Royal Papworth Hospital
NHS Foundation Trust

Performance Committee
Part 1 meeting
Held on 30 January 2025
0900-1045hrs via MS Teams

[Chair: Gavin Robert, Non-executive Director]

UNCONFIRMED M I N U T E S

Present		
Mr G Robert	GR	Non-executive Director
Ms C Conquest	CC	Non-executive Director
Dr C Paddison	CP	Non-Executive Director
Mrs S Harrison	SH	Chief Finance Officer
Mr H McEnroe	HMc	Chief Operating Officer
Mrs E Midlane	EM	Chief Executive
Ms O Monkhouse	OM	Director of Workforce and Organisational Development
Mr S Rackley	SR	Director of Estates & Facilities
Mrs M Screaton	MS	Chief Nurse
Mr A Raynes	AR	Chief Information Officer
Dr I Smith	IS	Medical Director
Mrs W Walker	WW	Director of Strategic Projects
In Attendance		
Mrs A Colling	AC	Executive Assistant (Minutes)
Mr T Collins	TC	Public Governor, Observer
Ms A Harris	AH	Head of EPRR, Observer
Mr K Mensa-Bonsu	KMB	Associate Director of Corporate Governance
Mr A Nyama	AN	Deputy Chief Finance Officer
In attendance for Item 5: Divisional Presentation		
Mr M Blastland	MB	Non-executive Director
Mrs D Leacock	DL	Non-executive Director
Mrs P Hales	PH	Chief Allied Health Professional
In attendance for Item 9.1 CT Backlog		
Dr B Agrawal	BA	Consultant Radiologist
Mrs H Rodriquez	HR	Operations Manager, Radiology
Mrs J Speed	JS	Director of Operations, STA
Apologies		
Mr B Davidson	BD	Public Governor, Observer
Mr T Glenn	TG	Deputy CEO & Director for Innovation and Strategy

[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**		
25/01	The Chair welcomed all to the meeting and apologies were noted.		

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2	**DECLARATIONS OF INTEREST**		
25/02	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 are appended to these minutes.		
5	**DIVISIONAL PRESENTATION - Allied Health Professionals**		
25/03	Pippa Hales, Chief Allied Health Professional joined the meeting. Allied Health Professionals staff group is the 3rd largest clinical workforce at RPH comprising occupational therapists, dietitians, physiotherapists, speech and language therapists, cardiac rehab, social work/discharge, planning/safeguarding, chaplains, health inequalities, operating department practitioners, radiographers and AHP alternative roles. PH shared the **Professional Support Services (PSS) dashboard** which showed performance in year 24/25 Q3. It covered supporting staff – Overtime, sickness, vacancy, Turnover & IPR. PH noted that absences have a big impact within a small team, and this is a challenge, which is managed by redeployment to enable patient safety. **Trust Leadership event September 2024 follow-up** PSS then held a focus Group to explore: - Purpose and motivation - Psychological safety and raising concerns - Building relationships and belongings - Career development and progression PH shared positive comments from colleagues in how they support patients and each other. **Delivery quality & care** The Committee were appraised of: - Friends and family score - PSS incident reported. Low over the year. **Top risks** 22 open risks PH ran through highest risks and mitigations in place to resolve. She noted the PSS education role funded by RPH Charity which will make a positive impact on the team and patients. I**mproving effectiveness: Cardiac rehab** This is a service for patients following their procedure when they have left the hospital and then the patients come back for cardiac rehab, to improve their cardiac fitness. **Improving productivity** PH explained the impact of PSS work on moving people through the hospital. Early rehab contributes to earlier discharge and recovery. **Optimising the workforce** The slide detailed the % registered and unregistered staff in the team.		

