Royal Papworth Hospital
NHS Foundation Trust

# Meeting of the Board of Directors
# Held on 05 March 2026 at 9:30 am – 11:30 am
# Microsoft Teams
# HRLI, Royal Papworth Hospital

## UNCONFIRMED M I N U T E S – Part I

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| **Present** | Dr J Ahluwalia | (JA) | Chair |
| | Ms C Conquest | (CC) | Senior Independent Director/ Non-Executive Director |
| | Ms A Fadero | (AF) | Non-Executive Director |
| | Prof I Wilkinson | (IW) | Non-Executive Director |
| | Mr D Jones | (DJ) | Non-Executive Director |
| | Dr C Paddison | (CP) | Non-Executive Director |
| | Prof G Martin | (GMa) | Non-Executive Director |
| | Mrs E Midlane | (EM) | Chief Executive Officer |
| | Mr T Glenn | (TG) | Deputy Chief Executive Officer |
| | Ms L Sanford | (SH) | Interim Chief Finance Officer |
| | Mr H McEnroe | (HM) | Chief Operating Officer |
| | Ms L Howard-Jones | (LHJ) | Acting Director of Workforce and OD |
| | Mr A Raynes | (AR) | Chief Information Officer & SIRO (Teams) |
| | Mrs M Screaton | (MS) | Chief Nurse |
| | Dr I Smith | (IS) | Medical Director |
| | | | |
| **In attendance** | Mr J Elwood | (JE) | Associate Director of Corporate Governance |
| | Mr G Matenga | (GM) | Corporate Governance Lead (Minutes) |
| | Mr S Edwards | (SE) | Head of Communications |
| | | | |
| **Apologies** | Ms D Leacock | (DL) | Non-Executive Director |
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| **Observers** | Ms J Whisken (JW) – Deputy Chief Nurse (In person)<br>Ms A M Harris (AMH) – Staff Governor (In person)<br>Ms S Harrison (SH) – (In person, in transition post-maternity)<br>Ms A Halstead (AH) – Lead Governor<br>Dr C Glazebrook (CG) – Public Governor<br>Mr B Davidson (BD) – Public Governor<br>Ms M Hotchkiss (MH) – Public Governor<br>Mrs H Eccles (HE) – Public Governor (In person)<br>Ms A Atkinson (AA) – Public Governor<br>Ms D Cooper (DC) – Public Governor<br>Mr J Dyer (JD) – Public Governor<br>Mr P Webb (PW) – Staff Governor<br>Ms R Mahony (RM) – Public Governor<br>Mr T Collins (TC) – Public Governor<br>Ms S Anthony (SA) – Sister, Critical Care Practitioner | | |

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| **1** | **WELCOME, APOLOGIES AND OPENING ITEMS** | | |
| | a. JA welcomed everyone to the meeting and noted apologies as above.<br>b. He offered his sincere gratitude to LS at her final meeting, expressing appreciation for her hard work and wishing her every success in her future endeavours. | | |
| **1.i** | **Patient Story** | | |
| | JA welcomed Rebecca Thomas, Surgical Matron.<br><br>**Patient Story:**<br>a. MS introduced Rebecca Thomas a surgical matron from Level 5 to present the patient story that demonstrated how complex hospital processes and digital systems negatively impacted both patient experience and staff morale, especially when staff felt powerless despite doing the right things.<br>b. RT outlined the nature of the surgical ward, noting that it was a 75-bed surgical ward delivering major surgical procedures. The type and complexity of surgery undertaken meant that patients were at increased risk of significant post-operative pain, requiring nurses to manage complex analgesia regimes.<br>c. RT noted that the patient was a young double-lung transplant recipient who had undergone a clamshell thoracotomy (a large chest-opening incision). During the procedure, the patient had four large chest drains, each causing severe pain.<br>d. It was heard that critical care used MetaVision as its digital record system, while the surgical wards used Lorenzo, the hospital-wide EPR. Because these systems were not integrated and could not communicate with each other and the patient's epidural prescription had not transferred across at the point of handover. As a result, the patient did not receive their pain-relief medication after being transferred to the surgical ward.<br>e. It was highlighted that only anaesthetists could prescribe or adjust epidurals, and on the night of the transfer the sole on-call anaesthetist was already dealing with an emergency. As a result, no alternative prescriber was available, and the patient experienced significant, avoidable pain throughout the night.<br>f. It was commented that ward nurses had done everything right but were blocked by system design and narrow prescribing rules.<br><br>**Discussion:**<br>g. JA thanked RT, noting that the account was sobering. He commented that, although he had not known in advance what the subject matter would be, he and CC had just recently discussed the importance of ensuring that patients' pain is well managed. It was suggested that:<br>**Action: the Board to receive the planned pain management review, once it has been considered by the Quality & Risk Committee.**<br>h. AF questioned why the ITU-to-ward transfer occurred as late as 6 pm, | **MS** | |

