	HMc	COO
	Eilish Midlane	EM	CEO
	Oonagh Monkhouse	OM	Director of Workforce
	Andy Raynes	AR	CIO
	Maura Screaton	MS	CN
	Ian Smith	IS	Medical Director
	Julie Wall	JYW	PA to Chair (Minute Taker)
Apologies			
	Michael Blastland	MB	NED
	Lorraine Szeremeta	LS	Head of Nursing CUH
	Ian Wilkinson	IW	NED

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1	**WELCOME, APOLOGIES, AND OPENING REMARKS**		
	JW (Chair) noted that there were new Governors attending today and welcomed everyone to the meeting. Apologies were noted as above. ***Discussions did not follow the order of the agenda however for ease of recording these have been noted in the order they appeared on the agenda.*** JW informed the Council of Governors that EM had recently attended a meeting for NHS CEOs to discuss finances. • EM outlined the financial challenges currently being experienced by the ICS because of the impact of industrial action and the national impact of the prescribing budget. • There are two elements, the rise of the unit cost of many medicines due to inflation and long waiting lists which have increased the impact. • The money will be deployed within Integrated Care Systems (ICS). It will be the decision of the ICS to devolve the money to individual organisations. • RPH, NWAFT, CUH have cost pressures following industrial action and CPFT by the lack of capacity for mental health. It is expected that these are the areas that will be given financial support to address issues. • The NHS has a long-term responsibility to serve the community which is the guiding principle. • Going forward over the next 12 months there is a need to design plans and deliver those plans and to meet the emergency, mental health, and maternity targets across the NHS with financial balance.		

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	• Resources that are left will then be used to support elected demands. • Reframing will occur at the end of this year and into next year. • RPH is in a good position from a financial perspective and currently have a surplus due to strategic decisions, but control is needed to continue going forward and working together with partners within the ICS to deliver the ICS position. JW informed the CoG that RPH is in a good position. He added that Sophie Harrison has stepped up as interim CFO while Tim Glenn is working in Kent. Plans and strategies will be brought back at future meetings.	EM	
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 – 13 September 2023**		
	The minutes of the meeting held on Wednesday 13 September 2023 were agreed as a correct record.		
4	**PATIENT STORY – Told by Tallisa Martindale**		
	• The story is about an 86-year-old gentleman who attended the day ward regularly. • He is under the care of the Immunology Service. They taught him how to self-administer his haemoglobin treatment with an aim to send him home with home care approval before Winter as he relies on hospital transport and lives alone. • TM asked him standard questions when she met him, and he was very happy to talk with her. • He was asked if he had been given choices about his care, was included in discussion about his treatment, if he had been treated with dignity and respect and had he felt safe. He was asked if he understood his treatment plan and why he was attending. • He strongly agreed to all the questions that were asked. • He had a journey through the hospital which started on the Respiratory ward 4S and he was complimentary about everyone he had met and the care he had received. He commented that he always got the help that he needed, the staff were very pleasant, and nothing was too much trouble. • He had visited various hospitals in the region for tests but commented that RPH was by far “top drawer”. • He was asked what the worst thing was about coming to RPH,		

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	and to the day ward had been. He replied that was a difficult question because he couldn't think of anything. He appreciated the collaboration between the different teams that he had met. • Regarding his two weeks stay on 4S he said it was amazing. He felt that everyone was doing the best for him and was happy and helpful. • He attended the day ward for 16 weeks before his home care was set up. • He commented that attending RPH was like a day out to him. He dressed up for the occasion. He lives alone following the death of his wife in 2021 so can feel lonely. He has children that live close, but they are very busy. He enjoyed coming in socially and chatting with staff as well as getting his treatment. He developed a routine where he had coffee and a sandwich when he arrived and after his treatment, he had hot chocolate before going home. • He said it was nice to be around people and to watch people which made his visit so much more than just getting his treatment.		
5	**COMMITTEE CHAIR'S REPORT - NEDs**		
	i. Amanda Fadero NED – Chair of Workforce Committee **AF** explained that Workforce is a relatively new committee and there have been five meetings since it was developed. She chaired the August meeting and Jag Ahluwalia (NED) kindly chaired the September meeting on her behalf. • The Committee is always focused on consideration of the Board Assurance Framework and Risks. • In both August and September there were expressions of concern regarding risk but there is confidence that the risks are not deteriorating. The right controls are in place and focus continues to make sure a tight control and assurance is kept in place. A report will be given at the next meeting on the 30 November 2023. • There has been no change in the Board Assurance. • There is always a staff story or feedback about staff experiences within the Trust. • In August the Committee were told a staff story about the Trust Line-Management training. Two representatives gave comprehensive reports about the differences the training had made to their personal impact and how they feel about being a member of staff. They reported that it gave them the confidence and the ability to fulfil their difficult role as line managers. • At the September meeting Gerrie Powell-Jones co-chaired and outlined challenges of balancing work and being a chair or co-chair of a committee. It is felt that the organisation should continually consider this because the Networks play a vital role within the Trust. • A comprehensive report is given by Oonagh Monkhouse who covers the details of vacancies and appraisals. There is a very		