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	It highlighted PSS and physio red flags by type and how these are managed to keep patients safe. **The next 12 months** Challenges: Stabilising and sustaining a fit for purpose workforce and the higher acuity of patients. **Opportunities:** - Education role - Workforce optimisation - Collaboration – work closely with CUH and within region. - Digital: dedicated AHP nurse responsible for Digital innovations. **Discussed:** EM thanked PH for the insight into AHP work. She referred to the contribution that rehab plays to patients going home directly rather than to a different care setting and the benefit of the AHP team generally – could this be measured? Is there any benchmarking to do here (beds day saved, productivity)? PH will look into this. She mentioned the funding to support a better stroke pathway between RPH and CUH in rehab with focus on discharge destination. GR referred to productivity and asked what metrics would you use to measure PSS productivity? How can we measure this? Are there any measures to increase productivity and decrease length of stay? PH suggested this is bespoke to each team within PSS. She will look into this. She noted that "Surgeons add days to people's life, whereas PSS add life to people's days". MB referred to when PH presented the AHP strategy to Q&R which noted ambitions regarding responsibility, influence and leadership. Have these ambitions been achieved? PH feels that these are being achieved, but with the support of others and not in isolation, e.g. with the influence of those in this meeting. PSS Team is keen to get into other divisional meetings and possibly challenge some current structures. The Team appreciates the support of the charity in funding educational and occupational therapy roles. MB referred to the status of the AHP team which sits outside the divisional team structure. What are the advantages of working in this way. PH explained how the flexibility to move AHP staff to different areas is a benefit. It should not matter which area funds the AHP staff but it is important for PSS to be around the table and represented in the divisional conversations. CC today has been concentrated on PSS staff and not the wider aspects of AHP team – is it right to assume that the AHP staff are involved in the same staff surveys and working out what motivates them etc? PH advised that this staff group sits in STA Division; it was noted from staff surveys that other areas have a different work experience than those in PSS and working to develop and support this going forward. GR thanked PH for her presentation and the work that the AHP team does. 0925 PH, DL, MB left.		
0925hrs PH, DL, MB left			

Agenda Item		Action by Whom	Date
3	**MINUTES OF THE PREVIOUS MEETING 19 December 2024**		
25/04	**Approved**: The Performance Committee approved the Part 1 and Part 2 minutes of 19 December 2024 meetings and authorised for signature by the Chair as a true record.	Chair	30.01.25
4.1	**TIME PLAN OF TODAY'S AGENDA ITEMS**		
25/05	The Chair noted the agenda for Part 1 business, which is followed by a 15-minute Confidential Part 2 meeting. Colleagues from the STA Division will be attending to present the CT Backlog Update at Item 9.1.		
4.2	**ACTION CHECKLIST**		
25/06	The Committee reviewed the Action Checklist and updates were noted. EM reflected that several actions had been pushed forward to February. She suggested review by Executives to ensure actions have realistic timeframes when the new action checklist comes out. EM will take away and review with the team.	EM	27.02.25
4.2.1	**EPRR Timeline Update**		
25/07	**Received:** This paper aims to provide the committee with a clear view of timelines for the Emergency Preparedness, Resilience and Response (EPRR) core standards. This is an action requested from the Performance Committee held in November 2024. **Reported:** HMc introduced the paper updating on actions underway, noting that formal accreditation is not possible until the September submission date. One of the challenges refers to physical attendance at Local Health Resilience Meetings, which is now diarised for HMc to attend. HMc is confident of achievement of compliance by September for the EPRR system approval and sign off process. **Discussed:** GR felt this report gave assurance on actions and timelines. CC referred to Domain 9 – do we know the percentage of areas that have not completed the analysis? HMc confirmed this is approx. 48% (was previously 65-70%) – this refers to local ownership of BCPs. We are working to meet the compliance deadline for this. **Noted:** The Performance Committee noted the EPPRR timeline update.		
IN YEAR PERFORMANCE & PROJECTIONS			
6	**REVIEW OF THE BOARD ASSURANCE FRAMEWORK (BAF)**		
25/08	**Received**: A summary of the BAF risks and mitigations in place for risks above target. A copy of the BAF tracker report was attached. BAF 3433: CT backlog. See presentation later at Item 9.1. The update shows there was a decline in the rate of activity. BAF 3536 Cyber Risk - All discussions are noted in the Part 2 minutes.		

