

**Performance Committee
Part 1 meeting
Held on 26 February 2026
0900-1045hrs via MS Teams**
[Chair: Dave Jones, Non-Executive Director]

MINUTES

Present		
D Jones (Chair)	DJ	Non-Executive Director
C Conquest	CC	Non-Executive Director
C Paddison	CP	Non-Executive Director
T Glenn	TG	Deputy CEO & Director for Innovation and Strategy
S Harrison	SH	Interim Chief Finance Officer
H McEnroe	HMc	Chief Operating Officer
E Midlane	EM	Chief Executive
O Monkhouse	OM	Director of Workforce & Organisational Development
S Rackley	SR	Director of Estates & Facilities
A Raynes	AR	Chief Information Officer
L Sanford	LS	Interim Chief Finance Officer
M Sreaton	MS	Chief Nurse
I Smith	IS	Medical Director
In Attendance		
A Colling	AC	Executive Assistant (Minutes)
T Collins	TC	Public Governor (Observer)
J Dyer	JD	Public Governor (Observer)
H Eccles	HE	Public Governor (Observer)
J Elwood	JE	Associate Director of Corporate Governance
L Howard-Jones	LHJ	Deputy Director of Workforce
M Kaiser	MK	Director of Operations Improvement & Delivery (For Item 8.1)
M Wheeler	MW	Interim Deputy Chief Finance Officer
In attendance for Cardiology Divisional Presentation		
M O'Sullivan	MO	Consultant Cardiologist and Divisional Director, Cardiology
L Masih	LM	Divisional Director of Operations, Cardiology
S Mulrennan	SM	Head of Nursing, Cardiology
G Martin	GM	Non-executive Director
Apologies		
R Mahoney	RM	Public Governor, Observer

[Note: Minutes in order of discussion, which may not be in Agenda order]

Agenda Item		Action by Whom	Date
1	WELCOME, APOLOGIES AND OPENING REMARKS		
26/26	The Chair welcomed all to the meeting and apologies were noted. The committee noted that this would be the last meeting for O Monkhouse who leaves the Trust today; the Chair thanked OM for all her support to this committee.		

Agenda Item		Action by Whom	Date
	The committee welcomed Maria Wheeler as Interim Deputy Chief Finance Officer to her first Performance Committee meeting.		
2	DECLARATIONS OF INTEREST		
26/27	There is a requirement that Board members raise any specific declarations if these arise during discussions. No specific conflicts were identified in relation to matters on the agenda. A summary of standing declarations of interests is appended to these minutes in the Reference Pack.		
5	DIVISIONAL PRESENTATION: Cardiology Division		
26/28	<p>In attendance: Dr Mike O’Sullivan, Consultant Cardiologist & Divisional Director Sandra Mulrennan, Head of Nursing Luke Masih, Director of Operations</p> <p>MO shared the presentation slides with the committee and highlighted:</p> <p>Performance Overview: RTT Achieved 60% 18w target and on track to meet the Trust divisional target of 60.45% by Q4 end, this involves carefully planned lists and clinics and extra RTT validation. The waiting list in cardiology is at its shortest since 2024. Although there are some long waiters, this list has reduced. He explained the challenges including the lack of capacity for radiology and diagnostic tests and how this has impacted on waiting times. Referrals that come in late to us are also an issue along with patients not able to accept appointments offered within the 52w period.</p> <p>Elective recovery: TAVI (transcatheter aortic valve implantation) MO explained that this a growing service and how this increase has been managed. Urgent TAVI works consumes at least 5 of the 10 weekly TAVI slots. CT reporting is outsourced to a TAVI specialist which has helped.</p> <p>Challenges and next steps with TAVI: Cath lab capacity does not match the demand. There is an urgent need to identify extra capacity. Some growth is achieved through PSI lists at weekends, which is not economically sound and the preference is to move this to BAU. He explained the benefits of conversion of TAVI inpatients to urgent outpatients.</p> <p>Elective recovery: Cardiac Rhythm Management (CRM) This is a growing service where ablation and pacing procedures are 50% of the division’s 18w waiting list. There was also seven days of cath lab outage due to equipment failure (December and January).</p> <p>Challenges: cath lab capacity. The division is working to improve this with smarter scheduling, relocation of some work which could be done at other Trusts, but this is restricted by capacity at other hospitals. There is also a shortage of specialist electro physiologists which is identified as a cost pressure in current planning. There are approximately 10 cancellations per month which happen on the day, due to patients not taking appropriate pre-medication. This is being worked on by the nurse led pre-assessment clinic.</p>		