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| | noting this left only a two-hour window to rewrite the prescription before out-of-hours staffing began. RT clarified that the ward routinely accepted patients until around 7 pm, and that up to eight daily transfers had to be staggered because each required considerable setup time.<br>i. AR acknowledged that the story clearly showed the consequences of non-integrated systems. He added that with a proper enterprise-wide EPR, this manual transcription bottleneck should disappear. In the interim, he agreed that the digital team would review the situation to identify short-term mitigations.<br>j. EM questioned whether the prescribing requirement was unnecessarily restrictive and highlighted the productivity impact and risk of human error created by having two separate systems. RT confirmed that only anaesthetists could prescribe and manage epidurals, whereas intensivists could not, and did not routinely use Lorenzo.<br>k. Concern was shared that a technical barrier and system access, prolonged someone's suffering and CC asked if a manual paper prescription could have been used to mitigate the issues caused by the current system temporarily. It was explained that a paper note was not legally sufficient and that the same level of authorisation was required for approval on Lorenzo. It was also highlighted that the handover nurse had noted the prescription would be completed, but the doctor became tied up in an emergency; nurses had escalated repeatedly but had no alternative route.<br>l. MS suggested that cultural or procedural changes might be needed to empower nurses to escalate to consultants more readily.<br>m. DJ asked several questions about how often incidents like this happened, how were they logged, where are logs reviewed, and by whom and how incidents were managed and followed up. RT explained that incidents of this severity involving epidurals were extremely rare. She advised that these events were logged on Datix and escalated to her, which is how she came to present this story. She added that the pain service was currently under review.<br>n. DJ advised that the wider issue was that colleagues should not have to come to the Board for these problems to be known. He noted improvements including nurses being more empowered to contact consultants and hoped that this would give them confidence to escalate.<br>o. A question from DC sought clarification on whether any potential solutions, particularly technological ones, had been discussed, given the lack of communication between the two systems. HMc explained that the link between MetaVision and Lorenzo was inherently difficult and that the systems were already operating at their optimum. However, he noted that this exact scenario had been tested during the procurement of the new EPR, which had the capability to resolve this issue.<br>p. CP asked if a reliable escalation route at night had been established in order for colleagues to feel confident to call the anaesthetic consultant. RT advised that she had presented the case to the lead ICU consultant group. Prescription transfers were now being checked, and no further errors had occurred. Night-shift nurses were now able to escalate concerns, and it was also noted that nurses were now aware that patients should not leave critical care until the prescription was visible on Lorenzo.<br>q. PW questioned why the Trust had two separate systems that relied on human bridging. JA advised that the dual-system setup originated from | **AR** | |