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	comprehensive dashboard shared which regularly looks at performance against expectations and trends. • There are areas of concern which are being focused on and sickness is one of those. There are areas of improvement which are appraisals and mandatory training. • The Committee receives regular reports from Education. At the last meeting the Assurance report was shared which will be sent to NHSE and it has been confirmed to be a robust report. • There are regular reports from the Guardian of Safe Working so the Committee can gain understanding about what it feels like for juniors and other colleagues. Over the last two months there has been huge focus on Equality, Diversity, and Inclusion. Eight reports were received in August, although the reports were felt comprehensive it was difficult to understand a priority for what we were doing or what we could expect. At the last committee there was an Improvement Plan which was highly recommended and endorsed and was taken to the Board. • The Committee has oversight of huge amounts of information and detail, but it remains a challenge to penetrate all the detail to get to the essence of how the committee can assure the Board that it is doing the right things at the right pace in the right way to improve the experience of the whole workforce. JW commented that the Workforce Committee was developed for a variety of reasons. It is the thread that goes through everything and deserves to have its own committee. **Discussion:** JP asked if there is a reason for the increased long-term sickness between August and September. OM replied that discussions with managers regarding the reasons for absence have taken place and the conclusion is that there is a combination of basics not being done well in some areas. Managing absence by keeping in touch and supporting staff to attend well was a pattern seen. There is a link between attendance and staff engagement. The primary focus is on reminding managers to put into practice managing absence and supporting staff. There is also an increase with musculoskeletal issues being reported. **ii. Gavin Robert – Chair of Performance Committee** The Performance Committee has a wide range of matters within its responsibility. • Risks that are above target are monitored as part of the Board Assurance Framework and include waiting list management, cyber breach, continuity of supplies, ICS strategy, activity recovery, and industrial action impact on productivity. • Financial risks are below target, and those are achieving financial		

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	balance at Trust and ICS level. • A lot of discussion is focused on productivity because the risks within the Assurance Framework is around waiting list management and Industrial Action which are at 20 whereas financial balance is at a lower target of 8. • Divisional management reporting is regarded as an important part of assurance mechanisms and there have been presentations shown in the last quarter from Cardiology, Thoracic and Ambulatory • The picture seen regarding productivity over the last quarter is improvement against Industrial Action and the loss of activity of approximately 16-18% which shows the impact this is having on the hospital. • Consolidated reporting around productivity has been received from Harvey McEnroe to add more coherent discussions which the Committee benefit from. • The Committee look at underlying issues: Focus has been on the impact of Industrial Action and the measures that are put into place to reduce the impact of patient harm, especially patients on the waiting list. The loss of activity has been under review and a report will be given at the next meeting before going to the Board. • There is focus on the performance of the STA division and theatres. Six theatres are open which represents a huge improvement from 4.2 the same time last year. • There has been reduced occupancy in critical care. Less surgery was performed due to Industrial Action. However, it has been noted that in the absence of Industrial Action it would not be possible to open the full quota of 36 beds due to rostering and staffing challenges. This is a Workforce matter, but Performance keeps a close eye on this also. • The Patient Safety Initiative is essentially weekend working funded by the ICS to help the Trust eliminate patients who are waiting over 40 weeks and the impact on the waiting list will be significant. • There is an action plan to improve performance on the Cancer Pathway and breaches of targets are a focus. Discussion with the Operating Team and with Harvey McEnroe will be reported to the Committee with statistics to enable the Committee to understand how long it takes patients to be treated once they are referred to RPH. • Following Industrial Action, the Flow Improvement Programme puts RPH in a good position to treat as many patients from its waiting list as possible and to reduce patient harm. • There is good news around productivity improvement, but there is one caveat that is concerning which is if issues around culture, leadership and staff are not addressed those issues will undermine the sustainability of improvements that have been seen.		