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	<p>The Consultant workforce is reduced from previous capacity, and the division may need a locum Consultant. Patient initiated follow-up will further increase patient capacity in outpatients.</p> <p>Structural cardiology programme: the challenge is a limited Consultant team and an inherited large backlog. This area is showing improvement with the waiting list reducing, MO explaining the work which has enabled this to happen.</p> <p>Challenges: cath lab capacity. Workforce: looking to move the locum Consultant to a substantive post. We need TAVI and ECHO Consultants to support this service, and this is also part of budget planning We need to grow the Specialist Nurse Team to support the structural programme. The structural work is covered in the week by the cardiology team but done as overtime work by the anaesthetic team.</p> <p>Coronary intervention (elective); this is not a growing area with a reduction in the number of referrals, reflecting changes in clinical practice. This has enabled a switch of coronary lists to structural and TAVI. Challenge: radiology capacity where patients are awaiting investigations.</p> <p>Outpatient overview: There has been a dramatic reduction in patients awaiting their first appointment within the CRM service where MO explained how this has been managed. Clinics are adjusted so that monthly capacity exceeds the number of elective referrals with the aim to reduce the waiting time for the first Tavi appointment to 3 weeks.</p> <p>RTT activity – there are a number of non-RTT services in cardiology which are single consultant services, these are not as resilient with long follow ups. This is also included in the round of business planning to bolster these services.</p> <p>Questions from the cttee: TG referred to the issue of capacity in cath labs and how do we create capacity and manage demand? He asked MO to explain more on the frustrations around this when trying to improve turnaround times. MO advised the set-up of the Cath Lab Optimisation Group which has identified easy wins, but the enthusiasm has waned from the workforce (especially after Covid). There are issues where lists will often start late due to unavailability of staff. Turnaround time for patients is taking longer, there can be a lack of preparation of trollies, and the end of day is different for certain staff groups which impacts on cath lab capacity, particularly with the anaesthetics resource. Consultants are keen to progress the work, but this is difficult due to problems with culture and processes. An increase in capacity could be achievable with improvement in this area and this work has started.</p> <p>TG referred to the demand side and growth in non-elective TAVI work. It would be helpful to explore why that growth is happening, what our consultants want to do along with constraints on the commissioning side.</p>		

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	<p>MO advised that our TAVI patient cohort is an elderly patient group. And the outcomes for this group are good. We have ageing population and this is an increasingly recognised treatable condition where demand will continue to grow.</p> <p>We do more inpatient TAVI than any other Trusts in UK – due to long waiting lists and patients can deteriorate when then are admitted. He explained how patients can wait in hospital for 2-3 weeks deconditioning before receiving procedure. We are encouraging discharge of patients once stabilised and then to re-admit onto a scheduled list.</p> <p>TG noted that TAVI predominantly supports frail patients nearer to end of life, where life is extended. Although this is a growing service, there is less support from commissioners on this.</p> <p>CP asked for clarity on the current NICE guidelines and wanted to understand the alignment with our current approach and how and when this might be resolved?</p> <p>From an allocative justice perspective, if we do a certain procedure, is there then something else which we cannot do? What do we have in place to ensure sight across all areas.</p> <p>MO explained the process of TAVI referred patients and the Trust’s adherence to the current NICE guidelines for high risk patients in conjunction with surgical opinion.</p> <p>Regarding allocated justice, TAVI activity only impacts on other cath lab activity, and he explained how other procedures are managed around this. He does not think that TAVI work compromises other patient procedures, but this is a risk which needs to be monitored as the TAVI service grows.</p> <p>HMc referred to cardiology work to improve services where there is work we can do to improve productivity and efficiency in our services.</p> <p>MO added that a mobile lab would fix the capacity issues, but this is expensive. We need to look to in-house improvements first.</p> <p>MS noted that the day to day processes of cath labs/productivity are not new discussions. Some issues are more complex than others, but some should be quick wins; she was unsure why not some of these are not progressing and what support is needed to improve this? It would be useful to have a timeframe for some of the easier wins.</p> <p>MO explained how the work is drowned in process where small decisions can take a long time; this could be part of cultural issues. The team have enlisted project support to help with this, which will be vital for progress.</p> <p>DJ would appreciate follow up on this.</p> <p>We have heard of the many proposals for improvements and ideas to make better; it would be useful to have a follow-up with the action plan on how to achieve some of this.</p> <p>He referred to issues: radiology and CT reporting, cath lab capacity only 60% of what is required, problems with outages and equipment failure; concerns on PIFU and any ways of improving this approach for patients, along with cultural issues, how can this be improved.</p> <p>Regarding resourcing, capacity and single points of failure – how has this been considered in 26/27 operational planning? Do we have capacity and capability to do some of these things and what can’t we do?</p>		