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| | historical commissioning decisions and these systems were not designed to provide fully integrated functionality, resulting in unavoidable reliance on human input to bridge gaps between them. This would not be repeated with any future EPR whose effectiveness had been tested and provided significantly superior functionalities than the current separate systems.<br>r. He emphasised that the priority now was ensuring patients did not fall through gaps during the next 18-24 months.<br><br>The Board **noted** the patient story. | | |
| **1.ii** | **Declarations of Interest** | | |
| | a. There were no new interests declared.<br>b. AF Declaration need to be updated. | | |
| **1.iii** | **Minutes of the previous meeting** | | |
| | **Board of Directors Part I:**<br>• **05 February 2026**<br><br>a. AF asked if the Workforce Chair's report had been discussed at the meeting as it had not been referenced in the minutes. She requested that the report be circulated to Board as it had arrived late.<br>b. LS referenced the Item:3.iv Performance Chair's report (05 February minutes) and advised that the report related to Month – 09 instead at Month –10.<br><br>The Board of Directors **approved** the Minutes of the Part I meeting held on 05 February 2026 as a true record subject to the amendments requested. | **GM**<br><br>**JE/GM** | |
| **1.iv** | **Matters arising and action checklist** | | |
| | a. All actions proposed for closure were closed and the following updates were made. Commentary is given to some closed actions where necessary.<br><br>b. **Action:35/25 – Medical Revalidation Annual Report – Workforce Committee to consider what information was available on the quality of appraisals.**<br>IS confirmed that the appraisal paper had been considered by the Workforce Committee in January and provided assurance that the appraisal process was being applied consistently, supported by a system that requires full completion before sign-off. Survey feedback (40% response rate) showed strong satisfaction with the process, with all respondents willing to retain the same appraiser and around 90% reporting that it supported their professional development. The Board requested that the paper be recirculated and the action would be closed after circulation.<br><br>c. **Action:36/25 – Papworth Integrated Performance Report – HMC to provide a detailed breakdown of statistics for onward care patients, including active clocks and monitored patients, in the next financial year.** | | |

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| | HMc confirmed that the required statistical breakdown would be incorporated into the PIPR report from March, progressing through the Performance Committee cycle. This would include reporting on patients with active clocks. He also noted that realignment of statistics, as previously referenced by EM, is underway and would be built into the next operational planning cycle.<br>Action Closed<br><br>The Board **noted** the Matters Arising and Action Checklist. | | |
| **1.v** | **Chair's report** | | |
| | **Report:**<br>a. The Chair provided an update on key activities since the previous report in January.<br>b. He noted that the period had been particularly busy, including the successful appointment of several senior executive roles including Chief People Officer, Chief Financial Officer, and Chief Nursing Officer, with further detail to be considered at Remuneration Committee.<br>c. The Chair reported undertaking a series of visits across the organisation, including Thoracics, Radiology, Estates, and most recently Kingfisher House (KFH).<br>d. It was highlighted that KFH hosted between 120 and 150 colleagues but has physical workspace for fewer than 50, resulting in blended on-site and remote working patterns. Staff reported ongoing communication, technology, and IT challenges; however, they consistently demonstrated strong problem-solving capabilities and a clear commitment to service improvement.<br>e. The Chair emphasised the importance of supporting satellite teams, noting their essential contribution to organisational productivity. Several colleagues including the Medical Director, the Chief Technology Officer and the Chief Medical Information Officer had joined these visits, all of which were positively received. He encouraged other colleagues to make such visits as well.<br>f. The Chair also hosted, alongside Professor Robert Rintoul, Honorary Consultant Oncologist, a visit from David Bennett, incoming Chair of Macmillan Cancer Support, who was impressed by the quality and ambition of the services provided by the Trust.<br>g. The Chair highlighted a recent Consultant Forum, jointly chaired with the CEO and the Medical Director which generated energetic discussion and a notable level of engagement. It was noted that consultants expressed enthusiasm for improving productivity and reflecting on resource distribution across services, questioning whether some areas were over-resourced while others were under-supported. It was noted that attendance at the forums had increased with each session and follow-up engagement had remained strong.<br>h. The Chair also acknowledged the work of the Disability and Carers Network, whose recent event was positively received.<br>i. The Chair and the CEO attended the CEO/Chairs meeting at Duxford the previous week. The meeting reinforced that waiting lists and financial performance remained the two dominant system-level challenges. There was also focused discussion on value, resource utilisation, and ensuring that follow-through actions match the ambition | | |