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	• Finance: A small surplus has been achieved in the year to date which puts RPH in a relatively strong position especially when compared to the rest of the ICS and nationally. • The Cost Improvement Programme (CIP) is given a target to make efficiency savings every year and performance is tracked against that target. These efficiency targets are largely on track, but some divisions have fallen behind. Processes have been put into place to help them meet their targets by the end of the year. • The Trust follows the Code of Conduct, and the Better Payment Code of Conduct recognises the importance the Trust plays in the local economy and paying NHS and non-NHS suppliers on time. Since tracking this there has been good improvement by meeting the 90-day target under that code. • Capital expenditure allocated for the year is tracked and monitored closely to make sure the capital expenditure target is met. If this is not achieved, the Trust will not be allocated the capital for the following year. • The Trust will miss Tim Glenn while he is on his secondment but is delighted that Sophie Harrison is in post. She is a strong interim CFO who will be the Committee sponsor going forward for the next 12 months. JW thanked AF and GR for their comprehensive reports. **Discussion:** BD asked about the staffing fill rates on PIPR and commented that they seem to have been static from April. GR clarified that the Performance Committee look at the entirety of PIPR and have raised issues regarding staffing fill rates being below targets and explained that this is a primary responsibility under the Q&R Committee. MS agreed the staffing fill rates have been below where they should be and although the vacancies need to be filled the ward sisters look through mitigations every day to make sure patient safety is maintained. There has been good improvement over the last month and turnover has decreased overall. The pipeline is looking better for the next 3-6 months. There has been no occasion where the ratio of 1 nurse to 5 patients has fallen. The red flag system for quality, safety and staffing raises and escalates any issue arising. This continues to be monitored. SB asked if the Capital expenditure mentioned was for medical equipment or digital equipment. SH explained that it is for both medical and digital equipment expenditure. Most of the Capital paid equipment was purchased when the hospital moved into the new building. SB asked if the under spend would be spent in time as he understands it cannot be carried over. SH explained at the end of month 6 there was a very small under spend against the Capital Plan. Part of that is the phasing which is the time the		

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	orders come through and work is being progressed with the leads about various programmes, but she gave assurance that there is a plan to spend the allocation by the end of the year. JW commented that the Capital spend for the next two years will be much tighter. In the last month there have been visits by organisations who are on the New Hospital Building Programme because RAAC has been detected in their buildings and conversations have been had regarding the experiences of RPH build and move. JW explained that Industrial Action has cost the NHS approximately £1 million. After discussion with CUH it is estimated that every time there is Industrial Action, it takes them three weeks to recover. This includes the time of planning before and after the Industrial Action. JW asked HMc if he could explain the timing of recovery for RPH. HMc explained that there is a ramp up and ramp down phase. Ramp up takes about 3 days which is primarily associated to critical care patients with high dependency need. There is a stand down for 2-3 days on the elective pathway. It then takes another 2-3 days to ramp back up. A three-day industrial action takes about 9 days in totality. JW reiterated that the planning that has already been discussed is on the assumption that there is no industrial action planned for the next 6 months.		
6	**ICS UPDATE - Reported by Eilish Midlane CEO** EM informed the Council of Governors that since the last meeting she had attended two ICB meetings, one on the 8 September and one on the 10 November. • At the meeting on the 8 September the ICB received the ICS Annual accounts, and they were signed off. • A proposed response to the long-term Workforce Plan for the NHS, from the ICS was received. • Discussion focused on the Equality, Diversity, and Inclusion (EDI) agenda and some work which was proposed from the EDI Steering Group within the ICS to incorporate some work at ICS level across all organisations on an agenda which is supported by Beyond Difference. • OM led this piece of work as the EDI Lead within the ICS. This has been embraced by all organisations to take forward. • The ICB received the proposal for the Winter Plan which was signed off. • The Estates Strategy included the ramifications of considering potential new builds following the RAAC issues reported. There are several rebuilds mentioned within our ICS including		