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	Discussion: EM on reviewing **BAF risk 678 Waiting List:** controls are in place talk to PSI list which are now limited to STA, but the largest cohort of 18w patients are in respiratory – does the text need to be modified to reflect this? HMc – this is under review with work in hand and will be reflected in further BAF updates. CC asked if the level of assurance is still 'adequate'; she is unsure and feels it could be 'limited'. It is not clear that the actions will achieve what is required. HMc referred to the assurance challenge on BAF risk 678 Waiting List, which is a fair challenge. He will seek support to allow time to review the BAF and risk, outline the plan to bring assurance to Performance Committee and Audit Committee. GR and CC agreed. CP agreed with this response. Do you have resources you need to get the grip and control and if not, please flag to the Board. BAF risk 1021 is rated 20. When discussed at Audit Committee, it did not have assurance that Performance Committee was doing all it could to address these risks. GR – will take this away for review. **Noted:** The Performance Committee noted the review of BAF.	HMc GR	27.02.25 27.02.25
7.1	**FINANCIAL REPORT – Month 09 December 2024/25**		
25/09	**Received:** Financial Report which provided oversight of the Trust's financial position as at Month 09, December 2024/25. **Reported:** SH highlighted: • The position shows a year-to-date as breakeven, which is a change from last and previous months positions, recognising the further provision for redistribution of system funds. • The year-to-date provision at M09 is £2.6m of the total £3.5m of redistribution of system funds. • We are running with a year-to-date underlying surplus. • Agency expenditure: we are seeing some early shoots of improvements. See report on Temporary Staffing at Agenda item 7.1.2. • The SPC run rate charts on bank usage continue to flag increases. This is being picked up on establishment and safer staffing reviews. • The Cash position is healthy. Work on aged debt position will start to show an improving position. • The Capital position is behind plan; the accompanying report includes an update on orders which has seen further improvement since end of M09. She assured that this is being tracked with colleagues and there is good grip and demonstrable progress on orders. • Elective funding for this financial year. SH referred to a change by NHSE on ERF funding for 24/25, where there was the possibility of capping elective funding shared to secondary care providers. Last week the NHSE caps was shared, and we are looking into what this means for RPH. • This does not flag material risk to the RPH position, but this is not consistent locally, regionally, or nationally. SH gave a flavour of the scale of challenge of this in other areas. It is a stark and changing position where we are working with specialist commissioning colleagues on the system position.		

Agenda Item		Action by Whom	Date
	Discussion: CC the issue of reducing the waiting list but then elective is capped. How will this be managed? SH referred to productivity: to create more valuable patient care output with the resources available, along with different models of care, reform and value of work done. CP picked up on productivity – there is some merit to us as a Board on how we create value to the patient population and how this relates to what we invest our resource in. She does not have a clear understanding on what we choose to prioritise. How can we use data to best instruct where we choose to resource. She would like to know how to take this forward. GR suggested that he touch base outside of meeting with SH to look at this information in a strategic way. SH advised that we are having these discussions now with Executives and senior leaders and explained the detail of this. There are 3-4 key areas of focus as part of next year's planning round. This will be part of discussion at Board on the 5-year strategy refresh. HMc added that there is work ongoing looking at the 25/26 operating plan and 5-year strategy and what we can do with the capacity we have. He referred to work in TAVI and how this can be reciprocated in cath labs and theatres. This speaks to a different way of working for some clinical areas. **Noted:** The Performance Committee noted the financial position.		
7.1.2	**Temporary Staffing Update**		
25/10	**Received:** A paper to update the Performance Committee on: • Temporary Staff usage and spend trends • Drivers for temporary staff use and controls to reduce usage • KPIs and key divisional trajectories **Reported:** SH advised that the paper walks through the history and trends of temporary staffing usage, where we can now see progress being made. It talks to the drivers for temporary staffing along with some controls in place already and enhanced controls that we have put in place. It is complex. Further work is needed to embed controls and deliver trajectories. There is work with divisions to refine the trajectories. Review is also ongoing regarding temporary staffing usage in corporate areas. OM noted the trends on usage, which has gone down over the last 12 months, and bank staff has increased, which is the way we want to move. There is a new head of temporary staffing who is working in ward areas. We are encouraging the perspective that this is helping to strengthen their local controls on temporary staff linking into safer staffing. An internal audit is just starting on temporary staffing and controls. This review will be helpful. Usage is not always linked to costs i.e., when using higher cost specialist staff. This also links to timely recruitment for permanent staff. **Discussed:** CC asked how this relates to medical staffing; is the same process used? OM advised that medical temporary system follows a different process.		