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| | required to address these challenges.<br><br>The Board **noted** the Chair's report. | | |
| **1.vi** | **Board Assurance Framework** | | |
| | JE presented the Board Assurance Framework (BAF) that was taken as read.<br><br>**Report:**<br>a. There was a discussion around risk ID:3733 (IF the Trust does not have an affordable workforce plan and delivery plan integrated with operational and financial planning). It was advised that the residual risk rating had been reviewed at the January Workforce Committee, and it had been proposed to increase the likelihood score, resulting in an increase in the overall risk rating. This recommendation had been based on evidence of ongoing pay overspend and a growth in staff in post during 2025/26, both of which indicated that controls on pay expenditure were not sufficiently effective.<br>b. AF confirmed that the Workforce Committee had subsequently reviewed the position and agreed not to increase the score. Since January 2026, there had been a significant strengthening of workforce planning controls and closer alignment between workforce, operational, and financial planning, which provided assurance that the likelihood score did not need to change at that stage. It was noted, however, that the risk would need to be revisited following the staff survey results.<br>c. Concern was raised that in the Quarterly Tracker, Risk ID:3733 had consistently been scored at 16, contrary to what the main BAF report suggested. IS also noted a mistaken capital figure at risk ID:3725 (IF the Trust is unable to access a sufficient capital envelope), printed as £141m instead of £14.1m. EM explained that this discrepancy arose because risk information was manually transferred from Datix into the Board report summaries and tables, which led to inconsistencies.<br>d. CC expressed concern that Risk ID 3873 (IF the Trust fails to effectively and productively manage its clinical capacity to ensure timely access for elective, emergency, cancer and diagnostic patients) continued to show no gaps in assurance, despite this issue having been raised repeatedly. HMc confirmed that the position in Datix had now been updated correctly, including the identification of gaps in assurance.<br>**Action: JE/GM to review the process of transferring data from Datix to the BAF report.**<br>e. JA observed that several risks continued to sit above the organisation's stated risk appetite and had remained unchanged for several months. He questioned whether the Board had previously agreed an escalation trigger for risks that persisted above appetite for an extended period. He also noted that the way the risks were presented in the Quarterly Summary created the impression that no improvement was being made.<br>f. EM explained that although the high-level BAF summary did not show movement, there were meaningful changes occurring within the lower-level reports that fed into the BAF. These developments were not yet visible in the summarised version presented to the Board.<br>g. JA requested that the necessary corrections be made, acknowledging that the BAF and its supporting data processes remained a work in | **JE/GM** | |

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| | progress.<br><br>The Board **noted** the Board Assurance Framework update. | | |
| **1.vii** | **CEO's update** | | |
| | EM presented the CEO update that was taken as read.<br><br>**Report:**<br>a. It was noted that the Trust continued to prioritise operational planning, including ongoing commissioner discussions. There also remained a strong focus on implementing the strategy, with significant executive attention on fully deploying and embedding it.<br>b. The meeting heard that Oonagh Monkhouse had formally left her role as Director of Workforce and OD (DWOD) and Larraine Howard-Jones would be Acting DWOD until Marcus Riddell began his tenure as Chief People's Officer in the beginning of June.<br>c. It was announced that following a competitive interview process, Sophie Harrison had been appointed Chief Finance Officer and would start her tenure in the new Financial Year.<br>d. In respect of performance, it was heard that there continued to be performance improvements across referral to treatment time (RTT) and cancer targets, and that surgical site infection (SSI) rates had fallen for the third consecutive quarter; Dr Hannah Kiziltug's leadership of the SSI Stakeholder Group was gratefully acknowledged.<br>e. EM highlighted recent organisational developments, including the Innovation Fund Showcase, which presented staff-led innovation projects and generated strong cross-team engagement. She also referenced the launch of the NHS Blood and Transplant Assessment and Recovery Centre (ARC) pilot at the Trust. This pilot, driven by consultant advocacy, was expected to increase the number of viable lungs available for transplantation.<br><br>**Discussion:**<br>f. CC praised the positive report but emphasised the need for balanced public reporting, noting that challenges, such as the rising number of 52-week waits should be explicitly acknowledged alongside assurances on mitigation actions. JA was in agreement and recognised the importance of reporting on both challenges and achievements; he noted that the Annual Report reflected these points about balance<br>g. JA drew attention to the cancer 62-day target, noting that the January performance was 73%, compared with the 75% national standard. He also highlighted that the Trust's internal stretch target is 80% by the end of March and asked for an assessment of the likelihood of achieving this.<br>h. HMc advised that the February projection was expected to close at 77.2%. March was projected to reach approximately 80.1%, based on current known cases. It was cautioned that nine external referrals remained outside the Trust's control and if any incurred shared breaches, performance could fall around 2% below the stretch target. It was noted that achieving 80% would make the Trust the highest-performing 62-day pathway nationally.<br><br>The Board **noted** the CEO's Update. | | |
| | **NEDs update** | | |