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	Hinchingbrooke and Stamford Hospitals who are part of NWAFT. RAAC was found in some of the buildings used by CPFT and Cambridge Community Services. The Board received assurances that all Primary Care facilities have been surveyed and no RAAC has been found. • It was articulated that the view of the Board is to move from the forward planning stage into focus on delivery and as a result Management Executive meetings which were attended by multiple stakeholders across the ICS have now been stood down and replaced by a Delivery Board. Three key achievements from the first of the Delivery Groups are: 1. Diagnostic access and performance have increased across all providers and all radiology modalities in the last 6 months. There has also been more access to bronchoscopy, endoscopy, and physiologies. 2. The Integration of the East of England Ambulance Service and the development of an emergency hub. The ICS has opened a hub that triages some of the calls that would otherwise go to the ambulance service. The hub now has access to the "stack" which are the waiting calls, and the hub triages and pulls patients from that stack into the hub for virtual consultations and signposting to the most appropriate care. 3. Within Cambridge and Peterborough learning disability patients have a lower life expectancy than those who do not have learning disabilities and the annual checks of these patients are core to supporting people and keeping them well. Levels of those health checks through primary care had decreased during the pandemic and had not recovered post pandemic as expected. After review improvement of access to care has been seen. • At the ICB meeting on the 10 November an update on the Recovery Plan was received. • A detailed discussion was had on the End-of-Life Strategy • The development and the delivery of the green plan was discussed. • Updates were received regarding maternity and neonatal system plans as well as a presentation from the East of England Ambulance service around integration and their ongoing strategy. • The key risks to the ICS going forward were discussed: Workforce, prescribing risk, out of area placements, the potential of further industrial action and delivery of the break-even position based on the clear articulation of the national team of expectation over the next 18 months. **Discussion:** JP asked if issues such as bullying are discussed within the ICS. EM explained there had been specific discussions through the Workforce		

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	Committee. The Quality, Performance and Finance groups and the ICB have had significant discussions around bullying and how it is reported in Staff Surveys. The ICS was too newly formed to take part in the last round of national surveys last October. The ICS have conducted their own Pulse Survey recently and similar themes have come through in terms of staff experiencing bullying behaviour from patients because of frustrations to do with waiting lists. Pressures on staff has been reported and higher levels of staff to staff bullying. Organisations are working together and sharing experiences. OM explained that each organisation has its own survey and while there are themes there are different issues so although organisations share experiences there isn't a specific work programme or a central way of collecting analysis. The focus is on building a common ground of understanding about the Leadership Programme and models which will then in theory impact the culture of organisations across the ICB. CG asked who triages patients at the ambulance hubs and if it is 24/7 service. EM explained that within the hub there is a team of multidisciplinary professionals who are involved in triage, and they are supported by doctors and clinical staff. People are taken from the stack and cases that will benefit from other services are fast tracked rather than being taken by an ambulance to a busy A&E department. EM confirmed that it is a 24/7 service. JW commented that "Out of Area" placements were discussed at the last CEO and Chair meeting. There is a huge drain on ICS resources when people are sent out of area for treatment that is expensive and in Peterborough there are patients who are taking money out of that ICS, partly because they cannot access mental health care funding. PS commented that this has impact on County Council Social Care and can involve patients who are children and continue into young adulthood care. There is the need for more in house provision closer to home for better use of public funds.		
7	**SEPTEMBER INFOGRAPHICS – Eilish Midlane CEO**		
	Following the reports for Workforce and Performance many metrics in the infographics reflect RPH position. • Workforce- within September there have been 85 new starters. • There has been a significant improvement with mandatory training by directorate. • Friends and Family scores: despite challenges there are high levels of satisfaction for patient experience, both in the in-patient and outpatient categories • Performance: activity delivered was 9,500 patients attending outpatient clinics. This was within a month where there were five days of Industrial Action across consultant and junior doctor staff. These are some of the highest numbers of outpatient activity ever		