Agenda Item		Action by Whom	Date
0940hrs MO, SM, LM left	DJ and HMc to follow up afterwards on how to take this forward. DJ thanked MO and team for all their work and presentation today.	DJ/ HMc	26.03.26
3	MINUTES OF THE PREVIOUS MEETING: 29 January 2026		
26/29	Approved: The Performance Committee approved the Part 1 minutes of 29 January 2026 meeting and authorised for signature by the Chair as a true record. CC raised a governance issue that if the minutes are for approval, should they be in the reference pack or moved to the main pack? DJ agreed for the minutes to revert back to main pack.	Chair	26.02.26
4.1	TIME PLAN OF TODAY'S AGENDA ITEMS		
26/28	No adjustments to the agenda were raised.		
4.2	ACTION CHECKLIST		
26/29	The Committee reviewed the Action Checklist and updates were noted.		
4.2.1	Temporary staffing review (OM)		
	Received: Deep dive report to review the temporary staffing overspend – as requested at the December meeting. Reported: OM The report provides a summary of actions taken over the last year and provides an overview of the trajectory for next year in the Operational Plan. Agency use for vacancies and sickness has been virtually eliminated, except for highlight specialist posts in small teams. Bank usage has increased as agency has been reduced. Bank usage is not primarily related to vacancies; it is linked to sickness absence rate. The report looks at measures to reduce temporary staffing noting that at times bank staff will need to be used to maintain safe staffing levels. MS explained that staff absence is the biggest challenge and is being worked through. The scrutiny and sign-up process for bank staff is robust. There is less scrutiny over teams which sit outside of the ward establishment i.e., small teams within nursing or corporate divisions, where more can be done here on controls. There is a challenge around some back-fill for roles such as apprenticeship back-fill, where there may be provision via Charity on apprenticeship programmes. Some reductions have been seen but this is not consistent, and attention is needed in the highlighted areas. CC referred to the last page of the report where workforce planning submission projections were unclear for projected years. OM noted that the heading in the report was incorrect. LHJ confirmed that the figures for agency and bank reduction were for 26/27 and not over five years.		

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	<p>AR referred to Risk 1021 and will take away to review with the team. He added that some testing work is still ongoing before reducing the risk.</p> <p>Noted: The Performance Committee noted the review of BAF.</p>		
7.1	FINANCIAL REPORT – Month 10 January 25/26		
26/32	<p>Received: Financial Report which provided oversight of the Trust’s financial position as at Month 10, January 2025/26.</p> <p>Reported: LS summarised with key points: There is a small deficit against break-even plan at M10. The in-month position was managed by using non-recurrent items, primarily as a result of under-delivery of CIP and pay overspends. The ICB deduction of £1.3m has not been recognised in the position – it will be reversed but will leave approx. £350k liability to the Trust. This relates back to 24/25 and has potential impact into 25/26. Discussions are ongoing along with impact of national policy. We will ensure our internal policies to manage this are robust. We continue to forecast break-even position noting that the overall financial position remains challenging.</p> <p>Discussed: CP referred to over-performance at 119% against year-to-date contract plan. If that current position changes and we are not paid for over-activity, when would we know this. LS advised that we are currently assuming that that we would not be paid for this over-performance on this contract but there is continued discussions regarding this.</p> <p>LS advised that capital expenditure is below plan currently and the forecast is a small underspend. The plan was increased plan by £1.6m which has enabled access to frontline digitisation funding for EPR. We have ‘gifted’ £2m of CDEL cover to NWAFT which is accepted by the system. This currently leaves a small underspend, but we are looking still to see what might be brought forward to balance this.</p> <p>Noted: The Performance Committee noted the financial position.</p>		
7.2	INVESTMENT GROUP – Chair’s Report		
26/33	<p>Received: Chair’s update summarising the meeting held on 9 February 2026</p> <p>Reported: LS The report was taken as read. Key items: Three funding requests were reviewed, where two were included in the capital plan and approved an. One request related to defibrillators for the HLRI which was funded from the forecast underspend.</p> <p>Discussed: DJ noted approx. £1.5m in the plan which has low/medium confidence in terms of spend. Are there actions to improve this confidence? LS advised that the position is reviewed on a monthly basis and can</p>		