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| **1.viii** | | | |
| | a. JA advised of a forthcoming NEDs and Chairs meeting for the East of England, scheduled for April. He encouraged all who were able to attend, emphasising the value of maintaining visibility and engagement with colleagues across the wider regional footprint.<br><br>The Board **noted** the NEDs update. | | |
| **2** | **QUALITY** | | |
| **2.i** | **a. Quality and Risk Committee Chair's Report 29.01.26 and 26.01.26** | | |
| | GMA presented the Quality and Risk Committee Chair's report that was taken as read.<br><br>**Report:**<br>a. The meeting heard that IS had presented at the Q&R meeting positive outcomes for both elective and emergency Transcatheter Aortic Valve Implantation (TAVI) patients. The Committee had a wider discussion that considered equity, ethics and optimal use of resources.<br>b. The Committee noted that TAVI continued to be delivered within the Commissioners' agreed funding envelope, with no cost pressures or over-performance emerging against the contracted allocation. TAVI activity had not adversely impacted other pathways as well.<br>c. The Committee had received the quarterly antimicrobial stewardship report and accompanying an insightful gap analysis. It was requested that:<br>**Action: JE to circulate the updated version of the gap analysis.**<br>d. In respect of safeguarding Compliance, it was heard that all Band 5-6 nurses were now required to complete Level 3 safeguarding training; a plan to deliver this was in place with a timeline of 18–24 months due to capacity constraints.<br><br>**Discussion:**<br>e. In respect of Digital Clinical Safety Risk CP queried the limited assurance rating relating to digital clinical systems. MS confirmed that the issue related to clinical safety case reviews across multiple systems. It was noted that high-risk areas had been addressed, but wider safety cases required additional resource and a forward plan, which the Executive would bring back once developed.<br>f. IS confirmed that each year, 20–25% of the patients referred to the Trust for TAVI due to lack of other treatment options were not accepted for the procedure. JA noted that this supported the understanding that TAVI was not used by default and that decisions are based on careful clinical assessment.<br><br>The board **noted** the Quality and Risk Committee Chair's reports 29.01.26 and 26.02.26. | **JE**<br><br>**MS** | |
| **2.ii** | **Combined Quality Report** | | |
| | MS presented the Combined Quality report that was taken as read.<br><br>**Report:** | | |

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| | a. MS reported that the Combined Quality report mainly covered recent inquest activity, with no additional exceptions beyond what had already been reported through the Papworth Integrated Performance Report (PIPR).<br><br>**Discussion:**<br>b. CP sought assurance on staff wellbeing support, particularly following traumatic incidents, and whether sufficient resources were in place.<br>c. MS confirmed that staff were supported through immediate input from senior clinical colleagues and the Trust's Wellbeing Team. There were additional trauma-support options under consideration, including the Trauma Risk Management (TRiM) programme, which the Trust was exploring with a view to implementation, subject to securing the necessary funding.<br>d. She emphasised that while routine emotional challenges were part of the care environment, some incidents required enhanced trauma-informed support that the additional funding could strengthen.<br>e. JA sought clarification on Patient A's, (a patient who had a diagnosis of Duchenne Muscular Dystrophy, a serious muscle wasting disease, which adversely impacted both their respiratory and cardiac function and later died after contracting Covid-19) link to Royal Papworth. MS confirmed that the patient was under the Sleep Service for ventilatory support due to a likely neuromuscular condition.<br><br>The board **noted** the Combined Quality report. | | |
| **3** | **PERFORMANCE** | | |
| **3.i** | **Performance Committee Chair's report** | | |
| | DJ presented the Performance Committee Chair's report that was taken as read.<br><br>**Report:**<br>a. In respect of Data Quality and Reporting, DJ reported that the Committee remained focused on improving data completeness and accuracy across reports; NEDs continued discussions on achieving greater consistency in reporting standards.<br>b. It was noted that the Committee had received an excellent presentation from cardiology, which provided clear and valuable insights into current service pressures.<br>c. The meeting heard that approximately 60 TAVI cases were being added to the waiting list each week, while current capacity was around 40 cases per week, highlighting a significant and growing demand-capacity gap.<br>d. The presentation had also highlighted consultant dependency risks, including areas where only one consultant provided essential capability. The committee reviewed how these issues were reflected in the 2026–27 operational plan.<br>e. The Committee was advised that temporary staffing remained high. Although the Trust was performing better than the NHS average, spend continued to be misaligned with existing plans. The Committee would consider whether planning assumptions needed to be adjusted once all temporary staffing actions have been fully implemented. | | |