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	delivered. • Elective admissions, despite the reduced time able to deliver due to the Industrial Action was 1,618. • The Patient Safety Initiatives which have been running over the last few months have taken RPH into a good position and was noted at the recent ICB meeting. RPH now have 88 patients that have been on the waiting list for over 40 weeks. Waiting lists overall have grown but the largest level of risk is those patients that have been waiting the longest. This is a significant achievement. • There has been a high level of delivery in diagnostics, the imaging acquisition is at 94% time to scan with a 99% target which was pre pandemic. A caveat to the target is that there are challenges with the reporting of CT scans. This is being monitored closely. • Across all emergency pathways RPH continues to deliver timely, high-class care. • Transplant: no organs were declined in the last 3 years due to capacity. • HMc explained that the Patient Safety Initiatives primarily focused on the 633 patients who were on the waiting list for over 40 weeks for treatment. There are 88 patients remaining who have waited over 40 weeks. • This has been achieved by utilising capacity at the weekend to reduce the backlog which will continue for the next couple of months to make sure the 88 patients remaining are treated and to then concentrate on all patients waiting less than 40 weeks. • Patients on outpatient pathways have also gone through this route to treatment. This has not changed the RTT position which stands at about 70% but it has treated those patients who were at risk on long waiting lists. • This gives RPH the ability to be in a good position going into the next financial year, reduce waiting time burden and to potentially help other providers. • RPH has the fastest treatment pathways in the East of England. **Discussion**: CMc commented that on the September Infographics mandatory training has more green results and asked why PIPR didn't show the change. EM explained that it is due to percentages and the fact that the Teams are various sizes. OM added that PIPR highlights the total Trust number, but on the infographics, it is broken down by department. The data is the same, but the level is different. JW commented that the rationale behind PIPR is being discussed as it doesn't measure trends which can cause confusion. AH asked what the Friends and Family scores of 99% and 94% mean.		

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	EM explained that it is the proportion of people who have responded to the survey. MS added that the target benchmark is 95% JW commented that an issue was raised a few months ago, about this being a point survey on one day at one time. Discussion has been had at Board about how to capture the experience of people who are in the hospital for a long stay as well as the experiences of people who are in for short stay. JA commented that in the main pack sent out, on page 68, PIPR statistics are explained in more detail. AH asked in future if the reporting could state that this is the percentage of people who responded. LW asked if there is a timeframe for the recovery of reporting times of diagnostic imaging scans. EM explained that there are three different strands of work that are in progress in relation to diagnostic reporting. There are three specific demand drivers for the delay: 1. There is more activity generating more scans but there has been no increase in people to do the reporting. 2. RPH are also performing scans for other organisations because their waiting times are longer. 3. There is an issue with business change and processes. The Team are being supported to develop further solutions. The patients who are in the backlog are having their health history checked to determine if they at risk of harm. The ED team are supporting the Imaging Department with this but are not able to give a recovery time yet. The first element of scoping what the recovery actions are going to be is in progress. It was suggested that this item is brought back to a future Council of Governor meeting as well as going through the Performance Committee for their scrutiny. JW commented that he was interested in the role that AI would play with this in the future and what the ICS perspective is. EM agreed that this is a good point and recently in the press it was reported that RPH is one organisation in the East of England to develop artificial intelligence around lung screening reporting. This is important for RPH because the Lung Screening Programme is on the cusp of going live in the North of the ICS area and screening is used to drive earlier treatments and surgery. Neil Dardis CEO at Frimley Park hospital, a colleague of EM has recently been in dialogue with her following the release of a case study. His Clinical team are on the path of developing artificial intelligence within the lung pathway. Discussion has been had regarding sharing experiences with clinical teams to accelerate opportunities at RPH.	EM	

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	AR commented that his team are working hard with the provider of PACs and imaging systems and in some instances, there is technology within it already using AI. It is one of the most common tools supporting imaging and there is continuing progress.		
8	**GOVERNOR MATTERS**		
	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: ToR034 Access and Facilities Group** **For Approval:** ToR034 was ratified by the Council of Governors **For Approval**: Extension of Governors Assurance Committee was approved. **Membership Strategy: Abi Halstead - Lead Governor** AH explained that the Membership Strategy is due for renewal and that she had been asked to set up a Task and Finish Group to start discussing a Management Strategy. A meeting with the Group took place and following that AH contacted the Royal Brompton, North Devon and CUH who are Trusts with similarities to RPH. Those Trusts reported that they have a full-time member of staff whose entire job is the Membership. Unfortunately, RPH does not have a member of staff dedicated to this. AJ commented that she has spoken with OM regarding looking at ATIR and support that might be needed to help with the performance. Governors can help by engaging with people to encourage them to sign up. A case is being put together to support this. AJ commented that the new Trust Secretary has experience of Membership in his local area and will be able to share how they have linked in with Community organisations to help build up numbers. SAB asked if one of the Directors within the Trust has responsibility for the Membership. AJ replied that it sits with the Trust Secretary. JW commented that EM has this on her radar for the New Year to discuss a process going forward. AJ informed the Council that a recent PLACE Audit was performed on the 8 November and dates for 15 steps and other Visibility Rounds will be sent out in the New Year. There was an ICB Meeting in October for Governors and Josevine McClean attended.		