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	<p>adjust. Spend has been brought forward in some areas. The project managers of capital schemes are expected to have detailed plans and timelines in place to reach delivery, with escalation of issues where we can improve confidence on delivery.</p> <p>Noted: The Performance Committee noted the update from the Investment Group.</p>		
<p>7.3 7.4</p>	<p>A BRIDGE TO EXCELLENCE (CIP) REPORT: Month 10 January 25/26 COST IMPROVEMENT PLAN</p>		
<p>26/34</p>	<p>Received: An update report to Month 10 January 25/26.</p> <p>Reported: HMc The report sets out processes and steps being worked through at moment. He explained why the pipelines have reduced slightly with validation work ongoing. There is continued focus with divisions on CIP schemes.</p> <p>Discussed: CC referred to page 58 development, which looks ambitious for 26/27 delivery. What can you say to give further assurance that this will be met? HMc confirmed that systems are processes are working to that timescale with focus from divisional and operational teams. There are QIA processes and governance in place which are set to achieve this; although mindful that this is an amber/red view.</p> <p>TG shared concerned on this. The ideas are established but there is hard work needed over the next 3-4 weeks to achieve this. We cannot fully assure that the CIP delivery will be met entirely but we need to aim for this. He gave some granularity on the detailed work to push this.</p> <p>Noted: The Performance Committee noted the update on CIP M10 25/26.</p>		
<p>8</p>	<p>OPERATIONAL REPORTS</p>		
<p>8.1</p>	<p>Elective Care Recovery (ECR) Priorities</p>		
<p>26/36</p>	<p>Received: Update on effective and responsive delivery of the elective access pathway.</p> <p>Reported: HMc This work is moving to 'business as usual' oversight. RTT delivery in month is 75.5% and we continue to work towards a year/end outturn 80.01%. There is daily work with the three clinical divisions on operational grip and resilience in this area. The work on cancer and 31 and 62 day waits has seen improved consistency. The 52w position has continued delays which continues to cause impact to patients. This is a continued priority which is balanced against clinical priority, patient choice and urgent activity.</p> <p>Discussed: EM referred to 52w – have we captured conditions when we reached 'amber' status in order to recreate this? HMc noted that the current challenges relate to competing capacity and complexity of patients along with access and demand for radiology services.</p>		

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	<p>HMc referred to recreating past 'better' positions on 52w which the team have been working to since November. He will review this and report back to committee.</p> <p>DJ thanked all for the effort put into this work.</p> <p>Noted: The Performance Committee noted the update on Elective Recovery.</p>	HMc	26.03.26
10	AD-HOC REPORTS		
10.1	OPERATIONAL PLANNING 2026/27		
26/38	<p>Received: Verbal update</p> <p>Reported: LS Discussions on contracts are still live with commissioners. We continue to discuss allocation of growth with specialised commissioning. As regards block work activity, meetings are ongoing at pace with this.</p> <p>The system is still holding to the principles of no growth funding and transformation reserves, and we are looking at how we can work with this to improve our position.</p> <p>The Operational Plan was submitted on 12 February 2026 with no feedback from NHSE. As this is a break-even plan, we would not be expecting significant feedback.</p> <p>Discussion and queries raised: EM updated from the regional meeting of CEOs this week, where those Trusts who had not submitted a breakeven plan, would receive feedback by 31.03.26 and would be invited to discuss with the regional and national teams with the potential to re-submit their plan. Those with a break-even plan would not be invited to re-submit.</p> <p>TG referred to the commissioning offer in practice. In our table of risks, we are currently sitting at the downside on this – relating to commissioning and CIP. He explained how we would need to deliver £9.3m CIP to be able to utilise non-recurrent benefits to breakeven funding. TG was happy to discuss this separately if required.</p> <p>Noted: The Performance Committee noted the update on the Operational Plan 2026/27.</p>		
11	ANNUAL REPORTS		
11.1	Committee Terms of Reference		
26/39	<p>Received: Request for the Committee to undertake an annual review of its terms of reference.</p> <p>Reported: JE No substantive changes for this annual review – recommendations are minor changes</p>		