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| | f. In respect of finance, it was heard that the Trust remained on track to break even. The CIP target was unlikely to be fully met, though the committee received assurance that divisions are working hard to close the gap as much as possible.<br>g. Elective performance remained strong, with the waiting list 30% lower than the previous FY, reflecting sustained year-on-year improvement.<br>h. It was heard that the Committee had approved its Terms of Reference and had considered the Performance Committee Annual Self-Assessment and noting mostly positive feedback while recognising areas for improvement.<br>i. DJ expressed thanks to LS for her exceptional support to the committee, including preparation for meetings and overall coordination.<br><br>**Discussion:**<br>j. CP referenced a discussion at the Performance Committee, noting that the Committee had sought assurance regarding alignment with NICE clinical guidelines for TAVI. Assurance had been received that the Trust was adhering to NICE guidance by performing TAVI only in high-risk patients, recognising that NICE did not consider the procedure cost-effective in certain other patient groups.<br>k. CP noted that, while the clinical assurance provided was helpful, the broader question raised at the Committee regarding strategic resource allocation and system-level prioritisation across all service pathways had not been fully addressed. She observed that the response to the Committee had focused narrowly on the fact that TAVI did not currently compete for resources with other services due to existing Cath Lab capacity arrangements. However, she expressed only modest assurance on this point, stating that the explanation did not sufficiently consider the strategic, cross-pathway implications.<br>l. She emphasised that the wider issue concerned the trade-offs across pathways: increasing activity in one service area would inevitably constrain what could be delivered elsewhere. She therefore sought clarity on who held oversight for this whole-system balancing, and how such decisions were being coordinated across the Trust.<br>m. CP suggested that further and stronger assurance would be required regarding system-wide prioritisation, value, and efficacy across pathways, in order to ensure that resourcing decisions are aligned with the Trust's overall strategic objectives.<br>n. In respect of operational planning, capacity and service prioritisation, EM explained that a capacity review was underway in cardiology to understand opportunities for increased efficiency and productivity. She acknowledged that while improvements were possible, they would not close the full demand-capacity gap.<br>o. It was reported that procurement for external support had been temporarily paused due to financial pressures but emphasised that the work remained essential and would proceed in revised form.<br>p. TG added that the first priority would be to maximise internal efficiency and maintain all services where possible; this required meeting the CIP targets and achieving the required financial position. He highlighted work underway on low-value interventions within the CIP programme, examining areas where resources could be better redeployed to higher-value activity.<br>q. JA noted that while it was important to review low-value interventions, equal attention should be given to the high-value interventions that could be put at risk if resources became stretched. He emphasised that | | |