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	RPH does not use medical agency; we only use internal small bank/locum. We operate to a rate card and are in the process of moving locum/overtime work to a bank arrangement, to ensure we comply with legislation on annual leave, hours worked and improve sign off (via electronic ePay system). This will give greater line of sight on usage. GR referred to STA agency use which sees a trajectory with no reduction until September 2025 – is this sufficiently ambitious? OM noted it is a large area with complexities. It is managed well regarding the rate. Some vacancies can take a long time to recruit and need to use agency. MS added that theatres have a high agency and we are looking how to manage the work and the skill mix. OM confirmed that the trajectories in the paper represent the position proposed by each division – these will now be scrutinised and challenged as appropriate. GR would like to see this come back to the committee after the work on trajectories has been done. **Noted:** The Performance Committee noted the update on temporary staffing usage**.**	SH/ OM	March or April tbc
7.2	**A BRIDGE TO EXCELLENCE (CIP) REPORT: Month 07 October 2024/25**		
25/11	**Received:** An update report to Month 09 December 2024/25 **Reported:** SH The report was taken as read. SH confirmed that work is ongoing on the 2025/26 CIP plan. **Discussed:** As per discussion under Financial Report. **Noted:** The Performance Committee noted the update on CIP M09 2024/25.		
7.3	**INVESTMENT GROUP – Chair's Report**		
25/12	**Received:** Chair's update summarising the meeting held on 13 January 2025 **Reported:** SH **Discussed:** GR queried: 1) the potential postponement of work regarding resident doctors' mess, particularly as previous discussions highlighted the importance of this. EM added an update under Teams chat, summarised as: the ongoing work, with input from resident doctors, has now produced a clear plan which is with Skanska for costing. Once the costing is received it will be put forward to Investment Group for consideration. 2) The link between the proposed new role of Corporate Governance Manager and the existing Associate Director of Corporate Governance. OM added that the proposed role for Corporate Governance Manager was clear and discussed by Investment Group. It was approved for an 18 month fixed pilot period to allow time to strengthen corporate governance where gaps have been identified. OM offered to discuss further with GR outside of		