Agenda Item		Action by Whom	Date
	<p>Discussed: No items were raised.</p> <p>Approved: The Performance Committee approved the revised Terms of Reference.</p>		
11.2	Committee Self-Assessment		
26/40	<p>Received: Summary of responses where the committee is asked to review and discuss the findings from the Self-Assess and approve the report.</p> <p>Reported: JE DJ referred to a comment raised by a Governor. When we provide written feedback, we need to ensure it is anonymous, as in some cases it can be identifiable. This needs to be reviewed before this information is presented. JE will pick this up for future reviews and also request submitters to avoid including identifiable questions.</p> <p>JE advised that we are looking at how to extract the data from questionnaires as some of the data in pie charts does not align. How responses are presented from individual commentators will also be reviewed.</p> <p>He noted that in the final question, the overall rating out of 9, gives a response of 1 with no comments to back this up. He is unsure if this is a misunderstanding and will pick up in future surveys.</p> <p>Discussed: Regarding critical feedback from submitters, DJ would be happy to talk to colleagues/or submitters to refer to Exec colleagues, on how to do things differently to make the meeting more effective and receive the right levels of assurance and information.</p> <p>DJ thanked those who completed the annual self-assessment.</p> <p>Noted and approved: The Performance Committee noted and approved the Committee Self-Assessment.</p>		
FUTURE PLANNING			
12	QUARTERLY REPORTS		
12.1	Corporate Risk Register		
26/41	<p>Received: Report to provide the Committee with an overview of those risks graded 12 and above that are included on Corporate Risk Register (CRR). This report excludes draft risks, risks awaiting divisional sign off and risks awaiting risk manager approval.</p> <p>Reported: MS A number of risks have been added since the last report. Work is ongoing to ensure that all risks are updated and risks closed when required. At the time of reporting, there are 101 open corporate risks with a rating of</p>		

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	<p>12 and above. Much is driven by the operational planning cycle and cost pressures. There is a summary of closed risks on how these have been addressed – the appendix includes detail of this.</p> <p>Discussed: CC noted that some of the new risks relate to digital issues. Is there any particular reason for this? AR referred to ‘recovery from Cyber incident’ which is being worked through now on business continuity planning. Risk 3869 ‘lack of radiology/digital support’ – we are about to go to advert for this role which currently has interim cover, and these actions should reduce the risk.</p> <p>CC as these were shown as new risk, she was surprised these were not already on the risk register as known risks. AR offered to look into this. MS added that on recent review of the BAF format, there were still some risks within that which were felt needed to go onto the corporate register before closing the original risk This is part of the re-framing work on BAF which is why they are appearing as new risks.</p> <p>CP referred to the Oliver McGowan training and compliance with Level 2 - what is the position on this and could there be a spotlight in PIPR to clarify this. MS offered to put a spotlight in PIPR and confirmed that this is also receiving discussion at Workforce Committee. Regarding the Level 2 training position, the Trust is less than 10% fully compliant which is the same position at other organisations. This reflects the big challenge for all organisations. The Workforce Team are working hard on how we can approach this. MS added that a report did go to the last Workforce Committee regarding this, which can be shared. DJ asked for this report to be shared with the Performance Committee and to then decide if a follow-up is needed to the next Performance Committee.</p> <p>OM noted that this has also been flagged through Workforce Committee where there is an issue of cost pressure to deliver the level of training as required in national guidelines</p> <p>Noted: The Performance Committee noted the quarterly Corporate Risk Register update.</p>	MS	26.03.26
9.1	PAPWORTH INTEGRATED PERFORMANCE REPORT (PIPR)		
26/37	<p>Received: PIPR for M10 December 2025.</p> <p>Summary of the position was ‘Amber’, which comprised:</p> <ul style="list-style-type: none"> • One domain rated as Green (Caring) • Two domains rated as Amber (Safe and People Management & Culture) • Three domains rated as Red (Effective, Responsive and Finance). <p>Discussed:</p> <p>Safe (amber) MS Safeguarding Level 3 training has shown a huge dip which is due to a</p>		