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| | both ends of the spectrum needed consideration when assessing how activity and resources were prioritised.<br>r. EM acknowledged the complexity of the issue and the need for further analytical work before more definitive discussions could take place. It was agreed that a clearer update would be brought back to the Board once the relevant workstreams had progressed.<br><br>The Board **noted** the Performance Committee Chair's report. | **SH/HMc** | |
| **3.ii** | **Papworth Integrated Performance Report (PIPR) Month 10** | | |
| | LS presented the PIPR report for Month 10 – January 2026.<br><br>**Report:**<br>a. LS highlighted that the Trust's overall performance rating had moved from Red to Amber in January. People Management and Cultural Safety domains had also improved from Red to Amber.<br>b. Finance had deteriorated from Amber to Red due to the CIP position and in-year capital performance issues. It was noted that the forecast included a small underspend that was expected to be accepted by regulators. Actions had been taken to bring capital spend forward because of next year's pressures, particularly the EPR programme.<br>c. JA raised concern that the second most common complaint category related to the complaints process itself, questioning why this was occurring. EM explained that this reflected the increasing complexity and changing nature of complaints and highlighted that current staffing levels did not match the rising volume; this placed pressure on the process and contributing to delays and dissatisfaction.<br>d. HMc provided an update that on 52-week waits (as of 8am that morning): it was heard that there were 17 patients waiting over 52 weeks; 16 were in cardiology and one in thoracic. The longest wait was 62 weeks and that patient had been referred at 41 weeks. All breaches had been assigned treatment dates in March or early April.<br>e. Seven referrals had been received at over 40 weeks; three came in the last three weeks. It was noted that 10 patients had been with the Trust for their whole pathway, therefore missed targets for these patients were attributed to internal delays.<br>f. HMc reported that all patients that had breached the 52-week target had harm reviews and no harm had been identified. He advised that he personally oversaw weekly 52-week validation with divisions. This oversight had a high level of scrutiny. He acknowledged that the current performance was unacceptable, and that waits needed to reduce.<br>g. In respect of national benchmarking, EM reported that the Trust was 8th best for RTT performance and 20th for 52-week performance out of 134 trusts.<br><br>**Discussions:**<br>h. JA observed that the Trust had last met its theatre-cancellation target in April 2021 and had been unable to achieve it at any point over the subsequent five years. He questioned whether the measures currently in place were designed to deliver compliance and whether a clear resolution was being actively pursued. He noted that while some cancellations, such as those due to patient illness, were unavoidable, others, including those related to translation requirements, should be within the Trust's ability to improve. | | |

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| | i. DJ highlighted that cardiology cancellations were often attributed to equipment failure and that an open action existed in order to review cancellations more broadly, this included translation as well. JA noted that a helpful breakdown of causes (overruns, equipment, patient issues) would be useful.<br>j. AF reflected on the position regarding 52-week waits, noting that the Board had previously been provided with a clearer trajectory for achieving the 80% target. She therefore queried when the Trust expected to reach zero patients waiting over 52 weeks. HMc reported that, based on current national rules, the Trust was on trajectory to reach zero 52-week breaches between mid-April and early May. However, he noted that maintaining a sustained zero position was highly challenging, as the Trust continued to receive patients already waiting 48–50 weeks at the point of referral. He advised that, while the internal aim had been to achieve zero by November, this had been disrupted by the arrival of eight late referrals. He emphasised that the operational focus remained on ensuring that no patient on the Trust's own internal list exceeded the 52-week threshold. It was heard as well that structural and TAVI pathways ran at full capacity with no spare time or buffer, which caused late bottlenecks and led to long waiting lists.<br>k. AF emphaised that this needed to be reflected when setting next financial year's targets and evaluate the achievability of zero.<br>l. JA suggested that if there was a minimum time required to manage patients, referrals could be split accordingly. This helped avoid false expectations.<br>m. CC referenced that previous targets had not been in alignment with explanations on how they would be met. She emphasised that the Trust should develop suitable mitigations aimed at meeting the national target. HMc agreed that the current waiting lists had been unacceptable and these needed to be resolved for and maintained that drivers of delays had remained consistent.<br>n. HMc agreed to take forward actions to fully understand the pathway to recovery, to the drivers for recovery and assess whether the recovery plan is realistically achievable.<br>o. JA concluded that there was need to ensure that the system was operating as efficiently as possible before considering adding further resources to the recovery plan. He added that if, after optimising efficiency and efficacy, there was still a capacity gap, the organisation would have to make trade-off decisions. It was concluded that this would continue to be monitored through the Performance Committee.<br><br>The Board **noted** the Papworth Integrated Performance Report Month 10 – January 2026. | **HMc** | |
| **5** | **GOVERNANCE & ASSURANCE** | | |
| **5.i** | **Board Committee approved Part 1 Minutes** | | |
| | a. Quality and Risk Committee – 29.01.26<br>b. Performance Committee – 29.01.26<br><br>The Board **noted** the Board Committee Part I Approved Minutes. | | |
| **6** | **BOARD FORWARD PLAN** | | |
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| **6.i** | **Board Forward Plan** | | |
| | The Board **noted** the Board Forward Plan. | | |
| **6.ii** | **Review of actions and items identified for referral to committee/escalation** | | |
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| **7** | **ANY OTHER BUSINESS** | | |
| | There was no other business to discuss. | | |

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Signed

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Date

**Royal Papworth Hospital NHS Foundation Trust**
**Board of Directors Part I**
Meeting held on 05 March 2026