Agenda Item		Action by Whom	Date
	the meeting should this be helpful. **Noted:** The Performance Committee noted the update from the Investment Group.		
8	**PAPWORTH INTEGRATED PERFORMANCE REPORT (PIPR)**		
25/13	**Received**: PIPR for M09 December 2024. **Reported:** SH The position is reflected through the domains: • showing the impact of staff being on leave and staff sickness over the Christmas period. • impact of additional non-elective work, namely ECMO and high dependency patients in CCA. Summary of the position was 'Red', which comprised: • Four 'red' domains: Safe, Effective, Responsive, People Management & Culture. • One 'amber' domain: Finance. • One 'green' domain: Caring. **Discussion:** each sector as noted below.		
25/14	**Safe (Red)** MS No items were raised. This will be reviewed at Quality & Risk Committee.		
25/15	**Caring (Green):** MS This will be reviewed at Quality & Risk Committee. CP referred to Complaints and consent to share information with relatives. What is best practice on this and how do we get there? MS will pick this up outside of meeting with CP.		
25/16 *1014hrs BA arrived*	**Effective (Red)** HMc Ran through the slides, giving further detail on highlighted areas. Challenges on utilisation and bed occupancy driven by non-admitted activity/emergencies/ staffing; these affected ERU bed balance. Cath lab work: looking at full cath lab utilisation programme to look at productivity and reduce the TAVI backlog. Dec utilisation was 85% and there are opportunities to improve this. Theatres utilisation reflects significant increase in ECMO and transplant. PIPR includes a spotlight on TAVI where the position is much clearer on the TAVI profile and utilisation of labs. HMc will update the committee in February on the strategic utilisation of cath lab and effective ways to clear backlog. *1016hrs: the meeting moved to Item 9.1 CT Backlog.* *1039hrs: the meeting returned back to PIPR Effective.* CC referred to the SPC for ERU activity, is this a true reflection, as it seems to be consistently missing the target. SH noted that we do not yet have 12 months of data. She explained how		

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	SPC work on control limits and how this works. Looking at using slightly different version next year to tighten control limits.		
25/17	**Responsive (Red):** HMc CP referred to 62 day cancer wait data. What does this mean for patient outcomes. In June 2024 the target was reached: what were we doing differently that we can do now? HMc since June 2024 there has been a limit in access to diagnostic pathways at CUH which is a contributory factor; there is a plan for capacity to move to Northampton which should improve this. Regarding impact to patient outcomes, HMc offered to review outside of the meeting and pick up with CP outside of the Committee. GR asked what the position on PSIs is and is the programme now extended at premium rates to reduce the waiting list. HMc advised that the PSI programme is in place for TAVI and longest waiters. Waiters in STA and cardiology are coming down but thoracic and ambulatory care is not reducing. He will share more next month.		
25/18	**People Management & Culture (Red):** OM No items were raised.		
25/19	**Finance (Amber): SH** This was covered under Item 7. Financial Report.		
	Noted: The Performance Committee noted the PIPR update for M09 December 2024/25.		
9	**OPERATIONAL REPORTS**		
9.1	**CT BACKLOG**		
25/20 1016hrs *JS, HR arrived*	**Received:** The purpose of this paper is to update on the current challenges within the Radiology Department that are impacting on our ability to manage the workload and report on scans undertaken within the expected timeframes and may lead to a negative impact on the service we can provide to the organisation as well as the quality of the service that we provide to patients. For information and background purposes, included in the Reference Pack are two reports, the November paper that was presented to the weekly Executive Directors' meeting on 5 November 2024, the additional paper is the updated paper for Performance Committee on 30 January 2025. **Reported:** HMc, Bobby Agrawal, Jane Speed, Helen Rodriquez. HMc gave a brief background to challenges and reporting time delays. The current insourcing resource provider comes to an end soon; this is being re-evaluated along with mitigations to manage safety during this time . **Discussed:** BA presented slides detailing the current position and summarised: Diagnostic imaging background: • Increase in demand in CT not matched by increase in staff. • Recruitment and rostering challenges and solutions. • Difficulty in recruiting and retention of radiologists. • Challenge with increase in waiting list • Lost PACS Manager which is now being recruited to.		