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	JMc commented that this was the first time that she had attended and found the meeting very interesting. She explained that rural areas were discussed in terms of cardiac rehab and the lack of accessibility. JW commented that RPH cardiac rehab presented to the Board recently and there is on-line cardiac rehab taking place. CMc asked if there were anyone who would like to join committees who were not at the pre meeting to please contact AJ or AH. He also asked if there was a timeline for an update on the Membership strategy. JW confirmed that Kwame Mensa Bonsu will commence as Associate Director of Corporate Governance on 2 January 2024. EM has given a commitment to look at this from an executive point of view and the next update will be at the next Council of Governors meeting. PS asked if Kwame has experience with collaborating with neighbouring Trusts. JW confirmed that Kwame will be a member on the Board and will be open to discussions about the Membership. AJ explained that Trusts all have Membership categories. There is public membership and CUH have set up patient membership. There are slight differences which are in the Constitution. As a member you can be a member across different organisations. RPH works with CUH on a range of levels. There are links with Governors. It has been noted that Lorraine Szeremeta has not been able to attend our CoG meetings. Stephen Webb attends CoG meetings at CUH to link the meetings. Common areas are picked up in that way. AH has been asked to contact LS but has not been successful yet. JW reiterated that if LS is unable to represent CUH at our CoG then a representative must attend on her behalf.	EM/OM/KMB	
9	**Papworth Integrated Performance Report (PIPR)**		
	Received: Circulated for Information **No questions were put forward.**		
10	**Questions from Governors or the Public**		
	Paul Berry: Feedback on patient experience – Patient in Mental Health Crisis PB explained that he is also a volunteer and has a unique insight to the challenges that staff can experience. On this day he was volunteering in the atrium, meeting and greeting when the receptionist asked him to stop a man that had been wandering around in the atrium for a while, from leaving the building. He was a gentleman in his early 20's, a patient who left the reception desk and was heading towards the South door. The receptionist was then on the phone.		

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	He explained that he tried to follow the gentleman and he was aware that I was following him. He picked up his pace, left the hospital and disappeared towards the railway line. PB saw a member of the OCS security team doing his routine checks and spoke with him. The receptionist came out of the hospital very concerned as the patient had asked her for a pen and paper and had written a suicide note which he then handed to her. The patient was found at the back of the HLRI. Security sensitively stayed with him. PB returned to the atrium to report his whereabouts. At that time a crisis intervention team had been assembled following the phone call to the ward by the receptionist. PB saw the team returning into the hospital with the patient after some time. He wanted to highlight the responsiveness and speed of all staff involved and the sensitivity and humanity which was shown. The receptionist responded magnificently getting the help the patient needed. MS thanked PB for sharing this and asked if she could speak with him after the meeting.		
11	**Any other Business**		
	AH commented that there have been some issues at the Access and Facilities Committee meetings and would like to escalate concerns about how sometimes a committee is dealt with. It is felt that there is an issue with people not feeling heard and would like this added to the minutes. JW asked if AH could expand about specifics and asked if this had been brought up with the group involved. AJ commented that she will discuss this with AH outside of this meeting. SAB commented that she had sat on the panel for the Staff Awards evaluations and was amazed by staff who were going above and beyond their role. She was astounded by the number of statements from patients and colleagues about the care and compassion staff show every day. JW reminded everyone that the Staff Awards will be held on the 14 December and the Carol Service at Ely Cathedral will take place on the 17 December. OM commented that this is AJ last CoG and wanted to thank her for all her work, care, and support with the Governors. AH thanked AJ for supporting the Governors. AH added that it is also JW's last CoG meeting and thanked him for his hard work and support.		
12	**Future Meeting Dates**		
	• **20 March 2024** • **12 June 2024** • **18 September 2024 (Followed by the AMM)**		

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	• **13 November 2024**		

The meeting finished at 12.20.

Signed:
Date: 20 March 2024

Royal Papworth Hospital NHS Foundation Trust
Council of Governors Meeting
Meeting held on 15 November 2023