Agenda Item		Action by Whom	Date
	<p>change in denominator. New guidance suggests more staff should have training at this level. We have a trajectory to improve this which is challenging. The recovery looks like 18-24 month and we looking are looking how this can be speeded up. We are looking at top priority areas where most risk lies and targeting these.</p> <p>Caring (green) MS: No items were raised.</p> <p>Effective (red) and Responsive (red) HMc CP referred to radiology backlog and NWAFT's approach on fragility of services. She would like us to consider a more proactive approach on fragility of services. She would like a future conversation on taking a more proactive, systemic and strategic approach to give clarity on where focus should be by the Board.</p> <p>HMc advised that radiology division are due to present to next month's meeting on priority areas, where NWAFT is part of this discussion. It will also include steps on intervention work. HMc will add this to next meeting. AR added that VDI (virtual desktop infrastructure) working has been a focus with a much better use of this software now.</p> <p>CC referred to one previous issue highlighted of radiologist not being able to do reporting work off site - has this been improved? AR advised that this is working much better and we are looking to ensure all have better access. CC noted that this was an issue when recruiting in that home working was a problem. AR hopes that improvement in this area will aid recruitment, explaining the work ongoing to support. CC asked if there will there be a concerted effort to recruit. EM confirmed that this is in hand with interviews happening shortly, with candidates identified. OM added that this had been discussed with divisions at recent performance meetings. New staff onboarding were keen to work in the hospital rather than at home.</p> <p>People management and culture (amber) OM OM referred to the spotlight on Electronic Staff Record Supervisor Self Service and Dashboard, which looked at managers' access to information, improvement in processes and challenges of changes in process. We are keen to support managers on how to use the data to support the workforce and business planning.</p> <p>Finance (red) LS This is covered under Item 7.1 Financial Report M10 25/26. Moved from amber to red, driven by capital performance and CIP performance, covered in earlier discussions.</p> <p>Noted: The Performance Committee noted the PIPR for M10 January 2026.</p>	HMc	26.03.26
13	POLICY APPROVAL		
	There were no items for review.		

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14	ISSUES FOR ESCALATION TO OTHER COMMITTEES		
	No escalations were raised.		
15.1	COMMITTEE FORWARD PLANNER		
26/42	<p>Received: The updated Forward Planner for review</p> <p>Discussion: If there are any comments on the Forward Planner, please let DJ know.</p> <p>Noted: The Performance Committee noted the Committee Forward Planner.</p>	ALL	
15.2	REVIEW OF MEETING AGENDA & OBJECTIVES		
26/43	No items were raised by the Committee.		
15.3	BAF end of meeting wrap-up		
	No items were raised.		
15.4	Emerging Risks		
	None identified.		
16	ANY OTHER BUSINESS		
26/44	<p>1) CP point on asking for more assurance on BAF to go into a future meeting.</p> <p>2) CC will not be able to attend the next two Performance Committee meetings in March and April. CP confirmed that she can attend these to ensure NED quoracy.</p> <p>3) It was noted that the next committee meeting on 26 March is 'in person' in HLRI.</p> <p>Close: The meeting closed at 1047hrs</p>		
	FUTURE MEETING DATES		

2026	Time	Venue	Divisional Presentation	Apols rec'd
29 January	0900-1100hrs	MS Teams	Schedule tbc	
26 February	0900-1100hrs	MS Teams		
26 March	0900-1100hrs	In person HLRI rooms 88 & 89		
30 April	0900-1100hrs	MS Teams		
28 May	0900-1100hrs	MS Teams		
25 June	0900-1100hrs	MS Teams		
30 July	0900-1100hrs	MS Teams		
27 August	0900-1100hrs	MS Teams		
24 September	0900-1100hrs	MS Teams		
29 October	0900-1100hrs	MS Teams		
26 November	0900-1100hrs	MS Teams		
17 December	0900-1100hrs	In person HLRI rooms 88 & 89		

Royal Papworth Hospital NHS Foundation Trust
Performance Committee Part 1 Meeting held on 26 February 2026

Abbreviations and Acronyms

BAF	Board Assurance Framework
BAU	Business as usual
CCA	Critical Care Area
CDEL	Capital Departmental Expenditure Limit
CIP	Cost Improvement Programme
ERP	Elective Recovery Programme
FIPB	Financial Improvement and Productivity Board
ICB	Integrated Care Board
ICS	Integrated Care System
NED	Non-Executive Director
PIPR	Papworth Integrated Performance Report
PTL	Patient Tracking List
Q&R	Quality & Risk Committee
QIA	Quality Impact Assessment
RPH	Royal Papworth Hospital
RTT	Referral to Treatment
52W	52 week wait