Agenda Item		Action by Whom	Date
	Digital challenges and solutions: • Change to PACS system • Ability to work from home not matched expectations. Pinpointed to RPH digital issue which is being addressed by RPH. Activity and service challenges: • Report turnaround for CT has fallen short of national mandated four week reporting time. Leadership and culture and solutions: • A number of cultural issues in the department which are being positively addressed. • All staff are working at peak output to deal with backlog and address cultural issues. CT backlog update: • Using the insource company 'LC' for 5 months which has brought the backlog down. Any loss of LC services will have an impact. • We are looking at a digitally outsource package. This will provide a method for dealing with the backlog and ongoing management of delay in reporting during the recruitment period. • There are only two TAVI reporters which gives reduced capacity to report. Digitally connected outsource solution: • This will move imaging outside of the Trust for reporting by vetted radiologists, which is done by many other trusts. • Reporting demand now outstrips capacity, and we need to look at other solutions. Conclusion: • There has been improvement over the past few months. • Challenges and solutions defined and documented. • Ongoing commitment to enhanced culture and behaviours. • Acknowledged that this backlog Dept is under stress. • Grateful for digital support with technology. • Procurement and HR support is also needed to aid recruitment and retention. <u>Discussed</u> EM it is helpful for the Committee to understand the ongoing risk of using LC. It was noted that we have used LC for a fixed period of time and are now looking to extend to bridge gap. The contract has not delivered as expected. BA acknowledged that LC have delivered a significant amount of reporting. Without this help the backlog would have increased. To mitigate this, a new Consultant has started this week and one Consultant is due back from long term leave in March; all this will help bridge the gap. GR was not clear as to why digital outsourcing will resolve issues? IS explained the difference between insourcing and outsourcing. *Insourcing* involves a company (in this case, LC) working within RPH and using RPH systems to provide additional reporting capacity. Digital *outsourcing* involves making the images available outside RPH, allowing consultants		

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	anywhere to provide the reports. This would enable RPH to take advantage of a much larger pool of external capacity, meaning that it is not dependent on any one company, enabling RPH to use the resources of multiple companies/consultants. HMc explained that this is the is the medium-term model. There are some digital requirements to get there along with the need to agree a model and tender process. There is a gap before we will be able to take advantage of digital outsourcing which LC will continue to fill in the short term – this will be reviewed with Executives on how to manage and mitigate. BA added that the new Consultant Radiologist will add to reporting capacity along with the leaver coming back in March. The digital outsource is scheduled nearer to the summer. AR added that the digital enhancing work for the outsource is critical as imaging needs a large increase in data capacity. He explained how the digital team is working with radiology to support efficiency and cyber safety. HR supported all discussed so far. Operationally the position is better than we were. She added that the Consultants coming in are within the current vacancy rate and not extra but filling vacancy gaps. EM noted that this is an area where the team have worked hard and made inroads but is still an area of significant concern for Executives. The work to recover is recognised but this gives only partial assurance currently. GR agreed with EM. It is good to see the plan which seems more sustainable and not relying on one contractor. He acknowledged that other Trusts do use this type of outsourcing. GR thanked the division for all efforts to date and for attending to provide the update. **Noted:** The Performance Committee noted the update.		
1039hrs BA. HR, JS left			
FUTURE PLANNING			
10	**QUARTERLY REPORTS**		
25/21	**10.1 Corporate Risk Register**		
	Received: Quarterly update to provide the Committee with an overview of those risks graded 12 and above that are included on Corporate Risk Register (CRR). **Noted:** The report was noted and taken as read with no items raised.		
11	**POLICY APPROVAL** DN171 Innovation & Intellectual Property		
25/22	**Received:** The Performance Committee approved a detailed review of this policy in August 2024. Following further review, there are some minor amendments to the IP Policy which have been captured as tracked changes. **Approved:** The Performance Committed noted and approved the revisions to the policy.		

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12	**ANNUAL REPORTS**		
12.1	Annual Operational Plan 2025/26		
25/23	**Received:** A paper to provide the committee with key updates and draft financial position of the 2025/26 planning cycle, whilst national planning guidance is awaited. **Reported:** SH National planning guidance has not yet been received and is expected today. The Trust will work with divisional teams and there will be a change in narrative and way of thinking on cost pressures and service developments, due to cost pressures. This will mean operating in a framework with less funding and focus on productivity, where it will not be possible to focus on all work. This will need prioritisation on Trust's wide service portfolio and will involve difficult discussions. **Discussed:** GR noted that it seems we have to make unusually strategic choices this year given that context. He would like Executives to consider how to bring these strategic choices to the Board. He suggested EM chat with Trust chairman to plan this into agendas and meetings, for Board to have early sight to discuss strategic choices to support the operational plan. EM is happy to have this discussion. SH added that discussions will be clear and transparent to the Board Key considerations for RPH: • Elective funding risk • Negotiations with Commissioners to conclude • EPR risk • Development of CIPs and productivity plans Noted: The Performance Committee noted the update on the annual operation plan.2025/26	EM	27.02.25
12.2	**Committee Self-Assessment**		
25/24	**Summary received:** 12 Committee members and attendees were asked to provide a rating between 1 to 5 for each question (1 = strongly disagree, 5 = strongly agree) to each of self-assessment's 18 questions. 9 out of the 12 provided responses (as well as comments) and the combined version of these responses is attached as Appendix 1. **Reported:** KMB **Discussed:** GR referred to comments, where papers do not always reflect the verbal updates given at Committee meetings. This was noted and improvements will be made where possible.		

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	CC queried the response on the question regarding committee overall assessment where some could not give a scoring. Could the wording of this question be reviewed? This issue had also been raised on the Audit Committee self-assessment. KMB advised that he has changed the style of this question for Board and Committee self-assessments for next year. **Approved:** The Performance Committee noted and approved the Committee Self-Assessment.		
13	**ISSUES FOR ESCALATION TO OTHER COMMITTEES**		
13.1 25/25	**Internal Audit Report – Key Financial Systems: CIP** **Noted** and received for information only.		
14.1	**COMMITTEE FORWARD PLANNER**		
25/26	**Received**: The updated Forward Planner. **Reported:** KMB **Discussion:** The planner was taken as read. **Noted:** The Performance Committee noted the Committee Forward Planner.		
14.2	**REVIEW OF MEETING AGENDA & OBJECTIVES**		
25/27	All items were covered as planned with good time for discussion.		
14.3	**BAF end of meeting wrap-up**		
25/28	No items were raised.		
14.4	**Emerging Risks**		
25/29	None raised.		
15	**ANY OTHER BUSINESS**		
25/30	No items were raised. IS and OM sent apologies to the Part 2 meeting to follow. The meeting finished at 1016hrs.		
	FUTURE MEETING DATES		

2024/25	Time	Venue	Divisional Presentation	Apols rec'd
30 January 2025	0900-1100hrs	MS Teams	**AHPs**	
February	0900-1100hrs	MS Teams		
27 March	0900-1100hrs	MS Teams	**PHARMACY**	
25 April	0900-1100hrs	MS Teams		
29 May	0900-1100hrs	MS Teams	**RADIOLOGY**	
June	0900-1100hrs	MS Teams		
July	0900-1100hrs	MS Teams	**CCA**	
August	0900-1100hrs	MS Teams		
September	0900-1100hrs	Face to Face / HLRI	**THORACIC**	
October	0900-1100hrs	MS Teams		
November	0900-1100hrs	MS Teams	**CANCER**	
December	0900-1100hrs	MS Teams		

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Signed
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Abbreviations and Acronyms

ACS	Acute Coronary Syndrome
ATIR	Authority to Invest Request
BAF	Board Assurance Framework
CCA	Critical Care Area
CIP	Cost Improvement Programme
CUH	Cambridge University Hospitals NHS
ICB	Integrated Care Board
ICS	Integrated Care System
IHU	In-House Urgent
LoS	Length of Stay
NED	Non-executive Director
PIPR	Papworth Integrated Performance Report
Q&R	Quality & Risk Committee
RPH	Royal Papworth Hospital
RSSC	Respiratory Support and Sleep Centre
RTT	Referral to Treatment
STA	Surgery, Transplant, Anaesthetics Division
TAVI	Transcatheter Aortic Valve Implantation
52WW	52 week wait